A CBT Approach to Mental Health Problems in Psychosis

Emma Williams

ROUTLEDGE

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Dr Emma Williams is a Consultant Clinical Psychologist. She has worked with people with psychosis for over 20 years. Her interests are in the promotion of understanding, and development of treatments with an ethical foundation, in order to improve the acceptability and efficacy of NHS provision for people with psychosis. She has lectured both nationally and internationally and taught on Clinical Psychology training courses in England and Scotland. She has published widely including two previous books with Speechmark, *Anger Control Training* with Rebecca Barlow (1998) and *Interventions for Schizophrenia* (2004). She lives and works in Oxfordshire.

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For Loris: My love goes with you
as your love stays with me.

Introduction

This book goes beyond the traditional treatment focus of cognitive behavioural therapy (CBT) for psychosis, that of positive psychotic symptoms, to address a range of co-occurring mental health problems experienced by people with psychosis. As such it is the only handbook which focuses solely on the assessment and treatment of emotional and mood disorders in people with a diagnosis of psychosis. In addition the central role of stress in the exacerbation of symptoms and the important, but often overlooked, problems associated with negative symptoms are addressed.

The idea for this handbook emerged from many years of working with people with a diagnosis of psychosis who described long-standing problems with social anxiety, depression, obsessive-compulsive symptoms, post-traumatic stress disorder (PTSD) and mood disturbance. These concerns frequently remained untreated despite regular, and often long-term, contact with mental health services. Faced with the overt symptoms of hearing voices or delusional beliefs, many mental health professionals, myself included, tended to focus upon these psychotic phenomena, often to the exclusion of other, equally troubling, presentations.

Mental health problems such as anxiety-related disorders are often left undiagnosed and untreated in people with psychosis at levels which would trigger intervention in those presenting solely with that condition.

While CBT became a widely practised and successful treatment for a variety of common mental health conditions; primarily depression and anxiety-related disorders, it took several decades before CBT was first advocated in the treatment of psychosis. Since the 1990s many researchers and clinicians have focused on understanding the origin, development and maintenance of positive psychotic symptoms and how best to treat these particular phenomena. CBT for psychosis drew on the principles and interventions developed for anxiety and depression and modified these to treat psychotic symptoms. CBT for schizophrenia is now widely accepted as an effective treatment in the reduction of psychotic symptoms. Indeed, a review of findings led the National Institute for Health and Clinical Excellence to recommend 'offer[ing] CBT to all people with schizophrenia. This can be started either during the acute phase or later including in in-patient settings' (NICE, 2010). There are now many excellent treatment manuals available which focus on the assessment and treatment of psychotic symptoms (Kingdon & Turkington, 2004; Fowler *et al*, 1995; Chadwick *et al*, 1996; Beck *et al*, 2009).

Interestingly, however, despite its roots in the treatment of emotional disorders and the success of CBT for schizophrenia, the treatment of co-occurring emotional disorders in people with psychosis has been largely ignored. This is slowly changing and this book hopes to provide a guide for clinicians treating clients with psychosis who also present with common mental health conditions. There is a growing realisation that services need to adopt an individual and holistic approach to the treatment of psychosis, not merely focus on positive symptoms. Instrumental in this change has been the recovery movement; a growing body of service users who advocate self-help, empowerment and the right to be treated as everyone else.

Psychosis is common; about one person in a hundred is likely to receive a diagnosis of schizophrenia in their lifetime and the same prevalence is found in bipolar disorder (BPS, 2000). Emotional disorders are even more common, eg with lifetime prevalence rates tending to vary between 2 and 3 per cent for obsessional compulsive disorder (OCD), 8 per cent for PTSD and 13 per cent for social anxiety disorder. Moreover, in those with psychosis, the presence of a co-occurring emotional disorder is significantly higher, eg a typical prevalence rate for OCD of 15.8 per cent found in a sample of 76 people with schizophrenia is seven times higher than chance (Kruger *et al*, 2000). Given these increased rates and the consequences of co-occurring emotional disorders for people with psychosis, development of treatment tailored to these problems is essential.

Similarly, as so succinctly described by Dyck *et al* (2000), negative symptoms are not the 'squeaky wheel' of schizophrenia and as such have not attracted as much investment in the development of psychological assessment and treatment as have positive symptoms. Although they have been implicated in a number of vital factors such as poor long-term prognosis, lower subjective quality of life and relapse, people with high levels of negative symptoms tend to receive the same input as those with few or no negative symptoms (Dyck *et al*, 2000). Although negative symptoms were often believed to be intractable and CBT for negative symptoms is a relatively recent development, a number of notable treatment successes have been established (eg Rector *et al*, 2003).

A distinction is often drawn between affective psychoses which involve clear mood components, for example schizoaffective disorder, and the non-affective psychoses, such as schizophrenia and delusional disorder, which are seen as unrelated to mood disturbance. However, problems of elevated and low mood also arise in people with schizophrenia and delusional disorders. Mood disorders are often subsumed by a diagnosis of psychosis rather than seen as separate co-morbid disorders. In people diagnosed with schizophrenia in particular, mood variation can often be overlooked if it is not the primary presenting problem. However, recent advances in CBT for bipolar disorder are now finding their way into the treatment of people with a range of psychotic presentations.

This book draws together advances in the understanding, assessment and treatment of stress, negative symptoms, social anxiety, OCD, PTSD and mood disturbance in people with a diagnosis of psychosis, to provide a practical guide for clinicians.

Chapter outlines

Chapter 1 focuses on the critical importance of stress in psychosis. Stress exerts a major influence on the development and maintenance of symptoms. The vulnerability-stress model (sometimes called the diathesis-stress model) (Zubin and Spring, 1977) of schizophrenia is central to the understanding of the range of factors implicated in the onset and maintenance of psychosis. Acute or prolonged stress causes activation of somatic and cognitive vulnerabilities to psychosis and, for example, can increase the salience of distorted thoughts. This chapter outlines the role of stress in psychosis, describes the assessment of stress and provides a working model of stress and psychosis. Interventions are described in detail including measures to minimise the stress of therapy and ways of responding positively to stress. Cognitive and behavioural techniques are detailed for the successful management of stress, as are methods for building resilience and interpersonal effectiveness.

Chapter 2 addresses the very significant and often overlooked group of difficulties known as negative symptoms; the emotional, motivational and behavioural deficits common in psychosis. This chapter describes the variety of negative symptoms and their importance; it details the assessment of negative symptoms and how to differentiate them from symptoms with similar presentations such as depression. A cognitive model of negative symptoms is presented and a guide to formulation is explained and illustrated by case example. Treatment of negative symptoms is described in detail with reference to a proposed treatment path from convalescence through active cognitive-behavioural treatment to lifestyle changes. Client information sheets on understanding negative symptoms and overcoming negative symptoms are provided.

Chapters 3, 4 and 5 address the most common anxiety-related disorders in psychosis: social anxiety disorder, obsessional compulsive disorder and post-traumatic stress disorder. Birchwood (2003) argued that because such disorders are so prevalent in psychosis they should be understood by their core pathway rather than merely in terms of diagnosis. He suggested three core, but not mutually exclusive, pathways: emotional disorder intrinsic to psychosis, emotional disorder as a psychological reaction to psychosis and emotional disorder and psychosis as the product of disturbed developmental pathways. These pathways are explored for each of the disorders with the intention of understanding the aetiology and maintenance of anxiety in psychosis in order to inform formulation and treatment.

Each of the three chapters examines the significance of the particular anxiety disorder for people with psychosis, describes assessment issues and tools and provides a CBT working model by which to understand the condition. A guide to formulation of each disorder in people with psychosis is presented together with case examples to illustrate formulation in action. Detailed cognitive and behavioural treatment interventions are described with particular emphasis on modifications, challenges and contra-indications for this client group. Client handouts explaining the disorders and their treatment are provided at the end of each chapter.

The final chapter focuses on mood disturbance in psychosis. Types of mood disorder are described and the significance of mood fluctuation in psychosis discussed. Assessment of mood disturbance is outlined with a number of different approaches explained. A working model based on the vulnerability-stress model modified for bipolar disorder is presented and formulation is described with reference to an illustrative case example. A treatment plan for clients with mood disturbance is described including strategies for enhancing motivation to change in those whose elevated moods are problematic but not necessarily distressing. Specific measures to stabilise sleep and behavioural patterns are described together with identification of prodromal signs and how to respond positively. Client handouts for understanding mood disturbance are provided.

How to use this book

It is hoped that this handbook will be valuable to clinicians who are familiar with CBT for psychotic symptoms but who want to help their clients to actively manage stress, negative symptoms, emotional and mood disorders.

It is recommended that clients with psychosis be routinely assessed in regard to stress and coping, and their experience of negative symptoms. They should also be screened for any difficulties with social anxiety, OCD, past traumas and mood fluctuations.

This is a practice guide which provides an understanding of each of the areas of difficulty, together with assessment tools, and a working model. Case conceptualisation is assisted by a guide to formulation and it is suggested that the models and case examples be used to assist individual formulation. The treatment sections detail specific interventions and suggested treatment pathways. Treatment is, of course, a collaborative venture and each step – from assessment through to formulation and treatment planning – should be made with the client. Education about the approach is provided in client information sheets which are intended to introduce the treatment approach. These are designed to be used as a handout to aid discussion and to encourage clients to ask questions and be active in developing their own treatment plans.

1 Stress and psychosis

Stress appears to have both a general and a specific effect on people with psychosis. In general, stress has a clear impact on both physical health and psychological well-being. It is implicated in the exacerbation of many medical conditions and diseases including coronary heart disease, stroke, stomach ulcers and heart attack (Powell and Enright, 1990). In addition, stress is commonly implicated in the development and maintenance of many psychological disorders including anxiety, depression, obsessive-compulsive disorder and phobia. Stress plays a specific critical role in psychosis, indeed Zubin and Spring's (1977) seminal 'vulnerability-stress model' of schizophrenia continues to inform research and clinical practice today. The model proposes that certain characteristics such as limited attentional capacity and hyper-autonomic arousal serve as vulnerability factors and that environmental and personal stressors can precipitate psychotic episodes in vulnerable individuals (Nuechterlein and Dawson, 1984). Individuals who have poor coping skills or inadequate coping resources might have an underlying vulnerability to the development of psychosis (Norman and Malla 1993). A comparison of people at very high risk of developing psychosis with a control group found that they were significantly more distressed by events, felt that they coped more poorly and used more emotion-oriented coping strategies than did the comparison group (Phillips *et al*, 2012). The authors suggest that preventative interventions should include treatment focusing on stress management and enhancing coping skills.

Assessment of stress

Stress can be measured and monitored in a number of ways. A formal measure of emotional distress can be helpful in gauging a client's current emotional state. A range of measures to assess stress, stressors and coping is available:

- *The Depression Anxiety Stress Scales* (DASS) (Lovibond and Lovibond, 1995) are a set of three self-report scales designed to measure the negative emotional states of depression, anxiety and stress. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal,

and being easily upset or agitated, irritable or over-reactive and impatient. Clients use four-point severity-and-frequency scales to rate the extent to which they have experienced each state over the past week. The DASS is presented in the Appendix (*see* p. 146).

- *The Lifestyle Appraisal Questionnaire* (LAQ) (Craig *et al*, 1996) provides a comprehensive assessment of health and stress. It is an instrument designed to assess lifestyle from a multi-factorial perspective. It assesses cumulative risks and perceived stress of life. The questionnaire provides a sensitive measure of change with treated clients reporting a reduction in their cognitive appraisal of life stress (Craig *et al*, 1996).
- *Hassles scale* (Kanner *et al*, 1981) measures minor distressing events. This can be particularly useful as day-to-day stressors often have more impact than infrequent major life events (Malla and Norman, 1992). One hundred and seventeen potential irritants in the areas of work, health, family, friends, the environment, practical considerations and chance occurrences are listed. The client rates by severity (1–3) any item that occurred in the past month. The scale can be administered as a one-off measure of current hassles or completed over consecutive months to monitor stressors over time. Derived scores include frequency (number of items checked), cumulative severity (sum of the three-point rating scale) and intensity (cumulative severity divided by frequency), thus providing an index of how strongly or intensely the average hassle was experienced, regardless of the number of hassles checked.
- *Perceived Stress Scale* (Cohen *et al*, 1983) is a 14-item measure of the degree to which situations in one's life are appraised as stressful. It is designed to examine the role of non-specific appraised stress in the aetiology of disease and behavioural disorders and as an outcome measure of experienced levels of stress. General stress and perceived coping are measured.

Once a client has become proficient at recognising their stress levels, daily monitoring using a simple analogue scale can be helpful. Technical measurement is also possible; stress in 'real-world' daily functioning has been measured by experience sampling using palm computers to assess stress at various intervals during the day (Kimhy *et al*, 2010).

Working model of stress and psychosis

A working model of the role of stress in psychosis is presented in Figure 1.1. The model is informed by the vulnerability-stress model of schizophrenia (Zubin and Spring, 1977) together with models of stress in the general population proposed by Cooper (1981) its adaptation (Powell and Enright, 1990) and the work of Lazarus (1971) on stress and disease. Lazarus identifies three important components which

are incorporated into the model of stress: 1) the notion of demands taxing a system, 2) the appraisal or perception of threat, and 3) the importance of the response of that system.

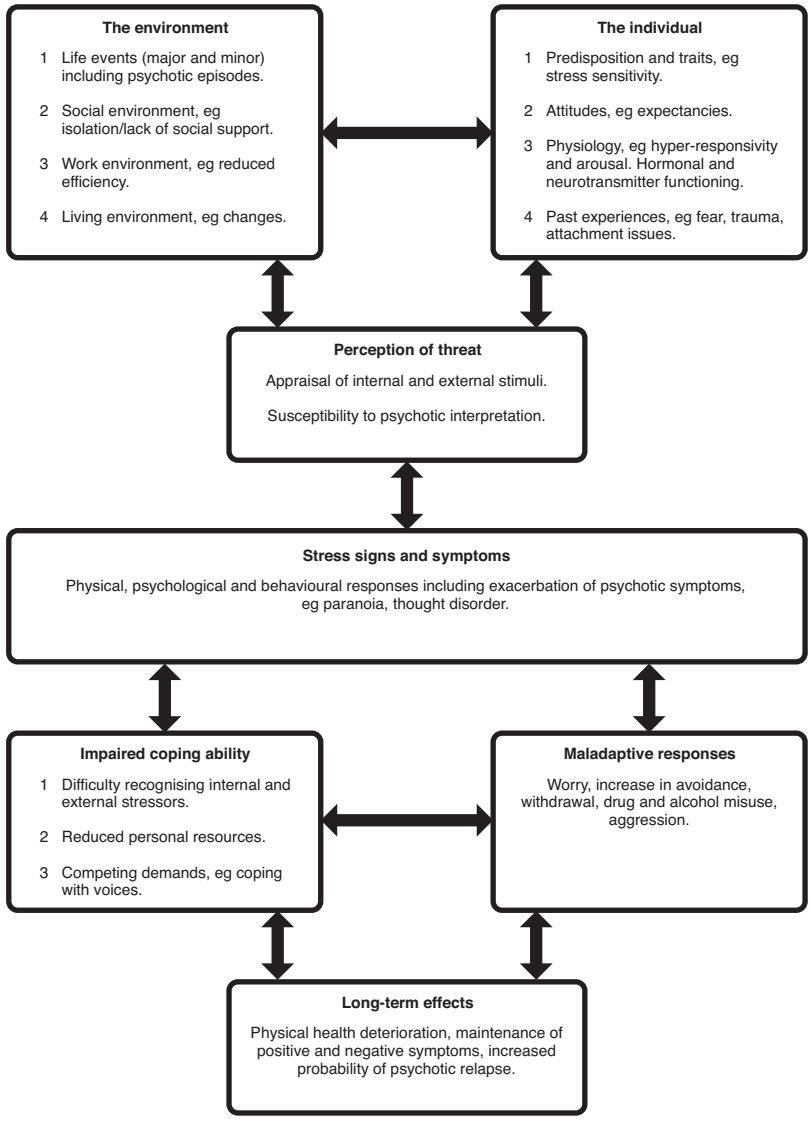

FIGURE 1.1 Working model of stress and psychosis

The environment

1) Life events

Life events which involve change – even positive change such as going on holiday or getting married – have been found to have significant effects on a person's

susceptibility to stress-related health problems (Holmes and Rahe, 1967). An accumulation of life events is often found in the period leading up to a psychotic episode. It appears that people with psychosis have a lower threshold for experiencing stress; indeed the course of psychosis seems to be less influenced by relatively rare major life events and more by the build-up of more common minor life events (Malla and Norman, 1992).

In addition, the development of a psychotic illness is itself a very significant life event and commonly leads to other profound changes in relationships, living environment, work, education, financial situation, recreation and personal achievement.

2) Social environment

Social contact is important: it enables people to have fun; can provide alternative perspectives, distraction, opportunity to talk about difficulties and to receive information and help, and can reduce rumination and introspection. People with mental illness often have minimal social contact due to reduced social abilities, fear of social situations, stigma and discrimination or simply due to being unable to attend work or other social settings because of psychotic symptoms. Social isolation reduces a person's opportunities to express their feelings and to gain support from others. This not only increases stress but can also provide fertile ground for the development of paranoid or suspicious beliefs because opportunity to receive feedback from others, which can help to reduce the expansion of inaccurate appraisals, is limited.

3) Work environment

People commonly show deterioration in work performance in the period prior to developing acute psychotic symptoms. This frequently leads to increased stress due to attempts to work harder or longer hours to make up for lost efficiency. In the prodromal phase a person is likely to struggle with tasks which were previously manageable, find difficulty relating to colleagues, and fear being reprimanded or made redundant. The effect of stress is to further reduce performance and a vicious cycle of deterioration and increased stress can ensue.

4) Living environment

Psychosis often develops in early adulthood when people are becoming independent and moving out of the family home, sometimes to a different geographical location and usually coinciding with changes in social environment, employment or education. The experience of psychosis itself commonly results in changes in living environment such as moving back in with family, living in shared accommodation or hospitalisation. This brings with it increased stress due to loss of independence, noise, lack of privacy and the demands of other people. Alternatively, social isolation and having to fend for oneself can result in significant stress.

The individual

1) Predisposition and traits

There are a number of personality characteristics commonly found in children who go on to develop schizophrenia: they tend to be more introverted and withdrawn and prefer to spend time on their own rather than with others (Ellison *et al*, 1998). Traits such as a tendency to suspiciousness or making external attributions might also be considered both to predispose to psychosis and to create stress.

2) Attitudes

There appear to be some people who are 'stress resistant': they experience significant stress but seem to be unaffected by it. In a study of such individuals three factors were found to be important in maintaining this resilience to stress: a sense of control over situations and events, having a sense of purpose and commitment, and an ability to be flexible and to deal with ambiguity (Kobasa, 1982). People with psychosis frequently lack a sense of control in their lives, they can feel at the mercy of their symptoms and indeed often delusional beliefs develop around the feeling of literally being controlled by others. Avolition and lack of motivation are common negative symptoms which can manifest as lacking a sense of purpose. People with psychosis often struggle with ambiguity and tend to be concrete rather than flexible. Similarly, many have defeatist attitudes, are sensitive to perceived criticism and have low expectancies for pleasure or success (Beck *et al*, 2009). Thus, people with a predisposition to psychosis might be said to be stress-prone rather than stress-resistant.

3) Physiology

Genetic variability creates individual differences in physiological arousal in the general population. The autonomic nervous system which controls the body's response to stress appears to be more reactive in people who develop schizophrenia. Electrodermal over-activity can lead to hyper-responsivity and such individuals become more easily aroused to stressors (Zubin and Spring, 1977). Overactive dopamine systems together with other biological components might be important in the development of schizophrenia. It has been proposed that normal life stressors might cause exacerbations of hormonal (eg cortisol) activity and neurotransmitter responses, particularly dopamine. Positive symptoms might result from the increase in dopamine activity, whereas negative symptoms might be considered as adaptive responses to stress (Walker and Diforio, 1997).

4) Past experiences

Many people who go on to develop psychosis have experienced childhood trauma such as physical, sexual, emotional abuse and/or neglect (Read *et al*, 2005). Commonly they will have been raised in a family where one or both parents had

mental health problems, and/or drug and alcohol abuse. Attachment problems are also a common feature in the histories of people with psychosis. These factors play a major role in later mental health and the ability to cope with stress.

Perception of threat

What one finds threatening and the degree of the perceived threat are dependent upon past experiences, knowledge, attitudes and beliefs. People who develop psychosis often experience common stimuli as potentially threatening, eg strangers. There is also a tendency to misinterpret neutral stimuli, eg an unintentional glance could be interpreted as having malevolent intent. Such individuals can become hyper-vigilant and sensitive to cues in the environment which might signal threat. Aberrant salience – the tendency to find significant meanings where there are none – is a common experience in people with psychosis, eg a person wearing a red coat might be interpreted as indicating a warning. Perceived threat is therefore very common in people with psychosis, and this is pivotal to the experience of stress.

The two-way arrows in Figure 1.1 indicate that the signs and symptoms of stress can themselves be misinterpreted and increase perceived threat. Misinterpretation of bodily sensations such as chest pains, palpitations or nausea can feed into delusional beliefs, eg of being poisoned or persecuted. People with psychosis commonly make external attributions of internal events (Beck *et al*, 2009).

Stress signs and symptoms

There are many physical, psychological and behavioural signs and symptoms of stress, including: palpitations, nausea, restlessness, inability to concentrate, irritability and insomnia.

If individuals misinterpret such signs as emanating from an external source, this can lead to distress and also to a strengthening of potentially delusional explanations such as delusions of control, paranoia or persecution, eg 'There is a devil inside me', 'I am being tormented'.

Difficulty concentrating, making decisions, forgetfulness and irrational ideas are all common psychological stress reactions found in the general population. In individuals with psychosis, positive and negative symptoms are likely to compound such stress symptoms.

Behavioural reactions to stress such as avoidance of anxiety-provoking situations and social withdrawal are also common reactions to stress and again can exacerbate such tendencies in people with psychosis.

Formal thought disorder can be viewed as part of a stress response to negative automatic thoughts elicited by various events. It has been suggested that the process is similar to that of stuttering, in that stressful situations exacerbate both types of symptoms and the phenomena can occur in anyone under certain traumatic

conditions (Beck *et al*, 2009). Thought disorder tends to worsen in conditions of increased stress such as discussion of emotionally salient topics (Docherty *et al*, 2003).

The common signs and symptoms of stress are shown in client information sheet 1.1.

Impaired coping ability

Resilience to stress depends on the individual's ability to successfully cope with stressors. However, three factors commonly impair coping ability.

1) Difficulty accurately recognising internal and external stressors

Mood disturbance, preoccupation with delusional beliefs, distraction by voices and loss of volition all contribute to reducing the ability to make accurate judgements about matters such as the source and effects of stress. In addition, the tendency to make external attributions for internal events exacerbates distress.

2) Reduced personal resources to deal with stress

Often a person's resources are limited by the effects of negative symptoms, depressed mood or other consequences of psychotic symptoms. Commonly a person directs their energy to coping with the demands of positive symptoms such as voices and does not have resources to deal with additional stressors when they arise.

3) Imbalance between competing demands and personal resources

People with psychosis are often struggling with the demands of the illness – including taking anti-psychotic medication, attending medical appointments and struggling to cope with the psychosis itself.

Maladaptive responses

As with the general population, people with psychosis often develop maladaptive responses in an attempt to cope with stress. Typical responses include excessive worrying, avoidance, social withdrawal, drug and alcohol misuse and aggression.

Long-term effects

Over time, maladaptive coping strategies can become problematic, eg drug and alcohol dependence, development of anxiety disorder and other 'co-morbid' conditions. Long-term stress also has physical repercussions such as high blood pressure, heart disease and other stress-related illnesses. Residual psychotic symptoms can be maintained or exacerbated and indeed there is an increased risk of psychotic relapse in those experiencing high levels of stress (Nuechterlein and Dawson, 1984).