PERSON-BASED COGNITIVE THERAPY FOR DISTRESSING PSYCHOSIS

Paul Chadwick
Royal South Hants Hospital, Southampton and University of Southampton

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To mum and dad

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ABOUT THE AUTHOR

Professor Paul Chadwick, PhD, is Head of Clinical Psychology at the Royal South Hants Hospital, and Professor of Clinical Psychology at the University of Southampton. He has an international reputation for his ground-breaking, applied research over the past 20 years on cognitive therapy for psychosis and is lead author on an influential book written with M.J. Birchwood and P. Trower – *Cognitive Therapy for Delusions, Voices and Paranoia*, also published by John Wiley and Sons.

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All client names are pseudonyms – indeed, certain details are changed to further protect anonymity – and all client-related materials (therapist and client formulation letters, client writing about therapy and therapy transcripts) are used with permission.

Chapter 1

PERSON-BASED COGNITIVE THERAPY (PBCT) FOR PSYCHOSIS

COGNITIVE THERAPY FOR DELUSIONS, VOICES AND PARANOIA

The mid-1980s to the mid-1990s was an inspiring and exciting decade to be working with people with psychosis. Leading psychologists in the United Kingdom such as Richard Bentall, Philippa Garety and Mary Boyle were beginning to subject psychosis to conceptual and experimental scrutiny, and there was a feeling of change – even revolution – in the air. In 1996 we summarised our own contribution over this decade in a book called *Cognitive Therapy for Delusions, Voices and Paranoia* (Chadwick, Birchwood & Trower, 1996). In that book we presented a cognitive therapy (CT) approach to understanding and alleviating distress associated with those leading positive symptoms of psychosis mentioned in the book title. This approach had eight defining characteristics, which are summarised briefly in the following subsections.

From Syndromes to Symptoms

Our work was not based in an illness model. We stated categorically that a medical, syndrome-based model was not a useful foundation for attempts to develop psychological understanding and intervention for psychosis. Based on key texts by Bentall (1990) and Boyle (1990), we rejected the concept of schizophrenia as invalid: 'It is our view that the major impediment to clinical cognitive approaches in this area has been the very concept of schizophrenia itself … psychiatry traditionally ignores or dismisses as irrelevant much that from a psychological perspective is of central importance' (p. xiv). In its place we adopted a symptom-based approach (see Bentall, Jackson & Pilgrim, 1988), and structured the conceptualisation of delusions, voices and paranoia around one cognitive framework, the ABC model (see below).

Continuity Not Discontinuity

Psychiatry has traditionally stressed discontinuity between on the one hand, psychosis, and on the other hand, affective disorders and ordinary experience. We were inspired by and adopted Strauss's (1969) conceptualisation that delusions and voices lay on continua with normal behaviour. This position encouraged theorists and therapists working with psychosis to draw on and apply existing psychological and clinical models. As Chadwick et al. (1996) stated: 'A key feature of our work on these symptoms has been an assumption of *continuity* between psychotic and nonpsychotic phenomena … one of the main achievements of the cognitive approach to symptoms has been to reveal how the assumption of discontinuity between ordinary experience and psychotic experience was imaginary – there is considerable commonality between delusions and strongly held beliefs, and what differences exist are often subtle and represent variation on common themes. To this extent our cognitive approach may be described as seeking to *normalise* an individual's experience' (p. 176, original emphases, see Kingdon & Turkington, 1994).

This shift from discontinuity towards continuity has been supported in research over the past decade, and, indeed, in changes to diagnostic descriptions of psychosis from DSM III to DSM IV.

Cognitive Therapy Targets Client Distress

We in fact moved even further away from a medical approach when we asserted that the focus of therapy was not symptoms, but distress. We were the first CT authors to apply this perspective to psychosis. We see this focus on distress as arguably the single most important contribution of the book. So central was this position to our understanding that we defined clinical problems in terms of distress and linked behaviour, and made this the first principle of our cognitive model (pp. 4–5). We stated: 'This definition of problems in terms of distress and disturbance is, we believe, one of the greatest strengths of the cognitive model. What most clients have been told by other professionals is that they do have a problem – it is their symptoms' (p. 47). We also stated explicitly a corollary of this position, namely that if a person is not distressed or disturbed by a symptom of psychosis, then this is not a problem and there is no rationale for CT.

Our perspective that symptoms were problems only if they distressed or disturbed clients provided the rationale for therapy, and for collaboration – that therapist and client would work together to understand and alleviate the latter's distress: 'the cognitive therapist has to convey that her interest is in the client's emotional and behavioural problems … cognitive therapy is a collaborative process and presumes a common focus

for change – emotion and behaviour' (p. 47). Again, we stated: 'the reason for ever questioning and testing beliefs in a collaborative way is to ease distress and disturbance' (p. 116).

Commitment to a Cognitive Mediational Model of Distress

The defining attribute of CT is a commitment to a mediational understanding of distress (Brewin, 1988) – that is, a premise that people are distressed not by events, but by the meaning they construct. In keeping with this central tenet, we argued that distress was not a direct consequence of psychotic symptoms, but was mediated by meaning given to these symptoms. To represent this we used Ellis's (1962) ABC framework to formulate people's experience of voices, paranoia and other symptomatic beliefs. The ABC framework is a general CT tool, not specific to Ellis's Rational Emotive Behaviour Therapy (REBT) – the components are identical to those included in Beckian analyses of current distress. We chose the ABC framework because it most clearly embodies a focus on distress as the therapeutic focus, and the mediational role of cognition in driving distress (the B sits between the A and C).

Table 1.1 shows examples of ABC analyses of a range of symptoms from the 1996 book, which all came direct from clients with whom I was working at that time.

Developing a cognitive mediational model for voices was less straightforward than with symptomatic beliefs. The breakthrough was the insight that voices are not cognitions (Bs), but sensations or events (As) within the ABC framework. As we stated: 'This manoeuvre has a profound impact upon the psychological understanding of voices because it makes clear that distress and coping behaviour are consequences not of the hallucination itself, but the individual's beliefs about the hallucination … Four types of belief are particularly important in understanding emotional response to voices; those about the voice's identity, purpose (is it trying to harm or help me?), omnipotence, and beliefs about the consequences of obedience and disobedience' (1996, pp. 19–20).

We used the ABC framework to formulate delusions and voices because it was a model for understanding distress, and linked behaviour, and because it embodied absolutely clearly that distress was the target for therapeutic change.

Linking Delusions, Schemata and Distress

In a seminal contribution to the understanding of delusions, Maher and Ross (1984) and Maher (1988) conceptualised delusions as reactions to and attempts to make sense of experience. That is, delusions might be viewed

Table 1.1 ABC analysis of 'delusions' and voices

Symptom	Activating event (sensation)	Beliefs (client's thoughts, images, beliefs)	Consequences (distress and linked behaviour)
Mind reading	Client cannot find a word, therapist supplies it	She's read my mind, I've found her out, I knew it	Elated Pressure to tell people
Paranoid	Car horn sounds outside house	They have come for me, to kill me	Fear Runs from flat
Reference	Doctor walks past window, head held high	He thinks he's better than me, he's letting me know	Shame Moves away from window
Grandiose	The queen says on TV she loves all her children	She means me, she loves me, I am her daughter	Elation
Voices	Richard hears a voice say 'hit him'	It is God testing my strength and faith	Does not comply Feels pleased
Voices	Jenny hears a voice say 'be careful'	It is the devil, he is watching, waiting to get me	Terror Avoids going to shops

Source: Chadwick et al. (1996).

as expressions of the human necessity to 'search for meaning', often in response to life experience that was painful, unusual or ambiguous. This insight formed the basis for our reformulation of delusions in cognitive therapy (see Chapter 4). In particular, we conceptualised delusions as inferences about how the world is – that is, as beliefs which in everyday speech might be called either true or false, thereby encouraging therapists to question the assumption of falsity current in psychiatric thinking about delusions at that time. Viewing delusions as causal inferences helped establish how they linked to distress and schemata (or what we then called person evaluations). Linking delusions and self-esteem was a key challenge at that time (Alford & Beck, 1994). Basing our position in established cognitive theory and research showing how distress reflected a combination of inferential and schematic/evaluative thinking, we argued that when delusions were associated with distress, this must reflect not only delusional inferences, but also underlying negative schematic/evaluative meaning. We gave case examples of how to downward arrow from delusions to these unconditional schemata – a procedure that has since been empirically demonstrated in research (Close & Garety, 1998).

All People Inhabit a World of Appearances

Our cognitive therapy was explicitly constructivist in its philosophical position on access to reality. We adhered to the Kantian view that it is impossible to say anything authoritative about the world as it really is. All any of us is in touch with is the world of appearances, that is, the world as we construct it through our sensory, perceptual and cognitive apparatus. In other words, Kant argued that all perception and knowledge was sense-dependent and mind-dependent. As we stated: 'In order for an individual to experience anything at all, to be a subject of experience, he or she must possess sensory, intellectual and cognitive capacities of one kind or another. In order for an object to be experienced, it must fit in with these predispositions – individuals can experience no other kinds of objects. It is therefore inevitable that people must always experience a world of appearances, comprising "things as they appeared" to subjects, but could not experience the world in itself' (p. 7). Kant specified three ways in which people cannot help but construct the world. These are that events be perceived as located in space (space) and occurring in temporal sequence (time), and that they be perceived as orderly and predictable (causality). While these properties specify the basic forms of any possible world of appearances, they cannot be assumed to exist in the world as it really is.

We all have to operate in the world of appearances, with a mind that has to simplify a bewildering array of sensory stimuli into a subjectively manageable and coherent flow of experience. Perception both gives coherence and meaning to sensations, and also regulates focus of attention. It is not that in generating meaning or selectively attending people do anything wrong, nor is their thinking faulty or irrational. Indeed, absolute 'truth–falsity' is not a valid construct to apply to meaning, precisely because people live in a world of appearances.

Primacy of the Therapeutic Relationship

We were explicit that the practice of CT occurred within a sound, person-centred relationship: 'There are at least two important prerequisites to the practice of effective cognitive psychotherapy. The first is the use of good basic counselling skills in order to (i) Establish a good working alliance, (ii) Engage the person fully in collaborative empiricism (Beck, Rush, Shaw & Emery, 1979), (iii) Understand the client's unique perspective and feelings, (iv) Help the client carry out the difficult and often painful work of therapeutic change … The second prerequisite is a sound knowledge of the principles of cognitive formulation and intervention and the use of a cognitive framework' (Chadwick et al., 1996, pp. 25–26).

Therapy as a Conceptual Process

A further defining feature of our approach was to present CT for psychosis as a clear conceptual process, with clearly delineated conceptual steps, rather than a manual of techniques: 'what we are proposing is a sequence of conceptual steps, not a sequence of technical ones' (p. 27). There were two main reasons for this. First, a technical manual is, in our view, insufficiently collaborative or person centred. Second, when working to a technical sequence, therapists struggle when therapy does not go according to plan.

THE NEED FOR A PERSON-BASED APPROACH TO PSYCHOSIS

We concluded our 1996 book suggesting that the psychology of psychosis had undergone a productive paradigm shift away from a syndrome model to a symptom model: 'the move away from studying schizophrenia as a syndrome, towards studying individual symptoms, liberated and energised psychological research and practice' (p. 179). This change occurred in part because of major scientific questions over the validity of the concept of schizophrenia (see Chadwick et al., 1996, pp. xiii–xviii) – concerns which persist to this day. We concluded by arguing that the time was right for a further shift away from a symptom model towards a person model. The reasons offered for this call were that the symptom model was essentially a transitional model. It faced some key challenges. For example, if a person's specific symptom – a voice, a grandiose delusion or a persecutory delusion – disappeared, what vulnerability remained? We could see no compelling, empirically established theory for the emergence of individual symptoms of psychosis. Indeed, it seemed clear that there were multiple pathways to each symptom. Also, people invariably presented with more than one symptom – was a separate theory needed to account for each? And this was to say nothing about clients' (often pre-existing) anxiety, depression, negative self schemata (NSS), and so on. We thus concluded: 'symptom based work may be seen as signifying more a rejection of syndromes than itself being a viable comprehensive psychological approach to clinical problems' (Chadwick et al., 1996, p. 180).

The challenge was to develop a broader, person-based context, within which symptom work would remain an important element. In 1996 we did not have a clear picture of what a person-based approach would be, but rather were sharing our aspirations at that time, hoping to provide a springboard for future developments. Looking back, what is apparent is that the call was for a context that was not solely theoretical, but also was fundamentally a framework for therapy. In other words, a person-based approach would supply an overarching, theoretical and therapeutic