Introduction

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"I actually looked forward to the CBT sessions and talking about my symptoms."
(A service user with severe paranoia)

What is psychosis?

Psychosis, neurosis, and normality all lie on a spectrum. In psychotic disorders, patients experience symptoms such as hearing voices that no one else can hear or believing things that others believe to be false. In psychosis there is difficulty in thinking and concentrating, and often problems with motivation. Social functioning such as self-care, friendships, and work often deteriorate without treatment.

What is recovery?

Over the medium term the outcome for psychosis is reasonably good. Recovery involves learning to overcome symptoms, to reach the very best level of social performance that can be achieved for any individual.

Why have we written this book?

In the year 2000, six mental health nurses were trained to use cognitive behavioral therapy techniques (CBT) for patients with severe nervous breakdowns (schizophrenia). The nurses went out into community mental health teams and used CBT for 257 patients with psychotic symptoms. Carers were also trained how to use CBT at home. The main finding from this study was that this new way of working was very much appreciated by patients and carers alike. The general feedback was that people with psychosis often felt very isolated, and often they had only medication and occasional supportive visits before the CBT sessions started. Users and

carers had so many questions that they wanted to ask, but there had simply never been the time before. The CBT nurse initially spent time listening to the patient's and carer's points of view and beliefs about what was going on in their lives, and often new and sometimes useful insights were arrived at. Thereafter the CBT nurse used normalizing to explain that anyone can have these frightening experiences, e.g., in some surveys one person in five had experienced recent paranoid thoughts. It was also explained that severe symptoms can improve, and that we can often work out what is keeping them going and then do something about it. The nurses tried to help patients engage and test out frightening symptoms, such as voices and beliefs of persecution. They then tried to make sense of the medication situation, improve self-esteem, and work out a relapse prevention plan. All the sessions were based on a ''working together'' approach, with both nurse and user doing some homework to try and investigate things further. Many patients felt that this way of investigating things together was the best form of help they had ever received. Many described success in fighting off unpleasant experiences and feelings, leading to a more active and fulfilling life.

''It was the first time someone had sat down with me and focused on my problems.'' (Service user)

Carers were equally enthusiastic as they felt that they understood the psychotic symptoms better and knew how to say and do helpful things. It must be said that carers were often initially angry at what they perceived as a lack of instruction as to how to help their relative who was suffering so desperately with these frightening symptoms.

''How come this service has never been available before?'' (Irate carer)

The CBT nurse could only agree about the lack of psychoeducation and family therapy in many areas and use CBT to reduce carer stress, and then start to develop a CBT strategy to help their relative. Carers often had automatic thoughts in the back of their minds as follows.[1]

Common carer automatic thoughts

''This is my fault.''
''I did something wrong in childhood.''
''I am a bad mother/father.''

[1] The term automatic thought refers to the first thought that comes into your mind when presented with a piece of information. This thought can often be of a negative nature.

Or

"I'm going to make them see sense and pull themselves out of this."
"They just need to find a good job."
"How dare they not take the medicine . . . it obviously helps."

If you are a carer then enter your automatic thoughts about your situation here:
1.

2.

3.
Both sets of thoughts lead to carers experiencing stress and exhaustion. The first set of thoughts cause sadness and anxiety in a carer, and often they end up doing too much for their relative. The second set of thoughts cause frustration and anger, and lead to a carer "overdoing it" in trying to force their relative back to health. Carers often have both sets of thoughts. Both sets of thoughts are distorted and can be corrected. The first set is too self-blaming and a good rational response (corrected thinking style) is "no one knows the cause of this illness, but it happens in every country in the world"; "any human person can have a breakdown . . . it's usually caused by a combination of genetics, personality, and stress"; "I'm still an OK parent." Similarly, for the angry thoughts the antidote for the thinking would be "too much pressure obviously doesn't help"; "we need to go slowly but steadily"; "I can back off a bit and try a different approach." Reducing carer stress in this way really helps to improve the atmosphere at home and can pave the way for further progress. Psychiatrists also suffer from these stressful thoughts. I have just had the thought pop into my mind that if I stayed up very late I could finish this chapter tonight. I felt a bit tense and a bit down because it is a big job. I used CBT to tell myself "you are having those workaholic thoughts again. Three pages a day will finish it in two weeks, and it will be better in quality" – I immediately felt less stressed as I knew I was right . . . a rushed chapter would be a less good chapter. In this way we can get to know our minds and the way they cause and handle stress. All users should also have a think about whether they feel stressed, and if so try to write the thoughts down in the space below.
1.

2.

3.

User example: *"I'm scared to stay in and scared to go out."*
Carer example: *"She's bone idle."*

Automatic thoughts are usually distorted ... are the thoughts on page 3 correct or can we correct them?
Magnification (making things seem worse than they really are).
Labeling (putting a global label on a person).

Examples of corrected thoughts:

User: *"Well I suppose I have not been attacked in the last number of months. Maybe at least I am safe in the house."*

Carer: *"My daughter is still recovering from a severe breakdown and has some medication side effects. She used to be a good worker–perhaps we can slowly get there again."*

The effect of this more rational thinking in the home is of improved optimism and reduced argument. From this point on, plans for future progress need to be jointly agreed and worked on together.

Try to write corrected thoughts below and then keep bringing these thoughts back to mind from time to time. Do you feel a bit easier?

1.

2.

Psychiatrists are not hostile to the idea of patients and carers being guided through CBT. Cognitive behavioral therapy is a therapy supportive of using antipsychotic medication, in a dose that is jointly agreed between user and psychiatrist. Although there can be side effects with antipsychotic medication, there is definite protection against relapse as well as real benefits for many patients in relation to distressing hallucinations, delusions, and thinking difficulties. Cognitive behavioral therapy also endorses the use of clozapine,[2] which can at times be very effective when other drugs have failed. Cognitive behavioral therapy can also be combined with group therapy and family therapy. It is, however, different from psychoeducation and psychoanalysis, and these should not be done at the same time as CBT or there might be a risk of some confusion. Please tell your psychiatrist or case manager that you wish to work with this book before you proceed, so that they can advise you how to use the book. The following are statements made by consultant psychiatrists who have had experience of CBT being delivered to patients with schizophrenia in their area of the UK.

"The CBT nurse has highlighted the need for making use of CBT skills ... we would like to have someone as an integral part of the team. CBT has helped keep people out of hospital." (Croydon)

[2] Clozapine is an antipsychotic medication.

"It has been very beneficial to staff and patients working with the CBT nurse. Our team has learned a lot and patients have clearly enjoyed and moved on following the programme." (Edinburgh)

"CBT is delivered in a professional, dynamic, and realistic fashion." (Liverpool)

"Most patients are much improved by CBT, and a demand from patients and carers has been created. Very positive for the Trust." (Leicester)

So, if patients and carers do invest time and energy in following the exercises in this book what can they expect? The vast majority of people derive some benefit and many derive a lot of benefit. The first thing is that by practicing these techniques they become less stressed and more optimistic. Nerves and sadness, which are almost always present in a severe nervous breakdown, can improve. Other symptoms, such as voices and paranoia, can often become more manageable as patients and carers understand them better and find new ways of dealing with them. As such there can be an improvement in insight leading to better coping, improved activity levels and relationships, and an improved overall quality of life. These effects, however, do not occur overnight; they usually develop slowly following a period of joint work. One of the most important effects of CBT is to prevent or delay relapse. In those who do relapse following CBT it tends to take longer, i.e., patients stay well longer. Also, in those who do relapse, having learned the new understandings and techniques of CBT they can tend to work their way out of hospital more quickly, i.e., they spend less time hospitalized. The effects on relapse and hospitalization on their own would be very well worth having, but CBT offers much more than this. On the down side one person in ten doesn't really like CBT, but it is a safe treatment, which doesn't lead to suicide or any dangerous side effects. As with any such treatment it is important not to rush at it like a bull in a china shop, but to do the exercises properly one at a time with the help of others and in particular your mental health worker and/or carer.

Why write this book now?

This is the ideal time to publish a book about CBT for severe mental health problems. An important government body (the National Institute for Health and Clinical Excellence, NICE) has examined all the evidence for different forms of treatment for schizophrenia. It has decided that atypical antipsychotics are to be made available,[3] as well as rapid access to clozapine if

[3] "Atypical" is a term used that refers to a newer form of antipsychotic that has fewer side effects than older drugs known as "typical" antipsychotics.

needed. It has also stressed the importance of psychoeducation, family therapy, work opportunities, and the need for a more optimistic "recovery" perspective. It made a strong statement about CBT. Cognitive behavioral therapy is to be made available for every patient in the UK with schizophrenia, but in particular for those with persistent symptoms, poor compliance with medication, and lack of insight. By persistent symptoms, NICE meant all symptoms such as hallucinations, delusions, thinking problems, anxiety, sadness, etc., which don't clear up with medication treatment. The National Institute for Health and Clinical Excellence has published its findings in a clinical guideline, which has been sent to the chief executive of every Mental Health Trust and Primary Care Trust in the UK. Chief executives have been given the role of implementing the guideline in their trusts and this will be audited. Because of this, many mental health workers are learning the CBT techniques outlined in this book. Cognitive behavioral therapy is often taught in psychosocial interventions schemes (PSI) or in specific brief courses on CBT for hallucinations, delusions, and negative symptoms. There should be, within the not-too-distant future, a local worker who can help you to work your way through this book. The book will be useful as a means of structuring the CBT sessions, so please tell your key worker about the book and ask for guidance and support. Finding practical, simple solutions to help with troublesome symptoms may only be a few pages away.

Family therapy has been recommended for situations where there is a lot of distress in the family and the patient is relapsing regularly. However, the majority of carers do not require a full intensive family therapy approach. Most carers want to understand more about the roots of the psychosis, about the factors that prevent it from settling down, and about the things that they can say and do that will be most helpful. This book is for them.

One caveat: if a user wishes to read this book without guidance that is OK, but the book is best used with help from a mental health professional. Some of the techniques do need explaining, and sometimes things can get slightly worse before they get better so do find someone to share with.

Who else is this book written for?

- Patients, carers, and friends who want to know some simple things that they can do to help.
- Mental health professionals in training (psychiatrists, psychologists, mental health nurses, social workers, and occupational therapists) as a primer and as a homework book.
- For use in groups, e.g., day hospital, rehabilitation, Hearing Voices, Rethink, MIND, when there is a group leader with knowledge of CBT for psychosis.

Why CBT for severe mental disorders?

- Cognitive behavioral therapy is the best researched therapy for patients with schizophrenia and other linked psychoses. This is not to say that other forms of individual therapy (e.g., supportive therapy, counselling, personal therapy, or interpersonal therapy) do not work. It's just that we know that we are on safe ground with CBT as it has been so widely researched.
- It is easy to learn, flexible, and safe.
- In 1952, using this method, Dr. Aaron T. Beck helped a man with severe paranoia (105 suspected persecutors) to become much less frightened and to lead a much improved life.
- Since then, 22 proper scientific studies have confirmed that CBT really helps in persistent symptoms, particularly hallucinations and delusions.

What do the CBT therapists really think of CBT?

- Cognitive behavioral therapy is used by all those who have learned it, to help themselves and their friends if troubled.
- I used to be very frightened about speaking in public, now I give lectures all the time. I discovered thoughts in my mind that the audience were thinking: "what a bore . . . this talk stinks . . . he looks bad . . . he should shut up and get off."
- My anxiety only reduced when I asked people directly what they thought of my lecture. To my surprise they were quite positive. I had to keep telling myself that I was OK and to keep going.
- With practice my confidence improved, and I started to enjoy the lectures and make them humorous and creative. My anxiety reduced. Anxiety is very often an important part of keeping paranoia and voices at a distressingly high level.
- Road rage is another good example. A man driving a car sees another man pull out directly in front of him almost causing an accident. The first driver gets very angry and rushes out of the car to attack the other driver only to notice that the driver's wife is giving birth in the back seat. There was no insult intended. The first driver got it wrong. Anger is often like that – it can worsen voices and paranoia; however, it can be reduced by checking things out as in this example. So we want to use CBT to reduce the unpleasant and unhelpful emotions of anxiety and anger.

The simple cognitive model is that we all think about the things happening in our life, and these thoughts are sometimes too extreme or not based on fact. If we change the thoughts we can feel better and do things differently. The more we do this, the better we feel.

So how can CBT help severe problems?

In much the same way, by improving understanding and using CBT to reduce distress and then by finding strategies that work to improve things.
These are some signals that indicate that you could be helped by CBT:

- voices and delusions
- strong emotions (anger, anxiety, shame, sadness)
- hiding away from the world
- getting into lots of arguments with others
- not thinking clearly
- not looking after yourself well, or not having any drive to do things.

If any of the above apply to you then working through the relevant sections of this book could be useful. Remember to read through the book slowly a page at a time and do the exercises suggested. They are not usually difficult or challenging and are best done when you can check the findings out with another person. You can jump straight to the most relevant chapter if you are very keen to get started and make some progress, but we would recommend reading through the explanations chapter, at least, before moving on to other sections. With all CBT, practice is the key ... the benefits build up gradually.

So why haven't people been using CBT for ages? It seems so obvious!

People who are suffering with a severe nervous breakdown with the above symptoms tend not to investigate things, or try enough things to fight back. Often they believe there is an incurable madness there, but the studies show that people can improve a lot. Much of this is down to society's attitudes to mental illness. People often just don't want to know if you're a voice hearer, or a bit paranoid, or have lost your drive. Then there is the label of schizophrenia, which has all kinds of negative connotations. People still think of schizophrenia as "multiple personality" (i.e., Jekyll and Hyde), which is a frightening idea. People also still have the old biblical idea of demon possession. Both of these common stereotypes are complete myths! Then there are the common stories in the newspapers about people with schizophrenia or paranoia being violent. This is actually extremely rare, but the media and news broadcast seems to always make a point of reporting it in a very sensational way.

What are your own automatic thoughts about your breakdown?

Perhaps you have thoughts like the ones above, which are making you feel stigmatized or ashamed?

User thoughts about schizophrenia/paranoia and psychiatry

Example: "*People with schizophrenia have nothing to offer and might as well give up.*" (Emotion: sadness and despair)

Response: "*Johnny Nash fully recovered and is a university professor!*" (Emotion: some optimism and a bit of determination!)

Put your own and your carer's automatic thoughts about mental illness below:

1.

2.

3.

Now the rational responses:

1.

2.

3.

Discuss these new ideas with friends, other users, etc. Consider writing a short letter about the subject, and send it to a local magazine or newspaper.

Cultural and religious aspects

It is common to think that a therapy like CBT "does not apply to me if I am from a particular cultural or religious background" or "what do they understand about my culture/religion?" Sometimes this assumption may be true, as every therapist does not understand every culture or religion. But CBT is not about challenging cultural or religious beliefs in a way that seems disrespectful. It is about understanding perspectives in order to ease the distress associated with symptoms such as voices or paranoid thoughts. The same assumptions apply to carers who may feel that "if I ask for support, it may sound like I am complaining – culturally, it is my duty to care." It is not the intention of the therapist to judge carers about their role and culture. The aim is to improve understanding and support the carers.

Every chapter in this book has a section on cultural and religious aspects, which shows how the process can be modified and applied to everyone. Do you have any worries that professionals may misunderstand you due to their lack of understanding of your culture or religion? Please list them:

1.

2.

3.

Discuss these with a therapist or a senior figure from your faith.

Who is this book for exactly?

- If you have been told that you have a severe nervous breakdown such as psychosis, schizophrenia, schizoaffective disorder, delusional disorder, or even psychotic depression this book may really help.
- It is important to realize that anyone can suffer in the way that you are suffering, and that you are not alone ... paranoid ideas are found in some 20% of the population and 15% of people hear voices at some point in their life. It may be helpful to join a support group – ask your therapist or local mental health voluntary group for details.
- The key message here is that something can be done and the more that you engage with your symptoms, your situation, and your life the more you can move toward better control and more satisfaction in relation to your life goals.

This book complements:

- taking good quality medication at the right dose
- family therapy
- community psychiatry
- rehabilitation
- employment placements
- always check with your consultant/key worker or primary care physician that it is a good idea in your present circumstances.

Summary

To get the most from this book, it would be best to complete the questions in this introduction before you move on to Chapter 1. Remember, Rome wasn't built in a day! Take your time, think things over, and keep trying these ideas out ... you will begin to change for the better!