

Cognitive Behavioural Therapy for Psychotic Symptoms:

A Therapist's Manual

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Preface

A substantial body of evidence now documents the significant prevalence of psychotic disorders mental health problems in the Australian community. The recent “National Survey of Mental Health and Wellbeing” reported that 4 to 7 people per 1000 of the Australian adult population have a psychotic disorder. This statistic translates to more than 100,000 Australian adults and clearly indicates that there are a significant number of people who are struggling with the severely debilitating symptoms and experiences associated with psychosis. Unfortunately people with psychosis in our society also carry a significant burden of distress, disability and social dysfunction and there is an identified lack of community based rehabilitation programmes that could help address these issues (Jablensky, et al 1999).

The extent and complexity of mental health and psychosocial problems, places enormous pressure on treatment facilities to provide appropriate and effective interventions. This treatment protocol helps address this need. It was developed by the Centre for Clinical Interventions (CCI), which provides specialist clinical treatments, training and clinically applied research programs. CCI was established to provide a scientific environment within which evidence supported clinical practice and the theoretical understanding of psychopathology are investigated, with the aim of decreasing patient distress and increasing patient empowerment. The establishment of CCI has allowed clinical practice, training and research to be mutually interactive and balanced.

This treatment protocol is the application of evidence based psychological practice to Psychotic Disorders. The manual has been written by clinicians for clinicians and presents a clinical guide based on empirical foundations and clinical evaluation.

The treatment protocol provides the therapist with a comprehensive, detailed and systematic approach to treatment delivery. The manual is divided into modules, which describe the treatment components of this individual therapy. Importantly, the manual does more than describe the content of ‘what to do’, but also describes the process by which each treatment component is delivered. Details about evaluation procedures are also included, as are activities and handouts for clients, self-monitoring diaries and materials to be used by the clinician.

I would like to express our gratitude to the Office of Mental Health of the Department of Health for their support of the quality improvement work carried out at CCI.

I would especially like to express our respect and gratitude to the clients who have so courageously participated in our interventions and thus travelled with us along the path to scientific discovery.

Whilst this manual provides a comprehensive guide to mental health practitioners, key competencies are required, and it is highly recommended that in order to apply the protocol most effectively appropriate training and supervision is undertaken.

Paula R Nathan (Director)

Introduction

Rationale for Treatment

Since the 1950s, the usual first-line treatment for persons with chronic psychotic disorders has been neuroleptic medication. The effectiveness of this type of treatment has brought about important improvements in the care and management of individuals suffering these disorders. Despite the significant advances made, there is a growing awareness that medication alone is not a sufficient treatment for psychotic illness in many cases.

Firstly, many patients continue to experience persistent and distressing psychotic symptoms despite appropriate doses of medication. In the recent National Survey of Mental Health and Wellbeing report, "People Living with Psychotic Illness", 61% of participants reported that they had experienced either delusions and/or hallucinations within the last month (Jablensky et al., 1999) - symptoms, which are typically highly distressing. This was despite the finding that the majority of those participants were taking prescribed medication for their mental health problems (86%) and most (83%) reported that their psychotic symptoms responded to this medication (Jablensky et al., 1999). In addition, 47.6% of male participants, and 36.8% of female participants reported experiencing a continuous course of illness with no remission of symptoms (Jablensky et al., 1999). In other words psychotic symptoms tend to persist or to re-occur over the long term for a majority of patients with psychotic illness.

Secondly, psychosis is associated with an increased risk of associated emotional disturbance. This is reflected in the prevalence of comorbid depression and anxiety in this group of patients and the elevated risk of suicide found in people with schizophrenia (and other psychotic illnesses) in comparison to the general population.

Thirdly, there is a significant degree of social disability associated with having a psychotic illness that is not (and can not) be addressed by use of medication alone. This includes the disability associated with persistent symptoms and associated emotional disturbance, but also reflects problems with social isolation, and difficulties in finding suitable accommodation and work. In the Australian setting a recent large-scale study of people living with a psychotic illness identified "a serious lack of lack of ... psychosocial treatment and management modalities" (Jablensky et al., 1999, p.94).

Cognitive Behavioural Treatments for Psychotic Disorders

Over recent years, psychosocial approaches to managing psychosis have shifted from a purely behavioural focus to an emphasis on the interaction of cognitions and behaviour the symptoms of psychosis. There has been a particular emphasis on the factors maintaining the experience of residual psychotic symptoms (e.g. hallucinations), but also on the distress and disturbance that can be associated with experiencing these symptoms.

Persistent psychotic symptoms

The London-East Anglia group in the UK carried out one of the largest and best-designed studies investigating the effectiveness of CBT for medication resistant symptoms. They investigated a manualised, individual treatment for medication resistant psychotic symptoms (including hallucinations and delusional beliefs). Their treatment contained cognitive and behavioural elements.

The treatment was first piloted with 13 patients (Garety, Kuipers, Fowler, Chamberlain, & Dunn, 1994). This small trial indicated that the treatment was helpful in reducing patients' conviction in their delusional beliefs. On the basis of these initial, positive results, the treatment trial was expanded to become a full randomised controlled trial - with a larger number of patients who were followed up over a longer period of time. The results of this larger trial were published in a series of papers highlighting different aspects of outcome and follow up.

The CBT group showed significant improvements over the course of treatment on a measure of psychotic symptomatology. The magnitude of the change in psychotic symptomatology was similar to that found in clozapine treatment trials with the same population of patients (Kuipers et al., 1997) - without the possible side effects associated with use of this medication. Additional analyses showed that 21% of the CBT group achieved a large clinical improvement and a further 29% of the showed a reliable clinical improvement (Kuipers et al., 1997) on the same measure.

The positive outcomes in this study could not be explained by medication – in fact, over the course of the trial, more control subjects had their medication increased, and none had their medication decreased, while two of the treatment subjects had reduced medication (Kuipers et al., 1997). This is a particularly important finding given that many patients identify significant impairment associated with medication side effects (Jablensky et al., 1999) – any maintenance or reduction of medication dosage is therefore a significant positive outcome of treatment. Patients also reported that they were generally satisfied with the CBT treatment, and found it an acceptable way of dealing with difficulties (Kuipers et al., 1997).

The treatment gains made were maintained (and in fact improved upon) at 18 month follow up – with 65% of the CBT group showing a reliable clinical improvement at follow up (Kuipers et al., 1998). There were also significant improvements in delusional distress and hallucination frequency – indicating that patients continued to improve on these measures after the cessation of treatment (Kuipers et al., 1998).

The treatment approach was also evaluated from an economic perspective (Kuipers et al., 1998). This evaluation, while not definitive, indicated that the costs of CBT were likely to be offset by reduced service utilisation costs in the follow up period (Kuipers et al., 1998).

Other research groups have also conducted randomised controlled trials investigating the effectiveness of CBT treatments for medication resistant symptoms. Tarrier and colleagues (1998) found that a shorter term, and more intensive CBT treatment was significantly superior to routine care alone in the treatment of patients with persistent psychotic symptoms. Sensky and colleagues (2000) compared CBT with a 'Befriending' (non-specific, supportive therapist contact) control condition – and found significant improvements with both treatments over the 9 month duration of treatment. However, these gains were only maintained at follow up for the CBT group (Sensky et al., 2000).

Cognitive Therapy for Voices and Delusional Beliefs

Paul Chadwick and colleagues have developed and investigated a cognitive intervention for people who hear voices (e.g. Chadwick & Birchwood, 1994; Chadwick, Sambrooke, Rasch, & Davies, 2000). This treatment approach focused on identifying and challenging a set of typical beliefs about voices – beliefs about omnipotence, control and personal meaning; and has been investigated with small groups of patients. A single case series trialling this approach has produced positive outcomes (Chadwick & Birchwood, 1994). In addition, patients attending a group based version of this therapy showed significant improvements on measures of conviction in beliefs about omnipotence and control (Chadwick, Sambrooke et al., 2000).

Chadwick and colleagues have also developed and evaluated a specific cognitive therapy for delusional beliefs (Chadwick & Lowe, 1990; Chadwick, Lowe, Horne, & Higson, 1994). They used a multiple baseline design with small numbers of patients to investigate the efficacy of verbal challenge and reality testing experiments and found that a combination of these two procedures resulted in a reduction of delusional belief conviction for a majority of subjects (Chadwick & Lowe, 1990; Chadwick et al., 1994).

Authors in the area of cognitive therapy for delusional beliefs have commonly identified the importance of collaboration and the therapeutic relationship in undertaking this type of therapy (e.g. Alford & Beck, 1994; Chadwick, Birchwood, & Trower, 1996). They identify that the process of investigating and challenging delusional beliefs can be a distressing one for the patient, and therefore suggest that it is vital to proceed in a collaborative and graded fashion (Alford & Beck, 1994). The treatment outlined in this manual also strongly emphasises the development of a sound and collaborative therapeutic relationship.

Conclusions

The outcome literature for CBT interventions with psychotic symptoms indicates that there is a growing body of support for a range of related CBT therapy programmes. Specifically, it appears that there is strong support in the form of randomised controlled trials for the use of individual CBT in treating persistent psychotic symptoms such as hallucinations and delusions. This form of psychological treatment have been shown to produce significant improvements in psychotic symptomatology and in distress associated with psychotic symptoms.

The treatment outlined in this manual is closest in terms of style, components and patient group to the cognitive behavioural treatments for persistent psychotic symptoms described above. We have chosen this type of treatment because it has a sound evidence base for use with a group of patients that are commonly seen in public mental health systems. That is, people with longstanding treatment resistant hallucinations and delusional beliefs; and is an acceptable and satisfactory treatment option for this group. It also allows for the targeting of secondary morbidity such as depressive and anxious symptoms.

The CCI Treatment Manual

While currently published psychosocial treatment guides provide useful theoretical perspectives and empirically validated techniques, they are typically not presented in a particularly accessible manner. Examination of these resources indicates a clear need for a clinician-friendly treatment resource, which provides step by step guidance in the evidence-based treatment for these chronic problems.

The “People Living with Psychotic Illness” survey reported that less than 20% of the participants had participated in any rehabilitation activities in the past year. The treatment proposed in this project may go some way to improving the self-efficacy of persons with psychotic disorders and enable a reduction in their social isolation due to the distress of their psychotic symptoms. The treatment will also be able to augment other structured treatments developed by CCI – particularly the “Social Skills Manual for People with Psychosis”.

As our extensive experience at writing psychosocial resources at CCI has shown, a well designed therapist manual needs to be not only clinician-friendly and clearly based on empirically validated principles, but be flexible enough to take into account the level of engagement and heterogeneity of problems of patients. The manuals also need to lend themselves to evaluation in terms of its usefulness to both practitioner and patient.

Treatment model

The treatment model underlying the CCI “Cognitive Behavioural Therapy for Psychotic Symptoms” manual has a number of key components. Our model emphasises a ‘stress-vulnerability’ explanatory model for the emergence of psychotic symptoms. We also focus on symptoms rather than syndromes, and on the distress and disturbance associated with psychotic symptoms (rather than the experience of symptoms in isolation) when planning treatment.

Stress Vulnerability

The principle underlying the stress vulnerability model can be summarised briefly as follows – “the patient has a biological, often genetic predisposition that interacts with stress to cause illness” (EPPIC, 1997, p.13). As we see it, this vulnerability can either be inborn (ie. genetic) or acquired (eg. perinatal complications, life events). An individual’s vulnerability to psychotic experience will then interact with their experience of stressful life events, and their ways of coping with those events, to alter the likelihood of experiencing a psychotic episode or symptoms (Zubin & Spring, 1977). We find that this is a particularly useful model for working with people with psychosis because it provides a rationale for working psychologically and for taking medication. This model therefore provides our patients with a helpful rationale for treatment, and gives us a ‘way in’ to address the individual’s style of coping with stress and with symptoms (including behavioural and cognitive aspects of coping).

Symptom based formulation

The model also focuses on the patient's experience of specific symptoms rather than their syndromal diagnosis. This means that there will be variations in the model and treatment plan depending on which symptoms are present, and of most importance to the patient. One of the advantages of focussing on symptoms is that the treatment manual can then be applied with individuals with a range of diagnostic labels in the psychotic spectrum – as long as they are experiencing the relevant symptoms. For example, a patient with a diagnosis of bipolar affective disorder who is experiencing residual psychotic symptoms in the form of delusional beliefs could be treated using this manual.

Distress and disturbance

In this CBT treatment, we aim to target the distress and disturbance that is often consequent on the experience of psychotic symptoms. In doing this we are aware that the degree of distress and disturbance experienced can vary considerably from person to person. For example one person hearing voices may feel angry and responds by shouting back, while another may feel unconcerned and will instead distract himself with other activities. This treatment focuses on understanding and modifying the factors (including the person's beliefs about their voices), that lead to emotional distress and behavioural disturbance.

We believe that understanding psychotic problems in terms of the distress and disturbance associated with them, is one of the greatest strengths of the treatment being proposed in this manual - as it avoids conflict and encourages therapeutic alliance. This is particularly important as the therapeutic engagement of people with psychotic disorders often presents significant difficulties.

Relationship to other treatments

The treatment model is most similar to CBT treatments that have been developed over recent years for bipolar disorder (Lim & Nathan, 2001a, 2001b), in that it prioritises self-management and prevention of episodes. While medication is an important component of any treatment of psychotic symptoms the CBT model is very dissimilar from any of the purely bio-medical models of psychosis or schizophrenia, in that it focuses on distress and disturbance consequent on symptoms rather than the symptoms themselves.

Patient group

This variant of CBT is different from CBT treatments for other disorders, in that the patient group is more likely to have the following characteristics.

- They are less likely to have requested therapy for their symptoms themselves (ie. more likely to be referred by their psychiatrist or multidisciplinary treating team). They are therefore likely to have a higher degree of ambivalence about treatment and uncertainty about its value to them.

- They are likely to have had more experiences with mental health professionals, and a wider range of experiences (e.g. inpatient treatment, case management) than other outpatients. They are also more likely to have been compulsorily treated (including hospitalisation or community treatment orders). Patients with psychosis may in fact have had more experience with mental health professionals, than we have in working with patients with psychosis.
- They may have had experiences of being ‘punished’ for disclosure of ongoing psychotic symptoms (e.g. hospitalised, increase in medication dose) or discouraged from talking about symptoms because it was not thought to be helpful. Rapport building is therefore a prerequisite for accurate description of symptoms.

All these factors are likely to have an impact on the individual’s degree of willingness to engage in psychological therapy.

While there is a considerable literature focussing on the use of CBT approaches with a first episode psychosis population, we are aware that within public mental health services, the majority of people with psychotic illnesses are likely to be experiencing recurrent or chronic symptoms. We have therefore targeted our treatment manual to this group of patients rather than those with first episode psychosis. However, many of the techniques outlined in this manual also have relevance for those experiencing a first episode of psychotic illness.

Treatment Goals

The goals of treatment with this manual are broadly:

- increased understanding of and insight into psychotic experiences
- improved coping with residual psychotic symptoms
- reduction in distress associated with auditory hallucinations
- reduction of degree of conviction and preoccupation with delusional beliefs
- maintenance of gains and prevention of relapse

The specific goals of treatment with each individual are likely to include several of the above general goals. However, they will vary depending on the person’s specific symptom profile, and life situation and, most importantly, on what they wish to get out of therapy. The early assessment modules of the treatment manual are directed towards establishing a set of specific and personal goals or targets for therapy.

Key Treatment Components

Engagement Strategies

One of the common denominators in published descriptions of cognitive behavioural interventions for people with psychosis is the emphasis placed on the importance of engagement with the patient. Descriptions of treatment programmes emphasise that assessment and engagement into treatment is likely to take longer and require more careful effort with this patient group.

It is likely to take a number of preliminary sessions before the focus and direction of therapy becomes clear to the therapist or the patient. Particularly in this early phase of treatment, the opportunity to talk at length about concerns and symptoms and to be understood; in other words rapport is likely to be the principal thing that holds the patient in therapy.

Another important requirement is to flexibly respond to patient needs and requirements at different stages of illness and of therapy. It is not possible to maintain a sound collaborative therapeutic relationship without constant attention to the changing situation and requirements of the patient.

Given the key role that engagement and the therapeutic relationship play in this form of therapy, we have included an entire module (Module 3) focussing on early treatment engagement and orientation to therapy. We have also emphasised the importance of continually addressing issues of flagging motivation or disrupted engagement as they occur throughout the treatment process.

Module 3 also provides the opportunity for reinforcement of the patients' naturalistic coping strategies i.e. the active steps that the patient is likely already taking to manage their symptoms. There is some evidence that coping strategy enhancement is an effective therapy in itself for residual psychotic symptoms (Yusupoff & Tarrier, 1996). It also serves to develop a collaborative therapeutic relationship by highlighting the efforts that the patient is already making – and their role as an expert in their own symptoms.

Psycho-education

The psycho-education component of the manual serves a number of important functions. Firstly it is an opportunity to normalise and 'de-catastrophise' the experience of psychotic symptoms and to start providing (in a general sense) some alternative perspectives on their experience of these symptoms (Turkington & Kingdon, 1996).

Secondly, it also provides an opportunity for the patient to increase their understanding of their own symptoms and the context in which they occur. Ideally, this is done in a collaborative, individualised and non-didactic way, with the aim of building a shared model of the individual's difficulties (Fowler, Garety, & Kuipers, 1995).

Thirdly, it allows the clinician to further assess their patient's understanding of their own illness, thus providing more information for a cognitive formulation of the patient's difficulties – which will be drawn on in the later modules.

Cognitive Therapy

As described in the above review, cognitive therapy strategies such as verbal challenge and behavioural experiments have proved effective for many people with residual psychotic symptoms, such as delusions and hallucinations. Modules 5 and 6 in the manual outline the use of these cognitive techniques in addressing the two key positive psychotic symptoms – delusional beliefs and hallucinations.

This manual also includes a module (Module 8) outlining the use of cognitive strategies for targeting secondary symptoms such as anxiety and depression.

Behavioural Skills Training

The behavioural skills training module (Module 7) offers the clinician (and the patient) a choice from a range of effective behavioural strategies – depending on the nature of the patients presenting concern. The strategies outlined in this module include – relaxation, graded exposure, activity scheduling, distraction and problem solving.

These behavioural skills can be taught in order to improve coping with residual symptoms. For example, a patient who noticed that her voices were louder and more intrusive when she felt anxious and was physically tense may benefit from regular practise of an appropriate relaxation technique. They can also be useful in targeting the secondary symptoms of depression and anxiety.

Relapse Prevention Strategies

Relapse prevention strategies usually include identification of early warning signs for relapse, and development of plans for acting in response to these indicators. They have been used in combination with both pharmacological and psychological treatment regimes, over many years (Birchwood, 1996). They are also commonly used in psychosocial treatments of other severe mental disorders e.g. recurrent depression, bipolar affective disorder.

This treatment manual does not purport to describe a comprehensive relapse prevention treatment, but does provide some guidance in how to help the patient to anticipate and plan for future recurrences of symptoms and to maintain treatment gains into the future.

Assessing Treatment Outcome

Early stage assessment

There are two early stage assessment modules in the CBT for Psychotic Symptoms manual - Module 1 (General Assessment) and Module 2 (Symptom Specific Assessment). This early stage assessment requires considerable time and care, as it forms part of the patients' orientation to therapy. The assessment measures chosen cover the range of presenting symptoms that the patient group is likely to be experiencing. The general measures allow an assessment of diagnostic features, severity of psychotic symptoms, associated distress, and quality of life. These general measures are repeated at the end of therapy (as described in Module 10 - Post Treatment Assessment). The symptom specific measures tap into the important dimensions and features of delusional beliefs and auditory hallucinations.

Ongoing assessment

Many of the symptom specific measures (e.g. preoccupation and conviction in delusional beliefs) are repeated each session to provide a continuous measure of variation and change over the course of treatment. This ongoing assessment of treatment targets plays two roles in therapy. Firstly it provides useful feedback to the patient - about changes in symptoms over time, about improvements that they have made, and about factors which may influence their experience of symptoms. Secondly, regular assessment of these treatment targets enables the therapist to track the effectiveness of different components of the therapy and to maintain focus over the course of the treatment.

Treatment Modules

USING THE MANUAL

This manual is designed for use by clinicians that already have a sound knowledge of psychosis, and of CBT principles. It is intended as a supplement to supervision, peer support or consultation with more experienced professionals, for those who have existing skills and training in CBT.

For those with no experience in CBT or in working with psychotic clients, it is recommended that prior training be undertaken (e.g. a general CBT course) before attempting to apply this treatment manual. CBT for psychosis is an area of research and therapy that is still being developed and refined, so we also suggest that keeping up to date with the treatment and research literature will be particularly important. Throughout the manual we have provided relevant references and suggestions for further reading – these will provide a place to start, but it will be necessary to maintain an awareness of ongoing clinical developments and research findings.

This manual describes a modular treatment. The therapy is made up of a series of modules that you work through (or not) depending on the needs of the individual patient. This form of therapy gives you more flexibility than a session by session description would, while still providing the guidance of a framework based on the research evidence.

THERAPY MODULES

The manual is divided into ten modules. Each module starts with an overview, which includes a brief description of the objectives, and content of the module, the materials required and the key issues for working through the module. This is followed by extensive therapist notes for each module, describing the step-by-step process of working through the module content. There are also case examples in each module to illustrate how the content can be applied. Each module also includes references for relevant resources and articles.

Generally, it is easiest and most effective to work through the therapy modules in the order they are described in the manual. However, you may at times need to change the order of modules. For example, if your assessment indicates that your patient is having a lot of difficulty with anxiety, to the extent that it would get in the way of them doing things that might help them manage their psychotic symptoms, you might decide to cover some of the anxiety management strategies outlined in Modules 7 and 8 before working on Modules 5 and 6 (Cognitive Therapy for Delusions and Voices). This example also illustrates that any change to the therapy structure should be based on an assessment of the patient's needs.

The first three therapy modules (General Assessment, Specific Assessment and Early Treatment Engagement) are very closely related. Even though the principles of early treatment engagement are not described in detail until Module 3, engagement and rapport building is the first priority early on in treatment, above the gathering of assessment information.

TIMING

There is no set time that it will take you to work through each therapy module – the timing is determined by how long it takes to work through the material in the module with the individual patient with whom you are working.

CASE EXAMPLES

Throughout the manual we will use case material to illustrate how we have applied the therapy modules with some of our patients. These examples are drawn from work with our patients at CCI – but we have changed names and other details so individual patients can't be identified. We have tried to include examples that show the difficulties of applying this therapy model as well as the 'text book' cases.

STRUCTURE OF THERAPY SESSIONS

Each session in this cognitive behavioural treatment uses a similar general structure or format – regardless of which module it belongs too. Maintaining a stable structure helps to make each session as predictable and understandable as possible. It also helps to bridge the gaps between sessions and ensure that the therapist and patient share a sense of working steadily towards the treatment goals.

Progress & Homework Review

This part of the session has a number of functions. It allows the therapist and patient to...

- Review any practice tasks assigned (eg. completion of questionnaire measures, or self-monitoring)
- Review progress in coping with any problems or issues discussed in previous sessions
- Check if there are any questions regarding previous sessions

It is particularly important with this patient group – who may have had more frequent experience of negative social feedback; to provide much positive feedback on practice/ between session tasks. It is a good idea to provide positive feedback first and then follow with any corrective feedback (which needs to be clear and specific).

Once the Progress & Homework review is completed, the next step is to set an agenda for the session. This can be done in general or specific terms depending on the level of insight and functioning of the individual patient. In order to set an agenda collaboratively – you could ask very open questions like “What would you like to work on this week?” or more focussed questions like “It sounds like you had some trouble practising the relaxation technique, is that something we could spend more time on this week?”

Session Summary

In this part of the session it is important to...

- Review key points made during the session and allow the patient to note them for future reference
- Ask patients to note down any practice or homework tasks from the session

This summary allows the therapist to check the patients understanding of the material discussed in each session and the agreed homework tasks.

In each treatment module you will find suggestions for homework or practice tasks based on the content of the module.

Module 1

General Assessment & Introduction to Therapy

Module 1: General Assessment & Introduction to Therapy

Module Objectives

1. To commence rapport building and development of the therapeutic relationship
2. To complete diagnostic assessment of the individual
3. To obtain objective measures of psychotic symptoms, quality of life, and associated distress
4. To assess the patient's explanation of their disorder and attitude towards psychosis and mental illness in general
5. To provide feedback of assessment results to the individual patient
6. To introduce patients to the process of therapy and instil a sense of realistic hopefulness about outcome

Module Content

- Rationale for assessment
- Pre-treatment assessment – diagnostic assessment, associated distress, disability and quality of life
- Feedback of assessment results to patient
- Expectations of therapy

General Assessment Measures

Diagnosis

- Mini International Neuropsychiatric Interview (MINI Plus)

Disability & Quality of Life

- Schizophrenia Quality of Life Scale (SQLS)
- WHO Disability Assessment Schedule (WHO-DAS)

Psychotic Symptoms

- Brief Psychiatric Rating Scale (BPRS)

Associated Distress

- Depression: Calgary Depression Scale for Schizophrenia
- Anxiety: Spielberger State Trait Anxiety Inventory (STAI)
- Brief Symptoms Inventory (BSI)

At CCI we have used a selection of these measures – depending on patient presentation. You may also wish to use other measures that tap into these domains.

N.B: See “Further Information” at end of module for references and sources of these measures

Worksheets Required

- ✂ Client Expectations Questionnaire
- ✂ Session Summary

Key Issues

This module should be carried out in the context of engagement and rapport building and should therefore be viewed as more than an information gathering exercise. Our experience and a review of the relevant therapy literature, indicate that a slow and steady approach to assessment (where more attention is paid to the development of a sound relationship than to gathering information) is the preferable approach. It may be necessary to begin the assessment process in a more neutral environment than the therapist's office or outpatient clinic – this may be the patient's home or a location they attend regularly (eg. day programme or drop in centre). It is also likely that assessment will take longer than it might with another group of patients.

As described in the Introduction, there may be a number of obstacles to rapport. Past bad experiences with mental health services may be one such obstacle. For example, a number of our patients at CCI are able to describe in detail their first, negative, contacts with psychiatric services up to 30 years ago, and still act on the basis of these experiences. Another obstacle may be the generally elevated wariness or suspiciousness that characterises those with paranoia. In both these cases the slow and steady approach described above – where the timing of assessment is sensitive to the patient's presentation and preference, will be most helpful.

For these reasons, confidentiality is also likely to be a particularly important issue for this group of patients. Early on in treatment – in the first session preferably, it is important to discuss confidentiality and the limits on confidentiality. You might need to discuss issues such as sharing of information within the treatment team, whether you will be writing notes in a hospital file, or what happens to notes you take in sessions.

It is also important to balance assessment with consideration for the patient's current concerns. It may be necessary to schedule time in assessment sessions for brief interventions focused on immediate concerns e.g. problem solving, advocacy on patients' behalf, liaison with treatment team to arrange medical review, etc.

Therapist's Notes

PROVIDE A RATIONALE FOR ASSESSMENT

- An important aspect of developing rapport in the early sessions is to provide a rationale for the detailed assessment that will be required. Here is an example of the kind of statement that can be made ...

“From what your doctor has said it does sound like I may be able to help you with some of the problems you’re having ... but for us to be able to work together, I need to have a really good understanding of the problems you’ve been having ... as you’ve been having these problems for quite a while now – it will take some time to get a really good understanding ... what if we spend the next 3 sessions (although we might need longer than that) talking through the difficulties you’ve been having and how they’ve developed over time. How does that sound to you?”

- As described above, patients with psychotic symptoms may have had more negative experiences of interactions with mental health practitioners than other patients. They are also more likely to be experiencing an elevated level of suspiciousness or paranoia as a result of their illness. For these reasons it is particularly important that the assessment process is transparent and understandable.
- Ask questions to determine what the patient already understands about their diagnosis. This may include questions like “What do you think is causing these problems for you?” or “What did your doctor tell you about these problems you’ve been having?”

Note: It is important that the stance taken by the therapist throughout the assessment process is one of continual interest and curiosity about the patient’s experience.

PRE-TREATMENT ASSESSMENT

- The areas of functioning that we assess at this point relate to the overall aims of CBT for psychotic symptoms - to reduce distress and ultimately to increase quality of life. It is probably helpful at this point to briefly preview the role that this assessment information will play in treatment.
- At this stage the primary aim of the assessment is to gather information in order to develop a comprehensive formulation of the patient’s difficulties. (For general references relating to cognitive behavioural case formulation or conceptualisation see ‘Further Information’ at the end of this module.)
- In addition, some aspects of the assessment will be particularly relevant to future therapy modules ...

Diagnosis: This is an optional area for assessment, as a diagnosis will almost always have been made before the patient is seen for this type of therapy. You may choose to conduct a diagnostic assessment as a way of gathering qualitative information about

symptoms and experiences that you can later use in the cognitive and behavioural therapy modules. A diagnostic assessment may also be a useful basis for the “Psychoeducation” module.

Psychotic symptoms: Will inform your understanding about targets for treatment, and your choice of therapy modules. For example, if the patient describes auditory hallucinations you will likely need to work through the Cognitive Therapy for Voices module. The BPRS also provides information about associated symptoms such as depression and anxiety which will be relevant for Module 9 “Cognitive Therapy for Secondary Problems”.

Disability/ Quality of Life: As one of the aims of this form of therapy is to increase quality of life, it is important to develop an understanding of areas where the patient is experiencing more or less difficulty at this stage.

Associated distress: This will give you information about the degree of depression or anxiety that the individual is experiencing and will inform the decision about whether to use the “Cognitive Therapy for Secondary Problems” module later in therapy.

- Throughout the assessment process it is necessary to maintain an open mind about the assessment measures used and to express willingness to discuss assessment measures in detail. It may also be helpful to ask questions to determine the patient’s understanding of the assessment process and measures.

PROVISION OF FEEDBACK ON ASSESSMENT MEASURES

- The process of giving feedback on assessment is an important part of any cognitive behavioural intervention – as it forms a useful basis for a shared formulation and serves to de-mystify the process of therapy. However, as described above, it is particularly important when working with people with psychotic symptoms that the process be ‘de-mystified’ and transparent.
- It is important that feedback be brief and simple. It should also be qualitative in nature rather than quantitative – providing someone with their score on a measure is very rarely informative and can be unhelpful or distressing
- Feedback can be provided regarding the specific symptoms described e.g. “you mentioned that you’ve been hearing voices on and off since 1999”. In line with the aims of the therapy, we have found that it is also useful to emphasise the associated distress that the patient has reported e.g. “It seems like you’ve been feeling quite depressed/sad lately...”
- In keeping with the cognitive model the patient’s experiences should be described in terms of antecedents, beliefs and consequences. For example, “when you have an argument with your flatmate (A), you start to worry that they will move out of the flat (B), and then you feel really scared (C) rather than “it sound like your flatmate gets you down”. This helps to set the scene for any later cognitive therapy.

EXPECTATIONS OF THERAPY

- Understanding the patient's expectations of therapy is an important step in building motivation for therapy, and in building a collaborative relationship. People with psychosis may be more likely to be seeing you because it has been suggested by their doctor or case worker and less likely to have requested psychological therapy specifically.
- Elicit expectations about therapy from the patient through the use of questions like:
 - “What was it like when you saw a psychologist/ counsellor before?”
 - “What did you do?”
 - “What are your ideas about what we will do in these sessions?”
- Ask the patient to complete the “Client Expectations Questionnaire” either in the session or between sessions – this can provide a useful discussion point to clarify expectations about therapy and outcome. Specifically, it can help identify unrealistically positive or hopeless expectations for treatment.
- Once an understanding of the patient's experience and expectations of therapy has been reached – this will inform decisions about how treatment proceeds from here.

“...One of our patients was Gene - a 27-year-old man with auditory hallucinations and paranoid ideation. With careful discussion it became clear that he had generally negative expectations about the possible of therapy helping him to make changes. His therapist was then able to spend more time early on in therapy engaging in motivational interviewing and gentle challenging of his beliefs that: “things won't get better”, “I've done this (therapy) 4-5 times other therapists and it didn't help”. Spending time discussing other issues in therapy also enhanced motivation and rapport. Time was spent discussing problems with housing, personal interests (music and participation in a band), finance, medication and other support needs. As the therapeutic relationship developed, the focus of discussion could become more focussed on therapy...”

- Provide some information on the general structure and format of therapy, e.g., collaborative approach, role of homework, length and frequency of sessions.

Note: If a patient is unwilling or unable to attend a weekly appointment at the clinic, it may be necessary to negotiate about the timing, length, and location of sessions, e.g., having a couple of briefer sessions each week, meeting fortnightly, meeting at the patient's home or another venue.

SESSION SUMMARY

- Summary may include
 - key points from assessment
- Practise tasks for this module may include
 - completion of self report measures

FURTHER INFORMATION:

COGNITIVE-BEHAVIOURAL ASSESSMENT AND FORMULATION

Barlow, D. *Clinical Handbook of Psychological Disorders (3rd Edition)* New York: Guildford Press

Beck, J.S (1995) *Cognitive Therapy: Basics & beyond*. New York Guildford

Hawton, K., Salkovskis, P.M., Kirk, J., and Clark, D.M. (1989) *Cognitive Behaviour Therapy for Psychiatric Problems: A practical guide*. Oxford: Oxford University Press.

ASSESSMENT MEASURES

Mini International Neuropsychiatric Interview (MINI)

Reference: Sheehan, D. V., Lecrubier, Y., Sheehan, K.H., Amorim, P., Janavs, J., Weiler, E., Hergueta, T. Baker. R., & Dunbar, G.C. (1998). The Mini International Neuropsychiatric Interview (MINI): The development and validation of a structured diagnostic interview for DSMIV and ICD-10. *Journal of Clinical Psychiatry*, 59, 22-33.

Brief Psychiatric Rating Scale (BPRS)

Original reference: Overall, J.E. & Gorham, D.R. (1962) The Brief Psychiatric Rating Scale. *Psychological Reports*, 10, 799-812

Notes: Has been adapted and reproduced often since original publication and is fairly readily available within mental health services – does require training in its use but this is also available within services

Schizophrenia Quality of Life Scale (SQLS)

Reference: Wilkinson, G., Hesdon, B., Wild, D., Cookson, R., Farina, C., Sharma, V., et al. (2000). Self-report quality of life measure for people with schizophrenia: the SQLS. *British Journal of Psychiatry*, 177, 42-46.

WHO Disability Assessment Schedule (WHO-DAS)

Janca, A., Kastrup, M., Katschnig, H., Lopez-Ibor, J.J. Jr, Mezzich, J.E., Sartorius, N. (1996) The WHO's short disability assessment schedule (WHO DAS-S): A tool for the assessment of difficulties in selected areas of functioning of patients with mental disorders. *Social Psychiatry and Psychiatric Epidemiology*, 31, 349-354

Notes: A brief clinician rated measure - Axis II of the ICD-10 classification of mental disorders

Calgary Depression Scale for Schizophrenia

Reference: Addington, D., Addington, J. & Schissel, B. (1990) A depression rating scale for schizophrenia. *Schizophrenia Research*, 3, p.247-251

Notes: This scale is a clinician rated scale

Beck Anxiety Inventory (BAI)

Reference: Beck, A.T., Brown G.K., Epstein, N. & Steer, R.A. (1988) An Inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology*, 56, 6, 893-987.

Brief Symptom Inventory (BSI)

Reference: Derogatis, L.R & Melisaratos, N. (1983) The Brief Symptom Inventory: An introductory report. *Psychological Medicine*, 13, 595-605

Module 2

Symptom Specific Assessment

Module 2: Symptom Specific Assessment

Module Objectives

1. To continue building rapport and developing a sound therapeutic relationship
2. To assess the psychotic symptoms that the patient is experiencing and their explanatory model of these symptoms
3. To obtain objective measures of aspects of the patients specific psychotic symptoms – hallucinations, and delusions
4. To develop a functional analysis of the individual's psychotic symptoms (delusions and hallucinations) – using clinical interview and structured assessment
5. To provide feedback on the assessment
6. To collaboratively agree on targets for treatment

Module Content

- Rationale for symptom specific assessment
- Assessment of delusions and/ or voices
- Provision of feedback regarding assessment measures
- Goals/targets for therapy

Assessment Package

In addition to clinical interview, at CCI we have used the following measures to assess delusional beliefs and voices. There are also other ways of measuring delusions, which you could use, although we have found these to be helpful and relatively straightforward.

Delusions

Visual Analogue Scales: Ratings of Conviction and Preoccupation

Voices

Cognitive Assessment of Voices Interview
Beliefs About Voices Questionnaire-Revised
Topography of Voices Rating Scale

N.B: See “Further Information” at end of module for references and sources of these measures

Worksheets Required

- ✂ Goals for Therapy Worksheet
- ✂ Session Summary

Key Issues

As noted earlier there is a clear link between degree of rapport and accurate symptom description. This module should therefore be carried out in the context of engagement and rapport building and priority given to development of rapport and the therapeutic relationship at the expense of rapid information collection. For example, it may be necessary to stop the formal assessment and discuss other topics if the patient appears distressed.

As in Module 1 (General Assessment) it is important to balance assessment with consideration for the patient's current concerns. It may be necessary to schedule time in assessment sessions for brief interventions focussed on immediate concerns e.g. problem solving, advocacy on patient's behalf, liaison with treatment team to arrange medical review etc.

Some of the assessment measures should be repeated at regular intervals – particularly the visual analogue scale ratings of delusional beliefs and the topography of voices rating scale. This allows a more thorough understanding of factors that may be related to any observed changes or fluctuations in intensity.

Therapist's Notes

PROGRESS & HOMEWORK REVIEW

- Progress: Review progress in coping with any problems or issues discussed in previous assessment sessions
- Homework: May include completion of questionnaire measures, or self-monitoring of specific symptoms/ behaviours
- Questions?: Ask if there are any questions regarding what was covered in previous sessions – specifically check for concerns about the assessment measures or process

RATIONALE FOR SPECIFIC ASSESSMENT

- As in Module 1, it is important to provide a rationale for the detailed assessment of symptoms that is required in this module
- It may be useful to explain that you will be talking to the patient about their specific symptoms in detail, and ask for their permission to do this. For example, “In order to understand your situation properly it will be important to talk about your voices in detail – how do you feel about that?”

ASSESSMENT OF DELUSIONS AND/OR VOICES

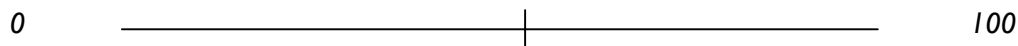
The general aim of this assessment is to develop an understanding or formulation of how delusional beliefs and auditory hallucinations operate to produce distress and disturbance in the individual. For some patients the target of therapy will be both delusional beliefs unrelated to voices and voices so both aspects will need to be assessed thoroughly. There will also be others who are primarily troubled by delusional beliefs or by voices – so only one of these aspects will need to be assessed. (For general references relating to cognitive behavioural case formulation or conceptualisation see ‘Further Information’ at the end of this module.)

Delusional Beliefs

- The aim of the assessment is to develop a functional assessment and formulation of delusional beliefs – including a understanding of predisposing, precipitating and maintaining factors
- The primary means of assessment here is clinical interview i.e. careful questioning, although we also use visual analogue scales to estimate the strength of beliefs and the patient’s degree of preoccupation with them. A visual analogue scale is simply a 10cm line with 0% at one end and 100% at the other end (see below for an example).
- When discussing delusional beliefs with the patient it is helpful to use their own language to describe them – and is likely to be unhelpful to describe them as ‘delusions’ if this is not a word that they have used themselves. In working with patients we have talked about ‘beliefs’, ‘worries’, ‘concerns’ or ‘preoccupations’

... A 73-year-old woman with a diagnosis of schizophrenia was referred for treatment of persistent delusional beliefs about being persecuted by her neighbour. In this case, the therapist followed her lead and discussed these beliefs as ‘concerns’. As the assessment progressed, the therapist was then able to ask Mavis to rate her degree of preoccupation with these beliefs using visual analogue scales. Using strength of belief ratings were not helpful with this patient because she was not willing to consider the beliefs as any less than 100% true – in fact any discussion along these lines threatened to damage rapport. Visual analogue scales were set up for her main ‘concerns’ – eg. ‘being bothered by Noreen (her neighbour)’, and ‘worrying about offending people’. Mavis could then quickly and easily rate her pre-occupation with each belief at the start of each session. For example:

Being bothered by Noreen



This provided a ‘way in’ to work later in therapy on things that would reduce her degree of preoccupation and the distress that this caused...

These ratings of the strength of delusional beliefs and the patient’s degree of preoccupation with them can readily be repeated throughout therapy. The ratings take very little time to complete each session and provide valuable and rich information about factors related to change in delusional belief and preoccupation over time.

Voices

- The aim of the assessment is to develop a functional assessment and formulation of auditory hallucinations – including an understanding of predisposing, precipitating and maintaining factors. Using the cognitive behavioural model, voices are understood as Activating Events or Triggers rather than Beliefs – we therefore need to focus much of our assessment on understanding the beliefs, and thoughts that the individual has about their voices that lead to distress and disturbance
- As with delusional beliefs, the primary means of assessment for voices is clinical interview, although we also use a structured interview measure and self-report scales to gather more complete information about voices. The visual analogue scales described above can also be used to rate strength of belief and preoccupation with specific beliefs about voices.
- If you are not using the measures described above, these are the areas it is necessary to gather information about in relation to voices. It is important to be as specific as possible in all these areas to get as useful an understanding as possible:

Physical characteristics: This includes features such as the number and gender of voices, frequency of occurrence, loudness, clarity, perceived location

Content: It is particularly important to be specific about content because the meaning that the patient attributes to the voice/s can affect their reports of content. For example a patient may say “the voice threatens me”, however closer questioning may reveal that the content of the voice is in fact quite neutral e.g. “make the sign of the cross”.

What does the voice say? Does it give commands? Comment on actions? Criticise or abuse? Give advice?

Beliefs: Research indicates that certain types of beliefs about voices are particularly important to understand (Chadwick et al., 1996; Chadwick, Lees, & Birchwood, 2000). These are the patient's beliefs about the identity of the voice; the degree of power or control the voice has over them; and the effects of complying with the voice (for those whose voices give commands).

Who do you think the voice/s might be? Do you think that the voice might be quite powerful? How do you know that it's powerful? What would happen if you didn't comply with the voice?

Cues: These include cues or triggers for hearing voices, and situations or times when they are not present

Some people mention that their voices are more active at certain times – have you noticed this about your voice/s? At what times or in what situations are your voices more active? Are there times when you don't hear the voice/s?

Emotional and behavioural consequences: voices may have positive, neutral or negative emotional and behavioural consequences.

How do you feel when you hear the voice? What do you do when the voice talks? Do you listen (willingly or unwillingly)? Swear or shout at the voice? Comply with what it says (willingly or unwillingly)? Do you ignore the voice or try to stop it talking?

- The following provides an example of the type of preliminary formulation that can be developed with an assessment of this kind:

...Terry is a 55-year-old man who was referred with persistent auditory hallucinations. After a few sessions spent on gathering assessment information a picture started to emerge. He described hearing male voices, which are perceived as originating in external space on his right hand side.

There are 3 different types of voice, which have different topographical characteristics and carry different types of meaning for him. The first of these is a loud, clear and compelling voice stating "pick up the knife and stab him" this voice also tells Terry to stab other people in different situations. This is the most commonly experienced voice – heard many times a day on initial assessment. The second voice is also loud, clear and compelling voice and says "take the baby and throw it on the ground". This voice is triggered when Terry sees a baby. Terry resists complying with these voices and has never done so. The third voice says, "make the sign of the cross" and is quieter and calmer than the other voices. Terry is less distressed by this voice than the other two voices and tends to comply with this voice when he hears it by making the sign of the cross or lifting his arms with his palms upward. Terry's voices appear to be more often present when he is feeling depressed or anxious and less present when he is distracted by a regular routine of activities

Terry believes that all these voices are very powerful and that he has no control over them. He also believes that he will be punished for complying with the voices that tell him to stab people or

throw the babies on the ground, but may also be punished for resisting “I must resist but what will happen to me if I resist?” Terry’s beliefs about the identity of his voices are expressed in different but related terms. He has said at various times that his voices are the Devil, that they are the Devil incarnate in him, that they are sent by Devil; or are a punishment by God for listening to them in the first place....

- As with ratings of delusional belief and preoccupation, ratings of various aspects of voices and beliefs about voices should be repeated regularly throughout therapy. For example, the Topography of Voices Rating Scale takes a minute or so to complete each session, and the BAVQ-R takes only a few minutes more. These measures both provide valuable about factors related to change in the experience of hearing voices over time.

PROVISION OF FEEDBACK ON ASSESSMENT

- As described in Module 1 – it is important to make time to provide feedback to the patient (according to their level of understanding) about the assessment, and your formulation. This will allow the patient to contribute their own perspective to the developing formulation, and provide an opportunity for you to check your understanding of their difficulties.
- In keeping with the cognitive model the patient’s experiences should be described in terms of antecedents, beliefs and consequences. For example, “when you hear the voice say “Kill him”(A), you start to worry that you will act on it (B), and then you feel really scared (C)” rather than “the voice scares you”. This helps to set the scene for any later cognitive therapy.

GOALS/ TARGETS OF THERAPY

- In order to facilitate the patient’s setting goals for therapy, the following questions may be useful – “What do you think that therapy can help you with?” “What things are most important for you to work on?” “What would you like to be different in your life?” “How would things be different if we were able to work together to help you with your voices?”
- The aim of this questioning process is to collaboratively agree on a limited number of targets or goals for treatment that are specific, measurable, realistic, and consistent with the patient’s capacities and the treatment approach. For example, “To never hear my voices again” is not likely to be a realistic goal for a patient with persistent auditory hallucinations, but “To feel less scared when I hear voices”, or “To be able to cope with my voices well enough to return to voluntary work” may be.
- Ask the patient to record their chosen goals on the Goals for Therapy Worksheet. Explain that this will be the guideline for therapy and will be reviewed as therapy progresses. Encourage the patient to review their goals for themselves from time to time and discuss any changes they wish to make in the therapy goals

...Gene, the 27 year old man described in Module 1, decided that a strong belief he had about being betrayed and his lack of confidence in social situations were the two areas he wanted to focus on in therapy. After discussion, these goals were further specified and recorded on the Goals of Therapy Worksheet. The first goal was: ‘Believe in myself and have the confidence to

talk more to others'. To make this goal clearer and more specific, Gene and his therapist came up with some objectives related to this goal:

- (1) increase my self esteem by not running out of situations I am afraid of
- (2) increase trust in others-especially people I don't know very well
- (3) feel more normal in social situations.

Gene's second goal was recorded as 'See whether my belief that I have been betrayed is true'. This goal included the following specific objectives:

- (1) test out whether some of my thoughts are delusional
- (2) have other people read confidential truths about me which are written down and be able to trust that they don't tell everyone
- (3) figure out whether I am being monitored or are under surveillance...

SESSION SUMMARY

- Summary may include
 - key points from assessment
 - targets chosen for treatment
- Practise tasks for this module may include
 - completion of self report measures
 - self monitoring of specific symptoms
 - review of "Goals of Therapy Worksheet"

FURTHER INFORMATION:

COGNITIVE-BEHAVIOURAL ASSESSMENT AND FORMULATION

Barlow, D. *Clinical Handbook of Psychological Disorders (3rd Edition)* New York: Guildford Press

Beck, J.S (1995) *Cognitive Therapy: Basics & beyond*. New York: Guildford Press

Hawton, K., Salkovskis, P.M., Kirk, J., and Clark, D.M. (1989) *Cognitive Behaviour Therapy for Psychiatric Problems: A practical guide*. Oxford: Oxford University Press.

ASSESSMENT MEASURES

DELUSIONS

Chadwick, P., & Lowe, C. F. (1990) Measurement and modification of delusional beliefs. *Journal of Consulting and Clinical Psychology*, 58(2), 225-232

VOICES

Cognitive Assessment of Voices Interview

Reference: Chadwick, P., Birchwood, M., & Trower, P. (1996). *Cognitive therapy for Delusions, Voices and Paranoia*. Chichester, UK: John Wiley & Sons Ltd

Beliefs About Voices Questionnaire-Revised

Reference: Chadwick, P., Lees, S., & Birchwood, M. (2000). The revised Beliefs about Voices Questionnaire (BAVQ-R). *British Journal of Psychiatry*, 177, 229-232

Topography of Voices Rating Scale

References:

Hustig, H. H., & Hafner, R. J. (1990). Persistent auditory hallucinations and their relationship to delusions and mood. *Journal of Nervous and Mental disease*, 178(4), 264-267

Chadwick, P., Birchwood, M., & Trower, P. (1996). *Cognitive therapy for Delusions, Voices and Paranoia*. Chichester, UK: John Wiley & Sons Ltd

Module 3

Early Treatment Engagement

Module 3: Early Treatment Engagement

Module Objectives

1. To continue building rapport and developing a sound therapeutic relationship
2. To reinforce patients' existing use of coping strategies
3. To facilitate motivation for psychological therapy using motivational interviewing strategies

Module Content

- Enhancing existing coping strategies
- Increasing motivation for psychological treatment
- Maintaining motivation

Worksheets Required

- ✂ Fire Drill for Coping Worksheet
- ✂ Change Process Balance Worksheet
- ✂ Session Summary

Key Issues

One of the common denominators in published descriptions of cognitive behavioural interventions for people with psychosis is the emphasis placed on the importance of engagement with the patient. These descriptions of treatment programmes always emphasise that assessment and engagement into treatment is likely to take longer and require more careful effort with this patient group.

As described earlier, the priority in these early modules of treatment is development of rapport – this is particularly important early on before the focus and direction of therapy becomes clear to the therapist or the patient. During these early stages (and throughout therapy) the following elements will help to promote rapport and engagement ...

General counselling skills

While general counselling skills are the foundation of any therapy, they are particularly critical with this patient group in order to convey that you will take the patient seriously, that you can be trusted and that you are willing to listen to their concerns. These skills should be used early on to give the patient the opportunity to talk at length about concerns and symptoms and to be understood.

Transparency about therapy process

The way that the assessment is handled in Modules 1 and 2 helps to introduce the idea that this form of therapy will be open as possible – providing feedback, and discussing expectations serves to remove some of the mystery from the therapy process. To foster this impression, it is also a good idea to give a brief introduction of yourself and describe your role in relation to other members of the treatment team. For example, a clinical psychologist may say something like *“I work together with people to help them understand their thoughts, feelings and behaviour and to help them find new ways to cope with problems.”* If appropriate, you may emphasise that you work in a team with other staff that the patient knows e.g. doctor, social worker, case officer. Be willing to answer questions about your role and clarify any misconceptions.

It is also consistent with the idea of transparency and collaboration to clarify issues of confidentiality and any limits to confidentiality. The early stages of therapy is also a good time to mention any time limits or other restrictions on therapy, so they do not come as a surprise for the patient later on in treatment. You may also need to clarify that the patient does not have to come and see you.

Flexibility

Another important requirement is to flexibly respond to patient needs and requirements at different stages of their illness and of therapy. It is not possible to maintain a sound collaborative therapeutic relationship without constant attention to the changing situation and requirements of the patient.

This will require, at the very least – checking in with the patient at the start of each session as to what they would like to work on. Some people you will work with will require more flexibility – perhaps in relation to the venue, timing or frequency of appointments.

Regular Review

In order to respond flexibly you also need to continually assess factors such as the patient’s mental state, experience of symptoms, degree of life stress and so on. This can be done partly using formal assessment (such as a regular rating of voices or delusional beliefs – as outlined in Module 2) or more informally through noting changes in the patient’s presentation.

Medication also needs to be regularly reviewed to ensure that it is as effective as possible and is not causing distressing side effects. Facilitating medication reviews will be easier if you are working within a multi-disciplinary team or where access to a doctor for regular review of medication is possible.

Dealing with Psychotic Material

The most helpful attitude to take to psychotic material, early on in treatment is to listening respectfully without challenging it or endorsing it. This attitude could be best

described as continually curious and open minded. Some people have described this as 'Colombo stance' or the 'Colombo technique' after the TV detective played by Peter Falk.

When listening to the patient's description of psychotic beliefs, or experiences – the aim is to attend to information that will help you build a cognitive behavioural formulation ie. the A's, B's and C's of their experience. It is also important to notice the times when the patient is aware of possible alternative explanations for their experiences (whether everyday experiences or psychotic experiences) – you can use these later in the cognitive therapy modules.

Therapist's Notes

PROGRESS & HOMEWORK REVIEW

- Progress: Check progress in general (e.g. “How have things been going this week?”) and specifically (e.g. “How did your doctors appointment go?”)
- Homework: May include review of goals and formulation, or ongoing self monitoring
- Questions: Ask if there are any questions regarding the goals for therapy or other issues

ENHANCING EXISTING COPING STRATEGIES

The purpose of this exercise is to reinforce and enhance the patient's active use of coping strategies that are already a part of the patient's repertoire and to highlight the patient's expertise in coping with their symptoms. As a clinician, this technique allows you to convey to the patient that you believe they are already actively coping with their symptoms and difficulties – rather than being a passive victim of them, thus reinforcing a collaborative therapeutic relationship. Coping strategy enhancement is also an effective therapy in its own right.

Coping strategy enhancement builds on the assessment made in Modules 1 and 2 and requires that you already have a sound understanding of the patient's symptoms. This section does not introduce new coping strategies – new cognitive and behavioural strategies will be developed during Modules 5 and 6: Cognitive Therapy for Delusions and Voices and Module 7: Behavioural Skills Training.

The steps in the process of identifying and enhancing existing coping strategies are as follows...

1. Elicit range of already used coping strategies from patient

Ask the patient, “*When you hear voices, what do you do to cope with them?*” or a similar question based on their own symptoms. If they are having difficulties thinking of their ways of coping, prompt them with information gathered during assessment sessions. For example you might observe, “*You said that the voices bother you less when you're with other people – is being with other people a way that you cope with voices?*”

Initially you are not distinguishing between helpful and unhelpful strategies but generating as large a list as possible, with the aim of emphasising that the patient is a person who is actively coping with their psychotic symptoms.

The types of strategies that are used most frequently by people with residual psychotic symptoms are:

Cognitive: distraction, narrowing attention, self-instruction

Behavioural: increase or decrease in social interaction, increase in solitary activity, avoiding triggers

Modifying sensory input: increased sensory stimulation (eg. turning on the radio or TV)

Physiological strategies: relaxation or breathing exercises

People may also describe 'self medicating' with alcohol or drugs (prescribed and non-prescribed).

... after first expressing considerable doubt that anything he did to cope with his voices was helpful, Terry (the 55 year old man described in Module 2), was able to describe a number of things that he did to cope with the day to day experience of persistent auditory hallucinations. He would turn on the radio or TV as a way of increasing his sensory input when his voices bothered him. He found it particularly effective to go for a walk while listening to his personal stereo with earphones. He also found going to church and receiving communion particularly helpful in reducing the distress associated with hearing voices. When his beliefs about the effectiveness of this strategy were explored, he said "I feel like I'm forgiven for hearing the voices for another week". One of his less effective coping strategies was to move from room to room in his house when hearing voices – in the hope that the voices would not be present in another room. Terry also described taking extra anti-psychotic medication or benzodiazepines when his voices were particularly intrusive – in order to put him off to sleep...

2. Discuss each strategy with the patient in detail

Work through each strategy with the patient to develop an understanding of the effectiveness of each strategy, how consistently the strategies are used, and any limitations to the use of the strategies.

It is important to gain a clear understanding of the strategies that the patient is already using and how they are using them. This will include understanding the consequences of the behaviour or strategy in the short term and the long term. Some strategies used may produce a short-term benefit, while maintaining distress and disturbance in the long term. For example, avoidance of social situations because of beliefs about others being able to read your mind may reduce immediate distress but will maintain and likely reinforce the belief in the longer term.

3. Select a few strategies to use more consistently and make plans for applying them

Ask the patient to choose a few strategies that are most useful (most effective, have the fewest limitations, etc.). Give the patient the *Fire Drill for Coping* worksheet (or an index card) and ask them to record the results of the discussion of coping strategies. The aim of this worksheet is to enable patients to record their most useful existing coping strategies in detail.

Set specific goals with the patient for using one or more of the identified coping strategies over the next week or so. If you identified any 'blocks' to the use of otherwise helpful strategies in step 2 – you could also set goals to overcome these blocks or impediments eg. "set aside some money each week to replace broken personal stereo", or "talk to a friend to make plan for walking regularly in the neighbourhood".

... Terry identified that walking regularly was a very helpful strategy for him – it provided a distraction and helped to lift his mood. However, he was having trouble getting back into a

'walking routine' after a hospital admission. To help him return to his routine of walking, he decided to set a goal to leave for a walk at the same time as his partner left the house for volunteer work ...

INCREASING MOTIVATION FOR PSYCHOLOGICAL TREATMENT

As in all psychological treatment, patients will often either openly express doubts about the merits of psychological treatment of their symptoms, or appear reluctant to engage in therapy related tasks. This is usually a reflection of some factor that is affecting motivation to change. For people with a psychotic illness there are likely to be some specific factors that affect motivation to change. Examples of these include:

- Perceived advantages of experiencing symptoms eg. a sense of companionship or comfort for those with auditory hallucinations
- Fear of loss of positive benefits associated with symptoms if therapy is effective eg. support from mental health professionals

Give out the Change Process Balance Worksheet and work through this worksheet with patients to discuss and record the costs and benefits of changing and not changing. This worksheet uses the principle of motivational interviewing – where a thorough and collaborative discussion of costs and benefits is used to ‘cement’ a decision to change (See ‘Further Information’ at the end of this module for references relating to motivational interviewing). It appears to be particularly helpful to the patient to generate and elaborate some of the possible positive aspects of a change in their symptoms (Yusupoff & Tarrier, 1996).

... As mentioned in Module 1, Gene (a 27-year old man) reported considerable doubts about the value of therapy for him. In discussing the costs and benefits with his therapist, the following 'decisional balance' emerged:

Negative consequences of current problem

Limits on what I can do - not very spontaneous

Anxious in some social situations eg. at work

Positive consequences of current problem

Managing OK - not very distressed

Benefits of change

Opportunity to talk about difficulties and increase my understanding of what's going on - gain some extra support

Possibility of increased quality of life

- *more variety in routine*
- *able to do more things*
- *more spontaneity*

Costs of change

Increased distress and discomfort of talking about difficult things (ie. disclosure)

Other people might find out about me and what I've done

Potential disruption to my routine

Gene's therapist spent time with Gene helping him specify the possible benefits of change – so they seemed more real and valuable.

This discussion also highlighted some elements that would need to be addressed in cognitive therapy – for example his delusional belief that other people knew about things that he had done or would find out if he spoke about them. It also provided information to his therapist about how quickly therapy should progress, what the obstacles would likely be and how much attention to give to maintaining and building motivation. For example, it was clear that any changes that would significantly disrupt the routine he had established for himself would not be welcome, but that a gradual process of increasing his ability to do things more spontaneously would be more acceptable.

Gene's degree of motivation fluctuated over the course of therapy – at times when there were a build up of stressors in his life, his motivation and insight into his difficulties would tend to flag. However, the attention paid to motivation early on provided a basis for proceeding with therapy that could be revisited again and again.

MAINTAINING MOTIVATION FOR THERAPY

As described in the example of Gene above, developing and maintaining motivation for therapy is not a 'one-off' task. Motivation will need to be monitored on an ongoing basis as the patient continues in therapy, as it will likely fluctuate over time.

Motivation and commitment to therapy can be reviewed by looking at the goals for therapy and asking the patient whether the goals set at the start of therapy are still relevant or important to them, and if there are now other things they would like to work on that they didn't think of at the start of therapy. You could also review the Change Process Balance Sheet at regular intervals.

SESSION SUMMARY

- Summary may include
 - Reminders of most helpful coping strategies
 - Most important identified benefits of changing

- Practice tasks for this module may include
 - Reading
 - Working on the *Fire Drill Worksheet* or *Change Process Balance Worksheet*
 - Planned practise of selected coping strategies.

FURTHER INFORMATION:

MOTIVATIONAL INTERVIEWING

Miller, W., Rollnick, S. & Conforti, K. (2002) *Motivational Interviewing: Preparing People for Change (Second Edition)*, New York, NY: Guildford Press.

Module 4

Psycho-Education

Module 4: Psycho-Education

Module Objectives

1. To continue building rapport and developing a sound therapeutic relationship
2. To provide patients' with information about psychosis and psychotic symptoms – suited to their level of insight and attitudes to illness.
3. To provide patients' with a 'normalising stress vulnerability model' of psychotic symptoms - with the aim of beginning to reduce hopeless and catastrophic cognitions about being psychotic and consequent anxiety, depressed mood, withdrawal and suicidal ideation.

Module Content

- What is Psychosis?
- Stress Vulnerability Model

Handouts Required

- 📄 What is Psychosis?
- 📄 Stress Vulnerability Model

Worksheets Required

- ✂ Stress Vulnerability Worksheet
- ✂ Session Summary

Key Issues

It is important to keep in mind that this module is not intended to be a didactic exercise. The aim is to develop a shared understanding with the patient about the nature and context of their difficulties and not to teach a standard set of facts about psychosis. As described in the Introduction to this manual, the psychoeducation component of treatment needs to be conducted in an individualised and collaborative way. For example, provision of information about psychosis at this stage will need to be 'titrated' or varied depending on the level of insight of each patient. For all patients, information should be delivered in a brief and straightforward manner using language that the patient can readily follow.

Usually it will make most sense to conduct this module after the assessment and early treatment engagement modules. However, there may be situations where the patient provides you an earlier opportunity to raise these issues. For example, by explicitly asking for information about their diagnosis or symptoms. In these cases it is more helpful to respond flexibly and allocate time earlier on in therapy to work through some aspects of this module.

Therapist's Notes

PROGRESS & HOMEWORK REVIEW

- Progress: Check progress with identified coping strategies and general issues
- Homework: May have included planned practise of coping strategies – if so it is important to review carefully to reinforce effectiveness of strategies or identify difficulties in implementing them

WHAT IS PSYCHOSIS?

Note: Any discussion about psychosis will have to be paced and structured according to what you already know about the person's insight into their illness, and their understanding of their symptoms or diagnosis. If the person you are working with is highly sceptical that they have a mental illness at all it may be more effective to focus your attention on developing a personalised stress vulnerability model for their distressing symptoms or experiences.

Before starting to talk specifically about symptoms or diagnoses it might be helpful initially to begin the discussion by asking broader questions such as:

"If you had to describe this illness to someone who knows nothing about it what would you say?"

or

"What do you say about your symptoms to your close friends and family?"

Symptoms of Psychosis and Types of Psychosis

Start to ask some more specific questions about symptoms and diagnoses. For example:

"You mentioned that your doctor diagnosed you with schizoaffective disorder – what does that mean to you?" or

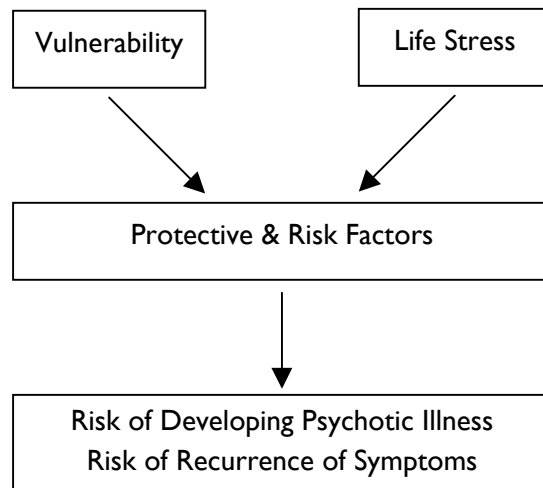
"What kinds of symptoms do you think someone with psychosis (or schizophrenia) experiences?"

The aim here is to review the patient's symptoms and relate them to the key symptoms or experiences of psychosis, through discussion and review of previously gathered information. This section of the module can be structured in different ways with different patients. Here are some examples...

- Write a list of the principle psychotic symptoms on a white board – as described on the 'What is Psychosis?' handout. Review this list of symptoms with the patient, asking them if they've had any similar experiences.
- Talk through the handout 'What is Psychosis?' with the patient – this outlines the main symptoms of psychotic illness and the different types of psychotic illnesses that a person could be diagnosed with. Invite feedback and discussion.
- Suggest that the patient look up some of the suggested web sites on the handout and bring the information they have found into the next session to discuss (this will only be appropriate for people with a degree of computer literacy and access to a computer)

As mentioned above, you may choose to spend more or less time on the diagnoses or types of psychosis depending on what you already know about the patient's understanding of or attitude to their diagnosis.

STRESS VULNERABILITY MODEL



The principle underlying the stress vulnerability model can be summarised briefly as follows – “the patient has a biological, often genetic predisposition that interacts with stress to cause illness” (EPPIC, 1997, p.13). It is a particularly useful model for working with people with psychosis or bipolar disorder (where there is more emphasis on biological vulnerability) because it provides a rationale for working psychologically as well as taking medication.

⇒ Draw the stress vulnerability model on the whiteboard and work through the key components in the model with the patient

By reviewing information gathered about past episodes with the patient, facilitate a general discussion about vulnerability factors, life stressors and triggers, protective and risk factors, emphasising the need to increase and enhance patients' protective factors and reduce their risk factors.

Some examples of the kinds of factors that may be significant in relation to each of the components of the model...

Vulnerability Factors

These are also sometimes known as ‘diathesis’ factors and may include things such as:

- Genetic vulnerability eg., family history of psychosis or related mental illnesses
- Neurodevelopmental/ biological vulnerability – this can be pre-natal eg., infection during pregnancy, birth trauma, illnesses or nutritional deficiencies; or post-natal e.g. head injury in childhood, drug abuse during important developmental stage
- Life stress vulnerability eg., low self esteem, poor frustration tolerance, age (adolescence, young adulthood)

Patients may sometimes have only minimal or incomplete information about these factors, but it is not necessary to have precise information about diagnoses and symptoms in order to discuss genetic or familial vulnerability.

...Terry had spent a lot of time describing some of his father’s unusual behaviours and moods. He said things like “my father used to shout for days and days and then he used to be quiet for a long time, sometimes he’s get in a really good mood and buy presents for us kids”. This discussion was summarised by the therapist saying, “you mentioned that your father had some difficulties that you now think might have been signs of a mental illness” – rather than trying to ‘pin down’ the specific diagnosis these behaviours may have indicated...

Life Stress Factors

A review of the literature indicates that the following stressors have been associated with the psychotic or psychotic-like symptoms:

- Recent bereavement/ grief
- Sleep deprivation
- PTSD
- Drug use eg. amphetamine psychosis
- Sensory deprivation
- Hostage situations
- Solitary confinement
- Sexual abuse

While you are unlikely to see many psychotic patients who have been taken hostage or placed in solitary confinement, many of the other stressors do have some relevance to our patients. The emphasis here is on placing psychotic symptoms in the context of normal human experience, with the take-home message that psychotic experiences can happen to anyone if put under enough stress. The graph on page 4 of the ‘*Stress Vulnerability Model*’ handout can be used to illustrate the relationship between vulnerability and the amount of stress required to trigger symptoms.

In discussing life stress factors – try to elicit from patient the kinds of stressors they have experienced, with particular emphasis on stress that was occurring prior to the first episode of psychosis and prior to any subsequent episodes. Some examples of stressors identified by our patients have been – starting university, moving to a new country, stress associated with adolescence and conflict with peers.

Protective Factors

May include factors such as:

- Use of coping skills (as described in Module 3)
- Social support or regular interaction with others
- Appropriate help seeking
- Regular use of anti-psychotic medication

Risk Factors

May include factors such as:

- Drug and alcohol use eg. “you mentioned that some of your episodes occurred after you’d been smoking a lot of marijuana, would you say that smoking marijuana is a risk factor for you?”
- Social isolation
- Unsatisfactory living situation

Record specific examples of these factors on the Stress Vulnerability Worksheet as you identify them with the patient. For example:

...Gene described experiencing more difficulties when his routine was disrupted or threatened with disruption. For example, although he frequently talked about his need for individuality and the necessity of him leaving the family home - this represented a threatening prospect. During therapy, his parent’s made a plan to move to Melbourne, for his step-father’s business. After discussing this plan with his family, he decided to remain in Perth so as not to disrupt his routine (eg. his work, social networks) too much. His parents therefore organised a unit for Gene to live in. When he discussed the upcoming move into his new unit in a therapy session, he was able to describe what it meant to him - “danger...and the increased chance that others will discover my past”. Given the meaning that moving out of home had for him it’s not surprising that he became significantly more stressed and experienced more symptoms around this time...

Note: It is important that this discussion be individualised for each patient, so that it suits his or her situation and degree of understanding. Different components of the model can be emphasised for different clients (e.g. the vulnerability factors may be emphasised for a client with a high genetic loading).

Discussion of the stress vulnerability model is an opportunity to draw together some of the information gathered in assessment (and to show that you were listening carefully!)

SESSION SUMMARY

- Summary may include
 - Relevant information about psychosis
 - Overview of personalised stress vulnerability model
- Practise tasks for this module may include
 - Reading
 - Stress vulnerability worksheet

FURTHER INFORMATION

If your patients ask for further information about psychosis – the following may be useful resources for them:

Books

E. Fuller Torey (2001) *Surviving Schizophrenia: A manual for families, consumers, and providers (Fourth Edition)*, New York: Harper Collins Publishers Inc.

Richard McLean (2003) *Recovered, Not Cured: A journey through schizophrenia*, NSW: Allen & Unwin

John Watkins (1993) *Hearing Voices: A self help guide and reference book*, Victoria: Richmond Fellowship of Victoria

Schizophrenia Fellowship of Victoria (1994) *Psychosis What is it? An introduction to psychotic illness in everyday language for carers, family and friends*, Schizophrenia Fellowship of Victoria

Mark De Hert, Geerdt Magiels & Erik Thys (2000) *The Secret of the Brain Chip: A self-help guide for people suffering from psychosis*, Belgium: EPO.

Websites

- Early Psychosis Prevention and Intervention Centre (Victoria, Australia)
<http://www.eppic.org.au/>
- SANE Australia
<http://www.sane.org/>
- Schizophrenia Fellowship of NSW
<http://www.sfnsw.webcentral.com.au/>
- Rethink UK (formerly National Schizophrenia Fellowship)
<http://www.rethink.org/>
- Expert Consensus Guidelines Series
http://www.psychguides.com/gl-treatment_of_schizophrenia_1999.html
- US National Institute of Mental Health
<http://www.nimh.nih.gov/publicat/index.cfm>

Module 5

Cognitive Therapy for Delusions

Module 5: Cognitive Therapy for Delusions



Module Objectives

1. To maintain rapport and a sound therapeutic relationship with client
2. To facilitate patients in understanding how their beliefs and thoughts influence their feelings and ability to cope
3. To collaboratively explore evidence for and against delusional beliefs
4. To facilitate the patient in designing and carrying out reality testing experiments to gather information about delusional beliefs
5. To help patients generate alternative explanations and thoughts that are helpful, healthy and balanced




Module Content

- Thoughts and feelings – ABC model
- Making the B-C connection
- Disputing delusional beliefs
- Experiments to test beliefs
- Balanced thinking

Handouts Required

-  Thinking and feeling
-  The feelings catalogue

Worksheets Required

-  My Thought Diary
-  Evidence log
-  Session Summary

N.B: If the patient you are working with only describes delusional beliefs that are related to voices, it will make more sense to skip this module and go straight to Module 6 “Cognitive Therapy for Voices”.

Key Issues

The aim of this module is to help patients re-assess some of the delusional beliefs that are causing them distress and to develop alternative balanced beliefs or explanations. It describes a step by step approach to understanding and challenging delusional beliefs.

The principle steps are...

1. distinguishing between thoughts and feelings
2. making the connection between thoughts and feelings
3. identifying the significant delusional beliefs
4. verbal challenging of delusional beliefs
5. behavioural experiments to test beliefs
6. developing alternative coping self-statements

Style

If you are more used to working with anxious or depressed patients in a standard CBT model, you may find that you need to make some adjustments in your style and way of working. Working with delusional beliefs in CBT is more like working at the core belief or schema level than at the level of automatic thoughts. For example, you will usually need to do more work to elucidate and clarify beliefs with the patient. It is also helpful to keep in mind that change in these beliefs will therefore require careful and focussed work in the longer term.

Understanding of psychosis

This module also requires a sound understanding of psychosis and some awareness of cognitive models of delusion formation and maintenance. We will not be able to cover these models in detail here - see 'Further Information' at the end of this module for some relevant references.

Before starting this module with a patient you will also likely need to review your formulation of the patients difficulties – particularly with regard to the assessment information gathered in Module 2 (Symptom Specific Assessment) about their delusional beliefs. You will need to have as clear an idea as possible about the specific delusional beliefs that cause most distress and the degree of conviction in these beliefs.

Therapist's Notes

PROGRESS & HOMEWORK REVIEW

- Progress: Review developing understanding of psychotic illness and discuss any obstacles to accessing information
- Homework: May have included reading of handouts or other resources about psychotic illness – it is important to take time to review this reading/information carefully to check the patients understanding of these materials

THOUGHTS AND FEELINGS – ABC MODEL

- Ask patient to describe a recent situation in which they experienced a strong feeling – initially, this does not need to be a ‘delusional’ example, in fact at this stage a more ‘everyday’, non-delusional example will be more appropriate.
- Then ask, “How did you feel in that situation?” - elicit emotions eg, anger, sadness, anxiety, frustration; and/or physiological sensations, eg, tightness in the chest, crying, knot in the stomach, etc.
- To elicit the automatic thoughts triggered in this situation, ask, “When this was happening, what were you thinking?” or “What were you saying to yourself?” or “What was going through your head at the time this happened?” If responses to these questions are not forthcoming, explain that our thinking process is very quick and automatic - can happen so quickly that often we are not aware of them. Give an example to facilitate response.
- After discussing the situation in this way, draw 3 columns on the whiteboard – ‘What happened?’ ‘What was I thinking?’ and ‘How did I feel? / What did I do?’ Record their description of the situation and their response in these columns (or use the My Thought Diary worksheet). Ask for the patient’s help in determining what parts of the event go in which columns.

Distinguishing situations, beliefs and feelings can be relatively straightforward for some patients and much more difficult with others. For example, some people can find it difficult to separate their interpretations of situations from the situations themselves...

... Mavis, the 73-year-old woman described in Module 2, would become very distressed when she heard noises made by her neighbour in the unit next door. She believed that this meant her neighbour was deliberately tormenting her. Mavis had a lot of difficulty separating out her beliefs (B) “She’s doing it on purpose” and “I’m being tormented”, from the situation (A) “Heard a noise of dishes clattering in the sink, from next door”, for her the meaning was implicit in the situation...

It is also very important at this point to ensure that thoughts are not being confused for feelings and vice versa.

Cognitive Style and Processes

There are a number of different cognitive models of delusional beliefs, and each of them focuses on different types of beliefs and cognitive biases differently. As a therapist, you will need to watch out for the following types of thoughts, beliefs, cognitive processes and cognitive biases:

- 1) Jumping to conclusions: a number of research studies indicate that people with delusions show a tendency to seek relatively less information before making a conclusion. This has also been described more specifically as a 'data-gathering' bias because it appears that while people with delusions will tend to gather less information before making a decision, they show no difficulties in using further information if it is made available to them (Garety & Freeman, 1999).
- 2) Attribution biases: People with persecutory delusions show a general tendency to blame other people (rather than chance, or themselves) for bad events happening to them. This is an exaggeration of the 'self serving bias' which most people show to a slight extent (Bentall, 1996).
- 3) Deficits in 'theory of mind'/ meta-representation: This refers to difficulties in understanding the thoughts, intentions and motivations of others. Preliminary research indicates that this type of difficulty is likely to be more prominent when the patient is more unwell or if they are experiencing relatively more negative symptoms (Garety & Freeman, 1999)
- 4) Psychotic patients may also demonstrate the types of unhelpful thinking styles that people with anxiety or depression report (see the CCI Mood Management therapist manuals for more information on these styles). For example, their delusional beliefs may reflect the operation of catastrophic misinterpretation of bodily sensations, selective attention to threatening information, or an 'all-or-nothing style'.

MAKING THE B-C CONNECTION

- Facilitate a discussion of connection between thoughts and feelings. You may find it useful to ask questions such as: *"How would you have felt if you were thinking differently in this situation?"* *What if you were thinking... how would you have felt then?"*
- Use the My Thought Diary worksheet to record additional examples of B-C connections from the patient's recent experience

At this point you will probably start to notice themes in the patients' automatic thoughts and beliefs.

... Mavis described a few ABC examples from different aspects of her day to day experience.

A: Saw treating psychiatrist in the corridor at the hospital, he greeted her but didn't smile

B: He doesn't want to see me again

He thinks I'm evil, dead inside

C: Distressed, anxious

A: Had to wait longer than other residents for her evening meal

B: They're doing this deliberately – because I'm evil and dead inside

C: Frustrated, anxious

A: Contemplating a return to voluntary work at the hospital

B: I won't know what to say next if a conversation starts

I'm evil and dead inside

C: Anxious

DISPUTING DELUSIONAL BELIEFS

Once delusional beliefs (or other unhelpful beliefs) have been identified, the next step is to help the patient begin to question, dispute or challenge their own beliefs. This effectiveness of this process is dependent on the work done in previous modules to strengthen the therapeutic relationship, develop a shared model of psychosis and understand the person's experience.

The aim of disputation is to reduce the distress produced by delusional beliefs by developing alternative explanations or helpful alternative beliefs. In general, it is most helpful to tackle the weakest delusional belief first and work towards the belief that is held most strongly by the patient. This is very like the strategy of working with automatic thoughts before tackling core beliefs in standard cognitive therapy for depression or anxiety. For example, with Mavis (see above) the initial, automatic thoughts like "He doesn't want to see me again", "They're doing this deliberately" or "I won't know what to say next" will be a better place to start than the more entrenched delusional belief "I'm evil and dead inside".

It can be particularly helpful to generate and test alternative/ non-delusional explanations for phenomena that are triggering delusional beliefs. These phenomena are often social cues or situations that the person notices day to day, but can also be other daily occurrences or somatic sensations.

... Gene described frequent paranoid beliefs triggered by social cues or situations. For example,

A: Whilst driving to his session, noticed another driver adjusting his rear view mirror

B: They're trying to see what I'm doing - check up on me

They know about me and what I've done

C: Anxious

A: Mother's friend parked her car in the middle of the driveway

B: They're trying to keep me trapped in the house – to track what I'm doing

C: Worried / Anxious

He found that the most helpful way of challenging these beliefs was to ask, “Is this the only explanation for this? Or “Is there any other possible explanation for this person’s behaviour?” With practice, he became able to challenge this type of belief so effectively that later on in therapy he could laugh about some of these situations and once noted “I can’t believe I used to think those things”...

EXPERIMENTS TO TEST BELIEFS

As described above, it seems that people with delusional beliefs may have a tendency to jump to conclusions before gathering sufficient data. Using simple experiments can help to counter this bias by encouraging the person to systematically collect additional information relevant to their beliefs. Experiments help people notice and use some of the information that is missed when they take the ‘shortcut’ of jumping to conclusions.

This section is included after the section on disputing delusional beliefs as there is some indication from recent research that skilful use of verbal challenging – followed up by experimental testing of beliefs; may be the most effective strategy in working with people with delusions (Chadwick et al., 1994).

The Experiment Log worksheet can be used to help with planning, and recording the results of experiments.

Behavioural experiments can also be used to deliberately sets up a contradiction between the way the client perceives themselves, and the outcome of the behavioural task - with the aim of gradually making the person less certain of the validity of their beliefs. The example below illustrates this process.

...As described above, Gene had a consistent belief that others knew about him and what he had done, or that they would find out about him after even brief or casual social contact. He therefore avoided many social situations because of this paranoid fear. After he had practised generating alternative explanations (as above) he then felt more confident to gradually go into some situations that would help provide some information relevant to these beliefs. For example, after discussion with his therapist he set tasks of going into his favourite record shop more regularly, and starting conversations with the person working in the guitar shop. He experienced considerable anxiety before trying these tasks as he predicted that these people would respond negatively to him e.g. by ignoring him or speaking rudely to him. Instead he was surprised to find that these people responded in a friendly way, appeared interested in what he had to say and often went out of their way to approach him and start conversations. He acknowledged that these experiences did not fit with his delusional belief and was able to use them to further weaken this long held belief...

Finally, it is important that experiments are planned carefully with a clear idea of what different outcomes would mean to the patient. For example:

...Mavis was concerned about catching public transport and believed that she would become extremely anxious if she caught a train. To test this belief, an experiment was planned which involved her catching a train to Fremantle and back, and observing how she felt during the trip. When she returned to therapy the week after trying this experiment, her therapist was surprised to hear her say that it had gone much worse than expected, even though she had completed the task as planned. She asked, “Did you feel anxious during the trip?” and Mavis replied that she

hadn't felt anxious but that this was also a problem. To Mavis, this outcome meant – "I'm dead inside because I didn't feel anxious" – leaving her in a 'lose-lose situation' with regard to the experiment. After this experience, the therapist changed the emphasis with behavioural experiments to help Mavis focus attention on successful completion of tasks rather than using how she felt as the only marker of success. ...

BALANCED THINKING

We tend to use the concept of balanced thoughts here because it highlights that cognitive therapy is not a 'black and white'/'right or wrong' process. The patient is encouraged to generate new explanations or coping statements that take into account the realities of the situation (both positive and negative) rather than negate or reject their original beliefs. To generate helpful coping self-statements or balanced thoughts patient's, use the patient's disputation ("How can I think differently?"), and the results of experiments. Record any useful self-statements on index cards to make 'coping cards' that the patient can refer to as required.

... Gene developed a coping card that included a reminder of the biased cognitive processes that he went through. On one side it said "When I feel threatened, I think others are giving me hints and clues which lead me to feeling more anxious and sometimes afraid for my safety". The other side of the card had reminders of what he could do in these situations such as "If I know the person, I could approach them" and a suggestion to ask himself "Are there any alternative explanations for their behaviour?" or "Do I have any more evidence of this?"...

These coping self statements are most helpful when they are based entirely on what the patient has found most helpful, rather than what we as therapist think is the 'best' piece of disputation.

...Mavis found it very helpful to remember some of the reassuring things her father used to say to her when she became distressed by her delusional beliefs. She would ask herself "What would my Dad say?"...

SESSION SUMMARY

- Summary may include
 - A review of the beliefs discussed in the session
 - Any helpful disputation or coping statements developed in the session

- Practise tasks for this module may include
 - Reading
 - Practise of thought diaries
 - Behavioural experiments with monitoring of results

FURTHER INFORMATION

Books

Paul Chadwick, Max Birchwood & Peter Trower (1996) *Cognitive Therapy for Delusions Voices & Paranoia*, Chichester, UK: John Wiley & Sons

David Fowler, Philippa Garety & Elizabeth Kuipers (1995) *Cognitive Behaviour Therapy for Psychosis: Theory & Practice*; Chichester, UK: John Wiley & Sons

Gillian Haddock & Peter D. Slade (1996). *Cognitive Behavioural Interventions with Psychotic Disorders*. London, UK: Routledge

Articles

Daniel Freeman, Philippa Garety, Elizabeth Kuipers, David Fowler, & Paul E. Bebbington (2002). A cognitive model of persecutory delusions. *British Journal of Clinical Psychology*, 41, 321-347.

Philippa Garety, Elizabeth Kuipers, David Fowler, Daniel Freeman, & Paul E. Bebbington (2001). A cognitive model of the positive symptoms of psychosis. *Psychological Medicine*, 31(2), 189-195.

Philippa Garety, & Daniel Freeman (1999). Cognitive approaches to delusions: A critical review of theories and evidence. *British Journal of Clinical Psychology*, 38(2), 113-154

Module 6

Cognitive Therapy for Voices

Module 6: Cognitive Therapy for Voices




Module Objectives

1. To maintain rapport and a sound therapeutic relationship with client
2. To facilitate patients in understanding how their beliefs and thoughts in relation to their voices influence their feelings and mood and coping.
3. To collaboratively identify beliefs about voices/hallucinations and explore evidence for and against unhelpful/ distressing beliefs.
4. To facilitate the patient in designing and carrying out reality testing experiments to gather information relating to beliefs about voices.
5. To help patients generate alternative explanations and thoughts about voices that are helpful, healthy and balanced.




Module Content

- Thoughts and feelings – ABC model
- Making the B-C connection
- Voices as triggers
- Disputing automatic thoughts about voices
- Behavioural experiments to test beliefs
- Balanced thinking

Handouts Required

-  Thinking and Feeling
-  The Feelings Catalogue
-  Detective Work

Worksheets Required

-  My Thought Diary
-  Experiment Record
-  Session Summary

Key Issues

The key message for this module – for both patient and therapist; is that it is not the experience of hearing voices alone, but the way that these voices are understood and interpreted by the voice hearer, that causes distress.

The aim of the module is to help patients re-assess some of their beliefs about their voices and develop more helpful or balanced ways of viewing their voices – with the ultimate aim of reducing the distress and disturbance they experience. Therefore, this module is only relevant for those patients who describe persistent auditory hallucinations with consequent distress.

This module works through a step by step approach to understanding and challenging unhelpful cognitions relating to auditory hallucinations that your patients may have. The principle steps are...

1. distinguishing between thoughts and feelings
2. making the connection between thoughts about voices and feelings
3. verbal challenging of beliefs about voices
4. behavioural experiments to test beliefs
5. developing alternative balanced thoughts

Before starting this module with a patient you will likely need to review your formulation of the patients difficulties – particularly with regard to the assessment information gathered in the “Symptom Specific Assessment” module. There has been a considerable amount of research into the nature of people’s beliefs about their voices, which you may find useful in developing your formulation (see ‘Further Information’ at the end of the module for references).

Therapist's Notes

PROGRESS & HOMEWORK REVIEW

- Progress: Review developing understanding of psychotic illness and discuss any obstacles to accessing information
- Homework: May have included reading of handouts or other resources about psychotic illness – it is important to take time to review this reading/information carefully to check the patients understanding of these materials

THOUGHTS AND FEELINGS – ABC MODEL

As in Module 5

N.B: If you have already worked through Module 5 “Cognitive Therapy for Delusions”, you will not need to repeat this section or the “Making the B-C Connection” section, but can instead go straight to “Voices as Triggers”

MAKING THE B-C CONNECTION

As in Module 5

VOICES AS TRIGGERS

Cognitive Model of Voices

It appears to be helpful to understand the patient’s beliefs about voices, as the outcome of an active search for meaning – a process of trying to make sense of a distressing and confusing experience. In many ways this process will not be much different from the type of process that any of us would go through when faced with a bewildering new experience. We would first experience confusion and uncertainty, then we would start to generate some possible conclusions about what is going on, we would then choose a particular conclusion that would become clearer and firmer as we found information to confirm it.

The cognitive model of voices is similar to the cognitive model of delusions in that it emphasises the role of biased appraisal processes in maintaining the unhelpful and distressing beliefs. In essence, the cognitive model suggests that people who hear voices are having trouble distinguishing between internal, private events (like thoughts) and external, public events (like voices). In other words, the person who hears voices is mistaking their thoughts for an externally generated voice.

Paul Chadwick and colleagues (eg. Chadwick & Birchwood, 1994; Chadwick & Birchwood, 1995) have theorised that the types of beliefs about voices that are likely to be most significant in producing distress are those relating to the power, identity and intention of the voices/s. That is, if people believe that their voices are very powerful or out of their

control, and wish to do them harm they will tend to feel more distressed by them. The Beliefs about Voices Questionnaire (BAVQ-R), and the Cognitive Assessment of Voices: Interview Schedule are both excellent sources of information about these beliefs.

... Terry believed very strongly that he was powerless in the face of his voices. When he completed the BAVQ-R early in therapy he indicated "Strongly Agree" for beliefs like "My voice is very powerful", "I cannot control my voices" and "My voice will harm or kill me if I disobey or resist it". Believing that he could not control his voices caused him significant distress and anxiety. Unfortunately, increased this stress and anxiety tended to exacerbate his voices, making things worse.

Using the Thought Diary

- After practising the ABC model with recent examples, specifically ask the patient to reflect on a recent experience of hearing a voice or voices
- Use the thought diary to record the specific content of the voice – in order to fill in the columns of the thought diary you'll need to ask the patient
 - exactly what the voice/s said (A) – its important that the patient records the voice content exactly as they heard it, rather than summarising or interpreting at this point. People will often be reluctant to repeat exactly what the voice/s have said, so you may need to move slowly to get the required detail
 - what the patient felt and did when they heard the voice/s (C) eg. "How did you feel when the voice said that?" "How do you usually feel when you hear this voice?"
 - what thoughts they had about the voices (B) eg. "What went through your head when you heard the voice?" "What did see happening if you did what the voice told you to do?"

... Terry was initially reluctant to describe his voices and his thoughts about them in detail, but with some careful questioning and reference back to the beliefs he had endorsed on the BAVQ-R, he was able to complete the first part of the thought diary...

| <i>What happened?</i> | <i>How did I feel? What did I do?</i> | <i>What was I thinking?</i> |
|--|--|---|
| <i>Heard voice saying ... "Take a knife and stab him"</i> | <i>Scared Confused Distressed Depressed Started pacing round the house</i> | <i>I might act on it I shouldn't be having these voices – I'm being punished by God The voice is the devil The voice is very powerful</i> |

DISPUTING AUTOMATIC THOUGHTS ABOUT VOICES

The process of disputing or challenging beliefs related to voices is very similar to the process of challenging the more general delusional beliefs discussed in the previous module, and is equally dependent on the work done in previous modules to strengthen the therapeutic relationship, and develop a shared model of psychosis. As with delusional beliefs in general it is usually most helpful to start with a less distressing belief before moving onto more distressing beliefs.

As mentioned above, there are certain types of beliefs that seem to produce the most distress for people who hear voices. These are beliefs relating to the power, identity and intention of the voices/s, and it is these beliefs that will likely be a useful focus for disputation.

Beliefs about the power and controllability of voices may already have been weakened as the person practises coping strategies for managing voices more consistently. We would often start the disputation process by highlighting the person's experiences of control. We would also gently explore any inconsistencies in the belief that you are working on. For example, if you were working on a person's belief that their voice was the voice of the devil, you may ask questions like "Were there ever times when you had some doubt that the voice was the voice of the devil?" or say "You mentioned a while back that you sometimes wondered if your voice was really the devil – can you tell me more about those times?"

... As described above, Terry was particularly distressed by his belief that his voices were very powerful and that he would not be able to resist their commands. A lot of time in therapy was spent exploring for any inconsistencies with this belief. For example, Terry had heard this voice for over 20 years and it had given similar commands for much of that time – so his therapist asked, "Have you ever acted on these commands?" Terry responded that he had never stabbed anyone or responded violently when he heard the voice. Terry's therapist expressed mild surprise that he had successfully resisted his voice's commands for so long, if the voice was indeed as powerful as he believed. Terry was also gently encouraged to review and discuss the doubts he had experienced about the power and identity of his voice over the years. Terry reported that discussing his voices, and the beliefs he held about them in this way helped him to feel that he did have some control over them and over his responses to them.

EXPERIMENTS TO TEST BELIEFS

As when working with delusions, using simple behavioural experiments can help people collect information relevant to their beliefs about voices.

For example, as in the example of Terry (above), many people who hear voices are distressed by the thought "I have no control over my voices". If the person can be encouraged to try out some different techniques for controlling their voices (like using earplugs or reading aloud) and then notices a change in some aspect of their voices, this can be very powerful challenge.

... In one of Terry's therapy sessions he reported in his ratings at the start of the session that his voices had been very frequent clear, and distressing over the past few days. During this session Terry's therapist spent some time engaged in discussion with him about one of his personal

interests – gardening. Terry discussed some plans he had for removing some plants that weren't thriving from his courtyard garden and replacing them with more suitable plants. He also described how enjoyable it was to sit in the garden and watch the birds splashing in the birdbath. After 5 or 10 minutes of this conversation, the therapist asked Terry "What did you notice about your voices while we were talking just now?" Terry identified that he had not noticed his voices and was feeling a little calmer – he was also visibly more relaxed. The rest of the session was spent discussing the results of this 'experiment' and planning ways of trying out the same experimental test at home – by engaging his partner or a friend in conversation at times when his voices were distressing him and monitoring the effects ...

BALANCED THINKING

As mentioned in the Key Issues section, the aim of this module is to help the patient develop more helpful or balanced ways of understanding their auditory hallucinations. We tend to use the concept of balanced thoughts here (rather than 'rational thoughts') because it highlights that cognitive therapy is not a 'black and white' / 'right or wrong' process. The patient is encouraged to generate new explanations that take into account the realities of the situation (both positive and negative) rather than negate or reject their original beliefs.

Coping cards

A useful way of 'cementing' the patient's disputation, balanced thoughts, and the results of behavioural experiments involves the use of coping cards. The patient can be encouraged to use these when they are troubled by voices.

Each coping card needs to be individually tailored but the following steps may help...

- Review thought diaries and record the most helpful information from the fourth column of the Thought Diary ("How can I think differently?") – keep in mind that the only judge of what is most helpful is the patient
- Review outcomes of relevant behavioural experiments and record on the card
- Review helpful coping strategies for controlling voices and record on card e.g. "There are some things I can do that are effective in controlling the voices" (with list of coping strategies)
- Record helpful statements or advice given by others in relation to coping with the voices

...Terry found it helpful to record the results of discussions in session on coping cards to use at home. He had cards for different situations – like when he was feeling anxious before a doctor's appointment, or when his voices were particularly intrusive. On one of his 'voices cards' he wrote "There are some things I can do to control my voices" and then recorded a list of things like using his personal stereo with earphones, going for a walk, doing a relaxation exercise, or sitting in the garden. This card provided a more balanced perspective than his original belief "I have no control over my voices"...

SESSION SUMMARY

- Summary may include
 - Review and summary of in-session thought diaries
 - Recording helpful and balanced thoughts on coping cards

- Practise tasks for this module may include
 - Reading
 - Practice of thought diaries
 - Behavioural experiments with monitoring of results

FURTHER INFORMATION

Books

Paul Chadwick, Max Birchwood & Peter Trower (1996) *Cognitive Therapy for Delusions Voices & Paranoia*, Chichester, UK: John Wiley & Sons

David Fowler, Philippa Garety & Elizabeth Kuipers (1995) *Cognitive Behaviour Therapy for Psychosis: Theory & Practice*; Chichester, UK: John Wiley & Sons

Gillian Haddock & Peter D. Slade (1996). *Cognitive Behavioural Interventions with Psychotic Disorders*. London, UK: Routledge.

Articles

Philippa Garety, Elizabeth Kuipers, David Fowler, Daniel Freeman, & Paul E. Bebbington (2001). A cognitive model of the positive symptoms of psychosis. *Psychological Medicine*, 31(2), 189-195.

Module 7

Behavioural Skills Training

Module 7: Behavioural Skills Training


Module Objectives

1. To maintain rapport and a sound therapeutic relationship with client
2. To build on the patients' existing coping repertoire to improve management of current problems, increase self-efficacy and reduce associated distress (i.e. depression and anxiety)
3. To teach appropriate behavioural skills including problem solving, relaxation, activity scheduling, and the use of behavioural hierarchies for graded exposure and task assignment

Module Content

- Review of existing coping strategies
- Skills training
 - problem solving
 - calming technique
 - activity scheduling
 - behavioural hierarchies: graded exposure/ graded task assignment

Handouts Required

-  Calming technique

Worksheets Required

-  Problem Solving Worksheet
-  Exposure Step Ladder Worksheet
-  Weekly Activity Schedule
-  Session Summary

Key Issues

In some ways, it is an artificial distinction to separate cognitive and behavioural techniques for managing symptoms of psychosis. With most patients you will find that these techniques work best in combination. For example, you might use behavioural skills training to help the patient gather information that will help shift their beliefs or might use cognitive disputation to help a patient reduce their fear about engaging in a behavioural task.

It is important that the choice of specific techniques for skills training is informed by an individualised formulation of the patient's difficulties and requirements. The rationale for any additional skills training also needs to be linked to the patient's treatment goals.

Skills training needs to be carried out from the perspective that each patient is someone who has a set of skills and is already actively coping with their difficulties. This is why we review existing coping strategies before moving on to new strategies or skills. In general it may be useful to conceptualise new strategies as tools that the patient can add to their existing "toolbag" and draw on as required.

Therapist's Notes

PROGRESS & HOMEWORK REVIEW

- Progress: Check on progress with challenging unhelpful beliefs
- Homework: May have included use of thought diaries or behavioural experiments

REVIEW OF EXISTING COPING STRATEGIES

- Spend some time reviewing the naturalistic coping strategies discussed in Module 3 (Early Treatment Engagement) and reinforce the continued use of helpful strategies
- Say *“Do you remember at the start of therapy we looked at some of the ways you’ve been coping with your symptoms?”* (Provide examples if necessary) *“Why don’t we spend some time reviewing how you’re doing with those strategies?”*

SKILLS TRAINING

The following areas have been found to be useful and applicable in some situations for people with psychosis. Each skills area is outlined relatively briefly in this manual and it may be necessary to seek additional information from other sources if you’re not familiar with a technique.

Problem Solving

There is evidence that problem solving training may be a useful core strategy in controlling the life stress experienced by people with psychosis, which is often implicated as a factor in vulnerability to relapse (Falloon, 2000). This strategy is particularly helpful because it is a straightforward and easily taught technique that can be applied to individuals, groups, and families.

The essence of problem solving is that it is a step by step process for addressing psychosocial problems the patient has identified. The steps are as follows...

1. Identify and define problem area
 - state problem as clearly as possible, in a way that facilitates its resolution
 - be objective & specific and describe the problem in terms of observable phenomena as well as subjective feelings
2. Generate potential solutions
 - list as many solutions as possible without evaluating their quality or feasibility
 - at this stage the idea is to list as many as possible, you can even include some ‘silly’ solutions to emphasise the importance of not ruling options out at this point

3. Evaluate alternatives

- eliminate less desirable or unreasonable solutions
- order remaining solutions in terms of preference
- weigh up pros and cons of each solution on the 'short list'

4. Decide on a solution

- specify actions and who will take action
- specify actions on how to maximise coping resources and how to overcome barriers to effective coping
- specify how and when the solution will be implemented
- implement the solution as planned

Steps 1-4 are outlined on the 'Problem Solving' worksheet – which can be used by patients to work through each step of the problem solving process.

There is also an additional step in the problem solving process that helps to reinforce the value of the process for patients – this step can be carried out in the session after the patient has tried out a solution.

5. Evaluate the outcome

- evaluate the effectiveness of the solution
- decide whether a revision of the existing plan or a new plan is needed to address the problem better

... Gene had been experiencing some difficulties with a disruptive housemate – this had caused an increase in stress, which was having an impact on his symptoms, and on his coping. The problem solving technique was used to help him consider the options he had for dealing with this situation and for taking some control over it. After discussion of the problem, Gene generated 4 possible solutions

- 1) Staying in the flat with the current flatmate
- 2) Moving back in with his parents
- 3) Staying in the flat but asking his flatmate to move out
- 4) Moving into another place by himself

He identified the advantages and disadvantages of the first three possible solutions – having decided that the fourth option was impossible for financial reasons.

| Advantages | Disadvantages |
|--|---|
| 1) <ul style="list-style-type: none">• Maintaining independence | <ul style="list-style-type: none">• Increased unpredictability• Reduced stability |
| 2) <ul style="list-style-type: none">• Increased predictability• Constant support | <ul style="list-style-type: none">• Decreased independence• Having to live under parents' rules |
| 3) <ul style="list-style-type: none">• Would be able to stay in flat – like living there• Less stress in the long run | <ul style="list-style-type: none">• Don't want to confront flatmate• Worried about damaging the friendship |

After looking at the advantages and disadvantages – Gene decided that the best option for him would be to move back to his parents' house, at least in the short term. He decided that maintaining a predictable life style was the most important thing for him, and was pleased to have made a decision that he thought would help him manage better...

Calming Technique

Physical arousal, or tension and the emotional state of anxiety have been implicated in the establishment and maintenance of positive psychotic symptoms. It follows then that teaching a skill for managing anxiety and arousal states will be particularly helpful for those with persistent psychotic symptoms. This is also a useful technique if a person is experiencing difficulties in sleeping and may also operate as a positive distraction technique for some patients.

It is helpful to 'personalise' the rationale for teaching a relaxation technique for each patient. For example, one person may be more troubled by physical symptoms of overbreathing like dizziness or tingling sensations, so the rationale for relaxation will focus on alleviating those symptoms. Another patient may have noticed a worsening of psychotic symptoms when they are anxious or tense, so the rationale will focus on controlling these symptoms instead.

For all relaxation approaches the key is regular practice. It will necessary to negotiate a practise schedule with the patient (usually it is helpful to practise at least once a day) and review this in subsequent sessions. It can be helpful to provide a tape of the chosen relaxation exercise for your patient to practise with until they get familiar with the relaxation routine.

Flexibility is also important here, as there are many relaxation approaches that can be taught. It may be necessary to practise a few of them with the patient and be guided by their preference. Two 'core' relaxation techniques are briefly outlined here...

1. Controlled Breathing

- Provide the rationale that when we become anxious our breathing rate often changes, resulting in a range of other physical sensations. Slowing down our breathing can help to control physical sensations quickly and therefore help us to feel more comfortable.
- Introduce the breathing technique (breathe in for 4 counts, hold for 2 counts, breathe out for 6 counts).
- Practise this exercise in the session for 5 or 10 minutes.
- Ask for feedback from the patient about how they found the experience and discuss any difficulties.
- Discuss that learning a slow breathing technique is more difficult than it initially seems, and requires a lot of practice. You could also suggest some ways of making the process easier, for example:
 - initially, only practice the breathing exercise when you're not feeling anxious
 - explain that some people describe feeling more anxious when they first begin using controlled breathing, because they are increasing their awareness of physical sensations that they have previously tried to avoid thinking about. It is important to persist with the technique, because this anxiety will decrease with practice
 - make sure to practice in a comfortable environment, e.g., lying down is easier than sitting in a chair, choose a quiet dimly lit room, and try to practice at a time when they will not be disturbed
 - the breathing pattern may be hard for some people to sustain so you might need to adjust it slightly (e.g. breathe in for 3 counts, hold for 1 and breathe out for 5, or breathe in for 3 counts, hold for 1 and breathe out for 3 counts)
- Provide the patient with a copy of the 'Calming Technique: Breathing & Relaxation' handout. This provides some basic information about the role of breathing in anxiety and in relaxation, and a reminder of the essentials of the breathing technique.

2. Relaxation via letting go

The aim of this form of relaxation technique is to help the person relax by releasing muscle tension with each outward breath. It builds on the controlled breathing technique described above. At CCI we use a 'script' like this for relaxation via letting go:

"Focus on your breathing ... Just focus on each breath, in and out ... As you continue this slow breathing, scan your body for any areas that are feeling particularly tense ... With each outward breath try to let go of tension in those muscles."

You then focus on specific areas of the body, starting with the muscles of the feet and ankles and working upwards, repeating the instruction to scan the particular

area as you breathe in and release any tension as you breathe out. Continue this exercise for 10-15 minutes

Activity Scheduling

Activity scheduling is often thought of as only a psychological treatment for depression – a way of achieving the ‘behavioural activation’ required to lift a depressed mood. However, it is also an effective technique for people with psychosis. This technique is particularly helpful if you notice that a patient has a lack of pleasant and rewarding activity in their daily routine – or just a lack of activity e.g. is alone most of the time, or is watching TV for long periods of time. This may sometimes be the result of some degree of depression or of negative psychotic symptoms like apathy or lack of motivation. Regardless of the cause, the same general process is used to help the person increase their activity level. This process involves a few steps:

- Ask the patient to record their activities for a week, so you can both have an idea of their ‘baseline’ level of activities. The ‘Weekly Activity Schedule’ worksheet can be used for this purpose. Remember to spend time carefully reviewing this record when the patient has completed it – to reinforce their efforts in tracking their activities.
- Once you have established a baseline level of activity, you can work with the patient to gradually extend existing activities (e.g. walking for ½ hour instead of 10 minutes) or add new ones (e.g. voluntary work). It is essential that the patient make the selection of activities, so they are as relevant and appropriate as possible (even if the therapist is more actively involved in making initial suggestions for activities). This step will often involve an element of gradual exposure or task assignment (see below), as some of the activities chosen may initially feel overwhelming or involve a lot of anxiety.
- You can also use ratings of ‘Pleasure’ and ‘Mastery’ on a scale from 0-10 to help the person reflect on which activities are most helpful or rewarding. ‘Pleasure’ ratings refer to how much the person enjoyed a given activity, while ‘Mastery’ ratings indicate how much of an achievement the activity was for them. For example, going to the post office to pay bills is more likely to be rated high on ‘Mastery’ than ‘Pleasure’, while watching your favourite programme on TV might have a high ‘Pleasure’ rating but not involve much of a sense of achievement or ‘Mastery’.

... In therapy, Mavis was able to reflect on some of the things she had learnt through coping with her psychotic illness over such a long time. One of the things she came to realise was that she is less preoccupied by her ‘worries’ (i.e. delusional beliefs) when she is more active and is spending more time out of the house. Her late father, whose opinion she valued highly, had often suggested to her that she try to keep active as a means of ‘keeping her mind off’ her concerns. However, at the time she started in therapy, her activity level had become reduced, and she had even stopped her regular voluntary work with the hospital auxiliary.

Mavis’ therapist first talked her through the ‘pros’ and ‘cons’ of returning to voluntary work. Mavis identified that there were many advantages to returning to her work but also a few obstacles. After discussing these obstacles and making plans to overcome them – Mavis was able to take the decision of reinstating her volunteer work. The next step was to help Mavis plan some additional activities. Gradually, Mavis was able to resume some things she had previously

enjoyed (like craftwork, and visiting her one friend) and to start some new activities (like attending the Senior Citizens Centre for morning tea). At times when she felt more reluctant to go out, she would remind herself “ If Dad was here, what would he suggest?”

As therapy was coming to an end Mavis was able to identify that where she had previously spent most days in (at home) she was now spending most days out and about, and was noticing significant improvements in her degree of preoccupation with her ‘worries’ as a result...

Behavioural Hierarchies: Graded Exposure/ Graded Task Assignment

The strategies of graded exposure and graded task assignment are both based on the following principle –

- take a task or goal that the patient wants to achieve
- break it into a series of more manageable tasks
- make sure each task is specific and realistic
- plan with the patient to gradually work through the series of tasks to achieve the overall goal.

These principles apply whether you are trying to help a person overcome a fear of catching public transport or overcome their lack of motivation and reluctance to start at a living skills programme.

We will illustrate this process by describing how it is used to set up a graded exposure programme for someone with anxious avoidance of situations, which is impacting negatively on their coping and lifestyle.

The first step is to discuss the patient’s avoided situations with them to get an idea of their avoidance patterns – e.g. how broad or specific they are, and how troublesome they are to the patient. At this point it may also be helpful to use some of the cognitive techniques described in Modules 5 and 6 to look at their fears about these situations as well.

Having developed a general understanding of the patient’s avoidance patterns, you then help them to develop a hierarchy of feared situations. The following questions can help to identify the steps of the hierarchy ... “Which of these situations would be harder to go into?” “What would make that situation easier/harder?” You can use the ‘Step Ladder’ worksheet to record the hierarchy.

Ask the patient to rate the steps of the hierarchy on the SUDS (subjective units of distress) scale where 0 = no distress or anxiety and 100 = the maximum distress or anxiety they have experienced.

The following is an exposure hierarchy with SUDS ratings for someone who is anxious about using public transport.

| | SUDS |
|---|------|
| • Walk to the train station car park and then walk home | 20 |
| • Walk onto the station platform, but don't catch the train | 40 |
| • Catch the train to the next stop and then get the next train back to your stop (in the morning around 10 am when its quieter) | 50 |
| • Catch the train for four stops but get off at the stop before Perth – then catch the next train back home | 70 |
| • Catch the train into Perth from home in the morning | 90 |

Collaboratively choose a task from low down on the hierarchy that the patient is willing to attempt. In the above example, this could be the first task on the list, which is rated at 20 on the SUDS scale. Discuss the obstacles and difficulties that will get in the way of doing the task and try to find ways around them. If the patient is not confident that they can achieve this task – you will need to break it down further.

Once the patient has started to work on exposure tasks, it is important to reinforce the importance of continuing with them by regularly reviewing progress. Emphasise the importance of attempting the tasks rather than focussing only on successful completion. It is also important to encourage the patient to reinforce his or her own progress with rewards

Note: It is important to distinguish anxious avoidance from strategic avoidance of overstimulation, which may be an adaptive coping strategy for individuals with psychosis. The only way to do this is through careful assessment of the function of any avoidance behaviour and careful monitoring of exposure exercises. For example, if a person is only avoiding situations when they are experiencing increased symptoms, and they are finding that this helps them cope better, this is more likely to be a case of helpful rather than unhelpful avoidance.

SESSION SUMMARY

- Summary may include
 - Review of the behavioural skill or skills covered in session

- Practise tasks for this module may include
 - Implementing chosen solutions from problem solving
 - Practise of calming technique with self monitoring
 - Exposure tasks
 - Activity monitoring or practise of chosen activities

FURTHER INFORMATION

The following books provide a good coverage of the behavioural skills discussed in this module:

Keith Hawton, Paul M. Salkovskis, Joan Kirk, & David M. Clark (1989) *Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide*, Oxford, UK: Oxford University Press\

Martha Davis, Matthew McKay, Elizabeth Robbins Eshelman (2000) *The Relaxation and Stress Reduction Workbook*, New Harbinger Publications

David H. Barlow (2001) *Clinical Handbook of Psychological Disorders (Third Edition)*, New York, NY: The Guildford Press

Module 8
(optional)

*Cognitive Therapy for
Secondary Problems*

Module 8: Cognitive Therapy for Secondary Problems

Module Objectives

1. To help patient apply cognitive therapy techniques to beliefs and thoughts associated with secondary problems (low self-esteem, depression, anxiety)
2. To facilitate patient to increase awareness of unhelpful thinking styles that are linked to experience of secondary difficulties
3. To help patients generate alternative explanations and thoughts that are helpful, healthy and balanced.

Key Issues

Often the experience of depression or anxiety in people with psychosis is very similar to that of our non-psychotic patients – they report similar thoughts, feelings, physical symptoms, and coping strategies.

If the patient's experience of anxiety or depression is more closely linked with psychotic symptoms e.g. they mainly feel anxious because of paranoid fears; then it would make more sense to continue to address these symptoms and associated beliefs as identified in Modules 5 and 6.

Therapist's Notes

When conducting this module we use the framework outlined in the following CCI therapy manuals:

- **Mood Management Anxiety: A Cognitive Behavioural Therapy for Anxiety**
- **Mood Management Depression: A Cognitive Behavioural Therapy for Depression**

When the patient is experiencing anxiety or depression that is relatively independent from their psychotic concerns, sections from the above individual treatment manuals can be used directly.

We have already covered some elements of these manuals eg. behavioural strategies such as relaxation, and graded exposure; however the specific anxiety and depression manuals describe the treatment provide more therapist notes, information, handouts and worksheets.

Where there is some overlap in manual content we would recommend continuing to use the relevant handouts or worksheets from this manual to reduce the possibility of confusion.

Module 9

Self-Management Planning

Module 9: Self Management Planning

Module Objectives

1. To maintain rapport and a sound therapeutic relationship with client
2. To facilitate patients identification of early warning signs of psychotic episodes
3. To help the patient develop a self-management plan to be activated when they begin to experience early warning signs and symptoms
4. To collaboratively review patients' progress from the beginning of therapy to the present – reinforcing changes and gains made




Module Content

- Early warning signs
- Self-management planning
- Review of skills and reinforcement of changes made in treatment

Handouts Required

-  Early Warning Signs

Worksheets Required

-  Early Warning Signs Worksheet
-  Self Management Plan Worksheet
-  Session Summary

Key Issues

Self-management is about the patient actively managing their symptoms. In essence this whole manual has been directed towards improving the patient's self management skills, so this module is more about 'tying together the strands' of the therapy than about learning new skills. As therapy is almost completed at this point, it is also an opportunity to complete the 'hand over' of responsibility for managing symptoms to the patient (in collaboration with their ongoing treatment team).

In working through this module it is important to have a clear idea of what constitutes an 'episode' of psychotic illness for the individual patient. For some, any re-emergence of psychotic symptoms would indicate an episode, while for others (who are coping with persistent psychotic symptoms), an exacerbation of symptoms, or re-emergence of specific symptoms would indicate an episode.

Therapist's Notes

PROGRESS & HOMEWORK REVIEW

- Progress: Review progress with any of the behavioural skills the patient has been practising
- Homework: May have included skills practise or ongoing use of thought diaries

EARLY WARNING SIGNS

Briefly review the patient's personalised stress vulnerability model – by looking at their completed 'Stress Vulnerability Worksheet' or by drawing a simple model on a whiteboard.

Firstly, review the vulnerability factors they have identified and discuss any ideas about their continued vulnerability to future episodes of psychosis eg. "Do you think that you're likely to experience more episodes?" "How likely do you think it is that you will have another episode?". This is a good opportunity to reinforce balanced and realistic beliefs about vulnerability to psychosis eg. "I have been doing pretty well for a while, but I've had quite a few episodes in the past, so its likely I do have a vulnerability to psychosis" or "Even though I do have a vulnerability to psychosis, there are things I can do to manage my symptoms". For some people, some cognitive disputation of unhelpful beliefs about vulnerability may be necessary eg. a person who is thinking "I don't need to worry because I'm never going to get unwell again" will not be motivated to do the work required to identify and monitor early warning signs.

Briefly review the typical symptoms that they experience when they experienced full blown psychotic episodes. In order to identify symptoms that could be used by the patient as early warning signs, you are trying to work backwards to identify earlier prodromal signs. Ask questions like

"Which of these symptoms do you tend to notice first?"

"If this was what was happening when you were right in the episode, what was happening before it had really started"

"What are the first things you notice changing?"

"What do you remember about what was going on in the couple of weeks before you went into hospital?"

At this early stage of becoming unwell - how do you feel?, what are you thinking?, what do you do? how do you get along with others at this time? what do others say to you?

The process of identifying early warning signs can often be a lengthy. It requires discussion and clarification of each early warning sign, so that it is specific and clearly identifiable. For example, "I start feeling strange" is a fairly non-specific early warning sign. It will be easier for a person to be sure if it has occurred if it is broken down into some more specific components like "I start thinking 'something very strange is going on here'" and "I feel anxious" and "I don't want to go out". Record the results of this discussion on the Early Warning Signs worksheet.

Also spend some time reflecting on the types of stressors that they identified as triggering episodes in the past and identify from this list which might be the types of stressful events to watch out for as possible triggers in the future. Record the results of this discussion on the Early Warning Signs worksheet under 'Life Stressors'.

...Gene found it difficult to identify early warning signs, as he had not experienced a distinct 'psychotic episode' for a long time. He did however notice that at times his persistent symptoms would worsen and he would feel 'less well' in himself. He also noticed that this usually occurred at times when he was experiencing more stress – perhaps conflict with his flatmate, or a change in routine. Having identified these exacerbations he could start to think about the early signs that these were occurring. In particular he noticed the following signs "I stop showering every day", "I forget to shave every day" and "I don't stay at work for the full day – leave a couple of hours early". He was able to use these indications as signs that he was not coping well, and as reminders to take steps to manage his stress...

Monitoring early warning signs

The main thing with self-monitoring is that it needs to make sense to the patient and be as straightforward and easy to manage as possible. This is particularly important for early warning signs of psychotic episodes, as they need to be monitored regularly over a long period of time, if they are to be used to prevent episodes.

As with the early warning signs, plans for monitoring symptoms need to be quite specific. As a starting point the Early Warning Signs handout includes some ideas for monitoring symptoms and early warning signs:

- Keep a list of your early warning signs and symptoms on a small card you carry in your wallet at all times
- Check off a list of your early warning signs once a week
- Ask people that you trust to let you know when they notice your early warning signs
- Ask your doctor to review your early warning signs at each appointment

At this point you could use a 'devil's advocate' approach to check how realistic the patient's monitoring plans are, asking questions like "It sounds like checking off that long list would be quite hard to keep up for more than a couple of weeks, what do you think?"

SELF-MANAGEMENT PLANNING

The next step is to make a plan about what to do when these early warning signs are identified. These plans need to be developed collaboratively – through questioning an exploration of options rather than being prescribed for the patient.

The kinds of plans that people establish often include some of the following elements

- accessing social support or asking friends/ family for help eg. letting people know that they have noticed some early warning signs and might need extra support or practical help eg. in making contact with services

- reminding self of previously identified coping strategies (eg. re-reading coping cards, worksheets and handouts)
- medical appointments or contact with other mental health professionals: ask the patient about their past experiences in contacting the mental health service, and check that the service has been able to respond and that the patient has the skills required to make such a request eg. assertiveness, knowledge of correct phone numbers, understanding of service procedures. If patient's don't have a regular doctor or a case manager who they trust, they may need to work to set up these support networks before they can use them in their self management planning
- self medication eg. use of additional sedative or antipsychotic medication that has been prescribed PRN. This is not always possible, but can often be negotiated with the patient's doctor, particularly if the person can demonstrate their ability to identify their early warning signs and manage their own medication

Initially these plans may need to be 'roughed out' in a therapy session and then refined after discussion with family members, friends and doctors and other people who may be asked to play a role in the plan. Without this step, plans could be established which sound reasonable to the therapist and patient but are not realistic given the constraints of the mental health system or the patient's specific circumstances. It is vital that self-management plans are **realistic**. For example, in most public mental health settings, it is not realistic to present to an Emergency Department with early warning signs and expect to be admitted.

...Terry identified that his partner often reported 'after the fact' that he had noticed signs that Terry was becoming unwell. For example, she would say things like "I thought you weren't doing well yesterday" or "I could tell the voices were bothering you". After a discussion in session about early warning signs, Terry identified that he would find it more helpful if his partner let him know that she had noticed changes earlier on. Terry thought this would help him identify his early warning signs better, and would cue him to take some of the other steps he had identified in his self-management plan. He discussed this with his partner, who agreed to mention any changes earlier on. They also made a plan to keep a list of early warning signs that they had jointly identified on the fridge so they would both be reminded of them regularly...

MAINTAINING CHANGES AND STAYING WELL

The 'Self - Management Plan' also offers an opportunity to reflect on the broader range of things that the patient can do to maintain psychological wellness in the long term. This ties together the person's pre-existing coping strategies, balanced thinking skills, behavioural skills and general 'common sense' ideas of how to help themselves stay well in the long term.

A systematic review of some of the topics covered in therapy sessions is one way to help the patient collect a list of "Things I can do to help myself". The following sections will be particularly helpful to review at this point:

- Pre-existing coping strategies
- Cognitive therapy modules – delusional beliefs and/ or unhelpful beliefs about voices, balanced beliefs that alleviate distress
- Behavioural techniques/ strategies that have proved helpful

The types of things that people often find helpful are:

- Regular practise of cognitive and behavioural skills eg. reviewing thought diaries or coping cards regularly; practising relaxation once a day
- Balanced lifestyle – maintaining a balance of regular activities. This will include doing some enjoyable or leisure activities, some activities that provide a sense of achievement and some social activities eg. maintaining volunteer work one day week, spend some time in the garden regularly
- Maintaining and developing relationships and social support eg. contacting a friend at least once a week, spending time with brother regularly

As with early warning signs and the plans for responding to them - this list of ideas for maintaining gains needs to be as specific as possible.

SESSION SUMMARY

- Summary may include
 - most important early warning signs
 - review of self management plan
- Practise tasks for this module may include
 - Work on the early warning signs worksheet and self management plan or discussion with friends or family to refine these worksheets
 - Listing of skills and strategies which have been helpful
 - Listing of changes made

Module 10

Post-Treatment Assessment

Module 10: Post-Treatment Assessment

Module Objectives

1. To obtain objective measures of psychotic symptoms, quality of life, and associated distress
2. To feed back assessment results to individual patient – thus providing additional information about changes/ improvements over the course of therapy

Module Content

- Rationale for Post- treatment assessment
- Completion of CCI Post-treatment Assessment package
- Provision of feedback on change in assessment measures

Assessment Package

Psychotic Symptoms

- Brief Psychiatric Rating Scale

Associated Distress

- Depression: Calgary Depression Scale for Schizophrenia
- Beck Anxiety Inventory

Disability & Quality of Life

- Schizophrenia Quality of Life Scale (SQLS)
- WHO Disability Assessment Schedule

Worksheets Required

- ✍ Session Summary

Key Issues

There are a couple of options for how you could administer the post treatment assessment. You could consider this module as separate and work through it after the completion of Module 9. You could also choose to run the two modules ‘side by side’ – combining the post assessment measures and feedback with the early warning signs and self-management planning components of therapy.

Therapist's Notes

PROGRESS & HOMEWORK REVIEW

- Progress: Review monitoring of early warning signs and make changes to self management plan as required
- Homework: May have included additions to the self management plan or completion of self report measures

PROVIDE A RATIONALE FOR POST-TREATMENT ASSESSMENT

- As with the pre-treatment assessment described in Module 1 – it is important that the patient is given a sound rationale for completing assessment measures at post-treatment. If you have been using assessment measures (e.g. ratings of voice activity or preoccupation with beliefs) throughout therapy and have provided helpful feedback as required, this task should be fairly straightforward.

POST-TREATMENT ASSESSMENT

- The areas of functioning that we assess at this point will include elements of the general and symptom specific assessment.
- The aim of the post treatment assessment is to check that the improvements have been made in the areas targeted by therapy. It is an important element of routine cognitive behavioural therapy practice.
- Assessment areas:

Psychotic symptoms: Repeating the Brief Psychiatric Rating Scale at post treatment provides useful information about how changes in coping strategies, beliefs, and behaviours have affected the person's overall symptom profile.

Disability/ Quality of Life: These areas are re-assessed to check that there have been improvements in the areas where the patient was experiencing difficulty at the start of therapy.

Associated distress: Symptoms of depression and anxiety usually decrease as the person is able to cope better with persistent psychotic symptoms (eg. Garety et al., 1994). If a person is continuing to experience a significant degree of depression or anxiety at the end of therapy – you may wish to consider referring on for specific follow up in this area.

Symptom Specific Assessment - Delusions and Voices: As mentioned in Module 3, aspects of these symptoms are usually monitored regularly over the course of therapy. For example, ratings of delusional belief/ conviction will usually be collected weekly. These symptoms will usually not need to be re-assessed at this point.

PROVISION OF FEEDBACK ON CHANGES IN ASSESSMENT MEASURES

Ask general questions to start with like: “How do you think things have changed since we started working together?” or “Have you noticed any changes in your symptoms lately?” If there are specific areas that have changed noticeably, you could ask specifically about them e.g. “Do you think you’re as preoccupied with your voices as you use to be at the start of the year?”

- It is important that feedback be brief and simple. It should also be qualitative in nature rather than quantitative – providing someone with information about change in numerical scores on a measure can be unhelpful and uninformative
- As mentioned above, changes in specific therapy targets (e.g. delusional conviction or preoccupation with voices) are usually monitored continuously so feedback can be provided in terms of graphs of changes over time. In this case you would need to ‘talk through’ the changes as well as showing them and any graphs would need to be as simple as possible.

SESSION SUMMARY

- This module will not generally require formal sessions summaries although – you the patient may wish to summarise or record elements of the feedback about assessment

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Appendix 1

Handouts

What is Psychosis?

The word *psychosis* is used to describe conditions that affect the mind, where there has been some loss of contact with reality. When someone becomes ill in this way it is called a *psychotic episode*.

A recent Australian study found that 4-7 adults out of every 1000 were experiencing a psychotic disorder at the time of the survey. Many more people will experience psychotic symptoms at some time in their lives. Some estimate that psychosis is more common than diabetes.

Many people make a full recovery from their first episode of psychosis but for others the psychotic symptoms can persist over time, even with medication.

Symptoms of Psychosis

There are three groups of psychotic symptoms – these are known as positive symptoms, disorganised symptoms, and negative symptoms.

Positive Symptoms

Hallucinations: People with psychosis may hear, smell, taste or see things that aren't there. The most common type of hallucination is when you hear voices talking to you or about you, that no-one else can hear. These voices can be comforting or frightening, scary or soothing – everyone's experience is different.

Delusional beliefs: Most people with psychosis will develop some unusual beliefs that don't fit with reality. You might believe that people are reading your thoughts or sending you messages through the radio, newspapers, or TV.

Distorted perception: This symptom refers to difficulties in making sense of what you see, hear, smell, touch, and taste. You might find that you are more sensitive to background noises, colours, or lights – distractions that you would normally be able to 'tune out'.

Disorganised Symptoms

Thinking, speech, and behaviour can become disorganised when a person is psychotic. This might mean that, when you are unwell, other people may find it hard to understand what you are saying, or you might find it difficult to think clearly or plan ahead. These experiences are sometimes called 'thought disorder'.

Negative Symptoms

People with psychosis also experience something called ‘negative symptoms’ because they describe the lack of things that used to be present. Negative symptoms include things like apathy or loss of interest, finding it hard to get motivated to do things, talking less, and changes in emotions so you feel flat or don’t respond to something happening.

This information is based on the Expert Consensus Treatment Guidelines for Schizophrenia (1999)

TYPES OF PSYCHOSIS

There are a number of different psychotic illnesses that people can be diagnosed with. This diagnosis will depend on your individual pattern of symptoms and will require a careful assessment by your doctor. Often when a person first becomes psychotic, it is hard to work out what diagnosis should be given, so for some people their diagnosis may change over time.

A diagnosis is a label that helps your doctor decide how to treat your psychosis. However, it is also very useful to understand each person’s unique pattern of symptoms and experiences.

These are the most common types of psychosis:

Schizophrenia

When people talk about psychosis, they are most often referring to the mental illness called schizophrenia. This diagnosis is given if a person experiences psychotic symptoms (like those described on page 1) for longer than 6 months. If you have experienced psychotic symptoms for less than 6 months, you may be given the diagnosis *schizophreniform psychosis*.

Schizo-affective Disorder

This is the diagnosis given when a person experiences psychotic symptoms and symptoms of a mood disorder (such as depression or mania) at the same time.

Other types of psychosis

Sometimes a psychotic episode can be triggered by the use of drugs or alcohol. While a *drug induced psychosis* is often relatively short lived, the symptoms can last longer for some people. This is a good example of how it can be hard to work out a person’s diagnosis straight away.

Psychosis can also occur as part of a *mood or affective disorder*, such as bipolar disorder (manic depression) or when very severely depressed (this is called psychotic depression).

Psychotic symptoms can also be caused by injuries or illnesses affecting the brain such as long term alcoholism, encephalitis or Alzheimer's Disease. When a cause like this can be identified, the diagnosis would be *Organic Psychosis*.

If you are unsure about the diagnosis that your doctor has made or would like to discuss your diagnosis further, please talk to your GP or psychiatrist.

Further information

If you are interested in finding out more about psychosis, the following websites are a good place to start. If you don't have access to a computer you could go to your local public library:

- Early Psychosis Prevention and Intervention Centre (Victoria, Australia)
<http://www.eppic.org.au/>
- SANE Australia
<http://www.sane.org/>
- Schizophrenia Fellowship of NSW
<http://www.sfnsw.webcentral.com.au/>
- Rethink UK (formerly National Schizophrenia Fellowship)
<http://www.rethink.org/>
- Expert Consensus Guidelines Series
http://www.psychguides.com/gl-treatment_of_schizophrenia_1999.html
- US National Institute of Mental Health
<http://www.nimh.nih.gov/publicat/index.cfm>

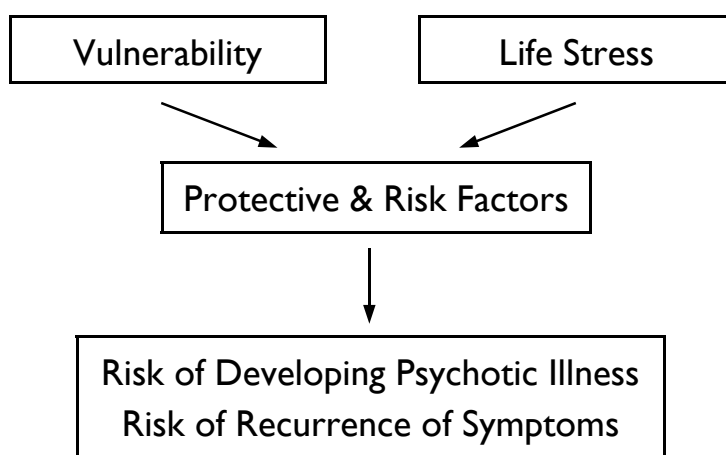
There are also some good books and pamphlets available. You could ask your therapist, case manager, or doctor to recommend some to you.

STRESS-Vulnerability Model

What Causes Psychosis?

No one factor has been identified to cause psychosis, that is, it is not caused by a person, event, or experience. There are a number of factors that interact with each other that may contribute to the development of this disorder in some people. In this handout, we present to you a way of understanding how all these factors come together to trigger the onset of this illness—called a stress vulnerability model.

STRESS VULNERABILITY MODEL



First, we begin by looking at two key factors in this model, namely, vulnerability (which includes genetic, neuro-developmental and environmental vulnerability) and socio-environmental stress (or life stress).

VULNERABILITY

Genetic

Children who have a parent with schizophrenia face a 13% risk of getting the illness versus 1% in the general population. Identical twins are also more likely to both develop this disorder than fraternal twins. While these results indicate to some extent that this disorder is genetically inherited, they also suggest that there are other factors that may contribute to its development. It is also clear that for many people who develop a psychotic illness, they have no family with a history of a similar illness.

Neuro-Developmental

Neuro-developmental vulnerability factors are those things that have an effect on the way the brain develops. For example, infection during pregnancy, or birth complications can have an impact on the developing brain that may make us vulnerable to psychosis later in life. Other neuro-developmental factors include illnesses, nutritional deficiencies and head injuries during childhood.

Age is also a vulnerability factor with 80% of people with a psychotic illness developing their first psychotic episode between the ages of 16 and 30 years.

Environmental Vulnerability

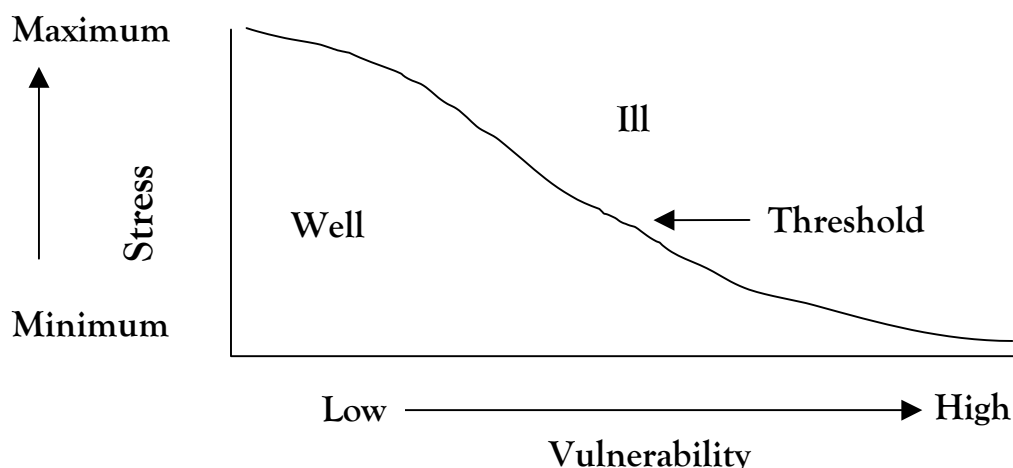
Environmental vulnerability refers to external experiences and circumstances that influence the likelihood of developing a disorder. It can include traumatic events, family experiences, experiences during school years and other life events or experiences.

SOCIO-ENVIRONMENTAL STRESS

Stressful events or circumstances in a person's life, such as, family conflicts, illness, employment difficulties, or bereavement can place extra demands on the person, leading to them feeling stressed, frustrated, anxious, angry or sad. Even positive events, such as starting a new relationship, having children, or moving house can result in a lot of stress. Stressful circumstances can also be chronic or longstanding – examples of more chronic stressors could be being in a unhappy relationship, chronic illness, living on a fixed income, or living in unsatisfactory accommodation.

The occurrence of psychotic illnesses can thus be explained as an interaction of the above two factors. A person who is biologically vulnerable may not necessarily develop a psychotic illness – their likelihood of developing a psychotic illness is affected by the way they cope with stressors in their life. For example, a person who has a family history of diabetes may not develop diabetes if they are careful with what they eat and have enough exercise. This brings us to a discussion on protective and risk factors.

The way that vulnerability and stress work together is illustrated in this graph – you can see that if a person has a high level of vulnerability it will take less stress to trigger an episode than for someone who has a low degree of vulnerability.



PROTECTIVE & RISK FACTORS

A risk factor is something that will increase the chances of a person who is already vulnerable becoming ill. Examples of risk factors are poor or maladaptive coping strategies, alcohol or drug use, interpersonal conflicts, and stressful events. Protective factors, on the other hand, are those things that can help to prevent a vulnerable person from becoming ill. Protective factors include good coping strategies, strong social support networks, regular use of anti-psychotic medication, effective communication and problem solving skills. It is when the risk factors outweigh the protective factors, that the chances of developing the disorder (or experiencing a relapse or recurrence of symptoms) are high.

Early Warning Signs



How do we know that a storm is about to break? Perhaps we hear thunder in the distance, the skies are dark and grey with rain clouds, and it becomes very windy. If we do not want to be caught with the worst effects of the storm, we would probably go back to our homes, close all the windows, bring our washing in from the line, and secure any loose items outside the house. Similarly, if a person with psychotic illness becomes more aware of the early warning signs that signal the onset of a psychotic episode, they can take steps to prevent full-blown episodes. Early detection of an impending “storm” – in the case of psychotic illness, a psychotic episode – can lead to early intervention and prevention of a psychotic episode.

The first step in being able to detect an oncoming episode is to learn to recognise your own early warning signs and symptoms. Each person has their own unique set of signs and symptoms although some will be common to other people with psychosis.

Once you are able to recognise the early warning signs and symptoms of a psychotic episode, the next step is to monitor them regularly. It will not be much good if you are aware of your early warning signs and symptoms, but you continue to go through your daily life without paying much attention to the onset of the symptoms. Similarly, a person who knows that ominous grey clouds, thunder, lightning, and rushing wind signal an impending storm can still get caught in the storm if they are sitting on a park bench too engrossed in a book to look around them. Therefore, regular symptom monitoring is important for the purpose of early intervention to prevent relapse.



Planning Early Interventions

Symptom Monitoring

Here are some ideas for monitoring your symptoms and early warning signs:

- Keep a list of your early warning signs and symptoms on a small card you carry in your wallet at all times
- Check off a list of your early warning signs once a week
- Ask people that you trust to let you know when they notice your early warning signs
- Ask your doctor to review your early warning signs at each appointment

Once you have identified your early warning signs and worked out a way to monitor them regularly ... the next step is to develop an **self management plan** for what to do when you recognise the early warning signs that signal the onset of a psychotic episode. It is important to be prepared so that when the time comes, you know what to do.

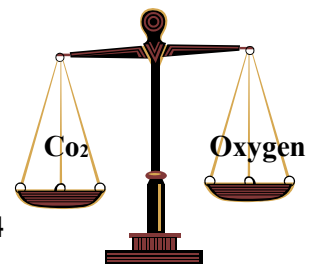
Plan what you will do, what you will say, and what you will ask your friends and family to do for you. For example, your action plan may include calling to request an appointment with your doctor or asking a friend to drop by to visit you. Once you have thought about what you could do, record your ideas on the 'Self Management Plan' worksheet

Detail your early intervention plans carefully and keep them somewhere (On your fridge? On your bedside table?) where you can refer to them easily when the need arises.

Calming Technique - Breathing & Relaxation

In order to appreciate the role of breathing in anxiety, it is important to first understand the fundamentals of breathing. We won't go into too much detail here but basically (as you probably know already), the human body needs oxygen to survive. When you take in a breath of air, the lungs take in oxygen, where it is used by the body, and then produce carbon dioxide (CO₂) which we breathe out.

In order for the body to run efficiently, there needs to be a **balance between oxygen and CO²**. This balance is maintained chiefly through the rate and depth of breathing. Breathing too much will increase levels of oxygen in the blood and decrease levels of CO², because the oxygen is not used at the same rate that it is taken in. Breathing too little will decrease levels of oxygen and increase levels of CO². The appropriate rate of breathing when calm and relaxed is around 10 - 14 breaths per minute. *How does this compare to your rate of breathing?*



Check your breathing rate

If you're interested in understanding more about your breathing pattern could check your breathing rate. Count your breathing rate for one minute, where each breath in and out counts as one breath.

Most of the body's mechanisms, including breathing, are 'automatically' controlled, but breathing can also be put under voluntary control. For example, it is quite easy for us to hold our breath when swimming or speed up breathing when blowing up a balloon. Factors such as stress and our general mood can also change our breathing. Being able to voluntarily alter our breathing is good news for people who experience high anxiety symptoms. **By learning how to maintain a calm and relaxed rate of breathing it is possible to reduce many of the unpleasant symptoms that would otherwise follow on from 'anxious' breathing.**

More on how to do this later.

Effects of Overbreathing

So how does breathing cause all of those unpleasant physical symptoms? Quite simply, our body uses the amount of CO² as a marker for breathing rates. When we overbreathe (or hyperventilate), the level of CO² drops in relation to the level of oxygen and when this drop in CO² is detected, the body responds with a number of chemical changes that show up in two broad categories of symptoms:

- symptoms produced by the slight reduction in oxygen to certain parts of the *brain* (including dizziness, light-headedness, confusion, breathlessness, blurred vision, unreality);
- symptoms produced by the slight reduction in oxygen to certain parts of the *body* (including an increase in heart rate to pump more blood around, numbness and tingling in the extremities, cold, clammy hands and muscle stiffness).



There are also some other effects of overbreathing. After periods of stress and anxiety, have you ever felt tired and exhausted? Well, overbreathing for extended periods of time requires more energy and effort— it's like you've been constantly walking uphill! Perhaps you've felt hot, flushed and sweaty from overbreathing. Also, because you might breathe from your chest rather than your diaphragm (the large muscle underneath the lungs) you might have felt some tightness in your chest or actually felt chest pains, all because the chest muscles are overworked. Finally, this overbreathing might have led you to sigh or yawn a lot. As you can see, how we breathe certainly has a large impact on how our body functions.

As with the other symptoms associated with anxiety, these changes are NOT HARMFUL. In fact, hyperventilation is sometimes used as a medical test.

Facts about Hyperventilation

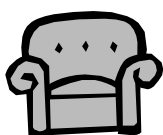
- ◆ When people are overbreathing, they tend to feel as if they are choking or experience a smothering sensation, as though they are not getting enough air. In fact, this is the opposite of what is happening - as the person is actually getting too much oxygen!
- ◆ Breathing patterns are an important part of the body's emergency response (fight/flight) and are intended to protect the body from danger. If faced with a fight or flight situation, a state of overbreathing would not develop because the oxygen would be used at the rate it is taken in.
- ◆ Sometimes people are concerned that if they overbreathe for too long, they may eventually collapse or faint. Fainting almost never occurs as a result of overbreathing. When it does happen, it usually happens with people who have a history of fainting because there is often some other part of their biological make up that makes them more likely to faint.
- ◆ You might recognise many of the symptoms described here but it doesn't feel like you're hyperventilating. Sometimes hyperventilation can be very subtle so that you're breathing just a little more rapidly throughout a whole day or over an extended period of time. There might not be a dramatic drop in CO₂ so that you experience those intense symptoms constantly, but when your CO₂ levels are lowered, all it takes is a sigh, or a yawn, or an anxious thought, and then all of a sudden it seems you're lightheaded, your heart's pounding, or you have a full blown panic attack.

Gaining Control Over Your Breathing

Gaining control over your breathing is an important skill to develop. It is essentially a calming technique and as such the technique must be practiced consistently in order for you to benefit fully. This calming technique will enable you to

- (1) reduce some of the physical effects of overbreathing that we just described
- (2) facilitate general relaxation through breathing.

It's probably best, when you start, to practice in safe, low stress situations such as in the lounge room at home, or when you're waiting for a bus. Once you've mastered the technique you can try to use it to reduce feelings of intense anxiety or panic. It's a bit like sport's practice – you really want to have mastered your skills before you get to the finals. For now, just become as well practiced as you can.



When you do the exercise, try to find a comfortable chair and eliminate any potential interruptions. As you do the breathing be sure to keep count in your head, as this is an important aspect of the calming technique. You will find that your mind wanders and you forget to count, this is quite natural and to be expected. Simply allow yourself the thought and then return to the counting. Do not try to take in deep breaths - just stick to your own natural depth of breath. Aim for smooth, easy breathing. It is a good idea to try and breathe exclusively through your nose as this facilitates control.

Calming Technique

- 1. Ensure that you are sitting on a comfortable chair or laying down on a bed**
- 2. Take a breath in for 4 seconds (through the nose if possible)**
- 3. Hold the breath for 2 seconds**
- 4. Release the breath taking 6 seconds (through nose if possible).**

Thinking & Feeling

People often believe that the feelings and emotions they experience are determined by external events, situations, and the behaviour of others. For example, we may hear ourselves say, “My partner made me so angry,” “My boss made me so nervous,” “This trip down south made me feel so relaxed,” or “I’m depressed because I didn’t get the job I wanted.” What is the assumption underlying these statements? That someone or something other than ourselves was directly making us feel the way we did.



We come to these conclusions automatically without asking ourselves if this assumption is true. However, if we stop to analyse the process that connects an external situation to our emotional responses, we will find that there is a step in between.

How Our Thoughts Influence Our Feelings

What really makes us feel and respond the way that we do, is not the situation or the words and actions of another person, but how we have perceived that situation or that person’s actions. It is how we see something or someone and what we think about it that really determines how we feel. It is our thoughts and beliefs about an event that defines our emotional responses.

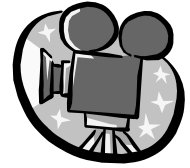
Here’s an example. Suppose you went to a small party and your host introduces you to Mike. As you talk to him, you notice that he does not look directly at you but often looks around the room. How would you feel if you thought, “Boy, this guy is so rude! He won’t even maintain eye contact while I’m talking with him! What an insult!” On the other hand, if you were to think, “Mike must think that I’m really unattractive and uninteresting. I must be a really boring person. Nobody wants to talk to me!” What about if you were to think, “Mike’s probably waiting for a friend to come. Maybe he’s getting a bit anxious.”

You probably realised that you felt three different emotions as a result of those three very different thoughts. Often, we are not aware of our thoughts and beliefs because they are so automatic and happen quickly. But they are there, and they affect the way we feel. Try the exercise on the following page and see if you can identify the possible feelings and thoughts in each of the scenarios.

The Thought Analysis

If you want to influence the way you feel, especially when your moods are causing you long term emotional distress, you need to learn to be aware of and “capture” those automatic thoughts and beliefs, with the ultimate aim of changing them. To do that, let’s start by doing a Thought Analysis.

The Thought Analysis begins with reflecting on a situation in which you felt a strong, unpleasant feeling. Describe the event by writing it down in a Thought Diary, in the first column on the left. Record the situation the same way a video camera might record – just the facts. This means that you do not include your thoughts about why the situation occurred, who was responsible and how you felt about it. Just describe the event simple, without any ‘frills.’



The next step is to identify exactly how you felt and what you did, that is, your feelings and your actions or behaviour. Record these in the third column to the right of the Thought Diary. Write down the words that best describe your feelings. If you are not sure how to describe or put a name to your feelings, The Feelings Catalogue provides you with a list of both positive and negative feelings. When you have written down these words, rate the intensity of the emotion from 0 to 100. The higher the number, the more intensely you felt the emotion. You may also want to note any actions that you carried out, eg, drew all the curtains, put on the answering machine, and went to bed.

Now, bearing in mind the situation and the feelings you experienced, identify the thoughts and beliefs you experienced in that situation. Ask yourself “What was I thinking of when the event occurred?” “What was going through my mind at the time?” When you have completed the list, rate how much you believe each one of the statements on a scale from 0 to 100. The more firmly you believe each statement, the higher the number of your rating and the more intense will be the emotion you experience.

After you have done this, we will tackle the issue of where we go from here. At this point, it is important that you understand how to identify your feelings and thoughts surrounding a particular situation, especially one in which you have experienced unhealthy, negative emotions. Unhealthy, unhelpful, or disturbed emotions are those that elicit a stronger physiological reaction in your body, such as a tightness in the chest associated with anxiety, an increase in blood pressure associated with anger, a sense of heaviness associated with depression. Emotions such as: depression, guilt, fear, rage, anxiety, etc, may also lead to avoidance and destructive behaviours towards self and others, may obstruct appropriate problems solving behaviours, and may cause long term physiological (e.g., hypertension and heart disease) and psychological harm (e.g., psychiatric problems).

Doing the Thought Analysis is taking the first step toward learning how to manage your unpleasant feelings and help yourself feel better.

The Feelings Catalogue

POSITIVE FEELINGS

Affectionate
Alive
Amused
Aroused
Brave
Calm
Compassion
Cheerful
Comfortable
Confident
Content
Courageous
Curious
Delighted
Desirable
Eager
Energetic
Excited
Exhilarated
Enthusiastic
Ecstatic
Forgiving
Friendly
Fulfilled
Generous
Glad
Good
Grateful
Happy
Hopeful
Humorous
Joyful



NEGATIVE FEELINGS

Afraid
Angry
Anxious
Apprehensive
Ashamed
Awkward
Bitter
Bored
Confused
Defeated
Depressed
Desperate
Devastated
Disappointed
Discouraged
Distrustful
Embarrassed
Enraged
Exasperated
Fearful
Foolish
Frantic
Frustrated
Furious
Guilty
Hateful
Helpless
Horrified
Hostile
Humiliated
Hurt
Impatient
Insecure
Irritated
Jealous
Lonely
Melancholy
Miserable
Misunderstood
Outraged
Overwhelmed
Panicky
Pessimistic
Prejudiced
Pressured
Remorseful
Resentful
Sad
Self-conscious
Shy
Sorry
Stubborn
Stressed
Terrified
Threatened
Tired
Touchy
Trapped
Troubled
Uncertain
Uncomfortable
Uneasy
Unfulfilled
Uptight
Vulnerable
Worn-out
Worried

Detective Work

Previously, we established that it is our thoughts that influence our feelings, emotions, and behaviours – this is also called the Thinking-Feeling connection. Often, depressed people will think negative thoughts that lead them to feel depressed, miserable, and distressed. This, in turn, maintains the depression.

The key to changing the way we feel is found in challenging and changing our unhealthy thoughts and beliefs.



The process of challenging and changing our automatic and often, unhealthy thoughts and beliefs, begins with you taking a good hard look at them. To find out whether or not your thoughts and beliefs are true, you need to gather and examine evidence. As such, we liken this process to that of being a detective. Like all good detectives, we need to find out the facts, and gather the evidence. Here

are some helpful questions:

- Where is the evidence (or proof) that my thoughts/beliefs are true?
- Are there any evidence that disproves my thoughts/beliefs?
- How do I know that my thoughts/beliefs are true?
- Are there facts that I'm ignoring or I've overlooked?
- What other explanations could there possibly be?
- How realistic are my thoughts, beliefs, and expectations?

Thus, “Detective Work” is looking for evidence that does or does not support your thoughts and beliefs. Remember that you are also to be asking questions that challenge your thoughts, beliefs and expectations, ultimately testing and challenging whether or not they stand true, and whether they help or hinder you. Here are some other helpful questions to ask yourself:

- Are there other ways of viewing the situation?
- How might someone else view the situation?
- If I were not depressed, how might I view the situation differently?
- What are the odds of that happening?
- Where is it written that I must ... ?
- How helpful is it for me to keep thinking this way?
- Where does thinking like this get me?
- Even if it were true, is it really that bad?

Evidence testing is about trying to be objective about our thoughts. It is about analysing them, assessing and evaluating them to see if they are indeed true, as opposed to accepting these thoughts blindly without question.

When you have finished gathering the evidence and challenging your thoughts and beliefs, take a step back and make a decision. Examine your original thoughts and beliefs, taking into account the evidence you have gathered and the challenges you have made. Are these thoughts and beliefs really true? If they are not, how can you revise them? How can you change them to become healthy, balanced thoughts and beliefs?

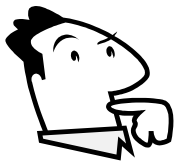
A balanced, healthy thought/belief is one that takes into account all the evidence and includes all objective information. In your Thought Diary, write down your healthy, balanced thought in the last column on the right. How do you feel after you have replaced your unhealthy thoughts with healthy, balanced ones? Often, you will find that the resulting feelings are not as extreme and distressing. If your original thought “I’m never going to get better, I’ll always be depressed,” is replaced by “I’ve only just started group treatment. There is no evidence to suggest that I won’t recover. Moreover, I don’t know for sure that I won’t get better. In fact the evidence suggests that with time and effort, I can get better.” With the balanced thoughts, you may find that you feel better. Instead of feeling despair and hopeless, you may find that you feel a little hopeful. You may still feel concerned about your own well-being and future, but this is much better than experiencing an extreme negative, unhealthy emotion such as despair or depression.

You have now completed the Thought Analysis. Congratulations! But remember to keep practising. Whenever you experience an unpleasant feeling, use your Thought Diary and do a Thought Analysis. You will find that this whole process will get easier and you will feel better and more emotionally healthy.



Appendix 2

Worksheets



Expectations Questionnaire

Please read each statement below and circle the scale number underneath that best fits your expectations.

1. What personal benefits to changing yourself do you expect ?

| | | | | |
|-----------------|--------|----------|-------|------------|
| 1 | 2 | 3 | 4 | 5 |
| Absolutely none | Slight | Moderate | Large | Very large |

2. If you change yourself, what level of cost do you expect ?

| | | | | |
|-----------------|--------|----------|-------|------------|
| 1 | 2 | 3 | 4 | 5 |
| Absolutely none | Slight | Moderate | Large | Very large |

3. If you weighed up the costs versus the benefits of changing, in which direction would the scales tilt?

| | | | | |
|----------|--------------------------|------------------------|--------------------------|-------------|
| 1 | 2 | 3 | 4 | 5 |
| All cost | More costs than benefits | Equal costs & benefits | More benefits than costs | All benefit |

4. To what extent do you think your current mode of functioning contributes to the problems you are experiencing ?

| | | | | |
|-----------------|----------|------------|---------|---------|
| 1 | 2 | 3 | 4 | 5 |
| Absolutely none | Slightly | Moderately | Largely | Totally |

5. If solving your problem/s involves changing yourself, how willing are you to engage in this change process ?

| | | | | |
|------------|----------|------------|---------|---------|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | Slightly | Moderately | Largely | Totally |

6. How confident are you that you can change your current mode of functioning?

| | | | | |
|------------|----------|------------|---------|---------|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | Slightly | Moderately | Largely | Totally |

7. Following treatment, do you think that your problem will have ...

| | | | | |
|-------------------|-------------------|---------------------|------------------|------------------------|
| 1 | 2 | 3 | 4 | 5 |
| Remained the same | Slightly improved | Moderately improved | Largely improved | Disappeared completely |



Fire Drill for Coping

List some ideas you might have for coping with stress and symptoms.

1.

2.

3.

4.

5.

The Change Process Balance Sheet

| | |
|---|--|
| <p>List the negative consequences of experiencing your current problem</p> | <p>List the positive aspects of experiencing your current problem</p> |
| <p>List the personal benefits that you expect if you change yourself</p> | <p>List the personal costs that you expect if you change yourself</p> |

STRESS-Vulnerability Worksheet

Vulnerability Factors: List any factors that you think might have increased your vulnerability to developing a psychotic illness or episode













Stress Checklist: Were you stressed by anything happening in your life before you became unwell?













Risk Factors: What things might increase your risk of developing a psychotic episode?













Protective Factors: What are some of the resources and strengths you might have that might decrease your risk of becoming unwell?





















Early Warning Signs Worksheet

What are some of the signs that might alert you to the possibility that you are becoming unwell?

| | |
|---|---|
| <p>My Behaviour</p>  | <p>My Thoughts</p>  |
| <p>How I feel</p>  | <p>How I get along with others</p>  |
| <p>What significant others notice about me</p>  | <p>Things that stress me</p>  |







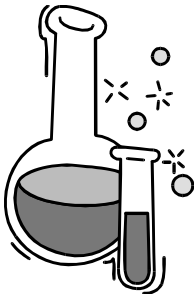
Weekly Activity Schedule

Use the schedule below to plan your activities for the coming week. Remember to balance pleasant activities and times for rest and relaxation with your daily responsibilities and duties.

| | Mon | Tues | Wed | Thur | Fri | Sat | Sun |
|-------------|------------|-------------|------------|-------------|------------|------------|------------|
| 8 to 9am | | | | | | | |
| 9 to 10 | | | | | | | |
| 10 to 11 | | | | | | | |
| 11 to 12pm | | | | | | | |
| 12 to 1 | | | | | | | |
| 1 to 2 | | | | | | | |
| 2 to 3 | | | | | | | |
| 3 to 4 | | | | | | | |
| 4 to 5 | | | | | | | |
| 5 to 6 | | | | | | | |
| 6 to 7 | | | | | | | |
| 7 to 8 | | | | | | | |
| 8 to 10 | | | | | | | |
| 10 to 12 am | | | | | | | |

My Thought Diary

| <p>What happened?</p>  | <p>What was I thinking?</p>  | <p>How can I think differently?</p>  |
|---|--|--|
| <p>This may include an actual event or situation, a thought, mental picture or physical trigger, leading to unpleasant feelings.</p> | <p>What thoughts were going through your mind when the event occurred?</p> | <p>What other ways are there of viewing the situation? What evidence do I have that show that this thought is not completely true all of the time?</p> |
| <p>How did I feel? What did I do?</p>  <p>Describe how you feel and include any physical sensations you experience, as well as your actions and behaviour.</p> | | |



Experiment Record

Thought to be tested

Prediction: What would happen if this thought were true?

Possible Problems

Plan to deal with possible problems

Outcome of Experiment: What actually happened?

Did the experiment support the thought being tested?



Problem Solving

1. Identify and Define the Problem

- ✍ try to state the problem as clearly as possible; be objective and specific; describe the problem in terms of what you can observe rather than subjective feelings

| Problem Definition |
|--|
| |

2. Generate Potential Solutions

- ✍ list as many solutions as possible without evaluating them
- ✍ discard less desirable or unreasonable solutions after all possible solutions have been listed
- ✍ list the remaining solutions in order of preference

| List of Possible Solutions |
|--|
| |

| Preferred Solutions |
|---------------------|
| 1. _____ |
| 2. _____ |
| 3. _____ |
| 4. _____ |
| 5. _____ |
| 6. _____ |

3. Evaluate alternatives

- ✍ evaluate top 3 or 4 solutions in terms of their pros and cons

| | Advantages | Disadvantages |
|-----------------------|-------------------|----------------------|
| Potential Solution #1 | | |
| Potential Solution #2 | | |
| Potential Solution #3 | | |
| Potential Solution #4 | | |

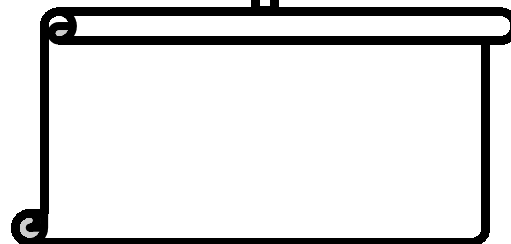
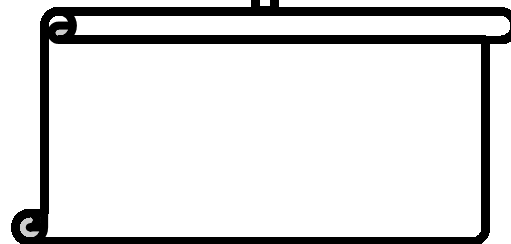
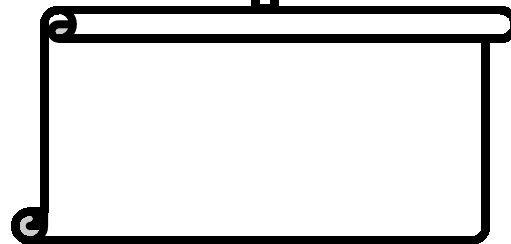
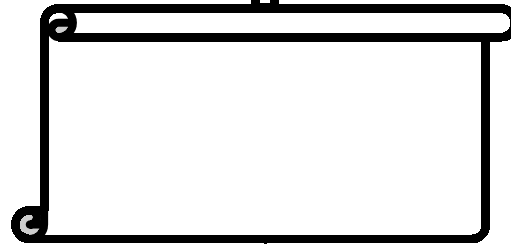
4. Decide on a solution

- ✍ decide on one or two solutions
- ✍ specify actions and how and when the solution will be implemented



| ACTION STEPS |
|---------------------|
| |
| |
| |
| |
| |
| |
| |
| |
| |
| |

Step Ladder



Self Management Plan



Name: _____

Date: _____

My most significant early warning signs are:

| |
|--|
| |
| |
| |
| |
| |

My plan of action for relapse prevention:

| |
|---|
| What I will do if I notice these early warning signs.... |
| |
| |
| |
| |
| What I would say to my friends and/or family ... |
| |
| |
| |
| |
| What I would ask my friends and/or family to do to help me out ... |
| |
| |
| |

What are my support options?

| Friends | Family | Community |
|---------|--------|-----------|
| | | |

Professional support network eg. GP, psychiatrist

Phone numbers

| <p>What are all the things I can do to help myself?</p> | <p>What situations are potential problems for me?</p> |
|--|--|
| | |

What coping strategies have I found most useful?

What are my common unhelpful thoughts?

What are my balanced beliefs ?
