Interventions for Positive Psychotic Symptoms:
A CBT approach for Delusions, Voices and Paranoia

Schizophrenia is characterised (Crow, 1980) by **positive symptoms**, such as hallucinations, delusions and thought disorder and **negative symptoms**, such as social withdrawal, poverty of speech and lack of motivation. In regard to hallucinations, auditory hallucinations and particularly voices are the most common, especially in Western societies. There are remarkable individual differences in the type of delusions and in the type of auditory hallucinations people experience. As Bentall (2000) had suggested, schizophrenia is a disease with:" No particular symptoms, no particular course, no particular outcome and which responds to no particular treatment".

Various theories have been developed about the origins of schizophrenia, with the stress-vulnerability model being currently the most predominant one. About 1% of the population are affected by schizophrenia, while 10%-15% of the population have heard voices or experienced hallucinations at some point in their life but have not come into contact with professionals. It is not hallucinations or delusions per se that determine whether people seek help from psychiatric services, but how well they are able to cope with these experiences.

In this presentation, the focus will be on how Cognitive Behavioural Therapy (CBT) can be effective in lessening the severity and impact of persistent hallucinations and delusions and in maximizing the patient's ability to cope with their symptoms. For most people with schizophrenia, anti-psychotic medication offers relief from their symptoms. A range of cognitive behavioural strategies may offer a very useful adjunct to medication in helping people to manage their experiences.

The main concept of CBT is that psychological difficulties depend on how people think or interpret events (cognitions), how people respond to these events (behaviour), and how it makes them feel (emotions). CBT seeks to achieve the desired changes by modifying the underlying thoughts and beliefs. It is a structured and time-limited approach and has three main goals: to reduce the distress and disability associated with psychotic symptoms; to increase people's capacity to cope with their experiences and to promote their active participation in preventing relapse. Overall, it mainly aims to improve functioning and reduce distress rather to completely remove or 'cure' any symptoms. Generally, it is recommended that CBT is given to the patient when they are at their least psychotic, both because rapport is likely to be easier to retain and also because less firmly held delusions are easier to challenge.

CBT begins with a period of building and establishing a collaborative, non-judgmental and empathic therapeutic relationship, where the patient feels understood. Good rapport and trust are essential ingredients as the relationship the patient has with the therapist may be the only reason to attend the sessions. This can be a challenge for people with psychosis as they may be suspicious, angry at mental health services or deny the relevance of therapy for their problems. Gradually the therapist moves to a more structured assessment interviewing. The therapist aims to arrive at a preliminary set of shared goals that are realistic and which provide hope for the future. (i.e: to facilitate the patient to feel less paranoid when out of home).

The second stage involves the therapist offering a new perspective about the nature of the patient's experiences which is based on the cognitive formulation of psychotic symptoms and vulnerability. The formulation is a statement of what the person sees as a problem, how these may come about and what is keeping them going.

The third stage typically involves the therapist promoting insight work and providing training in the use of various cognitive behavioural strategies to help the patients cope with distressing psychotic experiences. An important step in treating people with psychosis is the 'normalisation' of their experiences, that is the attribution of delusions and hallucinations to events such as biochemical disturbance, extreme stress and sleep deprivation. This process of normalisation aims to decatastrophise their experience and to make psychotic experiences seem less frightening. Psycho-education about psychosis and the symptoms of schizophrenia can act effectively in reducing patient's distress associated with their experiences.

Usually CBT can be applied more quickly to auditory hallucinations than to delusions because the phenomenon of the voices can be more easily agreed and discussed. In regard to hallucinations, the main approach is to accept that the experience of the hallucination is real but then to work with the patient to modify the interpretation of that experience. Since judging voices and delusions as threatening can be very disturbing and frightening for the individual, the primary aim of CBT is to disempower them. Typically the therapist works with the content of the hallucination and the belief about its origin. During the assessment the therapist can examine whether the patient has found or noticed anything that affects the voices, i.e: that make them better or worse. According to Chadwick (1994) exercises that challenge beliefs about the uncontrollability of the voices can have a significant effect in how powerful and distressing they are considered by the individual. The most usual end goal of insight promotion is for the person to understand that the voice comes from within them, as they mistake their inner speech as other people's speech (Bentall, 2003).

The most commonly reported strategies discovered by people to help control their voices involve some sort of distraction that engages their attention and in particular, activities that involve the use of language. This is because the language areas of the brain are involved in auditory hallucinations and thus using these areas for some other language activity prevents them from being used to produce hallucinations. The more attention is demanded from the person for the activity, the more effective the activity will be as a distraction, but this has to be balanced with the problem of engaging the patient in a demanding task.

In the case of auditory hallucinations, it is usually a good strategy to start CBT by suggesting to the patient to try to use an earplug or Walkman to stop them. This is the most effective and popular way of controlling the voices. It can provide the patient with immediate relief from the voices but also the realisation that they have a certain amount of control over them. Sub vocal speech (talking quietly to oneself) can also be very beneficial by preventing the vocal chord movements that accompany at least some auditory hallucinations. Other strategies include repeating sequences of number and sub vocal singing, which may be less attention demanding. Additional commonly used techniques include: increasing or decreasing social contact depending on whether it makes the symptom worse or better; setting aside a set period in each day when they listen to the voices and ignore them at other times and relaxation/ breathing exercises since hallucinations are more likely to occur when the patient is aroused (Tarrier, 1993).

While techniques that distract the person's attention from the voices have been found useful, in some cases focusing on the voices can also reduce the frequency of their occurrence. This can be done by recording details about the voices and focusing on its physical characteristics (i.e.: volume, clarity, gender, accent and identity, number of voices, whether they speak together or separately). This can help people to distant themselves from the voices and the power that they have over them. Often patients have difficulty distinguishing such characteristics and this can act as evidence that it is different from the voices of other people and that they do not come from a physical source. It is a good technique to ask whether other people hear it. Most report that others do not hear the voice, which is inconsistent with the view that it comes from a real person. Additionally, carefully challenging the evidence for the validity of the hallucinations -for example by showing to the patient that the voice 'tells lies'- can be very effective in reducing its authority and importance. In general, in CBT, therapists try to encourage the person not to believe their voices and to decrease feelings of personal responsibility for voice content. Therapy may only rarely actually stop the voices, but sometimes clinically significant changes in the way a person reacts to voices can be achieved (Folwer, 1995).

Haddock et al (1996) suggested that a combination of both distraction and focusing techniques would be the most appropriate treatment strategy for many patients.

In the fourth stage, therapy proceeds towards a focus on specific delusional beliefs and paranoid misinterpretations, ensuring first that a good trusting relationship has been established and then attempting belief modification. Patients usually make ‘cognitive biases’’ such as concentrating on evidence confirming their delusions while passing over evidence that contradicts them and they may ‘jumb to conclusions’ on the basis of inadequate evidence. An error of thinking that occurs most frequently in schizophrenia is that of ‘personalisation’ or ‘self-reference’. Often several CBT strategies are used in combination and they all involve gentle discussions about the evidence for the belief, rather than directly confronting and challenging the belief. Any direct question that implies doubt about the person’s delusions is likely to lead to loss of rapport and to adversely affect the therapeutic alliance. The therapist attempts to modify the patient’s interpretation by using logical reasoning and looking for alternative explanations. The therapist guides the patient’s thinking by asking appropriate questions (‘Socratic questioning’) and reality testing is used to question the evidence for the assumptions on which delusional beliefs are based.

The fifth stage in therapy targets the person’s dysfunctional assumptions about themselves (i.e: belief of being worthless, unwanted, dangerous) and others (belief that other people harbour negative attitudes towards the person). In psychotic patients we often come across the “Poor me” paranoid delusions where people tend to believe they are innocent victims of conspiracies and the “Bad-me” delusions, where they tend to believe that others have a good reason to harm them. Work involves advice on how to use CBT strategies for psychotic symptoms, strategies to manage social disability, identify prodromal signs of relapse and develop an individualised plan to manage future occurrences of the symptoms. The essence is for the person to be able to identify the symptoms when they occur, so that s/he can put into effect measures to counter them. Where medication has proved beneficial, a key aspect of CBT may be to improve medication compliance (Bentall, 2003).

Although the evaluation of CBT for psychosis is in its early stages, evidence is accumulating for its efficacy and cost-effectiveness. There is convincing evidence from controlled trials for the effectiveness of CBT at reducing symptoms, particularly symptoms of delusions and hallucinations and associated distress (Chadwick, 1994). One should also take into consideration however that traditional techniques of cognitive therapy might face significant obstacles when applied in psychotic patients. While diaries and homework assignments can be a very useful tool in helping the patient to discover the links between thoughts, feelings, physiology and behaviour, it might not always be feasible, as patients may be unwilling to do written homework and may find it difficult to work at that abstract level of thinking.

Communication difficulties might also exist and in severe cases of thought disorder therapy cannot be used, as it might be hard to follow what the patient is saying. The highly structured approach of CBT may help, but the therapist also need to be prepared to be creative and flexible taking into account the changes and fluctuations in the patient's mental state. Typical strategies include not holding rigid agendas, having shorter sessions, simplifying statements and continuously checking for the patient's understanding. Finally, it is worth mentioning that most often CBT is offered to people who have some distressing experiences but who are able to attend outpatient's appointments and it is less often provided in those who are in-patients in a hospital, even though they can also benefit from psychological interventions. It is crucial to identify which aspects of CBT interventions are most relevant for the care of individuals in hospital settings and to evaluate their effectiveness in these settings. Providing psychological interventions, together with medication, can be very effective for the patients who will receive a more holistic approach to their care that matches better their various needs.