THE CASE STUDY GUIDE
TO COGNITIVE BEHAVIOUR THERAPY OF PSYCHOSIS

Edited by
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ABOUT THE EDITORS

David Kingdon is a Professor of Mental Health Care Delivery and a consultant psychiatrist with a mental health team in Southampton. He is co-author, with Douglas Turkington, of Cognitive-Behavioural Therapy of Schizophrenia (New York: Guilford Press, 1994) and has produced many papers and chapters on CBT in severe mental illness over past decade. He has worked as a senior medical officer with the Department of Health, is a member of many project groups, including the National Service Framework for Mental Health external reference group, and is chair of a Council of Europe expert working party on “Psychiatry and Human Rights”.

Dr Douglas Turkington is a senior lecturer and consultant psychiatrist based at the Department of Psychiatry in the University of Newcastle-upon-Tyne. Having trained in Glasgow he moved to Sheffield where he received basic cognitive therapy training and achieved the advanced certificate in rational emotive therapy. He has worked with CBT for psychotic patients for the last 15 years and has co-authored one of the first books on the subject. He has lectured and run workshops throughout Europe and North America, and has published widely on the process of therapy and on the evidence base for CBT in schizophrenia and other psychoses. Currently he is attempting to prove that the good outcomes found in randomised controlled trials can be replicated using mental health team workers in community settings.
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PREFACE

Within the past year, research has confirmed that non-expert community psychiatric nurses can safely and effectively deliver cognitive behaviour therapy (CBT) to patients with schizophrenia and their carers (Turkington et al., 2002). It is reasonable to expect that other disciplines within mental health would achieve similarly encouraging results (Turkington & Kingdon, 2000). Such interventions are greatly appreciated by patients and carers, improve job satisfaction for the practitioner and lead to improved insight and coping. It is now contended that case management should be supplemented by such viable, high-quality psychosocial interventions if improved outcomes are to be achieved for patients with schizophrenia (Thornicroft & Susser, 2001). It certainly seems that low case loads alone do not produce such outcomes, as the UK 700 study (Burns et al., 1999) has demonstrated: how the increased time available is spent would appear to be fundamentally, and not unexpectedly, important.

This pathway towards the application of CBT principles to their psychotic patients has been trod by increasing numbers of community mental health team professionals over the last ten years in the United Kingdom, Australia, Canada and certain European countries. The dissemination of these techniques in other areas has depended upon local initiatives and has often lacked published case material to support enthusiastic practitioners; thus the pressing need for this casebook. CBT is a collaboration between patient and therapist, so to illustrate the variation that can occur, each chapter begins with a description of a mental health professional’s own personal development and training in CBT for psychosis. The contributors then describe a case to illustrate certain key principles, which are explained in varying depths. The cases have been carefully chosen to give the early practitioner a good feel for the process of therapy in a variety of different psychotic presentations. A brief introduction to the general techniques is given at the beginning of the book, and it ends with a discussion on training, supervision and implementation issues.

The first case describes the key principles of working with a patient who has a systematised, grandiose delusion which is antipsychotic-resistant. Douglas Turkington, a psychiatrist, stresses the importance of maintaining
collaboration, working up a formulation and generating interesting homework exercises. Laura McGraw, a community nurse (with the assistance of Alison Brabban), describes her experience of introducing CBT to a patient whom she has known for many years. She describes the complexities for the patient and the therapist of making sense of their experiences and of working towards a shared explanation on which reality testing and activity scheduling can begin. Lars Hansen, a senior trainee psychiatrist, shows how to work with hallucinatory experiences, some of which are seen as pleasant and supportive by the patient. Isabel Clarke illustrates her model of therapy with a patient with longstanding problems whom she met through her work as a senior clinical psychologist in a rehabilitation service. David Kingdon, together with Nicky, shows how practising consultant psychiatrists can integrate CBT into their workload to produce improved quality of management—in this particular case by understanding the link between Nicky’s underlying guilt and psychotic symptoms. With Damien, a process of therapy is clearly described for those very difficult patients who abuse hallucinogenic drugs thereby exacerbating psychotic symptoms. Ron Siddle, a nurse therapist, shows us how to work with those voices that command actions and are linked to depression. Such patients, unless effectively treated, are of course at high risk of eventual suicide. Paul Murray provides a detailed description of a patient who received a brief intervention as part of the Insight into Schizophrenia study (Turkington et al., 2002), but nevertheless seemed to gain significant benefits from it. Nick Maguire, a clinical psychologist, describes two patients with paranoid delusions, and shows clearly not only how to help the patients to recognise that their delusions are beliefs and not facts but, in a guided discovery manner, to help the patients to test them gradually in a real situation. His model for doing so is clearly explained. Pauline Callcott, a nurse therapist, describes work with a very traumatised and fearful woman using CBT for psychosis, combined with some of the treatment methods used in post-traumatic stress disorder. This had mixed results—symptoms improved but admission was necessary and remains quite a controversial way of working with psychotic patients. Jeremy Pelton, a nurse therapist with the Insight project, describes how to engage the family as co-therapists and shows how beneficial that can be in improving joint understanding and coping, which can be of real and lasting benefit to psychotic patients who, it would seem, can be helped to move into ‘the real world’. The casebook should provide great encouragement to those mental health professionals who have always intuitively believed that such interventions could be appropriate for the many patients experiencing severe mental health problems. We hope that by clear case illustrations, and by describing the research evidence available, we
may also help those who are more sceptical to understand why we believe these developments to be so important in the management of such disorders.

Douglas Turkington
David Kingdon
18 December 2001
INTRODUCTION

“We can talk”, a major American journal announced in 1997: “Schizophrenia is no longer a disorder in which psychological approaches have no place” (Fenton & McGlashan, 1997). Many people, including users of services, their carers and staff, are now trying to understand why people who are going through a troubled period in their life, feel or behave the way they do, and think about frightening, confusing, depressing or distressing matters. Irrespective of whether they are users or patients, carers, friends, nurses, social workers, doctors or psychologists, it is important that they have the capacity to control their emotions effectively. Some people seem able to do this intuitively, but most of us need help. We hope this book can provide some of that help by giving examples of how a variety of people from different backgrounds have spent time trying to understand and offer assistance in these circumstances.

People who have participated in the use of CBT—of one form or another—will be described. This will include not only users or patients who have experienced psychotic symptoms, but also those who have worked with them as carers or therapists. Both groups vary considerably in their experiences of symptoms and of using CBT with these symptoms. Participation and collaboration in therapy has been an essential basis for any progress that is seen. In their guided discovery of the experiences that have led to their meeting for therapeutic purposes, the patient and therapist will both have taken a lead.

Over the years, we have also been closely involved in training and supervising mental health workers and describe some of the positive and negative experiences involved. Similarly, the implementation of CBT in mental health services has progressed and is gradually becoming embedded in clinical services—but not uneventfully. Again this will be discussed and evidence for the effectiveness of CBT in psychosis will be reviewed briefly.

Finally, we would recommend that you read one or more of the available texts on CBT in psychosis, as they differ and complement each other in a