Opportunities and limitations of CBT for psychosis: not a quasi-neuroleptic

Max Birchwood
‘CBTp reduces (drug resistant) psychotic symptoms, promotes insight and increases medication adherence’

NICE, 2008
- Tim Beck
- Nick Tarrier
- Dave Kingdon and Doug T.
- Chadwick Birchwood Trower
- Garety Fowler & Kuipers.
John Percival (1838) the first cognitive therapist in psychosis

Percival, John. *A Narrative of the Treatment Experienced by a Gentleman, During a state of Mental Derangement; Designed to Explain the Causes and Nature of Insanity, and to Expose the Injudicious Conduct Pursued Towards Many Unfortunate Sufferers Under That Calamity.* 2 vols. London: Effingham Wilson, 1838 and 1840.

*(A mad people’s history of madness. Dale Petersen, Ed. Pittsburgh, PA, University of Pittsburgh Press, 1982)*
What is CBTp?

• Verbal therapy to ease distress by reducing positive symptoms
• Mobilises the client’s capacity to reflect on and to question delusional or self evaluative beliefs
• A ‘collaborative empirical’ enterprise
Common ingredients

- Engagement, rapport and trust
- Shared formulation (why psychosis; why now; why me?)
- Focus on delusional beliefs and alternatives to delusional thinking
- Weighing evidence; antidote to ‘jumping to conclusions’
- Negative self-evaluative thinking
- Schema
- Relapse prevention
CBTp meta-analysis, Wykes et al 2007

Fig. 1. Forest Plot of the Effect Sizes for the Trials Shown in Table 2.
Figure 2. Effect Size Estimates (Hedges' g) and the Statistical Tests of the Acute Treatment Efficacy of CBT Compared to Placebo on the Primary Continuous Anxiety Measures for the Identified Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Hedges' g</th>
<th>95% CI</th>
<th>z</th>
<th>p</th>
<th>Hedges' g and 95% CI</th>
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<tbody>
<tr>
<td>Acute Stress Disorder</td>
<td></td>
<td></td>
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<tr>
<td>Bryant et al[2] (1998)</td>
<td>1.49</td>
<td>0.60 to 2.38</td>
<td>3.29</td>
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<tr>
<td>Bryant et al[3] (1999)</td>
<td>1.28</td>
<td>0.52 to 2.04</td>
<td>3.29</td>
<td>.00</td>
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<tr>
<td>Bryant et al[4] (2003)</td>
<td>1.66</td>
<td>0.75 to 2.58</td>
<td>3.57</td>
<td>.00</td>
<td></td>
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<tr>
<td>Bryant et al[5] (2005)</td>
<td>1.08</td>
<td>0.47 to 1.69</td>
<td>3.47</td>
<td>.00</td>
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<tr>
<td>Generalized Anxiety Disorder</td>
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<td></td>
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<tr>
<td>Borkovec and Costello[6] (1993)</td>
<td>0.57</td>
<td>-0.08 to 1.21</td>
<td>1.71</td>
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<tr>
<td>Wetterell et al[7] (2003)</td>
<td>0.44</td>
<td>-0.21 to 1.10</td>
<td>1.34</td>
<td>.18</td>
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<td>Obsessive-Compulsive Disorder</td>
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<tr>
<td>Foa et al[8] (2005)</td>
<td>1.65</td>
<td>0.95 to 2.35</td>
<td>4.62</td>
<td>.00</td>
<td></td>
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<tr>
<td>Greist et al[9] (2002)</td>
<td>0.74</td>
<td>0.40 to 1.08</td>
<td>4.32</td>
<td>.00</td>
<td></td>
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<tr>
<td>Lindsay et al[10] (1997)</td>
<td>2.08</td>
<td>0.91 to 3.26</td>
<td>3.48</td>
<td>.00</td>
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<td>Panic Disorder</td>
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<tr>
<td>Bakker et al[11] (1993)</td>
<td>0.43</td>
<td>-0.09 to 0.96</td>
<td>1.62</td>
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<td>Barlow et al[12] (2000)</td>
<td>0.23</td>
<td>-0.35 to 0.61</td>
<td>0.77</td>
<td>.44</td>
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<tr>
<td>Black et al[13] (1993)</td>
<td>0.26</td>
<td>-0.40 to 0.92</td>
<td>0.78</td>
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<td>Craske et al[14] (1995)</td>
<td>0.49</td>
<td>-0.25 to 1.22</td>
<td>1.29</td>
<td>.20</td>
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<td>PTSD</td>
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<td>Blanchard et al[15] (2003)</td>
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<td>0.11 to 1.20</td>
<td>2.35</td>
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<td>Bryant et al[16] (2003)</td>
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<td>0.68 to 2.29</td>
<td>3.61</td>
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<tr>
<td>Foa et al[17] (1991)</td>
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<td>-0.39 to 1.28</td>
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<td>Marks et al[18] (1998)</td>
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<td>2.28</td>
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<td>McDonagh et al[19] (2005)</td>
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<td>-0.50 to 0.77</td>
<td>0.41</td>
<td>.68</td>
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<tr>
<td>Neuner et al[20] (2004)</td>
<td>0.41</td>
<td>-0.32 to 1.14</td>
<td>1.10</td>
<td>.27</td>
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<tr>
<td>Social Anxiety Disorder</td>
<td></td>
<td></td>
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<tr>
<td>Clark et al[21] (2003)</td>
<td>0.89</td>
<td>0.25 to 1.53</td>
<td>2.72</td>
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<tr>
<td>Cotgreave et al[22] (2000)</td>
<td>0.51</td>
<td>-0.02 to 1.04</td>
<td>1.89</td>
<td>.06</td>
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<tr>
<td>Davidson et al[23] (2004)</td>
<td>0.52</td>
<td>0.09 to 0.96</td>
<td>2.36</td>
<td>.02</td>
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<tr>
<td>Heimberg et al[24] (1998)</td>
<td>0.94</td>
<td>0.36 to 1.52</td>
<td>3.15</td>
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<tr>
<td>Lucas[25] (1994)</td>
<td>0.43</td>
<td>-0.23 to 1.09</td>
<td>1.28</td>
<td>.20</td>
<td></td>
</tr>
<tr>
<td>Smits et al[26] (2006)</td>
<td>0.53</td>
<td>-0.15 to 1.21</td>
<td>1.52</td>
<td>.13</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>0.73</td>
<td>0.56 to 0.90</td>
<td>8.62</td>
<td>.00</td>
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</table>

Effect size = 0.73
<table>
<thead>
<tr>
<th></th>
<th>Mean Weighted Effect Size</th>
<th>95% Confidence Interval</th>
<th>Heterogeneity Test (df), Significance Level</th>
<th>No. of Studies</th>
<th>Sample Size</th>
<th>95% CI Interval</th>
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<tbody>
<tr>
<td><strong>Target symptom</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>High CTAM</td>
<td>0.223</td>
<td>0.017, 0.428</td>
<td>27.73 (11), significant at the 5% level</td>
<td>12</td>
<td>1124</td>
<td>0.037</td>
</tr>
<tr>
<td>Low CTAM</td>
<td>0.534</td>
<td>0.343, 0.725</td>
<td>35.35 (20), significant at the 5% level</td>
<td>21</td>
<td>840</td>
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<td><strong>Positive symptom</strong></td>
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<tr>
<td>High CTAM</td>
<td>0.222</td>
<td>0.016, 0.427</td>
<td>27.83 (11), significant at the 5% level</td>
<td>12</td>
<td>1124</td>
<td>-0.067</td>
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<tr>
<td>Low CTAM</td>
<td>0.487</td>
<td>0.311, 0.664</td>
<td>27.35 (19), not significant</td>
<td>20</td>
<td>794</td>
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<tr>
<td><strong>Negative symptom</strong></td>
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<td></td>
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<tr>
<td>High CTAM</td>
<td>0.206</td>
<td>-0.104, 0.516</td>
<td>28.33 (8), significant at the 5% level</td>
<td>9</td>
<td>631</td>
<td>-0.107</td>
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<tr>
<td>Low CTAM</td>
<td>0.610</td>
<td>0.200, 1.020</td>
<td>83.33 (13), significant at the 5% level</td>
<td>14</td>
<td>637</td>
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<tr>
<td><strong>Functioning</strong></td>
<td></td>
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<tr>
<td>High CTAM</td>
<td>0.147</td>
<td>-0.172, 0.466</td>
<td>8.49 (4), not significant</td>
<td>5</td>
<td>347</td>
<td>-0.094</td>
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<tr>
<td>Low CTAM</td>
<td>0.509</td>
<td>0.221, 0.797</td>
<td>23.04 (9), significant at the 5% level</td>
<td>10</td>
<td>520</td>
<td></td>
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<tr>
<td><strong>Mood</strong></td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>High CTAM</td>
<td>0.084</td>
<td>-0.154, 0.322</td>
<td>9.21 (5), not significant</td>
<td>6</td>
<td>685</td>
<td>0.048</td>
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<tr>
<td>Low CTAM</td>
<td>0.680</td>
<td>0.174, 1.186</td>
<td>32.96 (8), significant at the 5% level</td>
<td>9</td>
<td>268</td>
<td></td>
</tr>
</tbody>
</table>

*Note: CTAM, Clinical Trial Assessment Measure.*
Cognitive–behavioural therapy for refractory psychotic symptoms of schizophrenia resistant to atypical antipsychotic medication

Randomised controlled trial

LUCIA R. VALMAGGIA, MARK VAN DER GAAG, NICHOLAS TARRIER, MARIEKE PIJNENBORG and CEES J. SLOOFF

Results Participants receiving cognitive–behavioural therapy had improved with regard to auditory hallucinations and illness insight at the post-treatment assessment, but these findings were not maintained at follow-up.

Conclusions Cognitive–behavioural therapy showed modest short-term benefits over supportive counselling for treatment-refractory positive symptoms of schizophrenia.

Tayside–Fife clinical trial of cognitive–behavioural therapy for medication-resistant psychotic symptoms

Results to 3-month follow-up

ROBERT C. DURHAM, MOYRA GUTHRIE, R. VICTOR MORTON, DAVID A. REID, LINDA R. TRELIVING, DAVID FOWLER and RANALD R. MACDONALD

Results Treatment effects were modest but the CBT condition gave significantly greater improvement in overall symptom severity than the SPT or TAU conditions combined (F(1.53)=4.14; P=0.05). Both the CBT and SPT conditions combined gave significantly greater improvement in severity of delusions than did the TAU condition (F(1.53)=4.83; P=0.03). Clinically significant improvements were achieved by 7/21 in the CBT condition (33%), 3/19 in the SPT condition (16%) and 2/17 in the TAU condition (12%).
Editorial

Cognitive–behavioural therapy for severe mental disorders: back to the future?

Jan Scott

Summary
Like recent medication studies, it appears that when cognitive–behavioural therapy is tested in pragmatic effectiveness trials involving routine clinical populations it does not fare as well as in efficacy trials. Given the multitude of factors that can 'muddy the waters' in clinical trials, how do we best make sense of the findings?

Declaration of interest
Jan Scott was Principal Investigator on the Medical Research Council effectiveness study of cognitive–behavioural therapy for bipolar disorders and on the Trial Steering Committee for the Welcome study under Garety et al (in this issue). She has received honoraria from Continuing Medical Education talks on psychological therapies for severe mental disorders from Astra, SMI-Oska, Eli Lilly, GlaxoSmithKline, Janssen-Cilag and Shire Aventis.

Cognitive–behavioural therapy for severe and recurrent bipolar disorders

Randomised controlled trial

JAN SCOTT, EUGENE PAYKEL, RICHARD MORRISS, RICHARD BENTALL, PETER KINDERMAN, TONY JOHNSON, ROSEMARY ABBOTT and HAZEL HAYHURST

Cognitive–behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: randomised controlled trial

Philippa A. Garety, David G. Fowler, Daniel Freeman, Paul Bebbington, Graham Dunn and Elizabeth Kuipers
Reason could be...

- CBTp works for some groups and certain contexts (Not: FEP; in 12 months after acute episode; relapse prevention)
- Is a complex intervention and key ingredients camouflaged.
- Variation in CBTp model between centres/trials
Could also be..

• PANSS is poor outcome for CBT: symptoms not always synonymous with distress or behaviour.
• CBTp a weak intervention for + symptoms
• Problems with the neuroleptic metaphor

CBTp: a neuroleptic metaphor?

Primary outcome = Severity of psychosis (PANSS)

Inclusion criterion = Drug resistant symptoms
The neuroleptic metaphor

• PANSS is poor outcome for CBT:
  1. symptoms not always synonymous with distress or behaviour.
  2. Can get 30% change in PANSS with no change in psychosis
  3. Can get change in PANSS+ but no change in delusional conviction
• CBTp a weak intervention for + symptoms?
• Problem with the neuroleptic metaphor
Psychosis (PANSS)

Person and context

- Delusional conviction
- Unusual thought content

Affect/Distress

Behaviour
Social Cognition: Emotional Appraisal

Hallucinations

T1

No depression

Depression

T2

Distressing psychosis

T3

Baseline delusional ideation/depression

± 7000

1 year

± 5600

2 years

± 4800

Independent course of childhood auditory hallucinations: a sequential 3-year follow-up study*

SANDRA ESCHER, MARIUS ROMME, ALEX BUIKS, PHILIPPE DELESPAUL and JIM VAN OS

• 80 children (mean 12 yrs) with ‘voices’ recruited from community
• 60% voices discontinued after 3 yrs
• Continuation and distress predicted by: emerging negative beliefs about voices and development of depression
Psychosis (PANSS)

- Person and context
- Affect/Distress
- Behaviour

- Delusional conviction
- Unusual thought content
The interface of affect, threat and delusional thinking
Persecutory thinking

Affect

(Mis)interpretation

Dimensions of threat

Identity/source

Intent;power

Threat mitigation

Event/hassle

Appeasement

Safety behaviours
Interventions

- Change mis-interpretations (e.g. JTC)
- Affect, esp anxiety and worry:
- Dimensions of threat, esp. power vs. intent

Q: Can we change threat /distress without changing delusional conviction?

Q: Can we change the ‘affectivity’ of psychotic experience without changing content?
BELIEFS
[Power; intent]

EVIDENCE

AFFECT
Fear, guilt, elation, depression

SAFETY BEHAVIOURS

Voice
Activity

Omniscience: shame; predictions
Control

Threat Mitigation
Appeasement
Appraisals, psychotic symptoms and affect in daily life

Emmanuelle Peters, Inez Myin-Germeys, Sally Williams, Kathryn Greenwood, Elizabeth Kuipers, Jan Scott & Philippa Garety
Institute of Psychiatry, U.K.
The Experience Sampling Method

- 10 random times a day
- 6 consecutive days
- provides ‘on-line’ measurement

Myin-Germeys et al, Arch Gen Psychiatry 2001
Do voice appraisals predict distress?

<table>
<thead>
<tr>
<th>Dependent variables (Multi-level linear regressions)</th>
<th>Voice intensity ratings (range 2-7) (β)</th>
<th>Power appraisals (β)</th>
<th>Control appraisals (β)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Negative affect</td>
<td>.07</td>
<td>.15*</td>
<td>.05</td>
</tr>
<tr>
<td>2. Symptom distress</td>
<td>.38*</td>
<td>.24*</td>
<td>.05</td>
</tr>
</tbody>
</table>

* = p < .001

Appraisals about power, but not control or intensity of voices, are related to negative affect; power and intensity both related to symptom distress.
The 'expressed emotion' of voices?

Power EE reflects the relationship hierarchy infringements of relationship boundaries
Appraisal of voices (n=72)

- Hi EE: 41%
- Hi EE + Hi power: 15%
- Hi power: 3%
- Lo EE + lo Power: 41%
# Depression and suicidal thinking
(FEP; n=74)

<table>
<thead>
<tr>
<th>Variables selected</th>
<th>Beta</th>
<th>t</th>
<th>Sig.</th>
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<tbody>
<tr>
<td>Voice Frequency <em>(psyrat)</em></td>
<td>.342</td>
<td>3.198</td>
<td>.002</td>
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<tr>
<td>Power X EE *</td>
<td>.596</td>
<td>5.567</td>
<td>.000</td>
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</tbody>
</table>
Cognitive therapy for command hallucinations

- Undermining the power of the voice, especially its perceived ability to harm or shame
- Increasing the power of the voice hearer
- Affirming boundaries

Cognitive therapy for command hallucinations: randomised controlled trial

PETER TROWER, MAX BIRCHWOOD, ALAN MEADEN, SARAH BYRNE, ANGELA NELSON and KERRY ROSS

Command
Funded by the Medical Research Council

A Multicentre, Randomised Controlled Trial of Cognitive Therapy to Prevent Harmful Compliance with Command Hallucinations.
MILLIONAIRE
‘URGED BY VOICES TO BATTER HIS LITTLE GIRL’

A TOP City executive accused of a horrific attack on his toddler daughter may have a severe mental illness, it emerged last night.

Millionaire insurance boss Alberto Izaga was said to have ‘flipped’ for no obvious reason. He is alleged to have launched a savage attack on two-year-old Yanire, punching and kicking her and hitting her head against a bedroom floor.

Yesterday, as Mr Izaga was sectioned under the Mental Health Act, friends said he claimed voices in his head told him to attack his daughter at their London home.

Doctors have warned that the little girl is unlikely to recover. Mr Izaga’s wife Ligia, who tried desperately to protect Yanire, is likely to face the further nightmare of being asked for permission to turn off her life support.

Spanish-born Mr Izaga, 36, is a top executive at the insurance giant Swiss Re. He had recently been promoted to its main UK board, with an annual salary of up to £500,000.

“The pressure is enormous at that level,” a friend said last night. They all

Turn to Page 4
CTCH: The Theory in Brief

A Cognitive Model of Distress and Behaviour within an Interpersonal Relationship
The Compliance Behaviour Cycle

B: Power Beliefs
Identity “The Voice is ...............“(%) Evidence .....  
Control “I cannot control my voices...”(%) Evidence .....  
Compliance “If I don’t do what my voices say...”(%), “If I don’t listen to my voices.....” Evidence .....  
Meaning & Purpose “My voices intention is to ...........”(%) Evidence .....  

B: Core Beliefs:  
“I am .............” “Others are ...........”(%) Evidence .....  

Safety Behaviors  
Appeasement  
Compliance  

Emotional Consequences  
Fear, Anxiety, Depression
Prevalence Rates

• Command hallucinations, occur at a high rate in adult psychiatric patients (median 53% across eight studies with a wide range from 18 to 89%) Shawyer et al (2003) Equivalent prevalence rates in forensic populations
• 48% of CHs stipulate harmful or dangerous actions
• 33% comply with CHs
• 33% ‘appease’ or show minor compliance, remain at risk of later compliance
# Commands to Kill Others

<table>
<thead>
<tr>
<th>CTCH Trail 1 Prevalence</th>
<th>Example</th>
<th>Compliance</th>
<th>Appeasement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Command to Kill Others</td>
<td>‘cut her throat’</td>
<td>Four patients in the sample had attempted to kill someone, either by suffocation, poisoning or physical assault with a hammer.</td>
<td>Three patients used appeasement behaviours including arming themselves with knives, baseball bats and an axe and making guns out of tin foil.</td>
</tr>
<tr>
<td>(Treatment n = 6)</td>
<td>‘go and kill someone’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Control n = 7)</td>
<td>‘kill the therapist’</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘kill your husband and daughter’</td>
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<td></td>
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</tbody>
</table>
### Commands to Harm Self

<table>
<thead>
<tr>
<th>CTCH Trail 1 Prevalence</th>
<th>Example</th>
<th>Compliance</th>
<th>Appeasement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Command to Harm Self (Treatment n = 9) (Control n = 3)</td>
<td>‘burn yourself’ ‘cut yourself’ ‘set yourself alight’ ‘pour hot water on yourself’ ‘go into the road’</td>
<td>Nine patients had harmed themselves in response to commands. This included cutting, swallowing nail polish remover or bleach, jumping in front of cars, walking on glass and setting oneself alight</td>
<td>Three patients used appeasement behaviours including picking at previous wounds, and standing on the kerb</td>
</tr>
</tbody>
</table>
CTCH From the Client’s View....
I’m More Powerful Than my Voice if I can...........

• Stop it
• Reduce it
• Start it
• Listen when I’m ready
• Resist without penalty
There are Benefits if I Resist..

• I will not go to jail or hospital
• I will not upset others I care about or who care about me
• I can hold my head high again
• I can get on with my life
Do my Powerful Voices…

• Always speak the truth?
• Predict the future accurately?
• Mean what they say – are they unambiguous in their meaning?
Testing out the Power…

- I don’t always appease and nothing happens
- There are times when I don’t comply and nothing happens
- Can’t harm the therapist or others that I care about
Cognitive therapy for command hallucinations: randomised controlled trial

PETER TROWER, MAX BIRCHWOOD, ALAN MEADEN, SARAH BYRNE, ANGELA NELSON and KERRY ROSS

The **COMMAND** trial
DESIGN

• Prospective, randomised, single blind, intention to treat RCT
• CT vs TAU
• Treatment over 6 months; 6 months follow up
% appeasing or complying at 12 months

<table>
<thead>
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<th></th>
<th>TAU</th>
<th>CTCH</th>
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<tbody>
<tr>
<td>12 months</td>
<td>53%</td>
<td>14%</td>
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</tbody>
</table>

Pre= 100%, both groups
Mean scores on the Voice Power Differential Scale

Voice more powerful

Mean score

I am more powerful

Assessment

Group X time : p<0.001
Mean Scores on Negative Content (PSYRATS)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>CTCH</th>
<th>TAU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>3,4</td>
<td>3,6</td>
</tr>
<tr>
<td>6 month</td>
<td>3,1</td>
<td>3,4</td>
</tr>
<tr>
<td>12 month</td>
<td>3,6</td>
<td>3,7</td>
</tr>
</tbody>
</table>

0 = None
1 = Some
2 = Abusive re behaviour
3 = Abusive re self
4 = Extreme commands
The future of CBTp?

“ The remarriage of emotion and psychosis”

• Cognitive model and treatment of distress/behaviour not ‘psychosis’
  (PANSS secondary outcome)
• Interventions on the interface between delusional thinking and emotion.
• CBT for ED and origins in ‘social defeat’
Fantasy futures (NICE, 2012)

- CBTp eliminates distress and (harmful) ‘acting on’ voices and paranoid delusions, but ‘psychosis’ can remain relatively unchanged
- CBTp reduces relapse by a) stress sensitivity + b) ‘roll-back’ attenuated psychotic thinking... using real time ESM
- CBTp eliminates social anxiety, depression and suicidal thinking
- CBTp for ED in prodrome prevents psychosis
John Percival (1838) the first cognitive therapist in psychosis

Percival, John. *A Narrative of the Treatment Experienced by a Gentleman, During a state of Mental Derangement; Designed to Explain the Causes and Nature of Insanity, and to Expose the Injudicious Conduct Pursued Towards Many Unfortunate Sufferers Under That Calamity.* 2 vols. London: Effingham Wilson, 1838 and 1840.

(A mad people’s history of madness. Dale Petersen, Ed. Pittsburgh, PA, University of Pittsburgh Press, 1982)
John Percival wrote a lengthy account of his experience of madness.

John Percival was one of twelve children of Spencer Percival the only English prime minister to have been assassinated….

When 27 he started seeing visions and hearing voices that told him to do strange things. His behaviour became so erratic that a 'lunatic doctor' was called who strapped him to his bed and gave him broth and medicine….
"Those voices commanded me to do, and made me believe a number of false and terrible things.

I threw myself out of bed - I tried to twist my neck, - I struggled with my keepers. When I came to Dr Fox's I threw myself over a style, absolutely head over heels, wrestled with the keepers to get a violent fall, asked them to strangle me, endeavoured to suffocate myself on my pillow, &c., threw myself flat on my face down steep slopes

... and upon the gravel walk, called after people as my mother, brothers, and sisters, and cried out a number of sentences, usually in verse, as I heard them prompted to me - in short for a whole year I scarcely uttered a syllable, or did a single act but from inspiration"
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The cognitive therapy
"On another occasion being desired to throw myself over a steep precipice near the river Avon - with the promise that if I did so, I should be in heavenly places, or immediately at home, I refused to do so for fear of death, and retired from the edge of the precipice to avoid temptation –

…but this last was not till after repeated experiments of other kinds had proved to me that I might be deluded.

For I was cured at last, and only cured of each of these delusions respecting throwing myself about, &c. &c., by the experience that the promises and threats attendant upon each of them were false. When I had fairly performed what I was commanded, and found that I remained as I was, I desisted from trying it …

I knew I had been deceived - and when any voice came to order me to do any thing, I conceived it my duty to wait and hear if that order was explained, and followed by another - and indeed I often rejected the voice altogether: and thus I became of a sudden, from a dangerous lunatic, a mere imbecile, half-witted though wretched being: and this was the first stage of my recovery."
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