

In this article...

- Why cognitive behavioural therapy is now used to treat schizophrenia
- How CBT can normalise the experiences associated with schizophrenia
- The role of mental health nurses in delivering psychosocial interventions

How cognitive behavioural therapy can help in the treatment of schizophrenia

Key points

1 Schizophrenia is a severe and enduring mental health condition, which can be seriously debilitating

2 Cognitive behavioural therapy can be used to treat schizophrenia alongside neuroleptics to help manage symptoms

3 CBT helps by demystifying and destigmatising schizophrenia so people can find alternative meanings for their symptoms

4 A fundamental aspect of CBT is the development of a therapeutic relationship based on empathy, congruence and unconditional positive regard

5 Through optimising the skills of mental health nurses, CBT could be made more accessible

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Abstract The perceptions and treatment of schizophrenia have changed radically in recent years. Today, alongside antipsychotic medications, the National Institute for Health and Care Excellence recommends the use of cognitive behavioural therapy for people who experience schizophrenia. CBT has been shown to normalise the experience of hearing voices by reducing the stigma associated with schizophrenia and allowing people to re-evaluate their beliefs. However, only about 10% of service users receive CBT. Mental health nurses could help to bridge the gap.

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Schizophrenia used to be treated with antipsychotic medication only, but today the perceptions of the condition have changed and cognitive behavioural therapy is recognised as a useful treatment option. Unfortunately, only a minority of people who experience schizophrenia have access to this therapy.

A diagnosis of schizophrenia is made when an individual presents with positive symptoms – such as hallucinations, delusions and disorganised speech and/or behaviours – and negative symptoms – such as avolition (lack of motivation), alogia (lack of speech) and the affective flattening of emotions (Semple and Smyth, 2013). Schizophrenia is classified as a severe and enduring mental health issue (Bradshaw and Mairs, 2011) and affects more than 21 million people around the world (World Health Organization, 2016). In England, 220,000 people are thought to live with the condition (Schizophrenia Commission, 2012).

Schizophrenia can be seriously debilitating, is connected with higher morbidity and mortality rates (Nash, 2010), and is associated with discrimination and stigma (Romme and Escher, 2012).

Treatment options

In the past, neuroleptic medication was the only treatment option for people diagnosed with schizophrenia (Read and Sanders, 2010). Neuroleptics have been shown to have a positive impact on symptoms, potentially reducing the intensity of hallucinations and delusional ideation (false, fixed beliefs held with complete conviction) (Mutsatsa, 2013); however, they do not work for 30% of people who take them, who are described as having treatment-resistant symptoms (Moncrieff, 2009). Further problems with neuroleptics are:

- They can cause an intense lack of motivation, resulting in the exacerbation of symptoms;
- They are often poorly tolerated,

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Cognitive behavioural therapy can be used in conjunction with oral antipsychotic medication to treat schizophrenia and psychosis

causing, in particular, distressing extrapyramidal side-effects including pseudo-Parkinsonism (muscle stiffness, stooped posture, a shuffling gait and drooling), tardive dyskinesia (involuntary movement of the head, neck and limbs, including protruding and twisting movements of the tongue) and acute akathisia (inner restlessness and muscular discomfort) (Healy, 2009).

The National Institute for Health and Care Excellence endorses both medication and CBT as treatment options for anyone with a diagnosis of schizophrenia (NICE, 2014). Box 1 outlines some of NICE's (2014) recommendations.

CBT, which is a psychosocial intervention (PSI), can be used alongside neuroleptics to help individuals manage symptoms of schizophrenia. NICE (2014) recommends that CBT should be delivered on a one-to-one basis over 16 sessions. Others believe that brief CBT – delivered in as little as six sessions – can be helpful (Naeem et al, 2014).

Mixed evidence

CBT examines a person's emotions, thoughts and behaviours to discover the unhelpful meanings that underpin distress and uncover more useful perspectives (Davidson et al, 2010). It was first developed as a PSI for common mental health issues and was initially not considered to be a useful treatment for people experiencing psychosis (Grist, 2015). Beck (1991) originally argued that, in

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schizophrenia, cognitive impairment and fixed ideation were so severe that individuals had a reduced capacity to view their own thoughts objectively, which limited their ability to engage in CBT. However, in the 1980s and 1990s, clinicians began focusing on developing treatments that helped people cope with some of the most troubling experiences associated with psychosis (Bentall, 2004) – CBT was therefore adapted for use to treat and manage schizophrenia.

Tarrier et al (1993) published the first randomised controlled trial of the effectiveness of CBT for people who experienced psychosis: they found that people who had treatment-resistant symptoms and received CBT showed a greater improvement than members of the control group, who were taught simpler problem-solving techniques. However, other RCTs have shown mixed outcomes ranging from moderate to impressive improvements (Bentall, 2004).

Although NICE (2014) specifically recommends CBT use in treating schizophrenia, it is difficult to find evidence that the intervention is more efficacious than any other PSI (Bentall, 2004). This is thought to arise from a confirmation

Box 1. NICE guideline on psychosis and schizophrenia

The National Institute for Health and Care Excellence's (2014) guideline on preventing and managing psychosis and schizophrenia includes the following recommendations:

Preventing psychosis

If a person is considered to be at increased risk of developing psychosis, offer:

- Individual cognitive behavioural therapy with or without family intervention
- Interventions recommended in this NICE (2014) guidance for people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse

First-episode psychosis

For people who have first-episode psychosis, offer oral antipsychotic medication in conjunction with psychological interventions (family intervention and individual CBT).

Advise people who want to try psychological interventions alone that these are more effective when they are delivered in conjunction with antipsychotic medication. If the person still wants to try psychological interventions alone:

- Offer family intervention and CBT
- Agree a time (up to 1 month) to review the treatment options, including introducing antipsychotic medication
- Continue to monitor, on a regular basis, symptoms, distress, impairment and level of functioning (including education, training and employment)

Acute episodes of psychosis or schizophrenia

For people who have an acute exacerbation or recurrence of either psychosis or schizophrenia, offer oral antipsychotic medication in conjunction with psychological interventions (family intervention and individual CBT).

bias in research (Gerrish and Lacey, 2010) that has become known as 'the Dodo effect' (Bentall, 2004): it is believed that the outcomes of research are directly due to researchers' allegiances to specific treatments (Bentall, 2004).

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Review

Other critics of research processes suggest that PSIs are not as effective in clinical practice as they are in academic research (Shafran et al, 2009), while some maintain that research findings can be generalised to clinical environments (Weisz et al, 2005). Recent evidence, which includes data from a meta-analysis, has led researchers to conclude that CBT is an effective intervention that is useful in the treatment of schizophrenia (Cooke, 2014).

Normalising the experience of psychosis

There are many ways in which CBT can be used for people who experience schizophrenia. Kingdon and Turkington (1994) were the first to develop a CBT framework for normalising the experience of psychosis. Their intention was to make experiences related to psychosis less frightening and to demystify schizophrenia by explaining that experiences such as hearing voices are common, and pointing out that hallucinations and paranoia are in fact similar to other everyday mental states (van Os, 2014). There are times when we all can feel paranoid – for example sometimes we misinterpret the actions of our friends.

Underpinning the normalisation approach is the view that everyone is at risk of developing schizophrenia and that, as a consequence, people with the condition are not unlike other people (Kingdon and Turkington, 2005). In a normalisation context, hearing voices is conceptualised as existing on a continuum that is part of the normal spectrum of human experience (Romme and Escher, 2012). In fact, it is thought that around 10% of people who do not have a mental illness hear voices in the absence of any stimuli (Cooke, 2014).

By decatastrophising schizophrenia, these facts can reduce people's stress and help them find alternative meanings for their symptoms (Everitt and Siddle, 2002). Moreover, normalisation helps people to understand that experiences such as hearing voices originate in themselves (van Os, 2014) and are often linked to emotional states and life experiences (Cooke, 2014). Normalising the experiences of schizophrenia has been found to be therapeutic – in line with NICE's (2014) guidance, it helps to destigmatise the illness (Kingdon, 2012) and allows people to comprehend and re-evaluate their beliefs and perceptions.

The therapeutic relationship

While CBT is underpinned by research, it requires skill in its delivery (Dudley and

Further resources

- **World Health Organization fact sheet on schizophrenia**
Bit.ly/WHOSchizophrenia
- **Information about the Schizophrenia Commission**
Bit.ly/SchizophreniaCommission
- **Overview of schizophrenia, causes, diagnosis and treatment**
 - Bit.ly/RethinkSchizophrenia
 - Bit.ly/NHSCoicesSchizophrenia
- **Video and information leaflet from the Royal College of Psychiatrists**
Bit.ly/RCPsychSchizophrenia
- **'Understanding Schizophrenia', from mental health charity Mind**
Bit.ly/MindSchizophrenia
- **'Help with Schizophrenia', American Psychiatric Association**
Bit.ly/APASchizophrenia

Kukyten, 2014) and is supported by:

- Creating a therapeutic relationship;
- Understanding communication is the vehicle through which change occurs;
- Believing that the intervention exists to improve the individual's mental health (Pilgrim, 2009).

A fundamental aspect of CBT is the development of a therapeutic relationship based on empathy, congruence and unconditional positive regard (Rogers, 1957), and one which also features trust, rapport, warmth and collaboration as essential components (Bradshaw and Mairs, 2011). Callaghan et al (2009) stated that the therapeutic relationship is central to improving outcomes in people with mental health issues, while others argue that it is actually more important to an individual's recovery than the PSI itself (Bentall, 2009).

QUICK FACT
220,000
Number of people thought to live with schizophrenia in England

In CBT, a therapeutic alliance is imperative: it allows the practitioner to:

- Observe the person's ability to participate in the intervention
- Help the individual explore meanings of presenting problems (Department of Health, 2004; Everitt and Siddle, 2002).

Limitations of CBT

CBT is not thought to be a universal remedy for emotional distress (Bentall, 2004) and is not beneficial or suitable for everyone with schizophrenia (Cooke,

2014). Indeed there is reliable evidence that its use can lead to an increase in suicidal ideation and depression (Kingdon and Turkington, 2005). The positive symptoms of schizophrenia can be very real and convincing, and people who experience them may find them unbearable and too distressing to discuss (Kingdon, 2012).

In addition, people who have previously undergone compulsory detention in hospital might, understandably, be reluctant to talk about their experiences; this may be compounded by a lack of insight and by negative symptoms – avolition and alogia, in particular, can be significant barriers to engagement (Sarma, 2007). Service users themselves have advised that they should only be offered CBT when they are motivated and ready to engage with it (Cooke, 2014). There is also good evidence that other practical interventions, including solving accommodation problems or finding employment, can have a dramatic effect on outcomes and quality of life (Bentall, 2004).

In its report *The Abandoned Illness*, the Schizophrenia Commission (which was established by Rethink Mental Illness) states that 43% of service users said that, alongside the use of medication, they valued CBT, compared with only 13% who said they had benefited from self-help (Schizophrenia Commission, 2012). In other research, service users have expressed the view that CBT is as useful as medication (Byrne, 2014; Cooke, 2014).

Role of mental health nurses

Despite NICE recommending that people with a diagnosis of schizophrenia should be offered CBT (NICE, 2014), it is thought that this happens in <50% of cases (Shafran et al, 2009). More worryingly, the Schizophrenia Commission (2012) found that only 10% of service users had received the therapy. Many mental health charities and service user groups are campaigning for CBT to become more widely accessible (Cooke, 2014).

In the US, the National Institute of Mental Health identified that increasing the availability of PSIs was required to improve the provision of mental health care and outcomes for service users (Insel, 2009). The Schizophrenia Commission (2012) has stated that mental health nurses are best placed to bridge this gap, and the British Psychological Society (Cooke, 2014) suggests this could be achieved cost-effectively by equipping the mental health nursing workforce to deliver simple PSIs.

The Nursing and Midwifery Council (2015) states that nurses should provide evidence-based, person-centred care; to do so, it is imperative that mental health nurses have an understanding of PSIs to refer to when caring for people with a variety of mental health issues (Chellingsworth, 2014; Turkington et al, 2006).

Conclusion

A sufficiently strong evidence base has led NICE (2014) to recommend that all people with a diagnosis of schizophrenia should be offered CBT, as normalisation has been shown to improve outcomes through decatastrophising and destigmatising the condition. While use of medication alone helps to alleviate symptoms, CBT also addresses the causes and secondary consequences of emotional distress, and offers a person-centred approach tailored to the individual's lived experience (Turton, 2015).

Although CBT is not a suitable intervention for everyone who has a diagnosis of schizophrenia, some service users have said they value it more than other interventions. Unfortunately, it is not universally available to all people who experience schizophrenia. However, by optimising the skills of mental health nurses, CBT could be made universally accessible (Turkington et al, 2006), in line with NICE guidance. The intervention could then be used as an integral part of compassionate care (Davidson et al, 2010) and that which is recovery based (Goldspink and Riordan, 2012; Department of Health, 2004). **NT**

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