Cognitive behavioural therapy for risk management in schizophrenia


Summary
This article proposes that cognitive behavioural therapy – as recommended by the National Collaborating Centre for Mental Health (2002) – can be used to form part of a risk management strategy for people diagnosed with schizophrenia. This may be a more effective and acceptable intervention because of its collaborative nature. The article includes case studies from practice to illustrate strategies that can be used.

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RECENT REPORTS, including the inquiry into the care and treatment of John Barrett who was convicted of the manslaughter of Denis Finnegan in London in 2005 (Robinson et al 2006) and the report of the national confidential inquiry into suicide and homicide by people with mental illness by the University of Manchester (2006), have highlighted the difficulties mental health services encounter when they attempt to predict and prevent deaths involving people with serious mental illness.

Since 1999, the NHS care programme approach has required mental health services to include risk assessment and risk management. However, risk management strategies can often be reduced to focusing on medication concordance and monitoring of a person's mental health state by professionals with little collaborative working with patients or their families.

Forensic mental health services in the UK were developed for people with mental disorder who are offenders or at risk of offending. Specialist services are provided by the NHS, private sector providers and by the criminal justice system in secure and community settings. People with mental disorder who are offenders or at risk of offending can often attract negative labels such as 'difficult' or 'dangerous' and can be vulnerable to drug and alcohol misuse, self-neglect and exploitation by others. Their past and current risk behaviours are often used as a predictor for future risk of harm to self and/or others.

In the NHS, the current focus of forensic care is mainly in hospital settings, which have low, medium and high security definitions, but specialist community services do exist and people are regularly discharged into the community. However, not all localities have specialist forensic mental health teams and people with a forensic mental health history often access general mental health services, even when specialist services exist.

Histories of offending and mental health problems do not automatically mean that NHS specialist teams accept these people. Acceptance criteria for treatment by forensic teams involve complex specialist assessments of dangerousness, treatability and predicted length of stay in secure facilities. These people may also be cared for in mainstream NHS services once they have had a period of treatment in forensic care.

Most people who are cared for in forensic NHS residential units are first admitted under a detention order made by a court under Part III of the Mental Health Act 1983. They may also be transferred to these units from prison, having...
Schizophrenia and forensic care

During 2005-2006 there were 25,740 formal admissions under the Mental Health Act 1983 to NHS facilities in England (Information Centre for Health and Social Care 2007). Of these 1,362 were under Part III of the act, which represented 5% of all formal admissions to NHS hospitals. Of these, 1,169 adults were detained because they had mental illness, 80 had a diagnosis of psychopathic disorder, 52 had a diagnosis of mental impairment, three had serious mental impairment and 58 were unclassified.

It is not possible to say how many of those detained had a diagnosis of schizophrenia because the Mental Health Act-approved doctor is only required to detail the category of illness and not a specific diagnosis under the medical recommendation. However, the Information Centre for Health and Social Care publishes an annual bulletin which presents information submitted by each health authority on the use of the Mental Health Act in England. James et al (2002) researched the outcomes of these psychiatric admissions through the courts. They indicated that 78% of people admitted to hospital via the criminal justice system had a medical diagnosis of schizophrenia. Given these figures it is reasonable to assume that schizophrenia is the largest diagnostic category for people currently being detained under Part III of the Mental Health Act in NHS facilities. Therefore, it is important to consider how health professionals working with this group can best develop their risk management practice while helping people to recover from their experience.

There is a growing body of evidence that demonstrates the effectiveness and utility of psychosocially based interventions in managing the problems of people with schizophrenia. The National Collaborating Centre for Mental Health (2002) published guidance for people with schizophrenia. It recommends that cognitive behavioural therapy (CBT) and family interventions should be available as treatment options for those with a diagnosis of schizophrenia – the aim being to prevent relapses and reduce symptoms.

If these therapies contribute to relapse prevention in patients with schizophrenia then they may also contribute to harm reduction, particularly where criminal behaviour has specifically been linked to the clinical symptoms of mental illness. It is proposed that CBT can play a crucial part in the development of risk management plans for people with schizophrenia.

In the past 30 years there has been an increasing amount of literature suggesting that people with medication-resistant hallucinations and delusions may benefit from CBT. Early case studies by Beck (1952), Watts et al (1973) and Fowler and Morley (1989) demonstrated that there were benefits. Later non-controlled studies continued to support the potential benefits of CBT for patients with schizophrenia in reducing distress, disability and re-hospitalisation (Chadwick and Lowe 1990, Kingdon et al 1994, Turkington and Kingdon 2000).


Auditory hallucinations

Interventions to reduce the frequency and duration of auditory hallucinations and the distress they cause are designed to give people more control over them (Haddock et al 1993). The theory, which supports the use of these techniques, is that auditory hallucinations are the result of an individual misattributing his or her inner speech (Bentall et al 1994).

Distraction techniques Keeping busy and activity...
scheduling are important aspects of therapy because they can provide helpful distraction. Competing stimuli can sometimes drown out the voices, for example, the use of personal stereos, television and radios. Doing something interesting and absorbing can also divert attention from the voices. A case study is shown in Box 1.

**Normalising rationale** This attempts to explain anomalous experiences, for example, delusions and hallucinations, and can help to reduce anxiety and alienation. It provides an explanation for puzzling and distressing symptoms and a strategy to deal with catastrophic cognitions concerning insanity and social rejection (Turkington and Kingdon 1996). People’s experience is explained in terms of a continuum of ‘normal’ human experience.

Bentall (1996) believes that any understanding of the psychological processes responsible for hallucinatory experience must be informed by five key observations:

- **Although hallucinations are usually attributed to schizophrenia, people who are otherwise ‘normal’ and who do not describe themselves as mentally ill report them.**
- **Cultural differences exist in the way that hallucinations are reported and expressed throughout the world.**
- **Hallucinations are more likely to occur during periods of stress.**
- **People who experience hallucinations report more hallucinations when deprived of sensations or when exposed to unpatterned stimulation such as white noise.**
- **Auditory hallucinations tend to be associated with sub-vocalisation or micro movements of the speech muscles.**

Ohayon (2000) explored mental disorders and hallucinations (visual, auditory, olfactory, haptic (relating to touch) and gustatory (relating to taste)) hallucinations, out-of-body experiences, hypnogogic (stage between being awake and asleep) and hypnopompic (state immediately preceding waking up) hallucinations.

A representative sample \( n = 13,057 \) from the non-institutionalised general population of the UK, Germany and Italy aged 15 years or over was surveyed by telephone. Overall, 38.7% of the sample reported hallucinatory experiences (19.6% less than once in a month; 6.4% monthly; 2.7% once a week; and 2.4% more than once a week).

Shergill et al (2003) found that auditory hallucinations in people with schizophrenia were associated with activation in the same parts of the frontal and temporal cortices that are usually engaged in the generation and perception of inner speech.

The relationship between stress and symptoms can also be explained using the Stress Vulnerability Model (Zubin and Spring 1977). The stress vulnerability hypothesis indicates that increased stress increases symptoms. Therefore, an attempt can be made to get the person to understand that there can be a discernible reason why symptoms occur (Box 2).

**Focusing** This helps people to become exposed to the content of their voices to reduce the distress or ‘desensitise’ the person to the content of the voices. It has been shown to be a useful strategy (Haddock et al 1996). Nelson (1997) believes that encouraging the person to be objective about the ‘voices’ creates a distance between him or herself and the experience – thereby disempowering the voice.

**Rational responding** This is a cognitive approach that seeks to identify and reduce the impact of automatic negative thoughts, which are a reaction to a perceived situation. Originally designed for use with depressed and anxious people (Beck et al 1979), rational responding helps individuals to challenge negative attributions, for example, catastrophising – which is perceiving that a situation will affect or damage the individual more than is rational, or that because an individual makes a mistake he or she will think he or she is useless at everything, which is an over-generalisation.

Kingdon and Turkington (1994) developed their theoretical application in the treatment of delusions and hallucinations. Their techniques aim to help people to identify the content of their ‘voices’ and the associated automatic negative thoughts they generate. In this way these automatic negative thoughts can be identified and the individual can be helped to generate alternative responses to them by challenging the

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**BOX 1**

**Distraction techniques**

A young man left alone would ruminate for hours on the origin of his voices and, as a result, was neglecting self-care and social goals. He developed an activity schedule around self-care, social activities and accessing community resources. The activity schedule had the effect of structuring his life and instead of spending hours ruminating and neglecting self-care and social goals, it enabled him to spend more time visiting friends, shopping and going for walks. This reduced the amount of rumination and increased his self-esteem and social functioning.

**BOX 2**

**Normalising rationale**

A woman was surprised to learn that everyone experiences inner speech which, at times, is critical towards them. This she identified with her own experience of critical voices. She was then able to acknowledge that what she was experiencing could be explained and that her reaction was understandable.
thought, undertaking self-affirmation and the use of relaxation techniques to reduce the physical symptoms of anxiety. For example, if a ‘voice’ is making derogatory comments about an individual such as ‘you are a bad person’ or ‘you will never be liked’, rational responding is used to combat the effect of the voice by thinking of examples when the person did a good deed or when someone said he or she liked being with him or her.

Belief modification strategies are used to change a person’s assumptions about the delusions. They can also be successful in attempting to change the person’s beliefs about his or her voices (Chadwick and Birchwood 1994). The aim is to reduce the distress experienced by the person by challenging some of the key assumptions about the ‘voices’ through the provision of rational alternatives and reality testing. For example, a person may believe that the voice he or she hears is the voice of god. In an attempt to reduce the person’s belief about the omnipotence of the voice, the therapist challenges some of the assumptions about the voice. Through reality testing the therapist can demonstrate that ‘voices’ cannot cause catastrophic events or have power over free will (Box 3).

Delusions and unusual beliefs

Strategies advocated in the treatment of delusional ideas or unusual beliefs are similar to those developed for hallucinations. They include belief modification, rational responding and normalising the experience. However, it is recommended that the link between thoughts, feelings and behaviour is demonstrated before attempting to modify a person’s thinking (Chadwick and Lowe 1990). This may be best done by using the person’s own descriptions of when he or she becomes distressed.

It is important to encourage individuals to understand their feelings by monitoring them through homework tasks: that is, they are encouraged to attempt to monitor their thoughts and feelings when they become distressed by keeping a diary. In this way we can identify the automatic negative thoughts and the emotion that accompanies them. Trigger situations can be identified and rating the feelings at the time will indicate the power of the trigger situation (Box 4).

Belief modification and rational responding help individuals to question the evidence that underlies their beliefs sensitively. These techniques appear to be useful where the individual is particularly distressed by persecutory ideas. The person will usually be motivated to change his or her situation because of the severity of distress involved, even though he or she may not see things from the therapist’s perspective. However, there may be problems in situations where an individual has grandiose beliefs. Because these beliefs are often not distressing to individuals and may function to protect their feelings of low self-esteem, they may be less likely to attempt to modify their behaviour.

Distress in these circumstances is often caused by interpersonal difficulties of communication and relationships when the person is not believed.

Coping strategy enhancement This has been described as an approach that is designed to promote an adjustment to symptoms while developing the person’s existing coping repertoire (Morrison 1998). It works by concentrating the person’s resources on the most distressing symptom. Coping can include many of the strategies already mentioned. It may also include the use of self-affirming positive statements and relaxation techniques (Box 5).

Relapse prevention

A crucial aspect of delivering CBT is not only to deliver a treatment which reduces the severity or impact of symptoms, but also to provide the person with strategies to reduce the likelihood of symptoms returning. Morrison (1998) suggests that the following components are necessary for relapse prevention:

Schema-focused intervention Addressing core beliefs and dysfunctional assumptions that act as vulnerability factors for relapse and become reactivated during critical life events, for example: ‘I’m generally disliked by most people,’ or: ‘I always get things wrong’.

Developing a blueprint This should include a written summary of what has been achieved and learned during therapy, including all strategies for challenging and testing beliefs and automatic negative thoughts.
**Prodromal monitoring** This should include early warning signs, indicating all the belief cognitions and behaviour identified as having preceded the last acute episode. A ‘time line’ is often useful. A time line can be used to document the person’s experience before the last upsurge of symptoms, admission to hospital or acute episode. It can identify stressors, coping strategies and early warning symptoms or ‘prodromal signs’ before the relapse. The purpose of prodromal monitoring is to provide early interventions during the prodromal phase of the illness (Birchwood et al 2000). This information can be used to create a ‘relapse drill’, that is, a list of what to do if early warning signs are present. This relapse drill is rehearsed with the individual and any family or carers if appropriate.

**Cognitive therapy and risk management**

Clinical risk assessment in mental health settings generally involves assessing vulnerability, risk of self-neglect as well as more serious risk of suicide, self-harm and risk of harm to others, including child protection issues.

Clinical risk is the likelihood of an identified behaviour occurring in response to changing personal circumstances (Morgan 1998). The outcomes are more frequently harmful for self or others, although occasionally they may have a beneficial aim in pursuit of a positive change.

Bowers (1997) stated that risk is not a discrete phenomenon. It is continuous and unpredictable, and exists in and across a number of different dimensions, usually simultaneously. Therefore, risk decisions should be well informed, based on a clear rationale and owned by individuals, the team and the organisations involved.

The central theory of CBT is that a person’s behaviour is determined by the way he or she perceives a situation through the thoughts and emotions that a particular circumstance may generate. CBT works by teaching an individual to recognise trigger situations and to either modify his or her behaviour or challenge the automatic negative thoughts that arise. The outcome is to reduce the frequency and intensity of distressing negative emotions, such as anger and fear (Box 6).

CBT has its basis in the experimental method so a hypothesis or formulation is formed about

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**References**


why and when a person behaves in the way he or she does. This hypothesis can be subject to controlled testing, sometimes only involving visualisations. Therapy aims to reduce the negative impact of the person’s interpretation of the situation through techniques already described. It is a collaborative style of therapy and the person is informed that the approach is largely one of self-help (Hawton et al 1989).

CBT formulations attempt to explain the dynamics of the way people behave in certain situations and why they behave as they do. In this way, CBT formulations aim to predict future behaviour. Understanding and mapping a person’s belief systems will help him or her and the health professional to understand the circumstances which increase or decrease the risk of undesirable behaviours occurring. This will inform the process of relapse prevention and risk management.

This belief system, or cognitive mapping, in relation to behaviour can act as a treatment guide and be potentially invaluable in the process of risk management. If we can help people to understand why behaviour is risky in certain situations, we can help them avoid the situations, cope better with the emotion the situation generates or cognitively restructure their thinking to prevent negative emotion being generated.

**Conclusion**

If mental health nurses wish to prevent relapse and reduce the risk of serious harm in people with a diagnosis of schizophrenia who have a forensic history, they should strive to develop intervention strategies. Monitoring mental health states, promoting concordance with medication and identifying risk histories is not enough to prevent mental anguish and information processing difficulties associated with stressful events for people who are vulnerable to psychosis (Zubin and Spring 1977). Mental health nurses should work collaboratively with people and their families to develop new ways of coping with symptoms, dealing with stressors, preventing relapse, promoting social recovery and restructuring negative assumptions about themselves and the world in which they live.

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**References**


