SCHIZOPHRENIA (AND OTHER PSYCHOTIC DISORDERS) COGNITIVE-BEHAVIOUR THERAPY RESEARCH PROGRAMME

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Abstract

The present study evaluated the effectiveness of a treatment that combined techniques from Cognitive-Behaviour Therapy (CBT) and Acceptance and Commitment Therapy (ACT) to alleviate the psychological distress and symptom severity resultant from psychotic-type disorders. This treatment (EVoLVE Therapy; an acronym for Exposing Virtues of Living Valued Existences) was designed to primarily target the psychological distress associated with psychotic disorders and secondarily to facilitate improvement in psychotic-type symptoms. Participants in this study were selected based on previous diagnoses of schizophrenia, schizoaffective, and other psychiatric disorders with psychotic features. Seven participants, who had each been long-term consumers of mental health services, completed 10 weeks of therapy. Post-graduate students, in training to become professional psychologists, delivered supervised therapy using a structured treatment manual written by the researcher. Pre-treatment, post-treatment and 5-week follow-up data were collected, using a variety of measures to assess the effectiveness of treatment. Results were quite positive overall, with some clients making considerable improvements in a number of domains. All 7 participants showed a decrease in symptom severity after treatment. In addition, 6 out of the 7 participants reported an improved quality of life following treatment. Marked improvement in negative affect was also evident, with a slight improvement in positive affect noted.

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CHAPTER 1. INTRODUCTION

1.0 Project Overview

Over the last 10 years there has been a resurgence of interest in psychological treatments for people diagnosed with schizophrenia and other disorders with psychotic features. The research that has been undertaken in this area has suggested that non-drug psychological interventions have much to offer those suffering from serious mental illness and psychoses (British Psychological Society, 2000; Fenton, 2000). Much of this work has been initiated to address the failure of some clients to respond adequately to the frontline treatment for schizophrenia and other disorders with psychotic features – antipsychotic medications – and the adverse side-effects of this treatment approach. In addition, antipsychotic medications fail to address the negative symptoms, such as anhedonia, and other social and occupational deficits. The main goal of most psychological treatments for psychotic disorders is fundamentally different from medically oriented treatment in that their foci is to lessen the distress and interference in social functioning caused by the psychotic experience, rather than treating the illness itself (Garety, Fowler, & Kuipers, 2000).

The present study aimed to contribute to this burgeoning area by evaluating the effectiveness of a new approach to alleviating the distress resultant from psychotic problems that combines Cognitive-Behaviour Therapy (CBT) and Acceptance and Commitment Therapy (ACT). This treatment was designed primarily to address the psychological distress resulting from the positive, negative and affective symptomatology

in people diagnosed with psychotic-type disorders. A secondary goal was to assess whether reduction in these areas equates to improved quality of life.

The literature review that follows provides the relevant background to the present study. First, information on the diagnosis, epidemiology, psychological distress, aetiology, and course and outcome of schizophrenia is provided. Schizophrenia is the focus of this study, however, other disorders with possible psychotic features are also briefly outlined. Second, the health engendering effects of positive emotions are presented. Third, the treatment of schizophrenia, both past and present, is discussed with particular emphasis on cognitive-behaviour therapy. Third, a rationale for the study of manualised, brief, cognitive-behavioural therapy for people diagnosed with schizophrenia, or other psychotic-type disorders, is outlined, with research related to this area critically reviewed. Finally, an overview of Acceptance and Commitment Therapy is provided, along with the rationale for its use in the present study.

With regard to terminology, people suffering from schizophrenia will be referred to throughout this proposal as 'people diagnosed with schizophrenia', to reflect the fact that not everyone agrees schizophrenia is a discrete categorical illness/disorder (British Psychological Society, 2000). Further, the dehumanising term 'schizophrenic/s' has been avoided; this term has connotations that people are their illness, which is simply not the case. The same applies to other psychiatric disorder diagnoses.

1.1 Defining Schizophrenia

This section orientates the reader to the definition and diagnosis of the primary disorder focused on in the present study – schizophrenia. Facets of the diagnosis that promote a better understanding of schizophrenia, which are considered pertinent to the present study, have been included.

The term *schizophrenia* is derived from the Greek words *schizein* meaning "to split" and *phren* meaning "mind"; and was so called by Eugen Bleuler in 1908 (Davison & Neale, 2001). In current terms schizophrenia refers to a heterogeneous group of symptoms involving disturbances in several major areas – thought, perception, emotion, motor behaviour, and life functioning (Bradshaw, 1998; Halford, 1994; Morrison, Haddock, & Tarrier, 1995).

These characteristic symptoms of schizophrenia include problems with perception, inferential thinking, affect, language and communication, hedonic capacity, behavioural monitoring, fluency and productivity of thought and speech, volition and drive, and attention (American Psychiatric Association [APA], 1994).

Unlike most other diagnostic categories in the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV), no essential symptom must be present for a diagnosis of schizophrenia; rather, the diagnosis entails the identification of a constellation of problems associated with a marked occupational or social dysfunction

(APA, 1994). See Appendix A for the DSM-IV American Psychiatric Association (APA; 1994) criteria for a diagnosis of schizophrenia.

In addition, a number of subtypes are specified – paranoid, disorganised, catatonic, undifferentiated, and residual types – and the diagnosis of these particular subtypes depends on the predominant symptomatology at the time of evaluation (APA, 1994). However, since the 1980s, the main symptoms of schizophrenia have tended to be classified as positive and negative (Kaplan & Sadock, 1998). Positive symptoms comprise excesses and distortions such as delusions, hallucinations, disorganised speech and disorganised behaviour (APA, 1994). While negative symptoms of schizophrenia consist of behavioural deficits such as affective flattening or blunting, alogia, avolition, anhedonia, and social withdrawal (Kaplan & Sadock, 1998).

Delusions are erroneous beliefs usually based on incorrect inferences about external reality (perceptions or experiences), which are strongly held despite clear contradictory evidence regarding its veracity and that are out of keeping with one's social, cultural, educational or religious background (Kingdon & Turkington, 1994). Delusional content may include a range of themes, such as persecutory, referential, somatic, religious, or grandiose, and may include beliefs about thought insertion, thought withdrawal or thought broadcast (Morrison, et al., 1995). According to the World Health Organisation's (1973) International Pilot Study of Schizophrenia, incidence rate figures showed that 67% of people diagnosed with schizophrenia have delusions of reference, 48% delusions of control, and 64% persecutory delusion.

Hallucinations are sensory experiences that occur in the absence of any stimulation from the environment; they appear real and of external origin to the hallucinator, but are not experienced by others (APA, 1994). Hallucinations may develop in any sensory modality – for example, auditory, visual, olfactory, gustatory, and tactile (APA, 1994). However, the most common hallucinations are auditory ("voices") with reported incidence rates ranging from 60% to 75% (Bentall, 2000; Liebman & Salzinger, 1998). These "voices" can be threatening, obscene, accusatory, commanding or insulting; conversely they can be positive or neutral.

Disorders of thought are considered by some (Kaplan & Sadock, 1998) to be the core symptoms of schizophrenia. Thought disorders refer to problems in effective communication and include dysfunctions of thought content, form of thought, and thought process (Kaplan & Sadock, 1998). Disorders of thought content encompass delusions, covered previously. Disorders of the form of thought include derailment (difficulty sticking to one topic), looseness of associations, incoherence, tangentiality, echolalia, verbigeration, word salad and mutism. Disorders in thought process affect the way ideas and language are developed (Kaplan & Sadock, 1998), and include flight of ideas, thought blocking, attentional impairment, poverty of thought content, perseveration, and poor abstraction abilities.

Grossly disorganised behaviour may range from childlike silliness to unpredictable agitation, and may include difficulties in executing activities of daily living, the manifestation of inappropriate sexual behaviour, and unpredictable and spontaneous agitation (APA, 1994).

The American Psychiatric Association (1994), also includes a three dimensional approach, which has received considerable empirical support, as an alternative way of viewing the psychopathology of schizophrenia. The three dimensions are (i) psychotic, including delusions and hallucinations; (ii) disorganised, factors such as disorganised speech, disorganised behaviour and inappropriate affect; and (iii) negative, including the various negative symptoms.

1.2 Mood Disorders

People diagnosed with a mood disorder can also present with psychotic symptoms. Some of these people may suffer similar psychological distress, as a result of their psychotic experiences, to those diagnosed with schizophrenia. Similarly, this distress could be a maintaining factor and/or a precipitant to their psychotic episodes.

Mood disorders are characterised by two fundamental symptom patterns – depression and mania (Kaplan & Sadock, 1998). The fundamental aspect of a Major Depressive Episode is a depressed mood or anhedonia (a loss of interest or pleasure in almost all activities) for a period of at least 2 weeks and the presence of at least four criterion symptoms which also persist most of the day, nearly every day, for a period of at least two weeks (Ghaemi, 2003). The criterion symptoms include changes in appetite or weight, sleep, and psychomotor activity (agitation or retardation); decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts (Rehm, Wagner, & Ivens-Tyndal, 2001). Further, the episode must be accompanied by clinically significant

distress or impairment in social, occupational, or other important areas of functioning (APA, 1994). Major Depressive Disorder (MDD) is characterised by one or more Major Depressive Episodes. In addition, psychotic features may be present in Major Depressive Disorder.

A Manic Episode is defined by a definite period (of at least one week) during which a person experiences an abnormally and persistently elevated, expansive, or irritable mood (APA, 1994). The mood disturbance must be accompanied with three (if euphoric) or four (if irritable) of the seven criterion symptoms. The criterion symptoms include: distractibility, decreased need for sleep, inflated self-esteem or grandiosity, pressured speech, flight of ideas, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasure-seeking activities with a high risk for painful consequences (APA, 1994). Also, the disturbance must be severe enough to cause marked impairment in social and occupational functioning or to require hospitalisation, or psychotic features are present. A Hypomanic Episode has an identical list of characteristic symptoms as a Manic Episode but hypomania is not sufficiently severe to cause marked impairment in social or occupational functioning or require hospitalisation.

A Mixed Episode is defined by a distinct period of time (at least one week) in which the criteria are met for both a Manic Episode and for a Major Depressive Episode nearly every day, with the individual experiencing rapidly alternating moods occurring with symptoms of a Manic Episode and Major Depressive Episode severe enough to cause marked impairment in functioning, require hospitalisation or be accompanied by psychotic features (APA, 1994).

A diagnosis of bipolar disorder is given when both manic and depressive episodes have occurred (Rehm et al., 2001). Bipolar disorder is separated into Types I and II. The criteria for Bipolar I disorder is a clinical course that includes one or more manic or mixed episodes, usually accompanied by one or more Major Depressive Episodes (APA, 1994). Bipolar II disorder is characterised by at least one Hypomanic Episode (but not a manic or mixed episode) and one or more Major Depressive Episodes (APA, 1994).

Psychotic depression describes a Major Depressive Episode accompanied by psychotic features (Dubovsky & Dubovsky, 2002). Psychotic depression is considered by some clinicians to be relatively infrequent; However, Dubovsky and Thomas (1992) reported that most studies show 16–54% of depressed people have psychotic symptoms (i.e., delusions and/or hallucinations). In addition, Pope and Lipinski (1978), and Akiskal and Puzantian (1979), showed that psychotic features dominate the clinical representation of bipolar disorders in as many as 50% of cases.

Psychotic symptoms in mood disorders are often a result of the mentally ill person trying to make sense of the core experiences of their mania or depression (Akiskal, 2002). Manic psychosis or psychotic depression is usually characterised by the content of delusions or hallucinations (typically auditory) being mood-congruent; that is, they are consistent with the manic or depressive themes the person is experiencing (APA, 1994). Less commonly, mood-incongruent psychotic features may be present. Mood incongruence is often associated with a poorer prognosis (APA, 1994), and may result from the abuse of alcohol and drugs or arise from the powerful cognitive experiences of mania (Akiskal, 2002).

Manic psychosis is often characterised by delusions of great wealth, power, and extraordinary mental and physical abilities; or delusions of reference and persecution, based on the idea that the person is being persecuted out of jealousy because of their special abilities (Akiskal, 2002; APA, 1994; Kaplan & Sadock, 1998). Enhanced perceptions during mania, such as vivid senses and rapid and vibrant thought processes, can easily be transformed into a visual or auditory hallucination (Akiskal, 2002).

During psychotic depression, delusions or hallucinations consistent with the predominant depressive theme or mood are present – such as delusions of persecution due to some personal inadequacy or moral transgression; delusions of guilt, disease, nihilism, death, and poverty (APA, 1994; Rehm et al., 2001). Hallucinations, when present during psychotic depression, are typically brief and not detailed and may involve voices that castigate the person for inadequacies or moral transgressions (APA, 1994).

In brief, the DSM-IV specifies which symptoms an individual must have for a specific diagnosis to be made. Many believe that the symptom-diagnosis approach simplifies communication and permits a relatively brief and uncomplicated way of describing complex problems (Kaplan & Sadock, 1998). However, as the British Psychological Society (2000) points out, psychiatric diagnoses are 'labels'; they do not tell us anything about the nature or causes of the experience. Labels ignore much of the epidemiological information.

1.3 Epidemiology

Using the current DSM-IV diagnostic criteria for schizophrenia, about one person in a hundred will be diagnosed with schizophrenia during their lifetime (Birchwood, Hallett & Preston, 1988). Lifetime prevalence rates for schizophrenia range between 0.2% and 1.5% (APA, 1994; British Psychological Society, 2000; Kaplan & Sadock, 1998; Scott & Wright, 1997).

1.3.1 Age and gender differences

Although schizophrenia is equally prevalent in women and men, the two sexes differ with respect to age of onset and course of illness. The model age at onset for men is between 15 and 25 years, and 25 to 35 years for women (Kaplan & Sadock, 1998). Further, the age-at-onset distribution is bimodal for women – with approximately 3% - 10% of women having an age at onset after 40 – but unimodal among men (APA, 1994).

Women with schizophrenia tend to have had better premorbid functioning (Ritsher, Coursey, & Farrell, 1997), tend to express more affective symptoms, and fewer negative symptoms than men (APA, 1994). In general, women have a better prognosis than men.

1.3.2 Cultural and socioeconomic factors

Culture and socioeconomic status are important variables to research when investigating schizophrenia (and other disorders) diagnoses, prevalence and course, impact on the patient and their family, and treatment participation, as these variables may influence both treatment implementation and outcome. It was expected that some participants in the

present study would identify a culture other than the dominant western culture; therefore, cultural factors were potentially important to this study.

Cultural variations in the frequency and form of hallucinations exist in both people who regard themselves as normal (Bourguignon, 1970), and those regarded in need of psychiatric help (Al-Issa, 1978). Bentall, Baker, and Havers (1991) presume that cultural variations exist because information about what kinds of events are likely to be experienced is encoded in cultural practices and beliefs. Further, cultural differences must be taken into account when assessing the symptoms of schizophrenia in cultural or socioeconomic situations that are different from one's own (APA, 1994). Indeed, different cultures vary on whether specific experiences are seen as symptoms of "mental illness", as normal (possession by spirits, and religious and spiritual beliefs), a positively valued experience, or even as 'spiritual gifts' to be exalted (Al-Issa, 1978; Bourguignon, 1970; British Psychological Society, 2000).

Birchwood and Shepherd (1992), and Weisman (1997) report on research studies providing overwhelming evidence that, compared to people diagnosed with schizophrenia in Western industrialised countries, those diagnosed in developing countries have a more favourable clinical course and outcome. Weisman (1997) theorises that:

> *In developing countries a social ambience that externalises causation, stresses mutual family interdependence rather than independence, and allows for realistic expectancies regarding ill individuals' performance may result in more supportive and healthful family relationships, and*

consequently, better illness prognosis for relatives suffering from schizophrenia in developing societies

(p.31)

In addition, the effect of mental illness in a specific cultural context may be contingent on the way that culture regards mental illness and those diagnosed with a mental disorder (Tsai, Butcher, Muñoz, & Vitousek, 2001). However, while knowing that someone diagnosed with a mental disorder is affiliated to a particular ethnic group, and this alerts one to potential cultural issues in psychopathology, it does not mean that the person holds fast to all the cultural values, beliefs and practices of that group (Lopez & Guarnaccia, 2000). Indeed, the heterogeneity within specific ethno-cultural groups must be recognised.

In industrialised nations, the highest rates of schizophrenia are found in people in the lowest socioeconomic class (Kaplan & Sadock, 1998). Two alternative hypotheses have been proposed to explain the correlation between social class and schizophrenia. The *downward drift hypothesis* proposes that people who are given a diagnosis of schizophrenia move into, or fail to rise out of, a low socioeconomic group because of this illness (Kaplan & Sadock, 1998). The second theory, the *social causation* or *sociogenic theory*, suggest that stressors associated with being a member of a low socioeconomic group contributes to the development of schizophrenia (Kaplan & Sadock, 1998). What is apparent is that poverty and the diagnosis of schizophrenia are interconnected, but they are difficult to interpret in causal terms.

1.3.3 Comorbid disorders

It is not uncommon for people diagnosed with schizophrenia to have problems with alcohol or drug use, and depression or anxiety (British Psychological Society, 2000). Bustillo, Lauriello, and Keith (1999) posit several reasons to explain co-morbid substance abuse (also known as dual diagnosis) in schizophrenia: the existence of various social factors that may promote substance abuse – for example, low socioeconomic status, the use of substances to handle some elements of the illness (negative symptoms, depression) or to lessen neurological side effects of antipsychotic medications (lessen the effects of antipsychotic drug-induced dysphoria), and the potentiality of a common genetic vulnerability for both disorders. Unfortunately, dual diagnosis is associated with more frequent relapse, medication non-compliance, higher rates of violence and suicide, poorer psychosocial functioning and poorer prognoses for recovery (Liberman, Kopelowicz, Ventura, & Gutkind, 2002).

Depression amongst those diagnosed with schizophrenia is common with estimates of co-morbidity varying widely, from approximately 20% to 80% (Altamura et al., 2000; Hall & Tarrier, 2003). Depression in schizophrenia is a risk factor for suicide. Altamura and colleagues (2000) note that depressive symptomatology is common throughout the progression of schizophrenia, and may be due to either the illness itself or the side-effects of antipsychotic medications.

1.4 Psychological Distress and Schizophrenia

Those who suffer from schizophrenia may experience a high degree of psychological

distress as a result of the positive and negative symptoms, and the social and occupational deficits associated with having the disorder. Psychological distress may be the maintaining factor in a variety of problems related to schizophrenia, and can even trigger psychotic episodes (to be discussed more fully in Section 1.5.1). Furthermore, the psychological distress associated with early trauma may have a causative role in the onset of psychiatric disorders, such as schizophrenia (Read, 1998).

Anhedonia is common and is apparent by a loss of interest and pleasure (APA, 1994). Dysphoric mood is often present, and may manifest as depression, anxiety, or anger (APA, 1994). Fear and phobias, common in schizophrenia, may also contribute to an individual's psychological distress. Heightened anxiety – that is, autonomic arousal – has been associated with relapse and a poorer prognosis (Tarrier & Turpin, 1992).

Psychological distress may be experienced as a result of the interference in social and occupational functioning that often occurs for those suffering from psychosis. Indeed, possible effects of psychosis, potentially resulting in psychological distress, include stigmatisation, social isolation, loss of social support, and poverty (British Psychological Society, 2000). The subsequent consequences of these difficulties may result in low self-esteem, depression, hopelessness and suicidal ideation (Hall & Tarrier, 2003).

1.5 Aetiology

The cause of schizophrenia is presently unknown, although a vast number of possible causes have been proposed. Major areas of aetiological research include the stress-

diathesis model, the cognitive theory of schizophrenia, biological factors, and genetic factors. The stress-diathesis model and cognitive theory of schizophrenia are particularly relevant to the present study.

1.5.1 Stress-diathesis model

Stress-diathesis models have dominated etiological theories of schizophrenia for nearly 30 years (Walker & Diforio, 1997). The stress-diathesis (or stress vulnerability) model integrates biological, psychosocial, and environmental factors; recognising that many aspects of an individuals' life are significant in producing the symptoms associated with schizophrenia. According to the stress-diathesis model, a person may have a specific vulnerability (diathesis) – possibly but not necessarily of genetic, congenital, or neurodevelopmental origin – that, when acted on by a stressful influence (which may be social, psychological or biological, such as adverse environments, major life transitions, or drug misuse), allows the symptoms of schizophrenia to develop (Bellack, 1986; Garety, et al., 2000; Kaplan & Sadock, 1998; Kingdon, Turkington, & John, 1994; Liberman, Kopelowicz, & Young, 1994; McGovern & Turkington, 2001; Mueser, 2001; Tarrier & Calam, 2002; Tsai et al., 2001). Notably, the vulnerability (diathesis) may be heightened by childhood experiences, whether social, psychological, or biological (Garety et al., 2000).

Indeed, as previously alluded to, research by Read (1998) supports the idea that child abuse may have a causative role in severe psychiatric disorders. With regard to schizophrenia, Read and associates (Read & Fraser, 1998; Read, van Os, Morrison, & Ross, 2005) highlight the convincing statistical relationship between childhood abuse and

psychosis in general, and the positive symptoms of schizophrenia in particular. Research by Ritsher and colleagues (1997) found that most women and men (76% and 72% respectively), in a severely mentally ill population, had been sexually or physically abused.

A number of theories exist as to how trauma leads to psychosis (for a review see Read et al., 2005). However, Read and colleagues (2005) caution that to understand how early abuse or trauma leads to psychosis requires an integration of biological and psychosocial paradigms that recognise adverse events can change brain functioning.

At the same time, Eifert and Forsyth (2005) suggest that an important psychological vulnerability and risk factor for the development, maintenance, and exacerbation of anxiety-related problems is a "rigid repertoire of emotional and experiential avoidance" (p. 66) – that is, an individual's efforts to avoid, control, reduce, suppress or alter the impact of aversive thoughts, feelings or bodily sensations. And, Morrison and colleagues (Morrison, 1994; Morrison, et al., 1995) propose that emotional avoidance strategies exacerbate positive psychotic symptoms in the seriously mentally ill – in particular, intrusive thoughts, psychological distress, autonomic arousal, and auditory hallucinations. It is possible that many of the symptoms of schizophrenia are the result of emotional avoidance processes, for example, the avoidance of painful memories and experiences. Therefore, the researcher became interested in using intervention strategies in the present study aimed at teaching individuals to accept unavoidable aversive private events. Emotional avoidance and acceptance are discussed more fully in Section 1.14.

1.5.2 Cognitive theory of schizophrenia

There are a number of cognitive theories to explain psychotic experiences; however, these can generally be separated into two distinct types of problems: cognitive deficits (impairments in thought processes such as perception, memory, and attention) and cognitive biases (where people's experiences have led them to interpret the world in certain ways) (British Psychological Society, 2000).

Cognitive deficits appear to be connected with psychotic experiences and vulnerability to psychotic experiences, rather than with 'schizophrenia'. However, much of the deficit research has been carried out on this broad diagnostic category, and when schizophrenia has been compared with bipolar disorders few differences have been found (British Psychological Society, 2000). The failure of cognitive deficit theories to fully explain psychotic experiences and the problems with diagnostic categories has led researchers to study cognitive biases in relation to specific experiences.

Research on cognitive processes in psychosis has proposed that delusions and hallucinations may be extreme variants of 'normal' appraisal processes and belief formation (Rector & Beck, 2001). Garety and colleagues (2000; Garety, Kuipers, Fowler, Chamberlain, & Dunn, 1994) suggest that people who have delusional beliefs tend to 'jump to conclusions' on the basis of limited evidence resulting in false inferences. Bentall, Haddock, and Slade (1994) confer with this idea, and add that people with delusions have a biased attributional style in which other people are blamed for negative events.

Some researchers (Bentall, Kinderman, & Kaney, 1994; Morrison et al., 1995; Sellwood & Haddock, 1994) suggest that delusions are motivational in origin and have a defensive function (defending a person against threats to self-esteem). Once delusional beliefs have formed, they may be perpetuated in a similar way to 'normal' beliefs – that is, supporting evidence for the belief is enlisted and disconfirming evidence is overlooked or discounted (Rector & Beck, 2001).

Hallucinations may be connected with comparable biases. Approximately 5% of the general population report experiencing auditory hallucinations (Tien, 1992); and yet, generally, recognise that they are internally generated and remain unperturbed by them (Rector & Beck, 2001). Conversely, people diagnosed with schizophrenia are more prone to make hasty and overconfident judgements about the source of their auditory hallucinations ('voices') and have a bias toward misattributing their perceptions to an alien or external source (Bentall, 1990; Bentall et al., 1994; Farhall & Voudouris, 1996).

Indeed, there is an assumption that auditory hallucinations are associated with speech processing in some way – for example, people who experience 'voices' have a problem differentiating their inner speech from speech from an external source (British Psychological Society, 2000; Haddock et al., 1998). Work by Chadwick, Birchwood, and colleagues (Beck-Sander, Birchwood, & Chadwick, 1997; Birchwood, & Chadwick, 1997; Chadwick & Birchwood, 1994; Chadwick & Birchwood, 1995), has highlighted the notion that a mediating factor between the voice experience and the serious disturbance associated with hearing voices is a person's beliefs about their voices. Beliefs about the voices' power and authority, and purpose, and the consequences of obeying and

disobeying the voices are particularly important. Taken as a whole, it appears that a person's orientation to their internal processes (including hearing voices and strange beliefs) is a potent predictor of psychotic problems. Interventions that address this element of a vulnerable individual's functioning may be useful from a therapeutic and preventive viewpoint.

1.6 Course and Outcome

Contrary to what Kraepelin believed many years ago – that is, outcome for schizophrenia followed a deteriorating course marked by progressive intellectual deterioration (Davison & Neale, 2001) – course and outcome of schizophrenia are highly variable (Birchwood, 1994; Bradshaw, 1998, British Psychological Society, 2000; Liberman et al., 1994). Kraepelin's pessimistic view of schizophrenia persists in some areas of the mental health system today; resulting in severe stigmatisation, and clinicians/practitioners who limit their time and professional skills on people diagnosed with schizophrenia (Liberman, et al., 2002).

However, there is a growing body of research evidence showing that most people do eventually recover from schizophrenia (Bradshaw, 1998; Halford, 1994). Liberman and associates (2002), believe that optimal recovery from schizophrenia occurs under two conditions: (i) when treatment is delivered early in its course and with judicious use of antipsychotic medication; and (ii) when chronic or relapsing forms are treated for lengthy periods with comprehensive, well-coordinated, and continuous services. It appears that

many people diagnosed with schizophrenia are capable of recovery, if treated appropriately.

Presently, approximately 20% of people diagnosed with schizophrenia make a relatively complete recovery after having one or two psychotic episodes; and about 15% have ongoing psychotic experiences that seriously decrease their quality of life (Liberman, et al., 1994). The majority of people tend to have multiple psychotic episodes interspersed with longer periods of complete or partial recovery; although, some residual disability in social and occupational functioning persists (British Psychological Society, 2000). Birchwood, McGorry, and Jackson (1997), believe that early intervention in schizophrenia is crucial to positive long-term outcomes. They argue that this early phrase of psychosis – termed the crucial period – is formative, as crucial biological and psychosocial changes occur during this period.

Whilst the introduction of atypical neuroleptic medication has significantly improved the management of psychotic symptoms, a large number do not respond to antipsychotic medication (Brown & Hertz, 1989); Close and Garety (1998) note that up to 23% of people with psychotic illness endure positive symptoms that are medication resistant. Furthermore, between 20% and 60% stop taking medication at some point (Scott & Wright, 1997). This cluster of findings leads to the notion that medically oriented treatments, while useful and important, may need to be augmented with more psychologically oriented therapies.

1.7 Emotions

As previously mentioned, emotional avoidance can impact negatively on an individuals psychological well-being. Similarly, prolonged exposure to negative emotions can also result in psychological distress and create an array of psychological problems (Fredrickson, 2004).

1.7.1 Negative emotions

Experiences of negative emotion – such as fear and anxiety, anger, and sadness – are inevitable, and at times useful (Fredrickson, 2000). For example, the negative emotion of fear prepares the body for specific action – usually the urge to attack or escape – in a dangerous situation, which fulfilled the ancestral purpose of promoting survival (Fredrickson, 2000). Indeed, according to Fredrickson (2000; 2001; 2004), negative emotions narrow an individual's momentary attention, cognition, and action (which Fredrickson refers to as the 'thought-action' repertoire), to promote quick and decisive action in these life-threatening situations. This action typically involves the arousal of the autonomic nervous system, resulting in increases in heart rate, blood pressure, and vasoconstriction, together with other changes (Fredrickson, Maynard et al., 2000).

However, when negative emotions become extreme, prolonged, or contextually inappropriate, they can produce a wide array of problems for individuals and society; ranging from phobias and anxiety disorders, aggression and violence, eating disorders and sexual dysfunction, depression and suicide, to a multitude of stress-related physical disorders (Fredrickson, 2004). Consequently, as purported by Fredrickson (2000),

negative emotions gain a hold on an individual's mind and body, and a narrowed habitual thought-action repertoire results.

1.7.2 Health engendering effects of positive emotions

Conversely, Fredrickson (1998) cited evidence that, over time, positive emotions – such as joy, interest, contentment, pride, and love – broaden an individual's momentary thought-action repertoire (that is, broaden the scope of attention, cognition, and action, through play and exploration), which in turn can help build that individual's enduring physical, intellectual, psychological, and social resources; what Fredrickson refers to as the *broaden-and-build model of positive emotions*. The individual can then draw on these resources at a later stage, to improve their ability to cope with stressful situations.

Experiences of positive emotions have a number of other benefits. Experiencing positive emotions heightens an individual's sense of subjective well-being (Fredrickson, 2004). Also, positive emotions can optimize health through their capacity to put people's bodies at ease (Fredrickson, Tugade, Waugh, & Larkin, 2003). In fact, according to Fredrickson and colleagues (2003), experiences of positive emotion can overcome or undo the lingering cardiovascular aftereffects of negative emotions. In other words, positive emotions have the potential to counteract the psychological and physiological effects of negative emotions. Furthermore, positive emotions may help buffer against stress (Folkman & Moskowitz, 2000; 2004). Recurrent experiences of positive emotions may help people build psychological resilience – that is, the ability to demonstrate effective coping and adaptation in the face of negative/stressful experiences (Fredrickson, 2000; 2001; 2004; Tugade & Fredrickson, 2004).

In summary, momentary experiences of positive emotion, over time, can build psychological resiliency (an enduring personal resource) and trigger upward spirals toward enhanced emotional well-being in the future (Fredrickson, 2001; 2004). Therefore, intervention and change strategies that foster positive emotions (and ameliorate negative emotions) should be effective in reducing the psychological distress that stems from excessive, prolonged, or contextually inappropriate negative emotions that can occur in psychotic-type disorders. Consequently, the researcher included intervention strategies intended to cultivate positive emotions, and undo the effects of negative emotions, in the therapy for the present study.

1.8 Quality of Life

Over the past 20 years, quality of life (QOL) has become a popular concept, reflecting a biopsychosocial perspective on health (Awad, Voruganti, & Heslegrave, 1997). In 1994, the WHOQOL (World Health Organisation Quality of Life) Group defined QOL as:

> *Individual's perception of their position in life in the context of culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad-ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships and their relationship to salient features of their environment.*
>
> (cited in Saxena & Orley, 1997, p.263s)

With the person's spirituality/personal beliefs/religion being added as one of the domains of QOL; interestingly, this addition was done on the insistence of patients and healthy subjects (Saxena & Orley, 1997).

According to Saxena and Orley (1997), QOL assessment aims to add a humanistic component into health care, which, they believe, is becoming progressively preoccupied with mechanistic treatment of disorders and amelioration of symptoms. Indeed, empirical studies on the treatment of delusions and hallucinations in schizophrenia have yet to investigate whether improvements in core symptom domains translate to improved social functioning and quality of life (Rector & Beck, 2001).

As a result, the author of the present study became interested in assessing whether a reduction in psychological distress translated into an improved quality of life.

1.9 Treatment

1.9.1 History

Emil Kraeplin formulated the concept of schizophrenia (1856-1926) (Kaplan & Sadock, 1998). Kraeplin described the disorder using the term *dementia praecox,* and, as previously mentioned, identified an early onset and deteriorating course. Consequently, schizophrenia was considered untreatable and led to the recommendation that people diagnosed with schizophrenia be institutionalised (Kingdon & Turkington, 1994). Not only was schizophrenia considered chronic, but it was also considered a biologically

determined disorder; and, despite accumulating evidence to the contrary, this is still considered a truism in some areas of mental health (Halford, 1994).

Beck, a cognitive therapist who has been so influential in the development of cognitive therapy for depression, published a case study in 1952 on the modification of delusions in a patient suffering from schizophrenia (Beck, 1952). In subsequent years there was little interest shown in psychological treatments for psychosis; with psychosis generally viewed as outside the scope of these treatment approaches (Sellwood & Haddock, 1994).

During the 1950s, behavioural approaches were used in institutional settings. More recently, behavioural approaches have been used in the area of rehabilitation; for example, token economies (Paul & Lentz, 1977), and social skills training (Hersen & Bellack, 1976). However these approaches were largely targeted at functioning deficits, not the symptoms of psychosis (Sellwood & Haddock, 1994). This prompted Bellack to describe schizophrenia as behaviour therapy's "forgotten child" (Bellack, 1986).

1.9.2 Medication

The first major advance in treating schizophrenia came with the development of neuroleptic medications in the 1950s, which reduce positive symptoms in most clients (Bustillo et al., 1999). However, neuroleptics are not cures, they do not help everyone, and they may cause adverse side effects, which for some people can be worse that the original problem (British Psychological Society, 2000). These side-effects include the following: drug-induced dsyphoria; extrapyramidal side effects (EPSEs) such as Parkinsonianism, akathisia (physical restlessness), dystonia (muscular rigidity), and

tardive dyskinesia (involuntary and unsightly movements of the mouth and tongue which can be irreversible); and there is risk of serious blood disease such as agranulocytosis.

More recently, atypical antipsychotics, such as clozapine, have been developed which may have better antipsychotic efficacy, produce fewer side effects, and improve negative symptoms more than traditional antipsychotics (Bustillo et al., 1999). However, neuroleptic medications offer only a partial solution; it has been reported that positive psychotic symptoms persist in nearly half of the clients (Yusupoff, Haddock, Sellwood, & Tarrier, 1996). Further, while medication can improve some of the symptoms associated with schizophrenia, it has little effect on the social and occupational impairment that characterise the disorder and limit functioning and quality of life (Huxley, Rendall, & Sederer, 2000). Therefore, psychological intervention is an important adjunct in the treatment of psychotic-type disorders.

1.9.3 Psychological treatments

Similar to the United Kingdom, it is unusual in New Zealand for individual psychological treatment to be made routinely available to people diagnosed with schizophrenia, or those experiencing psychosis. Even though there is a growing body of meta-analytic evidence supporting the use of psychological intervention (Gottdiener & Haslam, 2003), most people are offered drug therapy in the first instance, and then cared for within the mental health system without access to individual psychological interventions. Public mental health systems tend to fail because they deliver fragmented care, instead of the co-ordinated, comprehensive and continuous care people diagnosed with schizophrenia require to improve their long-term outcomes (Liberman et al., 1994). However, over the

last 10 years there has been an increase, both in New Zealand and overseas, in the amount of research into psychological interventions for psychotic experiences.

Schizophrenia is no longer behaviour therapy's "forgotten child". Recently, clinical psychologists and other skilled professionals in cognitive-behaviour therapy (CBT) have been turning their attention to developing a number of effective psychological interventions for psychotic experiences (Chadwick, Birchwood, & Trower, 1996; Kingdon & Turkington, 1994). According to Fenton (2000), this recent interest has resulted from a move away from finding the single "best" treatment for schizophrenia, to a realisation that no single treatment can ameliorate the multitude of symptoms and social and occupational deficits associated with the disorder. Indeed, as the British Psychological Society (2000) note, the integration of medical, psychological and practical treatments parallels the increasing recognition that social and psychological factors interact with biological factors in psychotic experiences. Further, many researchers (Birchwood, 1994; Bradshaw, 1998; Chadwick et al., 1996) advocate focusing on psychotic symptoms at an individual level, rather than the syndrome of schizophrenia.

However, Strauss and Carpenter (1997) showed that clinical recovery was not a prerequisite for social recovery; that is, quality of life changes might not naturally follow decreases in psychotic symptomatology (Yusupoff et al., 1996). Therefore, as previously mentioned, effective intervention may require many psychological and psychosocial strategies – for example, coping skills enhancement, social support, problem-solving strategies, supportive involvement from family and friends, effective medication management, work skills, social interaction, and relapse prevention work. Nonetheless,

emerging models of CBT offer promising intervention strategies in the psychological treatment of schizophrenia (Bradshaw, 2000).

1.10 Cognitive Behaviour Therapy

Cognitive behaviour therapy is a collective term for a range of treatment techniques and strategies that share a set of basic principles and assumptions (Hazlett-Stevens & Craske, 2002). First, psychological disorders are understood in relation to mechanisms of learning and information processing. The main assumption behind CBT is that psychological problems are determined by how people interpret events (cognitions), how people react to these events (behaviour), and how it makes them feel (emotions) (British Psychological Society, 2000). Second, the CBT approach to treatment is influenced by an experimental position regarding human behaviour, and any given behaviour is seen to serve a particular function. Third, the premise that change occurs as a result of new learning experiences that overcome former unhelpful learning and information processing ways of thinking. And, finally, the value of scientific method for CBT – that is, CBT therapists generate hypothesis about an individual's thinking and behaviour sequences, devise treatments according to these hypotheses, observe the outcome, modify their hypothesis based on this observation, and so on (Hazlett-Stevens & Craske, 2002). Indeed, according to Tarrier and Calam (2002), it is this latter principle – the commitment to empirical validation – that has distinguished cognitive-behaviour therapies from other types of psychotherapy.

1.11 Cognitive Behaviour Therapy for Schizophrenia

Historically, cognitive-behaviour therapy was developed and applied to the management of neurotic disorders, such as anxiety and depression (Haddock, Tarrier et al., 1998; Senesky et al., 2000), but is now used for a wide range of psychiatric disorders, including psychotic disorders. CBT is a structured and time-limited approach to the management of the difficulties faced by people diagnosed with schizophrenia (Fowler, Garety, & Kuipers, 1995). CBT techniques used to treat psychotic disorders include: operant procedures to reinforce non-psychotic behaviour (Sellwood & Haddock, 1994); normalising psychotic experiences to destigmatise the symptoms and lay them open to rational argument (Kingdon & Turkington, 1994); distraction techniques to reduce auditory hallucinations (Dickerson, 2002); thought-stopping to treat intrusive thoughts (Haddock, Sellwood, Tarrier, & Yusupoff, 1994); belief modification to alter the strength of delusions (Dickerson, 2002); focusing on auditory hallucinations to reduce the frequency of voices and the distress associated with them (Sellwood & Haddock, 1994); systematic desensitisation to reduce anxiety and distress (Haddock et al., 1994); and coping strategy enhancement (Tarrier, Harwood, Yusupoff, Beckett, & Baker, 1990).

1.11.1 Summary of effectiveness

There is consistent evidence from a large number of trials that CBT is an effective intervention for both acute psychosis (Birchwood, Todd, & Jackson, 1998; Chadwick & Birchwood, 1994; Drury Birchwood, Cochrane, & Macmillan, 1996; Haddock, Morrison, Hopkins, Lewis, & Tarrier, 1998; Lewis et al., 2002), and persistent positive symptoms (Bentall et al., 1994; Bradshaw, 1997; Bradshaw, 2000; Chadwick, Lowe, Horne, &

Higson, 1994; Farhall & Voudouris, 1996; Fenton, 2000; Garety et al., 2000; Garety et al., 1994; Haddock et al., 1999; Johns & Os, 2001; Kingdon & Turkington, 1994; Kingdon et al., 1994; Kuipers et al., 1997; Morrison, 2001; Senesky et al., 2000; Tarrier et al., 1993; Tarrier et al., 1999; Tarrier et al., 1998; Wiersma, Jenner, van de Villige, Spakman, Nienhuis, 2001; Yusupoff et al., 1996). Comprehensive reviews of some of this research appear in Dickerson (2002); Haddock, Tarrier et al., (1998); and, Rector and Beck (2001).

While the above trials looked at CBT as an adjunct to medication, a small number of trials (Chadwick & Birchwood, 1994; Morrison, 1994; Morrison, 2001) have investigated, with promising results, CBT for auditory hallucinations as an alternative to medication. Further, Tarrier and colleagues (1993), and Mueser and associates (Mueser et al., 2002), both reported success with ameliorating negative symptoms of schizophrenia. Indeed, recent meta-analyses of CBT for schizophrenia ascertained that effect sizes for CBT were large – an effect size of 1.3 for positive symptoms and an effect size of 1.13 for negative symptoms – and these gains were maintained over follow-up (Rector & Beck, 2001). Also, Haddock, Tarrier et al. (1998) note that CBT interventions for schizophrenia have produced benefits that have generalised outside the treatment session, and to other symptoms.

With regard to early intervention in acute psychosis, Drury and associates (1996) found that CBT accelerated recovery of first episode psychosis – demonstrated by shorter hospital stays and lower relapse rates – indicating that the earlier a person receives treatment the better the long-term outcome. Further, early treatment has a beneficial effect on quality of life (Browne et al., 2000). Cognitive-behaviour therapy appears to be

an acceptable intervention for people diagnosed with schizophrenia. Turkington and McKenna (2003) report an average drop-out rate across studies of only 12-15%. While CBT approaches for people diagnosed with schizophrenia have not been associated with any significant side-effects (Yusupoff et al., 1996; Morrison, 2001), Chadwick and colleagues (1996) warn that negative side-effects, such as symptom substitution, can occur.

1.11.2 Background and major aims

According to Fowler et al. (1995), the three main goals of cognitive-behaviour therapy for people with medication-resistant psychosis are: to reduce the distress and disability caused by residual psychotic experiences; to reduce emotional disturbance; and to help the individual arrive at an understanding of psychosis that promotes the active participation of the individual in reducing the risk of relapse and levels of social disability. Treatment is generally conducted in four stages, and usually involves the following elements: engagement and detailed assessment; formulation of key problems generated collaboratively with the client; interventions aimed at reducing the severity or occurrence of key problems; and reducing relapse (Lewis et al., 2002).

Rector and Beck (2001) have outlined a comprehensive list of goals of CBT, they include: (1) the building and establishment of a strong therapeutic alliance, characterised by acceptance, support, and collaboration; (2) developing a new understanding about the nature of psychosis, informed by cognitive formulations of psychotic experiences and stress-diathesis models of psychotic disorder; (3) reducing the distress associated with the disorder; (4) cognitive and behavioural techniques and strategies to reduce the occurrence

and distress associated with psychotic experiences; (5) targeting comorbid affective states – for example, anxiety and depression; and (6) relapse prevention.

A thorough detailed assessment of the wide array of experiences and key problems associated with an individual's psychotic episode is essential, to allow a cognitive-behavioural formulation of how symptoms might relate to cognitions, behaviour, emotion, and coping mechanisms (Lewis et al., 2002). Morrison (1998) believes a thorough assessment would gather: demographic information, including the individual's ethnic identity; information on the family situation; information regarding social problems; detailed information about the frequency, duration, content, distress, and meaning of the symptoms; the antecedents and context of each symptom; and, the individual's view of his/her problems.

Therapeutic engagement is essential to this information gathering process. Garety et al. (2000) emphasise a need to start by working from the client's own perspective to try and understand why the client believes what they do, and then moving on to provide credible alternative explanations to their beliefs. Beutler, Machado, and Allstetter Neufeldt (1994), and Orlinsky, Grawe, and Parks (1994), mention the importance of the therapeutic relationship and the fact that it has been shown to mediate therapy outcome.

Following the engagement and assessment stage, the analyses of problems requires an atmosphere of "collaborative empiricism" in which the client and therapist jointly discuss issues (Alford & Beck, 1994) in an effort to foster engagement and motivation for treatment. The choice of target problems is based on the client's preference and/or the

severity of the difficulties experienced (Dickerson, 2002). Interventions are then selected that attend to the particular client's problems. According to Tarrier and Calam (2002), intervention should be formulation-driven to enable problems to be translated into treatment goals, and should follow a strategic approach. Interventions may target primary symptoms of psychosis – for example, delusions and voices – or the secondary problems associated with psychotic experiences, such as depression, anxiety, negative symptoms, medication issues, and social functioning deficits.

To date, the most effective techniques for the treatment of delusions are belief modification processes and reality testing (Chadwick & Lowe, 1990). Belief modification and reality testing involve assisting the client to sensitively examine the evidence for and against their belief, gently pointing out any inconsistencies, and then helping them set up behavioural experiments to test the reality of their belief (Haddock, Tarrier et al., 1998).

A similar approach targets hallucinations. Following the model that client's distress and voice-driven behaviour are created by their beliefs about the voices' power, identity, and purpose, therapy is directed at lessening the client's beliefs by challenging those beliefs through verbal challenge and reality testing. Bentall, Haddock et al., (1994) suggest that interventions for hallucinations fall into three groups: techniques that emphasise distraction methods (compensation approaches); techniques that encourage focusing on the voices (exposure); and techniques that involve anxiety reduction.

1.11.3 Combination cognitive-behavioural therapy

In response to the series of difficulties (which extend across a number of domains)

experienced by people diagnosed with schizophrenia, and other psychotic-type disorders, a number of authors have used cognitive-behavioural techniques and strategies targeted at reducing the distress and occurrence of psychotic symptoms and combined them with a range of strategies aimed to reduce other psychological problems associated with psychosis – for example, techniques aimed at reducing anxiety and depression and increasing self-esteem, and strategies aimed at reducing negative symptoms (Haddock, Tarrier et al., 1998). Results from trials to date (Garety et al., 1994; Kuipers et al. 1997) appear very promising.

Kingdon and Turkington (1994) have adapted traditional cognitive behaviour therapy and added additional methods for psychosis, along cognitive-behaviour therapy principles, to deal with problems of engagement, rapport, comorbid anxiety and depressive symptoms, hallucinations, delusions, thought disorder, negative symptoms, self-esteem and relapse prevention (McGovern & Turkington, 2001). This approach is illustrated in Figure 1.

Results of their studies suggested that by using their treatment as an adjunct to an overall treatment package, improvements in a range of symptomatology, medication, compliance, and social performance could be achieved (McGovern & Turkington, 2001). However, some aspects of this approach are complex to administer and require the skills of experienced clinical psychologists. Furthermore, as previously mentioned, psychological treatment for long-term consumers of mental health services in New Zealand, who have been diagnosed with a psychotic disorder, is largely unavailable. This cluster of issues leads to the notion that a manualised CBT based programme that is administered by less experienced mental health workers, would be very useful in the New Zealand context.

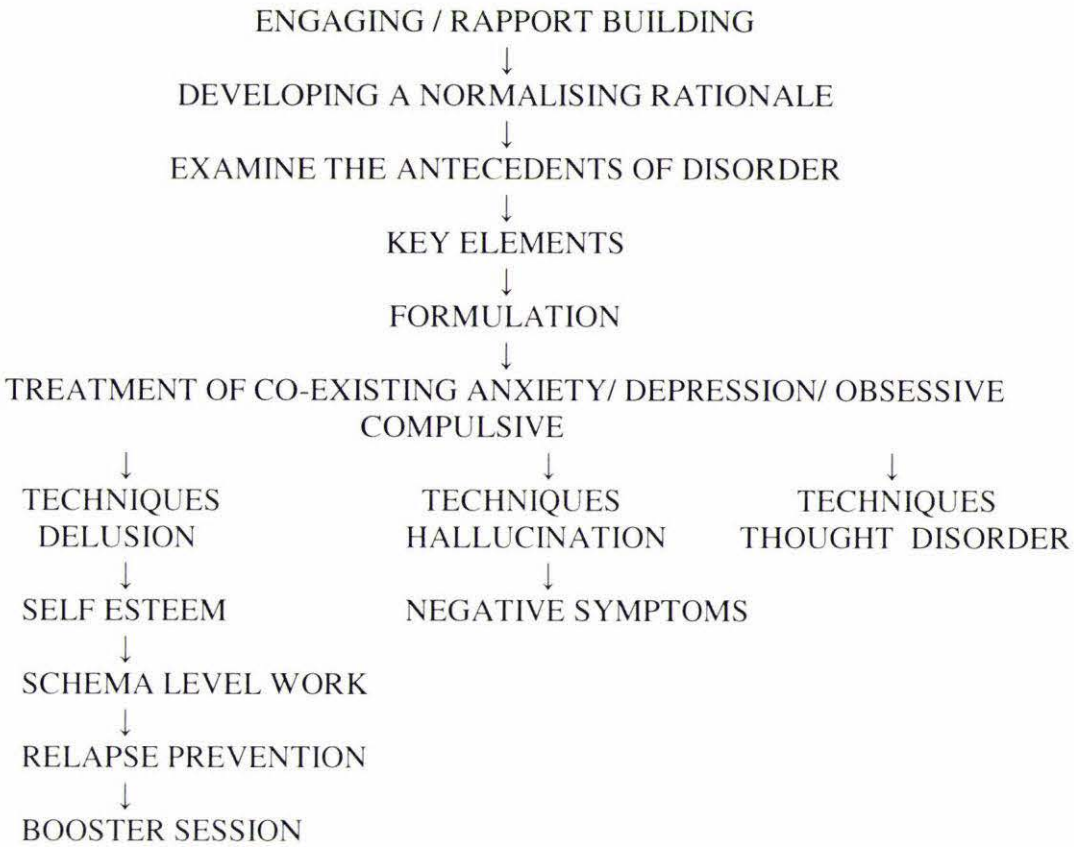

Figure 1. **Cognitive behaviour therapy for schizophrenia model** (D. Turkington and D. Kingdon Presentation at the meeting on Psychological Approaches to the Management of Psychosis, Withington Hospital, University of Manchester, 1994). Reprinted from McGovern and Turkington (2001) p. 163.

1.12 Manualised Cognitive-Behavioural Therapy for Schizophrenia

Greater emphasis is being placed on the use of treatment manuals in treatment outcome research (Koss & Shiang, 1994). In fact, Goldfried and Wolfe (1998) regard the inclusion of treatment manuals as an essential facet in psychotherapy outcome research. Treatment manuals may contain a broad description of treatment phases and principles or contain detailed session-by-session outlines of therapy (Chambless & Hollon, 1998). Indeed, the

decision-making process can be guided through the use of an organised, clear, specific overview of the technical principles of the treatment approach (Koss & Shiang, 1994).

The use of treatment manuals in psychotherapy outcome research is important for a number of reasons. First, a treatment manual aids the clear description of the treatment so that replication is possible – a methodological requirement in treatment trials when determining the effectiveness of therapy (Goldfried & Wolfe, 1998; Tarrier & Calam, 2002). Second, the clear description that treatment manuals provide makes it possible to carry out integrity checks to ensure that the treatment described was actually delivered as intended (Kazdin, 1994a). Third, treatment manuals present an explicit and organised way of training and supervising therapists involved in the research project (Lambert & Bergin, 1994); thereby, minimising variability in treatment delivery (Kazdin, 1994a). And finally, manuals are a valuable means of transferring the innovative and effective components of a treatment, devised by researchers, to practicing clinicians (Chambless & Hollon, 1998).

A number of treatment manuals exist in the area of cognitive-behaviour therapy for psychosis. The treatment manual used in this study adapted elements from previous treatment manuals for psychosis (e.g. Chadwick et al., 1996; Fowler et al., 1995; Kingdon & Turkington, 1994), and from standard treatment manuals of cognitive-behaviour techniques for anxiety and depression (e.g. Greenberger & Padesky, 1995; Padesky & Greenberger, 1995).

However, the treatment manuals for psychosis, mentioned above, describe treatments that

usually last for between 20 and 25 sessions, and tend to involve contact time of about one year. Therefore, these treatments may be out of reach – both in terms of commitment time, and monetary cost – for many people diagnosed with schizophrenia, and other serious and persistent mental illnesses.

1.13 Brief Therapy

Over the last 10 years there has been an increased emphasis on brief therapy treatment approaches across all areas of psychotherapy (Koss & Shiang, 1994). Koss and Shiang (1994) report a number of reasons for this growing interest in brief treatment modalities.

Firstly, people entering psychological treatment are generally after specific and focal problem resolution, and prefer a brief treatment. Indeed, Garfield (1986, cited in Koss & Shiang, 1994) found that the average duration of therapy contact, regardless of therapist therapeutic orientation, is six to eight sessions. Secondly, brief therapy has been shown to be successful in treating a wide range of psychological problems (if treatment goals are kept tenable), not just less severe problems. Finally, the same success rates are generally being reported for brief treatment methods as for longer treatment programmes. Therefore, it seems relevant to continue developing and testing brief forms of therapy across all areas of psychotherapy, and all psychological problems.

Cognitive-behavioural approaches are especially suited to brief therapy formats. Typically, CBT treatments are brief and time-limited anyway, and many of these treatments lead to meaningful clinical improvement and symptom reduction in as few as

10-20 sessions (Hazlett-Stevens & Craske, 2002). According to Hazlett-Stevens and Craske (2002), treatment researchers are now working to "streamline existing effective CBTs to make them even more efficient, cost-effective, and affordable" (p.3).

In fact, brief treatment modalities have many pragmatic advantages. The increased cost-effectiveness of brief therapy could make treatment accessible to more people in need of psychological assistance (Hazlett-Stevens & Craske, 2002). Further, brief therapy reduces therapist time, enabling more people to be treated.

1.14 Acceptance and Commitment Therapy

One such brief therapy – Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) – became of interest to the researcher as a therapy that may be effective in achieving the goals of the present study.

ACT is a recent emergent within the CBT tradition; in fact, ACT uses the best of the empirical and cognitive-behavioural traditions while also considering the breadth and depth of human experience (Hayes et al., 1999). This therapy is based on the idea that a large portion of psychopathology is the result of unhealthy ways of avoiding or suppressing unwanted private experiences such as thoughts, feelings, or bodily sensations – that is, the use of experiential avoidance (Hayes et al., 1999). Higher levels of experiential avoidance have been found to be associated with higher levels of psychopathology and psychological distress, and a lower quality of life across a variety of psychological problems (Hayes, Strosahl et al., 2004).

According to Hayes, Strosahl and colleagues (2004), experiential avoidance is not a theory; rather it should be regarded as a process. ACT and its underlying theory of language and cognition – Relational Frame Theory (RFT) (see Hayes et al., 1999) – provides one description of experiential avoidance. RFT posits the notion of the bidirectionality of human language. The idea that learned verbal relations can be derived for any particular event, thought, emotion, behaviour or bodily sensation, and then recalled or predicted via language itself. Hence, the bidirectionality of human language hugely increases the "range of situations that are aversive, because symbolic behavior permits the categorization of private events and contact with them in almost any setting" (Hayes, Strosahl et al., 2004, p. 555). For example, Hayes, Strosahl and associates (2004) explain that people learn to categorise a vague group of situational signs, bodily responses, and set of behaviours, and other cues, as "anxiety" and to assess it as "bad" (p.555). This "emotion" (anxiety) can then be recalled or predicted via language (e.g., "I felt anxious while out shopping yesterday" or "I am worried I will get anxious when I board the plane to come home tomorrow"); therefore, emotional and psychological distress cannot be eluded simply by avoiding the anxiety-provoking external situation, because aversive states of mind of this kind can be brought into a situation by language itself (Hayes, Strosahl et al., 2004). Consequently, cognitions associated with "anxiety" then become the focus of avoidance.

Unfortunately, in the short-term, the effects of experiential avoidance are often seemingly positive (Hayes et al., 1999). Indeed, the immediate effect of thought suppression, such as cognitive distraction, is a reduction in the avoided event (Hayes, Strosahl et al, 2004); however, long-term, the avoided thought often increases in frequency (Gold & Wegner,

1995; Wegner & Zanakos, 1994). According to Hayes, Strosahl and associates (2004), the resulting short-term reduction in the avoided thought leading to a long-term increase can create a self-amplifying loop that might be quite difficult to shift.

In fact, a number of studies (Clark, Ball, & Pape, 1991; Gold & Wegner, 1995; Wegner & Zanakos, 1994) suggest that the suppression or avoidance of unwanted thoughts and feelings may incite the very thoughts and emotions we are trying to avoid. Gold and Wegner (1995) report that thought suppression may not only increase the frequency of the avoided thought, but may also enhance the emotional reaction to those thoughts.

A study by Hayes, Strosahl and colleagues (2004), provided support for an ACT and RFT conception of experiential avoidance, in that cognitive entanglement, excessively negative evaluations of private experiences, negative self-references, inability to take needed action in the face of private events, and a high need for emotional and cognitive control were operational characteristics related to a significant degree; and, as the theory suggests, these processes correlated with many forms of psychopathology.

A number of other therapy approaches have explored the role of experiential avoidance, and have devised ways of lessening it – these include Dialectical Behavior Therapy (Linehan, 1993a; 1993b); Mindfulness-based Cognitive Therapy (Segal, Williams, & Teasdale, 2001); and, Integrative Couples Therapy (Jacobson & Christensen, 1996), to name but a few (Hayes, Strosahl et al., 2004).

ACT takes an experiential approach to behaviour change. ACT aims to teach clients how to recognise and relinquish internally oriented control strategies such as distraction, thought suppression, and avoidance; teach clients to accept unavoidable and unwanted private experiences; teach clients to learn to "just notice" the existence of these thoughts and feelings (i.e., practice mindfulness), without arguing and struggling with them, or taking them literally to be true; and to teach clients to identify and focus on actions that produce valued outcomes (Bach & Hayes, 2002). Indeed, acceptance of unavoidable and unwanted private experiences requires that an individual reduce unsuccessful attempts to avoid or control unwanted thoughts, feelings, and bodily sensations, and instead focus on, and commit to taking action in the pursuit of personally significant goals (Bond & Bunce, 2003; Hayes et al., 1999; McCracken, Vowles, & Eccleston, 2004).

Empirically the domain is new, however, a number of studies have produced positive results with clinical populations that are experiencing psychosis. A brief version of ACT was found to reduce the rate of hospitalisation over a 4-month period by 50% in a relatively chronic group of hospitalised patients experiencing positive symptoms of psychosis (Bach, & Hayes, 2002). Further, a recent single-case study using ACT showed that this approach was useful in dealing with auditory hallucinations (Garcia & Pérez, 2001).

In addition to being used for the treatment of psychotic symptoms, ACT has also been employed successfully in the treatment of anorexia nervosa (Heffner & Eifert, 2004; Heffner, Sperry, Eifert, & Detweiler, 2002), chronic pain (Dahl, Wilson, & Nilsson, 2004; McCracken et al., 2004), smoking cessation (Gifford et al., 2004), polysubstance abusing

methadone maintained opiate addicts (Hayes, Wilson et al., 2004), and trichotillomania (Twohig & Woods, 2004).

Given the success of recent studies using acceptance and mindfulness techniques mentioned above, it was felt these techniques would be useful additions to the CBT approach used in the past. Particularly because many psychotic processes are very difficult to change, but may be able to be accepted (not avoided) in such a way as to reduce distress and improve quality of life.

In fact, components of ACT therapy, such as mindfulness and other acceptance techniques that underpin ACT, were specifically utilised in this study to help clients become more comfortable with their internal sources of distress and their illness. In particular, these techniques focused on assisting the client to treat their thoughts as less fearsome; helping the client to treat their thoughts and symptom content as less real; and, highlighting to the client that thoughts and actions are different – that is, promoting the notion that just because you are thinking something does not mean you have to act on it. Given the distress that thought disturbances often create for people suffering from chronic psychotic-type illnesses, an important consideration of the study was to move clients from avoiding their internal experiences toward being able to just notice thoughts, rather than being fearful of them, fighting with them, believing them and acting on them (Bach & Hayes, 2002; Hayes et al., 1999).

1.15 EVoLVE Therapy

EVoLVE Therapy (Exposing Virtues of Living Valued Existences Therapy; Gillingham, 2004), the therapy used in the present study, was written with a view towards helping people diagnosed with schizophrenia and other serious psychiatric disorders with psychotic features. EVoLVE Therapy combines CBT and ACT principles and assumptions, and uses a format deliverable by novice therapists and counsellors. Components of EVoLVE Therapy have been taken from treatment manuals used for treating people with schizophrenia (EPPIC, 1996; Garety et al., 1994; Turkington & Kingdon, 1996; Kuipers et al., 1997); from self-help workbooks for relaxation and stress reduction (Davis, Robbins Eshelman, & McKay, 2000) and anorexia (Heffner & Eifert, 2004); from Linehan's (1993a; 1993b) cognitive-behavioural treatment of borderline personality disorder; and, from Acceptance and Commitment Therapy (Hayes, et al., 1999).

EVoLVE Therapy utilises a number of techniques designed to: 1. Educate clients about the role stress may play in the onset and maintenance of their disorder, 2. Provide strategies to help reduce the experience of stress in clients' lives, 3. Assist clients to make small changes in the way they are living in order to help them achieve their goals, 4. Provide strategies to help clients' improve their functioning, despite living with unwanted experiences, and 5. Promote self-acceptance.

Through the use of CBT and ACT techniques, EVoLVE Therapy was essentially designed to reduce the frequency and intensity of negative emotions and increase the

frequency and intensity of positive emotions for those suffering from psychotic type disorders. Interventions included in the study to increase the incidence of positive emotions involved engaging the client in productive, enjoyable activities and socialization; imagery; relaxation training; and, eliciting life values and goals so the client could move toward what they most valued in life (a core component of ACT). Strategies included in the treatment to reduce distress or negative emotion involved relaxation training, and increasing the client's acceptance of their internal experiences.

1.16 Components of EVoLVE Therapy and their Rationale

1.16.1 Session 1

Introduction to the programme and CBT

Session 1 provided the study participant (referred to as the client in the treatment manual) with an overview of EVoLVE Therapy and of CBT. Aims for the session include:

- Taking the clients history and working toward establishing a therapeutic relationship
- Assessing motivation
- Instilling hope (establishing positive expectations that are realistic)
- Presenting and explaining the CBT model
- Introducing a functional analysis
- Establishing treatment ground rules, and
- Providing a rationale for extra-session tasks (homework)

The first session of any therapy is the most significant, and often the hardest, because the therapist has to attend to a number of areas. Of most importance is the establishment of a

therapeutic relationship using the common factors of most psychotherapies and good psychotherapists – namely, empathy, warmth, genuineness, support, collaboration, and unconditional positive regard (Turkington & Kingdon, 1996). Indeed, according to Lambert and Bergin (1994), these factors are central to effective psychological treatments.

Another important first session task is to assess and, if necessary, address the motivation of the client to be in therapy and engage in the therapy process (Kazdin, 1994b). According to Kazdin (1994b), an unmotivated client is unlikely to remain in therapy.

Also important in the initial session is to provide an explanation and rationale for CBT, and introduce to the client the CBT Five-Part Model (by working through an example); highlighting the interconnection between thoughts, feelings, bodily sensations, behaviours, and environment (Greenberger & Padesky, 1995). According to Greenberger and Padesky (1995), if clients understand that the above five components contribute to any problem, they are then better able to see: how change can occur; how new, more effective skills can replace old habits; and how "homework" to facilitate practice of these new skills is very important.

1.16.2 Session 2

Normalising Rationale

The tasks for the second session include:

- Explaining the role of stress on the production of symptoms
- Discussing the biopsychosocial aspects of the illness i.e., The Vulnerability-Stress Model

- Decatastrophising catastrophic cognitions about their illness
- If applicable, providing an explanation of the symptoms of depression and/or anxiety
- Explaining symptoms as 'continua of functioning', and
- Explaining the difference between thoughts and actions

Psychoeducation is a big component of session 2. The intention is to educate the client – using Zubin and Spring's (1977) Vulnerability-Stress Model – about the role of personal vulnerability and stressful life circumstances, and their interaction, in the production of their particular symptoms and psychological distress. By exploring and discussing their experiences in this way it is hoped to decatastrophise/normalise (not minimise), and help reduce the stigma of, the client's disorder/problems by discussing the presence of schizophrenia-like, psychotic symptoms, in 'normals' (Kingdon & Turkington, 1994; Turkington & Kingdon, 1996). Explaining the client's psychotic symptoms as a 'continua of functioning' is also employed as a way to present to the client the idea that symptoms in schizophrenia and other psychotic-type disorders merge with 'normal' behaviour (Kingdon & Turkington, 1994; Turkington & Kingdon, 1996). Through this process, it is hoped that the clients will begin to see themselves as people – not as their mental illness – and begin to feel better about themselves; with the ultimate aim being to lift self-esteem. Evidence that psychotic symptoms occur in the general population as a reaction to stress (e.g., sleep and sensory deprivation) and appear to exist on a continuum is used to "normalise" psychotic experiences in an effort to reduce stigma, decatastrophise symptoms, and reduce fear associated with psychotic experiences – that is, psychological distress (Kingdon & Turkington, 1994).

It is also important to provide an explanation of affective symptoms at this point. Affective symptoms can be delusionally misconstrued and can also lead to poor compliance with treatment (Turkington & Kingdon, 1996). Further, as previously mentioned, marked hyperarousal and anxiety in psychotic clients can worsen psychotic symptoms (Kingdon & Turkington, 1994).

Finally, another important activity in this second session is to introduce to the client the difference between thoughts and feelings – the notion that just because you are thinking something does not mean you have to act on it – as a forerunner to the mindfulness work to come, where the option of just noticing thoughts rather than believing and acting on them will be introduced (Bach & Hayes, 2002; Hayes et al., 1999).

1.16.3 Session 3

Promoting Better Patterns of Living

Specific tasks for session 3 include:

- Presenting, and discussing sleep hygiene information, and
- Educating about nutrition and exercise

Session 3 concentrated on promoting better patterns of living in the areas of sleep, nutrition, and exercise. Improving sleeping patterns is an important area to cover because sleep disturbances are common amongst people diagnosed with a psychotic-type disorder (Turkington & Kingdon, 1996), and there is evidence that sleep deprivation can lead to the onset of psychotic symptoms (Oswald, 1974).

In addition, moving towards eating a balanced diet and increasing exercise – that is, moving toward a healthier body – is promoted as an important strategy to improve the ability to cope with the inevitable stresses of life. Good nutrition is a "building block of good health"(Davis et al., 2000, p.237). Exercise is one of the simplest and most effective ways of decreasing the stress response (Davis et al., 2000). Furthermore, encouraging the client to engage in a form of exercise or activity they enjoy may cultivate positive emotions and, thereby, also improve health and well-being (Fredrickson, 2000).

Simple behavioural exercises (targeted at improving the sleep regime, nutrition, and increasing exercise) that can be easily mastered are incorporated in this session. Homework to practice these new skills is also provided. Simple behavioural tasks may enhance the therapeutic relationship and produce a sense of mastery in the client (P. L. Merrick, pers. comm. 5.3.02). Good homework assignments – individualised to the client, and set collaboratively with the goals of the session and the overall goals of therapy in mind – provide an opportunity for the client to maximise, and practice, what was learned in-session (Beck, 1995).

1.16.4 Session 4

Relaxation Training

A number of important tasks for session 4 include:

- Providing background information on the importance of correct breathing
- Teaching breathing relaxation exercises, and
- Playing the relaxation tape

The goals of session 4 include providing background information on the importance of correct breathing, and the consequences of poor breathing technique; increasing the client's awareness of their own breathing habits; teaching the client how to use breathing as a relaxation skill; providing exercises to enhance relaxation and release tension (using progressive muscle relaxation techniques); and, teaching the client how to use breathing for symptom control or release (Davis et al., 2000). Increasing the client's awareness of their current breathing patterns and moving them to increase correct abdominal breathing, may help in reducing their muscle tension and anxiety connected with stress-related thoughts, feelings, and behaviour, and elicit the relaxation response (Davis et al., 2000).

In addition, Fredrickson (2000) posits that relaxation therapies elicit the positive emotion of contentment. Contentment is described as a mindful emotion, in that it involves being fully aware and receptive to momentary experiences; delighting in, and integrating these experiences into the self; and, in turn, gaining insight (Fredrickson, 2000). In fact, Fredrickson (2000) characterises contentment as an emotion that "broadens individuals' momentary thought-action repertoires, and builds their personal resources" (p. 9). Fredrickson (2000) believes that the tension-release sequences of progressive muscle relaxation appear to mirror those of intense laughter, thereby inducing an overall reduction in muscle tension and action readiness – considered key components of contentment.

1.16.5 Session 5

Dropping the Rope: Letting Go of the Struggle

Tasks for session 5 include:

- Tracing the antecedents of psychotic breakdown/problems
- Developing and prioritising a problem list, and
- Presenting the *"tug-of-war"* metaphor; that is, the idea of letting go of the struggle

The specific goals of session 5 include providing the client with a basic formulation of their problems based on the information collected to date; listing the current problems/struggles that are standing between the client and moving toward what the client most values in life, and prioritising them; presenting to the client the idea that letting go of the struggle (the *"tug-of-war")* that they are having with their unwanted thoughts, feelings, and experiences may be a viable option; and, introducing to the client the idea of stopping trying to avoid unpleasant feelings and experiences and to become more accepting of such experiences (Hayes, et al., 1999).

According to Turkington and Kingdon (1996), the rationale behind providing the client with a basic formulation of their problems is so the client can learn to understand their own thoughts, feelings, bodily sensations, and behaviours. Also, finding out about how the client has dealt with problems in the past, and whether these have worked or not is important (Hayes et al., 1999). In this way, the client begins to learn to become a good observer of his or her own reactions to situations, and how they have previously coped with their problems.

According to Hayes and associates (1999), stopping unworkable strategies is difficult, as these strategies are learned behaviours that the client has often used to try to overcome their problems, and to the client there often is no clear alternative way of dealing with the

situation. The purpose of presenting the *"tug of war"* metaphor at the end of this session was to leave the client with the idea that letting go of futile struggle, with unwanted thoughts and feelings, is an alternative viable option (Hayes et al., 1999). Clients are then informed that techniques to help them let go of the struggle, and move toward acceptance of unwanted thoughts and feelings, will be presented at future sessions. Session 5's homework is planned as a self-monitoring task, designed to have the client gather data about situations where they engage in struggle in their daily life as a way of enhancing self-awareness (Hayes et al., 1999).

1.16.6 Session 6

Becoming an Observer

Specific tasks for session 6 include:

- Introducing to the client the idea that control may be their problem, not their solution
- Examining the apparent success of control strategies and the costs of using control strategies in the wrong places
- Presenting the *Chocolate Cake Exercise*
- Presenting the *Tug-of-War with a Monster* metaphor, and
- Showing the client the idea of becoming an observer – *Advice to a Friend Experiment* – of being present in the moment

A number of important goals are intended for this session. These include: introducing the client to the idea that their efforts to control their problems (their thoughts, feelings/emotions, physical symptoms) – by using such techniques as avoidance, distraction, numbing, and direct control – are the problem, not the solution to their

problem (that is, control is the problem, not the solution) (Heffner & Eifert, 2004); examining the apparent success of control strategies, but show the costs of using them in the wrong places (Bach & Hayes, 2002); showing the client, using an experiential exercise (the *Chocolate Cake Exercise*), how ineffective deliberate verbal control can be when applied to thoughts, feelings, and even physical reactions (Hayes et al., 1999); re-introducing to the client the idea that letting go of futile attempts to control unwanted thoughts may be a viable option (the *Tug-of-War with a Monster* metaphor) (Hayes et al., 1999); start introducing to the client the notion that there is an alternative to control strategies; that is, being present (*Advice to a Friend Experiment*) (Hayes et al., 1999).

The *Advice to a Friend Experiment* involves getting the client to think about a problem that a friend might be having, and then asking the client to think about the advice they could provide to assist their friend with the problem. Usually the client finds it easier to offer advice to a 'friend' than if they themselves had the problem, because they are 'an observer' of the problem – that is, they are able to step back and observe rather than get tangled up in strong thoughts and feelings (Hayes et al., 1999). Being able to step back and observe gives a clearer perspective and enhances the ability to adopt a different approach to a problem (Hayes et al., 1999).

The purpose of the above work is to get the client to see that letting go of the struggle with whatever is troubling them, and starting to live instead (and do all the things they want to do) requires them to include their problem/psychological distress as a legitimate part of these life changes – that is, the idea that they can live their life despite whatever is troubling them (Hayes et al., 1999).

1.16.7 Session 7

Becoming a Mindful Observer

Tasks for session 7 include:

- Introducing mindful observation
- Preparing to be mindful
- Mindful observation exercises, and
- *Take Your Mind for a Walk* exercise

The goals of session 7 involve: introducing mindfulness to the client, and helping them prepare for mindful observation; assisting the client to become a mindful observer of their thoughts and feelings – the willingness to observe whatever thoughts and feelings their mind serves up to them without trying to change them, hold on to them, push them away, avoid them, or distract from them (Heffner & Eifert, 2004); instilling in the client the notion that mindfulness is about letting thoughts, feelings, and sensations come and go, rise and fall away, without attempting to exert control (although it is important to point out that, in reality, the client is in control and can stop the process at any point) (Hayes et al., 1999); begin teaching the client to live in the present moment and to focus their attention on what they are doing right now, rather than thinking about the past and worrying about the future (Heffner & Eifert, 2004).

Further, consistent with EVoLVE Therapy's focus on providing strategies to reduce stress, the purposes of the above goals are also to reduce the stress in our clients' lives. Much stress comes from thinking about the past and worrying about the future (Heffner & Eifert, 2004); living in the present moment with our attention focused on what we are

doing right now (that is, being mindful) leaves no room for anything else to enter our minds – including fears, desires, or anything that could be stressful (Davis et al., 2000).

The purpose of the "*Take Your Mind for a Walk*" exercise is to illustrate how busy and evaluative minds can be, and introduce to the client the idea that they don't have to respond to what their mind says; instead, they can just simply notice what their mind is 'saying', and carry on with what they want to do with their life (Hayes et al., 1999).

Again, Fredrickson (2000) proposes that mindfulness, another form of relaxation therapy, creates conditions for the positive emotion of contentment to develop. In addition, Fredrickson (2000) believes that mindfulness cultivates the ability to cease unnecessary goal-directed action and give up unnecessary control.

1.16.8 Session 8

Emotion Regulation Training

The important tasks for session 8 include:

- Outlining the goals of emotion regulation training
- Describing to the client two kinds of emotional experience
- Describing the role of emotions in people's lives
- Presenting a **theory of emotions**
- Presenting the concept of recognising, describing, and naming emotions
- Discussing why people have emotions
- Presenting methods for reducing emotional vulnerability
- Outlining the steps for increasing positive emotions, and
- Discussing letting go of emotional suffering and being mindful of their current emotion

A number of important goals are outlined for this session. They include: introducing emotion regulation training to the client to help them understand the emotions they experience and to assist the client in learning how to regulate their affective levels (Linehan, 1993b); identifying the functions of emotions, especially negative emotions, as an important first step toward change (Linehan, 1993a); presenting ways the client can reduce physical and environmental stress in an effort to reduce proneness to emotional reactivity (Linehan, 1993b); encouraging the client to increase the number of positive events in their life in an attempt to increase positive emotions (Linehan, 1993a); and, carrying on from the mindfulness work done last session, by reiterating to the client that mindfulness regarding current emotions means experiencing emotions without judging them or inhibiting them, pushing them away, or distracting from them (Hayes et al., 1999; Heffner & Eifert, 2004; Linehan, 1993a).

According to Folkman and Moskowitz (2004), emotion regulation is the process "by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions" (p. 762). The aim in this session was to assist the client in ameliorating their negative emotions and helping them to cultivate their positive emotions – that is, enhancing their coping process (Folkman and Moskowitz, 2004).

1.16.9 Session 9

Eliciting Life Values/Goals

Specific tasks for this session include:

- Discussing the difference between values and goals
- Eliciting the client's life values

- Setting 'smart' goals
- Defining the actions that will be used to accomplish these goals, and
- Discussing barriers to the attainment of these goals

A number of goals were defined for this session. These goals were as follows: learning to distinguish values from goals; finding out what the client most values in life; encouraging the client to define their life direction; the setting of "smart" goals; defining how these goals will be achieved, and barriers that might arise on the way to goal attainment. Indeed, the purpose of this session was to assist the client in writing their values down and ranking them in order of the importance placed on them, and working with the client to generate goals and the concrete steps that the client can take, that would express these values (Hayes et al., 1999). Effective goal setting also involves looking at the barriers that the client is likely to encounter that may prevent the client from taking action toward their goal (Heffner & Eifert, 2004).

Similar to ACT, determining the clients' values and goals was deemed a very important part of EVoLVE Therapy. Knowing what is important to us in life – what our values are – gives our life direction (Heffner & Eifert, 2004). In ACT, values are regarded as choices – a selection among alternatives made in the presence of reasons; and, goals are used as a means to participate in a process and maintain direction toward what is valued (Hayes et al., 1999). The "C" of ACT – that is, "Commitment" – is about getting the client to focus on overt behaviours that move them in the direction of their values, while accepting the presence of unwanted thoughts and feelings (Bach & Hayes, 2002; Hayes et

al., 1999). Further, engaging in meaningful activities represents powerful coping and is related to positive affect (Folkman & Moskowitz, 2000; 2004)

1.16.10 Session 10

Review, Relapse Prevention, and Wrap-up

Important tasks for the final session include:

- Reviewing EVoLVE therapy
- Relapse prevention
- Facilitating continued progress
- Wrap-up therapy

This final session of EVoLVE Therapy involved some important goals, including: reviewing the important points of each individual therapy session and tying each session together; assisting the client to recognise their changes in behaviour, emotion, and thoughts that precede relapse; that is, their particular 'relapse signature' (Birchwood, 1996); helping the client identify high-risk situations (identify triggers) relevant to relapse (Rowan & O'Hanlon, 1999); establishing a step-by-step action plan to deal with setbacks (Birchwood, 1996); if applicable, discussing the option of referral back to their primary clinician/carer to explore what might be accessible to facilitate continued progress; and, closing the therapy and saying goodbye.

1.17 The present study

The present study aimed to show the effectiveness of a brief, manualised, combination

CBT and ACT (EVoLVE Therapy) approach for treating people diagnosed with schizophrenia, and other serious and persistent psychiatric disorders with possible psychotic features, who are relatively stable on antipsychotic medication, but who are still experiencing psychological distress from residual symptomatology, and secondary symptoms of psychosis. The aim was to provide integrated treatment, based on CBT and ACT techniques, to reduce the psychological distress associated with residual symptomatology and psychosis that a person diagnosed with schizophrenia, and other psychotic-type disorders, might present with. In addition, reducing the psychological distress using this treatment approach was expected to have the secondary effect of reducing the symptoms of these disorders. Further, it was expected that the treatment would result in an increase in positive affect and a decrease in negative affect. And finally, reducing the psychological distress and symptoms of these disorders, and increasing positive affect, was expected to equate to an improved quality of life.

1.17.1 Goals of the present study

The goals of the present study were:

1. To evaluate the effectiveness of Evolve Therapy with regard to its ability to increase positive affect and reduce negative affect.

2. To determine if EVoLVE Therapy would produce the secondary effect of actually reducing the psychotic symptoms themselves.

3. To determine whether EVOLVE Therapy would result in an improved reported quality of life among the participants.

In summary, this project was intended to ascertain the effectiveness of a manualised, 10-week therapy protocol in relation to indices of positive and negative affect, psychotic and depression symptoms, and overall quality of life for clients diagnosed with schizophrenia and other serious and persistent psychiatric disorders with possible psychotic features. It was hypothesized that clients would evidence an increase in positive affect and overall quality of life as well as decreases in negative affect, psychological distress and psychotic symptoms, at the end of treatment and at 5-weeks post therapy.

CHAPTER 2. METHOD

2.0 Design

The original intention was to use a multiple-baseline across participants design, however, owing to time constraints and the express desire of a number of the participants to be finished the therapy and post-treatment assessment before Christmas, all participants started treatment after a two-week initial period of observation, which will be referred to as the baseline period. The baseline phrase provides information about the existing level of behaviour before treatment begins (Kazdin, 1994a). The criteria for a baseline measure of at least three measurements was fulfilled (Garfield & Bergin, 1994), except in the case of two of the participants who only filled in two questionnaires of the baseline measure, during the two-week baseline period. Eight participants began treatment, although, one participant dropped out after four sessions citing family reasons for the withdrawal. Treatment consisted of a brief standardised cognitive-behavioural therapy (CBT) comprising 10 sessions.

2.1 Setting

For the comfort of potential research participants, the initial individual meeting and screening interview between potential participant, assessor and co-ordinator of the project (Ruth Gillingham), and the follow-up sessions with participants, took place at the offices of SF Manawatu, 3rd Floor Ansett House, 16 Broadway Avenue, Palmerston North. For the first eight sessions, all psychotherapy was conducted at the Psychology Clinic at Massey University's Turitea Campus. As two sessions per week were required towards

the end of therapy to allow participants to be finished before Christmas, some of the later sessions took place at the offices of SF Manawatu (no rooms were available at the Psychology Clinic). All sessions were conducted in a private interview room. Functions of the Psychology Clinic include providing training for students in the Clinical Psychology Programme, and providing a setting for research projects to be carried out, under the supervision of experienced clinical psychologists. The Head of School, School of Psychology, Professor Ian Evans, granted permission for the researcher to conduct this particular research project at the Psychology Clinic. Consultation with the Psychology Clinic Director, Cheryl Woolley, and the Psychology Clinic Tutor, Jan Dickson, was carried out, to discuss the best ways to manage this research programme to enable the clinic to continue running smoothly.

The screening interview and assessment session was audiotaped. Each individual therapy session with the client was audiotaped, and made available for random assessment for treatment integrity/fidelity by a senior clinical psychologist familiar with the treatment programme.

The researcher tried to make the entire experience of meeting the assessor and therapist, and coming to therapy, a positive one for research participants. For example, a relaxed atmosphere was promoted for the initial screening and assessment session between potential participant, the assessor and the research co-ordinator, with drinks (cup of tea, coffee or Milo) being offered. At this initial meeting the research programme was outlined, the screening interview and assessments carried out, two copies of the baseline

measure (the PANAS) were handed out, and appointment times were issued for the first therapy session. Further, a drink was offered before and after each treatment session.

2.2 Participants

2.2.1 Referral and selection

All eight participants were sourced from the Manawatu region. Schizophrenia Fellowship (SF) Manawatu, an organization that supports families in mental illness, referred participants to the research programme. SF Manawatu agreed to refer, and seek funding for, suitable consumers for this research.

2.2.2 Inclusion/Exclusion criteria

To participate in this study, participants were those over the age of 18 who were competent to provide informed consent, with English as their first language. Eligible participants were those who had been long-term consumers of mental health services who had a serious and persistent psychiatric disorder. Participants were eligible for the project if they had previously received a past diagnosis of schizophrenia or some other persistent and serious psychiatric disorder with possible psychotic features, and if they had already received appropriate treatment for their disorder. Further, participants were included if they were currently taking psychotropic medications, but still experiencing psychological distress and in need of psychological treatment. Although, participants did not need to be on psychotropic medication as long as they didn't meet any of the exclusionary criteria.

Potential participants of the project were excluded if they were experiencing their first

episode of psychosis or had been diagnosed with a serious or persistent psychiatric disorder within the last 12 months, as this group might be expected to recover to some degree during the 10-week period, regardless of the treatment. Participants were those in a more chronic/stable state of mental illness, but who were not actively unwell.

Participants were those currently under the supervision of a primary clinician or carer who had overall responsibility for their treatment programme. Potential participants were asked to give the name and phone number of their primary clinician/mental health worker to the researcher, so the researcher could contact the clinician and obtain the clinicians agreement for the potential participant to participate in the research programme. Indeed, owing to ethical constraints, if the potential participant had not consented to the researcher contacting their primary clinician/mental health worker they would have been excluded from the study.

Prospective participants were excluded if they exhibited an intellectual disability, could not speak English, were actively unwell, were undergoing psychological treatment for alcohol or drug abuse, and were considered an acute suicide risk by their primary clinician/carer. If any of the potential participants had met the above exclusion criteria they would have been encouraged to seek more appropriate services through their primary clinician/carer. Further, if potential participants had been considered ineligible because they were considered an acute suicide risk, they would have been told that their primary clinician/carer would be notified.

Those participants for whom it seemed especially important to encourage continued progress were, at the completion of the 10 week CBT treatment programme, referred by the CBT therapist back to their primary clinician/carer – to explore what might be accessible to facilitate their continued progress.

2.3 Assessment

To ensure an effective assessment and formulation of problems, a scientist-practitioner approach is recommended (Read, 1997). The scientist-practitioner model uses a scientific hypothesis testing approach to clinical practice that is designed to meet the need of each individual client. Read (1997) recommends that psychologists should avoid replicating the skills of other disciplines when assessing people diagnosed with schizophrenia; instead, they should begin with a thorough assessment based on client needs in the same way they would with other clients. Assessment needs to be a respectful and collaborative process designed to concentrate on issues important to the client (British Psychological Society, 2000).

Areas of importance to concentrate on when carrying out an assessment include: affect (screening for depression, anxiety and suicidal risk); behaviour (asking clients to identify any behaviours or deficits which are troublesome); cognition (focusing on specific characteristics of the individual's hallucinatory or delusional experience); drugs (effects of both prescribed and non-prescribed); education (conceptualising the clients difficulties as "symptoms" of an "illness" to improve acceptance); family (assessing a family's impact, past and present); goals (focusing on the clients stated needs and goals); and,

history (obtaining a full psychological history) (Read, 1997). This information is then used to devise the psychological treatment plan to ensure that treatment interventions address the client's needs (Altamura et al., 2000).

In addition to the assessment of primary dysfunctions (psychotic experiences) associated with schizophrenia, the assessment of secondary dysfunction is also important, for the purposes of designing treatment. These secondary problems include stigmatisation, social isolation, poverty, cognitive deficits, and occupational problems, to name but a few.

Finally, Read (1997) advocates that "Psychologists should not shy away, or be pushed away, from using their research-based knowledge and skills to enhance the quality of life of clients deemed to be "psychotic" " (p.287).

Owing to the clinical and investigative nature of this proposed research, a number of measures were used to gather data. The initial assessment (pre-treatment) involved collecting sociodemographic information, administering a semi-structured interview to assess psychopathology, and the administration of self-report inventories to assess symptomatology and positive and negative affect (to be discussed shortly). The semi-structured interview and the self-report inventories were also administered again within one week of treatment completion and then again at five weeks post-treatment. Owing to time constraints, no further post-treatment assessments were conducted for this thesis.

One self-report inventory – the PANAS (Positive and Negative Affect Schedule; Watson, Clark, & Tellegen, 1988) – was administered weekly during baseline and prior to every

treatment session during treatment to monitor changes over time.

2.4 Assessor

To reduce the possibility of researcher/therapist bias, an independent assessor carried out all assessments. The independent assessor was Reneé Seebeck. Reneé is a PhD student, a graduate teaching assistant, and in training to be a clinical psychologist (she is in the clinical programme), at the School of Psychology, Massey University, Palmerston North. She has an MA – Psychology, and has completed a clinical assessment paper. Reneé was trained in the use of the semi-structured interview, the BPRS (Brief Psychiatric Rating Scale; Ventura, Green, Shaner, & Liberman, 1993); and, an experienced clinical psychologist, Dr Patrick Dulin, supervised her. Reneé had no vested interest in the research project. She carried out pre-treatment, post-treatment and follow-up assessments, and she was paid $40 per participant, per assessment, for her involvement in this process. The assessment sessions were all audiotaped. Following the pre-treatment assessment, Reneé filled out an Assessor's Confirmation of Participant's Ability to Provide Informed Consent Form (see Appendix D) for each participant.

2.5 Semi-Structured Interview

The Brief Psychiatric Rating Scale Expanded Version 4.0

The expanded Brief Psychiatric Rating Scale (BPRS; Ventura et al., 1993) is a 24-item measure that assesses psychotic symptomatology (e.g., hallucinations, delusions, cognitive disorganisation), as well as non-psychotic symptoms (e.g., anxiety, depression,

tension, emotional withdrawal) – see Appendix H. The BPRS generates a number of scores for interpretation in research and clinical settings – either a global measure of psychopathology or in terms of four major factors (Paranoid Disturbance, Thought Disturbance, Emotional Withdrawal/Motor Retardation, and Anxiety/Depression) (Mueser, Curran, & McHugo, 1997).

The total BPRS score was used to represent an overall measure of psychopathology and to evaluate total change from pre-treatment to post-treatment, and at follow-up (Guy, 1976). The total BPRS score is the sum of ratings on all 24 symptom constructs, each rated on a 7-point scale of severity ranging from 'not present' to 'extremely severe' (if a symptom construct is not rated, an NA – not assessed – is recorded).

In addition to the total BPRS score, clinical change was evaluated in terms of four higher order factor scores, which were obtained by summing ratings on the three BPRS symptom constructs most highly related to each factor: Paranoid Disturbance (hostility, suspiciousness, and unco-operativeness); Thought Disturbance (hallucinations, unusual thought content, and conceptual disorganisation); Emotional Withdrawal/Motor Retardation (emotional withdrawal, motor retardation, and blunted affect); and Anxiety/Depression (anxiety, guilt, and depression) (Guy, 1976; Mueser et al., 1997; Overall & Porterfield, 1963).

The Brief Psychiatric Rating Scale Expanded Version 4.0 used in this pilot study was a semi-structured interview, to assess psychopathology, containing operational definitions

for anchor points (behavioural descriptions) for rating signs and symptoms (Lukoff, Neuchterlein, & Ventura, 1986; Woerner, Mannuzza, & Kane, 1988).

The BPRS was administered pre-treatment, post-treatment, and at follow-up. The pre-treatment scores from the BPRS were compared with the post-treatment scores. Kuipers and colleagues (1997) defined a reliable clinical change as a decrease of five points on the total BPRS score, and a large clinical change as greater than or equal to 10.

2.6 Self-Report Measures

Sociodemographic Questionnaire

Information was collected on clients' age, ethnicity, gender, marital status, educational qualifications, employment status, and average daily dose of antipsychotic medication (see Appendix G) (Jackson et al., 1998).

Brief Symptom Inventory

The Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) is a 53-item self-report symptom inventory derived from the SCL-90-R, a self-report inventory that has been developed and widely used in a number of clinical settings and applications (Derogatis & Melisaratos, 1983; Lezak, 1995). The BSI (see Appendix I) is designed to assess the psychological distress and symptom patterns of psychiatric and medical clients, as well as community samples (Conely & Kramer, 1989). The instrument contains 53 items selected to reflect best the nine primary symptom dimensions (Somatisation, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic

Anxiety, Paranoid Ideation, Psychoticism) of the SCL-90-R in a brief measurement scale (Derogatis & Melisaratos, 1983). There are also three global indices of distress associated with the BSI (Global Severity Index, Positive Symptom Distress Index, and the Positive Symptom Total) (Conely & Kramer, 1989).

Participants rate each item of the BSI on a 5-point scale (0 – "Not at all" to 4 – "Extremely") how much they were "distressed by" each of the symptoms during the past 7 days "INCLUDING TODAY" (Lezak, 1995). Test administration usually takes less than 10 minutes, with one to two minutes being devoted to introducing the instrument (Derogatis & Melisaratos, 1983).

The internal consistency reliabilities (Cronbach's alpha) on each of the BSI symptom scales are very acceptable ranging from a low of .71 on Psychoticism to a high of .85 on Depression (Peterson, 1989). Test-retest reliability over a two-week period range from a low of .68 on Somatisation to a high of .91 for Phobic Anxiety; the stability co-efficient for the global Severity Index was .90, strongly indicating that the BSI is a reliable measure over time (Derogatis & Meliseratos, 1983). For psychiatric outpatients, correlations between the BSI and the SCL-90-R for the symptom dimensions ranged from .92 on Psychoticism to .99 on Hostility.

The BSI can provide useful indices of problem severity; a high number of reported problems (T above 63) on the BSI suggest high problem severity (Groth-Marnat, 1999). An indicator of problem severity is useful in that it can enable treatment to be focused on the symptomatic areas causing the client the greatest distress. Further, the BSI is sensitive

to a client's level of motivational distress – the degree to which the client subjectively experiences their problem and is apparent chiefly in heightened anxiety, confusion, or depression (Groth-Marnat, 1999). Motivational distress can be quite changeable and can be governed by environmental experiences; therefore, a client's level of motivational distress needs to be monitored from session to session (Groth-Marnat, 1999). Owing to the brevity of the BSI, this instrument is suitable to administer to clients each session to assess problem severity, motivational distress, and change over time, although in this study, the BSI was administered pre-treatment, post-treatment, and again at follow-up.

Positive and Negative Affect Schedule

The Positive and Negative Affect Schedule (PANAS; Watson et al., 1988) comprises two brief, easy to administer scales developed to measure the two primary dimensions of mood – Positive and Negative Affect. According to Watson and colleagues (1988), Positive Affect (PA) reveals the degree to which a person feels enthusiastic, active, excited and alert. High energy levels, full concentration, and pleasurable engagement characterise high PA; low PA is represented by unhappiness and apathy. In contrast, Negative Affect (NA) reflects subjective distress and unpleasurable engagement that underlies a number of aversive mood states, with low NA being a state of composure and peace.

The schedule comprises 20 words that describe different feelings and emotions (see Appendix J). The 10 descriptors for the PA scale are: *interested, excited, strong, enthusiastic, proud, alert, inspired, determined, attentive* and *active*. The 10 items for the

NA scale are: *distressed, upset, guilty, scared, hostile, irritable, ashamed, nervous, jittery,* and *afraid.*

Participants are asked to indicate on a 5-point scale the extent to which they had experienced each mood state during a specified time frame. The points of the scale are labelled very slightly or not at all, a little, moderately, quite a bit, and extremely. The specified time frames that can be used to ask participants how they feel include: "right now, that is, at the present moment" (*moment* instructions); "today" (*today*); "during the past few days" (*past few days*); "during the past week" (*week*); "during the past few weeks" (*past few weeks*); "during the past year" (*year*); and, "in general, that is, on the average" (*general*) (Watson et al., 1988). The PANAS was administered pre-treatment (and as a baseline measure), during treatment, post-treatment, and follow-up.

The internal consistency reliabilities (Cronbach's alpha) of the PANAS PA and NA scales were .86 and .87 respectively for a non-psychiatric adult sample (Watson, et al., 1988). For a small psychiatric inpatient sample, the PANAS scales were reliable (PA, α = .85; NA, α = .91), with high test-retest reliabilities of .81 for NA and .79 for PA (Watson, et al., 1988). Finally, according to Watson and company (1988) the two 10-item scales also have excellent convergent and discriminant correlations with lengthier measures of the underlying mood factors.

Revised Schizophrenia Quality of Life Scale

The Revised Schizophrenia Quality of Life Scale (SQLS-R4; Oxford Outcomes, 2003) is a practical, brief, 33-item self-report schizophrenia-specific quality of life measure,

developed according to standardised methodology and possessing good psychometric properties (see Appendix K). The SQLS-R4 has two well-defined domains – Psychosocial, and Vitality – and the scales show good internal consistency reliability (.78 to .93) (Wilkinson et al., 2000).

The Psychosocial domain focuses on various emotional problems, such as feeling lonely, depressed or hopeless, as well as feeling worried about the future and feelings of difficulty mixing in social situations (Wilkinson et al., 2000). The Vitality domain concentrates on problems associated with motivation and energy, such as lacking the will to do things (Wilkinson et al., 2000). The SQLS only included items and domains that were very applicable to people diagnosed with schizophrenia, as the items were produced after discussions with clients themselves (Wilkinson, et al., 2000), a tradition that has continued with the SQLS-R4. Further, all items in each scale of the SQLS-R4 correlate well with the overall scale score. A high score on the SQLS-R4 denotes a poor quality of life; conversely, a low score denotes a good quality of life (Oxford Outcomes, 2003). The SQLS-R4 can be completed in 5-10 minutes, and was administered pre-treatment, post-treatment, and at 5-week follow-up.

Satisfaction and well-being are subjective experiences (Awad, 1995); and questions have been raised on the reliability of using self-report QOL measures amongst patients diagnosed with schizophrenia (Saxena & Orley, 1997). However, studies have shown that subjective feelings can be consistently and reliably measured in this population (Awad, 1995; Awad et al., 1997). In fact, Wilkinson and colleagues (Wilkinson et al., 2000)

believe that, based on the definition of QOL a measure cannot be classified as measuring QOL unless it is a subjective measure.

To summarise, the BPRS, BSI, PANAS, and SQLS-R4 were chosen to assess outcome for this pilot study to fulfil a number of important practices in assessing outcome put forward by Hill and Lambert (2004). Namely, to measure change from multiple perspectives, using several types of rating scales and methods; the use of symptom-based, atheoretical measures; and the use of measures that examine, to some degree, patterns of change over time (Hill & Lambert, 2004). Further, the above multi-trait scales assess a wide variety of symptoms and thus capture elements of functioning that may not be immediately obvious or identifiable prior to the study (Hill & Lambert, 2004). And finally, because of the brevity of the scales chosen for this study, they can be administered concurrently without unduly burdening clients. Table 1 shows a summary of the measures used in this study.

Table 1

Summary of the Measures Used

	Measures used
Pre-treatment	BPRS, BSI, PANAS, SQLS-R4, Sociodemographic Questionnaire
Treatment	PANAS
Post-treatment	BPRS, BSI, PANAS, SQLS-R4
5-week follow-up	BPRS, BSI, PANAS, SQLS-R4

2.7 Therapists

All the therapists were post-graduate students – including the researcher – all of whom have been accepted into the Massey University Clinical Psychology Programme and in

training to become professional clinical psychologists. The therapists had all completed the graduate-level paper 175.707 – Psychotherapy I, which covers cognitive-behavioural therapy. Further, an experienced senior clinical psychologist (the principal supervisor for the project, Dr. Patrick Dulin) conducted training in the use of the manual to be used in the study. Part of this training involved practicing parts of the treatment, as per the treatment manual, with 'mock' clients. In addition, Dr. Patrick Dulin supervised all therapists, with weekly supervisory meetings being held.

As previously mentioned, all screening/assessment and treatment sessions were audiotaped, and the tapes were made available to be reviewed for treatment integrity/fidelity by a clinical psychologist familiar with the treatment programme.

2.8 Treatment Manual

Therapy followed a 64-page manual – "EVoLVE Therapy: Exposing Virtues of Living Valued Existences" (a cognitive-behavioural therapy programme for long-term consumers of mental health services who have a serious and persistent psychiatric disorder) – compiled by the researcher (see Appendix N). As previously outlined, this manual is based on some of the latest CBT strategies and techniques available, described in a number of other publications. It is not a complete, in-depth CBT course of treatment per se. Rather, it is a generic treatment protocol particularly aimed at promoting better patterns of living, reducing the stigma associated with mental illness, introducing the vulnerability-stress model, and presenting the CBT functional analyses model to participants. CBT strategies and techniques such as providing normalising rationales;

activity scheduling; mastery and pleasure exercises; relaxation techniques; education about nutrition, exercise and sleep hygiene (to name a few), are used in the manual. Each of these techniques is carefully explained in the treatment manual for delivery by the therapists, and a number of accompanying handouts are provided for the participants to take away for future reference.

Owing to the differing symptoms experienced amongst the participants, therapy was carried out in a flexible way, tailored to individual needs, while still maintaining treatment integrity/fidelity.

As there is a direct association between the therapeutic alliance and positive therapeutic outcome (Koss & Shiang, 1994), every attempt was made to pace the therapy to the individual client's speed and to foster a strong therapeutic relationship.

2.9 Intervention

Each participant received ten sessions of EVoLVE Therapy, typically occurring on a weekly basis. Although as previously mentioned, owing to time constraints, later session's involved two sessions in one week. Each session was an individual psychotherapy session. A written overview of EVoLVE Therapy was presented to each participant at the start of therapy (see Appendix L). A support person could accompany the client to therapy, as long as that support person was willing to co-operate fully with the research project; although, this option was not taken up by any of the clients.

Most therapy sessions were supported by the use of homework to reinforce particular strategies/interventions used during the session. The initial screening and assessment, and the first treatment session, took approximately 90 minutes, with each subsequent session being one-hour duration. From session two on, the one hour treatment session was broken down roughly as follows: the first 10 – 20 minutes was spent introducing the outline of the forthcoming session, reviewing homework from the previous session, and attending to any concerns the participant may have had; the next 30 – 45 minutes was spent delivering that session's fundamental strategies/interventions; and the final 5 – 10 minutes involved reflecting on the present session, ensuring participants had understood, and setting homework for the coming week. The PANAS was completed prior to the start of the therapy session each week; this strategy was to improve compliance (Michael Lambert, pers. comm., 21.09.04). The content of each therapy session was discussed in chapter 2.

2.10 Treatment Materials

A number of resource materials were used to educate the client about, and reinforce, in-session treatment strategies and goals. These resource materials were given out during the session, as each topic was covered. Each participant was given a clear-file folder at the beginning of therapy to hold all therapy resource material. These materials included information about the CBT 5-Part Model, the Vulnerability-Stress Model of Symptom Emergence, the body's arousal reaction, anxiety cues, sleep hygiene, exercise and nutrition, and relaxation. Also, the resources included introduction to mindfulness work, emotion regulation worksheets, values and goals worksheets, and relapse prevention and

support planning. In addition, worksheets for homework (or 'self-research', as one participant put it) were also included in the resource material.

2.11 Treatment Integrity

All treatment sessions were audio taped. A clinical psychologist familiar with the treatment programme reviewed randomly selected sessions for treatment integrity. A checklist, containing key EVoLVE therapy objectives and individual session components, was used to assess whether treatment had been carried out as per the manual's instructions. No treatment violations were found.

2.12 Procedure

In the first instance, a Memorandum of Understanding (see Appendix B) was signed. Then, information sheets for participants (see Appendix C) were posted to Christine Zander at SF Manawatu. Christine Zander distributed the information sheets to consumers of SF Manawatu that were deemed to meet initial, inclusionary criteria. Christine then contacted potential participants via telephone and arranged an appointment time for an initial assessment/screening interview with the independent assessor and the researcher.

At the initial assessment/screening interview, the outline of the research programme was fully explained to the potential participants by the researcher, and any questions answered. Potential participants were then asked if they were still interested in taking part in the

study and, if they were, the Research Consent Form (see Appendix E) and My Contract Form (see Appendix F) were signed. In addition, sociodemographic information was collected. Then the independent assessor, Renee Seebeck, administered the semi-structured interview, the Brief Psychiatric Rating Scale (BPRS; Ventura et al., 1993) – which collected important data relating to somatic concerns, psychological problems, and psychosis. Further, the BPRS also covers hostility and suicidality, which provided the assessor with important safety information. During this initial assessment (the pre-treatment assessment), the participants also completed the following self-report measures: the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983), the Schizophrenia Quality of Life Scale (SQLS; Wilkinson et al., 2000), and the Positive and Negative Affect Scale (PANAS; Watson et al., 1988). Following the initial assessment, the independent assessor signed a form verifying the potential participants ability to provide informed consent.

Baseline assessment was then carried out for two weeks. As previously mentioned, owing to time constraints, a two-week baseline had to be used for all participants. The measure used to create a weekly baseline, and used for weekly assessment during treatment, was the Positive and Negative Affect Scale (PANAS; Watson et al., 1988). The PANAS provided information on two scales – Positive Affect and Negative Affect.

Therapy was then begun. The day before each therapy session the researcher gave each participant a courtesy call reminding them of their appointment date and time. Prior to each therapy session the PANAS was administered. Following the ten sessions of EVoLVE Therapy, a one-and-a-half hour assessment interview was carried out within one

week of therapy completion (the post-treatment assessment) and again at five weeks after treatment completion (the follow-up assessment). Assessment measures used at the post-treatment and follow-up assessments were all the measures used at the pre-treatment assessment, and were administered by the independent assessor, Renee Seebeck. At the one-week post-treatment assessment each participant completed an EVoLVE Therapy Evaluation Form (see Appendix M).

2.13 Ethical Considerations

The study was reviewed and approved by the Massey University Human Ethics Committee and the Manawatu/Whanganui Ethics Committee, and was conducted in accordance with the ethical guidelines of the New Zealand Psychological Society, 2002. An explanation of how the researcher dealt with the relevant ethical issues in the proposed study is outlined under the following headings: access to participants, informed consent, confidentiality, potential harm to participants, uses of the information, and conflict of interest or roles.

2.13.1 Access to participants

1) The researcher approached Schizophrenia Fellowship (SF) Manawatu with a written information sheet about the study and what it involved. The importance of the proposed study was stressed. The recruitment of potential participants relied on co-operation from key personnel in SF Manawatu – namely Christine Zander and Jan Holdaway. A Memorandum of Understanding (MOU) (see Appendix B)

was drawn up between SF Manawatu and the research programme co-ordinator (the researcher).

2) The researcher and therapists remained sensitive to ethnic, cultural and social differences among participants, and ensured competent research practices relating to all participants was carried out.

2.13.2 Informed consent

The researcher was aware of the ethical issues surrounding informed consent. That is, the participants in the study had the right to know what the researcher intended to expose them to during the study, before they agreed to permit it. Informed consent was managed by:

1) Providing participants with a written information sheet about the study and what it involved. A general overview of the study was presented, including what the participants would be exposed to.
2) Participants were informed about the broad nature and purpose of the study; the people involved in carrying out the research; the people involved in delivering the psychotherapy; the type of data that would be collected, and what would be done with the data.
3) The researcher answered truthfully any questions that a participant asked about the study.
4) The researcher provided a consent form to each participant that was separate from the written information sheet. Ensuring that potential participants had understood the study, and were capable of giving informed consent, was of paramount importance. As previously mentioned, after the initial assessment, the

independent assessor was required to sign a form verifying the potential participants ability to provide informed consent. The consent form has been retained for future reference.

5) The researcher informed participants they had a right to decline, even after agreeing to participate, at any stage during the study – before, during or after. The researcher periodically asked participants whether they wished to withdraw from the study, to ensure the ethical issue of participation was adequately addressed.
6) Prior to participation, the researcher gave the participants some idea of the time involved in the study.
7) The researcher ensured no deceit or coercion was involved in obtaining informed consent at any stage during the study, and at any stage when a participant decided not to participate in the study.
8) Payment for participating in the research was not used as a form of coercion to participate.

2.13.3 Confidentiality

The researcher was aware that the ethical issue involved here involved safeguarding the participants right to privacy. The following were ways this was addressed:

1) As part of the procedure for obtaining informed consent, the researcher explained to the participant who would have access to the information collected, who would use it, and how and what it would be used for. Reassurance was given to the research participant that all information obtained during the study would remain confidential.

The researcher put procedures in place to address the confidentiality issues. For example, no identifying features were on any of the data where it was not necessary for the aims of the study; participants' data and audio tapes were identified with a code, rather than by name; all documents and audio tapes pertaining to the study were kept in a locked secure cabinet at the Massey Psychology Clinic; the consent forms and participant code reference list were kept away from the research data so confidentiality could be assured; only the researcher, the supervisors of the project, and the therapists involved in the study were allowed to peruse the data; after the study, all audio tapes were destroyed, or, with the consent of the participants, were stored in a research archive; and, finally, no participant was identifiable in any presentations of the research data.

2.13.4 Potential harm to participants

1) The researcher, along with her supervisors, ascertained the degree of risk that the research participants would be exposed to in the proposed study, relative to the risks that they normally experienced in everyday life. That is, whether a research participant would be a "participant at risk" or a "participant at minimal risk" (Rosenberg & Daly, 1993, p.311).
2) As therapists were post-graduate students in training to become professional psychologists, they were trained to deliver the CBT programme, and closely supervised, by experienced registered clinical psychologist, Dr Patrick Dulin.
3) As part of obtaining informed consent, the participants were informed of any risks involved in the study.

4) It was reiterated to participants that they could withdraw at any stage from the study.
5) The researcher proposed that the potential benefits of the study outweighed the risks to participants.
6) The researcher ensured that all elements of the proposed research complied with ethical standards at all times, and observed stringent safeguards to protect the rights of the participants in the study.
7) If any of the research procedures had resulted in undesirable consequences to the participants, the researcher would have removed or corrected these, and any long-term effects, to the extent possible.

2.13.5 Uses of the information

1) The researcher explained to potential participants what the information would be used for, as part of obtaining informed consent. And, if the research data had the potential to be used for any other purpose than the proposed study, then this was explained to the participant and agreed to as part of obtaining informed consent.
2) Confidentiality of the information obtained about a research participant was maintained, or as agreed to as part of informed consent.
3) After the data was collected the researcher offered, and then provided, the participant with information regarding the nature of the study – that is, debriefed the participants. Each participant was offered an opportunity to obtain a copy of the completed article.
4) Participants were informed how the data would be stored after the study was completed.

5) The participants were informed that the data was to be used for a thesis to be submitted in partial fulfilment of the requirements for the degree of Master of Arts in Psychology, and possible inclusion in a research journal.

2.13.6 Conflict of interest or roles

1) To avoid conflict of interest or roles, the researcher would not have provided any of the after-care to participants, should they have required it.
2) Independent psychologists, not involved in the study, would have provided after-care to any study participants adversely affected by their participation in the present research programme. The programme would have paid for this care, had this situation arisen.

CHAPTER 3. RESULTS

3.0 An Overview of the Results Section

The results are separated into three sections. The first section provides a summary of the participants in the study. The second section reports the pre-, post-, and 5-week follow up assessment results for the Brief Psychiatric Rating Scale (BPRS), the Brief Symptom Inventory (BSI), and the Revised Schizophrenia Quality of Life Scale (SQLS-R4). Finally, the third section comprises a direct comparison of changes across time for each participant, throughout baseline and treatment, for the Positive and Negative Affect Schedule (PANAS).

In addition, data was analysed for clinically significant change, as defined by the authors of the relevant measures. Clinical significance refers to the meaningfulness of change – the practical value or importance of the effect of an intervention to the client or to others (Kazdin, 1994a). The clinical significance of change occurring after treatment is an important consideration when evaluating treatment outcome. Therefore, the clinical significance of any change, if it occurs, will be reported.

Further, Cohen's *d* (Cohen, 1988) was used to calculate effect size estimates of the 'gain score' on the repeated measures used in the present study. As used in this study, Cohen's *d* reflects the extent of (standardised) change on the outcome measures from pre-treatment to 5-week follow-up. Cohen's *d* corrects the pooled standard deviation for sample bias. An effect size of 0 would reflect no change across treatment; an effect size of 1.00 would indicate a one standard deviation reduction in psychopathology score at 5-week follow-

up, and an effect size of -1.00 would indicate that the psychopathology score on the outcome measure worsened by one standard deviation at post-treatment (Rector & Beck, 2001). Cohen (1988) describes an effect size of 0.2 as small, a moderate effect size as 0.5, and a large effect size as equal to 0.8; these terms are used to describe the magnitude of change in the present study.

3.1 Participant Characteristics

Table 2 provides a summary of the participants in the study. Participant details have been kept to a minimum to protect participant confidentiality.

3.2 Pre-Treatment, Post-Treatment, and 5 Week Follow-Up Assessment Results

3.2.1 Brief Psychiatric Rating Scale Expanded Version 4.0

BPRS scores were analysed according to the authors' (Ventura et al., 1993) recommendations, to produce a global psychopathology score and scores for each of the four major BPRS factor scores (Paranoid Disturbance, Thought Disturbance, Emotional Withdrawal/Motor Retardation, and Anxiety/Depression). Table 3 (see page 88) shows the total psychopathology scores for all seven clients at pre- and post-treatment, and at 5-week follow-up. Total psychopathology scores ranged from 24 to 62. Higher scores depict higher symptom severity.

Table 2
Summary of Participant Characteristics

	Particip. 1	Particip. 2	Particip. 3	Particip. 4	Particip. 5	Particip. 6	Particip. 7
Age	33	54	29	46	30	26	58
Sex	M	M	M	F	F	M	F
Ethnicity (self-described)	Nzer	Nzer	European	European	NZer	Pakeha	European
Past diagnosis	Schizophren.	Bipolar II	Schizo-affective d/o	Major Depressive Disorder	Schizo-affective d/o	Schizophren.	Bipolar II
Length of time since initial diagnosis	11 years	18 months	11 years	Recurrent episodes over approx. 29 years	11 years	8 years	Approx. 20 years (had anx. & depress in her 20's)
Marital Status	Single	Married	Single	Divorced	Single	Single	Married (2nd marriage)
Number of children	0	3	1	2	0	0	3
Years of secondary education	3 yrs	2.5 yrs	5 yrs + some part-time tertiary	2.5 yrs	5 yrs + 3 yrs part-time tertiary	4 yrs	5 yrs
Employment status	Unemploy	Employed Part-time	Unemploy	Employed Part-time	Employed Part-time	Unemploy	Employed Part-time
Accommo-dation	Lives with Parents	Own home	Rented flat, but spends large amount of time with parents	Rented flat	Rented flat	Supported adult housing	Own home
Current medication	Olanzapine; Celepram	Aropax; Olanzapine; Zipaclome	Olanzapine	Nil	Nil prescribed medication (St. John's Wort)	Olanzapine	Olanzapine; Venaflexine; Clonazapine (as required)
Previous interventions used	Inpatient; Various antipsychotic medications	Nil	Inpatient; Various antipsychotic medications	Inpatient age 17 for 3 mnths – ECT & various medications for depress.	Inpatient; Stelazine; Haloperidol; Epilim; Cypramil	Inpatient	Inpatient; Lithium; Epilim; ECT

Table 3

Total Brief Psychiatric Rating Scale (BPRS) Scores for Pre-treatment, Post-treatment and 5-Week Follow-up

Participant	Pre-treatment	Post-treatment	5-Week Follow-up
1	52	37	34
2	39	27	24
3	62	35	33
4	43	31	29
5	47	43	36
6	54	36	32
7	38	29	29

As can be seen from Table 3, all seven participants showed a decrease in their global psychopathology scores, indicating a decrease in global symptom severity.

Figure 2 graphically depicts the global psychopathology for each of the seven clients pre- and post-treatment and at 5-week follow-up. All participants showed a decrease in global psychopathology between pre-treatment and post-treatment. Participant 3 experienced the biggest decrease (of 27) in global psychopathology scores between pre-treatment (62) and post-treatment (35), and then decreased a further 2 at 5-week follow-up. Participant 6 decreased 18, from 54 to 36, and a further 4 at 5-week follow-up. A decrease of 15 for Participant 1 occurred between pre-treatment and post-treatment, with a further decrease of 3 between post-treatment and follow-up. Participants 2 and 4 experienced an equal decrease in severity of 12 between pre- and post-treatment with Participant 2 dropping a

further 3 at follow-up and Participant 4 a further 2. Participant 7's global psychopathology score dropped 9 between pre- and post-treatment, from 38 to 29, and then stayed on 29 at follow-up. Participants' 1, 2, 3, 4, and 6 all showed a large clinical change in psychopathology; as previously mentioned, defined by Kuipers et al. (1997) as a decrease of 10 points or greater on the scale. Participant 7 showed a reliable clinical change in total psychopathology – defined by Kuipers and colleagues (1997) as a decrease of at least five points. Participant 5 did not meet this criterion, only dropping 4 points in severity between pre-treatment and post-treatment. However, participant 5 did drop 7 between post-treatment and follow-up – a total drop of 11 points between pre-treatment and follow-up.

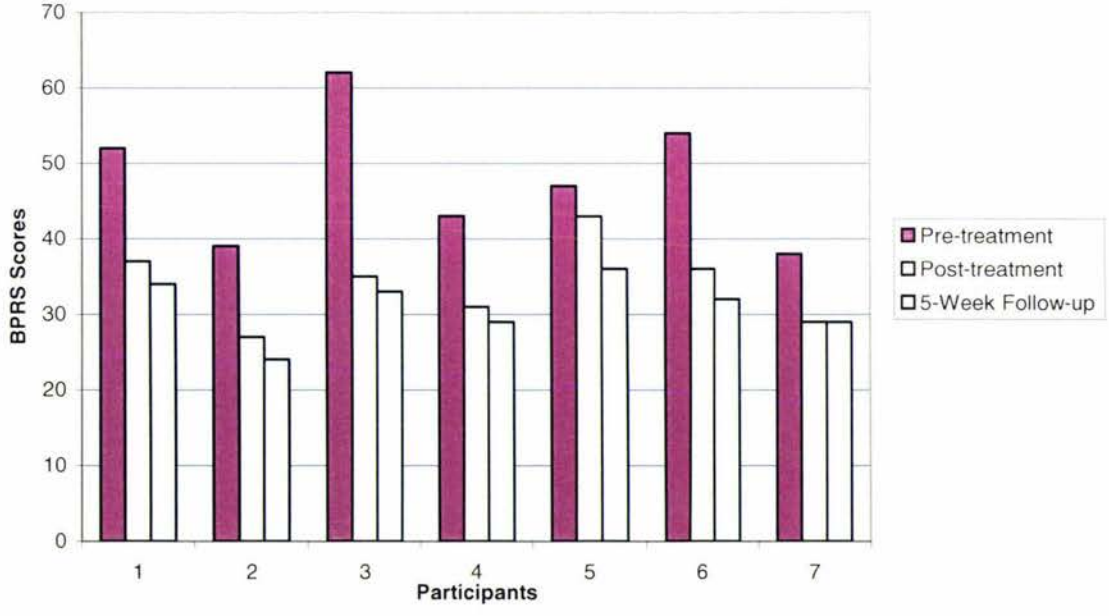

Figure 2. **Brief Psychiatric Rating Scale (BPRS) Total score at pre- and post-intervention and 5-week follow-up for each participant.**

The four major factor scores of the BPRS showed some decreases in symptom severity, for some participants, from pre-treatment to post-treatment (see Figures 3 - 6).

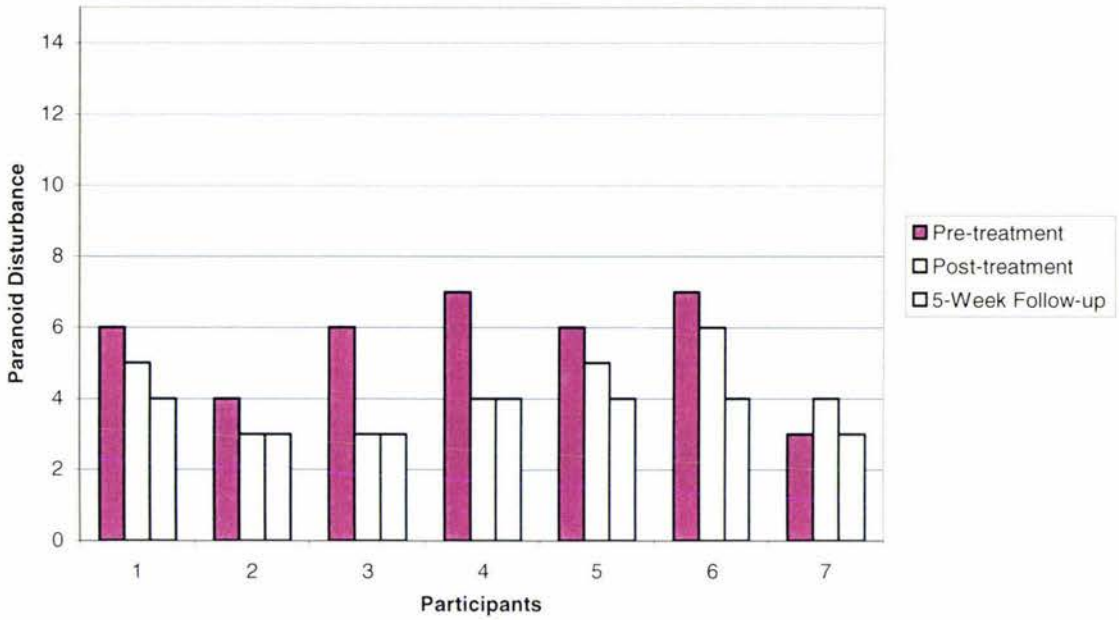

Figure 3. **Brief Psychiatric Rating Scale (BPRS) Paranoid Disturbance Factor score for each participant at pre- and post-intervention and at 5-week follow-up.**

Paranoid Disturbance scores (Figure 3) decreased from pre- to post-treatment, for all participants except participant 7. Participants 3 and 4 experienced the largest decrease (3 points) on this factor; from a score of 6 to 3 and 7 to 4 respectively. Participant 7 rose 1 point (from 3 to 4) from pre- to post-treatment, and then fell 1 at follow-up.

Thought Disturbance scores (see Figure 4) showed participants 3 and 6 experienced a decrease of 5 points between pre- and post-treatment (both then followed with an increase

of 1 at follow-up). Participants 2 and 7 showed no change on this factor across all three measurements.

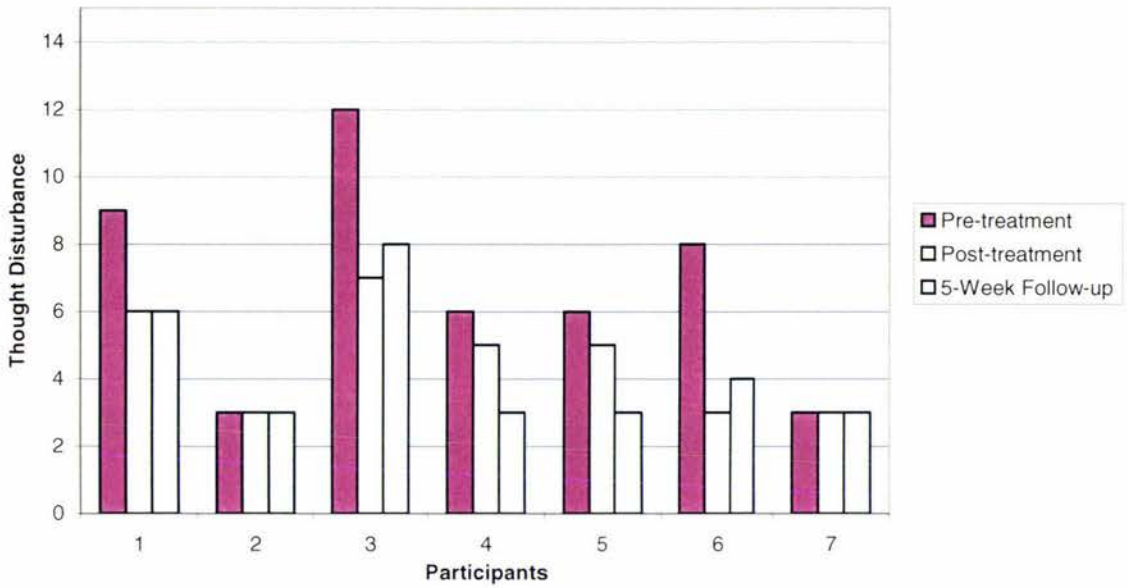

Figure 4. **Brief Psychiatric Rating Scale (BPRS) Thought Disturbance Factor score for each participant at pre- and post-intervention and at 5-week follow-up.**

The least amount of total change was found on the Withdrawal/Motor Retardation (see Figure 5) Factor score. Change ranged from decreases of 2 to 1 between pre- and post-intervention across all participants, except for participants 4 and 5. Participant 5 increased 3 points on this factor and then fell back 3 at follow-up. Participant 4 showed no change across all three measurements.

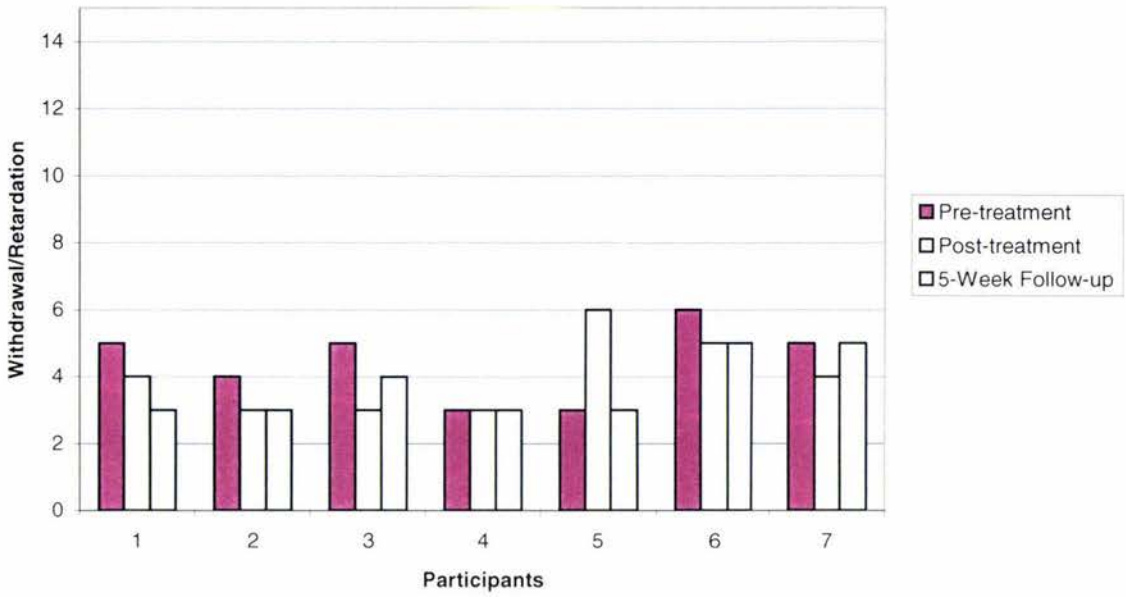

Figure 5. **Brief Psychiatric Rating Scale (BPRS) Withdrawal/Motor Retardation Factor score for each participant at pre- and post-intervention and 5-week follow-up.**

The Anxiety/Depression participant scores (see Figure 6) showed the largest decreases in symptom severity. Participant 3 experienced the largest decrease from a score of 14 at pre-treatment to 5 at post-treatment and 5-week follow-up – a drop of 9 points. Participant 2's pre-treatment score was also 14, and dropped 8 to 6 points at post-treatment. Participant 2 then dropped a further 3 to a score of 3 at 5-week follow-up. For the other 5 participants, decreases ranged from 3 to 7 from pre-treatment to post-treatment on the anxiety/depression factor.

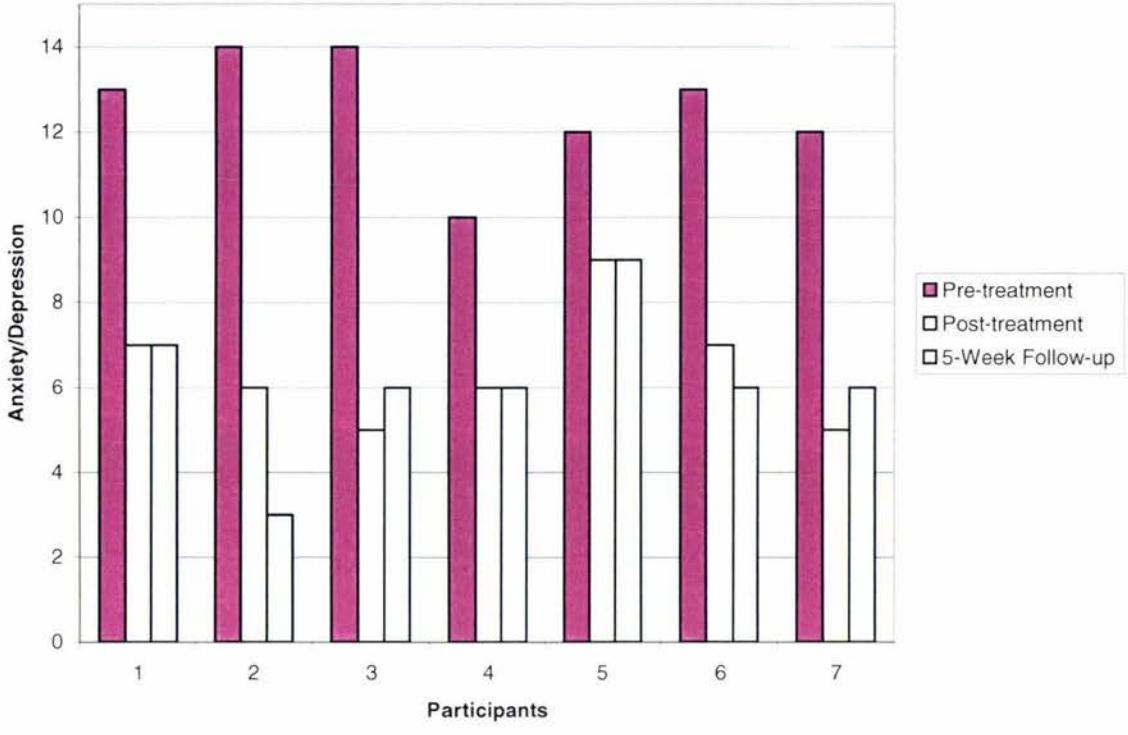

Figure 6. **Brief Psychiatric Rating Scale (BPRS) Anxiety/Depression Factor score for each participant at pre- and post-intervention and at 5-week follow-up.**

Figure 7 shows the group mean scores across time for the four major factor scores of the BPRS. As can be seen from Figure 7, the group mean on the Anxiety/Depression factor dropped 6 points between pre-treatment (M = 12.57; SD = 1.29) and post-treatment (M = 6.43; SD = 1.29) and was maintained at 5-week follow-up (M = 6.14; SD = 1.73).

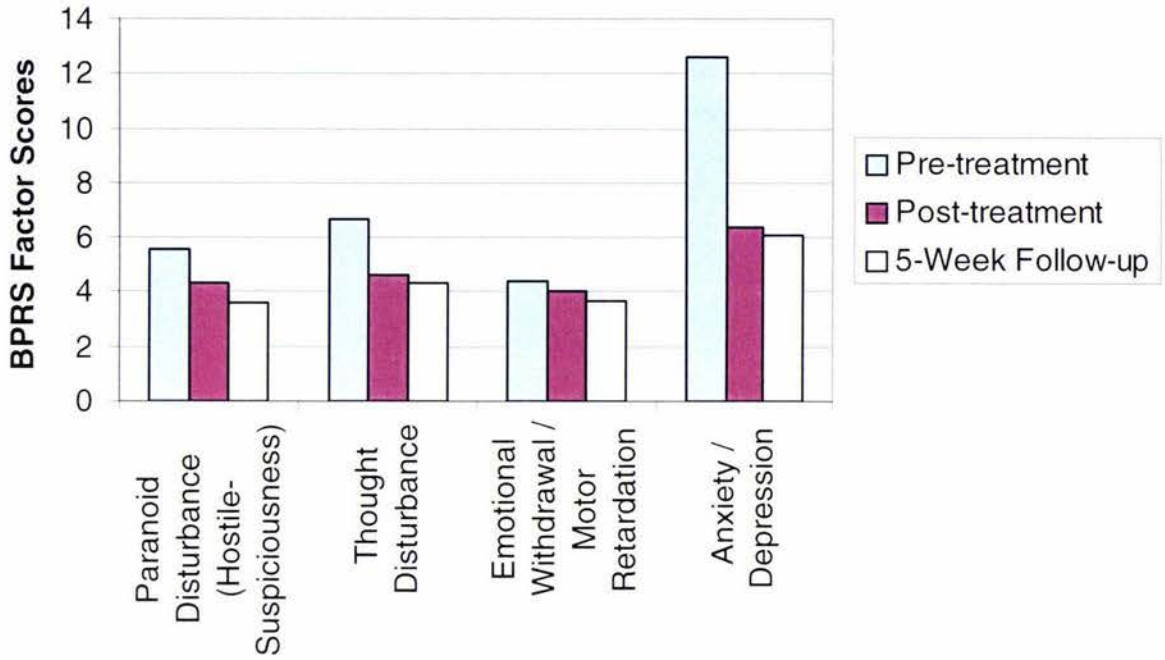

Figure 7. **Mean group scores on the four Brief Psychiatric Rating Scale (BPRS) Factors at pre- and post-treatment and 5-week follow-up.**

Figure 8 illustrates the mean group total BPRS score at pre-treatment (M = 47.86; SD = 8.06) and post-treatment (M = 34.00; SD = 5.04) and at 5-week follow-up (M = 31.00; SD = 3.70). A reliable clinical change of nearly 14 points in total group mean psychopathology score, from pre-treatment to post-treatment, can be seen; and, this change was maintained at follow-up.

Effect size for the mean group Total BPRS score from pre-treatment to 5-week follow-up is 2.87 (SD = 5.87). This effect size represents a large clinical change on this outcome measure.

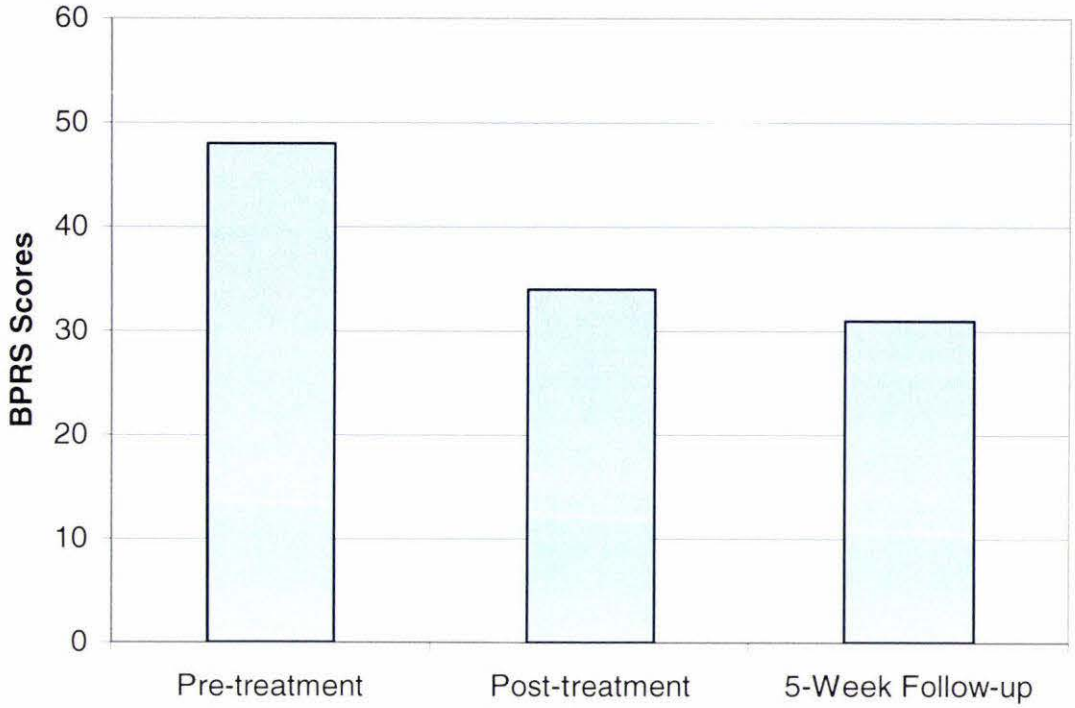

Figure 8. **Mean group Total Brief Psychiatric Rating Scale (BPRS) score at pre- and post-treatment and 5-week follow-up.**

3.2.2 Brief Symptom Inventory

The raw BSI scores for the 9 Primary Symptom Dimensions and three Global Indices were converted to standardised T scores using the Adult Psychiatric Outpatient Norms (Derogatis, 1993). It was felt the Adult Psychiatric Outpatient Norm group best represented the participants in this study.

Figure 9 displays the group mean scores on the BSI across time. High problem severity equates to a T-score above 63; and while, as a group, no mean score was above this cut-off, Figure 9 shows that a reduction in T-scores on all Primary Symptom Dimensions and Global Indices was achieved from pre- to post-treatment and was then maintained at 5-week follow-up.

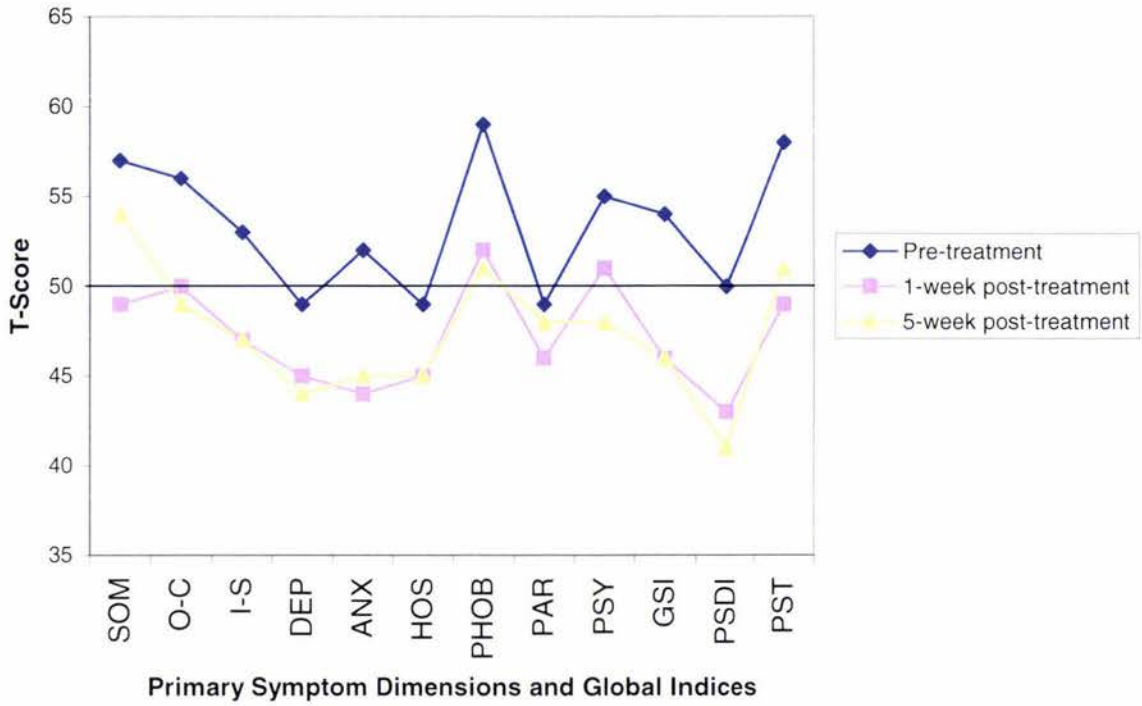

Figure 9. **Brief Symptom Inventory (BSI) group mean scores on all Primary Symptom Dimensions and Global Indices at pre- and post-treatment, and 5-week follow-up.**

Note: SOM = somatisation, O-C = obsessive-compulsive, I-S = interpersonal sensitivity, DEP = depression, ANX = anxiety, HOS = hostility, PHOB = phobic anxiety, PAR = paranoid ideation, PSY = psychoticism, GSI = Global Severity Index, PSDI = Positive Symptom Distress Index, PST = Positive Symptom Total.

Effect size (ES) was calculated for the GSI, the PSDI, and the PST from pre-treatment to 5-week follow-up on this outcome measure. Large treatment effects are observed for the GSI (ES = 0.80, *SD* = 9.68), and the PSDI (ES = 0.92, *SD* = 8.98), and moderate effects are observed for the PST (ES = 0.70, *SD* = 11.03)

BSI profiles for each participant – designed to graphically illustrate the participants' psychological symptom status at pre- and post-treatment and 5-week follow-up – are presented in Figures 10 to 16. As previously mentioned, T scores above 63 equate to high problem severity.

Participant 1 (see Figure 10) displayed high problem severity (T above 63) on the Somatisation, Obsessive-Compulsive, Phobic Anxiety, and Pyschoticism symptom dimensions at pre-treatment; while levels of other symptom dimensions at this time are in the average to slightly above average range. This profile suggests that participant 1 is experiencing distress resulting from perceptions of bodily dysfunction (Somatisation); is experiencing unremitting and irresistible thoughts, impulses, and behaviours that are unwanted, (Obsessive-Compulsive); is experiencing persistent fear responses that are irrational and disproportionate to the stimulus – that is, a person, place, object, or situation (Phobic Anxiety); and is experiencing an above average degree of social alienation and/or psychosis (Psychoticism)(Derogatis, 1993).

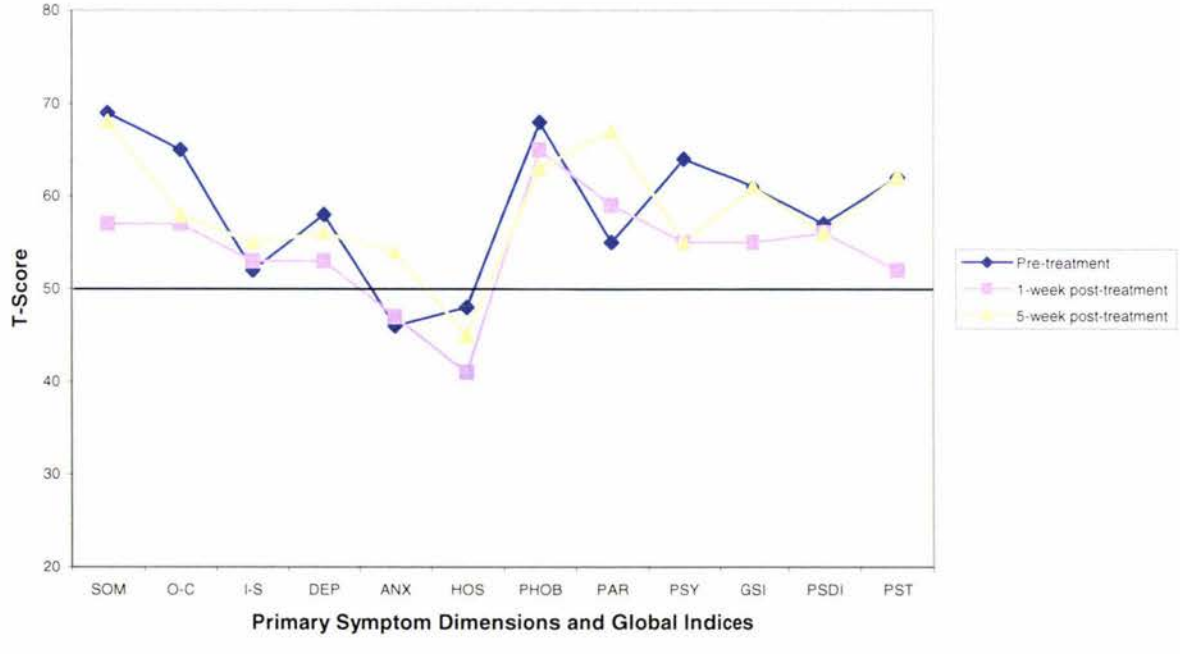

Figure 10. **Brief Symptom Inventory (BSI) Primary Symptom Dimension scores and Global Indices scores for participant 1 at pre- and post-intervention and 5-week follow-up.**

Note: SOM = somatisation, O-C = obsessive-compulsive, I-S = interpersonal sensitivity, DEP = depression, ANX = anxiety, HOS = hostility, PHOB = phobic anxiety, PAR = paranoid ideation, PSY = psychoticism, GSI = Global Severity Index, PSDI = Positive Symptom Distress Index, PST = Positive Symptom Total.

The post-treatment profile shows symptom dimension T scores in the average to slightly above average range, except for Phobic Anxiety; indicating that Participant 1 is still experiencing high problem severity in this area. At 5-week follow-up Phobic Anxiety had dropped slightly; however, Somatisation had risen almost to pre-treatment levels. Also, Paranoid Ideation (representing a disordered mode of thinking) had risen from slightly above average levels at pre- and post-intervention to a T score (67) indicating high problem severity at 5-week follow-up.

Figure 11 illustrates participant 2's BSI profiles which show general symptomatic distress levels are average to low average at pre-treatment, and fall to low average at post-treatment and follow-up.

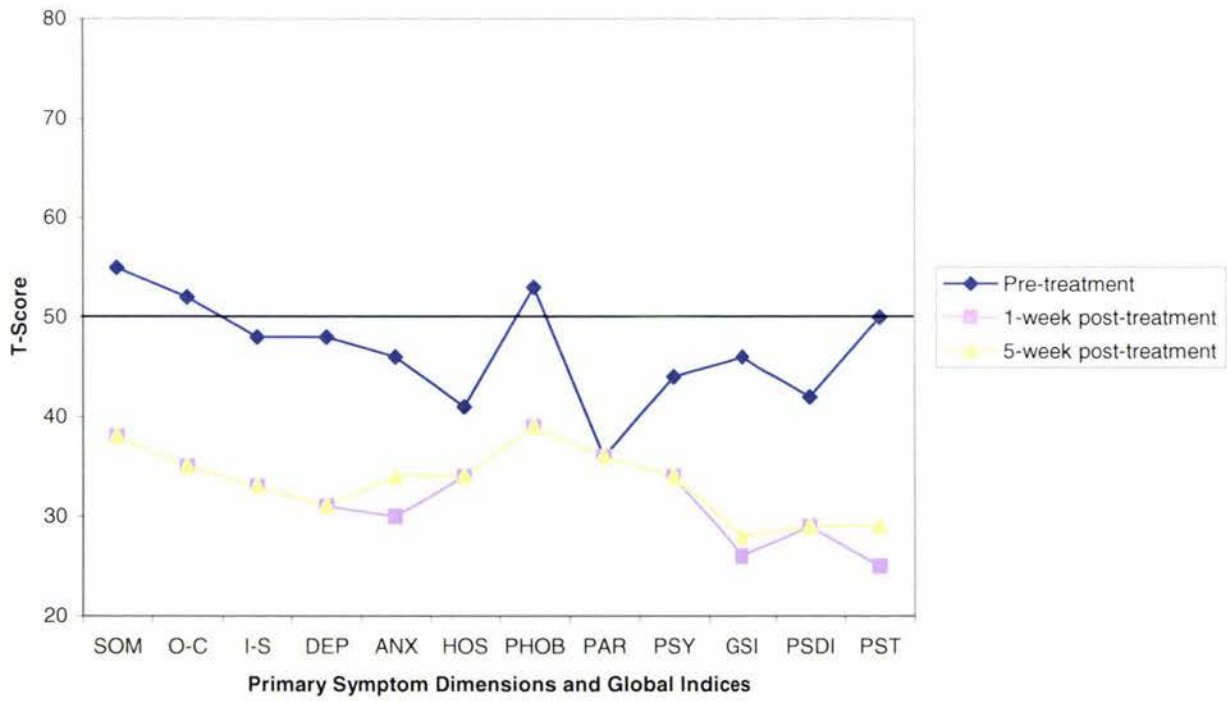

Figure 11. **BSI Primary Symptom Dimension scores and Global Indices scores for participant 2 at pre- and post-intervention and 5-week follow-up.**

Note: SOM = somatisation, O-C = obsessive-compulsive, I-S = interpersonal sensitivity, DEP = depression, ANX = anxiety, HOS = hostility, PHOB = phobic anxiety, PAR = paranoid ideation, PSY = psychoticism, GSI = Global Severity Index, PSDI = Positive Symptom Distress Index, PST = Positive Symptom Total.

Participant 3 (see Figure 12) experienced high problem severity on the Somatisation and Psychoticism symptom dimensions at pre-treatment. Also, participant 3's Global Severity Index (GSI) – the most sensitive single indicator of the participants distress levels, which combines data about numbers of symptoms and identity of distress (Derogatis, 1993) – is in the high severity range, with a T score of 64. The Positive Symptom Total (PST) is also high at pre-treatment; which reveals the high number of symptoms participant 3 reported experiencing. Other symptom dimensions were in the above average range. At post-treatment, the Somatisation symptom dimension and the PST remained high, all other dimensions were in the average to slightly above average range. At 5-week follow-up Somatisation had fallen out of the high problem severity range, and the PST global indices had fallen to T score 64.

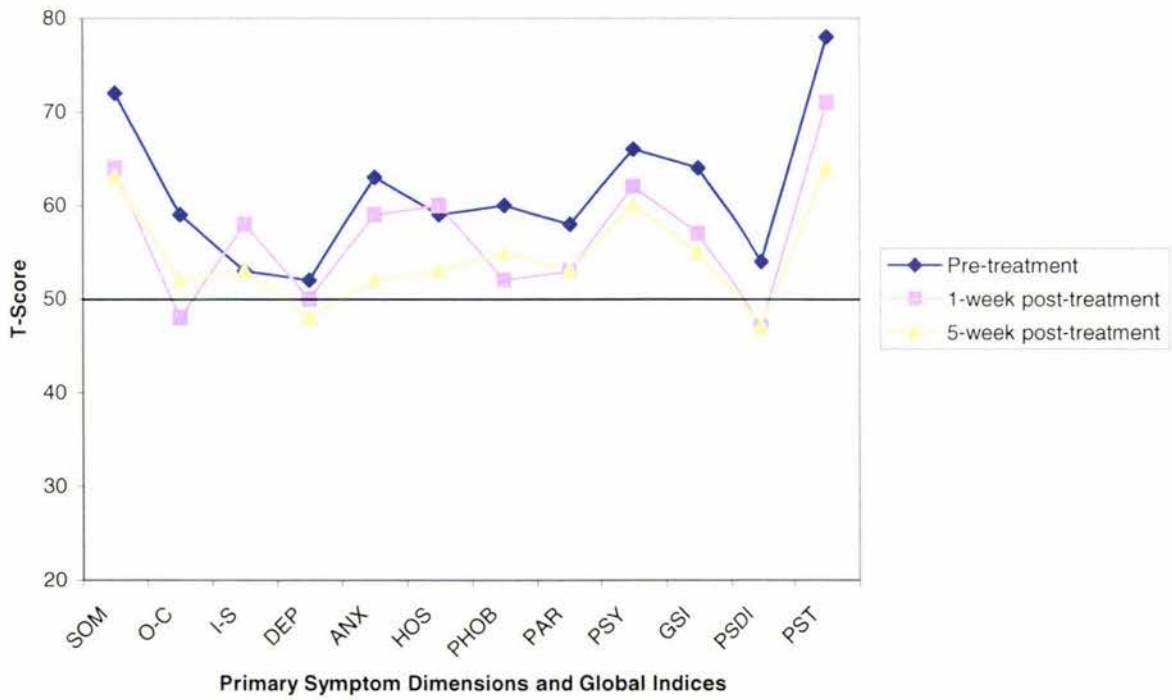

Figure 12. **BSI Primary Symptom Dimension scores and Global Indices scores for participant 3 at pre- and post-intervention and 5-week follow-up.**

Note: SOM = somatisation, O-C = obsessive-compulsive, I-S = interpersonal sensitivity, DEP = depression, ANX = anxiety, HOS = hostility, PHOB = phobic anxiety, PAR = paranoid ideation, PSY = psychoticism, GSI = Global Severity Index, PSDI = Positive Symptom Distress Index, PST = Positive Symptom Total.

Figure 13 shows participant 4's BSI profiles at pre-, post-treatment, and at 5-week follow-up. Paranoid Ideation – representing paranoid behaviour as a disordered mode of thinking – is above average for participant 4, as is the number of symptoms experienced (PST) at pre-treatment. However, at post-treatment and follow-up all scores are in the average to low average range.

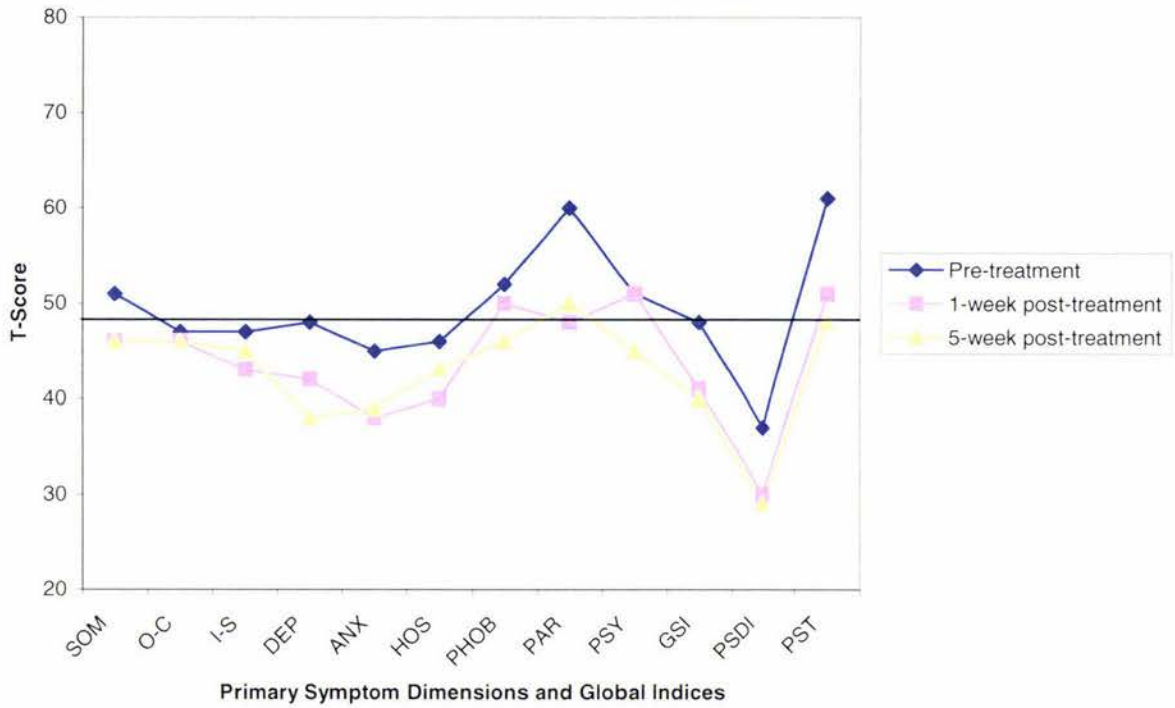

Figure 13. **Brief Symptom Inventory (BSI) Primary Symptom Dimension scores and Global Indices scores for participant 4 at pre- and post-intervention and 5-week follow-up.**

Note: SOM = somatisation, O-C = obsessive-compulsive, I-S = interpersonal sensitivity, DEP = depression, ANX = anxiety, HOS = hostility, PHOB = phobic anxiety, PAR = paranoid ideation, PSY = psychoticism, GSI = Global Severity Index, PSDI = Positive Symptom Distress Index, PST = Positive Symptom Total.

Participant 5's profile (see Figure 14) shows all scores in the average range. There is evidence of an above average degree of Phobic Anxiety at pre-treatment, which falls to average levels at post-treatment and follow-up.

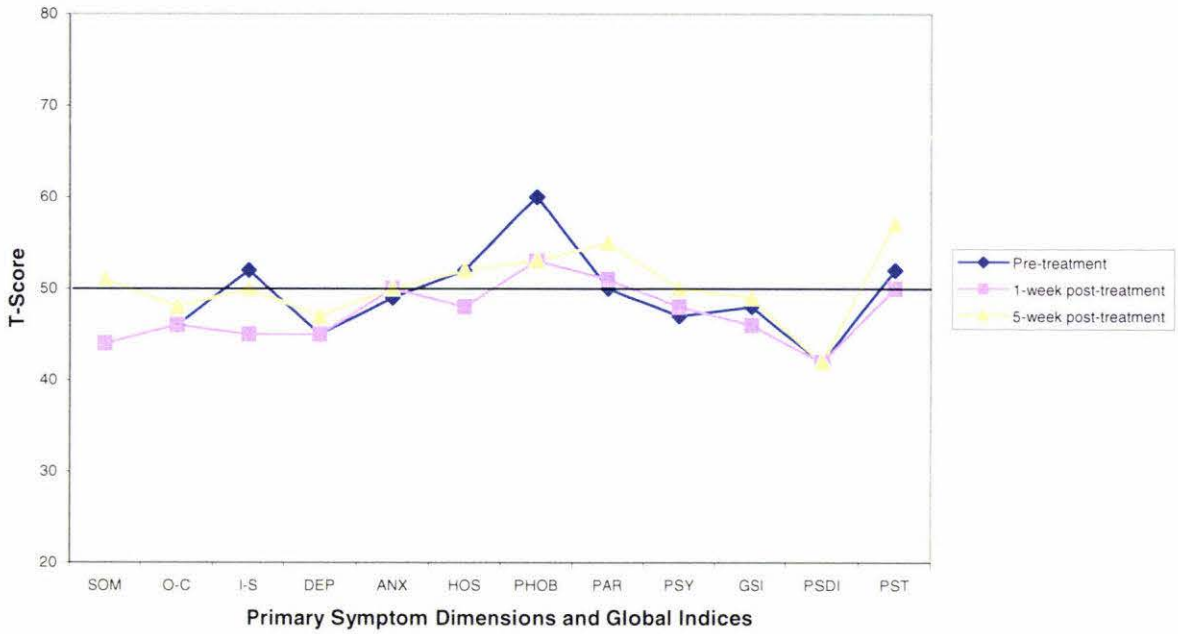

Figure 14. **Brief Symptom Inventory (BSI) Primary Symptom Dimension scores and Global Indices scores for participant 5 at pre- and post-intervention and 5-week follow-up.**

Figure 15 illustrates participant 6's profiles on the BSI. Phobic Anxiety T score at pre-treatment was slightly above average, and fell to average levels post-treatment.

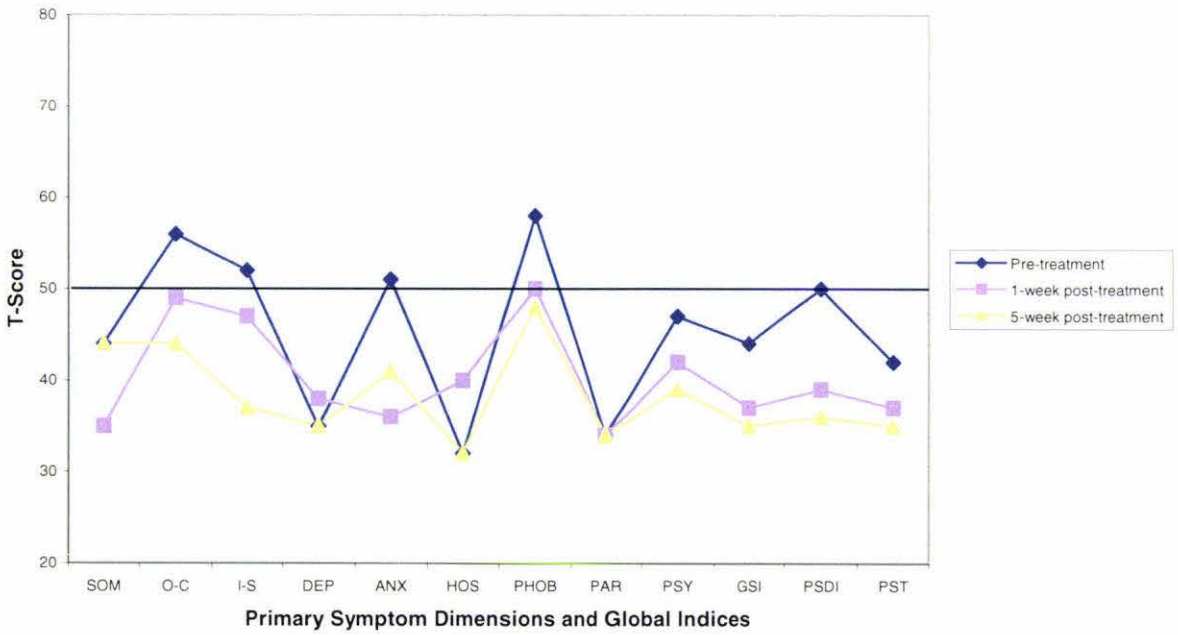

Figure 15. **BSI Primary Symptom Dimension scores and Global Indices scores for participant 6 at pre- and post-intervention and 5-week follow-up.**

Participant 7's BSI profile (see Figure 16) showed high symptom severity on most primary symptom dimensions and above average scores on the global indices. Elevated primary symptom dimensions include Somatisation, Obsessive-Compulsive, Interpersonal Sensitivity (feeling inadequate and inferior, particularly in comparison with others), Anxiety (general signs of), Hostility (thoughts, feelings, or behaviours reflecting anger), and Psychoticism. All three global indices – the GSI, PST, and the Positive Symptom Distress Index (PSDI; and intensity measure, providing information about the average level of distress participant 7 is experiencing) – are in the high range. At 1-week post-treatment only Obsessive-Compulsive and Psychoticism were in the high symptom severity range. Profile scores at 5-Week post-treatment show Somatisation had increased into the high symptom severity range; however, of note, is the decrease of all other primary symptom dimensions and global indices to an average/slightly above average range.

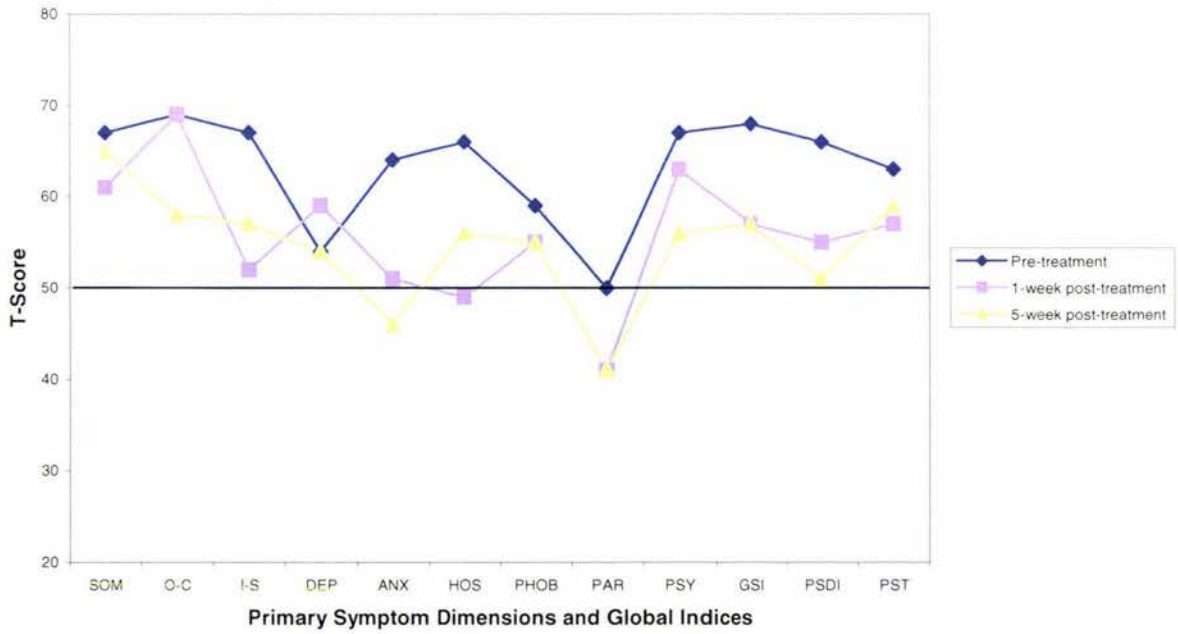

Figure 16. **Brief Symptom Inventory (BSI) Primary Symptom Dimension scores and Global Indices scores for participant 7 at pre- and post-intervention and 5-week follow-up.**

3.2.3 Revised Schizophrenia Quality of Life Questionnaire (SQLS-R4)

The SQLS-R4 was scored according to the author's instructions (Oxford Outcomes, 2003). According to the authors', each domain and the total score range from 0 to 100, where 0 equates to no problem at all and 100 equals maximum level of problem; that is, a high score reflects a poor quality of life and a low score indicates a good quality of life.

Table 4 displays the SQLS-R4 group mean scores and standard deviations at pre-treatment, 1-week post-treatment and 5-week follow-up. Table 4 shows that the groups total score on the SQLS-R4 decreased by 16.54 points from pre-treatment to post-treatment and was maintained at follow-up. Effect size for the Psychosocial Domain from pre-treatment to 5-week follow-up is 1.37 (*SD* = 14.17), for the Vitality Domain effect size is 1.12 (*SD* = 11.73), and effect size for the SQLS-R4 Total is 1.34 (*SD* = 12.71).

Table 4

Revised Schizophrenia Quality of Life Questionnaire (SQLS-R4) Group Mean Scores and Standard Deviations at Pre-Treatment, 1-Week Post-Treatment and 5-Week Follow-Up.

Domain	Pre-treatment		1 week post-treatment		5-week follow-up	
	M	*SD*	*M*	*SD*	*M*	*SD*
Psychosocial	59.66	11.82	38.96	20.27	40.19	17.84
Vitality	51.39	12.07	41.21	18.80	38.20	12.98
Total	56.37	11.24	39.83	19.23	39.37	15.58

A summary of participants' individual scores on the SQLS-R4 may be found in Table 5. For all participants the Psychosocial Domain scores decreased between pre-treatment and

post-treatment – ranging from a small 1.2 decrease (participant 6) to a large 48.7 decrease in score for participant 2. Participant 2 also experienced another large decrease of 42.3 from pre- to post-treatment on the Vitality Domain; with a total score decrease of 46.2. Participants 1, 3, and 5 showed total scores above 60 at pre-treatment (baseline) – 67.4, 68.9, and 64.4 respectively – indicating a perceived poorer quality of life. All three participants recorded lower scores at 1-week post-treatment, and at 5-week follow-up had maintained their score (participant 3) or had decreased further (participants 1 and 5).

Table 5

Scores on the Revised Schizophrenia Quality of Life Questionnaire (SQLS-R4).

Client	Domain	Baseline	F1	F2
1	Psychosocial	73.8	62.5	60.0
	Vitality	57.7	57.7	51.9
	Total	67.4	60.7	56.8
2	Psychosocial	50.0	1.3	10.0
	Vitality	50.0	7.7	15.4
	Total	50.0	3.8	12.1
3	Psychosocial	75.0	56.3	60.0
	Vitality	59.6	50.0	46.2
	Total	68.9	53.8	54.5
4	Psychosocial	60.0	42.5	40.0
	Vitality	46.2	42.3	34.6
	Total	54.5	42.4	37.9
5	Psychosocial	65.0	52.5	51.3
	Vitality	63.5	69.2	55.8
	Total	64.4	59.1	53.0
6	Psychosocial	40.0	38.8	40.0
	Vitality	25.0	30.8	32.7
	Total	34.1	35.6	37.1
7	Psychosocial	53.8	18.8	20.0
	Vitality	57.7	30.8	30.8
	Total	55.3	23.5	24.2

Figure 17 graphically depicts the total score on the SQLS-R4 for each participant at pre-treatment (baseline), post-treatment (F1) and 5-week follow-up (F2).

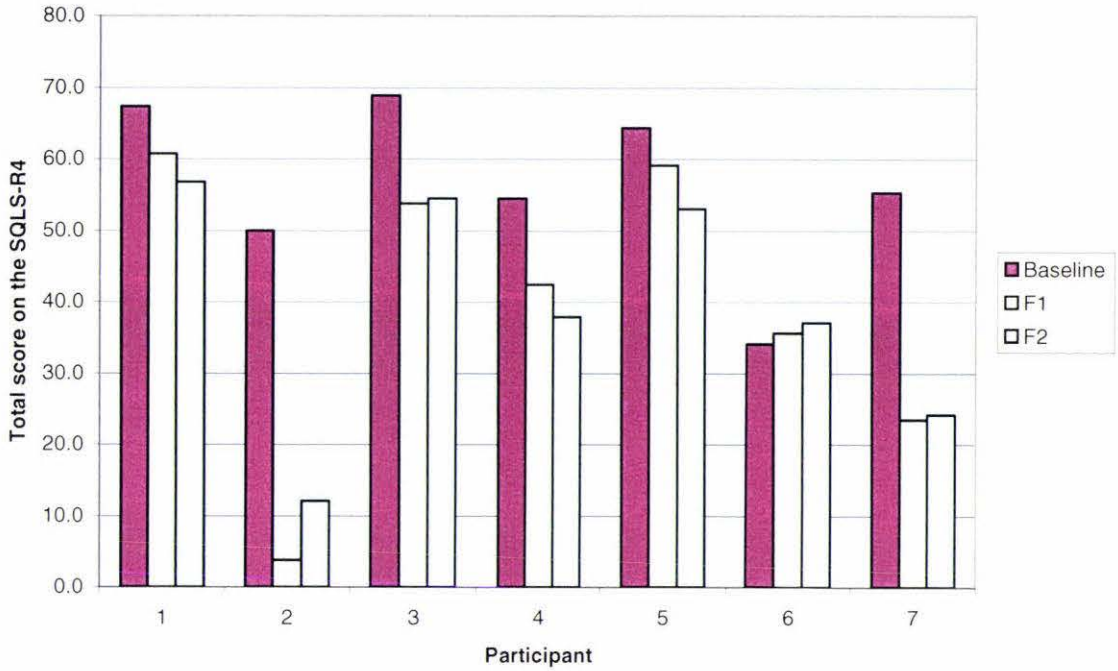

Figure 17. **Revised Schizophrenia Quality of Life Questionnaire (SQLS-R4) scores for each participant at pre-treatment (baseline), post-treatment (F1) and follow-up (F2).**

3.3 Positive and Negative Affect Schedule (PANAS) Scores

The Positive and Negative Affect Schedule was used to indicate the extent to which each client had experienced each of 20 mood states (10 positive and 10 negative) during the past week. During treatment it was expected that positive mood scores on the PANAS would increase and negative mood scores would decrease.

PANAS group mean scores, including standard deviations, across time for the Positive Scale are presented in Table 6. From Table 6 it can be seen that group mean scores on the Positive Scale of the PANAS increase across time.

Table 6

PANAS Group Mean Scores and Standard Deviations Across Time for the Positive Scale.

Time	*M*	*SD*
B1	24.71	6.13
B2	24.86	9.40
B3	28.20	4.31
Week 1	27.57	6.48
Week 2	23.14	8.41
Week 3	26.43	8.47
Week 4	26.00	8.09
Week 5	26.14	7.32
Week 6	28.00	6.61
Week 7	31.14	6.53
Week 8	28.43	8.81
Week 9	26.43	7.29
F1	27.86	7.04
F2	28.14	8.82

Note: Abbreviations – B1 (pre-treatment), B2 and B3 (baseline), F1 (1-week post-treatment), and F2 (5-week follow-up assessment).

The group mean scores and standard deviations across time for the Negative Scale of the PANAS are presented in Table 7.

Table 7

PANAS Group Mean Scores and Standard Deviations Across Time for the Negative Scale

Time	*M*	*SD*
B1	26.29	9.00
B2	25.29	6.65
B3	23.80	5.42
Week 1	23.86	6.73
Week 2	22.14	6.94
Week 3	17.00	4.84
Week 4	19.71	8.70
Week 5	21.57	9.48
Week 6	20.71	9.88
Week 7	17.00	6.46
Week 8	16.29	6.39
Week 9	17.71	6.56
F1	16.29	5.34
F2	18.57	6.80

Note: Abbreviations – B1 (pre-treatment), B2 and B3 (baseline), F1 (1-week post-treatment), and F2 (5-week follow-up assessment).

From Table 7 it can be seen that group mean scores on the Negative Scale of the PANAS decrease across time.

The PANAS group mean scores across time are graphically depicted in Figure 18. Abbreviations on the weekly assessment axis of Figure 4 relate to B1 (pre-treatment), B2 and B3 (baseline), F1 (1-week post-treatment), and F2 (5-week follow-up assessment). As can be seen clearly from Figure 18, there is a trend toward an increase in positive symptoms and a decrease in negative symptoms within the group of participants.

Effect size was calculated for both PANAS scales. A moderate effect size of 0.48 (*SD* = 7.11) is observed for the Positive scale, and a large effect size of 1.03 (*SD* = 7.47) is noted for the Negative Scale.

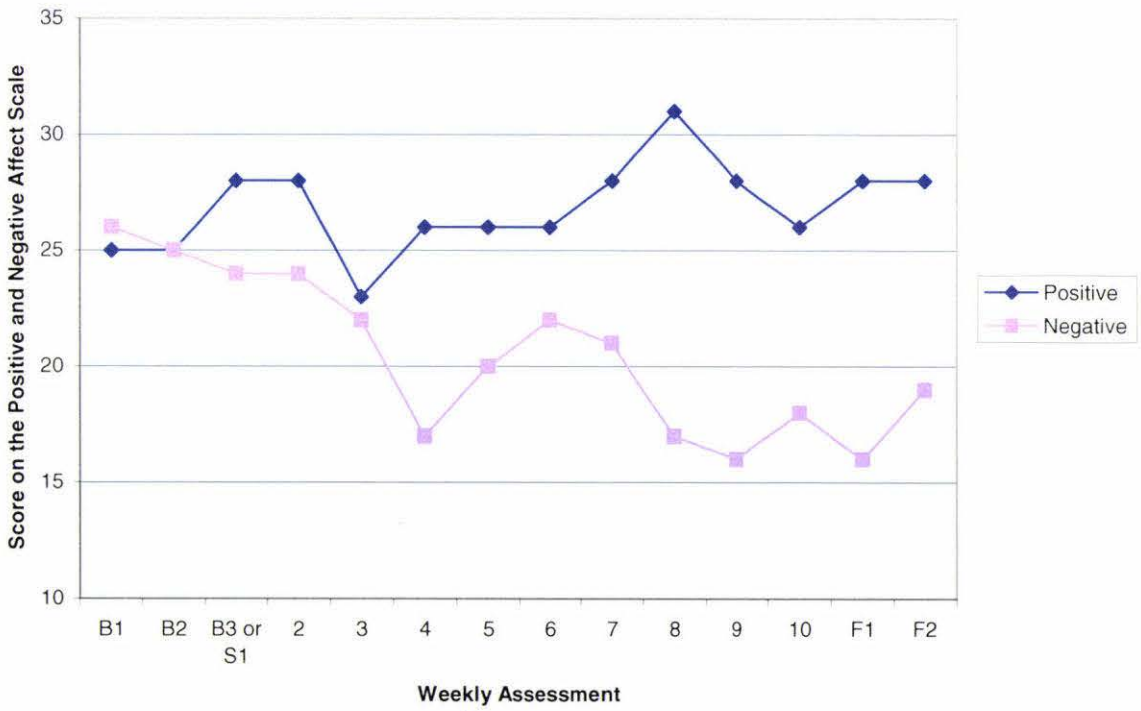

Figure 18. **Positive and Negative Affect Schedule (PANAS) group mean scores pre-treatment, during baseline and treatment, and 5-week follow-up.**

3.4 Individual PANAS Profiles Across Time

Participants' changes in their scores on the PANAS are displayed in Figures 19 – 25. Abbreviations on the weekly assessment axis of the figures relate to B1 (pre-treatment), B2 and B3 (baseline), F1 (1-week post-treatment), and F2 (5-week follow-up assessment).

It was proposed that participants would show decrease in psychological distress associated with their disorder during and following treatment, but would not show improvement on the same measure during baseline. As previously mentioned, owing to time constraints and participants' wishes, the planned varying lengths of baseline could not be implemented.

Baseline scores on the PANAS were not as stable as expected. However, as treatment was introduced, there was an upward trend in positive affect, for most participants. In contrast, participant 5 (Figure 23) displayed high negative affect and low positive affect during early sessions of treatment. Although, as treatment progressed negative affect started to decrease and positive affected started to increase. It is important to note that for participants' 1 and 4 the weekly assessment data point at baseline 3 is missing, owing to participants' 1 and 4 not completing these forms as required.

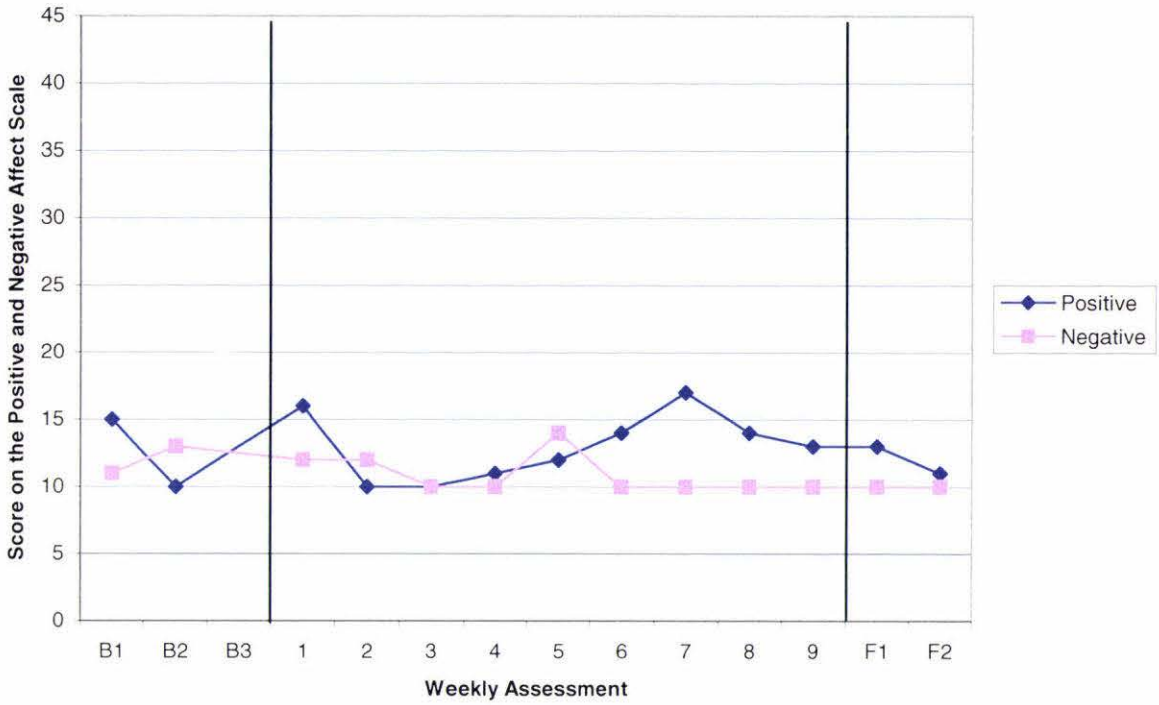

Figure 19. **Scores on the Positive and Negative Affect Schedule (PANAS) across assessment and treatment sessions for participant 1.**

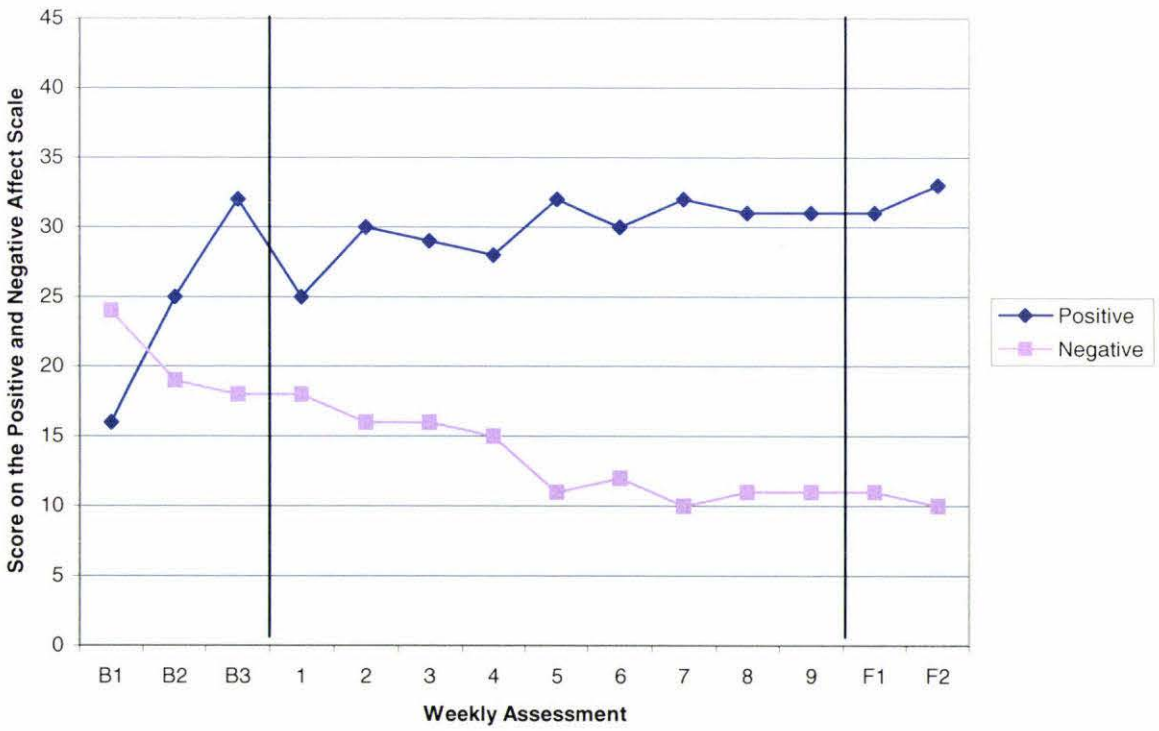

Figure 20. **Scores on the Positive and Negative Affect Schedule (PANAS) across assessment and treatment sessions for participant 2.**

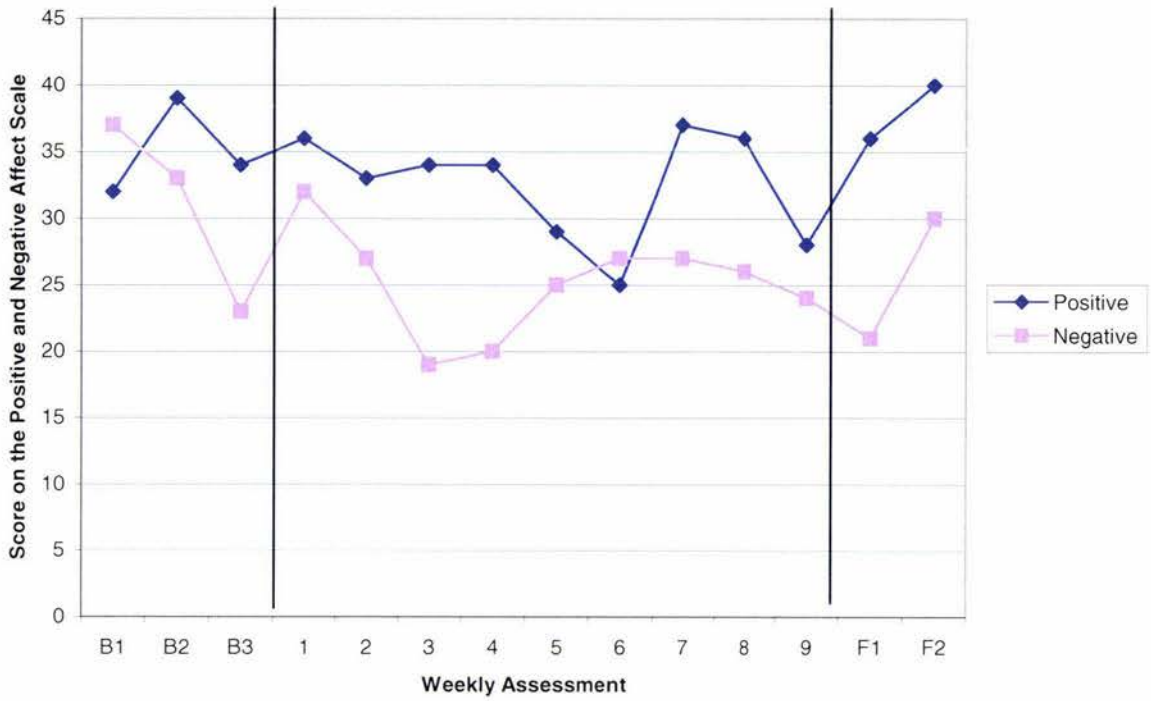

Figure 21. **Scores on the Positive and Negative Affect Schedule (PANAS) across assessment and treatment sessions for participant 3.**

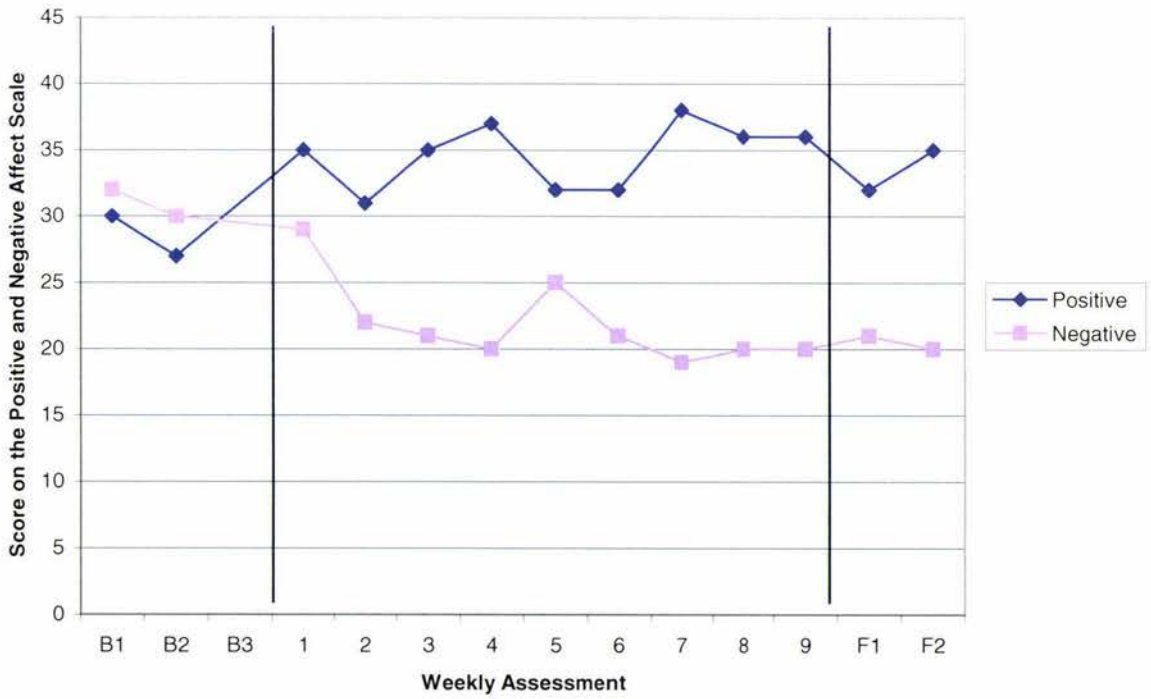

Figure 22. **Scores on the Positive and Negative Affect Schedule (PANAS) across assessment and treatment sessions for participant 4.**

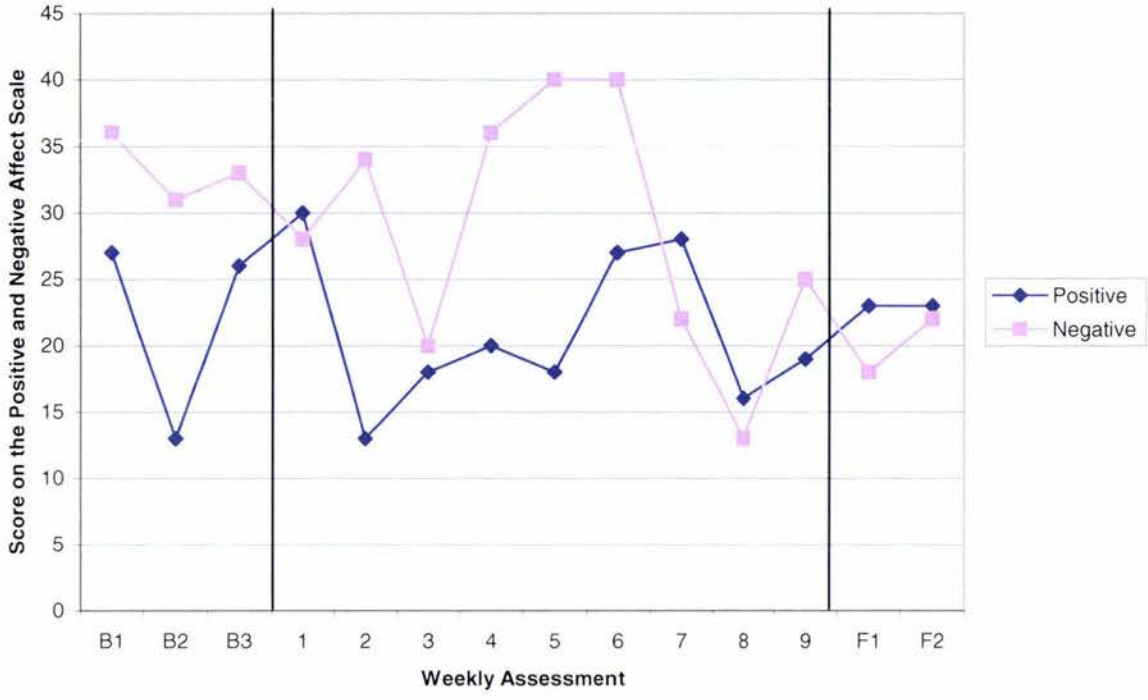

Figure 23. **Scores on the Positive and Negative Affect Schedule (PANAS) across assessment and treatment sessions for participant 5.**

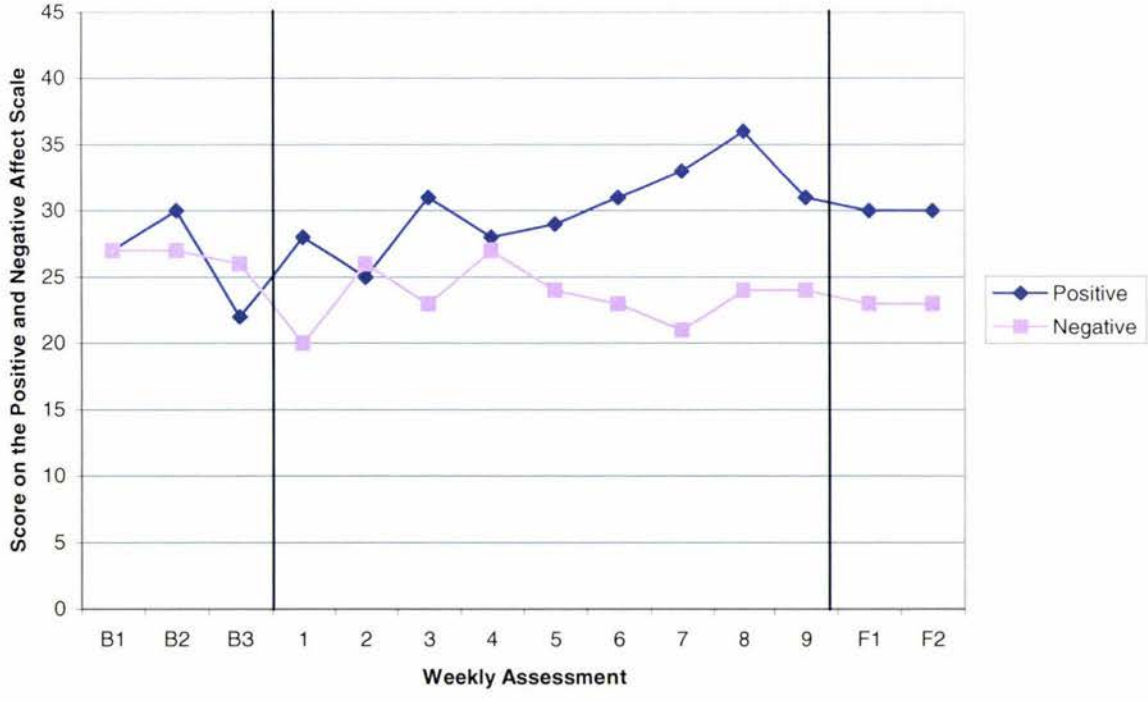

Figure 24. **Scores on the Positive and Negative Affect Schedule (PANAS) across assessment and treatment sessions for participant 6.**

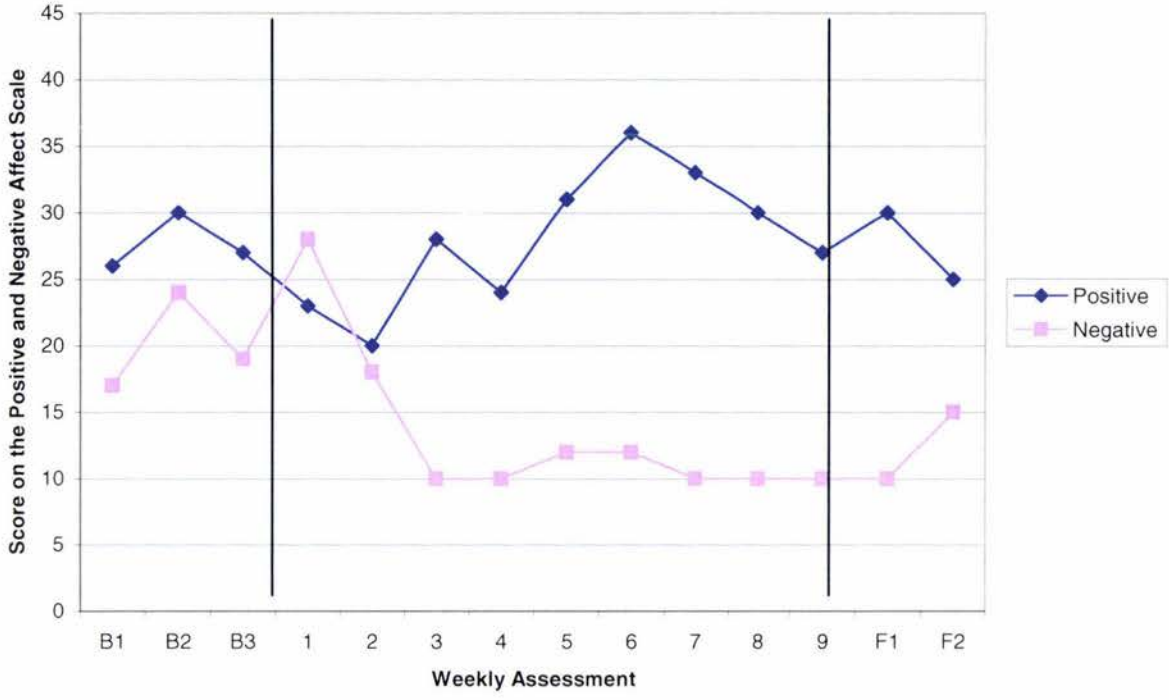

Figure 25. **Scores on the Positive and Negative Affect Schedule (PANAS) across assessment and treatment sessions for participant 7.**

CHAPTER 4. DISCUSSION

4.0 Summary of the Findings

Overall, the results of the present study provide support for the effectiveness of the 10 session, manualised, generic combination CBT intervention (EVoLVE Therapy; Gillingham, 2004) used in this study. EVoLVE Therapy appears effective in reducing the psychological distress experienced by the participants involved. In addition, EVoLVE Therapy also appeared promising in producing the secondary effect of actually reducing the symptoms of these types of disorders. Further, 6 out of the 7 participants that completed treatment reported an improved quality of life after completing EVoLVE therapy, with the remaining participant reporting a relatively unchanged quality of life from pre-treatment to post-treatment. Multi-method assessment using a semi-structured interview, and a number of self-report measures, showed favourable outcomes for most participants from pre-treatment to post-treatment.

The goal of the interventions included in this study, consistent with ACT, was essentially to change participants' relationships with their thoughts and symptoms rather than to change their frequency of occurrence (Bach & Hayes, 2002). It was envisaged that the ACT components of the present treatment would result in participants having a decreased, literal belief in their thoughts. It was hoped that this would result in reduced psychological distress as well as an increased acceptance of their thoughts and symptoms, which in turn would lead to a reduction in negative emotions. And finally, this overall positive change in behaviour would then lead to a reported improved quality of life.

The chief means of data evaluation in single case methodologies is visual inspection (Kazdin, 2003). Therefore, visual inspection of the results was used to compile the following summary.

Taken as a whole, the results from this study support our initial hypotheses. Participants demonstrated a small improvement in positive emotional functioning and notable reductions in psychological distress and psychopathological symptoms. Further, 6 out of 7 participants reported an improved quality of life.

Group mean data showed that psychological distress and psychiatric symptoms, as measured by the BPRS (see Figures 7 and 8) and the BSI (Figure 9), reduced across all dimensions from pre-treatment to post-treatment, and were maintained at 5-week follow-up. Of note was the improvement shown on the group mean anxiety/depression factor and the large clinical change for the group mean total score on the BPRS. Further, a large group treatment effect (Cohen's *d*) was observed on the BPRS, and moderate to large treatment effects were noted on the BSI. Therefore, the hypothesis that psychological distress and psychotic-type symptoms would decrease following treatment, and be maintained at follow-up, was supported.

Group mean scores on the PANAS (Figure 18) showed a slight increase in positive affect, (with a moderate treatment effect size of 0.48 being observed from pre-treatment to 5-week follow-up), and a larger decrease in negative affect (effect size of 1.03). Hence, the hypothesis that clients would evidence an increase in positive affect by the end of treatment was moderately supported while the hypothesis that negative affect would

decrease was well supported. Although, there was a noticeable increase in overall mean positive affect in the group during weeks six through to eight, which coincided with the mindfulness component of the therapy. Perhaps, as proposed by Fredrickson (2000), mindfulness helped create conditions for the positive emotion of contentment to develop; as a result, positive affect increased.

Interestingly, during the same period (week six through to eight of therapy), overall mean negative affect decreased noticeably. As previously mentioned, mindfulness was also included as a strategy to reduce stress, by way of having the client focus attention on the present moment and thereby reduce the stress associated with thinking about the past and worrying about the future. The noted reduction in negative affect could be the result of this reduction in stress.

A possible explanation to account for the fact that positive affect only slightly increased, in comparison to the larger decrease noted for negative affect, is that EVoLVE Therapy was oriented more to reducing negative experiences in our clients' lives – for example, reducing stress, fear, anxiety, and other psychological distress; and the negative effects of using unhelpful control strategies. That is, the therapy was focused on reducing negative affect. Comparably, a smaller component of EVoLVE Therapy was directly involved in increasing positive affect.

This study also demonstrated that participants evidenced an improved quality of life over the course of treatment, as measured by the SQLS-R4 (6 out of 7 participants reported an improved quality of life, while the 7th participant reported no change in quality of life).

These improvements were also maintained at 5-week follow up. Large effect sizes were noted for both the Psychosocial Domain (1.37) and the Vitality Domain (1.12), and the Total SQLS-R4 score (1.34). Hence, the hypothesis proposing that clients would experience an improvement in overall quality of life was supported. Indeed, there was a notable decrease in the Psychosocial Domain score during treatment, on the quality of life measure used. Over the course of therapy, it is probable that the reductions in psychological distress – worry, fear, paranoia, and negative affect – and the improvements in social relationships (as measured by items on the SQLS-R4), translated into the improved psychosocial functioning noted.

Qualitative information collected from the therapists during this study indicated that most participants at the start of the therapy took their thoughts literally and found them extremely distressing. Prior to treatment, they indicated that they used a number of avoidance strategies, such as thought suppression and distraction, in an effort to avoid the fear and discomfort associated with disturbing thoughts and internal experiences.

Indeed, one participant (participant 7) reported that she had always taken her thoughts as "truths" to be believed or acted upon, and, given that these thoughts centred on suicide, she had found her thoughts extremely frightening and distressing. Toward the end of therapy, after being introduced to ACT techniques, she disclosed that she had been settling down to practice ACT techniques one evening and had found herself thinking "come on thoughts, bring it on". Participant 7 is notable for her reliable clinical change (decrease) on the Anxiety/Depression Factor of the BPRS (Figure 6), and the decrease in symptom severity – from high symptom severity to an average/slightly above average

range – on most Primary Symptom Dimensions of the BSI (Figure 16). Her PANAS profile (Figure 25) shows a similar trend to the group mean, in that she experienced a noticeable increase in positive affect during the mindfulness work. Negative affect decreased during treatment. Most importantly, participant 7 reported an improvement in her overall quality of life (see Table 5).

Another participant (participant 6), who had a diagnosis of paranoid schizophrenia and lived in supported accommodation, similarly began to realise that his thoughts about what other people might be thinking about him were not facts to be taken literally and acted upon. Consequently, he reported that he began to accept his thoughts, symptoms and experiences without fighting with them (which in the past he admitted had been very draining). He went on to enthusiastically identify his values and goals; and, he reported at follow-up that he had started to work toward his goals. Of note, is participant 6's reliable clinical change on the Anxiety/Depression Factor of the BPRS (Figure 6), the reduction in Phobic Anxiety on the BSI (Figure 15), and the increase in positive affect and reduction in negative affect (PANAS profile – Figure 24) he experienced during treatment. However, these seemingly positive changes did not translate to an improved quality of life for Participant 6 (see Table 5) – being the only participant who reported no improvement in quality of life, as measured by the SQLS-R4.

Participant 3 reported finding the vulnerability-stress model and the normalising rationale component of EVoLVE Therapy particularly useful, having never had his mental illness explained in this way before. Correspondingly, participant 3 appeared to experience a decrease in negative affect during the early stages of therapy (PANAS profile – Figure

21). He showed an overall decrease in negative affect throughout treatment, although overall positive affect, while fluctuating somewhat, remained relatively unchanged. Pre-treatment, participant 3 had the highest Total BPRS score (Figure 2) and then experienced the largest clinical change between pre-treatment and post-treatment, which was maintained at follow-up. Of particular note for participant 3 is the reliable clinical change shown on the BPRS Thought Disturbance Factor score. Indeed, toward the end of therapy, participant 3 reported feeling less distressed by his thoughts and feelings.

Participant 2 responded well to EVoLVE Therapy. Like participant 3, he engaged well with the vulnerability-stress model. Notable was participant 2's decrease on the Anxiety/Depression Factor score (Figure 6), and the decrease in nearly all Primary Symptom Dimensions and Global Indices of the BSI (Figure 11) – although, none of these were particularly high at pre-treatment. Participant 2 reported a large improvement in quality of life at post-treatment.

Participant 4 also responded well to EVoLVE Therapy – in particular her paranoid ways of thinking decreased during therapy. Similar to participant 6, she reported her realisation that her thoughts about what other people might be thinking about her were not facts to be taken literally. Notably, her Paranoid Ideation score on the Primary Symptom Dimensions of the BSI, representing paranoid behaviour, reduced from above average to the average range at post-treatment.

Participant 5's BPRS Total scores (Figure 2), BSI profile (Figure 14), and reported slight improvement on the quality of life measure (Table 5), indicated a slight reduction in

psychological distress and symptomatology throughout treatment. Her PANAS profile (Figure 23) showed high levels of negative affect at pre-treatment, however, by the end of treatment her level of negative affect had dropped considerably. Interestingly, similar to other profiles, negative affect began to drop during the mindfulness work, which participant 5 also reported she found a useful strategy. Overall, positive affect remained relatively unchanged.

Participant 1's scores on the PANAS (Figure 19) resulted in a rather flat profile. This could indicate under-reporting, although, scores on other measures completed by participant 1 do not show this pattern. Participant 1 reported to the assessor at the pre-treatment assessment that he was feeling quite depressed; he reported to his therapist, as therapy progressed, that his depressed mood was beginning to improve (reflected in his Anxiety/Depression Factor score on the BPRS – see Figure 6). His depressed mood may account for his seemingly flat affect, as measured by the PANAS.

As the use of a combination therapy using CBT and ACT components is an empirically new research area, little data is available for comparison. Although, as previously mentioned, there are numerous studies showing the efficacy of CBT techniques in the treatment of psychotic-type disorders, and ACT can be referred to as a CBT-based intervention (Hayes et al., 1999). Further, a recent study using ACT to prevent the rehospitalisation of psychotic patients (Bach & Hayes, 2002) provided promising results. Finally, a number of recent studies – still under manuscript review – using ACT for people diagnosed with psychotic-type disorders also produced promising results (Empirical Studies on ACT, ACT Components, or ACT Processes, 2004).

Therefore, the results of the present study add weight to the usefulness of a combination CBT and ACT intervention for people diagnosed with psychotic-type disorders. And, these positive findings highlight the potential for relatively inexperienced therapists to be involved in the delivery of manualised treatments, such as EVoLVE Therapy, to long-term consumers of mental health services who have been diagnosed with a serious and persistent psychiatric disorder. However, it must be remembered that the therapist's involved in the delivery of the treatment used in the present study had received specific training in the use of the manual, and were extensively supervised throughout the therapy process.

The development of a brief combination CBT and ACT approach such as this, which has been shown to be effective both in terms of outcome and cost of delivery, might persuade those in mental health management in New Zealand to routinely offer this kind of treatment to those that are often not afforded the opportunity to receive individual psychotherapy. Indeed, in New Zealand most treatment for psychotic-type disorders involves antipsychotic medications, acute inpatient care in a psychiatric unit if required, and then community-based care, usually managed by care-workers, psychiatric nurses, and/or GP's. Specific interventions delivered in community care typically involve group-based work. There appears to be little opportunity for empirically validated individual psychotherapy.

The findings of the present research have important implications for theory, research and practice, in that this research adds support to the idea that individual psychotherapy should be more readily available to long-term consumers of mental health services who

have a serious and persistent psychiatric disorder. Consistent with cognitive-behavioural principles and assumptions, treatment in the present study focused on the interaction between thoughts, feelings, behaviours, bodily sensations, and the environment, and interventions to create new learning experiences that would help overcome former unhelpful ways of being. In addition, consistent with acceptance and commitment theory, treatment used an experiential approach to behaviour change and was targeted at encouraging acceptance of unwanted experiences by dispensing with control strategies, and a move toward committing to a valued existence. The positive outcomes achieved in the present study provide support for formulating and treating psychotic-type disorders within a cognitive-behavioural, and acceptance and commitment, framework.

The combination of CBT and ACT led to a reduction in psychological distress experienced by the participants; produced the secondary effect of reducing the symptoms themselves; and, in 6 out of the 7 participants, there was an improvement in their subjective report of quality of life.

4.1 Limitations of the Present Study

The results of the present study are limited in a number of ways. The generalisability of the results may be limited owing to the small sample size; seven participants is simply too small a number to generalise from. Hence, the results of the present study must be viewed as preliminary evidence only of EVoLVE Therapy's efficacy.

Also, it would have been preferable that the design of the study had been multiple baseline across participants (although this design also has its limitations), so as to ascertain more clearly that it was the introduction of the treatment that produced change, not some other variable. Owing to time constraints, all participants in the study had a two-week baseline period; therefore, it is difficult to compare across participants whether change began to occur with the introduction of the treatment. Had the study been able to utilise varying lengths of baseline across participants, change coinciding with the introduction of treatment would have been easier to identify, and increased the accuracy of the results.

Further, owing to the multiple treatment components in the present study, it was not possible to determine which treatment elements were active in bringing about change. The present intervention was not only multi-faceted, but it also combined two specific, empirically validated methods of treatment. For example, treatment components in the present study included traditional cognitive and behavioural techniques – such as understanding problems using the 5-Part Model, decatastrophising catastrophic cognitions, psychoeducation, sleep hygiene, and relaxation training – and experiential exercises based on ACT theory (namely, acceptance, mindfulness, and determining values and goals). It will be difficult to determine what techniques were the most effective in bringing about change and the relative contribution of these. Nonetheless, it is important to determine the active components of EVoLVE Therapy so that the intervention can be developed to further improve treatment delivery and efficiency.

Furthermore, as most participants in the study had ongoing contact with their psychiatrist/GP, were on medication and/or taking herbal supplements, and had contact with other support people and care-workers throughout the study period, there was the potential for multiple treatment interference. However, as previously mentioned, given the multiple service needs of people with a serious and persistent psychiatric disorder, single treatment modalities would generally not provide sufficient support and treatment for this group.

Next, one of the strengths of this study was the high completion rate (there was only one participant who dropped out); on the other hand, this could also be considered a methodological limitation. The participants in the study were free to choose to participate in this study and free to leave at any time, therefore, it could be said that this group were highly motivated, willing, and had sufficient insight to engage fully in the treatment process. Less motivated clients may produce less positive results. For all that, the participants in the present study could be regarded as "worse bet" candidates for therapy, as they had been experiencing psychological distress and symptoms of psychotic-type disorders for many years and had not responded to traditional methods of treatment (Bentall et al., 1994, p. 63).

Another limitation of the present study is the use of a schizophrenia-specific measure to assess quality of life (that is, the SQLS-R4), rather than a generic quality of life measure normed on other serious and persistent psychiatric disorders, especially psychotic-type disorders. As previously mentioned, there is a paucity of appropriate quality of life

measures and it was felt that the items in the SQLS-R4 had high face validity, and the items were pertinent, for the participants in this study.

A further limitation in the present study is with regard to the length of the individual therapy sessions. The standard therapy hour in most adult outpatient settings runs for 50-60 minutes. In the present study, therapy sessions usually ran to approximately 75 minutes. Therefore, transferring EVoLVE Therapy to outpatient settings may be problematic given its current session duration of over one hour. It is envisaged by the author that EVoLVE Therapy will be slightly modified before further research is carried out, and session length will be high on the agenda for modification.

Finally, a major limitation of the present study is the absence of a control condition. The lack of a control group limits the conclusions we can draw from the results, as we don't know if the improvement seen was not due to placebo factors.

4.2 Recommendations for Future Research

The present research is a preliminary study to determine the efficacy of the individual, manualised psychotherapy (EVoLVE Therapy), combining CBT and ACT techniques, used in this study. The intention is to carry out further research on EVoLVE Therapy; therefore, the recommendations for future research to be discussed are specifically aimed at providing direction for this future research.

First, future research studies need to focus on issues of generalisability of the current findings to other ethnic groups. Given that there are considerable differences among different ethnic groups regarding mental illness and psychotic experiences (Al-Issa, 1978; Bentall et al., 1991; Bourguignon, 1970; British Psychological Society, 2000), it is important that interventions are culturally appropriate and fit with the clients' ethnic and cultural background. Hence the importance of having cultural supervision to identify those clients that may require, or benefit from, specific cultural components; and the importance of having experienced cultural consultants who can provide this specialised input.

The second recommendation is that future research could use larger sample sizes, and include group comparison and factorial designs. Randomised controlled trials, with wait-list control groups (an ethical obligation given the apparent success of this pilot study), are needed so that moderating variables may be identified and comparison across participants who differ in several features – for example, gender, age, and ethnicity – can be made.

Third, as previously mentioned, future research could investigate which treatment components were active in bringing about change. As noted above, it will be a difficult job to ascertain the critical components of therapeutic change, but a necessary one; so that EVoLVE Therapy can be improved and made even more effective and efficient in bringing about change.

Further, it will be important for future research to ascertain the durability of treatment gains by ensuring longer intervals for follow-up assessments. The present study showed that, at least in the short-term, the effects of treatment appeared durable. However, owing to time constraints in the present study, the follow-up period of 5 weeks is short, and there is no information on the durability of the effects noted in the study in the medium or long-term. Follow-up assessments of at least 12 months should be aimed for when carrying out doctoral level research (K. R. Ronan, pers. comm., 24.10.04). In addition, the inclusion of 'booster' sessions may add to the maintenance of clinical improvement (Hall & Tarrier, 2003), and should also be a consideration in future research.

The next recommendation for future research involves investigating the effectiveness of involving participants' families in the treatment process. While effective individual treatments are considered important for this population, as discussed in the introduction, family involvement in therapy could enhance treatment outcomes. For example, treatment components such as psychoeducation could help confused family members understand their loved ones psychiatric illness better; families may be able to reinforce and support in-session work outside of the session; and, family members may be able to support the client in understanding and accepting unwanted experiences and helping them work towards living a valued existence. Given that a large number of people diagnosed with a serious and persistent psychiatric disorder often have high levels of parental support and involvement, it would be interesting to see if families involvement in therapy made a difference to treatment outcomes.

Another recommendation is that future research needs to investigate the ideal time duration of each session to ensure the intervention can be easily transferred to outpatient settings; and to ensure the intervention meets both the requirements of effective treatment, and cost and time effectiveness issues (Girling-Butcher, 2000).

Finally, future research could investigate the efficacy of introducing this treatment approach at the prodromal, and first episode/early psychosis stage of illness. Given the success of the treatment used in the present study with chronic clients, and the success of an ACT study preventing rehospitalisation in both recent onset and chronic clients (Bach & Hayes, 2002), consideration should be given to trialling this therapy with recent onset psychosis in an effort to prevent the long-term consequences of psychosis. Indeed, early psychosis intervention may lessen the long-term social and occupational consequences of suffering from a psychotic-type disorder.

4.3 Conclusion

Despite the limitations noted above, EVoLVE Therapy appears to result in reliable clinical change in terms of reducing psychological distress and symptomatology, and improving subjective quality of life in psychotic populations. Recent emergent CBT-based techniques used in EVoLVE Therapy, such as acceptance and mindfulness, are treatments in their infancy. With the promise shown in this study, further research using these interventions for people diagnosed with a serious and persistent psychiatric disorder, addressing the limitations mentioned above, would be highly beneficial.

At the same time, given the multiple service needs and social support that people diagnosed with a psychotic-type disorder require, quality care must focus on providing an easily accessible, integrated, multiple treatment approach.

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APPENDICES

Appendix A – DSM-IV Criteria for Schizophrenia

DSM-IV (APA, 1994) criteria for a diagnosis of schizophrenia:

A. *Characteristic symptoms:* Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
   (1) delusions
   (2) hallucinations
   (3) disorganized speech (e.g., frequent derailment or incoherence)
   (4) grossly disorganized or catatonic behavior
   (5) negative symptoms, i.e., affective flattening, alogia, or avolition
   Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. *Social/occupational dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, inter-personal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6 month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. *Schizoaffective and Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. *Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Classification of longitudinal course (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms):

Episodic With Interepisode Residual Symptoms (episodes are defined by the reemergence of prominent psychotic symptoms); a/so specify if: **With Prominent Negative Symptoms**
Episodic With No Interepisode Residual Symptoms Continuous (prominent psychotic symptoms are present throughout the period of observation); *also specify if:* **With Prominent Negative Symptoms**

Appendix B – Memorandum of Understanding

(Massey letterhead)

MEMORANDUM OF UNDERSTANDING

18/2/2004

BETWEEN THE SCHIZOPHRENIA FELLOWSHIP (SF) MANAWATU (hereinafter referred to as "the SF Manawatu")

AND THE CBT AND SCHIZOPHRENIA RESEARCH PROGRAMME, MASSEY UNIVERSITY – CO-ORDINATED BY RUTH GILLINGHAM (hereinafter referred to as "the Research Programme")

RECITAL

IN recognising that the SF Manawatu and the Research Programme have separate missions and standards,

AND acknowledging that each party brings to its respective tasks valuable expertise and resources,

AND acknowledging full co-operation between both parties at all levels as essential to ensure the co-ordinated, effective and efficient delivery of the Research Programme to meet the needs of consumers who are undertaking treatment.

BOTH PARTIES AGREE TO THE FOLLOWING:

1 INTRODUCTION

1.1 The following matters are agreed in principle between the SF Manawatu and the Research Programme to give guidance to SF Manawatu staff, and the supervising registered clinical psychologists (and their post-graduate students) administering the Research Programme.

2 RESPONSIBILITIES

2.1 The SF Manawatu agrees to the following to assist the Research Programme:

- Obtain funding for the Research Programme, for a total of 15 consumers.

- Recommend 15 suitable consumers for the Research Programme as described in the executive summary for this project.
- If possible, for the comfort of consumers, make available recreation space for the initial meeting between consumers and therapists, make available an office for the screening interviews and assessments of potential research participants, and an office for follow-up sessions with consumers/families.

2.2 The Research Programme agrees to the following:

- Conduct the Research Programme in accordance with the ethical principles of the New Zealand Psychological Society, and other relevant agencies e.g Midcentral Health.
- Deliver a formal protocol of 10 one-hour sessions to each consumer, typically occurring on a weekly basis depending on individual schedules. Each session being an individual psychotherapy session based on the latest CBT principles.
- Conduct the Research Programme within a calendar year, with the majority of the individual psychotherapy for the 15 consumers conducted between 1st August 2004 and 1st November 2004.
- Keep all sessions and issues discussed confidential, unless it is felt that there is a threat to the consumer's safety in any way and then additional supports will be requested.
- Ensure that the data collected for the purpose of research remains confidential and anonymous.

3 CHARGING FOR SERVICES

3.1 The cost to consumers will be $30 per individual psychotherapy session, paid as a one-off payment of $300 per consumer at the start of treatment. As previously mentioned, funding for the Research Programme to be sourced by SF Manawatu.

4 AMENDMENT VARIATION

4.1 The parties agree that these understandings may be amended or varied by mutual agreement between parties in writing.

By signing this partnership agreement both parties agree to be active partners and agree to abide by this agreement.

Signed by: .....
On behalf of the SF Manawatu

Signed by: .....
On behalf of the Research Programme

Appendix C – Information sheet for participants

(Massey Letterhead)

Schizophrenia Cognitive-Behaviour Therapy Research Programme

Information Sheet for Participants

This research is being carried out by Ruth Gillingham, under the supervision of Dr Patrick Dulin, as part of her Master of Arts degree in Psychology at Massey University. Ruth has been accepted into the Clinical Psychology Programme at Massey University, and will begin her formal training to become a clinical psychologist in 2006. Ruth can be contacted on 09 4327000; and Dr Patrick Dulin, Massey University, telephone 06 3505196 ext. 2060.

What is this research about?
This is a research programme involving individualised therapy for 10 weeks for people diagnosed with schizophrenia or other psychotic disorders that are currently on medication, and under the care of a key mental health worker, but are still experiencing some distress from their symptoms. The purpose of this pilot study is to determine how effective the individualised 10-week cognitive-behavioural intervention will be. This treatment is based on much longer treatment programmes, which have been shown to be successful in a number of overseas studies.

If you agree to participate in this study you will help us in the process of identifying whether cognitive-behavioural techniques are successful and efficient therapy interventions for people diagnosed with psychotic disorders in New Zealand. These findings will be helpful to you, to Schizophrenia Fellowship (SF) New Zealand, and to other people that might be having similar problems to you.

What would you need to do?
If you agree to participate in this research programme you will need to attend a one-and-a-half hour assessment meeting to see whether this therapy programme is suitable for the kinds of problems you are experiencing. This assessment meeting will involve filling out some forms and answering some questions about your problems. If it is found that this therapy is unlikely to help you with your problems, you will be encouraged to consult with your case manager about more appropriate services.

The assessment sessions will be carried out by Renee Seebeck. Renee is a PhD student, a graduate teaching assistant and training to be a clinical psychologist, at the School of Psychology, Massey University, Palmerston North. Postgraduate students who are in training to become professional psychologists will provide treatment. Experienced registered clinical psychologists who are on the staff of the Psychology Clinic and the School of Psychology will provide training, and close supervision, of these postgraduate students. You will meet your therapist at the initial assessment meeting.

During the initial assessment process you will be asked to provide written consent to allow the researcher to contact your GP/clinician to obtain their agreement for you to participate in the research.

After the assessment process, treatment will involve attending a one-hour cognitive-behavioural treatment session per week, for 10 weeks, aimed at helping you to learn new skills, helping you to manage stressful events, and helping you to live with, and become more accepting of, unpleasant feelings and experiences. In addition to this 10 week time period, you will be invited to take part in two one-and-a-half hour assessments (immediately after the treatment and then again at five weeks after the treatment) where you will be asked to complete more forms, to see how successful the treatment has been. You may bring a support person to any of the sessions, as long as that support person is willing to cooperate with the overall research programme.

Schizophrenia Fellowship (SF) Manawatu are supportive of this research programme, and are actively seeking funding for 15 participants, so that this treatment will be provided free of charge to all participants. Assessment meetings will take place at the SF Manawatu offices (3rd Floor Ansett House, 16 Broadway Avenue, Palmerston North) and all treatment will take place at the Massey University Psychology Clinic (Turitea Campus, Palmerston North).

What will be done with the information you provide?
Assessment and treatment will be audio- and or video taped, if your prior consent is given, for supervision purposes. These audio- and videotapes will be destroyed at the completion of the research programme. All personal information you provide will remain completely confidential to the researchers. All records will be identified by code number, will only be seen by those directly involved in the study (the researcher, her supervisor, a trained assessor completing the assessments, and trained research therapists), and will only be used for the purposes of this research. It will not be possible to identify individuals in any reports of the results. If you withdraw from the research at any time but wish to continue receiving treatment, all information collected for treatment purposes after withdrawal, will be excluded from the research.

On completion of this research project, there is a requirement that information be retained for 5 years and then destroyed.

If you are interested in the outcome of this research you will be sent a summary of the findings.

The information collected will only be used for this research and any publications arising from this research project.

What are your rights as a participant?
Your rights as a participant are:

- To know that participation in this research is entirely voluntary;
- To decline to participate in the study and withdraw from the study at any time;
- To refuse to answer any questions;
- To withdraw consent at any time to have assessment or treatment sessions audio- and or videotaped;
- To ask for the audio/video tape to be turned off at any time during the interview;

- To withdraw from the actual research at any time, and still be able to continue receiving treatment from the research programme;
- To ask questions, and have these answered, about any aspect of the study at any time during participation in the study;
- To provide information on the understanding that your name will remain confidential, unless you give permission to the researcher;
- To have your confidentiality protected;
- To be given access to a summary of the findings when the study has been concluded.

If you are interested in taking part in this research please let Christine Zander know at the SF Manawatu Office, 3rd Floor Ansett House, 16 Broadway Avenue, Palmerston North, or phone Christine on 06 355 8561. Christine is acting as liaison person for Ruth Gillingham, who lives out of Palmerston North.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Application 04/97. If you have any concerns about the conduct of this research, please contact:

Professor Sylvia V Rumball, Chair
Massey University Campus Human Ethics Committee
Palmerston North.
Telephone 06 350 5249,
E-mail humanethicspn@massey.ac.nz

In addition, this project has been reviewed and approved by the Manawatu/Whanganui Ethics Committee, M/W Ethics Register: 04/08/030.

Contact:
Sheryl Kirikiri
Administrator
Manawatu/Whanganui Ethics Committee
Telephone 06 350 8199
E-mail centralethics@xtra.co.nz

Appendix D – Assessor's Confirmation of Participant's Ability to Provide Informed Consent Form

Schizophrenia Cognitive-Behaviour Therapy Research Programme

Assessor's Confirmation of Participant's Ability to Provide Informed Consent Form

I, _____(assessor's name), have carried out an initial brief screening interview with_____ (participant's name) and, based on the information provided to me by the participant and my own assessment, I confirm that the above participant is able to give informed consent to participate in the research.

Assessor's signature: _____

Date: _____

Appendix E – Research Consent Form

(Massey letterhead)

Schizophrenia Cognitive-Behaviour Therapy Research Programme

Research Consent Form

I have read the Information Sheet version 2 dated Aug 2004 and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to provide the name and contact details of my GP/clinician to the researcher.

I agree that the researcher can contact my GP/clinician to obtain their agreement for me to participate in this research.

I agree/do not agree to my GP/clinician being informed of my individual results.

I understand that this therapy will not interfere with any other ongoing treatment.

I agree/do not agree to the initial assessment session and follow-up session being audio taped. The audio tapes will be kept secure at The Psychology Clinic and on completion of the study they will be erased.

I agree/do not agree to the treatment sessions being video taped. The video tapes will be kept secure at The Psychology Clinic and on completion of the study they will be erased.

I realise that the audio/video tapes will not be returned to me at the conclusion of the study.

I agree/do not agree to written information about me being stored in a secure research archive.

I also understand that I have the right to withdraw from the study at any time and to decline to answer any particular questions in the study.

I agree to provide information to the researchers on the understanding that it is totally confidential – as set out in the information sheet – and that my name will not be used without my permission. *(The information will be used only for this research and publication arising from this research).*

I agree to participate in this study under these conditions and those set out in the Information Sheet.

Signature_____ **Date**_____

Full Name – Printed _____ **Code**_____

Appendix F – My Contract Form

(Massey letterhead)

Schizophrenia Cognitive-Behaviour Therapy Research Programme

My Contract

I _____ have chosen to participate in Ruth's Cognitive-Behaviour Therapy Research Programme at The Psychology Clinic. This treatment programme is designed to help me with the ongoing difficulties I have, associated with a psychotic disorder.

I understand this treatment programme is:

- Time limited.
- For 10 sessions over a 10 week period.
- In addition to any other treatment I might be receiving.

I will continue to:

- Remain with my key mental health worker's.

I understand that the treatment programme:

- Is in addition to my current mental health treatment and is not a substitute for it.

I agree to continue with my current mental health treatment and medication.

Client's signature _____

Ruth's signature _____

Sociodemographic Questionnaire

Name:

Address:

Phone number:

Date of Birth: Age:

Ethnicity:

Marital Status:

Years of education: Employment Status:

G.P: G.P's Ph. No.:

Other health professional: Ph. No.:

Case Manager/Health Worker: Case Manager/Health Worker's Ph. No.:

Name and phone number of the person you would like us to contact in the event of an emergency?

The name and dosage of medication currently being taken?

Appendix H – Brief Psychiatric Rating Scale (BPRS)

Brief Psychiatric Rating Scale
BPRS (24)

ID: _____ **Date (dd/mm/yy):** _____

Person Completing Form: _____ **Indicate Period:** __Baseline __Follow-up 1 __Follow-up 2 __Follow-up 3 __Follow-up 4

FILL THE APPROPRIATE CIRCLE to represent level of severity for each symptom in the PAST WEEK.

	not present	very mild	mild	moderate	moderately severe	severe	extremely severe
1. SOMATIC CONCERNS – degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the client, whether they have a realistic basis or not.							

Have you been concerned about your physical health in the past week?

Have you had any physical illness or seen a medical doctor lately?

What does your doctor say is wrong?

How serious is it?

Has anything changed regarding your appearance?

Has anything about your health interfered with your ability to perform your daily activities and/or work?

Did you ever feel that parts of your body had changed or stopped working properly?

[If client reports any somatic concerns/delusions, ask the following]:

How often are you concerned about ... (use client's own description)*?*

Have you expressed any of these concerns to others?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

2. ANXIETY – reported apprehension, fear, panic or worry. Rate only the client's statements, not observed anxiety which is rated under the item "Tension".

Have you been worried at all during the past week?

Have you felt nervous, apprehensive, or frightened?

What do you worry about?

Are you concerned about anything? For example, do you find yourself worried about things like money or the future?

When you are feeling nervous, do your palms sweat, or your heart beat fast (or shortness of breath, trembling, choking)?

[If client reports anxiety or autonomic accompaniment, ask the following]:

How much of the time have you been ... (use respondent's description of anxiety)*?*

Does it interfere with your usual activities?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

3. DEPRESSION - include sadness, unhappiness, anhedonia, preoccupation with depressing topics, hopelessness, loss of self-esteem. Don't include vegetative symptoms.

What has your mood been like in the past week?

Have you felt depressed, sad, down in the dumps, unhappy, as if you didn't care?

When you feel like that, are you able to switch your attention to more pleasant topics when you want to?

Do you find you've lost interest in or get less pleasure from things you used to enjoy, like friends, family, hobbies, eating or watching T.V?

[If client reports feelings of depression, ask]:

How long do these sad feelings last?

Do they make it difficult for you to do your usual activities?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

4. SUICIDALITY – expressed desire, intent or actions to harm or kill oneself. Has felt as though life is not worth living, or felt like ending it all. If reports suicidal ideation, does the client have a specific plan?

Have you felt that life wasn't worth living?

Have you thought about harming or killing yourself?

Have you felt tired of living or as though you would be better off dead?

Have you ever felt like ending it all?

[If client reports suicidal ideation, ask the following]:

How often have you thought about ...(use client's description of suicide)?

Did you (Do you) have a specific plan?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

5. GUILTY – overconcern or remorse for past behaviour. Rate only the client's statements; do not infer guilty feelings from depression, anxiety or neurotic defenses.

In the past week, is there anything you feel guilty about, or feel ashamed of?

Have you been thinking about past problems?

Do you tend to blame yourself for things that have happened in the past?

Have you done anything you're still ashamed of?

[If patient reports guilt/remorse/delusions, ask the following]:

How often have you been thinking about... (use client's own description)?

Does it interfere with your usual activities?

Have you told anyone else about these feelings of guilt?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

6. HOSTILITY – animosity, contempt, belligerence, threats, arguments, tantrums, property destruction, fights and other expressions of hostile attitudes or actions.

In the past week, how have you been getting on with others (family, co-workers, etc.)?

Do you find you've been unusually grumpy, or easily irritated by other people?

How do you show it? Do you keep it to yourself?

In the past week, have you found you've been losing your temper or getting so irritable that you shout at others, start arguments or get into fights?

Have you found yourself yelling at people you didn't know?

Have you hit anyone in the past week?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

7. ELEVATED MOOD – a pervasive, sustained and exaggerated feeling of well-being, cheerfulness, euphoria, optimism that is out of proportion to the circumstances.

Have you felt so good or high that other people thought that you were not your normal self?

Have you been feeling cheerful and "on top of the world" without any reason?

[If client reports elevated mood/euphoria, ask the following]:

Did it seem like more than just feeling good?

How long did it last?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

8. GRANDIOSITY – exaggerated self-opinion, self-enhancing conviction of special abilities or powers or identity as someone rich or famous. Rate only client's statements, not his or her demeanor.

Is there anything special about you?

Do you think you have any special abilities or powers?

In the past week, have you thought that you might be somebody rich or famous?

In the past week, did you often feel superior or special compared to other people?

[If the client reports any grandiose ideas/delusions, ask the following]:

How often have you been thinking about ... (use client's description)?

Have you told anyone else about what you have been thinking?

Have you acted on any of these ideas?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

9. SUSPICIOUSNESS – expressed or apparent belief that other persons have acted maliciously or with discriminatory intent. Include persecution by supernatural or other non human agencies.

Do you feel uncomfortable in public?

Does it seem as though others are watching you?

Are you concerned about anyone's intentions toward you?

Is anyone going out of their way to give you a hard time, or trying to hurt you?

Do you feel in any danger?

[If client reports any persecutory ideas/delusions, ask the following]:
How often have you been concerned that... (use consumer's description)?

Have you told anyone about these experiences?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

10. HALLUCINATIONS – reports perceptual experiences in the absence of relevant external stimuli.

Some people say they can hear noises or voices when no one else is around. Has this happened to you in the past week? Ever seem to hear your name being called?

(If hears voices …) *What does the voice/voices say?*

In the past week, did you ever have visions or see things that others do not see?

Did you smell any strange odours that others don't smell?

(If yes to any hallucinations …) *How do you explain these things?*

How often did you experience these (use respondent's description of hallucinations)?

Have these experiences made it difficult to go about your usual routine?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

11. UNUSUAL THOUGHT CONTENT – unusual, odd, strange or bizarre thought content (thought insertion, withdrawal, broadcast, grandiose, somatic, persecutory delusions).

In the past week, did you ever feel that someone or something could control your thoughts/behaviour, or that someone could read your mind?

Have you been receiving any special messages from people/objects around you?

Have you seen references to yourself on TV or in newspapers in the past week?

Do you have a special relationship with God?

Is anything like electricity, X-rays, or radio waves affecting you?

Are thoughts being put in your head that are not your own?
[If so]: *How often do you think about …*(use client's own experiences)?
Have you told anyone? How do you explain the things that have been happening [specify]*?*

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

12. BIZARRE BEHAVIOUR – reports of behaviours which are odd, unusual or psychotically criminal. Not limited to interview period. Include inappropriate sexual behaviour and inappropriate affect.

Have you done anything that has attracted the attention of others?

Have you done anything that could have gotten you in trouble with the police?

Have you done anything that seemed unusual or disturbing to others?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

13. SELF NEGLECT – hygiene, appearance or eating behaviour below usual expectations, below socially acceptable standards, or life threatening.

How has your grooming been lately?

How often do you change your clothes?

How often do you take showers?

Has anyone (parents/friends/workmates...) complained about your grooming or dress?

Do you eat regular meals?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

14. DISORIENTATION – does not comprehend situations or communications, such as questions asking during the entire interview. Confusion regarding person, place or time.

May I ask you some standard questions we ask everybody?

How old are you?

What is the date [Allow + or – 2 days]?

What is this place called?

What year were you born?

Who is the prime minister?

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

15. CONCEPTUAL DISORGANISATION – degree to which speech is confused, disconnected, vague or disorganised. Rate tangentiality, circumstantiality, sudden topic shifts, incoherence, blocking.

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

16. BLUNTED AFFECT – restricted range in emotional expressiveness of face, voice and gestures. Marked indifference or flatness even when discussing distressing topics.

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

17. EMOTIONAL WITHDRAWAL – deficiency in client's ability to relate emotionally during interview situation. Presence of "invisible barrier" between client and interviewer. Include withdrawal apparently due to psychotic processes.

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

18. MOTOR RETARDATION – reduction in the energy level evidenced by slowed movements and speech, reduced body tone, decreased number of spontaneous body movements. Rate on the observed behaviour of the patient only.

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

19. TENSION – observable physical and motor manifestations of tension, nervousness and agitation. Self-reported experiences of tension should be rated under the item "anxiety".

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

20. UNCOOPERATIVENESS – resistance and lack of willingness to cooperate with the interview. The uncooperativeness might result from suspiciousness.

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

21. EXCITEMENT – heightened emotional tone, or increased emotional reactivity to interviewer or topics being discussed, as evidenced by increased intensity of facial expressions, voice tone, expressive gestures or increase in speech quantity and speed.

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

22. DISTRACTIBILITY – degree to which observed sequences of speech and actions are interrupted by stimuli unrelated to interview. Distractibility is rated when client shows a change in the focus of attention or marked shift in gaze.

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

23. MOTOR HYPERACTIVITY – increase in the energy level evidenced by more frequent movement and/or rapid speech.

not present | very mild | mild | moderate | moderately severe | severe | extremely severe

24. MANNERISMS/POSTURING – unusual and bizarre behaviour, stylised movements or acts, or any postures which are clearly uncomfortable or inappropriate.

Appendix I – Brief Symptom Inventory (BSI)

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	HOW MUCH WERE YOU DISTRESSED BY:
1	⓪	①	②	③	④	Nervousness or shakiness inside
2	⓪	①	②	③	④	Faintness or dizziness
3	⓪	①	②	③	④	The idea that someone else can control your thoughts
4	⓪	①	②	③	④	Feeling others are to blame for most of your troubles
5	⓪	①	②	③	④	Trouble remembering things
6	⓪	①	②	③	④	Feeling easily annoyed or irritated
7	⓪	①	②	③	④	Pains in heart or chest
8	⓪	①	②	③	④	Feeling afraid in open spaces or on the streets
9	⓪	①	②	③	④	Thoughts of ending your life
10	⓪	①	②	③	④	Feeling that most people cannot be trusted
11	⓪	①	②	③	④	Poor appetite
12	⓪	①	②	③	④	Suddenly scared for no reason
13	⓪	①	②	③	④	Temper outbursts that you could not control
14	⓪	①	②	③	④	Feeling lonely even when you are with people
15	⓪	①	②	③	④	Feeling blocked in getting things done
16	⓪	①	②	③	④	Feeling lonely
17	⓪	①	②	③	④	Feeling blue
18	⓪	①	②	③	④	Feeling no interest in things
19	⓪	①	②	③	④	Feeling fearful
20	⓪	①	②	③	④	Your feelings being easily hurt
21	⓪	①	②	③	④	Feeling that people are unfriendly or dislike you
22	⓪	①	②	③	④	Feeling inferior to others
23	⓪	①	②	③	④	Nausea or upset stomach
24	⓪	①	②	③	④	Feeling that you are watched or talked about by others
25	⓪	①	②	③	④	Trouble falling asleep
26	⓪	①	②	③	④	Having to check and double-check what you do
27	⓪	①	②	③	④	Difficulty making decisions
28	⓪	①	②	③	④	Feeling afraid to travel on buses, subways, or trains
29	⓪	①	②	③	④	Trouble getting your breath
30	⓪	①	②	③	④	Hot or cold spells
31	⓪	①	②	③	④	Having to avoid certain things, places, or activities because they frighten you
32	⓪	①	②	③	④	Your mind going blank
33	⓪	①	②	③	④	Numbness or tingling in parts of your body
34	⓪	①	②	③	④	The idea that you should be punished for your sins
35	⓪	①	②	③	④	Feeling hopeless about the future
36	⓪	①	②	③	④	Trouble concentrating
37	⓪	①	②	③	④	Feeling weak in parts of your body
38	⓪	①	②	③	④	Feeling tense or keyed up

39	⓪	①	②	③	④	**Thoughts of death or dying**
40	⓪	①	②	③	④	**Having urges to beat, injure, or harm someone**
41	⓪	①	②	③	④	**Having urges to break or smash things**
42	⓪	①	②	③	④	**Feeling very self-conscious with others**
43	⓪	①	②	③	④	**Feeling uneasy in crowds, such as shopping or at a movie**
44	⓪	①	②	③	④	**Never feeling close to another person**
45	⓪	①	②	③	④	**Spells of terror or panic**
46	⓪	①	②	③	④	**Getting into frequent arguments**
47	⓪	①	②	③	④	**Feeling nervous when you are left alone**
48	⓪	①	②	③	④	**Others not giving you proper credit for your achievements**
49	⓪	①	②	③	④	**Feeling so restless you couldn't sit still**
50	⓪	①	②	③	④	**Feelings of worthlessness**
51	⓪	①	②	③	④	**Feeling that people will take advantage of you if you let them**
52	⓪	①	②	③	④	**Feelings of guilt**
53	⓪	①	②	③	④	**The idea that something is wrong with your mind**

Positive and Negative Affect Schedule (PANAS)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to that word. Indicate to what extent **you have felt this way during the past week**. Use the following scale to record your answers.

1	2	3	4	5
very slightly or not at all	**a little**	**moderately**	**quite a bit**	**extremely**

_____interested

_____distressed

_____excited

_____upset

_____strong

_____guilty

_____scared

_____hostile

_____enthusiastic

_____proud

_____irritable

_____alert

_____ashamed

_____inspired

_____nervous

_____determined

_____attentive

_____jittery

_____active

_____afraid

Appendix K – Revised Schizophrenia Quality of Life Questionnaire (SQLS-R4)

The Revised Schizophrenia Quality of Life Questionnaire (SQLS-R4)

We are interested in finding out about the quality of your life **OVER THE PAST SEVEN DAYS, INCLUDING TODAY**. Please respond to all the following statements by ticking one box for each statement.

1. I lacked the energy to do things.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
2. I couldn't be bothered to do things.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
3. I was worried about my future.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
4. I felt lonely.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
5. I felt hopeless.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
6. I felt panicky.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
7. I was able to carry out my day to day activities.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
8. I took things people said the wrong way.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐

OVER THE PAST SEVEN DAYS (Including today):

	Never	Rarely	Sometimes	Often	Always
9. I found it hard to concentrate.	☐	☐	☐	☐	☐
10. I found it difficult to mix with people.	☐	☐	☐	☐	☐
11. I felt down.	☐	☐	☐	☐	☐
12. I felt that I could cope.	☐	☐	☐	☐	☐
13. I felt very mixed up and unsure of myself.	☐	☐	☐	☐	☐
14. I slept well.	☐	☐	☐	☐	☐
15. My feelings swung from high to low.	☐	☐	☐	☐	☐
16. I felt concerned that I wouldn't get better.	☐	☐	☐	☐	☐
17. I worried about things.	☐	☐	☐	☐	☐

OVER THE PAST SEVEN DAYS (Including today):

18. I felt that people tended to avoid me.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
19. I got upset thinking about the past.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
20. I had trouble remembering things.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
21. I felt cut off from the world.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
22. I felt uncomfortable with people.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
23. I had trouble thinking clearly.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
24. I had upsetting thoughts.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
25. I had suicidal thoughts.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐
26. I felt happy.	Never ☐	Rarely ☐	Sometimes ☐	Often ☐	Always ☐

OVER THE PAST SEVEN DAYS (Including today):

27. I felt depressed.	Never	Rarely	Sometimes	Often	Always
	☐	☐	☐	☐	☐
28. I felt drowsy.	Never	Rarely	Sometimes	Often	Always
	☐	☐	☐	☐	☐
29. I felt restless.	Never	Rarely	Sometimes	Often	Always
	☐	☐	☐	☐	☐
30. I was concerned about my social life.	Never	Rarely	Sometimes	Often	Always
	☐	☐	☐	☐	☐
31. I felt tired.	Never	Rarely	Sometimes	Often	Always
	☐	☐	☐	☐	☐
32. I felt physically weak.	Never	Rarely	Sometimes	Often	Always
	☐	☐	☐	☐	☐
33. I felt like I wasn't leading a normal life.	Never	Rarely	Sometimes	Often	Always
	☐	☐	☐	☐	☐

Thank you for your time

Appendix L – Client EVoLVE sessions

EVoLVE Therapy Sessions

Session One

- Complete PANAS Questionnaire.
- Introductions.
- Getting to know you, and obtaining a history of your problems.
- Discuss Cognitive-Behavioural Therapy and **EVoLVE** therapy.

Session Two

- Complete PANAS Questionnaire.
- Catch up on how the previous week went.
- Discuss the role of personal vulnerability and stressful life circumstances, and their interaction, in the production of your symptoms and psychological distress.

Session Three

- Complete PANAS Questionnaire.
- Catch up.
- Discuss alternative/improved patterns of living and ways to create structure in your life, to enable you to work towards a more valued existence.

Session Four

- Complete PANAS Questionnaire.
- Catch up.
- **EVoLVE** Relaxation Training.

Session Five

- Complete PANAS Questionnaire.
- Catch up.
- Develop a list of current problems/struggles that are standing in the way of you moving toward a more valued life.
- Increasing workable strategies to cope with problems.

Session Six

- Complete PANAS Questionnaire.
- Catch up.
- Discuss control-oriented strategies that may work in the short-run, but not in the long-run.
- Introduction to becoming a good observer of your thoughts and feelings.

Session Seven

- Complete PANAS Questionnaire.
- Catch up.
- Introduce and discuss mindful observation.
- Mindful observation exercises.

Session Eight

- Complete PANAS Questionnaire.
- Catch up.
- Discuss emotion regulation.

Session Nine

- Complete PANAS Questionnaire.
- Catch up.
- Discuss your life values and goals.

Session Ten

- Complete PANAS Questionnaire.
- Catch up.
- Review of **EVoLVE** therapy.
- Preventing relapse.
- Celebration for completing **EVoLVE** therapy.

EVoLVE Therapy

Evaluation Form

For each of the following statements, please circle the number that best describes your overall impression.

Please circle only one number for each statement.

Please answer every question.

1. How useful was the explanation of the Cognitive-Behaviour Therapy Five-Part Model (the diagram highlighting the interconnection between thoughts, feelings, bodily responses, behaviours, and the environment/situation)?

1	2	3	4	5
not at all	a little	somewhat useful	quite useful	really useful

2. How useful did you find the presentation on the Vulnerability-Stress Model (the explanation of how vulnerability combined with stress may have led to your particular problem or illness occurring)?

1	2	3	4	5
not at all	a little	somewhat useful	quite useful	really useful

3. How useful was the discussion and information on sleep hygiene?

1	2	3	4	5
not at all	a little	somewhat useful	quite useful	really useful

4. How useful was the information on nutrition?

1	2	3	4	5
not at all	a little	somewhat useful	quite useful	really useful

5. How useful was the information on exercise?

1	2	3	4	5
not at all	a little	somewhat useful	quite useful	really useful

6. How useful was the relaxation training?

1	2	3	4	5
not at all	a little	somewhat useful	quite useful	really useful

7. How useful was the Tug-of-War metaphor and the idea that you could "drop the rope" and let go of the struggle with your unwanted thoughts and feelings?

1	2	3	4	5
not at all	a little	somewhat useful	quite useful	really useful

8. How useful did you find the mindfulness observation work?

1	2	3	4	5
not at all	a little	somewhat useful	quite useful	really useful

9. How useful did you find the emotion regulation work?

1	2	3	4	5
not at all	a little	somewhat useful	quite useful	really useful

10. How useful did you find discussing and writing down your life values and goals?

1	2	3	4	5
not at all	a little	somewhat useful	quite useful	really useful

11. How useful did you find the handouts that accompanied the therapy?

1	2	3	4	5
not at all	a little	somewhat useful	quite useful	really useful

12. To what extent have you practiced session exercises at home?

1	2	3	4	5
not at all	a little	some	quite a lot	a great deal

13. Has your distress associated with your problems/illness reduced since you started EVoLVE Therapy?

1	2	3	4	5
not at all	a little	some	quite a lot	a great deal

14. Are you glad you participated in EVoLVE Therapy?

1	2	3	4	5
not at all	a little	some	quite a lot	a great deal

15. Please give an overall rating of EVoLVE Therapy.

1	2	3	4	5
very poor	poor	o.k	good	very good

16. What did you find the most helpful?

.....

.....

.....

.....

17. What did you find the least helpful?

.....

.....

.....

.....

18. Please give an overall rating of the therapist.

1	2	3	4	5
very poor	poor	o.k	good	very good

19. What could the author do to improve EVoLVE Therapy?

.....

.....

.....

.....

20. Please add any other comments that you would like to make.

.....

.....

.....

.....

Exposing Virtues of Living Valued Existences

EVoLVE Therapy

A cognitive-behavioural therapy programme for long-term consumers of mental health services who have a serious and persistent psychiatric disorder.

Compiled by Ruth Gillingham

Ten Steps of Therapy

1. Treat client with respect, and show respect for the client's theories.
2. Give power to the client – promote autonomy.
3. If in doubt, place responsibility/expectation on the client, i.e. we must respect the client, but they should take responsibility.
4. Work with the client in the spirit of collaborative empiricism.
5. Promote self-acceptance throughout therapy.
6. Follow important emotional material.
7. Encourage the idea that there is more than one explanation for everything. Generate multiple explanations; then let the client choose.
8. Place a strong emphasis on the idea "you can live your life despite..." As therapists, we are here to try and increase their energy/motivation and ability to do what they want to do with their lives.
9. Make allowances for memory and attention deficits (this is one of the reasons there are written copies of homework sheets and session summaries).
10. And, remember the values of mental health models, such as Te Whare Tapa Wha, and cultural concepts that might need to be accommodated.

Guiding Principles of EVoLVE Therapy

1. Educate our clients about the role stress may play in the onset and maintenance of their disorder, and provide strategies to help reduce the stress in our clients' lives.

2. Assist our clients to make small changes in the way they are living in order to help them achieve what they want to do with their lives.

3. Provide strategies to help our clients' improve their functioning, despite living with unwanted experiences.

4. Promote self-acceptance.

Typical Therapy Session

1. Have the client fill out the self-report assessment measure, the PANAS.
2. Update on mood since last session.
3. Create a bridge from the last session by reviewing previous session and discussing homework (maintains continuity between sessions).
    - Summary of previous session and important issues addressed,
    - Attend to any concerns that have arisen for the client,
    - Check that rationale for homework was understood,
    - Check what the client learned from it, and
    - If applicable, discuss reasons for failing to do homework.
4. Present the outline of the upcoming session.
5. Apply the relevant session's key interventions. Periodically check that the rationale for any exercises/homework is clearly understood by the client, as per the suggested questions to the client outlined in the manual.
6. Review the present session; obtain the client's feedback on the session; check client has understood the session, and set homework.

Task 1 should be done before the session begins, and should take about 5 minutes. As a guide, for each one-hour session, tasks 2, 3, and 4 should take approximately 10-20 minutes, and task 5 approximately 30-45 minutes. The final 5-10 minutes should be spent on task 6.

Session 1

Introduction to the Programme and CBT

Tasks

- Take history and begin to establish therapeutic relationship
- Assess client's motivation
- Instill hope (establish positive expectations that are realistic)
- Explain the CBT model
- Introduce functional analysis
- Establish treatment ground rules
- Provide a rationale for extra-session tasks (homework)

Session Goals

The first session is the most important and often the most difficult because the therapist must address several areas.

- Begin to establish a relationship with the client
- Understand and validate the client's life perspective, creating a climate of openness and trust
- Provide a rationale for the treatment
- Socialise clients to the CBT model; direct their attention to the relation between thoughts, feelings and behaviour
- Establish the structure for the remaining sessions; provide an overview of the following sessions, and discuss treatment termination.
- Try to understand what the major lifestyle difficulties are for the client.

Key Interventions

History and Relationship Building

During this first session, therapists should spend a large amount of time getting to know the clients, obtaining their histories from them, finding out

the client's understanding of the problem, determining what led them to seek treatment, and what they have tried before.

First though, after introducing yourself, therapists need to discuss some important ethical issues with the client. These include:

- Telling the client you are in training to become a clinical psychologist.
- Informing the client that Dr Patrick Dulin and Shane Harvey, both qualified clinical psychologists, are your supervisors and information will be shared with them (perhaps frame this as, "these two supervisors are interested in tracking what each therapist is doing, to ensure treatment is being carried out as planned").
- Inform the client that they can talk to Patrick Dulin regarding any aspect of treatment, if they so wish.
- Inform them of the limits of confidentiality i.e., other than Patrick and Shane, no other person will be privy to any information discussed in the therapy sessions, unless the client's safety is at risk – either by what they might do to themselves or to others.
- And therapists, in the event of talk of harm to self or others please inform Patrick.

History taking can now begin.

"I know you have spent quite some time answering questions already, but now as we start treatment, I hope you can answer some more questions that should be able to help you and I plan where we go from here".

Allow the client to lead the discussion; that is, facilitate the discussion, don't interrogate. Possible open-ended questions to elicit reasons for seeking treatment and treatment history, and client's understanding of their problem, are as follows:

- Tell me about yourself and your difficulties. How you got to this point?
- What concerns you most?
- Do you have an explanation for why your problem/ill health started when it did?
- What effect does your problem have on you?
- How long do you expect it to last?
- What problems has your problem/disorder/ill health caused you?
- What do you fear about your problem/disorder?
- Have you been in treatment for your problem/disorder/ill health before?
- If yes, when was that? How long did you stay there? What was it like? How did it work for you? What did you like or not like about the programme? Why did you leave?
- How do you feel most of the time? Have you been depressed or down? Have you ever thought about hurting yourself? Have you ever done so? When does it happen?
- What do you worry about? When you get frightened, what happens to you? Do you ever have times of great fear or anxiety/panic attacks? Are there any distressing memories that keep coming back to you? Is there any situation/thoughts you avoid because it really upsets/scares you?

Therapist's notes: Engaging and rapport building

- Empathy, warmth, genuineness, support, collaboration, and unconditional acceptance, are vital to developing a positive therapeutic relationship.
- The process (therapeutic relationship) is more important than the content (key interventions) of therapy.
- When building up relationship with client, vital not to do anything either verbally or non-verbally to invalidate their experience i.e., avoid confrontation and humouring.

- Validate the client's experience, without validating the reality of it.
- Encourage information seeking – help the client to become expert in gathering information and finding alternative explanations. Watch out for biases!
- Agree to disagree. Avoid arguing with, or challenging the client – you and the client have the right as individual's to express an alternative point of view.
- Permission to withdraw/change subject (tactically), especially if the client becomes distressed. This should be noted and appropriate support given.
- If you get stuck, try reflecting back underlying feeling, try paraphrasing (or reflecting content – a concise and simple summary of the client's basic message), or try some self-reflection (e.g., I think...).

Assess Client's Motivation

Address the motivation of the client to be in therapy and engage in the therapy process. Help client to come up with reasons why they're there. Sample questions might include:

- How do you think this therapy might help you?
- What are the most important results you hope to receive from this treatment?
- What don't you like about your life?
- **What do you want from life?**
- **How have you tried to achieve this?**
- **How has that worked?**

Instill Hope

"Scientific research which has been carried out on the type of therapy we are going to use throughout this programme – cognitive-behaviour therapy – has been found to be useful for problems/disorders such as yours. Indeed,

there is consistent evidence from a large number of trials that CBT is an effective intervention for such problems/ disorders ".

Explain the CBT Model

Next, therapists should provide an explanation and rationale for the treatment.

- Present the **Five-Part Model. (HANDOUT)**. Highlighting the interconnection between thoughts (beliefs, images, memories), moods (emotions, feelings), physical reactions (biology, body), behaviours (actions), and environment (past and present, situations, history, culture).

  "These are the five components to any problem. Each of the five components affects and interacts with the others. The main assumption behind CBT is that psychological problems are determined by how people interpret events (cognitions), how people react to these events (behaviour), and how it makes them feel (emotions)".

- Explain that by understanding this process, people can then see how change can occur.

  "Small changes in one area can lead to changes in the other areas. Most problems require small changes in all five areas in order to feel better. Change occurs as a result of new learning experiences that overcome former unhelpful learning and information processing ways of thinking. This doesn't mean that our thinking is wrong when we experience an intense mood/emotion. But when we feel intense moods, we are more likely to distort, discount, or disregard information that contradicts our moods and beliefs – this happens as an automatic process that we are not often aware of (they pop into our heads without any effort on our part). Cognitive therapy can help you look at all the information available".

- Help develop new, more effective skills to replace old habits.

  "It's not just about understanding these automatic processes, but learning to do things differently. As we go through therapy, you will learn more about these automatic processes. And, we'll help you unlearn some of your old, less effective strategies of dealing with your problems and learn some new, more effective ones. It'll take some time and a lot of practice to learn some new skills, but I bet you've already got some pretty effective ways of coping already that we can use".

- Practice is essential. Provide rationale for homework.

  "It takes practice trying out new ways of responding to old situations. We'll practice during sessions, but each week we'll also talk about how you can practice new skills outside our sessions. It won't seem natural or easy at first. Think back to when you learnt to ride a bike, or think about people who play the piano – it takes a lot of practice before these skills are mastered well. By sticking it out and practicing outside of our meetings though, you'll learn a lot about yourself and what works and doesn't work for you. You can always bring problems in and talk about new ways of coping. Can you see yourself doing some practice outside of sessions?"

Introduce Functional Analysis

Therapists should now work through the 'self-disclosure' example of public speaking anxiety (modeling), conducting a full functional analysis using the Five-Part Model.

"To get an idea of how all this works, let's go through an example. Let me give you an example of mine. I had to give a speech ...

Establish Treatment Ground Rules

In addition to treatment goals and tasks, it is important to establish clear expectations for the client in terms of treatment, your obligations, and the client's responsibilities. The following areas should be reviewed and discussed.

- Scheduling of sessions and length of treatment
- Importance of regular attendance
- Calling in advance if the client will miss the session or be late (**HANDOUT – give client Phone Card**, if necessary). The client can phone the psychology clinic (06 3505196) and leave a message with Annette, the receptionist, or leave a message on the answerphone.
- Briefly explain session structure
- Provide **Overview of Sessions (HANDOUT)**
- **NOTE:** For those coming to sessions by taxi, hand out the taxi vouchers (filled in) for return home and for the following week.

Key Outcomes

Therapists need to know whether the client has taken on board what has occurred in the session, and whether treatment session goals were achieved. To ascertain this, therapists might ask:

- What do you understand about the Five-Part Model? What does the model show?
- What has been the key point you are taking away with you today?

Therapist's notes:

- Avoid giving clients the answers when checking therapy outcomes. Get the client to think; avoid putting words in their mouth.

Homework

The homework exercise for today's session is to ask the client to read over the Five-Part Model handout.

"I appreciate you taking the time to come to this first session and the efforts you made to provide the information we need to work together. We have only a few minutes left today, so let me get some feedback from you on how you think this therapy might go for you and any reactions you might have to us working together"

If applicable … *can I call you a taxi?*

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Session 2

Normalising Rationale

Tasks

- Explain the role of stress on the production of symptoms
- Discuss biopsychosocial aspects of the illness
  i.e., The Vulnerability-Stress Model
- Decatastrophise catastrophic cognitions about their illness
- If applicable, provide an explanation of the symptoms of depression and/or anxiety
- Explain symptoms as 'continua of functioning'
- Explain the difference between thoughts and actions

Session Goals

- Educate client about the role of personal vulnerability and stressful life circumstances, and their interaction, in the production of psychiatric symptoms and psychological distress.
- Through the use of education, decatastrophise/normalise (not minimise), and help reduce the stigma of, the client's disorder/problems i.e., discuss the presence of schizophrenia-like, psychotic symptoms in 'normals'.
- To get the client to see themselves as a person – not an illness.

Key Interventions

Presenting the Vulnerability-Stress Model

Present, and explain, the **Vulnerability-Stress Model of Symptom Emergence HANDOUT** and, if applicable, the **Causes of Psychosis HANDOUT**.

"Stress seems to affect people in different ways, depending on their make-up. This includes any family susceptibility, personality, and possibly even brain structure. The same sort of stressful event may make some people

depressed or anxious, but they may not affect others at all. In your circumstances/case, you have experienced..."

The symptoms/psychological distress that your client is experiencing or has experienced (as per their answers to your questions in session 1), are then explored and discussed on an individual basis. Therapists need to lead the client towards an understanding that there is probably a discernible reason or reasons why the symptoms have occurred and the possibility that anyone stressed in certain ways could become psychotic i.e., normalise their experiences.

"We are now going to look at the types of stressors which can typically produce psychotic symptoms in 'you' or 'I'". See **HANDOUT – Psychosis and Normal Human Experiences.**

Therapist's notes:

- Be careful with words like 'psychosis'. Think carefully about the terms you are using to describe symptoms. It is preferable to use the client's own language here; despite the fact this terminology is used on the handout! You could explain that this is a standard handout that you thought they might be able to relate to some aspects of.

Other stressors that can produce psychotic experiences include:
"(1) Sleep deprivation – there is evidence that lack of sleep can lead to illusions, hallucinations and paranoid ideation (Oswald, 1974);
(2) Post-traumatic stress disorder – as we have previously discussed, significant life events often precede the development of psychosis. For example, hallucinations were very common amongst veterans of the Vietnam War (Wilcox et al., 1991);
(3) Sensory deprivation – bed rest in a dark room and water tank immersion can both lead to the development of simple and eventually complex hallucinations (Slade, 1984);
(4) Hostage situations – (Siegel, 1984);

(5) Solitary confinement – Psychotic symptoms can emerge in prisoners kept for prolonged periods without contact with others (Grassian, 1983)*;*
(6) Sexual abuse – hallucinosis is surprisingly common in those clients who have undergone repeated or particular brutal sexual abuse (Ensink, 1992).

NOTE: IF THE CLIENT IS INTERESTED IN READING ABOUT ANY OF THE ABOVE JOURNAL ARTICLES/BOOK CHAPTERS, I CAN GET A COPY FOR THEM. PLEASE LET ME KNOW.

Therapist's notes:

- The above work can improve the therapeutic relationship, help the client feel more "normal" and less alienated, and allow work on non-threatening and explanatory areas prior to tackling the client's own personal distress/symptoms in more depth.
- Indeed, without glamourising or trivialising the experience, this intervention aims to present some of the phenomena of psychosis (primarily hallucinations) as an intrinsically human event, something experienced by a wide range of people under various circumstances. It aims to assist people to incorporate their psychotic experiences into their perceptions of themselves as normal, functioning members of the human race, rather than stigmatizing themselves as vehicles of events alien to themselves and their species.

Explanation of the Symptoms of Depression or Anxiety

Provide, and explain, the two **HANDOUTS** on the CNS → fight/flight response **The Body's Arousal Reaction** and **When You're Scared Your Body Can ...**

"Can you recognise any of these in yourself?"

"Some people experience psychosis as a consequence of an underlying major mood disorder. As their mood stabilises their symptoms of psychosis

resolve. Mood disorders can generally be thought of in two groups; depression and mania."

HANDOUTS – 'Symptoms of Depression' and 'Symptoms of Mania'

Therapist's notes:

- Take care not to lecture client.
- The importance of introducing an explanation of affective symptoms at this stage is that affective symptoms can be delusionally misinterpreted and can also lead to poor compliance with treatment.
- Evidence has shown that marked hyperarousal and anxiety in psychotic clients can exarcerbate psychotic symptoms.
- Reattribute symptoms of anxiety. For example, a client might interpret tinnitus as a signal from another planet, or parathesia (the 'tingling' associated with hyperventilation) interpreted as 'electric shocks' or 'creatures running up and down my skin'. Therapist needs to reinterpret these as anxiety symptoms so the client can consider another alternative explanation for what they are experiencing.

Explain Symptoms as 'Continua of Functioning'

The client may have been taught a different model so present the following as another way of thinking about their difficulties; in an attempt to encourage the client to feel less anxious about their symptoms, i.e. not like an illness we have to cure!

Present to the client the idea that symptoms in schizophrenia and other psychotic type disorders merge with 'normal' behaviour.

"We found out earlier in the session that similar, if not identical, symptoms and signs of psychotic experiences (such as hallucinations and delusions) can occur in 'you' or 'I' if we are sufficiently stressed. There is also evidence that the symptoms a person diagnosed with schizophrenia/other

psychotic disorders/mood disorders experience, are different in degree from, or are exaggerations of, normal responses to stress. That is, they are points on a continuum of functioning. Let me illustrate".

Draw on the whiteboard a continuum line, using delusions, overvalued ideas, strongly held beliefs and opinions as intermediate points on a functional continuum. The same can be done for hallucinations, using hallucinations, pseudohallucinations, illusions, and normal perception.

Therapist's notes:

- If applicable, delusional beliefs and passivity phenomena can be related to commonly occurring cultural beliefs held by many members of society e.g., thought broadcasting and insertion (beliefs in telepathy), delusions of control by external forces (beliefs in poltergeists, astrology, religious and magical forces, and hypnotism).
- If applicable, fleeting grandiose ideas, ideas of reference, and paranoid thoughts can be described as very common, perhaps even universal, in the normal population e.g., the belief that one would make a better prime minister than the present one is a remarkably common grandiose idea. Also, in certain circumstances the belief that everyone "is getting at me" when a series of events have gone against one is not uncommon. These beliefs occur spontaneously and are usually dismissed rapidly. However, at times of stress a "search for meaning" – a basic need to explain what is happening – can probably lead to more ready and lasting acceptance of such beliefs.

Explain the Difference Between Thoughts and Actions

It is important to stress the difference between thoughts and actions. The fact that a person thinks unacceptable sexual or aggressive thoughts does not mean that they have to act upon such thoughts. They retain the power of choice over their actions, even if thoughts come into their minds in an apparently uncontrollable way and even though they may feel out of control.

"Thoughts and actions are quite different. Just because you are thinking something does not mean you have to act on it. You retain the power of choice over your actions. Even though your thoughts might have come into your mind in an uncontrollable way and even though you may feel out of control, ***you*** *retain the power of choice over your actions".*

Key Outcomes

Therapists might ask:

- What do you understand about the role stress may have played in the onset of your problems/symptoms?
- How do you see yourself and your problems after this session today?

Homework

Ask the client to read over the handouts given out today. And, in preparation for next week's session, ask the client to fill out their typical daily routines for the week – including sleep patterns, when they get up, what they do, where they go etc. **HANDOUT: Daily Routine Chart**.

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Session 3

Promoting Better Patterns of Living

Tasks

- Present, and discuss, sleep hygiene information
- Education about nutrition and exercise

Session Goals

- To promote better patterns of living to enable clients to work towards a more valued existence.
- Provision of simple behavioural exercises that can be easily mastered; may enhance therapeutic relationship and produce a sense of mastery in the clients.

Key Interventions

"Today's session will provide some suggestions that may promote improved living patterns to enable you to work toward a more valued existence".

Sleep Hygiene

Provide the client with the **Sleep Hygiene HANDOUT**; read through the important points with your client and discuss the changes they might be able to make to help them develop good/better sleep habits. Write these changes down for the client.

Nutrition and Exercise

First, educate client on the benefits of good **Nutrition (HANDOUT)**.

"A healthy body responds better to the inevitable stresses of life, and good nutrition is a building block of good health. Eating well can help prevent many health problems such as high blood pressure, heart disease, diabetes, indigestion, constipation and obesity. Good eating habits may also reduce irritability, headaches and fatigue".

NOTE: For those clients with eating disorders, work through the alternative nutritional handout.

"After reading the handout I've just given you, compare these guidelines to your own eating habits and decide what changes you would like to make or you think you could make. You can begin to apply these guidelines today. Although, I would suggest that to make lasting changes in your diet, plan on gradually introducing a few changes at a time that you are confident you can stick with. Changing your eating habits will take some time. Making too many changes at a time can be stressful, so insure your success by going slowly. Also, ensure the changes you make are tasty ones, otherwise you will feel deprived and have difficulty sticking to your plan".

Discuss the nutrition handout together, and ask clients what small changes they think they could start making in this area, toward a more positive healthy lifestyle. Write these changes down.

"You have the power to take charge/make informed choices with your eating habits, and taking charge/making informed choices will make a positive difference to your life. Keep the ten steps of healthy eating in mind and gradually make changes in your food selections. Also, keep them in the back of your mind when you shop."

Next, talk to the client about the benefits of **Exercise (HANDOUT)**.

"Exercise is one of the simplest and most effective ways of reducing stress and helping move toward a more positive healthy lifestyle. When the body is in the 'fight or flight' state of arousal (which we talked about last session), vigorous physical exercise is the natural outlet for the body; exercise returns your body to its normal balance by releasing natural chemicals that build up during stress. Exercise helps improve self-esteem as well as releasing endorphins, brain chemicals that trigger positive feelings of wellbeing".

NOTE: Again, for those clients with eating disorders who may use over-exercise as a control strategy, work through the alternative exercise handout.

"You probably get a certain amount of exercise each day doing such things as walking, climbing stairs, housecleaning, shopping, and gardening. While these activities are of benefit to us, they often don't provide us with enough vigorous physical exertion to counter our stress build-up. Brisk walking, swimming, cycling, jogging, to name but a few, are exercises we can do in addition to our daily activities. A minimum of 20 minutes of uninterrupted, continuous exercise, such as a brisk walk, 3-5 times per week is all that is required".

Go through the exercise handout and discuss with the client ways in which they could incorporate exercise into their day e.g., take the dog for a walk, walk to the shops/a friends place etc. Write these ideas down for the client. N.B. Important to point out to the client that it is wise to check with their doctor or health care provider when starting an exercise programme.

"Regular and adequate exercise is an excellent way to relieve chronic muscle tension caused by stress. The greater flexibility and better posture gained through exercise can relieve lower back pain caused by stress. Improved metabolism can relieve indigestion and chronic constipation caused by stress. Exercise will fight both chronic fatigue and insomnia caused by stress. Exercise also provides relief from emotions such as depression and anxiety. As you can see there are numerous benefits to regular and adequate exercise".

Key Outcomes

Therapist might ask client:

- What changes do you think you might be able to make to help you develop better sleep habits?

- Given that it is better not to make too many changes at a time to your eating habits, what do you think might be one of the first gradual change you would be able to make?
- How do you think you might be able to incorporate a bit more exercise into your day?

Homework

The homework exercise for this session is to ask the client to read over the handouts, and to start incorporating some of the ideas that were written down during the session regarding changes they believe they can make to improve their patterns of living and their health. Think about making an exercise plan with a friend, so you can encourage each other.

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Session 4

Relaxation Training

Tasks

- Provide background information on the importance of correct breathing
- Teach breathing relaxation exercises
- Play the relaxation tape

Session Goals

- Increase the client's awareness of their breathing habits
- Teach the client how to use breathing as a relaxation skill
- Provide exercises to enhance relaxation and release tension
- Teach the client how to use breathing for symptom control or release.

Key Interventions

Background on the Importance of Correct Breathing

***** Check out first with your clients whether they have done relaxation training before – if so, explain to them the benefits of repeating it here and inform the client that there are many different techniques, and the following might be different from what they have experienced in the past. *****

CAUTIONARY NOTE – some people are anxious about being relaxed. Reassure client you will take them through the following exercises with care.

It is important to provide background information on the importance of correct breathing, and the consequences of poor breathing technique. However, depending on the client, explain as much or as little as you feel the client is able to take in.

"As you are probably aware, with each breath of air, we obtain oxygen and release the waste product carbon dioxide. Poor breathing habits reduce the flow of these gases to and from our bodies, making it harder for us to cope with stressful situations. People under prolonged periods of stress unintentionally develop a poor breathing technique, which itself adds to feelings of stress. Breathing usually becomes shallow and often irregular and rapid (hyperventilation), only using the upper part of the chest (chest or thoracic breathing), instead of breathing deeply into the diaphragm (abdominal or diaphragmatic breathing).

Chest breathing is often associated with anxiety or other emotional distress. Improper breathing (chronic overbreathing or 'hyperventilation') contributes to frequent sighing and yawning; erratic heart beats; poor sleep; anxiety, lightheadedness and panic attacks; chest pains; depression; muscle tension; headaches; fatigue; irritability and the feeling of 'air hunger'. If an insufficient amount of air reaches your lungs, your blood is not properly oxygenated, your heart rate and muscle tension increase, and your stress response is turned on.

As you learn to be aware of your breathing and practice slowing and normalizing your breaths, your mind will quiet and your body will relax. Breathing awareness and good breathing habits will enhance your psychological and physical wellbeing – you can reduce the muscle tension and anxiety present with stress related symptoms or thoughts. The correct breathing technique for optimum health involves 'diaphragmatic breathing'. Inhaled air is drawn deep into the lungs and exhaled as the diaphragm contracts and expands. Breathing is even and nonconstricting. The respiratory system is able to do its job of producing energy from oxygen and removing waste products.

Diaphragmatic breathing is the easiest way of eliciting the relaxation response. When the relaxation response is practiced regularly, the body becomes less responsive to stress hormones at all times. Benefits include:

increased body awareness; increased ability to relax in the midst of high-stress situations; a reduced resting level of the autonomic nervous system so that one becomes more relaxed all of the time; improved concentration; and a generally greater sense of well-being.

Breathing Relaxation Exercises

Breathing exercises have been found to be effective in reducing GAD, panic attacks and agoraphobia, depression, irritability, muscle tension, headaches and fatigue. They are used in the treatment and prevention of breath holding, hyperventilation, shallow breathing, and cold hands and feet. While a breathing exercise can be learned quickly and some benefits experienced straight away, the profound effects of the exercise may not be fully appreciated until after months of persistent practice.

Work through the following three **HANDOUTS:**

1. **Breathing for Awareness and Relaxation –** especially the two exercises 'Breathing Awareness' and 'Diaphragmatic Breathing'.
2. **Breathing to Release Tension** – especially 'Breath Counting' and 'The Relaxing Sigh'.
3. **Breathing for Symptom Control or Release –** especially the exercise 'Abdominal Breathing and Imagination'.

HANDOUT – THE BOOKMARK

Progressive Muscle Relaxation

HANDOUT – Relaxation.

Progressive muscle relaxation is based on the premise that the body responds to anxiety-provoking thoughts and events with muscle tension. This physiological tension, in turn, increases the subjective experience of anxiety. Deep muscle relaxation reduces physiological tension and is incompatible with anxiety: the habit of responding with one blocks the habit of responding with the other.

Most people do not realise which of their muscles are chronically tense. Progressive muscle relaxation provides a way of identifying particular muscles and muscle groups and distinguishing between sensations of tension and deep relaxation.

HANDOUT – Progressive Muscle Relaxation Exercise.

Play RELAXATION TAPE. **A copy of the tape is to be given to the client for their personal use.**

Key Outcomes

Therapists might ask:

- What do you think your breathing habits have been like? Do you think you have been predominantly a chest breather or an abdominal/diaphragmatic breather, in the past?
- Why is abdominal/diaphragmatic breathing important?
- What is a breathing technique that you might be able to use in the midst of a stressful situation?

Homework

The homework exercise is to ask the client to read over the breathing exercise handouts, and to set aside some time each day to practice the correct breathing technique and listen to the relaxation tape. Other relaxation and breathing activities such as yoga and pilates could be suggested.

References

Davis, M., Eshelman, E. R. & McKay, M. (2000). *The relaxation and stress reduction workbook* (5th ed.). Oakland, California: New Harbinger Publications, Inc.

Wharton, L. (2002). How to learn the relaxation response: Part three of a series on executive stress. *The National Business Review, October 18, 34.*

Session 5

Dropping the Rope: Letting Go of the Struggle

Tasks

- Trace the antecedents of psychotic breakdown/problems
- Develop and prioritise problem list
- Present "tug-of-war" metaphor: letting go of the struggle

Session Goals

- To ascertain the life events/stressors that preceded the client's psychotic breakdown/problems.
- List of current problems/struggles that are standing between the client and moving toward what the client most values in life, and prioritise them.
- Present to the client the idea that letting go of the struggle ("tug-of-war") may be a viable option.
- Introducing to the client the idea of stopping trying to avoid unpleasant feelings and experiences and to become more accepting of such experiences i.e., how to live with unwanted experiences.

Key Interventions

Trace the Antecedents of Psychotic Breakdown/Problems

Use the information obtained during the first session, and information obtained from questioning within this session, to provide the client with a basic formulation of their problem.

"Remembering back to the first session where we looked at the Five-Part Model, and we talked about the interconnection between thoughts (beliefs, images, memories), moods (emotions, feelings), physical reactions (biology, body), behaviours (actions), and environment (past and present, situations, history, culture), let's take a closer look at this model in relation to some of the stresses you have experienced in the past that may have contributed to your problem".

Therapist's notes: Basic formulation

- The rationale behind this exercise is that we want the client to learn to understand their own feelings, and to become a good observer of their own reactions to situations.
- From the information provided by the client, we want to end up with a formulation that looks something like this:
  Event (hear voices) → Thought (It's the devil or I'm the devil) → Feeling (scared) → Behaviour (pray and visit church or hurt self).

Develop and Prioritise Problem list

Ask the client for a list of current psychological problems/struggles that are standing in the way of the client moving toward a more valued life, and prioritise. At this point remind/talk with client about the ways they have handled these situations in the past, and whether they have worked or not. That is, explore their previous approaches to coping with problems or symptoms of psychosis.

Present Tug-of-War Metaphor: Letting go of the struggle

For many clients, stopping unworkable strategies is difficult; these strategies are learned behaviours that the client has used to try and cope with their problems, and to the client there often is not a clear alternative response. Metaphors are very useful at making the point that less analysis and less struggle can increase adaptive responses.

"We have talked about the ways you have struggled with your thoughts and feelings (your mind) in the past... Some of the ways in which you have worked hard to cope with your struggles have kind of worked for you e.g.,... and despite working hard with other ways of coping e.g.,... they haven't worked for you. I'd like to talk about another option you have that you may not have thought of. What about accepting the thoughts and feelings you have about yourself, because you have them anyway; indeed, our thoughts are not that controllable, they pop into our minds when sometimes we don't want them to. So... what about just accepting them and not struggling with

your unwanted thoughts and feelings, by not trying to get rid of them or change them, by not arguing with them, by not doing what they say and just letting them go. If you're a little confused at this point, let me provide you with an image."

Put on the hand-puppets, place the marker in the middle between the two puppets and pick up the rope, explaining at the same time that you're about to get a bit 'silly' to illustrate the image!

"Think about a tug-of-war. How does a tug-of-war usually end? (For example, either the team on the right wins by pulling on the rope harder than the team on the left, or vice-versa). The teams will spend a great deal of energy fighting each other until one team has won; they will fight to the end. However, there is another way to end a tug-of-war which most people don't think of...one of the teams could drop the rope! Imagine what would happen then? The fight would be over.

So, let's imagine that the team on the left is your unwanted thoughts and feelings...now imagine that the team on the right is all your thoughts that you use to try to avoid or change those thoughts, calm yourself or make yourself feel better. Have you noticed what happens with your own unwanted thoughts because you are fighting with them to go away? Does it feel like the left team always comes back at you no matter how hard the right team fights back? So you pull and pull, but the harder you pull, the harder the left team (unwanted thoughts) pulls back.

But what if one day you come along, pick up the rope, and then when the other team starts pulling... you drop the rope. You just let it go. Imagine that you stop trying to decide which thought is right and which is wrong... which thought to have or not to have... which thought you will try to avoid or change and which you won't...which thought you will act on and which you won't. In other words, you stop trying to control your upsetting thoughts and feelings. What would happen if you stopped being on one side

of the rope ***or*** *the other? After all, both teams are yours they are* ***both*** *your thoughts!*

Can you also see from this image I've just presented, that the problem is not our symptoms, or thoughts, or feelings/emotions, but how we respond to them?

After presenting this metaphor, some useful questions and suggestions might be:

- What would it be like for you to stop fighting this tug-of-war of the mind?
- What would it feel like?
- What could you do instead with all the time and effort you have, in the past, put into fighting the tug-of-war? This is something we will look at shortly.
- If the client mentions that they would prefer to win, then you could say, *"I understand that you would prefer one team to win once and for all, but how long are you willing to fight the other team, and how much energy are you prepared to use to win this game? And remember, the two opposing teams are really one team: you."*
- If the client asks, "How do I do that?" after hearing this metaphor, the therapist should reply with something along the lines of, *"Well, I don't know how to answer that right now. But the first step is simply to see that you are holding the rope".*
- The therapist should present the drop-the-rope image as a learned skill that will take time to acquire.

Therapist's notes:

- This exercise is helpful in exposing to the client the idea that letting go of futile struggle (the argument with thoughts and feelings) may be a viable option.

- We want people to learn to live with (accept) unwanted experiences, because when people numb their thoughts and feelings, and avoid situations, it limits their quality of life.
- Depending on how the client reacts to this metaphor, the therapist can use the analogy in future situations e.g., if the client comes in to future sessions with a new struggle/challenge, it might be talked about as an opportunity to 'drop-the-rope' (drop the safety behaviours!).

Key Outcomes

Therapists might ask:

- After listening to the tug-of-war image, what do you think this image was trying to tell you?
- What do you think you could now do with your unwanted thoughts and feelings, instead of fighting them?

Homework

The homework for this session is a self-monitoring task designed to gather data about situations where the client engages in struggle. Provide client with the **Self-Monitoring Form HANDOUT.**

"One thing you can do between now and the next session is to try to become aware of how you carry out this struggle in your daily life. See whether you can just notice all the things you normally do; all the ways you pull on the rope. Getting an idea of what pulling is for you is important because, even if you drop the rope, you will probably find that old habits are so strong that the rope is back in your hands only moments later. So we will have to drop the rope many, many times. It might be useful to make a list that we can look at when we get back together; all the things like distraction, self-blame, talking yourself out of it, avoiding situations etc., that you have been doing to try to solve the problem. I'm not asking you to change these

actions; just try to observe how and when they show up. We want you to take the role of an observer of the game; to become a good observer."

To illustrate, a short role-play may be needed. For example:

"Let's try it here in the office. I'm going to do some self-observation. Okay, what did I do today? Hmmm, one of my problems is that I avoid unpleasant tasks. Did I do that today? Yes, I was supposed to … but, I put it off. Well, I won't beat myself up about it. That is just me …

Now it is your turn – how can you be a good observer of yourself?"

References

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiental approach to behavior change*. New York: The Guilford Press.

Session 6

Becoming an Observer

Tasks

- Introduce to the client the idea that control may be their problem, not their solution
- Examine the apparent success of control strategies and the costs of using control strategies in the wrong places
- Present the *Chocolate Cake Exercise*
- Present the *Tug-of-War with a Monster* metaphor
- Show the client the idea of becoming an observer – *Advice to a Friend Experiment* – of being present in the moment

Session Goals

- Introduce client to the idea that their efforts to control their problems (their thoughts, feelings/emotions, physical symptoms) – by using such techniques as avoidance, distraction, numbing, and direct control – are the problem, not the solution to their problem. That is, control is the problem, not the solution.
- Examine the apparent success of control strategies, but show the costs of using them in the wrong places.
- Show the client, using an experiential exercise (the *Chocolate Cake Exercise*), how ineffective deliberate verbal control can be when applied to thoughts, feelings, and even physical reactions.
- Re-introduce to the client the idea that letting go of futile attempts to control unwanted thoughts may be a viable option (the *Tug-of-War with a Monster* metaphor).
- Start introducing to the client the notion that there is an alternative to control strategies; that is, being present (*Advice to a Friend Experiment*).

Key Interventions

Control Strategies: Control could be the problem not the solution

Introduce to your client the idea that their efforts to control their problems (their thoughts, feelings/emotions, physical symptoms) – by using such techniques as avoidance, distraction, numbing, and direct control – could be their problem, not the solution to their problem. Begin this session by looking at why we use control in our lives and the ways we use control. Promote the idea that we use this method of coping because taking control does work well in certain situations.

"We finished last week's session with the Tug-of-War image; the idea that a tremendous amount of energy can be spent trying to control our unwanted thoughts, feelings and experiences. In fact, it can be quite exhausting. Yet, many of us use control as a coping strategy to rid ourselves of these unwanted thoughts and feelings. We use such control-oriented strategies as:

Go through the **HANDOUT – "Control-oriented strategies that may work in the short-run, but do not work in the long-run"**.

Avoidance – *not doing things that cause us to experience unwanted thoughts and feelings e.g., not going to a friend's party because we feel embarrassed talking to other people;*
Numbing – *trying to ease or escape from our pain by using drugs/alcohol or staying in bed/oversleeping);*
Distraction – *diverting our attention from our primary problem and onto something else e.g., developing a work-aholic lifestyle), or we use*
Direct control – *doing something that directly stops or changes what is bothering us e.g., trying to stop our thoughts or emotions by saying 'Don't be sad' or 'Don't cry', or bossing other people to get them to do what you want them to).*

Ask your client if they have used any of the above control strategies and in what situations.

"Why do we use these strategies? One of the reasons is that some of these strategies can work in the short-term, but do not usually bring lasting change. Another reason is because society constantly bombards us with the message that being in control of emotions is the way to be, and the more we can control our thoughts and feelings, the better off we are. That is, to be psychologically healthy we should be free of any disordered or distressing emotions and thoughts! However, in reality it is psychologically healthy to feel bad feelings as well as good feelings. For example, sad and crying at a funeral are natural healthy reactions to the grief of losing someone you care about – these are not 'bad' emotions that must be avoided or escaped from. Our experiences of sadness, anger, fear, and other emotions are often normal reactions to difficult situations.

Another reason we use control strategies is that taking control does work well in certain situations. For example, you can throw away clothes you don't like; and if you don't like the taste of your toothpaste you can change it. You can control quite a few things in the external world – and, if you are in a controllable situation and you don't like what you've got, then go ahead and change it!

However, it is not that easy to control our internal world – our thoughts and feelings. Indeed, we suffer most when we try to change what we have no control over."

To illustrate further to the client the contrast between behaviour that can be controlled and behaviour that is not regulated successfully by verbal rules/purposeful control, present the following:

"Think about this. If somebody said to me, 'Vacuum the floor or I'll make you eat worms' I'd start vacuuming the floor like crazy. If somebody said to me, 'Paint the house or I'll make you eat worms,' I'd be out there furiously slapping on the paint. That's how the world outside the skin works – you have some control over it. But if somebody simply said to me, 'Relax, or I'll make

you eat worms,' not only will it probably not work, but also it's the other way around. The very fact that somebody would ask me to do this would probably make me very nervous – especially as I particularly don't fancy eating any worms!

It's like when you're angry and someone says 'calm down'!"

Ensure that you show your client that you recognise they may have some painful emotional material that they would rather not experience.

*"Some of your thoughts and feelings are painful and unpleasant; you probably wish you didn't have them, and you may not like what you see and feel. However, your thoughts and feelings – all of them – are a part of you. They are not **YOU**, but they are all a part of you. And remember, none of your thoughts and feelings are there permanently, all of the time – they come and go, they pass into and out of your body and mind.*

It is when we try to struggle against our unpleasant feelings and thoughts, or try to suppress them or avoid them, that they usually stick around longer and become stronger."

The Chocolate Cake Exercise: Futility of Thought Suppression

Present the *Chocolate Cake Exercise* to your client, to help illustrate how ineffective conscious purposeful control can be.

NOTE: For those clients with an eating disorder, ask them not to think about a white polar bear. A fluffy white polar bear frolicking around on the ice ... darting and playing under the water ... etc.

"Suppose I tell you right now that I don't want you to think about something. I'm going to tell you soon what that something is. And when I do, don't think it even for a second. Here it comes. Remember, don't think of it. Don't think of ... warm chocolate cake! You know how it smells when it first comes out of the

oven. ... Don't think about it! The taste of the chocolate icing when you bite into the first warm piece. ...Don't think of it! As the warm, moist piece crumbles and crumbs fall to the plate. ...Don't think of it! It's very important; don't think about any of this!

Ask the client if they could do it! **See Additional Notes if client says YES!!** Now repeat the exercise with respect to a physical reaction.

"Let's try another example. ...Don't drool when I ask you to imagine biting into a wedge of lemon. Don't drool as you imagine the taste of the juice on your lips and tongue and teeth."

Tug-of-War with a Monster: Letting go of the struggle

Re-introduce to the client (using the tug-of-war metaphor) the idea that letting go of futile struggle with unwanted thoughts and feelings (anxiety and other distress) may be a viable option.

"At the end of the last session we talked about the tug-of-war, and about dropping the rope. Let's take that image one step further. Imagine that the problem/distress/situation you are in is like being in a tug-of-war with a monster. It is big, ugly, and very strong. In between you and the monster is a ditch, and so far as you can tell it is very deep. If you lose this tug-of-war, you will fall into this ditch. So you pull and pull, but the harder you pull, the harder the monster pulls, and you edge closer and closer to the edge of the ditch. The hardest thing to see is that our job here is not to win the tug-of-war. ... Our job is to drop the rope."

Therapist's notes:

- The above work is carried out in an effort to get the client to see that ending the struggle with what ever is troubling them, and starting to live instead (and do all the things they want to do) requires them to include their problem/distress as a legitimate part of these life changes. That is, "you can live your life despite ..."

- Convey to the client that we cannot suppress unwanted thoughts and feelings forever … and it is just not helpful or psychologically healthy to do so.
- Research studies have shown that we recover better from our emotional wounds if we allow ourselves to experience the feelings and thoughts we have, rather than attempt to push them away. To become an observer of our feelings.

Advice to a Friend Exercise: Becoming an Observer

1. Ask the client to think of a problem that a friend/family member might have. Ask them to make one up if need be. The problem could be of an emotional or physical nature, or even a problem with a neighbour.
2. Write the suggested problem down on the whiteboard.
3. Then ask the client to think about giving advice/offering help to their friend to assist their friend with the problem.
4. Make a list on the whiteboard of all the suggestions/advice your client gives to their 'friend'.

Therapist's notes:

At the completion of the exercise:

- Ask your client if they found it easier to give advice to a 'friend', than if they them self had the problem.
- Suggest to your client that it is usually easier to help a friend because you are 'an observer' of your friend's problem.
- Introduce your client to the idea that 'being an observer' allows you to step back rather than get all tangled up in strong thoughts and feelings. Being able to step back and observe gives you a clearer perspective and allows you to adopt a different approach, just as if you were doing it for a friend.

"And remember, you have no better friend than yourself anyway. So…be gentle with yourself! Next week we are going to look at strategies to help you

become a good observer of your own problems, and learn how to experience and deal with emotional discomfort."

Key Outcomes

Therapists might check how today's session has gone by asking:

- What are three control-oriented strategies that might work in the short-term, but will probably fail in the long-term?
- What do you understand by the idea that control might be the problem, not the solution?
- If you 'drop the rope', what are you essentially doing?
- Why is helping a friend with a problem often easier to do than if you were facing the same problem?

Homework

For this session's homework, ask the client over the next week to try and tackle any problems that might arise as if they were giving advice to a friend. Ask them to think about taking a step back from their situation and being 'an observer' of their problem, rather than get all tangled up in strong thoughts and feelings. And remember, *"be kind to yourself – develop a less combative relationship with yourself!"*

References

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiental approach to behavior change.* New York: The Guilford Press.

Heffner, M., & Eifert, G. H. (2004). *The Anorexia Workbook: How to accept yourself, heal your suffering, and reclaim your life.* Oakland, CA: New Harbinger.

Session 7

Becoming a Mindful Observer

Tasks

- Introduce mindful observation
- Prepare to be mindful
- Mindful observation exercises
- *Take Your Mind for a Walk* exercise

Session Goals

- Introduce mindfulness to the client, and help them prepare for mindful observation.
- Help the client to become a mindful observer of their thoughts and feelings – willingness to observe whatever thoughts and feelings their mind serves up to them without trying to change them, hold on to them, push them away, avoid them, or distract from them.
- Instill in the client the notion that mindfulness is about letting thoughts, feelings, and sensations come and go, rise and fall away, without attempting to exert control (although it is important to point out that, in reality, the client is in control and can stop the process at any point).
- Begin to teach the client to live in the present moment and to focus their attention on what they are doing right now, rather than thinking about the past and worrying about the future.

Key Interventions

Introduce Mindful Observation

"I would like to introduce a new idea to you. A different way of experiencing your thoughts and feelings you may not have heard of before – mindful observation – it involves stepping back and watching your self and your own experience.

Much of our stress comes from thinking about the past or worrying about the future. When we live in the present moment and our attention is focused on what we are doing right now, there is no room for anything else to enter – including fears, desires, or anything that could be stressful.

One way we can learn to do this is by mindful observation. Learning to be mindful of our thoughts and feelings. Being mindful means that we do not try to change our thoughts and feelings (in the last session we talked about ways we usually try and do this e.g., distraction, avoidance, numbing, trying to stop the thought). As a mindful observer, we simply note when thoughts of past and future, desires or aversions, or anything else that our mind dishes up to us, arise, and then we turn our awareness gently back to the present. We watch our thoughts and feelings/emotions come and go, ebb and flow, without attempting to change them, hold on to them, or run away from them.

In fact, the key to mindfulness is your willingness to observe and experience your thoughts and feelings without trying to change them, hold on to them, or run away from them.

In the past, when you experienced an uncomfortable thought or feeling, you reacted in ways to stop the thought or numb the feeling... (use client's own way of reacting here, ascertained from previous session). *And it is this reactivity to 'what is' and the stories you tell yourself about what you notice that create your suffering or pain. For example, just say while you are sitting during your mindful observation you find your attention drifting to your left knee, which has become quite stiff; next minute you are creating a story...* ***Oh my left knee is really hurting, it will never stop, it's going to get worse, I won't be able to get up and walk after this...***

Sound familiar?

Have you found yourself doing this about your thoughts/feelings in the past?

So, what I am suggesting is, try to encounter what arises during mindful observation with a gentle, nonjudgemental, and embracing attitude. Use a bare-bones attention to simply notice wherever your attention wanders, let go of it without judgement, and return back to the object of your focus that you have chosen – be it whether you are focusing on your breath (which we will start with shortly), your thoughts, or your emotions.

In the above example I gave, you would simply notice the thought or story and return back to your focus without getting caught up in the content – that is, you are mindfully observing! Mindfully observing actually trains you to encounter stressors in your life, whether internal or external, in a similar way. When you encounter stressors, catch yourself before you go into a habitual reaction that leads to suffering – rather than getting stuck in reactivity, breathe, pause, and make new choices about how to respond.

Handout – Mindfulness Handout: States of Mind.

"This handout presents the three primary states of mind described in mindfulness work: "reasonable mind," "emotion mind," and wise mind."

"Reasonable mind: this is your rational, thinking, logical mind. It is the part of you that plans and evaluates things logically. It is your cool part. This is the part of people that builds homes, roads, follows instructions, run meetings – it can be very beneficial. Reasonable mind is easier when people feel good and much harder when they don't e.g., "if only I could think straight, I would be alright.

Emotion mind: you are in emotion mind when your emotions are in control – when they influence and control your thinking and behaviour. A certain amount of emotion mind is beneficial, and desirable – intense love is motivation for relationships, intense devotion or desire motivates staying with very hard tasks, sacrificing oneself for others.

Problems with emotion mind occur when the results are positive in the short term but negative in the long term, or when the experience is very painful, or leads to other painful states e.g., anxiety and depression. Emotion mind is exacerbated by (1) illness; (2) sleep deprivation, tiredness; (3) drugs, alcohol; (4) hunger, bloating, overeating, poor nutrition; (5) environmental stress (too many demands); and (6) environmental threats.

Wise mind is the integration/combination of emotion mind and reasonable mind. You cannot overcome emotion mind with reasonable mind. Nor can you create emotions with reasonableness. You must go within and integrate the two. Wise mind is that part of each person that can know and experience truth – wisdom, wise mind, or wise knowing. It is similar to intuition. For example, it is "feeling" the right choice in a dilemma, when the feeling comes from deep within rather than from a current emotional state.

Everyone has wise mind (it is like having a heart – everyone has one!); some simply have not experienced it. Also, no one is in wise mind all the time.

To tell the difference? If intense emotion is obvious, suspect emotion mind. Give it time; if certainty remains, especially when you are feeling calm and secure, suspect wise mind."

Before preparing to be mindful, go through **HANDOUTS – 'Important Points About Mindfulness' and 'Why Learn Mindful Observation'** – with the client.

Preparing to be Mindful

Go through the **'Preparing to be Mindful' HANDOUT**, regarding selecting a location, body position, and centering oneself.

Mindful Observation Exercises

ASK the client if they would like to try some mindfulness exercises. Tell your client that the first one will focus on their breathing, and the second will focus on their thoughts, feelings/emotions, and perceptions.

Mindfulness of breath

"The simplest way to be a mindful observer is to focus on your breath. Let's start by choosing a comfortable sitting posture, and then centering and grounding ourselves – being mindful of our surroundings."

1. Get settled into your chair or cushion and close your eyes. First, turn your attention to yourself inside this room. Picture this room and some of the things inside this room. Picture the wall, the floor, the door. Next, notice any sounds that may occur inside this room ... and outside. Notice any smells in this room. Now picture yourself in this room. Notice how you are sitting in your chair *(or on your cushion)*. Then focus on the place where your body touches the chair *(or cushion)*. What are the sensations there? How does it feel to sit where you sit? See whether you can notice exactly the shape that is made by the parts of your body that touch the chair *(or cushion)*. Next, notice the places your body touches itself. Where are your hands? Notice the spot where your hands touch your legs. What about your feet – are they crossed? How do they feel in the position they are in? What sensations can you notice in the rest of your body?

2. Now focus on your breathing.

3. Bringing your attention to the gentle rising and falling of your breath in your chest and belly. Like ocean waves coming in and out, your breath is always there. Notice each breath. Focus on each inhale and exhale. Observe the cool air pass through your nose. Feel your diaphragm (stomach) expand. Imagine your lungs fill like a balloon. Listen to the

sound of your exhale. Stay focused on your breathing … how you inhale and exhale.

4. If you notice your monkey mind wandering off and thinking all sorts of thoughts, accept it as a natural phenomenon. Then, gently bring your attention back to rest on your breath. Again, focus on the rising and falling of your breath in your chest and belly. Ride the waves of your breath and let your breath begin to anchor you to the present moment.

5. If you find yourself becoming distracted by bodily sensations, thoughts and feelings, notice them and acknowledge their presence. Do not try to hold on to them or make them go away. Allow them to be, watch them dissipate/disappear, and gently bring your attention back to rest upon your breath.

6. A good way to deal with feelings is to name them as you notice them. If you notice you are worrying, silently say to yourself, "Worry, worry, worry, there is worry." You can do the same if you are *planning, longing, thinking, reminiscing,* or whatever else you experience. Label the thought or emotion and move on. This will help you experience the difference between yourself and your thoughts. You have thoughts and feelings but you are not what those thoughts and feelings say, no matter how persistent or intense they may be. Your thoughts are not facts about yourself.

7. Notice your thoughts … label them … allow them to be … watch them disappear … and then gently bring your attention back to rest upon your breath. Allow your breath to be your anchor to this present moment.

8. Gently open your eyes, and pause for a while.

Debrief: Ask the client how they felt?

What they experienced?

What they thought of the experience?

How useful was it?

How do you think it might help you?

Mindfulness of Thought, Feelings, and Perceptions

"Your task in this exercise is to observe passively the flow of your thoughts, feelings/emotions, and perceptions, one after another, without trying to figure out their meaning or their relationship to one another. This will allow you to see what is on your mind and then let it go."

1. Get settled into your chair or cushion, close your eyes, and centre yourself. First, turn your attention to yourself inside this room. Picture this room and some of the things inside this room. Now picture yourself in this room. Notice how you are sitting in your chair *(or on your cushion)*. Then focus on the place where your body touches the chair *(or cushion)*. See whether you can notice exactly the shape that is made by the parts of your body that touch the chair *(or cushion)*. Next, notice the places your body touches itself. What sensations can you notice in the rest of your body?

2. Imagine that you are sitting on the bank of a stream or river, watching a leaf drift slowly downstream. When you have a thought, feeling, or perception, see it as a leaf and then let the leaf drift out of sight. As an alternative, you can imagine your thoughts rising in puffs of smoke from a barbeque, or your puffs of breath on a really cold morning. Observe one thought, feeling, or perception, at a time on each leaf (or puff) and then let each leaf drift slowly downstream out of sight. Return to gazing at the river, waiting for the next leaf to float by with a new thought, feeling, or perception.

3. Think whatever thoughts you think and allow them to flow freely on each leaf. One by one. Imagine your thoughts floating by like leaves

down a stream. Don't think about the contents of each leaf. Just observe it. Sometimes the same leaf may come by many times, or several leaves will seem related to each other, or the leaves may be empty. That's all okay. Don't allow yourself to be concerned with these thoughts. Just watch the leaves come and go in front of your mind's eye.

4. Now allow yourself to move down into the stream and take the perspective of the stream … you are now the stream. Hold each of the leaves and notice the thought that each leaf carries as it sails by. Just let them flow …

5. Move out of the stream and back to sitting on the bank watching each leaf drift slowly downstream; observing one thought, feeling or perspective, at a time on each leaf. Allow each thought to flow freely on each leaf. Just let them flow.

6. If you feel yourself becoming distracted by thoughts and feelings, simply notice them and acknowledge their presence. Do not try to force them away. Allow your thoughts to flow freely on each leaf.

7. Gently bring your attention back to rest upon your breath, and let your breath be your anchor back to this present moment.

8. Gently open your eyes, and pause for a while.

Debrief/discuss client's experience of this exercise:

What did they think of this idea?
What did they experience?
How useful was it?
How do you think it might help you?

Briefly discuss and explain the two **Mindfulness HANDOUTS – Taking Hold of your Mind: "What" Skills** and **Taking Hold of Your Mind: "How" Skills.**

'Take Your Mind for a Walk' Exercise

This exercise can provide a powerful experience of how busy and evaluative our minds can be.

"We are now going to do a little exercise together that provides you with an opportunity to practice observing your thoughts. The point of this exercise is for you to learn how to separate your behaviour from your thoughts and feelings; that is, you can have thoughts and feelings without needing to do what they say.

One of us will be a Person, the other will be that Person's Mind. It might be easier if you start out as the Person, and I'll pretend to be your Mind. The Person (you) is going to draw a picture on the whiteboard, anything you want to draw and however you want to draw it just go ahead. The Mind (me) must stand behind you and must communicate nearly constantly about anything and everything: describe, analyse, encourage, evaluate, compare, predict, summarise, warn, cajole, criticise **(careful with this one)**, *give directions, make judgemental statements etc.*

The Person (you) cannot communicate with the Mind (me). If the Person tries to talk to the Mind, the Mind will intervene. The Mind will monitor this carefully and will stop the person from minding the Mind by saying, 'Never mind your Mind'. The Person should listen to the Mind without minding back and draw or do whatever they want. The Person is in control of what they do, not the chattering Mind in the background.

After at least 3 minutes, and the Mind will monitor this, we will switch roles. The Person (you) becomes the Mind, and the Mind becomes the Person. The same rules will apply for 3 minutes. Then we will stop, and each sits in our

chairs quietly with a piece of paper and just draw, noticing that we still have a chattering mind – this time, however, it is just the familiar Mind that is inside our head. Follow the same rules as before during these last 3 minutes: calmly, passively let the Mind describe, analyse, encourage, evaluate, compare, predict, summarise, warn, cajole, give directions, pass judgement etc, without minding back.

Before we begin though, lets make a list of the thoughts our mind commonly feeds us with regard to our drawing abilities and being watched doing something (positive and negative thoughts), so that we can feedback some of these thoughts when we play the Mind."

After the completion of this exercise ask the client:

- How difficult did they found this exercise to do?
- How difficult was it to concentrate on what they were doing and what they wanted to do, while the Mind kept up its constant chatter?

Therapist's notes:

- Discuss with the client that this exercise can be difficult because we are often compelled to respond to these statements in one way or another.
- The purpose of this exercise is to introduce to the client the idea that they can break this habit and just simply notice these statements as thoughts and statements, and carry on with what they want to do in life.
- Having all of the client's "mindstuff" come from an external source can precipitate some defusion and allow the client to become aware of the mind's tendency to chatter, often in quite unhelpful ways.
- The important thing to remember is to stay on your chosen path – no matter what your mind feeds you! Strong feelings and thoughts are NOT facts – you don't have to buy into them.

And to finish this session:

"Remember when practicing these exercises be gentle and patient with yourself. You do not have to be perfect. At times, you will find it difficult to do these exercises and follow the instructions. Mindful observation is a process. Changes will occur gradually over time.

Eventually, you will learn to live in the present moment and focus your attention on what you are doing right now rather than thinking about the past and worrying about the future. Continued practice will enable you to develop a less combative relationship with yourself and your nagging thoughts and feelings – you will find yourself dropping the rope more and more."

Key Outcomes

- What is mindful observation?
- How useful did you find the mindfulness exercises? Why/Why not?

Homework

Ask the client to read the Mindfulness handouts and to try and schedule some time each day to practice the Mindfulness exercises. Suggest that the amount of time be what they are comfortable with – 15 minutes is usually recommended to begin with, but if they only feel comfortable doing the exercises for 5 minutes then that is fine.

References

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Session 8

Emotion Regulation Training

Tasks

- Outline the goals of emotion regulation training
- Describe to the client two kinds of emotional experience
- Describe the role of emotions in people's lives
- Present a **theory of emotions**
- Present the concept of recognising, describing, and naming emotions
- Discuss why people have emotions
- Present methods for reducing emotional vulnerability
- Outline steps for increasing positive emotions
- Discuss letting go of emotional suffering and being mindful of their current emotion
- Present the idea that the client can change emotions by acting opposite to their current emotion

Session Goals

- Introducing emotion regulation training to the client.
- Identifying the functions of emotions, especially negative emotions, as an important first step toward change.
- To present ways the client can reduce physical and environmental stress in an effort to reduce proneness to emotional reactivity.
- Encouraging the client to increase the number of positive events in their life in an attempt to increase positive emotions.
- Carrying on from the mindfulness work done last session; by reiterating to the client that mindfulness to current emotions means experiencing emotions without judging them or trying to inhibit them, block them, or distract from them.
- Promoting the idea to the client that exposure to painful and distressing emotions, without association to negative consequences,

will extinguish their ability to stimulate secondary negative emotions.

- To present the idea to the client that one strategy to change or regulate an emotion is to change its behavioural-expressive component by acting in a way that opposes or is inconsistent with the emotion.

Key Interventions

Goals of Emotion Regulation Training

Orient clients to the skills to be learnt in this session and the rationale for their importance. Mention to the client that some of the ideas to be talked about today have already been presented in previous sessions, and today's session will be a chance to tie all these ideas together – to see how they fit together.

Provide client with **HANDOUT – Goals of Emotion Regulation Training** – and go through, using the following as a guide to your discussion.

Maybe take examples from the problem areas the client has identified previously.

A. **Understanding one's own emotions.**
   1. Learning to **identify emotions** as they are experienced: applying the mindfulness skills of observing and describing to emotions.
   2. Learning to identify what gets in the way of reducing intense negative emotions by analysing the **functions of emotions** – the purposes they serve or needs they fulfill.

B. **Reducing emotional vulnerability.**
   1. Learning to **decrease negative vulnerability** – to prevent negative emotional states by reducing the likelihood of being overly emotionally sensitive and increasing emotional hardiness.

2. Learning to **increase positive emotions** and thus to reduce negative emotional sensitivity.

C. **Decreasing emotional suffering.**

1. Letting go of painful emotions by **being mindful to them**, instead of fighting them or walling them off.
2. At times, modulating or changing a negative or painful emotion by acting **in a manner opposite to it**. This should include both overt actions (e.g., doing something nice for a person one is angry at, approaching what one is afraid of) and postural and facial expressiveness. With regard to the latter, however, we must learn that the idea is not to block expression of an emotion; rather, it is to express a different emotion. There is a very big difference between a constricted facial expression that blocks the expression of anger and a relaxed facial expression that expresses liking. ILLUSTRATE THIS WITH FACIAL EXPRESSIONS OF ANGER, FOLLOWED BY CONSTRICTION, AND THEN AN ADORING HALF-SMILE!

Describe Two Kinds of Emotional Experiencing

"Some emotional experiences are primarily reactions to events in one's environment (being angry at someone for criticising, feeling sad at a funeral, feeling happy that a loved one is coming to visit, being surprised that it is a nice day when rain was predicted, etc.).

Other emotional experiences are primarily reactions to one's own thoughts, actions, and feelings (guilt about feeling angry, anger at being unable to remember something, shame at not doing well on a task, pride at winning a race, etc.). In this session, we will focus on both kinds of emotion."

Describe the Role of Emotions in People's Lives

"Emotions can be useful or destructive, or (more rarely) neutral."

Elicit from the client when emotions have been useful and when they have been destructive. Assist client if necessary.

Have the client discuss the emotions that give them the most trouble; for example, guilt and/or anger. What has been the function/purpose of the emotion?

Which ones would they most like to work on?

Therapist's notes:

- It is very important to get across the idea that the goal of emotion regulation is not to get rid of emotions or give people flat affect! The idea is to reduce their suffering.
- Don't forget the effect of medication. Drug treatment changes the intensity of the feeling but not the feeling itself.
- Determine which clients are afraid of losing all their emotion and which are trying to get rid of all their emotion.

"Appraisals of emotions – that is, what we say to ourselves about emotions – can influence our ease and comfort with them. We can react to negative emotions with secondary emotions of guilt, shame, or anger. These secondary emotions cause all sorts of problems. In particular, they confuse the picture and make identification and description of the primary emotions very difficult. The primary emotions, are overshadowed by the secondary emotions; thus, problem solving in regard to the primary emotions is difficult."

Elicit examples from the client of occasions when they have had a secondary emotional reaction to a primary emotion (e.g., getting depressed about being depressed, getting angry or feeling ashamed for getting angry).

Ask which usually cause them more trouble and pain – the primary or the secondary emotion?

Present a 'Theory of Emotions'

"There are probably about 8 or so primary or basic emotions – anger, sorrow, joy, surprise, fear, disgust, guilt/shame, interest – people are born with the potential, or biological readiness, for these. All others are learned, and are usually some combination of the basic emotion.

Emotions are particular types of patterned reactions to events. They are complex and involve lots of components.

Emotions come and go. They are like waves in the sea. Most emotions only last from seconds to minutes. Emotions are also self-perpetuating. Once an emotion starts, it keeps restarting itself. When an emotion seems to stay around it is called a 'mood'."

Recognising, Describing, and Naming Emotions

Present client with **HANDOUT – Model for Describing Emotions.**

"Describing an emotion involves describing:

1. ***Prompting events** (inside or outside) and situation.*
2. ***Interpretation** of the event or situation (i.e., thoughts, assumptions, beliefs).*
3. ***Body responses** that are sensed (or can be if one pays attention).*
4. ***Verbal communication** of the emotion.*
5. ***Action urges** and action taken.*

Emotions also have after-effects. Intense emotions have powerful aftereffects on memory, thoughts, and even the ability to think, physical function and behaviour.

Discuss Why People Have Emotions

Go through the **HANDOUT – What Good Are Emotions?**

Reducing Emotional Vulnerability

Go through the **HANDOUT – Reducing Vulnerability to Negative Emotions.**

Steps for Increasing Positive Emotions

Present the **HANDOUT – Steps for Increasing Positive Emotions** – and the accompanying **HANDOUT – Adult Pleasant Events Schedule.**

Discuss with the client the events that would prompt positive emotion (such as love, joy, pride, self-confidence, and calm) for them, from the Adult Pleasant Events Schedule; add clients own if necessary.

Letting Go of Emotional Suffering: Mindfulness of Your Current Emotion

Go through the **HANDOUT – Letting Go of Emotional Suffering: Mindfulness of Your Current Emotion.**

Point out to the client that this is a review of what they did in the last session/last week; that is, mindful observation.

NOTE: If you run out of time, leave the following handout as it is quite complex. DO NOT HAND IT OUT IF IT HAS NOT BEEN DISCUSSED WITH THE CLIENT.

Changing Emotions by Acting Opposite to the Current Emotion

Present the **HANDOUT – Changing Emotions by Acting Opposite to the Current Emotion.**

Therapist's notes:

- It is very important to convey to the client that the idea here is to act contrary to an emotion, NOT to mask or hide emotions.

- Explain to the client that we have to throw ourselves into acting opposite to the emotion. But we do not have to suppress our feeling. Our behaviour or actions communicate to our brain, and the effect is a slow but steady change in our emotions. This procedure works when our emotions are not realistic for the situation. Thus, if the problem is fear, we should only enter fearful situations if there is no serious danger. If the problem is guilt or shame, don't repeat actions that in your wise mind you believe are immoral. USE EXAGGERATED EXAMPLES HERE TO MAKE THE POINT.

Key Outcomes

- What pleasant events could you do each day to increase positive emotions?

Homework

This session will probably have been fairly full on! For homework, suggest to the client that they read over the handouts, and be thinking about ways they could incorporate some of these ideas into their everyday lives. If they so wish, they could make notes on the above and bring them into the next session.

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Session 9

Eliciting Life Values and Goals

Tasks

- Discuss the difference between values and goals
- Elicit the client's life values
- Set 'smart' goals
- Define the actions that will be used to accomplish these goals
- Discuss barriers to the attainment of these goals

Session Goals

- Learn to distinguish values from goals.
- Find out what the client most values in life.
- Encourage the client to define their life direction.
- Setting "smart" goals.
- Define how these goals will be achieved, and barriers that might arise on the way to goal attainment.

Key Interventions

The Difference Between Values and Goals

Explain to the client the difference between values and goals.

"Values are parts of life that are important to most people – the things that are most worthwhile or desirable to you. We typically have priorities involving such things as family, friends, romantic relationships, leisure, education, career, citizenship, health, and spirituality. Some of these overlap; for example, the value of education can lead to a career and your career can lead to meeting new friends.

Values are ideals. They are the things, experiences, qualities, and principles that we would most like to have in our life. Not everyone has the same values, and not everyone has values in every area.

Values cannot be fully satisfied, permanently achieved, or held like an object. For example, the value of 'having intimate, trusting relationships' is not a static/fixed achievement; it must be continually sought on a day-by-day basis. We never 'reach' being a loving person in the way that we can reach Auckland.

Knowing what is most valuable to us gives us direction in life. We can focus the majority of our time and effort on these values, rather than on things that are less important to us. And, when we have to choose between alternatives, we can look to our priorities/values to help us make our decision.

Goals are real and specific. Goals are objectives that you want to achieve, given the constraints of your time and other resources. Goals are destinations. Once you reach your goal, the work is done, and you are finished. For example, getting married is a goal. Once that ring is on your finger, your goal is achieved. Values are life-long journeys and you never ask 'Am I finished yet?' You continually pursue what you value throughout life.

Elicit Life Values

Work through the **HANDOUT – 'Values Assessment and Ranking Form'.**

Set 'Smart' Goals, Define Actions, and Discuss Barriers

Work together with the client through the **HANDOUT – 'Goals, Actions, Barriers Form'.**

PLEASE NOTE: PHOTOCOPY THE 'VALUES ASSESSMENT AND RANKING FORM' AND THE 'GOALS, ACTIONS, BARRIERS FORM' TO KEEP ON THE CLIENT'S FILE, AS A RECORD OF THIS SESSION.

Note: Barriers to achieving goals could include: fear of failure, fear of unknown, pressure from ourselves or others, fear because of past failures, goal seems too big or not achievable, too much to do at once, not sure how to approach goal or where to start, not thinking far enough ahead.

While working through the goals-action part of this handout, keep in mind the following questions:

- Will this action, if taken, actually produce the goal or lead to it?
- Is the action feasible and within the client's range of abilities?
- Does the client understand the temporal relationship between the action and the goal?
- Is the client generating goals that are too large or heroic? Encourage the client to 'accumulate small positives' or 'steps in the right direction', rather than trying to take huge heroic steps towards their goals.

End with:

"Valued living is a lifelong process in which roadblocks and barriers will arise along the way. Remember, each day is a day to move in a valued direction and take your thoughts and feelings with you, painful or otherwise.

Therapist's notes:

- While setting goals, stress to the client that reaching a particular goal is just one of the many steps in a valued direction.
- Care is needed in this session to ensure goals aren't confused with values e.g., "I want to be happy" sounds like a value, but it is not a value. Being happy is a kind of an emotional goal. It is something you can either have or not have. Essentially, being happy is an outcome, a result that may (or may not) happen *after* you start moving toward your values.

Key Outcomes

- Explain to me what you think is the difference between values and goals?

Homework

Ask the client to read over the values, goals, actions and barriers that have been recorded today, and see if they can think of any more they would like to add to their forms.

References

Davis, M., Robbins Eshelman, E. R. & McKay, M. (2000). *The relaxation and stress reduction workbook* (5th ed.). Oakland, California: New Harbinger Publications, Inc.

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Session 10

Review, Relapse Prevention, and Wrap-up

Tasks

- Review of therapy
- Relapse prevention
- Facilitation of continued progress
- Feedback session
- Wrap-up therapy

Session Goals

- To review the important points of each individual therapy session and tie each session together.
- Assist the client to recognise their changes in behaviour, emotion, and thoughts that precede relapse; that is, their particular 'relapse signature'.
- Help client identify high-risk situations (identify triggers).
- Establish a step-by-step action plan to deal with setbacks.
- If applicable, discuss the option of referral back to their primary clinician/carer to explore what might be accessible to facilitate continued progress.
- Ask for feedback from the client on how they found the therapy.
- Close the therapy and say goodbye.

Key Interventions

Review of Therapy

Go back through the treatment manual and briefly review each therapy session; highlight important issues, particular 'light-bulb' moments for the client (previously noted in the column as it occurred), and tie the therapy sessions to each other with specific reference to the 'Guiding Principles of EVoLVE Therapy' on page 3 of this manual.

Relapse Prevention

Regardless of the mental illness, it is important to anticipate relapse without predicting that it is inevitable or creating an expectation for it.

Part of preventing relapse is to ensure that all concerned have a list of warning signals indicating that previous problems are about to recur.

Discuss the **HANDOUT – 'Early Signs of Psychosis'.**
IF NO PSYCHOSIS, USE THE CLIENT'S DIAGNOSIS/PROBLEM E.G., ANXIETY, DEPRESSION, MANIA ...

Now work through with the client, and record on a blank piece of paper, the client's individual 'relapse signature' – which will probably include core or common symptoms together with features unique to the client. Identify the client's high-risk situations (identify triggers) – for example, stressful periods, watching t.v (could be a trigger for 'ideas of reference') etc.

"By identifying the changes in behaviour, emotion, physiological reactions, and thoughts that might be suggestive of reduced wellbeing, opens the possibility for you to initiate early intervention strategies to prevent relapse."

Engaging friends, family, and other social supports can be important in preventing or bouncing back from relapse. Work through the **HANDOUT – 'Social Circle Technique'.**

"The 'Social Circle Technique' helps us identify those individuals and groups we can rely and gain support depending on how close each relationship is – it maps the individual or family support system."

Focus on what the person and others have done to help recovery or prevention in past experiences.

Using the information from above, and further collaboration with the client, establish a step-by-step action plan to deal with set-backs. Write this down for the client's future reference.

Facilitation of Continued Progress

If applicable, discuss with the client the option of referral back to their primary clinician/carer to explore what might be accessible to facilitate continued progress.

Ask For Client Feedback

Obtain feedback from the client about EVoLVE Therapy.
Ask the client if they would mind filling in the **'Client Feedback Form'.**

Wrap-up

In closing, ask the client:

How is it going to be for you not coming in anymore?

How has the therapy gone for them? How has it been for you?

Tell the client how you have felt about it and tell them you will miss them coming in, or similar.

Thank the client for their continued participation in 'EVoLVE Therapy'.

Close the therapy session and say goodbye.

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EPPIC. (1996). *The psychoeducation in early psychosis manual.* Victoria, Australia: EPPIC Statewide Services.

Birchwood, M. (1996). Early intervention in psychotic relapse: Cognitive approaches to detection and management. In G. Haddock & P. D. Slade (Eds.), *Cognitive-behavioural interventions with psychotic disorders* (pp.171-211). London: Routledge.

Rowan, T., & O'Hanlon, B. (1999). *Solution-oriented therapy for chronic and severe mental illness.* New York: John Wiley & Sons.