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Title: Emotional Processes in Understanding and Treating Psychosis

In R. Menzies, M. Kyrios, & N. Kazantzis (eds*) Innovations and Future Directions in the Behavioural and Cognitive Therapies*. Bowen Hills, QLD: Australian Academic Press

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Overview

The role of emotion within CBT for psychosis (CBTp) has evolved as treatment research and clinical practice has progressed over the past three decades. For example, early case reports framed emotions such as anxiety as a downstream *consequence* of delusional thinking. Similarly, most CBTp goal setting guidance emphasized that treatment need should follow the distress and interference *caused* by symptoms, not their mere presence. Yet, it has become clearer that emotional dysregulation may act as an upstream driver of psychosis, with the possibility it has a strong role to play in causing distressing mental experiences. These observations have unfolded alongside the emergence of the third wave of behaviour therapy approaches. With this we have seen renewed interest in understanding the mediators and moderators of clinical improvement along with a greater focus on the transdiagnostic processes that govern the development and maintenance of problems of emotion, cognition, and behaviour. As a result, we now have more refined therapeutic targets (e.g. specific symptom experiences such as anhedonia), new

clinical formulations (e.g. transdiagnostic accounts of how anxiety processes such as worry affect symptom development and maintenance), and new treatment techniques (e.g. mindfulness based approaches). Some of these trends, findings, and future directions for CBTp are presented below.

Major Findings

CBTp has undergone a remarkable transformation from something of a curiosity in the early 1990s to its modern day status as a major branch of applied therapy research. We now know that talking to people about their hallucinations and delusions does not make them worse, and in many cases it may help them to process and make sense of their experiences in a more adaptive way. We have also learned that there is not really a monolithic entity that we can call CBTp. The proliferation of meta-analyses have shown that the family tree of CBTp has many branches across the dimensions of treatment target (command hallucinations vs. all symptoms), stage of illness (early psychosis vs. long standing experiences) and style of intervention (e.g. highly behavioural vs. very cognitive). Outcome data across CBTp trials also shows that a treatment response can occur in domains not directly targeted as part of the intervention protocol. For example, secondary outcomes such as depression and social anxiety can improve even when these have not been targeted for change. Following these data, emotional processes have become important targets for intervention in newer generation CBTp protocols. Processes such as worry, rumination, traumatic memory retrieval, and experiential avoidance are now the focus of empirical testing and evaluation in experimental work and trial contexts. This work has also stimulated the adoption of treatment manoeuvres that may have previously been considered

irrelevant or too difficult to implement in the context of psychosis (e.g. metacognitive strategies).

Clinical Implications.

Psychological therapies are increasingly recognised as a mandatory component of good quality care for people experiencing psychosis but there is much still to do. First, we need better models of specific problematic experiences faced by people with psychosis. In many ways we are moving away from the era of "CBT for psychosis" into a more transdiagnostic phase where the processes underpinning specifiable problems are identified and then used to drive problem focused psychological formulations and treatment plans. Prominent emerging transdiagnostic problem targets include suicidality, anhedonia, loss of meaning and purpose, and depressed mood. Traditional psychotic symptoms such as hallucinations and delusions will still warrant therapeutic attention for many people experiencing psychosis; however, the next generation of treatment approaches need to be more closely matched to the processes underpinning these problems and their functional consequences. For instance, while symptom elimination may remain a chosen goal for some people, others may be better served by learning new ways of relating more productively to their mind and living well in the presence of symptoms. Also, while distraction and behavioural coping based strategies may help many people manage harmful symptom experiences in the short term, long term and generalized improvements in functioning will most probably require development of a deeper understanding of ones own mind and its vagaries. The techniques in third wave approaches that shape up more adaptive ways of reacting to our mental experiences focus therapeutic attention on promoting

skills that support autonomy, self-determination, and the pursuit of a personally meaningful life.

Future Directions

The move by NIMH to determine funding allocations on Research Domain Criteria (RDoC) instead of DSM diagnoses has stimulated new conversations about the best way to understand and treat mental health problems. This has helped dissolve arbitrary dichotomies between neurosis and psychosis, and has supported moves toward transdiagnostic approaches to formulation and treatment. However, the RDoC approach has drawn criticism for being overly focused on neuroscience research and reductionist models of illness. Hence, there is a need for robust psychological models that understand psychosis *in context,* and can play a major part in shaping better and more effective care. This endeavour may also be helped by using new concepts such as stratified medicine to drive innovative thinking in understanding mental ill health in a personalized and targeted way. As evidence of these developments, therapy protocols are beginning to emerge that target specific sub-types of symptoms that trouble many people with psychosis such anhedonia, and specific classes of hallucinations. These new applied research efforts will bring us closer to genuinely person-centred care that makes meaningful differences to the lives of those seeking psychological help.

Further Readings

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