

## CORRESPONDENCE

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### Balancing the cognitive-behavioural approach with an analytic perspective

Although traditional psychiatrists view delusional beliefs as being held in the face of contrary evidence normally sufficient to destroy them, Freeman & Garety (2006) contend that they are held by evidence powerful enough to support them and their validity. They also argue for a continuum in intensity from normal to overvalued ideas to delusions, inviting consideration of similar mechanisms by which paranoid thoughts arise in the normal population and delusions in psychosis.

As a general psychiatrist using a psychoanalytic framework to relate to patients in everyday practice and aiding junior doctors through weekly psychosis workshops, I would hold a different attitude. I would distinguish the genesis of paranoid thoughts, that can occur in all of us, from delusions in major psychotic disorders.

Delusions are held in the face of contrary evidence, but we still need to know how and why they are formed. I believe that cognitive-behaviourists are correct that both emotions and reasoning come into play. What I find missing in their formulations is the integration of analytic concepts, namely the domination of the internal fantasy world over external reality in psychosis, the use of pathological projective identification in delusion formation and the importance of our countertransference feelings and sensitivities.

In the psychoanalytic model, the person with schizophrenia projects troublesome thoughts and feelings into memories stored in the mind for the purpose of disowning them, thus forming the delusion. These insights arose originally from very detailed analytic case studies by Bion (1958). I have observed that what is often disowned in the delusion is the individual's sanity.

While being in agreement with the cognitive-behaviourists that there is meaning to delusions, I believe that the primary task is to decipher their meaning through understanding the projections and subsequent rationalisations.

For example, a patient might claim that he is Prince Edward, son of Henry the Eighth. His delusion becomes understandable when it emerges that he has been assaulting his young wife, who is in a women's refuge. The delusion can be seen as his disowned sanity critical of his manically aggressive behaviour. His sanity is saying that he is acting like a son of Henry the Eighth, inventing his own rules

and doing what he wants to his wives, and he wishes to disown this awareness.

I believe that APT's online correspondence could provide a lively forum for reflection and debate on differences and similarities in psychological approaches towards the understanding of delusional content.

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Freeman, D. & Garety, P. (2006) Helping patients with paranoid and suspicious thoughts: a cognitive-behavioural approach. *Advances in Psychiatric Treatment*, 12, 404–415.

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### CBT for psychosis

Paranoia is a fascinating, yet challenging symptom. It still remains relatively unexplored. The extent to which it brings both subjective and objective distress or dysfunction influences its underreporting. Of more relevance to psychiatrists is how it is understood and managed in clinical practice.

Freeman & Garety's (2006) article is of immense help in dealing with patients' paranoid symptoms, and it provides an insight into the multiple dimensions of delusions. It must not be forgotten that intelligence is largely well preserved in people with paranoia, and often responses and behaviours are consistent with the paranoid ideas. As far back as 1962, psychological interventions were offered early in the illness for these reasons.

Cognitive-behavioural therapy (CBT) helps professionals not only to clarify clinical issues, but also to fix the focus of the therapy. It becomes a guided discovery into the relevance and the understanding of the individual's experiences. A genuine curiosity and much empathy is required in a therapist. The passivity that often develops in the patient during therapy can be a hindrance, although it can also have more constructive uses. Trials have shown that good outcome can be predicted by the degree of cognitive flexibility concerning delusions. Evidence has demonstrated enduring and significant benefits of cognitive therapy applied in the acute phase of a non-affective psychotic disorder. Patients who received CBT showed significantly improved insight and fewer negative symptoms (Drury *et al*, 2000). Expert CBT also helps in engagement, including

treatment adherence (Turkington *et al*, 2006). Trials of brief therapy demonstrate protection against depression and relapse. Those who do relapse have a delayed time to admission and significantly reduced time spent in hospital. Turkington *et al* also highlight the role of mental health nurses trained in brief CBT for schizophrenia as a supplement to case management and family interventions. More detailed therapy can be focused on individuals who are treatment resistant.

The use of CBT in the treatment of psychosis remains underdeveloped compared with its use for neurotic disorders. Further complications are its restricted availability in the NHS, the paucity of trained therapists and haphazard CBT supervision for psychiatric trainees. We believe that CBT should be further emphasised during psychotherapy supervision and routine consultant supervision for psychiatric trainees.

There is also a case for longer-term individual, group and family dynamic psychotherapies within early intervention teams (Martindale, 2007). Less evident are the benefits of non-specific, supportive counselling (Grich, 2002).

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### Relevance of attachment theory

Kenneth Ma (2007) very aptly emphasises the significance of attachment theory in relation to the therapeutic relationship, which has important implications regarding the treatment and prognosis of psychiatric disorders. Although an offspring of psychoanalysis,

attachment theory has been conspicuously neglected for a long time by the main proponents of Freud and Klein. Fonagy (2001) has attempted to integrate the overlapping areas of attachment theory and psychoanalysis, and deserves credit for reawakening interest in Bowlby's work. Although some of the criticisms of attachment theory are not unfounded, there is evidence that concepts of the theory can be used in making significant predictions regarding relationships, styles of coping with stressful situations, and communication between couples (Brennan & Shaver, 1994). Similarly, Holmes (2000) has suggested that attachment theory can help with clinical listening and identifying, and intervening with different narrative styles in therapy.

However, it is essential that we guard ourselves against becoming overoptimistic about attachment theory. We need to remind ourselves that, although important, Bowlby's observations were based on children who had been separated from their primary caregivers during the Second World War (Lemma, 2003). In other words, attachment theory was based on behaviours that occurred during stressful situations rather than under normal circumstances. As Field (1996) has pointed out, a wider and in-depth understanding of attachment requires observation of interactions between mother and infant during natural and non-stressful situations.

I concur with Dr Ma that more rigorous research is required in the areas highlighted in his two articles (Ma, 2006, 2007). The idea of using attachment theory for service configuration seems to me very overambitious.

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