

CBT for Psychosis

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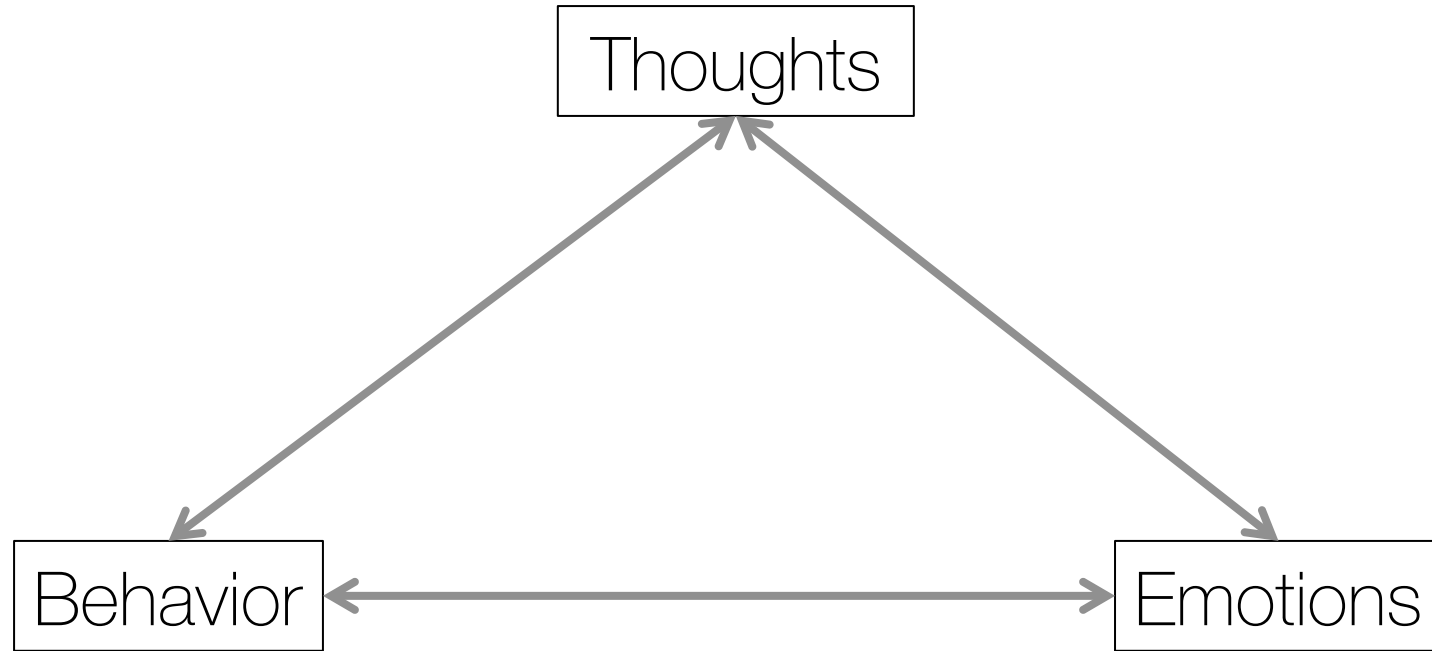
What I hope you learn today...

1. Refresher of CBT basics
2. Understand CBT for Psychosis
3. How to use CBT to address negative symptoms
4. The importance of homework in CBT

Quick Review of CBT

Basic Principles and Structure

The Cognitive Model



How we think about a situation affects how we feel and how we behave

Situation	Thoughts	Feelings	Behaviors
<p>Walking down the street, see friend Jane. Wave at her. She doesn't wave back.</p>	She doesn't like me.	Sad 😞	Avoid Jane; Reduce social activities
	She is mad at me.	Worried 😟	Ask Jane if she is mad at me
	She didn't see me.	Neutral	Say hi to Jane next time

CBT Core Characteristics

- Collaborative project between patient and therapist
- Structured & active engagement
- Empirical in approach
- Problem-oriented
- Guided Discovery/Socratic Questioning
- Behavioral Methods
- Summaries and Feedback

Structure of CBT Session(s)

- Agenda Setting (~2 min)
- Homework review (5-10 min)
- Clinician Item & homework setting (15 min)
- Client Item (15 min)
- Feedback (~2 min)

The 3 C's

CATCH IT, CCHECK IT, CHANGE IT

Work to identify, evaluate, and reframe distorted cognitions related to identified problems.

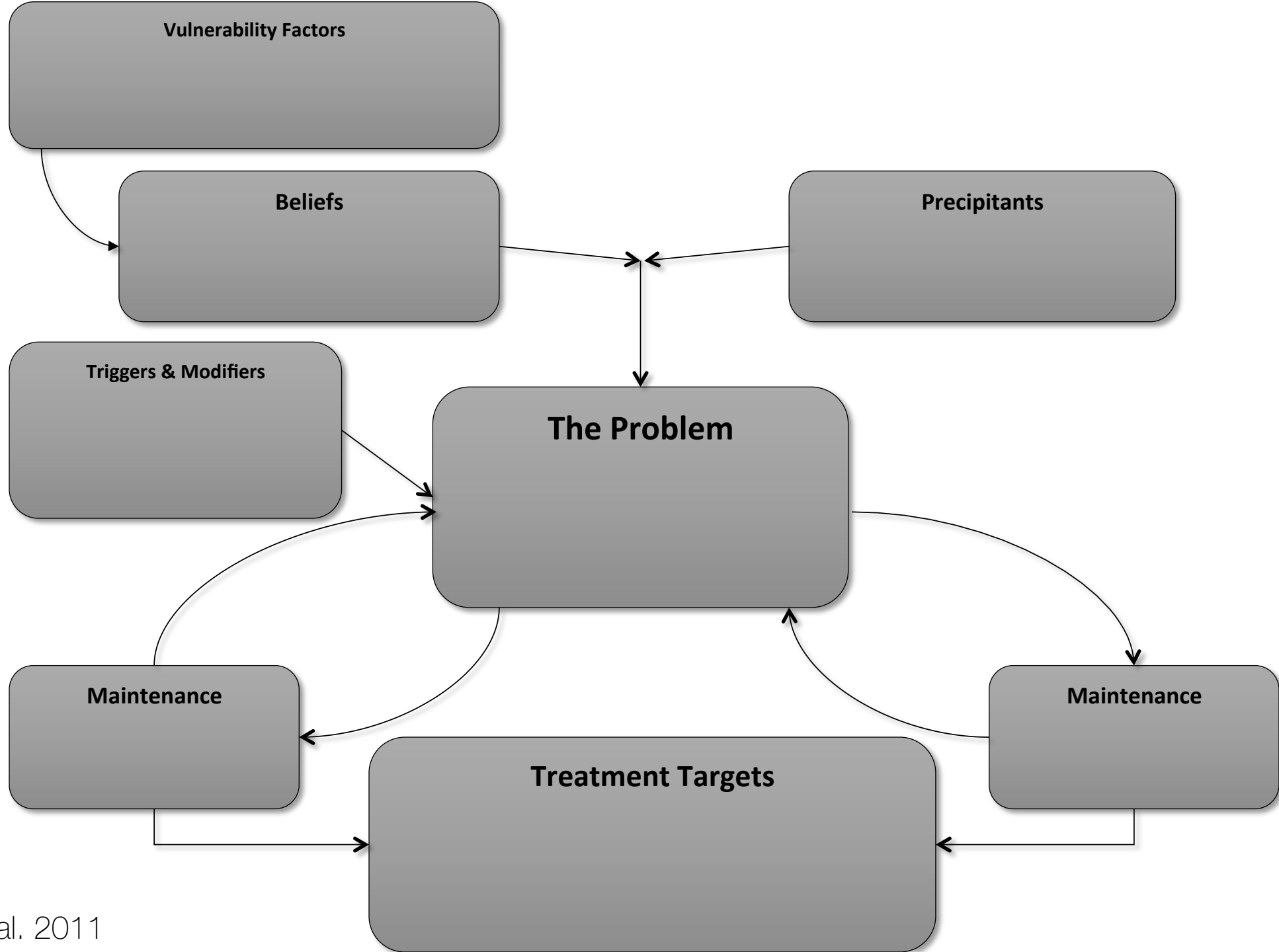
Use both cognitive and behavioral techniques

Based on CBT case formulation generated together

What is a CBT Case Conceptualization?

- Uses the CBT model to develop:
 - Description of the current problem(s)
 - Account of why and how these problems developed
 - Analysis of processes that maintain the problems
- Identification of maintenance processes informs intervention choices
- Focus on maintenance processes because:
 - Causal processes are not always the same as maintenance processes
 - Easier to obtain clear info on maintenance than original events
 - Easier to change current processes than change the past!

If you want to put out a fire, you need to tackle the elements keeping the fire going - heat, fuel, oxygen - rather than look for the spark that started the fire



Common Maintenance Processes

- Safety Behaviors & Avoidance
- Reduction of Activity
- Catastrophic Misinterpretations
- Self-fulfilling prophecies
- Performance Anxiety
- Fear of Fear
- Perfectionism
- Short-Term Rewards

CBT for Psychosis

Applying the cognitive model to psychotic symptoms

Applying the cognitive model to Psychosis

- Psychosis traditionally discussed as difficulty distinguishing what is real from what is not real
 - Delusions = fixed false beliefs held in the face of contrary evidence
- BUT:
 - Depression => distorted beliefs re: self-worth & efficacy
 - Anorexia => distorted beliefs re: body image
 - Panic Disorder => distorted beliefs re: physical safety
 - OCD => distorted beliefs re: thought-action fusion

Applying the cognitive model to Psychosis

- Psychosis is characterized by **culturally unacceptable** interpretations of experiences
 - Stigmatizing & distressing => maintains psychosis?
- Implications:
 - Normalizing may reduce stigma & distress
 - CBT techniques that are successful at addressing distorted beliefs in depression, anorexia, panic disorder, and OCD may be successful in psychosis too!

S-REF Model

- Self-Regulatory Executive Functioning Model
 - Conceptualize psychotic symptoms as “intrusions”
 - Cognitive impairments, especially executive functioning, contribute to salience of intrusive experiences
 - Metacognitive Beliefs about intrusions e.g. “Thinking about this could make me go mad/means I’m a bad person” causes distress
 - Interpretation of intrusions is what distinguishes individuals with psychosis from other diagnoses

CBT theory of Auditory Hallucinations (AHs)

- AHs are misattributed internal mental events (e.g. verbal thoughts, inner speech)
- Individuals with psychosis are:
 - less likely to recognize thoughts as own
 - less likely to recognize own voice played back with minor distortions.
 - tend to assume that ambiguously sourced info was generated externally

AHs: Failure of Source Monitoring

- Difficulty identifying where stimulus/thought came from
 - ⇒ Assume it came from outside the self (thought)
 - ⇒ Triggers NATs about state of mind (thoughts)
 - ⇒ Triggers anxiety/fear (feelings)
 - ⇒ Efforts to reduce anxiety (behavior)
- Maintained by anxiety reduction/avoidance behaviors
 - Use CBT model & intervention techniques to get at the thoughts and break the maintenance cycle

AHs: Conflict with Metacognitive Beliefs

- Often intrusive/distressing/violent thoughts that don't match beliefs about the self
 - ⇒ Triggers NATs about intrusive thoughts (thoughts)
 - ⇒ Triggers negative emotional states/distress (feelings)
 - ⇒ Generate alternate explanation for intrusions (thoughts/behavior)
 - ⇒ Avoidance of triggers/suppression of thoughts (behavior)
- Maintained by reduction in conflict/cognitive dissonance

CBT theory of Delusions

- Some delusions may be rational attempts to explain anomalous perceptual experiences or culturally unacceptable explanations of life events
 - Result of rapid, overconfident reasoning style:
 - More likely to jump to conclusions (cognitive distortion)
 - BUT... more willing to change hypotheses with new information.
- CBT Implications: clients may benefit from learning how to evaluate competing hypotheses

Delusions: Unusual Interpretations of Experience

- Interpretation of intrusions is key!
- Example: Experience intrusive/unusual thought that people are talking about them
 - Interpretation #1: “It’s my imagination; I’m just tired/stressed”
⇒ Get some sleep, reduce stress.
 - Interpretation #2: “They are trying to hurt me”
⇒ Hypervigilance for other instances, adopt safety behaviors

General Tips:

- Psychoeducation & normalization of experience is key
- Always place in the context of case conceptualization
- Use Guided Discovery: Simply telling client that they are wrong will not change the belief
- Process causing distress may not be the psychotic symptom itself

Practical Tip #1: Symptoms as the “situation”

- Place the symptom in the “situation” column of your thought record
- CATCH IT: identify **interpretations** (i.e. thoughts) of the symptom and the resulting feelings & behaviors
- CHECK IT: evaluate accuracy of the thought
 - Identify patterns of distortion
 - Evidence for and against
- CHANGE IT: generate alternate interpretations
 - More realistic beliefs/interpretations
 - Normalize!

Interpretation	Evidence For	Evidence Against
<p>A higher power (e.g. God talking to me)</p>	<p>The voice can predict unlikely things happening Imagery of higher power Physical feeling - it feels very powerful</p>	<p>Prediction could be coincidence A lot of what they predict doesn't occur</p>
<p>A sign of illness</p>	<p>It can be associated with elevated mood It can be triggered by paranoia</p>	<p>It doesn't seem to happen at work It is different to elevated mood</p>
<p>An unusual thought process</p>	<p>It could be a stress response It can be triggered by cannabis What they talk about is similar to things I think about</p>	<p>It feels real</p>

Practical Tip #2: Content of Symptom as “thoughts”

- Evaluate content of psychotic symptom as thoughts in thought record
- CATCH IT: identify content of voices or delusional thinking, place in “thoughts” column.
- CHECK IT: evaluate accuracy of content
 - Identify cognitive distortions
 - Evidence for and against (“for” first!)
- CHANGE IT: generate alternate thoughts, “come back” thoughts

Practical Tip #3: Reduce Conviction

- Goal may not be to remove distorted belief entirely; reduction of conviction can be very helpful
- Examine alternate explanations for the intrusion/experience and see how each explanation effects conviction level
- Pie chart technique can be helpful here

Practical Tip #4: Pros & Cons of Holding Belief

- Some cognitions are less amenable to “CHECK IT” phase
 - Hard to evaluate accuracy of erotomaniac belief
 - Evaluation could cause more distress
- Examine pros & cons of holding the belief, regardless of accuracy
- Can do this for both past and present - some beliefs may have been useful at some point!
- Always review Pros first

Practical Tip #5: Promote Internally Generated Explanations

- Encourage internal attributions and explanations for experiences
 - Could voices be own thoughts?
 - How can we test this? (behavioral experiment)
- Psychoeducation is important here
- Behavioral experiments = excellent method to promote internally generated explanations

Negative Symptoms

Applying CBT techniques to negative symptoms

How to address negative symptoms?

- Negative symptoms not necessarily unchangeable
- Build case conceptualization to determine factors that might be contributing/maintaining observed symptoms
- Behavioral interventions are typically more successful than cognitive
- Behavioral Activation/Activity Scheduling is a key intervention!

Environmental Influences on Negative Symptoms

- Social Isolation -> Absence of stimulation
 - Generate solutions to increasing social supports/interactions
- Trauma & PTSD -> emotional numbing & avoidance
 - Trauma informed CBT/TF-CBT to address trauma symptoms
- Social Anxiety -> social withdrawal
 - Identify and address anxiety symptoms
 - Behavioral activation

Depression & Negative Symptoms

- Possible relationship between negative self beliefs (“I will fail”) and negative symptoms
 - Treat with activity scheduling, mastery & pleasure ratings.
 - Use The Three C’s to address cognitive distortions and core beliefs

Self-Efficacy & Negative Symptoms

- Belief that actions will not lead to successful outcomes:

“There’s no point; my choices/behaviors won’t make a difference”

- Use behavioral experiments to challenge negative self-efficacy beliefs
- Use The Three C’s to identify, evaluate, and reframe cognitive distortions

Anxiety & Negative Symptoms

- Anxiety could lead to avoidance and numbing, which can look like negative symptoms
 - Use case conceptualization to identify triggers/modifiers & maintenance factors
 - Choose appropriate cognitive & behavioral interventions for maintenance factors

Negative Symptoms as Safety Behaviors

- Associated with unusual/delusional thinking -> flat affect prevents mind reading
 - Avoidance of traumatic treatment interventions -> flat affect prevents feared outcome
- Examine pros & cons of behavior
- Behavioral Experiments to test predictions

The importance of homework

Assigning homework and addressing barriers

“The idea that homework enhances therapy should be replaced by the idea that therapy enhances homework”

Rationale for Homework

- Beliefs/distorted cognitions rarely change through discussion alone
 - Therapy session = only brief part of client's week
 - What happens outside of session is more important
 - Sense of achievement
 - Linear evidence of progress over course of therapy
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- *In SZ, treatment that includes homework results in 60% more improvement than treatment without homework*

Types of Homework

- Information Collection
 - Current functioning
 - Current symptoms, experiences, thoughts, affective states, etc.
 - Track substance use & relationship to symptoms
- Experiments
 - Discover what happens when client thinks/behaves differently
 - Exploration of different outcomes from different actions
- Practice New Skills
 - Intense repetition is necessary for behavior change

WHAT to choose for homework: The Three Rs

- Is it **RELEVANT**?
 - To the model?
 - To the case conceptualization?
 - To the content of the session?
 - To the client's goals?
- Is it **REALISTIC**?
 - Is it achievable?
 - Is it challenging enough to feel significant but not so difficult it is impossible?
- Is it the client's **RESPONSIBILITY**?
 - It is within the client's control?
 - Is it the client's responsibility to address?

HOW to choose homework

- Negotiating homework is COLLABORATIVE
 - NOT the client deciding alone.
 - NOT the therapist deciding alone.
- If client cannot generate ideas:
 - Does the task meet the 3 Rs?
 - Is the lack of response due to barriers that can be addressed?
 - Does the client understand the session content?
 - Does client understand the rationale for homework?
- Work with client to *do something, no matter how small.*

How to increase homework compliance

- Call it “PRACTICE” instead
- Ensure client understands rationale & consequences
- Allow enough time on agenda to decide on homework!
- Check for understanding
- Problem solve ahead of time, work out the details
- Provide necessary materials
- Involve family/support network

Common reasons why homework is NOT done

- Client has no, vague, or wrong understanding of why homework is important to therapy
- Therapist leaves 30 seconds at end of session to assign homework
- Therapist doesn't include "homework setting" on agenda
- Assign homework without figuring out the implementation details
- Not writing homework down; assuming client will remember
- Homework setting is not collaborative; therapist assigns without discussion

If a client does not do homework...

- Therapist must find out why client did not do or complete the homework
 - Do not just shrug and move past it – need to figure out what got in the way so that you can address these barriers for the next homework.
 - Be prepared for this problem solving to take the majority of the session
 - Be curious, not confrontational.
- May need to dedicate session to reviewing homework rationale
- May need to do some motivational interviewing
- Involve support network (family, siblings, partners etc.)

Take Home Messages

- A detailed case conceptualization is essential for effective CBT
- Use The Three C's to structure your long-term treatment approach
- Place psychotic symptoms as situations or thoughts in the model
- If time is limited, psychoeducation is a powerful intervention for reducing distress and stigma
- Negative symptoms are best addressed with behavioral techniques
- Homework is cornerstone of treatment; if no homework, gains will be limited

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