CBT for Psychosis

Laura M. Tully, Ph.D.

VP Clinical Services, ChatOwl Inc.

Volunteer Clinical Faculty, Department of Psychiatry, UC Davis

(Director of Clinical Training, UC Davis Early Psychosis Program, 2017-2023)

March 8th 2023

Three Part Series on CBT for Psychosis

Part 1:

- CBT refresher: principles & techniques
- Applying the cognitive model to psychosis
- Phases of CBT for Psychosis

Part 2:

- Addressing Positive Symptoms
- Addressing Negative Symptoms
- Discussion of Case Example(s)

Part 3:

- Using CBTp in the the Coordinated Specialty Care model
- Trauma Integrated CBTp

Three Part Series on CBT for Psychosis

Part 1:

- CBT refresher: principles & techniques
- Applying the cognitive model to psychosis
- Phases of CBT for Psychosis

What is CBT?

Basic Principles and Structure

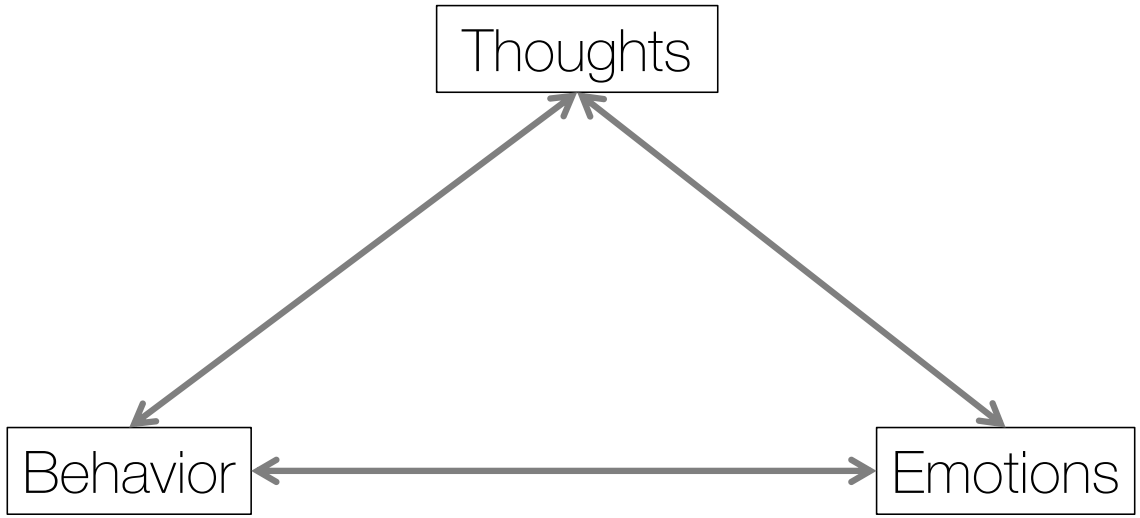
1. CBT is a theoretical model for psychological distress

Aaron T. Beck

The father of C(B)T

It is not the situations in our lives that cause distress, it is the interpretations of those situations. In short, thoughts do not equal facts, but they affect us just the same.

The (basic) Cognitive Model



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

2. CBT is an approach to psychotherapy

- Collaborative project between client and therapist
- Structured, active engagement
- Time-limited and brief
- Empirical approach
- Problem-oriented
- Guided Discovery/Socratic Questioning
- Behavioral Techniques (in vivo experiments)
- Frequent Summaries and Feedback

3. CBT is formulation driven

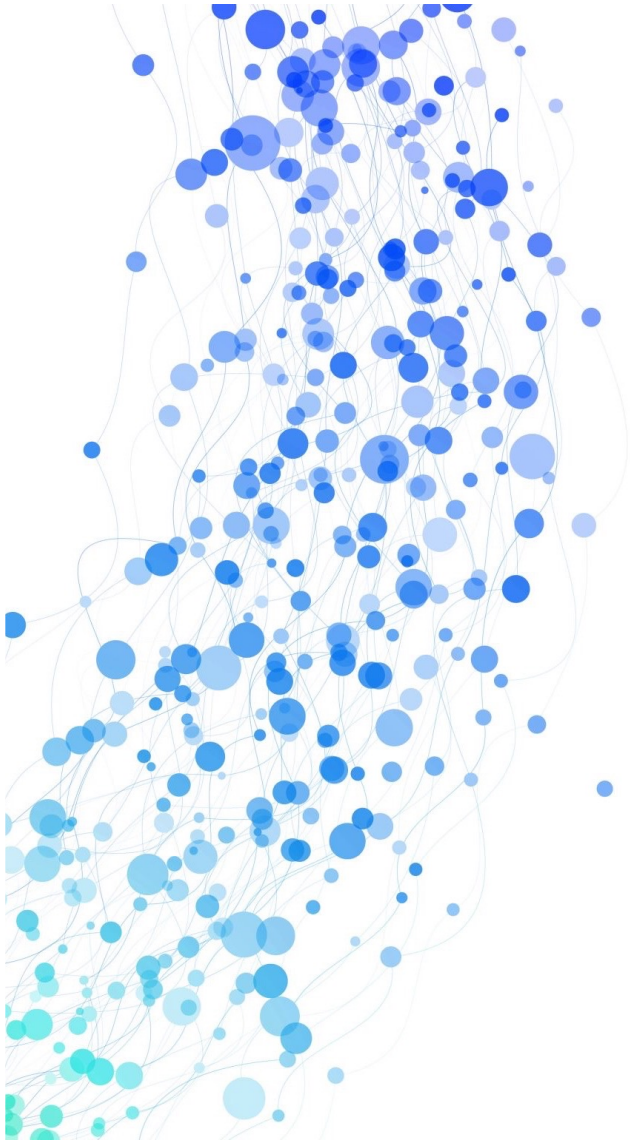
CBT is a theory of how psychological difficulties develop, are maintained, and change – i.e., a way to conceptualize a person, a problem, or a symptom

Intervention selection will depend on your conceptualization and could draw from multiple EBPs in order to shift cognitions (MI, exposure, family interventions, trauma interventions, etc.)

“Waves” of CBT: Therapeutic approaches rooted in the cognitive-behavioral model

“First Wave” – rooted in behaviorism to change overt behavior	Behavior Therapy, Exposure & Response Prevention (ERP) …
“Second Wave” – integrates thoughts/beliefs into the model to understand and change/adapt a person’s beliefs & behavior	Cognitive Behavioral Therapy (CBT), Trauma-Focused CBT (TF-CBT), Prolonged Exposure (PE), Cognitive Processing Therapy (CPT)…
“Third Wave” – integrates person’s relationship to thoughts/feelings than their content. Emphasize acceptance, values, mindfulness, & metacognition	Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (CBT), Mindfulness Based Cognitive Therapy (MBCT), Metacognitive Therapy (MCT), Functional Analytic Psychotherapy (FAP)…

Hayes & Hoffman 2017

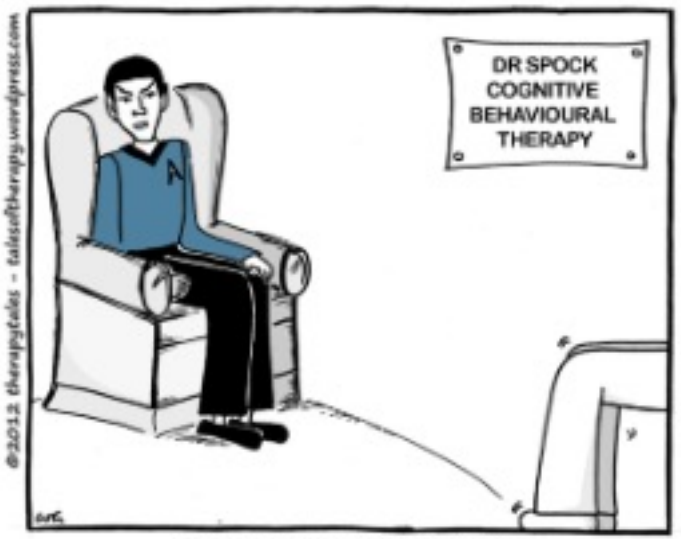


The “T” in CBT: Therapy

You are not a CBT robot!

Common factors for good psychotherapy.

CBT <u>is not</u>…



"Your reasoning is illogical"

Or…

AUTOMATIC THOUGHT RECORD

When you notice your mood getting worse, ask yourself, **"What's going through my mind right now?"** As soon as possible, fill in the table below.

Date, Time	Situation	Automatic Thoughts (ATs)	Emotion/s	Adaptive Response	Outcome
	• What led to the unpleasant emotion? • What distressing physical sensations did you have?	• What thought/s or image/s went through your mind? • How much did you believe the thought at the time (0-100%)?	• What emotion/s did you feel at the time? • How intense was the emotion (0-100%)?	• Which thinking styles did you engage in? • Use questions below to respond to the automatic thoughts/s. • How much do you believe each response (0-100%)?	• How much do you now believe your ATs (0-100%)? • What emotion/s do you now feel? At what intensity?

Questions to compose an Adaptive Response: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) What's the worst that could happen? What's the best that could happen? What's the most realistic outcome? (4) If a friend were in this situation and had this thought, what would I tell him/her?

Incorporate CBT into your practice as a "whole clinician"

Using CBT as a treatment approach does not mean you leave all your other clinical skills at the door!

The Common Factors Contextual Model (Wampold 2015)

- Contextual model theorizes therapy works through three pathways:
  - **The therapeutic Relationship:** provides connection to a caring and empathic person -> promotes healing.
  - **Client Hope & Expectations**: Client expectations and hope for therapeutic change as a result of an explanation of why and how problems developed. i.e., therapist give client hope that they are capable of coping and that change is possible.
  - **Specific Ingredients**: specific theoretical elements of certain psychotherapies which lead to specific actions. E.g., improving a patient's social relationships (interpersonal therapy), aid client in evaluating and shifting maladaptive thinking patterns (CBT), or aid client in being more accepting towards themselves (ACT).

This models is nicely summarized in Cuijpers et al. 2019 review paper

The Therapeutic Relationship

- Your clinical skills and bedside manner matter!
- You are not a CBT robot rigidly following a protocol.
- Use specific techniques in the context of warmth, trust, understanding and acceptance
- Foster Collaboration & agreement on therapy tasks and goals

Use Rogerian Principles for Strong Therapeutic Alliance

Accurate Empathy – build a shared world view

- Sensitively tracking the moment-to-moment feelings and thoughts of the client, with all their nuances and implications, and conveying this to the client partly by summarizing or restating what the client says. Can also use similar tone & body language to reflect back.

Congruency / Transparency – communicate your own experiences transparently

- Therapists must not put up a façade of any kind or deceive clients about their feelings. Congruent responses should be stated in the first person, without false objectivity: "I feel," "This is how I experience," and so on. A therapist who cannot or does not want to answer a question should give a personal reason: "I don't know enough," "I feel uncomfortable talking about that."

Unconditional Positive Regard – value client as an autonomous person

- *Unconditional positive regard* is the way a therapist conveys to clients that they are regarded as valuable and worthwhile, without accepting or condoning everything they do or think. It means prizing clients as persons.

https://www.health.harvard.edu/newsletter_article/Client-centered_therapy

Remember…

Slow down! You're not just here to problem solve.

- Listen, reflect, validate, pause.

You are human and fallible. Model this to show acceptance

- Admit when you do not know things and explore together

Don't ask them to do anything you wouldn't do

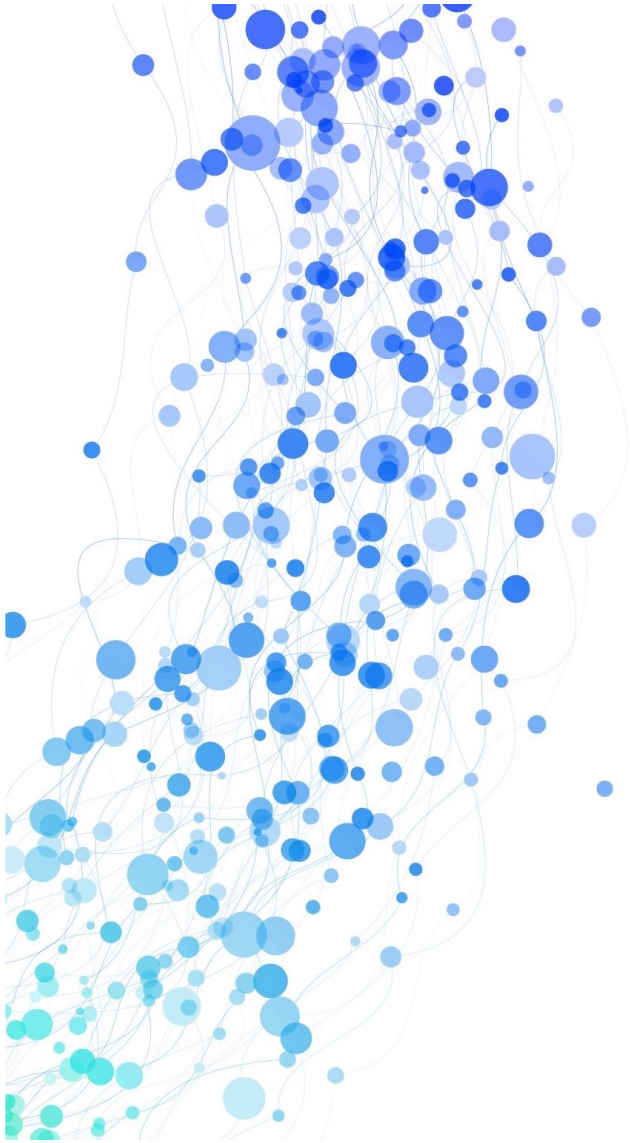
- In fact, do as much of what you ask them to do as well!

Sometimes the clinician-patient hierarchy helps you, sometimes it doesn't.

- Be familiar if you can; bring expertise as part of the collaborative approach
- Consider some appropriate disclosure (congruency/transparency)

Part of your job is to build hope

- Normalize, support self-efficacy, find models of success



The “C” in CBT: Therapy

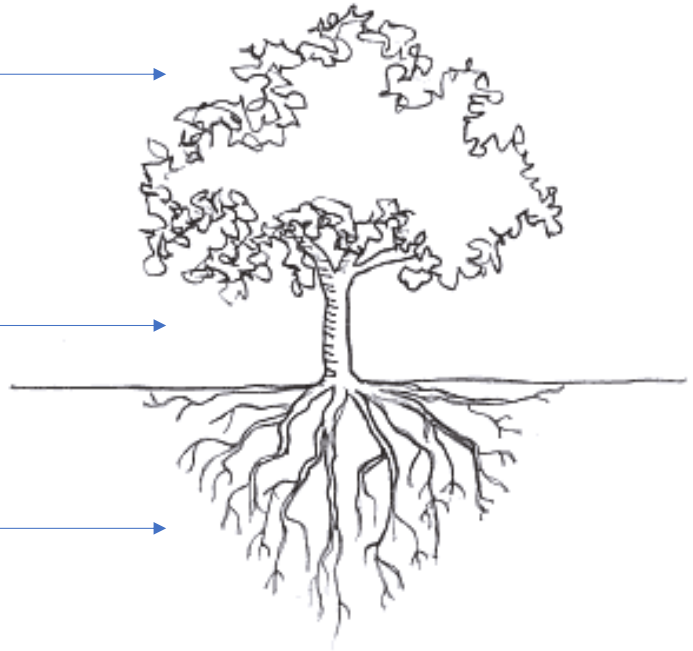
The thoughts and interpretations of our experiences and the world around us

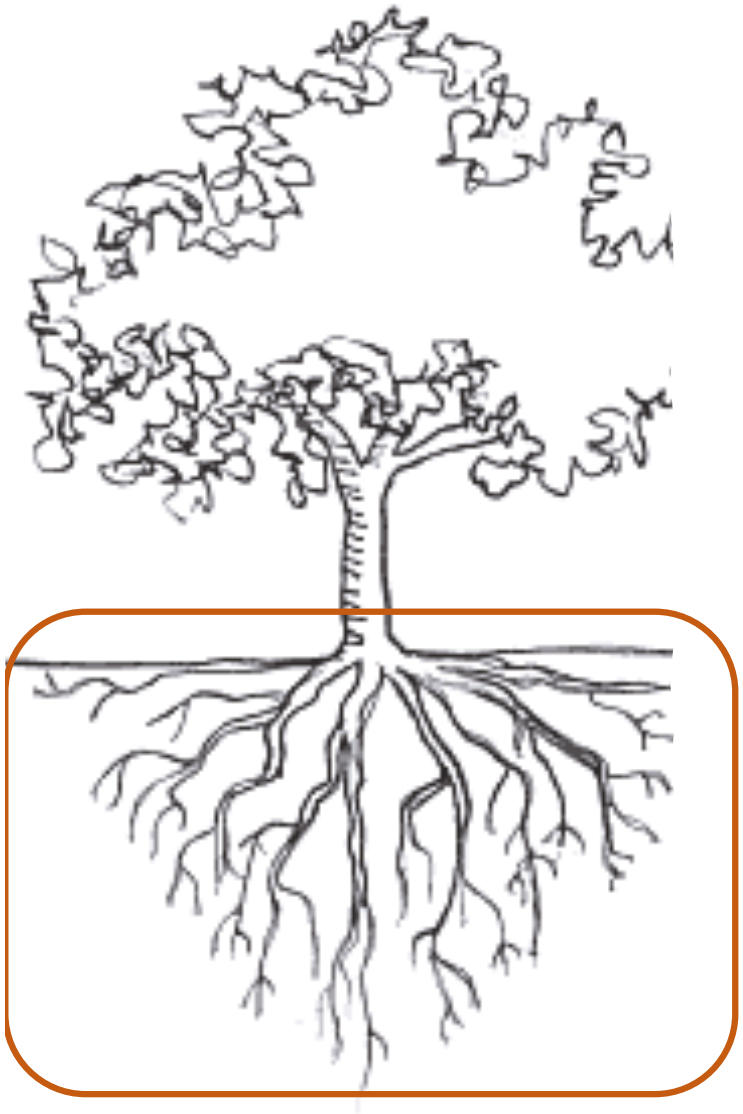
Levels of thoughts/interpretations

Automatic Thoughts

Intermediary Beliefs

Core Beliefs





Core Beliefs

- These are the “roots” of who we are as people; our “core” understanding and beliefs about ourselves, others, and the world.
- They are deeply held and very difficult to change
- They develop over the course of our lives, often before adulthood, or after significant life events, and influenced by our environment
- We may not be aware that they are affecting our thinking and behavior

Common (Problematic) Core Beliefs

Beliefs about the self: I Am..

- … unlovable
- … disgusting
- … a burden
- … helpless
- … inept/incapable

Beliefs about the future: It is…

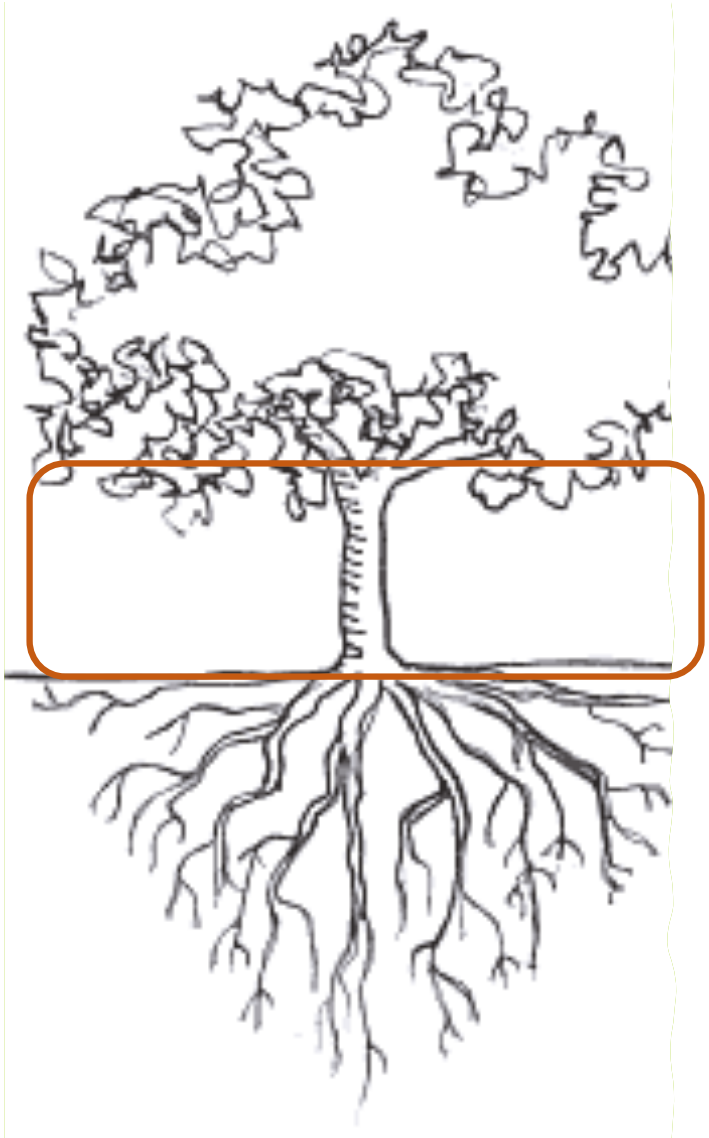
- … bleak
- … hopeless
- … awful/unlivable

Beliefs about the world: it is…

- … unpredictable
- … dangerous
- … unfair

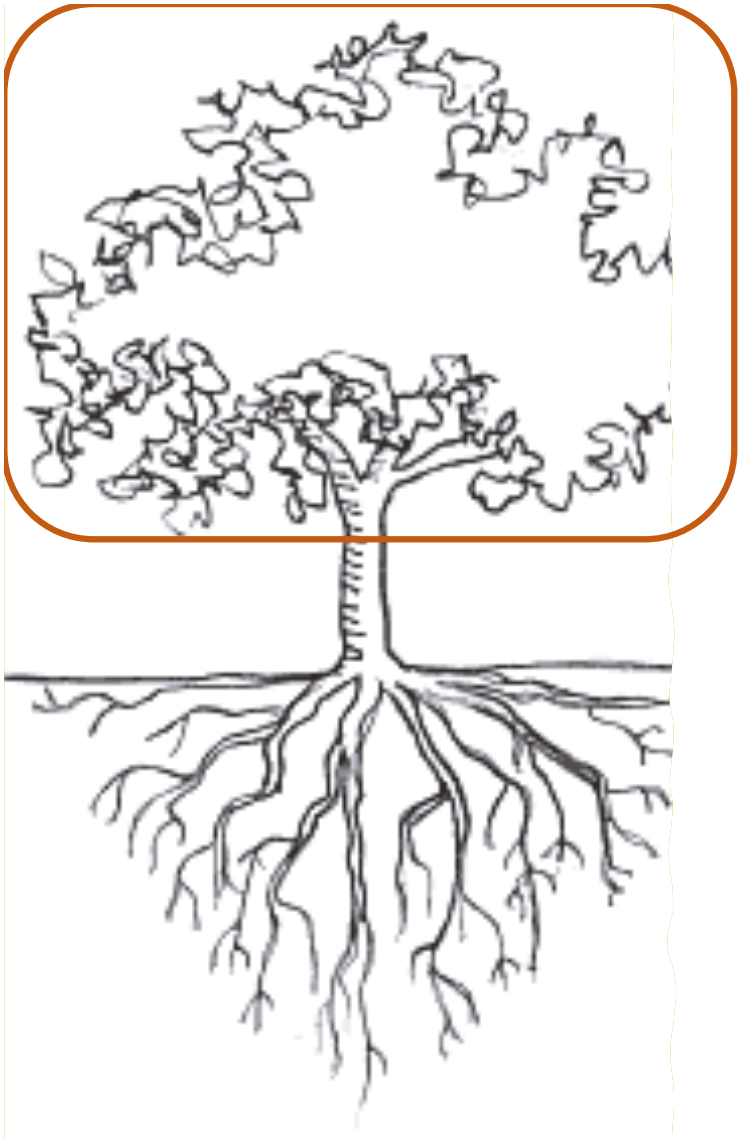
Beliefs about others: They...

- ..cannot be trusted
- ..will hurt me
- ..are out to get me



Intermediate Beliefs

- Rules, expectations, assumptions, schema that shape thoughts
- Often expressed as "if…then…" judgments:
  - **If** I'm not smart, people won't value me
  - **If** I express my dissatisfaction, people will abandon me
  - **If** I'm not on guard, something bad will happen
- Often develop via experience, **culture**, values, internalized stigma, reactions to *core beliefs*
- Can test using behavioral experiments…



Automatic Thoughts

- Quick interpretations or images that arise in a specific situation
- We have tens of thousands per day, sometimes may only notice emotions that follow
- The types of thoughts that arise in a situation is shaped by our prior experience and typically linked to our *core beliefs*
- Can become problematic if automatic thoughts are inaccurate, or unhelpful, or too rigid

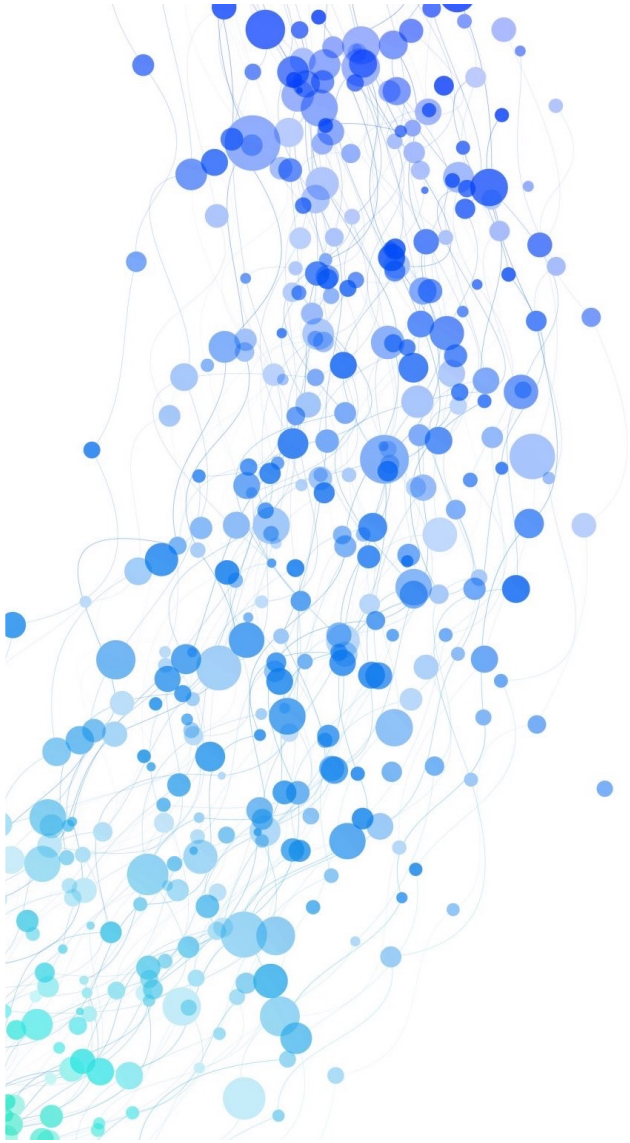
Cognitive styles arise from our core & intermediate beliefs

Core beliefs influence the kinds of automatic thoughts we experience and can lead to a go-to “cognitive style”

Different kinds of psychological problems are associated with different “cognitive styles”

Use these as “templates” to generate hypotheses about client’s go-to style

Depression example: negative beliefs about the self, the world, and the future



The “B” in CBT: Therapy

Our actions and behaviors that maintain / reinforce our thoughts and beliefs

The Behavior Principle

Behavior maintains/reinforces how we think about ourselves and our environment and shapes our reactions.

Changing behavior can be an effective, *and often easier,* method of changing cognitions…

Interrupting compensatory behaviors and prompting alternate actions can provide new evidence for new interpretations

Behavioral Experiments

A series of small experiments designed to test the validity of the client's thoughts about themselves, others, and the world.

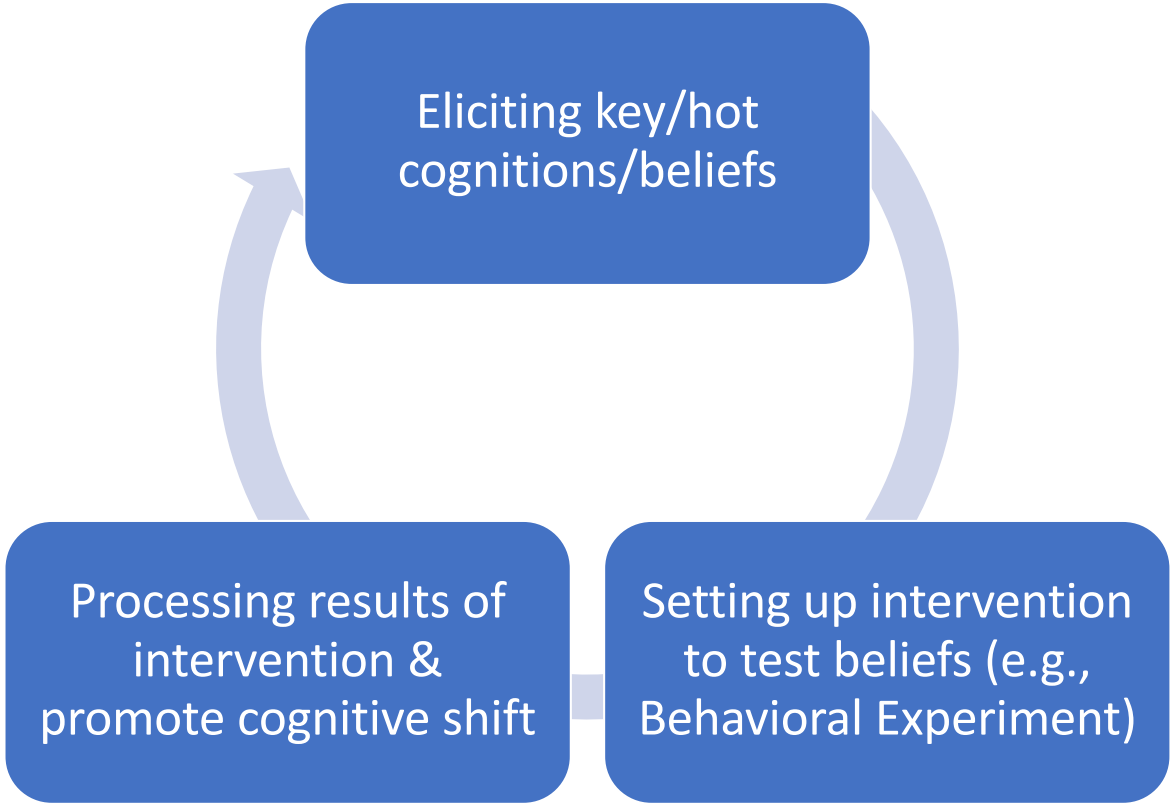
What does CBT actually look like?

What are you doing in the room?

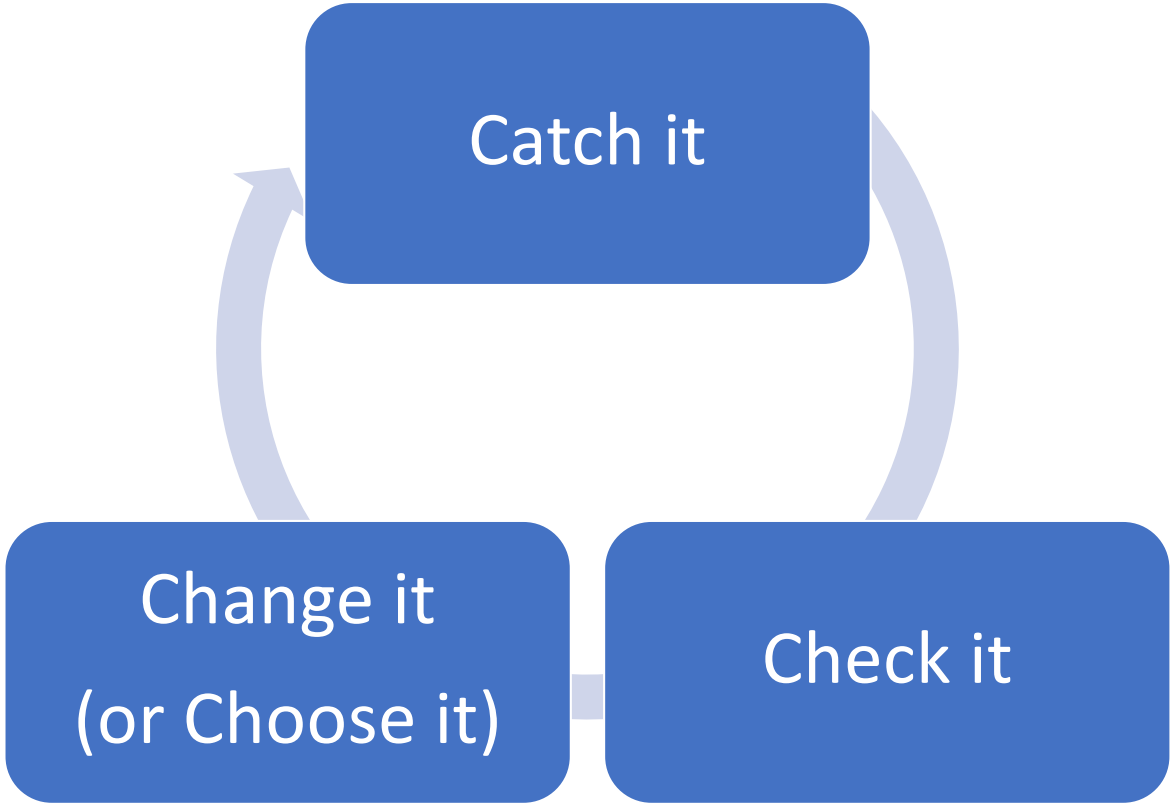
Structure of CBT Session(s)

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

What are you doing in the room/in CBT?



AKA “The Three Cs”



Granholm et al. 2016

The 3 C's

CATCH IT, CHECK IT, CHANGE IT

Work to identify, evaluate, and reframe distorted interpretations & attributions related to identified problems.

Use both cognitive and behavioral techniques

Based on CBT case formulation generated *together*

Granholm et al. 2016

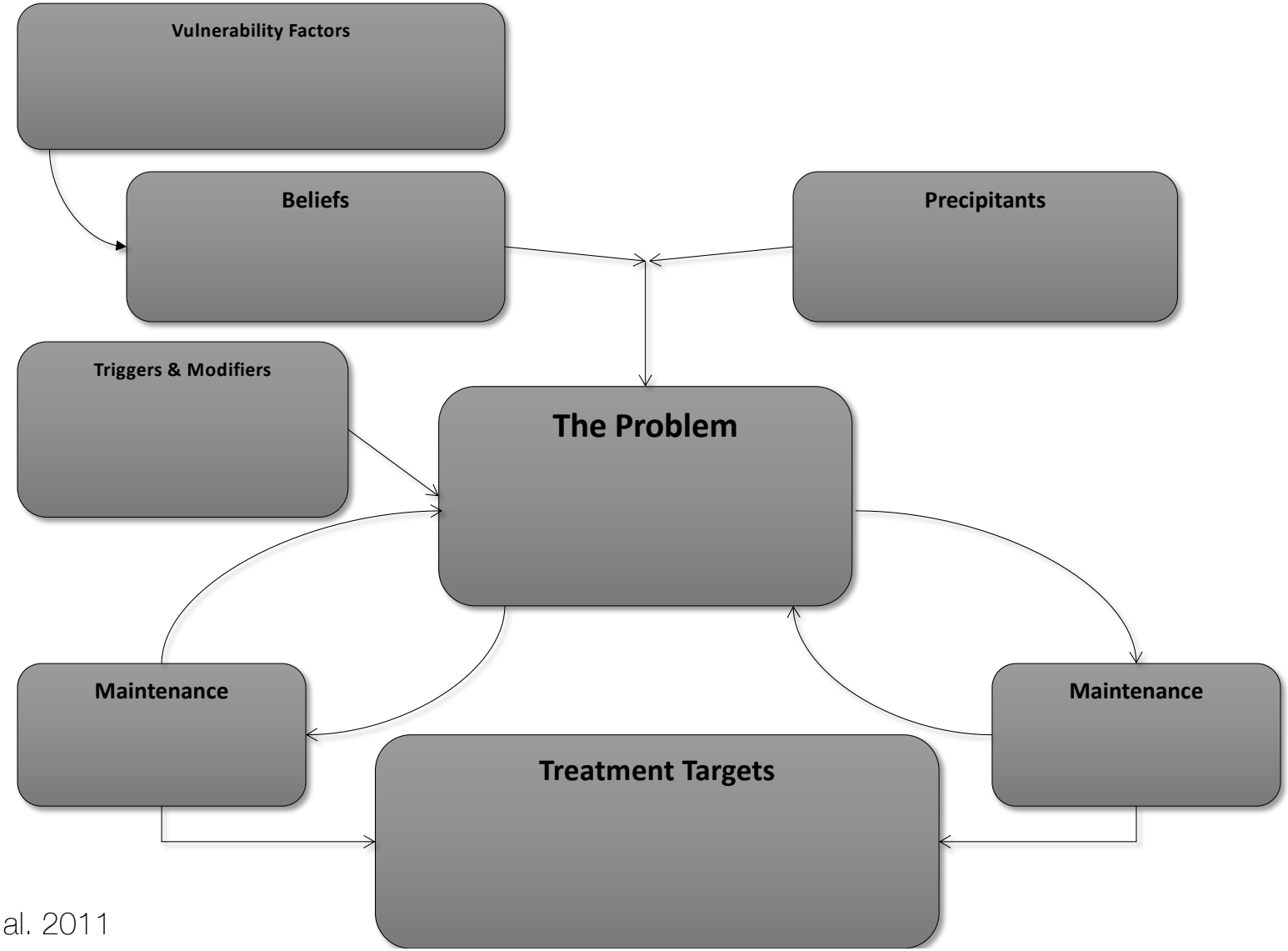
What is a CBT Case Formulation?

- 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!

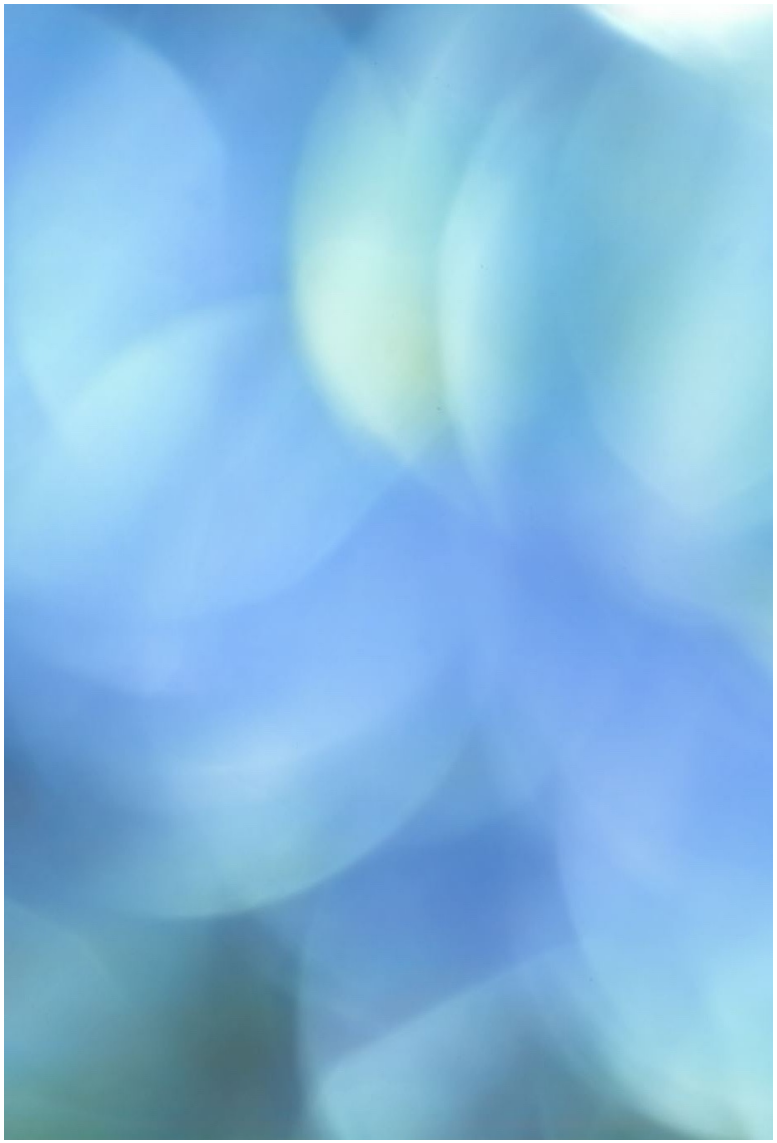
Westbrook et al. 2011

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

Westbrook et al. 2011



Westbrook et al. 2011



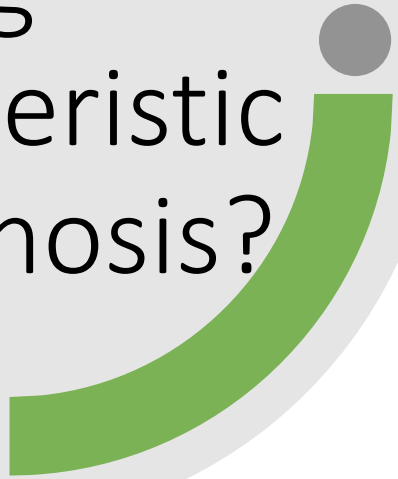
Common Maintenance Processes

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

CBT for Psychosis

Applying the cognitive model to psychotic symptoms

What is the defining characteristic of psychosis?



Psychosis is traditionally described as difficulty distinguishing what is real from what is not real

e.g., Delusions are fixed false beliefs in the face of contrary evidence

BUT … Many psychological difficulties are defined by distorted beliefs

Depression

“I am worthless”

“I am a failure”

Held with strong conviction during an episode

Panic Attacks

“I’m going to die”

“I cannot survive this”

Held with strong conviction in the moment

Anorexia

Convinced body is larger than it is; perfection = value

Held with very high conviction

OCD

"If I don't do this ritual, something bad will happen to my family”

Held with high conviction

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!

Morrison et al. 2004; Morrison 2017

What is 'Normal' anyway?

- All people have the potential to hallucinate or have delusional thinking under the right circumstances
- In the general population…
  - 30-40% have weekly paranoid thoughts
  - 10-20% have brief paranoid beliefs that they firmly believed and caused significant distress (e.g., I can detect coded messages about myself)
  - 8% of the general population hear voices on a regular basis
  - 60-80% the general population have heard a voice
- So what is the difference between this and psychosis?
  - Causes distress; stigmatized; it's getting in the way
  - ***Culturally unacceptable*** interpretations of experiences
  - Interacts with cognitive symptoms…

Van Os, 2009; Freeman, 2006

Slide Credit: Dr. Daniel Shapiro

S-REF Model – AKA “the filter model”

- **S**elf-**R**egulatory **E**xecutive **F**unctioning 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

Morrison et al. 2004; Morrison 2017

Symptoms as a Failure of Source Monitoring

- Voices are misattributed internal mental events (e.g., verbal thoughts, inner speech)
- Difficulty identifying where stimulus/thought came from
  - ⇒Assume it came from outside the self (thought)
  - ⇒Triggers negative automatic thoughts 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

Bentall et al. 1991; Johns & McGuire, 1999; Morrison et al. 2004

Symptoms as a Conflict with Metacognitive Beliefs

- Often intrusive/distressing/violent thoughts that don't match beliefs about the self
  - ⇒ Triggers negative thoughts about what the voices are saying (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

Morrison et al. 2004

Symptoms as Unusual Interpretations of Experiences

- Delusions may be rational attempts to explain anomalous perceptual experiences or culturally unacceptable explanations of life events
- How we interpret anomalous experiences influences our response
- 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

Morrison et al. 2004; Morrison 2017

The 3 key ingredients of CBTp

1. Psychoeducation to normalize psychotic experiences, reduce the stigma and, consequently, reduce distress.
2. Collaborative development of a case formulation to inform understanding of psychotic symptoms & make sense of the experiences
3. Acceptance of psychotic experiences & working to reduce associated distress/conviction may be better than attempting to change symptom occurrence

Phases of CBT for Psychosis

Hardy “CBTp Fact Sheet”; Morrison 2017

General Tips:

Psychoeducation & normalization of experience is key

Always place in the context of case formulation

Use Guided Discovery: Simply telling client that the belief is inaccurate will not change the belief

Process causing distress may not be the psychotic symptom itself

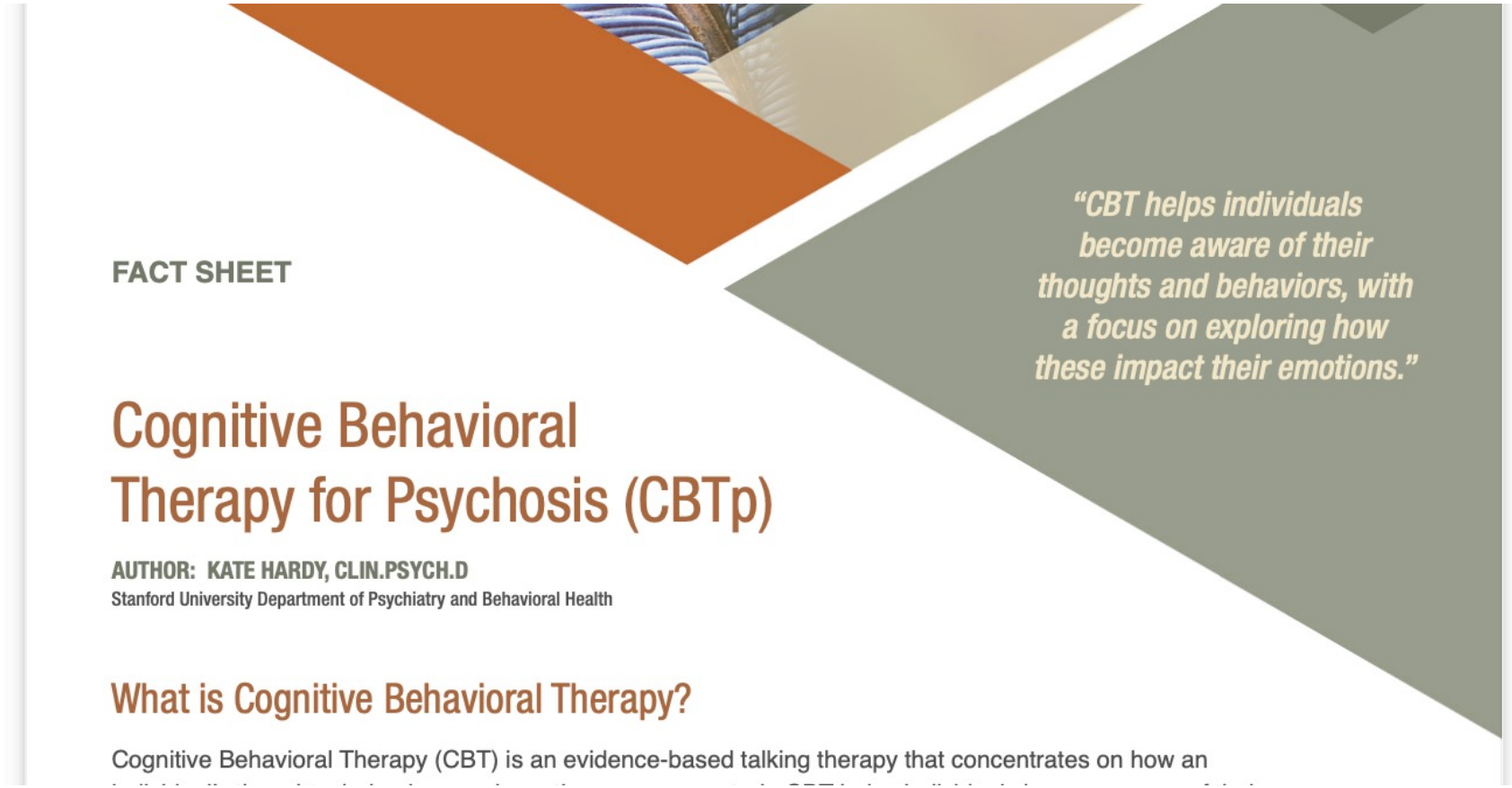
Always work within a recovery-oriented framework

Hardy "CBTp Fact Sheet"; Morrison 2017; Brabban et al. 2016

What to expect in part 2

- How to use CBTp to address positive symptoms
- How to use CBTp to address negative symptoms
- Group discussion of case examples & practical applications

Useful CBTp Fact Sheet from SAMHSA



FACT SHEET

"CBT helps individuals become aware of their thoughts and behaviors, with a focus on exploring how these impact their emotions."

Cognitive Behavioral Therapy for Psychosis (CBTp)

AUTHOR: KATE HARDY, CLIN.PSYCH.D
Stanford University Department of Psychiatry and Behavioral Health

What is Cognitive Behavioral Therapy?

Cognitive Behavioral Therapy (CBT) is an evidence-based talking therapy that concentrates on how an

References Cited

1. Bentall, R. P., Baker, G. A., & Havers, S. (1991). Reality monitoring and psychotic hallucinations. *British Journal of Clinical Psychology*, *30*(3), 213-222.
2. Cuijpers, P., Reijnders, M., & Huibers, M. J. (2019). The role of common factors in psychotherapy outcomes. *Annual review of clinical psychology*, *15*, 207-231.
3. Granholm, E. L., McQuaid, J. R., & Holden, J. L. (2016). *Cognitive-behavioral social skills training for schizophrenia: A practical treatment guide*. Guilford Publications.
4. Hayes, S. C., & Hofmann, S. G. (2017). The third wave of cognitive behavioral therapy and the rise of process-based care. *World psychiatry*, *16*(3), 245.
5. Johns, L. C., & McGuire, P. K. (1999). Verbal self-monitoring and auditory hallucinations in schizophrenia. *The Lancet*, *353*(9151), 469-470.
6. Morrison, A., Renton, J., Dunn, H., Williams, S., & Bentall, R. (2004). *Cognitive therapy for psychosis: A formulation-based approach*. Routledge.
7. Morrison, A. (2017). A manualised treatment protocol to guide delivery of evidence-based cognitive therapy for people with distressing psychosis: Learning from clinical trials. Psychosis. https://doi.org /10.1080/17522439.2017.1295098
8. Westbrook, D., Kennerley, H., & Kirk, J. (2011). *An Introduction to Cognitive Behaviour Therapy: Skills and Applications*. SAGE Publications.

Thank you!

QUESTIONS?