

Cognitive Behavioral Therapy for Psychosis



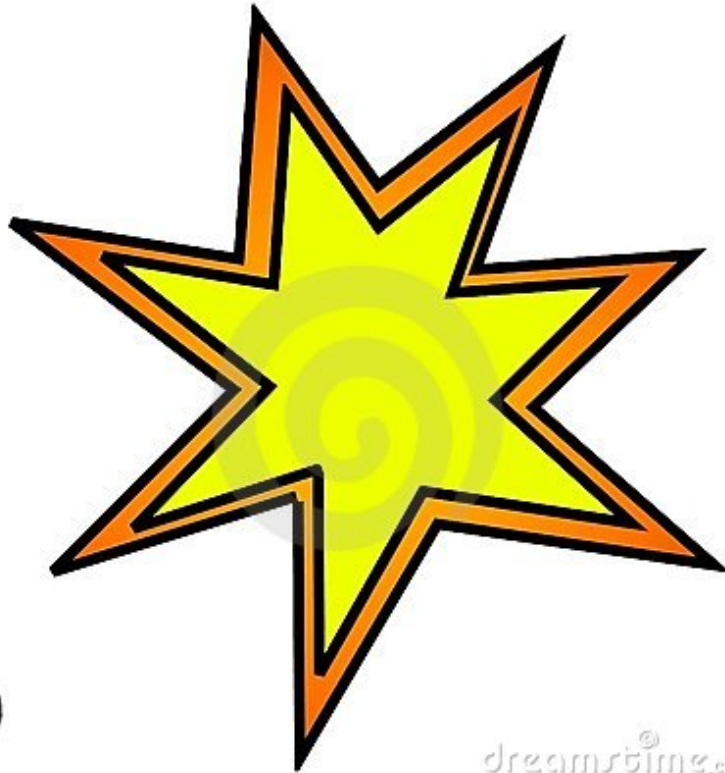
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Objectives

- Review the evidence base for CBTp
- Describe engagement strategies for working with psychosis
- Present formulation as a way of understanding the origin and maintenance of psychotic symptoms
- Use formulation to identify culturally sensitive interventions

What is Cognitive Behavioral Therapy anyway?





dreamstime.com

What is CBT?

- How you think leads to changes in how you feel and what you do.
- Thinking includes how you think about:
 - Yourself
 - The world
 - Other people
- Here and now focus though draws upon past experiences to explain beliefs are formed

How does CBT apply to psychosis?

History of CBTp

- First described by Beck (1952)

However ...

- Largely overlooked as an intervention for psychosis
 - Prominence of biological/medical models
 - Studies in the 80's that reported talking therapies as damaging to people with psychosis
 - Long held assumption psychosis lies outside of realm of 'normal psychological functioning'

CBT for psychosis

- Focus is on reducing the distress caused by positive symptoms including hallucinations and unusual thoughts
- **Thoughts**
 - Interpretation of the event that causes distress rather than the event itself
 - Need to check the accuracy of the interpretation
- **Behaviors**
 - How are current behaviors maintaining the problem?
 - Need to check the helpfulness of current behaviors

CBT for psychosis

- Other target areas:
 - Symptoms of depression and anxiety
 - Past traumatic events
 - Social skills
 - Negative symptoms including lack of motivation
 - Problem solving and decision making
 - Developing coping skills
 - Relapse prevention planning

IS THERE ANY EVIDENCE THAT CBTP IS
USEFUL?

Evidence base for CBTp

- Highly acceptable to consumers (Morrison et al, 2004)
- Reduced days in hospital (Jolley et al, 2003)
- Delayed impact with most improvement at follow up (Sarin et al., 2011)
- Decreased activation in brain areas associated with threat perception (Kumari et al., 2011)

Evidence Base Cont:

- Stafford et al. (2013)
 - Meta-analysis reviewing interventions to prevent transition to psychosis
 - 'moderate quality evidence' for CBT preventing transition to psychosis at 12 months (risk ratio 0.54)
- Jauhar et al. (2014)
 - Concluded that CBTp has therapeutic effect in the 'small range' (reduces when controlling for bias)
- Turner et al. (2014)
 - Significant efficacy in reducing positive symptoms (when compared with other psychosocial interventions)

Indispensable CBTp Interventions

CBTp techniques for all

1. Engagement and befriending
2. Embracing curiosity and normalizing
3. Understanding distressing voices and beliefs



ENGAGEMENT AND BEFRIENDING

Common Barriers to Engagement

- Incomprehensible/disorganized
 - Stay with the client and remain curious
 - Information elicited may lead to fuller formulation
 - Provide structure
- Silent
 - Remain patient
 - Be aware of cognitive impairment and internal distraction
- Over talkative
 - Structure the session
 - Attempt to interrupt (use humor)

Kingdon and Turkington (2008)

Engagement and befriending

- Essential to developing therapeutic relationship
- Ongoing process throughout therapy
- May require increased amounts of befriending depending on symptoms
 - Paranoia
 - Hallucinations
 - Severe Negative Symptoms

Engagement

- Befriending
 - » Focus on neutral non threatening topics
 - » No active formulation or treatment
 - » Non confrontational
 - » Empathic
 - » Supportive
 - » Accepting
 - » Non colluding
 - » Strength based

Kingdon and Turkington (2008)

Engagement continued

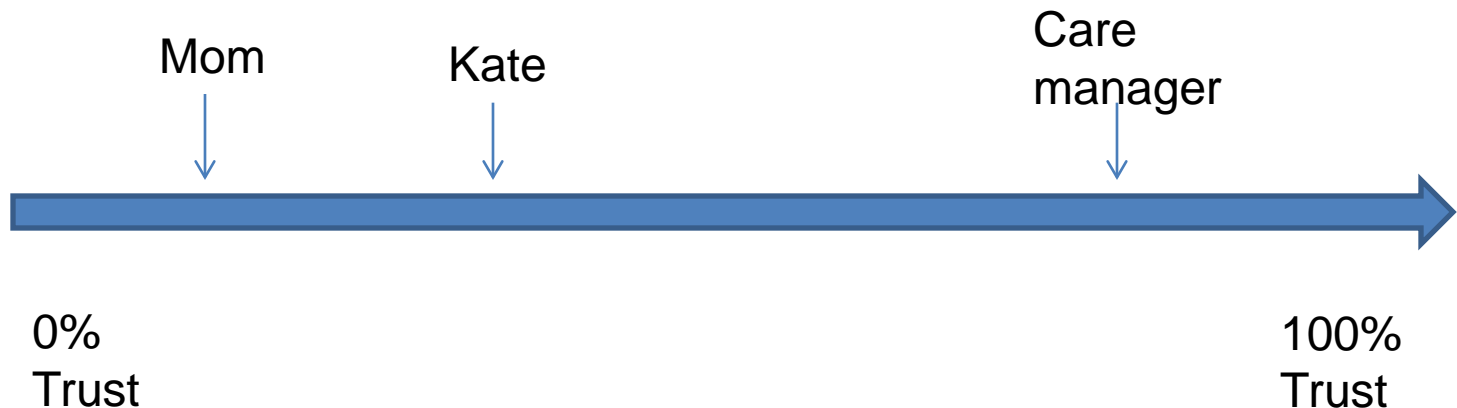
- Non confrontational
 - » Avoid confrontation but avoid collusion also
 - » Show interest in the subject with non judgmental questioning
 - » Treat delusion as a belief rather than a fact
 - » Don't get stuck in discussion of 'reality' of the situation
- Pacing
 - » Slower pace with simple achievable goals
 - » Use aids to help client to follow session
 - » Be aware of internal distracters that may impact ability to concentrate

Engagement continued

- Tactical withdrawal
 - » If increase in agitation or distress move from topic to neutral non threatening topics developed through befriending
 - » Agree to disagree on topic

Pacing of CBTp

- Ensure pacing matches client pace
 - Once a week vs. multiple sessions per week
- Prepare for paranoia?





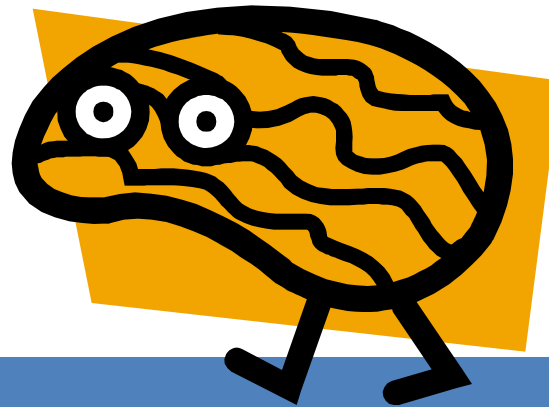
EMBRACING CURIOSITY

NORMALIZING AND QUESTIONING

Normalization

- CBT is inherently normalizing
 - We all experience negative thoughts
 - We all engage in unhelpful thinking
 - We all use coping strategies that aren't always the most healthy choices
- Allows for normalizing of psychotic symptoms as well

Psychosis exists on a continuum



- Stress
- Drugs
- Trauma
- Life experiences
- Sleep deprivation

No psychosis

Psychosis

Normalization of psychotic symptoms

- “Normalization is the antidote to stigma”
 - Avoid catastrophizing
 - Mental Illness is a common experience (1 in 4 people)
 - Psychosis can affect anyone regardless of age, ethnicity, gender, SES
 - Large number of people can overcome symptoms
 - Symptoms may be viewed positively in different cultures
- Normalizing experiences – not dismissing them
 - Check in how the information is received (invalidating?)

Normalizing: How

- Encourage people to research and read personal recovery stories
 - Elyn Saks
 - John Nash
 - Eleanor Longden
 - Rufus May

Normalizing: How

- Research prevalence of symptoms (depression, hearing voices, paranoia etc)
 - 15-20% population experience frequent paranoid thoughts without significant distress
 - 3-5% population have more severe paranoia

(Freeman, D. 2006)
- Connect with other people experiencing psychosis
 - Intervoice
 - Psycope.co.uk
 - Paranoia.com

Tips for Curious Questioning

- Be curious
- Don't make assumptions
- Be open to different explanations
- Explore all possibilities
- Ask questions



UNDERSTANDING DISTRESSING VOICES AND BELIEFS

FORMULATION

Formulation

- Stress Bucket
- Mini Formulation
- *Morrison's Interpretation of Intrusions*

Stress Bucket



Hearing Voices

Parents arguing

Exams coming up

Applying for college

Talk to voices
Stay up all night
playing video
games

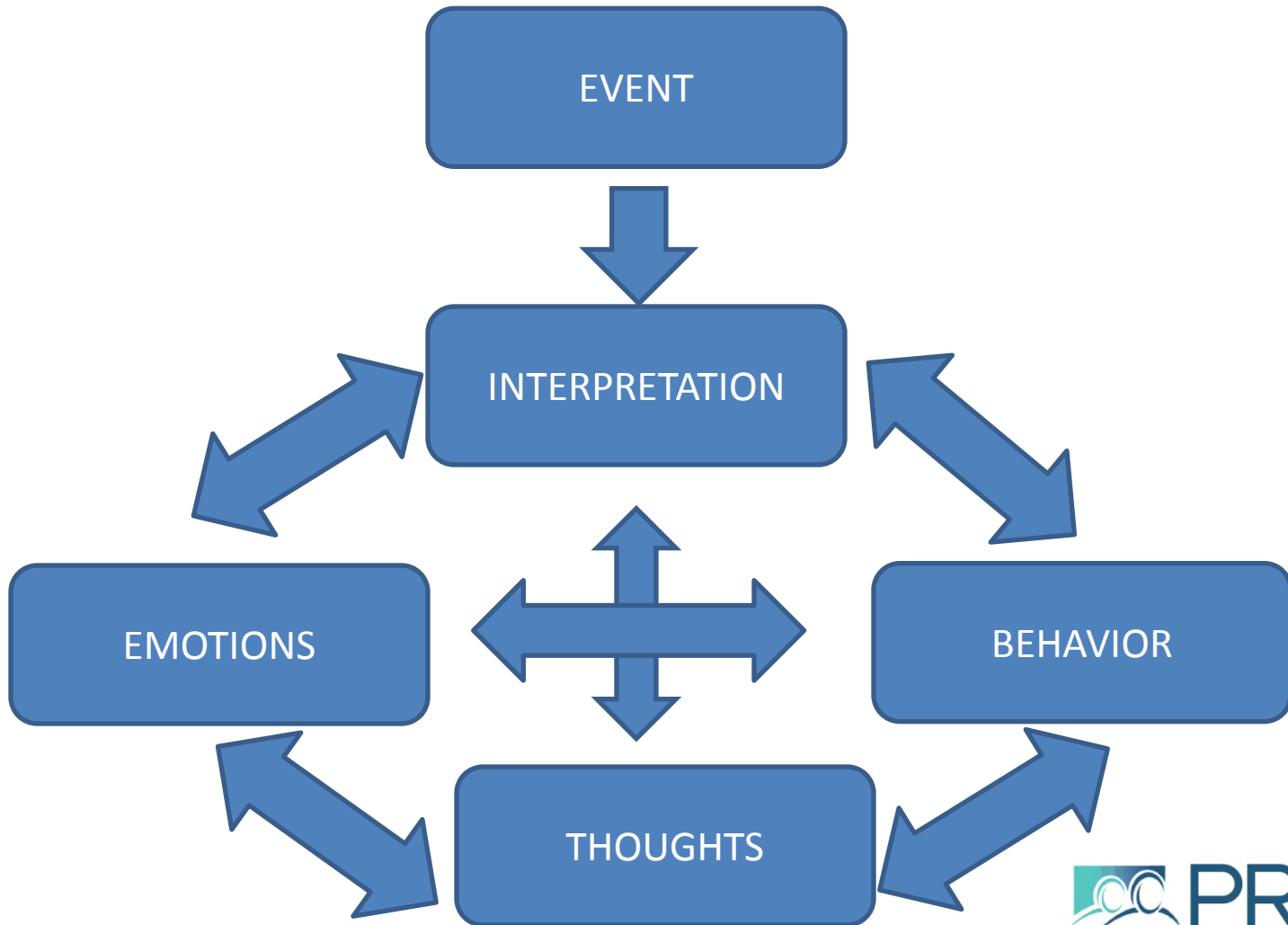
Buffer Zone

Stress Level

Play video
game for
one hour

Go for a walk

Mini Formulation



Mini Formulation



Group exercise

- In pairs...
- Person 1 -> think of a fact that you know to be absolutely true of yourself (i.e. eye color, hair color, place of birth)
- Person 2 -> ask person 1 about their 'fact' and do everything in your power to convince them that this fact is not true. You can dismiss the fact, provide evidence to the contrary, argue with your partner but **DO NOT** acknowledge that they might be right

Cognitive Intervention: Exploring the evidence

Thought: the people across the hall are talking about me (90%)

Evidence For	Evidence Against
They said my name I feel afraid when I am around them I've heard shouting from that room before	They've never actually directly spoken to me The noise was a whisper and not a shout When I recorded the voice and played back the tape there wasn't anything there

Belief: the people across the hall are talking about me (40%)

Alternative possibility: I am hearing an auditory hallucination (60%)

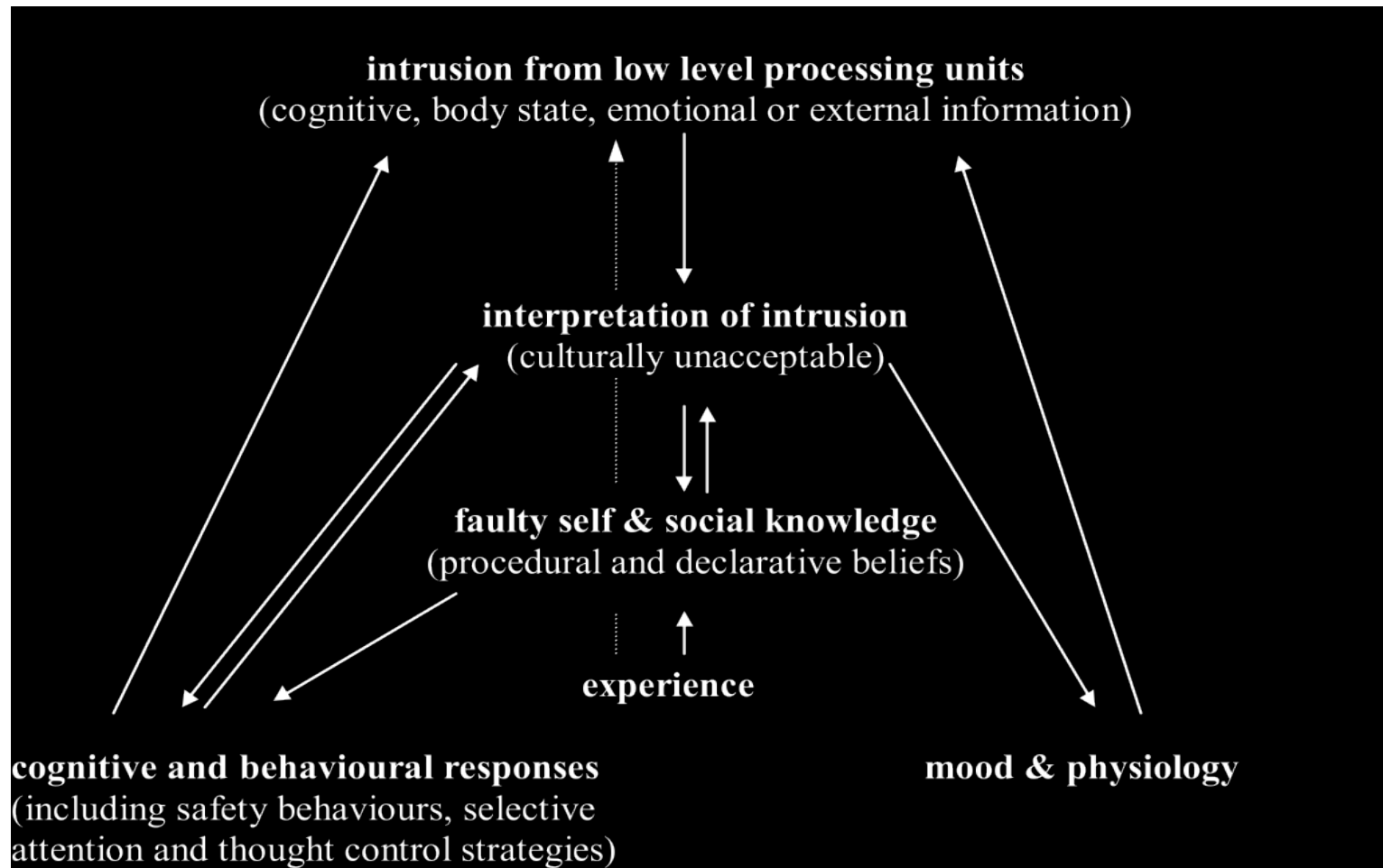
Mini Formulation



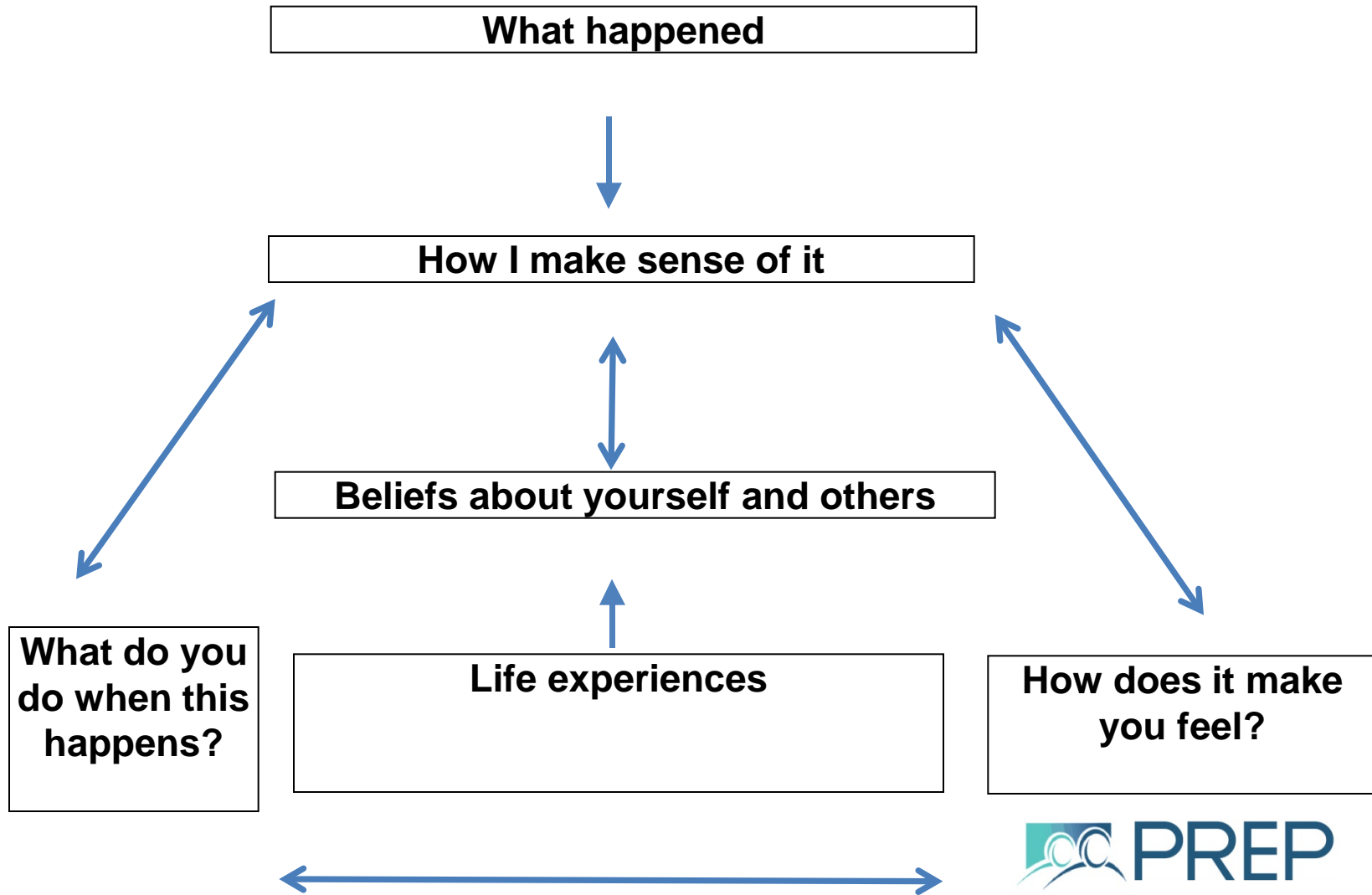
Morrison's (2001) Model of Psychosis

- Positive symptoms are conceptualized as intrusions into awareness
- The interpretation, rather than the intrusion, causes distress and disability
- Symptoms are maintained by mood, arousal and mal-adaptive cognitive-behavioral responses (e.g. avoidance)
 - » Morrison (2001) The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusions. Behavioral and Cognitive Psychotherapy, 29, 257 – 276

Theoretical Model



Client friendly version of the formulation



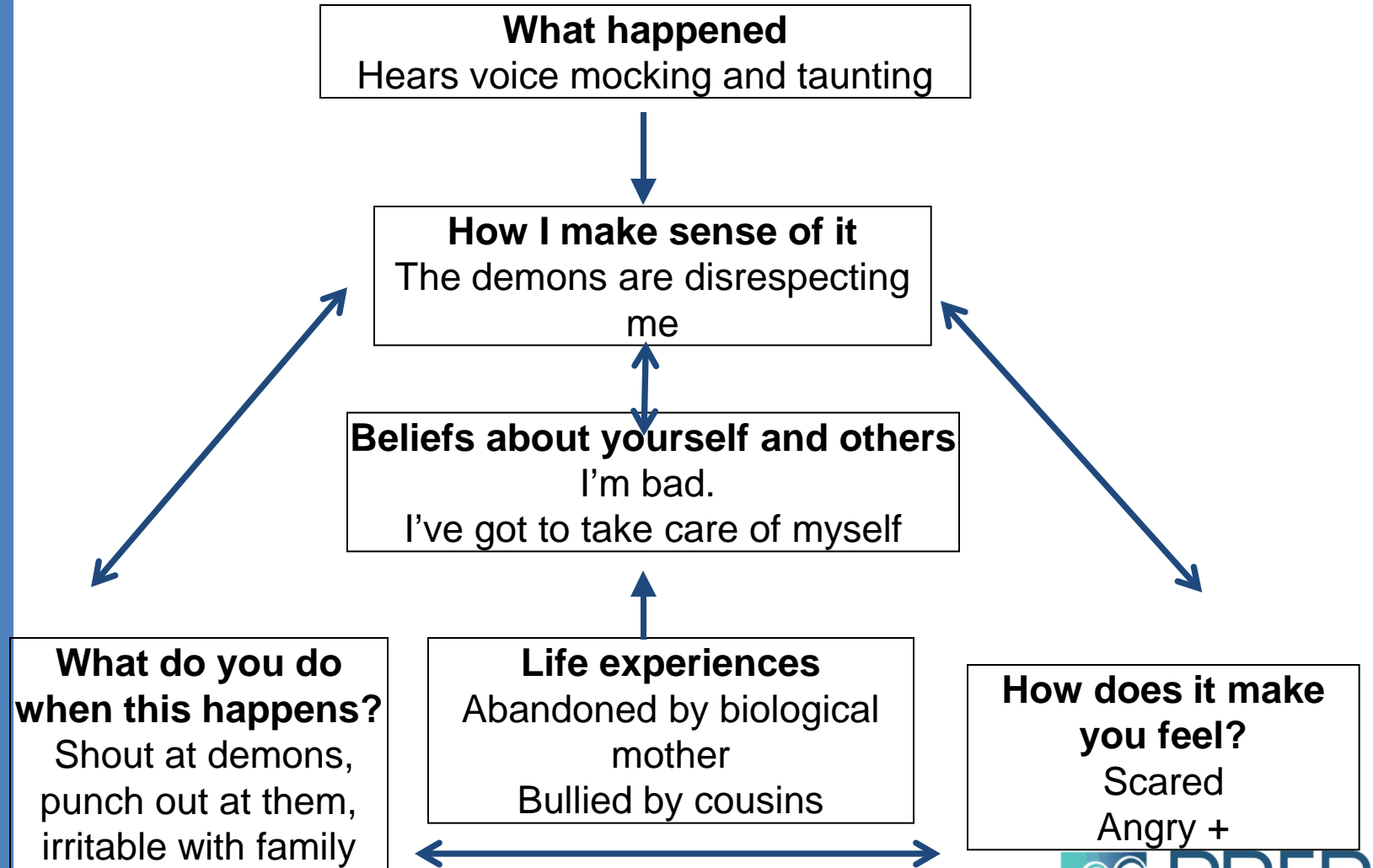
Case example

- 17 year old Afro-Caribbean female (Rena)
- Lived on small Caribbean island with adopted family
- Reported seeing witches coming out of her cupboard from age 8
- Family understood this experience in context of belief in the spirit world prevalent to the island and consistent with family beliefs
- Initially sought alternative treatments specific to local culture

Case example cont

- Decrease in functioning and increase in symptoms led family to seek westernized treatment
- Came to PREP SF (2010) for three months of CBT treatment (28 sessions total) and medication management
- Presenting complaint
 - Auditory and visual hallucinations in form of demons taunting and mocking her

Collaboratively developed formulation



(Morrison, 2009)

The need to incorporate culture

- The community perspective
 - High number of ethnic minorities and first generation immigrants in Bay Area
 - Criticism from community clinicians that CBTp 'not applicable' to their culturally diverse client population
 - Misperception of CBT as tools and skills only
 - Misperception of CBT as 'explaining away' cultural experience

Incorporating culture

- “We believe that a therapist who uses a ‘color-blind’ approach to therapy is a therapist with an ethnically based disability (Harper and Iwamasa, 2000)
- CBTp acceptable for BME with culturally appropriate adaptation (Rathod, 2010)
- CBTp through ‘cultural lens’

Framework for CBTp through a cultural lens

1. Identify culturally related strengths and supports.
2. Use the client's list of culturally related strengths and supports to develop a list of helpful cognitions to replace the unhelpful ones.
3. Develop weekly homework assignments with an emphasis on cultural congruence and client direction.

(Hays, 2009)

Case example cont

- Cultural strengths based focus
 - Skilled in crystal healing, yoga,
 - Identification of a ‘spirit guide’ or angel. Positive and supportive influence. Consistent with family beliefs.

Interventions

Cognitive

- Explore thought “the demons are disrespecting me”
- Develop alternative (helpful and accurate) thought

Behavioral

- Draw upon existing coping skills (and learn new ones)
- Practice for homework and report back in session

Core Belief (Schema)

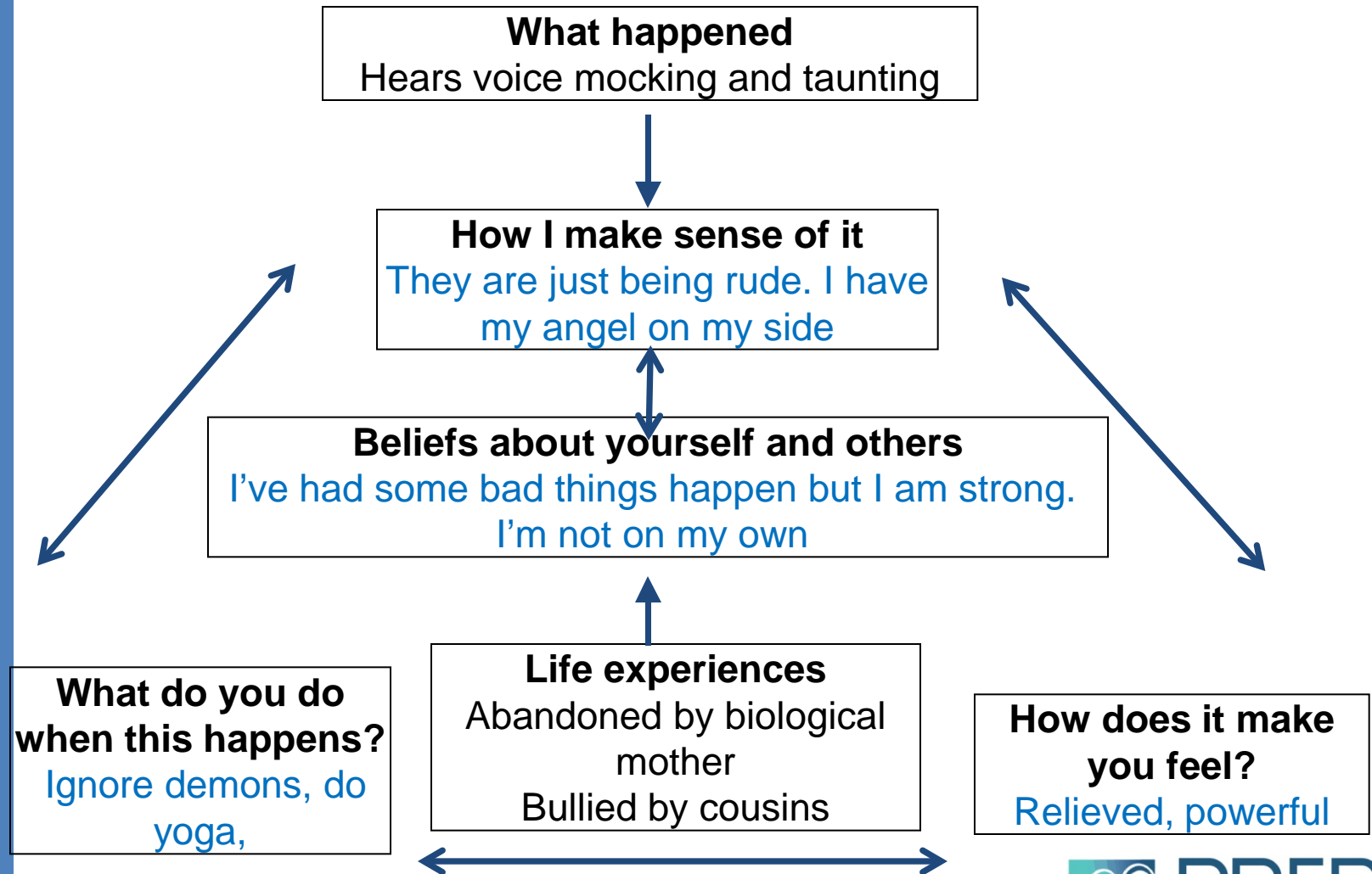
- Explore beliefs “I’m bad” and “I got to take care of myself”
- Develop healthier core beliefs

Applied framework for CBTp through a cultural lens

1. Identify culturally related strengths and supports.
 - Yoga, crystal healing, spirit guide
2. Use the client's list of culturally related strengths and supports to develop a list of helpful cognitions to replace the unhelpful ones.
 - "I'm not on my own", "I am strong"
3. Develop weekly homework assignments with an emphasis on cultural congruence and client direction.
 - Practice yoga and healing, enlist angel to help her dismiss voices

(Hays, 2009)

Collaboratively developed re-formulation



(Morrison, 2009)

Further Training Recommendations

- CIMH/FSA training collaboration with Doug Turkington
 - Three-day Intensive
 - May 12th – 14th
 - Two day ‘Train the Trainer’
 - May 15th – 16th
- Training and supervision available for teams

Questions?

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