CBT for Psychosis

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March 22nd 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 2:

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

Review of part 1

Reviewed CBT Foundational Concepts

Discussed the importance of incorporating CBT into your practice as a “whole clinician”

- Don’t leave your other clinical skills at the door!

Reviewed levels of cognitions using the “thoughts as tree” analogy

- core beliefs (roots), intermediary beliefs/schema (trunk), automatic thoughts (branches/leaves)

Introduced the "three Cs" as mnemonic for the cycle of activities you are doing in the room

- Catch it, check it, change it: identify cognitions, evaluate accuracy/helpfulness, change/choose alternate

Reviewed behavioral principles and the role of behavioral experiments in behavior change & cognitive shifts

- changing behavior can be an effective, often easier, method of shifting beliefs

Discussed the importance of a formulation driven approach

- CBT formulation is a way to understand the problem and what is keeping it going
- Use the formulation to guide intervention choices

Applied CBT model to Psychosis

Challenged the idea that psychosis is uniquely characterized by difficulty distinguishing what is real from not real

- Many psychological difficulties are characterized by firmly held distorted beliefs
- Psychosis is characterized by *culturally-unacceptable* distorted beliefs

Conceptualized psychotic symptoms as intrusions

- Cognitive impairments, especially executive functioning, contribute to intrusions having more saliency
- Interpretation of intrusions is what distinguishes psychosis from other psychological difficulties

Discussed symptoms as a failure of source monitoring

- Symptoms may be misattributions of internal events to external sources

Discussed symptoms as conflict with metacognitive beliefs

- Symptoms may be an externalization of distressing thoughts that clash with metacognitive beliefs

Discussed symptoms as interpretations of unusual experiences

- Symptoms may be rational explanations for unusual experiences

Part 2

Treating Positive and Negative Symptoms

The importance of homework

AKA “Therapy Practice”

The role of homework in CBT

- Integral component of treatment
- Especially important in the EARLY phases of treatment
- Beliefs will rarely change through discussion in therapy sessions alone
- In SZ, treatment that includes homework results in 60% more improvement than treatment without homework (Glaser et al. 2000)
- Important to make sure the client understands the rationale for homework

Cognitive Therapy for Psychosis: A formulation-based approach. Morrison, A.P., Renton, J.C., Dunn, H., Williams, S.. Bentall, R.P. 2004.

Rationale for Homework

- Therapy session = only brief part of client's week
- What happens outside of session is more important
- Supports generalization of skills
- Can gives a sense of achievement [mastery activity]
- Provides evidence of progress over course of therapy

Cognitive Therapy for Psychosis: A formulation-based approach. Morrison, A.P., Renton, J.C., Dunn, H., Williams, S.. Bentall, R.P. 2004.

"The idea that homework enhances therapy should be replaced by the idea that therapy enhances homework"

Cognitive Therapy for Psychosis: A formulation-based approach. Morrison, A.P., Renton, J.C., Dunn, H., Williams, S.. Bentall, R.P. 2004.

Types of Homework

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

WHAT to choose for homework: The Three Rs

- Is it **RELEVANT**?
  - To the CBT model?
  - To the case formulation?
  - 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?

Cognitive Therapy for Psychosis: A formulation-based approach. Morrison, A.P., Renton, J.C., Dunn, H., Williams, S.. Bentall, R.P. 2004.

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?
- If cannot agree on task, get client to *do something, no matter how small.*

Cognitive Therapy for Psychosis: A formulation-based approach. Morrison, A.P., Renton, J.C., Dunn, H., Williams, S.. Bentall, R.P. 2004.

How to increase homework completion

- Call it “PRACTICE” instead
- Choose homework TOGETHER
- Ensure client understands rationale & consequences
- Allow enough time on agenda to decide on homework!
  - Always more time than you think you will need
- Check for understanding
- Problem solve ahead of time, work out the details
  - *“what might get in the way of you completing this task?”*
- Provide necessary materials

Cognitive Therapy for Psychosis: A formulation-based approach. Morrison, A.P., Renton, J.C., Dunn, H., Williams, S.. Bentall, R.P. 2004.

Common reasons why homework is NOT done

- Therapist has provided little or no information regarding how homework helps support progress toward their goals
- 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 has difficulty doing homework…

- Therapist should work to find out why client did not do the homework
  - **Do not just shrug and move past it** – need to figure out what got in the way so that you can problem solve for the next homework.
  - Be curious, not confrontational
- Can be helpful to do the homework together in session
  - This can help address any anxieties or confusion about the homework (e.g., exposures)
- Involve support network (family, siblings, partners etc.) in homework support
- May need to dedicate some of the session to reviewing role of homework in the model
  - Find out what the client's theory of change is; what do they expect out of therapy?
- May need to do some motivational interviewing

Factors that influence homework completion

- Increased completion:
  - Understanding the link between therapy goals & homework
  - Completion of prior homework => increased understanding
  - Therapeutic relationship & collaborative approach to choosing homework
- Decreased completion:
  - Client Exhaustion
  - Client anticipating homework is too difficult / too scary
  - Confrontational stance of therapist / non-collaborative

Take home messages

- Homework is necessary for therapy gains
- During initial phases of therapy, explain what CBT is & why homework is important (rationale)
- Always set an agenda and always include homework review & homework setting
- Return to rationale if necessary
- Be collaborative
- Engage family/support network.

Positive Symptoms

Applying CBT techniques to positive symptoms

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 Interpretations of Unusual Experiences

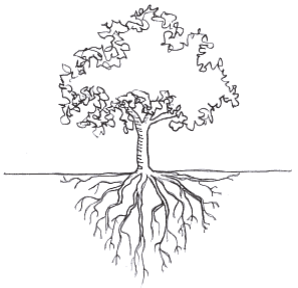
- Delusions may be rational attempts to explain anomalous perceptual experiences or culturally unacceptable explanations of life events
- How we interpret anomalous experiences influences our response
- Example: Experience intrusive/unusual thought that people are talking about them
  - Interpretation #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

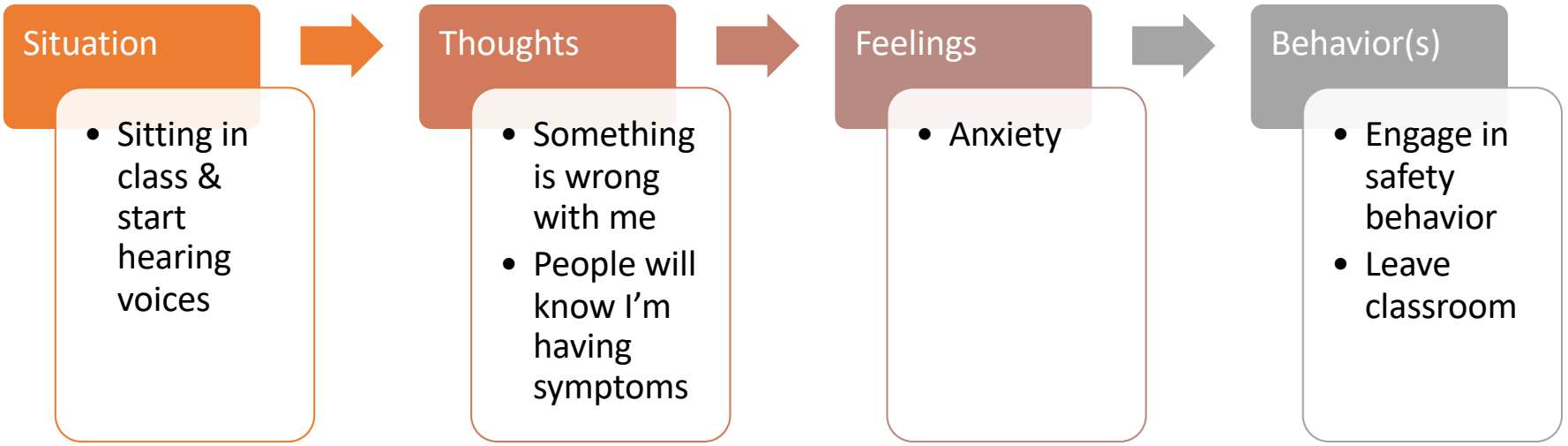
Morrison et al. 2004; Morrison 2017

Ways to conceptualize positive symptoms

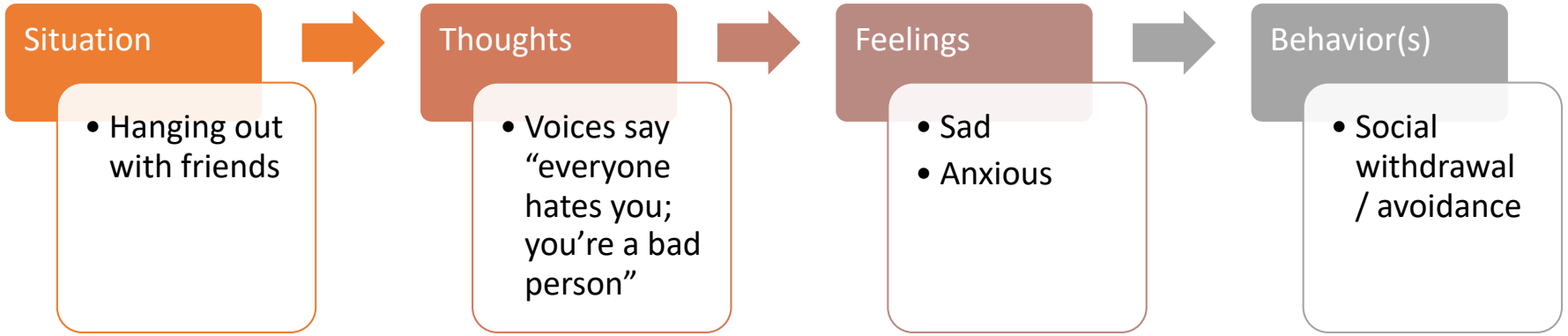


- Conceptualize symptom as *situation* (causing distress)
  - Situation = hearing voices
  - Thoughts = interpretation of voices and/or their content
  - Feelings = emotional reaction to NATs about voices
  - Behaviors = safety behaviors/response to voices
- Conceptualize *content* of symptom as thoughts:
  - Situation = hanging out with friends
  - Thoughts = voices saying “everyone hates you”
  - Feelings = emotional reaction to content of voices (e.g., sad, anxious)
  - Behaviors = safety behavior (social withdrawal/avoidance)

Conceptualize Symptom as “situation”



Conceptualize content of symptom as thought



Common negative beliefs associated with symptoms of psychosis

Symptom	Cognition/Belief
Amotivation:	“I’ll fail, why try”
Asociality:	“Others won’t like me”
Anhedonia:	“I won’t enjoy, I can’t…”
Alogia:	“I won’t make sense, my brain is broken”
Hallucinations:	“I/My thoughts are out of my control, dangerous, powerful, correct”
Delusions:	“I/ my thoughts are out of control”
Suspiciousness:	“I will be rejected, others will criticize me, I’m not as good as others”

Grant et al. 2011; Baker & Morrison, 1998; Freeman & Garety, 1999; Morrison et al. 2002

Practical Tip #1: Reduce Distress

1. Provide psychoeducation to normalize experiences and reduce stigma
2. Work to identify what the source of distress is – it might not be the psychotic symptom itself
3. Use recovery-oriented framework and validation / acceptance skills

Morrison, 2017; Brabban et al. 2016

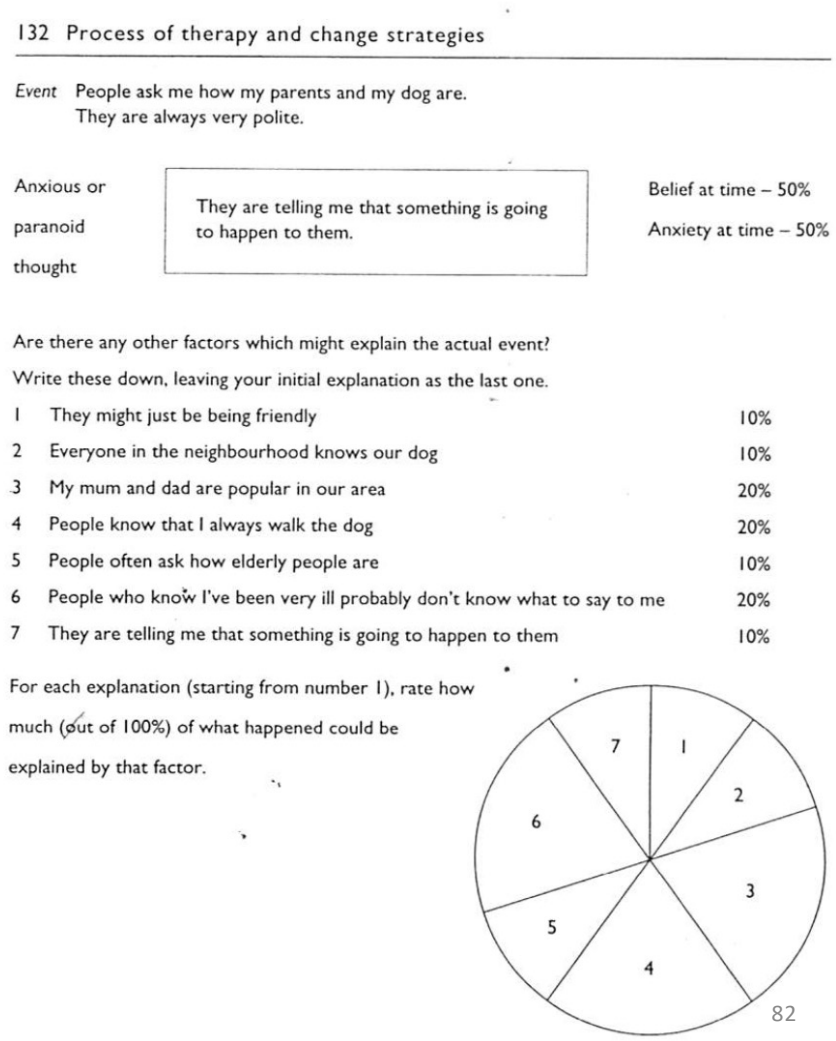
Practical Tip #2: Reduce Conviction

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 is a useful tool for acknowledging multiple explanations for an experience

Pie Technique (referential thinking example)



132 Process of therapy and change strategies

Event People ask me how my parents and my dog are. They are always very polite.

Anxious or paranoid thought: They are telling me that something is going to happen to them.

Belief at time – 50%

Anxiety at time – 50%

Are there any other factors which might explain the actual event?

Write these down, leaving your initial explanation as the last one.

1	They might just be being friendly	10%
2	Everyone in the neighbourhood knows our dog	10%
3	My mum and dad are popular in our area	20%
4	People know that I always walk the dog	20%
5	People often ask how elderly people are	10%
6	People who know I've been very ill probably don't know what to say to me	20%
7	They are telling me that something is going to happen to them	10%

For each explanation (starting from number 1), rate how much (out of 100%) of what happened could be explained by that factor.

Screenshot image from Morrison et al. 2004

Examine evidence for & against different interpretations (voices example)

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

Practical Tip #3: Pros & Cons of Holding Belief

- Some cognitions are less amenable to “CHECK IT” phase
  - Hard to evaluate accuracy of some beliefs
  - 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
- Can also do “helpful/not helpful” vs. “true/not true” exercise

Pros & Cons of Belief: Danai Gurira (whom I have never met) is in love with me

Pros of holding / acting on this belief

- Makes me feel special
- Consistent with my belief that I have a soulmate
- Makes my life feel like an adventure

→More adaptive belief: "*It is irrelevant that Danai loves me, because my partner loves me and I love them and we can build a rich life together*"

Cons of holding/acting on this belief

- Frustration when Danai and I do not meet
- Causes difficulties with my partner
- Makes me angry with my partner for not being Danai
- Upsets my family
- My therapist says this is a problem
- It costs a lot of money to keep visiting LA in an effort to meet Danai

Use helpful/unhelpful & accurate/inaccurate matrix

Situation: Hearing Voices

HELPFUL/ACCURATE This is an unusual thought process that happens when I am stressed	**HELPFUL/INACCURATE** This is the voices of a higher power talking directly to me and no one else
UNHELPFUL/ACCURATE This is a sign of psychotic illness	**UNHELPFUL/INACCURATE** This is a sign that I am going crazy and will never succeed in life

Practical Tip #4: Find the function of the belief

What function does the belief play for the client (e.g., grandiose belief about important role >> desire to be valued and have purpose)

How can the client achieve that function in their lives independent of the belief?

Find and acknowledge the kernel of truth and how it may protect/serve them (e.g., it can be dangerous to walk home alone in the dark, being hypervigilant can keep you safe)

Practical Tip #5: Promote internally generated explanations

Encourage internal attributions and explanations for experiences

Provide psychoeducation about psychosis & the filter model

Conduct behavioral experiments 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 formulation 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!

Aleman et al. 2017; Ellis et al. 2013; Morrison et al. 2004

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

Aleman et al. 2017; Ellis et al. 2013; Morrison et al. 2004

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

Aleman et al. 2017; Ellis et al. 2013; Morrison et al. 2004

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

Aleman et al. 2017; Ellis et al. 2013; Morrison et al. 2004

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

Aleman et al. 2017; Ellis et al. 2013; Morrison et al. 2004

Negative Symptoms as Safety Behaviors

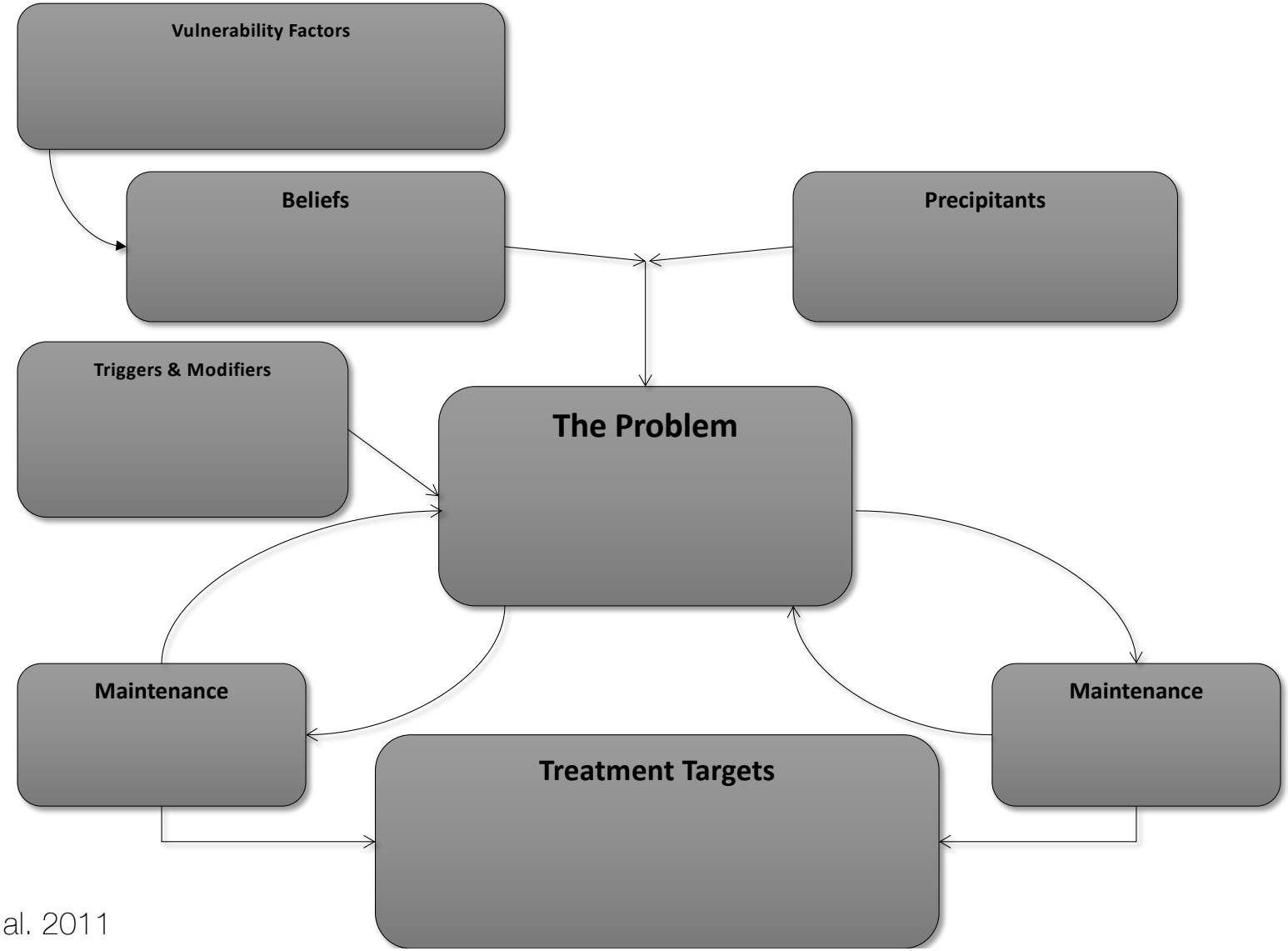
- Associated with unusual/delusional thinking -> flat affect prevents mind reading
- Avoidance of traumatic treatment interventions -> flat affect prevents feared outcome

→Examine pros & cons of behavior

→Behavioral Experiments to test predictions

Aleman et al. 2017; Ellis et al. 2013; Morrison et al. 2004

Case Example



Westbrook et al. 2011

Shae

Shae is a 23-year-old African American non-binary queer-identifying individual who uses they/them pronouns and presents femme. They work as a line manager at a box production company and is married with a 3-year-old daughter. They have a diagnosis of Schizophrenia and experience voices telling them negative things about themselves and delusional thoughts that they might not actually exist. These thoughts are particularly distressing to Shae and you decide together to focus on them in therapy.

In social situations Shae is quiet and anxious and experiences thoughts that they might not actually exist and may in fact be invisible or just a figment of someone else's imagination. As a consequence, Shae has stopped attending social events and doesn't talk to anyone at work. Shae states that these thoughts started happening after they came back to work from parental leave and the birth of their daughter. This was also around the same time that Shae came out as non-binary to their boss and requested people use they/them pronouns.

Over a few sessions Shae tracks how often this thought happens (~5-12 times per day), how convincing the thought is (~50-70%) and how distressing the thought is (6-8/10 distressing). Shae noticed that these thoughts are more likely to happen on days when they have to run manager's meeting and on days when they need to leave work early to take care of their daughter.

Shae – case formulation

- What were the precipitants to Shae's symptoms?
- What triggers Shae's symptoms?
- What intermediary beliefs might be related to Shae's symptoms? (if… then…) statements)
- What core beliefs might be contributing to Shae's symptoms?
- What might be maintain Shae's symptoms?
- What treatment approaches might you take with Shae?
  - Cognitive approaches?
  - Behavioral experiments?

Take home messages

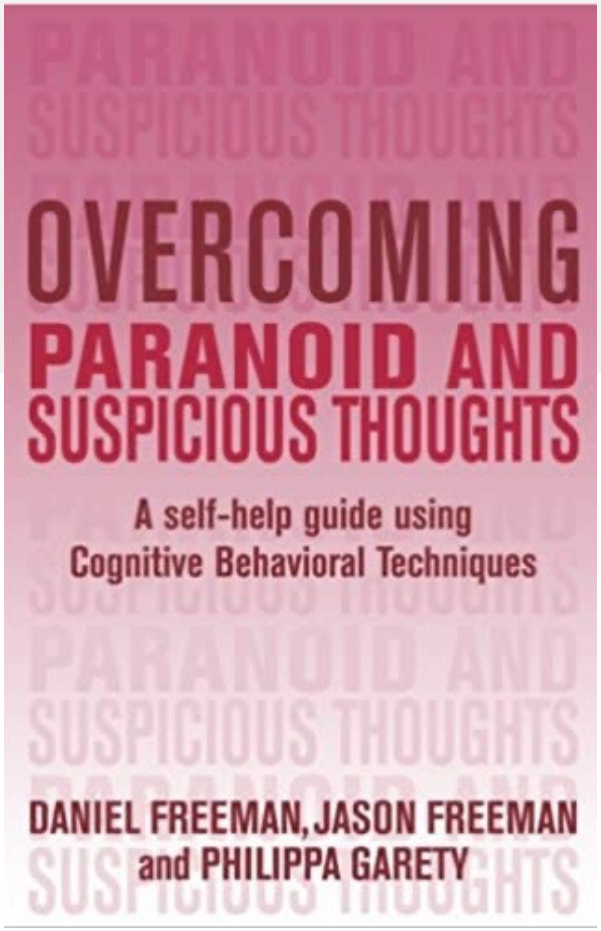
- There are many ways to conceptualize positive symptoms; find the conceptualization that fits the specific symptom.
- It is not always helpful to challenge the accuracy of a belief – evaluating how helpful/unhelpful the belief is can be more powerful.
- Negative symptoms are more responsive to behavioral interventions
- Work to evaluate possible cognitions associated with negative symptoms
- Evaluate other comorbidities that could be mis-identified as negative symptoms & select appropriate intervention

Useful Resources

- UC Davis EPI-CAL Free Educational Video Series: https://www.youtube.com/@epi-cal526/videos
- North American CBTp Network: https://www.nacbtp.org
- UK CBTp Training Resource: https://www.psychosisresearch.com/cbt/
- PEPPNET: https://med.stanford.edu/peppnet.html

Books that clients might find helpful

- Overcoming Distressing Voices: https://books.google.com/books/about/Overcoming_Distressing_Voices_2nd_Editio.html?id=yq9fDwAAQBAJ
- Overcoming Paranoid & Suspicious thoughts: https://books.google.com/books/about/Overcoming_Paranoid_and_Suspicious_Thoug.html?id=9JowjwEACAAJ



Thank you!

QUESTIONS?

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