COGNITIVE BEHAVIORAL THERAPY FOR PSYCHOSIS (CBTP)

SPONSORED BY UNIVERSITY OF WASHINGTON

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Whole Person

We are committed to enhancing our understanding of the **whole person, including:**

- how people self-identify and are experienced by others, as it relates to age, gender, race, ethnicity, sexual orientation, dis(ability), trauma, religion, native language, socio-economic status, family status, and occupation and education for the people we serve, for you, and for ourselves.

We are committed to better understanding and addressing structural racism and systemic discrimination of marginalized groups that result in disparities.

We invite you to privately or publicly offer additional feedback.

INTRODUCTIONS AND LOGISTICS

- Break: halfway for 15 minutes
- Feel free to ask questions
- Know where snacks and bathroom are located

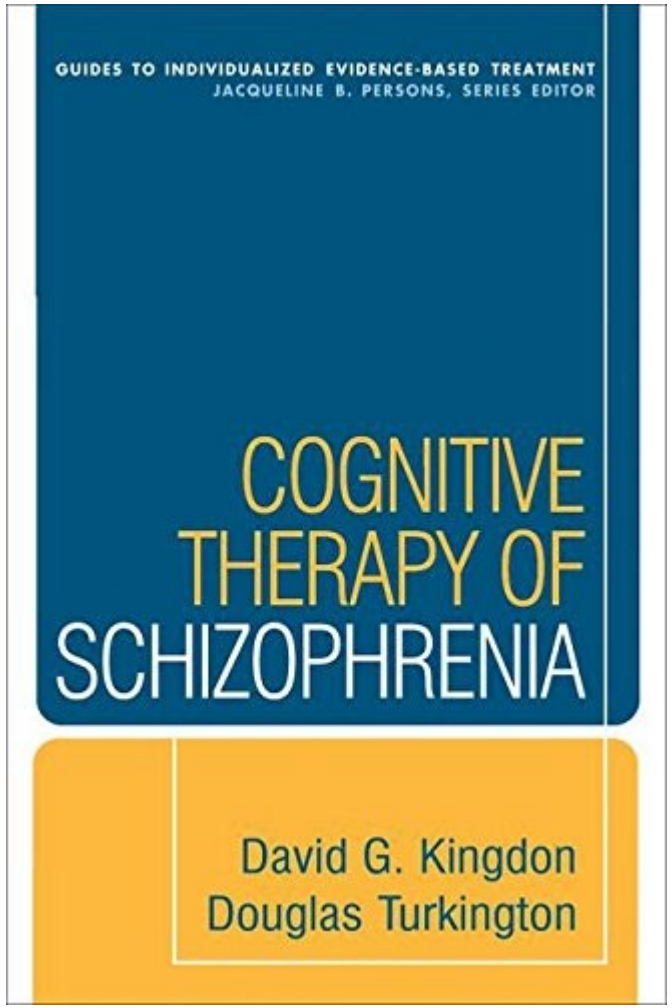
OUTDATED COMMENTS

- Only medications help with psychosis
- People with psychosis never get better
- You can't do therapy with a person that has schizophrenia
- Always redirect people when they talk about a delusion
- "Schizophrenic"

LEARNING OBJECTIVES

- Learn and Understand the basics of CBTp
- Provide individuals with psychotic disorders the best researched, effective, and up to date treatment.
- Correct the statements on the previous slide!

CBTP



Kingdon, D.G., & Turkington, D. (2008). *Cognitive Therapy of Schizophrenia*. New York: The Guilford Press

EVIDENCE FOR CBTP

- CBTp added to antipsychotic medications is a first-line treatment
- Over 40 years of research.
- Meta-analysis and over 60 randomized controlled studies (18-65 yr olds, Acute Wards, and Community).
- Commonly used across Europe, Australia, and South America. Under 0.1% trained in US.

AIMS OF CBTP

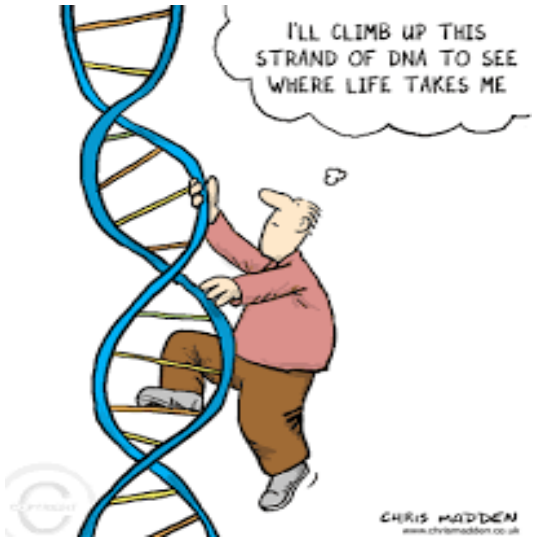
- Reduce distress caused by SPMI
- Empower and enhance recovery
- Improve medication adherence

HOW CBTP DIFFERS FROM "TRADITIONAL" CBT

- Agendas are less explicit
- Homework is used sparingly
- Emphasis on understanding the first episode in detail
- Acceptance of diagnosis is not required
- Belief that everybody gets stressed, it's the way we react that differs

BIOLOGICAL VULNERABILITIES FOR SCHIZOPHRENIA

- Certainly a genetic component.
- Multiple genes acting independently
- 50% among children w/ both parents. 36% identical twins, 14% fraternal twins
- Birth complications increase by 20%, especially for onset before 22 (10x for cesarean). Prolonged labor found with 40%
- More likely for late winter or spring birth.



SOCIAL VULNERABILITIES FOR SCHIZOPHRENIA

- Higher rates in urban areas
- Possibility of negative schemas (victims of crime)
- Easy to find substances
- Poor medical care
- 2nd generation immigrants have higher incidence
- Early trauma (child abuse) is linked to hallucinations
- Sleep deprivation worsens hallucinations

VULNERABILITY STRESS MODEL

- Person has biological risk factors
- Stress pushes them over
- It's a combination!

CHALLENGES IN EARLY INTERVENTION FOR PSYCHOSIS

- Improve long-term outcomes vs. erroneous labeling
- Early use of meds vs. side effects
- Prodromal symptoms (hard to define)
- Duration of untreated psychosis (mixed evidence)
- Frequently dismissed as personality D/O or substance use

TYPES OF PSYCHOSIS ACCORDING TO KINGDON AND TURKINGTON

- Sensitivity Psychosis: gradual onset (teen or young adult) and stress (leaving home, a job, school, social)
- Drug-Related Psychosis: cocaine, LSD, ecstasy
- Traumatic Psychosis: BPD and PTSD (voice of abuser)
- Anxiety Psychosis: acute, onset late 20s or onward

Dogs vs. Cats

Dogs are far superior

Dogs, if I have to choose

I have no preference

Cats, if I have to choose

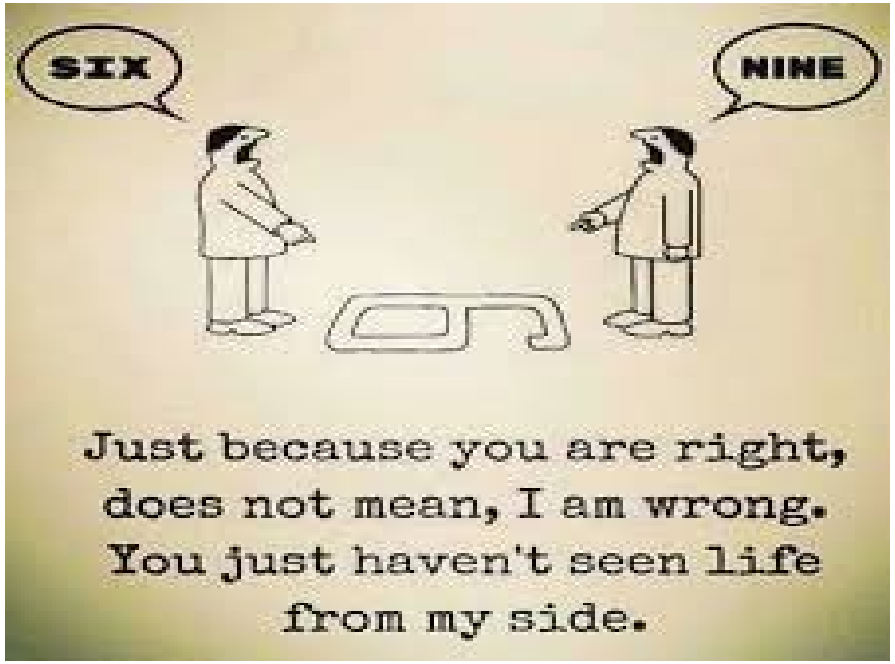
Cats are far superior

LET'S HAVE SOME FUN

1. Does toilet tissue go over or under the role
2. Best college basketball team
3. The best BBQ
4. Dogs vs. Cats

MIDDLE GROUND

- Middle ground between confrontation and agreeing with delusions is necessary!



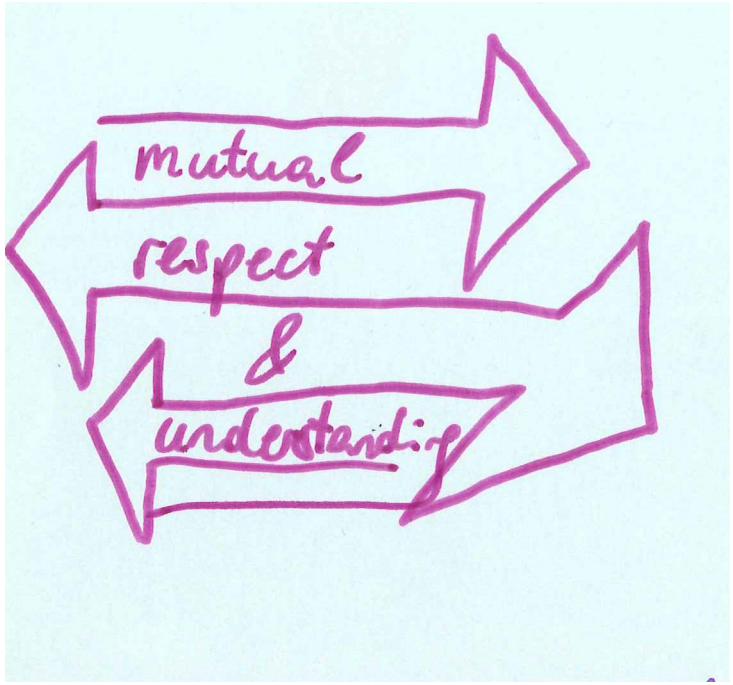
THERAPEUTIC RELATIONSHIPS: CAN'T DO ANYTHING WITHOUT RAPPORT

- Understand that delusions have meaning. Most are comprehensible.
- Take beliefs at face value.
- No direct confrontation and no collusion; it will always make delusions more entrenched.
- Have an agenda, but people often don't tolerate structure (agenda driven by person).
  - Need to be open to a wide range of topics. Show interest in the topics.
- Be careful about humor.
- If agitated, move away from the subject to "befriending" topics.

What are some strategies you have used to build a relationship with a person?

BEFRIENDING

- Relaxed conversation about nonclinical issues
- Be respectful (it takes time to trust), advocate, and instill hope.
- Be prepared to complete homework set by people (look-up alien abductions etc).
- Pace: Can be very slow. Maybe one target each session.
- Ask for Feedback! Encourage the person to respond.



ASSESSMENT

- It is rarely smooth. Starting with history may be easier
- Detailed info about events leading to first episode.
  - When did things first start to go wrong?
  - When did you first see a psych or hospitalized?
  - Understanding what the person was doing or thinking is crucial.
- Inquire about family Hx, income, and housing.
- Collect collateral information
- Standardized Instruments: Can appear mechanical and hurt rapport. Only after relationship established.

BE CURIOUS!

- Questions about sleep, appetite, and relationships provide opportunities to explore symptoms.
- Ask about AH: Do you hear people talking when no one around?
- Delusions frequently come out in conversation. They vary so much that standard questions can miss them.

TREATMENT PLANNING

- Current problems (is initial problem still an issue?)
- Clarify thoughts, feeling, behavior, physical symptoms, and social issues that are relevant to illness.
- Don't assume that people want to eliminate positive symptoms!
- Explain stress vulnerability model to the person.
- Identify underlying concerns (I need a girlfriend etc).
- List protective factors.
- Share formulation with the person. Plan can be to address specific areas or the underlying beliefs.

ORIENTING THE PERSON TO TX

- Balance between explaining therapy and confusing the person.
  - You can describe therapy more at later stage if needed.
- Advocate for combo of therapy and meds. CBTp can continue if people stop meds.
- If possible, combine roles (therapist and CM) when adherence to meds is difficult or engagement issues.
- People can have topics "off limits".
- Weekly sessions more effective. It is helpful to taper near termination.

PSYCHO ED AROUND DX

- Help people have a clear understanding of what is known about psychosis and what is a myth/assumed.
- Individualize:
  - "What would you like to know about what has happened to you"
  - "How has it previously been described to you".
  - If people feel uneasy or reject Dx, don't push it.
- What about Dx does the person agree with? Disagree with?
- Stigma of psychosis: people being scared can attribute to stress and paranoia
- Avoid technical terms.

PSYCHO ED AROUND MEDS

- Explore understanding of intended effects of meds and side effects.
- Negotiate don't disagree with people about meds. Never "command". People have the right to make their own decision.
- Some people see no benefit of meds (only see side effects). Negotiate a reduced level rather than no meds.

PSYCHO ED AND NORMALIZING

- Continuum of psychosis: trauma, sleep deprivation, fear (hostage), substance, fever, grieving etc.
- Hypnagogic hallucinations- hearing name called when tired.
- "Unscientific" phenomena (God, alien visits, ghosts).
- Beliefs vs. delusions can be cultural.
- You walk into crowded room that goes quiet.

PSYCHO ED AND AUTOMATIC THOUGHTS

- We all have them, all the time.
- It is central in CBTp to distinguish between thoughts and actions!!
- "What are you thinking about when you are trying to sleep".
- Discuss triggers (word or visual).
- Aggressive/hostile thoughts may lead to people accusing themselves of being bad.
  - "How could I think something like that".
- Thoughts may be disowned as voices or thought insertion.

Steve is working with a person and they state the following. Select all the statements that are delusions.

I won the lottery

I have a PhD in Chemistry

I'm a psychiatrist

My cousin is in the NBA Hall of Fame

I have three children

I was born in 1848

There is a Tasmanian devil in my apartment

The FBI is sitting outside my apartment watching me right now

DELUSIONS

- Often contain a kernel of truth. It is a result of the person misinterpreting the environment.
- Try to determine when first occurred. Onset most of the time may not seem to be dramatically stressful.
- This can be explored fairly early in process. May have to look at records or use natural supports.
- Exploration of thoughts about event is goal. Avoid asking about feelings. People may present thoughts as fact (if in doubt, let the statement stand).
- Not what is commonly called "reality testing"!

DELUSIONS II

- Frequently the first time the person has discussed the entire sequence of events (imagine being constantly redirected).
- Most people are clear about what belief they want to discuss first. If it starts to cause distress/agitation, talk about something else.
- Let the person lead and allow the conversation flow naturally.
- Numerous questions may be needed (sometimes closed questions are better). If the person becomes agitated, turn to general discussion! You can return to questions later.
- Once the story appears complete, examine it. Proceeding without a good framework can seriously harm relationship. Often people will let you know when they have stated everything relevant.

DELUSIONS III

- Discussing evidence without contradicting people can lead to change in delusion!
- Inference chaining: "If others agreed, what would it mean to you?" Get more specific when needed.
- Pros and Cons: What does the person view as the advantages of the belief? What are the disadvantages?
- Taking focus off delusions may be necessary for progress. No direct confrontation!
- Schemas: Not helpful with psychotic disorders.

CBTP AND PARANOIA

- People come to a conclusion without enough evidence (They are guessing too early).
- Ask:
  - How others with similar beliefs get by?
  - How might such trouble be avoided?
  - How can you take care of your life regardless of belief?
  - How did you rule-out other options?
- The person does not have to think like us.
- We don't have to change the belief! Our role is to help people live despite the belief.

ABC FORMULATION FOR PSYCHOSIS

- **A**ctivating event (hear voice).
- **B**elief (neighbors are trying to steal from me).
- **C**onsequences (set-up trip wires, yell at neighbors).

FIRST THOUGHT

What is your first thought when you hear this song?

CBTP AND HALLUCINATIONS

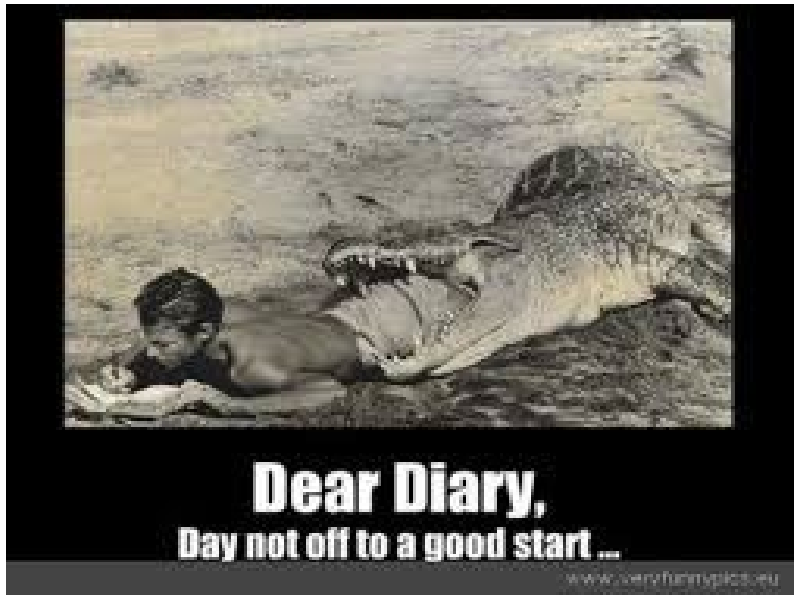
- Viewed as automatic thoughts that the person perceives as originating externally.
- Crucial to clarify details about hallucinations and impact on the person.
- Voice might be a clue (person unhappy about something)
- What does voice represent (worried about what neighbor thinks)?
- Explore possible explanations and modes of transmission.
- People do not have to get rid of the voice, just don't let it have too much influence!
- Common fear that voice will yell louder
- Thoughts are not the same as actions

HALLUCINATIONS II

- Engage AH: question what AH says, list evidence, list positive things, act against AH, give AH ten minute slot, attempt to record, check with a trusted friend, let AH choose what to do (if acceptable). It may get worse at start.
- Coping: warm bath, walk, exercise, relaxation tape, music, quiet place, reminding no one else can hear, calling therapist, playing a game, TV, puzzles, meditation, prayer, humming, hobby,
- No coping skill works in all situations. Person needs a variety.
- The person's attitude toward voice is key.

VOICE DIARY/LOG

- Log 7-day period.
- What was the person doing?
- Intensity of voice
- Affective response/how did they feel?
- Coping attempts



CBTP AND THOUGHT DISORDER

- Thought broadcasting: often related to other symptoms and recedes as mood improves.
- Thought withdrawal and thought blocking: Train of thought is interrupted when anxious.
- Thought insertion: automatic thoughts that are violent/embarrassing. Person believes they could not think of something so bad.
- Thought echo: more distracting then distressing. Isolation may reinforce.

THOUGHT DISORDER II

- Focusing on what the person believes is often best place to start.
- Encourage people to express their point of view. Trying to understand the person is essential. Make educated guesses that are short and to the point.
- Go slow and ask for clarification (may need closed questions). If asking further questions is not successful, move on.
- If people become irritated, just listen. The person may be anxious and not trust the therapist.
- People might have trouble understanding non-verbal. Don't educate the person, ask them to watch for eye contact, etc.
- It can be hard to find the meaning, however over time some order emerges.

CBTP AND NEGATIVE SYMPTOMS

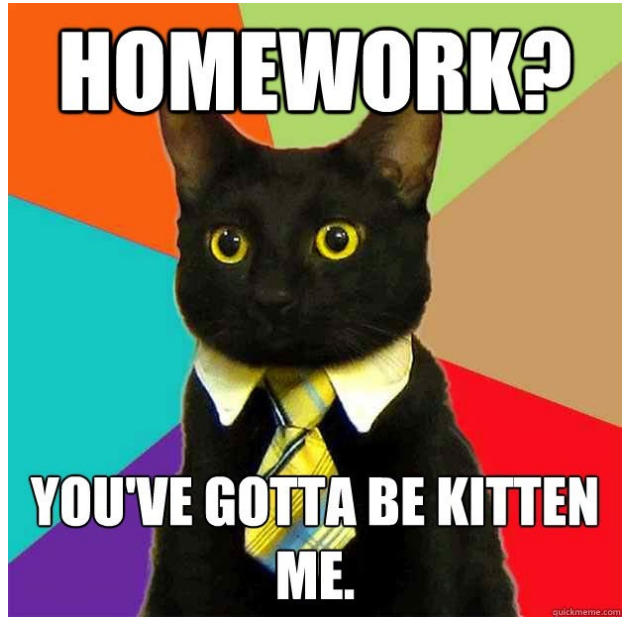
- Viewed as primary symptoms and a defense position to unbearable stress.
- Parallel work with positive symptoms.
- If symptoms present for years, recovery may take years. Let people recover at own pace, you can't push people out of negative symptoms
- Morning can be difficult with people rushing. Less stress during night.
- Medication while helpful for positive symptoms can increase negative (sedation, stiffness).

NEGATIVE SYMPTOMS II

- Gentle conversations with low targets.
- Education is important!
- Natural supports may try to help by pushing/applying pressure (person seen as lazy or willful). Natural supports find stepping back very difficult. Initially, reducing contact may be only way.

HOMEWORK

- Make sure to decide together the rational for the homework
- Make homework meaningful but achievable (check for obstacles)
- Use prompts
- If not completed, do it together early in the session.
- Experiments



CBTP AND COMORBID CONDITIONS

- Use a hierarchical approach of treatment (organic conditions, schizophrenia, depression, anxiety).
  - Treating higher Dx help with lower.
- Therapy needs to be combined with CM.
- Assist with healthy living skills, as people might misinterpret physical symptoms as punishment.

RECOVERY MAINTENANCE

- It's not that it won't happen again, it is knowing how to cope next time.
- From person's point of view, a worsening is relevant.
- Natural supports can provide info about early warning signs.
- It may be directly related to an event or not so obvious (times of year, specific people, med change, TV/movie, physical).
- Be proactive, don't wait for relapse to occur before developing strategy. People are frequently fearful of relapse.
- Most important is the person's feeling of control. Remind people that return of symptoms is not a relapse. Disaster and be handled.
- Keep in contact with people if inpatient and visit them. Advocate to reduce traumatic experiences while inpatient.

TERMINATION

- Treatment process is likely to require years, but many people can have low levels of contact.
- Reflect on work done and positive changes.
- Ideally people initiate after recognizing internal and external resources to move on (decrease in symptoms, sufficient coping skills, confident detecting relapses, and meaningful activity).
- A person who is isolated and guarded about symptoms is probably not ready
- People who d/c themselves frequently come back later.

DIFFICULTIES IN THERAPY

- Very Actively Psychotic Person with little insight:
  - Brief 10-15 minutes 2-3 times a week.
  - Go slowly, be empathic, and develop trust with appropriate use of normalization.
  - Take small clear steps toward areas of distress with focus on clarifying concerns.
  - Initially the person will dominate the interaction.
  - Do not attempt symptom management until the person is ready.
- Unmotivated Person:
  - Be patient and use lots of befriending.
  - Focus on identification of anxiety/depression and how it relates to current issue.
  - Try inquiring about past and current hobbies.

DIFFICULTIES IN THERAPY II

- Delusions that are grandiose:
  - Start with focus on pre-psychotic life. Work on underlying beliefs. Mostly have to build rapport and wait. Not uncommon for changes without what may appear to be critical work.
- New Affects emerging:
  - Embarrassment or amusement as therapy progresses. These should be recognized and dealt with in session. It can be painful to give up a long held belief. Normalize that people change beliefs daily.

DIFFICULTIES IN THERAPY III

- Aggressive Behavior: Watch for increase in command AH, persecutory delusions, stress, or substance use. Rehearse coping strategies in session. Practice exposure and response prevention with imagery and later real life. Normalizing that everyone has automatic thoughts at times of stress.
- SI: Risk elevated during first 10 yrs of illness. 5-10% making plans at any particular time. Inquire about SI regularly. Risk factors are substance use, impulsive, command AH. Discuss effects suicide would have on others. Instill hope by review of strengths and potential. Spiritual beliefs may protect sanctity of life.

DIFFICULTIES IN THERAPY IV

- Therapist incorporated into delusions: One option is to return to befriending. Second option is to move discussion quickly to underlying beliefs.
- Hallucinations within session: Can be an opportunity. However, it may also be a sign the person is stressed by the session. People can test first hand if others can hear the AH. Location of voices can be worked on in session and possible origins. Affect and behavior can be noted. Coping skills can be attempted

DIFFICULTIES IN THERAPY V

- Therapist feels progress is completely lacking: Progress will be slow at the start. Sometimes best to go back to history and gather more detail. Key issues may be discovered by standing back and listening.

WATCH THE MASTERS' AT WORK

- Doug Turkington: CBTp techniques https://www.youtube.com/watch?v=-Wc7MUNBSRo

- Doug Turkington: CBTp techniques https://www.youtube.com/watch?v=w8namZ5rt2k

REMEMBER THAT PEOPLE WITH PSYCHOTIC DISORDERS CAN RECOVER!

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