

**Cognitive Behavioral Treatment
of Psychotic Symptoms**

Ronald J Diamond

Cognitive-Behavioral Therapy for Severe Mental Illness:
Wright, Turkington, Kingdon and Basco 2009
Slide set adapted from David Turkington

CBT [cognitive behavioral therapy]

- Our thoughts strongly influence how we feel--while we cannot directly control our thoughts we can control what we choose to think about
- If we change our “tapes” our automatic and maladaptive thinking, our mood will change
- CBT is based on a collaborative relationship between therapist and client
- CBT does not presume to tell people how they should feel

CBT: Assumptions

- All of have “automatic thoughts”
- Distortions in our thinking is very common
- Some distortions cause major problems
- Recognizing and correcting these distortions can help

Ex:

**I never do anything right (absolute judgment)
I make more errors than anyone else in the
office (jump to conclusion, false assumptions)**

Levels of Cognition

- Core Beliefs
“I’m useless”, “The world is unfair”, “things will never work out for me”
- Dysfunctional Assumptions
Conditional unrealistic and maladaptive rules :
“It’s better not to try than to risk failing”
- Negative Automatic Thoughts
“I’m going to fail”, over estimation of risks

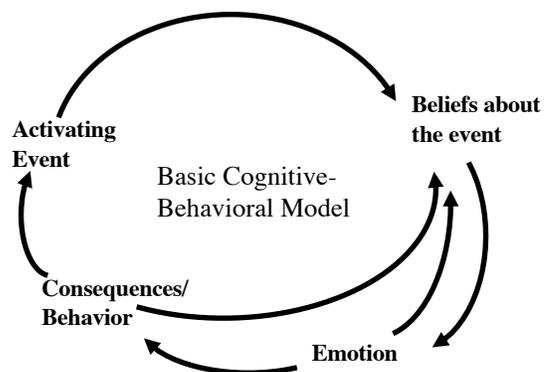
Judy Beck

OVERALL AIM OF CBT FOR PSYCHOSIS:

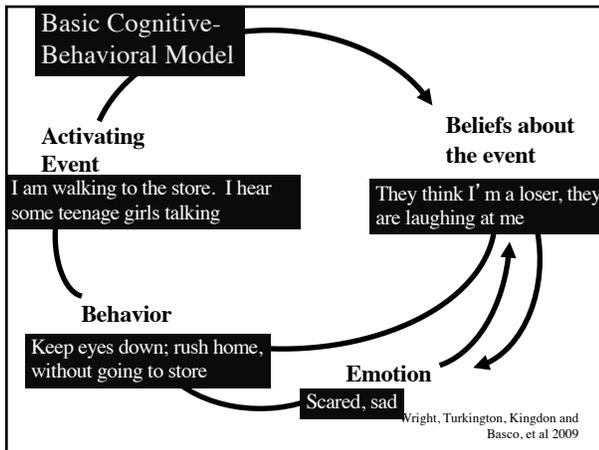
To reduce

- **DISTRESS &**
- **DISABILITY**

***REDUCING DELUSIONS &
HALLUCINATIONS IS SIMPLY A MEANS
TO THAT END***



Wright, Turkington, Kingdon and Basco, et al 2009



ABC of Cognitive Behavioral Therapy for Schizophrenia (Ellis and Harper 1961)

A Activating event
 B Beliefs (cognitions) about that event
 C Consequences (Behaviors)

All Clinical Problems Are C

Patients almost always focus on A

Cognitive Distortions

Arbitrary inference:
 specific conclusion is drawn arbitrarily

Selective abstraction:
 client focuses on detail taken out of context

Overgeneralization:
 drawing general rule or conclusion from an isolated event

Magnification and minimisation:
 over or under valuing magnitude of an event

Personalization:
 relate external events to himself

Absolutistic, black/white thinking

Common automatic thoughts in people with schizophrenia

Automatic Thought	Cognitive Errors
"I am mad"	labeling, magnifying
"I will never get better"	jumping to conclusions, all-or-nothing thinking
"I can't be trusted"	Disqualifying the positive, magnifying
"I will end up on the streets"	Jumping to conclusions, catastrophizing
"I will never get a job"	Jumping to conclusions, all-or-nothing thinking
"I must be possessed by a demon"	Lack of evidence
"People will be scared of me"	Jumping to conclusions, magnifying

Types of Beliefs or Cognitions

- Images
- Inferences
 - Hypothesis that may be true or false
- Evaluation
 - Some action is good or bad
 - "person evaluations", fixed total condemnation of a person
- Dysfunctional Assumptions

Chadwick, Birchwood and Trower:
 Cognitive Therapy for Delusions, Voices and Paranoia

Steps for CBT of Psychosis

1. Engagement and assessment
2. Normalizing and educating
3. Case formulation and treatment planning
4. Working with specific symptoms

1. Engagement: what do you want to work on?

Start with a problem that the client wants to work on

Start from the client's point of view

Take an attitude of persistent curiosity

Be interested in details of the person's experience

Follow the client's lead

Use language and style that fits client's way of communicating

Use vulnerability-stress model to explain illness

Ex. Engaging a Patient with Paranoia
Developing a shared agenda

What does the consumer want to change?
 Being able to go to consumer store
 But this is not possible because....

Why else might the girls be laughing—why else do girls laugh?
 How would we get more information about this?
 Is this something you could do?

Engagement

Obtain sufficient information before assessment

Don't jump to conclusions, take comments at face value

Persist but retreat if distress increases

Use a conversational style, rather than staccato questioning

Don't try to do too much but keep the flow of discussion going

Aim for sessions to be positive, even enjoyable, experiences as far as its reasonable to do so

Tracing Antecedents: How did it start?

Direct approach: 'when did you first think that...?'
 'when did you last feel well'

Introduce doubt: how sure are you that....

Develop through personal history:
 birth, childhood, adolescence & then ...

Use accounts from relatives, clinical records, family doctor notes to prompt

Matching Treatment and Readiness

Pre-contemplation:		Increase awareness and raise doubt
Contemplation:		Tip the balance
Preparation:		Negotiate a plan
Action:		Assist behavior change through small steps
Maintenance:		Prevent relapse and help lifestyle change

Todd C. Campbell 2003

Enhancing Motivation to Change

- Express empathy:
 LISTEN
 Ambivalence is normal and expected
- Encourage the consumer to talk about what her or she wants to be different
 Encourage the consumer to explore what can make things different
- What role can sobriety, or medication, or other behavioral change, play in this?
 Consumer's belief in the possibility of change is an important motivator

Learned Helplessness

- **Depression: withdrawal, sadness, slow movement, irritability, anger, demanding**
- **Generalized Failure mindset: I can't do it, I failed once, I will always fail. Other's can do it but I can't do it**
- **Motivational deficits: apathy, passive compliance, lack of motivation, "what I do doesn't matter" "mental health runs my life"**

Pat Deegan

Normalizing Statements for people with hallucinations

- Many people hear voices
- People who are deprived of sleep for long periods are prone to hallucinate
- People who have been involved in combat or severe trauma can experience hallucinations
- One person in every 50 is a voice hearer
- Lots of famous people are voice hearers
- Voice hearers often hold down good jobs
- The human brain hallucinates fairly easily in response to stress

Wright et al 2009

Individualize formulation and treatment planning

- Anxiety psychosis
- Sensitivity psychosis
- Drug-related psychosis
- Traumatic psychosis

Building a timeline

- When is the last time that you felt well?
- What age were you and what were you doing?
- Were there any particular problems?
- How did things first start?
- What was happening at that time
- What was going through your mind?

Continuum of abnormal beliefs

- How strongly person holds the belief about the bizarre experience
- Degree of cultural or stimulus determination for the experience
- Amount of time spent preoccupied with the experience
- Implausibility of the experience

Strauss 1969 as reported in Kingdon and Turkington

Cognitive Conceptualization of Delusions

- **Egocentric bias: pt's belief that other's attention is focused on them**
- **Externalization or attributional bias: pt's belief that certain internal events are caused by external forces**
- **Intentionalization bias: external explanatory bias overrides more normal internal explanations. Reality testing for hypsalient ideas is defective**

Beck, Rector, Stolar and Grant 2011

Examine the Evidence for the Problem

What is the evidence that people are reading your mind?

What is the evidence that someone has put a chip into your head?

What is the evidence that this is god talking to you?

ABC analysis of delusions

Antecedant	Belief	Consequence
Car horn sounds outside	They have come for me, to kill me	Runs from apartment
Staff walks in front of client	He thinks he is better than me, he's letting me know	Shame Avoids staff person
Hears Actor on Shopping TV Network say what he was just thinking	My thoughts are being transmitted	Panic Stops watching TV

Adapted from Chadwick, Birchwood and Trower: Cognitive Therapy for Delusions, Voices and Paranoia 1996

CBT with delusions:

- Less strongly held beliefs targeted first
- Direct confrontation is avoided
- Discussion focused on evidence for the belief, and not on the belief itself
- Therapist worked to get client to voice arguments against the belief, even if achieving this required direct questioning

Hole et al 1979 as reported in Kingdon and Turkington

Process of CBT therapy in schizophrenia

- Clarify history and current sources of stress
 - Explore possible connections between stress and current symptoms
 - Explore beginning/antecedents of belief/symptoms
 - Explore discrepancies in belief
- Joint discovery of alternative explanations
- Seed doubt and wait

Pursue delusions

- Elicit alternatives: 'any other possibilities?'
- 'If someone said that to you, how would you respond?'
- Gentle prompt:
 - 'What about...? Do you think just possibly..?'
- Exploration/investigation (NOT homework)
 - Any theoretical proposition: but don't expect them to do it.....
- Sew, seed & wait

Resistant delusions

- If going round in circles
 - AGREE TO DIFFER - & stand back
 - Review key issues & concerns that have emerged
 - Revisit/complete the formulation
- Consider inference chaining
 - Factual implications:
 - 'If you have an alien inside you, how did it get there?'
 - Emotional underpinning, concerns or consequences of beliefs

Inference chaining

- ‘OK, I do have some problems with this ... but if other people did accept what you are saying,
 - what difference would that make to you’
 - what would distress you most about it’
 - why would it be so important?
 - what could you do about it’

Inference chaining

- Follow through to specific change, relationship, etc
 - ‘I wouldn’t be lonely’ ‘well, is there anything else we can do about that’
 - ‘I’ll be beaten up’
- Then deal with the emerging issue
 - ‘Although I may not be able to accept you’re Attila the Hun, I may be able to help you do something about your loneliness’
 - Explain procedures: ‘are there safety measures you can take...e.g. Carry alarm’

Are there any practical approaches that might help the problem

The person is already attempting to cope, but this is not working very well

What might help better?

What else might be worth trying?

Cognitive Conceptualization of Hallucinations

- Predisposition to auditory imagery
- Hyperactive beliefs and cognitions
- Perceptualizations: some hypervalent cognitions exceed threshold for unintended images and are experienced as identical to external sounds
- Disinhibition; normal restraints on involuntary imaging is weak
- Externalization bias
- Deficient reality testing

Beck, Rector, Stolar and Grant 2011

ABC analysis of hallucinations

Antecedant	Belief	Consequence
Hears a voice saying he will be killed	It is the devil coming to take me	Feels terrified, afraid to leave apartment
Hears voice telling him he is a bad person	He knows the real me—this is accurate	Feels very depressed, stops doing anything because he does not deserve it

Adapted from Chadwick, Birchwood and Trower: Cognitive Therapy for Delusions, Voices and Paranoia 1996

HALLUCINATIONS

- Discuss phenomena: not illusions
 - ‘someone speaking to you like I’m doing now.. maybe louder or whispered’
- Explore individuality of perception
 - ‘can anybody else hear what is said?’
 - ‘not parents, friends, etc?’
 - ‘Can you tell me if it happens while you are here with me?’
 - if only occurring when alone, ask them to tape voices
- Discover beliefs about origin:
 - ‘why do you think others can’t hear them?’

HALLUCINATIONS

- Explore beliefs about origin of voices
 - explore doubts: ‘I’m not sure how they come..’
- Look for explanations:
 - ‘it may be schizophrenia’ (‘but I wish the neighbours would shut up’)
 - use ‘normalising’ alternatives: Sleep deprivation and other stressful circumstances: e.g. bereavement, hostages, *dreaming*, PTSD
- Aim towards allowing the possibility, however unlikely, that the voices may be from within the person

Case formulation

- Schema: Client’s working hypothesis about the world and the problem
- Hypothesis: Staff’s working hypothesis about the world and the problem
- Treatment plan: What specific steps will help

CONTENT OF VOICES

Explore what they say:

if abusive, violent, obscene
relevance to previous traumatic events
or drug-related experiences
misinterpretation of ‘automatic thoughts’

Discuss beliefs in omnipotence of voices

Chadwick & Birchwood, 1995

‘Just because a voice says something, however loudly and forcefully, doesn’t mean it is true Or that you have to act upon it’

Coping strategies

Behavioural control

e.g. relaxation, warm bath, go for walk

Socialisation

e.g. friends, day centres: avoidance unusual

Medical care

e.g.. control of medication, call key worker

Symptomatic behaviour

e.g. get drunk or drugged, punch policeman

Cognitive control

e.g.. TV, music, crosswords

Case Formulation and Treatment planning

1. What is the problem that the client wants to address?
2. What do we know about the beginnings of that problem?
3. What are the person’s thinking about the problem?
4. What assumptions are being made?
5. What “automatic thoughts” is the person having?

Case formulation

Event: argument with boss at work

Automatic thoughts:

He doesn’t know his job

He’s jealous

I know what customer’s want

Emotions

Irritated and angry

Behaviors

Paces up and down, drink more coffee

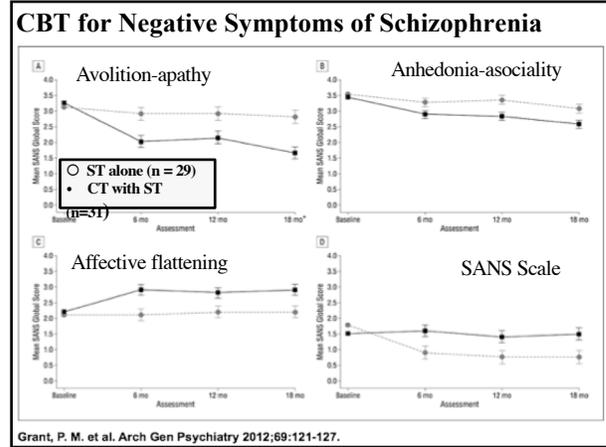
Case formulation

Event: hear a voice saying “hurt Maria”

Automatic thoughts:
 I might harm the baby
 I’m not safe to be with her
 It must be the devil talking with me

Emotions
 Anxiety, abdominal churning, rapid breathing

Behavior
 Run out of son’s home



**You can't push patients
 out of negative symptoms**

But you may be able to help them find & open doors

CBT

Curiosity, not interrogation
 [Columbo, not Dirty Harry]

Stay goal directed, and always follow
 client’s lead

Identify assumptions and automatic
 thoughts