Substance Abuse and Mental Health Services Administration

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Stanford MEDICINE

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover

Introduction to Cognitive Behavioral Therapy for Psychosis
Module 1

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This webinar is hosted by Research and Training Center for Pathways to Positive Futures (Pathways RTC), Portland State University, a partner in the National TA Network for Children's Behavioral Health, operated by and coordinated through the University of Maryland.

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Overview

- ## Module 1
  - Overview of CBTp & evidence base
  - Engagement, normalizing, and questioning

- ## Module 2
  - Formulation and intervention
  - Trauma, substance abuse

- ## Module 3
  - CBTp models
  - Training

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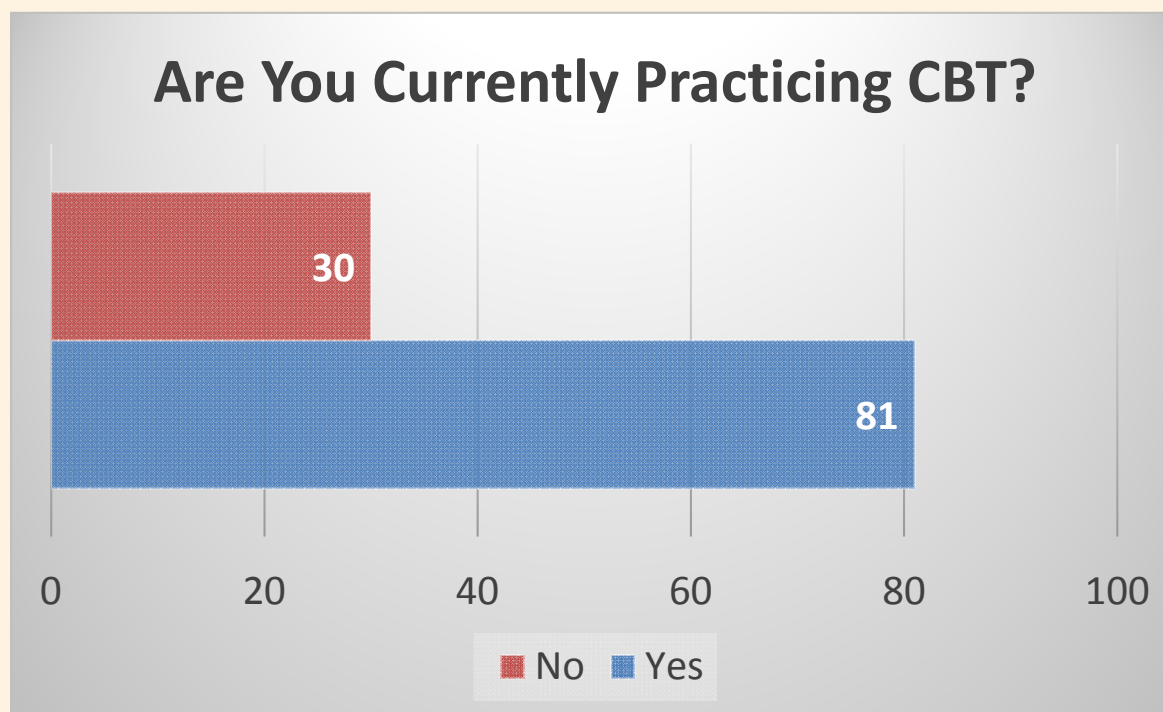Substance Abuse and Mental Health Services Administration

Module 1

- Provide a background to CBTp

- Overview of the evidence base

- Key skills associated with CBTp

  – Engagement and befriending

  – Normalizing

  – Curious Questioning
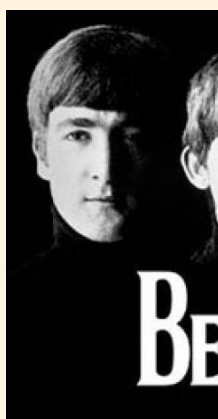
What do you know?

Poll:

Are You Currently Practicing CBT?

No: 30
Yes: 81

What do you know?

Poll:

Are You Currently Practicing CBTp?

No	69
Yes	39

(horizontal axis: 0, 20, 40, 60, 80)

Legend: No, Yes

What do you know?

Poll:

How Much Do You Know About CBTp?

Range	Value
81-100%	0
61-80%	15
41-60%	26
21-40%	29
0-20%	45
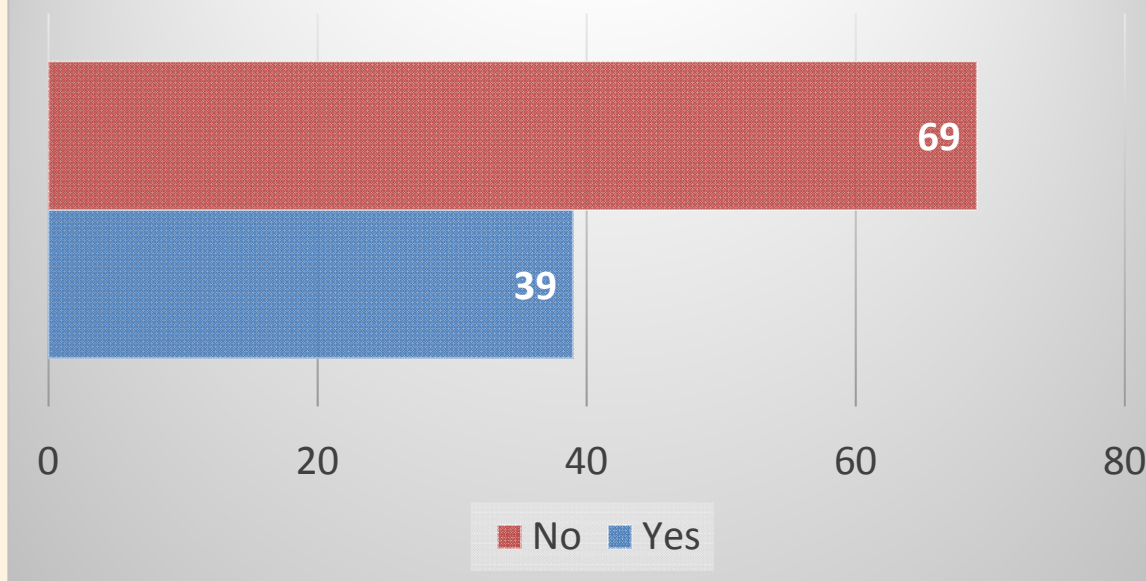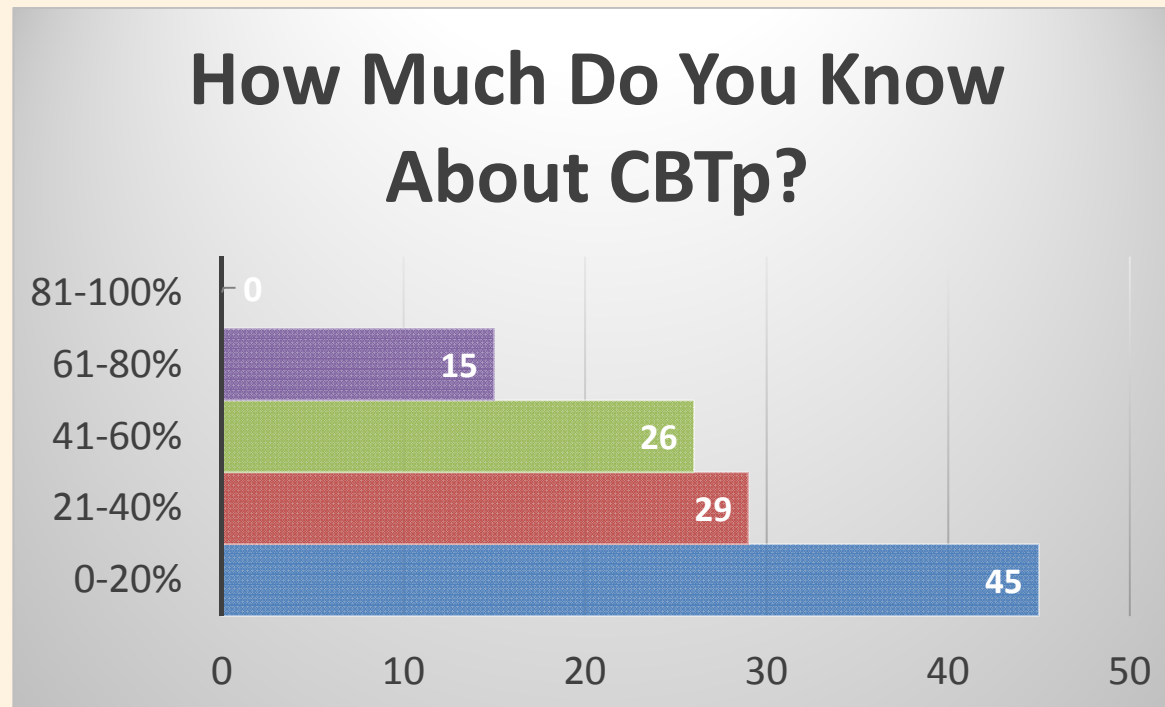
What is CBT?

- How what you think and what you do affects how you feel.

- Thinking includes how you think about yourself, the world and other people

- Here and now focus though draws upon past experiences to explain schema formation
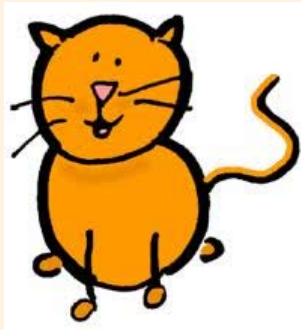
What is CBT?

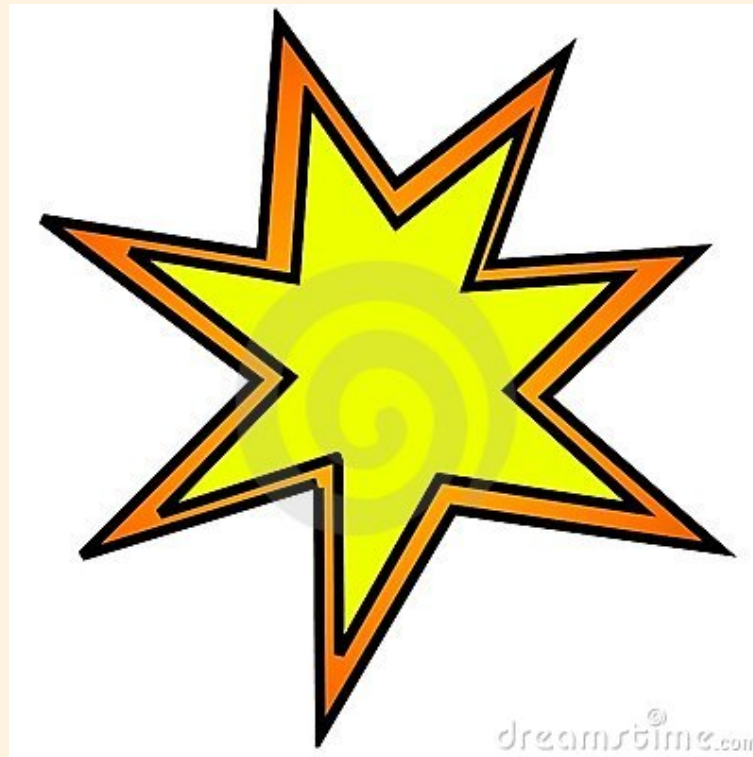- Early experiences lead people to develop core beliefs

- From core beliefs unhelpful assumptions are generated that organize perception and govern behavior

- Critical incident triggers the assumptions

- Leading to negative automatic thoughts (NAT'S) which impact mood, behavior and physiology

Friend is 20 minutes late for dinner

They don't like me
They never wanted to have dinner with me

Check phone
Ruminate

Nauseous

Anxious
Sad

Critical incident activates assumptions

If people get to know me they'll reject me
I have to always please people or they'll reject me

Others can't be trusted
I'm no good

Bullied at school
Socially isolated
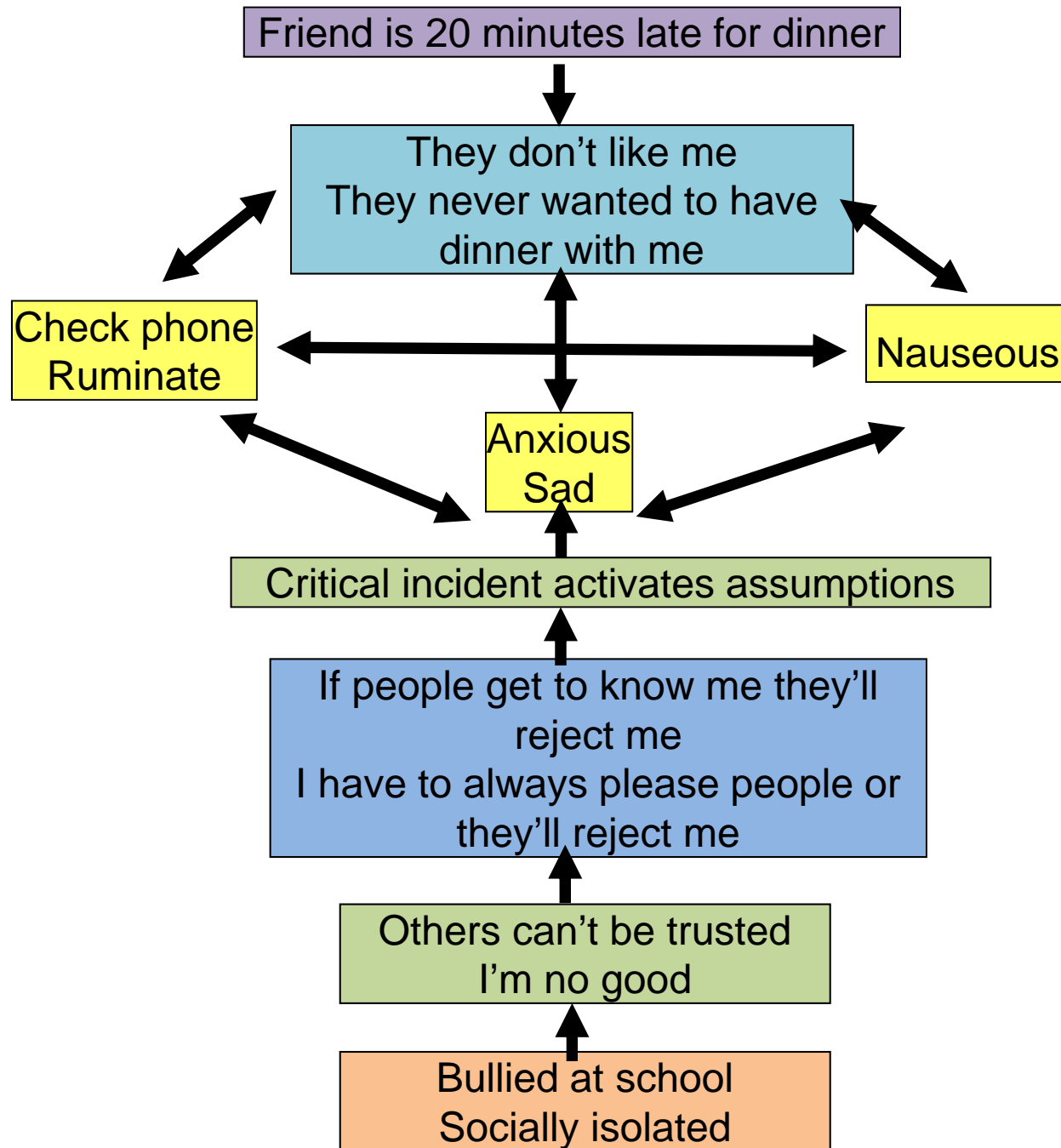
Thoughts vs. Feelings
(A note on language)

- I feel angry.

- I feel like things aren't fair.

- I thought it was scary.

- I feel freaked out.

- I feel like you're being a jerk.

CBTp background

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'

![SAMHSA logo — Substance Abuse and Mental Health Services Administration](logo)

- Formulation based CBTp
- Funding for national training roll out
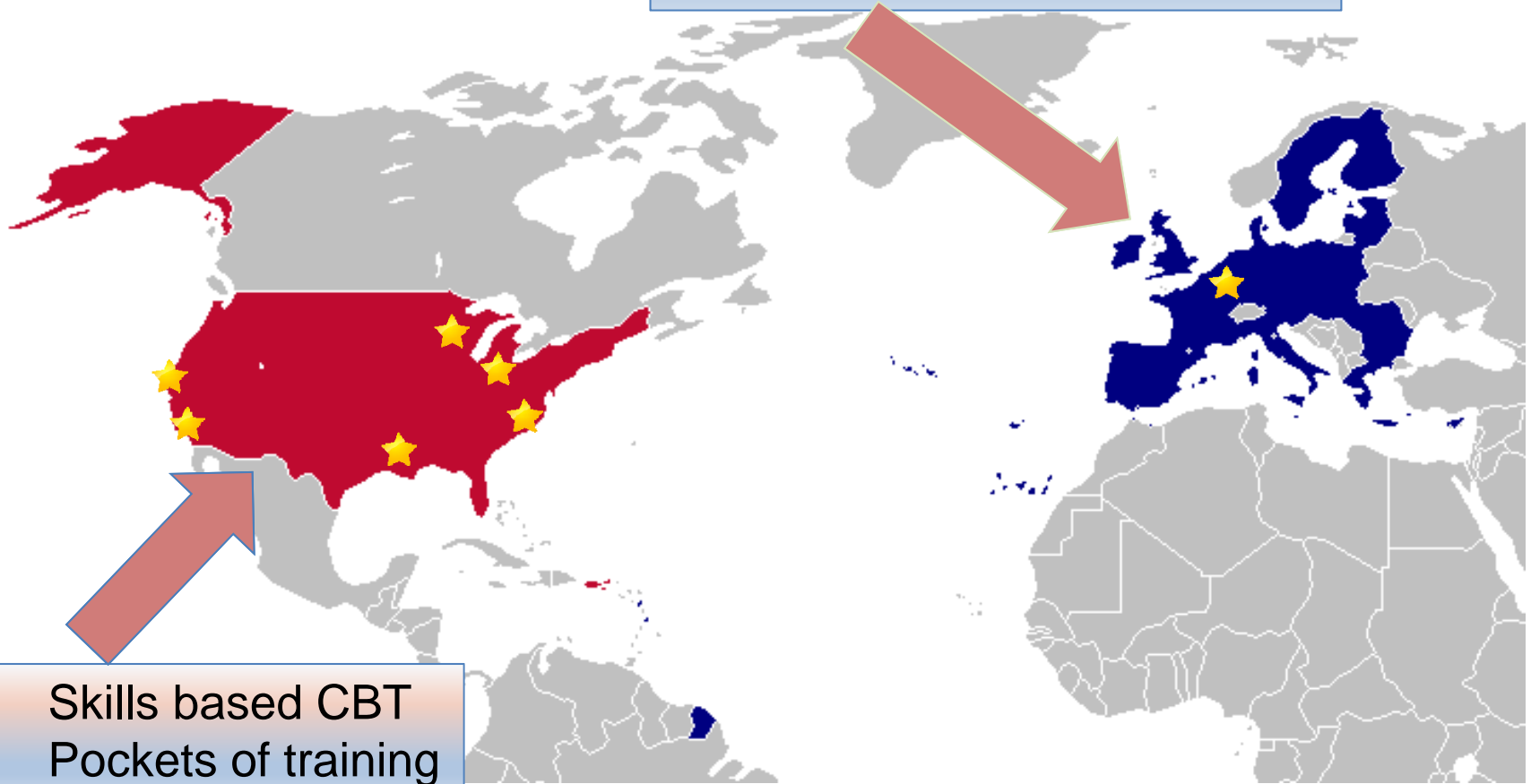
- Skills based CBT
- Pockets of training

CBT for psychosis: Models

- Formulation Based CBTp
  - Individualized formulation informs intervention
- Individualized Resiliency Training (IRT)
  - Manual based intervention supports skill acquisition

Further Information

- http://med.stanford.edu/peppnet/resources/TreatmentWorkGroupVideos.html
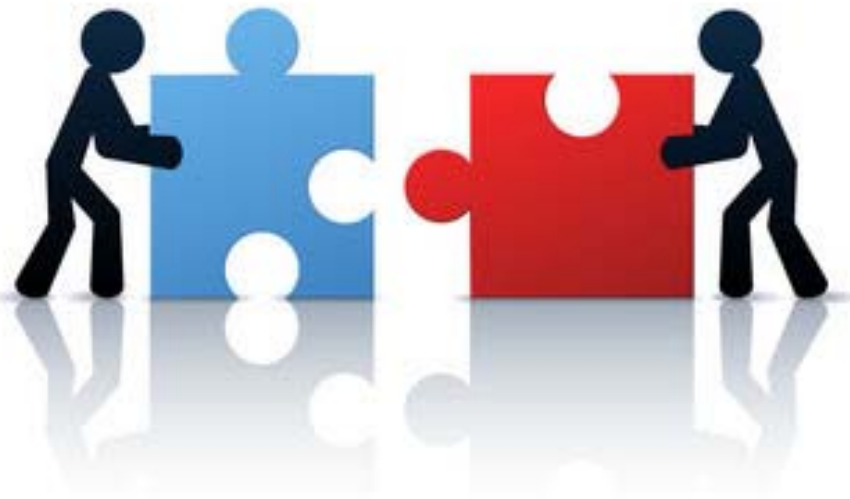
How does CBT apply to psychosis?

CBT for psychosis

- Focus is on reducing the ***distress*** caused by positive symptoms including hallucinations and unusual thoughts and ***supporting functioning*** by addressing negative symptoms

•**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

Why provide CBTp for early psychosis?

Early Intervention Principles *	CBTp
Provide interventions with demonstrated efficacy	Evidence Based
Provide services that actively partner with young people (Shared Decision Making)	Client generated problem list Collaborative approach (the "collaborative fence") Development of shared understanding (formulation)
Challenge stigmatizing and discriminatory attitudes	Normalization
Generate optimism and expectation of positive outcomes and recovery Respect the right to recovery and social inclusion	Problem list and goals Focus on functional recovery (not symptom reduction) Development of skills and tools to support and maintain recovery Wellness Planning
Culturally Sensitive Services	Individualized formulation
Respect the right for family & friends to participate in treatment	Include family and important support people in wellness planning

*based on values and vision described in Bertolote and McGorry (2006)

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CBTp at different stages (generally)

- **Clinical High Risk**
  - Address attenuated symptoms
  - Testing out and developing new explanations for experiences
  - Addressing comorbid anxiety/depression
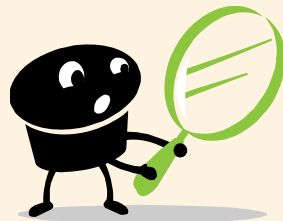 - School/peer functioning
- **Early Psychosis**
  - Addressing fully psychotic symptoms
  - Explanatory models and beliefs about psychosis/stigma
  - Medications
  - Involving families
- **Chronic Psychosis**
  - Wellness planning
  - Developing/refining coping skills
  - Addressing functional goals

Is there any evidence that CBTp is useful?

Evidence base for CBTp

- Highly acceptable to consumers (Morrison et al, 2004)

- Reduces positive symptoms, negative symptoms and increases functional outcomes (Wykes et al, 2008)

- Reduced days in hospital (Jolley et al, 2003)

- CBT for those at risk of psychosis prevents transition to psychosis at 12 months (Stafford et al, 2013)

Evidence Base continued

Sarin et al. (2011)
- CBTp had delayed impact with most improvement at follow up

Kumari et al. (2011)
- CBTp led to significant clinical improvement and decreased activation in brain areas associated with threat perception.

Morrison et al. (2014)
- CBTp without antipsychotic medication
- Mean PANSS scores significantly lower in CBTp group compared with TAU

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Meta-analysis debate

Jauhar et al. (2014)

- Applied stringent masking to analysis and exploration of publication bias
- CBT has an effect on 'schizophrenic symptoms in the "small" range'

Burns et al. (2014)

- Meta-analysis for medication resistant positive symptoms
- ES 0.47 (positive symptoms) & 0.52 (general symptoms) at end of treatment
- 'patients with medication resistant positive symptoms may derive more benefit from an adjunctive psychotherapy… than from adjunctive medications'

Turner et al. (2014)

- Comparison of psychosocial treatments for psychosis
- CBT significantly more effective (p<0.05) in reducing positive symptoms than other PSI (befriending and supportive counselling)
- Social skills training more effective in reducing negative symptoms

CBT for CHR

- Stafford et al. (2013)
  - Meta-Analysis of RCT's including psychological, nutritional, pharmacological or combination
    - 11 studies (1246 participants)
      - Moderate quality evidence for CBT
      - Very low quality evidence for omega 3 fatty acids
      - Low to very low quality evidence for integrated interventions
- No evidence to support use of anti-psychotic drugs to prevent transition
- CBT (with or without family component) may be most sensible first line treatment (+ omega 3?)

CBT for CHR

Van der Gaag et al., (2012)

- 18 month follow-up data
- CBT more effective in preventing transition to psychosis than TAU (p = 0.3)
- Results maintained at four-year follow-up (Ising et al., 2016)

Ising et al., (2016)

- Cost effectiveness of CBT for CHR compared with routine care
- CBT had high likelihood of averting transition to psychosis and lower costs (83%)
- CBT had high likelihood of quality of life gains (75%)

Evidence Base Summarized

- CBTp effective in reducing positive symptoms, negative symptoms, general symptoms
- Evidence to suggest most effective in CHR, early phase psychosis and stable chronic symptoms (Birchwood et al, 2014)
- More research required on:
    - 'active ingredients' of CBTp
    - Identification of predictive client characteristics
    - Number of required sessions

Recommendations

CBTp should be offered adjunctive to medication management

- Dixon et al (2010)
  - Patient Outcomes Research Team (PORT)
- NICE (2013)
  - Psychosis and Schizophrenia in Children and Young People
- NICE (2014)
  - Psychosis and Schizophrenia in Adults

CBTp: a word of caution

- Complaints of publication bias and 'overselling' (Jauhar et al 2014)
- CBTp only effective if delivered in full (Dunn et al, 2012)
- Poor therapeutic alliance predictive of poor outcomes (Dunn et al, 2015)
- CBTp should only be delivered when good therapeutic alliance is possible

CBTP: CLINICAL OVERVIEW

Main Components of CBTp

- Engaging with the client

- Normalizing experiences

- Collaborative exploration of experiences

- Formulation

- Formulation informed intervention

- Generalization of skills

- Wellness planning

Engagement and Befriending

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

Befriending

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

Engagement Issues

- Non confrontational
  - » Avoid confrontation but avoid collusion also
  - » Show interest in the subject with non judgmental questioning
- Pacing
  - » May need to be at a slower pace with simple achievable goals set for each session
  - » Use aids to help client to follow session (white board etc.)
  - » Be aware of internal distracters that may impact on clients ability to concentrate

Pacing of CBTp

- Ensure pacing matches client pace
    - Once a week vs. multiple sessions per week

- Prepare for paranoia?

Mom   Kate   Care
                                              manager

0%   100%
Trust   Trust

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This actually did happen to a real person, and the real person was me. I had gone to catch a train. This was April 1976, in Cambridge, U.K. I was a bit early for the train. I'd gotten the time of the train wrong. I went to get myself a newspaper to do the crossword, and a cup of coffee and a packet of cookies. I went and sat at a table.

I want you to picture the scene. It's very important that you get this very clear in your mind. Here's the table, newspaper, cup of coffee, packet of cookies. There's a guy sitting opposite me, perfectly ordinary-looking guy wearing a business suit, carrying a briefcase. It didn't look like he was going to do anything weird. What he did was this: he suddenly leaned across, picked up the packet of cookies, tore it open, took one out, and ate it.

Now this, I have to say, is the sort of thing the British are very bad at dealing with. There's nothing in our background, upbringing, or education that teaches you how to deal with someone who in broad daylight has just stolen your cookies.

You know what would happen if this had been South Central Los Angeles. There would have very quickly been gunfire, helicopters coming in, CNN, you know. . . But in the end, I did what any red-blooded Englishman would do: I ignored it. And I stared at the newspaper, took a sip of coffee, tried to do a clue in the newspaper, couldn't do anything, and thought, what am I going to do?

In the end I thought, *Nothing for it, I'll just have to go for it*, and I tried very hard not to notice the fact that the packet was already mysteriously opened. I took out a cookie for myself. I thought, *That settled him*. But it hadn't because a moment or two later he did it again. He took another cookie. Having not mentioned it the first time, it was somehow even harder to raise the subject the second time around. "Excuse me, I couldn't help but notice . . ." I mean, it doesn't really work.

We went through the whole packet like this. When I say the whole packet, I mean there were only about eight cookies, but it felt like a lifetime. He took one, I took one, he took one, I took one. Finally, when we got to the end, he stood up and walked away. Well, we exchanged meaningful looks, then he walked away, and I breathed a sigh of relief and sat back.

A moment or two later the train was coming in, so I tossed back the rest of my coffee, stood up, picked up the newspaper, and underneath the newspaper were my cookies.

The thing I like particularly about this story is the sensation that somewhere in England there has been wandering around for the last quarter-century a perfectly ordinary guy who's had the same exact story, only he doesn't have the punch line

Important to Remember:

- It is ok to be flexible and creative in sessions
    - Go for a walk, talk about shared interest, break for a game

- Do not have to adhere to strict CBT structure

- **ABOVE ALL NEED TO BE RESPONSIVE TO THE CLIENT**

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
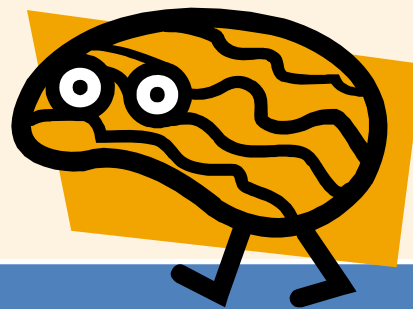
No psychosis

Psychosis

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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
- Develop library of recovery stories?

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, 2006)
  - 5% of population hear voices (Tien 1991)
  - People hear voices without seeking mental health services (Romme & Escher 1989)
  - 9% people hold delusional beliefs (van Os, 2000)
  - Common to see or hear loved one following bereavement (Grimby 1993)
- Connect with other people experiencing psychosis (including working with peers)
  - Intervoice
  - Psycope.co.uk
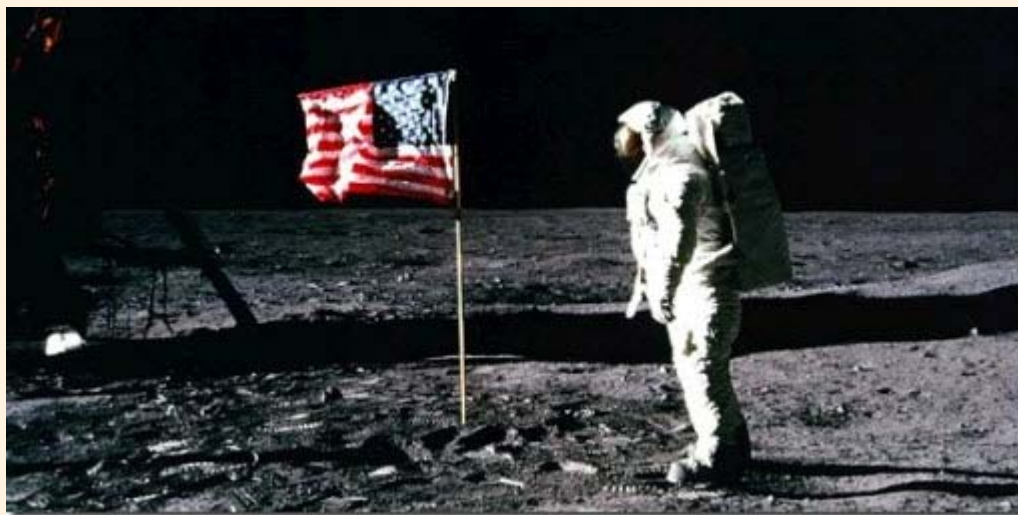 - Paranoia.com

Normalizing: Examples

- Encouraging staff (and families) to consider times when they have had psychotic-like experiences
  - Hearing phone ring
  - Baby cry
  - Paranoia examples
  - Things that didn't make sense
  - Supernatural

Curious Questioning

https://www.youtube.com/watch?v=XtW72nT7cYQ

Questioning Styles

- **Didactic**
  - Teaching new skill
  - Providing psycho-education

- **Socratic Questioning**
  - Leading client to a particular answer

- **Guided Discovery**
  - Asking informational questions
  - Listening
  - Summarizing
  - Synthesizing

  It's ok to not know where line of questioning is going (sometimes best) – remain curious