SPEAKER NOTES

Cognitive Behavioral Therapy: How It Can Help with Psychosis

Summarized by Thomas T. Thomas

At our September 25 meeting, Clinical Psychologist **Kate Hardy, Clin PsychD,** discussed Cognitive Behavioral Therapy (CBT), an evidence-based approach widely used for many mental health problems. Hardy is a licensed psychologist at the University of California San Francisco and received her doctorate from the University of Liverpool, United Kingdom.

The basic premise of CBT is that how we think (our cognitions) and how we act (our behaviors) can impact how we feel (our emotions). By helping a person examine thoughts and behaviors, and subsequently make changes in these areas, we can help the individual make choices to reduce distress.

KATE HARDY, CLIN PSYCHD

More recently, this approach has been applied in the treatment of psychosis, with research suggesting that Cognitive Behavioral Therapy for psychosis (CBTp) can help reduce symptoms and improve functioning.

Hardy has presented the principles of CBTp to clinicians in the U.S. and U.K., to family groups and caregivers, and—in California—to a number of county mental health organizations. "How can we get these skills and ideas out to families?" Hardy asked. "CBT shouldn't be a mystery, because it's thinking about what's going on in our lives, how you think about yourself, the world, and other people. It's based on the here and now, but also things that have gone before."

She gave the example of sitting in bed at night and hearing a loud crash. If you think it's someone breaking into the house, you might be scared and perhaps hide under the covers or call 911. If you think it's the cat or raccoons outside, you might be relieved but also annoyed. How you interpret what's going on sets up different feelings and actions. And your interpretation will often depend on past experience and other social factors.

Cognitive Behavioral Therapy originated in behavioral therapy, which posited that our behavior is shaped through the reinforcement we receive. This was too simplistic a view of human nature for many psychologists, who posited that our thoughts influence our behavior and emotion. In the 1950s, the two approaches were melded into CBT. For a long time, psychologists believed that the symptoms and effects of psychosis were beyond the reach of any kind of "talk therapy," that it was a biological illness, and medication was their preferred approach. But in the 1990s CBTp was introduced with a focus on reducing the distress caused by

positive symptoms like hallucinations, hearing voices, and having unusual thoughts.

CBTp is *cognitive,* because it helps the person look at the accuracy of the interpretation he or she puts on events. For example, if someone believes the FBI is after him based on seeing five blue cars pass by the house, one might ask what is the normal traffic pattern, and does the FBI actually use all blue cars? CBTp is *behavioral,* because it helps the person evaluate the efficacy of his or her behavior. If the response to hearing voices is to sit in a room and listen to them, is that really helping?

"This is not just for positive symptoms," Hardy said, "but also for depression and anxiety, social skills, post-traumatic evaluation, and negative self-image."

The evidence for efficacy of CBTp is based on various surveys and studies. It has shown to be acceptable to consumers: people like it, and the treatment has a low dropout rate. It reduces positive and negative symptoms and increases functional outcomes. It reduces days spent in the hospital. As the person acquires CBTp skills, the therapy can delay the impact of a psychotic break, with the most improvement at follow-up. For a person at risk for psychosis, CBTp may prevent the transition to psychosis at 12 months.

What can a person expect from CBTp? The therapy takes place in three phases. First is engagement and socialization to the model. Then comes formulation development—"what's going on"—and skill acquisition. And finally, generalization of skills and relapse prevention planning, so that the therapy works not just during sessions but in the outside world as well.

Key principles of CBTp include:

- Collaborative between therapist and client.
- Client-driven agenda—problem list is up to client.
- Goal directed—therapy moves toward a result.
- Structured approach.
- Jointly developed explanation of difficulties.
- Time limited—recommended treatment period in the U.K. is nine months.
- Includes "homework" for the client to complete on his or her own.

Skills that the client and family members can learn during CBTp therapy include:

- Embracing curiosity.
- Recognizing and managing stress.
- Coping strategies for distressing voices.
- Understanding distressing voices and beliefs.
- Wellness planning.

We all engage in negative thoughts and unhelpful thinking patterns, Hardy said. When faced with a big project, we might think "I'll never finish," "I wish I were someplace else," "There's nothing good about this," and "They'll hate me." Our coping strategies—perhaps having another glass of wine—are not always the best choices. All of us are on a continuum from "no psychosis" to "psychosis" based on our stress levels, amount of sleep, the drugs we're taking, trauma, and life experiences. Recognizing this allows a person to normalize psychotic symptoms as well.

"Normalization is the antidote to stigma," Hardy said. "Mental illness is common—about one in four people have some form of it, and it affects people regardless of age, gender, and ethnicity. A large number of people can overcome their symptoms. Different cultures may view symptoms positively. And finally," she said, "normalizing psychotic symptoms is not the same as dismissing them."

Hardy used a group exercise, with people confronting each other in pairs, to demonstrate how hard it can be to move a person off a firmly held belief simply by challenging or dismissing it.

Too often when faced with a family member who is acting strangely or distressed—for example, a son whose apartment is suddenly a mess, or he won't leave his bedroom—we engage in automatic thoughts and catastrophic thinking, which is usually distorted. Instead, we can ask questions, gather more information, and be open to explanations and be open to rational responses.

Managing stress is all about recognizing situations that can build up levels in our daily "stress bucket"—like hearing voices, arguing with family, preparing for exams—and ways to reduce stress that may not be effective, like staying up all night talking to the voices and playing video games, or more effective, like playing for an hour or going for a walk.

People with psychosis can cope with distressing voices and beliefs in as many as sixty different ways. But three dominant approaches are:

- **Distraction**—such as listening to music, playing games, writing, or going for a walk. This is not the most helpful, as the distressing situation is still going on, and the distraction can be isolating.
- **Focusing**—hearing the voice and then murmuring (subvocalizing), breathing deeply, or responding rationally to focus on thoughts you want to have. Some people keep "voice diaries" to show when and where the voices occur and what they are saying—helpful or hurtful?
- **Meta-cognitive approaches**—such as detached mindfulness and acceptance. These practices require practice and high-order thinking.

After her presentation, Hardy invited questions.

Q. Can CBTp be used with bipolar disorder?

Yes, but the therapy is different, focusing on mood management and balancing. That is, finding what are your acceptable levels of high and low during mania and depression.

Q. Your examples relate to therapeutic sessions. Is this something we can do at home?

We would all be healthier individuals if we practiced these principles ourselves. The therapist often works with families as well as individuals.

Q. What if the person is not actually hallucinating but just experiencing low self-esteem?

Self-esteem issues underpin many psychotic symptoms. The practice is to examine negative and automatic thoughts and the core beliefs and distortions—"I'm unlovable," "I'm no good," "I'll always be alone"—a behind them.

Q. Can CBT help alcohol and drug abuse?

CBT is similar to motivational interviewing. Rather than telling a person "Drinking is wrong," you ask "What does it do for you?" and probe belief levels

and patterns of unhelpful thinking. You help the person identify the permissions we give ourselves to continue the unhelpful behavior.