The Garety *et al.* Model of CBT for Psychosis

Dr Anna Rowe
Clinical Psychologist
Kirklees 'Insight' Early Intervention in Psychosis Team

Overview

- South London and Maudsley NHS Foundation Trust and the Institute of Psychiatry CBT for Psychosis Course
- A cognitive model of the positive symptoms of psychosis (Garety *et al.,* 2001)
- Example formulation
- Implications for therapeutic interventions
- Questions

Introduction

- CBT for psychosis is a relatively new and developing area
- CBT for other difficulties is more established, developed, improved and implemented (depression, panic, OCD, PTSD etc.)
- Growing evidence base – particularly for those with distressing and persistent symptoms
- CBT for psychosis aims to enhance outcome *alongside* medical interventions
- Patchy availability of CBT for psychosis in NHS today?

SLaM CBT for Psychosis Course

- Background: NICE Schizophrenia (2003) guideline (updated Mar 2009) stated that CBT should be offered to everybody with a schizophrenia spectrum diagnosis; particularly those with persistent and distressing symptoms and a history of relapse
- Identified substantial gap between current provision and level of provision proposed by NICE
- NICE guidelines evidence review includes only studies evaluating an adherent cognitive therapy approach delivered by qualified cognitive therapists

CBTp vs. CBT informed case management

- Differentiate between CBT for Psychosis and CBT informed case management
- However, this does *not* minimise the importance of developing skills of staff within a team in using CBT informed approaches

<table>
<tr><th colspan="2">CBT informed Case Management for Psychosis</th><th colspan="2">Formal CBT for Psychosis</th></tr>
<tr><th>Basic Level</th><th>Intermediate Level</th><th colspan="2">Developing & Independent therapists</th></tr>
<tr><td rowspan="2">Establishing a therapeutic relationship; maintaining regular meetings with appropriate boundaries; assessing presenting problems; using monitoring and recording techniques to understand difficulties; developing an understanding of difficulties which promotes well-being; promoting behaviours which contribute to well-being (coping strategies, activity, social inclusion, treatment concordance)</td><td rowspan="2">Specific CBT-style techniques such as relapse prevention; medication concordance; insight work; management of mood, anxiety, anger; problem solving</td><td colspan="2">Interventions drawn from a psychological formulation making use of complex and detailed information about the person's experiences, beliefs, thoughts emotions and behaviours, developed in collaboration with the client.</td></tr>
<tr><td>Developing therapists

Require further supervised experience</td><td>Independent therapists

Able to take responsibility for own further professional development</td></tr>
</table>

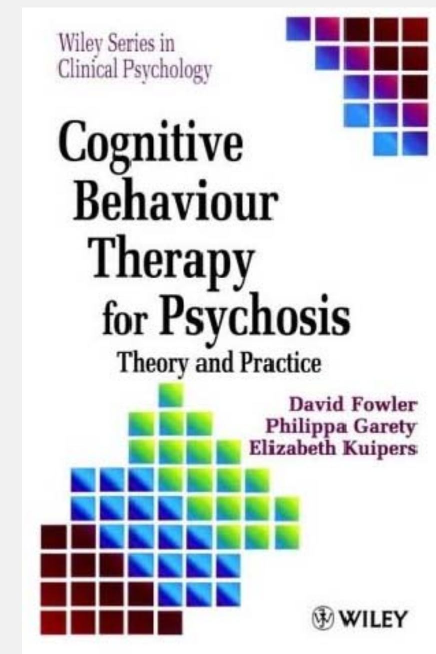
From: SL&M ICMD Programme Board Guidance on Therapist Competence – May 2006

SLaM CBT for Psychosis Course

- Started 2004/2005 (I completed the pilot year)
- Course Directors : Philippa Garety and Elizabeth Kuipers
- Course Leaders: Suzanne Jolley and Juliana Onwumere
- Intake of 16 from a variety of professional backgrounds (clinical psychology, nursing, social work and occupational therapy)
- Attendance 1 day per week
  - Group supervision
  - Formal teaching/workshop
  - Session audiotape rating (CTS and R-CTPAS)
- Caseload of 4 therapy clients (taped if client consented)
- Assessment (3 case reports, 1 formulation, 1 tape rated)
- Further year of supervision, monthly workshops focused on specific skills and supervising others
- From 2006, Postgraduate Diploma in CBT for Psychosis - accredited by Institute of Psychiatry, Kings College London

Revised Cognitive Therapy for Psychosis Scale (R-CTPAS)

- Research tool to ensure therapy adherence to a manual
- Adherence and competence
- Startup *et al.* (2002) developed the Cognitive Therapy for Psychosis Adherence Scale (CTPAS) based on the Fowler *et al.* (1995) manual
- Revised-CTPAS for PRP trial (Garety *et al*., 2008)
- Useful tool for supervision



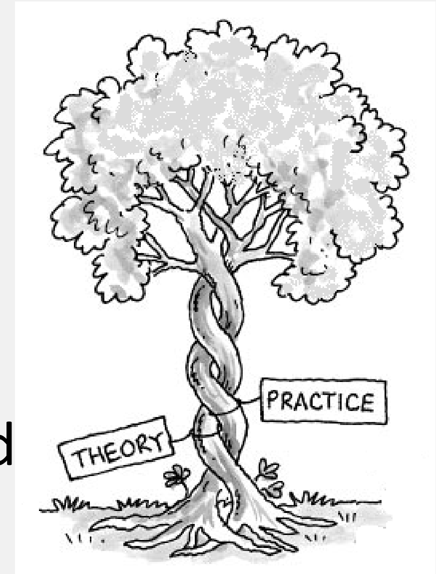
R-CTPAS (Rollinson *et al*., 2008)

R-CTPAS (Rollinson *et al*., 2008)

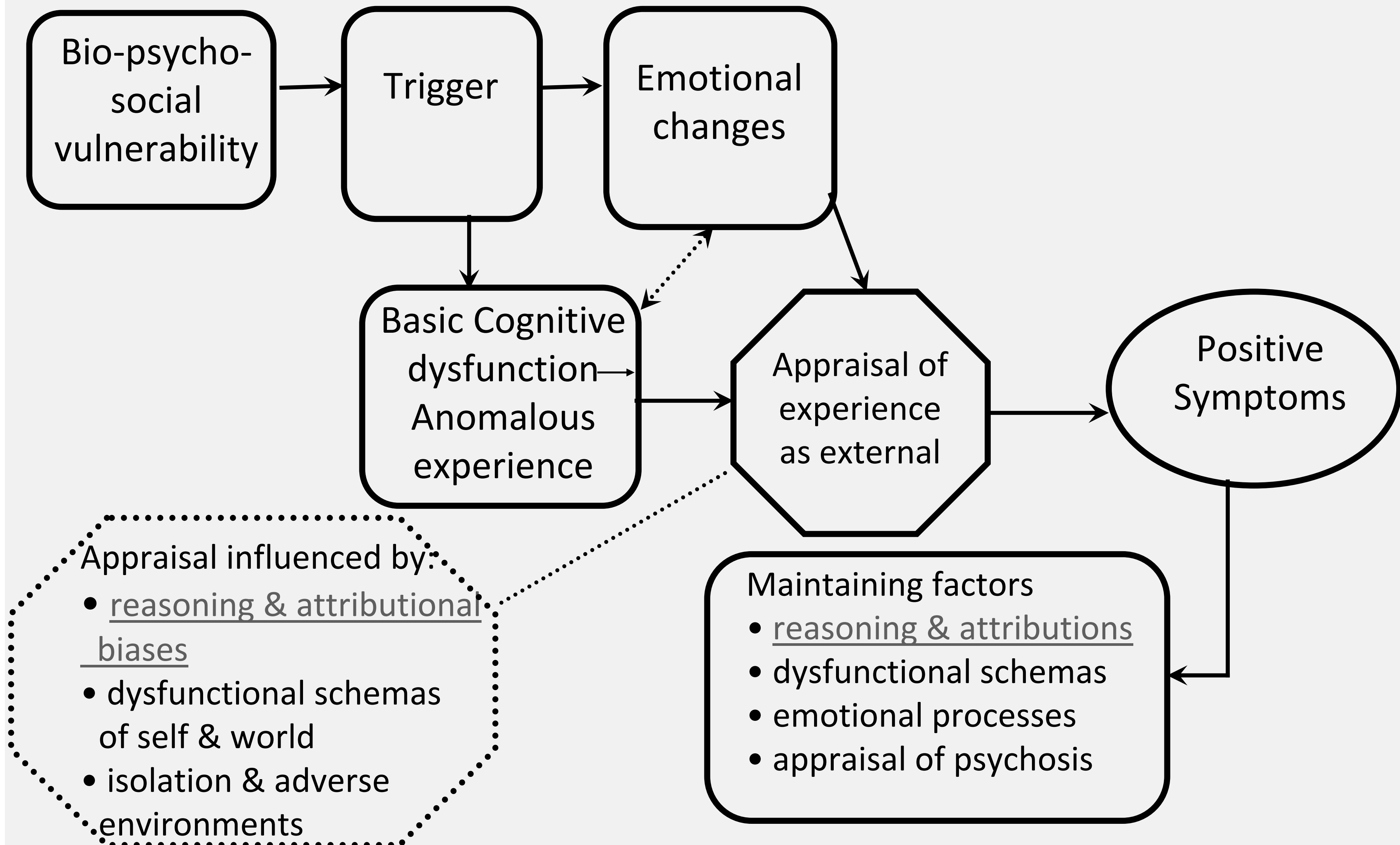
R-CTPAS (Rollinson *et al*., 2008)

Cognitive models of psychosis

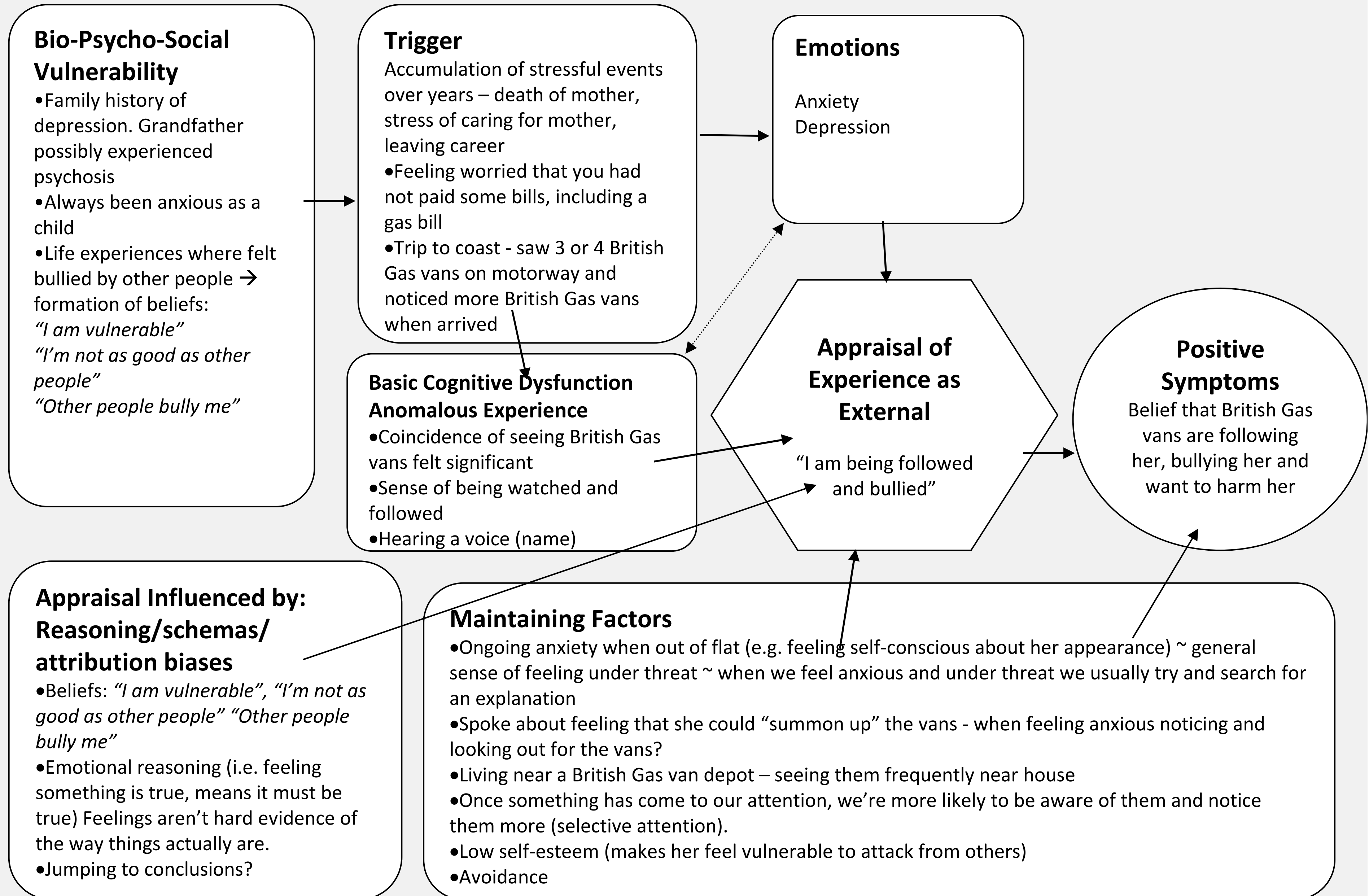
- In the last decade theoretical models have started to provide a framework upon which CBT for psychosis can be developed
- Garety *et al.* (2001) and Morrison (2001) have proposed cognitive models of positive psychotic symptoms
- Theoretical models form the basis of individualised formulation and treatment in CBT for psychosis
- Theories have allowed clinicians to make sense of often complicated and confusing symptoms
- CBT for psychosis is therefore theory (rather than technique) driven - in line with CBT for other disorders where treatment is clearly theory driven (e.g. PTSD)



A Cognitive Model of the Positive Symptoms of Psychosis (Garety *et al.*, 2001)



Example formulation - Judith



Implications of the Model for Therapy

- Collaborative development of formulation and sharing (aspects of) this with the person
- Change appraisals (e.g. voices as internal thoughts or worries)
- Address/compensate for biases in reasoning (jumping to conclusions, tendency to attribute blame to others, selectively attending to negative stimuli, theory of mind difficulties)
- Re-evaluating self-esteem and negative schemas, interventions for anxiety and depression
- Addressing isolation and responses to stressful environments
- Appraisals of psychosis (e.g. stigma, loss, controllability)
- Relapse prevention

Suitability and Aims of Therapy

- Suitable for those who are distressed by their experiences (grandiosity more difficult) and able and (at least a bit) willing to talk about their difficulties
- Working on a problem identified by client
- Might be around *change*, might be around *understanding*
- If the person is difficult to engage, the initial goal might be to meet for a bit and "see how it goes" – try to establish a shared purpose a few sessions in
- Realism of goal - reducing distress, increasing an aspect of functioning, reducing relapse are all feasible; getting rid of voices is not
- Try to keep therapy focused on the shared aim and keep this the focus of formulation
- Minimum 12 sessions, more likely to be around 20+ over a year or so depending on attendance

Therapeutic Style

- Engagement is key for successful CBT for psychosis
- Therapists must be open-minded, validating & normalising
- Always showing empathy
- Have the “reduction of distress” as primary goal
- Flexibility of contact – short meetings, informal settings, sensitivity to mental state, change topic of discussion
- Balance between a non-colluding yet non-confrontative style
- Viewing the person as a reasonable and rational person attempting to cope with difficult, confusing and distressing experiences “a survivor in the face of adversity”
- Interventions are characterised by collaborative empiricism and guided discovery

Interventions (1)

- Engagement (key throughout therapy)
- Assessment
- May introduce coping strategies early on (engagement and can learn from behavioural change) – “There is something I can do that helps” “It isn’t all uncontrollable”
- Formulation:
  - The formulation is the focal point for change and is an ongoing process
  - Aiming to “connect up” seemingly unconnected factors - beliefs, life events, emotions, thoughts, behaviours and symptoms
  - Collaboratively construct a model that makes psychotic experiences and distress understandable and explainable
  - Develop an alternative account of experiences that is acceptable and non-stigmatising
  - Develop a plausible ‘biases-in-psychological-processing’ explanation of experiences
- Normalising (“other people have similar experiences” – “anyone who has been through what you have been through…”

Interventions (2)

- Working on emotional changes e.g. cognitive-behavioural interventions for anxiety and depression
- Schema work
- Maintenance factors
  - Understanding and compensating for biases in reasoning (e.g. jumping to conclusions, selectively attending to negative stimuli)
  - Address and reduce ‘safety behaviours’ - strategies that are used to prevent harm (e.g. avoidance) but in fact serve to maintain beliefs (fearful predictions) and symptoms
  - Learn that having psychotic experiences does not necessarily equate to a lifetime of ‘illness’
- Relapse prevention: learn that steps can be taken to reduce the likelihood of relapse - engenders self-control and empowerment (impact on mood)
- Focus on family and social contexts

Formulation Sharing

- Links in with assessment – gradual sharing and checking info as you go – maybe a little bit of model building ("is that related to that" type questions)
- It often makes sense to break down into onset and maintenance – but whatever makes sense to the person
- Start with little more than a narrative – developing a story together
- Be aware of what picture of the person you are building up – emphasise positives – strengths/"survivor"
- Gradually start making links, relationships between parts of the formulation – can try to access socratically – but will often need to offer directly
- When making suggestions – float them as ideas for the person's consideration, rather than facts – be prepared to backtrack
- Keep the normalising rationale strongly in mind – "anyone who had been through what you have been through…"
- Aim is to try to 'soften the edges' of the person's belief system, while trying to build up a viable alternative together – *not* challenging
- Some people may not accept any 'softening round the edges' or links, may need to work *within* the person's belief system – focus on beliefs about the meaning of what going on, coping strategies

Reasoning Biases: Jumping to Conclusions

- Jumping to Conclusions: On the "beads" task people with delusions "jump to conclusions" taking fewer beads to make a decision – on 85:15 tasks 40-70% decide on one bead – a data gathering bias. Replicated widely.
- Also shown in people who have recovered and at high risk mental state
- Influences the appraisal of experiences and events so that immediate, salient experiences are rapidly appraised, with little reflection or generation of further evidence (onset and maintenance)

Reasoning Biases: Externalising and Theory of Mind

- Externalising Attributional Bias (Bentall): (relevant for persecutory beliefs), externalising bias in explaining negative events (i.e. explain failure in terms of other people rather than self) and internalising bias in explaining positive events
- Theory of Mind (Frith): Poor social understanding. Some people with persecutory beliefs are impaired at complex theory of mind tasks – the attribution of knowledge and intention to others – does this contribute to sense of persecution?

Reasoning Biases: Belief Flexibility & Belief Confirmation

- Belief flexibility: The willingness and capacity to reflect on one’s own beliefs. To review and change one’s views in the light of evidence and to consider alternatives
- Belief confirmation bias: People tend to look for evidence consistent with their beliefs – may be particularly strong in people with delusions

Questions

Email: anna.rowe@swyt.nhs.uk