The Garety et al. Model of CBT for Psychosis

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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>
<thead>
<tr>
<th>CBT informed Case Management for Psychosis</th>
<th>Formal CBT for Psychosis</th>
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<tbody>
<tr>
<td><strong>Basic Level</strong></td>
<td><strong>Developing &amp; Independent therapists</strong></td>
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<td>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>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>
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<td><strong>Intermediate Level</strong></td>
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<td>Specific CBT-style techniques such as relapse prevention; medication concordance; insight work; management of mood, anxiety, anger, problem solving</td>
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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)
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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)

Bio-psycho-social vulnerability → Trigger → Emotional changes

Basic Cognitive dysfunction
  Anomalous experience

Appraisal of experience as external

Positive Symptoms

Appraisal influenced by:
- reasoning & attributional biases
- dysfunctional schemas of self & world
- isolation & adverse environments

Maintaining factors
- reasoning & attributions
- dysfunctional schemas
- emotional processes
- appraisal of psychosis
Example formulation - Judith

**Bio-Psycho-Social Vulnerability**
- Family history of depression. Grandfather possibly experienced psychosis
- Always been anxious as a child
- Life experiences where felt bullied by other people → formation of beliefs:
  "I am vulnerable"
  "I’m not as good as other people"
  "Other people bully me"

**Trigger**
Accumulation of stressful events over years – death of mother, stress of caring for mother, leaving career
- Feeling worried that you had not paid some bills, including a gas bill
- Trip to coast - saw 3 or 4 British Gas vans on motorway and noticed more British Gas vans when arrived

**Emotions**
- Anxiety
- Depression

**Basic Cognitive Dysfunction Anomalous Experience**
- Coincidence of seeing British Gas vans felt significant
- Sense of being watched and followed
- Hearing a voice (name)

**Appraisal of Experience as External**
- "I am being followed and bullied"

**Positive Symptoms**
Belief that British Gas vans are following her, bullying her and want to harm her

**Appraisal Influenced by: Reasoning/schemas/attribution biases**
- Beliefs: "I am vulnerable", "I’m not as good as other people" "Other people bully me"
- Emotional reasoning (i.e. feeling something is true, means it must be true) Feelings aren’t hard evidence of the way things actually are.
- Jumping to conclusions?

**Maintaining Factors**
- Ongoing anxiety when out of flat (e.g. feeling self-conscious about her appearance) ~ general sense of feeling under threat ~ when we feel anxious and under threat we usually try and search for an explanation
- Spoke about feeling that she could “summon up” the vans - when feeling anxious noticing and looking out for the vans?
- Living near a British Gas van depot – seeing them frequently near house
- Once something has come to our attention, we’re more likely to be aware of them and notice them more (selective attention).
- Low self-esteem (makes her feel vulnerable to attack from others)
- Avoidance
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

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