Basics of Cognitive therapy in Psychosis

Presenter

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Neil A.Rector PhD1, AaronT. Beck *(Can J Psychiatry 2002;47:39–48)*

and

A Therapist's Guide to Brief Cognitive Behavioral Therapy. Department of Veterans Affairs South Central MIRECC, Houston. To request a copy of this manual, please contact Michael Kauth at michael.kauth@va.gov Suggested citation: Cully, J.A., & Teten, A.L. 2008.

Session 1
Orient the Patient to CBT. Assess Patient Concerns. Set Initial Treatment Plan/Goals.

Session 2
Assess Patient Concerns (cont'd). Set Initial Goals (cont'd)

Technique :
Maladaptive Thoughts, Behavioral Activation, Problem Solving, Relaxation

Session 3
Begin/Continue Intervention Techniques

Session 4
Re-assess Intervention Techniques

Session 5

Refine Intervention Techniques.

Session 6

Intervention Techniques.

Session 7

Intervention Techniques. Discuss Ending Treatment and Prepare Maintaining Changes.

Session 8

End Treatment and Help Patient to Maintain Changes.

Cognitions

- Cognitive events
- Cognitive processes
- Cognitive structures

Cognitive Events

- Thoughts
- Images
- Day dreams
- Dreams
- Automatic thoughts

Automatic Thoughts

- Occur automatically
  - involuntarily
  - repetitive
  - autonomous

Patient makes no effort to elicit them

Difficult to “turn off”

Evaluative cognitions or “hot cognitions”

self-referential, negative

Non-evaluative cognitions or “cold cognitions”

Cognitive Process

- Errors in the recognition processing of information

- "Cognitive appraisals"
  - Attention
  - Encoding
  - Retention

Cognitive Distortions

- Are distortions in the processing of information

Selective abstraction

Arbitrary inference

Overgeneralization

Magnification/exaggeration

Dichotomous or polarized thinking

Mind reading

Personalization – extent to which a particular event is related to one's self (overestimation)

In making judgements under uncertainty people have great confidence in their fallible judgement and have difficulty searching for disconfirming information to test hypotheses

Ordinary people rely on a limited number of heuristics, which sometimes yield reasonable judgements and sometimes lead to severe and systematic errors.

What distinguishes ill people is the fact that several types of dysfunctional cognitive appraisals occur together in clusters and in a significantly higher frequency of situations than in ordinary people.

Interacting Cognitive Subsystems

Meaning based

- Propositional-***logical & verbal***
- Implicational-***generic,immediate,vivid***

Sensory/proprioceptive

- Signals arousal
- Anxiety,anger,depression,withdrawal

Pattern recognition

- Matches experiential patterns
- Matches events through associations

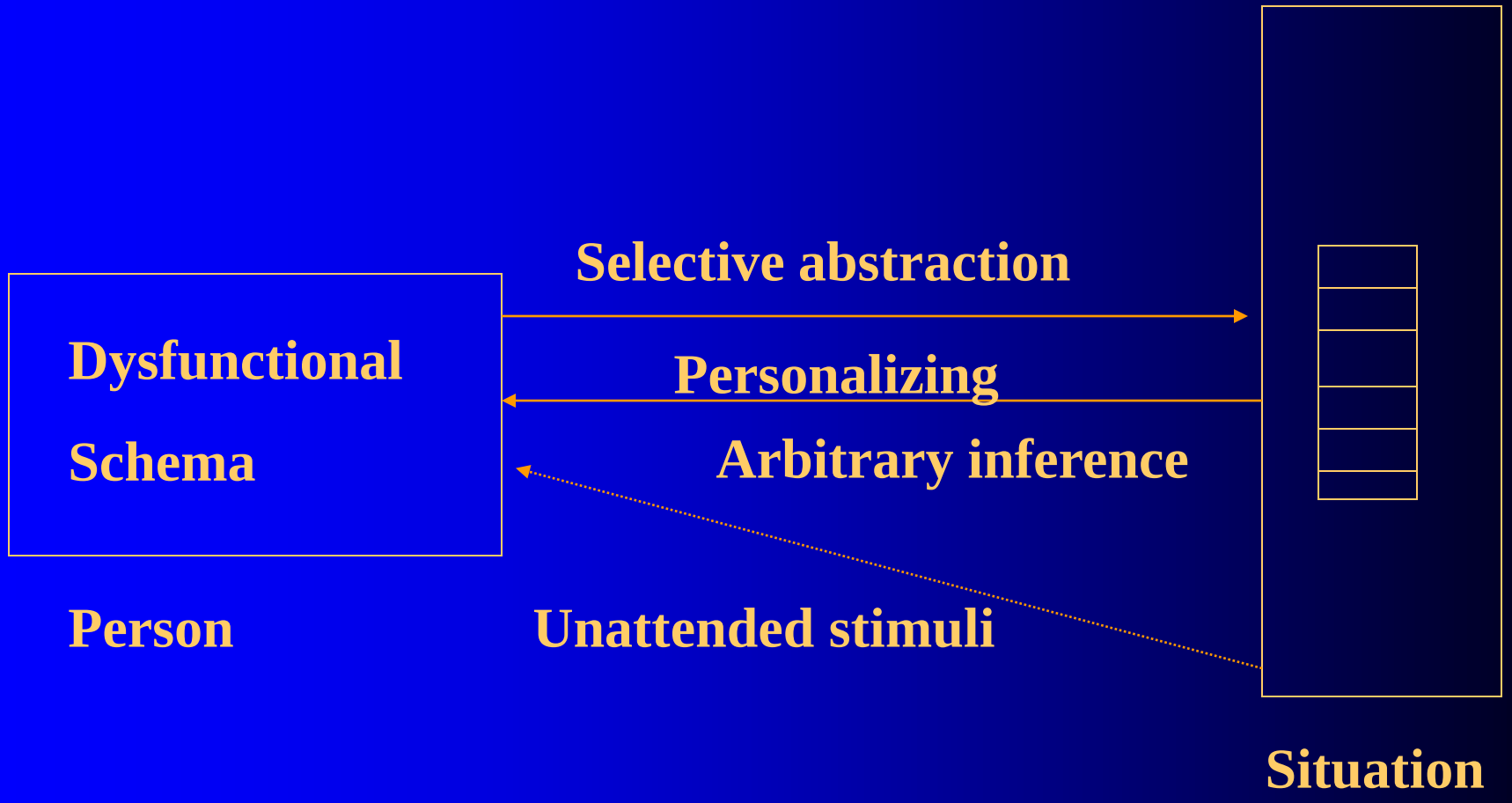
Implicational subsystem	A threatening event in current life reawakens memory of past traumatic event in the form of voices
	This results in physiological arousal, anxiety, panic, depression *because of the awakened pattern implying the event is happening* ***now***
Propositional system	Instead of activating logical awareness that the traumatic event happened a long time ago, that it is not happening now, that one is safe now.

Cognitive Structure or Schema

Basic assumption, belief system, core construct, concept, meaning structure

- Systems for classifying stimuli
- Relatively enduring aspects of cognitive organization
- Used to label, classify, interpret, evaluate, assign meaning
- Making inferences about situations that are not as yet observed

“ a complex pattern which is considered to be assimilated by a person through experience. In combination with an object how the object is recognized and how a new interpretation is formed” (English & English, 1958)


Selective abstraction
Dysfunctional
Schema
Personalizing
Arbitrary inference
Person
Unattended stimuli
Situation

Goals of Cognitive Psychotherapy

- To help patients to become aware of their most fundamental dysfunctional assumption or dysfunctional life rules and help them recognize the cognitive distortions that sustain these dysfunctional self-images
- Correct cognitive distortions
- Restructuring self-scheme and therapeutically guided recollection of the development of dysfunctional meaning structures

Principles of Individual Therapy

1. Therapeutic relationship
2. Collaborative empiricism

- It is important in an early phase that the patient is given the opportunity to learn the most elementary principles of therapy and to understand what is expected

3. The Problem Inventory and Goal Setting

- Various symptoms count as problems
  use rating scales (self-rating)

Characteristics of the Cognitive Psychotherapeutic Dialogue

Use of the Socratic Method

- The main aim is to refine the patient's CAUSAL MODEL

  and refine his/her PREDICTIVE ABILITY

Hypotheses are derived through Socratic method and are subjected to verification through further deductive questioning – home work assignments

Barriers to Participation

Passivity and lack of structure to the day

Absolutistic and enmeshment

Dysfunctional thinking

Procrastination

Task Interfering thoughts

Breaking Passivity and Structuring the Day

Distancing

Absolutistic ⟶ relativistic and flexible

Dealing with Dysfunctional Thinking

- Use of Socratic method

Procrastination and Task-Interfering Thoughts

- Cognitive Rehearsal: relate through visualization anticipated difficulties and how to overcome them
- Making lists of pros and cons of carrying out certain tasks
- These focus on relatively superficial problems, suitable in initial phases

Recognition of Cognitive Distortions

- Pin-point a trying situation
- Record feelings and thoughts related to it
- 3 – 4 column technique

- Corrections using Socratic method
- Experiments to understand distortions validity
- Approach a “less important” distortion first
- When learning has occurred, apply to the distortions of a paranoid dimension

Predicative Thinking

- Premature assignment of meaning

Egocentric Over-inclusiveness

- Inability to keep responses to the external world separate from the fantasy processes that are going on at the same time
- Includes a much greater number of objects (stimuli) that that really belong to a given set

DELUSIONS

DIMENSIONS

1. CONVICTION: EXTENT TO WHICH THE PATIENT IS CERTAIN OF THE VALIDITY OF THE DELUSIONS.

2. EXTENT: DEGREE TO WHICH THE DELUSIONS INCLUDES DIFFERENT ASPECTS OF THE PATIENTS LIFE.

3. SIGNFICANCE: THE BELIEF'S IMPORTANCE IN THE PATIENTS OVERREACHING MEANING SYSTEM.

4. **INTENSITY: THE DEGREE TO WHICH IT PREVENTS OR DISPLACES MORE REALISTIC BELIEFS.**

5. **PERVASIVENESS: THE EXTENT TO WHICH THE PATIENT IS PRE-OCCUPIED WITH THE DELUSIONS. GOALS DICTATED BY DELUSIONS. INTERPRETS DIFFERENT EXPERIENCES ON THAT BASIS.**

6. **INFLEXIBILITY: DEGREE TO WHICH THE BELIEF IS IMPERVIOUS TO CONTRARY EVIDENCE, LOGIC OR REASON.**

CONTENT

**** REFLECTS EVERYDAY CONCERNS SUCH AS BEING DEMEANED, EXCLUDED, MANIPULATED AND ATTACKED.

**** REFLECTS PATIENTS PRE-DELUSIONAL BELIEFS.

EX: RELIGIOUS, PARANORMAL, GRANDIOSE, PARANOID

**** EXTREME END OF A BELIEF CONTINUUM RATHER THAN CATEGORICAL ABNORMALITY.

COMMON COGNITIVE CHARACTERISTICS

EGOCENTRIC BIAS:

PATIENTS BECOME LOCKED INTO AN EGOCENTRIC PERSPECTIVE

IRRELEVANT EVENTS BECOME SELF-RELEVANT

EXTERNALIZING BIAS:

INTERNAL EXPERIENCES ARE ATTRIBUTED TO EXTERNAL AGENTS

INTENTIONALIZING BIAS:

MALEVOLENT AND HOSTILE INTENTIONS ARE ATTRIBUTED TO OTHER PEOPLE'S BEHAVIOUR

EXAGERRATED SELF-SERVING BIAS

BLAME OTHERS WHEN THINGS DO NOT GO WELL

COGNITIVE THERAPY OF DELUSIONS

GOAL: DELUSIONS AS HYPOTHESES ABOUT THE MEANING OF EVENTS RATHER THAN AS ABSOLUTE, RIGID "TRUTHS"

MEANS: UNDERMINE THE RIGID CONVICTION AND CENTRALITY OF THE DELUSION

THE PROCESS

1. UNDERSTAND THE PATIENTS LIFE CONTEXT

IMPORTANT PAST LIFE EVENTS

THEIR APPRAISAL

2. ASSESSMENT PHASE:

= PRE-DELUSIONAL BELIEFS THROUGH

DAY DREAMS, FANTASIES.

= PROXIMAL EVENTS CRITICAL TO

THE FORMATION OF THE DELUSION

SPECIFIC TRIGGERS

EXTERNAL

INTERNAL

SPECIFIC CONSEQUENCES

EMOTIONAL: FEAR,ANGER,SADNESS

BEHAVIOURAL: WITHDRAWAL

AVOIDANCE

CONFRONTATION

EDUCATION

= COGNITIVE MODEL

= LEARN TO IDENTIFY LINKS BETWEEN

LEARN THE ROLE OF COGNITIVE BIASES

DISTORTIONS:

MAGNIFICATION

SELECTIVE ABSTRACTION

COLLOBORATIVE, SOCRATIC APPROACH

* INITIALLY DEAL WITH INTERPRETATIONS AND EXPLANATIONS THAT ARE MORE PERIPHERAL

QUESTIONING:

WHAT LEADS YOU TO BELIEVE THIS IS LIKELY?

WHAT IS THE EVIDENCE THAT SUPPORTS THIS?

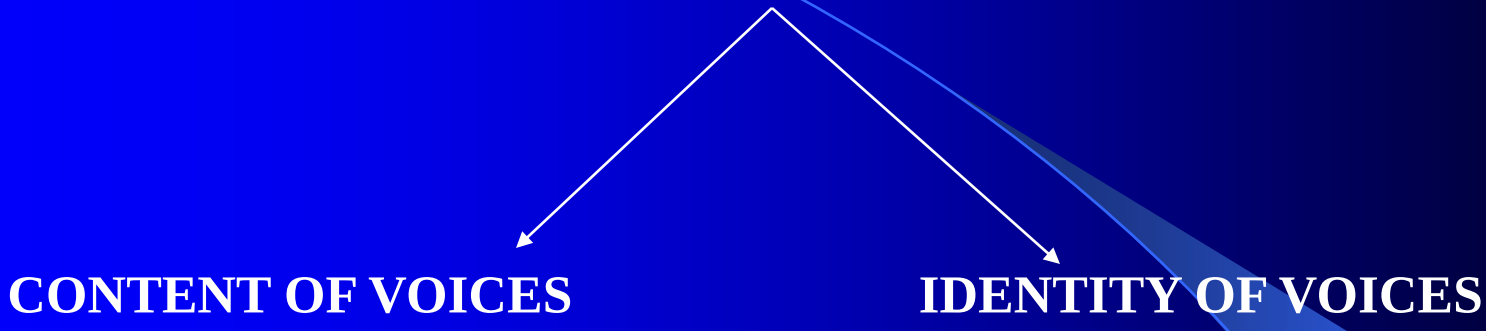
WHAT ALTERNATIVE EXPLANATIONS?

VISUALIZE AND DESCRIBE THE PEOPLE AND EVENTS

BEHAVIOURAL EXPERIMENTS

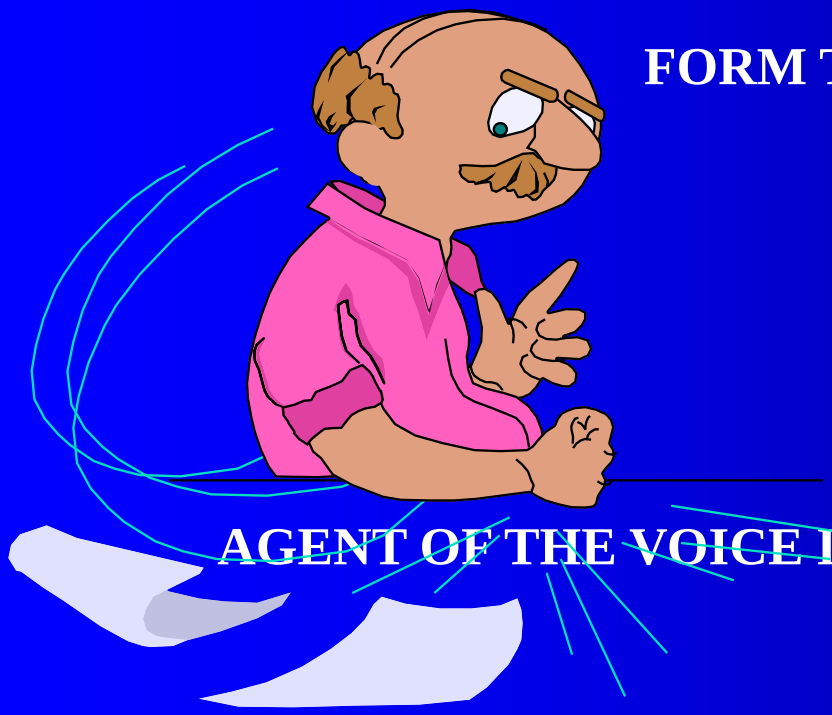
TEST THE ACCURACY OF INTERPRETATIONS

HALLUCINATIONS



EXTERNALLY ATTRIBUTED NEGATIVE THIOUGHTS

FORM THE CONTENT



AGENT OF THE VOICE IS PERCEIVED AS

POWERFUL, CONTROLLING AND ALL-KNOWING

FIRST

IDENTIFY, TEST AND CORRECT DISTORTIONS

IN THE CONTENT OF VOICES

SECOND

IDENTIFY, QUESTION, AND CONSTRUCT ALTERNATIVE BELIEF ABOUT THE VOICES' IDENTITY, PURPOSE AND MEANING.

THOROUGH ASSESSMENT OF

- **FREQUENCY**
- **DURATION**
- **INTENSITY**
- **VARIABILITY OF VOICES**
- **TRIGGERS**

VOICES MORE LIKELY IN THE CONTEXT OF

- **INTERPERSONAL DIFFICULTIES**
- **NEGATIVE LIFE EVENTS**
- **INTERNAL CUES**

USE THOUGHT RECORD

GET VERBATIM ACCOUNT OF THE VOICES

RELATION BETWEEN SITUATIONAL TRIGGERS

MOOD STATES

ACTIVATION OF VOICES

ELICIT BELIEFS PATIENT HAS ABOUT VOICES

ASSESS LIFE CIRCUMSTANCES DISTAL AND PROXIMAL TO THE ONSET

PRECEDING EVENTS

TRIGGERS

ASSESS PATIENTS REACTION TO THE VOICES

UNCONTROLLABILITY

DEMONSTRATE THAT THEY CAN INITIATE,

DIMINISH

TERMINATE

OMNIPOTENCE

OMNISCIENCE

SET UP EXPERIMENTS THAT WILL DEMONSTRATE THAT THE PATIIENT CAN IGNOIRE COMMANDS WITHOUT CONSEQUENCES

PARALLEL RECORDS

- **THOUGHT RECORDS**
- **VOICE CONTENT RECORDS**

DEMONSTRATE OVERLAP

Cognitive Therapy for Schizophrenia: From Conceptualization to Intervention

Neil A. Rector, PhD[1], Aaron T. Beck, MD[2]

Objectives: To outline the cognitive understanding of symptoms of schizophrenia, such as delusions, hallucinations, and emotional withdrawal, and to review the cognitive therapy approach to ameliorating these symptoms.

Method: We identified studies examining cognitive factors associated with symptoms of schizophrenia by electronic search (using Medline and Psycinfo). This paper integrates experimental findings and clinical treatment.

Results: Recent studies focusing on the psychological aspects of schizophrenia demonstrate the importance of common cognitive biases and distortions that are functionally related to the maintenance of symptoms. Understanding the disorder in cognitive terms provides a framework for psychotherapeutic intervention. Adapting cognitive strategies successfully used in cognitive therapy of depression and anxiety provides an important adjunct to standard treatment of schizophrenia.

Conclusion: Given that the outcome of current treatment for schizophrenia remains poor, attention to therapist training in psychological approaches is essential.

(Can J Psychiatry 2002;47:39–48)