COGNITIVE-BEHAVIORAL TREATMENT OF PTSD IN PSYCHOSIS

Dr Ben Smith
Consultant Clinical Psychologist (C-PAS Trial)

University of Reading, Berkshire Healthcare NHS Foundation Trust and North East London NHS Foundation Trust
ACKNOWLEDGEMENTS

Jennifer Gottlieb, Ph.D.

Dartmouth Psychiatric Research Center
Dartmouth Medical School
And
Massachusetts General Hospital
Schizophrenia Program
AGENDA

• Trauma and Psychosis (Case Examples)
• Overview of CBT Program and C-PAS Trial
• Specific Step-by-Step Program Components
• A Focus on Cognitive Restructuring
• Clinical Material - Examples
• Addressing Trauma-Related Beliefs
• Special Issues in Psychosis
• Treatment Fidelity
BACKGROUND: TRAUMA AND PSYCHOSIS
Cognitive Models of Psychosis

• Cognitive models (e.g. Morrison, 2001; Garety et al, 2001) specifically propose that as emotional disorder increases, psychotic symptoms worsen.

• Emotional disorder is thought to occur against a backdrop of negative schematic beliefs that derive from early adverse traumatic experiences.

• It is also argued that the content of psychotic experiences (e.g. the content of negative voices) relate to underlying negative schematic beliefs and trauma.
Cognitive Models of Psychosis

- Freeman and Garety (2003) propose that delusions can be direct representations of emotional concerns

- Birchwood (2003) believes that emotional dysfunction is central to psychosis

- Birchwood (2003) suggests that traumatic early experience can lead to negative schematic beliefs and that these may fuel both voices and paranoia
A Cognitive Model of the Positive Symptoms of Psychosis (Garety et al 2001)

Vulnerabilities
Bio, Psycho, Social

Triggers

Emotional changes

Change in Brain Function: Unusual Experiences

Making Sense of It: External and Threatening

‘Symptoms’ of Psychosis

Factors that maintain the ‘symptoms’ once they have started

Factors that influence how an individual makes sense of their experiences
Associations - Trauma & Psychosis

- High levels of traumatic events reported in individuals with psychosis (e.g. Shevlin et al., 2008)

- Co-morbid PTSD/psychosis rates of between 15 and 40% (McFarlane et al., 2001; Mueser et al., 2004).

  Being bullied or severely abused associated with a significantly increased likelihood of developing psychosis

- Those who had been sexually abused were over fifteen times more likely to develop psychosis than those who had not
Associations - Trauma & Psychosis

• Scott et al (2007) - Community survey (n=10,000); endorsement of delusional ideas associated with exposure to traumatic events

• This association was strengthened the more traumatic events had been experienced and further more by a diagnosis of PTSD

• The associations remain significant after controlling for other factors predictive of psychosis (e.g. male gender, young age, cannabis usage)
Associations - Trauma & Psychosis

• Campbell and Morrison (2007) found that bullying experienced by 14-16 year old school children was associated with a pre-disposition to psychotic experiences.

• Campbell and Morrison (2007a) found combat veterans with a diagnosis of PTSD were more likely to hold delusional beliefs than those without a diagnosis of PTSD.
Associations - Trauma & Psychosis

• Hardy et al (2005) found 53% percent of their psychosis sample of 75 reported a traumatic event that still impacted upon them negatively

• Of that group, 45% exhibited an emotional theme (e.g. threat, guilt) in their auditory hallucinations that corresponded to the emotional theme of the traumatic event

• 12.5% experienced hallucinations where the content was directly linked to the content of the traumatic event (e.g. voice of attacker)
How are Trauma & Psychosis Associated?

BRIEF CASE EXAMPLE: SIMON

• Strongly held belief (90%):
  ‘There is a higher alien power in charge of the human race, many people are in-fact aliens and they intend to harm me’

• Evidence:
  Odd intrusive, frightening and sudden perceptual experiences and murmuring voices interpreted as the alien power
How are Trauma & Psychosis Associated?

SIMON:

• **Vulnerability:**
  ‘I have always been vulnerable and weak’

  ‘Others are **always** good, trustworthy, fair and honest’

Protected family life, never left home, only child

Science-fiction fan: ‘I have always believed in aliens’
How are Trauma & Psychosis Associated?

SIMON:

• Trauma: (6 months prior to onset of psychosis)
  New job - bullied
  Work sabotaged
  Verbally abused
  Beaten up
How are Trauma & Psychosis Associated?

SIMON:

• **PTSD symptoms:**
  Intrusive memories, images and thoughts of the bullying
  Avoidance of reminders
  Intense emotion and high arousal

• **Interpretation of trauma and PTSD symptoms:**
  ‘That was impossible to understand’
  ‘That wasn’t human behaviour’
  ‘They were trying to break me’
  ‘They are trying to send me mad with these flashbacks’
How are Trauma & Psychosis Associated?

SIMON:

- **Explanation of Simon’s presentation:**
  Janof-Bullman (1985) shattered assumptions; ‘The world has gone mad’ **NOT** ‘I have gone mad’

Steel at al (2005) – individuals appraise intrusive phenomena within the context of their prior schizotypal beliefs (e.g. aliens) and conclude that someone, or something, is actively interfering with their mind
DEVELOPMENT OF THE C-PAS CBT PROGRAM

(MUESER ET AL)
EXPOSURE THERAPY

• Promotes confrontation with feared objects, situations, memories & images (habituation rationale)

• Clients relive memories (imaginal) and confront safe, avoided situations (in vivo)

• Goal: Habituation or desensitization to trauma stimuli & memories

• Elaboration and contextualisation of the trauma memory
COGNITIVE RESTRUCTURING

- Examine evidence supporting thoughts
- Challenge & modify
- Learn that the thoughts we have are often automatic & come from previous (often traumatic) experiences
- Learn how to challenge those thoughts or develop plans for dealing with the upsetting situation
Persistent PTSD
(Ehlers & Clark, 2000)

Nature of Trauma Memory

Negative Appraisal of Trauma and/or its Consequences

Current Threat
- Intrusions
- Arousal Symptoms
- Strong Emotions

Avoidance Strategies to Control Threat/Symptoms

Triggers
Treatment Goals
(Ehlers & Clark 2000)

- Trauma memory **elaborate**
- Appraisals of trauma and/or consequences **identify and modify**
- Triggers **discriminate**

- Current threat
  - Intrusions
  - Arousal
  - Strong emotions **reduce**

- Dysfunctional behaviours/ cognitive strategies **give up**
RATIONALE FOR FOCUS ON CR

- Less stressful - concerns over high affect
- More experience with CR than exposure in CBT for psychosis
- Effects of CR on depression
- Problems with exposure therapy with complex emotions
TREATMENT MODIFICATIONS FOR THIS POPULATION

• Eliminated exposure components
• Simplified strategies for teaching CR skills
• Emphasised close coordination with the wider treatment team
• Increased flexibility to attend to individual needs of clients
RESEARCH ON CBT PROGRAM (MUESER ET AL)

- High rate of retention in program
- CBT clients improved more in
  * PTSD symptoms
  * depression
  * trauma-related thoughts
  * alliance with primary clinician
- Effects most prominent with severe PTSD
- Homework associated with more benefit
- Changes in trauma-related thoughts mediated improvement in PTSD
CBT FOR PTSD IN PSYCHOSIS
- TREATMENT OVERVIEW
CBT FOR PTSD PROGRAM

- 12-16 week CBT
- Individual therapy
- Weekly sessions, tapers off to biweekly
- 8 therapy modules
- Focus is on Cognitive Restructuring (CR)
THERAPY MODULES

1. Overview (Session 1)
2. Crisis plan (Session 1)
3. Breathing retraining (Session 1)
4. Psychoeducation I (Session 2)
5. Psychoeducation II (Session 3)
6. Cognitive restructuring I (Sessions 4-6)
7. Cognitive restructuring II (Sessions 5-14)
8. Generalization Training & Termination (Sessions 12-16)
STRUCTURE OF SESSIONS

- Review previous session
- Review homework
- Present brief agenda for session
- Cover material for session
- Assign homework
MONITORING PTSD & DEPRESSION

- Monitoring provides clinician information about target symptoms throughout course of treatment

- Use PCL, PTCI and BDI-II to monitor symptoms

- Recommended monitoring at sessions 1, 4, 7, 10, 13, 16

- Incorporate monitoring into treatment
CBT FOR PTSD TREATMENT IN SCHIZOPHRENIA:

INITIAL MODULES: 1-5
MODULE 1: OVERVIEW

- Review of overall program
- Discussion of psychoeducation, breathing retraining, & cognitive restructuring
- Logistics of treatment program
- Homework and structure emphasised
- Instill hope
MODULE 2: CRISIS PLANNING

- Identification of warning signs of crisis
- Exploration of social supports
- Agreement on monitoring strategies
- Formulation of crisis plan
- Discussion of who to involve in crisis
EXAMPLES OF CRISIS SITUATIONS

• Suicidal thinking
• Emergence or worsening psychosis
• Severe depression & social withdrawal
• Emergence or increased self-injurious behavior
• Relapse or increased substance abuse
DISCUSSING SUBSTANCE USE

• Substance use common, often related to self-medication in PTSD (e.g., anxiety or sleep)

• Explain focus of CBT program on learning & practicing new skills for dealing with negative feelings & other problems

• Importance of not using substances before:
  – practicing skills each day
  – attending therapy sessions

• Check in with client every few sessions to evaluate possible changes in substance use
MODULE 3: BREATHING RETRAINING

• Education about impact of breathing on anxiety
• Instructions on how to modify breathing to reduce anxiety
• In-session practice and assigned homework
• Tailoring breathing retraining to individual clients
• Alternative relaxation methods: muscular relaxation, imagining a pleasant scene
MODULE 4: PSYCHOEDUCATION I

- Common Reactions to Trauma I: PTSD Symptoms
  - Re-experiencing
  - Avoidance
  - Overarousal
Common Reactions to Trauma II: Associated Difficulties

- Negative feelings: Fear & anxiety, sadness, depression, guilt, shame, anger
- Relationship difficulties
- Alcohol and drug abuse
GOALS OF PSYCHOEDUCATION

• Help client conceptualise their trauma-related symptoms as part of a cohesive disorder about which much is known

• Let clients know “you are not alone” in experiencing common symptoms - validation

• Explore how trauma & PTSD have affected client’s life

• Motivate client to participate in program & set positive expectations for change
PRINCIPLES OF PSYCHOEDUCATION

- Interactive
- Pause frequently & ask questions to help clients relate information to their own experiences
- Adopt client’s language
- Use worksheets to help clients identify their own symptoms & trauma consequences
- Complete some worksheets in session; assign homework to complete others
- Ask review questions to check client understanding
- Extremely thorough
UNDERSTANDING THE CLIENT’S PERSONAL PRIORITIES FOR PTSD TREATMENT

- Explore how trauma & PTSD have affected their life
- Identify specific ways client would most like life to be different
- Probe: “If you didn’t have these problems related to PTSD any more, what would you be doing? How would things be different?”,” “In what ways has PTSD affected your life that you care most about?”
- Encourage that the program can help make meaningful changes in their life
CBT FOR PTSD TREATMENT IN PSYCHOSIS

TRANSITION TO CR: MODULE 6
MODULE 6: COGNITIVE RESTRUCTURING I

- Cognition-emotion model
- Automatic thoughts
- Where do thoughts & beliefs come from? Influence of trauma & life experience on beliefs about ourselves, other people, & the world
- Common Styles of Thinking (CST)
COMMON STYLES OF THINKING (CST)

- All or nothing thinking
- Overgeneralization
- “Must,” “should,” or “never” statements
- Catastrophizing
- Emotional reasoning
- Overestimation of risk
- Inaccurate or excessive self-blame
- Mental filter
PACE FOR TEACHING THE COMMON STYLES OF THINKING

• 1-3 sessions devoted to teaching CST

• Not all Common Styles need to be taught in first session

• Homework to identify & correct Common Styles of Thinking

• Decision to move onto teaching the 5 Steps of CR based on familiarity with CST & some ability to use skill outside session, or 3 sessions completed on CST
STRATEGIES FOR IMPROVING FOLLOW-THROUGH ON HOMEWORK ASSIGNMENTS

• Develop assignments collaboratively
• Consider using other word for “homework”
• Review importance of homework: “real” work in program is what client does outside of therapy sessions
• Make assignments as specific as possible
• Plan when assignments will be done, how client will remember, where homework materials will be stored
• Have client do part of assignment (or practice it) in session
• When assignment not done, have client try to do part of it at beginning of session
• Troubleshoot & problem solve to remove obstacles to doing homework
• Explore how significant others or other supportive persons might be able to facilitate follow through on homework
CBT FOR PTSD TREATMENT IN PSYCHOSIS

THE HEART OF THE INTERVENTION: MODULE 7
COGNITIVE RESTRUCTURING II: THE 5 STEPS OF CR

1. **SITUATION**: “What happened that made me upset?”

2. **FEELINGS**: “Identify your strongest feeling(s)”

3. **THOUGHTS**: “What am I thinking that is leading me to feel this way?”

4. **EVALUATE THOUGHTS**: List “Evidence For” & “Evidence Against” “Is there an alternative way of thinking about this situation?”

5. **DECISION**: “Does the evidence support my thought or not?”
   
   A) If NO, what is a more realistic thought?
   B) If YES, develop an action plan

*Note: Sometimes appropriate to develop a new thought AND action plan too*
5 Steps of Cognitive Restructuring

1. **Situation**
   Ask yourself, “What happened that made me upset?” Write down a brief description of the situation.

____________________________________________________________________

2. **Feeling**
   Circle your strongest feeling:
   - Fear/Anxiety
   - Sadness/Depression
   - Guilt/Shame
   - Anger

3. **Thought**
   Ask yourself, “What am I thinking that is leading me to feel this way?” Write down your thoughts below:

____________________________________________________________________

____________________________________________________________________

Is this thought a **Common Style of Thinking**?
If yes, circle the one:
- All-or-Nothing  Over-Generalizing  Must/Should/Never
- Catastrophizing  Emotional Reasoning  Overestimation of Risk
- Self-Blame  Mental Filter
4. **Evaluate Your Thought:**
Now ask yourself, “What evidence do I have for this thought?” Write down the answers that **do** support your thought and the answers that **do not** support your thought.

*Things that DO support my thought:*
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

*Things that DO NOT support my thought:*
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. **Take Action!**
Next, ask yourself, “Do things mostly support my thought or do things mostly NOT support my thought?”

☐ **NO**, the evidence does *not* support my thought. Come up with a new thought that is supported by the evidence.
New Thought
________________________________________________________________________

☐ **YES**, the evidence *does* support my thought. Decide what you need to do next in order to deal with the situation. Write down your Action Plan for dealing with the upsetting situation:
Action Plan: _________________________________________________________________
5 STEPS APPROACH TO COGNITIVE RESTRUCTURING (CR)

• Experience of negative feelings drives selection of situations for using CR
• CR gradually increases focus on trauma-related situations over therapy
• CR used both to alter trauma-related beliefs that contribute to PTSD & address upsetting situations or unresolved feelings
• 5 Steps as “self-management tool”
TIPS ON TEACHING CR

1. Focus on teaching CR as a skill rather than changing client’s beliefs
2. Initiate work on CR as soon as negative feeling or problem situation identified
3. Don’t get bogged down in CR & fail to get through all the steps
4. Pause frequently to review previously covered steps in CR
5. Reinforce small steps in learning CR
6. Focus on asking questions rather than giving answers
7. Encourage client to take responsibility & ownership over CR
STRATEGIES FOR DEVELOPING MORE REALISTIC THOUGHTS IN STEP 5

• Ask questions to help client articulate alternative thought
• Incorporate evidence against old thought into the creation of a new thought
• Does the client find the new thought more believable than the old thought?
• Help client develop method for reminding self or practicing new thought
FINDING SITUATIONS TO USE FOR THE 5 STEPS IN SESSION

1. Reports of situations that were upsetting
2. HW examples where client got stuck
3. Continued PTCI, BDI and PCL-endorsed symptoms

**After initial teaching, help client move toward going through the steps and writing with only clinician prompting**
DEVELOPING ACTION PLANS (STEP 5)

• Not all negative feelings are the result of problematic thinking
• Action Plans = problem solving
• Don’t be afraid to help client develop Action Plans if review of evidence supports thought (even if therapist isn’t totally convinced)
• Action Plans are important - they provide a skill that counters common avoidant patterns
• Need to be specific, written, & followed up
STEPS OF AN ACTION PLAN

1. **Define Goal**: what is desired consequence of plan?

2. **Brainstorm Possible Solutions**: then select best solutions or combination of solutions

3. **Plan for Implementation**: consider: What information is needed? Do you need help? Who is going to support you? What obstacles could interfere with plan? How could I prevent/deal with those obstacles?)

4. **Set Follow-Up Date to Review** success of plan & troubleshoot as needed
COMMON SITUATIONS CALLING FOR ACTION PLANS

• Coping with distress related to PTSD symptoms after inaccurate thinking has been addressed (e.g., trouble getting to sleep, anxiety/distress when exposed to reminders of trauma)

• Where symptoms of psychosis complicate changes in cognition

• Addressing obstacles to achieving goals (e.g., finding places to meet new people in order to make new friends, coping with anxiety about driving because it reminds person of accident even though person accepts driving as not highly dangerous)
BRINGING TRAUMA-RELATED BELIEFS INTO FOCUS

WORKING WITH THESE THOUGHTS IN SESSION
ADDRESSING TRAUMA-RELATED BELIEFS

• Focus initially just on teaching CR as skill for managing negative feelings
• Trauma-related thoughts often emerge spontaneously without any special attempts to uncover
• If trauma-related thoughts don’t occur over a few sessions of CR, use strategies:
  – Questions to link thoughts & beliefs to traumatic events (e.g., fear of shopping due to having been mugged, fear of men due to being sexually abused)
  – Explore possible trauma-related themes across multiple CRs (e.g., fear of wide range of situations reflecting belief that world is unsafe because person was assaulted)
  – Address trauma-related thoughts from homework assignment, “How Trauma Affects Our Thoughts and Feelings”
ADDRESSING TRAUMA-RELATED BELIEFS (Cont.)

- General trauma-related thoughts can be made more explicit by overtly linking it to trauma:
  - “I’m shameful” because: I didn’t tell anyone about the sexual abuse & should have / I didn’t stop it & could have / I felt some sexual feelings which means I’m bad or not normal”
  - “Because I was physically abused by my parents & boyfriend, nobody can be trusted”
  - “I have to be on guard all the time because I was abused as a child & have been assaulted as an adult”
  - Items from the PTCI are very helpful here
1. **BRIEFLY DESCRIBE THE UPSETTING SITUATION**

Ask yourself, “What happened that made me upset?” Write down a brief description of the situation.

Situation: **Thinking about the sexual assault**

- **IDENTIFY YOUR STRONGEST FEELING**

  Ask yourself, “Am I feeling fear or anxiety? Am I feeling sad or depressed? Am I feeling guilty or ashamed? Am I feeling angry?” Write down the strongest feeling you are experiencing.

  Strongest Feeling: **Guilt and Shame**
3. **IDENTIFY YOUR THOUGHTS**

   Ask yourself, “What am I thinking that is leading me to feel this way?” Write down your thoughts below.

   Thoughts: 1) I am responsible for the sexual assault.

   2) I am a sick, twisted, weak individual who acted against his own principles.

   3) I am disgusting because I willing engaged in a relationship with another man.

   Choose one thought, from the list above, that is most strongly related to your strongest feeling (identified in Step 2).

   Thought **most strongly** related to strongest feeling: #1

   Ask yourself, “What common style of thinking am I using here?”

Common Style of Thinking: **All or None Thinking**
CHALLENGE YOUR THOUGHT

Thought most strongly related to strongest feeling (from Step 3):

I am responsible for the sexual assault.

Now, ask yourself, “What evidence do I have for this thought?”, “Is there an alternative way to look at this situation?”, “How would someone else think about the situation?”
Write down the answers that do support your thought and the answers that do not support your thought.

Things that DO support my thoughts:
I was drinking that night and passed out.
I engaged in a consensual relationship with him following the assault.
I should have known better.
He was a friend.
I should not have been hanging out with him, but I needed a place to live.
Things that **DO NOT** support my thought:

- It was against my will. I was held down by one man and raped by another.
- I did not want to be raped.
- I was unable to protect myself.
- I was in a compromised situation (i.e. I needed him to provide me with shelter).
- I had no reason to suspect that a "friend" would rape me.
Next, ask yourself, “Do things mostly support my thought or do things mostly NOT support my thought?” Look at all the things that support your thought and balance that against all the things that do not support your thought. Check below whether your thought is supported by the evidence or not.

☐ NO, my thought is NOT supported by the evidence.

☐ YES, my thought IS supported by the evidence.
5. **TAKE ACTION!**

If your thought is **NOT** supported by the evidence, come up with a new thought that is supported by the evidence. These thoughts are usually more balanced & helpful. Write your new, more helpful thought in the space below. And remember, when you think of this upsetting situation in the future, replace your unhelpful automatic thought with the new, more accurate thought.

**New Thoughts:** While my drinking and other circumstances may have put me at risk, I am not responsible for the abuse.

If your thought **IS** supported by the evidence, decide what you need to do next in order to deal with the situation. Ask yourself, “Do I need to get more information about what to do?” , “Do I need to get some help?” , “Do I need to take steps to make sure I am safe?” Below, write down below the next step you will take to deal with the upsetting situation.

**Next Step:**
COGNITIVE RESTRUCTURING: SPECIAL ISSUES IN PSYCHOSIS
COMMON CHALLENGES & SOLUTIONS

• Psychotic Distortion/Delusional Elaboration

• Recurrent, Disruptive Voices

• Cognitive Impairment/Negative Symptoms
PSYCHOTIC DISTORTION

- Avoid trying to “get to the bottom” of psychotic distortion
- Focus on underlying feelings
- Explore connections between psychotic beliefs & trauma exposure
- Use Socratic method to help make connections
- Don’t get bogged down in details related to the delusional beliefs – instead, fish out the important trauma-related material
- Treat the belief as you would any other type of overvalued idea that people have which is amenable to CR
PERSISTENT DISRUPTIVE AND DISTRESSING VOICES

- Voice content often ties back to trauma-related beliefs (See Hardy et al)

- Use voice content directly in 5 Steps practice

- Utilize in-vivo breathing retraining as needed in session to reduce distress from voices
COGNITIVE IMPAIRMENT/NEGATIVE SYMPTOMS

- Simplify 5 Steps of CR:
  1. Focus on only a few Common Styles
  2. Catch it-Check it-Change it ("3 C’s")
  3. Meta-cognitive awareness
     ("There goes my thinking again")

- Involve significant others, including clinical staff, in helping client practice CR outside of session

- More concrete, less abstract examples
SUMMARY OF CLINICAL TIPS

-- Consistent redirection back to current distressing situations

-- Start with non-trauma and non-psychotic scenarios

-- Focus on how trauma affecting current functioning

-- Not getting bogged down in details of delusions

-- Not challenging veracity of delusional beliefs or “elaborations”

-- Examining underlying content of beliefs and using for CR
MODULE 8: GENERALISATION
TRAINING & TERMINATION

• Plan for meeting with case manager before termination
• Discuss (& role play, if possible) client teaching case manager cognitive restructuring
• Have joint meeting with client & case manager in last or second to last session - create a summary document of all that has been concluded/changed/learnt
• Explore other possible supportive persons who can help practice cognitive restructuring
• Review accomplishments
• Discuss potential stressors
• Consider progress towards personal goals & next steps
WORKING TOWARD TREATMENT FIDELITY

THE ADHERENCE/FEEDBACK SCALE
CBT FOR PTSD FIDELITY

1. Agenda setting
2. Homework review
3. Overview of program
4. Crisis plan
5. Breathing retraining
6. Use of educational materials
7. Psychoeducation
8. Cognitive restructuring
9. Problem solving
10. Trauma focus
11. Assign homework
12. Manual adherence
13. Teaching effectiveness
14. Interpersonal effectiveness
15. Pacing & efficient use of time
16. Reduction of client distress
17. Overall session quality

* Each Category rated on 0-5 Scale
CBT FOR PTSD FIDELITY

___1. Agenda Setting
   – Articulate specific agenda
   – Identify other issues
   – Implement specific agenda

___2. Homework Review
   – Review prior homework
   – Praise all efforts
   – Troubleshoot obstacles

___3. Overview of Program
   – Focus of treatment program
   – Length of program & logistics
   – Description of treatment components

___4. Crisis Plan
   – Rationale
   – Discussion of nature of crises
   – Warning signs of crisis
   – Identification of resources
   – Discussion of response plan
   – Written crisis plan
5. Breathing Retraining
   - Rationale
   - Explanation
   - Demonstration
   - Practice by client

6. Use of Educational Materials
   - Utilize handouts & worksheets
   - Distribute & review materials
   - Elicit & answer questions

7. Psychoeducation
   -- Information about trauma & PTSD
   -- Information about associated symptoms
   -- Elicit client’s symptoms
   -- Answer questions

8. Cognitive Restructuring
   -- Thought-feeling model
   -- Connect negative feelings to thoughts
   -- Challenge thoughts
   -- Generate alternative thoughts
   -- Practice alternative thoughts
    -- Identify realistic concerns
    -- Establish feasible goal
    -- Explore possible options
    -- Develop specific plan to address problem

___10. Trauma Focus
    -- Effects of trauma & PTSD on functioning
    -- Monitor & discuss PTSD symptoms
    -- Connection between trauma & beliefs
    -- Challenge trauma-related beliefs
    -- Cope with traumatic memories

___11. Assign Homework*
    -- Develop homework assignment
    -- Collaborate with client
    -- Make specific plan
    -- Troubleshoot obstacles

___12. Manual Adherence*
    -- Follow session format
    -- Use of manual rationale & teaching strategies
    -- Show flexibility in face of problems
13. Instill motivation to learn information & skills
   -- Teach information & skills
   -- Modeling/Practice of skills
   -- Adaptation of skills as needed
   -- Reinforcement of small steps/Shaping
   -- Encouragement
   -- Use significant others to facilitate learning

14. Interpersonal Effectiveness*
   -- Facilitate communication (empathic nature)
   -- Use client’s own language & phrases
   -- Warm/Confident/Professional
   -- Provision of hope

15. Pacing and Efficient Use of Time*
   -- Session length kept to 1 hour
   -- Efficient structuring of time
   -- Tactful limiting of peripheral & unproductive discussion

16. Reduction of Client Distress*
   -- Identify & respond to client distress
   -- Empathy to show understanding
   -- Use of education or CBT skills to reduce distress
   -- Make plan to address persistent distress

17. Overall Session Quality
‘Suspicion Is My Friend’

A Detailed Case Example (Tim)

• Despite the theoretical assertions and empirical findings linking trauma and psychosis, there are only a few existing accounts of how to conduct clinical interventions (e.g. Callcott, Standart & Turkington, 2004; Kevan et al, 2007)

• This case example aims to describe the process of Cognitive Behavioural Therapy (CBT) within a case of psychosis where trauma is a key part of the formulation
‘Suspicion Is My Friend’ – A Case Example (Tim)

Assessment Information

• Aged 21 years old
• Living in the UK for 2 years
• Migrated from Africa
• Living with his cousin - difficult relationship
• Studying at college and working full-time (for cash)
• Seeking asylum
• No stable immigration status
• No access to benefits or housing
‘Suspicion Is My Friend’ – A Case Example (Tim)

Assessment Information

- Diagnosis of paranoid schizophrenia
- Recently admitted to hospital
- Unresponsive to anti-psychotic medication
- Persecutory beliefs and auditory hallucinations
- Hyper-vigilant to other’s actions and words
- Rumination about his persecution
- Depressed
‘Suspicion Is My Friend’ – A Case Example (Tim)

**Assessment Information**
- Auditory hallucinations
- The voice of his cousin
- ‘He is lazy, look at him, he is a failure’
- Tim believed that his cousin was using some form of black magic to transmit these voices
‘Suspicion Is My Friend’ – A Case Example (Tim)

**Baseline SAPS:**
- Auditory Hallucinations: 3 (Moderate)
- Persecutory Delusions: 3 (Moderate)
- Delusions of Reference: 3 (Moderate)
- Mind Reading: 2 (Mild)
- Global Rating of Delusions: 3 (Moderate)

**Baseline PSYRATS:**
- Hallucinations Sub-Scale: 4 (Max 24, Min 0)
- Delusions Sub-Scale: 14 (Max 24, Min 0)
‘Suspicion Is My Friend’ – A Case Example (Tim)

Baseline Belief & Distress Ratings

• Tim endorsed his persecutory beliefs with 70% belief conviction and a subjective distress rating of 5/10

• It had been suggested to Tim that he had had a nervous breakdown. He rated this belief at 50% belief conviction but it was far more distressing (9/10) than the persecutory belief
‘Suspicion Is My Friend’ – A Case Example (Tim)

**Background Information**

- Harsh upbringing
- Only child
- Migration from the city to a rural village aged 5 years
- Taught that ‘Success is the mark of a man’
- Bullied at school
‘Suspicion Is My Friend’ – A Case Example (Tim)

**Traumatic Event**

- Aged 18 violently attacked by a vigilante group
- This attack was planned from within his village
- An attempt to rid the village of ‘People like you’
- Suspiciousness starts
- ‘From that point onwards suspicion was my only friend’
• **Tim**: ‘They were trying to show me that they hated me and that they could ruin me at any time. They were my friends and they never warned me that the attack was being planned. Afterwards, I kept asking myself ‘*Why did no-one warn me*’? My friends were from that village – my family were immigrants. It just shows you that your so-called friends will betray you and that you can’t trust anyone’.
Transcript from CBT Session 2

- **Tim**: ‘It was after that that I got so suspicious. Suspicion to me became like a protection. You keep an eye out. To counter the conspiracies out there to get you, to ruin you. You have to stay one step ahead you see. Suspicion protects me. I do it consciously. The incident with the mob changed me. I realised that I needed to be strong and to analyse even the smallest thing’.
‘Suspicion Is My Friend’ – A Case Example (Tim)

**Triggers for Psychosis**

- Lost job
- No money
- Arguments with cousin
- Homeless – cold UK winter
- Alcohol misuse
Tim: ‘My cousin threw me out on the street. I couldn’t believe it. I felt like my trust had been shattered. I felt he was laughing at me. I slept rough for weeks to show him that I could handle the test he was running on me. I was thinking ‘Maybe this is just the beginning of more humiliations and tests to come’. It was like another chapter for me. First the mob and now my cousin in the UK. Suspicion is my friend even if no-one else is’.
‘Suspicion Is My Friend’ – A Case Example (Tim)

Baseline Cognitions

• You can’t trust anyone
• You have to analyse even the smallest thing to be strong
• Suspicion is my only friend
• Why was I attacked without warning?
• They were showing me they could ruin me
• These voices are part of the plan to ruin me
• They are all in on it, running tests on me, conspiring to make me fail
• You can’t be too careful
Suspicion Is My Friend’ – A Case Example (Tim)

Shared CBT Formulation (Key Points)

1. Trauma lead to significant changes in the way Tim processed information (i.e. filtered through suspicion)

2. Job loss, low mood and anxiety – triggers for psychosis

3. Small indications (e.g. particular words), filtered through his suspicious mind set, very rapidly became hard evidence of an ongoing conspiracy
‘Suspicion Is My Friend’ – A Case Example (Tim)

CBT Formulation (Key Points)
4. Social isolation provided few opportunities to disconfirm his persecutory beliefs

5. Poorly integrated memories of the mob attack regularly intruded into his consciousness, maintaining current threat
‘Suspicion Is My Friend’ – A Case Example (Tim)

**Initial Treatment Phase**

- Increase pleasurable and valued activities - ‘reclaim your life’ (Ehlers & Clark, 2000)
- Restart college
- Increase contact with people
- Behavioural experiments to test the prediction – ‘others cannot be trusted’
- Normalise post-traumatic stress
‘Suspicion Is My Friend’ – A Case Example (Tim)

‘A traumatic event is an emotional shock. It is not easy to take in what has happened and to come to terms with it. After a trauma, it is quite normal to experience all kinds of unpleasant feelings, emotions, and body sensations. These may take some time to die down. In the meantime, memories and images of the trauma, and thoughts about it, come into your mind even if you try to shut them out. These experiences may be confusing and even frightening. You may wonder if you will ever get over the trauma. These worries are entirely understandable. This is a natural, human reaction to extreme stress’.
‘Suspicion Is My Friend’ – A Case Example (Tim)

CBT Progress
Tim’s Developing Psychological Insight

The transcript illustrates how the shared formulation and cognitive behavioural interventions were beginning to influence Tim’s thinking style ………………….
Therapist: ‘So your trust has come back because you are now watching out for the suspicion rather than seeing it as your only friend?'

Tim: Yes.

Therapist: Thinking back, where do you think that extra suspicion came from in the first place?

Tim: From the way in which I lost everything in one go. First my pride and self-respect after the humiliating attack, then last winter when I was on the streets’.
Tim: ‘I was so upset I couldn’t understand it all, I went into hyper-drive thinking, thinking, thinking. I was hearing the voices too which kept calling me a failure and lazy. It just felt so personal and like an attack.

Therapist: When you look back now at the period last winter, and the incidents with your cousin, does it still feel suspicious?

Tim: I know that him treating me so badly made me feel suspicious.

Therapist: Rather than that he set out to ruin you in collaboration with others?’
Transcript from CBT Session 10

**Tim:** ‘Yes. I was forgetting that he is very harsh. I mistook that for some kind of nasty plan.

**Therapist:** We were also speaking about the mob attack last week in quite some detail. It sounded as if the discussions we have had about it had changed your view a little…….

**Tim:** For years I was convinced they were all in on it but I realise now that the leaders were to blame. I was just a good target. I fitted the bill. The others followed them because they were scared, they had to. Those who organised the mob were bad – not all of those who took part – it was a mob mentality – you can’t say no’.
Transcript from CBT Session 10

**Tim:** ‘When I got in touch with that guy from the village recently he confessed that they had been misled by the village elders and forced to take part. He said sorry and you could see he felt awful about it.

**Therapist:** Is that important information both in terms of what you said about your cousin and the mob?

**Tim:** Yes. Not *everyone* is a threat.
‘Suspicion Is My Friend’ – A Case Example (Tim)

<table>
<thead>
<tr>
<th>Session 10 - SAPS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory Hallucinations</td>
</tr>
<tr>
<td>Persecutory Delusions</td>
</tr>
<tr>
<td>Delusions of Reference</td>
</tr>
<tr>
<td>Mind Reading</td>
</tr>
<tr>
<td>Global Rating of Delusions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session 10 - PSYRATS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallucinations Sub-Scale</td>
</tr>
<tr>
<td>Delusions Sub-Scale</td>
</tr>
</tbody>
</table>
‘Suspicion Is My Friend’ – A Case Example (Tim)

Revised Cognitions – Session 10

• You can trust some people, just not everyone
• You *can* over-analyse and lose perspective
• I have other friends now
• Many of those who took part in the mob were forced to
• People who hated outsiders organised the mob
• The voices were part of the mental strain
• My cousin is just cold and harsh. I mistook that for some kind of nasty plan
• You *can* be too careful
‘Suspicion Is My Friend’ – A Case Example (Tim)

Outcome – Session 10

• Tim now endorsed his persecutory beliefs with 5% belief conviction and a subjective distress rating of 2/10.

• It had been suggested to Tim that he had had a nervous breakdown. He now rated this belief at 90% belief conviction and it was now far less distressing (2/10).
‘Suspicion Is My Friend’ – A Case Example (Tim)

End of CBT – Session 12

- Tim to be deported from the UK
- Decided to voluntarily return home
- In the 2 months prior to him leaving he was housed in 4 separate towns in the UK and interviewed by officials on 6 occasions
- Increase in paranoia?………………………………………………
‘Suspicion Is My Friend’ – A Case Example (Tim)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>End of CBT - SAPS:</strong></td>
<td></td>
</tr>
<tr>
<td>Auditory Hallucinations</td>
<td>0 (None)</td>
</tr>
<tr>
<td>Persecutory Delusions</td>
<td>0 (None)</td>
</tr>
<tr>
<td>Delusions of Reference</td>
<td>0 (None)</td>
</tr>
<tr>
<td>Mind Reading</td>
<td>0 (None)</td>
</tr>
<tr>
<td>Global Rating of Delusions</td>
<td>0 (None)</td>
</tr>
</tbody>
</table>

| **End of CBT - PSYRATS:**                  |        |
| Hallucinations Sub-Scale                   | 0 (Max 24, Min 0) |
| Delusions Sub-Scale                        | 6 (Max 24, Min 0) |
Conclusions

Tim’s case shows clear and meaningful links between trauma and psychosis (e.g. Tim’s posttraumatic shift to a suspicious thinking style)

Morrison et al (2005) have proposed that for some individuals suspiciousness and paranoia are used as survival strategies following interpersonal trauma

Beliefs such as ‘If I were not paranoid others would take advantage of me’ and ‘It is safer to be paranoid’ and ‘My paranoia protects me’ may be employed as a deliberate strategy for managing interpersonal threat
Conclusions

Tim’s beliefs that ‘Suspicion is my only friend’ and ‘You can’t be too careful’ acted as a survival strategy - it was important to reappraise them

Tim’s status as an asylum seeker in the UK is another important factor

Fazel et al (2007) - refugees settled in western countries 10 times more likely to have PTSD than the general population

It is plausible to hypothesise that the relative insecurity of seeking asylum may further increase this risk
Conclusions

In clinical settings a thorough assessment of an individuals’ trauma history is important when conceptualising psychosis.

Understanding and validating trauma can shape the CBT intervention.

The case shows how CBT techniques developed for PTSD can be adapted for work in psychosis.

CBT can help target factors that lock someone into trauma-psychosis.