

Cognitive Behavioral Therapy for Psychosis

Summarized by Thomas T. Thomas

At our September 27 speaker meeting, **Michelle Sallee, PsyD**, a licensed clinical psychologist with the Department of Psychiatry at Kaiser Permanente, told us about her work to develop and run programs on Cognitive Behavior Therapy for Psychosis. Dr. Sallee also has worked as a forensic correctional psychologist. She came to our attention last spring when her clinical colleagues at Kaiser nominated her for a Mental Health Achievement Award, given by the Mental Health Association of Alameda County.

Her work on cognitive behavior therapy (CBT) for psychosis began with a book by [Aaron T. Beck](#). Dr. Sallee also cited two research studies supporting this form of treatment. One, from 2016, followed 58 students over 45 CBT sessions to examine “dosing”—or the amount of CBT skills training classes needed before it is significantly helpful with psychotic symptoms (see *The Journal of the Association of European Psychiatrists*, October 2016). Focusing on results after five, fifteen, twenty-five, and forty-five weeks of sessions, the study found the students reported reduction in the stresses associated with their psychotic symptoms after 15 weeks, but that 25 sessions are the more appropriate dose of CBTp, as that is when the frequency of positive symptoms of psychosis and negative symptoms of psychosis reached a minimum.



MICHELLE SALLEE, PSYD

A second study, from 2011, examined the functional effectiveness of CBT versus treatment as usual (TAU) with brain scans by magnetic resonance imaging and showed positive results.

Dr. Sallee developed a 13-week program, Cognitive Behavior Therapy for Psychosis, in December 2012, which undergoes updating and modification at the end of every 13-week skills-based training group therapy program. The program includes a teaching manual and workbook authored by her and Dr. Jessica Bergstrom, who was the Doctoral Practicum student at the time. The course is used by patients with a range of diagnoses, including Schizophrenia, Schizo-Affective Disorder, Major Depressive Disorder with Psychotic Features, and Substance Use Disorder. Some of the patients are on medication, while others are not. The goal is to give them the tools and skills to deal with and reduce the stresses resulting from symptoms such as hallucinations like hearing voices and delusions—although she avoids that word, her patients preferring “thoughts and beliefs that cause stress.”

After each course, Dr. Sallee examines with class members what has worked for them and what didn’t, and she has made changes. She is now teaching her sixteenth such course at Kaiser. Her work has been so successful that the Kaiser organization

in Northern California considers it a best practice and has asked her to train seventy other clinicians around the system to give the course.

CBT was originally used for depression, then for anxiety, and now psychosis. It works from two models. The **circular model**, followed by Dr. Beck, traces the relationship among thoughts that lead to moods, which lead to behaviors, which create more thoughts. The goal of this model is to notice the cycle and break it. “You can’t break the cycle at the *mood component* of the circular model,” she said, “but you can come into the cycle at *thought*, separating yourself from your belief, examining it, and asking yourself if your thought is a fact or a belief. You can also interrupt at *behavior*, by changing a behavior such as going outside for a walk.” That was one idea from a two-page handout listing other adaptive behaviors.

The other is the **ABC model**, which stands for *action*, *belief*, and emotional *consequences*. “Something happens and you feel a certain way,” she said. “It’s not because of the action but your belief about it that makes you feel this way.” The model suggests the patient put feelings and thoughts in their right place. To this ABC model, “D” is for *distortion*, and her course focuses on 13 distortions that people with psychosis engage in (e.g., jumping to conclusions, fortune telling, mind reading, and other thinking styles that get us all into trouble), which color perception and interpretation of what was seen or heard.

As an example of how CBT works in the course, Dr. Sallee addressed the issue of hearing voices. Often it’s not the content but the patient’s relationship with the voice that causes stress. She identified three domains into which this relationship can fall: **malevolent**, in which the voices wish the patient ill will; **omnipotent**, with the voices “knowing all”; and **benevolent**, where the voices intend good things. For patients whose symptoms do not include hearing voices, then the relationship can be with the “voice in your head” representing your thoughts that cause distress. In all these domains, the therapy is to separate self from the thought or belief and test to see whether they want to stay with that belief or consider an alternative belief.

The goal of the training is to move the patient’s score on the BAVQ-R (Belief About Voices Questionnaire–Revised), which is an instrument developed by the *British Journal of Psychiatry* (2000) designed to measure how patients interact with their A/H. The omnipotent domain can be stressful because it represents an invasion of the patient’s privacy. Dr. Sallee and Dr. Celia Yu-Hsuan Liu, who was the Doctoral Practicum Student at the time, looked at pre- and post-test scores, with their pilot group showing movement from a score of eight to a five. For the benevolent domain, the goal would be for the score to remain the same or increase. In their review, the score stayed the same. For the malevolent domain, the goal would be to decrease the score. Their pre-and post-testing with the pilot group showed movement from a score of five to a score of one.

Dr. Sallee teaches four “disputing strategies” for “beliefs that cause distress” (or delusional thoughts) to help patients argue with their thoughts. The first is a strategy called “**Evidence**,” (the “E” column in the ABCD model). Here the patient acts as a lawyer arguing against a belief, such as asking someone with paranoia what evidence there might be that Robert De Niro is *not* actually following him or her. Next is **cost/benefit analysis**, in which the patient weighs the pros and cons of a belief. If a patient believes the FBI is watching, the benefit is he or she feels

important, but the cost is negative feelings of paranoia and isolation. Third is the **survey method**, where the patient asks seven people he or she respects, trusts, and with whom the patient willing to share the stressful belief. (If the patient is unwilling to share, then he or she is asked to internalize what those people would say.)

And if those three strategies don't work, the patient can always **act as if it's true**, and what is he or she going to do about it? For example, with a patient who feared an imminent earthquake that would destroy just his own home, the treatment was to prepare an earthquake kit and to learn photography in order to document the results. This positive activity kept the person busy and less stressed.

In addition to these various strategies, the course discusses topics like:

- Auditory hallucinations, their triggers, and coping strategies for breaking their cycle.
- Negative symptoms of psychosis—things that were there before but are now absent, such as expression of emotion, self-care and hygiene, and goal-directed activities—along with their triggers and interventions.
- Commanding voices and the Opposite Action model. For example, if a voice commands violation of an apartment building rule, patients identify the opposite action (opposite of the command) and develop a list of pros and cons to that opposite action. This strategy results in consideration of potential consequences, decreases impulsivity (of obeying a command) due to the time it takes to do this four-step strategy, and they are encouraged to call someone they trust to help with this strategy, which adds the benefit of checking in with someone else about a behavior that could lead to negative consequences (e.g., eviction, police department involvement, etc.).
- Things that worsen psychosis and depression, such as isolation, sleep deprivation, alcohol and drug use, and stresses from emotional conflict and high emotional expression and drama in the household.
- Safety planning, including intermediate steps a patient can take before a break, call to 911, and hospitalization, and triggers that lead such a break.
- A one-hour class facilitated by Kaiser's Assistant Chief of Intensive Services, John Huh, MD, focused on information about medication, behaviors and choices that interfere with how effective medication can be, management of side effects, and patients are encouraged to ask questions (verbally but also anonymously on paper submitted in advance) to help them make informed decisions about medications vs. choices based on fear and lack of education about how medications work.
- Symptoms that are *not* helped by CBT, such as disorganized behavior and visual hallucinations, were added to the program by Dr. Anastasia Finch, who was the Doctoral Practicum Student at the time, when participants requesting learning what *does* work.

The program includes homework for the participants. For example, they are each given a seven-page list of pleasurable and nearly free activities to break the behavioral feedback cycle and asked to try one.

The CBT program is not for everyone, but patients are encouraged to try these strategies and decide for themselves. All participants are seen by Dr. Sallee for a 45-minute office session prior to joining the program. If they are clinically not a match for a group setting, there is a discussion about how the interested participant can

learn the strategies. If they are a match for a group setting, the focus of the office setting is “joining” the program in progress (so that patients do not need to wait 13 weeks for the next series to begin, they can start the next week if they choose).

If CBT is not a good fit for the patient’s clinical needs or interest, they consider the 12-week Affect Regulation for Moods Associated with Psychotic and Bipolar Spectrum Disorders Program. This uses DBT, ACT, psychoeducation, mindfulness practices, and the recently added class, The Impact of Nutrition on Moods Associated with Psychosis and Bipolar Spectrum Disorders, developed by Angie Gereis, MA strategies. The 12-week program was developed by Dr. Sallee and Dr. Sara Dodd, who was the Doctoral Practicum Student at that time. These programs are limited to Kaiser Permanente members. The course includes skills and tools for managing, regulating, tolerating, and decreasing paranoia, suspiciousness, fear and anxiety, anger, depression and guilt, and hypomanic irritability.

CBT does not work for all psychotic symptoms. For example, while it addresses auditory hallucinations like voices, it has no effect on visual hallucinations. This may be because the therapy is language oriented and these symptoms are not verbal.

The results from CBT for Psychosis have had some variation—statistical outliers—and the treatment does not work for every patient. For example, a patient who thinks too deeply, and becomes stressed by thinking about his or her thinking, may not have a positive response. Dr. Sallee measured the overall success of the program by looking at hospitalization rates before and after the program, then at six, twelve, and eighteen months after finishing. On this basis, the results have been consistently positive.

Other intervention programs at Kaiser in Oakland include the six-week Family Education Support Group for families and friends of patients with mental illness; the Wellness Club (combining skills training, support, and art therapy); the Wellness Graduates Group (a support process group for patients with psychotic and bipolar spectrum illness), Life Skills Group (focused on patients primarily with negative symptoms of psychosis and chronic illness), the 12-week Bipolar Education Group (psychoeducation and support), and the Bipolar Support Group.

Currently, Dr. Sallee, Dr. Myron Hayes, PhD, ABPP, and Michelle Renwick, currently Oakland Kaiser CCM’s Doctoral Practicum Student, are working towards proposing to present both the CBT for Psychosis program and the 12-week Affect Reg Program at the 126th Annual American Psychological Association Convention (August 2018).

For patients outside the Kaiser system, Dr. Sallee suggested they or their loved ones consult PsychologyToday.com to find therapists with special training in CBT and psychotic spectrum and Bipolar spectrum diagnoses. Parents can also help their loved one by undertaking CBT themselves and modeling it for their loved ones.