SPEAKER NOTES

Cognitive Behavior 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 change they experienced with the number of sessions. Focusing on results after five weeks and then at fifteen weeks of sessions, the study found the students reported reduction in the stresses associated with their psychotic symptoms after 15 weeks, and a full effect—minimum stress—after just 25 weeks. 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.

MICHELLE SALLEE, PSYD

Dr. Sallee then developed a 13-week program, Cognitive Behavior Therapy for Psychosis, for which she wrote the manual and workbook. The course is used by patients with a mix of diagnoses, including schizophrenia, schizo-affective disorder, depression, and substance abuse. 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* stage, which is a result," she said. "But you can come

into the cycle at the *thought* stage, separating yourself from your belief, examining it, and asking yourself if it's real. And you can interrupt at the *behavior* stage by doing something different, like going outside for a walk."

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 model, Dr. Sallee adds a "D" for *distortion,* and her course lists 13 distortions that people with psychosis practice, such as jumping to conclusions, fortune telling, mind reading, and other unwarranted presumptions that can color the patient's reactions.

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; ***omniscient,*** with the voices knowing everything about the patient; 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 it is actually true.

The goal of the training is to move the patient's score on a scale that measures belief in the voice and response to the stress. For the omniscient domain, which can be stressful because it represents an invasion of the patient's privacy, the goal is to move the response from an eight to a five. For the benevolent domain, the patient wants belief and response to remain the same or go up a bit. And for the malevolent domain, the goal is to go from a beginning score of five down to and score of one.

Dr. Sallee also discussed four "disputing strategies" to help patients argue with their thoughts. The first is ***evidence,*** the "E" column in the ABC 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 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 orders the patient to smoke in the hallway, which could start a fire through carelessness, consider the pros and cons and counter the command with a positive instruction like going outside to smoke.
- 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.
- Other symptoms like disorganized speech and behavior and visual hallucinations.

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, and Dr. Sallee prescreens prospective patients for referral, sometimes spending as long as an hour with them before they are invited to join. The program is limited to Kaiser Permanente members.

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 measures overall success of the program by looking at hospitalization rates before and after taking the class and then at six, twelve, and eighteen months after finishing. On this basis, the results have been consistently positive.

In addition to CBT, Dr. Sallee developed an 11-week Affect Regulation program using dialectical behavior therapy (DBT) to regulate mood, which is applicable to patients with manic, psychotic, and bipolar symptoms. The course includes skills and tools for distress tolerance, emotional regulation, mindfulness, and interpersonal effectiveness.

Other intervention programs at Kaiser in Northern California include a Wellness Club, which combines skills training with support group discussions; a Life Skills Class, which is more of a support group; and a 12-week Bipolar Education class with ongoing support.

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