

# Psychotherapy for Psychosis



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"Non-schizophrenic" paranoia and projection	"Schizophrenic" paranoia and projection"
<b>Disavowed aspects of the self are projected outside the boundary of the self representation, where they are experienced as an external threat. Aspects of the self "go missing" but remain in consciousness lodged in mental representations outside the boundary of the self.</b>	
Malicious intent is projected into mental representation of other people with whom the person has an actual social history.	Malicious intent projected into mental representation of strangers, parts of the body, and inanimate things. Self and object representations fuse.
The patient believes that the other person's true selfish and hurtful motives are hidden beneath the surface appearance of a deceptively benign social presentation.	The patient fears that a plot focused on the self are hidden beneath the surface appearance of seemingly mundane events, like the glance of a stranger.

"Non-schizophrenic" paranoia and projection	"Schizophrenic" paranoia and projection"
The patient is always on the look-out to discover evidence of the hidden hurtful nature of the other person, ready to seize on any seeming evidence of what the patient knew to be true all along.	The patient sees evidence of the hidden plot everywhere, but the precise motives of the conspirators often is unclear. There is a constant expectation of harm that is often delayed indefinitely.
The person fears that if he or she trusts another person, against his/her own best judgment, the person will be betrayed by the individual whose love he/she seeks, and suffer an unbearable annihilation of self esteem for having been shown to be a fool at the same time the world is revealed to be a place without love, as he/she had always suspected.	The person fears being killed.

"Non-schizophrenic" paranoia and projection	"Schizophrenic" paranoia and projection"
Effort to find evidence of the persecutor's malicious intent so as to trap the persecutor and elicit a confession and reparation.	Avoid the persecutor, or kill the persecutor before being killed. The person does not sustain an on-going interpersonal relationship with the persecutor.
The anonymity of the larger world is preserved.	The anonymity of the larger world is lost. The patient feels himself to be the subjective center of the universe.
Socially engaged with people who retain their real identities	Socially isolated and in flight from, or attacking other people assigned delusional identities

"Non-schizophrenic" paranoia and projection	"Schizophrenic" paranoia and projection"
Psychological boundaries between thoughts, feelings, and perceptions remain intact.	Psychological boundaries break down. Hybrid mental states that blend thoughts, feelings, and perceptions enter consciousness.

## Pathogenesis of Psychosis

- 1. Prodrome**  
 anomalous self states  
 mounting social failure in which needs for satisfaction and security cannot be achieved (HS Sullivan)  
 developmental impasse - intra-psychic conflict
- 2. Delusional mood** (Jaspers)  
 heightened awareness of environment  
 something of great importance is about to happen

## Pathogenesis of Psychosis

### 3. Ideas of reference

The person becomes the subjective center of the universe. Otherwise mundane events are laden with personal meaning

- apophany      the "pop" of sudden understanding that comes with solving a puzzle or getting a joke
- anastrophe    hyper-reflexive self awareness

### 4. Weakening of the "I" at the subjective center of experience - dissolution of the self

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## Pathogenesis of Psychosis

Upon reflection years later, I think the main warning signal was my identity – the safety of knowing that I was an "I" – was starting to crumble. I became increasingly insecure about whether or not I really existed, or if I was only a character in the book or of being someone had made up. I was no longer certain of who was controlling my thoughts and actions; was it me, or was it someone else – the author maybe? ...In my diary I replaced "I" with "she" and after a while I started thinking like this as well; "she was walking to school. She was sad and wondering if she was going to die." And some place within me, something was questioning if "she" was still "me," and it found out that that was impossible, because "she" was sad, and I, well, I was nothing. Just gray. Lauveng *The Road Back From Schizophrenia* pg 5

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## Pathogenesis of Psychosis

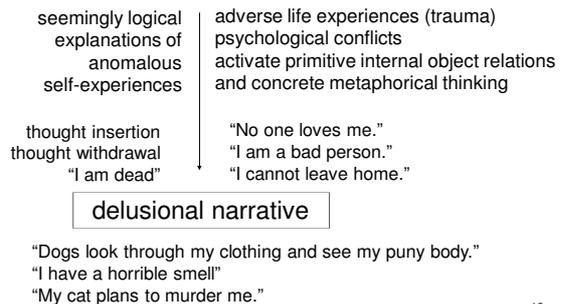
Breakdown of psychological boundaries between ...

- thoughts, feelings, fantasies, and perceptions  
thoughts out loud / auditory hallucinations
- mental representations of the self and psychological objects  
delusional identities

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## Delusion Formation



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## A Clinical Example of Psychosis

The man who believed dogs were looking through his clothing with x-ray vision and mocking his puny body with their eyes.

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## A Clinical Example of Psychosis

**In Psychosis, the Problem Appears to the Patient to be in the Outside World Rather Than Within the Self**

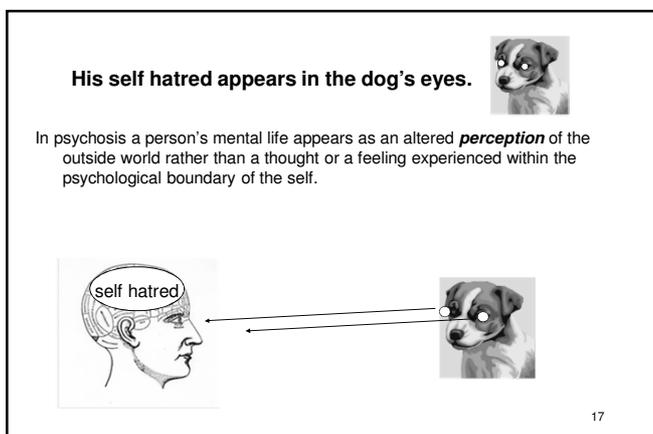
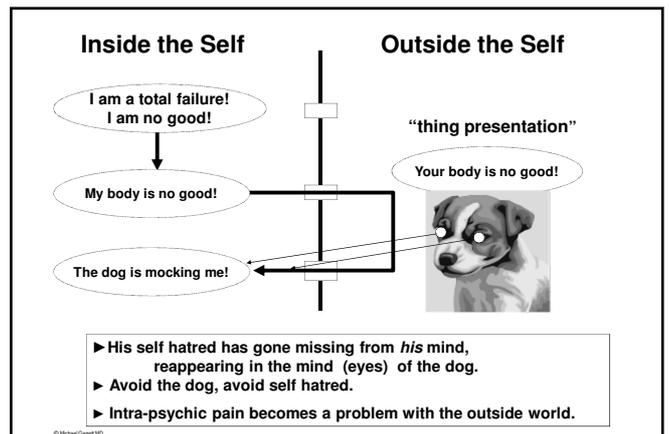
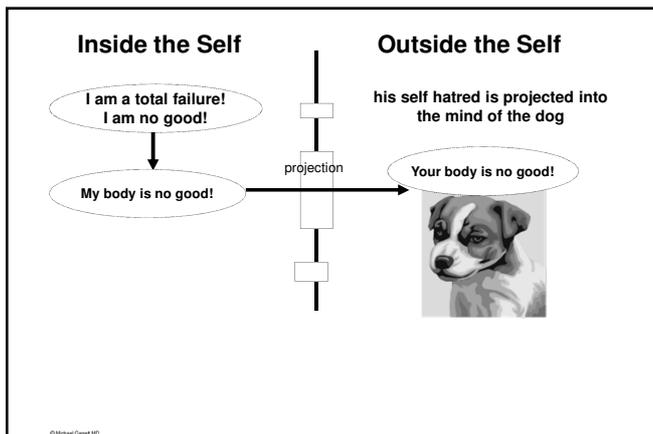
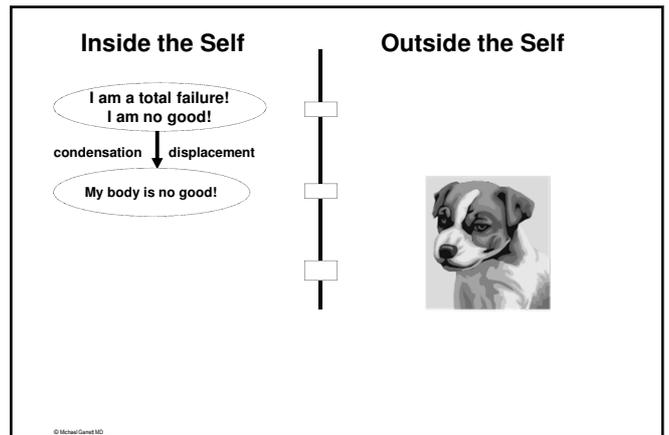
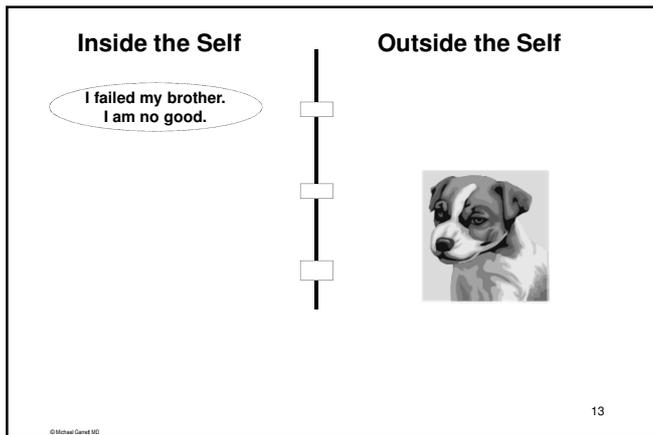
**Jason:** The man who believed he was being mocked by dogs

First psychotic episode in the Navy  
Had hoped to lead his family out of poverty  
Younger brother died in a drug related slaying  
Blamed himself



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**Modification of Psychotherapy Technique**

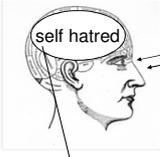
In psychosis, the patient believes his problem is located in the outside world

- First, use CBTp techniques first to help the patient discover the **literal falsity** of the delusional belief
- Then, use a psychodynamic approach, according to the patient's needs and capacities, to explore the **figurative truth** of the delusion

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### Inside the Self

thoughts and feelings



trauma

### Outside the Self

perceptions



a fragment of the patient's mind (his self hatred) resides in the eyes of the dog

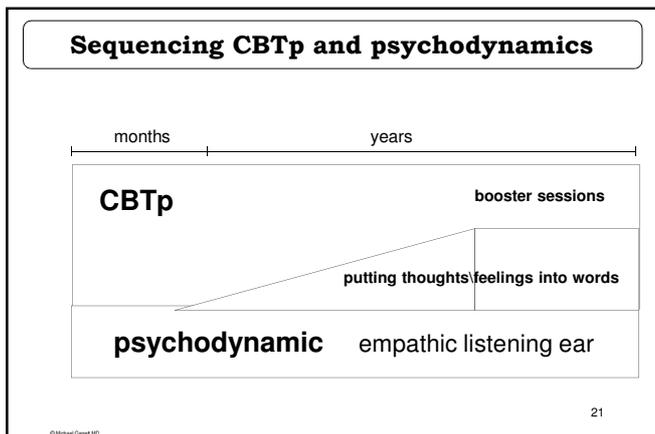
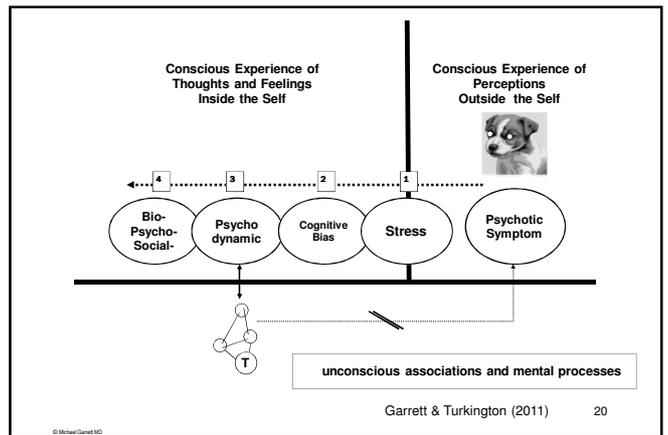
**Start with the dog, not his self hatred**

Do you feel that way about all dogs, or just one? Does that one dog look at you only? What precisely is different about the way the dog looks at you compared with looking at others?

If a dog looks at someone other than you, can you tell what the dog is thinking?

Let's read about canine intelligence.

**unconscious mental processes**



- ### The Developmental Psychology of Psychosis
- Why do psychotic people think their problems lie outside themselves in the real world?
  - How can psychotic symptoms be related to normal development and ordinary mental life?
  - How can this understanding make psychotherapy for psychosis more effective?
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### Internal Objects in Ordinary Mental Life

The superego contains two internal objects that are in relationship with the self.

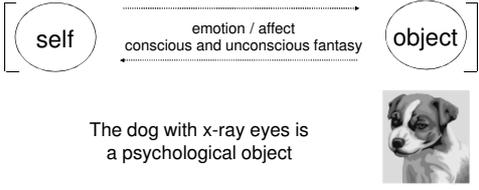


The part of the mind that feels the lash is not the same as the part that wields the whip. The mind is not a homogeneous whole but rather it is split into a federation of internal psychological objects.

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### The Developmental Psychology of Psychosis

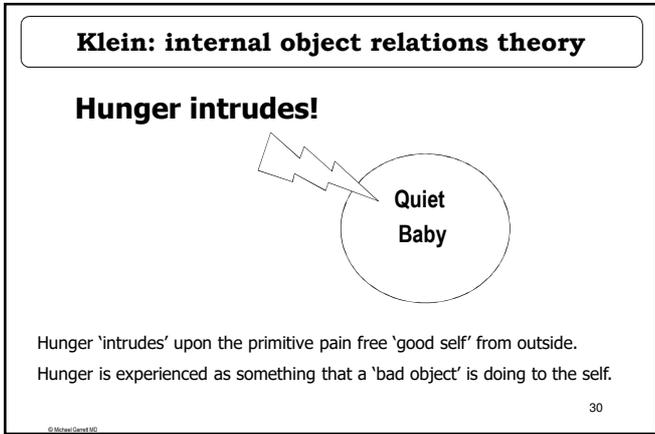
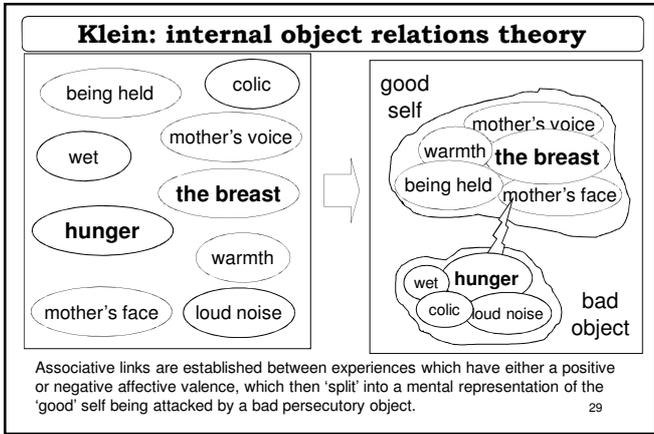
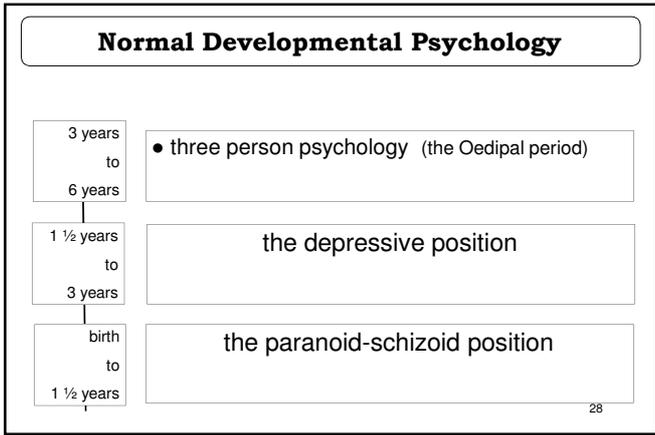
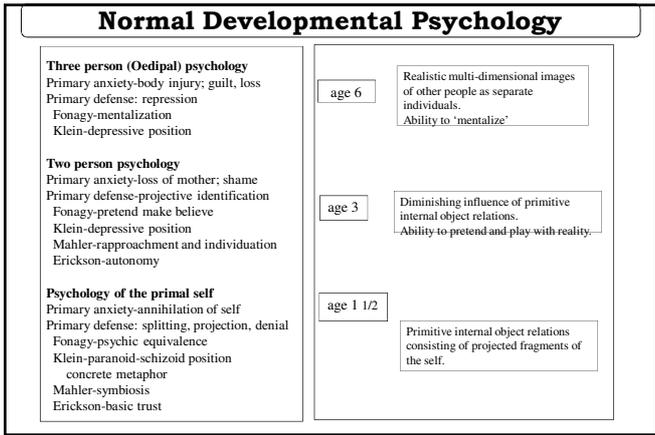
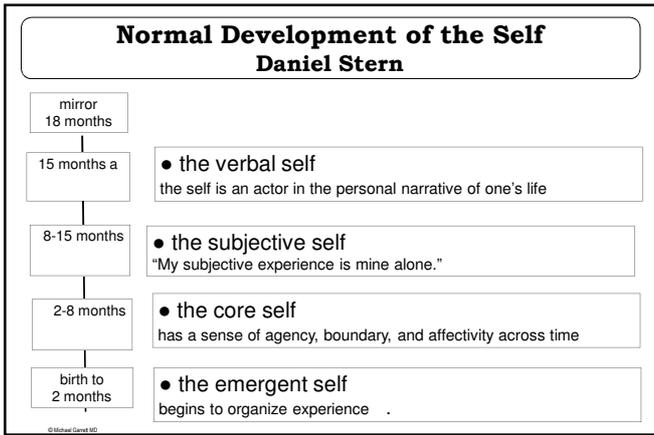
**1. Primitive object-related phantasies**



The dog with x-ray eyes is a psychological object

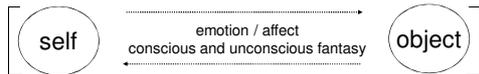
A puny devalued self is attacked by a fragment of the patient's punitive superego that has been projected into the patient's mental representation of the dog.

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### Klein: internal object relations theory

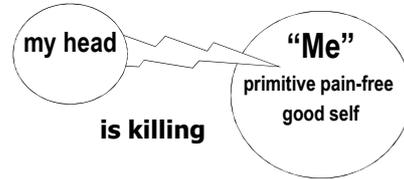
- In the first year of life, projection fashions the basic psychological structure of the human mind, in which a 'self representation' is connected to an 'object representation' with an affective (emotional) valence (link).
- The psychological "object" is a mental representation of another person or thing located outside the mental boundary of the self, in which the person is emotionally invested
- These primitive internal object-related phantasies become the building blocks for fairy tales and delusions



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### persecutory objects

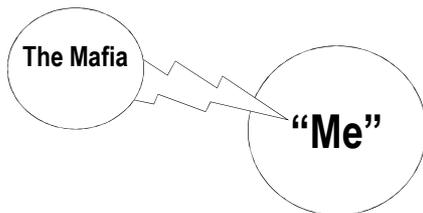
When we have a headache we are apt to say,  
"My head is killing me!"



The self would have been pain free  
were it not for the intrusive attack of the head.

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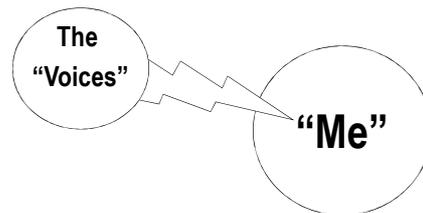
### persecutory objects



" Mafia has a contract out to kill me!"

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### persecutory objects



" The "voices" are tormenting me.  
They say I am a total loser."

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### The Paranoid-Schizoid Position

- the primary anxiety regards the survival of an integrated self capable of binding intense, contradictory affects
- mental representations of other people consist primarily of disavowed parts of the self projected into mental representations of other people, e.g. paranoid jealousy
- self and object representations tend to be all good or all bad rather than nuanced mixtures of good and bad traits
- 'good' and 'bad' objects must be kept separate in the mind for fear of the bad object destroying the good object
- an idealized perfectly good object is the mental antidote to the persecutory bad object

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### The Paranoid-Schizoid Position

- if idealized object is perfect, it has no flaw, no fault, no portal through which the bad object can conceivably attack the mental representation of the self
- self and object representations tend to be perfectly good or perfectly bad rather than nuanced mixtures of good and bad traits
- 'good' and 'bad' objects must be kept separate in the mind for fear of the bad object destroying the good object
- a perfect good object is the mental antidote to the persecutory bad object

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## The Paranoid-Schizoid Position

Illustrations:

- Superman

**Arguments**

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## Movement Between the Depressive and Paranoid-Schizoid Position

**Example: an argument with one's significant other**

- "I can't believe you didn't remember we are going to my sister's tonight! You *never* listen to *anything* I say."

**paranoid/schizoid position**

- Brave thoughts: "Why do I have to put up with this!" Fleeting fantasies of divorce. Self righteous indignation.
- Silent treatment
- Mundane small talk, but no apology. "I'll pick up some milk."
- Your dependent needs reassert themselves. "I over-reacted. I am sorry."

**depressive position** is re-established

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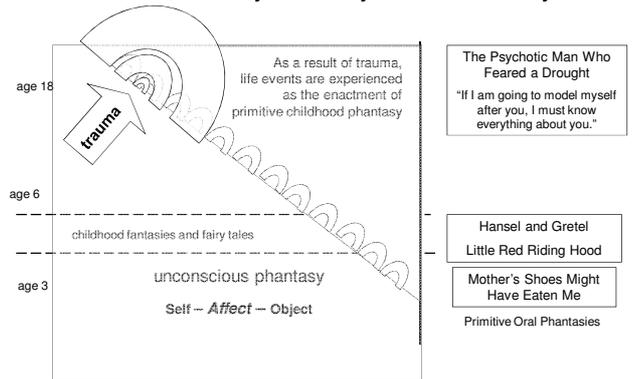
## Primitive Pre-verbal Unconscious Phantasy

### The frightening shoe

- A little girl of one year and eight months, with poor speech development, saw a shoe of her mother's from which the sole had come loose and was flapping about. The child was horrified, and screamed with terror, for about a week she would shrink away and scream if she saw her mother wearing any shoes at all, and for some time can only tolerate her mother's wearing a pair of brightly colored house shoes. The particular offending pair was not worn for several months. The child gradually forgot about the terror, and let her mother wear any sort of shoes. At two years and 11 months, however (15 months later), she suddenly said to her mother in a frightened voice, "where are Mummies broken shoes?" Her mother hastily said, fearing another screaming attack, that she had sent them away, and the child then commented: "they might have eaten me right up." The flapping shoe was seen by the child as a threatening mouth, and responded to as such, at one year and eight months, even though the fantasy could not be put into words. Here, then, we have the clearest possible evidence of the fantasy can be felt, and felt is real, long before it can be expressed in words." *Isaacs (1948) pg 85*

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## Unconscious Phantasy In Ordinary Mental Life and Psychosis



## Body Based Metaphor in Ordinary Mental Life

Examples of body based metaphor in ordinary mental life.

- "I had to swallow my pride."

"Pride is something you can orally incorporate, like something you eat and have inside you. I didn't completely surrender to the other person. I held on to my self-esteem by swallowing it into an interior body space where it remained intact, from where it can safely re-emerge when the persecutory object has left the scene and the interpersonal coast is clear."

Little Red Riding Hood

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## Ordinary Figurative Metaphor

"America is a melting pot."

X is like Y

Figurative metaphor requires an awareness of similarities and differences.

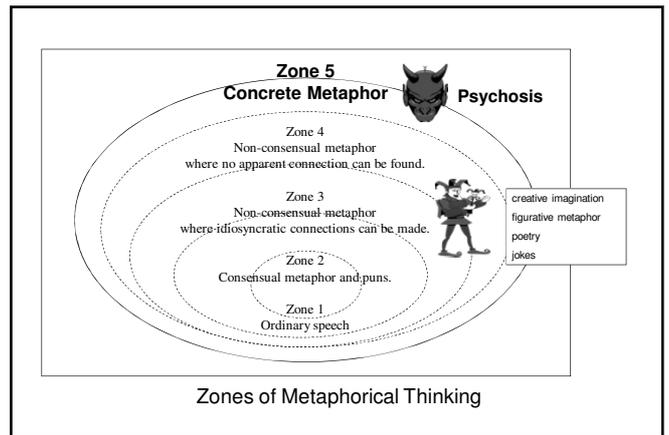
X is like Y in some regard, but X is fundamentally different than Y in other ways.

In psychosis, X = Y

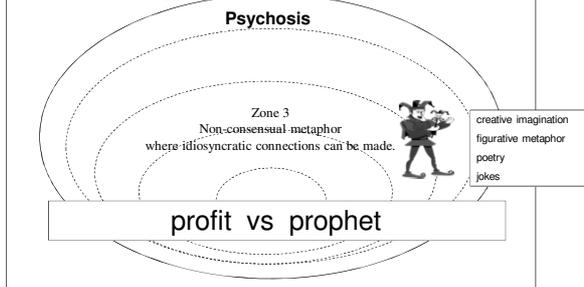
### Concrete Metaphor

- Early in treatment a psychotic man insisted that his statement that people are sheep was a literal fact, drawing no associative meaning from the figurative metaphor that the age of modern technology has turned people into herds of sheep. Later in treatment while sitting outdoors for a psychotherapy session, the same man gathered up a handful of leaves, saying "These are people. This is how completely cast off, forgotten, and useless some people, including me, feel themselves to be."

Harold Searles



Atheism is ...



### Concrete Metaphor

- Imagine a moment when you were aware of an aspect of yourself about which you feel particularly self critical. For example, imagine a moment that you believe called for courage where you did not act bravely, but instead took the safe course. Imagine your intensifying self criticism leads to the thought, "I am in essence a coward!"
- "In essence a coward..." means that although you may be aware of having some positive traits, you feel these positive traits do not offset and merely disguise the true essential nature of the bad object which lies at the core of the self.

### Concrete Metaphor

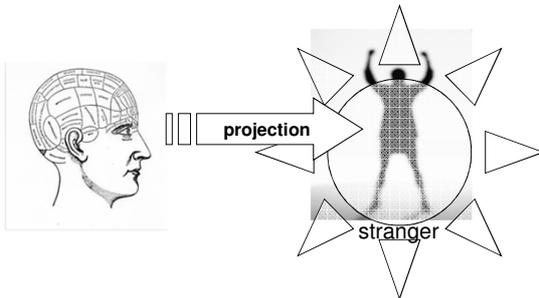
- In this affectively intense state of mind, instead of thinking 'I behave like a coward at times, but bravery is sometimes foolish, and I have other redeeming features' you double down hard on yourself – "I am in essence a coward"
- 'I am a coward through and through' = "I am as bad as Benedict Arnold" =
  - The delusion as a concrete metaphor: "I am Benedict Arnold"

$$X=Y$$

### Concrete Metaphor and Delusional Narratives

- Mental representations of the self and others coalesce into concrete metaphorical identities that become the cast of characters that populate delusions.
- These concrete metaphorical identities are woven into stories that are meaningful expressions of the psychotic person's mental life.

### Breakdown of Ego Boundaries-Biological Factors

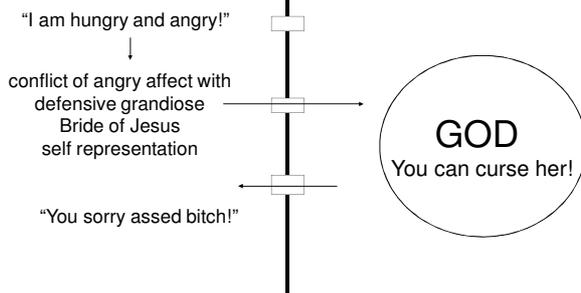


### New Psychodynamic Possibilities

"I am the Bride of Jesus. My roommate did not save me a plate of dinner. I was angry, but I couldn't curse her because I am a Christian woman and I am the Bride of Jesus. But then I heard God's voice. God said, 'You can curse that sorry assed bitch! And God told me what to say.'"

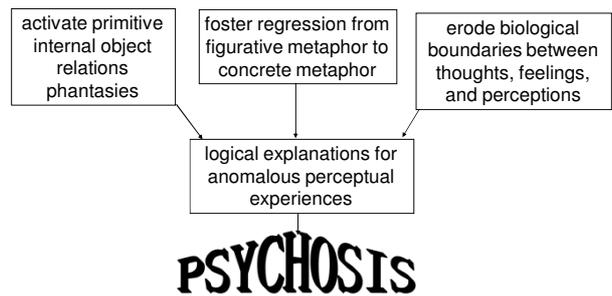
### Inside the Self

### Outside the Self



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### adverse life events



### What is CBTp?

#### CBTp is a ...

- A specialized form of psychotherapy which combines
- an emphasis on cognition rather than affect
- familiar psychotherapy skills
- a radically different doctor-patient relationship
- a specialized 'tool box' of CBT techniques

#### CBTp is NOT ...

- a substitute for medication
- a rejection of the importance of biological factors in psychosis

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### Evidence Base for CBTp

#### 34 randomized trials - 3 meta-analyses

#### United Kingdom

- Tarrier et al (1993:1998)
- Kingdon & Turkington (1996),
- Sensky et al (2000),
- Turkington et al (2002)
- Drury, Birchwood et al (1996),
- Trower et al (2004)
- Kemp, David et al (1996)
- Kuipers, Fowler & Garety et al (1994:1998)
- Gumley et al (2003),
- Durham et al (2003)
- Lewis et al (2002)

#### North America & elsewhere

- Lecompte & Pelc (1998)
- Pinto et al (1999)
- Jenner et al (2001)
- McGorry et al (2002)
- Granholtm et al (2002)
- Rector et al (2003)

#### Meta-analysis

- Tarrier (2007)
- Wykes (2008)
- Jauhar (2014)

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**Jauhar, et al. (2014) Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias** *British J of Psychiatry* 204, 20-29.

**Background**  
Cognitive-behavioural therapy (CBT) is considered to be effective for the symptoms of schizophrenia. However, this view is based mainly on meta-analysis, whose findings can be influenced by failure to consider sources of bias.

**Aims**  
To conduct a systematic review and meta-analysis of the effectiveness of CBT for schizophrenic symptoms that includes an examination of potential sources of bias.

**Method**  
Data were pooled from randomised trials providing end-of-study data on overall, positive and negative symptoms. The moderating effects of randomisation, masking of outcome assessments, incompleteness of outcome data and use of a control intervention were examined. Publication bias was also investigated.

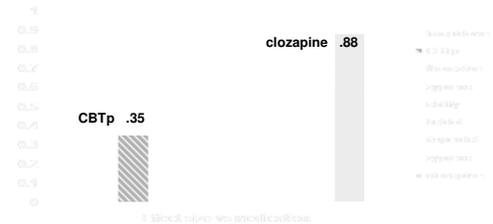
**Results**  
Pooled effect sizes were **-0.33** (95% CI -0.47 to -0.19) in 34 studies of overall symptoms, -0.25 (95% CI -0.37 to -0.13) in 33 studies of positive symptoms and -0.13 (95% CI -0.25 to -0.01) in 34 studies of negative symptoms. Masking significantly moderated effect size in the meta-analyses of overall symptoms (effect sizes -0.62 (95% CI -0.88 to -0.35) v. -0.15 (95% CI -0.27 to -0.03),  $P = 0.001$ ) and positive symptoms (effect sizes -0.57 (95% CI -0.76 to -0.39) v. -0.08 (95% CI -0.18 to 0.03),  $P < 0.001$ ). Use of a control intervention did not moderate effect size in any of the analyses. There was no consistent evidence of publication bias across different analyses.

**Conclusions**  
Cognitive-behavioural therapy has a therapeutic effect on schizophrenic symptoms in the 'small' range.

**Effect Sizes for CBTp vs Neuroleptics**

Leucht et al pubmedhealth/PMH0057475

**Impact on acute psychotic symptoms**



Wykes T, Steel C, Everitt B, Tarrier N: Cognitive behavior therapy for schizophrenia: effect sizes, clinical models, and methodological rigor. *Schizophr Bull.* 2008;34(3):523-37.

**APA Practice Guidelines**

- 'A number of psychosocial treatments have demonstrated effectiveness. These include...supported employment, assertive community treatment ... and cognitively orientated psychotherapy February 2004
- NICE Guidelines in Great Britain

**Three Models Underlying CBTp**

- 1) **Continuum**  
between psychosis and ordinary mental processes
- 2) **Stress \ vulnerability**  
model of the etiology of psychosis
- 3) **A-B-C**  
cognitive model of delusion formation

**The Continuum- John Strauss MD**

"This view stresses the notion that schizophrenia and the symptoms that characterize it are understandable exaggerations of normal function and not exotic symptoms superimposed on the personality. When the distortion and exaggeration reach a certain level of eccentricity or begin to impair social function they are called symptoms."

Strauss, J.S. Hallucinations and delusions as points on continua function. *Archives of General Psychiatry*, 20:581-586, 1969.

**The Continuum**

- **reasoning**  
cognitive biases
- **perceptions**  
hallucinations of everyday life
- **beliefs**  
superstitions\idiosyncratic beliefs

### The Capacity for Logic is Preserved

Delusional patients perform as well as 'normals' in formal tests of syllogistic reasoning.

Kemp et al. Reasoning and Delusions. Brit J of Psychiatry, 170:398-405, 1997

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### Judging Probabilities

Kemp et al. Reasoning and Delusions. Brit J of Psychiatry, 170:398-405, 1997

Bill is 34 years old. He is intelligent but unimaginative and compulsive. At school he was good at mathematics but weak in social studies and the arts. Bill most likely....

- (a) plays jazz for a hobby
- (b) is a ballet dancer
- (c) is an accountant who plays jazz for a hobby

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### Judging Probabilities

Kemp et al. Reasoning and Delusions. Brit J of Psychiatry, 170:398-405, 1997

Bill is 34 years old. He is intelligent but unimaginative, compulsive, and generally lifeless. At school he was good at mathematics but weak in social studies and the arts. Bill....

- (a) plays jazz for a hobby
- (b) is a ballet dancer
- (c) is an accountant who plays jazz for a hobby

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### Conjunction Fallacy

All people who play jazz for a hobby

The larger set of people who play jazz for a hobby contains the smaller set of jazz players who are also accountants. Therefore, answer (a) is most probable.

jazz players who are also accountants

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### Prior Beliefs Effect 'Evidence'

Lord et al. Biased Assimilation. J of Per and Soc Psychol, 11:2098-2109, 1979

Beliefs about capital punishment as a deterrent to murder.  
24 students pro / 24 con

pro or con with two different designs: (before and after capital punishment) and (neighboring states with and without)

Brief Card - Full Critique - Rebuttal Card - Full Critique

**RESULTS:** Subjects accepted evidence consistent with their prior belief and rejected rebuttal.

**23%** felt even more strongly convinced of the truth of their initial belief after reviewing data contrary to their initial belief.

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### Common Cognitive Biases In Psychosis and Ordinary Mental Life

- Confirmation bias
- Jumping to conclusions
- Self referential thinking

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## Beliefs In The General Population

60,000 British adults in a 1989 Gallup poll

- 68% God
- 50% thought transference
- 50% the future can be predicted
- 25% ghosts
- 25% reincarnation
- 23% horoscopes
- 21% the Devil is real
- 10% Black Magic

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## Beliefs In The General Population

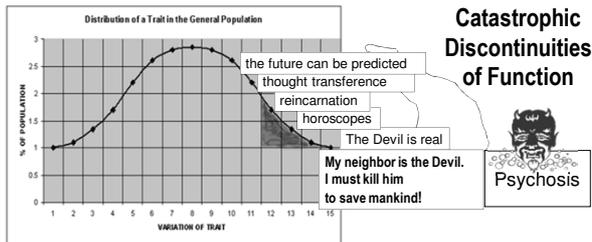
- 68% God
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- 10% Black Magic

60,000 British adults in a 1989 Gallup poll

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## Psychosis Lies At One Extreme of a Continuum



### Catastrophic Discontinuities of Function

Claridge, G. 'The Schizophrenias as Nervous Types' Revisited. *British Journal of Psychiatry*, 515:735-743, 1967

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## Hallucinations in a Community Sample

375 'normal' college students in a psychology class

- Questionnaire with 14 types of auditory hallucinations

"Almost every morning while I do my housework, I have a pleasant conversation with my dead grandmother. I talk to her, and quite regularly hear her voice actually aloud.....Anything similar happen to you?" **5%**

Posey, T. and Losch, ME. Auditory hallucinations of hearing voices in 375 normal subjects. *Imagination, Cognition, and Personality*. 2:99-113, 1983

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## The Relationship of Auditory Hallucinations to Ordinary Mental Life

### Leudar et al. What voices can do with words: pragmatics of verbal hallucinations. *Psychological Medicine*. 1997

- voices are rarely bizarre  
typically aligned with family members
- voices have stable individual identities conferred by:
  - quality of voice
  - gender
  - accent
  - knowledge and ignorance
  - verbal style
  - analogy to known people

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### Voices Do Four Things Leudar (1997)

- Issue Directives
- Evaluate the Person
- Engage in Questions and Answers
- Convey Information

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### Issue Directives

- mostly relating to mundane daily activities
- the person can cognitively mediate most directives
- during preparation for activity, voice suggests action

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### Issue Evaluatives

68% reported abusive voices  
25% approving

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### Questions and Answers

- 50% reported 'voices' asking questions
- patients engaged in back and forth dialogues with their 'voices'
- all but a few patients reported getting answers to their questions

Plato-"Thinking is having conversation with our own mind."

76

### Provides Information

- typically something known to the voice hearer, but out of mind
- 47% heard 'voices' telling them something they thought they didn't already know
- predictions of the consequences of the voice hearer's actions
- occasional accurate predictions of the future

77

### Daalman, Marco, Boks et al. The Same or Different? A Phenomenological Comparison of Auditory Verbal Hallucinations in Healthy and Psychotic Individuals *J Clinical Psychiatry* 72(3), 320-325, 2011

Auditory hallucinations in 118 psychotic outpatients compared with 111 normal controls.

'Voices' were similar in all regards, except healthy subjects had ...

- earlier onset (12 vs 21 years old),
- more positive emotional valence toward the voices
- more control over the voices
- voices occurred less frequently

78

## Hallucinations in Ordinary Mental Life

- Hypnagogic hallucinations
- Sensory deprivation states
- Hallucinations of everyday life
  - Hearing your name called on the street (64%)
  - The crying baby is asleep
  - Grieving spouses (50% hear or see the deceased)
  - Example: flowers at a funeral
  - Did the phone ring, or did I imagine it?

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## 'Voices' Are a Form of Inner Dialogue

Do you ever 'talk to yourself'?  
When you do, what do you say?

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## 'Voices' Are a Form of Inner Dialogue

"Just do it!"  
"Who are you kidding?"  
"Not bad!"  
"You idiot!"  
"What are you doing?"  
"I could fly or take the train."

One part of the mind stands in relationship to another part of the mind as a speaker to a listener.

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## 'Voices' Are a Form of Inner Dialogue

"Just do it!"	<b>Directive</b>
"Who are you kidding?"	<b>Q&amp;A \ Evaluative</b>
"Not bad!"	<b>Evaluative</b>
"You idiot!"	<b>Evaluative</b>
"What are you doing?"	<b>Q&amp;A \ Evaluative</b>
"I could fly or take the train."	<b>Information</b>

One part of the mind stands in relationship to another part of the mind as a speaker to a listener.

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## Auditory Hallucinations and Inner Speech

- **Inner speech**  
is the 'speaker system' through which thoughts are played and listened to by the self.
- **Count from 1 to 10 silently**  
One part of the mind articulates the numbers while another part of the mind perceives them.

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## The Developmental Origins of Inner Speech

### L.S. Vygotsky

- Every mental function appears twice in development, first interpersonally, then intra psychically.
- The mind contains speaker-listener dyads, which operate as points of internal dialogue between parts of the mind and the self.

**Fernyhough (2004)** Alien voices and inner dialogue: towards a developmental account of auditory verbal hallucinations. *New Ideas in Psychology* 22:49-68

84

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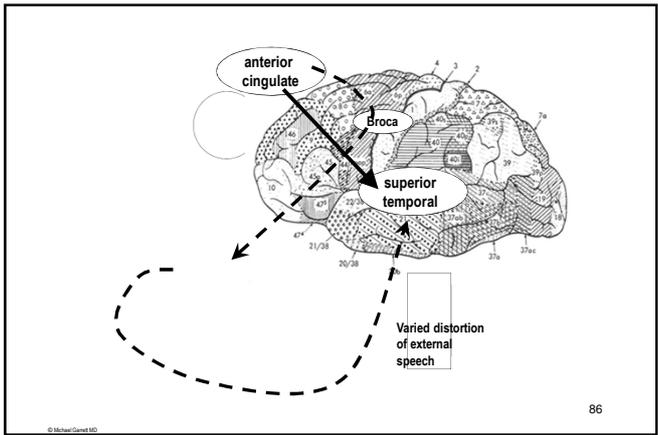
### L.S. Vygotsky and Inner Speech

<b>condensed inner speech</b>	thinking in meanings ↳ abbreviated syntax ↳ predominance of words with personal meanings over conventional meaning, including hybrid words with complex subject-specific meanings	pre-conscious unconscious
<b>expanded inner speech</b>	internal dialogue with self	2 dimensional percept-like
<b>private speech</b>	external dialogue with self	3 dimensional auditory perception
<b>external speech</b>	external dialogue with others	3 dimensional auditory perception

**'voices'**

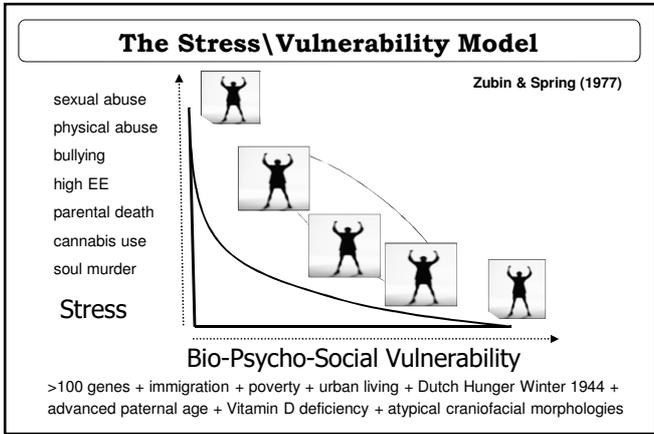
**normal development**

85



- ### Conclusions so far ...
- psychotic people can think logically
  - ordinary people think irrationally
  - people not otherwise mentally ill share a range of beliefs, perceptions, and cognitive biases with psychotic patients
- 87

- ### Implications of the Continuum For the Doctor-Patient Relationship
- Everyone, including the clinician, has a bit of what the patient has. The doctor relates the patient's experiences to his own experiences, and at times may be self disclosing.
  - The power relationship between doctor and patient shifts to a more equal footing.
  - When stigma is reduced, the possibilities for meaningful psychotherapy are greatly enhanced.
- 88



- ### The Stress\ Vulnerability Model
- Instead of 'You have an incurable brain disease called *schizophrenia*' which sets you apart from the human community ...'
  - 'You have a biological and/or psychological vulnerability to stress which can lead to disturbing experiences (psychotic symptoms) which lie along a continuum with the experiences of ordinary people. You have never left the human community.'
- 90

**10** min

break

2:45-2:55 PM

91

## A Cognitive Model of the 'Positive' Symptoms' of Psychosis

Garety et al, A cognitive model of the positive symptoms of psychosis. *Psychological Medicine* 31:189-195 (2001)

92

### A Cognitive Model of Delusion Formation

**Triggering event in a biologically, psychologically, socially predisposed person** → **Anomalous experiences** → **Meta-cognitive judgment: Is it inside or outside me? Outside the Self DELUSION FORMATION** → **Belief maintenances: safety behaviors**

hallucinations  
 ideas of reference  
 thought insertion

1. Cognitive biases  
 2. Dopaminergic hypersalience  
 3. Psychological processes-splitting and projection

Garety et al, A cognitive model of the positive symptoms of psychosis. *Psychological Medicine* 31:189-195 (2001)  
93

### The A-B-C Cognitive Model

**A** (activating event) → **B** (beliefs) → **C** (Consequence Emotional / Behavioral)

hallucinations, ideas of reference, thought insertion, thought blocking → meta-cognitive judgment "These events arise outside me." → anxiety, depression, assault, suicide

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### The A-B-C Cognitive Model

Start with the 'C'  
Where is the patient's distress?

**A** → **B** → **C** (Consequence Emotional / Behavioral)

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### Clinical Principles of CBTp

Therapist and patient use logical reasoning to:

- ...jointly investigate
- ...alternative explanations of the patient's experience
- ...by weighing evidence for and against different theories
- ...to reduce distress by changing beliefs about the person's experiences

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### Clinical Example

Ms. A – who believed she was being monitored and pursued by administrators at her college

### Ms. A

- 32 y.o. Jamaican female
- Paranoid break in college. Partial recovery. Recurrent florid psychosis age 29 after her mother's death, followed by homelessness.
- Multiple delusions and auditory hallucinations
- Assisted Outpatient Treatment (AOT)
- Auditory hallucinations resistant to medication—partial response to Abilify 70 mg

### Dissolution of a Delusional Memory

"I don't think I remembered that correctly."

How big was the tree? What type of rope did they use?

Vivid MEMORIES can be mistaken!

This is a MEMORY not a FACT

They almost hung my mother because of me.

The 'voices' went away with medication. – I have a mental illness.

Is it possible you have other distorted memories? ....



### Other Distorted Memories

- Audiotapes of me were being played all over campus, and then in New York.
- They planted a tracking device in my vagina.
- I remember my step-father raping my father.
- My mother was the victim of a homosexual rape.

### Working with 'Voices'

She had two types of 'voices'....

#### 1. A mundane, contradictory 'voice'

The patient thinks: "Jerry in my program is a nice guy."

The 'voice' says "No he isn't!"

...CBTp intervention...

"It (the voice) sounds like a little kid on the playground saying, 'I know you are but what am I.'"

### Working with 'Voices'

#### 2. Accusatory 'voices'

"Your mother is a lesbian!" "You are a child molester!"

...CBTp intervention...

"You are sitting in the last row of the theater. You probably have to pay *some* attention to the 'voices', but they are way up there on the screen, far away. You don't talk back to the actors on the movie screen. You really don't need to engage with the voices either."

## CBTp Course of Treatment

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## Psychotherapy for Psychosis CBTp in a Psychoanalytic Frame

- This approach useful for many, but not all patients.
- Comprehensive treatment plan should include many other bio-psycho-social elements in addition to individual therapy.
- CBTp first, then PDPTp, according to the patient's wishes and capacities.

■ Garrett, M. & Turkington, D. (2010) Cognitive Behavioral Therapy in a Psychoanalytic Frame. *Psychosis* 2(1) pgs 2-13

104

## CBTp Course of Treatment

25 sessions

- Engaging the Patient
  - Timeline
  - Introduce Treatment Coping strategies
  - Review the 3 models
  - Apply the models to the patient's experiences
  - Challenge and reformulate
  - Maintenance and booster
- 3-4 sessions
  - 2-3 sessions
  - 2-3 sessions
  - 2-3 sessions
  - 5-7 sessions
  - 4-5 sessions
  - PRN

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## CBTp Course of Treatment

### 1) Engaging the Patient

- Many patients are eager to have a good faith conversation with a mental health professional who will take a genuine interest in their story, but many are anxious or suspicious.

**The therapist must be relaxed, open, familiar, genuine, and transparent rather than neutral, remote, and impersonal.**

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## *In Never Promised You a Rose Garden* JG

### The Therapist Must Be Authentic

"The struggle between the Nose, Hobbs's Leviathan, and the patients went on. His rigid fundamentalist beliefs made him see insanity as a just desert for its victims, as God's vengeance, or as the devil's work, and sometimes as all three at once. As the days passed, his fear waned and the time of his righteous wrath was at hand. He saw that he was suffering persecution for his faith." "Against his loathing, the sick fought in their sick way. The literate rewrote the Bible or ridiculed its passages to make him horrified. Constantia made flagrant sexual advances to him. Helene took the towel he brought her with a little curtsy, saying, "From Paraclete to Paranoid. Amen, amen." And Deborah made a few pointed observations about the similarity between psychotics and religious fanatics." pg 92

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## CBTp Course of Treatment

- How did the patient come to be referred? Was it the patient's idea, or someone else's? What is the patient's understanding of the purpose of the meeting? Any specific anxieties about the meeting.
- Less specific introductions. "If it is OK with you, we can meet a few times and talk through what has been happening to you to see if there is some way to think about your situation that makes it less distressing." OR
- More specific. "You were referred to me because I am trained in a particular approach to helping people called 'cognitive therapy.' It is a way to think about person's situation in an effort to help a person deal with distressing experiences."
- Does the patient have an immediate, overriding concern that must be addressed before the patient can focus on the therapy, e.g. need for concrete services?

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### CBTp Course of Treatment

- Inquire about prior interactions with the mental health system, which may have been toxic/traumatic. Address confidentiality.
- Allow the patient a 'Panic Button' if he gets anxious to not talk about issues that make him too uncomfortable. Ask, 'How are we doing so far?'
- Be aware, the patient may believe he is putting himself at great risk by even talking with the therapist.
- Go slowly, testing the waters. If the patient is reluctant to talk about his symptoms, find something else the patient is willing to discuss.
- 'NORMALIZE' psychotic symptoms. Level the playing field in the doctor-patient relationship.

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### CBTp Course of Treatment

#### 2) Elicit the patient's story. Timeline and Initial Assessment

- What is the patient's personal narrative, the patient's formulation of events?
- What does the patient think is happening, and why?
- What evidence does the patient have for his beliefs?
- One (or a few) seminal events?
- Repeated events, accumulating evidence (ideas of reference)?
- Patient's actions create a social reality in keeping with his expectations, e.g. avoiding others leads others to avoid the patient

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### CBTp Course of Treatment

- Are there any aspects of the patient's story the patient finds confusing, or about which he already has doubts?

#### psychotherapy gold

- Rate the degree of preoccupation with the belief, on a 1-100 scale
- Rate the degree of conviction about the belief, on a 1-100 scale (be careful not to challenge the patient)

111

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### CBTp Course of Treatment

- What about the patient's current situation does the patient find most distressing?
- Empathize with the patient's belief and feelings from the patient's point of view
- "Having heard what you went through, I can see why you came to the conclusions you did. When you first started paying attention to people in your neighborhood looking at you, you came to believe that you were under surveillance."
- Aim to convey to the patient that he has been understood.
- What do other people think about the patient's belief? What do family members say? Does anyone share the patient's point of view?

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### CBTp Course of Treatment

- Expand the **TIME LINE**
- Write down history along a horizontal line drawn on a piece of paper. This grounds the history in a visual linear time sequence and helps to stabilize the content of the history so it can be examined and links established, e.g. X followed Y.
- It prepares the way for a 'stress-vulnerability' formulation. "You were under stress. Then you experienced X"
- Gets the patient used to working on paper. Prelude to patient education, homework, and assessment instruments
- Any history of physical or sexual abuse, bullying, early loss, or other significant trauma. When relevant, reference the literature showing a high incidence of 'voices' in people with trauma.
- History of substance abuse

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### CBTp Course of Treatment

#### Assessment of voices

- Identity
- Purpose
- Power relationship to the patient
- Consequences of compliance/non-compliance
- Omniscience

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## CBTp Course of Treatment

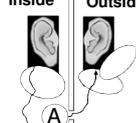
### Voices typically do one of four things

- Evaluate the patient
- Issue directives
- Provide information
- Engage in back and forth dialogues

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In your mind      Inside      Outside      In the outside world



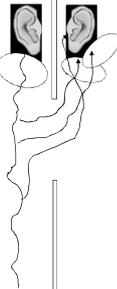
- ALERTS**
- 'Hearing' your name
  - 'Hearing' the telephone
  - 'Hearing' a sleeping baby cry

thoughts

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Inside      Outside



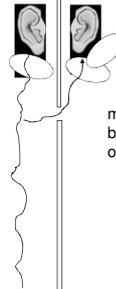
stress opens the window between thoughts and the outside world

thoughts

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Inside      Outside



medication closes the window between the inside ear and the outside ear

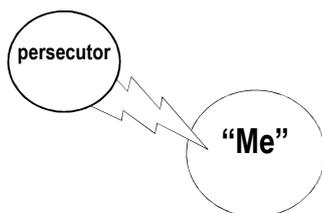
thoughts

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## CBTp Course of Treatment

### Identify persecutors - a core psychodynamic



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## CBTp Course of Treatment

- **When did the diagnosis of 'mental illness' occur as a historical event in the patient's time line.** What is the meaning of 'mental illness' to the patient, in general, and as it applies to him, in particular.
- Assess the secondary impact of psychotic symptoms on social functioning and self esteem. Screen for depression. Ask about periods of despair, hopelessness, and/or suicidal ideation. Assess anxiety.
- Consult collateral sources of information (family, chart, etc)
- Consider a formal assessment of the patient's symptoms with standardized scales, e.g. PSYRATS

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## CBTp Course of Treatment

### 3) Therapist Initial Formulation

- Make an initial formulation of delusions and hallucinations in the A-B-C format (to share with the patient later in treatment).
- Three types of formulation, which may or may not be combined, depending on the patient's capacity to grasp the formulation
  1. Stress/vulnerability – e.g. you tend to hear voices when you are under stress and haven't slept
  2. Cognitive bias  
Jumping to conclusions  
Self referential thinking
  3. Integrated bio/psychosocial – varying complexity  
Psychodynamic account of the psychotic symptoms

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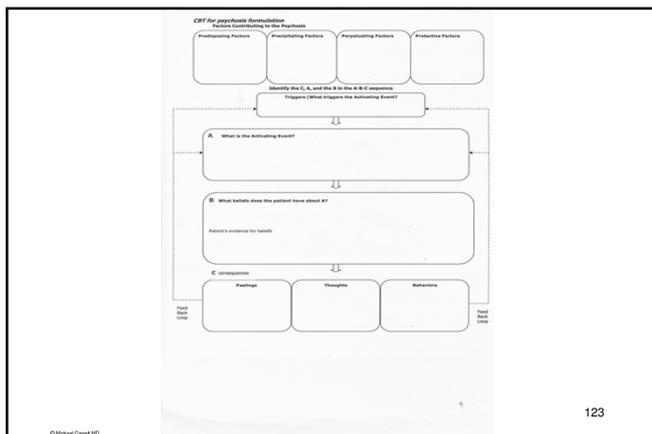
## CBTp Course of Treatment

### In a formulation, consider ...

- Predisposing factors (vulnerabilities)
- Precipitating factors – precipitating events provide clues to the nature of the stress leading up to the psychosis. Traumatic events. Abuse, loss, death of a family member, abandonment, divorce.
- Perpetuating factors. Social circumstances that make recovery more difficult. Family environment high EE. Safety behaviors.
- Factors contributing to relapse. Triggers, e.g. what external time, place, social context, or internal mental states tend to 'bring on' symptoms. Substance abuse.
- Protective factors (strengths): What strengths does the patient possess which may aid in recovery? Do not hesitate to describe perceived strengths to the patient, e.g. "It is clear you were trying to do the right thing when all this started." Or, "You seem to me to be a thoughtful person."
- Fill out formulation diagram (revise as you go along)

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## CBTp Course of Treatment

- Summarize to the patient the history as you understand it, with minimal causal connections, empathizing with what is most distressing to the patient in his story.
- "Your first hospitalization seemed to have occurred right after your mother's death. That was clearly a terribly stressful period in your life."

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## Overview of Day 2

8:30 AM

### Day 2 morning

- CBTp Technique and Course of Treatment (continued)
- Clinical example 2: the woman who believed she had a terrible smell

### Day 2 afternoon

- Clinical example 3: the man who murdered his parents
- Clinical example 4: the man who heard the 'voice' of PsychoGirl
- Clinical example 5: the woman whose 'voices' predicted death
- Live interview/audience case presentations
- Planning group supervision for on-going work

4:30 PM

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## CBTp Course of Treatment

### 4) Introduce Treatment: Initially Focus on Coping Strategies

- Begin to formulate general goals for treatment with the patient, focusing on the patient's distress. The basic goal of CBTp is to reduce distress by changing beliefs.

#### Goals might include:

- Increased understanding of and insight into the psychotic experience
- Improved coping with residual symptoms
- Reduction in distress associated with delusions and hallucinations
- Maintaining gains and prevention of relapse

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## CBTp Course of Treatment

- Examine the patient's current coping mechanisms. If a patient indicates he has abandoned any effort to cope, this may indicate despondency and suicidality
- Attempt to strengthen coping techniques. Introduce techniques other people use. This gives the implicit message that what is happening to the patient is happening to others. The patient is not alone.
- Coping cards
- Coping with hyper-arousal - relaxation techniques
- Redirecting attention: switching or narrowing the focus of attention

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## CBTp Course of Treatment

Begin explaining how CBT works.

- "I hope the therapy we will be doing together will add some benefit to what you are already doing to cope with your distress. Let me give you a little background information about cognitive therapy."
- CBT for psychosis relies on three basic models,
  - the stress/vulnerability model of psychosis
  - the continuum between psychosis and ordinary mental life
  - A-B-C cognitive model.

The therapist needs to be fluent in each of these models.

- Have in mind examples from your own experience to illustrate all 3 models

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## CBTp Course of Treatment

- Start by discussing the stress/vulnerability model. When you are explaining your ideas to the patient, avoid appearing the expert teacher lecturing the student about complex ideas. Be aware that many patients may have failed in school.
- One might say, "Everyone experiences stress at some point in their life. Stress can result in upsetting worries, depression, lack of sleep. I have certainly felt the effects of stress myself. If I understand you correctly, what is most distressing in your current situation is .... (be specific). I hope I can help in some way to reduce that distress."
- Be open, relaxed, conversational, professional, but informal.

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## CBTp Course of Treatment

### 5) Introduce the A-B-C model

- **A** event → **B** belief → **C** emotional consequence
- It is the patient's belief about A rather than *A per se* that is the source of distress.
- 'Normalize' the stress/vulnerability and A-B-C models in a simple example from personal experience.

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## CBTp Course of Treatment

### 5) Introduce the A-B-C model

- "I remember on my old job, a new boss had just come in. I got a message he wanted to talk to me right away. The message stressed me out. I thought maybe I had done something wrong. I was nervous when I called him back. It turned out it wasn't what I had expected! He had some visitors coming to town and he wanted me show them around. I jumped to a stressful conclusion, but it turned out my belief was not right. In cognitive therapy we think about beliefs in the A-B-C way. A is an event that happens. B is a belief you have about the event. C is the reaction you have to that belief. In my case the A was the phone message, the B was my belief that my boss was upset with me, and the C was I was anxious and worried. Has anything like this ever happened to you, where you thought something at first, then later realize you had jumped to a conclusion?"

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## CBTp Course of Treatment

"A lot of your distress comes from the beliefs you have about the meaning of your experiences. If there are other ways to explain what has been happening to you, then you may have been suffering needlessly. It is in your interest for us to work together to see if there are any other ways to understand what has been going on."

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### CBTp Course of Treatment

- Use the ABC model to analyze a relatively neutral event in the patient's life, or a hypothetical event. This gives the patient and therapist practice using the A-B-C model. Do not preach or be overly academic or abstract. Patients may feel inferior to the therapist as teacher and authority figure.

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### CBTp Course of Treatment

- Invite the patient to examine a distressing A activating event the patient would like to look at in more detail, using the A-B-C model. If the patient cannot start, you might start with an A-B-C sequence where the patient has already expressed some doubt or confusion about the event.
- Do an A-B-C analysis of this event, keeping the distressing aspect of the event in focus.

**Remember: no distressing 'C,' no treatment**

- The patient's distress motivates the treatment.

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### CBTp Course of Treatment

- Clarify the **A**. What precisely did the patient experience? What precisely did the patient hear? The patient may have actually only experienced a muffled sound, but later concluded it was a 'threat.' An '**A**' may be a mental event, like a voice or idea of reference, or it may be an event in the external world.
- Patients often merge A-B, leading to C. Attempt to separate A and B, and to quantify As, Bs, and Cs.

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### CBTp Course of Treatment

- As you start to apply the A-B-C model to the patient's core psychotic experiences, continue to 'normalize' symptoms.
- There is a continuum of beliefs and perceptions in the general population
- Cautious self disclosure – describe an analogy to a delusional or hallucinatory experience you have had.
- "People sometimes have unusual or upsetting experiences in response to stress. It has occasionally happened to me. I would be interested in learning more about the experiences you have had."
- Does the patient's response to the symptom tend to maintain it, e.g. avoidance/social withdrawal precludes the patient having any new experiences which provide evidence opposed to their delusional belief

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### CBTp Course of Treatment

Reiterate the patient's A-B-C sequence.

- "You experienced A. Your belief about A was B. This led to your feeling/doing C. From what you have told me, I can understand why you came to belief B, and if your explanation for A is correct, your reaction is quite understandable. Your belief/explanation B leads to distress. But if there are other possible explanations for A besides B, explanations that are less distressing, it would be important for us to discover them. Let's look at the evidence together, and see what we find."

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### CBTp Course of Treatment

- Use the A-B-C model to examine beliefs and evidence. Try to get two columns down on a piece of paper, to examine alternative beliefs.

<b>Delusional Belief</b>
Evidence 1
Evidence 2

<b>Alternate Belief</b>
Evidence 1
Evidence 2

"Let's look at the evidence together."

Joint investigators. Watson and Crick not Freud and Dora. 'Columbo style'

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### CBTp Course of Treatment

Try to understand the  
 'evidentiary chain'  
 which supports the delusion in the patient's mind

- The capacity for logical thinking is preserved
- If the therapist understands the logical sequence which led to the delusional idea, the therapist is better able to change the delusional belief

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### 'Bayesian' Equation for Beliefs

$$\text{Probability belief B is true} = \frac{\text{Information Value of Event D for B being true}}{1} \times \frac{\text{Probability B is true in light of past experience}}{2}$$

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### 'Bayesian' Equation for Beliefs

trauma

ideas of reference  
hypersalience

$$\text{Probability belief B is true} = \frac{\text{Information Value of Event D for B being true}}{1} \times \frac{\text{Probability B is true in light of post psychotic experience}}{2a} \times \frac{\text{P true past experience}}{\text{P false past experience}} \times \frac{\text{P false past experience}}{\text{P true past experience}} \times \frac{\text{P false past experience}}{\text{P true past experience}}$$

1                      2a                      2b

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### 'Bayesian' Equation for Beliefs

$$\text{Probability belief B is true} = \frac{\text{Information Value of Event D B true}}{\text{Information Value of Event D for B being false}} \times \frac{\text{Probability B is true in light of post psychotic experience}}{\text{P false post psychotic experience}} \times \frac{\text{P true past experience}}{\text{Probability B is false in light of past experience}}$$

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### CBTp Course of Treatment

- Investigate beliefs and evidence with the CBT 'tool box' of specific techniques.
- Triggers or settings in which 'A' tends to occur
- When does 'A' tend not to occur?
- Can the patient do anything that increases or decreases the symptom? Control implies empowerment. Control locates the causal locus within the self.

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### CBTp Course of Treatment

- Agreeing to disagree about alternate explanations. Avoid a vote. "Let's see how it turns out in the end."
- Peripheral questioning "Let's go into the details of what actually happened."
- Rating the likelihood of beliefs
- Rating the value of particular evidence
- Informational handouts – increasing real world knowledge

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### CBTp Course of Treatment

- Inference chaining “If that turned out to be true, what would that mean to you?”
- Reality testing experiments - must be carefully designed
- Homework assignments, e.g. voice hearing diaries
- Challenge the power relationship with the ‘voices’

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### CBTp Course of Treatment

#### Building self esteem

- *Self esteem intervention:* Patient lists two positive qualities. Patient rates confidence he possess these qualities. Generate examples. Rehearse autobiographical memories.
- Keep a dairy during the week. Re-rate in the next session. Reinforce positive qualities.

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### CBTp Course of Treatment

#### Reformulate the Patient’s Story, and Challenge Beliefs

- “Normalize.” Offer an enriched stress/vulnerability, cognitive, or bio/psycho/social formulation, an alternate belief, which can play a more adaptive role in the patient’s recovery. Making connections between past events and current symptoms can diffuse the present implications of the psychotic symptom, e.g. the ‘voice’ is a flashback to a past experience of abuse
- “Stress led you to believe B, and you had good reasons for believing B at the time, but we can now see that there are alternate explanations of A.” Offer a new formulation.

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### CBTp Course of Treatment

- Stress/vulnerability: “Your mother’s death was very stressful for you. You weren’t sleeping well, and were using drugs to ease the pain. In that totally stressed out state you had some disturbing experiences, like thinking your neighbor was trying to poison you. We can now see that those experiences and beliefs were the result of the upset state of mind you were in at the time.”
- Cognitive bias: “You have a cognitive bias where you tend to jump to the conclusion that people know you and want to hurt you.” “You tend to personalize events, believing people are referring to you when they are not.”

#### Catch It – Check It – Change It

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### Bio-psycho-social formulation

- “You felt if you had set a better example for your brother, he might not have died so young. You felt guilty, and when you couldn’t get your life going after you came back from the Navy, you felt ashamed. You criticized yourself. You didn’t feel you were a man. Over the years those feelings of guilt and shame built up, and you came to feel that shame everywhere you went, including when a dog was looking at you. You gave up, and stopped going outside.”



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### In Never Promised You a Rose Garden JG

- “Now I turn detective,” she said, “and I tell you that your story stinks to heaven! A five-year-old lifts up a heavy baby, carries it to the window, holds it on the sill with her own body while she opens the window and practices leaning out, lifts the baby out over the sill, and holds it at arm’s length out the window ready to drop it. Mother comes in and in a flash of speed this five-year-old whips the child inside where it starts to cry so that the mother takes it—” “No—by that time it was back in the bassinet.” “Most interesting,” Furi said. “Now, am I crazy or did you make that story up when you were five years old and walked in and saw that baby lying there and hated it enough to want to kill it?” “But I remember ...” “You may remember hating, but the facts are against you! What did your mother say when she came in? Was it: ...Put that baby down! or ...Don’t hurt the baby!” “No, I remember clearly. She said, ...What are you doing here?” and I remember that the baby was crying then.” “What astonishes me about this whole business is that I was so busy listening to the emotional content—the hatred and the pain—that I lost the facts and they had to shout at me again and again before I could hear them.”

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### ***In Never Promised You a Rose Garden JG***

"The hatred was real, Deborah, and the pain also, but you were just not big enough to do any of the things you remember doing, and the shame you say your parents felt all these years was only your guilt at wishing your sister dead. With the false idea of your own power (an idea, by the way, that your sickness has kept you from ever growing out of), you translated those thoughts into a memory." "It might as well have been real; I lived with it for all those years as if it were real." "Yes, that's true," Furi said smiling, "but no longer will you be able to flagellate yourself with that particular stick. Our would-be murderess is no more than a jealous five-year-old looking into the cradle of the interloper." "Bassinnet," Deborah said. "Those ones on legs? My God, you couldn't even reach into it then. I turn in my detective badge tomorrow!" Deborah was back in the room being five again and standing with her father for a view of the new baby. Her eyes were on the level of the knuckles of his hand, and because of the ruffles on the bassinet she had to stand on her toes to peep over the edge. "I didn't even touch her ..." she said absently. "I didn't even touch her..." pg 219

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### **CBTp Course of Treatment**

'Normalize' a 'bio\psycho\social formulation of 'voices'

"There is a window in the mind in all of us between our thoughts and the outside world which is always open just a crack. Under conditions of stress that window opens wide, and our thoughts go out through the window and come back to us as though we are hearing them just like we hear people talking. Medication can help close that window."

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### ***In Never Promised You a Rose Garden JG***

"It's nice to walk with Lactamaeon when he is in a good mood. After the sewing class, where I don't belong, or the church choir where I am a stranger, it's good to walk home with someone who can laugh and be silly or turn beautiful and make you cry, looking at the stars while he recites." "You know, don't you, now, that you made him up out of yourself—that you created him out of your own humor and your own beauty?" Furi said gently. "Yes—I know now." It was an admission that gave much pain. "When were you at last able to see this?" "You mean with all my eyes?" Furi nodded. "Well, maybe I always saw it, partly far in the place where it was safe, but I guess it's been getting nearer and nearer to me for a long time. Last week I was laughing secretly with Idat and Anterrabae. They had written a choral setting of a poem by Horace, and when they sang it, I said, That was one of the few texts I know by heart all the way through. And Anterrabae said, Of course! And then we started the kind of banter—the kind you have when you are kidding and hurting someone at the same time. I said, Teach me mathematics, and they laughed, but they admitted at last that they could not go beyond my knowledge. Pg 245

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### **CBTp Course of Treatment**

- CBT, first; psychodynamic interpretation next, according to the patient's needs and abilities
- An inter-personal battle with an externalized danger in the form of a delusion or hallucination becomes an intra-psycho problem, and evolves into a personal narrative which emphasizes the patient's strengths, courage in the face of adversity, self-empowerment, and realistic hopes for recovery in the future.

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### ***In Never Promised You a Rose Garden JG***

"Tell me, do you love your parents?" "Of course I love them." "And your sister, whom you never murdered?" "I love her—I always did." "And your friend Carla?" "I love her, too." She started to cry. "I love you, too, but I haven't forgotten your power, you old mental garbage-collector!" "How does it feel to go about without all that old, stinking garbage?" Deborah felt Anterrabae begin to rumble. Were he, Lactamaeon, Idat, and all the beauties of her many places in Yr to be lumped together with the Pit, the Punishment, the Collect, the Censor, and all the plagues of past reality? "Does it all have to go? Do we pile it up and throw it all out?" "It cannot be a decent bargain now—don't you see?" Furi said. "You have to take the world first, to take it on faith as a complete commitment ... on my word, if no one else's. Then, on what you yourself build of this commitment you can decide whether it's a decent bargain or not..." pg 270

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### ***In Never Promised You a Rose Garden JG***

"How about the shining things? Must I never think about Lactamaeon, so black on his black horse, or Anterrabae, or Idat, now that she keeps her form and is so beautiful? Am I never to think of them again or of the words in Yr that are better than English for certain things?" "The world is big and has much room for wisdom. Why have you never drawn pictures of Anterrabae or the other ones?" "Well, they were secret—you know the laws against mingling the worlds." "Perhaps the time has come to share the good parts, the lovely and wise parts of Yr, with the world. Contributing is building the commitment." pg 270

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## CBTp Course of Treatment

### Assessment of Therapist Adherence to CBTp technique

- Did the therapist set an agenda for the session in collaboration with the patient?
- Did the therapist ask for feedback from the patient?
- Did the therapist show understanding and empathy?
- Was the therapist's interpersonal manner effective, i.e. warm, engaging?
- Did the therapist foster a collaborative alliance?
- Was 'guided discovery' employed?
- Did the therapist focus on key cognitions?
- What the therapist's choice of intervention appropriate?
- Was homework reviewed/given?

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## CBTp Course of Treatment

### Maintenance and Booster Sessions

- Develop a collaborative description with the patient of early signs of relapse.
- Anticipate what to do if early signs occur.
- Practice the patient's response to hypothetical early signs.
- Invite the patient to use PRN sessions to think through events using the A-B-C model.

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## Cautions ...

- Integrating multiple points of view within the treatment team can sometimes be difficult
- Avoid colluding with delusions when 'normalizing' symptoms
- Boundary issues with self-disclosure
- The clinician's 'disingenuous stance' – 'Columbo style'
- That symptoms may have a psychological meaning does not imply that 'schizophrenia' has a purely psychological etiology.

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## In summary ...

- Cognitive-behavioral therapy is a promising addition to pharmacological treatments of psychosis.
- Past failures of psychodynamically oriented psychotherapy for schizophrenia may explain a reluctance to include CBTp and PDPTp in a treatment plan.
- Unlike in Europe, where CBTp is an established modality, CBTp is in the early stages of implementation in the USA.

This training is an effort to foster CBTp.  
You are the very model of a modern psychotherapist!

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15 min

coffee break

10:00-10:15 AM

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Clinical  
Example

Ms. J – who did not leave her home  
because of a delusion she had a bad smell

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### Clinical Model -Psychotherapy for Psychosis

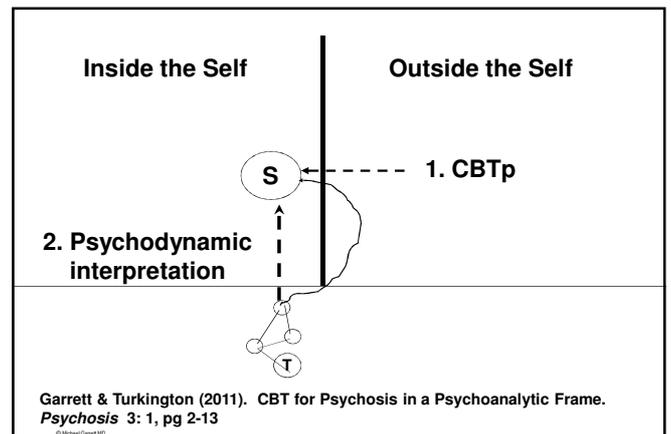
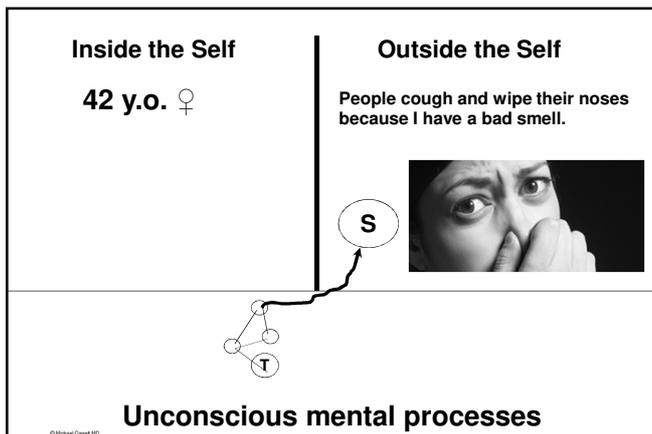
- A person defends against unbearable emotional pain by expressing the pain in an altered perceptual experience of the outside world.
- The problem (the psychotic symptom) now appears located outside the self in the real world
- Phase One – CBT to raise doubts about the patient's maladaptive beliefs
- Phase Two – offer psychodynamic interpretation as an alternate explanation of the psychotic person's experience

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### What Is the Most Important Element in Any Psychotherapy?

1. An affectionate, respectful relationship between the patient and the therapist
2. An affectionate, respectful relationship between the patient and the therapist
3. An affectionate, respectful relationship between the patient and the therapist

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Video testimony

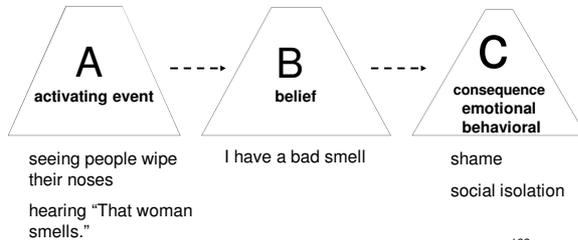
### Session 1

- I closed the window
- Began age 22. Did not mention trauma.
- Evidence
  - 20 years ago a person behind her once said, "That woman smells."
- Explained the A-B-C model

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### Session 1

#### ABC outline of delusional idea



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### Session 1

- Normalized cognitive bias  
chairman story
- Normalized hallucinations  
black dog story
- Homework – think of an ABC → mistaken conclusion

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### Session 2

**Therapist:** Did you have any thoughts about the first session, any thoughts in between? I think there was homework you were going to do?

**Patient:** Yes, I was thinking about, I was thinking about the first session. And, it did help a lot. It get me thinking about the years that I've been isolated and, you know what I should do to get out. The homework was concerning the A-B-C.

**Therapist:** Right. So we went over the A-B-C idea last time. So what did you come up with?

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### Session 2

**Patient:** I came up with one more because I was trying to remember one incident. You know, sometimes I am so isolated that I really don't talk to anyone, my neighbors, or anything. So sometimes when I hear my bell, someone ring my bell, I will just assume that it is someone trying to bother me. So at one time I heard my doorbell. I assumed it was one of my neighbors, you know, playing a prank, or something. And it was the super, the building super.

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### Session 2

**Therapist:** Yes.

**Patient:** So before I knew it was him I went to the door angry and fearful, thinking it was my neighbor, and it was the super instead.

**Therapist:** That's a perfect example of the kind of thinking that we all go through sometimes.

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### Session 2

Therapist: "Have you noticed anything to indicate I am reacting to a bad smell?"

Patient: "Yes, or course! When I came to your office last week you immediately opened the window."

False memory of therapist opening the window

Patient: "I guess I am looking for it."

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### Session 3

#### Assessment of factors contributing to the delusion

1. attention hyper alert to any sniffing
2. refers the sniffing to herself
3. false memories of the behavior of people changing when she arrives – black dog story
4. “That woman smells” We hear what we expect to hear.

#### Alternate explanations of coughing/sneezing

- colds
- allergies
- Behavioral experiment: receptionist 1 was sniffing

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### Session 4

- Behavioral experiment
  - a walk around the hospital
  - no one coughed in the elevator
  - two woman talked about her
- Feeling a little more comfortable going out
  - Wants to plan a trip to visit her cousin
- Homework assignment: timeline of experiences of shyness

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### Session 5

- Time line – shy as a child
- Interest in perfume as an adolescent
- Out of wedlock pregnancy age 22 **trauma revealed**
- Abandoned by father
- Gave birth to her first born child in a public shelter
- Sent the infant away to be raised by her aunt

#### Shaming experiences

- Fear of shameful smell is a ‘cover’ (her word) social anxiety?
- Planning trip to visit her cousin in another state
  - “I would like to see my mother again before she dies.”

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### Session 6

- She revealed a wider range of psychotic symptoms
- Cocaine addict ‘crack head’ neighbors
  - “They follow me when I go out.”

Auditory hallucinations: “They whisper ‘fish, fish’ through the walls.”

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### Session 7

- Planned her plane trip to visit cousin

electronic tickets  
baggage size and weight restrictions

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### Session 8

- Anxious during trip, but a success overall
- Worried that a friend in cousin’s kitchen turned her back because she had a smell
- “Perfume isn’t working anymore!”
- “You have never noticed a smell. Your family, friends, and doctors say you don’t have a smell, yet you remain unconvinced?”
- “People I know don’t want to hurt my feelings. Strangers have no reason to lie.”

#### Behavioral experiment

- Can’t ask strangers on the street to test it out. Call receptionist?
- Patient’s eyes filled with tears.
  - “She answered right away. She didn’t hesitate.”

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### Session 9

- Beginning 'self talk' – 'good' internal objects  
"Maybe he has a cold." "Maybe it isn't about me."
- Detective show - Three levels of evidence  
Clear and convincing evidence  
Preponderance of evidence – 34 friends  
vs 100s of impartial strangers  
Circumstantial
- Dove website

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### Session 10

- She reveals she heard 'fish, fish' on her trip
- 'Voice' 20 years ago  
Some doubts  
"They were behind me."  
"I think that is what I heard."  
black dog story
- Design behavioral experiment with a stranger

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### Session 11

- Behavioral experiment with 'stranger' from the business office

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### Session 12

- Played audio tape of behavioral experiment
- She labeled the tape 'true evidence'

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### Session 13

- Meeting with patient and her son
- He talked about his hurt as a child and adolescent  
"She couldn't come to my high school or college graduation."
- Proud of his mother's hard work in therapy
- The son said, "I love you. There is nothing to forgive."

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### Session 14

- Worked on initial psychodynamic formulation with patient
- Shy person who as a child was already worried about becoming a social outcast
  - She is abandoned by her father,
  - which led her to think of herself as a bad person
  - someone who (metaphorically) 'stinks' as a person
  - a social outcast as an adult

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### Session 15

- Understood role of shyness
- Could not understand father rejection → smell  
"I have always been careful about my hygiene."
- Metaphor – 'food for thought'  
'That situation stinks.' 'I stink as a person.'
- A crack addict says, "It's not true. She doesn't have a smell." more 'good objects'!

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### Session 16 – waking from a bad dream

- We see a dream image *after* our mind has made it, but we can't see our mind *while* it is making the image
- 20 years ago you were in so much pain your mind looked for an image which could express how badly you felt about yourself, but you couldn't see your mind finding the smell image.
- You are finally waking from a nightmare

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### Session 16

age 22 - trauma of pregnancy

now - IF I had a bad smell

#### How other people felt

My father was disappointed in me.

Family thought I was a failure. I threw away my opportunity.

Family pulled away.

#### How I felt

I was disappointed with myself

Ashamed I let my mother down.

Alone. No one on my side.

Confused

Low self esteem

#### How other people would feel

She has bad personal hygiene.

She is a nasty woman.

People would pull away.

#### How I would feel

Embarrassed. Ashamed

Disappointed with myself. I failed.

Alone. No one on my side.

Confusion and anxiety

Social isolation

Low self esteem

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### Session 16 – waking from a bad dream

**Therapist:** I think the feeling you had twenty years ago with your pregnancy and your rejection by your family, the social isolation, your father not wanting you in the house, that got translated into the smell idea, the idea that people don't want to be with you because you because you had a bad smell. So the feeling got carried over from the past into what you were seeing and hearing around you all these years. As you went outside you weren't seeing your father expressing his disapproval, but it was like everyone's face in the general public was expressing the same rejection you experienced from your father. The feeling was deep inside you that you had been rejected by somebody who is very important to you. I think the smell idea carried forward these feelings from that time on.

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### Session 16 – waking from a bad dream

So, I'm going to make a connection between these things, these feelings when you were in your 20s and these feelings you have had for 20 years. It's connected through the smell idea. (At this point I added a box linking the two columns at the top of the page, and wrote in 'smell idea'.) The fear that you had a bad smell continued the same feelings you had when you were in your 20s. These feelings didn't go away. They just went underground and moved over and got expressed through the smell idea. Your belief that your family didn't want you around became your belief that strangers didn't want you around because of a smell.

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smell idea

age 22 - trauma of pregnancy | now - IF I had a bad smell

#### How other people felt

My father was disappointed in me.

Family thought I was a failure. I threw away my opportunity.

Family pulled away.

#### How I felt

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She is a nasty woman.

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Embarrassed. Ashamed

Disappointed with myself. I failed.

Alone. No one on my side.

Confusion and anxiety

Social isolation

Low self esteem

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### Session 16 – waking from a bad dream

Patient: Hummmm. I am trying to understand it.  
Therapist: Would you say there are similarities between the way you felt in your 20s and the way you have felt about the smell?  
Patient: Yes there are. A lot of similarities. And I know that during that time I had low self-esteem, which I have now. So all of that played into what happened. My not having confidence. ...so I'm beginning to see something now.

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### Session 16 – waking from a bad dream

Therapist: What I think has been difficult to understand, which is not surprising, because it's very hard to see it, is how did all these feelings which are so similar to how you felt here, how did those feelings get changed into the smell idea? I think today the main message is to try to show you the way you felt during that painful period when you were pregnant is very similar to the way you have felt over the years. In the beginning, it was your father's rejection. Late, it seemed like everyone was rejecting you because of your smell.  
Patient: Yes  
Therapist: You didn't have the smell problem when you were 18. It came after the pregnancy.

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### Session 16 – waking from a bad dream

Patient: Yes. So it would have to be the result of being pregnant, right?  
Therapist: Yes. And we were talking last time about metaphors and ways of talking about things. Like when we say "that situation stinks" or "I stink as a person" or something like that. So I think what happened here is your negative sense of yourself, your negative self-esteem, it was expressed in the idea that people don't like me, that people are having a negative reaction to me.  
Patient: Yes  
Therapist: The idea, "I stink as a person because I didn't handle myself very well." So all of those negative feelings about yourself came together in the feeling of the bad smell. Do you follow me so far?

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### Session 16 – waking from a bad dream

Patient: Yes  
Therapist: Let's go back to thinking about how your negative self-esteem got changed into the smell. I assume you have dreams from time to time?  
Patient: Yeah  
Therapist: Sometimes when we have a dream we wake up in the morning and we think we know what the dream was about. Has that ever happened to you?  
Patient: Yes it has. It's hard to remember. But sometimes I dream about the last thing I was thinking about. Maybe the last show I saw on TV. It will come in my dream.

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### Session 16 – waking from a bad dream

Therapist: All right. Let's look at that.. When you have a dream that was a result of a show that you saw, the dream isn't exactly like the TV program, right? Maybe the dream has a character from the show ...  
Patient: Yeah  
Therapist: It's not exactly the same as the dream.  
Patient: It's not exactly the same.  
Therapist: So the dreaming changes the show a bit.  
Patient: Yes  
Therapist: And when you dream do you have visual experiences or you hear things or both  
Patient: Both

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### Session 16 – waking from a bad dream

Therapist: We all have dreams. My dreams are mostly visual, but sometimes I hear conversations. And I can sometimes figure out what one of my dreams is about. Usually something I have been thinking about during the day, and I realize when I wake up I continued thinking about that same thing in my sleep, in the dream. But the dream I had is not exactly the same as the way I was thinking about when I was awake. We have a name for this in psychology. We call it the dream work. When you are asleep your mind is working on something, and then it produces the dream. It comes up with an image.  
Patient: Yes

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### Session 16 – waking from a bad dream

Therapist: OK. The point I want to make is we can know our dreams, but we can't see the dream work itself. We can't see ourselves making the dream. The dream is just there when we are finishing making it.

Patient: Yeah

Therapist: We have the dream and we can't see what happens just before our mind made the dream. That's silent. That's quiet. But there's a process going on that produces the dream.

Patient: Yes

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### Session 16 – waking from a bad dream

Therapist: I think that's what happened to you with the smell. It's was like your mind started dreaming when you're awake. At the time this all started you were full of all these negative feelings about yourself, and then your mind came up with a picture, it made an image that pulled together all of those feelings into one image.

Patient: Yeah

Therapist: .... an image of you being a stinking person that would be rejected by everyone around you. You saw the end result of the image your mind found, in the belief you had about the smell, but you couldn't see your mind making the smell image. Your mind did it quietly, without you knowing, in a state of terrible confusion.

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### Session 16 – waking from a bad dream

Just like in a dream, there is a silent space before you have the dream where you can't see your mind working. No. You just get the finished dream. And what happened to you is that you were full of all these painful feelings at this time, and like when you have a dream, your mind made an image that captured all these feelings. It was as though without your knowing it your mind was saying "What image can I find that expresses how terrible I am feeling? What picture can I make of how I feel now?" And the smell image is the picture your mind came up with.

Patient: It could be.

Therapist: You're crying.

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### Session 16 – waking from a bad dream

Patient: No, I'm not crying. I need to cough. I think there is something stuck in my throat. I know what it has to do with ....

Therapist: Let's get you some water.....

Patient: Thanks. I believe that it has to do with my mind, because everywhere I go it's the same reaction. If it was physical, you know, I think that it wouldn't happen all the time. So I think it has to do with my mind.

Therapist: I think you are right about that.

Patient: Yeah

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### Session 16 – waking from a bad dream

Therapist: You were full of painful feelings in your early 20s. You had low self-esteem, and your mind made an image of how you felt, which was the smell image. Instead of focusing inside yourself, on how badly you felt, on what you thought about yourself, you began to focus outside, because it was just too painful. You focused outside, on what you thought other people were thinking about you.

..... Let me ask you something, which may seem like a strange question. As we have been talking about the smell idea, which would you prefer to be the case, that this has been in your mind or that you actually have a bad smell?

Patient: In my mind.

Therapist: You prefer that it would be in your mind.

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### Session 16 – waking from a bad dream

Patient: Yes. Because if it was physical, don't you think a doctor would have noticed it years ago?

Therapist: Yes, absolutely

Patient: And if it was physical, it would be hygiene, or it could be a medical condition.

Therapist: No one has ever found any problem like that with you.

Patient: Some say there are medical conditions like diabetes, that some people have an odor. Something like that.

Therapist: That's true, but in those medical conditions where people have an odor, everyone smells the odor! The doctor smells the odor. The family smells the odor. The patient ....

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### Session 16 – waking from a bad dream

Patient: The patient smells the odor. (the patient smiles)  
Therapist: I think we can begin to make some sense of what happened to you. It was very painful, your pregnancy with your son and your father rejecting you. You were feeling strong emotions. Its like you were torn apart by what happened to you. So with these are powerful forces working in your mind, it's not surprising that something like the smell idea would happen. And saying it another way, instead of dwelling over and over on how painful it was that your father rejected you and didn't stand up for you, and how bad you felt about yourself, instead of focusing on that, what did you focus on?  
Patient: My smell

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### Session 16 – waking from a bad dream

Therapist: Yes, your smell. It is painful to think about the smell. But it's not as painful in a certain way as thinking about your family, your own uncertainties about what happened with your son. You were very worried and felt guilty, but things turned out very well with your son. He seems like a great guy, the strong silent type. You did very well with him.  
Patient: Thank you! (patient laughs)  
Therapist: So what happened is that was a very painful period in your life. You were full of all kinds of complicated feelings about your family and about yourself.

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### Session 16 – waking from a bad dream

All of that was swirling around in your mind and it was hard to feel that way, and like a dream, but not exactly a dream, your mind pulled together all those feelings of you being an outcast in one image, one main problem, the smell. The smell idea carried forward from your 20s all those feelings of isolation and shame. So the good news is that you don't have a smell. And now I think you are getting near to the point where you are just an ordinary person with the kinds of feelings and problems that come up for everyone in family life.  
Patient: That would be nice! (patient laughs)

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### Session 16 – waking from a bad dream

Therapist: You are not a person who has a bad smell, but you're someone who had a bad dream that has dominated your thinking for all this time because you got locked into it, like a broken record, because you seemed to be seeing confirmation every day that you had a smell, even though it wasn't really true evidence. It was all your interpretation. So the good news is that you have now to face the ordinary anxieties of life. So it doesn't mean that its going to be smooth sailing from now on and no problem. Going to vocational rehab, dealing with your family issues, and there will be other issues.

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### Session 16 – waking from a bad dream

Patient: (the patient smiles and jokes) And you know the outside world will still be wiping their nose and coughing (smiles)  
Therapist: Yes. And your challenge, by thinking about what we have talked about, is to over time get over that idea that the world doesn't want you, and to say to yourself, the world will welcome me if I just go out.  
Patient: Yeah  
Therapist: "The world is not pushing me away. If I can get out of my house the world will greet me. I can have a life. I can make my kids more proud of me by working and making some money. I'm going to travel, going to go see my mother." All these nice possibilities will happen if you can let go of the smell idea.

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### Session 16 – waking from a bad dream

Patient: Yeah.  
Therapist: So what I am trying to do is to help you wake up from a painful dream.  
Patient: That would be so good!  
Therapist: To wake up from a nightmare.  
Patient: I think I am beginning to wake up.  
Therapist: I think you are too!  
Patient: Yeah. I think I am beginning to wake up. Because I'm feeling different. I'm not totally there yet but I can feel a change. I am feeling more happy and excited to get out. A little bit more confident. It's very good!

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### Session 16 – waking from a bad dream

Therapist: You are registered for the employment rehab training, which is great. That is a positive step. And as you are actually going out in the world and having some positive experiences, some success, it will be easier to talk about your life in a positive way.  
Patient: That would be very good. I think I will be stronger and more confident!  
Therapist: The more you get out, the more positive experiences you will have, and your self-esteem will improve. You have to find your own language for this, but I think you are going through a period of change and growth in your life which is like waking up from a bad dream that started 20 years ago.

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### Session 16 – waking from a bad dream

Patient: Yes. I understand it now. I don't completely feel it yet, but I am getting there.  
Therapist: The dream that you had because you were feeling so terrible about yourself during that period got locked in like a broken record because you kept finding what seemed like evidence for it in the outside world, so the dream continued on year after year. But fortunately the dream is an illusion, something you can deprogram in yourself, to wake up from the dream and go on with your life. You will have grandchildren at some point. You will have birthdays and graduations to attend.  
Patient: And my kids will get married!  
Therapist: Yes, you will have weddings to go to. You need to be out and about in the world.

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### Session 16 – waking from a bad dream

Patient: Yes. That's true.....All of my doctors all these years have been saying the same thing. They've been taking me back to that time (the pregnancy). They never really explained it clearly to me, like the way you are explaining it. Because I keep asking myself, "Why do they keep going back here?" And I'm now I am seeing the reason why.  
Therapist: If I had tried to talk you about all this the first time we met ...  
Patient: No. It wouldn't have worked.  
Therapist: It wouldn't have made any sense. It takes time to see these things.

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### Session 16 – waking from a bad dream

As we discussed before, when we make a dream, we don't actually see our mind making the dream. What's been puzzling for you and what's been hard for you to understand is that your mind made an image, like a dream, the smell idea that captured and expressed how you were feeling at the time.  
Patient: Yeah  
Therapist: (referring to the table diagram) We see all the connections here. It's almost the same state of mind.  
Patient: Yes it is. It's just that now is the same state of mind, but with the smell.

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### Session 16 – waking from a bad dream

Therapist: What your mind did was to shift the whole thing over to the smell idea, which simplified things in a way, but at a terrible price. Because it was hidden in the smell idea, you didn't have to think about how ashamed you felt of yourself because of the pregnancy, but your worry about the smell made it impossible for you to participate in work and family life. I'm being a little silly here, but when you announce that you have fully awakened from the dream, we will celebrate by having some wakeup morning tea or coffee here in the office.  
Patient: That would be good! (she laughs warmly)

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Clinical Example

Mr. S – who murdered his parents during a psychotic episode

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### The Man Who Murdered His Parents

- 50 y.o. man who at the age of 35 murdered both his parents during a psychotic episode.
- Maintained on clozapine 600 mg.
- Delusional belief that he was hypnotized by a group of Evangelical Christians.
- Did not deny that he was mentally ill, but saw no relationship between his crime and his illness.
- No violent episodes in 15 years in the hospital, but no insight into his illness.
- Likely to die of old age in a state hospital

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### The Man Who Murdered His Parents

- 'I wasn't in my right mind when I killed my parents. The Evangelicals hypnotized me.'
- Therapist: "I agree with you could not have been in your right mind. I would like to work with you to better understand how that happened."
- **collaborative investigator**
- Therapist: "There are certain psychiatric syndromes in which people fail to identify family members. Would you like to read about this?"
- **real world knowledge**

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### The Man Who Murdered His Parents

- Capgras Syndrome
- "You weren't in your right mind." Two columns.

Evangelicals	Mental Illness ?
Temporal contiguity of contact the Evangelicals Their piercing stare A whirlwind entering his brain	with

- Temporal context can be misleading.
- My dogs. "We don't want to burst his bubble."

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### The Man Who Murdered His Parents

- Capgras Syndrome
- "You weren't in your right mind." Two columns.

Evangelicals	Alternate explanation ?
Temporal contiguity of contact with the Evangelicals Their piercing stare A whirlwind entering his brain	

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### The Man Who Murdered His Parents

- Therapist: "What is your understanding of your psychiatric diagnosis?" "Schizophrenia. Split personality."

#### real world knowledge

- Therapist: "Schizophrenia can lead to states of mental confusion."
- Patient: "Not confusion. Total insanity!"

#### Evangelicals vs mental illness

- Therapist: "Which explanation would you prefer to be true?" **inference chaining**
- Patient: "You mean, which is the least guilty explanation? If it was the Evangelicals, I was stupid. If it was mental illness, I am garbage and should rot in hell!"

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### The Man Who Murdered His Parents

- "What she did was not premeditated. She should receive treatment rather than punishment."
- Therapist: "Was your killing your parents premeditated? No. **unconscious guilt**
- "I have recovered the ability to pray! When I came into the hospital, God had stopped listening to me. Now he is listening again."

#### behavioral experiment

- Walk around the hospital grounds.  
Now has off grounds accompanied pass privileges.

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Clinical Example

Mr. D – an 18 y.o. who heard a “voice” he called PsychoGirl

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Patient C and ‘Psycho Girl’

social isolation  
auditory hallucinations  
ideas of reference

delusion: A shaming video of him was transmitted over the internet. All the students at school know about it.

evidence:  
-a student turned away from him in the auditorium  
-the way other students look at him  
-a notice on Facebook to not open a link

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Patient C and ‘Psycho Girl’

Four aspects of his ‘voice’ hearing experiences

An “inner voice” stream of consciousness which he identifies as his own thoughts	his thoughts are experienced within the self
An ‘outside voice’ that repeats exactly what he is thinking, which he calls <i>Psycho Girl</i>	outside the self
Second person ‘broken record’ thoughts about sex, which he believes are being inserted into his head “You are watching porn.” “You are gay.”	Inside the self, but with a compulsive ‘not me’ quality
A second ‘outside voice’ which blames his ‘mind’ for having sexual thoughts	outside the self

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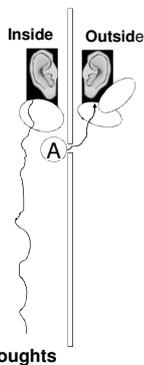
Patient C and ‘Psycho Girl’

‘Normalizing’ self referential bias

- The trainee, the librarian, and the water bottle

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In your mind



In the outside world

thoughts

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Patient C and ‘Psycho Girl’

Six pieces of evidence for ‘Psycho Girl’

1. Patient was hearing intense voices during his 2nd hospitalization that were referring to him constantly, 24 hrs a day.
2. He noticed two students from school in a car parked across the street from his house. They were recording him on a video which was distributed that video over the internet. He received an email of Facebook confirming this.
3. A student at school mimicked the way he had moved at home the night before.
4. A person in the church mimicked the way he moves when at home.
5. A guy on the street came to him and mentioned something that people were saying that he did at home, something which was not true. The patient did not feel comfortable saying what was mentioned to him by the guy on the street.
6. Patient hears the voices of the neighbors when he is at home. The voices refer to him.

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## Patient C and 'Psycho Girl'

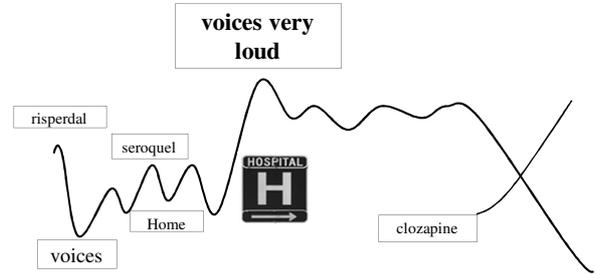
### Eight pieces of evidence against 'Psycho Girl'

1. His voices diminish when he pays attention to something else, like reading.
2. Medication closes the 'window' in his mind
3. Other people have had similar experiences and recovered
4. Other people do not hear the 'voices'
5. The budget for spying on him would exceed \$250,000
6. 'Voices' intensify at sleep, which is to be expected
7. Psycho Girl appears to be all talk and no action.
8. His idea: his attention outside vs inside is out of balance, with too much attention to his stream of consciousness

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### Time line – the 'evidentiary chain'



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### Clinical Example

Ms. D – who heard "voices" saying someone was going to die

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### 'Voices' Predicting People Will Die

56 y.o. woman - first psychotic episode when her divorce and her mother's death occurred in the same year

- Ideas of reference and 'voices' – coded license plates and a government computer which 'voices' can access.
- Two inpatient admissions, then stable in the community for 8 years.
- Prior bad experiences with psychiatry. Refused to see a doctor. Refused medication.
- Treatment - once a week for 45 minute over 12 weeks

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### 'Voices' Predicting People Will Die

- **Start with the 'C'** Most distressing symptom – 'voices' can predict that certain people will die.
- **A-B-C** Evidence for the belief: "The 'voices' accurately predicted Frank Sinatra's death."
- **Normalizing** 'voices' "I hear my name."
- Discussion of phenomenology  
**real world education**
- 'Window in the mind' diagram

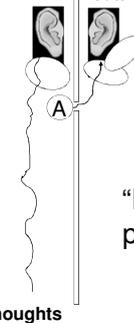
233

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In your mind

Inside Outside

In the outside world



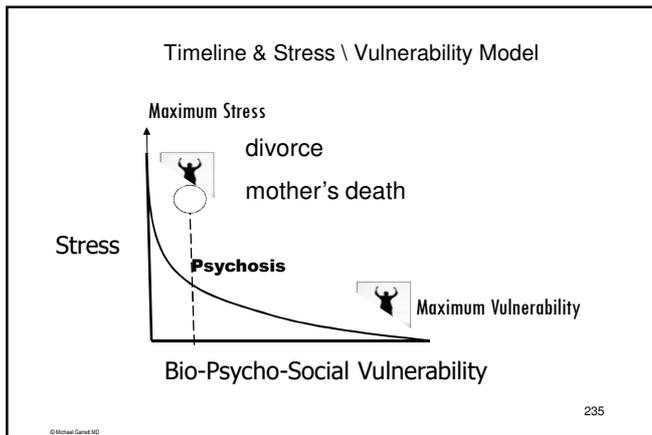
- ALERTS
- 'Hearing' your name
  - 'Hearing' the telephone
  - 'Hearing' a sleeping baby cry

"I never realized other people heard 'voices'."

thoughts

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### Her Coping Techniques

- Distraction with tasks of interest which required her full attention
- We reviewed a list of additional coping techniques

Building the therapeutic alliance and beginning to shift the power relationship with the 'voices'

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### 'Voices' Predicting People Will Die

- **Real world education** Discussed her diagnosis of schizo-affective psychosis, ideas of reference and circumstantial thinking. Tracking license plates.
- Computer programmer who maintained an inner dialogue with his 'voices' to help him write computer programs.
- "I think when I am listening to the 'voices' jump from one thing to another, I am watching the 'voices' engage in circumstantial thinking."

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### 'Voices' Predicting People Will Die

- "Maybe that idea that Frank Sinatra was going to die was back there in my mind already somehow."
- Deepening collaboration to figure out the meaning of the 'voices'
- Session 5: **Weakening the 'thing presentation' of mental life.** "Now I say to myself, I am not hearing this. I am thinking this."
- Voices decreased by 50%, and she is no longer afraid of their predictions.

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### 'Voices' Predicting People Will Die

- "He didn't put away the Italian bread!"
- "Throw the five!"
- Who is Nancy?

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### Who is Nancy?

- "Nancy, you are not in this!"

Quick course in psychoanalytic theory

sex and drugs

- Nancy is Italian.
- Nancy is an outsider who hates doing housework
- "Nancy is like me."

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### Who is Nancy?

- Nancy is a lonely, outsider.
- Tearfully, "I miss my mother!"

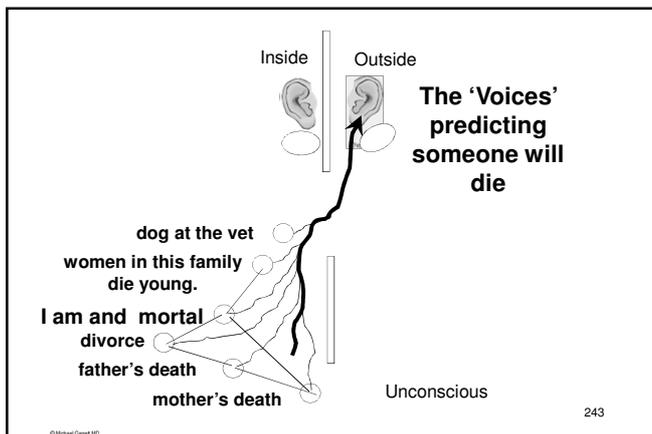
**Therapist: "Your 'voices' are the voice of your grief, for the loss of your marriage, for your mother's death, for your dog, and your fear of more losses to come."**

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### Medication and Outcome

- "Medication might help further close the window in your mind." She was interested to hear more.
- Aripiprazole 5 mg. 'Voices' stopped.
- Occasional ruminative worry that someone in her family will die, which she recognizes as her own thoughts.
- Works as an assistant to an elderly relative.

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**Clinical Example**

Ms. R – who thought her cat was planning to murder her

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- 40 y.o. woman was an abused child who became an emotionally needy adult who called her boyfriend so many times a day he had to limit her calls.
- She believed her cat was stealing his affection. The cat planned to kill her to have her boyfriend all to herself
- Therapist drilled down on the "A." How did she know what the cat was thinking? The cat snuggled up in the bed between her and her boyfriend, coming between them (concrete metaphor/persecutory object).
- How did the cat plan to kill her? "She will bite my jugular, like the lions do on TV!"
- Therapist: "Where is your jugular?" "The cat will have only one chance to bite you before you wake up."
- Next session: "I still believe my cat plans to kill me, but I no longer believe she has the means."