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Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover

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Introduction to Cognitive Behavioral Therapy for Psychosis
Module 3

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CARING FOR EVERY CHILD'S MENTAL HEALTH
Systems of Care

THE TA NETWORK
the national technical assistance network for children's behavioral health

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This webinar is hosted by Research and Training Center for Pathways to Positive Futures (Pathways RTC), Portland State University, a partner in the National TA Network for Children's Behavioral Health, operated by and coordinated through the University of Maryland.

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Objectives Module 3

- Formulation to inform intervention
- Working with comorbidities
  - Substance abuse
  - Trauma
- Incorporating culture
- CBTp models
  - Different approaches
  - How to ensure the best fit
  - Training models

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Using formulation to inform intervention

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Mini Formulation

“People are talking about me and intend to harm me”

Believe people are talking about me and they are talking about me **= Not Safe**	**Believe people are talking about me and they are not talking about me** **= “crazy”**
Don’t believe people are talking about me and they are talking about me = Really not Safe	Don’t believe people are talking about me and they aren’t talking about me = “that would be great!”

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Working with Unusual Thoughts

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Aims in working with unusual thoughts

- To help client to
  - Understand how beliefs and thoughts influence feelings
  - Explore evidence for and against these beliefs
  - Develop behavioral experiments to test out the reality of the belief
  - Generate alternative explanations and thoughts
  - Provide behavioral interventions to reduce distress associated with thoughts

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In working with unusual thought

- Ultimate aim is to:
  - EITHER
    - Help client develop a new more helpful and realistic belief
  - OR
    - Develop behaviors that allow the client achieve their goals while still holding the belief

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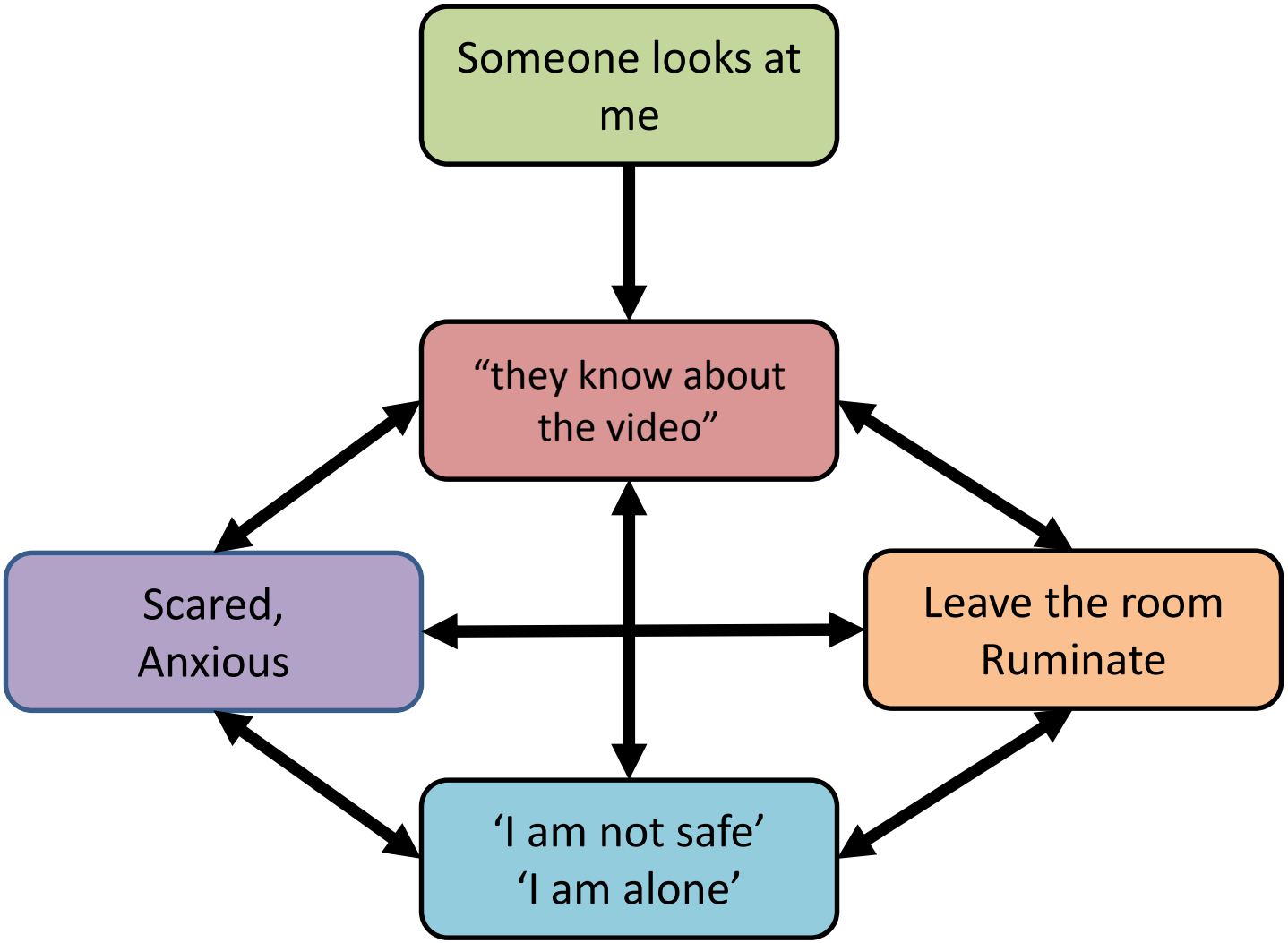

Mini Formulation

Exploring thoughts

- Ask client to generate all the evidence they can think of that a) supports the thought and b) does NOT support the thought
- Can be as creative as they want and over inclusive – continue with lists until all possibilities exhausted
- Re – evaluate belief in thought based on the evidence
- Re – rate associated feeling
- Generate alternative explanation based on all evidence collected

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Cognitive Intervention: Exploring the evidence

Thought: people have seen a video that portrays me as a bad person (90%)	
Evidence For	Evidence Against
People started to be mean to me at school People look at me in a hostile manner People talk about me at school	I've never been able to find the video No one I know has seen the video A survey of 50 people I don't know hadn't seen the video I don't know for certain that people are being hostile
Belief: people have seen a video that portrays me as a bad person (40%)	
Alternative possibility: I ***worry*** that people have seen a video that portrays me as a bad person (60%)	

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Behavioral Experiments

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Behavioral Experiment

- Have to be carefully developed to be win-win
- Developed collaboratively
- Should be meaningful to the client and test a belief/behavior that is important to them
- Should also take into account all the things that can go wrong with the experiment

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Behavioral Experiment

Thought to be tested:					
Belief in thought (0-100%)		Before experiment :		After experiment:	
Experiment	Likely problems	Strategies to deal with problems	Expected outcome	Actual outcome	Alternative thought

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Example of a behavioral experiment

http://wn.com/cbt_for_psychosis?upload_time=all_time&orderby=relevance

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Working with Hallucinations

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Aims in working with voices

- To help client to
  - Understand how beliefs and thoughts relating to voices influence feelings, mood and coping
  - Identify beliefs about voices
  - Explore evidence for and against distressing beliefs
  - Develop behavioral experiments to test out the reality of the belief
  - Generate alternative explanations and thoughts about voices
  - Provide behavioral interventions to reduce distress associated with voices

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Further assessment of the voices

- When do they occur?
- How make sense of them?
- Reactions
- Emotions
- What helps/coping styles
- Voice diary
- Who
- Where do you hear them
- Image?

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Voice Diary

What happened?	What were you doing?	How were you feeling?	What did you think?	What did you feel? What did you do?
Voice told me that I am not safe. People want to hurt me	Preparing to go to a class	Anxious	"The voice doesn't want me to go"	Scared Anxious Stopped getting ready Laid down on the bed
Voice told me I'm stupid and no good	Looking at facebook Reading about a party that classmates had gone to	Sad	"The voice is right"	Sad Thought about all the things I am missing out on

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Coping Styles (Howard et al, 2013)

Style	%
Distraction	70
Focusing	27
Meta cognitive	3

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Coping styles

- Distraction e.g. music (listening), playing the guitar, art, walk, pets, writing, DVD, computer games.

- Focussing e.g. sub-vocalization, deep slow breathing, rational responding, schema work.

- Meta-cognitive e.g. detached mindfulness, acceptance.

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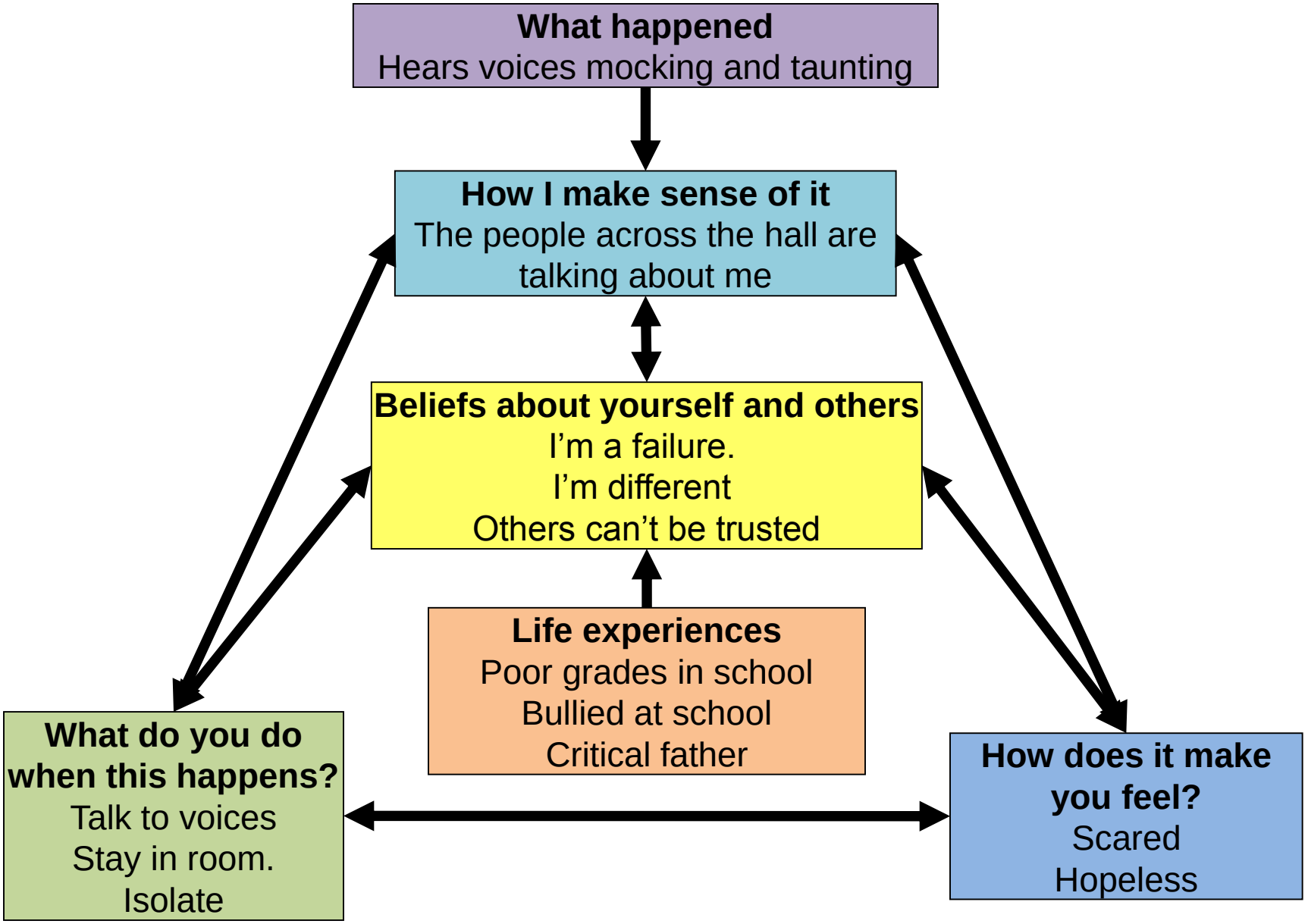

(Morrison, 2001)

Distraction: Assess and implement coping skills

- Review list of coping skills
    - Check with client what skills they have used that have worked/not worked
    - Which they might be interested in trying
    - Which they would never use
- Make a plan/develop experiment to test which are most helpful
- Ensure tracking outcomes and that target is mutually agreed i.e. worry about the voice, distress, impact on functioning

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Focusing strategies

- Rational responding to the experience of the voice
- Evidence for and against what the voice says
- Coping cards
- Normalizing

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Behavioral Experiment

Thought to be tested: The voices I hear are people across the hall talking about me					
Belief in thought (0-100%)		Before experiment : 95%		After experiment:	
Experiment	Likely problems	Strategies to deal with problems	Expected outcome	Actual outcome	Alternative thought
To record the voices when they occur					

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Acceptance Strategies

- Address schema
  - I'm a failure (positive logging)
- Assertiveness with the voice
- Compassion towards the voice
  - https://www.youtube.com/watch?v=VRqI4lxuXAw
- Develop skills to continue with activity despite voice
- Identify what voices represent
  - Anxiety
  - Stress
  - Fatigue

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Introducing homework

- Don’t call it homework!
  - Practice at home, skill building, experiment, trying it out
- Homework is used to build CBT skills for managing problems in real life situations
- Adds structure to sessions – should be on the agenda!
- 168 hours in a week – only one hour of that is spent with therapist (hopefully!)
- What can you, as the therapist, do as homework?
- Should be informed by the formulation, and intervention, discussed in the session

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MI and CBT

- Complementary approaches
- MI used as a framework to support discussion about substance use and encourage ‘change talk’
- CBT then used to explore cognitions and behaviors related to substance use and develop skills associated with this

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Role of cognitions and behaviors

- **Cognitions**
  - Identification of permission giving thoughts that lead to substance use
    - Modification of these thoughts
    - Support client to catch, check, change thoughts
- **Behaviors**
  - Identification of behaviors/triggers that lead to the person using i.e. socializing with certain friends, use of alcohol before using meth
    - Modification of behaviors and plan to avoid triggers
    - Reward based intervention to support change?

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Retrospective Review: Time Line Exercise

At home Smoking cannabis x2/week	Back to college Cannabis 1/day	At college. Cannabis 2-3/day	Exams coming up Cannabis “all day”	Back home Cannabis x2/week
August	**September**	**October**	**November**	**December**
Low mood “uncomfortable”	Anxious	Paranoid	Paranoid Hard to leave the house Scared that friends want to hurt me	Low mood Anxious Not as suspicious of people

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Prospective Exploration

- Develop experiment to determine if there is a link between substance and symptoms for the individual
- Can individual agree to not take substance for X amount of time
- Track meaningful outcomes before, during, and after this period
  - Symptoms
  - Functioning
  - Positive and negative outcomes (paranoia, creativity)

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Trauma and psychosis

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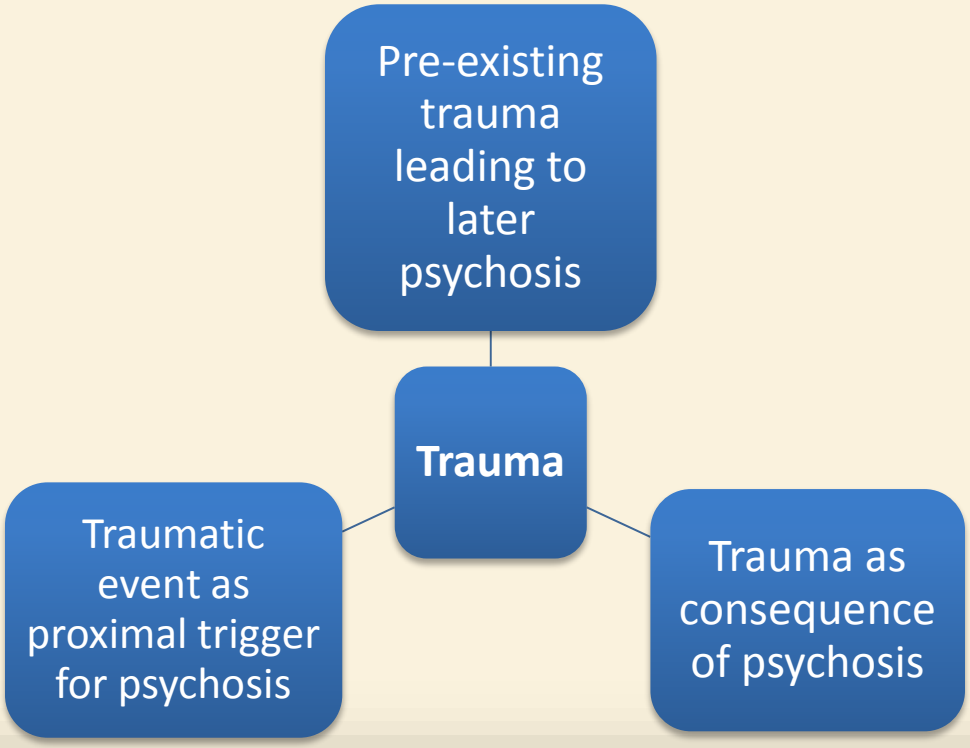

Multiple Pathways to Trauma and Psychosis

Pathways to trauma

Pre-existing trauma

- Patients with psychosis 2.72 times more likely to have been exposed to childhood adversity (Varese et al. 2012)

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Pathways to trauma

Trauma as proximal cause of psychosis

•Symptoms of PTSD can exacerbate stress, leading to a psychotic experience (Mueser et al. 2002)

•70% of voice hearers developed their hallucinations following traumatic event (Romme and Escher 1989)

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Pathways to trauma

Trauma as a result of psychosis

Trauma can result from hospitalization or even the experience of the psychotic symptoms themselves (Frame & Morrison, 2001; McGorry et al., 1991; Morrison et al., in press; Shaw et al., 2001)

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Trauma and psychosis: clinical considerations

We SHOULD be asking all individuals about potential traumatic experiences

- If we don't routinely ask the information is rarely freely volunteered (Read and Fraser 1998)

Clinicians should be trained in how to ask about trauma and respond to trauma disclosure

- One of the primary reasons people don't ask is fear (Read et al. 2007)

Trauma and psychosis: clinical considerations

- **Interventions should address trauma (if appropriate)**
  - Consider skill building and distress tolerance initially (especially with younger clients?)
  - Utilize existing trauma protocols (PE + EMDR)
    - Dutch T-TIP study
    - Straight into PE/EMDR intervention with no prior skills building
  - Cognitive restructuring techniques
  - Imaginal exposure and rescripting

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Naomi – clinical vignette

23 year-old female currently living with parents and younger sister. At age 14 Naomi was raped and physically assaulted by a family friend who has since moved away. Naomi told her mom about this after discovering that she was pregnant. Pregnancy was terminated at 14 weeks.

Last year Naomi started hearing a critical male voice. Over the course of a couple of months the intensity and frequency of the voice increased and she began hearing multiple voices. Entered EI service and commenced anti-psychotic treatment. Voices improved with medication leaving the original male voice that she believes to 'probably be the devil'.

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Predisposing	**Precipitating**	**Perpetuating**	**Protective**
Family history of mental health problems Bullying at school Rape and termination	Recent break up of relationship Left college and unable to find a job since	Conflictual relationship with father Unemployed	Supportive family Resilient Strong future goals

Current concerns

1. "devil talking to me"

THOUGHTS	FEELINGS	ACTIONS
What he says is true I don't deserve to live I am to blame (for the rape and termination)	Scared Low mood Low self-esteem Hopeless	Listens to the voice MJ use for relaxation

SOCIAL	PHYSICAL
No close friends Frequent fights with family	Poor sleep pattern

UNDERLYING CONCERNS

"I am to blame" "Others can't be trusted" "I am a bad person"

Interventions for Naomi

1. Suicide risk assessment and intervention
2. Develop coping strategies
    i. Sleep hygiene
    ii. Relaxation strategies
    iii. Distraction
3. Assess/Address marijuana use
4. Normalization/validation
5. Explore beliefs about voice
    - Devil vs. auditory hallucination
6. Historical review of trauma, formulation, and cognitive restructuring
    - I am to blame vs. it was not my fault
7. Address core beliefs

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Culture and CBTp

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The need to incorporate culture

- Criticism from community clinicians that CBTp ‘not applicable’ to their culturally diverse client population
- Misperception of CBT as tools and skills only
- Misperception of CBT as ‘explaining away’ cultural experience

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Incorporating culture

- “We believe that a therapist who uses a ‘color-blind’ approach to therapy is a therapist with an ethnically based disability (Harper and Iwamasa, 2000)
- CBTp acceptable for BME with culturally appropriate adaptation (Rathod, 2010)
- CBTp through ‘cultural lens’

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Framework for CBTp through a cultural lens

1. Identify culturally related strengths and supports.
2. Use the client's list of culturally related strengths and supports to develop a list of helpful cognitions to replace the unhelpful ones.
3. Develop weekly homework assignments with an emphasis on cultural congruence and client direction.

(Hays, 2009)

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Case example

Rena is a 17 year old Afro-Caribbean female from a small Caribbean island. She lives with her adopted family. Reported seeing witches coming out of her cupboard from age 8 and family understood this experience in context of belief in the spirit world prevalent to the island and consistent with family beliefs. Initially sought alternative treatments specific to local culture. Decrease in functioning and increase in symptoms led family to seek treatment in the US. Rena complains of demons who are 'taunting and mocking' her (auditory and visual hallucinations).

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Case example cont

Cultural strengths based focus

- –Skilled in crystal healing, yoga,
- –Identification of a ‘spirit guide’ or angel. Positive and supportive influence. Consistent with family beliefs.

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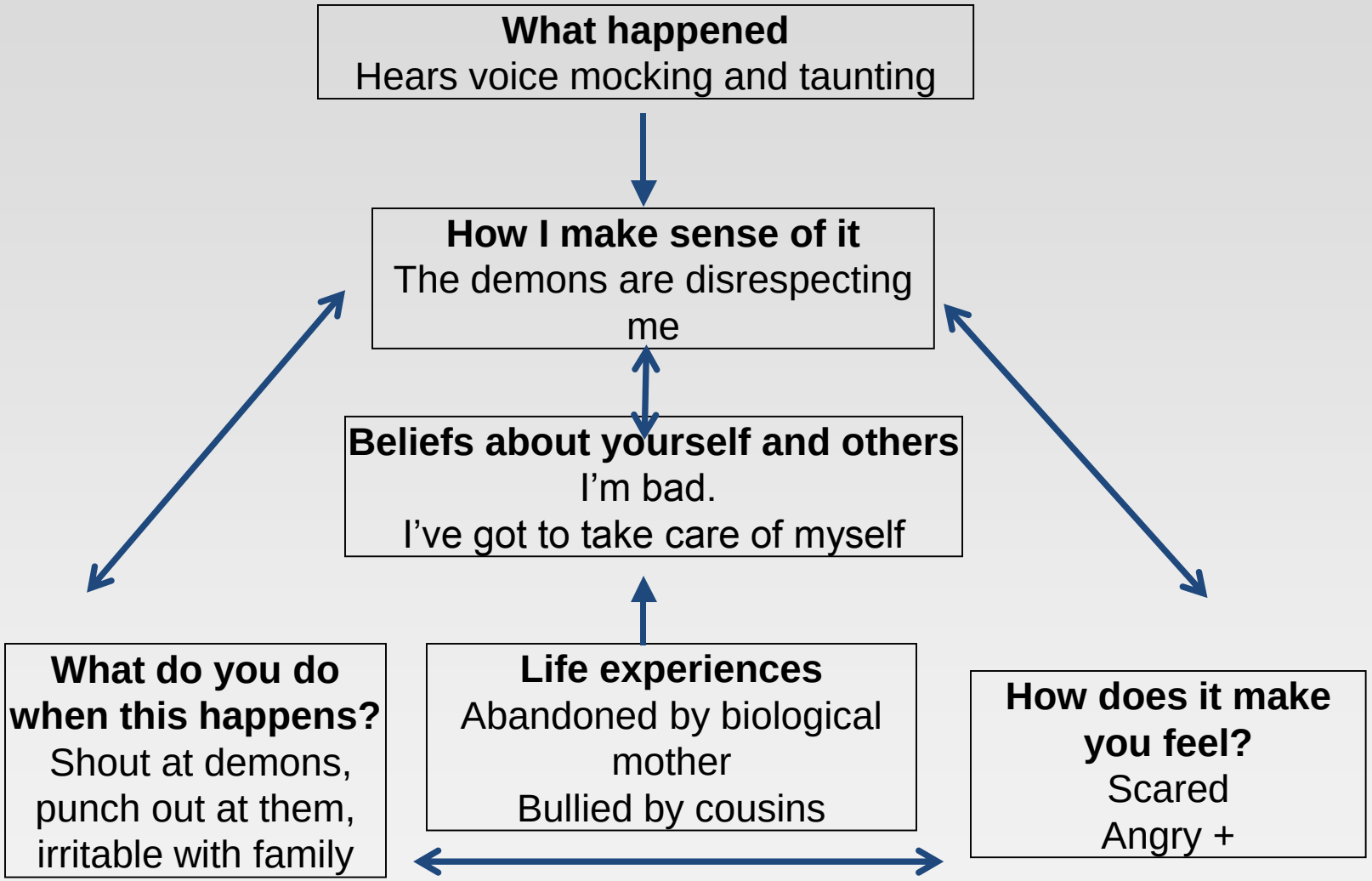
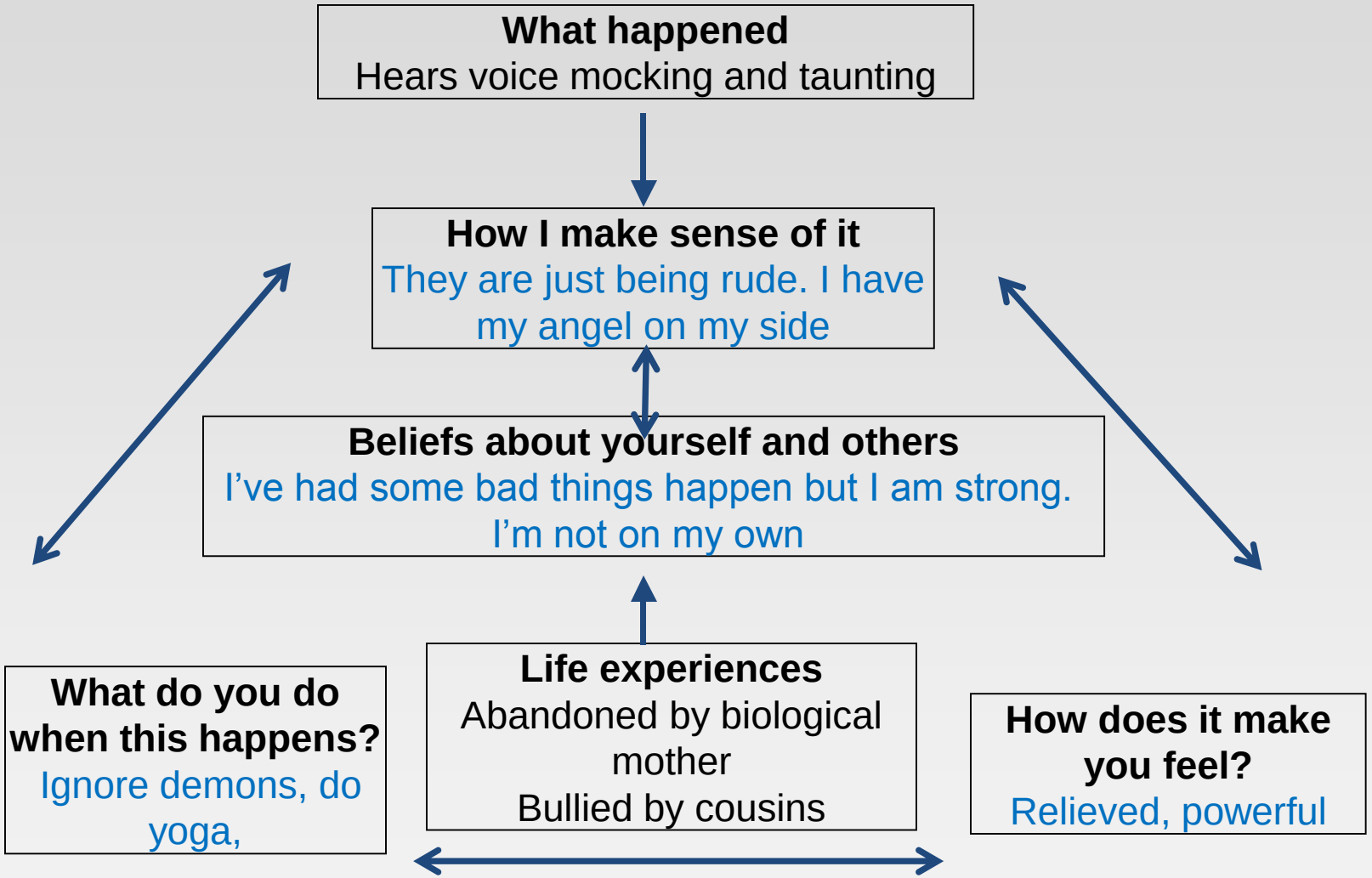
Collaboratively developed formulation



(Morrison, 2009)

Collaboratively developed re-formulation



(Morrison, 2009)

Applied framework for CBTp through a cultural lens

1. Identify culturally related strengths and supports.
   - Yoga, crystal healing, spirit guide
2. Use the client's list of culturally related strengths and supports to develop a list of helpful cognitions to replace the unhelpful ones.
   - "I'm not on my own", "I am strong"
3. Develop weekly homework assignments with an emphasis on cultural congruence and client direction.
   - Practice yoga and healing, enlist angel to help her dismiss voices

(Hays, 2009)

CBT for psychosis implementation models

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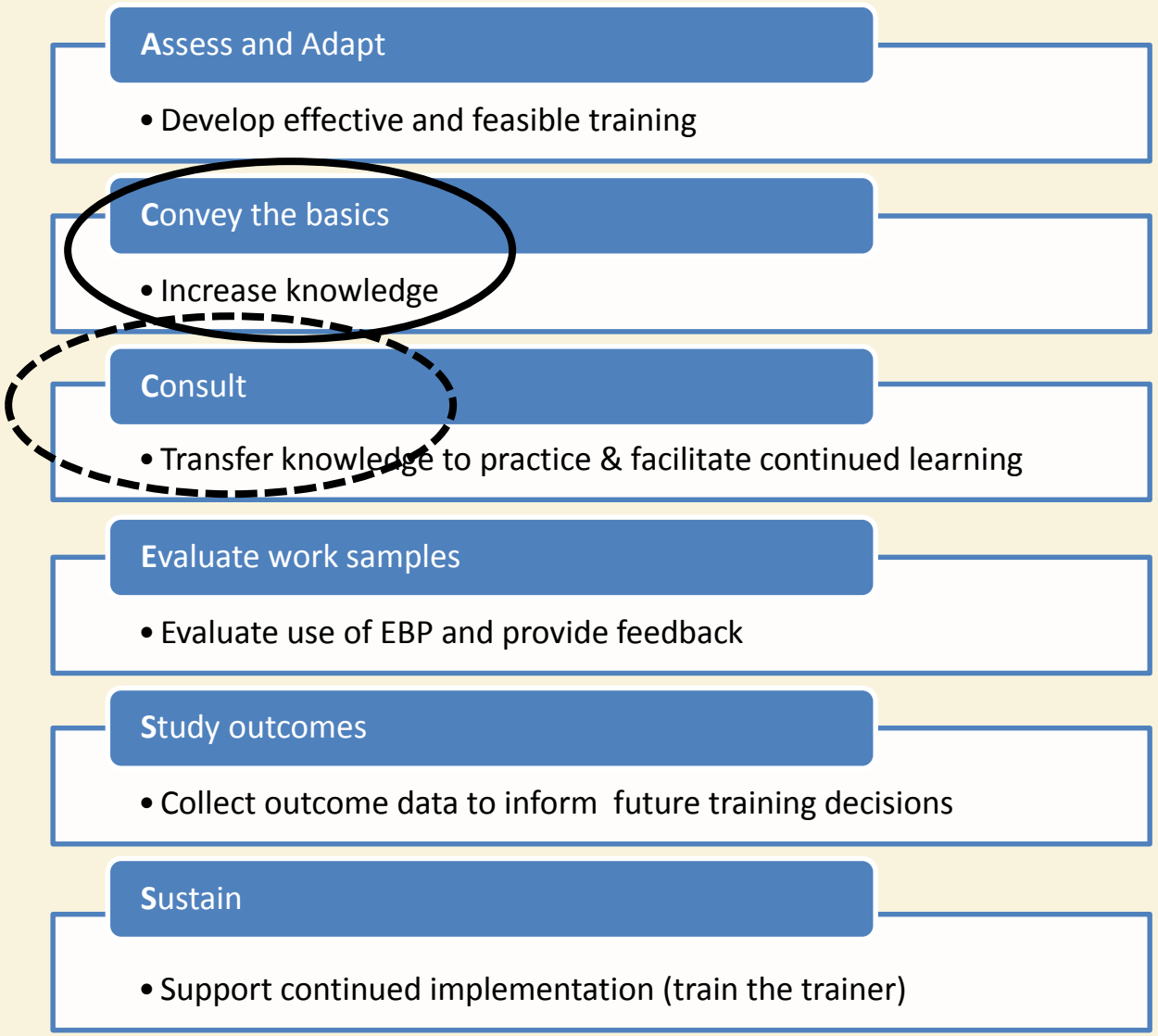
ACCESS Model (Wiltsey - Stirman et al. 2010)

Model developed to support implementation of EBP's in community mental health settings



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CBTp implementation models

- CBT informed interventions (i.e. IRT, Skills groups)

- Formulation Based CBTp for clinicians

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CBT Informed Interventions

- Individual Resiliency Training (IRT)
- Part of Navigate program
- 14 Manualized modules
  - 7 Standard (4-6 months to complete)
  - 7 Individual
- Strength Focused
- Accessible
  - http://navigateconsultants.org/materials/

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CBT Informed Interventions

- 2 day training as part of Navigate training
- Master's level clinicians recommended
- Weekly clinical supervision recommended for 12 months (every two weeks for 6 months, monthly for 6 months)
- Fidelity check to ensure appropriate delivery of IRT
- Flexibility increases as clinician becomes more expert at delivering manual?

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Formulation Based CBTp

- Engagement and normalization emphasized as initial interventions
- Increased flexibility (not manualized)
- Helpful for complex presentations/team formulation
- Individualized through formulation
- Requires trained clinicians with background in CBT
- Established competency requirements
- Supervision/consultation is ongoing process

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Formulation Based CBTp for clinicians

- **3-day training**
  - Covers all aspects of gold standard CBT practice
  - Combination of didactic, role play, case discussion, and demonstration
  - Addresses positive and negative symptoms, trauma, working with families

- **Weekly consultation**
  - Discuss implementation of skills and challenges
  - Develop and share formulation
  - Identify areas for intervention
  - Role play
  - Review tapes

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Formulation Based CBTp for clinicians

- **Monthly tape submission**
  - Tapes reviewed using the Cognitive Therapy Scale –Revised (CTS-R)
  - Competent tape = 50% and above
  - Competence = 3 consecutive competent tapes
  - Average of 6 tapes to reach competence

- **Train the trainer?**
  - Identify local champions of the model to support continued implementation
  - Watch a training, co-lead a training, lead a training
  - Training on CTS-R and tape review to establish consensus rating

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CBTp Models: Service Considerations

- Staff turnover
- Staff training level (CBT background)
- Resources for ongoing consultation/tape review
- Ability to set up internal supervision
- Integration of the model into the service
- Local CBTp ‘champion’?
- Clinician preference

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CBTp Models: Client Considerations

- Engagement needs
  - Ability to engage with manual vs. CBT session
  - Engagement before intervention occurs?
- Acuity of symptoms
- “psychologically minded”
  - Cognitive capacity
- Client preference

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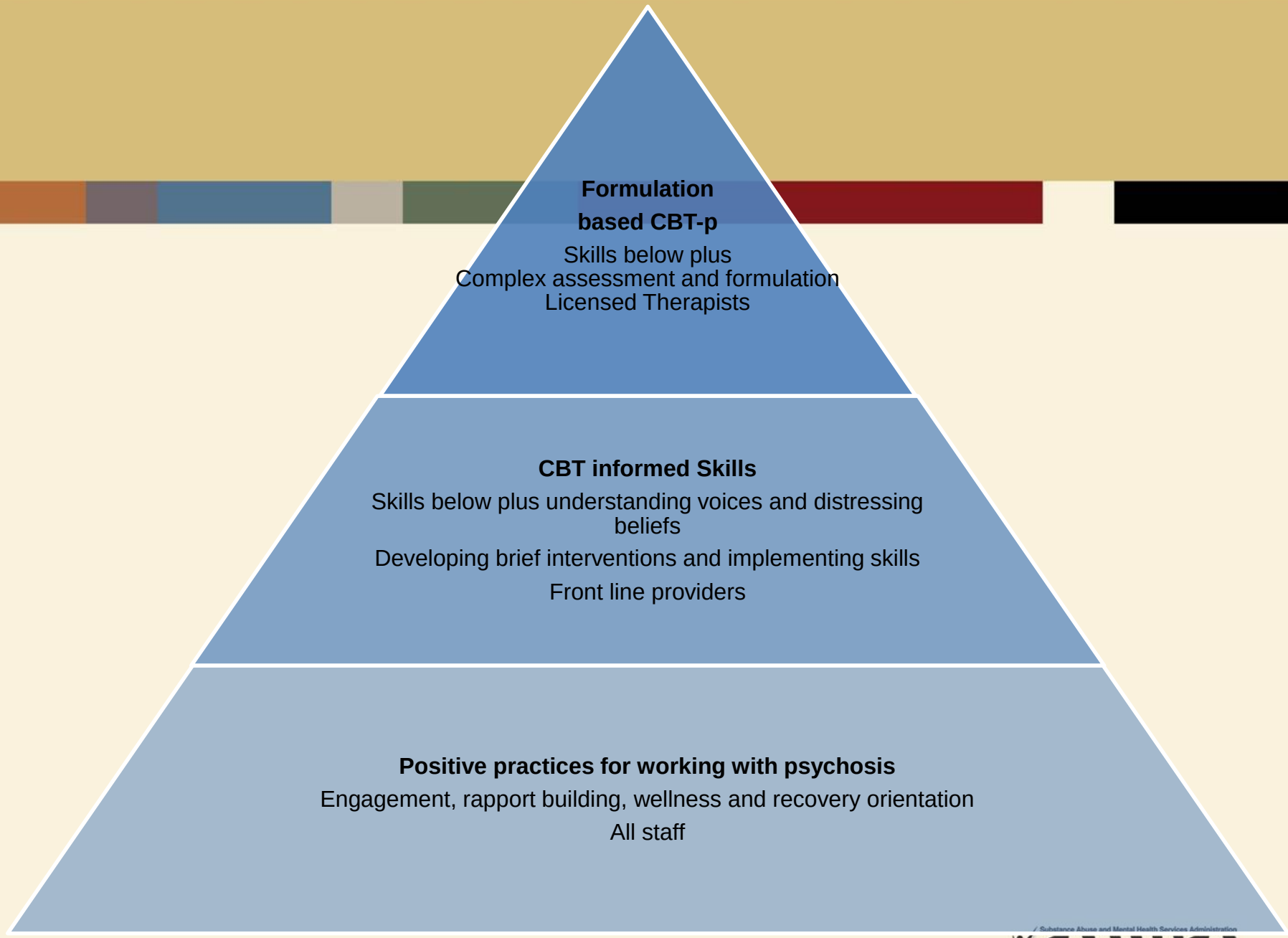
Formulation
based CBT-p
Skills below plus
Complex assessment and formulation
Licensed Therapists
CBT informed Skills
Skills below plus understanding voices and distressing beliefs
Developing brief interventions and implementing skills
Front line providers
Positive practices for working with psychosis
Engagement, rapport building, wellness and recovery orientation
All staff

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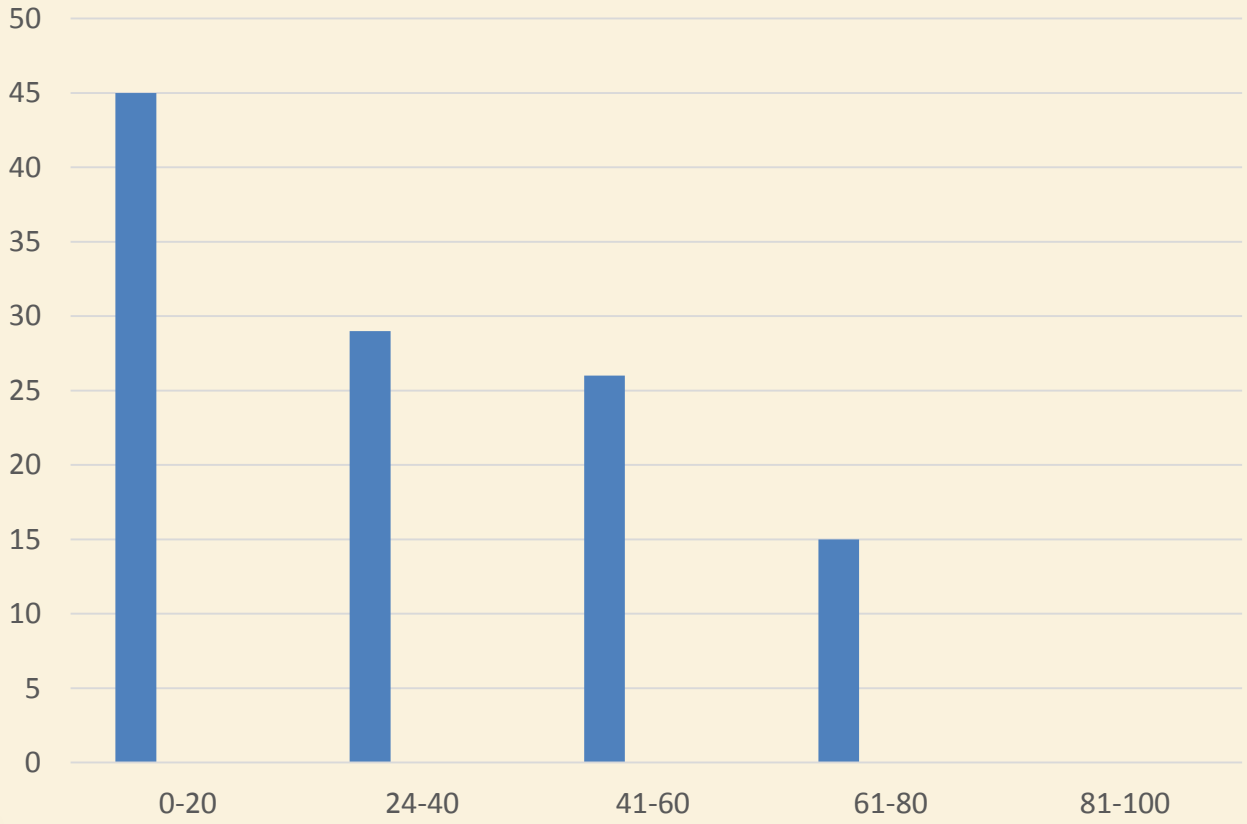
What did you know at the start of this training?



What do you know at the end of this training?

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Questions? Examples?

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Thank you

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