

Cognitive Behavioral Therapy and Recovery with Persons in Early Stages of Serious Mental Illness

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Objectives

- In this webinar, we will
 - Describe what we know about first episode psychosis and recovery;
 - Present the state of the science of CBT for people in the early stages of severe mental illness (SMI);
 - Describe Cognitive Behavioral Therapy (CBT) and its integration with the Recovery Movement;
 - Explore issues related to the implementation of CBT in real-world settings; and
 - Address participant questions



First Episode Psychosis: Recovery and Risk Factors



Recovery from First Episode Psychosis

- Many individuals who experience a first episode psychosis (FEP) will reach clinical remission
 - Some recover fully and return to their previous roles and trajectories¹
 - 35-70% experience relapse²
 - With each relapse, the risk of developing persistent psychotic symptoms and long-term impairment increases³



Risk of Relapse: Delayed Treatment

- Many people experience significant periods of misdiagnosis and delayed treatment after onset of symptoms and impairment
- The delay between onset and treatment increases the likelihood of long-term morbidity and impairment¹

Risk of Relapse: Stress

- Presence of and sensitivity to stress are also important predictors of the onset and recurrence of schizophrenia¹
- Our understanding of the exact mechanism is still evolving, but the association between experienced stress and relapse is well established

Risk of Relapse: Social Support

- Following an FEP, many individuals lose a sizable portion of their social network¹
- Those with poorer social support are often slower to recover and may experience ongoing depression even after recovery from the FEP¹
- However, the presence of even a few emotionally close and positive relationships can be a strong protective factor related with lower rates of relapse²



Risk of Relapse: Family Factors

- Families often react to an individual's FEP with distress¹, which can lead to (or exacerbate) unhelpful patterns of interaction in the family
- Increasing family isolation, criticism, and hostility in turn increase risk of relapse and impairment²



Risk of Relapse: Disruption of the Narrative

- Important developmental transitions often coincide with onset of FEP, creating a disruption of the individual's trajectory
 - Late adolescence and early adulthood are pivotal times for development of autonomy, independence, individuation
 - FEP can threaten the individual's success in these transitions¹

Recovery from First Episode Psychosis

- FEP treatment guidelines include development of an active relapse prevention plan¹
- Insufficient evidence to identify a clear evidence based practice for people who have experienced a FEP, but CBT is emerging as the treatment of choice
 - Even less data available about implementation in real world settings²



Cognitive Behavioral Therapy for People in Early Stages of Severe Mental Illness



CBT: What are we really talking about?

- Cognitive Behavioral Therapy
 - An umbrella term for a wide range of intervention strategies that focus on changes in behavior, thinking, and feelings
- Cognitive Therapy
 - The original approach developed by Aaron Beck, focused on changes in cognition that lead to changes in feelings and behavior
 - Case Conceptualization driven, rather than technique or manual driven
- Cognitive remediation
 - Behavioral treatment using drills, paper and pencil tasks, and practice to improve cognitive impairment in areas like memory, attention and problem solving

Is CBT effective for individuals experiencing Schizophrenia?

- All evidence suggests that individuals with schizophrenia do best with a combination of pharmacological and psychosocial interventions¹
 - Critical to have effective psychological treatments to complement pharmacology
- CBT is recommended by most schizophrenia treatment guidelines^{1,2,3}
 - More than 30 clinical trials showing benefits
 - Most focused on positive symptoms (sometimes just a single symptom), a few on negative symptoms and distress
 - Functional outcomes examined as secondary outcomes, if at all

1 PORT: Dixon et al., 2009 2. APA, 2004 3. National Institute for Clinical Excellence, 2002



CBT for FEP

- Very few published random clinical trials of CBT for people experiencing an FEP
 - One of the most rigorous studies¹ showed that CBT and supportive therapy improved symptoms over treatment as usual
 - Treatment was delivered in just 5 weeks during the most acute phase
 - A second study showed those receiving CBT showed more rapid improvement²
 - Effect waned at 1 year
 - Group CBT with social skills training was superior to waitlist for symptoms, self esteem, coping strategies and social support³



Specialist FEP Programs

- Combine early detection with quick commencement of phase-sensitive treatment for individuals and their families¹
- May reduce risk of relapse and re-hospitalization compared to standard mental health services^{2,3}
- Implementing multimodal CBT (individual, family) for relapse prevention within an FEP program may reduce relapse in the first year, compared to the FEP program alone⁴

1. International Early Psychosis Association Writing Group, 2005 2. Craig et al., 2004 3. Goldberg et al., 2006

4. Gleeson et al., 2009.



CBT for Schizophrenia:

The questions that remain

- We know CBT, combined with pharmacological intervention, can facilitate recovery
 - Which modality?
 - Variation exists in focus (goals? symptoms?), length of treatment, interventions that have been studied
 - With what focus?
 - Positive symptoms? Negative symptoms? Functional outcomes? Quality of life? Acceptability to individuals receiving services?
 - Can this work in the real world?
 - Almost all work has been done in academic settings

1Dixon et al., 2009 2. American Psychiatric Association, 2004 3. National Institute for Clinical Excellence, 2002



Cognitive Behavioral Therapy and the Recovery Movement



A Focus on Recovery

While the federal government has mandated recovery-oriented care for behavioral health providers in the United States,¹

billions of dollars are simultaneously being allotted to train community providers in evidence based practices (EBPs)²

Providers often struggle to translate a recovery orientation into specific interventions or to integrate recovery principles with EBPs



Recovery: Important Ideas

- Those who have fully recovered identify three key factors:
 - Ability to engage in productive work
 - Meaningful relationships with others
 - Managing their own stress and experiences

Recovery Movement: What is needed?

- A theoretical framework for understanding individual problems
- Strategies to solve problems/implement recovery goals
- Development of an evidence base

Fusion of CBT and Recovery

- Traditional cognitive behavioral therapy has similar components as recovery:
 - Long-term goals
 - Collaboration
 - Engagement
 - Emphasis on positive assets
- Recovery-oriented Cognitive Therapy = fusion Cognitive Therapy and recovery principles

Recovery Oriented Cognitive Therapy



What is Recovery Oriented CT?

- Driven by engagement and the individual's goals
- The individual sets the goals for recovery
 - Goals are broken down into concrete steps
 - Obstacles to goals are the therapy targets
 - Conceptualization is the key to the obstacles
 - Achieving the goals reinforces the curative beliefs



Recovery: The Central Players

- Two experts meet:
 - Individual: The expert in his / her personal experiences and goals
 - Practitioner: The expert in ways in which many others have recovered
- Encounter loses impact if the practitioner:
 - Does not have a recovery orientation
 - Tries to do the other expert's job



Recovery: Additional Players

- Milieu training
 - Every interaction is an opportunity for intervention
- Shared case conceptualization leads to the whole team “speaking the same language”
- Continuity of care
 - Facilitates a faster, effective, cohesive approach
 - Example: start-up of intervention begins 30 days sooner in Extended Acute Care (EAC)

Efficacy of Recovery Oriented CBT

- Effective in a randomized clinical trial¹
- Compared to individuals receiving standard care in the community, those who received standard care plus CBT showed:
 - Better functioning ($d = 0.56$)
 - Reduced avolition-apathy ($d = -0.66$)
 - Reduced positive symptoms ($d = -0.46$)

1. Grant et al., 2012



Implementation in the Real World



Implementation in Real-World Settings

- Most studies of CBT for FEP have been completed in academia or outside of the US
 - There is a need to replicate them within the US health care system¹
- Since 2007, the Beck Initiative has implemented CBT in a wide range of levels of care and for many different behavioral health needs across several states

The Big Picture in a Brief Snapshot

Level of care

- Extended Acute Care
- Acute inpatient
- Assertive Community Treatment Teams
- Residential
- Low demand housing
- Homelessness outreach
- Addictions services / MAT
- Intensive Outpatient
- Adult / Child outpatient
- Schools
- And more...

Focus

- Schizophrenia
- Addictions
- Homelessness
- Trauma
- Incarceration
- Social isolation
- Poverty
- Suicidality
- Externalizing
- Internalizing
- And more...

Roles

- Psychiatrists
- Psychologists
- Creative arts therapy
- Full ACT team staff
- Social workers
- Case managers / ICM
- Peer specialists
- Psychiatric technicians
- Behavioral specialists
- Food services
- And more...



In for the long haul

- Implementing any practice in a real world setting is challenging enough
 - Feasibility
 - Acceptability
 - Fit
 - Fidelity
- A major issue that is absent from essentially all of the clinical trials literature is sustainability
 - After the initial investment, how do we maintain the services?

Example: The Beck Initiative in Philadelphia

- 44 programs in 35 agencies successfully trained in CBT
 - 85% of clinicians reached a level of competency commensurate with clinical trials
 - Rates were maintained at 2- and 4-year recertification
- Continuity of care among providers as people from diverse services are trained
- Detailed system of sustainability includes process for replenishing after staff turn-over, peer network among trained agencies, tailored sustainability plans for each agency

Philadelphia, cont'd.

- Two extended acute care units transformed into recovery oriented CT milieus
 - Staff trained across all three shifts
 - Individual and group therapy
 - Psychiatrists, psychologists, social workers, creative arts therapists, peer support staff, nursing staff, techs, and others
- Trained ACT teams begin care prior to discharge then support reintegration into the community

Philadelphia, cont'd.

- In a 24-bed locked acute-care unit, 29 staff members were trained in Recovery-Oriented Cognitive Therapy (CT-R)¹
 - Staff perceptions of the therapeutic environment improved significantly
 - Incidences of seclusion and restraint were cut by over half (from 19 to 7) comparing the 4 month periods before and after training
- In a second program, peer specialists were successfully trained and reported:²
 - Increased empathy and engagement with individuals being served
 - Application of the skills to their own recovery



Example: The Beck Initiative in Georgia

- Implementing recovery-oriented CBT in all 6 Regions
 - 1 completed, 1 wrapping up, 2 in full swing, 2 to go
 - 110 trainees across disciplines and levels of care
 - 110 individuals with Serious and Persistent Mental Illness (SPMI) and counting are now receiving CT-R
 - Creating continuity of care among providers
- Feasibility proving to be excellent
- Outcomes being measured now



Example: Mary

- 57 y.o. Irish American woman
- Referred by her psychiatrist of 25 years
- Lived with a sister, isolated, received help with most ADLs
- Blunted affect and paucity of speech
- Daily auditory and visual hallucinations
 - “Kill yourself.” “We will kill you.” “Useless!”
- Delusions
 - People are coming to kill me. I need to save local hospitals
- Called police, FBI, hospitals, family 15x/day (10 during baseline)
 - Caused her to quit her job, remain unemployed, be banned from CMHC programs, and have frequent police visits (which upset sister)
- Average of 5 inpatient admissions per year across 2 decades

Example: Mary

- Attended 70 individual 50-minute sessions weekly in year 1 and biweekly in the following 6 months
- Early: Collaboratively set a list of personal goals, foster engagement, become active, learn coping skills for hallucinations
- Middle: Learned skills that translated to volunteering and developing adaptive beliefs about herself, corrected unhelpful paranoid thinking, broadened coping skills for hallucinations
- Late: Relapse prevention, increase socializing, generalize volunteering to new tasks and situations

Example: Mary

- After 70 individual sessions:
 - No hospitalizations over a 24-month period
 - At session 50, stopped making calls to police and hospitals
 - Replaced calls with volunteering and a new friend
 - Relationship with sister improved, reported being happy when with her family
 - Better control over voices
 - Decreased conviction about paranoid beliefs
- Significant increase in global functioning at 18 months that was maintained at 24 months
- Reduction in avolition-apathy and positive symptoms at 18 and 24 months
- 2 standard deviation improvement over baseline in a measure of everyday functional skills
- 1 standard deviation increase on neurocognitive battery
- Compared to the cost of 10 hospitalizations over the 2 years, roughly a \$91,000 savings



Wrap up



Any Questions?



**For more information about CBT
development or implementation,
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Additional information

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