Implementation of Cognitive Behavioral Therapy for Psychosis in California

A collaboration between California Institute for Behavioral Health Solutions and Felton Institute

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Objectives

Practice Overview
• Review the Evidence Base for CBTp
• Describe engagement strategies for working with psychosis
• Present formulation as a way of understanding the origin and maintenance of psychotic symptoms

Implementation Protocol
• Training
• Clinical Consultation and Coaching
• Administrative Consultation and Coaching
• Evaluation Support

Pricing

Cognitive Behavioral Therapy for Psychosis

Thank you! Slides and training from Kate Hardy, Clin.Psych.D
Practice Overview

- Review the evidence base for CBTp
- Describe engagement strategies for working with psychosis
- Present formulation as a way of understanding the origin and maintenance of psychotic symptoms

What is Cognitive Behavioral Therapy anyway?
What is CBT?

• How you think leads to changes in how you feel and what you do
• Thinking includes how you think about:
  – Yourself
  – The world
  – Other people
• Here and now focus though draws upon past experiences to explain beliefs are formed
How does CBT apply to psychosis?

First described by Beck (1952)

However...
Largely overlooked as an intervention for psychosis

- Prominence of biological/medical models
- Studies in the 80’s that reported talking therapies as damaging to people with psychosis
- Long held assumption psychosis lies outside of realm of ‘normal psychological functioning’
Psychosis exists on a continuum

CBT for psychosis

Focus is on **reducing the distress** caused by **positive symptoms** including hallucinations and unusual thoughts

**Thoughts**
- Interpretation of the event that causes distress rather than the event itself
- Need to check the accuracy of the interpretation

**Behaviors**
- How are current behaviors maintaining the problem?
- Need to check the helpfulness of current behaviors
CBT for psychosis

Other target areas:
– Symptoms of depression and anxiety
– Past traumatic events
– Social skills
– Negative symptoms including lack of motivation
– Problem solving and decision making
– Developing coping skills
– Relapse prevention planning

Is there any evidence that CBTp is useful?
Evidence Base for CBTp

- Highly acceptable to consumers (Morrison et al., 2004)
- Reduced days in hospital (Jolley et al., 2003)
- Delayed impact with most improvement at follow up (Sarin et al., 2011)
- Decreased activation in brain areas associated with threat perception (Kumari et al., 2011)

Evidence Base for CBTp

**Stafford et al. (2013)**
- Meta-analysis reviewing interventions to prevent transition to psychosis
- ‘moderate quality evidence’ for CBT preventing transition to psychosis at 12 months (risk ratio 0.54)

**Jauhar et al. (2014)**
- Concluded that CBTp has therapeutic effect in the ‘small range’ (reduces when controlling for bias)

**Turner et al. (2014)**
- Significant efficacy in reducing positive symptoms (when compared with other psychosocial interventions)
Clinical Principles
CBTp techniques for all

1. Engagement and befriending
2. Embracing curiosity and normalizing
3. Understanding distressing voices and beliefs
Engagement and Befriending

Common Barriers to Engagement

**Incomprehensible/disorganized**
- Stay with the client and remain curious
- Information elicited may lead to fuller formulation
- Provide structure

**Silent**
- Remain patient
- Be aware of cognitive impairment and internal distraction

**Over talkative**
- Structure the session
- Attempt to interrupt (use humor)

Kingdon and Turkington (2008)
Embracing Curiosity
Normalizing and Questioning

Normalization

• CBT is inherently normalizing
  – We all experience negative thoughts
  – We all engage in unhelpful thinking
  – We all use coping strategies that aren’t always the most healthy choices

• Allows for normalizing of psychotic symptoms as well
Psychosis exists on a continuum

Normalization of psychotic symptoms

“Normalization is the antidote to stigma”

– Avoid catastrophizing
  • Mental Illness is a common experience (1 in 4 people)
  • Psychosis can affect anyone regardless of age, ethnicity, gender, SES
  • Large number of people can overcome symptoms
  • Symptoms may be viewed positively in different cultures

Normalizing experiences – not dismissing them
  • Check in how the information is received (invalidating?)
Tips for Curious Questioning

- Be curious
- Don’t make assumptions
- Be open to different explanations
- Explore all possibilities
- Ask questions
Understanding distressing voices and beliefs – Formulation

Formulation

- Stress Bucket
- Mini Formulation
- *Morrison’s Interpretation of Intrusions*
Stress Bucket

- Hearing voices
- Parents arguing
- Applying for college
- Exams coming up
- Talk to voices
- Stay up all night playing video games
- Play video game for one hour
- Go for a walk
- Buffer Zone
- Stress Level

Adapted from UNSW Counseling Services & Carver et al., 1989

Mini Formulation

EVENT

INTERPRETATION

EMOTIONS

BEHAVIOR

THOUGHTS
Mini Formulation

Cognitive Intervention: Exploring the evidence

<table>
<thead>
<tr>
<th>Thought: the people across the hall are talking about me (90%)</th>
<th>Evidence For</th>
<th>Evidence Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>They said my name</td>
<td>They've never actually directly spoken to me</td>
<td></td>
</tr>
<tr>
<td>I feel afraid when I am around them</td>
<td>The noise was a whisper and not a shout</td>
<td></td>
</tr>
<tr>
<td>I've heard shouting from that room before</td>
<td>When I recorded the voice and played back the tape there wasn't anything there</td>
<td></td>
</tr>
</tbody>
</table>

Belief: the people across the hall are talking about me (40%)

Alternative possibility: I am hearing an auditory hallucination (60%)
Morrison’s (2001) Model of Psychosis

- Positive symptoms are conceptualized as intrusions into awareness
- The interpretation, rather than the intrusion, causes distress and disability
- Symptoms are maintained by mood, arousal and mal-adaptive cognitive-behavioral responses (e.g. avoidance)

Theoretical Model

intrusion from low level processing units
(cognitive, body state, emotional or external information)

interpretation of intrusion
(culturally unacceptable)

faulty self & social knowledge
(procedural and declarative beliefs)

experience

cognitive and behavioural responses
(including safety behaviours, selective attention and thought control strategies)

mood & physiology

Formulating Psychosis
(Morrison, 2001)

What happened
Hears voices mocking and taunting

How I make sense of it
The people across the hall are talking about me

Beliefs about yourself and others
I'm a failure.
I'm different

What do you do when this happens?
Talk to voices
Stay in room.
Isolate

Life experiences
Poor grades in school
Bullied at school
Critical father

How does it make you feel?
Scared
Hopeless
Interventions

**Cognitive**
- Explore thought “the people across the hall are talking about me”
- Develop alternative (helpful and accurate) thought

**Behavioral**
- Learn new coping skills for voices and apply
- Practice for homework and report back in session

**Core Belief (Schema)**
- Explore beliefs “I am a failure” and “I am different”
- Develop healthier core beliefs

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**Formulating Psychosis**

**What happened**
Hears voices mocking and taunting

**How I make sense of it**
This is an auditory hallucination
I have skills to manage these voices

**Beliefs about yourself and others**
I have succeeded in several areas of my life
Everybody is unique

**Life experiences**
Poor grades in school
Bullied at school

**What do you do when this happens?**
Use coping skills

**How does it make you feel?**
Stronger

(Morrison, 2001)
Implementation Protocol

Implementation support is provided utilizing CIBHS Community Development Team (CDT) Model, one of three evidenced-based approaches to Implementation support of Behavioral Health Practices.

Why implementation support and not just training?

- Practicing without fidelity can lead to worse outcomes than usual practice
- Promotes retention of Knowledge, preservation of skills, and clinical innovation
- Provides data and evaluation strategy which allows for practice improvements in “real time”
- Protects the ‘investment’ in the practice-practitioners are able to facilitate client improvement, more skillfully/quickly
CBTP Training and Implementation Protocol

- Pre-Implementation Planning Meeting (in-person or webinar, conf. call)
- Training Coordination-Logistical coordination of Training Events
- Three-Day Initial Clinical Training
- Weekly Clinical Supervision Calls (1 hr) for 6 months
- Review of 6-8 Audio-tapes using CTS-R coding for fidelity and adherence monitoring

Implementation (cont)

- Monthly Administrator Calls (for TA, peer to peer learning support)
- Evaluation Protocol and Strategy-measure effectiveness of practice at client level
- Data Coordination and Collection
- Bi-annual Program Performance Dashboard Reports
- Two-Day CBTP Booster Training
Pricing for the Practice includes ALL the aforementioned activities and supports. Pricing is based on the following assumptions:

- A minimum team size per agency of 4 Clinicians, maximum of 6 in one team.
- Teams are trained in “cohorts” that may be made up of teams from multiple agencies.
- These ‘cohorts’ remain intact throughout the implementation cycle.

- Price for a team of four is 20,000, or 5000.00 per clinician.
- Price for every clinician added after 4 is 4500.00. For instance, a second team of 4 clinicians would be 18,000 vs. 20,000 for the first team.
In the United States (U.S.), case managers are the frontline point of contact for people with schizophrenia, providing day-to-day assistance with activities, entitlements and transportation for their clients.

Case managers may or may not hold undergraduate or advanced degrees or have clinical training. Case managers spend more time with their clients than do other clinicians working on a community mental health center team.

Therefore, training case managers to use high-yield CBT-p (HYCBT-p) techniques during brief (15-30 minute) encounters in the course of their usual work could have substantial impact on the people with schizophrenia receiving treatment in the U.S. public mental health system.

High yield cognitive behavioral techniques for psychosis are a series of techniques that can be used by healthcare workers during their interactions with patients who have a diagnosis of schizophrenia.

The techniques are not seen as therapy and are not used in traditional therapy sessions – however they enable conversations to be structured in such a way that builds on therapeutic engagement, increases understanding and creates a collaborative partnership between the healthcare worker and the patient.

The techniques sit within a cognitive behavioral philosophy in a service where patients can seamlessly move between healthcare workers.
• Case Manager High Yield Training
  – Challenging
  – Interactive
  – Fun
  – Relevant
  – Collaborative
  – Rewarding

Two Days Training

• Essential follow on from the training
• Overcoming Obstacles
• Sharing Best practice/Success
• Continual Development

Supervision
CBTP Training and Implementation Protocol

- Pre-Implementation Planning Meeting (inperson or webinar, conf. call)
- Training Coordination-Logistical coordination of Training Events
- 2-Day Initial Training
- 1 Day additional Training for supervisors
- Monthly Supervisor Coaching Calls

Implementation (cont.)

- Monthly Administrator Calls (for TA, peer to peer learning support)
- Evaluation Protocol and Strategy-measure effectiveness of practice at client level
- Data Coordination and Collection
- Bi-annual Program Performance Dashboard Reports
Pricing

• Pricing for the Practice includes ALL the aforementioned activities and supports.
• Pricing is based on the following assumptions:
  – Teams are trained in “cohorts” that may be made up of teams from multiple agencies
  – These ‘cohorts’ remain intact throughout the implementation cycle
  – Teams must include a supervisor

Pricing

• 1500.00 Per Frontline Practitioner
• 2500.00 Per Supervisor
FIND OUT MORE

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