Recovery-Oriented Cognitive Therapy (CT-R) Approaches in Treating People with Serious Mental Illness Including Discussion of the 2018 TTI Initiative

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Objectives

• Introduce the theory and research underlying Recovery-Oriented Cognitive Therapy (CT-R)

• Describe the basic CT-R approach

• Describe how CT-R has been implemented across several state systems
CT-R Theory & Research
Connection

• Connection is a basic human need

• Individuals with serious mental health conditions have considerably fewer connections

• Connection is at the core of CT-R

Negative symptoms are a major contributor to disconnection

Negative symptoms predict hospitalization and increased length-of-stay
Dr. Beck’s revolutionary 1963 paper

Introduction to the cognitive model and cognitive therapy

As I look back over the past 65 years, my professional life has been filled with what I can best describe as a continual series of adventures. For the most part, the challenges that I’ve confronted were of my own making. Like Theseus in the labyrinth, whenever I seemed to find a solution to a problem, I was confronted with another problem. My initial difficult confrontation occurred when I was a fellow at the Austin Riggs Center in Stockbridge, Massachusetts. I was assigned to work with a young man with a pervasive delusion of being followed by government agents. To my surprise, even though the therapy was for the most part supportive, the delusion disappeared. In 1952, I subsequently published this case history as the first reported successful psychotherapy of an individual with schizophrenia (Beck, 1952). This case report is of particular interest since 50 years elapsed before I returned to the psychotherapy of schizophrenia: a form of mental illness that is considered, then and now, to be relatively impervious to psychotherapy. In 1956, fresh from having passed my boards in who were not depressed. To our surprise, the patients with depression showed less hostility in their dreams than did the nondepressed individuals. This negative finding posed a dilemma for us: It would seem that the absence of manifest hostility in dreams, which had been characterized by Freud as the “royal road to the unconscious,” invalidated the theory of inverted hostility. However, after examining the content of dreams for a second time, we found that the dreams of the patients with depression consistently portrayed the dreamer or the action in the dream in a negative way. Conversely, this consistent finding was not evident in the dreams of the nondepressed patients. We then reasoned that the hostility was unable to penetrate through the dreams, but it still existed at an unconscious level and assumed the form of a need to suffer. Because of this theme, we labeled these dreams as “masochistic” and found that using this negative portrayal of the dreamer as a symbol of the need for personal suffering clearly differentiated the patients with depression from those without (Beck & Horwich, 1959).
Transdiagnostic

- Panic
- Personality disorders
- Anger
- Loneliness
- Marital conflict
- PTSD
- Sleep disorders

- Depression
- Anxiety
- Substance abuse
- Criminality
- Eating disorders
- Schizophrenia
- Chronic pain
- Terminal illnesses
Cognitive Model

For Challenges-

- **Self**: weak, vulnerable, ineffective, and worthless
- **Other**: controlling, dangerous and rejecting
- **Future**: uncertain, forbidding

For Resilience and Empowerment-

- **Self**: I am a good person; I have purpose; I am successful
- **Other**: People appreciate me; I belong; things go better with other people
- **Future**: I can contribute and make a difference

Basic Science
Defeatist Beliefs

“Taking even a small risk is foolish because the loss is likely to be a disaster.”

“If I fail partly, it is as bad as being a complete failure.”

Impact

- Performance on tests of attention, memory, executive function
- Negative symptoms
- Leaving the house
- Community participation
- Work outcomes
- Effort
- Belonging


Asocial Beliefs

“I prefer hobbies and leisure activities that do not involve other people.”

“People sometimes think I’m shy when I really just want to be left alone.”

Impact

– Access to motivation

– Community participation

Sources of Neurocognitive Performance

Validation
Clinical Trial of Recovery-Oriented Cognitive Therapy Compared to the Standard Treatment (ST) patients, CT+ ST patients had:

- Better functioning \((d = 0.56)\)
- Reduced avolition-apathy \((d = -0.66)\)
- Reduced positive symptoms \((d = -0.46)\)
Gains maintained over the course of 6-month follow-up in which no therapy was delivered:

- Better Functioning \( (d = 0.53) \)
- Reduced Negative Symptoms \( (d = -0.60) \)
- Reduced Positive Symptoms \( (d = -1.36) \)
Clinical Trial Follow-Up

Figure 2

NOTE: 'p < .10, * p .05, ** p < .01

Importance of Positive Beliefs

- 35 individuals with low neurocognitive scores and elevated negative symptoms
- Guided Success vs Control
- Changes in positive beliefs and mood most impact improvement in card sorting performance

Translating Science to Practice
Modes

- Activation of Maladaptive Mode
  - Deactivation of Positive Goals, Meaning, Beliefs
    - Activation of Negative Beliefs, Goals, etc.
    - Negative Expectancies
      - Failure
      - Rejection
      - Lack of Pleasure
      - Avoidance, Withdrawal, Non-responsiveness
  - Deactivation of Negative Goals, Meaning, Beliefs
    - Activation of Positive Beliefs, Goals, etc.
    - Positive Expectancies
      - Success
      - Acceptance
      - Pleasure
      - Engagement, Activity, Social Participation

- Activation of Adaptive Mode
CT-R Applications

• Individual therapy

• Group therapy

• Milieu approach

• Community-based team approach
Individual & Group Therapy Structure

- Opening: Energizer
- Bridge: Shared Mission
- Aspirations: Elicited and Developed
- Challenges: Problem Solving in Context of Aspirations
- Action Plan
Adaptive Mode

Access  Energize  Develop  Actualize  Strengthen
## CT-R Recovery Map

<table>
<thead>
<tr>
<th>Recovery Map</th>
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<tbody>
<tr>
<td><strong>ACTIVATING THE ADAPTIVE MODE</strong></td>
</tr>
<tr>
<td>Interests/Ways to Engage:</td>
</tr>
<tr>
<td><strong>ASPIRATIONS</strong></td>
</tr>
<tr>
<td>Goals:</td>
</tr>
<tr>
<td><strong>CHALLENGES</strong></td>
</tr>
<tr>
<td>Current Behaviors/Challenges:</td>
</tr>
<tr>
<td><strong>POSITIVE ACTION &amp; EMPOWERMENT</strong></td>
</tr>
<tr>
<td>Current Strategies and Interventions:</td>
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</tbody>
</table>
Adaptive Mode: Connection

Access  Energize  Develop  Actualize  Strengthen
When are people at their best?
Energizing the Adaptive Mode

• Establish connection through repeated engagement in meaningful pleasurable activities
  – Reveal strengths and capabilities
  – Energize non-patient-related identity
  – Experience belonging and meaningful role
  – Develop trust
  – Begin to think about the future

• Access to motivation + energy
Adaptive Mode: Hope

Access  Energize  Develop  Actualize  Strengthen
Developing the Adaptive Mode

- Identify
- Enrich
- Meaning behind long-term aspirations
- Action now linked to the meaning
Developing the Adaptive Mode

- Steps vs. Aspirations
- Challenges vs. Aspirations
- Unlikely/Distant Aspirations
- Dangerous Aspirations
Developing the Adaptive Mode

Finding the meaning

• What would be good about that?
• What would be the best part?
• What would it mean about you to accomplish that?
• How would other people see you?
• What would it feel like?
Positive Action

• Breaking down aspirations into small/achievable steps

• Addressing challenges as it impacts steps towards aspirations

• “Learning through Doing”
Actualizing the Adaptive Mode

• Community participation (going to church with family and friends, cooking family dinners, performing at an open mic)

• Meaningful role

• Growing social network

• Achieve Aspirations
Adaptive Mode: Resilience

Access  Energize  Develop  Actualize  Strengthen
Conclusions
- Draw attention to positive experiences
- Strengthening beliefs through targeted questions
  - Connection
  - Control
  - Capability
  - Energy

Developing resiliency in the face of stress and challenges

Adaptive mode becomes dominant mode
### Drawing New Conclusions: Guided Discovery

<table>
<thead>
<tr>
<th>Question</th>
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</tr>
</thead>
<tbody>
<tr>
<td>When were there times when you felt better/worse?</td>
<td>In what ways did you have more/less control?</td>
</tr>
<tr>
<td>How did this go better or worse than expected?</td>
<td>How did this get you closer to or further from what you want?</td>
</tr>
<tr>
<td>How would it be helpful to do more or less of this?</td>
<td>What does it mean about you that you accomplished all this?</td>
</tr>
</tbody>
</table>
Resilience
Building Resiliency

Troubleshooting difficult experiences

• Perceived/real rejection

• Perceived/real failure

• Disappointment

• Feeling overwhelmed
Implementation
Outcomes during six months of supervised recovery-oriented cognitive therapy for a sample of 376 individuals with low-functioning schizophrenia*

*100 (27%) treated in state hospitals, 130 (34%) treated by ACT teams, and 146 (39%) treated in outpatient settings.


***All 376 had significant functional impairment: prominent negative symptoms = 214 (57%); delusions = 184 (49%); hallucinations = 163 (43%); thought disorder = 26 (7%); behavioral obstacles such as substance use, aggressive behavior, hypervigilance = 304 (81%); environmental obstacles = 192 (51%); and physical health problems = 28 (7%).

<table>
<thead>
<tr>
<th>Recovery Dimension **</th>
<th>n (%)</th>
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<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td></td>
</tr>
<tr>
<td>• Engaged in positive activity outside sessions: 189 (39%)</td>
<td>220 (59%)</td>
</tr>
<tr>
<td>• Moved toward valued aspirations: 147 (39%)</td>
<td></td>
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<tr>
<td>• Began participating in a hobby</td>
<td></td>
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<tr>
<td>• Obtained employment: 34 (17%)</td>
<td></td>
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<tr>
<td>• Took on a new/unique role: 24 (6%)</td>
<td></td>
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<tr>
<td>• Started participating in school/college: 9 (2%)</td>
<td></td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td></td>
</tr>
<tr>
<td>• Spent time with others outside the treatment team</td>
<td>107 (28%)</td>
</tr>
<tr>
<td>• Joined an organization</td>
<td></td>
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<tr>
<td>• Started dating</td>
<td></td>
</tr>
<tr>
<td>• Made a new friend</td>
<td></td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td></td>
</tr>
<tr>
<td>• Engaged in physical activity outside sessions</td>
<td>186 (49%)</td>
</tr>
<tr>
<td>• Experienced improvement in obstacles *** to recovery</td>
<td></td>
</tr>
<tr>
<td><strong>Home</strong></td>
<td></td>
</tr>
<tr>
<td>• Experienced an improvement in environmental obstacles (legal, housing, economic, support system)</td>
<td>36 (10%)</td>
</tr>
</tbody>
</table>

PROGRESS WITHIN AT LEAST ONE RECOVERY DIMENSION 260 (69%)
Philadelphia Outcomes

Sample = 116 individuals

Incarceration
• Resulted in a 83.9% decrease in jail stay

Hospitalization
• Resulted in 50.5% decrease in hospital level of care
New York

- Staten Island
  - South Beach
    - State Hospital
    - Transitional Living Residences
    - Mobile Crisis Team
- Rockland
- Manhattan
- Columbia University
New York State Outcomes

• 50% of previously non-responsive group moved to less restrictive care
• Reduced loneliness
• Decreased hopelessness
• Increase in flourishing
• Increase in functional skills
- Montana State Hospital
- AWARE
  - 2 Programmatic Residences
- Center for Mental Health
  - Outpatient
  - Day Treatment
  - Residential
  - Vocational
- Train-the-Trainer
  - State hospital champions
  - Outpatient champions
  - State Administrators
• Vermont Psychiatric Hospital (State Hospital)
• Pathways
  – Housing First
  – Soteria Program
• Washington County Mental Health Services
• Clara Martin Center
• Middlesex Therapeutic Residence
Georgia

• Phase 1:
  – State Hospital
  – Community Treatment Team
  – Community Service Board
  – Continuity of Care
• Phase 2:
  – Center of Excellence (COE)
  – Retraining the state
  – First Episode
• Phase 3:
  – Peers
  – Supervisor
  – Adolescent
4 Behavior Health Homes
- Oaks Integrated Care
- All Access Mental Health
- Catholic Charities Dioceses of Trenton
- Hackensack-Meridian Health
Tewksbury State Hospital
Carney Hospital (Acute setting)
Department of Mental Health Brockton PACT
Behavioral Health Network's Forensic PACT
Service Net's Prevention and Recovery in Early Psychosis (PREP West)
Eliot Community Services' PATH team (Project for Assistance in Transition from Homelessness)
Specialists

• Case managers
• Direct-care staff
• Social workers
• Psychologists
• Psychiatrists

• Art and rec therapists
• Nurses
• Occupational therapists
• Peers
• Drug & Alcohol
Sustainability

Training CT-R champions

CT-R informed documentation

Ongoing internal CT-R consultation among staff

Learning collaborative

Quality & Fidelity Scale
Benchmarks

• Helps everyone involved know
  – what we’re going for
  – how well they’re doing

• Oriented toward specific outcomes and different sustainability models
SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.

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