RECOVERY-ORIENTED COGNITIVE THERAPY (CT-R) APPROACHES FOR INDIVIDUALS WITH SERIOUS MENTAL HEALTH CONDITIONS

INTERNATIONAL INITIATIVE FOR MENTAL HEALTH LEADERSHIP AND INTERNATIONAL INITIATIVE FOR DISABILITY LEADERSHIP
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BECK INSTITUTE CENTER FOR RECOVERY-ORIENTED COGNITIVE THERAPY
TAKE HOME MESSAGES

- A desired life is possible for everyone…it just might take longer for some
- We can create this life through meaningful participation rather than symptom reduction
- Anyone can play a significant role in an individual’s progress
- Sometimes the best treatment doesn't look like treatment
- An evidence-based approach can be successfully implemented at all levels of care – it is a matter of retooling the work of existing staff to produce transformative outcomes
- This has been successfully done in several state systems
ANECDOTES
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
The clinical and theoretical papers dealing with the psychological correlates of depression have predominantly utilized a motivational-affective model for categorizing and interpreting the verbal behavior of the patients. The cognitive processes as such have received little attention except insofar as they were related to variables such as hostility, orality, or guilt. The relative lack of emphasis on the thought processes in depression may be a reflection of—or possibly a contributing factor to—the widely held view that depression is an affective disorder, pure and simple, and that any impairment of thinking is the result of the affective disturbance. This opinion has been buttressed by the failure to demonstrate any consistent evidence of abnormalities in the formal thought processes in the responses to the standard battery of psychological tests. Furthermore, the few experimental studies of thinking in depression have revealed no consistent deviations other than a retardation in the responses to “speed tests” and a lowered responsiveness to a Gestalt Completion Test.

In his book on depression, Kraines on the basis of clinical observations indicated several characteristics of a thought disorder in depression. The objective of the present study has been to determine the prevalence of a thought disorder among depressed patients in psychotherapy and to delineate its characteristics. An important corollary of this objective has been the specification of the differences from and the similarities to the thinking of nondepressed psychiatric patients. This paper will focus particularly on the following areas: (1) the idiosyncratic thought content indicative of distorted or unrealistic conceptualizations; (2) the processes involved in the deviations from logical or realistic thinking; (3) the formal characteristics of the ideation showing such

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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 & Horvath, 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

<table>
<thead>
<tr>
<th>For Challenges-</th>
<th>For Resilience and Empowerment-</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self:</strong> weak, vulnerable, ineffective, and worthless</td>
<td><strong>Self:</strong> I am a good person; I have purpose; I am successful</td>
</tr>
<tr>
<td><strong>Other:</strong> controlling, dangerous and rejecting</td>
<td><strong>Other:</strong> People appreciate me; I belong; things go better with other people</td>
</tr>
<tr>
<td><strong>Future:</strong> uncertain, forbidding</td>
<td><strong>Future:</strong> I can contribute and make a difference</td>
</tr>
</tbody>
</table>

BASIC SCIENCE
DEFEATIST BELIEFS

Impact

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

“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.”


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

VALIDATION
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 ($d = -0.46$)
Six-Month Follow-Up of Recovery-Oriented Cognitive Therapy for Low-Functioning Individuals With Schizophrenia

Paul M. Grant, Ph.D., Keith Bredemeier, Ph.D., Aaron T. Beck, M.D.

Objective: The study examined six-month follow-up results and the impact of length of illness on treatment outcomes of recovery-oriented cognitive therapy (CT-R).

Methods: Sixty outpatients (mean age 38.4 years, 33% female, 65% African American) with schizophrenia or schizoaffective disorder and elevated negative symptoms were randomly assigned to CT-R or standard treatment. Assessments were conducted at baseline, mid-treatment (six and 12 months), end of treatment (18 months), and follow-up (24 months, N=46 after attrition) by assessors blind to treatment condition. Global functioning, measured with the Global Assessment Scale, was the primary outcome. Secondary outcomes were negative symptoms (avolition-apathy score on the Scale for the Assessment of Negative Symptoms) and positive symptoms (total score on the Scale for the Assessment of Positive Symptoms). Length of illness indexed chronicity (less chronic, one to 12 years; more chronic, 13 to 40 years).

Results: Intent-to-treat analyses (hierarchical linear modeling) at follow-up indicated significant benefits for individuals assigned to CT-R compared with standard treatment: higher global functioning scores (between-group Cohen's d = 5.3), lower scores for negative symptoms (d = 1.36), and lower scores for positive symptoms (d = 1.36). Length of illness moderated treatment effects on global functioning, such that those with a less chronic illness began to show improvements earlier (at the trend level by six months and reaching significance by the end of treatment), whereas the group with a more chronic illness did not show significant improvements until later (at follow-up).

Conclusions: CT-R produced durable effects that were present even among individuals with the most chronic illness.

Psychiatric Services 2017; 00:1–6. doi: 10.1176/appi.ps.201600413
CLINICAL TRIAL FOLLOW-UP

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

TRANSLATING SCIENCE TO PRACTICE
MODES

- Activation of Maladaptive Mode
  - Deactivation of Positive Goals, Meaning, Beliefs
    - Activation of Negative Beliefs, Goals, etc.
- Activation of Adaptive Mode
  - Deactivation of Negative Goals, Meaning, Beliefs
  - Activation of Positive Beliefs, Goals, etc.

Negative Expectancies
- Failure
- Rejection
- Lack of Pleasure

Avoidance, Withdrawal, Non-responsiveness

Positive Expectancies
- Success
- Acceptance
- Pleasure

Engagement, Activity, Social Participation
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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</thead>
<tbody>
<tr>
<td>ACTIVATING THE ADAPTIVE MODE</td>
</tr>
<tr>
<td>Interests/Ways to Engage:</td>
</tr>
<tr>
<td>ASPIRATIONS</td>
</tr>
<tr>
<td>Goals:</td>
</tr>
<tr>
<td>CHALLENGES</td>
</tr>
<tr>
<td>Current Behaviors/Challenges:</td>
</tr>
<tr>
<td>POSITIVE ACTION &amp; EMPOWERMENT</td>
</tr>
<tr>
<td>Current Strategies and Interventions:</td>
</tr>
</tbody>
</table>
IMPLEMENTATION
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
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>
</tr>
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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>
</tr>
<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

- South Beach Psychiatric Center
  - State Hospital
  - Transitional Living Residences
  - Mobile Crisis Team
- Rockland Psychiatric Center (pilot)
- Manhattan Psychiatric Center
- 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
NEW YORK: NEXT STEPS

Bronx
Creedmoor
Kingsboro Pilgrim
Mid-Hudson
Manhattan
NYSPI
Kirby
Rockland
- 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
MONTANA NEXT STEPS

- Train the trainer – 3 regions (50 trainers)
- Expanding the CT-R network (250 providers)
VERMONT

- Vermont Psychiatric Hospital (State Hospital)
- Pathways
  - Housing First
  - Soteria Program
- Washington County Mental Health Services
- Clara Martin Center
- Middlesex Therapeutic Residence
• Introduce fidelity scale to bolster implementation
• Focus on work, forensic, and homelessness programs
NEW JERSEY

4 Behavior Health Homes (integrative care)

- Oaks Integrated Care
- All Access Mental Health
- Catholic Charities Dioceses of Trenton
- Hackensack-Meridian Health

Rutgers Train-the-Trainers
MASSACHUSETTS

- 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 – QUALITY IS MEASUREABLE

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

• Oriented toward specific outcomes and different sustainability models
THANK YOU!

• An evidence-based approach can be successfully implemented at all levels of care – it is a matter of retooling the work of existing staff to produce transformative outcomes

• This has been successfully done in several state systems

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