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Challenging Our Understanding of Psychoses and Exploring Alternatives for Recovery
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Hearing Voices Groups using CBT for Psychosis Tools & Principles

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Agenda

- Welcome & Introduction
- The Program
- The Process
- The Emerging CRCT Model
- Program Evaluation

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Learning Objectives

- Be introduced to a non-medical community-based psychological service model for individuals experiencing distressing voices.
- Understand rationale and benefits of psychological programming (CBTp) from several perspectives (participant, CBTp consultant/therapist, social worker facilitator, peer-worker facilitator, organizational)
- Get ideas about how to implement a similar service model in your agency.

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Test your Hearing Voices IQ:

QUIZ

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Quiz

1. Which of the following can bring on hallucinations:
   a) bereavement, b) being held hostage, c) sleep deprivation,
   d) sensory deprivation, e) all of the above?

2. Hearing voices is a sign of mental illness—**T or F**?

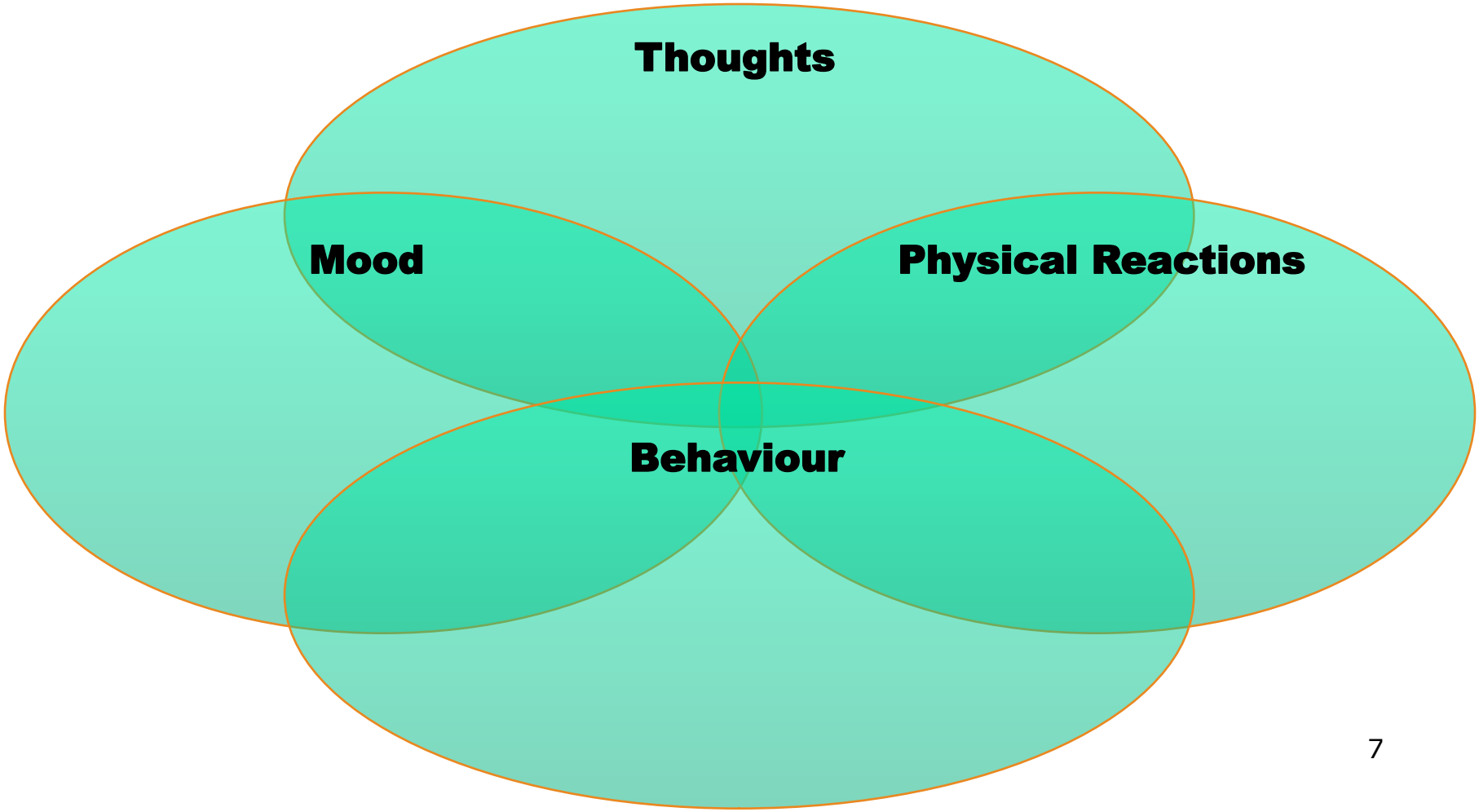
3. About one in ten of the adult population hears voices—**T or F**?

4. Auditory hallucinations are accompanied by movements of the speech muscles —**T or F**?

What is CBT?

<u>Situation/Trigger</u>

Eating lunch with co-worker in cafeteria, your boss abruptly asks to speak with you in her office afterward.



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The Program

- Hearing Voices group utilizing CBT for Psychosis tools and principles.
- 16-week, 2 hour weekly group sessions for 6-8 individuals who are voice-hearers distressed by their voices.

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AIM

- To empower participants by providing psycho-education, normalizing information, and instruction in self-management strategies in order to reduce distress associated with hearing voices, as well as demystify, depathologize, and destigmatize the experience of hearing voices.
- **The goal is not necessarily to eliminate the voices.**

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Rationale

- Empirical knowledge (e.g. UK: NICE, 2002, 2009; USA: Lehman et al., 2004; Dixon et al., 2009; Australia and New Zealand: McGorry, 2005; Canada: Addington et al., 2005; Haarmans, in press).
- An alignment with recovery philosophy
- Benefit of peer support (Escher 1993)
- Trauma-informed

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Rationale (cont'd)

- Empowers people with an evidence-based choice:
  - For individuals who choose not to take medication
  - Where there is only partial or no response to medication
  - For those who discontinue medication*
  - "The literature makes it abundantly clear that service users want to be offered more than just medication" (Warner, Mariathasan, Lawton-Smith, & Samele, 2006)

* CATIE trial reveals that approximately 75% of individuals chose to discontinue medication within the first 18 months of treatment (Lieberman et al., 2005)

The Process

- The First Phase:
  - RFP
  - 1ST Training
  - Pilot group
- The Second Phase: Formalizing the CBTp Initiative
  - Developing CRCT's Manual (facilitators and participants)
  - Outreach & Recruitment
- The Third Phase: Emerging CRCT Model
- The Fourth Phase: The Groups & Evaluation
  - Scarborough
  - Downtown Toronto

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EMERGING CRCT MODEL

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Emerging CRCT Model

- Depathologizing, trauma-informed, culturally-responsive
- Facilitator Training for CBT for Psychosis
- Co-facilitators - peer & social worker
- Individual Orientation Interviews
- Bi-weekly clinical supervision (via Skype/face-face)
- 2-hour weekly group
- 1-hour pre-group planning & 1-hour post-group debriefing
- Ongoing booster sessions for participants & booster training for facilitators

Conceptual Framework

Based on a cognitive-behavioural conceptualization for psychosis that people's beliefs about voices shape how they feel, what they do and how they cope with them. Types of beliefs for understanding emotional responses to voices:

1) voice's identity,
2) purpose
3) omnipotence, and
4) beliefs about the consequences of obedience and disobedience (Chadwick et al., 1996, pp19-20).

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Manual Development

- Accompanies PowerPoint & participant manual
- Accompanied by Resource Book: *"Think You're Crazy, Think Again!"*
- Provides step-by-step detailed procedures
- Provides TIPS, PRINCIPLES & POINTS TO CONSIDER sections
- Allows for easy adaptability
- Allows 'how to' support for new CBT facilitators

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Personal Reflections from the Facilitators

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Why I Was Drawn to CBTp

- Tackles stigma, taboo, shame
- Lack of affordable and accessible therapeutic resources
- Need for non-medical/medicinal therapy
- Participants heard and accepted for who they are not their label
- Holistic approach
- Addressing issues in a way that has not be done before

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What I get From the Program

- Job dynamism
- Satisfaction of seeing participants learn, grow and achieve
- Expansion of my professional toolkit
- Inspiration
- Greater sense of hope

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Contributing from lived experience

- **Very collaborative and fairly time intensive** fully worth it as a contributor and a training experience
- **It called on being reflective** of personal experience with 'larger-than-life' emotions, thoughts and experiences (trauma)
- **Enjoyable and rewarding** to see a useful and distress reducing tool transform into something that can be of personal benefit to others
- **A non-traditional peer experience**
- **Increased personal responsibility** in creating quick thought records for myself

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The process

- **Asking questions** - what messages come, is this doable, is it helpful
- **Teamwork -** Creative & conceptual
- **Lots of communication** and active listening
- **Challenge:** 'journeying with' and 'journeyed as' together it was work creating and finding understanding
- **Humour** and breakthroughs when we did find it
- **Challenge: translating terminology** to lay-language and being faithful to the work and integrity of the material
- **Challenge:** equally valuing my own contribution

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Training benefits

- **Provided marketable and transferable work skills** and experience - including stronger knowledge of CBT and specifically CBT for distressing voices facilitation
- Created **a 'role bridge'**
- Strengthened own experience of **CBT**
  -- as an empowerment strategy

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Evaluation & Feedback

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Feedback/Research Evaluation Results

- Peer developed CHOICE questionnaire
- Informal chats and phone calls
- The in-group feedback (weekly Check-Out)
- Content-specific questionnaire

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ER Visits

	None	Visited ER once	Visited ER more than once
6 months prior to start	9	4	1
4 months after the group started	15	1	0

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What We've Learned

- Ratings were not as helpful because participants had some difficulty with assigning numbers,
- Narrative was more informative.
- Our actuals may vary slightly because not everyone might have included responses
- We started the groups with 29 participants
- Final evaluations were completed by 19 participants, with an attrition rate of 34 %

Reported Outcome

- Participants' level of knowledge about their voices,
- Most felt that they've learned new methods that helped them manage their experience better,
- Some felt that they became more hopeful, confident and positive.

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"The Best thing about the group for me was the realization that I was not the only one."

"My voice is constant, but I am learning to live with it."

"I was always thinking, 'why do I have this stupid voice controlling my life?'-- Now I know other people also deal with it, and they cope. I want to get there."

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"I learned not to see myself as someone controlled by the devil. Other people who are important hear the voice and they control it"

"Learned to examine my thoughts and how it gets the cycle going. I am learning to control how my thoughts affect my actions."

"I can breathe and think about things before I do what the voice tells me. I am learning to challenge what the voice is telling me."

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Lessons Learned & Recommendations

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Who dropped out – and why

- Pressure to join (e.g. workers or family members)
- Inaccurate information about the purpose
- Lack of readiness
- Lack of access to appropriate psychological support (e.g. delusions, depression, anxiety)
- Lack of access to individual CBT support
- Physical illness
- Language/literacy barriers

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Lessons Learned

- Support & dedication to approach from upper management is important
- Facilitators belief in effectiveness of CBTp is critical
- Be flexible enough to respond to varying individual needs e.g. modifying/adapting session content
- Face-to-face individual participant orientation meetings essential
- Keep the group size 6-8 max

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Lessons Learned (cont'd)

- Regular Clinical supervision is essential
- Co-facilitator reflection questions early in the process
- Establish clear roles & responsibilities for all program personnel
- Offer individual as well as pair supervision
- Reducing attrition by—
  - clarifying purpose of the group
  - building in follow-up supports (e.g. phone calls)
  - exploring with the group the value of their continued participation
  - soliciting ongoing feedback (e.g. session check-out, 1-1)

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Some Final Recommendations

- One-on-one CBTp is offered to group participants.
- Training providers (e.g. case managers) on CBTp principles and tools
- Train facilitators who speak other languages to enable CBTp service in participant's first language
- CBTp education for families and friends (those who are a support to the person)

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KEY REFERENCES

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THANK YOU!