

COGNITIVE PROCESSING THERAPY WITH DIVERSE POPULATIONS

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COGNITIVE PROCESSING THERAPY (CPT) IS...

a short-term,
evidence-based
treatment for PTSD

a specific protocol
that is a form of
cognitive-behavioral
treatment

predominantly
cognitive and may
or may not include a
written account

a treatment that can
be conducted in
groups or
individually

CPT: PHASES OF TREATMENT

Pretreatment assessment and pretreatment issues

Education regarding PTSD, thoughts, and emotions

Processing the trauma

Learning to challenge

Trauma themes

Facing the future

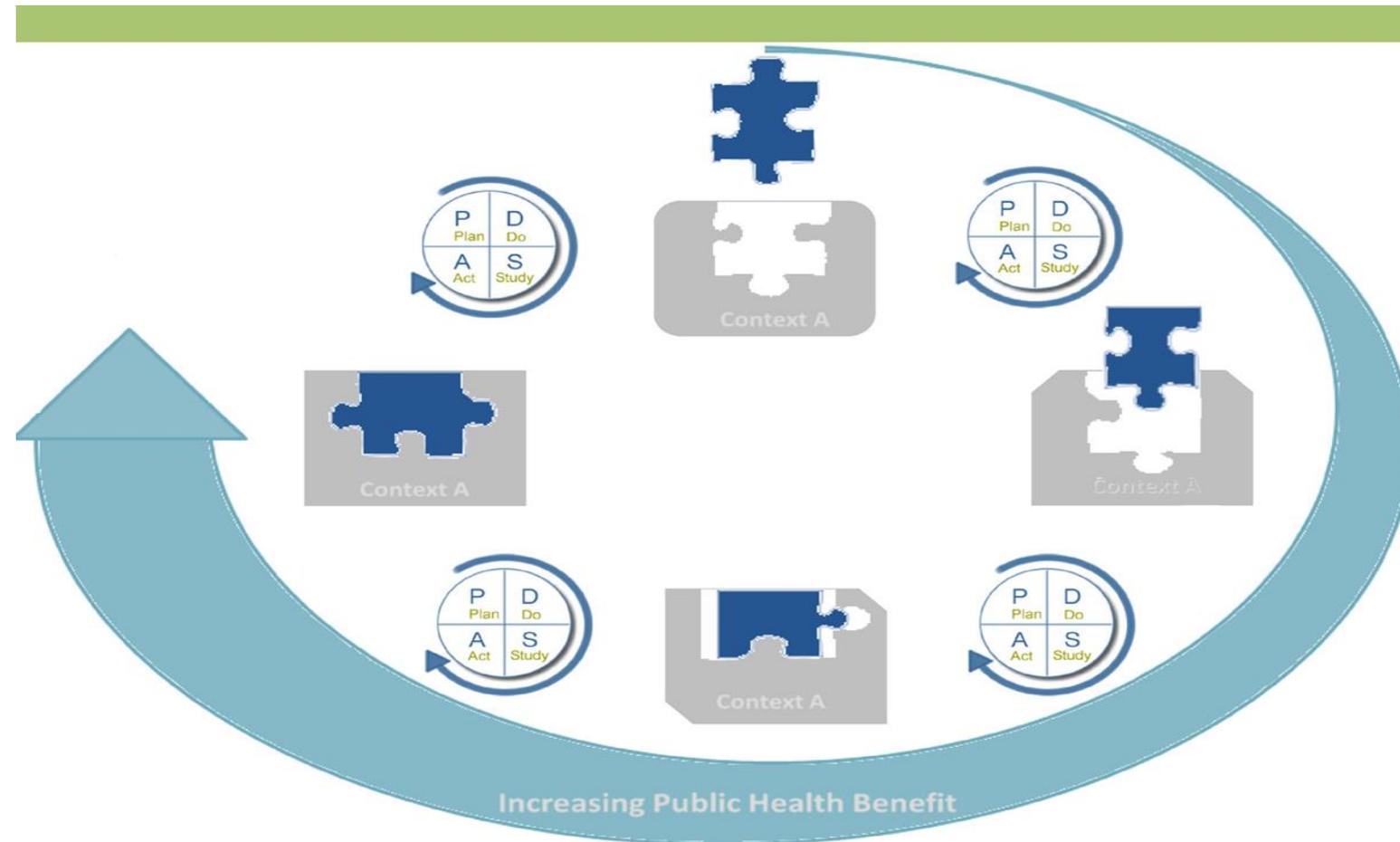
Earlier CPT trials

- 25-30% African American female participants (Resick et al., 2002; Resick et al., 2008)
- 45% of the African American participants completed treatment
- 73% of Caucasian participants completed treatment
- African American women were 1.5 times more likely to drop out, 3.5 times more likely not to start treatment
 - Findings held even after controlling for age, education, treatment expectancies, income, and trauma exposure
- No significant differences in treatment outcomes
- African American women were doing better than Caucasian women who dropped out at the time of dropout
- Possible social and logistical barriers may contribute to dropping out when “good enough” improvement is experienced

ADAPTATION?

When, why, and how?

Adaptation to optimize Interventions



What do we mean by core elements?

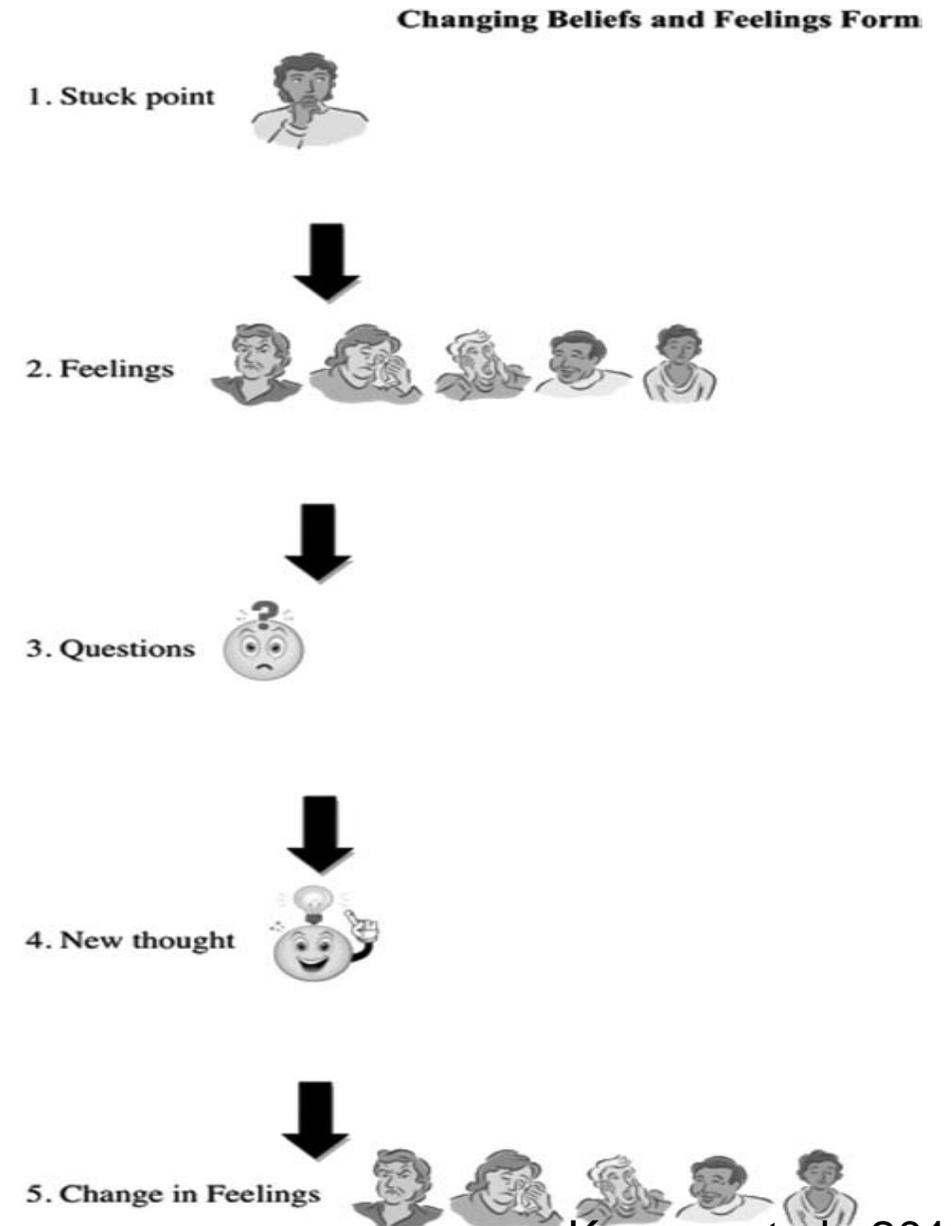
- Parts of the intervention that are empirically or theoretically associated with desired outcomes/impact
- Parts of the intervention that are effective and necessary
- Might mean attending to *function*, rather than *form* in complex settings and interventions (c.f., Mittman, 2018)
- *These may not be the same in all contexts*

Core elements vs. Core functions



Example: CPT in Kurdistan

- Iterative adaptation process, with stakeholders involved (“*how can we make this concept work here?*”)
- Therapists were high-school educated, non-mental health professionals
- Eliminated jargon
- Modules on safety, trust, power and control, esteem, and intimacy tailored to cultural context
- Options for homework completion for illiterate individuals



Example: CPT for Bosnian Refugees

- 53 Refugees
- 2/3 had been tortured
- Experienced multiple war-related traumas
- Delivered through interpreters
 - Translators, not “cultural brokers”
- Longer sessions (1.5-2 hours)
- ~17 sessions, including 3-4 for intake and assessment
- Delivered in-home or in an office
- Consideration of cultural context, gender roles
- Grief, acculturation, resettlement addressed within cognitive behavioral framework
- Relaxation training at Session 1
- Verbal impact statement, option of verbal trauma account
 - In native language if needed
- Graded exposure to address agoraphobia (cognitive restructuring first)

Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence

(Bass et al., 2013)

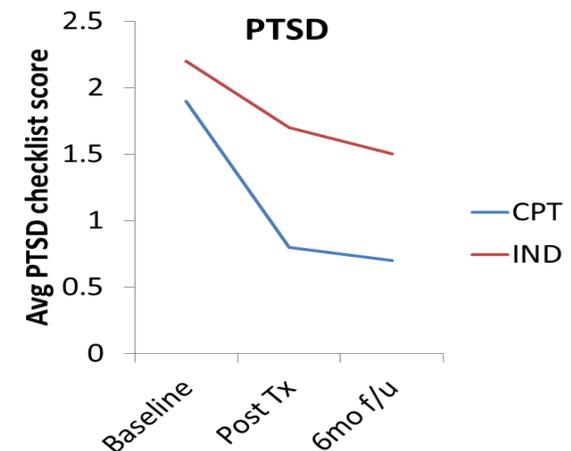
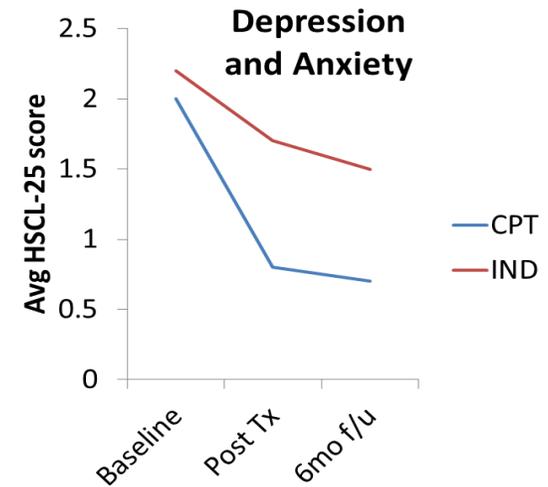
- RCT of group CPT in the Democratic Republic of Congo
 - CPT: 7 villages (n= 157)
 - Individual Support: 8 villages (n= 248).
- Therapists had high school education or less.
- Participants were illiterate, so worksheets were simplified and participants memorized the forms and concepts.
- War was going on around them.
- Assessed pretreatment, post treatment and 6 months follow-up.

CPT in the Democratic Republic of Congo

- Needed an intervention for women who experienced sexual violence
- Identified CPT and contacted treatment developers
- Lots of work to lay groundwork for a study to see if it would work
- One week training—CPT adapted along the way
- Treatment delivered in villages, some in high conflict areas
- Supervision by a physician
- No written homework
- ABC worksheets—mnemonics
- Memorized 3 questions for cognitive restructuring
- Translation of concepts “homework” became “small work”
- Group members supported one another outside treatment

Results

- 6 months later: 91% of CPT group didn't meet criteria for depression, anxiety, or PTSD; compared to 58% in individual support treatment (Bass et al., 2013)
- *"Before, I felt ashamed when I passed by others. I felt that they were judging me. I no longer feel ashamed, I feel at ease. I can walk around without shame and without fear of being judged"*
- *"Why didn't we get this sooner?"*
- CPT increased social capital (Murray et al., 2014)
 - Women in the CPT villages increased group membership and emotional support seeking after the intervention



CPT in community mental health

- Community Mental Health Agency implementing CPT for PTSD
- 19 therapists
- 58 clients
 - 68% Female
 - 48% Hispanic/Latino
 - ~60% High School education or below
- CPT protocol piloted, then adapted; outcomes didn't differ between adapted & original versions

Adaptations to CPT manual

- Piloted Spanish CPT manual
- Therapist feedback: Not user friendly
 - Manual difficult to use
 - Some handouts and worksheets were confusing to clients
 - Need to address literacy
 - Need to tailor language, clinical examples
- Manual was refined, using Democratic Republic of Congo manual
 - Simplified terminology, worksheets
 - Layout changed
 - New clinical examples, addressed cultural differences

Cognitive Processing Therapy for Spanish-speaking Latinos: A Formative Study of a Model-Driven Cultural Adaptation of the Manual to Enhance Implementation in a Usual Care Setting

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Common themes

- Disrupted family structure
 - Family response to perpetration within the family
 - Family role obligations
 - Belief that disclosure of trauma causes family suffering
- Religion (typically viewed as protective/helpful)
- Repeated exposure to violence
 - Community violence

Delivering Cognitive Processing Therapy in a Community Health Setting:
The Influence of Latino Culture and Community Violence
on Posttraumatic Cognitions

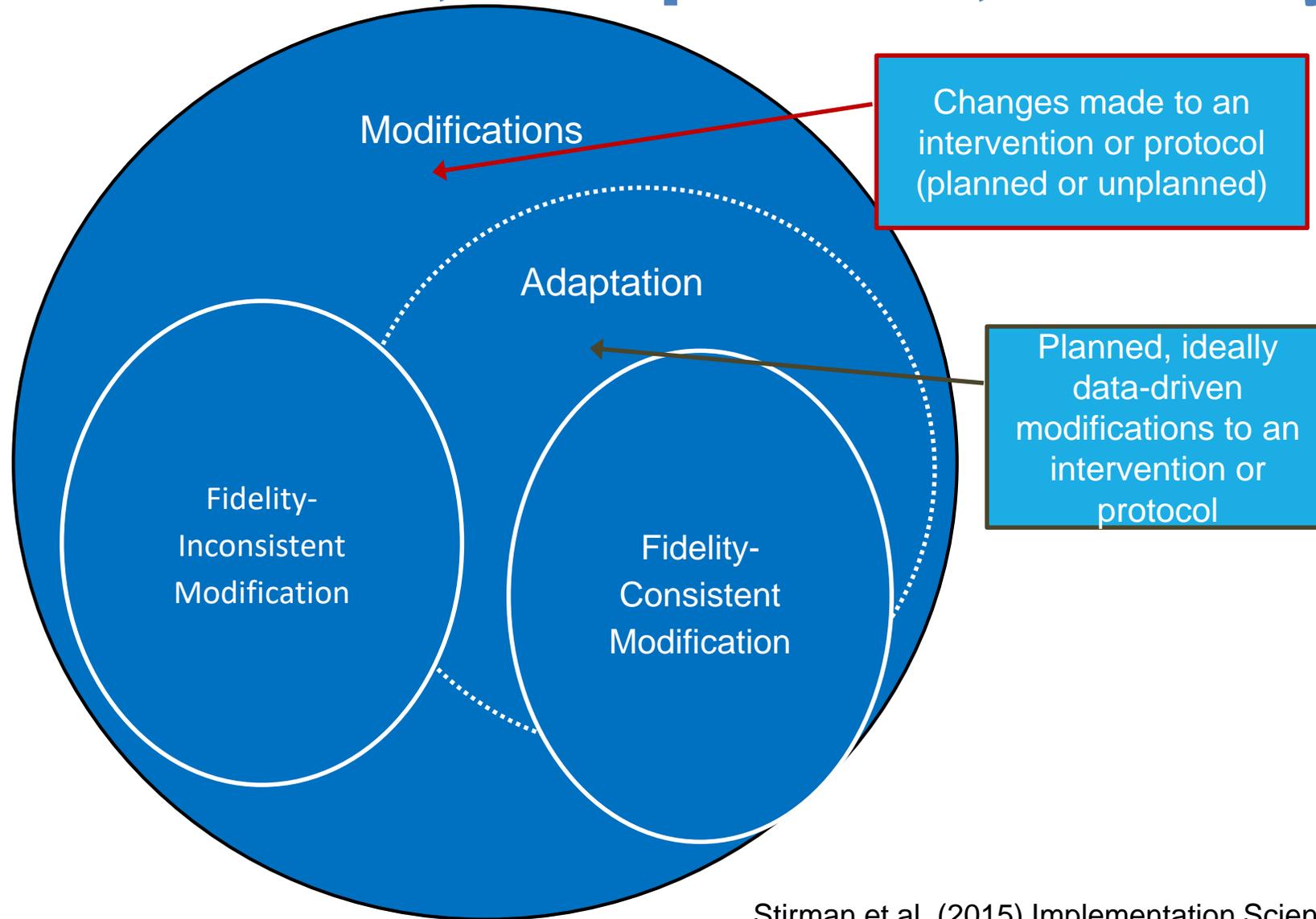
Stuck points-Community setting

- Similar for Latino and non-Latino clients
- Fewer stuck points identified for Latino clients
 - Possibly due to language/communication
 - Stuck points around power/control not always identified even when in the account
- Marques and colleagues (2015) caution that beliefs around discrimination or individuals' immigration status may not be disclosed immediately, but may impact beliefs about power and control
- Strategy: Look for stuck points, also look for what people may be able to control even if the larger context suggests individuals may in fact not have much power/control in some situations

Treatment Fidelity

- Fidelity: the skilled/appropriate delivery of core intervention components
 - Adherence: Use of core elements
 - Competence: Skill

Modification, Adaptation, Fidelity



Method

- Every session was reviewed for fidelity and adaptations by trained observers
 - Adherence, skill/competence, and adaptations were coded
- Adaptations were grouped into fidelity-consistent (consistent with key elements of CPT) and fidelity inconsistent
- In this study, fidelity inconsistent adaptations were highly negatively correlated with adherence
 - This suggests that most fidelity inconsistent adaptations involved removing an element of CPT
- Analyses examined the association between adherence, competence, fidelity-consistent adaptations, and symptom change

Results

- Average # of sessions attended =9
- 68% experienced clinically meaningful change at or before 12 sessions
- Mean adherence =90% of CPT session elements
- Mean competence=3.5 (out of 5)



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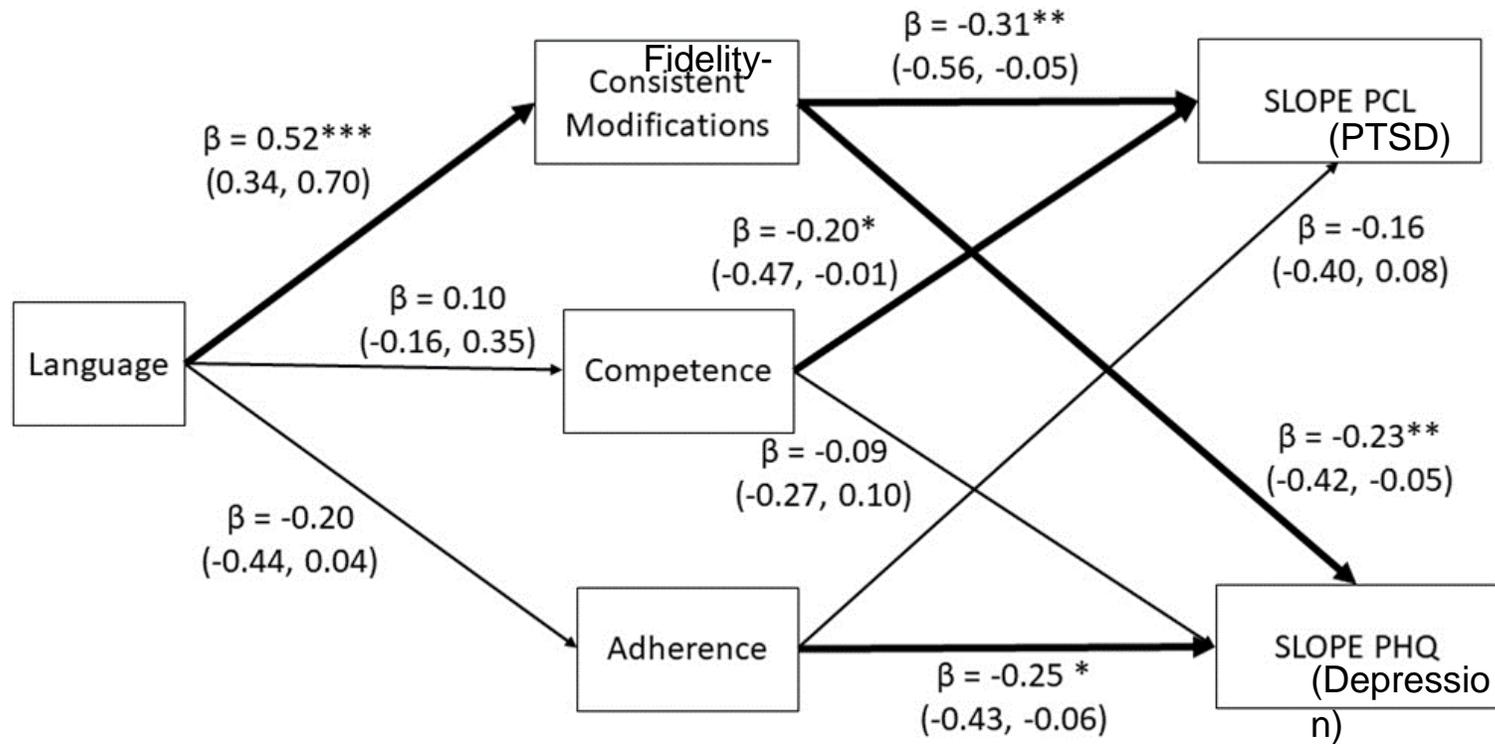
2019, Vol. 87, No. 4, 357–369
<http://dx.doi.org/10.1037/ccp000384>

Provider Fidelity and Modifications to Cognitive Processing Therapy in a
Diverse Community Health Clinic: Associations With Clinical Change

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Fidelity, Modifications, and Outcomes in CPT for PTSD



Results

- Session language associated with more fidelity-consistent adaptation
- Competence was associated with greater PTSD symptom improvement
- Adherence was associated with greater depression improvement
- **Fidelity-consistent** adaptations were associated with both depression and PTSD symptom change

IMPLICATIONS FOR PRACTICE

Implications for Practice

With individual clients

- CPT can be effective in other languages, through translators, and with populations who have experienced multiple traumas and have fewer resources
- Small adaptations that preserve core CPT elements/functions may be sufficient
- Use measurement-based care
- Consider causes of dropout
- Alliance and trust are as important as ever
- Our clients are resilient

For Organizations

- Engage stakeholders in decisions about whether and how to adapt
- Attend to core elements and functions
- Collect practice-level data to inform adaptations
- Identify opportunities to provide support and consultation

Rigid religious and spiritual beliefs

- Gentle, curious questioning
- When and how were rigid beliefs formed?
- Does everyone who practices this faith have the exact same belief about this?
 - If not, why?
- What does their faith say about love, forgiveness, redemption, etc.?
- Re: “punishment”: concept of free will
- Consider when and how to involve spiritual leaders--seek information first

On integration

- Consider timing
- Consider goals
- Are integrations consistent or inconsistent with the treatment model/theory of change?
- Consider advantages and disadvantages of focusing on one thing at a time

Case conceptualization

- Use information about an individual's experiences, culture, and belief system to inform conceptualization
- What can and can't be addressed within the theory and framework?
- Discuss conceptualization to increase engagement and collaboration
- Recognize when there might be some truth to “stuck points”, but use respectful curiosity and interest to assess
- Work within what's possible when clients have limited power and control



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The lines are muted to avoid background noise.



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*Return to
TRAIN for
evaluation.*



*Follow the
directions to
print
certificate.*

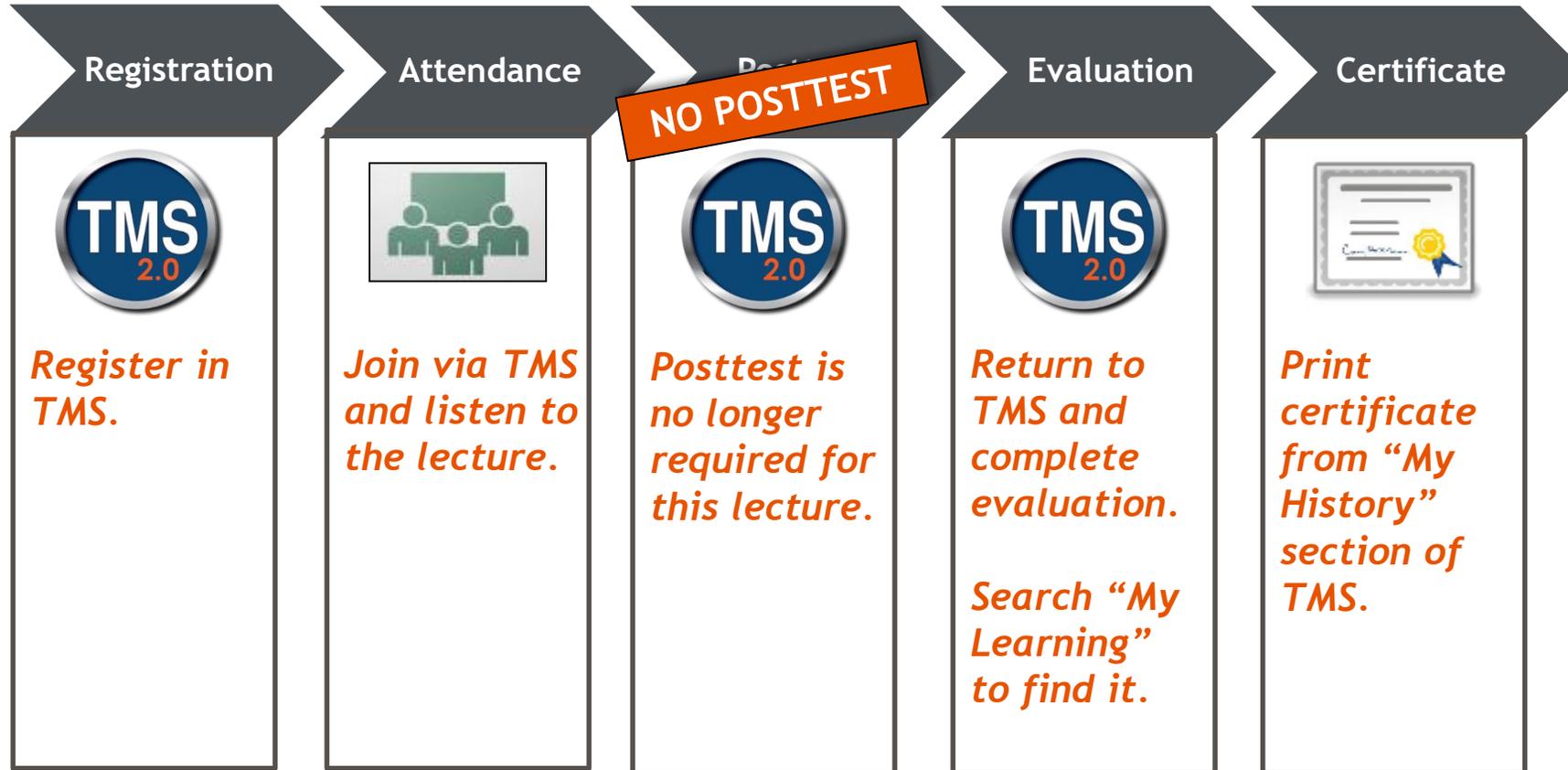
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CEU Process (for VA employees)





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UPCOMING TOPICS

SAVE THE DATE: Third Wednesday of the Month from 2-3PM (ET)

July 17	<i>Genetics research on PTSD: New findings from the Psychiatric Genomics Consortium</i>	Karestan Koenen, PhD
August 21	<i>Focal Brain Stimulation for PTSD</i>	Paul Holtzheimer, MD
September 18	<i>Treating PTSD and Cognitive Impairment from Traumatic Brain Injury</i>	Amy Jak, PhD
October 16	<i>Unconventional Interventions for PTSD: Available but Evidence-Based?</i>	Paul Holtzheimer, MD
November 20	<i>Addressing Sleep: A Strategy for Symptom Reduction & Suicide Prevention?</i>	Wilfred Pigeon, PhD
December 18	<i>Treating Comorbid PTSD and Borderline Personality Disorder</i>	Melanie Harned, PhD, ABPP
January 15	<i>Dissociation, Somatization, and Other Challenging Presentations of PTSD</i>	Abigail Angkaw, PhD

For more information and to subscribe to announcements and reminders go to www.ptsd.va.gov/consult