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

1. Pretreatment assessment and pretreatment issues
2. Education regarding PTSD, thoughts, and emotions
3. Processing the trauma
4. Learning to challenge
5. Trauma themes
6. 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

Kaysen et al., 2013
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)

Schultz et al., 2006
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

Bass et al., 2013
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

Marques et al., 2019
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
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
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

Modifications

Fidelity-Inconsistent Modification

Fidelity-Consistent Modification

Adaptation

Changes made to an intervention or protocol (planned or unplanned)

Planned, ideally data-driven modifications to an intervention or protocol

Stirman et al. (2015) Implementation Science
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)
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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*SAVE THE DATE: Third Wednesday of the Month from 2-3PM (ET)*

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<td>Karestan Koenen, PhD</td>
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<td>August 21</td>
<td>Focal Brain Stimulation for PTSD</td>
<td>Paul Holtzheimer, MD</td>
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<td>September 18</td>
<td>Treating PTSD and Cognitive Impairment from Traumatic Brain Injury</td>
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<td>October 16</td>
<td>Unconventional Interventions for PTSD: Available but Evidence-Based?</td>
<td>Paul Holtzheimer, MD</td>
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<td>Wilfred Pigeon, PhD</td>
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<td>Treating Comorbid PTSD and Borderline Personality Disorder</td>
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