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SPEAKER:

Good afternoon, and welcome to today's SAMHSA's presentation titled From Theory to Therapy: The Evolution of Cognitive Behavioral Therapy for Psychosis in U.S. Mental Health Care. Presented on behalf of the national alliance on mental well-being.

Today's presentation will be recorded and the recording link, slides, and a certificate of attendance will be sent via email to everyone who attended today. Closed captioning is available and can be viewed by clicking the CC icon at the bottom of your screen or clicking the link in the chat bot to view in a separate window. We also have a ASL interpreter who should be seen spotlight on your screen.

During the presentation, please add your questions and comments in the chat box and questions will be asked out loud to the presenters who answer. To answer at the end of the presentation. When the presentation ends, please take a few moments to complete a brief survey that will show in your browser as you exit the platform. Thank you again for joining us and we will now begin today's presentation.

DR. SARAH KOPELOVICH:

Hi everyone, welcome. I am so heartened to see so many people here for this topic, which is obviously near and dear to my heart. I will just read the disclaimer before we get started. So this webinar was developed in part from the contract by the Substance Abuse and Mental Health Services Administration.

Which is part of the US Department of Health and Human Services. The views, policies and opinions are my own and do not reflect those of SAMHSA or HHS.

So I am a doctor Sarah Kopelovich, I am an associate Professor of psychiatry and behavioral sciences at the University of Washington. I also hold a professorship in Cognitive Behavioral Therapy for psychosis. So what I will be talking about today is really the bread and butter of my work.

I work specifically on trying to enhance access to evidence-based psychological treatments like CBT for psychosis throughout the United States.

I received research funding from the National Institute of mental, provide consultation to a private company called Lyssn.io and holds contract with state, county, and other organizations for training and consultation. All content has been developed independently and is free from commercial bias.

Just in terms of source material for this webinar, I borrowed heavily from a couple of papers that I have written. One of which is out and is open access. And the other will be published in October. So the first is the namesake of this presentation from theory to therapy, and that will be published by the American Psychiatric Association Journal in October.

And the second is an article that was published in 2024 in psychological services that talks about how organizations like the one that I run at the University of Washington can partner with community health organizations, hospital systems, and state governments to better disseminate and implement evidence-based treatments.

I am leveraging a lot of the work that I spent the last ten years doing in partnerships with stakeholders across the mental health ecosystem.

I will talk to you all today about how Cognitive Behavioral Therapy supports recovery from psychosis related to stress and impairment. I will talk a bit about the evidence-based for CBT psychosis and try to give a bit of a timeline from theory to therapy. Right? Really try to help understand how we got to where we are today with CBT for psychosis. And then we

have left ample time in the Q&A to invite questions where I can expand on those points of discovery.

And then I will also look at to efforts to enhance access to CBT for psychosis for Americans with serious mental illness.

I really think it is important just to zoom in a little bit on an individual person before we zoom out and take this broader perspective. So I want to talk first about Leo.

Leo was diagnosed with schizophrenia at age 24. He was a bright guy who was working at his dad's AC repair business to save up money for college. And at the time, he was kind of bored, he was drinking a lot of energy drinks. So high doses of caffeine. He was smoking cannabis pretty much daily.

Sometimes throughout the day. And staying up late drinking with friends. He started to notice that the paranoia, the feeling that people were watching him, that he would feel when he was smoking cannabis was not wearing off. He would sometimes hear voices telling him that other people were looking at him... telling him people are judging him, or the voices would call him a low life. It took about two years for Leo to get diagnosed. Which is right around the national average. We are starting to see that average take-down with first episode psychosis care.

Over time, these concerns that had sort of started off as these low-level concerns, they did not really hold him back from going to work or hanging out with people started to escalate into these more firmly held ideas that others were plotting to harm him or even to kill him.

And that the voices were protecting him. Leo was really fortunate that he was able to connect with the psychiatrist in his area. I was contacted by Leo's parent who had heard about Cognitive Behavioral Therapy for psychosis and were trying desperately to find a therapist. There is a story like Leo's in my inbox at least once a week.

So let's talk a little bit about what CBT is, how it works, and why it is so hard for people like Leo and his family to locate.

So Cognitive Behavioral Therapy is a familiar, I think, one of the more familiar and recognized psychotherapies. It is also the most well researched. There have been thousands of clinical trials that indicate that CBT is evidence-based for more than sixty different psychiatric conditions and problems of daily living, things like sleep disturbance, or performance anxiety.

So what is it? It is a time-limited, structured form of talk therapy. Although I call it a doing therapy, because we should be doing just as much, if not more, as we are talking.

And a typical course can be anywhere from a single session to around twenty-four sessions. Depending on the chief complaint. So it is focused on some of the most fundamental aspects of the human experience. The way that we think, right? Our ability to construct meaning using language.

Those are our thoughts, our beliefs, our assumptions. The second is our feelings, which consists both of our emotions and for physical experiences connected to those emotions. And our behaviors. Each of these elements of the human experience are interconnected. Each impacts the others.

So a CBT therapist is really skilled in pattern recognition. We are looking for behavioral patterns and patterns in the way that our clients are thinking that are making their distress or impairment worse.

I called this compounded suffering. Right? We might have a painful feeling that is an inevitable part of life, but we can really compound our suffering by having judgmental thoughts about those feelings.

And then we are kind of caught in this unhelpful pattern. I apologize, I am not doing the screenwriting. So if you see these kind of marks on the screen, they do not have any significance.

I will say, I think the elegance of CBT and the thing that appeals most about it to me, is in its simplicity. Once we understand the interconnectedness of these core elements, we recognize that we have the power to change any of these elements simply by altering one of the others.

And we can actually dig a little deeper. We can start to identify that these thoughts that we have on a daily or even moment to moment basis, often times, these are recycled thoughts. Right? The kind of thoughts that might have this emotional residue or might be driving our behavior are recycled, you know, from day-to-day.

And they can really be distilled down into this handful of core beliefs that are driving arm in the moment interpretations. They are called core beliefs because they operate under the surface and they are deeply held beliefs. That are often formed early on in our lives. They can be quite rigid, quite absolute, and because as humans, we are also susceptible to confirmation bias, right? This idea that we are going to look for evidence that already confirms our belief, these core beliefs about ourselves, about other people, and about our future, can cause all sorts of distortions in how we are processing information.

CBT therapy really strives to bring attention to these patterns. That is not enough, right? The phrase knowing is half the battle. Knowing is half the battle. Right? So what do we want to do with these new insights?

A CBT therapists can do strategies to help individuals make changes in their life on the basis of these insights. How we think about psychosis and how are thinking of psychosis has evolved over the past few decades has really made the application of CBT to psychotic symptoms possible.

Right? Psychosis used to be seen as this really aberrant experience, it is unlike other human experiences, people with psychosis have thought disorders, so they are not appropriate for talk therapy. And all of that has actually been really re-conceptualized in the past few decades.

We understand psychosis as this transient break from what we call consensus reality. Right? The reality that we all have this unspoken agreement of. And this retreat into an unshared personal reality. When we understand it in that way, one, there is more optimism, right? It is transient. It does shift for people.

And two, it becomes a lot less pathological and intractable. We now have a way of understanding psychosis in a way that can empower us to make some (indiscernible) and it also helps us take a curious stance. I want to know more about this person's idiosyncratic reality and how it formed.

When we do that, when we take that curious stance, and learn from the individual about how these ideas take shape, we can often find the nugget of truth in these really unusual beliefs. Right?

We can often times see themes of trauma or feeling a lack of control or themes of shame that really help us understand what would otherwise be bizarre, unusual, or un-understandable beliefs.

And then we really take this focus on thoughts, feelings and behaviors that are more balanced, more helpful, more flexible. We are not getting into a tug-of-war about how true or untrue something is. But rather, how balanced that thought is. How helpful. In what ways is that thought helpful. In what ways might that thought of thinking be holding you back.

We promote tolerance for uncertainty. Which is one of the markers of psychological health for all of us. We look to enhance feelings of safety. And we try to promote insight about where these kind of thoughts or perceptions are coming from. What role they are playing in

the individual's life. In other words, how might they be holding them back or keeping them stuck?

And then how stress is interacting with these experiences. Those are the kinds of insights that we are striving for in a course of CBT for psychosis.

So I want to share with you how I might talk to a clinician who I am training in CBT for psychosis about the kinds of areas of focus that we might take in a course of CBT. (Video plays)

SPEAKER:

The central idea of the CBT is this what we think impacts how we feel and what we do. This is the cognitive model in a nutshell. Now, the way we think has to do with what information we take in. And how we interpret it.

Research suggests that people with psychosis may be more likely to not take in all available information. Not process all the information they take in. And to not think through all of the information in a reasonable way. These kind of mental shortcuts become major maintaining factors for psychotic symptoms as well as for general levels of stress, anxiety, or depression.

CBT for psychosis helps highlight the brain's natural tendency to take fast shortcuts and teaches them to slow down the think, feel, act process. When clients with psychosis practice flex ability in their thinking, they experience better outcomes. This is because they can be more intentional about the information they are taking in and how they are processing it.

In this module, you will learn the key steps involved in helping your clients better cope with distressing thoughts by slowing down, teasing out the situation from the interpretation and considering alternative explanations.

DR. SARAH KOPELOVICH:

Alright. So we are helping our clients to slow down, we are helping them to tease apart the situation from how they are interpreting the situation, right? The meaning they are making from it.

And how that makes them feel and what they want to do next with that. A key strategy we use as clinicians that we also encourage family members and other supports to be using is called riding the collaborative fence. I think about this as a teeter totter. Right? On the one hand, we have collusion where we say, "yes, that is right, that is really happening."

We know that that kind of approach might do more harm than good. On the other end of that teeter totter, we have the confrontation, right? Where we are saying that is not possible, please stop, please stop thinking that way.

And in the middle is this collaborative area. This area where we can come together... in their distress. We are we can say it is hard for me to see that they are being threatened because I cannot hear the voices but I can absolutely hear the distress and see the distress that you are experiencing. And I really want to help with that. That is where we can partner, that is where we can do to good work, is creating that shared goal to reduce the individual's distress.

So we are going to do a very brief timeline, how the theories that are really the bedrock of Cognitive Behavioral Therapy for psychosis evolved to where we are now in August, 2025. This was recently chronicled in the paper that I mentioned earlier which should be coming out in October.

There is a couple of other papers that I think are important that I will reference in this timeline. So one thing most people do not know is that the origin story of CBT for psychosis is actually the origin story of CBT. It started in 1952, Dr. Aaron Beck was a psychiatrist, psycho-dynamically trained, who was working with a twenty-eight-year-old outpatient who was presenting with paranoid and guilty delusions. Dr Becker worked with him for about thirty sessions.

He applied a psycho-dynamic formulation but he started to focus his therapeutic techniques on really working with this individual to identify the meaning of these feelings of guilt and paranoia, right? These cognitive appraisals. How he is thinking about it. The patient really benefited a great deal from that.

Dr. Beck then spent the next 10 to 15 years honing this core therapeutic technique into what we now know as the cognitive theory or the cognitive model, which I presented a few slides back.

This cognitive model is one of the two theoretical foundations of CBT. The second was really in 1977 there was a psychologist named Joseph Zubin, he was at the New York State psychiatric Institute and he teamed up with Bonnie spring, who is completing her doctoral training at the University of Pittsburgh.

They had a seminal paper that they published in 77, it was called vulnerability, a new view of schizophrenia. This paper reconciled the great the debate that was happening at that time about whether mental illness was primarily due to genetics or due to environment, right?

It was the nature nurture debate. And they advance this theory that these were working in tandem with each other. And that there was a catalytic event or there were stressors that were exposing underlying vulnerabilities.

This laid the groundwork for bio-psycho-social models and really opened the door for cognitive behavioral formulations and cognitive Behavioral Intervention. In the 1980s, in the US, we were using a lot of structure behavior interventions. Token economies, social training, psycho-educational programs, all of these were gaining traction in the 80s.

Some of these, many of these, are still used today. But in CBT, we are really trying to gather more insights so that we can help the person understand that some of their behavior patterns might be unhelpful or unhealthy and to adopt some new strategies.

And then in the late, I would say, mid-1990s into the 2000's, in the United Kingdom, there was an explosion of research into applying Cognitive Behavioral Therapy into psychosis. There is so much to unpack within this time period, this could be his own timeline in and of itself.

These two decades where were we really saw the biggest and fastest advance in theory and (indiscernible) in CBT. There are two wonderful references. If you really want to get into the weeds here. The first is by (unknown name) in their 2022 paper where they do a chronological account of CBTp empirical research and where we are and where we are going. And then Peter (unknown name)'s paper in 2017 compared and contrasted different CBTp models.

We had several models that were being advanced and each of these models had different approaches for CBT for psychosis. That umbrella has grown and grow to now include digital interventions, virtual-reality interventions, and the like.

In the 2010s, it was well recognized at this point that CBT was effective for psychotic symptoms like hallucinations and delusions. But that there were real systemic challenges to implementing CBTp. In response to that, there was a grassroots coalition in the United States of clinicians, researchers, advocates, to develop the North America CBT for psychosis network.

That was officially recognized in 2015. It has played an instrumental role in curating training materials. Fostering a professional community. Serving as an advocacy body, and now we are involved in turning the competency standards that we have developed for CBT for psychosis into CBTp specialty certification.

Just in these last five years, we have really seen concerted efforts to translate the evidence that I will share more about in a minute into action.

In 2019, we had this meeting that the Substance Abuse and Mental Health Services Administration held at their headquarters that included people with lived experience, administrators, CBTp experts, and really asked us all to think about how do we get CBTp into routine care settings. On the basis of that meeting, I worked with SAMHSA to develop as CBTp Implementation Guide which was published in 2021.

And also the National Association of State Mental Health Program Directors turned that into a position statement which was up on their website and will be again soon.

So this was really a watershed moment in the United States. Up until this time, CBT for psychosis had been included in professional treatment guidelines but there had never been a federal entity that came out with any kind of guidance about administering CBT for psychosis. I actually copied the language for this Implementation Guide because it is so important.

And every administrator and every mental health system in the United States should know this quote from this text. CBTp should be implement it within our mental health systems, and CBTp informed care at a minimum should be implemented in primary care, correctional and forensic settings, and educational settings. This is the equivalent of a (indiscernible). This message is clear.

Evidence-based therapy is not optional, it is essential. So my work has really been trying to translate this policy into practice. But that is the first thing that you need to know about policy advances in the US within the last five years. I encourage you to go to the SAMHSA's website to download this guide. The other thing that is so important for everyone to know about recent advances is the most recent treatment guideline for schizophrenia spectrum disorders from the American Psychiatric Association was published in 2020.

It based a lot of its recommendations on a systematic review that I was involved with with the agency for health research quality.

And if you look at the family version of these guidelines, there is a quote in their that indicates that psycho-social treatments are an equally important part of care.

And that medications are a complement to psycho-social interventions. That really turns establish doctrine on its head. Right? We have been trained to think about medications as the front line and everything else as tertiary. This is saying we need to front-load psycho-social treatments like psychotherapy, psychiatric rehabilitation, social skills training, and in addition to that, we need to explore other biological interventions as well.

So I do not take for granted that you should be focused on CBT for psychosis. There is lots of things that administrators and clinicians could go out to learn. Could go out to invest their time and money in. So why should we be focused on CBT for psychosis when those same national treatment guidelines that I just referenced call out seven psycho-social interventions of which CBTp is one.

Let me give you some reasons. First is that CBT for psychosis includes components of other interventions that those guidelines recommend. So CBTp will provide recovery oriented psycho-social education, it will include some illness self-management strategies. So CBTp is a flexible and adaptive approach to meet the needs of each individual.

The second is that CBTp can be incorporated into other kinds of interventions. So for instance, a prescriber who is working with an individual to explore different medication options will need to understand that when they are experiencing medication inconsistency or they are not taking their medications or they are not taking them consistently, whether those barriers are practical, the person is just forgetting, or whether they are psychological. The person believes that the medications are poison.

And then formulate the appropriate interventions. CBT gives them the strategies to explore those explanations curiously to build motivation with the client to work on these together.

And to develop a concrete action plan. The third is very simple. And that is this idea that beliefs mediate recovery. So what do I mean by that?

Let's say you have a client who you are treating or a prescriber and you prescribe a medication and it is 100% effective. In other words, the symptoms result. -- Resolve. And the person is in a recovery phase. A lot of times we will see if a lot of functional disability remain even when we have symptom recovery.

And those can be tied back to these beliefs that the individual has. These may be self stigmatizing beliefs. Right? People like me do not get married and have kids, right? That is not something that is in the cards for me. They may be self-deprecating thoughts. Right? Why bother? I am just going to make a mess of things again.

When we normalize these thoughts, when we make them understandable, when we help people to adopt alternative ways of thinking and increase those valued actions, we can start to change the recovery trajectory. We can really start to shift symptom recovery into functional recovery.

The next is that CBT is trans diagnostic. Right? What do I mean by that? I mentioned earlier it is indicated for sixty different mental health disorders. Right?

It is critical for treating individuals who experience psychosis because we see such high rates of co-morbid psychiatric conditions. We see substance use, we see personality disorders, we see trauma, we see chronic pain.

And CBT is also indicated for those problems. We can help the individual to learn the strategies and let's say apply them to voice hearing. But then also learn how those same strategies can help them with their chronic pain. Or can be generalized to help them with their sleep problems.

That is incredible! No other, to my knowledge, feel free to disagree and we will hash it out in the discussion, no other medical or psychological intervention has proven itself to be more versatile than CBT. Right? Finally, CBT is the most well researched psychological treatment for psychosis.

Let's talk about that. Let's get into what the evidence base is. We have, at this point, roughly 60+ randomized clinical trials, over twenty meta-analyses, and over seven systematic reviews. These are F-Port -- approximate account, as of 2024, 2025.

What we see when we look at the literature is that CBT for psychosis has pose a statistically significant and a clinically significant effect on positive symptoms, like solutions and hallucinations, negative symptoms, although we tend to see smaller effect on negative symptoms.

They are still significant. We tend to see that it can improve functioning. It can reduce the likelihood of hospitalizations and if hospitalized, the duration of the hospitalization. It has a significant effect on mood and anxiety symptoms. And then this is really significant. We find that we do not have, you know, too many studies that have follow-up periods that go two, three, four, five years out? Folks who have had (indiscernible) of CBTp tend to maintain those gains over that follow-up period. That is unlike other interventions where those gains typically receipt after the intervention is stopped. The evidence supports the use of CBT for psychosis for individuals across different stages of psychotic illnesses.

From those who are at clinical high risk for psychotic episode, there is some evidence that suggest that a CBTp can minimize the risk of transitioning to a psychotic episode. For individuals who have experienced a first episode of psychosis and for not just multi-episode psychosis, but we also find that there is an indication for CBTp among people who either decided not to take medications or who do not have a good response to multiple trials of medications.

There is various researchers, primarily in the United Kingdom, who have been leading this research, one of them is on the webinar today, Dr. Doug (unknown name), Dr. Anthony and Dr. Toni Morrison also at the University of Manchester has a number of clinical trials.

Including a study that was published in 2018. That included nearly 500 individuals with clozapine resistant psychosis. Half of these individuals were randomized to twenty-six sections of CBT and have to treatment as usual. -- Sessions. They did find greater improvement in the CBT condition but the effect washed out at follow-up.

They concluded, and I agree with this interpretation, that twenty-six sessions is probably an inadequate therapy does for this population. They recommend obviously upping that dose. Looking across these studies and looking at studies, the general consensus is that CBTp can be used and is considered effective for individuals with medication resistant psychosis as well as those who choose not to take medication.

So let's start turning back to Leo and how we turn this evidence into practice, how we make it accessible, Leo story of course is not unique. I would imagine it resonates with many people who are on this webinar now.

Across the United States, we have 100,000 people each year who are diagnosed with a psychotic disorder. That is about 274 people every day.

And it will take the average American between 1 to 2 years to connect to treatment if they connect at all. Roughly 30% of Americans with a serious mental illness will not receive psychiatric care, that is according to the most recent national survey on drug use and health.

That was just published. Of those who do, based on a point prevalence estimate I conducted in 2021, fewer than 1% will receive even a single session of CBTp.

So what this means is that many American families are never even told that CBT for psychosis is an option, like Leo was. Fewer still can access it. That is despite the guidance that I spoke about earlier from the most respected governmental and nongovernmental mental health organizations.

Leo did end up connecting with this CBTp therapist who helped him managed his anxiety well enough that he was able to start to re-engage and to do the things he enjoyed. Those activities that he started to re-engage and really served as a testing ground for him where he was able to start testing out some of these concerns about his safety and what the voices were saying.

This is what Leo had to say about the impact that it had. He said, "my therapists helped me figure out what actually matters to me, like connecting with friends and music, and we build small steps towards doing those things again, even when the anxiety was loud. I started testing out the beliefs, looking for real evidence instead of just going with the fear. Over time, I stopped feeling like the world was out to get me. I still have moments, but now I know how to get grounded. It's like I got a map back to the parts of my life I thought I had lost."

We know that CBTp has the potential to change illness project race. But we have not resolved this looming question about how to scale up the results that we see in clinical trials to real world settings across the United States.

This is not just a million-dollar question, this is a $281.6 billion question. According to a recent report by the schizophrenia and psychosis action alliance, that is the annual cost of schizophrenia in the United States.

And we have been waiting on answers to that question for thirty years and counting. OK, so here's where we start to get an understanding of what are the factors stalling CBTp implementation and what is being done about it.

So first is mental health practitioner shortage areas. More than half of the United States is in a designated mental health provider shortage area. That means that they are without a licensed social worker, psychiatrist or psychologist.

So these shortages are more prominent, of course, in rural and economically stressed cities. But we see them in every state across the country.

The second is that we have poor access to training. That has historically been the case, I will say, that through the North America CBT for Psychosis Network, we are starting to see access to training improve. But it has still been costly and time-consuming. Next we see this system orientation. Right?

We have a resource scarce mental health system, and as a result, it has been oriented toward crisis and biological interventions. Psychological care requires time, it requires changes to systems that are serving individuals with serious mental illness. Right? Changing referral pathways, changing caseload sizes, changing schedules.

And making some of the workflow improvements to help people deliver the treatment... that is a real hurdle that needs to be addressed at the system level, as the SAMHSA CBT implementation guide addresses. And then we have these assisted... My work has primarily been ? I will focus on two of these examples and then we will open it up for discussion.

We can talk about more kind of system-level interventions that could help CBTp take root. A lot of what I will be talking about is chronicled in the paper I mentioned earlier. This talks a lot about the center that I co-direct at the University of Washington.

And our approach to doing research training and implementation in evidence-based treatment. Just another (indiscernible) for this paper, which is open access.

So when I came to the University of Washington in 2015, I followed more of a traditional CBTp training approach where I would partner with the healthcare organization, I would work with the mental health professionals they had on staff, who were therapists, and I would train them in formulation based CBTp. It was an intensive, year-long training.

But at the end of the training, almost everyone I trained was practicing that therapy to fidelity. The problem was that by the end of that training period, We had half the number of practitioners that we started with and one year later, two years post-workshop, we had half of that full stop so the return on investment was minimal. I shifted the way that we were approaching training and implementation to focus on delivering CBTp across disciplines.

We have ample research that affirms that a range of professionals, paraprofessionals, and nonprofessionals, right? Community members can learn to deliver different cognitive behavioral techniques. And a CBT step care has been successfully implement it in England's national health service. I have been fortunate to learn from my colleagues in the UK and make adaptations to this model for the US context.

This resulted in CBTp stepped care, as outlined in the papers that are referenced here, where we have decided that we can work across the whole mental health ecosystem to train everyone to the height of their scope of practice.

We want everyone, whether they have a formal role in the clinical setting, or whether they are the family or caregiver supporting an individual who experiences psychosis to learn about psychosis from a cognitive behavioral perspective to learn different kind of high-yield skills that folks with psychosis can see some relief from.

And then we can start to train more specialty versions of CBTp within the system. We can train therapists and non-therapists in low intensity CBTp, we can introduce group administered CBT for psychosis, which requires at least one licensed master or doctoral provider. And then we can also train our license and mastered and doctoral level provider in that formulation based CBTp.

Since we know that is such a limited resource, we can use the stepped care model to make sure that we are delivering the appropriate version of CBTp that matches the individual's needs.

Based on symptom severity, complexity, and also readiness. Right? What is their readiness to engage in a psychological treatment? So this is what it could look like. When we actually translate this step care model into a multidisciplinary treatment team. Our case manager can be applying low intensity CBT or CBT informed case management. Our therapist on the team could be doing formulation based CBTp and they may even decide to introduce a digital augmentation, right?

They can actually use apps that are evidence-based and use cognitive be skills to help facilitate skill rehearsal in the community in real time. Our prescribers, our vocational specialists, our peer specialists, can be reinforcing these high-yield cognitive be techniques and then we can train family members in those foundational CBTp competencies as well.

I just want to give you a bit of a snapshot of the impact on families when you provide not just psycho-education, which is powerful in and of itself, but psycho-education plus skills training to help them be a better support person for their loved one.

(Video plays)

(Music plays)

SPEAKER:

It is mystifying when you find out that your child has a serious mental illness and we really do not know what to do. That is where the CBTp gives you, you know, baby steps of how to work through this.

And see things happening for yourself.

SPEAKER:

We know our loved one situation better than anyone else. And we are in a position to have enough confidence in what we learn in order to be able to apply some of these things and just give them a try.

(Music plays)

SPEAKER:

That is human nature. That is not a psychosis phenomenon. That is what we all do when someone gets (indiscernible) or political views or religious beliefs, we dig our heels and actually, Amy, what was so important in your response (it was really quick so people might have missed it), but she actually said, "I think you might do experiments on me." It is very easy to transition, if we are denying our loved ones reality, for them to think, "well, maybe they are in on it. Was good right? Maybe that is why no one is telling me the truth.

SPEAKER:

It gives you a stronger stance to navigate these challenges. You are learning from the instructors and class, your learning from the other participants in the class. And so, you know, we feel we are pretty well trained in dealing with individuals that may have behavioral health issues.

SPEAKER:

I was on the phone with my husband because it was the first time anyone in this (indiscernible) had said there was a chance of recovery, you know? This is our life.

SPEAKER:

To see this group from (unknown name) actually devoting and attending to improve the lives of individuals and their families with this illness and to see a group of other families who are being appreciative of the academic research, the evidence-based research, and the in person compassion is like getting one big group hug to know someone cares about our loved ones.

In a concrete way that could possibly make a difference in their lives. It is just this one big group hug.

DR. SARAH KOPELOVICH:

Still get goosebumps and I watch that video. It has been such a powerful intervention. So here is what we have found. I want to present some of the research the stepped care model, when we trained this extended number of practitioners. First is focus on the right-hand side of the screen. We asked practitioners who had been trained in different versions of CBTp, we found no differences in how they were trained between the groups in terms of the acceptability of the intervention, the feasibility of delivering the intervention, or the appropriateness for their clients.

So some very high ratings across all three of those acceptability, feasibility, and appropriateness. This was really exciting. What we found on the left-hand side. So the first is reach. We found that we were able to train three times the number of providers when we moved to that step care model.

And that that in turn led to a more than threefold increase in the number of clients that they were able to treat. That is a return on investment. That is an exponential increase in the reach of this training model. The next outcome we looked at was fidelity. Right? Our practitioners who are training able to be adherent to the treatment model, are they delivering the treatment competently? And 80% of our trainees were able to obtain competence by that twelve month mark.

And then the next implementation outcome that we looked at was sustainment. Right? We really really want to ensure that we are introducing something that is sustainable for the healthcare organization at that twelve month follow-up mark, all four of the CBTp agencies that have been trained in step care, continue to deliver all four of this CBTp at their agencies at 80% of all the folks we have trained were still delivering CBT for psychosis. Those are beautiful outcomes!

Alright. So the next thing I want to do is think about when we train the workforce, it is just as much about workforce retention as it is about workforce development, right?

We do not only need this kind of training to improve clinical outcomes with our clients, we also needed to improve our outcomes with our workforce. So how can we address all of these concerns? We have high cost and poor access to psychotherapy skills training. We need to provide opportunities for folks to learn the intervention.

So we can think about, well, how do other specialists, how do other specialists in other fields learn to do how to do what they do? How do pianists, tennis players and surgeons get good at these skills?

Well, most of them get good because they have feedback. Right? The pianist can hear right away whether the note she had worked or did not work. The tennis player can decide whether the swing was good or not. The surgeon has? We do not have that kind of a process for psycho-therapy training.

Not only that, but psycho-therapy training is notoriously expensive, time-consuming, and very, very difficult to scale. So we want to be thinking about how can we start to learn to train psychotherapy skills the way that other disciplines get trained. And one way that we can do that within the psychotherapy world is actually by leveraging some of the recent technological advances to mimic that teacher at the elbow model.

So there is a new intervention that I developed based on my observation, my experience, that there is simply not enough CBT for psychosis trainers and when you do get a trainer, it is still quite difficult to get that proximal, specific feedback about your practice of these new skills.

So we partnered with a company called Listen to develop a machine learning technology to scale CBT for psychosis training. And we went through this very rigorous process. This was a NIH funded trial. And it was a our forty-two mechanism, which means the whole point of this thing was to shorten that pipeline between research and real-world.

So we did all of this within the span of five years. We started with user centered divine interviews where we went into clinics, we asked clinicians, "what do you most struggle with when you were learning CBT for psychosis?" We then did these design sprints where we would develop something and get their feedback on it.

And then based on that, we came up with what is called an alpha version of the tool, something we could do these feedback sessions to get their impressions of it. And we developed and validated a fidelity tool.

So when we are asking our clinicians, our learners to practice a skill, we had verified and validated benchmarks to judge the quality of that rehearsal.

We then got a data set of 5000 responses. From CBT for psychosis experts, clinicians, and (indiscernible) people to really get this large data set of which to train the machine to identify what is a high quality, moderate quality, or low-quality response.

And then we had a beta version. We had a version of this tool that we could actually pilot. And we did that in a community behavioral health clinic with twenty-one different providers.

And we follow that up with a randomized controlled trial with 100 providers and 300 clients so we could look both at learner outcomes and at clinical outcomes.

This is an example of responsibly developed AI. This is not generative, all-purpose AI. This AI has a very specific task and it was trained to that task. And what we found, you can review this in the papers that are in the Journal of psychotherapy, which is all open access.

You can download it for free. What we found is a very, very high level of reliability in the machine rating scores compared to the human rating scores.

We can have confidence that even though this court and feedback you will be getting from the AI will not be as specific as what you would get from me in real life, that it will be the same kind of feedback that I would provide.

So I will conclude the talk with just a couple of minute demonstrations. You can get a look and feel for this kind of a tool. There are lots of tools like this that are developing for motivational interviewing, for dialectical behavioral therapy, even for more discrete psycho-therapeutic techniques like empathy.

Like complex reflections. Right? So we can really think about these new, automated tools, as an opportunity to work with human trainers to get more practice and more feedback.

Alright, so let's just take a listen. I do want to note, this was also developed in partnership with international experts in CBT for psychosis, including Doug Tarkington, who was named as a consultant on this grant and Kate Hardy from Stanford.

When a learner comes into a field, you can see the learner on the left-hand side, they can choose if they want to go into the waiting room to meet the clients, to practice some of the fundamentals of CBT first. Or just to download ahead of that they could use with the client.

This learner is going to go into one of those skill modules where they will learn one of the core elements of CBTp. So in this case, they are going to choose while this planning or state of course. (Video plays)

SPEAKER:

's study showed that CBT can have lasting benefits for clients with psychosis and can reduce the risk of relapse and re-hospitalization even after the treatment has ended. How does CBT accomplish this?

By using the last stage of treatment to prepare our clients to stay the course. In other words, to pursue their wellness regardless of obstacles or setbacks. There are three things you will want to explore when setting up a wellness plan with your client. Triggers, early warning signs, and a relapse signature.

DR. SARAH KOPELOVICH:

We developed those videos for TikTok attention span, so they are no longer than a minute and 1/2, and then the learner can guide themselves through the didactic content of the course and they can go as deep or superficial in this content as they would like and we would like them to immediately put that learning into practice.

Here he is reading the instructions. His task is to talk about wellness planning with his client to give a rationale for developing wellness plan. Here is his prompt.

(Captioned video plays)

DR. SARAH KOPELOVICH:

We have set this up like they are in is in session. He will respond out to his client.

(Video plays)

SPEAKER:

Think that is a valid concern, especially considering your journey we have taken so far with this. I think what is important to remember is that progress is not linear. And two, you have done some incredible work, some incredible progress, in the sessions we have had together. When those moments of uncertainty arise in the future or if there is ever moments of doubt, remember what we have talked about and the skills we have come up with together and know that I am always here to help if you need it.

DR. SARAH KOPELOVICH:

Just a note here. Remember that in CBT, one of the things that sets CBT apart from competitor interventions is those lasting gains that I spoke about earlier. So ask yourself, as you reflect on that response, is this practitioner setting this client up for those lasting gains?

As you ask yourself that question, as you reflect on that, let's see how the AI is judging that. That rehearsal. And you will see two different scores here. One is a score for this skill itself of wellness planning and the second is a score that will learners will receive after every response they give regardless of which skill module they are in and that is interpersonal effectiveness, that warmth, that authenticity, that positive regard for the client, it could be a feature of everything we are doing within CBT.

We will always see that scored as well. What we see from this feedback is very typical from a new learner. That is that they are very warm, they are very good at demonstrating that warmth, empathy, and motivation, and struggle with layering on the CBT intervention. What we have heard is a lot of references for what we have done but not actually providing a rationale to identify triggers, early warning signs, or really honing in on the personal relapse signature, which is what the learner would have just learned in that module.

So here we have, within about four seconds, some automated feedback that will guide this practitioner to go back and to try again and he can try again with that same client. Sorry, or he could try again with another one of those clients.

Alright, you're just in the last couple of minutes, we will segue to Q&A, I am really excited to hear some of the questions that have been coming up in the chat. Before we do, I just want to share a very short video that my team and I put together at the UW Spirit Center that really speaks to the value of taking a systematic approach to implementing CBT for psychosis, whether that is just in a clinic, or even a program, you know, large healthcare entity or even as a (indiscernible) across the whole state. (Video plays)

SPEAKER:

Psychosis feels like you are losing your grip, being in a crowded room, having so many things coming at you, voices, images, you can't sleep.

(Music plays)

SPEAKER:

I was homeless for about three years, I just felt like I could not do anything right. Not knowing how to do stuff that I used to know how to do. Going shopping, walking down the street, I felt like everyone was talking about me everywhere I went. Even going to check the mail was scary.

DR. SARAH KOPELOVICH:

Psychosis is when an individual retreats into their own perceptions, their own thoughts, their own understanding of what is happening.

SPEAKER:

Some people see things that other people cannot see. Some people will have really, like, worried thoughts or feel like people are coming after them specifically.

DR. SARAH KOPELOVICH:

Cognitive Behavioral Therapy can help them to start to break out of there cocoon. -- their. Our work at the spirit Center is really about how we can train and prepare the workforce to provide culturally informed, trauma informed, and empirically supported care. Our mental health system is doing the best it can with the limited funds that it has, but we need to do better.

How do we help? How do we solve this problem? Traditionally, our medications have been on the front line. But our medications are not enough. Psychotherapy helps people learn about themselves. About what helps and what makes symptoms worse. (Video plays)

SPEAKER:

They mention to me two times about taking CBTp and at first I said, "I do not want to take anything like that." But this seems to be a good fit for me. My therapist made me feel understood.

They asked me things that no one has really asked me about my voices. I did not know that I was not being honest with myself about my voices. It was eye opening and I do not think I would have been able to do that without the therapy.

SPEAKER:

Cognitive Behavioral Therapy for psychosis is different in that really you can meet people where they are at, like, regardless of where they are at in terms of their recovery. It is just very flexible and it is really person-centered.

SPEAKER:

CBT has increased my confidence to talk to people, to walk down the street. I got so comfortable that I have been (indiscernible). So I just felt at home in my own body. It really takes therapy to another level.

DR. SARAH KOPELOVICH:

The data suggest that CBT is one of the most effective and efficient treatments that we have.

SPEAKER:

I feel like I am more effective with my client. And I feel like I am able to measure their progress and see their progress. It is giving people confidence. Confidence in their ability to manage their symptoms. To see someone do a 180 and all of a sudden be like baking again, traveling, it is amazing.

SPEAKER:

To be able to facilitate their change, that is remarkably powerful to a clinician.

SPEAKER:

I feel much better equipped as a therapist having being trained in CBTp. They do not teach you how to treat individuals with psychosis in grad school. It was also working with the Spirit Center. The training is really in-depth, there is so much support, right?

You always have someone to go to if you have a question or if you are confused about something.

SPEAKER:

The mission of the Washington healthcare state authority is to provide access to healthcare for folks in the State of Washington.

SPEAKER:

The state has partnered with us since 2015 to train the workforce in Cognitive Behavioral Therapy for psychosis. When we trained clinicians, we ask them the question, "do you have a clear sense of how to work with people with psychosis?" And only 17% agree with that statement.

By the end of our training, 95% of our trainees say that they have a clear sense of how to work with people with psychosis.

SPEAKER:

It is important to this date continue to fund workforce for development and we need to support individuals and trainings for these types of evidence-based, person-centered care models for CBTp.

DR. SARAH KOPELOVICH:

We need systemic investments to help change the course for the millions of Americans that have psychotic disorders.

SPEAKER:

When we invest in the workforce, we invest in the health of the state full stop

SPEAKER:

I believe it should be easier for people to get treatment in Washington State. Hearing voices is scary. And I want them to know that they are not alone.

If you do not want to live like that, you do not have to. CBT has increased my confidence, it has helped me in my life, just being.

DR. SARAH KOPELOVICH:

That part where she talks about going to get the mail in her socks always brings a smile to my face. Alright, we will transition now into Q&A. So a couple of things I want to call attention to: If you are a family member, a caregiver or loved one of an individual who is experiencing psychosis, we have been able to offer the psychosis reach CBTp training for families for free through philanthropy since we started doing this training.

Dr. (unknown name) and I started this training back in 2018. And we have never had to charge a family at. So I encourage you to go to the psychosisreach.org website and take a look at that training. We also offer CBTp training for healthcare organizations at the University of Washington spirit Center. If you are hoping to get what a sense of CBTp sounds like and feels like and hear it from the perspective of a clinician and from a client, the medical mind podcast which is a collaboration between the NAMI and American Psychiatric Association to the feature on this topic on their February 1, 2023 episode.

So I encourage you to check that out. I mentioned the North America CBT for Psychosis Network. This is their website. They have training offerings on their website. And you can always reach out with any questions you may have.

So with that, I will stop sharing and turn things over to Kelle for our Q&A session.

KELLE MASTEN:

Thank you so much for this presentation. I do not know if you were able to see the chat while you were presenting, but it was quite active. I want to remind everyone that we will share the recording with the slides along with a certificate of attendance to everyone who attended today.

One of the biggest questions was how can folks get training. So thank you for that last slide. So again, everyone will receive that information via email. Let me hot to the questions.

Let's see. -- Hop to the questions. Have you ever considered tele-health visits? A lot of health plans offer lower cost share when using this option.

I know a lot of the training was talked about in person. Folks wanted to know if you offered tele-health visits as well.

DR. SARAH KOPELOVICH:

Yes. So interestingly enough, not only is CBTp appropriate for tele-health, in many cases, but actually, Dr. Tarkington and I co-authored a paper together on how you would adapt CBTp for tele-health.

And we rode it at what was probably the height of the COVID pandemic. So that was really our frame of mind at the time. Many of the things that we talked about in that article would apply.

And I would be happy to send a reference for that paper to you all so that you can disseminate it with the other materials. I think what is important when you are considering

tele-health is you really have to make the decision for tele-health on a case-by-case basis. Right?

tele-health is not a one-size-fits-all. I have had clients that do not leave the house. Right? They may even qualify for a diagnosis of agoraphobia in addition to their diagnosis of a primary psychotic disorder.

I really want to work with that individual to get them out of the house to attend therapy appointments. Because that may be the one time each week that they are getting out of the house. So what I might say is, you know, I would be willing to do an intake appointment via tele-health. Where we can just decide whether we are the right fit for each other, whether this is the right time in your life to commit to therapy, what kind of therapy I offer that I think would be most helpful to you.

And then what would be entailed in that therapy. So I can really do that CBT informed consent with them. So that they can make a commitment to in person CBT or hybrid CBTp.

I think the other thing that can be a barrier to tele-health for this population is if there are specific concerns related to technology. They may not feel safe enough using that modality. Right? I do not want my client to be so anxious about the government potentially recording and monitoring our session that they either do not come or they are just not fully able to be present for that appointment.

The other consideration I would have for tele-health is can the person present for a tele-health session where we can do work together. Because we worked, right? We have fun in CBTp, but we also work hard. I have clients where they are so tired, either from the medications, or negative symptoms, or staying up all night, that they are taking the tele-health session from the bed while lying down.

Their eyelids are heavy, right? I need the client to be with me, take a while, splash water on their face, do the activities that promote the health and energy that they need to be in learning mode and in doing mode and not in sleep mode.

So those are some of the considerations. But otherwise, there is no contraindication for CBTp tele-health.

KELLE MASTEN:

Thank you. Is there a list or registry of practitioners trained in CBT for psychosis? And is that list, like, available for each state or region? Do you have that?

DR. SARAH KOPELOVICH:

Fabulous question. And that is one of my main objectives. I am currently serving my term as president of the North America scene network. That is one of my main strategic objectives for my turn. It is to get this directory online.

So we will have a directory, I am hoping it will come out in early 2026. It will include the United States and Canada, eventually, we would also like it to include Mexico. You will be able to search by region, you will be able to search by payer.

And then eventually, you will also be able to search by CBTp specialty certification. So I mentioned earlier that the NAS CBTp network is also working on specialty certification, that gives you some quality assurance that the practitioner that you or your loved one is working with has been sufficiently trained in this intervention.

So you will be able to filter your search, eventually, just to be able to look for folks with that specialty certification. It will include both individual practitioners and healthcare organizations that have practitioners that have been trained on their staff.

So it is not available now. But it will be, hopefully, within the next year.

KELLE MASTEN:

Who is the ideal patient for CBTp?

DR. SARAH KOPELOVICH:

That is a tough question for me. Because I actually find in practice that when I am working with clinicians or when I am working with healthcare organizations, they do more gate-keeping than is necessary for CBTp.

I think there is a lot of misconceptions that individuals will only benefit if they agree with their diagnosis, or if they do not have thought disorder, or if they are not also using substances. And those are not necessarily true. So an ideal candidate is someone who, after informed consent, after we lay out what we do in this treatment, how it works, the fact that this is a partnership, and that we will be working together on a weekly basis for about six months. If they say yes, I am in, then I am in too.

So we will need to do some adaptations to make sure that it works for them. If they are using substances, for instance. In that case, I need a commitment to them that they will show up to sessions sober.

Because being intoxicated will inhibit learning and memory, encoding memory. So if there is thought disorder, there is moderate or severe thought disorder, we will need to use some techniques to try to make progress in that area first before we can progress to other treatment targets. If there are cognitive impairments, moderate, or severe cognitive impairments, we used to identify whether CBT will be helpful for that person and so there is strategies that I will teach clinicians on how to assess for that.

Primarily, it is how can they make those connections between situations, thoughts, feelings, and behaviors as discrete things. And can they see the links between them.

The more severe the thought disorder, the more we will have to scale back on our treatment targets, keep sessions short, and very targeted.

So I would say let's throw away this notion that there is an ideal CBTp clients. Let's try to get everyone we can access to that and then help clinicians to make the adaptations that are needed to help this person as best we can.

The one thing that I will add to that is that based on what we are targeting, so for instance, if the individual is presenting with a lot of negative symptoms, meaning they have very low motivation, low energy, difficulty with experiencing affect, their emotions, or showing their emotions, not speaking a lot, so you do not have that back-and-forth exchange, the way we will target those negative symptoms is going to be, really, trying to do some skills training in the communication area.

Or getting the energy up with behavioral activation. And then we will progress into a more sort of, for lack of a better word, traditional CBTp once we have those negative symptoms diminished.

But that can take some time. So that course of therapy might take a bit longer.

KELLE MASTEN:

Thank you. This was a question that came up earlier in the presentation. Would you be willing to elaborate on what you meant by magic bullet? Do you remember?

DR. SARAH KOPELOVICH:

I do not remember when I said magic bullet. I actually do remember this moment in the podcast episode that I mentioned. Earlier. The medical mind podcast episode where I said, Ken (unknown name) was interviewing me, and I said, "with psychotic disorders, we do not have any magical bullets, but we have a lot of silver buckshot's." Right?

There is not one thing that is effective for people with psychotic disorders. There are a lot of things that are really effective in combination with each other. So the ideal combination for an individual who is really impaired by their symptoms of psychosis would be that we find the right medication regimen for them, and that we combine that with psychotherapy, with

skills training, with peer support, and then with nursing support as well to address a lot of the physical health conditions that might coincide.

KELLE MASTEN:

Thank you. You mentioned that CBTp is still underutilized in the US. What are some practical first step agencies can take to start building CBTp capacity?

DR. SARAH KOPELOVICH:

I think that is a really important question. I would say one of the most practical first steps is to start with broad foundational training. There is a CBTp-informed care care. Right?

A lot of what is in that is taking a recovery orientation. Right? It is learning how do we sit in the room with someone who is experiencing psychosis. How do we communicate effectively with someone who is experiencing psychosis? So that we are equipping case managers, peer specialists, psychiatric technicians, everyone within that ecosystem with basic strategies for engagement, for normalization, right? We can kind of do medical eyes or deep apologize some of these experiences and we find that when we do that, when we talk about the fact that a lot of people also have these kind of experiences, that it is incredibly helpful in and of itself.

And then also, we can teach these practitioners across the workforce different kinds of high-yield coping techniques and then the agencies can select a smaller group of clinicians to pursue more intensive training in individual or group CBTp.

I would say the other key here for organizations is to start small and focus. Many agencies have started to introduce CBTp for their first episode psychosis teams.

So then you have one or two practitioners who are trained, they can act as supports for other individuals in the agency to help get trained up and it helped get leadership buy in for a broader implementation. Really partner with organizations or state agencies that can use their resources for this training in your organization.

A lot of it is laid out in the SAMHSA Implementation Guide and the position statement. I would really encourage those resources for folks who are looking to bring CBTp to your healthcare organization or to your state.

KELLE MASTEN:

Thank you. Do have time to do one or two more questions. From a family or community perspective, how can people advocate for broader access to CBTp services in their local mental health systems?

DR. SARAH KOPELOVICH:

I love that question! And I love it because that is what inevitably has led to some of the biggest changes that we have seen in mental health care over the last two decades. I have been heavily involved in coordinating specialty care, in the roll-out in the Northwest United States specifically. And it is not lost on me that what compelled the federal government to use the mental health block grant to help fund the specialty care programs across states is not just the research, it was family members, many of whom were organized by NAMI to put pressure on their legislators to ask for evidence-based interventions.

So I would say, one thing is, go on to the NACBT website. If you go to the top that this research, you will find research organized by different kinds of topics.

One is policy where the resources that I just mentioned, the SAMHSA and (unknown name) statements are both on their full stop you will find research on treatment, effects and implementation.

Because knowledge is power for you, too. So once you are equipped with the information that CBTp is effective, that our treatment guidelines are recommending CBTp as the standard of care, you can then ask your loved ones treatment team or your treatment team, "why haven't I been offered CBT for psychosis?" And if they do not have the answer for that, then you speak with the leadership at the organization.

"Why is CBT for psychosis not on your menu of services?" Or if CBT is listed for other health conditions, why not for psychosis? Right?

I always say, when you're doing advocacy work, do with what is in your capacity. I have some family members and clinicians who only have capacity to advocate for one individual.

And I have others who can advocate at a national level. Figure out where you are at right now. And just ask these questions as a starting point. And if anyone tells you, well, CBT does not work for psychosis, now you know that is not the case. And now you know how to access the research otherwise.

KELLE MASTEN:

Thank you so much for this presentation today. And for just sharing this valuable information with everyone. I would like to take this time to thank SAMHSA for sponsoring the presentation. And again, thank you to the audience for joining us. The recording link, the slides, and the certificate of attendance will be email to everyone within a few days. And we want to remind you to please share your feedback. As you leave the platform, there will be a survey that will pop up, please complete that for us. We would like to know what you thought about today's presentation. Thank you so much for joining us today! And enjoy the rest of your afternoon.

Take care, everyone.

SPEAKER:

Thank you, everyone. This concludes today's session. You may now disconnect.

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