Culture, Outcomes, and Engaging Family

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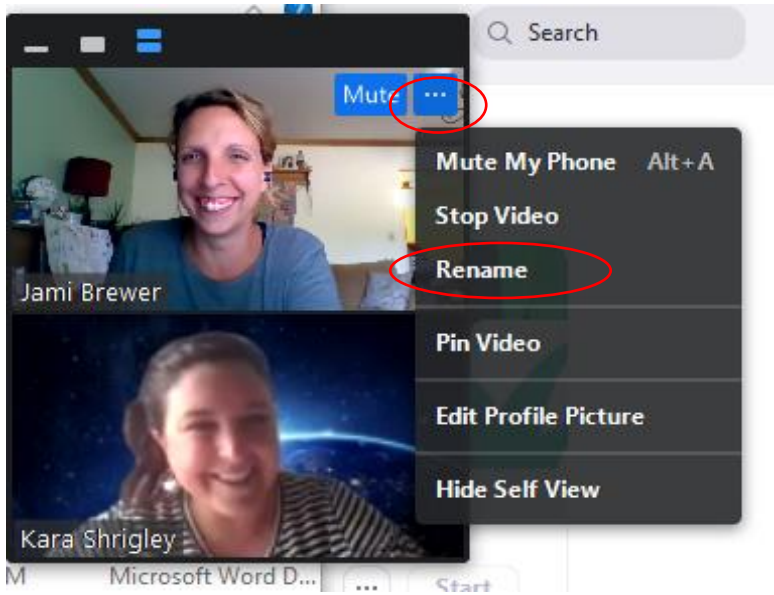
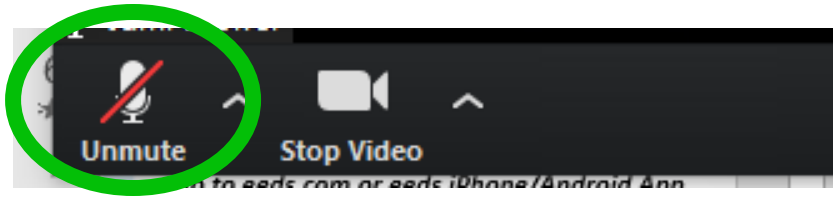


Helpful Tips

- Mute microphone when not speaking



  - Press *6 to mute/unmute if calling in

Let's Review

- Homework-
  - What actions did your try over the past week?
  - Look up any new information? Learn anything new?
  - What held you back from taking action?

LET'S SET THE AGENDA

Begin with culture humility

Describe common measures/Recovery

Working as a team; engaging family and friends

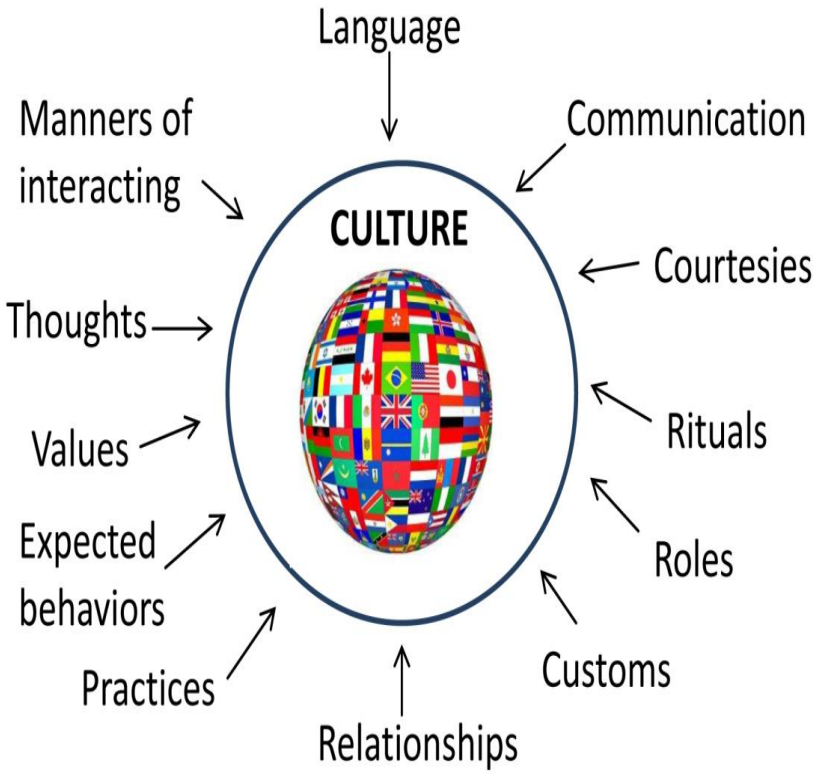
HUMILITY

CULTURAL HUMILITY

Honoring culture and background

CULTURAL HUMILITY

The ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the person.



"…. a basic attitude of humility toward patient experience, along with a reflective, self-questioning awareness about the clinician's own cultural values and culture-specific perspective on illness, symptomatology, and recovery."
(Jones and Luhrmann, 2016; p. 25)

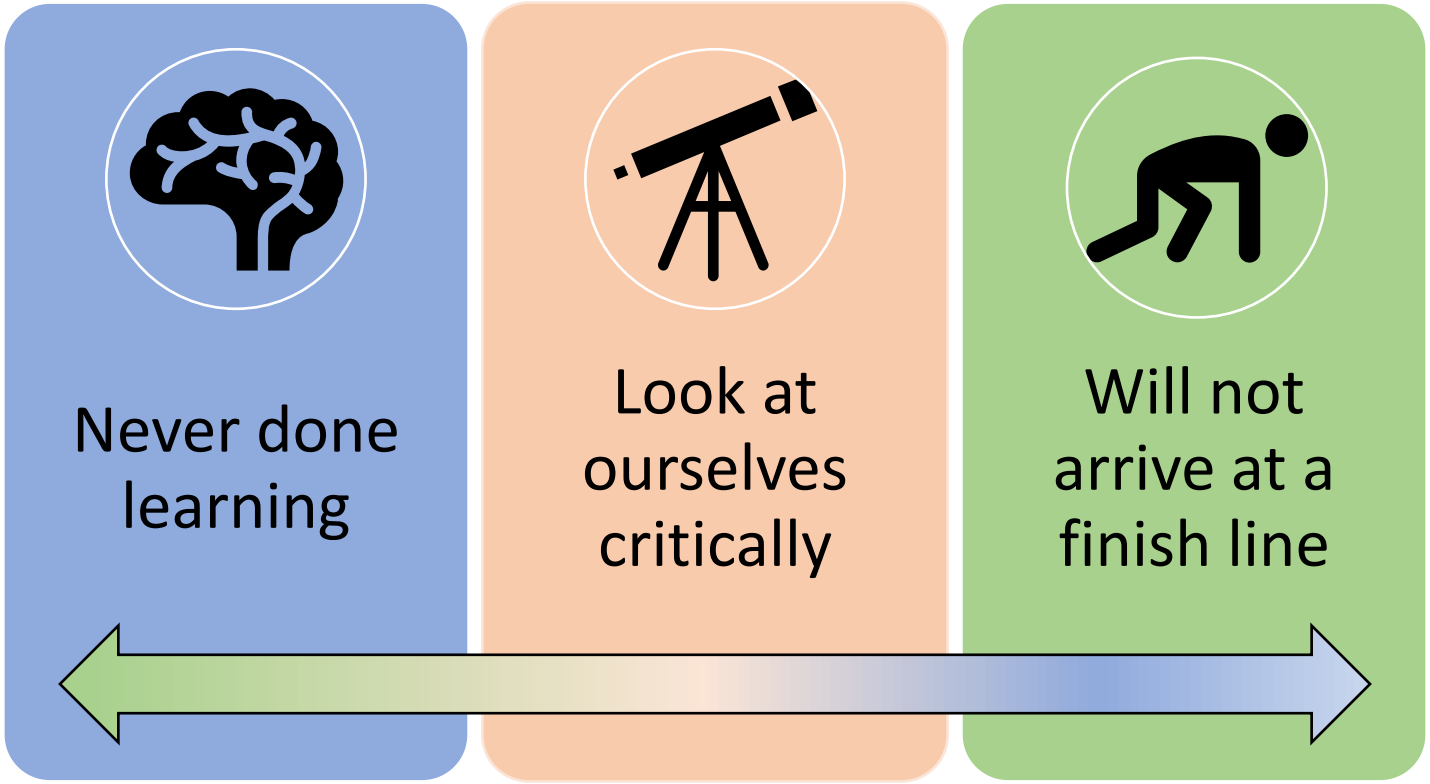
Waters & Asbill (2013) APA.org

CULTURAL HUMILITY

Three factors:	Lifelong commitment to self-evaluation and critique
	Equalize power imbalances
	Develop partnerships with advocacy individuals and groups

Waters & Asbill (2013) APA.org

LIEFELONG COMMITMENT



Waters & Asbill (2013) APA.org

EQUALIZE POWER IMBALANCES

Individual is the expert of their own life experiences

Provider holds a body of knowledge

Collaboration and learning from each other- ***teach and learn together***

Waters & Asbill (2013) APA.org

DEVELOP PARTNERSHIPS

- **Cultural humility is larger than the individual self**
- Community and groups can have a profound impact on systems
- Advocacy within the larger organizations that you work in

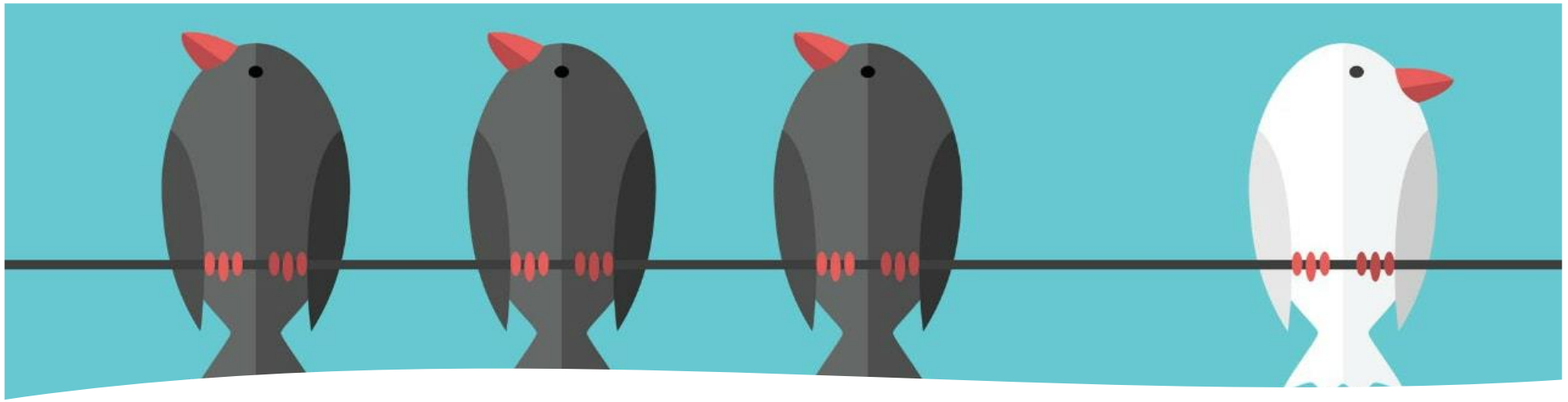
Advocacy & Humility

Waters & Asbill (2013) APA.org

Building a Bridge…

STARTING TO BUILD BRIDGES
UNDERSTANDING OUR OWN CULTURE VALUES

AND how they influence our practice



We are all prone to culture bias

- Structure of CBT therapy, expectations, etc. are imbued with Euro-American, Western values
  - Assertiveness in social interactions (i.e., versus subtle or more indirect)
  - Personal independence (over community or interdependence)
  - Open self-disclosure (over cautious protection of one's family reputation).

Hays (2006)

Local Culture- small and Large group activity-Breakout rooms and discuss

- Help us to understand the different cultures and diversity in this region
  - Describe your background growing up and your sense of cultural identity.
    - How many in your group speak a language other than English?
  - What do you identify most with about your own culture background?
  - How does my work reflect my own values and culture?
  - How does our agency respond to culture differences?

Comparison of Values

Common Traditional Values

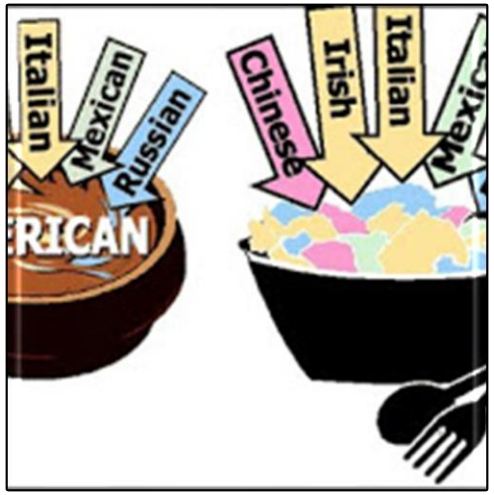
- Family and group orientation
- Extended family
- Status by age and position
- Relation with kin obligatory
- Arranged marriages
- Family decision making
- Doctor as authority
- Pride in family

Western Values

- Individual orientation
- Nuclear family
- Status achieved by effort
- Family relationship by choice
- Choice of partner
- Individual autonomy
- Doctor as consultant
- Pride in self

Adapted from Rathod et al., 2015

TRADITIONAL VERSUS MULTICULTURAL VIEW ABOUT ILLNESS



Traditional (Universalist view): Disorders present similarly across cultures and treatments and prevention operate similarly across cultures.

- Risk is that dominant social group imposes its values (individuality; autonomy are primary)

Multi-cultural view: Disorders present in ways influenced by culture and life experience

From Graham et al., 2013

SOME INITIAL ASSESSMENT NOTES

- Respect is essential- convey desire to learn
- Obtain a full description of the home environment
  - What is the client's personal orientation to his/her culture of origin?
- <u>Acculturation</u>
  - Integration
  - Assimilation
  - Separation
  - Marginalization

Acculturation Model

	Identification with Heritage culture: **HIGH**	Identification with Heritage culture: **LOW**
Identification with US culture: **HIGH**	**Integration (Bicultural)**	**Assimilation**
Identification with US culture: **LOW**	**Separation**	**Marginalization**

Image: Truong, H-T; Model: Berry, 1997

Therapeutic Stance: Awareness of…

Power-

Relative power of person/group represented

Privilege-

Advantages afforded dominant group in society

Marginalization-

A group that is view negatively by dominant social group

Microaggressions-

Both intentional and unintended biased actions based on a person's grouping

Therapeutic Stance

Awareness of factors influencing illness expression, access to treatment and perception of treatment modalities

Awareness of modal experience of the individual/group thru the lens of power

Initiating conversations about marginalized statuses- important for therapist to lead this as others from minority status may have been socialized to not disclose these concerns

From Graham et al., 2013; Torres-Makie, 2020

BRINGING UP RACE, CULTURE AND ETHNICITY IN SESSIONS

Ideas about working with therapist from a different background

- What has been your experience seeking help in different ways and places?
- Thoughts about working with me… similarities and differences in our backgrounds and how it may affect our work

How does identity influence your experience of anxiety (relationships) in daily experiences?

- "Because I recognize the importance of social group identities, I like to ask all of my clients about their reference groups". Ethnic, gender, sexual orientation- see Torres-Makie,2020

Psychoeducation: tailor to person's lived experience

Explicit acknowledgement and validation of unfair treatment as contributing to anxiety is essential

From Graham et al., 2013; see also Torres-Makie, 2020

Culture considerations for modifying CBT

Modifications to style and practice

- Authority- direct may be preferred to typical collaborative approach for some cultures
- Language- adapted as well as translated (get examples of concepts from the client)
  - *Describe a person you think of as assertive; how would they handle this situation?*
  - Teach skills and adapt CBT terminology using culturally relevant words and phrases
    - For example, when reviewing cognitive errors, explain the concept (e.g., black and white thinking) and ask the client if there is a label/idiom of distress that is more relevant to them.
    - Use culturally appropriate stories and metaphors in conveying messages and activating change.
- Explore cultural views re suppression and avoidance

Maura and Kopelovich, 2020; Cultural Considerations- practice brief; Rathod et al., (2015)

CULTURE CONSIDERATIONS FOR MODIFYING CBT- CONTINUED

- Support system- inclusion of extended family and religious/spiritual leaders

- Religion and Spirituality- 60%+ with serious mental illness find R/S important
  - Check faith based support systems- belonging/support versus isolation/exclusion
  - How does client frame their illness in terms of their faith background?
    - Benevolent versus Punishment themes (see religious coping styles)

- **Case formulation** intentionally building in culturally relevant information
  - Cultural identity/stressors/supports – see Figure 1 from Maura and Kopleovich practice brief

Maura and Kopelovich, 2020; Cultural Considerations- practice brief; Mohr, 2013- religious coping styles

Foster Lifelong Learning in Cultural Humility

REFLECTIVE LOCAL PRACTICE: A WAY TO IMPROVE CULTURAL HUMILITY (SANDEEN, 2018)

- **REFLECTIVE**: Increase self-awareness of assumptions

- Look for Hot spots, blind spots, and soft spots
  - Hot spot- when you experienced powerlessness in your own life
  - Blind spots- occur in situations in which you have held relative power (due to social or economic or situation factors).
    - E.g. Hand gestures in the US may mean something totally different than in other countries:

 = 2 different meanings within 3 different languages – can anyone guess?

 = a very different meaning here than in another country – can anyone guess?

  - Soft spots- area of unexamined assumptions that leads to a deviation of standard practice, usually with lowered expectations.

Reflective Local Practice:
A way to improve cultural Humility

LOCAL: explore your local culture

- First-hand experiences (events, activities, festivals)
- Books, movies, poetry
- Explore local history thru lens of power dynamics
- How many different cultures do you see in your home community

PRACTICE:

- <u>Learn specific skills</u>-
  - Practicing ways to take a culture history
  - Introducing a discussion of potential culture factors in a respectful way
- Compensate for hot, blind, and soft spots – be open to feedback

Sandeen, 2018

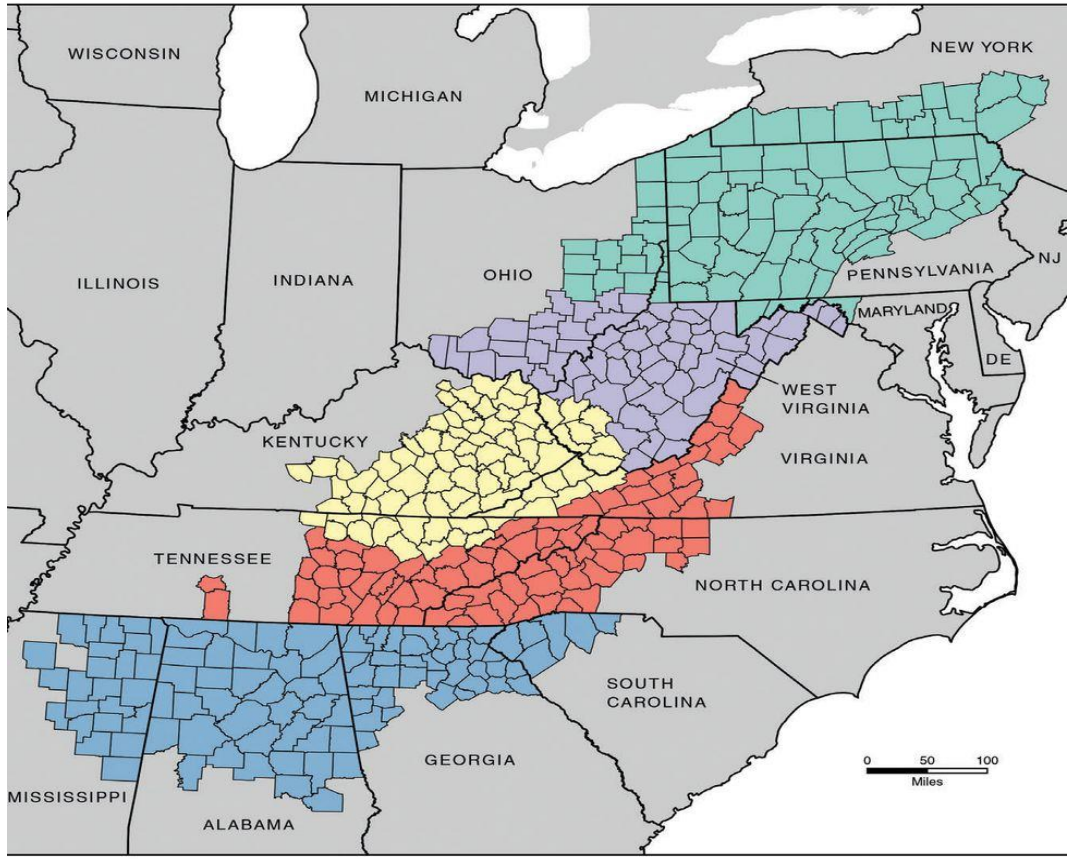
Appalachian Culture

- Heavily stigmatized as poor and backward
  - What was once considered a simple life is now considered as “poor”

- The kind of person they view themselves as being dictates what will be accomplished in that lifetime, not the other way around

- Important personal characteristics
  - **Individualism** – independence is highly valued
  - **Traditionalism** – do not plan or encourage change
  - Fatalism – endures miserable conditions with no hope for change
  - Action seeking – avoids routine, more risk-taking behavior
  - Person oriented – goals are defined and related to family and friends, need for group acceptance
  - Isolated – more highly educated individuals often leave the area, and leaves behind those who are accepting of “bare necessities” living style

Subregions in Appalachia



APPALACHIAN REGIONAL COMMISSION

Map Created: November 2009.

Appalachian Culture

- Very independent and content with the way they live
  - Close to nature, close to God
  - Helpful to each other
  - Strong sense of right and wrong
  - Hospitality
- Have long been exploited for the riches in the land (great natural resources)
  - Beautiful area
  - Industry has taken advantage of the local culture for profit
- Culture is preserved by family and religion
  - Based on subsistence farming and hunting, not on industry
  - There is an “equality among members of the culture”
- Four distinct groups
  - 1. Descendants of the original pioneers
  - 2. Hard working factory or coal minor worker
  - 3. Professional group – moved to Appalachia due to profession
  - 4. Returning Appalachians – left and then
  - came back; hard to adjust to coming back

Work to be done: Disparities

- Higher incidence rates of psychosis among individuals of Black descent
- Lower treatment and adherence rates for immigrant groups
- Less access to individual and family-based psychotherapy among Hispanic and African American populations.
  - Cited in: *Culturally and Linguistically Responsive Care for Early Psychosis*. Garcia, Maura, and Kopelovich (2020)

Appalachian populations:

- Poverty rates higher than national average
- Suicide rate: 17% higher than national average; Depression- 23% higher
- Higher opioid use
- 65% reporting significant trauma
  - Elder and Robinson, 2018, Mental Health Disparities: Appalachian People, Psychiatry.org https://www.researchgate.net/publication/335243462_Mental_Health_Facts_for_Appalachian_People

REVIEW: TENS STEPS TOWARDS CULTURAL HUMILITY WITH CBT

HAYES (2009)

6. Emphasize	Emphasize collaboration with attention to client-therapist differences
7. Cognitive Restructuring	With cognitive restructuring, use the “helpfulness” prompts more often than the “accuracy” prompts
8. Do Not Challenge	Do not challenge core cultural beliefs
9. Strengths	Use client’s list of strengths to develop list of helpful cognitions to replace unhelpful
10. Homework	Develop weekly homework with an emphasis on cultural congruence and client direction

REVIEW: TENS STEPS TOWARDS CULTURAL HUMILITY WITH CBT

HAYES (2009)

OUTREACH

- If you'd like to try your hand at outreach – there are ways to do this
  - Call on local pastors, ministers, priests, rabbis' secular or Buddhist meditation teachers
  - Find out how different religions value certain aspects of life
    - Hispanic and Mediterranean cultures have smaller personal space than those in our culture
    - Buddhists see their "higher power" as aspects of self with a guide to interpretation through the teacher
      - Sounds very self-centered and isolative
      - The work on "self" is for the express purpose of developing compassion for others and creating an enlightened society
    - Asian cultures value education to a different degree than those of us in the US.
      - Trouble at school, poor academic performance most common reason for teenage suicide (NIKKEI Asian Review)

https://asia.nikkei.com/Spotlight/Asia-Insight/Youth-suicide-Asian-teens-crack-under-growing-family-pressure#:~:text=Bangladesh%20and%20Thailand%20also%20had,at%204.8%2C%204.4%20and%203.7.

Questions and Feedback

TAKE HOME NOTES

- What are the take home points for you as it relates to honoring culture?
- What are some specific actions that you can take that helps to keep in mind the value of honoring culture?

Outcomes

INDIVIDUAL USE MEASURES

BASIS 24

- General Symptoms/Functionality

Recovery Assessment Scale: domains and Stages (RAS-DS)

- Recovery Oriented

DIALOG

- Recovery Oriented
- Empowering
- Satisfaction

More Outcome Measures to Consider

PSYRATS (Psychotic Symptom Rating Scale)

- Symptom Focused
- Voices and Delusions

BAV-Q (Beliefs About Voices Questionnaire)

- Symptoms Focused
- Concentrates on Voices

- These measures are not covered in this presentation, but they can be very useful
- Therapists can request a specific training on the use of these materials

If you choose to get training (quick training is all that is needed) - PSYRATS (S3: pp 4-10) and/or BAVQ (S3: 11-13)

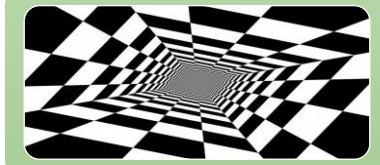
WHY BOTHER WITH OUTCOME MEASUREMENTS?

Helps clinicians to recognize change and respond appropriately

Helps clients recognize change

Can be used for treatment planning and goal setting

Can be used to structure a session



Routine assessments improves client outcomes

Macro-level Information

General Purpose	Therapeutic Orientation	Benefits
To discover if a therapeutic practice is helpful in general for a specific population To discover which type of therapy works best for a specific diagnosis or symptom	CBTp	Provides a significant positive effect on positive symptoms with 6-12 month follow up
	Social Skills Training	Excellent for reducing symptoms and increasing functionality and quality of life
	Psychoeducation	Improved quality of life, decreased relapse rate
	Family	Family dynamics have shown to be a factor in recurrence of symptoms. Family therapy significantly improves functioning and reduces hospitalizations
	Patient Focused	Studies fail to show significant changes in adherence to medications and quality of life
	Medication	Can significantly reduce positive symptoms, but there is a wide variety of responses. Often does not eradicate symptoms completely. May need to be supported by other therapy

Micro-level Information

General Purpose	Outcome Measure	Diagnosis/ Target	Symptom/ Target	Outcome
General Functioning	Basis 24	General Assessment	General Symptomology	Symptom distress level Is distress decreasing over time?
Treatment planning Goal setting	RAS-DS	Recovery from SMI	• Values • Future • Mastering Illness • Connection and Belonging	Value directed action Relapse prevention Coping skills Social connectedness
Treatment planning Goal setting To validate admission/ discharge	DIALOG	Recovery	Life domains Treatment aspects	Satisfaction with life domains and treatment

BASIS 24: Behavior And Symptom Identification Scale
1 Overall Functioning Scale & 6 Domain Scores

1. Depression/functioning
   - Measures depression/
   - Anxiety
   - Functioning
2. Interpersonal relationships
   - Perception of relationships with others
3. Self harm
   - Thoughts about self harm
   - Suicide
4. Emotional lability
   - "Excessive emotional response to a minor stimulus" (p. 17)
   - Mood Swings
   - Racing Thoughts
   - Irritability
5. Psychosis
   - Hallucinations and/or delusions
6. Substance abuse
   - Urges to use and consequences from using

Score of 4 or higher indicates more frequent problems in that area of questioning

Eisen et al. (2004)

BASIS 24

Reliability, validity, and psychometric properties are known to be strong when testing with adults (over 18 yo)

Currently, there is research occurring to explore its utility with adolescents.

Tested on both in-patient and out-patient settings

* No community normative data or clinical benchmark has been published, cultural norms are not represented in the outcomes

* Studies have shown that using the BASIS 24 is related to an increase in in-patient satisfaction with care after each of the domain scores are discussed with the patient and can be used to develop treatment plans

Can provide a range of treatment topics that may need to be on the treatment plan other than psychosis

Shirley Ryan Ability Labs website retrieved 1/21/21 (see reference list)

The Recovery Assessment Scale – Domains and Stages (RAS-DS)

- 38 items with Likert scale with 4 rating categories from:
  - Untrue
  - A bit true
  - Mostly true
  - Completely true
- 4 recovery domains
  - Doing Things I value
  - Looking Forward
  - Mastering My Illness
  - Connecting and Belonging

- Small number of users found it too confronting and hard to use, though most report easy to use
- Excellent internal and external reliability and validity scores

S3: pp 14-17

RAS-DS

- **Doing Things I Value**
  - Personal, not societal values

- **Looking Forward**
  - Viewing self outside context of illness
  - Hopeful for the future

- **Mastering My Illness**
  - Focus on control and management of symptoms, not amelioration of symptoms

- **Connecting and Belonging**
  - Greater diversity in social relationships
  - Family and broader communities
  - Reciprocated and personally satisfying

Recovery Assessment Scale Domains and Stages (RAS-DS)

Doing Things I Value

Looking Forward

Mastering My Illness

Connecting and Belonging

Mastering My Illness				
	UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
25. Domain Score = 19 warning signs of becoming unwell	1	(2)	3	4
26. I have my own plan for how to stay or become well	1	2	(3)	4
27. There are things that I can do that help me deal with unwanted symtpoms	1	2	(3)	4
28. I know that there are mental health services that help me	1	2	(3)	4
29. Although my symptoms may get worse, I know I can handle it	1	2	(3)	4
30. My symptoms interfere less and less with my life	1	2	(3)	4
31. My symptoms seem to be a problem for shorter periods of time each time they occur	1	(2)	3	4

Find the free manual and workbook online at https://ras-ds.net.au/
"Or type in RAS-DS My mental health recovery measure" in your browser to get complete instructions and workbook for use with clients

S3: pp 14-17

DIALOG

DIALOG	Totally Dissatisfied	Very Dissatisfied	Fairly Dissatisfied	In the middle	Fairly Satisfied	Very Satisfied	Totally Satisfied	Additional help Wanted? Yes/no
How satisfied are you with your Mental health?								
How satisfied are you with your Physical health?								
How satisfied are you with your Job situation?								
How satisfied are you with your Accommodations/housing								
How satisfied are you with your Leisure activities?								
How satisfied are you with your Partner/family?								
How satisfied are you with your Friendships?								
How satisfied are you with your Personal safety?								
How satisfied are you with your Medication?								
How satisfied are you with your Practical help you receive?								
How satisfied are you with your Meetings with mental health professionals?								

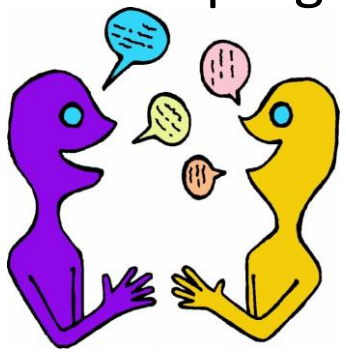
Pick the top three things that you would like to work on: **Updates since last review**

1	
2	
3	

S3: pp 18-20

DIALOG STRATEGY

- Introduce DIALOG as a way to help you work together
- Re-administer every 2-3 months
- Select no more than 3 domains to work on at a time
- Guidelines to select a focus
  - Area client really wants to work on
  - Satisfaction rating below 4
  - Distress associated with mental health item
- For review sessions
  - Always helpful to purposefully review areas of progress and decline

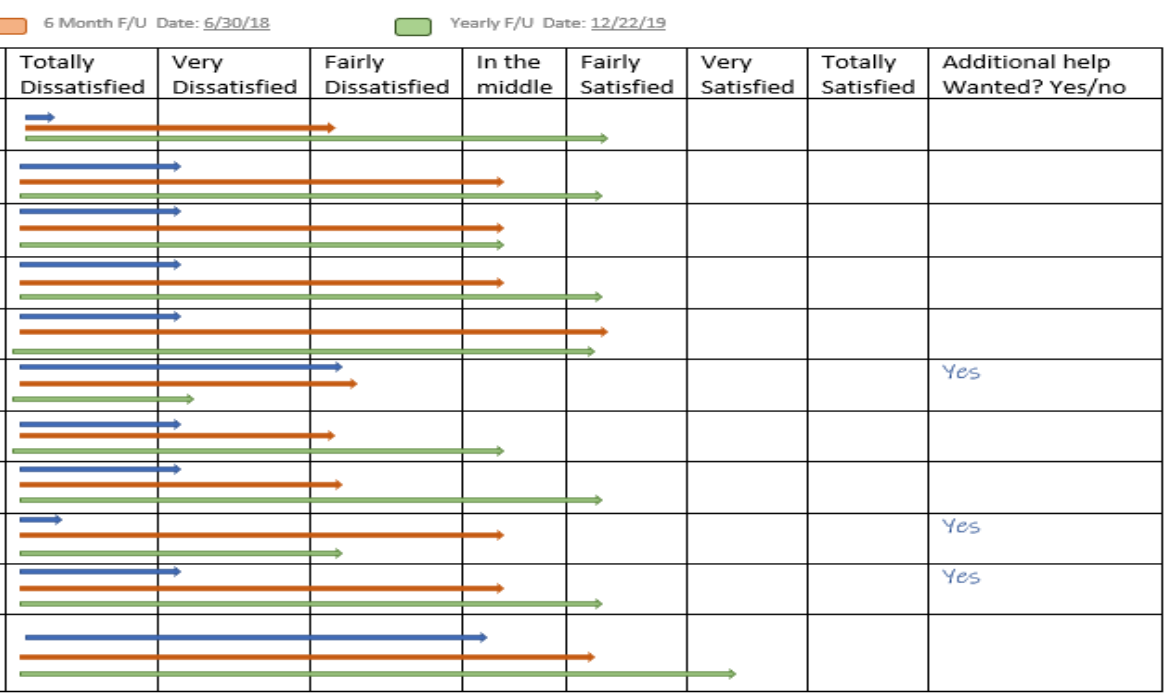


DIALOG OVER TIME

Name: Joe Rating interval: B, 3, 6, 9, 12 Date: _____

Intake assessment Date: 1/15/18 6 Month F/U Date: 6/30/18 Yearly F/U Date: 12/22/19

DIALOG	Totally Dissatisfied	Very Dissatisfied	Fairly Dissatisfied	In the middle	Fairly Satisfied	Very Satisfied	Totally Satisfied	Additional help Wanted? Yes/no
How satisfied are you with your Mental health?								
How satisfied are you with your Physical health?								
How satisfied are you with your Job situation?								
How satisfied are you with your Accommodations/housing								
How satisfied are you with your Leisure activities?								
How satisfied are you with your Partner/family?								Yes
How satisfied are you with your Friendships?								
How satisfied are you with your Personal safety?								
How satisfied are you with your Medication?								Yes
How satisfied are you with your Practical help you receive?								Yes
How satisfied are you with your Meetings with mental health professionals?								



Pick the top three things that you would like to work on:	Updates since last review/Progress to Goals
1. The voices are so loud. I never get peace.	1. Voices not so loud, but...how am I going to get a date? I'm so fat from the meds.
2. My parents are happy that I'm in a program, so they are being nicer to me.	2. My parents are back to being super hateful and mean. They think I'm better and don't need "babying" anymore.
3. I've been practicing using the bus, but I get lost sometimes, then I get scared.	3. I get around pretty well by using the bus. Maybe I'll start thinking about getting a driver's license.

DIALOG was developed by Stephan Priebe <s.priebe@qmul.ac.uk . Used with permission

S3: pp 18-20

RESEARCH SUPPORT

- DIALOG developed to structure work with clients
- DIALOG compared with standard care
  - Higher scores on quality of life measures, satisfaction, and unmet needs after 12 months
  - This occurred while symptom levels stayed the same
- Agency use was 90% across six healthcare settings
- Did not add significant time or cost
- Reasonable psychometrics:
  - Correlates with other measures of life satisfaction
  - Internal consistency= .71 for quality of life items

Priebe, et al (2007; 2012)

DIALOG+ COMPATIBLE WITH START MODEL

- DIALOG "4-step" approach applied to target areas:
  1. Understanding (Socialize and Target)
  2. Looking forward (Action phase)
  3. Exploring options (Action phase)
  4. Agreeing on actions (Review and Take Home)

- Qualitative studies suggest that DIALOG+
  - Led to increased self-reflection by clients
  - Clients felt able to express concerns more fully
  - Clients felt more empowered to be involved in decision making and taking responsibility for (65%) action items

Priebe et al., 2015; Omer, et al., 2016

So…what do I do when the client is filling out the survey?

1

It can be an awkward experience – sitting by while someone else is filling out forms, however, one can always

Look through papers
Check your mail
Look at your schedule

2

Take notes on specific questions or behaviors you notice while the client is taking the test.

Practical note, it may be difficult for the client to line up response to question. Help as needed.

3

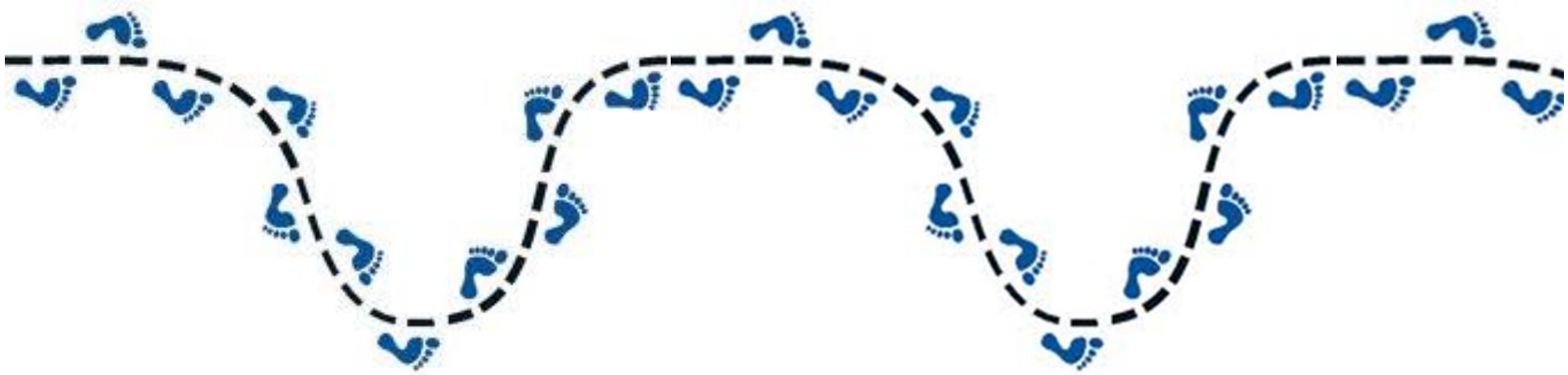
If you see an item marked that concerns you (e.g. questions about suicide), do not allow the client to leave until he/she has spoken with a licensed clinician.

4

Take the questionnaire to your supervisor and review it with them for your own education and understanding of the client

STEPS

- Engagement session(s)- relationship first
- Assessment session- use outcome measure to identify:
  - Key areas of strength and desire to change
  - Select at least one item to focus on from the assessment
  - Review progress on this area each session
  - Plan a date to review short term progress
- Treatment planning based on routine outcome assessment



Small group Discussion- Breakout room

- Review measure most likely to use
- Discuss steps to use
- Trouble shoot the process- what are the likely challenges
- Return to larger group to discuss main action points

Including family and Friends

ENGAGING FRIENDS AND FAMILY

- Plant the seed for family involvement then cultivate this (with client and family)
- **Inform families that they are a critical part of the treatment team**
  - **Step one** is the team recognizing the critical role of the family
  - **Step two** is helping the family understand that they play a role in ongoing treatment and recovery
  - **Step three** is helping the family to identify what this role looks like (will change over time) and supporting them in these efforts
- WORK to gain their trust
- Look to other treatment providers for insight

ENGAGING FRIENDS AND FAMILY

- Be a change agent
  - Set precedent that family and friend involvement matters and is the expectation, as opposed to the exception
  - Work with patients to identify supportive friends and family
    - Think outside the box
    - Avoid the word “family”
  - Start by setting the stage early
    - Make invitations known
    - Discuss expectations

ENGAGING FRIENDS AND FAMILY

- Consider:
  - When are ROIs signed?
  - Do those individuals who were identified by the patient receive reminder calls and invitations to appointments?
  - Do families know who to call with questions and concerns? Do they know the process for evening and weekends?
  - Who encounters the family most often? Who does the family work best with?
  - Consider cultural factors
    - Multicultural diversity, heritage, traditions, beliefs
    - Spirituality
    - Religious affiliations

Engagement and Understanding Family Beliefs

- We live in a diverse culture with many different beliefs operating within our client and within families
- Sometimes families will drop out as they feel the agency is not understanding of their religion or spiritual practice
  - Don't be afraid to ask about cultural/spiritual beliefs
  - Ask for clarity about their practice if you are unsure
  - Emphasize the religious/spiritual beliefs and mental health treatment can work together
- Addressing this early on may help families to feel more comfortable in seeking help and in keeping them engaged
- When we demonstrate that we are engaged in process of cultural humility, families tend to stay in the programs

Gurak, K., Weisman de Mamani, A., & Ironson, G., 2017

LET'S TALK ABOUT BOX

Resource Links

- BeST Center link
  - https://www.neomed.edu/ccoe/mental-health-resources/bipoc/
- The North America CBT for Psychosis Network
  - https://www.nacbtp.org/
- Practice Brief: Culturally and Linguistically Responsive Care for Early Psychosis
  - https://mhttcnetwork.org/centers/northwest-mhttc/product/practice-brief-culturally-and-linguistically-responsive-care-early
- Maura and Kopelovich (2020). Practice Brief: Cultural Considerations in Applying Cognitive Behavioral Therapy to Racial/Ethnic Minority Groups with Serious Mental Illness
  - https://mhttcnetwork.org/centers/northwest-mhttc/product/practice-brief-cultural-considerations-applying-cognitive

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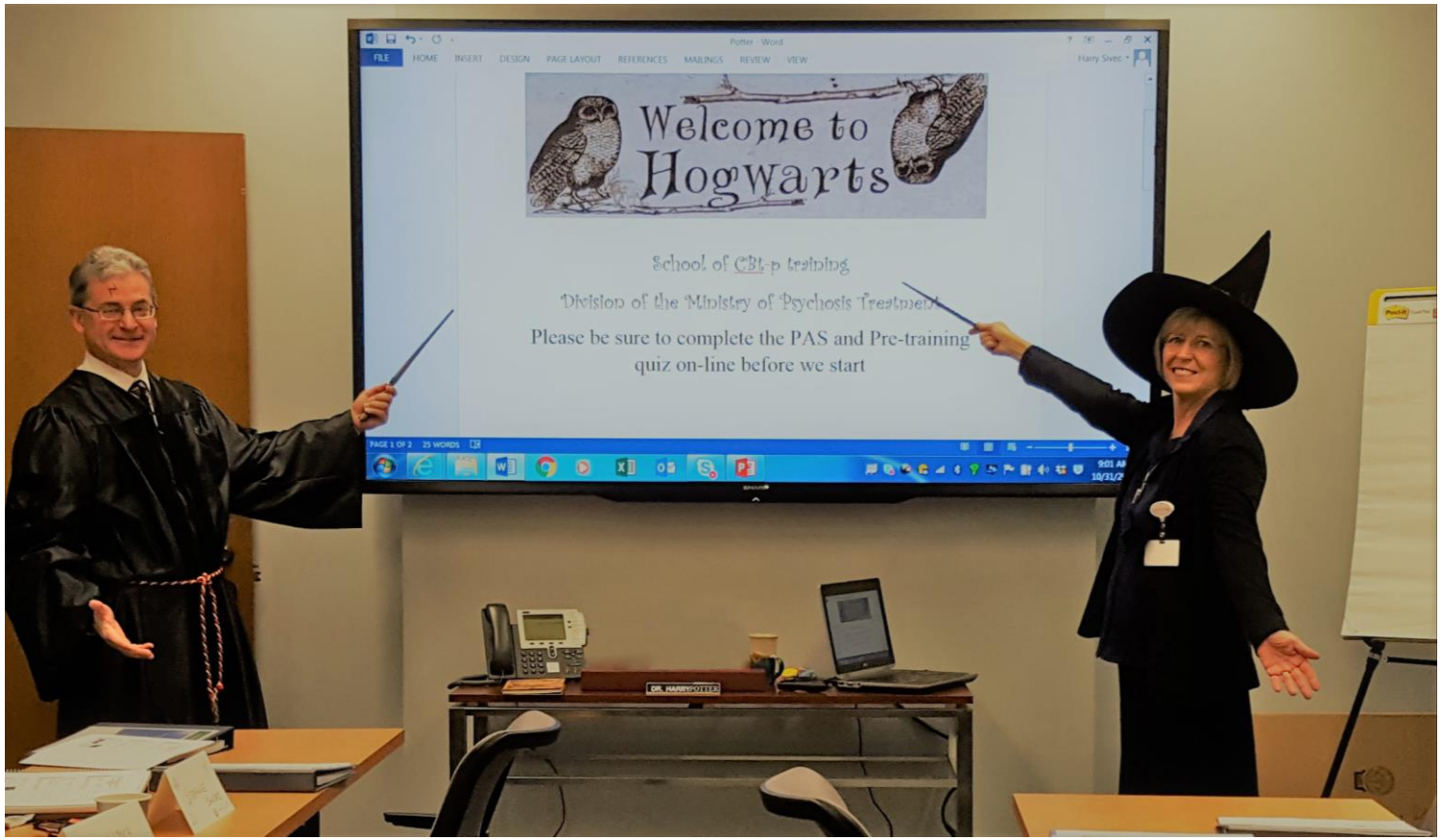

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