Our Response to Limitations of CBT in Community Mental Health Treatment

"Just Try Harder" Doesn't Heal

Addressing the Therapeutic Needs of Clients in Community Mental Health Treatment with Evidence-Based Innovation

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June 2020

THE INSTITUTE OF FAMILY & COMMUNITY IMPACT

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SUMMARY

Clients in community mental health treatment often face barriers and stress factors that limit the impact of treatment. Therapy-interfering conditions (TICs) such as housing, education, employment, and transportation are common unfulfilled needs for populations that utilize community mental health. Meanwhile, toxic stress and trauma often are heightened by clients' contexts. Therapy, therefore, must take these factors into account in order to be effective and focus on clients' basic needs—physical, social, and emotional—in addition to cognitive-behavioral treatments. Cognitive behavioral therapy (CBT) alone may not be adequate in this admittedly gargantuan task. Instead, by addressing therapeutic needs with a matrix of upstream interventions, contextual training for mental health professionals, and innovative therapies such as the Institute of Family & Community Impact's CBT Plus©, we have an opportunity to close disparity gaps in health, both psychological and physiological, and empower marginalized, underprivileged, and impoverished communities.

WHO SHOULD USE THIS PAPER

- Clinicians, therapists, and mental health professionals
- Program directors and policymakers
- Government and NGO social services agencies
- Managed care organizations and healthcare providers
- Researchers in health-related fields
- Community organizers and stakeholders

TAKEAWAYS & ACTION ITEMS

- Increase public health funding to connect clients to upstream solutions that address basic needs, such as housing, education, employment, nutrition, and transportation.
- Improve training and education for clinicians and mental health specialists, including clinical innovations that contextualize toxic stress and basic needs.
- Incentivize innovation and implementation of community-based and context-specific interventions.
- Advocate for policies that target poverty, racism, and other barriers of marginalization that diminish treatment efficacy.
- Empower clients and communities to advocate for their particular needs and to guide policymakers in creating solutions for addressing those needs.

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WHERE NEW PATHS BEGIN

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Introduction

Cognitive behavioral therapy (CBT) is a go-to intervention for the treatment of many mental health conditions such as anxiety, depression, and even posttraumatic stress disorder (PTSD). However, CBT has limitations in efficacy within community settings, particularly in homes and schools.

This is the second installment in our series on our response to limitations of CBT in community mental health treatment. Our previous paper explored CBT's evidence base, and future papers will zero in on specific clinical innovations and future research and funding pathways that could help fill in gaps left by limitations.

This paper will focus on the particular therapeutic needs of clients in home- and school-based settings. While some of these needs fall under traditional CBT treatment, many do not. Certain material needs and societal stressors that have a direct impact on mental health cannot be fulfilled solely by CBT or other interventions that are based on downstream care-delivery systems. Without more holistic approaches to addressing therapeutic needs, clients who are underprivileged, marginalized, and impoverished get stuck in a cycle of poor health—both psychological and physiological.

We have an opportunity to break this cycle and close disparity gaps. However, it will take creative thinking about public health, research, programs, and treatment implementation. The issues are complex, intersecting, and hard to track. But if we succeed at this task, we will empower vulnerable populations, create strong foundations for future generations, and leap forward in our mission to help build healthy communities and families.

Goals for Community Mental Health Treatment

Before we can determine how to address client needs, we must clarify the aim of community mental health treatment. By appreciating the opportunities that it offers, we can look forward to see where we can help the most.

WHO USES COMMUNITY MENTAL HEALTH TREATMENT?

Many clients who meet practitioners in their own homes and schools do so out of necessity. Lack of adequate transportation, scheduling complexities with underpaying jobs, and limited childcare coverage are just a few of the factors. This makes the option for home- and school-based treatment irreplaceable for many individuals and families. But these non-specialized environments—as opposed to past traditional settings intended for mental health treatment—often require customized, creative models of treatment for their particular needs, cultures, and other contexts. Mainly, this is due to clients belonging to populations that are more likely to be underprivileged, marginalized, and impoverished.

As with other health issues, people in these contexts are both underserved and overrepresented. Rates of illness may be higher while adequate treatment is less accessible, varying in quality, and its outcomes poorer. This is true for many cross-sections of these populations, whether we look at age, income, or other categories (Chow et al, 2003; Alegria et al., 2010; Cook et al., 2010; Roberts et al., 2011; Guerrero et al., 2013; Jimenez et al., 2013; Assari et al., 2018). The inequities of this reality compound the problem, forcing vulnerable demographics into cycles of ill health well beyond their control. No aspect of health is immune from social determinants; mental health is no exception (Allen et al., 2014).

We also know the roles that adverse childhood experiences (ACEs) and toxic stress play in long-term health. Overexposure to adversity and stress can come from abuse, neglect, addictive behaviors, death, and a host of variables that afflict families from all classes, races, and cultures. But, throughout the U.S., some of these are experienced more frequently by underprivileged demographics (Slack et al., 2017; Sacks & Murphey, 2018). Therefore, behavioral health interventions must be attuned to the impacts of trauma and toxic stress in order to help close health disparities.

INTERSECTING CONTEXTS CAN INCREASE RISK OF STRESS AND ADVERSITY

Social contexts can play an outsized role in mental health. Many developing countries, for example, may experience more adversity linked with mental illness yet have far too little treatment and far too few providers (World Health Organization, 2007). And, recently, we've seen correlations between the conditions in low-income countries—which experience low life expectancy and high deprivation—and those in both urban and rural U.S. neighborhoods entrenched in poverty. No matter how prosperous the country is around them, the people in these communities suffer worse health outcomes across the board than people in zip codes only a few miles away (Center on Society and Health, 2016).

But it's not just the stress of poverty itself that affects mental health in social contexts. While each specific situation contains unique stressors, most systems of marginalization overlap with each other and rarely act completely independently. The effects can be wide-ranging and devastating.

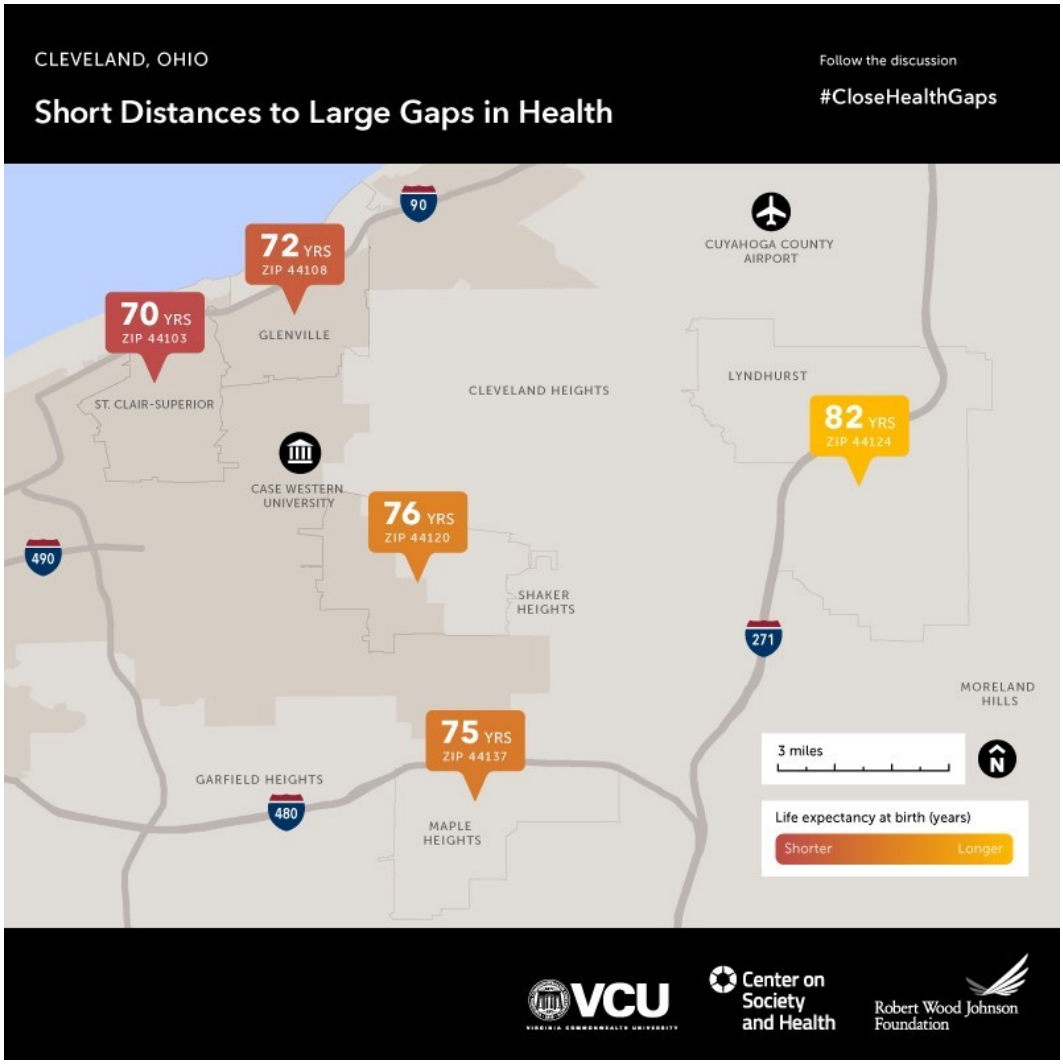


Fig. 1 – The Center on Society and Health

High, disparate rates of incarceration along racial lines rupture families, particularly among Black/African-American and Native/Indigenous communities (Blankenship et al, 2018; Moreno, 2019). Living with unsettled citizenship status and dealing with racial or ethnic profiling clouds the lives of many who trace their origins back to Central America (Torres et al., 2018). In many U.S. cities, people of Hispanic/Latinx origin are far less likely to be insured (Monnat, 2017). Refugees and asylum-seekers, carrying burdens of trauma and displacement, may face mistrust and resentment in their new neighborhoods (Liddell et al., 2019). Certain racial and religious groups sometimes find themselves targeted and discriminated against in education, employment, law enforcement, housing, and day-to-day interactions (Selod & Embrick, 2013). Members of the LGBTQ+ community and their families may suffer harassment both publically and privately (Hatchel et al., 2018). Generational trauma follows some people wherever they go, even beyond the contours that define poverty. Mortality rates vary wildly by race and by class, afflicting the most marginalized and the most impoverished.

Poverty, of course, is itself profoundly stressful (Kuruvilla & Jacob, 2007; Perese, 2007). Neighborhoods that are deprived of resources, labeled dangerous, or lacking social supports can add to that. We know that disparities exist along so-called class lines, and not just for people of color, as outcomes can differentiate between poorer and wealthier areas of the country that don't have a high representation of some of the minority popu-

lations mentioned; yet "data on health disparities are seldom presented along both axes [race-based and class-based views] of stratification" (Kawachi, Daniels, & Robinson, 2005). However, we assert that any and all disparities deserve attention to ameliorate unequitable health outcomes.

Without proper contextualization for the people affected by these disparities, treatment always will be inadequate. We should not be satisfied with standard care if the outcomes demonstrate inequity. Treatment models used by community-based therapists and mental health workers must incorporate these contexts and how they might intersect for the specific individuals, families, and communities they serve. It's a complicated venture. But the problems are obvious and demand our attention.

We will discuss how OhioGuidestone addresses these contexts and approaches treatment later in this paper. But first, we must clarify: What exactly are the client needs we are trying to fulfill?

Client Needs

With all these powerful, interlocking variables, how can we identify and address client needs in an effective manner?

This may be difficult, but it's possible by breaking down where we can (and where we need to) intervene to improve mental health.

WHERE CBT CAN HELP AND WHERE CLIENTS NEED SOMETHING MORE

Simply speaking, the main target of CBT is faulty thinking that impacts emotions and behaviors. The idea is that harmful thoughts negatively affect our well-being, leading to various psychopathologies such as depression and anxiety. We can't simply eliminate harmful thoughts. But we can become aware of them, discover how they affect our behaviors and feelings, and learn how to manage them. That, in short summary, is the goal of CBT (Fernández-Álvarez & Fernández-Álvarez, 2019).

But what if an individual's expression of depression and anxiety isn't fully derived from thought patterns? Is it really faulty thinking to be constantly worried about where your next meal may come from? Are symptoms of depression after someone calls you a racial slur something you can heal from by examining your own cognition? Will adjusting your behaviors protect the people you love from an elevated environmental risk of developing asthma or cancer or diabetes? Or how about inadequate healthcare services or high infant mortality rates, even in well-developed and well-equipped locales? Validating experiences and the thoughts behind them are key to CBT, but it doesn't actually rectify those experiences.

So what can? This is not to say that CBT can't be very beneficial to an individual living in poverty who has suffered racism and lost loved ones to preventable diseases or violence. But it can't directly modify a client's context any more than a client can. In essence, it can become a salve for wounds but never cure the affliction that causes them.

Even worse, if improperly and insensitively implemented, it can increase the mental anguish by burdening clients with overcoming the systemic injustices that entrap them.

Nothing is to be gained by making people stronger just so they can run into a brick wall. Instead, we need to complement CBT in order to draw out its best effects. To do that, we must focus on needs from a more holistic view.

CONTEXTUALIZING CLIENT NEEDS

Here are some basic client needs that are more common among those receiving community-based mental health treatment:

- **Housing.** This can include living arrangements that are affordable, safe, comfortable, accessible, stable, and useful. Even if all the other criteria are met, if a home isn't affordable then it isn't livable. Many clients in need of community mental health services live under constant threat of housing instability. This adds to stress and anxiety in individuals, families, and indeed whole communities.
- **Transportation.** Access to transportation varies greatly from neighborhood to neighborhood. Our clients need accessible, affordable transportation. Otherwise, they may struggle to get to medical appointments, grocery stores, social services agencies, and many more destinations beyond the daily requirements of work, school, and home.
- **Nutrition.** Options for meals are limited by cost, time to prepare, and neighborhood availability. Even clients who receive food assistance benefits often struggle to adequately feed their families and themselves. Meanwhile, food quality and accessibility directly correlate with neighborhood affluence and racial/ethnic demographics, placing many of our clients at a disadvantage they have no control over (Moreland et al., 2002; Li & Ashuri, 2018).
- **Employment.** Job opportunities for many of our clients may be limited by academic attainment, availability, family obligations, affordability, network, and other systemic injustices. Certainly, everyone wants to work jobs that are well-compensated and meaningful. Without steady, gainful employment, clients remain in poverty or in constant threat of it—and poverty itself can induce toxic stress.

A LIFE STORY

Here's a common life story for a community mental health client: You grew up in an impoverished neighborhood, living in uncertainty of where you would live and where your next meal would come from. Your single parent worked two low-paying jobs to try to make ends meet, leaving little extra time and energy to invest in you and your siblings. Close relatives like your grandparents helped out when they could, but they also worked multiple jobs.

You've had poor access to healthcare while running a higher risk of environmental health issues. In addition to elevated levels of disease diagnoses, the people you know and love (including yourself) have been likely to witness and experience violence, crime, eviction, incarceration, and food insecurity. Adversity and trauma, therefore, were prevalent among the children of your schools, where student-teacher ratios were inordinately high and support services were overwhelmed and underfunded. These conditions imposed a barrier to learning for many students. That, coupled with an economic need to help support yourself and your family, prevented you from seeking out post-secondary education opportunities, which can be very expensive investments of time and money, even when tuition costs are reduced.

So you found a low-paying job with no career ladder, where shifts are inconsistent and which only pays when you show up (no paid sick days or time off). The work is uninspiring at best and demeaning at worst. To get there, you commute for more than an hour on two bus lines. You have a toddler and another baby on the way, but you are lucky enough to find a daycare center that has openings and takes childcare vouchers. Still, you have to factor in another bus ride and another 30 to 45 minutes of commuting to drop off your child.

Your take-home pay barely covers bus fare and rent. To get assistance, you have to fill and file lots of paperwork. You also have to visit a number of different agencies, where waiting lines are long and slow, causing you to lose time at work and with your family. Fortunately, you qualify. But while you receive assistance for food and utilities, it doesn't cover phone and internet bills. These are absolutely necessary so that you can communicate with your family and your employer, make appointments, apply for and maintain assistance—not even considering the significant universal needs for information, connection, and relaxation.

Although you grew up in a loving and supportive home, your former caregivers are weary, in need, and look to you and your generation for care now. But the constant state of fighting for survival has left you mentally and physically drained and vulnerable. Adverse experiences from your childhood and the immense stress of your adulthood combine to create a number of health issues, including anxiety and depression. You have no time or transportation to go to an office, but you care about your mental health. So you enroll in community mental health services, squeezing in appointments between work shifts and childcare.

WHAT THIS TELLS US ABOUT NEEDS

When you read over the prototypical story on the previous page, you may feel exhausted. Certainly, living this life is more exhausting than some can imagine. And that highlights some of the other, non-material, emotional needs that CBT can't always fulfill because these needs are so deeply entwined in context: rest, relaxation, hopefulness, joyfulness, comfort, fun, pleasure.

In fact, clients in these contexts may be discouraged from activities that promote these feelings. They may believe, for example, that they can't afford to rest—or, as often imposed by popular opinion, they don't deserve to. They may think that if they just try harder and harder and harder they can heal themselves and overcome the immense barriers society has put up around their lives since the moment they were born. For a few lucky people, this can be true. For many others, it's an empty promise.

But we don't need to see this only as a story of overwhelming adversity and social barriers. Both we who are healthcare providers and people who have experienced significant toxic stress should see it also as a story with numerous opportunities and avenues for intervention and well-being. As we know, toxic stress and trauma can be counteracted by building resilience and community through supportive, healthy relationships, increasing access to support services that address basic needs, and focusing on the elemental human emotions of joy, play, and care (Center for the Developing Child, n.d.). Everyone has a right to experience joy.

LONG-TERM GOALS

When we add these emotional needs to the aforementioned physical needs, we create healthy, meaningful lives. This works towards our overarching goal: reducing disparities and improving health. As with education, eliminating gaps is a primary goal of public healthcare. But to accomplish that, the basic needs outlined in this section—both physical and emotional—must be fulfilled. They are instrumental to well-being, development, and quality of life. CBT can help some people discover these needs, but not all. So where do we go from here?

Where We Go from Here—and What We're Already Doing

At OhioGuidestone, we try to pair many of our treatment services provided by licensed mental health professionals with support services. Some of these include case management, therapeutic behavioral services, and psychosocial rehabilitation; recovery and substance use disorder treatment programs; school services; parenting initiatives and home visiting programs for families; workforce development for our clients and other underprivileged demographics; professional development and training for our own workforce and many other clinicians, health professionals, and school staff; and partnerships with other resource-fulfilling organizations.

As we've made clear, the connection between upstream interventions (such as housing, transportation, and employment) and health outcomes is strong, especially for low-income and at-risk populations. Although many in public health and public policy are aware of this connection, funding for public health remains in need of restructuring and innovation to better account for and address it.

We have to remain flexible and open-minded about what public health interventions look like and how we fund them. To accomplish health equity will require us always to be cognizant of wide-ranging and seemingly disparate problems. While this paper won't be able to go in depth on details, it will suffice to say for now that the issues and disparities in health outcomes and their connections to social determinants are complex and multifaceted (Hahn et al., 2018). Therefore, the solutions also must be multifaceted. We can't expect to put money in one area, such as education, and improve or even affect all of the others. However, we can multiply the benefits of social services and public health initiatives by combining them in creative, streamlined, and sustainable ways.

CASE MANAGEMENT

Case management is a classic element of social services that both health professionals and social workers alike are well-versed in. With it, workers can help connect clients to resources. Therefore, in the larger contexts of health, disparities, and needs, it can be a vital tool for improving health outcomes, reducing toxic stress, and augmenting the benefits of therapeutic interventions. For clients in community mental health, it is an absolute must.

However, the efficacy of case management integration into behavioral health treatment depends highly on funding (including insurance coverage and Medicaid reimbursement), training, accessibility, availability, and other factors that often lie well outside the scope of a single agency. The mechanisms necessary to achieve this will have to be discussed in another paper. But since it is so important in addressing client needs, we need to be clear that streamlining and integrating case management—in funding, training, and program implementation—is imperative for public health. Without it, treatment efficacy will be severely limited.

EVIDENCE-BASED TREATMENTS

One of the reasons CBT is (rightfully) highly valued and commonly implemented is its evidence-base. We examined this in our first installment of this series (Pope et al., 2019).

Whether practices are evidence-based or evidence-informed, we need to show through research and data that programs really do help people.

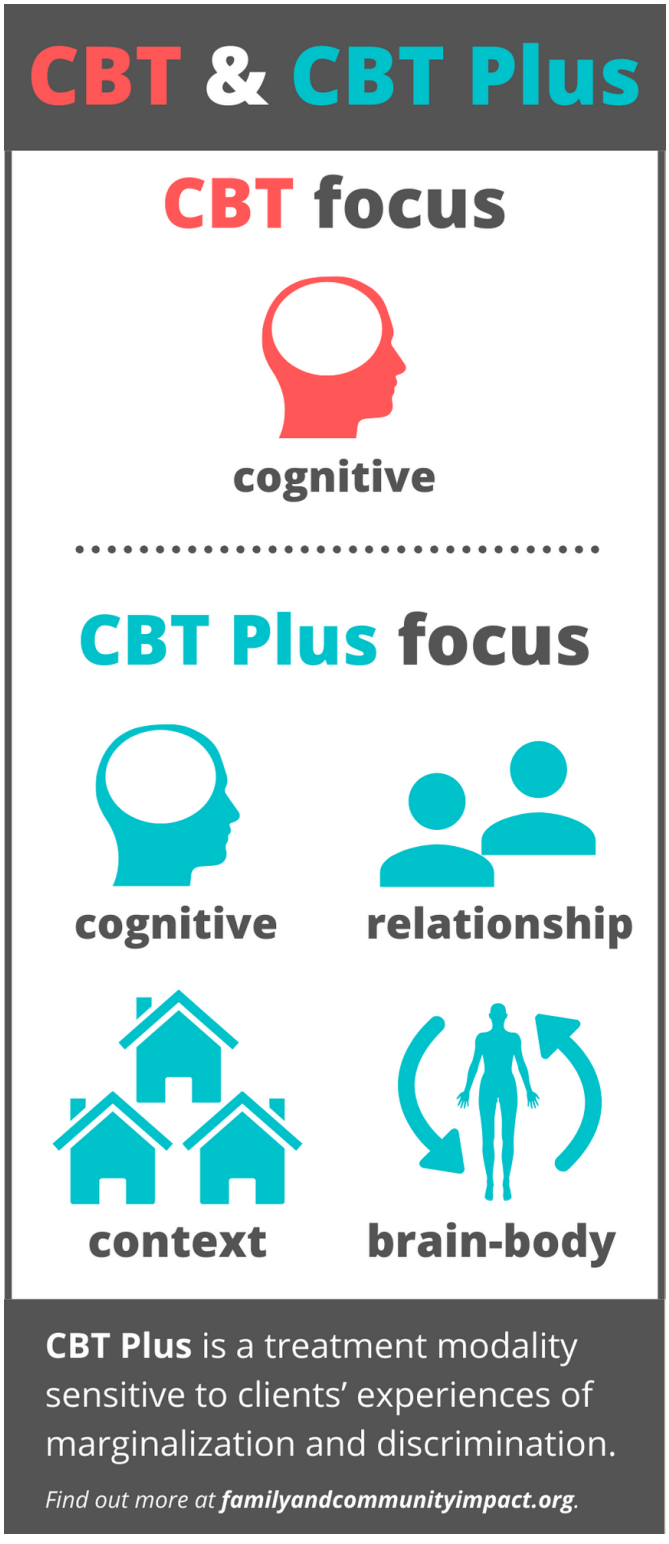
Because community mental health, like many aspects of public health, commonly happens in underprivileged spaces, managing symptoms amid high comorbidity often becomes the focus. We scramble just to try to bring basic symptoms closer to baseline. While this is important work, it easily can become a band-aid fix for a deep, open wound. We don't settle for band-aids.

The Institute of Family & Community Impact, as the applied science and research arm of OhioGuidestone, is focused on creating, sharing, and implementing clinical innovations in community mental health treatment. Drawing on our agency's wealth and diversity of experience in behavioral health, we've begun exploring treatment models suited to our clients and the communities we serve. That doesn't mean, however, that these can't be translated and implemented in other mental health settings.

Our next installment in this series will focus more in detail on specific treatments. The following are brief summaries of some of the innovative therapies we've developed.

CBT PLUS©

Because we do believe in the strong results CBT has long demonstrated in many settings, we wanted to take the best parts of it and expand it further to best serve our clients. So we created CBT Plus©, a modality sensitive to our clients' experiences, especially the effects of trauma and toxic stress, embedded in our clients' lives through systemic racism, marginalization, and discrimination. Because of our understanding of toxic stress—where it comes from and how it affects the body—treatment needs to target the neurobiological processes behind it. While mental health professionals can't break down the systemic barriers that are the sources of individual clients' toxic stress, we can guide clients toward experiences that foster hope,



joy, and connection, in defiance of the adversity forced upon them. This requires creating strong, supportive relationships to counteract the effects of trauma and toxic stress.

At the core of CBT Plus is relationship. Therapy is "intensely interpersonal and ultimately idiographic" (Duncan et al., 2004). Therefore, we believe that relationship is at the center of healing in treatment. CBT Plus honors this by focusing clinicians on building supportive, safe, caring, and compassionate therapeutic relationships. It acknowledges, too, the neurobiological impact of relationships and how relationship interacts with brain and body.

We also built the language of CBT Plus around acknowledging the conditions of trauma, toxic stress, poverty, marginalization, and discrimination, shifting from stigmatizing language to affirming. This makes it more inclusive and contextual for clients who experience these profoundly stressful social conditions. Even more importantly, we can use this language to connect clients to their communities. Strong communities can help our clients share and therefore reduce the burden of toxic stress. This, in turn, can help clients learn to advocate for themselves and their communities.

In essence, CBT Plus affirms that context, language, inequity, power differentials, values, and the body all matter. We believe that with this new way of approaching CBT, we can impact and empower individuals to a much greater degree. As such, we integrate it into our clinical manuals and training, and we will continue to gauge its effects and benefits in a variety of settings.

GUIDED IMAGERY NAARTIVES

While psychotherapies such as CBT are intrinsically language- and logic-based—and thus associated with left-brain activities—the emotional processes addressed in therapy often are difficult to put into words. Guided Imagery NaARTives instead look at emotions from a more right-brain perspective.

Through guided imagery and associated exercises, this technique is able to draw upon experiences that may linger beyond the edge of language and build a bridge between the brain hemispheres. It also creates connections for clients with images of safety, comfort, protection, community, and ability—connections which many clients struggle with. These exercises therefore open new opportunities for awareness, acceptance, insight—and most importantly resilience.

We continue to monitor the impact that art- and image-based therapies may have on a range of populations, of all ages and abilities.

STORY BUILDING THERAPY©

Like Guided Imagery NaARTives, Story Building Therapy© (SBT) is an intervention that activates right-brain processes. By use of a client's innate creativity, SBT helps rebuild their personal history into a story of hope and resilience. This empowers clients not only to see their stories in a new light but also to recognize the therapeutic ability they have within themselves to overcome pain. Right-brain interventions offer an opportunity to activate brain-body connections. As more research is gathered about these types of interventions and neuropsychobiology, we may learn new approaches for clients that help attune them to whole-body health.

Explore more about Guided Imagery NaARTives and SBT in *Brain Building: Co-regulatory and Integrative Interventions that Lead to a Healthy, Connected, and Joyous Life for All*, available for purchase at familyandcommunityimpact.org/shop.

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