Introduction to Strategies for Working with Psychosis informed by CBT-p: Schizophrenia, Recovery, and Models of Intervention

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Name Your Zoom Square

• Once you are in, please take a moment to rename your Zoom square to your full name.
  – Click on (...) in the upper right-hand corner of your square
  – Select Rename
  – Enter full name
Helpful Tips

- Mute microphone when not speaking

  - Press *6 to mute/unmute if calling in
Instructions for the virtual world

- Virtual adaptation of an in person, **interactive** training session
- Mute your mics unless speaking (bottom left, microphone)
- If connection gives out or lose session, log back in.
- When polls come up, respond as quickly as possible. They are anonymous.
- Use the summary guide for reflection points
INTRODUCTIONS

• Name and strength- Chat box
• What you want to learn- Answer poll
The BeST Center’s mission
• Promote recovery and improve the lives of as many individuals with schizophrenia as quickly as possible
• Accelerate the use and dissemination of effective treatments and best practices
• Build capacity of local systems to deliver state-of-the-art care to people affected by schizophrenia and their families

The BeST Center offers
• Training
• Consultation
• Education and outreach activities
• Services research and evaluation

The BeST Center was established
• Department of Psychiatry, Northeast Ohio Medical University in 2009
• Supported by Peg’s Foundation and other private foundations and governmental agencies
First 2-hour section
Slides 4 – 65

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CBT-p OVERVIEW

Efficacy

Different ways to apply CBT-p

Coordinating resources to maximize personal recovery
CBT-p Program Overview: What We Are About

- **We believe CBT-p can help individuals with psychosis reach their recovery goals!**
- CBT-p shows positive outcomes:
  - For treatment resistant clients: es = .47; (Burns, et al., 2014)
  - For hallucinations (es = .44) and delusions (es = .36) (van der Gaag, et al., 2014)
  - Relatively larger benefits for non-symptom domains such as
    - Quality of life (es = .49) and emotional well-being (es = .61) (Peters, et al., 2015)
    - General well-being (es = 1.16) Freeman et al., 2014
- We want to help agencies develop self-sustaining programs of providers who can provide a range of services informed by CBT-p/MI/Mindfulness to fidelity
CBT for psychosis

CBTp-informed
Digital applications
Formulation-based
Low-Intensity
Group
Self-Guided
Symptom-specific
Third Wave
Traditional Training/Implementation Models and Numbers Served

Context: Under-resourced agencies
Lengthy training process

Over Two Year Period

Staff turnover-rate 50%

Train and consult: 6 therapists

After 2 years: 3 therapists

Clients served: 1 provider = average 1 client per year

After 2 years: 6 clients served
Low Intensity Cognitive Behavioral techniques (CBT-p) consist of basic strategies derived from CBT principles that can be delivered within the context of a mental health workers other duties.

High Intensity Cognitive Behavioral Therapy (CBT-p) is an intervention delivered by licensed therapists with formal training in this model.
TREATMENT ON A CONTINUUM:
ACROSS DISCIPLINES AND PHASES OF TREATMENT

“Low intensity”
Pre-therapy
(case manager)

“High Intensity”
CBT-p
(Therapist)

“Low Intensity”
Case manager as “therapy extender”

Utilization starts low → Then increases → Then reduces
STEPPED CARE SERVICE DELIVERY MODEL

(Kopelovich et al., 2018)
Kopelovich for SAMHSA 5-17-2019

High-Intensity CBTp

Group CBTp

Low-Intensity CBTp

CBTp-Informed Care
(eg psychoeducation/normalization, empathic befriending, coping)

Measurement-Based Care
Shared Decision-Making
Personalized, Responsive care
DIFFERENT TYPES OF SERVICES INFORMED BY CBT-p

- Peer specialists
- Family/caregivers
- Community Health workers
- Self guided interventions

CBT-p Informed Care
- MA-level providers
- Psychiatrists

Low Intensity CBT-p
- MA-level providers with allied professionals
- ACT-p; CBSST; Group CBT-p

Group CBT-p
- MA & Doctoral - level clinical specialists

High Intensity CBTP
Stepped-care Training/Implementation Models and Numbers Served

Context: Expand training and services offered

Over Two Year Period

Impact: Increase providers trained

Train and consult: 18 providers

After 2 years: 9 providers

Clients served = average 2-3 clients per year

After 2 years: 54 clients
Expand Training
Expand modalities
Provide Systemic Support

More clients served

Traditional model

Stepped Care
AN INTEGRATED TEAM APPROACH

CBT-p
Case management
Front-line skills

Person
Vulnerabilities/
strengths

Peer Support

Family/Significant Other,
Community and Social Support

Medications
WORKING WITH PSYCHOSIS
# Foundations of Interventions

## Core 1: Understanding and Knowledge

- **Empathy for experience of psychosis**
  - Experiential

- **Definitions, descriptions, and meanings associated with psychosis**
  - Three models of viewing psychosis

- **Recovery mind-set**
  - Examples and implications

## Core 2: Interventions & Strategies Informed by CBTp

- **Strategies for Building Alliance**
  - Engagement

- **Strategies for reducing stigma**
  - Acceptance
  - Normalize

- **Strategies for new understanding and coping**
  - Overview of skill training areas

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**Expectation management**: will not cure psychosis with this training; will aid in the recovery process!!
CORE 1: UNDERSTANDING AND KNOWLEDGE
LET’S ALL GET ON EQUAL FOOTING
• If we haven’t been through what our clients’ have been through, it’s hard to have empathy

• Toward that end…. Let’s go from the inside out
  ✓ Listen to prompts and take notes
  ✓ Will be assigned to discussion group to reveal reactions
  ✓ Important to share reactions- verbal or chat box
REVIEW AND REFLECT

What are the themes that stood out to you?

- Challenges?
- Strengths?

What do you think is important for the client based on this experience?
THINGS TO KEEP IN MIND FROM THE EXERCISE

• Goals/interests before psychosis!
• How do people manage unusual experiences?
• How is family involvement perceived by the person experiencing psychosis?
• Thinking about oneself as mentally ill? Common reactions?
• How do people want to be treated during this type of experience?
ON BEING HUMAN:
Using the CBT model to understand how our brain processes information?
WE LIVE IN A WORLD OF “APPEARANCES”

• In other words, we see the world as we construct it:
  – SO, there is often more than one way to “accurately” interpret things.

• **How** we interpret things depends on
  – Sense-perception
  – How our brain/mind works (thinking, reasoning, memory, past learning)

*From Chadwick (2006)- Person-based CT for distressing psychosis.*
USING COGNITIVE MODEL TO UNDERSTAND EXPERIENCE
SITUATION OR EXPERIENCE LEADS TO...

Thought

Behavior

Feeling or Body sensation
Would you like to ride a Roller Coaster?
REACTIONS OF TWO PEOPLE IN LINE
HOW DO WE EXPLAIN "UNUSUAL" EVENTS?

• Please silently choose one of these playing cards and concentrate on it.

• Do not point at it or name it, and do not tell me which card you have chosen.

Adapted from Moritz, et al., (2011).
HOW DO WE EXPLAIN THINGS?

- The card you have chosen will now be selected and removed from the deck.
Has your card been removed?

How do you think this was done?
WHEN EXPERIENCES LEAD TO “UNUSUAL” BELIEFS

• How many believe
  – Believe in magic 27-67%
  – In witchcraft, voodoo or occult? 44%
  – That they are here for special purpose or mission? 37%
  – That thoughts can be transferred between people? 50%
  – That it is possible to predict the future? 50%
  – In ghosts? 15-25%

Cox and Cowling (1989)
COMMON THINKING HABITS

What is this?

- shirt
- rocky hill
- cave
- girl
- old tent
- fountain

Adapted from Moritz, et al., (2011).
**WHAT ARE SOME TAKE-HOME MESSAGES?**

- There is more than one way to look at situations
  - *So*... consider looking for different perspectives

- It is not the event, but how you react which is most important (*Epictetus*)
  - We are all prone to thinking habits which influence our decisions
  - *So*... let’s practice slowing down and identifying helpful and unhelpful responses.

- Consider teaching the CBT model to your clients!
UNDERSTANDING SCHIZOPHRENIA
CAUSES OF SCHIZOPHRENIA: DIFFERENT PATHWAYS TO ILLNESS

- Role of genetics

- Toxoplasmosis – increases risk by less than twofold
- Childhood adversity
- Cannabis use (during adolescence)
- Childhood viral infections of CNS

  Increase risk by two to threefold

- Daily use of high potency cannabis – increases by about fivefold

- Those who have suffered 5 different types of trauma (sexual, physical) – increases by about fiftyfold

DIFFERENT CAUSES, DIFFERENT TREATMENTS

The term “Schizophrenia” is *symptom* descriptive, but not *physiologically* descriptive.

Messamore, Eric (2017). Basics and Beyond. PowerPoint Given at BeST Center, NEOMED.
Schizophrenia Spectrum Disorders: Stats

- Affect approximately 2% of Americans
- 3 in 100 people will experience psychotic episode
- No difference in incidence rates between cultures
- Both genetics and environment play a role
**Warning Signs – Before the Psychosis Starts**

- Increased difficulty with work or school
- Difficulty concentrating
- Odd thinking or behavior
- Feeling like something is just not right
- Having trouble putting words and sentences together clearly – disorganized thoughts; confusion
- Emotional outbursts for no apparent reason

- Feeling afraid with no apparent reason
- Hearing things or voices that no one else can hear
- Withdrawal from usual interests, hobbies, friends and family
- Poor personal hygiene
- Baseline functioning begins to fail/deteriorate
### Positive Symptoms

Reflect an **excess or distortion** of normal functions – *something added*

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<tr>
<th>Symptoms may include:</th>
<th>Usually involve misinterpretation of perception or experience</th>
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<tbody>
<tr>
<td><strong>Delusions:</strong> Beliefs not based in reality</td>
<td>Can occur with any of the senses</td>
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<tr>
<td><strong>Hallucinations:</strong> Seeing or hearing things that don’t exist</td>
<td>Hearing voices most common</td>
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<td></td>
<td>One model – misperceived automatic thoughts</td>
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<tr>
<td>Symptoms may include (cont’d)</td>
<td><strong>Thought disorder:</strong> Difficulty speaking and organizing thoughts</td>
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<tr>
<td><strong>Disorganized behavior:</strong> May show in number of ways</td>
<td><strong>Examples:</strong> childlike silliness, unpredictable agitation</td>
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**NEGATIVE SYMPTOMS**

Diminishment/absence of characteristics of normal function – *something taken away*

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<th>Examples</th>
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<td>Loss of interest in everyday activities</td>
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<td>Appearing to lack emotion</td>
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<td>Reduced ability to plan or carry out activities</td>
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<td>Neglect of personal hygiene</td>
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<td>Social withdrawal</td>
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<td>Loss of motivation</td>
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NEGATIVE SYMPTOMS CONT’D

May appear with/without positive symptoms

Difficult to treat with medication

Impacts all aspects of individual’s life (i.e., work, school, relationships)

Many individuals are “blamed” for these symptoms (e.g., lazy)
# Cognitive Symptoms

<table>
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<tr>
<th>Cognitive Symptoms</th>
<th>Description</th>
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<tbody>
<tr>
<td>Problems with making sense of information</td>
<td>Problems with thought processes</td>
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<tr>
<td>Memory problems</td>
<td>Difficulty paying attention</td>
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May be most disabling symptoms in schizophrenia

Interfere with ability to perform routine daily tasks
WAYS TO THINK ABOUT SCHIZOPHRENIA

How we think about schizophrenia affects what we do

Different models for thinking about schizophrenia

Stigma

Biological

Recovery
STIGMA

- Beliefs about the illness:
  - Never able to get better
  - Always deteriorating
  - Nothing really helps
  - Person may be violent
  - They should be locked away
  - They are dangerous
IMPACT OF STIGMA

Actions that may follow from the stigma view:

- Exclusion
- Discrimination
- Avoidance
- Use of Intrusive interventions: Controlling or managing activities for the person with the illness; coercive measures (loss of freedom and self-direction). See Manuel et al., 2013
• Belief about illness and impact:
• Biological in nature
• Requires medical intervention
• Focus is on symptom management
• Doctors and medicine are paramount
• Can be more disease focused than person focused
• Client is an ACTIVE agent in recovery process
• There are many causes of psychosis
• Psychosis is seen as a continuum
  • All of us experience odd things at some point
  • Psychosis is an extreme variant of common experiences
• Responsibility: Much like the addiction model – one is not responsible for having the disorder, but one is responsible for recovery – and communities are also responsible to help
Your attitudes and expectations matter

- O’Connell and Stein (2011)
  - Clients of case managers who held more optimistic expectations about the internal resources of individuals with schizophrenia were employed significantly more days.
  
  - Compared with clients of case managers who held lower expectations about the personal resources or efficacy of individuals with schizophrenia.
Ben’s Story
**Ben’s Story - SMALL GROUP REFLECTION**

- What would it be like to have the experiences that Ben describes?

- Discuss his level of awareness or insight related to his experiences

- Take home message for you?
RECOVERY IS...

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

**RECOVERY EMERGES FROM HOPE**

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<tr>
<th>The belief that recovery is real and possible!</th>
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<tr>
<td>Recovery rates as high as 60+% for individuals with schizophrenia in the US and higher recovery rates are reported globally</td>
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<tr>
<td>Familiarize yourself with stories of recovery</td>
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<tr>
<td>See: Pat Deegan, Eleanor Longden, Fred Frese, Rufus May</td>
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</table>
HIGHLIGHTS OF THE RECOVERY MODEL?

• What stands out so far?

• What would you like to clarify?
Preparation for next meeting

Homework:
Read Section 1 of Manual- Recovery Enhancement Practices for Psychosis (REP): A treatment approach informed by Cognitive Behavioral Therapy for Psychosis

Explore strong 365 website

What is Psychosis?

https://strong365.org/what-is-psychosis/

Brain basics

https://strong365.org/brain-basics/smart-neuroplasticity/
References


- Chadwick (2006)- *Person-based CT for distressing psychosis*.


References

• Moritz, et al., (2011) Antipsychotic tx beyond antipsychotics: metacognitive intervention for schizophrenia patients improves delusional symptoms, *Psychological Medicine, 41*, 1823-1832


