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

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Rename 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 - shout out
  • Or use chat box 😊
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
<table>
<thead>
<tr>
<th>Content</th>
<th>Associated Group Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>Introduction Activity</td>
</tr>
<tr>
<td>CBTp Overview</td>
<td></td>
</tr>
<tr>
<td>Treatment on a Continuum</td>
<td></td>
</tr>
<tr>
<td>Stepped Care Model</td>
<td></td>
</tr>
<tr>
<td>Integrated Team Approach</td>
<td></td>
</tr>
<tr>
<td>Foundations for Interventions</td>
<td></td>
</tr>
<tr>
<td><strong>Core 1</strong></td>
<td></td>
</tr>
<tr>
<td>Empathy</td>
<td></td>
</tr>
<tr>
<td>Living in a World of Appearances</td>
<td>Process and Discuss</td>
</tr>
<tr>
<td>Understanding Schizophrenia</td>
<td>Process and Discuss</td>
</tr>
<tr>
<td>Stigma, Biological, Recovery Models</td>
<td>Process and Discuss</td>
</tr>
<tr>
<td>Ben’s Story – Real Life Experience</td>
<td>Process and Discuss</td>
</tr>
<tr>
<td>Very quick mention of role of stress and trauma</td>
<td>More on stress and trauma in later lectures</td>
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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
- Symptom-specific
- Self-Guided
- Third Wave

Kopelovich for SAMHSA 5-17-2019
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

Clients served: 1 provider = average 1 client per year

After 2 years:
3 therapists
6 clients served
**Treatment on a Continuum: Maximizing the Workforce**

**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 (e.g., psychoeducation/normalization, empathic befriending, coping)

Measurement-Based Care
Shared Decision-Making
Personalized, Responsive care
**Different Types of Services Informed by CBT-p**

- **CBT-p Informed Care**
  - MA level providers with allied professionals: ACTp; CBSST; Group CBTp
  - Peer specialists
  - Family/caregivers
  - Community Health workers
  - Self guided interventions

- **Low Intensity CBT-p**
  - MA-level providers
  - Psychiatrists

- **High Intensity CBTP**
  - MA & Doctoral-level clinical specialists

- **Group CBT-p**
  - Community Health workers
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 Therapy**
- **CBT-p Case management**
  - Front-line skills
- **Person**
  - Vulnerabilities/ strengths
- **Medications**
- **Peer Support**
- **Family/Significant Other, Community and Social Support**
A FRAMEWORK FOR WORKING WITH PSYCHOSIS

Phase 1: Engagement
Phase 2: Gaining Understanding
Phase 3: Improving Daily Living
Phase 4: Enhancing Adherence
Phase 5: Staying Well

Forming an Alliance
Working on Self-Confidence

Relapse Prevention And Wellness Plan
Education/Normalizing
Teaching about the Cognitive Model
Applying Adherence Strategies
Applying Coping Strategies

A FRAMEWORK FOR WORKING WITH PSYCHOSIS
LEARNING ABOUT PSYCHOSIS
CORE 1: UNDERSTANDING AND KNOWLEDGE
LET’S ALL GET ON EQUAL FOOTING
# 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

**Expectation management:** will not cure psychosis with this training; will aid in the recovery process!!
EMPATHY EXERCISE: GO THROUGH PROMPTS FIRST, THEN DISCUSS IN BREAKOUT ROOMS

• 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?
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.
Illusions: visual and Auditory
All of our brains do this! Isn’t it weird?
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.
HOW WE EXPLAIN THINGS

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

Messamore, Eric (2017). Basics and Beyond. PowerPoint Given at BeST Center, NEOMED.
## Causes of Schizophrenia: Different Pathways to Illness

<table>
<thead>
<tr>
<th>Role of Genetics</th>
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</thead>
<tbody>
<tr>
<td>Toxoplasmosis – increases risk by less than twofold</td>
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<tr>
<td>Childhood adversity (ACE studies)</td>
</tr>
<tr>
<td>Cannabis use (during adolescence)</td>
</tr>
<tr>
<td>Childhood viral infections of CNS</td>
</tr>
<tr>
<td>Daily use of high potency cannabis—increases by about fivefold</td>
</tr>
<tr>
<td>Those who have suffered 5 different types of trauma (sexual, physical, etc.) increases about 50-fold</td>
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NOW...IT’S CALLED THE MULTI-HIT THEORY

Schizophrenia is sometimes called a “syndrome” due to the many factors involved in its presentation

<table>
<thead>
<tr>
<th>Genetics/biology</th>
<th>Vitamin D deficiency in utero development in infancy</th>
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<tbody>
<tr>
<td>Environment</td>
<td>Viral infections</td>
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<tr>
<td>Cannabis use in adolescence</td>
<td>Smoking</td>
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<tr>
<td>Childhood trauma</td>
<td>Lower IQ</td>
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<tr>
<td>Social Defeat</td>
<td>Social Cognition – lack of emotion recognition</td>
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</table>
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*

<table>
<thead>
<tr>
<th>Symptoms may include:</th>
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<tr>
<td><strong>Delusions:</strong> Beliefs not based in reality</td>
<td>Usually involve misinterpretation of perception or experience</td>
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<tr>
<td><strong>Hallucinations:</strong> Seeing or hearing things that don’t exist</td>
<td>Can occur with any of the senses</td>
</tr>
<tr>
<td></td>
<td>Hearing voices most common</td>
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<td></td>
<td>One model – misperceived automatic thoughts</td>
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</table>
## Positive Symptoms Cont’d

<table>
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<tr>
<th>Symptoms may include (cont’d)</th>
<th>Thought disorder: Difficulty speaking and organizing thoughts</th>
<th>May result in stopping speech midsentence or putting together words in a meaningless way (known as “word salad”)</th>
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<tr>
<td>Disorganized behavior: May show in number of ways</td>
<td>Examples: childlike silliness, unpredictable agitation</td>
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Thought disorder: Difficulty speaking and organizing thoughts may result in stopping speech midsentence or putting together words in a meaningless way (known as “word salad”). Disorganized behavior: May show in number of ways as examples: childlike silliness, unpredictable agitation.
**NEGATIVE SYMPTOMS**

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

<table>
<thead>
<tr>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of interest in everyday activities</td>
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<tr>
<td>Appearing to lack emotion</td>
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<tr>
<td>Reduced ability to plan or carry out activities</td>
</tr>
<tr>
<td>Neglect of personal hygiene</td>
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<tr>
<td>Social withdrawal</td>
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<tr>
<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>
<thead>
<tr>
<th>Involve problems with thought processes</th>
<th>Problems with making sense of information</th>
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<tbody>
<tr>
<td></td>
<td>Memory problems</td>
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<td></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
**BIOLOGICAL**

- 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
RECOVERY

• 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

Recovery
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.
Language matters

• Sample 270 professional counselors and counselors in training
• Two versions of survey (CAMI- Community Attitudes Toward the Mentally Ill, Dear and Taylor, 1979)
  A. Pre-modified noun (“schizophrenic“)
  B. Post-modified noun (person with schizophrenia)

Surveys using “Schizophrenic” term showed statistically significant differences in the following ways:

• Higher scores on authoritarianism
• Higher scores on social restrictiveness
• Lower scores on benevolence (largest effect for practicing counselors)
• no difference on the scale measuring importance of community care

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.

The belief that recovery is real and possible!

Recovery rates as high as 60+% for individuals with schizophrenia in the US and higher recovery rates are reported globally.

Familiarize yourself with stories of recovery
See: Pat Deegan, Eleanor Longden, Fred Frese, Rufus May
HIGHLIGHTS OF THE RECOVERY MODEL?

• What stands out so far?

• What would you like to clarify?
CORE 2: STRATEGIES INFORMED BY CBT-p
<table>
<thead>
<tr>
<th>Content</th>
<th>Associated Group Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core 2</strong></td>
<td></td>
</tr>
<tr>
<td>Befriending and Engagement</td>
<td>Small Group Practice</td>
</tr>
<tr>
<td>How to build an alliance</td>
<td></td>
</tr>
<tr>
<td>Thinking About Future Goals</td>
<td></td>
</tr>
<tr>
<td>Linking Interests to Goals</td>
<td>Small Group Practice</td>
</tr>
<tr>
<td>Linking Values to Goals</td>
<td>Practice and Discuss</td>
</tr>
<tr>
<td>Using the CBTp Therapeutic Mindset</td>
<td></td>
</tr>
<tr>
<td>Importance of Acceptance and Empathy</td>
<td></td>
</tr>
<tr>
<td>How to begin to engage around psychosis</td>
<td></td>
</tr>
<tr>
<td>Normalization</td>
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WHAT DO INDIVIDUALS WITH SCHIZOPHRENIA WANT FROM TREATMENT?

• Schizophrenia commission report (2012) indicates that consumers want:
  • To be listened to
  • Have their experiences validated
  • To be seen as a person
  • To be given hope

• More information and choice and collaboration in treatment

• Regaining sense of self and rebuilding lives with optimism

What is the top-rated characteristic of a mental health provider?

a. Expertise  
b. Friendliness  
c. Problem solver
CORE 2: LET’S TRY SOME CBT-p STRATEGIES!

Befriending, Engagement and Common Ground

Acceptance

Normalization
ALL ABOUT ENGAGEMENT: THE ADAPTIVE MODE

• Mode 1 exercise
• Mode 2 exercise
WHAT DOES GOOD ENGAGEMENT DO?

ACTIVATE THE “ADAPTIVE MODE”

• “Befriending”- explore clients’ interest areas; neutral topics

• By identifying when clients are at their best -> look and feel more confident (affects problem solving and decision making)
  • What are you good at? Know a lot about?
  • “Focus on what is strong rather than what is wrong”

• Contrast with “patient” mode or “passive” mode
  • No power so why bother
  • Low energy, disinterest

BEFRIENDING/ENGAGEMENT COMPONENTS

Conversation starters and interest finders
Genuinely relate to interests
Set the stage for an equal partnership in all efforts
• Share control - Provide options and choices
• Recall that many are brought to treatment not by choice
Notice and affirm strengths often
Use language the conveys hope and optimism
• We will figure this out together
• Once we complete this goal, what would you like to work on?
• I’ve worked with many others who have found ways to improve their lives in significant ways with help from others

See Handout Engagement Strategies List
PRACTICE TIME

• What is your best conversation starter?
  • Share ideas about how to find interests / skills- befriending activities.
  • Report out: What is your best strategy?
HOW TO BUILD AND ALLIANCE?
Remember- there may be a gap in perspectives

Client’s perception: “I’m not ill”

Provider, family, friends, perception: “you need help”
Engagement is about finding common ground

Find the Common Ground a meaningful value, aspiration, or goal

Provider or family needs and wants

The patients’ needs and wants
HOW TO GO FROM INTERESTS/STRENGTHS TO GOALS

• Practice exploring the Activity – Value connections
  • I like to/want to do… (interest)
  • I am good at … (strength)
  • I really value… (value)

• Values clarification
  • What is it about _____ that appeals to you most?
    • Like to be productive/active (Value)
    • Like to earn money- to be self-reliant (Value)

• Long range goal planning:
  • With these interests and values- what would really like to be doing in one year? (long range goal)

When it comes to achieving our goals, our failures are nothing more than success in progress.
- Tanveer Naseer
**Personal Goal Setting**

1. **Working from Values**: It is helpful to develop personal goals from some of the values we hold dear to our heart, such as family, work, and personal goals. This will help us to know what is important in our life to feel really good about our lives.

   **Sample Values:**
   - Faith/Spirituality
   - Family
   - Independence
   - Humor
   - Adventurousness
   - Compassion
   - Gratitude
   - Responsibility
   - Creativity
   - Courage
   - Honesty
   - Success

2. **Identify some of your strengths** — the things that you are (or were) good about, showed within yourself, that can become a goal or can help you to reach your personal goals. Maybe volunteer at an animal shelter, find a used instrument to play with things you loved to do, but find yourself sleeping away from now.

   **Sample Strengths:**
   - Good with people
   - Good with animals
   - Play guitar/piano/instrument
   - Motivated
   - Willing to ask for support
   - Follow-through on tasks
   - Responsible
   - Hard worker

3. **Personal Goals**: These are goals that people want to reach in order to improve their lives. Reaching personal goals can create a sense of self-empowerment and they can help to guide us back to what we are working for in our life.

   **Sample Goals:**
   - Solving an ongoing problem
   - Making it to appointments on time
   - Reconnecting with the people with in your life relationships
   - Taking better care of your health (eating well, losing weight, quitting smoking)
   - Have some fun in your life
   - Begin dating again

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**Recovery Enhancement Plan**

4. **Decide on one or two goals to start with**: It really hard to work on more than a couple of goals right now. The goals should be things you want in your life. If we can take care of one or two things right now, we'll have more energy, finding supplies to achieve the other goal down the line.

   **What obstacles might you face in trying to achieve your goal?**

   **Stepping Stones and Target Dates**

   **If the plan isn't working as you wanted it to, there are three options (circle one):**

   - Keep working at same goal
   - Modify the goal
   - Pitch the goal and start with a fresh goal

---

See Personal Goal Setting Handout
PRACTICE: BEGINNING TO LINK INTERESTS FROM ENGAGEMENT DISCUSSIONS TO GOALS

• Think of current clients
• Practice going from interest/strength to value/aspiration to goals with your partner.
• Discuss within your working group what mini-goals that you might develop?
  • Think simple and achievable
GOT THE PROBABLE GOAL- NOW, WHAT’S GETTING IN YOUR WAY?

• Symptoms- voices won’t let me
• Defeatist beliefs (I can’t do it )
• Practical limitations and lack of resources- no ride
• Cognitive factors (concentration, memory, difficulty with strategy)
• Because you are working toward the person’s dreams and goals, you have permission and reason to address the barriers (which are often the symptoms!).

In this Engagement part of the relationship, we are just beginning to think about linking the client’s interests to goals. This is a time of discussion and exploration, not a time to make rigid plans for treatment. We are just beginning the relationship at this point.
TO REVIEW:

• Befriending/Engagement First
  • Makes it safe and find interests

• Finding Common Ground and Alliance
  • Often comes thru be-friending conversation
  • Client’s aspiration linked with adaptive mode
  • Aspiration gives reason to address symptom
    • “what gets in the way of becoming...; or doing...?” Usually symptoms
  • Working on goal together builds alliance and a chance to teach and learn

Going slow is the only way to go!
FOR IMPOSSIBLE GOALS

• Explore *value* beneath the belief—“if this happened, how would your life be different or what would you be doing differently?”
  • Develop goals based on response

• “What can be done in the short term to improve your life, while we work on understanding these concerns?”

“*Everyone to recognize that I am the president*”
“*Call lawyer. Arrest everyone who is persecuting me*”

From Recovery oriented-CT (Beck, et al.)
For No Goals or Vague Goals

• Values clarification exercise- **Demonstration**
  • Card Sort (identify goals/values in order of importance to client)
  • Values list- go from Values to goals
Pathways to goal setting: For *No goals or Vague goals*

- Values clarification / Valued goal
  a. Values list
  b. Card Sort

- Valued activities (may need to provide examples or a list here as well)

- Goals can be developed from values
LETS REVIEW-DISCUSS WITH YOUR TEAM

• What stood out in this section?
• New learning
• Things you want to practice?
• There are some short scales to use that can help determine level of alliance
  • Session Rating Scale (SRS)
    • Miller, Duncan, Johnson, 2002
  • Working Alliance Inventory (WAI)
    • Horvath (1984)
LISTEN AND RESPONDING TO PSYCHOSIS: HOW TO TALK ABOUT PSYCHOSIS IN A CBT-P WAY

REMEMBER: CLIENT WANTS TO BE HEARD!
We all need to treat ourselves gently — holding our hearts and our minds, and even our own judgments of self and others with the gentleness of a mother holding her new born baby.
STRATEGY BEGINS WITH MINDSET

• If you feel like you are pulling teeth or trying to pull the client across a finish line, you are both working too hard.

• Rather than play “tug of war” over a rather scary issue, simply:
  • Ask permission...
  • Find cues the client can use to slow the session down
  • Take breaks
  • Be kind
  • Be compassionate

## Acceptance

| Initially suspending disbelief | Psychosis: “Someone put a chip in my brain, can you help me get it out?”  
|                               | Response = Do not assume to know |
| “Tell me more to explore”      | Adopt a curious, interested approach; DO NOT directly confront or agree  
|                               | Tip: “I’ve not heard of that, can you tell me a little more so I can understand better?” What led you to this conclusion? |
| “Reflect to connect”           | Listen and reflect back without reaction or judgment  
|                               | Tip: “So let me see if I got this right,”.... repeat what client says  
|                               | Goal = client feels heard |

EXAMPLES OF ACCEPTANCE, AWARENESS, AND THE USE OF LANGUAGE

• I’d be interested in hearing more about that idea/experience
• What is happening in this moment?
• How do you explain these experiences?
• Tell me more about what you have tried to do in order to manage this experience.

Adapted from Moving Forward: Introduction to Psychosis (2012)
Empathy
Put yourself in the client’s position

Empathy is a choice, and it’s a vulnerable choice.
In order to connect with you, I have to connect with something in myself that knows that feeling.

Brené Brown
**Empathy**

- Empathize with what client says without agreeing with the content (from Amador)
  - Frustrations
  - Fears / Distrust
  - Discomfort
  - Desires/positive emotions

- If don’t feel empathy, then... (from Hazel Nelson)
  - Missing important information
  - Content may be hitting a sensitive topic for you
TRICKY QUESTIONS:

• Do you believe me? (psychotic experience)

• Do you think that I need medicine?
DO YOU BELIEVE/AGREE WITH ME? (from Amador, 2000)

• Empathize with experience

• Delay with respect: “I will answer your question. First, if ok with you, would like to learn more about…”

• Three A’s (for giving your opinion)
  • Apologize- that what I say may feel hurtful
  • Acknowledge- that I may be wrong
  • Agree- to disagree
**Small Group Practice - Resting in Engagement**

- Short role play example (volunteers)
  - Audience participation

- Practice listening to and responding to psychotic content
  - *First step is to understand their experience!!*

- **Skill development goal** - identify one new way to respond to psychosis (use engagement practice sheets for ideas)
  - Role Plays

Go to Page 8 & 9 in Section 1 Handout Packet
You will find scenarios and feedback forms
WHAT DID YOU LEARN?

• What was your experience exploring voice hearing?
• What was your experience exploring delusional belief?
• What was it like to manage disorganized thinking?
• What would you like to practice?
CHALLENGES TO ENGAGEMENT
COMMON BARRIERS TO ENGAGEMENT

Client factors
• Symptoms
• Blocking beliefs
  • Won’t listen to me
  • Will up meds or send me to hospital
• Other- Cultural, religious or other background factors

MHP factors
• Attitudes and blocking beliefs
  • People with psychosis are dangerous
  • It is my responsibility to help the person... remain in therapy... stay safe...change... make progress
  • I might upset the person if we talk about __
  • No one gets better with this illness
  • I feel so bad for this person (pity)
WHY DO CLIENTS LACK AWARENESS OF THEIR SYMPTOMS/ILLNESS?

Anosognosia – “lack of insight” into or “lack of awareness” of illness

• A result of anatomical damage to the brain by the disease process

• Not caused by damage to one specific area; A person’s awareness of illness involves a brain network, and damage in any part of this network can lead to impaired awareness of illness

• NOT the same as denial

• Believed to be the single largest reason why individuals with schizophrenia and bipolar disorder do not take medications

• Affects about 50% of individuals with schizophrenia and 40% of individuals with bipolar disorder with psychotic features

• When taking medications, awareness of illness improves in some individuals
ANOSOGNOSIA VERSUS DENIAL

More likely to be Anosognosia if the...

- Lack of insight is severe and persistent (months to years)
- Belief (not ill) is fixed and does not change with overwhelming evidence (poor self care for months, homeless, etc.)
- Illogical explanations or confabulations are used to explain away the evidence (this is common in brain injury). Ex. Homelessness? Doing market research...

Advantage of this model?

- The problem is brain dysfunction, not the person, which leads us to cognitive remediation efforts (i.e., strategies to help with areas of deficit). More hopeful and strategic.
**Desired Outcomes for Engagement**

- **Client feels heard**
  - Hearing the client and validating his or her concerns does not mean you agree, you condone, you are going to enable
  - It only means that you genuinely hear the client in a non-judgmental, compassionate way, with acceptance, and with genuine curiousness as to his or her experience

- **Instill hope**
  - This person has lost so much. He or she can still have good things happen, and in fact deserves good things to happen, and you can help!
COMMON MISSTEPS

• Jumping right to giving solutions before fully listening to client’s perspective (Amadore, 2000)
• Unsolicited advice: “You should....” (Amadore, 2000)
• Giving solutions
  • You should knit
  • How about exercise – let’s get you a membership
  • Let’s clean up this apartment
• Covering too many topics in one session
• Confronting and arguing
• Omitting something the client said
• Reacting defensively: “I know that YOU believe it’s true”

Whose recovery is it anyway?
WHEN TO TAKE A BREAK

• It is always ok to take a break from talking about symptoms, especially if client seems distressed (“tactical withdrawal”).

• Help the client transition- “this seems upsetting to you, why don’t we take a break and come back to this later if that is ok with you.”
How long to work on engagement?

• Can take several meetings before even approaching something that looks like a clear goal.

• Early on it is most important that the client feels safe enough to talk, really feels listened to, and becomes open to hearing another perspective.
FAVORITE WEB-SITES:

“KNOWLEDGE IS POWER AND KNOWLEDGE SHARING IS POWER SHARING” - PAT DEEGAN

• Strong365
https://strong365.org/
• Hearing voices network
https://www.hearing-voices.org/
• ACT for psychosis
https://contextualscience.org/
• Open Minded Online
https://openmindedonline.com/portfolio/engaging-with-voices-videos/
HIDDEN ROLE OF TRAUMA IN PSYCHOSIS

• Incidence of trauma
  • Very common for those who experience psychosis
  • Very often not specifically identified and treated

• Ways trauma comes through in psychosis
  • Voice hearing/hallucinations (intrusions/flashbacks)
  • Symbol and metaphor (the symptom, *voice content or delusional theme*, reflects something of the trauma)
  • Build up of stress and negative emotions (from early and repetitive traumatic experiences) eventually overwhelms the person

The development of schizophrenia used to be called a “one hit” theory

- Genetics/biology

Then came the “two hit theory”: The Stress Diathesis Model

- Genetics/biology
- Environment

STRESS-VULNERABILITY: A MODEL FOR UNDERSTANDING AND ACTION

- **Stress** - Current stress load
- **Vulnerability** - genetics/physiology and situational factors (role of past trauma)
- **Protective factors** - reduces impact of stress and vulnerability - minimize likelihood of psychosis
- **Risk factors** - increase likelihood of symptoms (substance use)

From Moving Forward: Introduction to Psychosis (2012)
THE STRESS BUCKET

- Daily Stressors
- Strength of Bindings: Resilience
- Effective Coping Strategies
- Size of the Bucket: Vulnerabilities
- The Hose: Ineffective Coping Strategies
- Symptoms
- Interpersonal Stressors

Adapted from Brabban and Turkington (2002)
Interpersonal Stressors
1. Mom and Dad argue about me all the time
2. Can’t find any friends, they think I’m weird
3. People don’t want to hire me

General Stressors
1. Can’t find a job
2. Can’t pay my bills
3. Medication makes me drool
4. Can’t find a girlfriend now
5. Can’t think straight b/c of meds

Resilience
1. I was really smart in High School
2. I helped my mom get through the divorce
3. I quit using drugs

Vulnerabilities
1. There’s lots of mental illness in my family
2. My Dad drinks and has “bipolar”
3. I did use a lot of drugs, especially pot
4. Mom doesn’t have any money – we live in government housing
5. We have nothing but welfare and food stamps

Begin to work on and change the unhelpful coping strategies. What do you need to work on?
1. I stay in bed most of the day
2. I eat a lot and never move
3. Sometimes I talk to my voices out loud and people think I’m strange
4. When I get really mad, I break things

STRESS BUCKET EXAMPLE
THE STRESS BUCKET

Used for an individual or with a family...

• The stress bucket can be used to identify current stressors, coping skills (healthy or unhealthy), and symptoms.

• It can be used to explain and demonstrate past difficulties.

• It can also be used to demonstrate a change in functioning (worse to better or visa versa).

• Additionally, it can be used as a preventive exercise: “What stressors do you anticipate?”; “What coping skills might be helpful?”; What do you know about your vulnerabilities?”; What resilient qualities can you pull from?”
PRACTICE NORMALIZATION STRATEGY
STRESS BUCKET MODEL

Demonstration Role Play – This is what it might look like......

Uses:
General education
Use to review a recent symptom or moment of distress
Use in comparison (rival explanations for symptoms)
SUMMARY AND PRACTICE POINTS

• Engagement strategies
  • Befriending
  • Finding Common ground
  • Asking questions while suspending disbelief
  • Use checklist to check self with strategies

• Normalization
  • Practice using self-disclosure
  • Practice providing education information
  • Practice using the stress-bucket

• Consider viewing: your brain on stress.
  https://strong365.org/this-is-your-brain-on-stress/

And do Study Guide 1.2 to have ready by Tuesday morning
Preparation for next meeting

Homework:

**Read Section 1 and 2 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/](https://strong365.org/what-is-psychosis/)

*Brain basics*

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


• Coursey. Schizophr Bull. 1995;21(2):283-301
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• Moritz, et al., (2011) Antipsychotic tx beyond antipsychotics: metacognitive intervention for schizophrenia patients improves delusional symptoms, *Psychological Medicine, 41*, 1823-1832


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• Values Card: See Moyers and Martino. (2006). What's important in my life: The personal goals and values card sorting task for individuals with schizophrenia.

