Psychotic experiences as barriers to Social Recovery

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Psychotic experiences as barriers to social recovery will cover....

- Psychotic / unusual experiences
  - As barriers to social recovery
- Assessment, formulation and intervention
  - Assessment and formulation
  - Normalising
  - SRT behavioural experiments

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Unusual experiences

- Perceptual abnormalities such as auditory hallucinations and others

- Paranoia/suspicious thoughts

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Auditory Hallucinations

- One or many voices talking when no-one is around
- Voices can shout, whisper, be clear or muffled.
- sentences or single words, constant or occasional
- also sounds like knocking, rustling, crying, screaming or music.
- can be positive, confusing, frightening, critical, threatening or commanding (depending on meaning)

hearing voices network website

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Other Hallucinations

- Visual
- Olfactory
- Gustatory
- Tactile

hearing voices network website

Paranoid/ Suspicious thoughts

- Feeling judged in a social situation
- Strangers looking a them judgmentally
- Sense of being talked about behind one's back
- Mild threat "someone deliberately wanting to irritate me"
- Threat of harm "someone wants to hurt me"
- Being controlled
- Conspiracy theories

These are relatively common experience that we've all been through at one time or another!

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Discuss!

What is your clinical experience with unusual experiences?

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Discuss!

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How might psychotic experiences impact on social recovery?

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URL: https://www.youtube.com/watch?v=9xUKrjA9jmA

Impact of unusual experiences on social recovery

- Exacerbate social anxiety issues and lead to avoidance
- Distracting (e.g. voices)
- Negatively affect self-esteem
  - undermining content
  - how it's made sense of: I'm different, something wrong with me
- (Over?) endorse stress vulnerability model
  - I must restrict what I do so I can protect myself
  - Wait until I feel better to…
- If previous psychosis and/or hospitalisation, potential for trauma

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Assessing and formulating psychotic/ unusual experiences

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Engagement

- Client could be reluctant or nervous
- Regular feedback to check for understanding
- Appear interested, not just going through the motions
- Look for common ground (shared interests)
- Everyday language
- Explain therapy process in detail
- Gather information gradually
- Consider social/cultural background

- Be HOPEFUL, ACTIVE and FLEXIBLE

French and Morrison (2004)

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Collaboration

- Where to see the client (service, home)
- Time of appointments
- Flexibility regarding cancelations, DNAs, rescheduling (perseverance and tolerance!)
- Explore client's previous experience of services
- Assertive outreach and case-management techniques promotes good therapeutic relationship
  - e.g. attending appointments, assisting with housing, etc.
- Offer information highlighting the non medical nature of the intervention as well as collaboration

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Assessment

Goal: Provide information that will support the collaborative development of a working shared formulation

Cognitive component

Behavioural component

Affective component

Environmental component

Focus on all of the areas can be simultaneous (e.g. hot cross bun) which also helps socialise to the CBT model

Interweaved with SRT assessment

French and Morrison (2004)

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Assessment

Cognitive component

- What the person thinks and believes (including about their unusua experiences)
- Images
- Attention (what and how)
- Presence of information processing biases
- What they remember
- How they control unwanted thoughts

Focus on client's interpretation and what it means to them.

French and Morrison (2004)

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Assessment

Behavioural component

- What they do
  - **before**
  - **during**
  - **after**

    a difficult situation

- Safety behaviours
- Avoidance

French and Morrison (2004)

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Assessment

Affective component

- How the person feels emotionally before, during and after a difficult situation
- Physiological components
- Sleep patterns
- Any organic patterns

French and Morrison (2004)

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Assessment

Environmental component

- Housing situation
- Cultural milieu
- Family or housemates
- Friends
- Opportunities for meaningful and valued activities

HOW ARE THESE EXPERIENCES IMPACTING ON SOCIAL RECOVERY?

French and Morrison (2004)

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Assessment

Also look at:

- Historical factors (childhood, school, family history, etc.)

- beliefs about themselves (about themselves, the world, other people and the future)

- drug use (cause of unusual experiences? to manage experiences? What, how much, how frequently and context, medication current and past and side effects)

- risk (Beck hopelessness scaled for suicidal ideation, service own risk assessment)

French and Morrison (2004)

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Formulation

- Slow development (preliminary formulation on second session)
- Formulation revisited and updated throughout therapy
- Formulation as alternative explanation explanation of symptoms along all others
- Facilitates choice of intervention and homework tasks, negotiated with client
- Move from general themes to more specific ways of understanding them

UNDERSTANDING HOW THESE EXPERIENCES MAY BE IMPACTING ON SOCIAL RECOVERY

French and Morrison (2004)

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Normalising psychotic/ unusual experiences

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Normalisation

"(…) taking time to understand context and making links between the context and the experience, can help normalise experiences for the individual and others and provide a functional alternative explanation for such experiences."

French & Morrison (2004)

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Normalisation

Clinicians' message: Don't panic!

- avoid escalation
- moving from the concept of schizophrenia to symptom and using concept of psychotic or unusual experiences
- Encourage symptom orientated approach
- Maintain hope

French and Morrison (2004)

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Normalisation

Clients' message: Don't panic!

- Address stigma (media, misinformation)
- Address expectations, which could lead to fear and anxiety and evoke further symptoms (vicious cycle)
- Development of negative symptoms as safety behaviours for avoiding feared outcomes (increases in medication, hospitalisation)

- Fear of "impending madness" does not mean it's accurate
  - acting accordingly (clinicians becoming concerned and encouraging psychiatric intervention) may exacerbate the symptoms

- Decatastrophising

French and Morrison (2004)

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Normalisation

- Normalise the experience without trivializing the distress

- It's not telling people they are fine, but rather they are having understandably distressing experiences, which are more common than they think, and for which they can get appropriate support

- Psychoeducation (e.g. Mind: 'Understanding Paranoia' booklet, hearing voices network resources)
- Real life examples (e.g. hearing voices Network: personal stories and famous voice hearers)

French and Morrison (2004)

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Normalising triggers

-Hypnogogic and Hypnopompic states
-Lack of sleep
-Hunger
-Physical illness
-Drugs
-Stress/worry
-Bereavement
-Abuse/bullying
-Other traumatic experiences
-Spiritual experiences
-Mental health problems

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Normalising paranoid/ suspicious thoughts

People generally find it difficult to talk to others about these, but these are fairly common experiences.

But society encourages these fears:

- Newspapers filled with violent crime
- Conspiracy theories
- CCTV
- Risk of terrorism “See it. Say it. Sorted”
- Internet monitoring, etc.

Freeman et al. (2004)

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Normalising hallucinations

- Romme et al (1992, Netherlands) self selected group; 30% had experienced hallucinations. Those in contact with services had distressing hallucinations.
- Johns et al (2004), population survey results (UK). 4% of people had experienced hallucinations
- Tien (1991) 4-5% annual incidence
- Slade & Bentall (1988) 25% population have experienced at least one.

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SRT Behavioural Experiments psychotic/ unusual experiences

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Generating and evaluating alternative explanations

- Generating alternative explanations which are less distressing (more consistent with evidence gathered)
- Belief ratings for each alternative (0-100%)
- Which emotions do these lead to?
  - useful to understand the CBT model, it's not the event, it's the interpretation…
- Evaluation of each explanation using techniques such as
  - Evidence for and against
  - Behavioural experiments
- Then re-rate conviction and or intensity

French and Morrison (2004)

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Evaluate alternative Explanations

- Evidence that contradicts explanation, or that it's not 100% true all the time?

- If someone close explained things to me this way, what would I say?
  - What would someone else say (e.g. best friend), and what evidence would they suggest?

- What have I learnt from the past?
  - Have I believed something 100% and it turned out not to be true?

- Am I jumping to conclusions, etc.?
- Am I doing/not doing something that could be maintaining this explanation (SBs/avoidance)?

French and Morrison (2004)

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Behavioural experiments

Rationale: familiarisation to Safety Behaviours

Are safety behaviours/avoidance maintaining unhelpful beliefs and acting as barriers to social recovery?

The safety behaviours metaphors: Vampires
Keeping elephants off the train tracks
Workman holding a wall
(Wells, 1997)

Socratic discussion

How can we test it out?

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#	Experiment	Belief tested	Outcome	Learning
Layer 1: Simple behavioural experiment	To drive the SRT therapist around whilst we look at other drivers and she waves	If I look at other drivers, they will swear and act aggressively towards me	No other drivers swore at us or acted aggressively, and some drivers waved back at us	Other people are not as aggressive as I thought they were and can be friendly
Layer 2: Additional promotion of social recovery	-	I can be trusted to drive the SRT therapist and get her back in time for her next appointment	I drove the SRT therapist safely and got her back to my house in time to leave for her next appointment	I am a trustworthy and responsible person
Layer 3: Capitalising in the moment	To carry on driving to a park in the next town	I can't drive to somewhere I haven't been before because I will get lost	We did get a little bit lost but made it to the park in time to have a look around	I can find my way to new places; it's normal to get a little bit lost sometimes; getting lost might not always be my fault but could be because something is poorly signposted

	#	Experiment	Belief tested	Outcome	Learning
	Layer 1: Simple behavioural experiment	Walk with client round the block, not returning home every time clients sees a car that seems suspicious	If I don't go home to safety I am in danger of being taken by someone in one of these cars	I was safe, cars did not seem dangerous (child seats, resident's permits)	Having thoughts that I might be in danger by others does not mean I am actually in danger
	Layer 2: Additional promotion of social recovery	-	If I stay out and about when I get anxious I am not able to cope.	I stayed out, kept going, realised cars did not seems suspicious after all.	I can coping with being out, even when I feel a anxious, I can stay in the situation
	Layer 3: Capitalising in the moment	Went to a shop that the client liked	There isn't much for me anyway, I am better off staying home	I did find a shop I wanted to go in.	I loved the shop I went into and the assistant was really friendly. I had a good time!

Selective attention as safety behaviour

Examples:

- looking for signs others think I am mad
- Really try and pay attention to noises, try and understand what voices are saying

- Experiment: focus on toes!

Addressing attention to current concerns likely to increase frequency of something being noticed, rather than its actual occurrence & maintains preoccupation.

Also: thought suppression/experiment

French and Morrison (2004)

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Activity scheduling

Isolation as a consequence and maintenance factor

Preoccupation with experiences can lead to isolation, and increase preoccupation with thoughts and experiences, leading to less chances to test things out and potentially depression.

Reduced repertoire of meaningful activities is likely to be a massive barrier for social recovery

Rate current activity (mastery, pleasure, mood and experiences/preoccupation)

Test out impact of meaningful activity in mood and unusual experiences!

French and Morrison (2004)

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Core beliefs

Negative core beliefs are likely to be barriers to social recovery. How?

- Identify through downward arrow and negative automatic thoughts

- Use continuum (Padesky) to reappraise beliefs
- Pros and cons of holding beliefs
- Evidence from experiments

- **Acting as if** (I was acting according to my values)

French and Morrison (2004)
Fowler et al. (2013)

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Systemic intervention

How are systemic factors acting as barriers to social recovery?

Advocate for the client within their social network

Educate about mental health and unusual experiences

Instill hope and an optimistic stance towards the client

Fowler et al. (2013)

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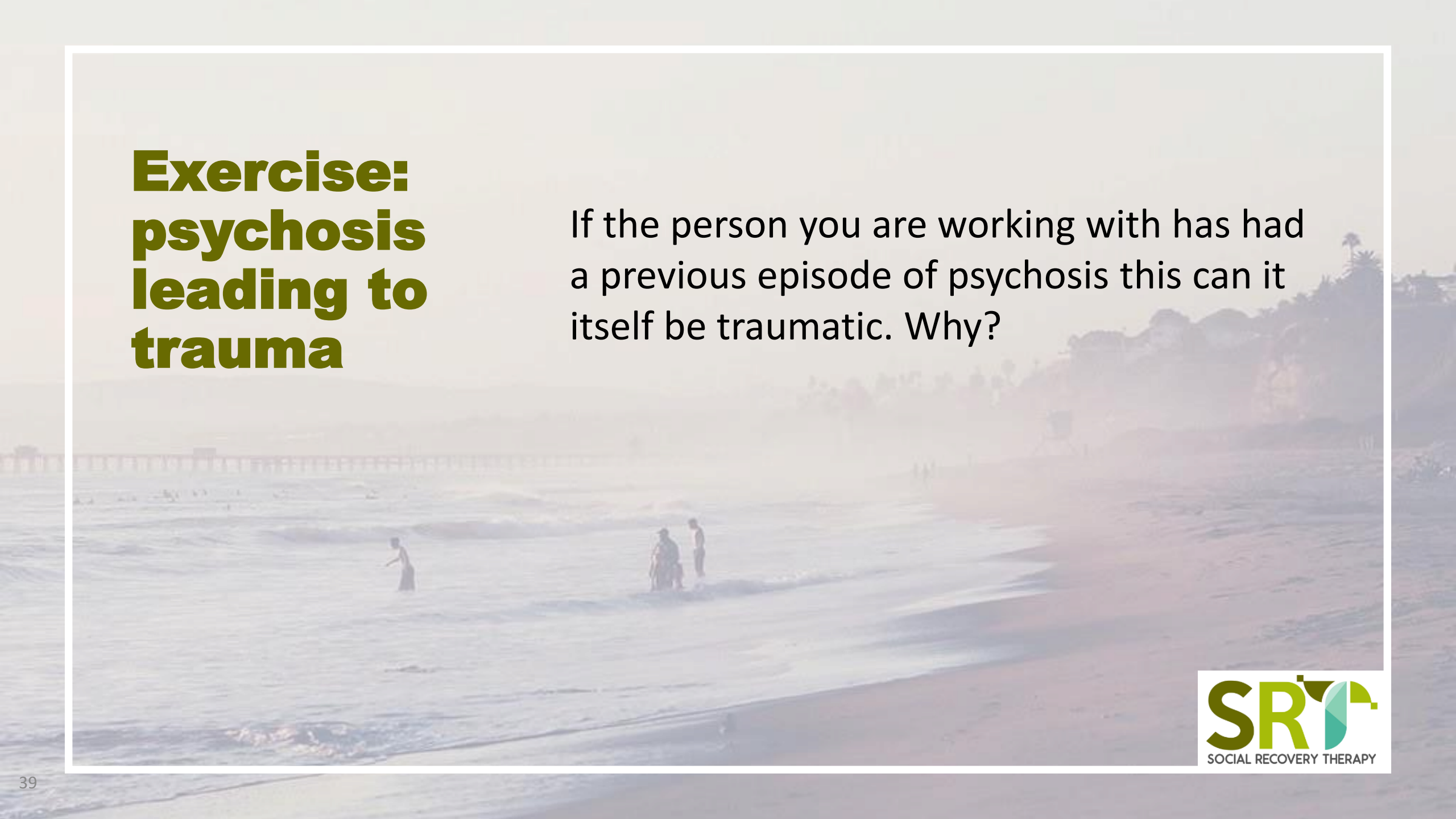
Exercise: psychosis leading to trauma

If the person you are working with has had a previous episode of psychosis this can it itself be traumatic. Why?



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Resources

French, P. & Morrison, A. (2004). Early detection and cognitive therapy or people at high risk of developing psychosis. A treatment approach. Chichester, John Wiley and sons.

Morrison, A., Renton, H. Dunn, J., Williams, S., Bental, R., (2004). Cognitive therapy for Psychosis. Hove: Brunner-Routlegde.

Fowler, D., Garety, P., Kuipers, E. (1995). Cognitive Therapy for Psychosis: Theory and Practice. Chichester, John Wiley and Sons.

Freeman, .D., Freeman J., Garety, P., (2004). Overcoming paranoid and suspicious thoughts. London: Robinson.

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Online resources

http://www.psychosisresearch.com/

https://www.mind.org.uk/

http://www.intervoiceonline.org/

www.hearing-voices.org

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