

Social recovery orientated cognitive behavioural therapy



Psychosis and associated social adversity may often be experienced as a traumatic event leading to hopelessness, stigmatisation and disruption to valued goals and expectations and thus to depression and social withdrawal

Adapting after a psychotic crisis

“Psychotic disorder is experienced as a life crisis which sets a series of adaptive demands for the individual.”

(Estroff, 1989)

Factors influencing adaptation include:

- a) Meaning attributed to, and coping with psychotic symptoms (altered feelings and thoughts)
- b) Appraisal of threats to self esteem e.g. loss of key roles, experience of social adversity

Problems at the recovery stage

**“I still feel ill” “Something’s wrong with me”
“I’m not quite right” “I feel different to before”**

**“Im fine” “Im ok” “don’t want help” “just want to get on with my
life”**

- **Amotivation**
- **depression**
- **social withdrawal and social disability**
- **anomalies of experience and beliefs**

- **NB: These problems are often missed in people who may be described as doing ok**

The Issues

- Suicide occurs in 10-15% of cases; mainly in first 5 years .
- Parasuicidal risk averages 20-30%
- Rate of post psychotic depression in first-episodes: 25%-80%


Depression as a psychological reaction to psychosis and trauma: recent psychological studies

- Depression in early psychosis is associated with increased loss shame humiliation and entrapment and lower social comparison (Iqbal et al, 2001; Plaistow, 2001)
- Depression, negative symptoms and social disability are strongly associated with each other at the recovery stage and also with the degree to which individuals can see themselves in meaningful roles and goals in the future (Day, 1999; Fowler et al, Submitted; Hodgekins, Submitted))
- Depression is also associated with reporting intrusive memories and avoidance of traumatic events (Harrison and Fowler, 2006; Fowler et al, In Press)

So, what does all this mean for early intervention??

- Amongst cases apparently symptomatically stable (in between psychotic episodes)
- We need to monitor and target depression and hopelessness, and prevent appraisals of loss shame and entrapment
- We need to carefully target patterns of social avoidance which may emerge initially as protective

*Social recovery CBT: a new psychological
therapy for case managers in early
intervention*



- Combines CBT for depression, social anxiety and psychosis with good practice in social and vocational recovery

The need to construct and solidify a clear positive self identity in recovery from psychosis

- The dangers of:
- Loss of identity after psychotic crisis
- Engulfment in a sick role
- Goffman (1966); Persons (1989)

Positive self and possible selves and recovery

- Positive views of self and others
- and
- balanced positive possible selves
- are associated with Quality of Life, Negative symptoms and involvement in functional activities at 3 months after first episode and predictive of social functioning at one year (Fowler et al, In Prep)

Creation of a positive resilient sense of self in recovery from psychosis

- A positive meaningful sense of self
- Taking account and validating past problems
- Linking to past hopes and dreams
- Fostering realistic but optimistic hope for the future
- Linked to engagement in functional social roles

Case examples

- Carol the childminder
- Alice the social worker
- Chris the computer guy
- Jimmy the musician
- Jane the mother
- Jim the mechanic
- Pete the eco warrior

John: the film set designer

- ✓ John è un giovane di 22 anni che, durante l'università, ebbe un grave episodio di paranoia associato all'uso di droghe (extasi, anfetamine e cannabis). L'episodio fu associato ad allucinazioni paranodi e deliri di riferimento, accompagnati da grave terrore e sfiducia nei confronti di amici, colleghi e nei rapporti personali, e gravi crisi di astinenza. La gestione dell'episodio richiese un ricovero coatto in risposta alla somministrazione di psicofarmaci. Comunque John rimase decisamente scioccato dall'episodio e in preda a sintomi di grave ansia sociale con idee occasionali di persecuzione e deliri di riferimento. Questi sintomi ripetuti lo portarono ad una mancanza di autostima, timore di una ricaduta e ad evitare un ritorno agli studi o alle precedenti attività sociali. Tornò a vivere con la madre verso la quale sviluppò una crescente dipendenza.

Alice: the social worker



✓ Alice aveva 22 anni.

Soffriva di una grave depressione e sentiva continue voci che la tormentavano. Le voci continuavano nonostante i trattamenti farmacologici. Aveva subito abusi sessuali da bambina. Occasionalmente si tagliava ed era ad alto rischio di suicidio. Nonostante desiderava impegnarsi ad intraprendere una carriera ed essere una persona normale.

Ian: the musician



- ✓ Ian ebbe un episodio di disorganizzazione. L'episodio si caratterizzò per comportamenti strani, disturbi del sonno, sbalzi di umore, allucinazioni bizzarre, e fantasie grandiose. Aveva talento per i lavori artistici e per il disegno, e all'inizio andava bene a scuola, ma il suo rendimento diminuì verso la fine dell'adolescenza e alla fine abbandonò gli studi. Ian aveva obiettivi non realistici per il futuro, iniziò a frequentare cattive compagnie che facevano uso di droga. Ian è ottimista riguardo il suo futuro ma i suoi genitori sono molto preoccupati.

Formulating and overcoming systemic barriers by planned case management

- It won't happen by accident!
- Promotion of a possible identity and hope is a good first step
- But lasting change requires the experience of real changes in life day to day and real possibilities for the future, this needs to be systematically planned
- To assist person to achieve their goals may mean careful formulation of the systemic barriers to recovery pathways in their lives, and on a practical level negotiation and goal setting with recovery partners to overcome blockages to recovery
- Family members
- Education, College
- Work

The case for Social Recovery oriented CBT in early psychosis

- Ideally best practice combines case management and vocational interventions (IPS) with structured psychological interventions (CBT)
- The aim is to promote activity which is meaningful to the person with respect to their identity and purpose in life, to construct a positive possible future sense of self

What is individual placement and support?

- Vocational workers focussing on social recovery who have links to employers and knowledge of employment issues work alongside case managers as part of an assertive outreach team (Bond)
- Hartford study (Mueser et al, J.Cons Clin Psychol, In Press) IPS (373 days employed) vs 176 days standard treatment
- Crowther et al BMJ, 2001 systematic review

Is Individual Placement and Support alone enough ?

- Effects are on low paid service sector employment which is transitive
- Needs attention to meaningful goals and career pathways
- At present suitable for people who are fully recovered ready to work

- Can psychological therapy prepare more people for IPS?
- Factors involved might include addressing hopelessness, amotivation, cognitive deficits and depression

Social Recovery CBT ingredients

Stage 1: Getting to know the person:

- **Assessing life background:** personal motivation, premorbid hopes/expectations
- **Assessing impact of illness:** extent to which self as agent developed premorbidly and/or degree to which premorbid agency shattered by symptom and illness impacts

Stage 2: Understanding and addressing fears about social predicament

- Formulation of self and psychotic illness
- Promoting hope for social recovery, destigmatising, promoting self as agent, addressing negative beliefs about self and others

Stage 3: Promoting social activity, work, education and leisure

- Promoting activity by behavioural experiments: recognising pleasure and mastery in exploring new social activity in safe and graded manner
- Linking goals and motivation to real social opportunities in work, education and leisure

What is social recovery in schizophrenia?

- **Maximizing opportunities for engagement in valued work and social activities**
- **Engaging with life, with ongoing symptoms**
- **Encouraging increased insight, where possible**
- **Increasing behavioral repertoire even w/o increased insight**

Assumptions in social recovery

- **The person is not ‘broken’, despite psychosis**
- **Seek to normalize the person, if not the disorder**
- **A value-driven and purposeful life can be lived, even in the face of anomalous experiences**
- **Encourages coping with life as it is**

Requirements of patient: A realistic but optimistic perspective needs to be fostered actively as part of the therapy process (motivational interviewing)

- **Fundamental ability to engage with another person in a process of exploration**
- **An interest in changing some elements of one's life**
- **A curiosity about internal experience**
- **A willingness at some point to commit to change**
- **Courage**

Basic treatment principles

- **People with psychosis can connect deeply with others**
- **....can live purposeful, value driven, committed lives**
- **The purpose of therapy is to help people live richer, fuller lives, as *they* define it, in the face of ongoing sx and problems**
- **Respect limitations: foster realistic hope**

Characteristics of SRCBT

- Tailored to address the difficulties associated with poor social recovery from first episode psychosis
- Utilises established CBT methodologies as described in the treatment of anxiety disorders, depression, and psychosis
- Emphasis placed on pragmatism and action orientation

Problems and barriers to implementing SRCBT

- Client presenting in demoralised state
- Restricted sense of self-agency
- Avoidance: cognitive, affective or behavioural
- Impoverished degree of social and occupational activity
- Residual low level psychotic symptoms
- Ruminations relating to impact of a psychotic episode

Typical problems

- Partial insight
- Low tolerance to stress
- rumination over psychotic episode
- Chaotic home environment
- But
- Responds well to being occupied

Typical formulation

Person stuck in negative ruminations which reflect chronic negative beliefs about self and others and reaction to the trauma of loss of autonomy associated with management of acute episode.

Affective response may include depressed mood, shame, and anxious arousal.

Behavioural response may reflect efforts to suppress negative affective states through avoidance.

Person may have *little experience of sustained employment and rewarding relationships.*

Could be ambivalent about returning to the fray.

Maintaining factors


- Possible assumptions regarding the consequences of increasing social and occupational activity can include e.g. “others will think I am weird”, “I will not cope”, “I am not strong enough”
- Avoidance and inertia results in fewer opportunities to test assumptions
- Implicit and explicit message from others that social recovery unlikely
- Influence of core negative beliefs/schemata

Formulation and reformulation in SRCBT

- **Formulation:** State of inertia reduces anxious arousal associated with change, it contributes to depressed mood and demoralisation. Negative self schema experienced as particularly salient. Far more likely to invite criticism from others.
- **Reformulation:** SRCBT seeks to agree an escape strategy, finding a route, providing cover if necessary, and making sure there are places to rest-up.

SRCBT approach

- Validates the reality of barriers to recovery. Acknowledges the adverse circumstances experienced by our clients
- Fosters self-image as 'hero' in active struggle
- Formulation reflective of specific barriers to social recovery
- Active therapeutic engagement (working in the field)
- Behavioural tests to establish positive sense of self and personal agency

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- Assessment of previous life/occupation
 - Identification of social goals
 - Assessment of obstacles to social goals
 - Formulation of a personal model of social recovery
 - Social recovery interventions
 - Social recovery cognitions

Goal setting in SRCBT

- X will have begun the process of considering other possible selves and futures
- X will have increased his behavioural repertoire and tackled the immediate barriers to recovery
- X will have taken safety behaviours and used them to his advantage
- X will have placed his recent experiences in context, and learnt to compensate for his difficulties
- X will have come to relish the challenges life poses and enter the fray

Setting goals for treatment

- **Patient centered**
- **Choose area(s) of functioning likely to lead to meaningful benefit**
- **Start with small, manageable goals**
- **Work toward larger goals, including ‘lost dreams’, where feasible**
- **Encourage willingness and commitment**

Different targets for behavioural expts

- Negative symptoms: testing expectation of feelings of lack of pleasure or mastery in social situations
- Social anxiety/paranoia: overcoming avoidance in response to worries about social appraisals
- Schizotypal symptoms: decreasing catastrophising about relapse due to feelings of overload
- Voices: overcoming avoidance in response to critical voices or commands

Getting to behavioral experiments

- **After formulation sharing and developing an alternative explanation for anomalous experiences and disturbing beliefs.....**
- **Look at costs of preserving vicious cycles**
- **Examine benefits/disadvantages of testing**

Design a behavioral experiment that does three things

- 1) Tests the formulation**
- 2) Is *both* cognitively and emotionally compelling**
- 3) Gets the patient into a situation that is of value to *him or her***

Building motivation to engage in behavioral experiments

Questions:

- 1) What do these experiences (vicious cycles) get in the way of?**
- 2) If it weren't for X (voices, paranoia, social anxiety etc.), how would you be living your life?**
- 3) Would you like for our therapy to be about achieving Y?**
- 4) Would you be willing to work toward Y, even if X persists?**

Behavioral experiments

- **Design with specificity, to insure that the formulations are carefully tested**
- **Secure compliance with testing via BE:
decide re: in session, in vivo, with or
without therapist presence**

BEs

- **After BE, review carefully for patient's assessment of what the evidence suggests both for the formulation and for achievement of desired treatment goals**
- **Rate for how emotionally compelling the results are**
- **Discuss implications of what was learned**
- **Design new BEs**

Behavioral experiments

- **Creates in-session, then in-vivo opportunities to test pt 'model' and alternative model**
- **Emotionally compelling**
- **Addresses *both* explicit and tacit levels of knowing**
- **Brings about cognitive, emotional, and behavioral change: flexibility**

Living despite symptoms

- **After formulation sharing and developing an alternative explanation for anomalous experiences and disturbing beliefs.....**
- **Look at costs of preserving vicious cycles**
- **Examine benefits/disadvantages of acting differently in response to symptoms**

Robbies problem list

- Feeling frightened when out
- Voices getting him down about doing nothing

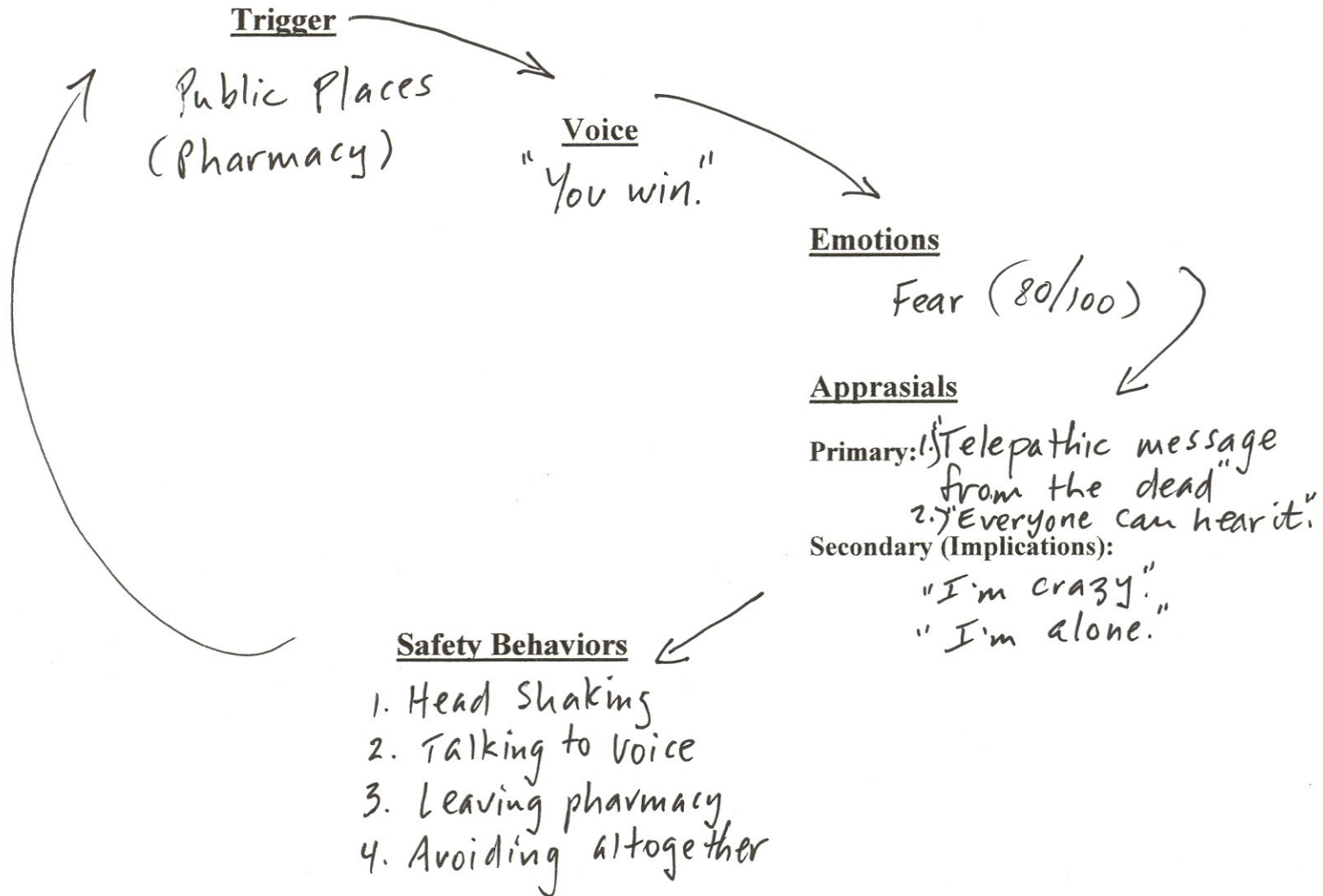
Cognitive behavioural analysis

- Doing the A B C s
- Analysing the context in which symptoms occur, antecedents and consequences
- Analysis of problem situations: symptoms in context

Acting differently by behavioural tests

- 1) Tests the formulation (will voices, paranoia get worse, will it be so bad if I go out)**
- 2) Provides experience which is *both* cognitively and emotionally compelling**
- 3) Gets the patient into a situation that is of value to *him or her***

Case Conceptualization



Thanks for listening!

“Everything I do is one step closer to getting back, and that makes me feel good, it improves my self-esteem... It’s not until you’ve been through it that you know... I don’t want to fail... and I think this time, feeling positive has got me through.”