Wisconsin Public Psychiatry Network Teleconference
(WPPNT)

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- Call 877-820-7831 before 11:00 a.m.
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- Questions may be asked, if time allows.
- To ask a question, press *6 on your phone to un-mute yourself. *6 to remote.
- The link to the evaluation for today’s presentation is on the WPPNT webpage, under today's date: https://www.dhs.wisconsin.gov/wppnt/2018.htm
NON-PHARMACOLOGICAL APPROACHES TO WORKING WITH PEOPLE WHO HAVE SCHIZOPHRENIA

Gregory Jurenec, Ph.D.
Professor of Clinical Psychology
Wisconsin School of Professional Psychology
Introductory Stuff

- My Background
- My Biases/Perspective
- Disclaimer
  - *Non $ interest in anything I’m saying*
  - *Unfortunately, I haven’t developed a “non-pharmacological” treatment program to promote.*
- Objectives
  - 1st, to look at the person’s phenomenological experience, rather than seeing a checklist of schizophrenic symptoms.
  - With a better understanding of the experience, I’d like to present an approach (and a few techniques) for working with people who are dealing with schizophrenia.
What Schizophrenia is....

- Schizophrenia is a Brain Disorder, which generally affects:
  - Thinking
  - Feeling
  - Perceiving

- Affects around 1% of the population, world wide

- As of today, it cannot be cured, but often can be effectively managed.

- It varies enormously in regard to:
  - Symptom expression
    - Types of symptoms shown
    - How the symptoms affect the person
  - Overall Severity
  - Outcomes
Variability in Onset

- Generally *identified* in late teens to late 20’s (although, I’d argue it usually starts long before it’s diagnosed)
- Onset for women tends to be later than men.
- Rarely has an onset later in life
- Acute vs. progressive (?)
- However.....
  - *Inquiry usually reveals that there were signs of the condition well before the episode that led to the intervention.*
  - *Research suggests that the cognitive deficits (in executive function) may actually become apparent in middle school well before psychotic Sx are seen.*
■ RELAPSE:

■ 80% of treated patients relapse at least once within 5 years of the initial episode.

- 12.2% = One episode only, no further impairment
- 14.6% = Several episodes, with minimal impairment
- 17.1% = Some continuing impairment after the 1st episode, with some additional episodes.
- 33% = Repeated episodes with increasing impairment & negative symptoms.
- 11% = Symptoms and impairment persist after the 1st episode without significant remission.
Core Problems

■ Feeling:
  - Blunted, flat, unemotional
  - OR, “affect” is “inappropriate” to the situation
  - Can be easily overwhelmed by emotions

■ Thinking:
  - Concrete
  - Loose associations: make connections to irrelevant aspects.
  - Tangential: Can’t stay on topic
  - Slowed, impaired information processing

■ Perceiving:
  - Hallucinations
  - Delusions

NOTE: Everyone does not have all of the symptoms.
People with schizophrenia often feel overloaded or overwhelmed, because they have trouble screening out the unimportant things, such as:

- Sounds, speech, physical sensations
- Emotions
- Their own thoughts
- Auditory hallucinations
Impairment in Affective Function

- **Flat / Blunt**
  - Lack of “fine tuning”
  - *But also, may be an effort to minimize stimulus overload.*

- **Inappropriate**
  - Examples
    - Alternative explanation

- Emotion as a “stimulus overload”

- Also:
  - Ahedonia
  - *Amotivation (Related to executive function)*
Hallucinations
Hallucinations

- The perception of a stimulus, in any sense modality, that in fact is not really there.
  - Auditory – most common type for schizophrenia*
  - Visual – sometimes, but not as frequent
  - Tactile – likely AODA withdrawal
  - Olfactory – more likely a brain injury or Seizure Disorder
  - Gustatory – associated with an organic condition, but sometimes goes with paranoia

- Hallucinations are simply a symptom, which can have multiple causes.
  - Brain injury/seizure
  - Drugs
  - Sleep deprivation
“Voices” that are NOT really hallucinations

- Internal thoughts and preoccupations, a “voice inside my head” or “loud thoughts” which are *not* seen as intrusive.
  - *People do experience Thought Insertion.*

- Flashbacks, associated with trauma

- “Hypnogogic” experiences

- Hallucinations in a cultural or spiritual context:
  - *Talking with the dead*
  - *Talking with God*
Qualities of Auditory Hallucinations

- **Realism**
  - Sometimes *indistinguishable from “real” voices*

- **Frequency**
  - *Episodic*
  - *Continuous Commentary*

- **Volume**
  - “Whispers”
  - Shouting

- **Perceived “Source”**
  - *Thoughts or sounds “inserted” “in my head”*
  - *External*
    - Other people – Unseen
    - Other people - Seen

- **Nature**
  - *Sounds, music, noises*
  - *Most often described are “voices”*

- **Quality**
  - *Voices of known people or strangers*
  - *Usually become “real people” or entities.*
  - *Often believe it is God, or other religious figures.*
    - Angels
    - Demons
Content of Auditory Hallucinations

- Benign (i.e. running commentary)
- Pleasant
  - Humorous
  - Advise and support
  - “Friends”
- Persecutory
  - Threatening
  - Insulting, critical
- Command (often goes with persecutory)

*Often, people experience a MIX of content.*
Variability & Heterogeneity

- Auditory hallucinations vary considerably between people on all of the dimensions discussed.

- They can also vary for the same person:
  - Over the course of the illness
  - Over the course of days or months...
  - Can change over the course of a day.
The Subjective Experience: Questions to consider…..

■ What must it be like to have hallucinations?
  - *The experience*
    ■ Hearing someone you can’t see and no one else seems to hear?
    ■ Being threatened, demeaned, criticized by an unseen voice?
  
  ➢ What might a 15 year old expect if they told their friends about their hallucinations?
    ▪ *Or their parents?*
  
  ➢ Why wouldn’t a person tell you or their doctor about their hallucinations?
    ▪ *You won’t believe them*
    ▪ *You’ll be shocked*
    ▪ *They will be prescribed more meds that they don’t want*

■ What would you make of someone telling you that the voice you hear “isn’t real”?
  - *Especially if the voice tells you the therapist is lying?*
  - *Which do you believe: What your senses tell you or what you’re told?*

➢ How would a 15 year old make sense of or explain hallucinations if they can’t talk to anyone about the experience?
Delusions:

- Beliefs, interpretations, fears that are *patently false*, AND
  - *Are held with conviction in the face of evidence*
  - *Are dysfunctional*
  - *Are NOT part of a common set of religious beliefs of customs*

- Some Types
  - *Persecutory*
  - *Jealous*
  - *Grandiose*
  - *Somatic*
  - *Erotomanic*
Variability in quality

- Conviction of belief
- Urge to act on the delusion
- Systematic vs. fragmentary
  - PJB: Agent of the UN
  - KF: Are people locked under my bed
- Bizarre…. to believable
  - PJB: He is an alien placed on earth (or the Holy Spirit)
    - Therefore cannot get medical services because they will discover this.
    - He will be picked up in a space ship and returned “home”
    - He “caused” earth quakes” as well as the treaty with Iran.
  - FB: Born out of mother’s rectum
  - “Brush on plaque”
  - Woman believed she had been “black balled” by a former music professor because she broke off an affair with him.
  - Young Black man believed he was being followed/watched/and was in danger
Subjective Experience of Delusions

- Delusions are often driven by an attempt to explain the hallucinations
- Consider what it would it be like to “know” that:
  - You’re being watched?
  - “Everyone” is talking about you?
  - People can hear your thoughts?
  - There is an invisible poison in your bed?
  - You are a very important/powerful person, but no one believes you?
Think about how voices or delusions might affect what you do?

- If you believed that every time you left your room, someone was stealing or damaging your things?
- If you believed that you owned a house on 10 acres, on a lake, that you could move into.
- A voice, who said he was God, was telling you that you have to stay awake all night to protect the universe.
- You knew that your psychiatrist and a judge told you that you had no mental illness and that you were free to leave whenever you wanted to.
- A voice who said he was the devil is telling you that he will take your soul while you sleep.
Consider the lives of our patients….

- Consider what is happening in the person’s life when schizophrenia begins.

- What are the “normal” things that we all want to have in our lives?
  - ?
  - ?
  - ?

- Consider how the achievement of these things will be affected by schizophrenia?
  - In some cases, harder but possible
  - But for many of the most seriously ill people that I see, these things are not likely at all.
  - How would this feel?
1st Person Account of the Experience

- https://www.youtube.com/watch?v=rWsYIoLZHYI&t=0s&index=11&list=PL83EB4759EDD815F1
- Patricia Deegan, Ph.D.
  - Has a YouTube channel
  - https://www.youtube.com/watch?v=DVIhfuKDjYE&list=PL83EB4759EDD815F1&index=5&t=28s
The Application of the Medical/Disease Model has consequences....

1\textsuperscript{st} choice is Pharmacotherapy

- Rarely desired or favored by the individual
- Rarely are alternatives to medication offered
- Side effects of medication
  - Unpleasant
  - Stigmatizing
  - May be worse than the illness

Therapeutic Relationship?

- Trust?
- Sense of understanding?
- Adversarial?
- Invalidation of the person’s experience
Implications for a person experiencing schizophrenia

- Invalidation of their experience, which is seen as just a symptom of a sickness
- Withdrawal and social isolation
- Development or continuation (and strengthening) of an unhelpful personal understanding/interpretation of their experience.
- “Squashed goals”
- Adversarial relationships with:
  - Providers
  - Family
What happens when a young person is diagnosed with schizophrenia?

- Family/caregivers are frightened
- Medical care is sought: Person is labeled as “sick”
- Lowered expectations
- Subjective experience:
  - *The person’s experience is seen as a function of this “sickness”*
  - *Therefore, they are told that their experience “isn’t real...it’s all in your head.”*
- Medical Care is prescribed (and often *imposed*)
- Social alienation begins (or continues)
  - *People are often removed from their social network*
  - *Placed on a different “track”*
There are other alternatives *outside* the US

- In Europe & UK, psychotherapy and psychosocial interventions play a bigger role.
- There are approaches that use antipsychotic meds *only*:
  - When the psychosocial approach is not working after 6-8 weeks
  - *AND*, the person *wants* to use the medication
  - **Example: Open Dialogue in Finland**
- However, I’m not aware of the availability of this program in the US.
- **AND**, treatment of schizophrenia *without* meds would be risky:
  - *Use of antipsychotic medication IS the standard of practice in the US.*
  - *Thus, failure to follow accepted practice opens the door to law suits and sanctions.*
So... what do we do if we aren’t in Finland?

It’s all about the **RELATIONSHIP**

- Nothing HAPPENS unless the person feels that:
  - You care
  - Understand (at least some, and/or are trying) and you accept them
  - And they believe that you can help

- More and more research finds that the **relationship** is the key ingredient to ANY treatment, be it “medical” or psychological.
Building the Relationship

■ The patient must feel accepted and understood by you.
■ Do not “reject” or minimize their experiences, or show that their experiences frighten you.
  - Do not bluntly dismiss hallucinations and delusions as “nonsense”, “all in your head”, and “not real.”
  - These are real for the person and so they understandably affect them.
  - Acknowledging the reality of their experience is not the same as saying that everyone else experiences it.
  - Don’t be frightened that the person “hears voices”, sees things, or believes frightening or unreal things.
■ Instead, imagine what it would be like to live as they do.
■ By doing the above, they can feel safe telling you things they cannot share with others.
■ Only if you can understand can you help.
■ If you try to “walk a mile in their shoes” it’s easier to show them respect as a person.
Respect

- General respect: Being mentally ill doesn’t mean you don’t care how you are treated.

- Don’t scold or punish:
  - *How would YOU respond to that?*
  - *Provide people a way to cooperate AND save face*

- **Frame things so they see it as to their advantage**
  - *Billy’s UDS*
  - *Rather than threatening to “take away”, encourage them to cooperate so the CAN have the item or do the activity*

- People are always more receptive if they feel you care about them.
Helping to manage Visual Hallucinations

- Rare
  - Often are distortions
  - Often intertwined with the AH and delusions
  - Tend to look different than other visual stimuli.

- To address:
  - Discuss their interpretation
  - You test it by touching the area of the hallucination.
  - Have the person “check out” by using multiple senses
Coping with Auditory Hallucinations

- Talking back, arguing, refuting
- “Commercial” technique
- Ignore and let it pass
- Drowning out
- Mindfulness/acceptance: letting them pass
- Address “believability”
Working with Delusions

- Reality testing (for milder delusions)
- Rarely effective to challenge them
- “agree to disagree”
- Manage delusions
  - Who do you tell?
  - Do you have to act on them?

- Work within the context of their delusion
  - KF: believes he has been shot. But, has no wounds. Interpret this as miraculous, and frame his rapid healing as wonderful defense.
    - So no need to fear being shot, b/c heals fast
  - CB: God requires her to stay awake to protect the universe.
  - JU: Satellites are transmitting signals into his mind. How can we block the signals?”
  - NA: “brush on plaque
Delusions may have a FUNCTION

- Grandiose delusions may be compensatory.
  - Richard: Chief justice of the Supreme Court
  - Phil: Grandiose delusions when felt belittled
  - “Gifts” to dying father

- May help them account for or explain their AH

- May be a way to “re-write” their history

- Paranoid/Persecutory
  - I don’t quite understand yet.
  - There is some speculation that they relate to experiences of abuse or trauma.
  - In some cases, the delusion may provide a face-saving way to explain their situation in life.
“Reality Testing”

Reality testing” can sometimes be useful for helping people cope with hallucinations & delusions.... provided there is someone they feel that they can trust.

- If something seems weird, “check it out” and ask a person you trust whether they see/hear it.
- Ask if what helper believes is actually happening or seems credible (i.e. testing delusions)
- Reality testing is more likely to work:
  - in early symptom emergence...
  - before they become compelling.
Emotional Expression

- Effect of emotional expression on information processing
  - Discussing emotional issues in therapy
  - Your affective behavior affects the client’s processing of emotion.

- So, be aware of “titrating” emotion.
  - Grief & loss
  - Trauma
Mr. Osborne, may I be excused? My brain is full.

Conclusions

- Try to see the world thru the eyes of your client. Only when you understand, can you help.
  - *Listen.* Ask questions to help you understand their experience
    - What do AH sound like?
    - How do you tell what to listen to?
    - What does that belief *do* for them?
  - Rather than challenge their experience, try to work with and within it.
  - Focus more on function and goals, as opposed to symptoms.
References


