

ISPS-US



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Psychosis, Citizenship, and Belonging:
Forging Pathways toward Inclusion and Healing

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Omni New Haven at Yale • New Haven, CT

**ABSTRACTS, TARGET AUDIENCE,
LEARNING OBJECTIVES & REFERENCES**

Abstracts are in alphabetical order by lead presenter. Posters are at the end.

Claire L. Bien, MEd

Psychosis, Citizenship, and Recovery: Mapping a Life's Journey

Intermediate

This workshop will apply a Citizenship lens to my own story of trauma, distress, alienation, psychosis, and recovery. The discussion will draw upon what I have learned about how social, societal, and environmental conditions can activate and exacerbate voices, and how social and psychological supports, including family, friends, work, faith, Hearing Voices and other social support groups, and compassionate psychotherapy, can provide hope. These supports can also foster greater understanding of ourselves, others, and the world.

I will use a Life Journey Map as a narrative tool for telling my story. Journey maps were developed as a way of improving business interactions—providing a graphic, chronological tool for understanding the inputs, responses, and process for customer relations. In the therapeutic context, journey maps allow us to name and chart human interactions—the people, events, and conditions that cause profound emotional, psychological, and existential distress, as well as those that bring comfort and joy. When we understand the people and conditions that activate negative and positive feelings and experiences, we are better able to consider their influence on our lives as a whole.

Applying a Citizenship lens to personal journey maps—a lens that upholds basic human rights, needs, and expectations—provides an additional, rather pragmatic way to consider our lives in the context of what philosophers, scientists, and many politicians, believe is necessary to live a full, happy, and productive life. Using this framework can allow people to consider the degree to which they—we—are in possession of each of the 5 Rs: Rights, Responsibilities, Roles, Resources, and Relationships, along with a sense of belonging and recognition for who we truly are. Armed with that knowledge and understanding, we can begin to work toward addressing areas of need and chart a more informed and intentional path toward healing.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe Dr. Michael Rowe's Citizenship model—the 5 Rs of Citizenship (Rights, Responsibilities, Roles, Resources, and Relationships) and demonstrate an understanding that the degree to which people feel that they are possession of those 5 Rs, accompanied by a sense of belonging and recognition for who they truly are, influences their sense of well-being, and ability to live fully in the world.
2. Discuss how to apply the 5 Rs and the ways in which their presence or absence influences vulnerability to hearing voices, seeing visions, and experiencing other unusual phenomena, which

will help in developing the tools needed to manage their experiences, allowing them the opportunity to acquire the understanding and skills needed to find and maintain recovery.

3. Describe life journey maps, which provide a concrete, visual tool for documenting those times in our lives when we have been most profoundly distressed, allowing us to reflect upon what happened during those times so that we can begin to work toward understanding and healing.

Davidson, L., (2016). The Recovery Movement: Implications for Mental Health Care and Enabling People to Participate Fully in Life. *Health Affairs* (June 2016): 1091-1097.

Ponce, A.N.; Rowe, M. (2018). Citizenship and Community Mental Health Care. *American Journal of Community Psychology*. Published online: <https://doi.org/10.1002/ajcp.12218>

Rowe, M. (2015). *Citizenship and Mental Health*. London: Oxford University Press.

Rowe, M. and Davidson, L. (2016). Recovering Citizenship. *Israel Journal of Psychiatry and Related Sciences*. Vol. 53 - No 1.

Steuer, A. (2018). What is Customer Journey Mapping and Why Is It Important? *Forbes Agency Council CommunityVoice*) <https://www.forbes.com/sites/forbesagencycouncil/2018/11/26/what-is-customer-journey-mapping-and-why-is-it-important/#622bcb8d5a76>

Styron T., Utter L., Davidson L. (2017). The hearing voices network: initial lessons and future directions for mental health professionals and Systems of Care. *Psychiatr Q.* 2017;88(4):769-785

Claire L. Bien, MEd, Barry A. Floyd, Caroline Mazel-Carlton, Brittany Quagan, MS/LPC

Plenary: *Finding Ourselves in Each Other: Four Lives, Four Journeys*

Introductory

Psychosis is one way in which the heart, mind, and spirit respond to feelings of loneliness, powerlessness, danger, and fear. Left unresolved, and especially when disbelieved or dismissed, those feelings can lead to alienation, isolation, and a reaching toward an inner world that offers something the outer world either cannot or will not. The individual becomes a stranger not only to family and community, but also, tragically, to self.

The Citizenship model developed by Rowe and colleagues offers a useful framework for considering the familial, social, and societal conditions that shape people's lives and minds. Rowe defines Citizenship as the connection individuals and groups have to the 5 R's of Rights, Responsibilities, Roles, Resources, and Relationships, accompanied by a sense of belonging to a group or system. Rowe asserts that the 5 R's, plus belonging, are essential to a person's ability to establish or maintain full citizenship—and therefore a life—in society. While full possession of each of the 5 R's can allow a person to become fully self-actualized, thereby reaching the pinnacle on Maslow's hierarchy of needs, absence or significant loss of any or all the 5 R's—through trauma, abuse especially at the hands of family or close associates, war, racism, generational poverty, displacement, and immigration, can lead to anger, grief, despair, alienation, further trauma, and in vulnerable individuals, psychosis.

Members of the Experts by Experience panel will consider the Citizenship model as they describe their experiences of life, psychosis, and recovery, noting where possible the degree to which the presence or absence of any or all of the 5 R's, along with the requisite sense of belonging, influenced their experiences of the world and their ability to build or re-build a life within it.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Name the 5 R's of Citizenship and articulate that possession of each of the 5 R's, plus belonging, impacts a person's ability to live fully in the world.
2. Explain that social supports—a sense of safety, trust, and belonging to a group—to the world—are

a vitally important to recovery and are necessary for living a full and productive life.

3. Discuss how trauma and abuse are common triggers for psychosis, and name at least three forms of trauma that can lead to psychosis in vulnerable individuals.

Davidson, L., (2016). The Recovery Movement: Implications for Mental Health Care and Enabling People to Participate Fully in Life. *Health Affairs* (June 2016): 1091-1097.

Geekie, J.; Randal, P.; Lampshire, D.; and Read, J. (2012) *Experiencing Psychosis: Personal and Professional Perspectives*. New York: Routledge

Gumley, A.; Gillham, A.; Taylor, K. and Schwannauer, M. (2013) *Psychosis and Emotion: The Role of Emotions in Understanding Psychosis, Therapy, and Recovery*. New York: Routledge.

McCarthy Jones, S. *Can't You Hear Them? The Science and Significance of Hearing Voices*. (2017). London: Jessica Kingsley Publishers.

Ponce, A.N.; Rowe, M. (2018). Citizenship and Community Mental Health Care. *American Journal of Community Psychology*. Published online: <https://doi.org/10.1002/ajcp.12218>

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Styron T., Utter L., Davidson L. (2017). The hearing voices network: initial lessons and future directions for mental health professionals and Systems of Care. *Psychiatr Q*. 2017;88(4):769-785.

Elizabeth Breier, MA, CPRP, Clinton Green, LMSW, Jeremy Reuling, LCSW, NYCPS

Walking the Fine Line: Perspectives of Professionals with Lived Experience

Introductory

Lived experience of recovery from mental health conditions is prevalent among people working in a variety of roles throughout the mental health system. Regrettably, the presence of stigma leads to an ongoing "us vs. them" mentality and creates fear on multiple levels for workers who may be considering disclosing and/or using their own histories as an advocacy tool to address structural inequalities and barriers to system reform. Furthermore, these issues are often complicated by the diverse backgrounds of these individuals by such factors as cultural norms and preconceived ideas regarding race, ethnicity, and nationality. This workshop, led by three peer-professionals, two of whom are social workers, will encourage an open dialogue around the issues of disclosure within the profession, roles, and internal stigma, including the varying challenges that arise due to a racially, ethnically, and culturally diverse workforce, while looking at how providers' disclosures of their own lived experiences may help to break down barriers throughout the health care system.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Critically examine the values that lead to the non-disclosure of behavioral health professionals.
2. Describe specific challenges regarding the intersection of disclosing personal lived experience and cultural diversity among individuals who choose to do so.
3. Discuss ways in which behavioral health professionals can continue to evolve, grow, and lead the advocacy for change within the field and health care.

Welder, L.E., & Salzer, M.S. (2016). *Creating Welcoming Work Environments Within Mental Health Agencies: Recommendations for Supporting Agency Staff with Mental Health Conditions*. Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities

Loran B. Kundra & Mark S. Salzer (2019): *Out of the shadows: supporting social workers with a*

mental illness, Social Work in Mental Health, DOI: 10.1080/15332985.2019.1576155

Gold, K.J., Andrew, L.B., Goldman, E.B., Schwenk, T.L. "I would never want to have a mental health diagnosis on my record": a survey of female physicians on mental health diagnosis, treatment, and reporting. *Gen Hosp Psychiatry*. 2016;43:51-57

Celia Brown & MaryAlice Brown

Anomie and Altered States

Introductory

Durkheim explored anomie with suicidal individuals in 1897. In 2019, anomie captures the experience of peers with lived experience of altered states. In this interactive introductory discussion, experiences will be presented with peers who were met in a soup kitchen. Just as Durkheim described anomie as the malady of the infinite, the challenges of living with altered states presents many challenges. Recent research has shown the wider impact of anomie on not only the individual but also the society. Efforts to challenge the anomie that leads to the breakdown of social bonds will be presented. Community organizing efforts have sought to blaze trails to forge new ties, to form meaningful relationships and to create safety for peers with altered states. Attendees will be encouraged to share the efforts of their local communities.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Review the unmet needs of people with lived experience being treated with the medical model.
2. Identify the limitations of utilizing a narrow medical model.
3. Identify the efforts to incorporate a person-centered recovery model and to able to discuss how these efforts will lessen anomie.

Castillo, E., et al. 2018 Community Public Policy and Recovery from Mental Illness: Emerging Research and Initiatives, *Harvard Review of Psychiatry*, March-April, 26, 2, 70-81.

Harrington, A. 2019 *Mind Fixers: Psychiatry's Troubled Search for the Biology of Mental Illness*, New York: Norton.

Hoverman, A., et. Al. 2015 Understanding the Devaluation of Vulnerable Groups: A Novel Application of Institutional Anomie Theory. *Social Science Research*, 52, 408-21.

Tejmorri, A., et.al., 2016 Revisiting the Measurement of Anomie, *PLoS One*, 11, 7.

Marie Brown, PhD, Elan Cohen, Tamar Lavy, MD

Resistance vs. Belonging: Progressive Early Career Professionals on Negotiating the System

Introductory

Early career professionals with progressive views on madness and mental health, via personal experience and/or ethical convictions, are in a precarious position when it comes to finding their place in the field. Whether they follow the traditional route of seeking licensure and credentials, find work as peer specialists, or forge their own path in developing alternative modes of practice, they are forced to reckon with a system that is resistant to change. They may experience administrative backlash including degradation, threats, and lack of support, or may feel pressured to suppress themselves in an effort to avoid conflict. These situations may, however, act as catalysts for change and progress. The panel includes four individuals with experience in multiple domains of the mental health profession (i.e., as a Peer Specialist, Psychiatrist, and/or Clinical Psychologist) who will share their perspectives on the process of finding where they belong in the field.

Topics of exploration will include:

- Navigating the shaky path of being true to themselves, their experiences, and their ethics, while engaging with conventional institutions (academic, professional, etc);

- Contending with the statuses associated with age, career level, gender, and personal experience of the psychiatric system;
- Making choices about working within or outside of the system;
- Carving out spaces in academic and training institutions that honor and value subjective experience;
- And maintaining integrity and optimism for change, while resisting co-optation and burnout.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe the unique challenges early career professionals with progressive views on madness and mental health face in navigating the field.
2. Identify solutions and creative ideas people apply in effort to achieve professional goals, while maintaining personal ethics and integrity.
3. Identify ethical issues in the training of mental health professionals, particularly pertaining to issues of disclosure.

Berry, C., Hayward, M.I., & Chandler, R. (2011) Another rather than other: Experiences of peer specialist workers and their managers working in mental health services. *Journal of Public Mental Health*, 10(4), 238-249.

Grice, T., Alcock, K., & Scior, K. (2018) Mental health disclosure amongst clinical psychologists in training: Perfectionism and pragmatism. *Clinical Psychology & Psychotherapy*, 25(4), 721-729.

Harris, J. I., Leskela, J., & Hoffman-Konn, L. (2016). Provider lived experience and stigma. *American Journal of Orthopsychiatry*, 86(6), 604-609.

<http://dx.doi.org.ezproxy.cul.columbia.edu/10.1037/ort0000179>

Hunter, N. (2015). Experiences of a black sheep in a clinical psychology program. In D. Knafo, R. Keisner, S. Flammenghi *Becoming a Clinical Psychologist: Personal stories of doctoral training*. New York: Rowman & Littlefield.

Robin S. Brown, PhD & Marie Brown, PhD

Paranoia as a Transformative Event

Introductory

In the first half of this panel, Robin will offer a theoretical presentation on paranoia. His approach will draw heavily from the psychoanalytic idea of enactment and Jung's notion of synchronicity. Reflecting the idea that objectively meaningful correspondences can occur between non-casually related events, Jung's theory of synchronicity challenges the implicit metaphysical assumptions of Western psychiatry. But while synchronicity was an enduring interest for him, Jung only published his thoughts on this matter towards the end of his career and in a relatively speculative manner which left much unsaid. Resultantly, the radical significance of this concept for clinical work has remained largely unarticulated. Exploring recent psychoanalytic thinking on the teleology of enactment, this presentation will argue that a synchronistic outlook has profound implications in enabling us to conceptualize paranoia as a transformative event.

The second half of this panel will include a "lived experience" perspective of the theories put forth by Robin. Marie will discuss her own personal experience of folie à famille, to understand how a shared paranoia within her family served the purpose of forging connections to their disavowed Sámi heritage. In keeping with the theme of Citizenship, she will demonstrate how paranoia can be understood to serve the teleological function of collective healing from historical systematic exclusion. Rather than being seen as a form of illness to be eradicated, paranoia is here described as a vehicle by which one can develop greater self-understanding and a connection to forgotten ancestral lineage.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Apply contemporary psychodynamic theory to the treatment and understanding of paranoia.
2. Identify the ways in which paranoia (or psychosis) can be transformative.
3. Critically appraise the metaphysical assumptions of Western psychiatry.

Atlas, G. and Aron, G. (2017). *Dramatic Dialogue*. New York and London: Routledge.

Brown, R.S. (2018). Imaginal Action: Towards a Jungian Conception of Enactment, and an Extroverted Counterpart to Active Imagination. *Journal of Analytical Psychology*, 63.2, 186-206.

Brown, R.S. (2019). *Groundwork for a Transpersonal Psychoanalysis: Spirituality, Relationship, and Participation*. London & New York: Routledge.

Brown, M. & Brown R.S. (Eds.). (forthcoming). *Emancipatory Perspectives on Madness: Psychological, Social, and Spiritual Dimensions*. London & New York: Routledge.

Davoine, F. & Gaudillere, J. (2004). *History beyond trauma*. New York: Other Press

J. Tyler Carpenter, PhD & Ronald Abramson, MD

The Ends of the Bow Drive the Arrow: Brain/Mind and Hitting the Therapeutic Narrative Intermediate

Historically, the soul of treatment for people diagnosed as psychotic has devolved into a split between mind and body, the concept and the reality. As the discipline of Psychiatry in the context of modern medicine has evolved into a predominantly biological Neuro-Psychiatry orientation, the treatment of psychoses has taken on a heavily biological bent. A search on Google Scholar using term "Treatment of Psychosis" yields a very large predominance of biological journal articles. Searching for "Psychological Treatments of Psychosis" yields a smaller number of articles featuring recently developed psychotherapies such as Cognitive Behavioral Treatment (CBTt) (2) or Mindfulness Treatment (3). Psychoanalytic approaches up until fairly recently have been standard (1). As Michael Robbins (2018) points out, in a confusion of Biblical proportions, practitioners of each approach tend to view the language and concepts of the other with disdain or outright contempt. To psychiatrists, whose main form of treatment has typically devolved into the prescribing of medicines, therapists speak an arcane language; and, psychosis is understood as a biological problem and clearly (to them) psychotherapy is ineffective (Abramson, 2017). To psychotherapists who have data as well as personal experience of the effectiveness and humanity of their approaches, as well as an understanding of the traumatic background of many people with psychosis, biological treaters lack basic humanity, use methods that don't help people with psychosis rejoin society, and tend toward arrogance. With such undead applied philosophy of medicine stalking our houses of healing, small wonder the cultural media is obsessed with zombies and vampires.

The major thrust of the scientific literature is that psychosis arises from both biological and psychological and traumatic origins. We believe that the most effective treatment combines these approaches. In cases of "split treatment" between a psychotherapist and a prescribing psychiatrist, there needs to be good communication and a sense of being on the same team between the clinicians. In this panel, clinical data in the form of case presentations and popular narratives and memes, i.e., broken brain, irrational ideas, chemical imbalance...illustrating these ideas, will be presented.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Explain how biological approaches and psychological approaches to treatment of people who are psychotic should work together.
2. Discuss how split treatment with poor communication between the treaters can sabotage treatment.

3. Explain how achieving an effective therapeutic relationship, which is difficult in this patient population, is promoted in the context of a team approach among clinicians with different theoretical orientations.

Abramson, R. D. (2017). *The Trouble with Modern Psychiatry: A Basis in Science for the Subjective Mind*. Mauritius: Lambert Academic Publishing.

Eigen, M. (1993/2018). *The Psychotic Core*. New York, NY: Routledge.

Robbins, M. D. (2018) *Consciousness, Language, and Self : Psychoanalytic, Linguistic, and Anthropological Explorations of the Dual Nature of Mind*, 1st Edition, New York, NY: Routledge.

Sarah Carr, PhD, Ana Florence, PhD, Corrine Hendy

Introducing Peer Supported Open Dialogue in England and United States: Some Opportunities and Challenges

Introductory

This panel will describe two experiences of Open Dialogue and Peer Support combined: Open Dialogue Development and Evaluation of a Social Network Intervention for Severe Mental Illness (ODDESSI) in the UK; and the Parachute Program in New York City. ODESSI is the first national trial evaluating OD in English NHS mental health services. The introduction of Open Dialogue (OD) in the English National Health Service (NHS) has received considerable support from mental health service users, close persons and practitioners. The role of peer workers is also being developed in the NHS, presenting opportunities for integrating peer practitioners into OD teams. This is a variation on the OD approach as originally developed in Western Lapland, with the added value of peer practitioners who have had their own experience of mental distress and personal recovery, and of using mental health services. The Parachute Program was implemented in New York City through a three-year federal grant in 2012. The aim of the program was to provide services to persons experiencing a mental health crisis combining a dialogical approach with peer support. Four respite centers and four mobile crisis teams were trained in both Open Dialogue/Need Adapted Treatment and Intentional Peer Support. This presentation describes: 1) the results of a qualitative research project that investigated how the Parachute NYC program was implemented and some of the challenges it faced; and 2) the ODDESSI OD research trial and the emerging challenges and benefits of the peer practitioner role in OD teams. Sarah and Corrine are researchers in the ODDESSI trial and have both experienced mental distress and service use. They will describe the service user and close person involvement in the study and discuss the foundational development work with peer practitioners from each of the five trial sites.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Identify the key principles that characterize Peer Supported Open Dialogue.
2. Compare two different applications of Peer Supported Open Dialogue.
3. Discuss challenges and opportunities this approach offers to the treatment of mental health problems.

Razaque, R. and Stockman, T. (2016) 'An introduction to peer- supported open dialogue in mental healthcare.' *British Journal of Psychiatry Advances*, 22(5) 348-356.

Cubellis, L. (2018). Care wounds: Precarious vulnerability and the potential of exposure. *Culture, Medicine, and Psychiatry*, 42(3), 628-646.

Tomi Bergström, Birgitta Alakare, Jukka Aaltonen, Pirjo Mäki, Päivi Köngäs-Saviaro, Jyri J. Taskila & Jaakko Seikkula (2017) The long-term use of psychiatric services within the Open Dialogue treatment system after first-episode psychosis, *Psychosis*, 9:4, 310-321

Lane Chazdon, LCAT, MME, MT-BC

My Music, My Reality: Clinical Music Improvisation with Veterans with Chronic Psychosis

Introductory

Music is most plastic of the arts. It is made in the dimension of time and propagated invisibly through the air. Capable of expressing infinite nuances of thought and feeling through isomorphic relationships to thought, visual image and emotions (Langer, 1957); linked through memory to past experiences and relationships from virtually any phase of life; musical improvisation, even when limited to simple percussion instruments, is malleable and suited to reflect various aspects of one's thought process and emotional experience. While formal musical performance admits of "right" and "wrong" notes, durations, phrasing, etc., musical improvisation in a clinical setting has less need for performance-based expectations. As such it serves as a venue for unconditional acceptance. Relationship dynamics, as well as intrapersonal ones, find inevitable expression in the spontaneously created music. Music-based interventions have been found to significantly improve negative symptoms in chronic psychosis (Lutgens, Garipey & Malla, 2017).

In clinical settings for chronically mental ill individuals, for whom community residential settings have proven untenable, communication impairments, misinterpretation of social situations and communication of others, system demands and life stressors upon staff members easily create conditions of replicating mis-attunement in individuals' early experiences with primary relationships. Such mis-attunements have been found to be correlated significantly with development of psychosis (Brent and Fonagy, 2014). The proposed mechanism for such correlation is impaired mentalization and metacognition, "the ability to think about states of mind . . . in the self and other people" (p. 245).

The presenter will provide brief experiences in musical improvisation in use by the presenter in a chronic mental health setting that encourage such individuals to mobilize basic musical for self-expression and link with others in a manner that moves toward empowerment, building or reclaiming abandoned mentalization skills and the healing of isolation and renunciation of social realities (Davies, Richards and Barwick, 2015).

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Explain how music can represent emotional and cognitive aspects of one's experience.
2. Identify at least three parameters of clinical improvisation facilitation.
3. Describe a technique for fostering mentalization in a clinical improvisation framework with individuals with chronic schizophrenia.

Brent, B. K. & Fonagy, P. (2014). A Mentalization-based treatment approach to disturbances of social understanding in schizophrenia. In: *Social cognition and metacognition in schizophrenia: Psychopathology and treatment approaches*, chapter: 15, Publisher: Elsevier Science & Technology, Editors: Paul Lysaker, Giancarlo Dimaggio, Martin Brune, pp.245-259.

Davies, A., Richards, E & Barwick, N. (2015). *Group Music Therapy: A Group analytic approach*. New York: Routledge.

Langer, S. (1957). *Philosophy in a new key: A Study in the symbolism of reason, rite, and art*. Cambridge, MA: Harvard University Press.

Lutgens, D., Garipey, G. & Malla, A. (2017). Psychological and psychosocial interventions for negative symptoms in psychosis: Systematic review and meta-analysis. *British Journal of Psychiatry*, 210, 324-332., 245-259. Elsevier.

Davies, A., Richards, E & Barwick, N. (2015). *Group Music Therapy: A Group analytic approach*. New York: Routledge.

Langer, S. (1957). *Philosophy in a new key: A Study in the symbolism of reason, rite, and art*. Cambridge, MA: Harvard University Press.

Lutgens, D., Garipey, G. & Malla, A. (2017). Psychological and psychosocial interventions for negative symptoms in psychosis: Systematic review and meta-analysis. *British Journal of Psychiatry*, 210, 324-332.

John Thor Cornelius, MD

Two Perspectives on Psychosis

Intermediate

This presentation explores the balance between two general perspectives of psychosis. The 'mechanical perspective', in its current form, conceives of the mind as being almost exclusively influenced by the hardware of the brain and therefore conceives of psychosis as primarily the result of failed brain hardware such as neurotransmitter imbalances and abnormal brain structure caused by faulty genetics. The psychic perspective conceives of the mind as being primarily influenced by the software (or better, firmware) of human experience and therefore understands psychosis as primarily resulting from complicated, difficult or traumatic experiences, often occurring early in life. In the presentation I will explore both perspectives and propose that there is currently an imbalance between the perspectives that is not supported by a review of the evidence base, case history or reason. I propose that a re-balanced view of the two perspectives might allow further nuance and insight into conceptions of psychosis that could improve treatment and redirect future research efforts into more effective areas.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Distinguish the mechanical perspective of psychosis from the psychic perspective of psychosis.
2. List the arguments supporting the mechanical perspective of psychosis.
3. Discuss the nature of the controversy regarding the mechanical perspective of psychosis.
4. Describe the history and development of the psychic perspective of psychosis.
5. Summarize the evidence supporting psychic treatments for psychosis.
6. Analyze the deficits in the evidence supporting the psychic model of psychosis.

Bergström, T., Seikkula, J., Alakare, B., Mäki, P., Köngäs-Saviaro, P., Taskila, J. J., . . . Aaltonen, J. (2018). The family-oriented open dialogue approach in the treatment of first-episode psychosis: Nineteen-year outcomes. *Psychiatry Research*, 270, 168-175. doi:10.1016/j.psychres.2018.09.039

Colin A. Ross & Andrew W. Ross (2018): Misleading use of heritability estimates in schizophrenia genetics, *Psychosis*, DOI: 10.1080/17522439.2018.1545862

Ebrahim, S., Bance, S., Athale, A., Malachowski, C., & Ioannidis, J. P. (2016). Meta-analyses with industry involvement are massively published and report no caveats for antidepressants. *Journal of Clinical Epidemiology*, 70, 155-163. doi:10.1016/j.jclinepi.2015.08.021

Freeman, A. M., Tribe, R. H., Stott, J. C., & Pilling, S. (2019). Open Dialogue: A Review of the Evidence. *Psychiatric Services*, 70(1), 46-59. doi:10.1176/appi.ps.201800236

Gordon, C., Gidugu, V., Rogers, E. S., Deronck, J., & Ziedonis, D. (2016). Adapting Open Dialogue for Early-Onset Psychosis Into the U.S. Health Care Environment: A Feasibility Study. *Psychiatric Services*, 67(11), 1166-1168. doi:10.1176/appi.ps.201600271

Hilker, R., Helenius, D., Fagerlund, B., Skytthe, A., Christensen, K., Werge, T. M., . . . Glenthøj, B. (2018). Heritability of Schizophrenia and Schizophrenia Spectrum Based on the Nationwide Danish Twin Register. *Biological Psychiatry*, 83(6), 492-498. doi:10.1016/j.biopsych.2017.08.017

Johnson, E. C., Border, R., Melroy-Greif, W. E., Leeuw, C. A., Ehringer, M. A., & Keller, M. C. (2017). No Evidence That Schizophrenia Candidate Genes are More Associated with Schizophrenia than Noncandidate Genes. *Biological Psychiatry*, 82(10), 702-708. doi:10.1016/j.biopsych.2017.06.033

Lakeman R, (2014), The Finnish Open Dialogue approach to crisis intervention in psychosis: a review. *Psychotherapy in Australia* 20:28

Lieberman, J. A., & First, M. B. (2018). Psychotic Disorders. *New England Journal of Medicine*, 379(3), 270-280. doi:10.1056/nejmra1801490

Mancke, F., Schmitt, R., Winter, D., Niedtfeld, I., Herpertz, S. C., & Schmahl, C. (2017). Assessing the marks of change: how psychotherapy alters the brain structure in women with borderline personality disorder. *Journal of psychiatry & neuroscience : JPN*, 43(3), 171–181. doi:10.1503/jpn.170132

Mueser, K. T. (2019). Is More Rigorous Research on “Open Dialogue” a Priority? *Psychiatric Services*, 70(1), 1-1. doi:10.1176/appi.ps.70101

Nevels, R. M., Gontkovsky, S. T., & Williams, B. E. (2016). Paroxetine-The Antidepressant from Hell? Probably Not, But Caution Required. *Psychopharmacology bulletin*, 46(1), 77–104.

Osborne, J. (2019). Evaluating the suitability and effectiveness of the Open Dialogue model within an NHS Trust. <http://isrctn.com/>. doi:10.1186/isrctn36004039

Read, J., Fosse, R., Moskowitz, A., & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry*, 4(1), 65-79. doi:10.2217/npv.13.89

Mark Napoli Costa, MD, MPH & Anthony J. Pavlo, PhD

Building Strategies for Moving Care for People Diagnosed with Psychosis Towards Personal Recovery

Introductory

Over the past few decades, the emphasis of mental health services worldwide has shifted from a model of care that focuses on symptom reduction and stabilization to one that more fully embraces the concepts of recovery and citizenship. By “recovery” we refer not only to a remission of symptoms or a return to premorbid functioning (clinical recovery), but also to the process of finding purpose and meaning in life, regaining citizenship, and occupying valued social roles despite an enduring illness or disability (personal recovery). Providing people diagnosed with psychosis opportunities to choose care based on their individual values, preferences, needs, and goals is a critically important component of a person-centered, recovery-oriented system of care. Individuals in recovery who are supported in making informed choices about their care, acquire the knowledge and skills needed to build their own recoveries, and take responsibility for following an agreed-upon course of action are better equipped to maintain their recoveries. In so doing they can in time fully reclaim the rights accorded all citizens of the countries they inhabit and once again occupy valued social roles despite an enduring illness or disability (personal recovery). Providing people with opportunities to acquire or reclaim valued roles and restore relationships with loved ones are also important components of care delivery that is responsive to individual needs and desires. This is especially important for persons diagnosed with psychosis, as they are often denied the opportunity to design or choose a course of treatment.

This workshop offers an opportunity to discuss recovery-oriented care strategies such as shared decision making, person centered care planning, peer support, and the citizenship, engaging participants in a dynamic conversation about the best approaches for care and treatment, and planning a course of action that will help ensure the best possible standards of recovery-oriented, person-centered care.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Identify the differences between clinical recovery and personal recovery.
2. Describe 3 characteristics of personal recovery.
3. Describe 3 characteristics of a recovery-oriented system of care.

Davidson, L., Tondora, J., Pavlo, A. J., & Stanhope, V. (2017). Shared decision making within the context of recovery-oriented care. *Mental Health Review Journal*, 22(3), 179-190.

Davidson, L. (2016). The recovery movement: Implications for mental health care and enabling people to participate fully in life. *Health Affairs*, 35(6), 1091-1097.

Jones, N., Rosen, C., Helm, S., O'Neill, S., Davidson, L., & Shattell, M. (2019). Psychosis in public mental health: Provider perspectives on clinical relationships and barriers to the improvement of services. *American Journal of Orthopsychiatry*, 89(1), 95.

Davidson, L. (2019). Recovering a Sense of Self in Schizophrenia. *Journal of personality*.

Pavlo, A. J., Flanagan, E. H., Leitner, L. M., & Davidson, L. (2018). Can there be a recovery-oriented diagnostic practice?. *Journal of Humanistic Psychology*, 0022167818787609.

Costa, M., Baker, M., Davidson, L., Giard, J., Guillorn, L., Ibáñez, A. G., ... & O'Connell, M. (2017). Provider perspectives on employment for people with serious mental illness. *International Journal of Social Psychiatry*, 63(7), 632-640.

Larry Davidson, PhD

Honoree Address: *Recovering the Self in Psychosis*

Introductory

Diverse theoretical orientations on psychopathology, including most recently phenomenological and neuroscientific approaches, consistently have viewed a core component of psychosis to be the loss, or distortion, of a person's sense of self as an effective agent in a shared, social world. How such a sense of self becomes lost or distorted, and the questions of whether or not, and if so, how it can be recovered have received considerably less attention. These questions are taken up in this lecture. Based on a career's worth of longitudinal and qualitative research, and enhanced by a growing trove of recovery narratives, this presentation focuses on the recovery of a sense of self as an effective social agent as core to the overall process of recovery in psychosis. Processes of reconstructing a sense of self begin with acceptance and an instillation of hope, which together provide a foundation for rediscovering one's efficacy in seemingly small but concrete ways, that then are incorporated into a sense of social identity as a worthwhile member of one's community. Finally, the implications of such an understanding for developing recovery-oriented practices are considered.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Explain the central role of the sense of self in recovery in psychosis.
2. Describe component processes of the restoration of a sense of self as an effective social agent.
3. Identify the implications of this understanding of recovery for the development of recovery-oriented practices.

Davidson, L.: After the asylum: A Basaglian-informed vision of recovery-oriented care. *Brazilian Journal of Mental Health*, 2017, 9(21): 128-139.

Davidson, L.: The Recovery Movement: Implications for mental health care and enabling people to participate fully in life. *Health Affairs*, 2016, 35(6): 1091-1097.

Tondora, J.; Miller, R.; Slade, M.; & Davidson, L.: Partnering for recovery in mental health. A practical guide to person-centered planning. London: Wiley Blackwell, 2014.

Ellen Dean, LCSW, Beth Broussard, MPH, CHES, Robert Cotes, MD, Lisa Spears, LPC, Angie S. Williams, CPS-P

Simpatico: Embracing Eclecticism and Polyphony in Georgia's Coordinated Specialty Care Programs for Early Psychosis

Intermediate

Recognizing that there are many paths to healing, Georgia's statewide initiative for recovery-oriented care for young adults with psychosis has welcomed a wide variety of approaches that resonate with the people our teams encounter, and with the practitioners on our teams. Largely informed by the Coordinated Specialty Care (CSC) model of OnTrackNY, Georgia's LIGHT-ETP (Listening, Inspiring, Guiding Healthy Transitions-Early Treatment Program) also acknowledges the strengths of the NAVIGATE model, Oregon's EASA program, as well as the many first-episode psychosis programs and other innovative psychosocial approaches from around the world. Georgia's LIGHT-ETP employs full-time peer support specialists on all of our teams, and has included the parents of young people who have faced challenges in a specialized role, called Certified Peer Specialist - Parents. Additionally, we have incorporated Hearing Voices Network groups, animal-assisted therapy, recovery through the arts, and consultation with an expert in Cognitive Behavioral Therapy for Psychosis and Psychoanalysis. Most recently, our team at Grady Health System is combining CSC with Open Dialogue. With so many various perspectives, how can CSC teams integrate all of these ideas into a coherent framework? In this presentation we will introduce and define the term "polyphony," which refers to a multiplicity of voices within a network. We will then extend the term to reference the multiple interventions with different philosophical orientations within CSC teams, and the different voices they speak from: "systemic polyphony." We will discuss lessons learned from how these perspectives, which at times may be divergent, and at times may be harmonious, can co-exist. In this discussion, we encourage the sharing of reflections, ideas, and opportunities for embracing an even wider worldview.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe how innovative psychosocial approaches can be adapted into a coordinated specialty care team for people experiencing psychosis for the first time.
2. Define the term polyphony.
3. Discuss the practical implications of how multiple perspectives can be incorporated into a team-based approach like coordinated specialty care.

Freeman, A. M., Tribe, R. H., Stott, J. C. H., & Pilling, S. (2018). Open Dialogue: A Review of the Evidence. *Psychiatr Serv*, appips201800236. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/30332925>. doi:10.1176/appi.ps.201800236

Gordon, C., Gidugu, V., Rogers, E. S., DeRonck, J., & Ziedonis, D. (2016). Adapting Open Dialogue for Early-Onset Psychosis Into the U.S. Health Care Environment: A Feasibility Study. *Psychiatr Serv*, 67(11), 1166-1168. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/27417900>. doi:10.1176/appi.ps.201600271

Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., . . . Heinssen, R. K. (2016). Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. *Am J Psychiatry*, 173(4), 362-372. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/26481174>. doi:10.1176/appi.ajp.2015.15050632

Nossel, I., Wall, M. M., Scodes, J., Marino, L. A., Zilkha, S., Bello, I., . . . Dixon, L. (2018). Results of a Coordinated Specialty Care Program for Early Psychosis and Predictors of Outcomes. *Psychiatr Serv*, 69(8), 863-870. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/29759055>. doi:10.1176/appi.ps.201700436

Barbara A. Deck, PhD, MBA

Identity, Belonging and Social Identity: Beyond Psychosis

Introductory

Fifty years ago, Yasin Balbaky, a Syrian-born psychiatrist, developed a unique approach to the treatment of individuals with schizophrenia and schizoaffective disorders. Dr. Balbaky noted that many of his clients struggled with a sense of identity and belonging. In the classic contexts of social identity – family, community and mental health settings, his clients were first identified and defined by their psychosis. Those aspects of identity, physical appearance, emotional make up, values, physio-chemical genetics, capacities and talents were submerged beneath an all-consuming mental health diagnosis. Dr. Balbaky's response was to create EIKOS, a residential community available to his clients and others where individuals were first members of a social, therapeutic community where their individual identity characteristics became the basis for community integration. This presentation will chronicle the evolution of the EIKOS approach to therapeutic community with a focus on three case studies of residents who have successfully moved beyond their psychosis identity to a sense of belonging both internal and external to EIKOS.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Identify specific therapeutic program components that contribute to individual and social identity community belonging.
2. Discuss the impact of a non-clinical therapeutic community on the emphasis non-psychotic identity connection in a community environment.
3. Discuss the importance of creating a "home-like" community setting in the development of a sense of safety and belonging for residents.

Seeman, M. (2017) "Identity and schizophrenia: Who do I want to be?" in *World J Psychiatry* 2017 March 22. Doi 10.5498/wip.v7.11.1

Newlin, M., Webber, M., Morris, D., Howarth, S. (2015) "Social Participation Interventions for Adults with Mental Health Problems: A Review and Narrative Synthesis". *Social Work Research*, Volume 39, Issue 3, September 2015, Pages 167–180.

Wang, E. (2019) *The Collected Schizophrenias*. Graywolf Press, Minneapolis, Minnesota.

Loren Dent, PhD, Jay Crosby, PhD, Jessie Roth, Jazmine Russell, NYCPs

Psychosis, Narrative and Neoliberalism: A Conversation

Introductory

The past 10 years has witnessed an exponential growth of new treatment and rehabilitation models for psychosis and severe mental illness in the United States. These paradigms have included state and federally-funded psychosocial interventions such as coordinated specialty care, need-adapted care and intensive occupational training and support. While such models are undoubtedly shifting the focus of care from hospitals to the community, there is also an increasing emphasis on rehabilitation, skills acquisition and psychosocial adaptation.

This panel will aim to generate a critical conversation between clinicians, activists, family members and those with lived experience of psychosis surrounding emerging neoliberal paradigms of care. Specifically, the panel participants will present a critical history of these emerging approaches, including their relationship to shifting social norms and economic expectations. Panel participants will discuss this history as it pertains to the gradual marginalization of the role of speech and narrative in understanding, connecting to and caring for persons experiencing psychosis. The central importance of narrative and expressive psychotherapy will be explored both theoretically and through shared experience of participants, as well as the contributions of storytelling, narration and other forms of expression.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Reflect on the relationship between neoliberalism and psychosocial interventions for psychosis.
2. Explain the role of narrative and expressive psychotherapy in facilitating care and healing for persons experiencing psychosis.
3. Describe the importance of multiple perspectives on caring for psychosis, including but not limited to family members, peer support and clinical care.

Hasson-Ohayon, I., Kravetz, S., & Lysaker, P. H. (2017). The special challenges of psychotherapy with persons with psychosis: Intersubjective metacognitive model of agreement and shared meaning. *Clinical psychology & psychotherapy*, 24(2), 428-440.

Lysaker, P. H., Hamm, J. A., Leonhardt, B. L., & Lysaker, J. T. (2018). 7 Disturbances in the dialogical self in psychosis. *Handbook of Dialogical Self Theory and Psychotherapy: Bridging Psychotherapeutic and Cultural Traditions*.

McWade, B. (2016). Recovery-as-policy as a form of neoliberal state making. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice*, 5(3), 62-81.

Eric Friedland-Kays, MA & Jeremy Andersen, LMHC

Cultivating a Welcoming Presence

Introductory

Every citizen or member of a society needs to feel that they truly belong. A deep sense of belonging is hard to come by, or even seemingly impossible, when one is consistently feeling ostracized. This difficulty is familiar to marginalized groups, including people with lived experience of extreme states associated with psychosis. In order to continually work toward a more welcoming and inclusive society, those of us who do not ordinarily feel so marginalized have a responsibility to recognize and work with our biases, both implicit and explicit. Ways to do this may include 1) cultivating greater awareness of our deep-seated sense of “other,” 2) our fear-based internal reactions and impulses, and 3) a habitual tendency to be blinded by our assumptions, stereotypes, and fixed beliefs. By honestly attending to a wider spectrum of our experience in this way, and by regulating strong emotions that may get evoked or provoked, we become better able to relate to our inner selves as well as others with clarity, openness, and warmth—as more welcoming fellow citizens.

This presentation will explore 1) ways our culture and habits shape our sense of relative safety and danger in relation to others; 2) how this sense of safety vs. danger affects us through its impact on our nervous system; and 3) ways we can cultivate greater awareness of how and when we are responding to a sense of threat, thereby enabling us to be more present, emotionally regulated, and safe to be around. We intend to use both didactic and experiential means as we draw upon Buddhist psychology, social psychology, and polyvagal theory.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe the concept of “neuroception”.
2. Identify the three states of the human nervous system associated with Polyvagal Theory.
3. Identify and utilize three skills for self-regulating their nervous systems.

The Polyvagal Theory in Therapy: Engaging the Rhythm of Regulation. Deb Dana. 2018. Norton Series.

"That's How the Light Gets In." (Article). Charles Knapp. 2018. *Journal of Humanistic Psychology*.

"Therapeutic Presence: Neurophysiological Mechanisms Mediating Feeling Safe in Therapeutic Relationships." (Article in *Journal of Psychotherapy Integration*). 2014. Shari Geller and Stephen Porges.

Making the World Safe for our Children: Down-regulation Defense and Up-regulation Social Engagement to 'Optimize' the Human Experience. (Article) Stephen Porges. 2015.

James E. Gorney, PhD

Engaging Stigma: Tourette's Syndrome as Paradigm

Intermediate

The Oxford English Dictionary defines stigma as “a mark made upon the skin by burning with a hot iron, as a token of infamy or subjection, a brand...a mark of disgrace or infamy; a sign of severe censure or condemnation”. Individuals who manifest lived psychotic experience have become objects of this very model of stigmatization and persecution since the dawn of history. Despite encouraging efforts toward empowerment provided by such groups as The Hearing Voices Network and, the Coming Out Proud movement, those with psychotic experience are still predominately “reduced in our minds from a whole and usual person to a tainted, discounted one ... not quite human” (Goffman, Stigma, 1963).

This presentation will engage the process of stigmatization, as well as effective strategies to escape its tenacious grip, by regarding Tourette's Syndrome (TS) as a parallel paradigmatic problematic lived experience. TS is a neurobiological disorder, usually first manifest in childhood, characterized by physical and/or verbal tics, motoric rituals, mannerisms, explosive sounds, cursing and repetitive behaviors. No two TS individuals display the same pattern of troublesome symptoms, ranging from mild to severe. The personally and socially disruptive behaviors of TS are not willful; they are insistent and compelling. Most notably, the lived experience of TS is publicly visible and usually regarded by others as strange, bizarre, and freakish. Throughout history, the TS individual, paralleling the psychotic, has been regarded as sub-human, perhaps being possessed by the devil.

The stigmatization process, and heroic efforts to triumph over it, will be illustrated via the TS protagonist of Jonathan Lethem's novel *Motherless Brooklyn*, as well as accounts of several thriving TS individuals. The empowerment strategies employed individually, socially, and organizationally, by the contemporary TS community will be examined in regard to their direct relevance for those with psychotic lived experience.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Explain the means whereby society constructs stigma and the stigmatizing process.
2. Identify the unique pattern of stigmatization associated with Tourette's Syndrome.
3. Integrate empowerment strategies employed by those with Tourette's Syndrome as relevant for those with lived psychotic experience.

Barber, L. (2016). *An Unlikely Strength: Tourette's Syndrome and the Search for Happiness in 60 Voices*. SQ Press: Seattle.

Corrigan, P.W., Michaels, P., Vega, E. (2015). “Diminishing the Self-Stigma of Mental Illness by Coming Out Proud”. *Psychiatry Research*, 229: 148-54.

Major, B., Dovidio, J., Link, B. (2018). *The Oxford Handbook of Stigma, Discrimination, and Health*. Oxford University Press: New York.

Novotny, M., Valis, M., Klimova, B., “Tourette's Syndrome: A Mini-Review”. *Frontiers in Neurology*, 9, 139-149.

Whitley, R., Campell, R. (2014). “Stigma, Agency and Recovery Amongst Those with Severe Mental Illness”. *Social Science and Medicine*, 107: 1-8.

Jillian Graves, PhD, LMSW & Christina Marsack-Topolewski, PhD, LMSW

A Developmental Approach to Crisis Management and Caregiving of People with Psychosis and their Families

Introductory

For all families, developmental changes require greater family flexibility and acceptance of changing roles and relationships. Normative changes, such as those associated with adolescent development, can precipitate significant family stress. For those families who are also facing the challenges of an emerging serious mental illness such as psychosis, normative developmental stressors can be exacerbated. Changes in family dynamics due to individual and familial development, for example when a child becomes a young adult and expects to have more autonomy, can create significant friction. It becomes further complicated when a family member with psychosis is symptomatic and in crisis and similarly struggles with both their own expectations and their family's expectations that they become more autonomous. Families may have difficulty knowing how to respond for many reasons including stigma associated with a family member's diagnosis (e.g. psychosis), stigma and shame associated with family violence, a lack of services, fears of law enforcement, protective and interpersonal factors in the family and a lack of understanding for the changing developmental needs of their family member. Families of people with psychosis are already often very flexible in caretaking by adjusting to the needs of the system. However, what has been less studied are the ways that development can intersect with family needs, requiring families to continually adapt to the needs of the system and the developmental needs of each family member.

This presentation seeks to take a developmental approach to supporting families who are caretakers of people with psychosis, especially in in periods of crisis and developmental transition. We use current literature and a qualitative data set to illustrate specifically how emerging adult identity development influences individual and family functioning. We also examine ways that families cope during other critical developmental periods (such as when parents become older and are less able to be caretakers). We examine these experiences through a multidimensional framework that includes neuropsychiatric, cognitive and physical development as well as through the lens of the family life cycle. We discuss how this framework enables mental health care providers to better support individuals and families as they continuously confront new realities. In addition, we will discuss the subset of families of people with schizophrenia \ who experience interpersonal violence. We hope to better understand the resources and vulnerabilities of families both from individualistic and systems perspectives to better understand the need to formulate coping and crisis management strategies that are flexible in response to developmental needs.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Identify the ways that personal and familial development influence caretaking relationships.
2. Analyze and formulate ways that social workers and other mental health providers can facilitate developmentally sensitive interventions.
3. Recommend developmentally sensitive interventions to crises related to schizophrenia.

Bishop, M., & Greeff, A. P. (2015). Resilience in families in which a member has been diagnosed with schizophrenia: Resilience in families with schizophrenia. *Journal of Psychiatric and Mental Health Nursing*, 22(7), 463-471. doi:10.1111/jpm.12230

Muralidharan, A., Lucksted, A., Medoff, D., Fang, L. J., & Dixon, L. (2016). Stigma: A unique source of distress for family members of individuals with mental illness. *The Journal of Behavioral Health Services & Research*, 43(3), 484-493. doi:10.1007/s11414-014-9437-4

Sharon, T. (2016). Constructing adulthood: Markers of adulthood and well-being among emerging adults. *Emerging Adulthood*, 4(3), 161-167. doi:10.1177/2167696815579826

Young, L., Murata, L., McPherson, C., Jacob, J. D., & Vandyk, A. D. (2019). Exploring the

experiences of parent caregivers of adult children with schizophrenia: A systematic review. *Archives of Psychiatric Nursing*, 33(1), 93-103. doi:10.1016/j.apnu.2018.08.005

Marty Cindy Hadge, IPS

Keynote Address: *Living in the Margins and the Struggle to Reclaim Citizenship*

Introductory

When resources are lacking, basic needs go unmet, rights are ignored, relationships betrayed, and valued roles hover out of reach, how does one adapt? Some individuals reach a point in their lives when they can no longer bear what they have experienced, and in their struggle to make sense of the senseless, become lost. This happens when individuals are told to believe in a reality that does not match what their hearts, minds, and bodies know to be true. Some may call that phenomenon "psychosis." Others may say it is a spiritual experience, an existential crisis, or blame governmental forces or aliens. Research has shown that this can be a necessary and protective response to trauma. But the effect on the individual, whose only certainty is that impending doom will be their companion in a hostile world, is devastating. In their efforts to find a path upon which some piece of themselves can survive, the individual's identity may be shattered or contorted. When they seek help, instead of finding care for and understanding of their own true selves, they are placed in a box; their identities stolen by diagnosis.

This workshop will provide mental health professionals with insight into the lives and minds of people who have lived on the margins and suggest tools for creating spaces where they can make meaning, reclaim their sense of self, and build a life they want to live. When love breaks through the fear, people who have become alienated from themselves can, with support, develop a sense of personal value, dare to trust, and find hope. They can learn to withstand bearing the truth of trauma, and the injustices of the world. In those moments, they may find the strength to own their broken parts and discarded selves. When shame and guilt are left by the way, people can heal, and new ways of navigating their outer and their inner worlds can develop.

Based on current research, and speaking from direct personal experience as well as learning gained through supporting others, this talk will address marginalization and ways of reclaiming citizenship. Such approaches as somatic healing, Maastricht Interview, and exploring the social supports that foster recovery will be illustrated.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Identify two ways in which marginalization can be a part of the context of a person's experience labeled as psychosis.
2. Name two characteristics of healing relationships: the knowledge that we are not alone in our experiences, and the value of acceptance, understanding, and support from like-minded others.
3. Name two ways in which mental health services can reduce the further marginalization of people receiving services.

Rowe M. *Citizenship and mental health*. NY: Oxford University Press, 2015.

Levine Ph.D., Peter A. and van der Kolk M.D., Bessel A. *Trauma and Memory: Brain and Body in a Search for the Living Past: A Practical Guide for Understanding and Working with Traumatic Memory* Oct 27, 2015.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.

Annie Harper, PhD

Financial Health and Mental Health: Making the Connection

Introductory

The presentation will address the connection between mental illness and poverty, focusing in particular on money management and access to financial services. People with mental illness are much more likely than those without to live in poverty, which can worsen symptoms, present barriers to recovery, and negatively affect quality of life. One aspect of poverty about which we know too little is access to financial services for effective financial management. People who are poor are much more likely than people who are not poor to lack access to banking services, relying instead on costly non-bank services such as check cashers and bill pay establishments. When they do have bank accounts, they are more likely to pay high fees. People with cognitive disabilities are even more likely than others to lack access to banking services. Other than the high fees, bank accounts lack features to help people control their spending and save money, and do not support shared decision making arrangements. People who are poor, including people with mental illness, are also more likely than others to be burdened by unmanageable debt. There is a strong, proven association between unmanaged debt and stress. We have few mechanisms in place to support people with mental illness around issues of poverty, including helping people make the best use of the income they have available to them, and avoid and manage debt. Current support focuses on removing financial control from individuals, or at best providing financial literacy training. Both can be helpful, but until the financial services system improves what it offers, people will continue to struggle. Dr. Harper will present results from her research on these issues and will provide suggestions for ways that clinicians can better support clients who have financial problems including regarding banking and debt.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe the extent to which people with mental illness live in poverty and lack access to good financial services.
2. Explain how lack of access to good financial services has a negative impact on the lives of people with mental illness.
3. List strategies, tools and products which can help people with mental illness manage their finances more effectively and with greater autonomy.

Harper, A. Staeheli, M., Edwards, D., Herring, Y. and M. Baker. Disabled, Poor, and Poorly Served: Access to and Use of Financial Services by People with Serious Mental Illness. *Social Service Review*, 2018, 92(2), p202-240.

Farr, B., Cash, B and Harper, A. (2019). Banking for All: Why Financial Institutions Need to Offer Supportive Banking Features. Yale Law School/Yale Department of Psychiatry.

Harper, A. (2018). Financial Management Support for SSA Beneficiaries: Looking Beyond the Payee. Working Paper 20185. Chestnut Hill, MA: Center for Retirement Research, Boston College.

Gail Hornstein, PhD

The Power of Hearing Voices Peer-Support Groups: Screening and Discussion of a New Film

Introductory

Hearing voices peer-support groups are transforming the lives of people all over the world, enabling them to understand and cope with experiences that have long confused and frightened them. Many have spent years in the psychiatric system, yet continue to struggle with extreme states or anomalous thoughts, perceptions, or feelings. Often labeled “chronic” or “treatment-resistant” patients, they can become increasingly isolated from others and estranged from themselves. Hearing voices groups offer a crucial alternative, allowing the transformational power of relationship to foster a deeper understanding of mental life, both in themselves and in other people.

By creating a non-judgmental and non-hierarchical space for members to share experiences and

learn from one another's coping strategies, these groups can enable radical change, even among people who have been distressed for many years. Some stop hearing voices entirely, once they understand the symbolic significance the voices have been serving (e.g., preserving a memory of trauma that has yet to be worked through). Others learn to accept and "live with voices" in ways that allow them to regain more control over their lives.

As part of a larger training and research project expanding the Hearing Voices approach in the US (supported by the Foundation for Excellence in Mental Health Care), we have created a 20-minute film documenting the power and effectiveness of these groups. A diverse range of voice hearers describe how these peer-support groups differ from the clinical groups mental health professionals are most familiar with. The film's creative team includes voice hearers, researchers, and other advocates for a broader range of options for people diagnosed with psychosis. This first screening and discussion at a national mental health conference will highlight the distinctive contributions of the Hearing Voices approach and seek to deepen the dialogue between practitioners and those with lived experience.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe key features of the Hearing Voices approach and the mechanisms by which hearing voices peer-support groups work.
2. Identify benefits of rooting clinical practice in first-hand experiences of voice hearers.
3. Identify similarities and differences between psychotherapy and hearing voices peer-support groups as means to reduce distress among voice hearers.

Longden, E., Read, J. & Dillon, J. (2018). Assessing the impact and effectiveness of hearing voices network self-help groups. *Community Mental Health Journal*, 54 (2): 184-88.

Hornstein, G.A. (2017). *Agnes's jacket: A psychologist's search for the meanings of madness.*, revised paperback edition, New York: Routledge.

Dillon, J. and Hornstein, G.A. (2014). Hearing voices peer support groups: A powerful alternative for people in distress. *Psychosis*, 5, 286-295.

Gerald Jordan, PhD

Positive Change Following a First Episode of Psychosis: A Citizenship Perspective

Introductory

A first episode of psychosis (FEP) is often a traumatic experience associated with great suffering. However, FEP may also lead to positive change. While positive changes have been reported following other experiences (e.g., war), little research has investigated positive changes following FEP. To address this knowledge gap, I will address two research questions: 1) What are the positive changes persons experience following FEP, and 2) What factors or processes facilitate such changes?

Methods: These research questions were addressed using a mixed methods convergent design, whereby participants completed a quantitative (n = 94) and qualitative component (n = 12). In the quantitative component, participants completed validated questionnaires assessing positive change and predictors of positive change. In the qualitative component, participants partook in semi-structured interviews assessing why they felt they came to receive services at an early intervention service; how they felt they changed following their experience; and what they perceive facilitated such change. Quantitative data were analyzed using multiple regression, and qualitative data were analyzed using thematic analysis.

Results: Following the FEP, participants experienced positive changes at the individual level (e.g., developing a stronger sense of self), interpersonal level (e.g., improving relationships with others) and spiritual/religious level (e.g., experiencing greater spirituality). These changes were facilitated by factors and processes at the personal level (e.g., coping, self-determination), relational or social level

(e.g., social support), contextual level (e.g., through receiving mental health services), as well as by processes unrelated to FEP (e.g., normative developmental experiences). Discussion: These findings will be discussed through a citizenship lens: I will discuss the broader contextual factors that may promote or hinder the experience of positive change (e.g., the availability of free healthcare; neoliberal economic systems fostering individualism; having one's right to live a self-determined life taken away, etc.).

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Explain that positive change is possible following a first episode of psychosis.
2. List the factors and processes that may facilitate positive change following a first episode of psychosis.
3. Describe the role of citizenship within the context of positive change following a first episode of psychosis.

Jordan G, MacDonald K, Pope M, Schorr E, Malla A, Iyer SN. (2018). Positive changes experienced following a first episode of psychosis: a systematic review. *Psychiatric Services*. DOI: 10.1176/appi.ps.201600586

Jordan G, Malla A, Iyer SN. (2016). Posttraumatic growth following a first episode of psychosis: A mixed methods research protocol using a convergent design. *BMC Psychiatry*. DOI:10.1186/s12888-016-0977-4

Jordan G, Pope M, Lambrou A, Malla A, Iyer SN. (2016). Post-traumatic growth following a first episode of psychosis: a scoping review. *Early Intervention in Psychiatry*. DOI:10.1111/eip.12349

Barbara Jean Kocsis, MD & Charlotte Jevons, PsyD

Psychoanalysis, Psychosis, and Hearing All Voices: A Case for Truly Listening
Intermediate

In our healthcare system and wider society, individuals who experience psychosis or extreme states are often isolated, excluded, or otherwise made invisible. This harmful state of affairs is maintained through complex, systematic ways of silencing these individuals and denying them the humanizing experience of attentive listening. One way this occurs is through the perpetuation of a myth in our healthcare system that individuals experiencing psychosis or extreme states don't benefit from psychotherapy. Our talk will begin with examining and countering this harmful myth by providing both historical context and current evidence for the effective use of psychoanalytic psychotherapy in the treatment of people with lived experience. We then intend to closely focus on the complex, multifaceted process of listening as it is effectively employed in psychotherapy for those experiencing psychosis and extreme states. Our talk will include a detailed examination of specific modes of listening illustrated through case examples. We will conclude with a discussion around the need to dismantle the imposed and harmful exclusion of individuals experiencing psychosis or extreme states from our society, and the incorporation of psychoanalytic psychotherapy as one crucial means of addressing this challenge.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Identify ways that relational psychodynamic psychotherapy is an effective treatment for psychosis and how it also directly addresses the invisibility and marginalization suffered by people with lived experience.
2. Describe different approaches to listening to communications from individuals experiencing psychosis or extreme states.
3. Explain why there is a need to dismantle the multifaceted, imposed, and harmful marginalization and exclusion of individuals experiencing psychosis or extreme states.

Civitaresse, G. (2015). Transformations in Hallucinosis and the Receptivity of the Analyst. *Int. J.*

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Haram, K. Jonsbu, E., Fosse, R., Skarderud, F., & Hole, T. (2018). Psychotherapy in schizophrenia: a retrospective controlled study. *Psychosis*,10(2), 110-121.

Karon, B., P. (2003). The tragedy of schizophrenia without psychotherapy. *The American Academy of Psychoanalysis and Dynamic Psychiatry*, 31(1), 89-118.

Marlow, N., I. (2015). Open Dialogue with R.D. Laing. *Psychosis*, 7(3), 272-275.
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Silver, A.S. (2013). Psychoanalytically Informed Treatment of Psychosis: Reflections on Its U.S. History and Current Dilemmas. *The Psychoanalytic Review*,100(2), 311-335.
doi:10.1521/prev.2013.100.2.311

Brian Koehler, PhD

Loneliness, Social Connection and "Madness"

Introductory

If you want to go fast, go alone. If you want to go far, go together.

I am sick in my sister, in my brother.

African Proverbs

In 1985, when researchers asked a cross-section of the American people, "How many confidants do you have?" the most common response to the question was three. In 2004, less than 20 years since the survey in 1985, when researchers asked again, the most common response, made by 25% of the respondents, was none. Twenty five percent of these Americans said they had no one at all with whom to talk openly and intimately. What would the result be today 15 years later?

We are a country that devalues interdependence and admires rugged independence. "Independence," the biologist Lynn Margulis reminds us, "is a political, not a scientific term" (Cacioppo & Partick, 2008).

In this paper, we will look at the subjects of loneliness, social exclusion and social connection across various relevant perspectives: social and affective neuroscience, developmental traumatology, epidemiology, psychological-psychodynamic, subjective-phenomenological and sociocultural-sociopolitical factors. We will look at the links between loneliness, trauma and social exclusion and "madness," including a transgenerational perspective.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Summarize the latest research on subjectively experienced loneliness in the USA.
2. Discuss the latest research on the links between social exclusion and "madness".
3. Summarize the recent research on the neurobiological and immunological effects of profound loneliness

Psychiatry Research 255 (2017) 209–214 "With a little help from my friends" social predictors of clinical recovery in first-episode psychosis. Jone Bjornestada, Wenche ten Velden Hegelstada, Inge Joaa,b, Larry Davidsonc, Tor Ketil Larsend, Ingrid Mellee, Marius Vesethf, Jan Olav Johannessena,b, Kolbjorn Bronnicka,b.

Social Justice Campaign for Persons with Psychiatric Issues

World Psychiatric Association

BILL OF RIGHTS FOR PERSONS WITH MENTAL ILLNESS (2017)

http://docs.wixstatic.com/ugd/e172f3_1ab8e92cff3f4efe979de5b5ea56f46e.pdf

Tobias, M. (2017). Social rank: a risk factor whose time has come? *The Lancet*:389 (10075), pp. 1172-1174.

Loneliness: Human Nature and the Need for Social Connection
by John T. Cacioppo and William Patrick 2008.

The Descent of Madness: Evolutionary Origins of Psychosis and the Social Brain 1st Edition
by Jonathan Burns 2007

Casadi “Khaki” Marino, PhD, LCSW, Berta Britz, MSW, CPS, Jim Probert, PhD

Experts by Experience Panel: Journeys of Alienation and Belonging

Intermediate

Individuals with lived experience of extreme states of consciousness have all too often been in the community without being full members of the community. They may exist in the social world but are not seen as contributors to its creation. The mental health consumer/ madness communities have stressed the individual's rights to inclusion in community life and self-determination regardless of disability status. Full citizenship is held as foundational for recovery rather than as a goal or end state of recovery. Citizenship is viewed as a framework for the social inclusion and participation of people with lived experience of extreme states. The social recovery stance envisions a life in the community for everyone and asserts that approaches are needed for helping people achieve meaningful participation, reciprocal relationships, and valued social roles. It is necessary to pay attention to the material, cultural, political, and economic environments that facilitate or create barriers to citizenship. Senses of community and belonging have long been held as basic human needs. Social inclusion is subjective and complex. Belonging can be defined as experiencing acceptance and interpersonal connection. Some individuals with lived experience have felt like outsiders beginning very early in life with little sense of having a place or being part of the world. They have known alienation and embodied the stranger. The expertise of individuals with lived experience is essential for the theorizing and knowledge production needed for system transformation and societal reform. This plenary will include personal testimonies of recovery journeys. There will be time for questions from the audience.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Distinguish between social recovery and citizenship.
2. Identify necessary elements of social inclusion.
3. Describe two facilitators of recovery.

Blank, A., Finlay, L., Prior, S. (2016). The lived experience of people with mental health and substance misuse problems: Dimensions of belonging. *British Journal of Occupational Therapy*, 79 (7), 434-441.

Kalathil, J. & Faulkner, A. (2015). Racialisation and knowledge production: A critique of the report *Understanding Psychosis and Schizophrenia*. *Mental Health Today*, Jan -Feb, 22-23.

Rowe, M. & Davidson, L. (2016). Recovering Citizenship. *Israel Journal of Psychiatry and Related Sciences*, 53 (1), 14-21.

Judy E. Murray, RN

When Spiritual and Existential Crisis Presents as “Psychosis”

Introductory

This is the personal story of my family's struggles as we attempted to navigate a faulty mental health system. My son Dan died by suicide after leaving the psychiatric hospital where he lost any hope of regaining his identity. He had been replaced with labels given to him by strangers objectively deciding who “Dan” really was.

Dan has been guiding and teaching me from the other side and is the driving force behind my voice. This is my redemption as I fight in his name to deliver a better understanding of folks who experience unusual perceptions outside of our five senses.

I will take you on a journey through Dan's life with his unconditional love and exceptional insights. I will share my vivid memories of Dan's lived experiences as he struggled through a spiritual crisis entering deeper and deeper into what we call a "world of madness".

The destiny of those exhibiting unusual symptoms related to environmental risk factors such as abuse, poverty, oppression or a spiritual event/crisis does not have to end in tragedy but alternatively transform into healing and growth.

Letting go of our "fear" and judgment for those who are different allows us to create a safe mutual space with acceptance and connection. This humanistic approach helps one to reclaim their identity creating hope for the future....

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Identify 3 triggers for spiritual/or existential crisis.
2. Identify three positive approaches to their experiences of voices, visions and other different perceptions.
3. Identify significant outcomes of a Spiritual awakening/or crisis.

Spiritual Science, Steve Taylor 2018

Kevin O. St. Arnaud & Damien C. Cormier (2017). Psychosis or Spiritual Emergency: The Potential of Developmental Psychopathology for Differential Diagnosis. *International Journal of Transpersonal Studies*. Volume 36 | Issue 2 Article 6. 9-1-2017
<https://pdfs.semanticscholar.org/b614/6d3e67070471618828bf28f7536f5b039b9a.pdf>

Spiritual Awakening Process, Mateo Sol; Psychospiritual Teacher, 2016

Jim Probert, PhD

Challenges and Opportunities Cultivating Rights-Based Resources for "Extreme" States within Universities and Other Mainstream Organizations

Introductory

In 2010, NPR called Judi Chamberlin a "civil rights hero from a civil rights movement you may have never heard of." In 2017, the UN Human Rights Council called for a "revolution" in mental health care—to "enable a long overdue shift to a rights-based approach." As the UN Special Rapporteur wrote, "We need bold political commitments, urgent policy responses and immediate remedial action."

The University of Florida Counseling and Wellness Center has established its own human rights emphasis. Availability of peer support alternatives and professional training in rights-based, trauma-informed suicide prevention and mental health recovery have been highlighted as the two "critical indicators" of movement toward compliance named in the UN report.

Our peer support groups include Intentional Peer Support, Wellness Recovery Action Plan and "Experiential Peer Support"--incorporating Hearing Voices Network training--for "exploring voices, visions, plurality, presences, premonitions, and other extreme, 'unusual,' poetic, spiritual or otherwise alternative beliefs, perspectives, or experiences." Professionals facilitating peer support engage from our own lived experience, including mine, living under the umbrella of the Hearing Voices Movement.

While students retain access to conventional approaches, training and advocacy are gradually

transforming clinical services. Clinicians increasingly acknowledge student clients deserve the same fluidity for establishing identities which include what the UN Special Rapporteur has called, “the diversity of human experience and the variety of ways in which people process and experience life” as they do for other historically excluded social identities.

As a psychologist who has reclaimed my own life--after involuntary hospitalizations in which my spiritual experiences and other “extreme” states were diagnosed as incurable mental illness--I will review our UF programs. I will also facilitate dialogue about challenges and opportunities we all may face, moving toward more genuine inclusion and healing, through cultivating rights-based resources within mainstream organizations.”

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe how the presence and availability of adequately non-compromised peer support alternatives, facilitated by individuals with lived experience, can support experiences of inclusion and healing among individuals experiencing “extreme” states as well as a gradual transformation of the perspectives and responses of clinicians.
2. Explain how rights-based, trauma informed clinical training in suicide prevention and mental health recovery can contribute both to a reduction in non-consensual and coercive clinical interventions and to a corresponding increase in rights-based, trauma-informed support for individuals experiencing “extreme” states.
3. Reflect on ways in which the mental health systems in which they participate are already moving toward fulfilling “critical indicators” of compliance with the UN 2017 United Nations Human Rights Council’s Report on the right to health—and/or also begin to construct, or at least imagine, a plan for moving toward those goals.

Longden, E., Read, J., & Dillon, J. (2017). Assessing the impact and effectiveness of hearing voices network self-help groups. *Community Mental Health Journal*, 1–5.

Longden, E. & Read, J. (2016). Social Adversity in the Etiology of Psychosis: A Review of the Evidence. *American Journal of Psychotherapy*. 70. 5-33.

Pūras, D. (2017). Human rights and the practice of medicine. *Public Health Reviews*, 38, 9.

Other references:

Except as noted, the resources below are all available—with additional reference citations— at: www.researchgate.net/profile/Jim_Probert/publications

Probert, J. (June 14, 2018). Building bridges: Introducing recovery supports and peer values on a university campus. Invited Presentation. Virtual Roundtable on Collegiate Recovery Supports for Underrepresented Student Populations, sponsored by SAMHSA’s Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS).

Probert, J. & Nash, S. (January 1, 2018). Challenges and opportunities awaiting the field in 2018. *Mental Health Weekly*, 28 (1): 4. (Republished, with edits and additional resources, as “A Human Rights Approach to Mental Health” on the University of Florida Counseling and Wellness Center website. <https://counseling.ufl.edu/wrap/>)

Probert, J. (2017, August). An Approach to Mental Health Recovery and Cultivating “Emotional Fitness”— for Wellness Recovery Action Plan (WRAP) Users . . . and Anyone Else! Alternatives Conference. Boston, MA. (Workshop handout.)

Probert, J. (2017.) About Experiential Peer Support. A University of Florida Counseling and Wellness Center group. UF CWC website. <https://counseling.ufl.edu/services/gw/groups/experiential/>

Probert, J. & Nash, S. (2015, November). Mental Health Recovery and Peer Support at UF: A Social Justice Perspective. Invited poster presentation at the UF Social Justice Summit, Gainesville, FL. (Poster and references.)

Probert, J. (2015, April). Toward a more trauma-informed and recovery-oriented practice of lethality assessment and suicide prevention. Workshop presented at American Association of Suicidology Conference, Atlanta, GA. (Multimedia presentation and references.)

Nash, S. & Probert, J. (2014, October). Intensive Coordinated Support at the University of Florida. Presentation to the Vice President of Student Affairs and the Vice President's advisory council, Gainesville, FL. (Multimedia presentation.)

Probert, J. (February 27, 2014.) Part 1. Toward a more trauma- and recovery-informed practice of lethality assessment and suicide prevention. SAMHSA Recovery to Practice Highlights, 5 (4). (Article and references.)

Brittany Quagan, MS/LPC, Catalina Mourgues, PhD, Albert Powers, MD, PhD

Voluntary Control of Voice-Hearing: An Alliance to Move Phenomenology to New Therapeutic Approaches

Introductory

Unusual perceptual experiences like voice-hearing occur across a wide range of individuals, communities, and cultures. While sometimes associated with psychotic illness, these experiences often occur in the general population, in individuals who may never develop the need to seek psychiatric care. These non-clinical voice-hearers have very similar experiences compared to many voice-hearers who do seek psychiatric care, but nonetheless function well on a range of measures. One aspect that consistently differentiates clinical from non-clinical voice-hearers is the endorsed ability to exert voluntary control over their experiences. However, our own work has demonstrated that individuals' experience of control is multifaceted, drawing upon neurological, psychological, and social factors that perhaps represent partially independent and differentiable processes. We have developed and validated a new self-report scale meant to capture these dimensions. These efforts have been made possible through the work of a large sample of voice-hearers from various stakeholder groups who have historically endorsed varying degrees of control over their experiences: voice-hearers with a diagnosis of a psychotic-spectrum disorder; clairaudient mediums and other spiritually-oriented voice-hearers; and members of the Hearing Voices Movement and others in the recovery movement. We have termed this partnership the SPIRIT Alliance--a consortium consisting of advocacy groups, people with lived experiences, spiritually oriented communities, and psychiatrists and neuroscientists engaged in a mutually-respectful effort to create a clinical understanding of unusual experiences that is maximally informed by lived experience. The SPIRIT Alliance exists as a new online portal where experts in lived experience across the globe can share their stories, provide valuable data in the form of scales and tasks, and connect with others with complementary experiences. In addition to providing a formal means for understanding control over perception, the SPIRIT Alliance may serve as a model for how other stakeholder-inclusive research efforts may be structured in the future.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Explain how control over unusual perceptual experiences may be a key factor that differentiates those with these experiences who function well and those who do not.
2. Explain how control over unusual perceptual experiences is multifactorial, with likely biological, psychological, and social dimensions that may be studied systematically in large collaborative samples of people with lived experience.
3. Discuss how fostering control over unusual perceptual experiences may be a key point of intervention, especially in individuals who are at risk of developing psychosis, in whom pharmacological intervention is seldom warranted.

Powers, A. R., Mathys, C., & Corlett, P. R. (2017). Pavlovian conditioning-induced hallucinations result from overweighting of perceptual priors. *Science*, 357, 596-600.

Powers, A. R., Kelley, M., & Corlett, P. R. (2017). Varieties of voice-hearing: psychics and the psychosis continuum. *Schizophrenia Bulletin*, 43(1), 84-98.

Powers, A. R., Corlett, P. R., & Ross, D. A. (2018). Guided by voices: hallucinations and the psychosis spectrum. *Biological Psychiatry*, 84(6), e43-345.

Nithya Ravindran, DO & Michael Dyer, LPC

Allying with and Maintaining Safety for a Young Person Experiencing Psychosis

Intermediate

In exploring the relationship between isolation and consensual reality, creating safety with someone with minimal shared reality presents a common barrier to wellness. We hope to present on challenges posed by a 16-year-old girl experiencing her first episode of psychosis associated with emerging schizophrenia, posing significant safety risk to herself and her family and struggling with isolation as a consequence of her psychosis.

D.T., a bright, academically gifted 16-year-old girl, was referred to our program following her first psychiatric hospitalization. Initially, she was approaching truancy from school due to very detailed and systematic delusional beliefs. Her relationships with family and friends were fragile due to her perceived invalidation of her experience. The care team at the clinic also had significant difficulty allying with her from the standpoint of diagnosis and treatment planning from the beginning. Eventually, some clinicians even became incorporated into her belief system, compromising her community and safety further.

In our panel, we will explore our approach with D.T. and how we used insight building and creative psychotherapy to collaborate with her in her care and help alleviate her alienation from her world. We hope to highlight some of the challenges posed by contradictions in her lived experience and providers' or family's perspectives, illuminating her right to her own narrative. We will also explore specific developmental aspects of minors experiencing psychosis and the hierarchy and distribution of responsibilities among parents and clinicians to keep them safe. We hope to delve into our interpretations of our countertransference reactions experienced when working with her and her family, which has led to greater reflection on our role in someone experiencing psychosis. This case is exemplary of a multi-disciplinary and trial-and-error approach often necessary in the first episode population and we hope to inspire discussion on our management and approaches.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Identify particular challenges for minors experiencing psychosis and how it can be isolating/alienating for them.
2. Appraise our management of a specific case of a 16 year old experiencing psychosis.
3. Gather others' experiences with this population and foster discussion on methods and their results.

Chen, F., Gearing, R. E., DeVlyder, J. E., & Oh, H. Y. (2014). Pathway model of parental help seeking for adolescents experiencing first-episode psychosis. *Early Intervention in Psychiatry*, 10(2), 122–128. <https://doi.org/10.1111/eip.12159>

Elowe, J., & Conus, P. (2017). Much ado about everything: A literature review of insight in first episode psychosis and schizophrenia. *European Psychiatry*, 39, 73–79. <https://doi.org/10.1016/j.eurpsy.2016.07.007>

Leonhardt, B. L., Benson, K., George, S., Buck, K. D., Shaieb, R., & Vohs, J. L. (2016). Targeting Insight in First Episode Psychosis: A Case Study of Metacognitive Reflection Insight Therapy (MERIT). *Journal of Contemporary Psychotherapy*, 46(4), 207–216. <https://doi.org/10.1007/s10879-016-9332-9>

Graziela do Carmo Reis, MPH, Mark Napoli Costa, MD, MPH, Anthony J. Pavlo, PhD

Trauma and Psychoses: What Life Stories Have to Say about Belonging and Recovery

Introductory

Overview: Trauma exposure impacts large numbers of people and must be considered a significant public health issue (Breslau et al., 1998; Kessler et al., 1995). Numerous public health consequences of trauma exposure have been identified and include mental health and substance use. Trauma and psychoses have no boundaries with regards gender, socioeconomic status, race, ethnicity, geography or sexual orientation. The need to address trauma and psychoses are increasingly viewed as an important component of social disparities and stigma.

This workshop will explore how trauma and psychoses impact the sense of belonging. The life stories are valuable tool to conceptualize Recovery as the process of identifying what trauma has taken away when causing psychoses. More importantly, highlighting the path to healing: transforming negative roles and identities, embracing responsibilities, and accessing the rights, resources, and relationships that define for each of us what constitutes a rich, full life. Life stories will be used to exemplify how relationships, resources, and rights are related to healing, belonging, and restoration. The desired goal is to build a framework that helps systems and workers “talk” to each other, to understand better the connections between trauma and psychoses and to guide systems to become person-centered care.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Define trauma and psychoses.
2. Discuss the outcomes from trauma and psychoses in the context of life stories and person centered care.
3. List the key principles of recovery and citizenship/belonging.

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, July 2014.

Citizenship and Community Mental Health Care, Allison N. Ponce Michael Rowe; First published: 11 January 2018.

Partnering for Recovery in Mental Health: A Practical Guide to Person-Centered Planning, Janis Tondora, Rebecca Miller, Mike Slade, Larry Davidson. 2014.

Michael Rowe, PhD, Patricia Benedict, Billy Bromage, MSW, Annie Harper, PhD, Bridgett Williamson

Plenary: *Citizenship and Psychosis: The 5 Rs, Belonging, and Advocacy*

Introductory

Psychosis is social and political as well as individual. Citizenship, defined as a strong connection of individuals and groups to the 5 Rs of rights, responsibilities, roles, resources, and relationship that society makes available to its members and a sense of belonging that is validated by others, offers a framework for approaching and acting on the first sentence. Further, citizenship is citizenship, period, not psychiatric citizenship. Its application may vary for different individuals and groups not only according to characteristic challenges or experiences of individuals and identified groups—people who experience psychosis, for example—but to social and economic contexts, challenges, resources, and solidarity or lack of it, that such individuals and groups face.

Citizenship in relation to psychosis has links to systems of care, communities, and society. It began in

the 1990s as, in part, an approach to 'a life in the community' promised decades earlier at the outset of the community mental health movement. More proximally, it began in response to integrated mental health systems that could offer treatment and a wide array of social supports and resources but could not offer its clients access to positive social identities. Instead, those systems of care could offer only 'program citizenship' in themselves, the vehicles, as foreseen by the community mental health movement, for peoples' access to a life in the community.

Members of the Citizens Community Collaborative of the Yale Program for Recovery and Community Health will present on a citizenship intervention based on the 5 Rs, on 'citizenship peer work' and peer-to-peer support, on financial health and empowerment, and on collective group advocacy including work with other, non-mental health-identified groups. They will then turn the question of citizenship and psychosis over to the audience for discussion and debate.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. State the definition of citizenship based on the 5 Rs and belonging.
2. Articulate 2 or more points regarding the relevance of the citizenship framework to people who experience psychosis.
3. Give examples of at least 3 types of citizenship interventions and/or supports.

Atterbury, K. & M. Rowe. Community, mental health, and the common good. *Behavioral Health Sciences and the Law* 2017, DOI: 10.1002./bsl.2293.

Bromage, B., L Kriegel, B. Williamson, K. Maclean, M. Rowe. Project Connect: A community intervention for individuals with mental illness. *American Journal of Psychiatric Rehabilitation* 2017, 20:3, 218-233.

Harper, A., A. Clayton, M. Bailey, L. Foss-Kelly, and M. Rowe. Financial health and mental health: Making the connections. *Psychiatric Services* 2015, 66 (12), 1271-1276.

Ponce, A.N. & M. Rowe. Citizenship and community mental health care. *American Journal of Community Psychology*, 2018, 61, 22-31. Rowe M & Davidson L. Recovering citizenship. *Israel Journal of Psychiatry and Related Sciences* 2016, 53(1): 14-21.

Rowe, M. *Citizenship and mental health*. Oxford University Press, New York, NY, 2015.

Rowe M & Davidson L. Recovering citizenship. *Israel Journal of Psychiatry and Related Sciences* 2016, 53(1): 14-21.

Jazmine Russell, NYCPS

Altered States & Deep Emotional Processing: A Holistic Approach to Meaning-Making

Intermediate

The experience of psychosis/altered states has the potential to be a life-threatening or a life-affirming and transformative experience. What makes the difference is often the social, familial, and institutional context in which the experience occurs. This context dramatically impacts a person's ability to define altered states within an experiential framework that aligns with their personal and communal values. The right to personal narrative isn't afforded to many, especially in the western world where altered states are almost always considered a biological defect and the result of serious mental illness. This framework not only elicits internalized shame, but also often prevents an individual from talking about, experiencing, and processing difficult emotions and trauma that may have given rise to the altered states.

In this workshop, we will explore the experience of psychosis/altered states not as a pathological response, but rather as a natural process through which difficult traumatic experiences and emotional

pain can be processed. Told from the perspective of someone with lived experience of altered states/psychosis outside of an inpatient setting, this presentation will describe possible holistic interventions that address the personal, spiritual, interpersonal, institutional, and structural aspects of our lives. We will discuss meaning-making strategies, and holistic, peer-based practices for working with those who experience altered states.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe multiple frameworks for understanding psychosis.
2. Discuss the complex relationship between deep emotional processing and altered states.
3. Identify holistic and peer-based strategies for supporting those in altered states.

Russell, J. (2018) Developing a Common Vocabulary: Questions of Purpose and Priority. *Journal of Humanistic Psychology*. <https://doi.org/10.1177/0022167818787971>

Brogan, K. (2016) *A Mind of Your Own*. New York, NY: HarperCollins.

Hunter, N. (2018) *Trauma & Madness in Mental health Services*. New York, NY: Palgrave Macmillan

St. Arnaud, K., & Cormier, D. (2017). Psychosis or spiritual emergency: The potential of developmental psychopathology for differential diagnosis. *International Journal of Transpersonal Studies*, 36 (2). <http://dx.doi.org/10.24972/ijts.2017.36.2.44>

Alexander “Sandy” Smith, MA & Alberto Fergusson, MD

The Community Bridges Project: Accompaniment in Rebuilding Connectedness and Citizenship from Colombia to Vermont

Introductory

This presentation will describe the work of the Community Bridges Project in Addison County Vermont done in collaboration Dr. Alberto Fergusson of Bogota, Colombia. The project is inspired by Dr. Fergusson’s experiences from the process of Sopo’ Colombia deciding to become a “therapeutic town” as he closed his nearby therapeutic community and helped establish meaningful roles of citizenship for the former therapeutic community residents. These efforts included mutual support pairings with elderly community residents who needed help and connection, and also with people settling in the town following displacement due to political violence. Dr. Fergusson found the “meaningfulness” of these roles and responsibilities had a notable positive impact on individual paths of recovery. The community mental health team in Addison County has been working with Open Dialogue for the past several years as a way to prioritize connection with personal networks, and has been looking for additional ways beyond current treatment frameworks to help restore community connectedness for people coping with isolation and disconnection as a result of long term mental health challenges. In addition to the inspiring experiences from Sopo’, Dr. Fergusson’s articulation of the helping stance of “accompaniment” has resonated with the CSAC team as a conceptualization of a way of “being with” while also valuing the “leadership” of the client in their process of recovery and reconnection. The Community Bridges Project is working with both client and community outreach to seek to form new possibilities for individual mutual support connection and for involvement in projects that meaningfully address community needs.

The presentation will describe: principles from Accompanied Self Rehabilitation and Open Dialogue with a particular focus on the role of “accompaniment”; findings from the experiences of Sopo’; will also describe the collaborative process for the Community Bridges Project getting started, and report on initial experiences and findings.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe principles from Accompanied Self Rehabilitation and Open Dialogue that help support connection and meaningful community involvement.

2. Summarize the concept of "accompaniment".
3. Examine the initial experiences of client and community engagement through the Community Bridges Project.

Bromage, B., Barranger, S.L., Clayton, A., Rowe, M., Williamson, B., Benedict, P., & Kriegel, L., (2018) Facilitating community connections among people with mental illnesses: Perspectives from grassroots community leaders. *Journal of Community Psychology*, Advanced online publication.

Fergusson, A. (2015) *Accompanied Selfrehabilitation*. Bogota Colombia Universidad del Rosario.

Mezzina, R., Borg, M., Marin, I., Sells, D., Topor, A., & Davidson, L. (2006). From participation to citizenship: How to regain a role, a status, and a life in the process of recovery. *Archives of Andrology*, 9(1), 39-61.

Seikkula, J.; Arnkil T. (2014) *Open Dialogues and Anticipations – Respecting Otherness in the Present Moment*. University of Jyvaskyla Press.

David L. Stark, MS

The Changing Viewpoint: Psychosis and its Treatment Limitations-- Constructing a Better Way Forward

Introductory

Historically mental health professionals have possessed the ability and practiced the tendency to impose their own views of illness and recovery on those whom they would seek to help. This intellectual domination has led to abuses of power, but even more subtly, it has created a treatment paradigm in which personal realities conflict rather than commingle, making cooperation elusive. Rather than support a one-sided dynamic in the treatment milieu, we should begin to understand how both the professional's and the recovering person's perspectives may be similarly limited, while creating and sustaining imbalances not only of authority or rights, but of the determination of truth and correctness.

I will focus on several aspects of the relationship between professionals and persons served in an attempt to expose these patterns of intellectual domination: 1) the prevalent use of the term "psychosis," for which I will offer substitutes; 2) the need to hold personal or lived views of reality as equivalent to scientific views; 3) the disservice done to the recovery process by having to repeatedly interpret it through the professional's vantage points; 4) the conflation of reality with consensus; and 5) the need to uphold a view and experience of belonging that works accurately and effectively for those with recovery challenges.

In seeking to identify experiences of belonging, we will navigate the dilemmas arising in the contrasts between rights and rules, identities and roles, feelings and facts.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Propose alternative language to "psychosis," such as "experimental reality" or "hypothetical reality."
2. Demonstrate how the professional's academic reality and the recovering person's experiential reality are both tentative or provisional, held to be true only until superseded by newer views, whether scientific or personal.
3. Illustrate the inherent imbalance in perspectives between treater and treated, which assume and expect that the person treated will be entirely capable of perceiving their unique experience through the multiple filters, layers and biases of professional education and practice.

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John Strauss, MD

Feelings and the Mental Health Field

Introductory

Feelings are a major part of our work, a crucial part of our human science. I chose the word “feelings” for the title of this presentation because so often in our field, especially in writings, research, theory and even training we use words like “affect” or “emotions” which cloud the power and importance of feelings in the lives of people we are trying to help. The impact of feelings can best be communicated by describing direct experience or by the arts, and gets washed out when we use the words and methods of traditional science. It is almost as with that story about the study comparing moose and bears. It was said that to have a valid comparison the investigator obtained a group of moose and a group of bears and in order to make the comparison scientific, cut all the antlers off the moose. Perhaps, like cutting off the antlers of the moose, we have somehow decided not to pay enough attention to the unique aspects of feelings.

There are common feeling experiences that we often take for granted and so do not look into the nature of their impact and how to make them more helpful. What are, for example, the feelings generated by “support” and how do they help? How do we decide what will be supportive, and for whom? Or, what does the feeling that we are “being with” patients mean as they struggle with their problems and how can we go about attending to that more effectively?

In this presentation I will describe personal and clinical experiences and examples from the arts that can help us recognize more centrally the roles and importance of feelings in our field and how we can use our understanding of them for more effective treatment, theory, research, and training.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe things in our training and beliefs that prevent us being open to the feelings of people with severe mental illness.
2. Enumerate ways to help hear the feelings of people with severe mental illness.
3. Describe treatment system impediments to hearing the feelings of people with severe mental illness.

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Corrine "Mitzy Sky" Taylor

Beyond the Story: Letting Go Judgment of Others, Getting to "Know Thyself"

Introductory

Taking a look at how unconsciously learned messages was an obstacle to having my best life experiences. Having positive support, basic human needs, and work has the potential that leads to taking risk, learning, moving forward, experiencing gratitude, empathy, compassion, creativity, innovation and giving back. Paying close attention to how emotional, physical, and sexual abuse; abandonment, poor education, poverty, bullying, racism, and sexism, hindered my confidence and awareness.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Demonstrate how to structure a three-part story.
2. Explore practicing shame resilience, forgiveness and awareness, to be present.
3. Explore moving forward using personal responsibility instead of pain as motivation.
4. Explore using the power of language to shape our own story and take back autonomy.

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Tolle, Eckhart, (1999) "The Power of Now: A Guide to Spiritual Enlightenment," Namaste Publishing.

Ruiz, M.D., Don Miguel, (1997) "The Four Agreements: A Practical Guide to Personal Freedom," Miguel Angel Ruiz, M.D., Janet Mills, Amber-Allen Publishing.

Lauren Utter, PsyD, Neha Agrawal, PsyD, Sohenga Depestre, MA, Helena Hansen, MD, PhD, Dietra Hawkins, PsyD, Amanda Weber, MA

Plenary: Culture, Psychosis, and Dialogue: Faculty and Trainee Perspectives

Introductory

There has been growing attention underscoring the importance of socio-cultural and socio-political factors in mental health. Recent developments have emphasized the benefits of integrating structural competency and intersectionality theories into the training of mental health practitioners as an effort to promote culturally-responsive care and social justice in mental health settings. These efforts are of utmost importance across settings, although particularly in clinics that specialize in the treatment of psychosis as issues pertaining to privilege, oppression, discrimination, and cultural differences are all too common. This plenary will offer a dialogue featuring three trainees discussing their respective experience providing clinical services to individuals with psychosis and accounting for socio-cultural and socio-political factors. Three mental health professionals will then offer thoughts, reflections, and suggestions for supporting culturally-responsive care and social justice in training and practice.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Identify 3 challenges for trainees in working in a first episode clinic considering culture and identity.
2. Name 1 way in which learning about structural competencies supports social justice approaches.
3. Identify ways in which citizenship addresses diversity factors.

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Ashley Weiss, DO, MPH, Serena Chaudhry, DSW, LCSW, MPH, Michael Dyer, LPC, Doug Headrick, LPC, Jane Lefkowitz, LMSW

Early Psychosis Intervention Clinic New Orleans: Creating Consensus through Creative Clinical Approaches

Introductory

Conceptualization and implementation of the Early Psychosis Intervention Clinic New Orleans (EPIC-NOLA) was guided by a vision of creating a safe space for people with lived experience to feel understood and supported during what we believe to be one of the most intense human experiences – psychosis. Within this safe space, clinic creators envisioned that collaborative, creative and holistic work be done to support someone experiencing psychosis, while integrating a variety of the of evidence-informed approaches in other coordinated specialty care models.

EPIC-NOLA's team-based approach is predicated on meeting people where they are to provide individualized treatment. In an ever-evolving clinical setting with providers, peers, families and friends, we aim to cultivate self-compassion, wellness, and empowerment. In addition, the founders of EPIC-NOLA believed considering the vibrant culture of New Orleans to be a necessity. From music to food, which sits alongside strong spiritual beliefs ranging from Catholicism to Voodoo, there is a uniqueness about our city that shapes day to day life. However, this richness runs parallel with pervasive violence, severe community-level trauma, but a profound resilience. This complicated and textured tapestry of New Orleans is woven into the approach we have taken as an early intervention program as well as our development of our community education program.

Our panel will describe the infrastructure of our clinic as well as our role in the community as advocates for those experiencing psychosis. Members of the clinical team will elaborate on a different aspect of our clinic. Topics to be presented include mindful approaches to individual therapy, family meetings, group therapy interventions and social engagement, peer work and community education and advocacy. We will elaborate on each approach in terms of the commonalities and contrasts to more structured FEP models and also how we have expanded over the past 4 years in order to meet our communities' needs.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe the foundational blocks of the EPIC-NOLA Clinic.
2. Identify how culture influences and guides the EPIC-NOLA clinic model.
3. Discuss how the various approaches at EPIC-NOLA are integrated deliberately with the intention of promoting consensus, recovery and healing.

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Pat Wright, MEd, Tanya Frank, MFA, Rebecca B. Jaynes, LCPC, Judy E. Murray, RN, Bunny Rodriguez, MSW

Plenary: Family Matters

Introductory

The family movement of ISPS has been growing in recent years, as evidenced by the ISPS-International organization seeking candidates with lived family experience for their recent election of board members. This is the first time such a request has been made within the organization's 50 year history!

Treatment for psychosis within the US has focused on how family members can get help for their loved ones; for the most part this has followed a dominant model of assisting with medication compliance and involuntary hospitalization. What has emerged as a result of this protocol of treatment is a growing body of research showing the harmful effects of psychotropic medication and forced hospitalization.

It is markedly clear that new ways of offering support and advocating for our loved ones is necessary. ISPS continues to be a leader in this mission.

It is important to recognize that not all families have equal resources available to them and that socio-economics, education, geographical locale, race ethnicity and housing all play a role with how much families can support loved ones.

Research has illustrated how the stress levels of those caring for a person with extreme states parallels the stress levels of soldiers with PTSD. These issues show that we need to "forge new pathways toward inclusion and healing" for all affected families. Our conference theme asks how we can do this and what might we gain in doing so?

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe the challenges of those in various roles experiences from the perspective of: sibling, parent and an adult child of 2 parents with psychosis.
2. Explain what have been (un)helpful strategies from different providers along the path.
3. Describe a unique recovery program that includes multiple families meeting together.

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Douglas Turkington and Helen M. Spencer, eds. (2019) *Back to Life, Back to Normality: Volume 2: CBT Informed Recovery for Families with Relatives with Schizophrenia and Other Psychoses*.

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Kate Wyer, MFA, John Flowers, Bonney Moxley, MA

The Consumer Quality Team: Peers Engaging in Quality Oversight of Maryland's Public Behavioral Health System

Introductory

The Consumer Quality Team (CQT), a program of The Mental Health Association of Maryland, employs people with lived experience of behavioral health disorders who interview consumers in Maryland's public behavioral health system about their satisfaction with the services provided. CQT visits all publicly funded psychiatric hospitals, day programs, wellness and recovery centers, and youth residential treatment programs.

CQT's process empowers consumers to be full participants in their own care. In this way, CQT works

to reduce alienation and disengagement and honors the insight and wisdom of those who may be experiencing un-shared reality. Their work cultivates consensus about the public behavioral health system by addressing the 5 R's of Citizenship: Rights, Responsibilities, Roles, Resources, and Relationships.

When meeting with a consumer, the CQT team first shares that they themselves, or family members, use behavioral health services, and then conducts semi-structured, voluntary, and consumer-led interviews. Utilizing open-ended questions and active listening techniques, the team nurtures trust to encourage consumers to share what is true for them that moment. Instead of validating or questioning someone's reality, CQT simply engages in a conversation. The team then uses the consumers' actual, unfiltered, first-person quotes to give feedback to providers and program funders.

These completed feedback loops are also shared with the state behavioral health administration, so consumers' perspectives are heard in their own words by people making decisions about the policies and directions of the behavioral health care system of Maryland.

This highly interactive presentation will include an overview of the CQT process and an in-depth discussion about creating a neutral, respectful space for people to have input into their care and treatment.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Explain how peers performing non-judgmental, non-clinical interviewing can improve the quality of care in the public behavioral health system.
2. Describe how CQT's feedback loops foster communication between consumers, providers, funders and policy makers, empowering consumers to be full participants in their own treatment, while also having a hand in shaping the behavioral health system.
3. Discuss how fostering consensus about the public behavioral health system reduces "otherness."

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Philip T. Yanos, PhD

Assisted Outpatient Treatment Orders and the Therapeutic Relationship in Assertive Community Treatment

Intermediate

Introduction: The therapeutic relationship has been found to be a powerful predictor of outcome in services for people diagnosed with psychosis. However, services for people with psychosis often include coercive aspects that can impact the therapeutic relationship. In New York City, 21% of individuals served by Assertive Community Treatment (ACT) teams are monitored through "Assisted Outpatient Treatment" (AOT), which involves explicit coercion- civil commitment to community-based treatment. There is evidence that participants mandated to services under AOT perceive this to be coercive, but it is unclear to what extent they perceive coercion in the ACT services offered through AOT. Furthermore, it is unclear whether the perceptions of ACT clients referred through AOT differ from those referred through traditional means. The present study aimed to advance the literature by comparing perceptions of the therapeutic relationship and associated factors (shared-decision making, perceptions of coercion, and perceived procedural justice) between ACT clients in New York

City who were and were not referred through AOT.

Method: Thirty persons (15 currently on AOT and 15 not currently on AOT), currently receiving ACT services were recruited for the study. We used both quantitative and qualitative means to explore experiences related to the referral experience and relationships with the ACT team.

Results: There were no differences between participants in working alliance, perceived procedural justice or shared decision-making. However, there was a relationship between the referral group and perceptions of "Negative Pressures." Qualitative data, analyzed using Consensual Qualitative Analysis, suggested a nuanced picture, with a significant subgroup of participants referred through AOT perceiving the relationship with the ACT team in ways that were coded as "Paternalistic/non-collaborative" or "mixed."

Discussion: The implications of findings for how coercive referral systems can impact working alliance in services that aim to be recovery-oriented will be discussed.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Identify how conflicting goals in mental health services can complicate the therapeutic alliance.
2. Identify how the therapeutic relationship of individuals referred to ACT through AOT differed from those referred through less coercive sources.
3. Explain how qualitative and quantitative data collection approach can produce different findings.

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Silvio Yasui, PhD, Disete Devera, MS, Fabrício Donizete da Costa, MD, Elizabeth Maria Freire de Araújo Lima, PhD, José Guilherme Nogueira Passarinho

Mental Health Policy in Brazil: How it is, Its Current Challenges and Some Experiences

Introductory

Mental health public policies in Brazil are the result of a long historical journey, involving the active participation of many stakeholders (health workers, health managers, users, families, researchers) that in different levels (health services, public management, user and family associations, universities) formed the basis upon which ethical-political principles and legal guidelines were built. That journey started with a paradigm shift from the medical model of mental illnesses - and the asylum as its corollary – to a citizenship framework inspired by Basaglia's work and the Italian experience of deinstitutionalization. Since its inception, the Brazilian Psychiatric Reform movement has focused on restoring citizenship for persons experiencing psychosis and other mental health problems with an emphasis on community inclusion, freedom, autonomy and equitable rights. Numerous creative and innovative strategies followed: Community Based Mental Health Services, Solidarity Work Cooperatives, Therapeutic Residences, Community Centers and others. With this panel we hope to foster a fruitful debate between cultures that through different historical pathways, theoretical frameworks and social contexts find themselves in agreement that recovery is possible and that systems of care should reflect that. We will discuss how citizenship and mental health care are articulated in the Brazilian context presenting: 1) an overview of the historical elements that led to the

development of current public policies; 2) the importance of training professionals within a citizenship/recovery framework; 3) two concrete experiences to exemplify innovative care strategies to vulnerable and underserved populations; and 4) challenges for the future.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe an overview of Brazil's Mental Health policy.
2. Discuss the important role of people's engagement in policy making.
3. Highlight intersectionality as an eminent axis for mental health policy.

Yasui, S.; Luzio, CA; Amarante, P. From manicomial logic to territorial logic: Impasses and challenges of psychosocial care. *Journal of Health Psychology*, v. 21, p. 400-408, 2016.

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Castro, ED; Lima, E M F A ; Inforsato, E A ; Buelau, R M; Valent, I U Território e diversidade: trajetórias da terapia ocupacional em experiências de arte e cultura. *Cadernos de Terapia Ocupacional da UFSCar*, v. 24, p. 3-12, 2016.

Lima, E. M. F. A.. Crossing borders and inhabiting margins in Brazil: art, subjectivity, health and participation in Lygia Clark's and Hélio Oiticica's poetics. *World Cultural Psychiatry Research Review*, v. 10, p. 175-188, 2015

Saras Yerlig & Rebecca B. Jaynes, LCPC

Integrating the Peer Perspective in a First Episode for Psychosis Program

Introductory

The Portland Identification and Early Referral program is the first early psychosis program in Maine and has recently begun to fully integrate a person with lived experience onto the team. This partnership creates a powerful bridge between participants, staff members, and the community at large. In collaborating across the clinical and the peer models, we have improved our team communication and included peer support to engage young people in treatment. Having a peer support partner in a full time position allows for the development of new outreach opportunities including speaking positions for graduates of the program. Learn about new opportunities for peer led groups in the community and how we have responded to the feedback from young people. We will discuss successes and challenges throughout this integration.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Explain how peer support on a coordinated specialty care team can offer opportunities to expand on the role of peer support.
2. Name three challenges to integrating the peer model into a FEP program and how these challenges can be mitigated.
3. Discuss the role of peers in community outreach and system change.

Jones, N. Peer Involvement and Leadership in Early Intervention in Psychosis Services 2016; Available from: https://www.nasmhpd.org/sites/default/files/Peer-Involvement-Guidance_Manual_Final.pdf

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approach.

Thurley, M., Monson, K., & Simpson R. Youth participation in an early psychosis service. Orygen Youth Health Research Centre. 2014. Draft.

Thurley, M., and Monson, K., Perspectives in Early Intervention Consumer participation in a youth mental health service. *Early Intervention in Psychiatry* 2011; 5: 381-388

Ljiljana Zecevic, PhD, Nicole Havas, LMHC, Shannon Pagdon, Kimia Pourrezaei, DO, Halle Thurnauer, MA, Adam Weg, LCSW

Alone We Can Do So Much, Together We Can Do So Much More

Introductory

OnTrack New York is a treatment program providing coordinated specialty care for adolescents and young adults in the early phases of psychosis, or extreme states, with the aim of helping individuals work towards recovery in a meaningful way. Participants in the program are offered a wide variety of services such as individual and group psychotherapy, guidance in pursuing educational or employment opportunities, medication management, family psychoeducation, and peer support. This presentation will introduce several team members from the Lenox Hill Hospital OnTrack site including a psychologist, psychiatrist, social worker, peer specialist, and supported employment and education specialist who will each discuss their role within the program. The multidisciplinary treatment model will be illustrated through the story of a young adult participant. In exploring this individual's journey toward recovery, the presenters will emphasize both the benefits and challenges of tailoring individualized, patient-centered treatment through a shared decision-making model. Additionally, the presentation will explore multi-theoretical approach and its integration in understanding and utilizing interpersonal clinical phenomena, such as transference, countertransference, and the therapeutic alliance. We will reflect on the concepts of personal agency, individuation/separation, identity formation, stigma, belonging, inclusion, and meaning making as parts of the recovery process.

Learning Objectives: At the conclusion of this activity, participants should be able to:

1. Describe OnTrack New York program, core principles, and basic research about coordinated specialty care and early intervention services.
2. Explain team members' roles and new strategies for engaging participants and tailoring treatment.
3. Discuss complexities of clinical work with young adults struggling in early stages of psychosis.

Mark Sanbrook, Anthony Harris, Roberto Parada & Peter Young (2003) The effectiveness of an early intervention team in the treatment of first-episode psychosis, *Australian e-Journal for the Advancement of Mental Health*, 2:1, 16-24, DOI: 10.5172/jamh.2.1.16

Sarah R. Kamens, Larry Davidson, Emily Hyun, Nev Jones, Jill G. Morawski, Matthew M. Kurtz, Jessica Pollard, Gerrit Ian van Schalkwyk & Vinod Srihari (2018) The duration of untreated psychosis: a phenomenological study, *Psychosis*, 10:4, 307-318, DOI: 10.1080/17522439.2018.1524924

Aubrey M. Moe & Nicholas J.K. Breitborde (2018) Psychosis in Emerging Adulthood: Phenomenological, Diagnostic, and Clinical Considerations, *Evidence-Based Practice in Child and Adolescent Mental Health*, DOI: 10.1080/23794925.2018.1509032

Michael Garrett & Douglas Turkington (2011) CBT for psychosis in a psychoanalytic frame, *Psychosis*, 3:1, 2-13, DOI: 10.1080/17522439.2010.544403

Fiona Switzer & Sean F. Harper (2019) A narrative review of the barriers to the implementation of Cognitive Behavioural Therapy for Psychosis (CBTp.), *Psychosis*, DOI: 10.1080/17522439.2019.1578400

Justin Stephenson (2018) I, Me, You & Us: can a psychodynamic model provide a relational perspective on psychosis?, *Psychoanalytic Psychotherapy*, 32:3, 267-281, DOI: 10.1080/02668734.2018.1487464

Jorge Luis Maldonado & Alberto Luis Solimano (2016) Reflections on trauma, symbolization and psychic pain in a case of neurosis and a case of psychosis, *The International Journal of Psychoanalysis*, 97:5, 1299-1320, DOI: 10.1111/1745-8315.12489

Maria J. O'Connell, Elizabeth H. Flanagan, Miriam E. Delphin-Rittmon & Larry Davidson (2017) Enhancing outcomes for persons with co-occurring disorders through skills training and peer recovery support, *Journal of Mental Health*, DOI: 10.1080/09638237.2017.1294733

Eoin J. Killackey, Henry J. Jackson, John Gleeson, Ian B. Hickie & Patrick D. McGorry (2006) Exciting career opportunity beckons! Early intervention and vocational rehabilitation in first-episode psychosis: employing cautious optimism, *Australian and New Zealand Journal of Psychiatry*, 40:11-12, 951-962, DOI: 10.1080/j.1440-1614.2006.01918.x

Miles Rinaldi, Eoin Killackey, Jo Smith, Geoff Shepherd, Swaran P. Singh & Tom Craig (2010) First episode psychosis and employment: A review, *International Review of Psychiatry*, 22:2, 148-162, DOI: 10.3109/09540261003661825

Elizabeth McCay, Heather Beanlands, Robert Zipursky, Paul Roy, Melyn Leszcz, Janet Landeen, Kathy Ryan, Gretchen Conrad, Donna Romano, Daphene Francis, Jennifer Hunt, Lucia Costantini & Eugene Chan (2007) A randomised controlled trial of a group intervention to reduce engulfment and self-stigmatisation in first episode schizophrenia, *Australian e-Journal for the Advancement of Mental Health*, 6:3, 212-220, DOI: 10.5172/jamh.6.3.212

POSTER ABSTRACTS

Posters will be displayed all day Saturday in the exhibit room, and will be presented from 5:00-6:00 p.m. Saturday. Poster presentations are not for credit. On Sunday morning, a prize will be awarded for the best student poster. Posters are listed alphabetically by lead presenter.

Grinasha Dillon

EPIC-ARTS: Creating Community and Inclusion Through Creative Expression

Art Therapy is an under-utilized recovery tool for early psychosis. At the Early Psychosis Intervention Clinic New Orleans (EPIC-NOLA), we use art therapy in the recovery phase of treatment. The relationship between art and psychosis is a creative form of treatment and takes advantage of the silent creative impact that art has on people. In our art group, EPIC-ARTS, we address issues related to social cognition through creative expression, community and inclusion. This enhances typical approaches to therapy and allows participants to experience themselves and their diagnosis in a different light.

Two key elements of the group are to encourage peer interactions and the expression of feelings without verbalization. Art, music and culture are an integral part of New Orleans and when we participate in one of these activities, it helps us to connect to our community. The objective of our art therapy process is to provide a less threatening approach to treatment and to get participants to provide a visual dialogue of their experiences. With this visual dialogue, providers can better identify stressors and barriers that participants may be facing.

Eren Kafadar

A Pavlovian Visual Pavlovian Conditioned Hallucinations Task

The predictive coding framework for perception postulates that we automatically infer what is around us by combining our sensory input with our prior beliefs about the world. Mathematical models based in Bayesian statistics have been used to describe this process, elucidating both typical as well as atypical brain processes, such as emergence of hallucinations. A previous study using a Pavlovian conditioning task showed that this phenomenon could be a result of over-weighting of prior beliefs about sensory information versus immediate sensory input. Individuals with Auditory Verbal Hallucinations (AVH) were more susceptible to conditioned hallucinations than individuals without AVH, regardless of a diagnosis of psychosis. This suggests a common underlying mechanism for the emergence of hallucinations irrespective of functional status. To further investigate the mechanisms behind hallucinations, we developed a visual conditioned hallucinations (VCH) task, modeled after the original AVH task. Using these two tasks together reveals the potential effects of sensory modality on the group-level differences, as well as the brain activation patterns. Furthermore, a task capable of inducing visual conditioned hallucinations can be used to investigate the mechanisms behind related phenomena such as visual flashbacks in future studies. Comparing the brain activation patterns of the VCH task with the AVH task can help us identify potential supra-modal brain regions which are involved in hallucinations regardless of sensory modality, as well as identify those regions that might be activated for hallucinations of a specific sensory modality. This will lead to more personalized treatment of individuals with distressing perceptual abnormalities, as treatment methods such as transcranial stimulation can target specific regions depending on clinical need.

Toshiko Kobayashi, MA & Eunhong Park, ATR

Inclusive and Integrated Application of Expressive Origami Therapy

Having over 20 years of experience using origami as a treatment method, data has been compiled in this presentation. It clearly shows the efficacy of origami for treating diverse populations. The Origami Therapy Association, established in 2007, is an affiliation of mainly art therapists from diverse backgrounds working in New York City, North and South America, Asia, North and South Africa, the Near East, and Europe. The Origami Therapy Association has conducted origami therapy in educational centers for the visually Impaired, with young people on the autism spectrum, in psychiatric

rehabilitation centers, in juvenile detention, and for emergency response relief work, as well as serving for the aging population. Rooted in the Expressive Origami Therapy theoretical framework, this presentation will show the versatility and potential clinical applications of origami. Data has been collected from EOT sessions. Some general conclusions have been drawn to create a universal method that conference attendees can adapt to their therapy sessions.

Mila Kirstie C. Kulsa & Paul S. Saks, PhD

Critical Review of Current Psychiatric Care and Solutions to Preventing the Relapse of Psychosis

From analyzing existing literature and considering personal observations and the perspectives of individuals who live with psychosis as well as those of various psychiatric providers, one can acknowledge that many of the currently-available inpatient and outpatient psychiatric treatment services are often unsuccessful in helping individuals to sustain healthy, productive lives after institutionalization. It is often a tremendous challenge for those who experience psychosis to find justification in recognizing and managing their symptoms if they do not have the crucial opportunities to cultivate meaningful, healing partnerships with their clinicians. We explore the issue of how to better engage individuals through person-centered, recovery-oriented interventions – which revolve around achieving idiosyncratically-significant, meaningful personal goals – as individuals flourish and simultaneously progress towards recovery after hospitalization.

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Catalina Mourgues, PhD

The Voice Hearing Control Scale: A Novel Instrument to Assess the Control over Voice-Hearing Experiences

Evidence suggests that the degree of control over voice-hearing experiences (VHE) is related to better general functioning. In a previous qualitative study, we showed that the capacity to control VHE is capable of being developed and is related to factors such as beliefs and acceptance of VHE, support network availability, and health-promoting habits (e.g., exercising).

In this study, we introduce the voice hearing control scale (VHCS) an instrument designed to assess the strategies used to control VHE and related factors such as beliefs about and acceptance of VHE. Response to items are collected with a 7-point frequency scale. The following steps were followed to develop the VHCS: (1) qualitative study to characterize the mechanisms and strategies used to control VHE; (2) systematic review of existing questionnaires to measure VHE; (3) creation of an initial pool of 281 items grouped in 22 dimensions; (4) classification of the items by 6 expert judges and assessment of their relevance ; (5) pilot study in which 6 Voice Hearing Network members, 30 self-identified psychics, and 24 self-identified mediums were assessed with the initial pool of items; a cognitive interview was conducted on a subsample of 8 subjects; (5) selection and rewording of items based on their performance (e.g., item correlation, response frequency, and internal consistency); (6) online administration of the selected pool of items and questionnaires assessing frequency, content, belief and modality VHE to 250 participants; (7) assessment of the psychometric properties of the scale (convergent, discriminant and structural validity and internal consistency). After the second

selection of items, the scale showed adequate psychometric properties. The VHCS is a novel scale capable of assessing the control over VHE and related factors in clinical and non-clinical populations. As such, it has the potential of advancing the study and understanding of this clinically relevant phenomenon.

Aly Negreira, PhD

Flashbacks and Hallucinations: Common Computational and Neural Mechanisms?

Trauma-based flashbacks (FBs) are considered a cardinal symptom of PTSD and defined as powerful and distressing perceptual re-experiencing of the traumatic event. FBs have historically been considered distinct from the auditory verbal hallucinations (AVHs) found in psychosis, yet phenomenological comparisons highlight remarkable degrees of overlap in the perceptual and dissociative characteristics of the two phenomena. Neuroimaging studies of FBs and hallucinations demonstrate engagement of significant overlapping brain regions such as the insula, anterior cingulate cortex, inferior frontal gyrus, and the relevant sensory cortices. Recent advances in the computational modeling of perception may help to uncover shared mechanisms. Specifically, work recently published in *Science* by Dr. Powers demonstrates that hallucinations can in fact be reliably, safely, and reversibly induced using a classical conditioning Conditioned Hallucinations (CHs) paradigm. These CHs occurred in all participants, but with markedly increased frequency in individuals with psychosis who endorsed daily AVHs compared to those who do not. Using a computational modeling approach, Dr. Powers found that CHs were the result from overly weighted prior perceptual knowledge in the context of incoming sensory information. Using functional magnetic resonance imaging (fMRI) CHs were accompanied by activation of a typically-identified hallucination network of brain regions, including anterior insula cortex, anterior cingulate cortex, inferior frontal gyrus, as well as auditory and superior temporal cortices. We plan to use the same methods to determine whether FBs might share computational and neural mechanisms with AVHs. We aim: 1) To determine if participants with and without FBs exhibit differential rates of CHs and higher prior-overweighting of perceptual knowledge; and 2) To compare the neural circuitry subserving CHs in participants with FBs as compared to participants with AVHs.

Jenna Pastorini, MSc

The First Episode Psychosis Experience of Filipino-Canadians in Montreal

Despite being the fourth largest immigrant group in the United States and 16.1% of the immigrant population in Canada from the 2016 census, the Filipino-North American community has been referred to as the “forgotten Asian Americans”. In a time where patient-centered psychiatric care is revealing greater importance for beneficial outcomes, the dearth of literature regarding the mental health of this marginalized population can be extremely damaging. This disproportionate representation was mirrored in the number of Filipino patients being seen by the first-episode psychosis program (FEPP) of the Jewish General Hospital in Montreal, despite Filipinos making up a large amount of the immigrant population in the catchment area. Within recent years an influx of Filipino patients, though almost entirely male, have begun treatment through FEPP. First episode psychosis refers to an individual’s first experience of impaired reality testing, with serious symptoms such as hallucinations, delusions, paranoia, disorganized behavior and thought disorder. The pervasive stigma surrounding severe mental illness (SMI), arises in part from historical depictions that have linked psychosis to deviance and dangerousness. The social construct surrounding the idea of the “crazy person” holds significant consequences on how those with diagnosed psychotic disorders experience how others react to them and how these individuals may internally regard themselves. There is an ongoing concern that reflections on the experience of psychosis do not grant enough agency to the sociocultural circumstance of the individual. Through use of qualitative interviewing, I look to explore the first-episode psychosis experience of Filipino-Canadians in Montreal and analyze the unique intersect between culture and psychosis within these first-person accounts. I hope to create a space in academia for how these individuals understand their experience and how we can better support them.

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Matthew Peters, MSc

The Faces of Medication Adherence: A Case Study Analysis of Neuroleptic Medication Decisions

Antipsychotic medication adherence is an important topic from the perspectives of patients, clinicians, and carers. In the first year of treatment, it is estimated to be below 50% and medication discontinuation can be as high as 70%. Treatment alliance, family and social support, symptom resolution, and side-effects are factors which have been identified as contributing to medication adherence. While qualitative studies have explored the experience of people taking antipsychotics, key questions still remain regarding how people make the choice to take medication. We used case study analysis to address this gap. Five in-depth interviews were conducted with people who had been prescribed antipsychotics for a diagnosis of affective or non-affective psychosis. The explanatory framework for mental illness which people develop previous to receiving treatment can either lead people to refuse medication or continue medication. Explanatory frameworks seem to be most influenced by people's family. Families are also an important source of social support. Severe side-effects which affect people's health or social and professional lives can also affect their medication adherence. Doctors who were responsive to people's concerns about side-effects and engaged people in their medication decisions encouraged higher rates of medication adherence. Ultimately, the participants in our study took medication for one of two reasons. For some, it helped facilitate their well-being and they were able to develop better relationships and resume work or hobbies. Others saw medication as a necessity because they felt it prevented any further crises. The participants' decisions to take medication were never simple and changed during the course of their treatment as they tried to maintain their well-being. This study highlights how clinicians need to better understand the experience of taking medication and the decision to take medication, and should work collaboratively with patients to inform their choices.

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Matthew Peters, MSc

Service Providers' Conceptualizations of Treatment for Psychosis in Specialized Early Intervention Settings: A Narrative Review

Background: Service providers' (SP) conceptualization of psychosis has been identified as a key factor in its treatment, affecting both the treatment provided and outcomes of treatment in long-term chronic care settings. Specialized Early Intervention Services (SEIS) for psychosis have developed in the last 20 years to serve young people experiencing a first-episode of psychosis. SEIS have philosophies of hope for recovery and integrated treatment models with an emphasis on joint-decision making. This makes them distinct from traditional service models and may affect how SP in these

setting understand the treatment and etiology of psychosis.

Aims: To identify relevant studies and summarize their findings on SPs' conceptualization of psychosis and its treatment at SEIS.

Methods: A systematic search strategy was used to identify studies which examined SPs' attitudes, understandings, or conceptualizations of psychosis or its treatment.

Results: An initial search identified 9 papers from PUBMED, PsycINFO, CINAHL, and Sociological Abstracts. Five of the studies concerned the use of medication or medication adherence. These papers revealed a perceived tension between joint-decision making and medication adherence, and a greater tolerance for side-effects if the formulation was seen as efficacious. SP recognized the important of lowering medication to improving service users' quality of life. Three papers compared SPs' beliefs about treatment with those of service users (SU). SP and SU rating of unmet needs at SEIS differed considerably, with SUs considering a wider variety of needs unmet than SP. Possibly reflecting this, SU also considered a wider variety of services as efficacious and had a greater skepticism for SEIS. The remaining paper examined how SP attachment styles affected their expectations for treatment and therapeutic alliance.

Conclusions: This study may yield valuable insights that can guide SPs' training programs so as to improve the service experiences and outcomes of young people with psychosis.

Brittany Quagan, MS/LP

A Qualitative Study of the Direct and Indirect Coping Strategies Used by Voice Hearers to Control Their Experiences

An increasing number of studies support the idea that voice-hearing experiences (VHE) appear on a continuum. In help-seeking and non-help-seeking populations, VHE have a rich phenomenological and linguistic (e.g., perceptibility, syntactic complexity, content) presentation. Non-help-seeking populations tend to develop coping strategies that help them reach higher functioning levels (e.g., income, social interactions). These strategies allow them to voluntarily influence the content and presentation of their VHE. Few studies have characterized the efficacious coping strategies developed by voice-hearers. In this study, we characterize the development, key features, and efficacy of some of these strategies.

Twenty-two participants from the Voice Hearing Network and 15 self-identified mediums, underwent 40-minute, semi-structured, qualitative interviews conducted at CMHC, New Haven, and CHR, Manchester, CT, to explore aspects of the VHE. Interviews were audiotaped and transcribed verbatim. The first round of open, axial, and selective coding of the interviews was conducted by one of the researchers and discussed with the research team (psychics, psychiatrists, and psychologists).

The analyses showed that the capacity to control VHE results from a complex interaction between factors such as beliefs and acceptance of the experiences, support network availability, and traumatic early experiences. A variety of strategies were identified that can be placed in a continuum between indirect (e.g., listening to music) to direct control (e.g., talking with the voices). Achieving direct control of VHE requires voice hearers to engage in meaningful interactions with the voices, takes time to achieve, and has a stronger relationship with self-acceptance and self-care behavior (e.g., exercising) than indirect strategies. These findings provide novel insights into the process of developing efficacious strategies to control VHE and open the door to teaching these strategies to help-seeking individuals. Furthermore, these findings can guide the exploration of the biological, psychological, and social determinants of the capacity to control VHE.

Daniela Ravelli Cabrini

Recovery in Brazil: Experiences of Mental Health Service Users

The purpose of this poster is to present some Recovery experiences in Brazil, highlighting its most relevant characteristics which contribute both to the process of changing the mental health policy and to the expansion of Recovery movement.

The mental health consumer/survivors movement started in the 1970s in the United States and advocated for recovery, representing a concrete proposal in the conquest of rights through the active participation of users and their families. Through the Americans with Disabilities Act and other public policy changes, recovery became a core vision informing behavioral health care across the country (Davidson et al., 2016).

Inspired by academic exchanges with Anglo-Saxon countries, Brazil has developed pilot projects for experimentation and systematization of participatory and empowering strategies for users and family members in mental health services related to knowledge development and service evaluation in psychosocial care (Pressotto et al, 2013). In this perspective, the inclusion of users in the productive cycle of mental health research is key. Service users and family members are recognized as having an important voice in the scientific knowledge formulation process bringing their lived experience to all stages of research.

From the years 2000 onwards in Brazil several projects were developed in that framework: (1) the Citizen Committee; (2) Mutual aid groups; (3) Autonomous Medication Management; (4) User and Family Defense Manual. Furthermore, other experiences can be considered recovery-oriented such as family Project Care Partners in Rio de Janeiro; Hearing Voices network in most of Brazilian capitals; Community Speech Project in São Paulo, Rio de Janeiro and Santa Maria (Presotto et al, 2013; Passos et al, 2013; Vasconcelos, 2017). Brazil has a unique history with inclusion through the arts and cultural initiatives very much in line with recovery principles such (1) Points of Culture, Carnival blocks Loucura Suburbana and Ta pirando, Tá Pirado, Pirou; (2) Solidarity Economy Projects.

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Jenae A. Richardson, MS

Clinicians' Experiences Implementing CBT for Psychosis

CBT for psychosis (CBTp) is recognized as an evidence-based treatment for individuals with schizophrenia and other psychotic disorders (Wykes et al., 2008). National treatment guidelines also recommend its use as an adjunctive treatment with antipsychotic medications for medication-resistant symptoms (Dixon, 2010; Kreyenbuhl et al., 2010; Lehman et al., 2010). Despite these recommendations, antipsychotics continue to be the primary treatment for individuals with schizophrenia, although about 25-50% of patients do not improve after taking them (Gould et al., 2001), and antipsychotics are costly to deliver (Riggs & Creed, 2016). In addition, CBTp is poorly disseminated and implemented in countries such as the United States (Kimhy et al., 2013). Little research has explored clinicians' challenges implementing this treatment in the U.S. In this qualitative study, we explored the experiences of clinicians (N = 24) who were currently practicing or had recently practiced CBTp in various treatment settings in the U.S. The purpose of this study was to systematically explore clinicians' experiences implementing CBTp in the U.S. to better understand factors impacting its implementation. Interviews were transcribed and the Auerbach and Silverstein (2003) coding method was used to identify repeating ideas, themes, and theoretical constructs. Inter-rater reliability was computed to determine the reliability of the study results, and the mean inter-rater agreement was substantial ($\kappa = .78$). Results indicated barriers to implementation at the sociopolitical, organizational, clinician, and client levels. Understanding the barriers that U.S. clinicians face implementing CBTp can aid in identifying solutions to redressing these barriers, which in turn can improve clients' access to the treatment. Identifying barriers can also inform training efforts, including training at the graduate-school level.

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Luyu Zhang

Understanding Psychosis Using Neuropsychological Profiles

Objective: Schizoaffective disorder shares features of both schizophrenia and bipolar disorder. The three psychotic disorders could overlap largely in clinical presentations. A diagnosis of schizoaffective disorder might change to schizophrenia or bipolar disorder over time. These diagnostic issues have raised the discussion over the nosological relationship of psychotic disorders: are they distinct disorders or actually on a continuum. The current study tries to answer this question using neuropsychological profiles as potential differential factors.

Methods: 50 patients (schizoaffective=18, schizophrenia=14, bipolar=18) were recruited. A current diagnosis was confirmed using Diagnostic Interview for Genetic Studies (DIGS). Cognitive functions were measured using MATRICS Cognitive Consensus Battery (MCCB).

Results: After controlling for years of education and premorbid IQ, the three disorders showed no significant differences in all cognitive domains except for processing speed.

ISPS-US 18th Annual Meeting

Psychosis, Citizenship, and Belonging: Forging Pathways toward Inclusion and Healing

Conclusion: Based on neuropsychological profiles, psychotic disorders cannot be sufficiently distinguished, which supports a dimensional rather than traditional categorical approach to understand psychotic disorders.

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