

TOPICAL WEBINAR FOR APA MEMBERS

An Educational Resource from McLean Hospital

Doing & Dialoging Together: Multimodal Treatment for Psychosis

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Jackson Ardery and Jessie Roberge have a working relationship with McLean Hospital. As such, they have both a financial and an intellectual interest in the webinar content. The purpose of this presentation is to provide a balanced view on integrated psychosocial approaches to the treatment and recovery of adults experiencing psychosis.

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ATTENDANCE

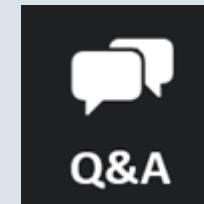
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Jackson Ardery, LICSW

PRESENTER

Jackson Ardery, LICSW is a clinical social worker and individual, group, and family psychotherapist at McLean Hospital's Appleton House residential program, specializing in care for adults with primary psychotic disorders and complex mental health conditions. Jackson applies advanced training in psychoanalytic, dialogic, and relational frameworks to partner with patients and families for psychological and functional change, in line with their values, dignity, and needed community engagement. Jackson's clinical and academic interests include the intersection of psychotic disorders and personality disorders; transdiagnostic and intermodal approaches; and centering themes of intersubjectivity and relational motivation within the therapeutic space.



**Jessie Robbins Roberge,
MSOTR/L**

PRESENTER

Jessie Robbins Roberge, MSOTR/L is an occupational therapist with two decades of experience specializing in psychiatric rehabilitation, functional recovery, and milieu-based therapy. She currently serves as the Occupational Therapist in the Bipolar and Psychotic Disorders Division at McLean Hospital's Appleton Residential Program, where she conducts comprehensive evaluations, develops individualized treatment plans, and provides both individual and group interventions aimed at maximizing functional independence and community integration. Jessie also plays an integral role in program operations, staff support, program development, and participation in hospital-wide initiatives, including the Schwartz Center Rounds Planning Committee.

Purpose

- A. To emphasize psychosis as a psychosocial phenomenon of ultimate, multifaceted isolation: from self, other, and community
- B. To propose an integrated model of intervention, uniquely suited to address this isolation at the functional, intrapsychic, and interpersonal levels: including Occupational Therapy (“Doing”), Dialogic Psychotherapy (“Dialoguing”), and Milieu Therapy (“Together”)
- C. To provide clinical examples of application in specialty residential care, with suggested adaptations at other levels of care and service settings

Objectives

After this presentation, participants will be able to

- (1) Understand the role of isolation in psychosis, including its shape in risk factors, symptom expression, and disease progression and prognosis.*
- (2) Describe 3 respective therapeutic elements of Occupational Therapy, Dialogic Psychotherapy, and Milieu Therapy in the treatment of psychosis.*
- (3) Implement or adapt 1 clinical skill or principle from each respective modality into my current treatment of adults experiencing psychosis.*

Agenda

Defining psychosis as state of ultimate isolation

- A. Descriptive Primer – Psychotic *Symptom* vs. Psychotic *Disorder*
- B. Analytic Formulation – isolation's role in etiology, symptom expression, and effect

Limitations of current models and interventions

- A. Medical Model; Dominant Psychosocial EBT; Service Delivery Constraints
- B. Current Outcome Data

Proposal for Multimodal Integrated Care

- A. Occupational Therapy – *Doing*
- B. Dialogic Psychotherapy – *Dialoguing*
- C. Milieu Therapy – *Together*

Case example for integrated application in residential care

Psychosis – *A Descriptive Primer*

- Psychotic ***Symptom***: A break with reality
 - *Positive*
 - *Negative*
 - *Disorganized Thinking/Speech*
 - *Disorganized Behavior/Motor*
- Transdiagnostic Presentation
- Lifetime Prevalence 5-7%
- Psychotic ***Disorders*** (DSM V):
 - Delusional Disorder
 - Brief Psychotic Disorder
 - Schizophreniform Disorder
 - Schizophrenia
 - Schizoaffective Disorder
 - Substance-Induced Psychosis
 - ...Due to Other Medical Condition
 - Catatonia
 - Bipolar Disorder, with Psychotic Features
 - Schizotypal Personality Disorder
- Lifetime Prevalence 3%

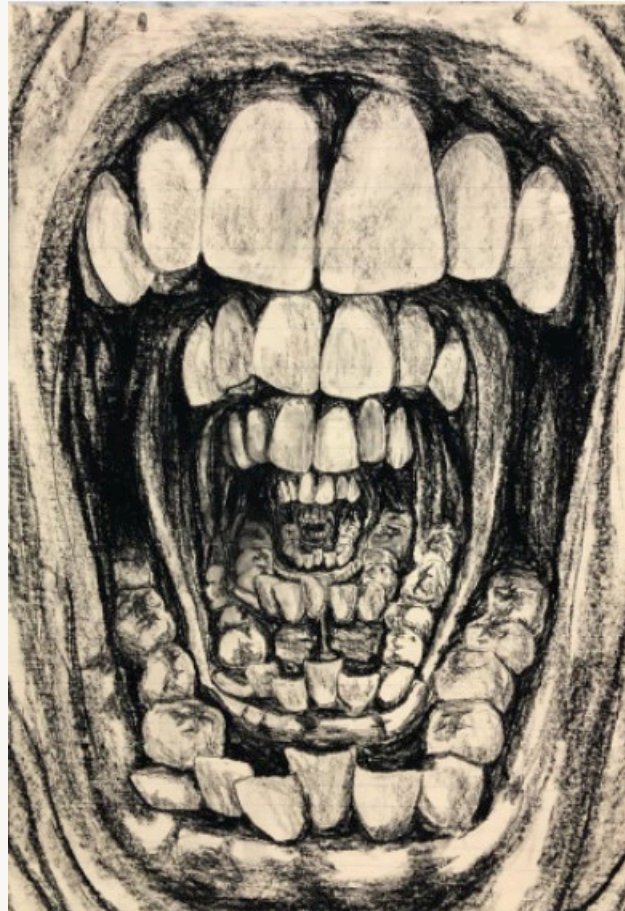
Psychosis – A State of Ultimate Isolation

	Self	Important Others	Community
Etiology	Identity Vulnerability - Existing MH condition - Default Mode Network - Emerging Adult On-set	Interpersonal Vulnerability - ACEs - Interpersonal Trauma - Social Isolation	Minority Stress
Expression	Boundaries <i>within</i> self break apart: (+) Self is Disorganized (-) Self Is Absent	Boundaries <i>between</i> self/other break down: - Others are Too Close - Others are Too Far Away	Absence of Shared Reality
Effect	Less Cohesion	Less Connection	Reduced Participation and Roles

Isolation in Etiology

**"Racism eats away
at the ego... the ego
starts to
deteriorate."**

Keris Myrick

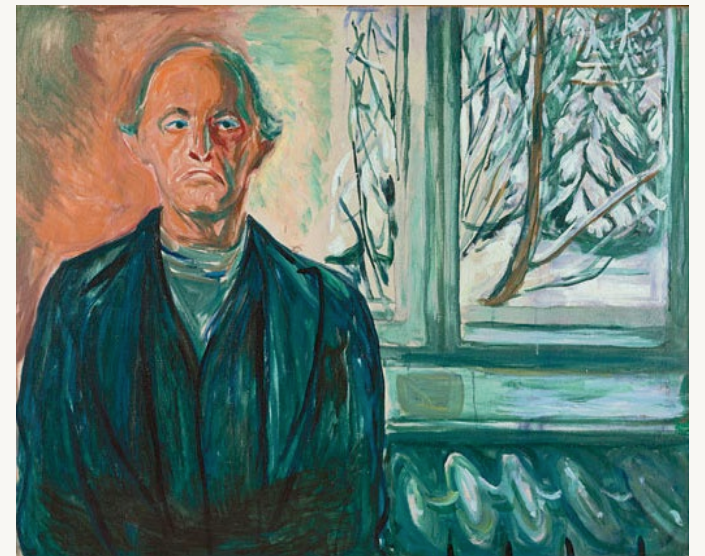
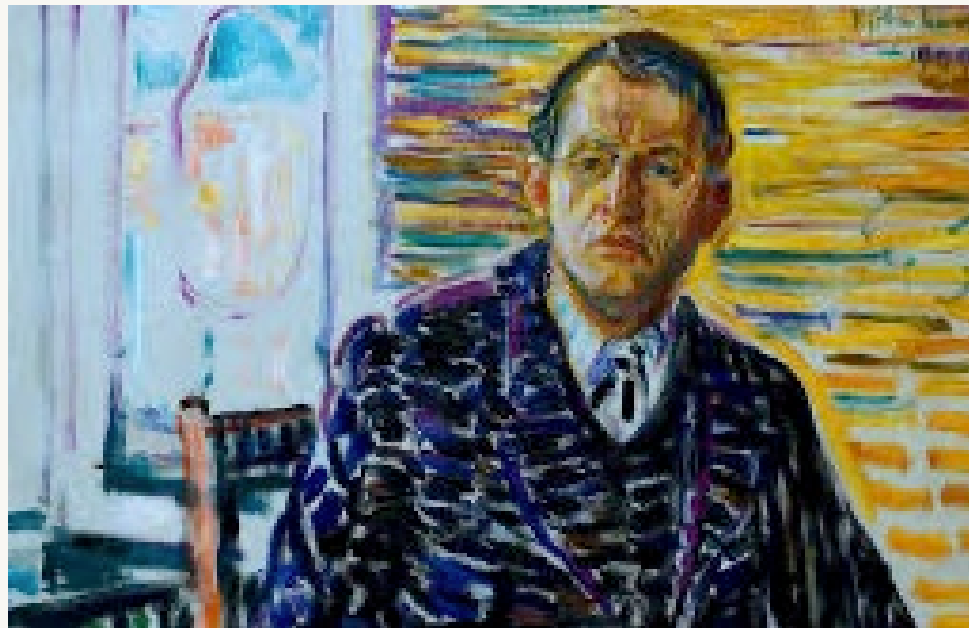


**As I drew my
self-portrait on a
white sheet of
paper, the
student next to
me said
“but you’re
not white.”**

Psychosis – A State of Ultimate Isolation

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Isolation in Expression



Self Portraits of Edvard Munch 1881, 1909, 1940

"One's center gives way. The center cannot hold. The 'me' becomes a haze, and the solid center from which one experiences reality breaks up like a bad radio signal."

Elyn Saks



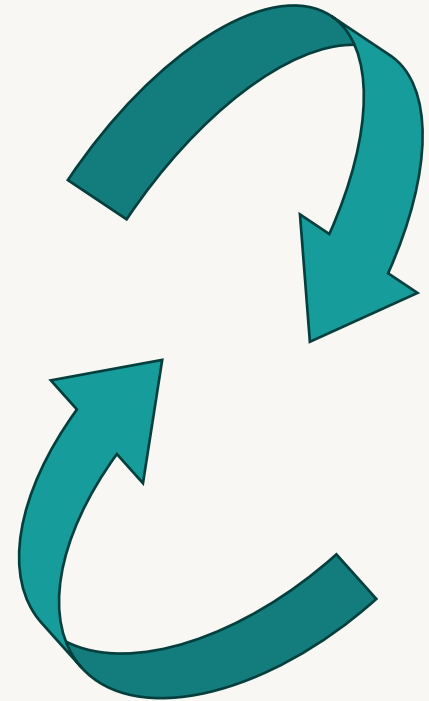
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Isolation in Effect

“Dropping in and out of your own life (for psychotic breaks, or treatment in a hospital) isn’t like getting off a train at one stop and later getting back on at another. Even if you can get back on (and the odds are not in your favor), you’re lonely there. The people you boarded with originally are far, far ahead of you, and now you’re stuck playing catch-up.”

Elyn Saks



Psychosis – A State of Ultimate Compounding Isolation

	Self	Important Others	Community
Etiology	Identity Vulnerability - Existing MH condition - Default Mode Network - Age of On-set	Interpersonal Vulnerability - ACEs - Interpersonal Trauma - Social Isolation	Minority Stress
Expression	Boundaries within self break apart: (+) Self is Disorganized (-) Self Is Absent	Boundaries between self/other break down: - Others are Too Close - Others are Too Far Away	Absence of Shared Reality
Effect	Less Cohesion	Less Connection	Reduced Participation and Roles

Current Limitations:

Medical Model:

- Response rate: ~20-50%
- Non-Adherence rate: 20-60%
- Largely target only positive symptoms
- Side effects are burdensome, can carry additional cardiometabolic risks

Current Psychosocial EBT:

- Small-to-medium effect sizes (CBT-P, MCT, SST)
- “Teach for the Test” results
- Do not directly target functional goals

Systems of Delivery:

- Coercive care can cause further trauma, mistrust
- IP -- removal from an individual's social network
- OP – access is low, attrition rates are high

Current Outcomes:

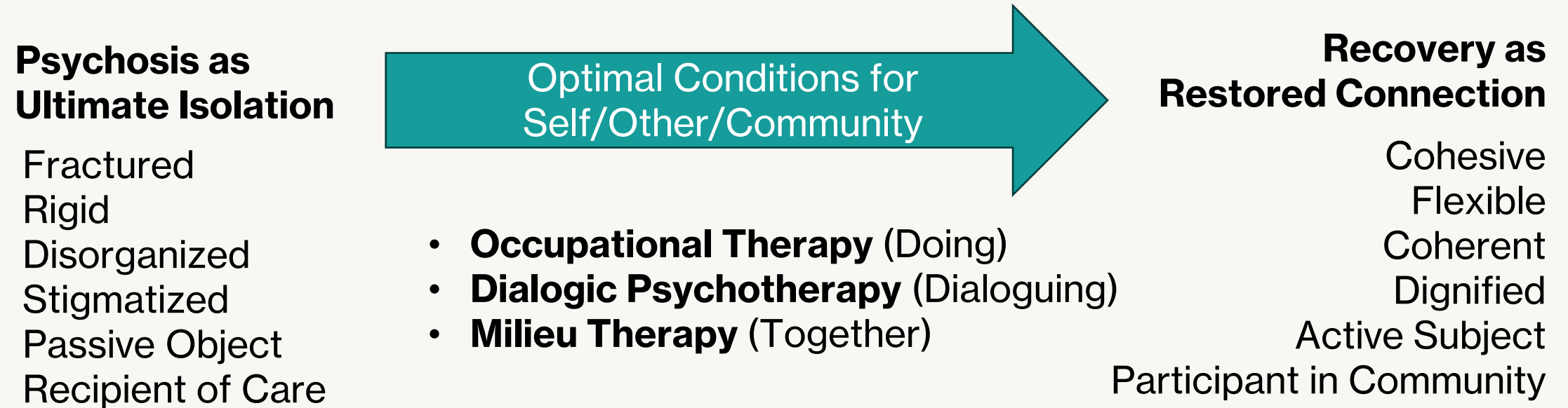
- Avg **15.37 years** reduced life-span
- Higher Rates of **Homelessness**
- Higher Rates of **Unemployment**
- Higher Rates of **Incarceration**

What then?

Cultivate optimal conditions for the rehabilitation of self/other/community connection, which research indicates:

- **Increases treatment engagement and adherence,** lowers the risk of relapse
- **Improves social cognition and social connection,** has strongest association with overall psychosocial functioning compared other all cognitive variables
- **Directly address functional goals,** to provide socialization, self-esteem, autonomy, community

Multi-dimensional Recovery Requires Multi-modal Intervention!



Occupational Therapy – Doing...

What is Occupational Therapy?

Occupation as the Core of OT Practice

- Engagement in meaningful occupation is both a **determinant and outcome of health**
- Participation is not just the goal – it is the **mechanism for change**

Definition of Occupation

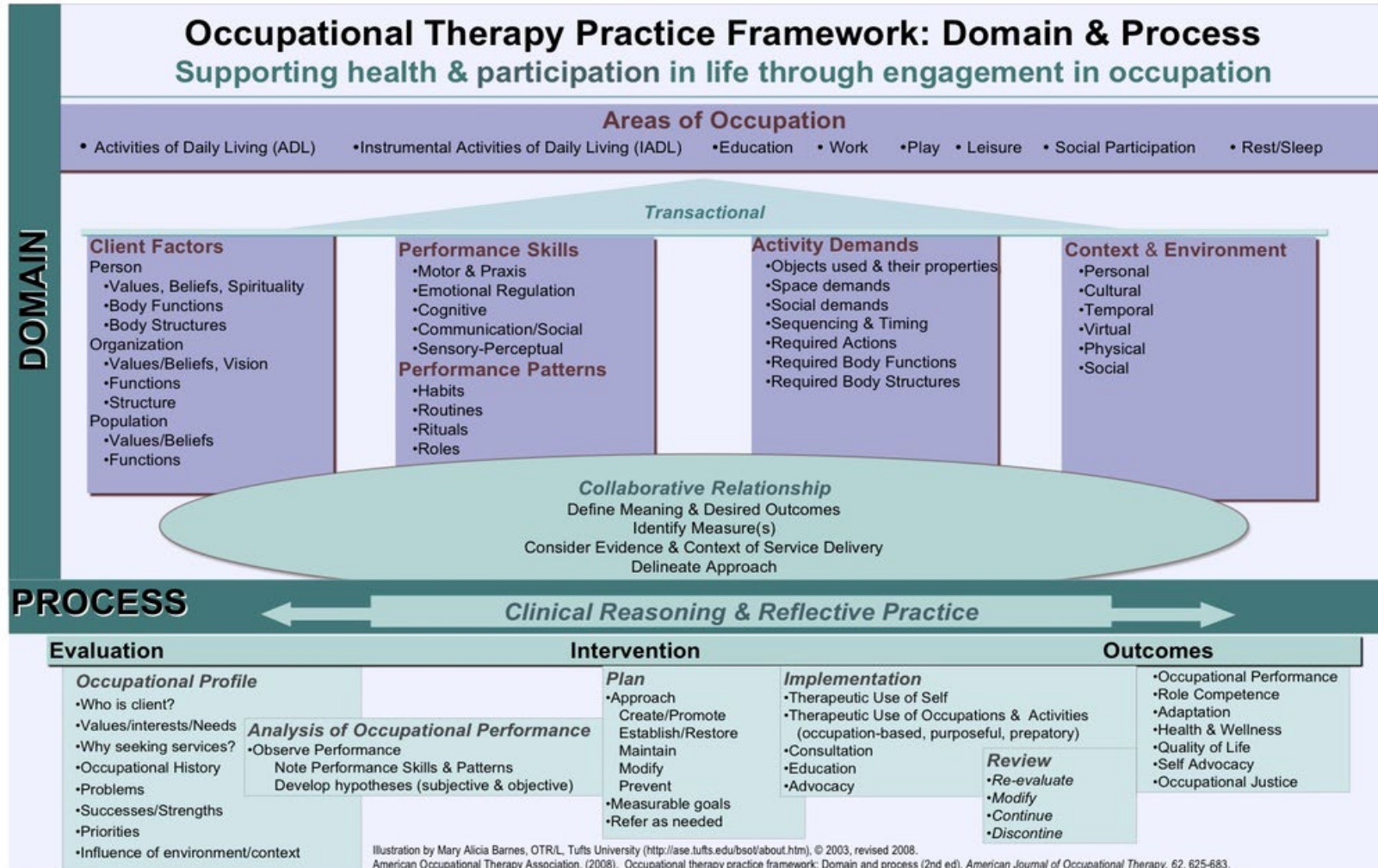
- Includes: ADLs, IADLs, work, rest/sleep, leisure, social participation
- Structures time, provides routine, and creates meaning and purpose

Occupation & Identity

- Central to identity and role fulfillment
- Disruption (injury, illness, psychosocial factors) can lead to: role loss, decreased self-efficacy, reduced participation

Implications for Practice

- Evaluation and intervention are **occupation-based and occupation-focused**
- Emphasis on: Functional, meaningful goals and participation in valued roles and routines



Occupational Therapy History in Mental Health

Moral Treatment Movement

- Shift from restraints/punishment → **compassion, dignity, respect**
- Emphasized: Structured daily routines , Meaningful activities, Social engagement
- Use of work, crafts, gardening, and recreation as therapeutic tools

Influence on Occupational Therapy

- OT evolved directly from these principles
- Continued focus on: Meaningful engagement , structured activity, Individualized care

Arts & Crafts Movement

- Promoted connection between **hand and mind**
- Valued creativity, productivity, and therapeutic use of craft

World War I Impact

- OT used in rehabilitation of soldiers
- Addressed both: Physical recovery and psychological well-being

Early Occupational Therapy



OT in Residential Care with Adults with SMI

- Functional recovery is center of program
- Initial Assessment
- 3 Phases of treatment
- 1:1 meetings
- Focus on steppingstones
- Constant observation/assessment
- Groups/House meetings
- Milieu management
- “Social Matchmaker”
- “Cruise ship director”

Dialogic Psychotherapy – Dialoguing...

Open Dialogue: "The History of the Idea"



- Both a **system of care** and a **therapeutic style**
- Developed in Finland in the 1990's for first-episode psychosis
- Heavily influenced by **humanist, intersubjective, family systems, narrative, and post-modern** philosophies
- **Finnish studies:** show overwhelmingly reduced rates of hospitalization, absence from school/work, and reliance on medication, with gains maintained at 5, 10, and 19 year follow up
 - Limitations: No current RCT data, not generalizable outside of Finland due to unique cultural and systemic factors
- **International studies:** show more positive perceptions of care by patients/families, reduced length of stay in the hospital, and improved social functioning
 - Limitations: Small sample sizes, Mixed fidelity criteria, qualitative data
- **Further research is needed for Open Dialogue to be considered evidence-based**
 - Current RCT underway **ODDESSI** study in the UK NHS

Dialogic Psychotherapy

Clinical Goal:

- Develop shared language
- Integrate multiple voices, perspectives
- Promote movement / “new” understanding
- Collaboration over coercion

Therapist Stance:

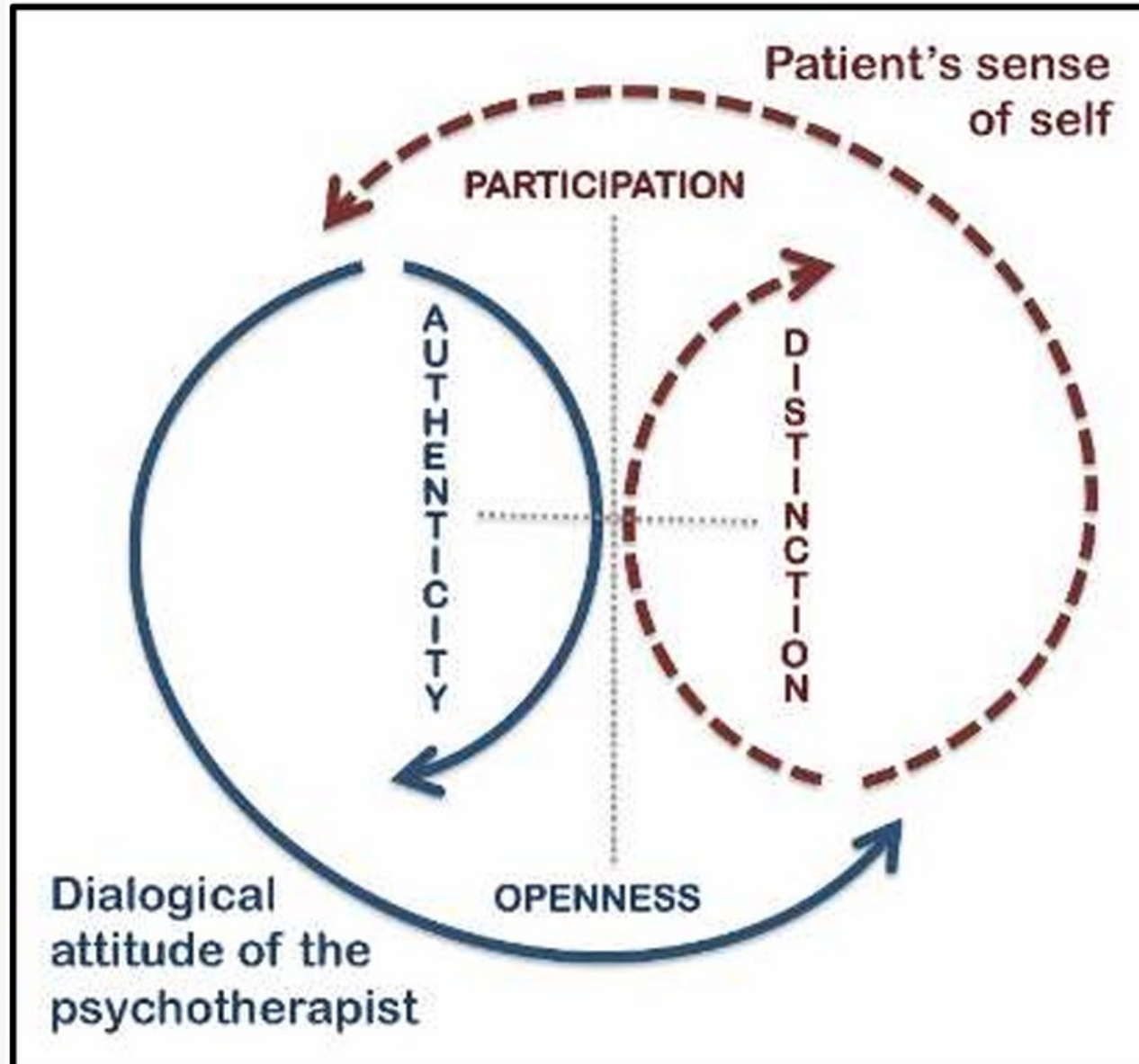
- Drop clinical gaze / jargon
- Curious, “not-knowing”
- Explicitly transparent, warm, hospitable
- Genuine, self-as-instrument

Structural Elements:

- Multidisciplinary Team Rounds in 3-Parts
- 2 therapists in the room whenever possible
- Active family/network involvement
- Treatment conversations with patient/family present whenever possible

Table 2: The Twelve Key Elements of Fidelity to Dialogic Practice in Open Dialogue

1. Two (or More) Therapists in the Team Meeting
2. Participation of Family and Network
3. Using Open-Ended Questions
4. Responding To Clients’ Utterances
5. Emphasizing the Present Moment
6. Eliciting Multiple Viewpoints
7. Use of a Relational Focus in the Dialogue
8. Responding to Problem Discourse or Behavior in a Matter-of-Fact Style and Attentive to Meanings
9. Emphasizing the Clients’ Own Words and Stories, Not Symptoms
10. Conversation Amongst Professionals (Reflections) in the Treatment Meetings
11. Being Transparent
12. Tolerating Uncertainty



**"Dialogic Dance"
creates greater self-
coherence via
safe experiencing of
relatedness**

Milieu Therapy – Together...

Milieu Therapy

Definition

- Intentional, structured environment designed to **promote behavioral change** and improve psychological functioning

Core Components

- Containment
- Support
- Structure
- Involvement
- Validation

Role in Treatment

- Promotes recovery, safety, and stability
- Enhances interpersonal relationships and sense of community

Client Outcomes

- Increases autonomy and responsibility
- Builds self-esteem and decision-making skills
- Reduces isolation

Basic assumptions of a therapeutic milieu

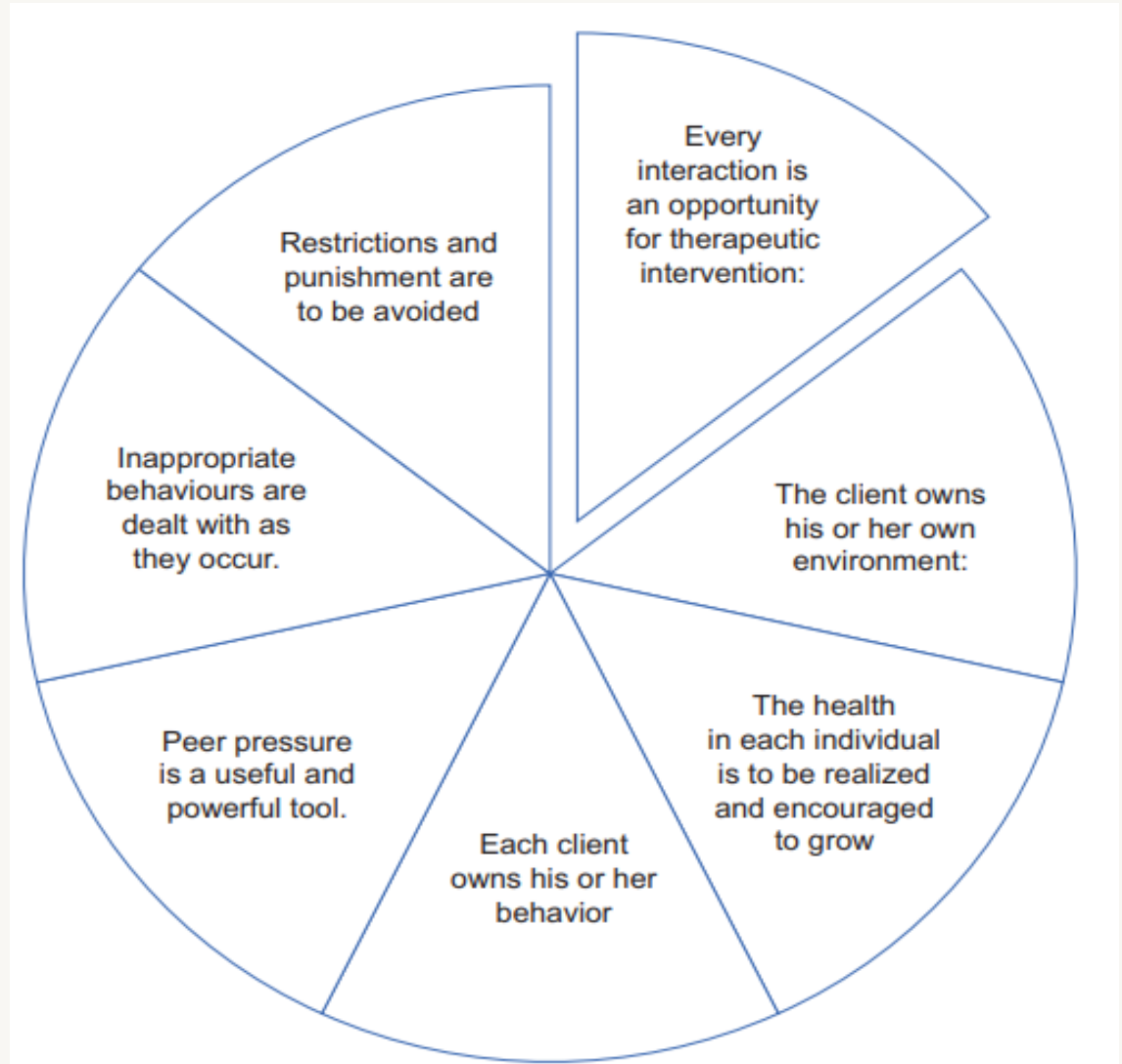


Figure 2: Basic assumptions of establishing a therapeutic milieu

Case Example

- **Clinical Blurb:** Single white male, 40s, with schizophrenia & polysubstance use.
 - Isolation as **etiology:** second-generation immigrant; DV homelife; vulnerable self-esteem; creative/romantic/occupational frustrations
 - Isolation as **experience:** grandiose and referential delusions; paranoia; became entirely homebound; refused treatment for 10 years
 - Isolation as **effect:** assaultive bx and traumatic arrests; court-committed to IPLOC and LAI; under guardianship; on probation
- **Occupational Therapy:** established goals; identified stepping-stones; gathered and discussed observed obstacles to completing stepping-stones; progressed to supported volunteer; returned to former hobbies and expanded to new communities.
- **Dialogic Psychotherapy:** relational emphasis built trust, disclosure, insight, medication adherence; network emphasis modulated imbalanced participation and was de-stigmatizing; “dialogic dance” allowed for Pt's experiencing dignity/vulnerability, connection/separateness safely and simultaneously (“dissolving” the problem vs. “solving” the problem)
- **Milieu Therapy:** involvement in group programming, van trips, became a leader in the milieu, encouraged others' participation, in-vivo social skills practice and habituation to formerly feared and avoided social situations
- **Outcomes:**
 - **For the individual:** Guardianship removed; Voluntarily receives LAI; Discharged to transitional living and ACT team; Still sober, quit cigarettes/vaping; Active regular participation in church, yoga, poetry slams, stand up comedy, Corrective experience with mental health care and reduced stigma
 - **For the network(s):** Contributed his strengths and passions to the milieu to the benefit of peers; Improved relationships with parents and siblings; Reconnected with niece with special needs; Parents stayed in couples therapy; Family vacation to country of origin

Multi-dimensional Recovery Requires Multi-modal Intervention!

Psychosis as Ultimate Isolation

Fractured
Rigid
Disorganized
Stigmatized
Passive Object
Recipient of Care



Optimal Conditions for
Self/Other/Community

- **Occupational Therapy** (Doing)
- **Dialogic Psychotherapy** (Dialoguing)
- **Milieu Therapy** (Together)

Recovery as Restored Connection

Cohesive
Flexible
Coherent
Dignified
Active Subject
Participant in Community

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AUDIENCE Q&A

FINAL THOUGHTS

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- Take our survey immediately after the webinar has concluded.

THANK YOU!

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