

Moderator: Hello and welcome to today's webinar, *Doing & Dialoguing Together: Multimodal Treatment for Psychosis*. This topical webinar is paid for by McLean Hospital, a psychiatric teaching hospital and affiliate of Harvard Medical School, specializing in mental health treatment, research, education, and patient care.

Some important points before we get started. 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. APA does not endorse any products or services. The content was created by McLean Hospital and does not reflect the views of APA or its editorial staff. Email advertising@apa.org to learn more.

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Now let me introduce our presenters. Jackson Ardery is a clinical social worker and an 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. He 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 with relational motivation in the therapeutic space.

Jessie Roberge 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 Division of Psychotic Disorders 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 Rounds planning committee. Welcome, Jessie Robbins Roberge and Jackson Ardery.

Jackson Ardery: Good afternoon. Thank you so much for having both Jessie and myself here today. It's a privilege to be here. We're excited to be here, particularly because neither of us are psychologists, and I realize that we're here presenting with

the APA. I think that actually is quite fitting for our topic today. Namely, that in the treatment of psychosis, which we'll really conceive as a disorder or series of disorders surrounding this theme of profound isolation, in that complex treatment we actually need all hands on deck. That includes all disciplines, and the more voices and people, the better. Just want to put that plug out there that we're glad to be here. I think it's actually fortuitous, this interdisciplinary arrangement.

Diving right in, our goal today—thank you for that introduction—is to think about psychosis from a psychosocial lens. We're not setting aside the medical model completely. It's certainly still very relevant, but for the purpose of today's conversation, we're really focused on relationships, functionality, and how we come about those outcomes in ways in addition to medication.

This kind of cheeky combination of "Doing," "Dialoguing," and "Together" is really focused around three main modalities: Occupational Therapy, Dialogic Psychotherapy, and Milieu Therapy. We'll end the presentation with providing some clinical examples of their application in specialty residential care. Then, ideally, we're going to have time at the end to take questions.

We'll start, actually, with a bit of a refresher. What is psychosis? What are we dealing with here? On the left, we're talking about psychosis as a symptom. Now, notably, psychosis as a symptom can actually occur transdiagnostically, and it can occur at a range of severity. What we're thinking about broadly when we talk about psychosis is a break with reality.

What that comes to mean, and specifically, can be different for different people. We're thinking about these main buckets of positive symptoms, which means anomalous or unique experiences like hallucinations or delusions, perceptual experiences that are added in. That's where we get this connotation of positive.

When we're thinking of negative symptoms, we can think about things that might normally be there actually being taken away. We think about abulia or anhedonia, poverty of thought (really blank or flat expressions). That's disorganized, or rather blunted affect and slowed thinking. Those are aspects of more healthy functioning that are taken away in psychosis.

Disorganized thinking and speech. Sometimes that can be tangential. That can be almost as if word salad, or somebody's thoughts are so jumbled that they're either hard to communicate, they're hard to know what they are in a linear and sequential way, and they can contribute to real difficulty in communication. That is really a foundation for forming relationships.

Then we have this bucket of disorganized behavior and motor. That can be in catatonia, or essentially just behavior that seems incongruent or bizarre to the scenario or situation. That can really set folks apart from the social setting that they're in. This lifetime prevalence for psychotic symptoms is higher than one might expect. It's at 5 to 7% lifetime. Again, it can occur even in the absence of a primary psychotic disorder. Which you'll see over on the right, our review of DSM V. Those are the main buckets of diagnoses that you might see coming across your caseload or your electronic medical record that refer to this more primary psychotic illness. That has a lower prevalence of 3%.

Between the two, is how we consider it is that it's somewhere on a spectrum of human experience on the more extreme side, and even if there's a smaller population grouping here, broadly, the impact is quite disproportionately large. These can be really debilitating illnesses in certain settings. It's worth our attention to think about how to treat them with greater effectiveness.

One of the ways that we do that, Jessie and I, in our program and in our work, is to think about psychosis from this psychosocial lens. Really conceiving of it not just as a biological disease, or something that's afflicting the machinery of the brain, but actually something that's a really lived experience of the mind and of the self. Particularly the relational self.

Looking at this chart we have here, if you have the three phases of illness—thinking: etiology, active symptom expression, and effect as the courses of illness over on the far left—then on the top right, we have these three relational domains: relationship with self, relationship to important others, and broadly, relationship to community; we can see that isolation has a great deal to do with psychosis and shows up actually in each of these phases and each of these poles.

When we're thinking about: "What are the risk factors?"—thinking about etiology here—where does isolation show up? Relative to that relationship to self, isolation shows up often in that somebody can often have an existing mental health condition that maybe sets them apart or has them feeling separate from their peers. There is also a lot of literature on the implications of the default mode network, which is this complex system in the brain that's largely thought to be responsible for consciousness and a sense of self.

Then the time at which psychotic disorders or psychotic experiences most frequently occur is in that young, emerging adult period, which is a real vulnerable state, both for the brain as an organism or machine, but also relatedly for the development of a sense of self and a sense of social self. "When do people remember identifying who they are, what they like, what their careers are, what their relationships are?" That real foundational, critical period is often when psychotic disorders can emerge.

An isolation happening in that context is notable. In terms of its relativity to interpersonal connection, we know risk factors like adverse childhood experiences, the experience of trauma, and either objective or subjective social isolation are prime. Then speaking to this larger community, what we also know is that minority stress is a big risk factor. We're going to toggle ahead for a second.

What we know about minority stress—and here I'm applying this broadly—is that for folks who have a variety of either identity-based factors or other factors are feeling apart from, separate from, or less than relative to the dominant cultural group as they perceive it, that can be a very big risk factor for psychosis. I'm going to be showing some art slides as we move through here. I think the imagery here on the right, which is part of a disability studies art presentation that was put forth by someone with lived experience, can capture how psychosis really can flourish in that space wherein someone is not feeling a part of. It can create this splintered identity and this sense of Keris Myrick, as she describes separately, this idea that the ego starts to deteriorate.

If folks are unable to read the quotation alongside this very arresting image, it says, "As I drew my self-portrait on a white sheet of paper, the student next to me said, 'But you're not white.'" Sitting with that arresting image and idea for a moment, I'm going to ask folks to hold that in their mind while we move forward.

What is psychosis in terms of the lived experience? How does this express itself? Moving from that image we just saw, we can think about relationship with self; boundaries within the self break apart. Those positive symptoms, those things being added in, like delusions, hallucinations, that is where we would think about the self, that sense of self being disorganized. It can be fractured.

When we think about negative symptoms, that removal of identity, thoughts, words, feelings, that's where what we would term the self as becoming absent. Then, thinking similarly, boundaries between self and other break down. As in paranoia, others are too close. "People are thinking of me. People are too attentive to me. Please, you need to step back. I don't feel safe." When folks are more internally preoccupied with their symptoms, or there's that remoteness from negative symptoms, others are experienced to be too far away. Again, this can have this impact that, globally or rather in a broader way, that sense of community, there's no shared reality. That's troubling and can characterize someone's sense of relationship with the world around them.

This is actually Edvard Munch. I don't know if folks know *The Scream*, which is a more famous painting. He was a painter who also had schizophrenia and was institutionalized later in life. The portrait on the left shows him as a young man, where there are very clear boundaries. It shows where he starts and where he ends. He maybe has a suspicious look on his face. Mind you, I'm not an art critic, nor do I mean to overanalyze this artwork, but I think it can provide a bit of an image and a felt experience of what psychosis can be like.

Moving from a sense of very discrete boundedness of self and other, to then here in the middle, when he first presented for care. This was actually a self-portrait that he did referencing being at an initial hospitalization where the colors are vibrant, but there's a breaking down of boundaries between himself and that around him. It's more unique. These are interesting colors that are not quite the same as on the left. On the far right, in these negative symptoms, he's almost regressed almost entirely into the wall. There's less differentiation between him as a vibrant, distinguished internal subject and the environs around him.

Here's another interesting example, but given the time, I want to keep us moving. I'll say here that Elyn Saks, *The Center Cannot Hold*, she says, "The me becomes a haze and the solid center from which one experiences reality breaks up like a bad radio signal."

Then what is the effect of all this? That if there's already a vulnerability with a diffuse sense of self, the effect of active, untreated symptoms means that there's less cohesion. If there's already a vulnerability with others not feeling connected, the effect of active symptom expression is then further less connection. Similarly, for community, if you're already feeling ostracized, oftentimes the effect is reduced participation in roles.

Elyn Saks has another quote that I want to call out, which says, "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." The idea is that this is a state of ultimate compounding isolation, which then increases somebody's risk the next time around.

Moving forward, where are we right now? What are the current dominant models for the treatment of psychosis? Broadly, it's thought to be the medical model of, "Treat folks with medication, with neurotherapeutic interventions." Those are really our frontline treatments, and for good reason. I think it's important to note that there are some limitations here. One, that the response rate, it's not a slam dunk every time; we're looking more at percentages of 20-50% for the antipsychotics being effective. Then there's also a very high nonadherence rate of 20-60% that for those whom the meds do work, some folks it's really hard to get them to stay on their medication. Oftentimes, because of the side effects, can be burdensome, or they can even carry other metabolic risks that have troubling effects that can make it hard to stay engaged in treatment.

The other evidence-based psychosocial manualized treatments that we have that are very good—CBT for psychosis, metacognitive training, and social skills training for schizophrenia—have good small to medium effects. There is some question of: Are they test for the test results? Are they able to really generalize to real-life social situations? Do they move the needle in terms of what we would term epistemic trust, that foundational sense of being able to apply a more robust and flexible defense in the world? Then this piece: Do they really target the functional goals adequately?

Our systems of care are also imperfect. Inpatient hospital, which many times is necessary for folks, does remove people from their most protective factor: that social network. At an outpatient level, specialty care can sometimes be hard to come by; access is low; attrition rates are high. Many systems of care have invested lots of important dollars into increasing or optimizing treatments and bettering outcomes. What we do know, though, is that still, even today, there's a greatly reduced lifespan, higher rates of homelessness, unemployment, and incarceration. These can really cause trouble for families, individuals, and communities.

It's not all doom and gloom. Why are we here? One, because this matters. Two, because I think we are in a position—Jessie and myself—to be able to actually pull lots of resources from different domains. We're not striated or siloed into just modalities operating in isolation; we actually get to leverage one another's skills and different interventions that complement each other really well. Where I think the unity is that they can really cultivate optimal conditions for this self, other, and community connection, which the research indicates is a really helpful predictive factor.

Ultimately, we're moving from psychosis as ultimate isolation to recovery as this idea of restored connection. These are the three modalities that we're going to dive into. I'm going to hand it over to Jessie. Here we go.

Jessie Roberge: Thanks, Jack. Occupational Therapy is grounded in the understanding that engagement in meaningful activity and occupation is a

determinant and an outcome of health. Participation isn't just the goal; it also can be the mechanism by which change occurs. We're using the word occupation in the broad OT sense. This encompasses activities of daily living, also known as ADLs, instrumental activities of daily living, also known as IADLs, work, sleep, leisure, and social participation. These activities organize our time, provide structure to our days, and are inherently tied to meaning and purpose in our lives.

Occupations are central to our identity formation and role fulfillment, and disruption in these occupations, whether it's due to injury, illness, or psychosocial factors, often results in role loss, decreased self-efficacy, and reduced participation in occupations. This is why both evaluation and interventions are occupation-based and occupation-focused. We're not just remediating impairments and isolation; we're analyzing performance within context, targeting function and goals, and facilitating participation in meaningful roles.

This very wordy slide right here is the Occupational Therapy Framework. It's organized into two parts: the domain and the process. The domain is what we address. The occupations, as I already said, ADLs, IADLs, work, and social participation, as well as all the factors that influence the participation. The process describes how we provide the services: through evaluation, outcomes, while staying client-centered and occupation-focused.

To give an example, if we're working with a 25-year-old individual experiencing auditory hallucinations, paranoia, and decreased motivation, they may have stopped working, having difficulty maintaining their apartment, and maybe spending most of their day isolated in their room. The OT first looks at how is psychosis affecting meaningful areas of their life. Maybe their showering and dressing has become inconsistent. Maybe they're having difficulty preparing meals, managing medications, maintaining an apartment. They may have stopped work or school. They may be avoiding friends or family because of these paranoid thoughts. They may no longer participate in leisure activities or social opportunities. They may have irregular sleep.

The OT question is: What does this person want and need to be able to do in their everyday life? The OT looks at the routines that might have changed. Maybe they used to have a morning and work routine that now is pretty inconsistent. They may now stay in bed most of the day. Maybe their meals or meds have become inconsistent. Maybe they've socially withdrawn from the people in their life. The goal isn't to simply eliminate the psychotic symptoms, but to help the person reestablish functional routines despite these symptoms.

The OT often considers many different client factors that might be affecting the occupational performance. The mental functions: attention, organization, motivation, reality orientation. The emotional functions: anxiety and fear related to the paranoid thoughts. Their beliefs and values, trusting people, having difficulty trusting others. Energy: maybe they have a decreased activity level. As well as looking at all the different environmental factors. Is the home environment supportive? Are there family members that can assist? Is the person able to access community resources? Does the person feel safe in their own environment?

The OT really provides interventions that are occupation-based. We might work on cooking. Rather than practicing attention, the OT is preparing a simple meal with the

person. Can work on sequencing, initiation. This is seen every week in the cooking group in our house. Might work on establishing morning routines, helping them figure out what a healthy morning routine looks like for them.

Once stable, the OT might help the person get out more in the community. Maybe take a short trip to the coffee shop, the library, or a volunteer opportunity to help them work towards their goals of being out more in the community or returning to activities that are important to them, as well as reconnecting with people that provide social opportunities in their life.

The key OT perspective is that psychosis may affect the person's ability to engage in occupations, but the occupation can also be the vehicle for recovery. The OT is often asking: How is the psychosis affecting the person's ability to live their life? How can engagement in meaningful occupation be used to support the recovery?

While only 3% of occupational therapists actually work in mental health, our roots are in mental health. The Moral Treatment Movement moved from harsh restraints and physical punishments to treating individuals with more compassion, dignity, and respect. This had us move towards more daily routines, meaningful activities, social engagement, using things such as crafts, working, gardening, recreational activities and seeing the therapeutic benefits. OTs directly evolved from the principles of Moral Treatment and early founders of the profession retained focus on meaningful engagement, structured activity, and individualized care.

The Arts & Crafts movement also had an influence on the profession of OT. The movement proposed that the increase of leisure and productivity through the connection of the hand and the mind were therapeutic.

Occupational Therapy during World War I played a crucial role in soldiers and rehabilitation of the soldiers focusing on both physical and psychological well-being. We can see some pictures of different early Occupational Therapy.

If I'm looking at Occupational Therapy in residential care, functional recovery is the center of the program. Occupational Therapy. I do an initial assessment of every individual that comes into our program. When I first meet with the resident, I have them share about themselves, but ask them to not share about their mental health. I tell them that in psychiatry, we are really good at asking what's wrong. There's a lot more to them than what's gone on recently in their lives. I eventually ask what's brought them to treatment and how it's affected them functionally.

I see my work in three phases with them. The first phase of treatment is really getting them settled into our program, into our milieu, getting into the groups, building daily structure, attending to their ADLs, participating in leisure activities, and building social connections in our house. The second phase is really getting the resident out into the community, doing the activities they want to be doing when they leave, including taking classes, volunteering, going to the gym, meeting up with family and friends. The third phase is setting up the structure and support for them to maintain the wellness that they gained for when they leave Appleton.

When I meet with them one-to-one, I work more specifically on their functional goals and look at ways that each week they can work on their long-term goals. We do this

by breaking down their long-term goals into smaller, more achievable stepping stones to set them up for success. We live with the residents. This allows us to have constant observation, assessment, and intervention. As the OT, I run different groups such as house meetings, interpersonal skills, a cooking group, freedom through structure, weekend planning. I also help with the milieu management and rely heavily on observations from all staff to assist with my Occupational Therapy work. I've been called the "Social Matchmaker" as well as the "Cruise Ship Director" in this role.

Jackson Ardery: Thank you, Jessie. Moving into now the second dialoguing portion of our treatment, what I'm referring to here is Open Dialogue. For those who may not be familiar, Open Dialogue is both a system of care and a therapeutic style that was actually developed in Finland in the 1990s, specifically for first-episode psychosis. If you're able to see this map here on the screen, it developed in the Lapland region of Finland, which is that top northwest corner on the border of Sweden. It's a unique place in that it was very remote. There was a heavy investment in the municipal healthcare system, and there was a lot of public support around addressing what had become this real surge of first-onset psychosis in the area.

The influences there philosophically, psychotherapeutically, heavy on humanism, family systems, and narrative therapies from the US, as well as postmodernist philosophies. It was, in some ways, outside of a more traditional framework. They had the intellectual ideas that the community support, and a relatively small and very niche community in which to try out some interventions that were less focused on the medical model and that were supported in a really unique way. We'll get to that in a second, but just to review the state of research on this.

The original Finnish studies done were remarkable. They had really, really incredibly strong outcome data that were maintained at 5-, 10-, and 19-year follow-up, with really compelling numbers around reduction in the use of antipsychotic and neuroleptic medication, big surges in resumption of school and employment, and way decreased hospitalizations. What I want to have a big asterisk and caveat here is that this was RCT data; it was not generalizable outside of Finland due to these unique cultural and systemic factors. Open Dialogue is not currently considered an evidence-based treatment.

There have been, since that time, a number of international studies that are more qualitative or smaller populations. They do show positive perceptions of care by patients and families, reduced length of stay in the hospital, and some improved social functioning. The exciting thing is that there is currently an RCT underway in the UK through the National Health Service. We're interested in and very much looking forward to the outcome of that data. At present, I want to really acknowledge that further research is needed for it to be considered evidence-based.

What exactly is Open Dialogue? It's a little bit funky and a little bit weird, but we like that. It's based around, if you see on the right side of your screen, these 12 key elements which mark fidelity to dialogic practice. These 12 elements—what I want to say, first off—the way that we apply them in our particular program—Jessie and myself—or really the way anyone applies it outside of this niche area of Finland, any of it is going to be an adaptation. None of it is going to be the purely distilled form in which it was created, simply because our healthcare system, the infrastructure of

things, is just so radically different. That being said, there are, I think, very valuable principles from dialogic psychotherapy that we've seen great benefit from, even within a very clearly Western traditional setting of care that we're in on the grounds of a psychiatric hospital.

The clinical goal is to develop this idea of shared language. If we're thinking about psychosis as really a disorder or a difficulty of ultimate isolation where someone's mind is maybe inaccessible even to themselves and is certainly inaccessible to those around them, this idea of having a shared language is really fundamental for one having a sense of self that's cohesive; then, let alone moving from that cohesive sense of self to a functional and collaborative communicative relationship with others is paramount. Understandably, for individuals experiencing psychosis and for those around them, language can get really tricky. Some people don't agree with the label of psychosis. Some people, very understandably, don't like the language that their loved ones might use. Family members and physicians may as well really struggle with trying to convince someone that their experience isn't real or that it's running up against the constraints of reality. People can get really stuck in their poles and positions and almost trying to convince the other person that reality is a different way.

The great part about dialogic psychotherapy and the ways that we implement it is that the intention is to integrate multiple voices and perspectives—part of why we're so excited to be here with such a multidisciplinary team here—to promote this idea of movement or new understanding and to emphasize collaboration over coercion. So many folks, because of low insight or the dangerousness that can accompany the desperation of psychosis, there often can be a need to involuntarily hospitalize someone, or there can be a paternalistic desire to make decisions for the safety of someone in the community. Those decisions often need to be made.

What we do know is that when folks are on board with those decisions or able to participate in those decisions, outcomes are usually better. Some of these elements here on the right, as well as the therapist's stance, help build that relationship. Fundamentally, Jessie's work is relationship. My work is relationship. Every member on staff, it's relational work. Even if the initial goal is not immediate symptom reduction, that may be ultimately a treatment goal. The way we get to it is via relationship and functional focus. That means that even if a symptom burden remains, we've still enabled them to make connections to those they love and to engage in the world in ways they feel valued, even if symptoms remain in the picture. Often, language can be a way that we get there.

The therapeutic stance notably is to try and drop the clinical gaze wherever possible, to not use a lot of jargon, to have this curious and not-knowing stance, and to be explicitly transparent, warm, and hospitable, while also being frank and direct when there are problem behaviors that we need to address.

As an example, moving down here to structural elements, the way traditionally Open Dialogue is centered around this idea of a network meeting where everybody is coming together. That means the individual at the center of concern, their family member, any community member who might love them or be a part of decision-making, the treatment team, so that it's really this social network intervention. The way that we apply that in our program is that we have rounds where everybody is in

the room together. We try to have as many of our treatment conversations with the patient present and also with the family present.

We typically break things into three parts wherein we'll hear from the resident first or the patient, and their experience. Then we'll ask them to pause, which is actually a very interesting moment. Then have the treatment team have a conversation about what we're hearing in front of the patient. That allows them to build trust that we are sharing things in front of them, that they know what we're thinking, that anything can actually be said. If we're thinking about psychosis and particularly psychotic symptoms as an expression of what otherwise cannot be said, there is a really wonderful modeling moment where we can demonstrate that anything can actually be said out loud in front of one another, and that we can all still be safe, and that we can figure it out together.

Also, in the efforts of keeping psychological stability for everyone, including the staff, we try to have two therapists in the room whenever possible. Not because anybody's physically in danger, but it can help us keep our own minds. We also want to bring in as many voices as possible with this idea that outer polyphony or horizontal polyphony—so many voices among the treatment team—often reflect different voices inside the person. Here, when I mean voices, I don't mean auditory hallucinations; I mean senses of self, ambivalence, different desires and ideas that might be in competition. When we're able, as a treatment team with and around the person, to put voice to thought in different directions, that can also help them draw those into cohesion vertically within themselves. Then they can take action from a more centered, values-driven place.

Just as Jessie's mentioning, when they're in a cooking group and doing something functionally together, that relational setting reduces the stress and allows them to be able to proceed in that functional way. Similarly, the encircling, rather, of the treatment team and the participation of everyone can allow enough safety that they can then psychologically take the next step in their own mind.

We also, as I mentioned, have active involvement of family and network wherever possible. This is brief, but this idea of a "Dialogic Dance" that we're asking just the therapists and clinicians, all of us on the team, are balancing moving close and moving back, as is the patient, him or herself, and that being in this together, we're working it out together. That can often have *safe* experiencing of relatedness that formerly they've not had, and that can build that necessary trust for engagement in other parts of care that might be complicated, including medication. This is all ideally working together. Jessie, I'll throw it back to you.

Jessie Roberge: Thinking about milieu-based therapy. Milieu Therapy is a mental health treatment approach that utilizes a person's entire surrounding environment, both the physical and the social, as a tool for healing. The core principles of milieu therapy are encompassed in the five processes identified by John Gunderson. They are containment, support, structure, involvement, and validation. These processes are essential for creating a therapeutic environment that fosters positive change and healing.

The therapeutic milieus really help facilitate recovery, safety, interpersonal relationships, as well as sense of community. Milieus offer opportunities for

autonomy, increasing self-esteem, increasing opportunities for decision-making, responsibility, independence, and decreased isolation. Therapeutic milieu is essentially showing how a structured environment in psychiatric settings can actively support recovery, not just through the treatment individual sessions, but everything that's happening around the client. Instead of therapy only happening in one-on-one sessions, the milieu, the setting, the people, the routines, the culture, continuously shape behaviors, emotions, and recovery.

This slide shows the basic assumptions of therapeutic milieu. My favorite piece of the pie is "Every interaction is an opportunity for therapeutic intervention." Having the opportunity to live with the clients, see them getting up in the morning, starting their days, interacting with people, getting out in the community, watching TV with peers, playing a game—all these provide opportunities for therapeutic intervention.

Jackson Ardery: Moving forward, let's try and lend a little bit of vitality to all these ideas. We'll talk through a case example. Thinking about, for a bit of a clinical blurb, we've got a single white male in his 40s, diagnoses of schizophrenia and significant polysubstance use. Let's think about where was isolation in terms of risk factors and illness onset. This individual was a second-generation immigrant. Growing up, there was a significant amount of domestic violence in his home life. He had his own intrapsychic personal vulnerability factors of vulnerable self-esteem. He felt "less than" quite a bit. Then, in his young adulthood, he was outside of that initial window of emerging adulthood, but still, early on, was having a number of creative, romantic, and occupational frustrations that really were setting him at odds with where he thought he should be and actually a sense of a cohesive social network around him. These were the risk factors for him in terms of isolation.

Once he actually had his first break and illness onset, what did that look like? There were these very big, grandiose, and referential delusions that, if you think about someone who, in reality, is feeling quite insecure about themselves and less than, and that's very hard to tolerate, a defensive psychological position is then to project the opposite. He was very preoccupied with the levels of fame and self-reference of things in the environment around him that were really speaking to how important and central his experience was when elsewhere in his experience, he actually felt quite small.

This then led also to paranoia. He thought that others were out to get him. He ultimately became entirely homebound and had to relocate back home with parents, where he refused treatment for about a decade and was living largely in his own bedroom. The effects of this untreated and escalating psychosis was that he eventually became assaultive with members of his family and with local authorities. He had a couple of traumatic arrests. He ultimately was court-committed to an inpatient unit and was on a long-acting injectable antipsychotic. When he came to us, he was under guardianship and on probation. Jessie, you want to take care of the start of treatment?

Jessie Roberge: Yes. When he first came into treatment, we helped him establish his functional goals. He had been working in the entertainment industry. One of his big goals was to get back on stage to an open mic night. He also wanted to develop more of a relationship with a niece and his family members, as well as work on his physical health were three main goals in Occupational Therapy.

We started to work on some stepping stones. He had been on an inpatient unit for quite a few months before, and so he was eager to get going on these goals. We started to get out there, and he said he was going to ride his bike to the local gym, and was not able to leave our little area of the campus because he started to have referential thinking around the sirens that he was hearing. We continued to gather and discuss the different obstacles for completing these stepping stones. He would often share these in my individual session, but was really quite guarded with Jack and the MD in fear of more treatment, more medications, labels put on him, so we would use our rounds to really bring in all the different voices of what he was sharing in the different sessions.

He eventually progressed to a supportive volunteer. He continued to have symptoms out in the community. He was in a van with a staff member going to a volunteer in Boston, thought the police officer directing traffic was doing hand signals to him. We continued to work through these different symptoms and helped continue to help him gain insight to his illness and continue to work on his functional goals. He returned to many former hobbies. He ended up on that stage many times. He expanded to new communities, joined a church community, gym community, made friends in the different communities out there, got into physical health. Now we can go back to the dialogical.

Jackson Ardery: Jessie's already spoken quite eloquently to the ways in which even the dialogic stance really got integrated from the start, and allowing his disclosures to Jessie be in the same room as the psychiatrist and the therapist, the things that he might have formerly associated with, "When I disclose these things, treatment clamps down, and I get restrained," or "I get this, that, and the other," he was able to have this experience that we could actually talk about that openly, and those outcomes didn't happen. We could, with curiosity, support him and be open to his experience without it having to be something that he had to guard, to hold close to his vest, or to convince us of anything.

Family work was really important for this particular resident, given the influence of family dynamics and the reality that he was under guardianship, and intended to have a pretty close relationship with his family moving forward. We were able to have that Dialogic Dance where he could trust me to temper some of the loud voices of family, to allow his voice to be present in a way that he felt dignified, and have a corrective experience overall. That doesn't mean that every family meeting was-- obviously, there were troubling times, and there were challenges, but the system was able to tolerate it, and he was able to tolerate it.

We also got him to voluntarily take his next LAI. When he entered treatment, he was very much opposed to that, and was very wary of medication, and had very low insight around diagnosis. The interesting thing was, particularly with the functional piece and the way that he was able to trust us and have these experienced relationships, was we didn't have to talk about the diagnosis that much. We could have the lived experience together of, "Oh," and he could have it too, that he noticed when he took his medication, he was able to connect with others better. He was able to have others say to him that they felt more connected to him, and because we had built this foundation, that we had this shared trust in his values and his goals, and he could experience us as really supportive of that—he was no longer under

guardianship at that point—he was able to independently make the turn and the decision to continue receiving the medication.

We've spoken a little bit to Milieu Therapy. I want to make time for questions. I think we can close on perhaps: I've spoken a little bit about the individual outcomes and how those were so positive. He's still doing very well in the community. He's not been hospitalized again, still sober, active, and participatory. I wonder, Jessie, if you can speak a little bit from the network's perspective, including the community of the house where you saw the benefits.

Jessie Roberge: He really prided himself about being a good student prior to illness, and the groups were an opportunity for him to shine at the beginning. He would take notes. He would reference skills that he was learning. Even just joining those from day one built his self-esteem a little bit more. Going out on our van trips with staff were safe to him of getting out in the community with others around. He became a leader in the milieu. He was able to see the benefits of having positive peer relationships, which then trickled over to the other relationships in his life and made him really think about other communities and relationships that he wanted for himself.

Jackson Ardery: This really was a quite incredible case. It's not unlike many others that we've seen: the results of this process. As a summation, our position is that if thinking about psychosis is ultimate isolation with this fractured, rigid, disorganized, stigmatized, passive object, recipient of care experience, the integration of these three modalities in particular: Occupational Therapy, Dialogic Psychotherapy, and Milieu Therapy can help move someone towards recovery as restored connection where someone is feeling cohesive in their identity, more flexible in their thinking, more coherent in their sense of self, dignified, they're an active subject, and most importantly, not just for them, but for those around them, they're a participant in their community where they not only benefit, but we benefit and their families and communities as a whole do as well. I think we're coming to a close there. If I can invite our moderator in, we may be transitioning to questions, Q&A here.

Moderator: We are now moving into the live Q&A. Thank you to everyone who submitted questions during registration and to those adding them in the Q&A box today. Jessie and Jackson will do their best to answer as many as possible, though they may not get to all of them. Your questions are appreciated. Let's dive in. Take it away.

Jackson Ardery: Thank you so much. Jessie, I'm pulling up our Q&A box here. I don't know if there's any one that jumps at you that you'd like to answer first.

Jessie Roberge: How about the one that says: "How do you handle disorganized behavior? For example, risky behaviors in the context of Open Dialogue." I would say that is something that we use and provide examples in the rounds and try to really use nonjudgmental language. Like, "I notice it's been difficult for Jack to wear clean clothing," or "I notice that he seems to be having a hard time getting to groups. I'm wondering if there's anything that we can help Jack with. Can we help him with different organizational tools?" Then the different members of the team will chime in with different suggestions they may have.

I think also the structure of our program can really help with disorganization, and the peers themselves help guide each other with the disorganized behaviors. We see people take on leadership roles in getting people to the different things and helping people stay organized. Any thoughts?

Jackson Ardery: Yes, I think that's fantastic. The other thing that I might mention is, from a dialogic perspective, tolerance of uncertainty is a big value. For many folks, they've had this experience, and for helpers and loved ones as well; there can be this knee-jerk desire that, "Oh, something is wrong, we need to act. We need to change a medication right away. We need to hospitalize someone." Particularly if somebody's behavior seems a bit bizarre, seems impulsive, there can be that urgency to act. In some cases, it's absolutely necessary that we act, and I think from a dialogic perspective, we want to pump the brakes a minute that, "Actually, is there a way that we can sit together and avoid hospitalization?" Because so often that can have an iatrogenic effect. It can damage self-esteem. It can damage therapeutic relationships. It may be the flash that's distracting from a solvable problem underneath. One, just having some caution around not acting too soon. As Jessie mentioned, really being compassionate, being curious with the person as to what's coming up for them.

Then also being transparent about boundaries. I might say, "I can really appreciate that Jessie just gets so taken by this idea of going running late at night. She just gets so taken by that. She wants to move her body. It feels good. She's been cooped up all day. She wants to go running. I notice part of myself really wants her to do that. I want her to feel free. I get that she's had a lot of experiences of not feeling that way, and I notice that part of myself is really worried because what if something were to happen? Jessie could be doing everything right, and what if she were to get injured and I wouldn't know how to get to her. That even owning our own multiplicity can be helpful."

I wonder if maybe one more question, because I know we have to stop at two till. Did anything get some upvotes here? It looks like there's a question about the overlap between sense of self being disorganized in psychosis versus dissociation. I think that's actually a really fantastic question. I appreciate asking it because, at least in my estimation, in a lot of the literature that I read, there can be some overlaps between the splits and fractured sense of self and dissociation and in psychosis. I think sometimes it's also really hard to tease apart because trauma often is a risk factor for psychosis. Obviously, not everybody who's experienced trauma or who even experiences dissociation can rise to the level of a frank psychotic symptom, but I think they are interrelated.

I think when we think about disorganization in psychosis—and I'm curious, Jessie, what you would add to this—as we see it in our program, that disorganization can express itself in a wider range of ways than just dissociation that we might see in trauma. There can be an element of bizarreness, or it's really incongruent or atypical in terms of the ways it can present itself rather than just the derealization or depersonalization. I'm curious if you'd add more to that, Jessie.

Jessie Roberge: I don't think so. I think that's really where we don't wait for those things to subside before getting them out, obviously, if there's a real safety concern, but really continuing to focus on the functional piece and what can the person do and

how can we use occupations and the day-to-day life at Appleton and the community to move them forward. Those things can really help with the organization of engagement, in that suddenly they have a schedule. We saw that this week with somebody here. Jack provided a very detailed schedule and it really helped in many other ways of their day-to-day life with organization and making safe choices.

Jackson Ardery: I want to thank everybody for these questions. I'm told that we're on a tight schedule, and I want to respect everyone's time. It's been a pleasure for both of us to be here to present and discuss, and just appreciate again, the APA for allowing us the platform and a chance to chat with everybody.

Jessie Roberge: Thanks so much.

Moderator: Thank you so much for joining us, Jessie and Jackson. Thank you to all our listeners for your participation. We'd also like to thank McLean Hospital for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen. Please take the survey and give us your feedback.

We thank you for your attention and hope you have a great day.