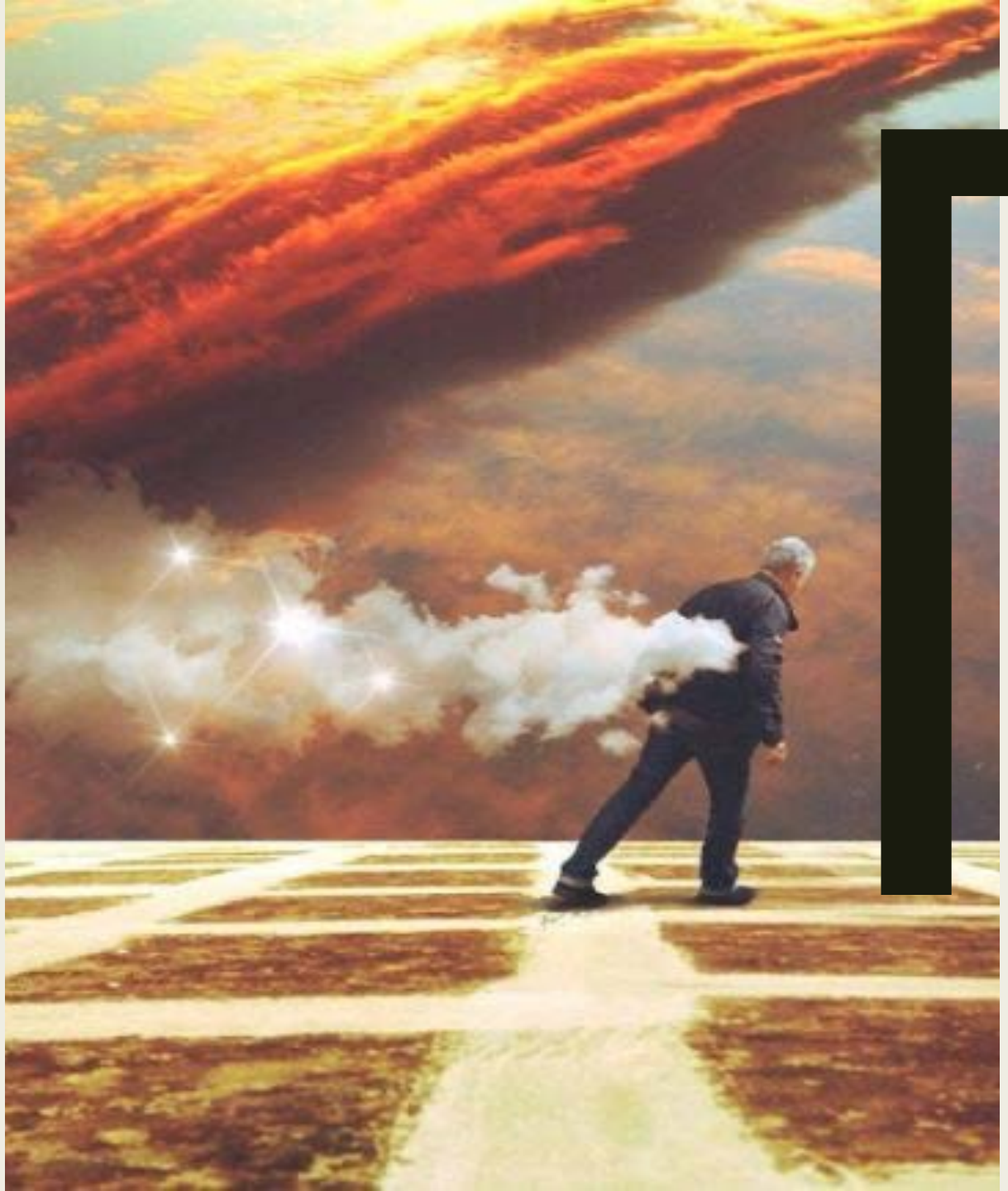

TRAVERSING SURREAL WORLDS: USING DESCRIPTIVE PSYCHOLOGY IN THE CLINICAL TREATMENT OF PERSONS WITH PSYCHOTIC AND DELUSIONAL THOUGHT DISORDERS

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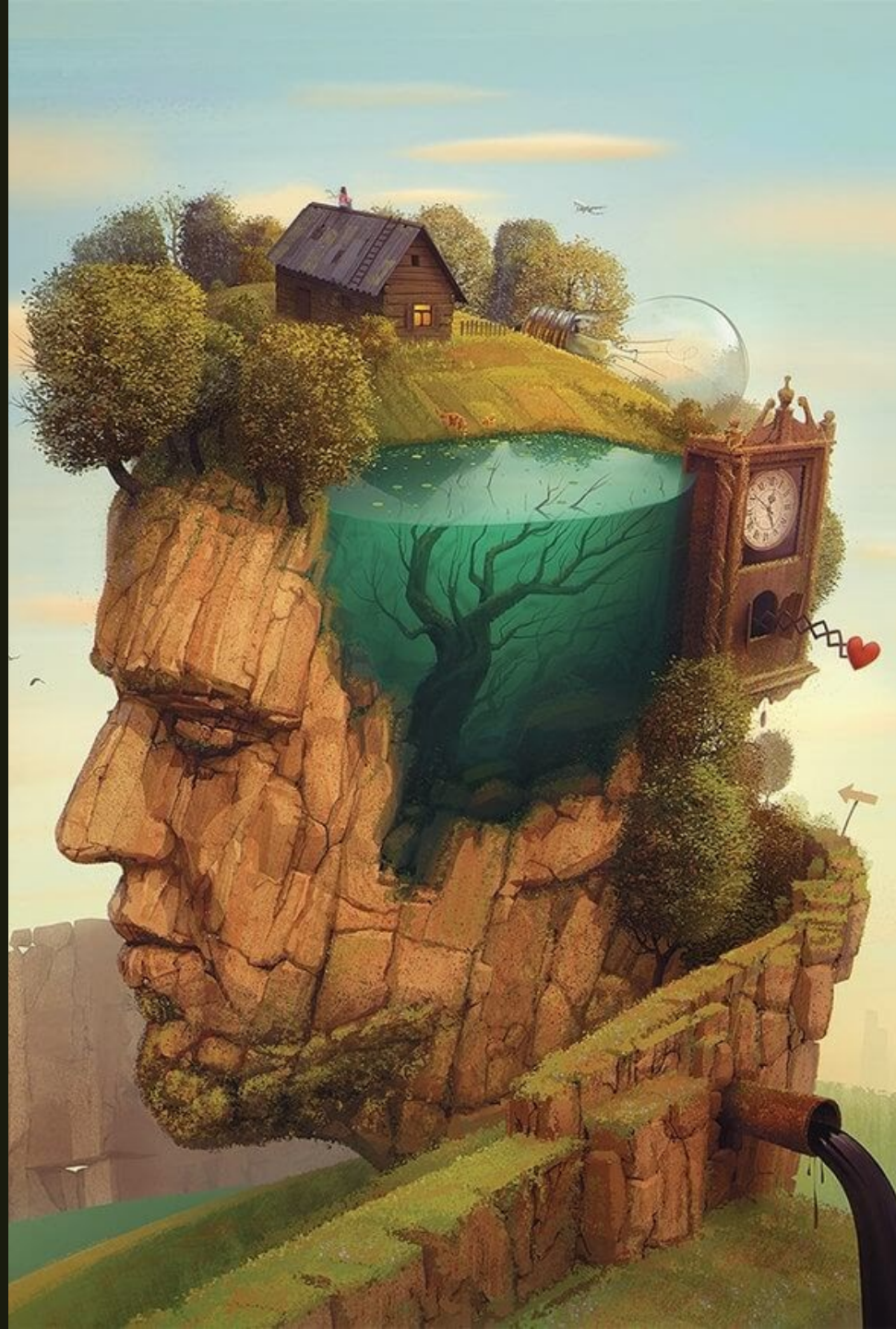
Learning Objectives:

Participants will, at the completion of this activity, be able to:

- *Apply Ossorio's "Three System System" to formulate baseline functioning of persons diagnosed with psychotic and delusional thought disorders.*
- *Differentiate diagnostic features of thought disorders and major mental illnesses with psychotic features using Descriptive Psychology concepts.*
- *Explain clinically defined features of psychosis and delusional thought disorder(s) in layman's terms when working with clients and supports.*
- *Assess risk and protective factors when working with persons diagnosed as having psychotic and delusional thought disorder(s).*



DSM 5 – Psychotic and Delusional Disorders

- Delusional Disorder
- Brief Psychotic Disorder
- Schizophreniform Disorder
- **Schizophrenia**
- Schizoaffective disorder
- Substance/Medication-Induced Psychotic Disorder
- Psychotic Disorder Due to Another Medical Condition
- Catatonia Associated with Another Mental Disorder
- Catatonic Disorder Due to Another Medical Condition
- Unspecified Catatonia
- Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

"Cluster A" Personality Disorders

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality disorder

- "Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder and is not attributable to the physiological effects of another medical condition. "

Positive (+) and Negative (-) Symptoms of Schizophrenia

POSITIVE SYMPTOMS

- Auditory and/or visual hallucinations
- Delusional and intrusive thoughts
- Bizarre behavior and stereotypical movements
- Positive formal thought disorder

NEGATIVE SYMPTOMS

- Alogia
- Affective flattening
- Poverty of speech
- Avolition / apathy
- Anhedonia / asociality
- Attentional impairment

The “Real world” and Behavior Significance

“To act effectively and live an authentic life in the real world as a person among persons you need to be generally successful at (a) identifying another person’s behavior on the basis of observation, (b) understanding the significance of that behavior, i.e., understanding the behavior in the real world context, and (c) understanding what behavior on the other person’s part might be anticipated. As it happens, such matters are not always clear, and when we miss something important, that is not always clear, either” (Ossorio 2006/2013).

“Informally, we may say that the state of affairs concept provides a representation of the public “real world” within which persons and their behavior necessarily have a place and with respect to which persons necessarily behave. Persons are a type of object within the state of affairs system, and their behavior is a type of process within that system” (Ossorio, 1969/1978/2010)

Objectivity and Agreement

“The objective nature of the situation is categorically unlike any person’s view of it. Because of this, it would be categorically impossible to ascertain or even approximate the objective nature of the situation by adopting some one view of it, e.g., a view which is shared by a set of “trained observers”, or by a set of observers which includes that important special case of “me”. Far from being a way of achieving objectivity, our standard requirement of observer agreement is a way of evading the problem by restricting our efforts in such a way that objectivity is not an issue between us”

(Ossorio 2010)

RELEVANT MAXIMS

A. A person takes it that things are as they seem unless he has reason enough to think otherwise.

B. A person will not choose less behavior potential over more.

C. What a person takes to be real is what he is prepared to act on. (And vice versa)

D. Reality takes precedence over truth

E. Status takes precedence over fact

F. In a social .system, a person views events in light of the values and concerns that go with his position in the system.

The State of Affairs System [SAS]

“People act in light of their circumstances. What they know about their circumstances is, “ultimately”, acquired by observation. If we ask what, most generally described, do we observe, the answer will be

- (a) OBJECTS,
- (b) PROCESSES,
- (c) EVENTS, and
- (d) STATES OF AFFAIRS. ”

(Ossorio, 1969/1978/2010)

The Person Concept

A **person** as a type of object (e.g. “type H-object”) is defined by the fact that its history is, paradigmatically, a history of intentional action (IA).

Intentional Action Diagram

- < B > = < I, W, K, KH, P, A, PC, S > where

  B = Behavior

  IA = Intentional Action

  I = Identity

  W = Want

  K = Know

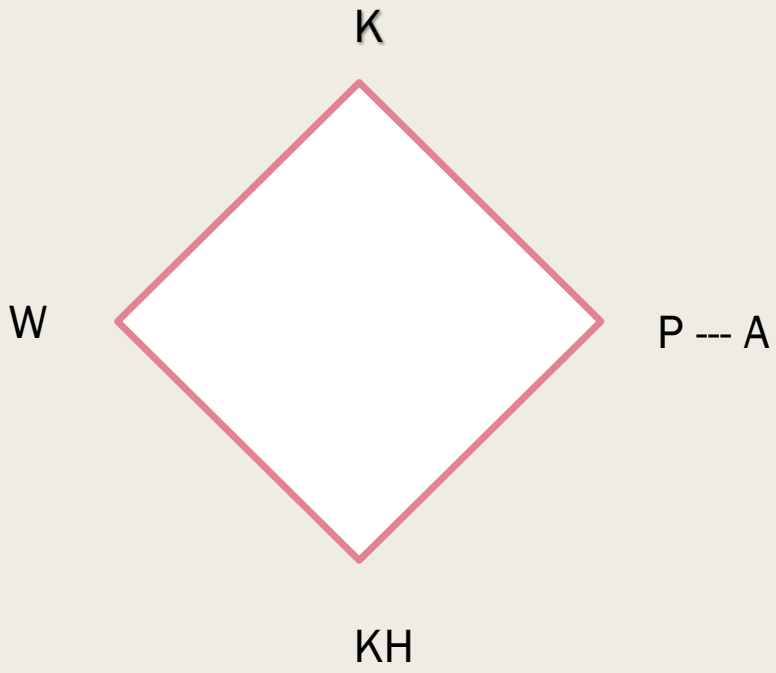
  KH = Know How

  P = Performance

  A = Achievement

  PC = Person Characteristic

  S = Significance



Person Characteristic <PC>

Dispositions

Traits
-
Attitudes
-
Interests
-
Styles

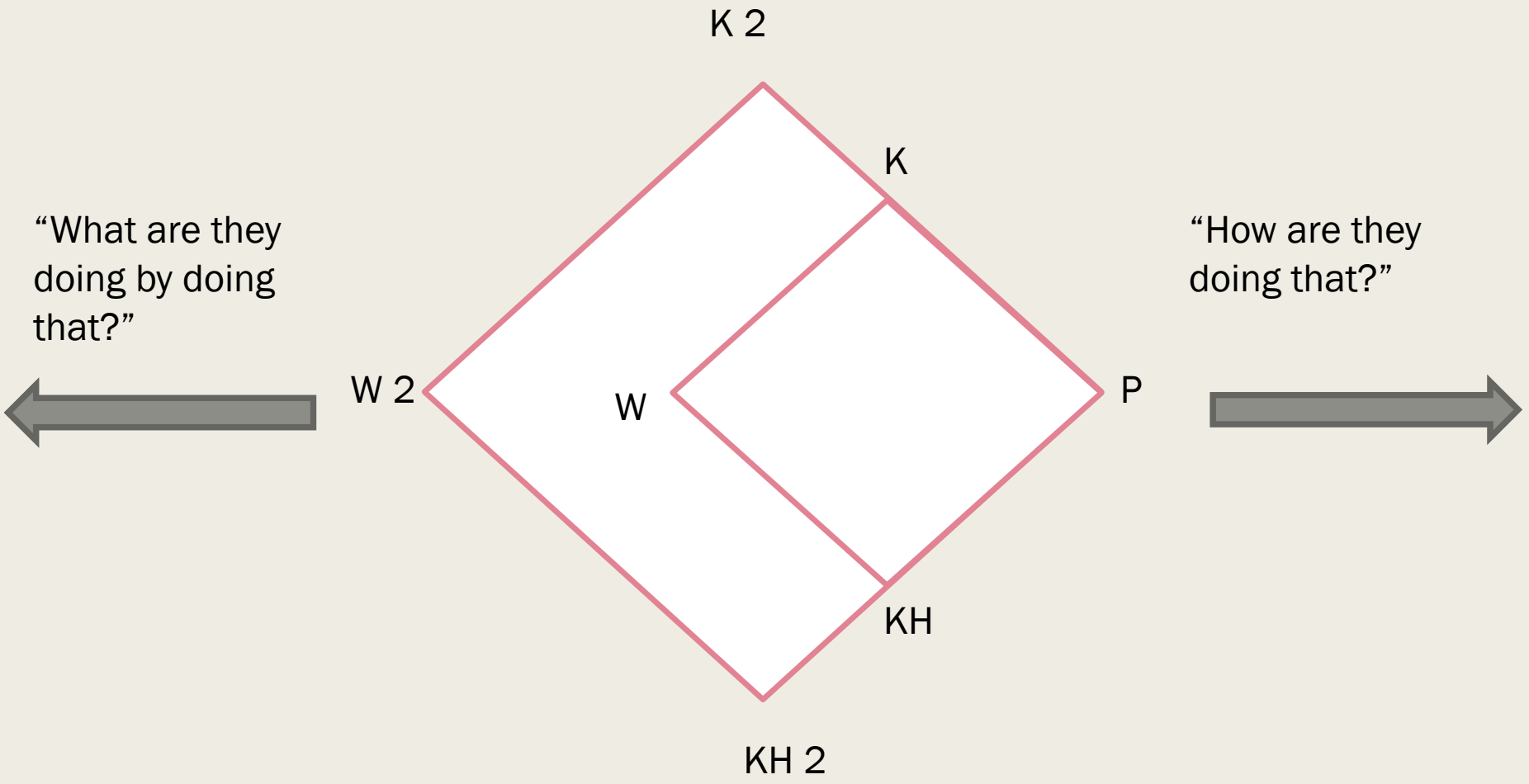
Powers

Abilities
-
Knowledge
-
Values

Derivatives

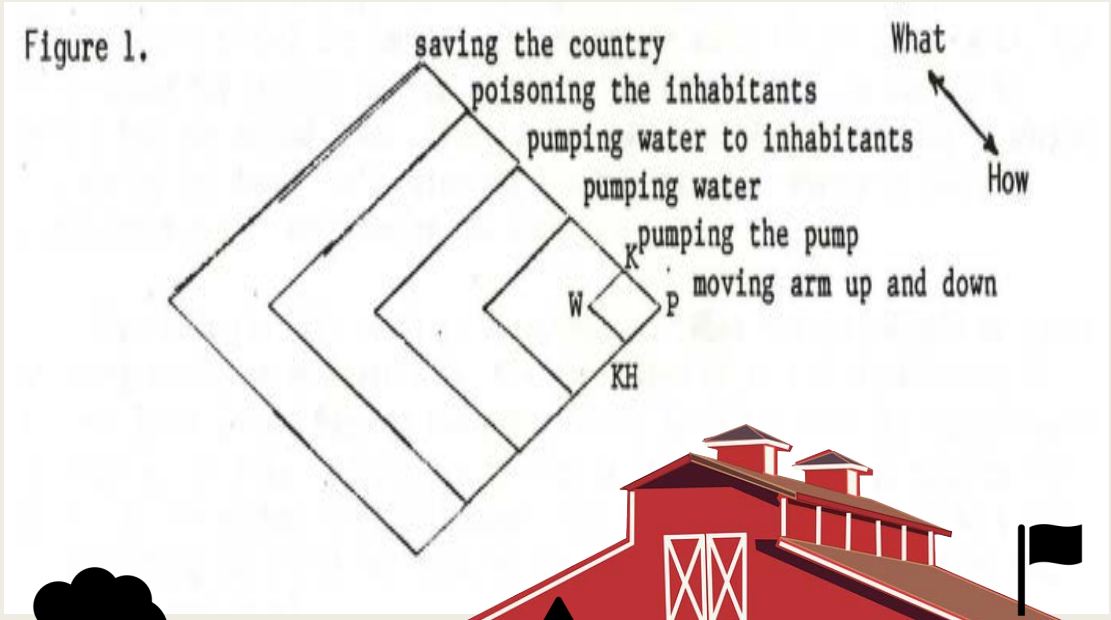
States
-
Capacities
-
Embodiments

Significance <S>



Understanding Significance

The Farmhouse Example



Dinner at 8:30 Example

SAS Basic Transition Rules

1. A state of affairs is a totality of related objects and/or processes and/or events and/or states of affairs.

2. A process is a state of affairs which is a constituent of some other state of affairs. [2a. So also is an object; so also is an event; and so also is a state of affairs.]

3. An object is a state of affairs which has other, related objects as immediate constituents. (An object divides into related, smaller objects.)

4. A process is a sequential change from one state of affairs to another.

5. A process is a state of affairs which has other, related processes as immediate constituents. (A process divides into related, smaller processes.)

6. An event is a direct change from one state of affairs to another.

7. An event is a state of affairs having two states of affairs (“before” and “after”) as immediate constituents.

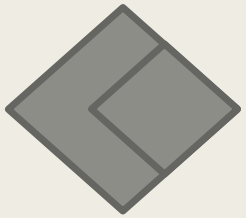
8. That an object and/or a process and/or event and/or a state of affairs has a given relation to another object and/or process and/or event and/or state of affairs is a state of affairs.

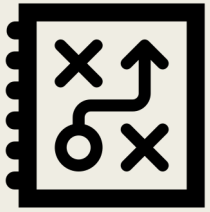
9. That an object or a process or an event or a state of affairs is of a given kind is a state of affairs.

10. That a process begins is an event and that it ends is a different event.

11. That an object comes to exist is an event and that it ceases to exist is a different event.(Ossorio 2013)

A “Three-System System”





A **person** as a type of object (e.g. “type H-object”) is defined by the fact that its history is, paradigmatically, a history of intentional action (IA).

In turn, **intentional action** as a kind of process is defined by eight parameters

(i.e. IA <I, W,K,KH,P,A,PC,S>

Types of intentional action can be defined by introducing some constraints on the values of the defining parameters

The three major conceptual elements, i.e., **the SA System**, the **concept of a person**, and the **concept of intentional action**, are delineated sequentially, beginning with the SA System…, then going to persons as the one type of object that is indispensable in the SA System, then to intentional action as a type of process intrinsically associated with persons.

In the latter development, the SA System is shown to be one of the parameters of intentional action. In this way we obtain a “**three-system system**” which is ***conceptually balanced and therefore neither needs nor could have a ‘foundation’ external to it.***

LITTLE WHITE BALLS EXAMPLE

Negative Symptoms of Schizophrenia

- In clinical practice, the distinction between primary and secondary negative symptoms of schizophrenia is crucial to the development of effective treatment interventions.
- **Primary Negative Symptoms**: involve an avolitional pathology, as characterized in the *Deficit Syndrome* concept (Carpenter et al 1988).
- **Secondary Negative Symptoms** ; result to factors extrinsic to schizophrenia or to other intrinsic features of schizophrenia (e.g. remaining quiet in response to intrusive hallucinations, paranoia, or other positive delusional ideas of reference”

The four major clinical subgroups of negative symptoms

- Affective.
- Communicative.
- Conational.
- Relational.

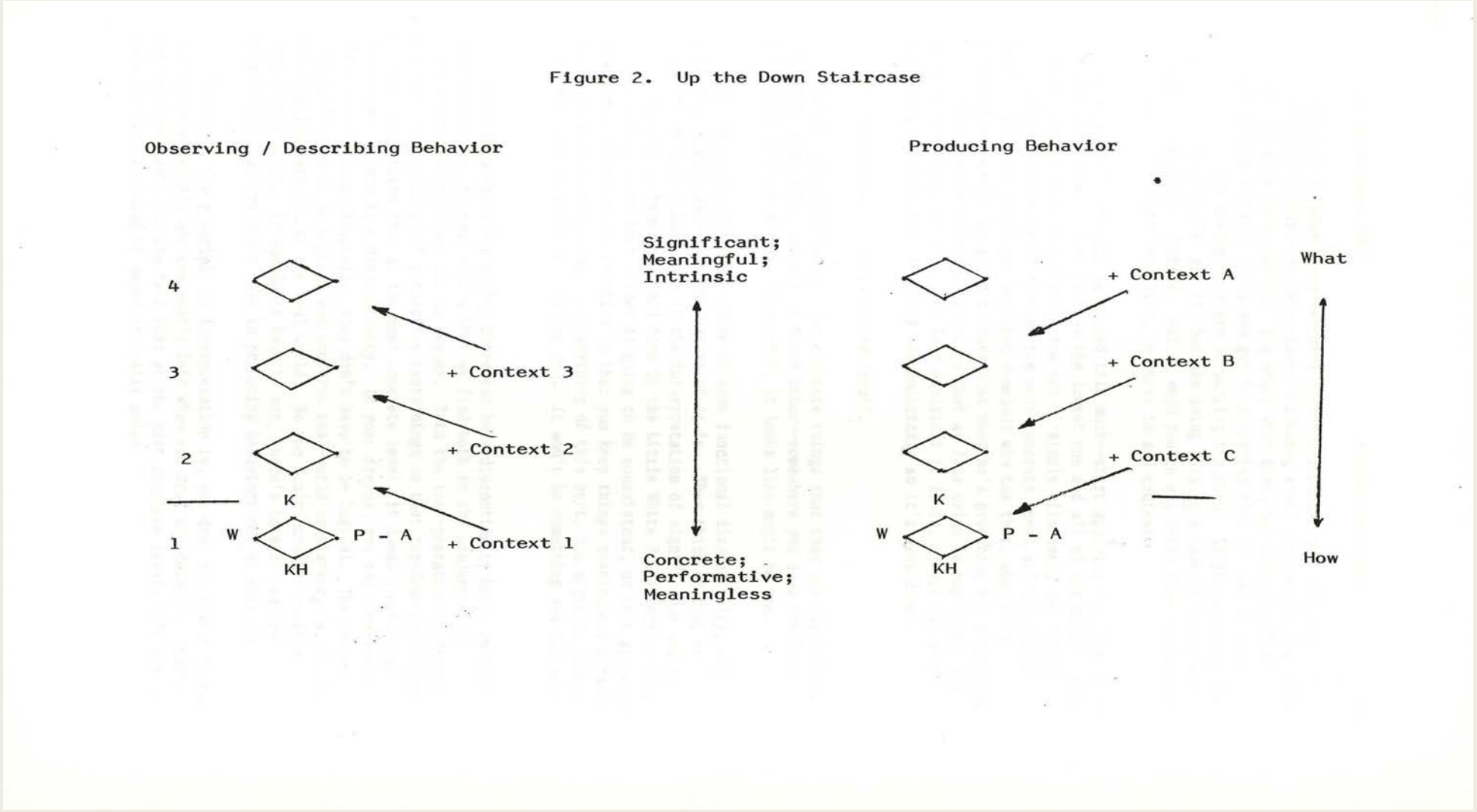
Social Functioning and its Relationship to Cognitive Deficits over the course of schizophrenia.

Retrospective parental reports suggest that in childhood, pre-schizophrenia patients show greater behavioral disruption – including inattention and thought \problems, social withdrawal, anxious-depressed behavior, and aggression- than do their healthy siblings (Neumann et al 1995)

Once established in premorbid and prodromal phases of the illness, individuals' relative levels of social functioning remain fairly stable, although acute phases obviously involve acute deterioration in social functioning. Premorbid social adjustment consistently predicts both social and general functioning over the life course (Bailer et al. 1996; Harding et al. 1987a, 1987b; Harrow et al. 1986, Johnson and Nyman 1991; Rund and Torgalsboen 1990).

Number of social relationships prior to first hospitalization consistently predicts both quantity and quality of relationships for several years afterward (Carpenter and Strauss 1991; Strauss and Carpenter 1972, 1974, 1977)

Up the Down Staircase



At this point, you can go two routes…

One is, you can talk about a simple disability with respect to significance, and that's, in effect, what's built into the instrument that just says some people are deficient, more or less, and we're going to assess the degree of deficiency.

If you consider, though, the fact that most schizophrenics were not always schizophrenic, you have a hard time using that simple an approach. You have to start asking “how can somebody lose the ability to appreciate significance?”.

It's one thing to treat it as though a person never had it, like being color-blind. It's another if you follow the general course of schizophrenia and say, No, for most of these people, it looks like at one time they had it, or at least certainly had more than they have, and they lost it. So the next question we face is, How could somebody do that, or why would somebody do that?

The Unthinkability Model

Now if we ask again why would somebody do that, how could somebody do that, we have an answer. We can give an answer that fits the notion of somebody becoming schizophrenic.

The answer is given by **the unthinkability model** of distortion of reality that says ***if you're in an impossible position, you're not going to see it as an impossible position; you're going to see it in some other way that leaves you some behavior potential***. And since you're not seeing it the way it is, you're distorting reality, and it's going to take somebody else to say that. As far as you're concerned, it is the way you see it.

Equating **context-sensitivity** to **contact with reality** opens up a lot of ideas, there. It says, Hey, maybe this is not empirical. Maybe it's not very empirical, because ***contact with reality has a definitional relation to psychosis***. And if significance has a conceptual relation to contact with reality, then its connection to schizophrenia may not be quite empirical either ....

'Disorder of Relating' construct

- The "**disorder of relating**" construct, which includes the negative symptoms of avoidance and withdrawal, shows strong negative associations with social functioning, surpassing social skills as a predicter of work performance in a role-play test (Hoffman and Kupper 1997). Specific "disorder of relating" symptoms also show strong individual associations with social and occupational function

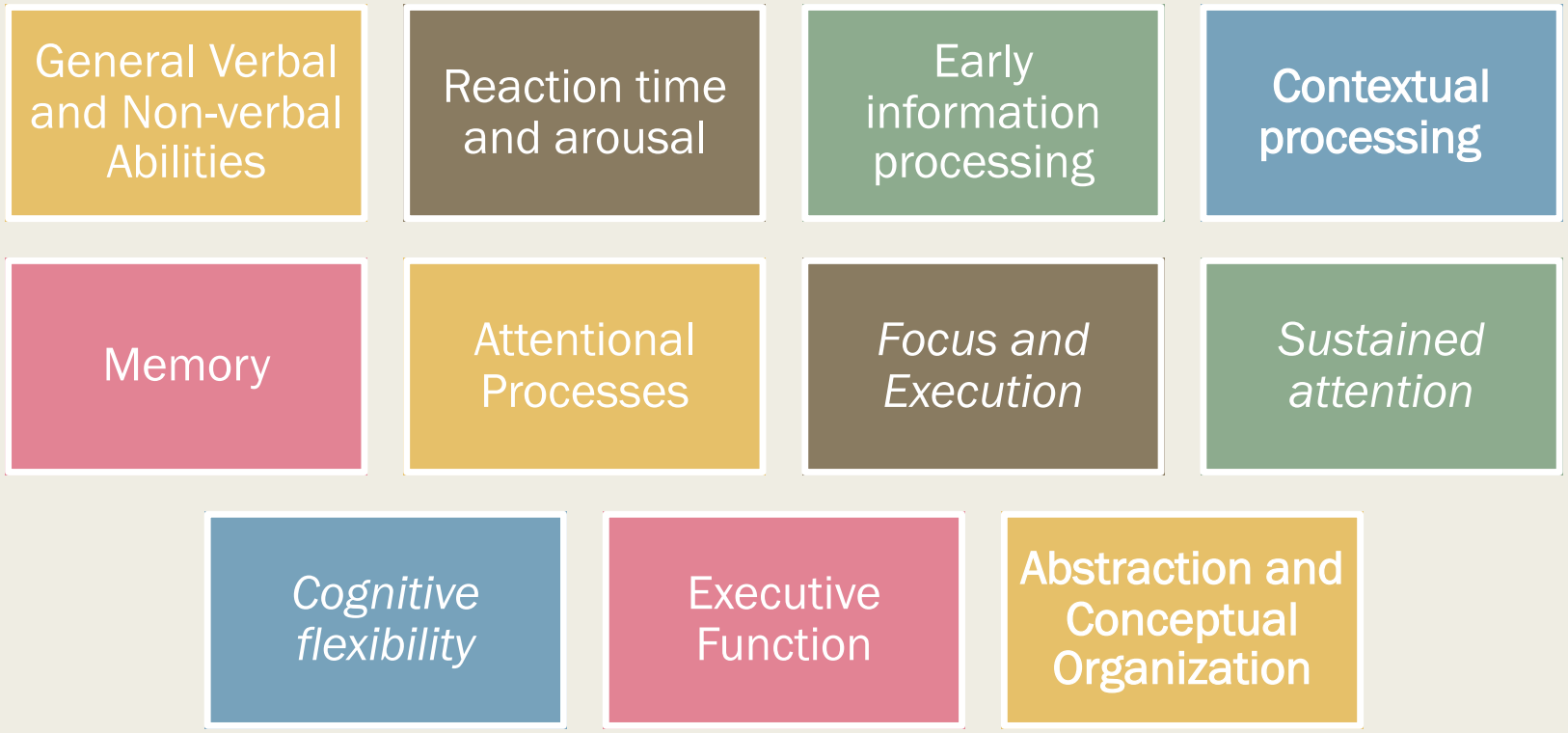
- Negative symptoms of schizophrenia are not a unitary construct. For example, deficits in affective response, long considered pathognomic of schizophrenia (Bleuler 1911/1950; Kraepelin 1919/1971), may actually represent two different dimensions , one of experience and another of expression,

Social Functioning, as measured by variables such as occupational functioning and community tenure without rehospitalization, has been found to be inversely associated with nearly all indices of illness severity among schizophrenic patients. In addition, it has been linked with poorer prognoses and higher risk symptoms for relapse (Johnstone et al 1990; Perlick et al. 1992; Sullivan et al. 1990).

At the simplest level, positive symptoms of schizophrenia may interfere with a person's ability to receive information from the external environment, to process it effectively, and to respond to it appropriately.

Although negative symptoms have been consistently associated with psychopathological severity and poorer social functioning (Bailer et al. 1996; Breir et al. 1991; Keefe et al. 1987; Maurer et al. 1996; Robins and Guze 1970; Salokangas et al. 1989), these observed relationships may be inflated by conceptual overlap.

Neurocognitive Deficits related to social functioning can include:



Contextual processing

Early information processing includes some aspects of contextual processing. An inability to discriminate between relevant and irrelevant information may impair social functioning because social behavior involves both perception of relevant social cues and initiation or appropriate responses. Experimental evidence shows that schizophrenic patients fail to evaluate information accurately on a consistent basis and use less effective strategies for screening out irrelevant information (Niwa et al. 1992).

Impairments in differentiating between target and irrelevant stimuli are observed in both auditory and visual tasks and therefore not modality specific (Harris et al. 1985)

Abstraction and Conceptual Organization

Persons with schizophrenia also have specific difficulties with abstract features of social situations, such as understanding the goals of specific behaviors, particularly when presented with an unfamiliar situation (Corrigan and Green 1993; Corrigan et al. 1996). Such difficulties in abstraction may lead to misreading of social contexts and the motivations of others.

Cognitive Remediation Interventions

Interventions aimed at specific neurocognitive deficits, whether used alone or in combination with other interventions, have been demonstrated to improve patient's social performance in controlled studies.

Social Competency & Cognitive Behavioral Skills Enhancement

Social skills are divided into three broad types:

Social perception skills

Cognitive skills, and

Behavioral skills (Wallace et al. 1980).

This tripartite conceptualization is based on the assumption that effective social behavior requires individuals to perceive relevant situational parameters (e.g., recognition of another person's emotion) formulate goals and select strategies for attaining those goals and enact these strategic plans through appropriate use of paralinguistic, nonverbal, and verbal skills.

Social Skills Training

Social skills can be defined as those specific abilities that enable individuals to achieve instrumental (e.g. purchasing an item at a store) and affiliative (e.g. making friends) goals in an interpersonal context (Liberman et al. 1989). Whereas *social skills* refer to the specific abilities necessary to achieve these goals, *social competence* refers to the actual attainment of these goals or the ability to meet societally defined role expectations (Mueser et al. 1990c.).

Family Interventions

Family interventions for schizophrenia have focused on reducing tension in the family, educating family members about schizophrenia, and empowering the family to cope better with the effects of the illness. Family intervention programs following this model and providing at least 9 months of treatment have significantly reduced rates either of relapse or of rehospitalization over 18-24 months (Baucom et al. 1998)

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