The Basics About Thought Disorders and Schizophrenia

Evidence Based Practices (EBP): Integrated System of Care; Universal Dual Diagnosis Capabilities; Principles of Empathy and Hope; Motivational Interviewing Approach; Stages of Change Model Design; Strength Based; Skill Building; Solution Focused; Neurochemistry Based Disorders of the Brain; Symptom Identification; Symptom Management; EBP Curriculum Topics, i.e. Nutrition, Stress Management, Cognitive Behavioral, and more…

Consistency in the Group Setting

The importance of *consistency* in a treatment setting can't be overstated. This is especially true when people are placed in vulnerable situations. *Inconsistency* can, at best, increase uncertainty and insecurity for the person receiving services. At worst, unpredictability can create a sense of helplessness while simultaneously decreasing a person's development of self-reliance. In fact, all human beings benefit from a dependable approach in the treatment of chronic disorders. When a person learns they can rely on consistency, they are less stressed and more relaxed. Consistency in the group setting includes the group structure, psychoeducational material, and the approach.

Each agency or facility will have different requirements – such as group receipts or paperwork – however, consistency can still include a structure similar to the following:

1. Group members pick up: a. Clip Board, b. Paper, and c. Pencil/Pen as they enter the room.
2. Group facilitator picks up the group receipts from each person in the group, and/or the group facilitator passes out the sign-in sheet for the group members to sign.
3. Group facilitator provides a Positive Group Beginning, Consistent Psychoeducational Material, Consistent Approach, and a Positive Group Closure.

Psychoeducational Groups and Crisis Event Processing (when requested)

Notes to Facilitator(s):

1. *The Basics, Second Edition* meets the definitions and goals of Psychoeducational Groups, Skill Building Groups, and Cognitive Behavioral Groups.
2. Group participants who have become accustomed to Interpersonal Processing Groups – as well as staff who have facilitated them – may find it a challenge to now facilitate Psychoeducational Groups.
3. Likewise, facilitators who may have followed a more lecture-style education presentation, may find it challenging to now devote at least 1/3rd of group time to specific topic discussions and interactions.
4. Both types of groups (Interpersonal Processing Groups and Psychoeducational Groups) are extremely important, yet each has different goals and structure.
5. The structure of Psychoeducational Groups, Skill Building Groups, and/or Cognitive-Behavioral Groups in no way means that there will not be *interaction* – far from it. It just means that the interactions, discussions, and exercises will be about the topic(s) of each group.
6. Facilitators *may* – or not – still want to allow time in each group for the group member(s) to discuss a crisis that may have occurred since the last group.
7. We do know, of course, that *every* person in group is typically experiencing many challenges each and every week; however, most of these incidents are often best resolved in ways other than group time where the event does not pertain to every group member.
8. Suggested responses to a challenge, problem, or crisis can also include suggesting the person contact their primary care provider; schedule a 1:1 appointment; reschedule their next 1:1 to an earlier time; or, meet with the facilitator after group to explore options and develop a plan.
9. A facilitator would, of course, not *"grade"* an event as being worthy or not for group time. If a person requests individual time in the group, then that would be accepted as valid and time allotted at the end of the group.
10. Over time, the group begins to understand the differences between a situation, a challenge, a problem, or a crisis and can make decisions to utilize group time or continue with the current psychoeducational topic.

Prepare Professionals

Suggestions for professionals to prepare themselves for group typically includes:

1. Review all content material, appendices, and/or handouts *prior* to group to avoid a lecturing style.
2. Decide beforehand the *key points* to be covered in each group to produce flexibility for group responses, discussions, or questions.
3. Gain an overall understanding of the content so summarizing is possible in order to create an interactive facilitation style.
4. Determine the group structure to achieve the essential balance between education and discussions.
5. Check group room to be sure there are enough clipboards, pencils or pens, and markers or chalk for the board.
6. Make enough copies of any handouts *before* group.
7. Write any group content on the board *prior* to the beginning of group whenever possible.

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Master Guide & Master Tips to Professionals

Note: *The Master Guide* (located at the beginning of Volume I & II) and the *Master Tips to Professionals* (located at the back of Volume I) have many topics to assist in the group process like Master Tip #39: Suggestions For Managing Handouts For Groups (pages Master Tips 64-67). Other tips include:

1. Master Guide: Interactive Style (pages Master Guide 10-11)
2. Master Tip #1: Suggestions for Beginning Group (pages Master Tips 1-4)
3. Master Tip #3: Empathetic Treatment Approach (pages Master Tips 7-9)
4. Master Tip #4: Promoting Hope (page Master Tips 9)
5. Master Tip #5: Maintaining a Consistent, Nonjudgmental, and Positive Attitude (pages Master Tips 10-13)
6. Master Tip #12: Responding to Requests for Copies of Appendices (pages Master Tips 27-29)
7. Master Tip #13: Depth of Psychoeducational Content (pages Master Tips 29-30)
8. Master Tip #14: Group Closure Suggestions (pages Master Tips 30-31)
9. Master Tip #16: Motivational Interviewing (pages Master Tips 31-32)

Present Curriculum/Topic

1. It is extremely important that each group participant leave every group with more Psychoeducation than they came in with – which may also include discussing a "familiar topic" yet with a "present-day" focus. Psychoeducational Groups are designed to provide education about all areas related to the management of Substance Use Disorders and Psychiatric Disorders. Psychoeducational Groups are not Interpersonal Processing Groups – even though interaction and processing the particular *psychoeducational topic(s)* is essential to individualizing the topic(s) or skill(s) presented.
2. It is recommended that a minimum of 1/3rd of group time be devoted to interaction (therapeutic counseling *topic* discussions). This can be accomplished – depending on the individual style of the group facilitator(s) – by any "present education-interact/discuss – present education-interact/discuss" combination while still structuring the group to include the curriculum/topic education to be covered.
3. The presentation of material will, of course, be modified by the facilitator to match the functioning skills of group participants. It is important to note, however, that *The Basics, Second Edition* was written in a conversational language while taking into consideration a wide-range of symptom acuity and severity. Persons with co-occurring psychiatric and substance disorders benefit from learning about their disorders and how to manage them, as do all individuals with any chronic disorder(s). Each group participant will retain what is meaningful to them at the present time.

Group Beginning Suggestions

A positive group beginning (and ending) is extremely important. There are many ways to begin (and end) a group in a positive way. Suggestions to choose from can include:

1. Reading the Thought For The Day from a meditation book. (Note: Meditation books that also contain an index at the end of the book – such as *Easy Does It* – are helpful in choosing a specific reading that matches the topic(s) presented in group like Self-Esteem.), or
2. Reading an inspirational or humorous curriculum handout from *The Basics, Second Edition*, or
3. Practicing a deep breathing or a stretching exercise, *or*
4. Sharing of one thing that each person is grateful for today, *or*
5. Sharing of one positive thing that he/she did that contributed to their recovery in the past few days, or
6. Reading an AA Slogan with a brief explanation or AA/NA/Dual Recovery inspirational reading.

* Recommended Beginning: Breathing Exercise (located on page Master Tips 3)

Practice Curriculum/Topic

Practicing subject material is the best way participants can internalize and personalize the curriculum content. Practice includes the group interactions, worksheets, exercises, handouts, and content discussions.

Based on a 2-Hour group: Two 50 minute segments	Time-Frame
Group Beginning	**20 Minutes Total**
Positive group beginning (suggestions are located on the previous page).	5 Minutes
1. Brief Group Introductions: (Note: The *interactions* in a psychoeducational group are discussions about the *topics*, not interpersonal processing or case management questions which do not apply to the entire group.) a. Ask the group members to tell the group their name. b. Welcome any group members who are new to this group or phase. 2. Crisis Processing (when requested and optional): a. Ask the group if anyone has experienced a crisis since their last group, and if they need/want additional time in this group to discuss it, i.e. what happened, how they managed the crisis, and/or explore options and develop a plan. b. Let the person(s) know that you will allow time at the end of this group for them to share their experience and receive support from their fellow group members.	10 Minutes
<u>Summarize Introduction of the Group Topic and Why It's Important (page Subject 2-34)</u>: A Thought Disorder is a category of Psychiatric Disorders that is identified by disturbances in thought processes like reasoning, perception, problem solving, and memory (Montrase & Daley, 1996). These illnesses also have an affect on how a person responds emotionally, how they relate to others, how they view the world around them, and how they behave. Today we will discuss Thought Disorders. In all treatment facilities there are topics that are discussed that won't directly apply to all of the participants in the group. For example, we discuss the effects of marijuana in groups where not all people in the group use marijuana. However, when looking at the *similarities* instead of the *differences*, a person will see there are effects of abusing marijuana that are the same as the effects of other drugs. In this group, there may be people who personally have Schizophrenia or know people with a thought disorder, or people who have relatives who have schizophrenia, yet many or most can relate to experiencing functioning difficulties. We will also discuss illusions, delusions, and hallucinations – times when thoughts and perceptions are disturbed. Psychotic symptoms – while mostly associated with Schizophrenia – can also be associated with other disorders like Bipolar Disorder or even drug reactions. Again, look for the similarities.	5 Minutes

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Skill Building Exercise and Discussion - Suggestions for topic discussion:	**Time-Frame**
To the Facilitator(s): 1. It is recommended that any group content for this particular group be written on the board prior to the beginning of group – whenever possible. 2. This group is never intended to diagnosis a Thought Disorder. It *is* intended to provide enough information for participants to decide if they relate to these symptoms of Schizophrenia and if they would like/need to explore this further with their therapist, counselor, case manager, etc. 3. In the cases where a person says these symptoms of a Thought Disorder are a part of the common cognitive and thinking disturbances caused by the early recovery process of Substance Disorders, a facilitator can let the person(s) know: a. If something does change, like symptoms of Schizophrenia or a Thought Disorder (delusions, flattened emotions, or any other symptoms) becoming more acute, *or* b. If symptoms of cognitive/thinking disturbances do not lessen with abstinence or harm reduction – the person is then encouraged to bring this up with their primary counselor for further discussion. 4. For the individual(s) who may see a strong identification with a Thought Disorder or has a history of symptoms of Schizophrenia or has a diagnosis of a Thought Disorder – it would be recommended that he/she follow-up right away with their primary service provider for evaluation and/or specific treatment planning. 5. You *may* or *may not* decide to cover the information in the group that is found in the next section (depending on your specific group) about the symptoms of a Thought Disorder. However, these points are *important* and you may want to interject them as you go or in the sequence below. **To the Group:** When talking about symptoms of any Psychiatric Disorder like a Thought Disorder, there are a few things to keep in mind: 1. A specific set of criteria must be met in order to diagnose a Psychiatric Disorder. 2. When any of us read about mental health disorders we experience common responses. We often look at the symptoms and say: "Oh my, I have *that one* and *that one* and *that one* too! I must have a psychiatric disorder." That is very typical among us human beings. 3. Remember to have a specific illness – a person would have to have specific *symptoms*, a specific *number* of symptoms, for a specific *amount of time*, and the symptoms have to be *severe enough* to cause *significant distress* in important areas of the person's functioning. 4. Also the diagnosis of a Thought Disorder must rule out or eliminate other causes for the symptoms. This would include Substance Use Disorders. In other words when symptoms of cognitive/thinking disturbances, delusions, etc. are caused by substance abuse or substance dependence, a diagnosis would be made of "Substance-Induced Psychotic Disorder." In that situation, the symptoms of a Thought Disorder would lessen or clear with continued recovery for Substance Use Disorders. 5. However, whether symptoms of Thought Disorder are substance-induced or not, it is still very important to address *any* symptoms that are persistent, or *any* symptoms that don't clear with recovery, or *any* symptoms you may have experienced for a long time, or *any* symptoms that are causing you distress at the present time. 6. Self-awareness is a skill to develop and education about symptoms is critical to that process. 7. We want you to be aware of any symptoms you may be experiencing now or may or experience in the *future*. We – your treatment team – want to be sure we are working *with* you in symptom management and treatment planning to meet your individual needs. 8. In other words, symptoms of a Thought Disorder or Schizophrenia are treated *as if* they *won't* clear with time.	30 Minutes 

Psychoeducation Part I: Topics & Focus	Pages & Location	Presentation Suggestions	Time-Frame
The Basics About Schizophrenia	Appendix II-37 – II-41	Summarize the sections of the table listed below. (1. The time you devote to the neurochemistry will depend on the interests of your particular group. 2. It is important to note, however, that the brain chemistry education is the most important to the group participaants – especially individuals with Schizophrenia. Individuals in treatment, at all levels of functioning, state over and over that the neurochemistry information helped them to: a. Finally understand what has previously been impossible to understand (Schizophrenia), b. Makes the treatment recommendations now meaningful, and c. Helps to relieve self-judgement.)	continued

1	Prevalence (#1 in table)	3	Causes (#4 in table)	5	Symptom Severity (#9 in table)
2	Men & Women (#2 in table)	4	Brain Chemistry (#5 in table)	6	Co-Occurring Disorders (#10 in table)

Note: Found under Co-Occurring Disorders – The abuse and alcohol is the key factor for persons with Schizophrenia who are hospitalized numerous times. The rest of people with Schizophrena are *not* typically hospitalized or have only brief stays if they are.

Differentiating Between Illusions, Delusions, and Hallucinations	Appendix II-44 – II-45	1. Summarize one paragraph. 2. Give the definitions of each of the followng using the text.

Illusions	Delusions	Hallucinations
1 Definition of Illusions 2 Types of Illusions	1. Definition of Delusions 2. Bizarre Delusions 3. Ideas of Reference 4. Non-Bizarre Delusions 5. Delusional Themes	1. Definition of Hallucinations 2. Types of Hallucinations 3. Visual or Sight Hallucinations 4. Auditory or Hearing Hallucinations 5. Gustatory for Taste 6. Somatic or Physical Sensation 7. Tactile or Touch

Not "Thinking Straight" Versus a Thought Disorder	Subject 2-34	Summarize one paragraph.
Schizophrenia	Subject 2-34	Summarize one paragraph.
Violence and Schizophrenia	Subject 2-34	Summarize brief paragraph.

Break	**10 Minutes**

Psychoeducation Part II: Topics & Focus	Pages & Location	Presentation Suggestions	Time-Frame with Crisis Processing	Time-Frame without Crisis Processing
Symptoms of Schizophrenia	Subject 2-35	1. Summarize one paragraph. 2. Discuss symptoms located in the table below.	15 Minutes	20 Minutes

Cognitive/Thinking & Positive Symptoms	Cognitive/Thinking & Negative Symptoms	Behavioral Symptoms & Functional Difficulties
Positive Symptoms: (the adding or increase of certain traits or what is there) delusions; hallucinations; thoughts run off course	Negative Symptoms: (the lack or diminishment of certain traits attributed to the loss of nerve cells or what is not there) little or no emotion; reduced frequency and productivity of thought and speech	Functioning Impairment: work, interpersonal relationships, etc. are at a noticeably lowered functioning level than prior to the onset of symptoms

Note: The expanded version of the Symptoms of Schizophrenia is located on Pages: Appendix II-41 – II-44.

Stages of Schizophrenia	Subject 2-35	Summarize information in table using the text:	1	Acute Phase	2	Stabilization Phase	3	Stable Phase

Skill Building Exercise and Discussion - Suggestions for topic discussion:

To the Group:

1. Are there any symptoms of thought disorders that you relate to personally?
2. How do you cope with these symptoms?
3. Have you had times – whatever the cause – where you had illusions, delusions, or hallucinations?
4. Do symptoms of thought disorders cause you problems in functioning in your daily life?
5. What symptom(s) cause you the most distress?
6. Do you experience times of thinking distortions, etc. not related to substance abuse or withdrawal?

Psychoeducation Part II: Topics & Focus (continued)	Pages & Location	Presentation Suggestions	Time-Frame with Crisis Processing	Time-Frame without Crisis Processing
Treatment of Schizophrenia	Subject 2-37 – 2-40	1. Summarize the first three paragraphs. 2. Discuss the treatment of Schizophrenia listed in the table below using the text.	15 Minutes	20 Minutes

1	Therapy & Mental Health Services	6	Self-Help Groups
2	Group Therapy	7	Medication Compliance
3	Family Education, Involvement, Support & Therapy	8	Stress Reduction
4	Multiple Family Group Therapy (MFGT)	9	Harm Reduction or Goal of Abstinence
5	Psychosocial Treatment		

Skill Building Exercise and Discussion - Suggestions for topic discussion:	**Time-Frame with Crisis Processing**	**Time-Frame without Crisis Processing**
To the Group: 1. All chronic illnesses have similar treatment recommendations. For instance, group therapy and self-help groups are a part of the treatment for Thought Disorders and are also recommended for individuals in recovery for substance disorders, anxiety, depression, and physical illnesses like cancer. Family education, involvement, support & therapy are also recommended for every chronic disorder as well. 2. Whether you personally have a Thought Disorder or not – as we look at the treatment of Thought Disorders – ask yourself how you are doing in each of these areas of a good recovery program that do apply to you personally. For example: Group Therapy helps a person change behaviors that get in the way of developing social relationships by practicing new behaviors in the safe environment of group. How are you doing in this area? 3. What areas of these treatment recommendations for the treatment of Schizophrenia, Thought Disorders, or other disorders do you relate to? 4. What area(s) have you made progress in or experienced success for the treatment of Schizophrenia or other disorders? How did you accomplish that? 5. What area(s) of treatment will you work to improve that will strengthen your recovery?	Continued	Continued
Crisis Processing	**Time-Frame**	
1. Ask the group member(s) to tell the group what happened. 2. Explore options and/or develop an immediate plan for coping. 3. Allow the group to offer support.	10 Minutes	
"Paper Work"	**Time-Frame**	
Group participants fill out Group Notes.	5 Minutes	
Group Closure	**Time-Frame**	
1. Read or ask a group participant to read an inspirational reading of your choice, *or* 2. Ask each group participant what they will do this week to protect their recovery, *or* 3. Ask each group member what they will practice this week from the areas of treatment for Thought Disorders – as it relates to either a thought disorder or their specific disorder of recovery, *or* 4. Read a daily meditation for the day.	5 Minutes	