Talking to Change: An MI Podcast

Glenn Hinds and Sebastian Kaplan

Episode 20: MI When Working with People With Psychosis, with Dr. Rory Allott

Sebastian Kaplan:

Hello, everyone, and welcome to another episode of Talking To Change - A Motivational Interviewing Podcast. My name is Sebastian Kaplan based in Winston-Salem, North Carolina. As always, I'm joined by my good friend Glenn Hinds from Derry, Northern Ireland. Hello, Glenn.

Glenn Hinds:

Hey Seb, how's it going, man?

Sebastian Kaplan:

It's going pretty well. It's the holidays. Times are a bit more low key now. So, it's been a relaxing few days. Hopefully, the same for you?

Glenn Hinds:

Yep. Been taken really easy. Looking forward to getting back to it, but easing my way into it, too.

Sebastian Kaplan:

That's right. So, before we introduce our guest and get on with our episode today, Glenn, why don't you orient everybody to the various social media platforms that people can access us and the podcast and leave comments and such.

Glenn Hinds:

No problem. Thanks, Seb. So, on Facebook, it's Talking To Change, on Twitter it's @ChangeTalking. We've recently added an Instagram account, which is now, TalkingToChangePodcast. For direct contact with myself or Seb, its podcast@glennhinds.com.

Sebastian Kaplan:

Great, thank you. Okay, well, today's topic, we'll be focusing our discussion on the use of MI with people who experience psychosis. We're very pleased to have a friend and colleague of ours, Rory Allott, on today. So, Rory, hello. Thank you for joining us, and tell us a bit about yourself and how you got into MI?

Rory Allott:

Hi, everyone. It's nice to be invited. Thanks very much. So, you just asked me how I got into MI and I really had to go deep into my memory banks there because it was a very, very long ago, before I even became a clinical psychologist. So, I'm a clinical

psychologist working in the National Health Service in the UK in a team that works with people in their first episode of psychosis. So, 14-year olds right up to 65.

Rory Allott:

Thinking back to how I got into MI, it probably started when I volunteered on a very big research trial that was looking at heavy drinkers in the Midlands in the UK. It was looking at people who'd never accessed help for their heavy drinking, but they were drinking huge quantities. They had to be drinking over 50 units a week, but they'd never come into contact with services. It was a qualitative trial with Jim Orford, that was really trying to answer the question, how can we access these people who aren't accessing any help, and, actually, is there a problem with their drinking, given that they haven't even accessed help?

The way that we did that is, we were all trained in Motivational Interviewing to have conversations that were centered around drinking. I think the difference, when I was introduced to MI back then, was that, probably, the directive elements of Motivational Interviewing was less emphasized so that we could just keep the conversation focused on drink, both, its benefits and its costs. So, that was probably, dare I say, 22 years ago or something. Yeah. So, that's when I got into Motivational Interviewing.

Glenn Hinds:

So, for many people, they'll recognize the relationship between Motivational Interviewing and alcohol as the origins of the approach, but as you're now describing, you're now working in a quite specialist field working with people with first experience of psychosis. I wonder, can you tell us a bit about how you move from that place where you're introduced to Motivational Interviewing, to where you are now and what the relationship is, now, for you working in that field and using Motivational Interviewing?

Rory Allott:

Yeah. I guess, all my life, I've been interested and fascinated by other worlds. The experiences that we can all have of different consciousness and experiencing hallucinations and the like. I've always had an interest in that, particularly the art of people who have been incarcerated in psychiatric institutions. So, I had an interest in psychosis all my life. I guess, having been introduced to Motivational Interviewing, I also developed a deep interest and, maybe, a passion that shaped the route of my life that was interested in person-centered approaches to helping others.

Rory Allott:

So, those two things have really, over the years, come together. I did my doctorate in hallucinations in Parkinson's disease, and, then, later graduated as a psychologist, and so moved into then working in assertive outreach in working with people who are often homeless and experiencing psychosis and taking substances and eventually was involved in a large randomized control trial... well, the largest of its kind, where we were combining Motivational Interviewing with cognitive behavioral therapy for people who are both misusing substances and experiencing psychosis. So, I guess, that was my trial in around 2010. I guess, the four years on that trial was the culmination of all my

interests, just reflecting on it now, psychosis, drugs and alcohol. I'd worked in drug services in the past. Then, this approach, that's a very person-centered approach, to working and helping people. Yeah.

Sebastian Kaplan:

Yeah, it's always great to hear people respond to this question. There always seems to be a thread of something that's out of their professional world, something about themselves personally, or maybe a non-professional interest that seems to link up pretty seamlessly with Motivational Interviewing and then helps guide one's career path in ways that, maybe, wouldn't have happened, had MI not been around for us to discover.

Rory Allott:

Hmm, definitely. Yeah, as I grow older and hopefully wiser, I look back on my life and wonder why I made the choices I did, in terms of career, and the way that I work with people. I guess, one moment that was quite influential, my Irish family were Quakers, and my grandfather once told me a story about a man who came into a Quaker meeting and, I don't know if you'd know, but they're held in silence and no one talks, unless they're moved to talk within the silence by a spirit, by Christian, godly spirits. A man came in drunk. My grandfather didn't say he was psychotic, but he certainly sounded psychotic. He was talking to himself and he came into the meeting, and he was disrupting the meeting.

Rory Allott:

Now, there's no priest or anything in these meetings, but one of the elders stood up and they turned to him. They said to him, you're absolutely welcome to stay at this meeting, but what happens here, is that we sit in silence, and we contemplate, and you're free to stay, but you're also... if you'd rather be shouting, yeah, then you're free to go as well. Yeah. So, we'd like to give you that choice. With that choice, he became really tearful and then just sat in the congregation in the meeting.

Rory Allott:

I guess, having been told that story all those years ago, probably, before I was even a clinical psychologist, the embodiment of spirit of emphasizing autonomy, giving responsibility, showing absolute respect, these are the qualities that other people have got in spades, but aren't calling it MI, necessarily. So, I suppose, the culture of my family have shaped, and, then, I rediscovered that through Motivational Interviewing, I guess.

Glenn Hinds:

So, it sounds for you, that this was in you from previous generations or the culture in which part of you has arisen from, and that when you were introduced to Motivational Interviewing, you recognized it. Perhaps not initially, but, in hindsight, you now recognize, you know what, this, this goes beyond MI. This is the nature of good helping, and understanding and empathy, and it resonates with you.

Rory Allott:

Absolutely. Yeah. The interesting thing there, that you said, was that, I think this is worth, for listeners, who are setting out on learning Motivational Interviewing, that I recognized it and, you stopped yourself and said, maybe, not at first. Certainly, at first, I didn't recognize this long culture that I'd come from. Yeah. But, nor did I recognize what Motivational Interviewing was. Yeah. I couldn't even do it. Yeah. So, when they were teaching me at Birmingham University to do these qualitative interviews, I had people sit in on my interviews, and I was only... I was probably, I don't know, I think I was about 19, 20.

Rory Allott:

I used to feel a bit ashamed of saying this, but I've realized, over the years, there's no shame in not being able to do something. But, at the time, I was asking people about their drinking and why they'd started and that was the aim of the interviews. These people would tell me some really traumatic things, some terrible, terrible things. I remember, this guy telling me... I won't go into the detail, but some traumas that had led to him wanting to drink, to really to just numb himself against those traumas. At the end, when I was getting feedback on my interview, the person giving me feedback, the researcher, said, "What did you think when he told you about that trauma?" I said, "Well, I didn't think anything. I was thinking, I wonder how that relates to his drinking, yeah, and what's my next question going to be?" She said, "Did you not feel anything when he said that?" I said, "Nope, I didn't feel anything." She said, "Didn't you think that he was distressed?" I said, "Well, now that you said it, yeah, I guess he probably was because it was so traumatic. But I didn't feel that." She said, "Right. Well, next time, maybe, what you could do is, just, if you hear something like that, even if you don't feel it, maybe, you could just hand it back. Maybe you could just say, wow, that sounds like it was a difficult time."

Rory Allott:

In those early days, I didn't really understand what empathy was. I didn't feel it, I'd look over at the person and hand those things back, in a matter of fact way, because I knew that that was the rule. Yeah. But over time, doing that, over and over again, has developed an emotional empathy in me. Now, people say that I am very empathic, but that wasn't natural, although it was in my culture, and I recognize it now, it was something that I had to learn, yeah.

Sebastian Kaplan:

It seems to speak to a common question that, maybe, we've all been asked from time to time, which is, can anyone learn or can everyone learn how to use reflective listening or to experience that empathy that we talk about in MI? Well, I don't know what the answer is, if anyone can, but you certainly speak from an experience of someone who couldn't do it early on and really was missing some of the key parts of your MI work now, certainly. But, over time and with some, I guess, gentle yet poignant feedback from your supervisor at the time, has really helped you grow into to being the empathic person that you are now.

Rory Allott:

Yeah, without a doubt. For me, it started with mechanics. Obviously, I meet people who are oozing with empathy and emotional empathy, they can genuinely feel what the other person can feel, and I can feel that now, but back then I couldn't. I guess, I always look at those sorts of people and wonder how that happens. Yeah. But, I guess, they just had an innate ability to do that. I think you're right, that has really taught me that you can go... Bill Miller, I think, has said this himself, that you really can teach the mechanics of listening and the feelings of listening will follow. I think I'm a classic example of that, really.

Rory Allott:

I guess, it'd be important to, at some point, think about psychosis. When we go on to think about that, I think that there's an added challenge there for when you're working in psychosis to be ultra-sensitive to the emotions that are in front of you. To what's happening and unfolding in front of you. So, I'm not sure I would have wanted to have learned the mechanics of Motivational Interviewing with people who were acutely psychotic, let's say. Because, psychosis is such a big umbrella, most people that I meet with psychosis are no different to you or I. They may have had some psychotic experiences, they may still be having some odd ideas and, maybe, even hearing a voice, but, to all intents and purposes, they're like every one of us who are having thoughts while we're having this conversation. So, I don't want to be too over inclusive with the word psychosis as though it applies to one group because it isn't, but people who are acutely psychotic, I think the emotions are close to the surface and you have to be sensitive to that and know what you're doing in, in offering empathic.

Glenn Hinds:

Hmm. It's interesting as you're talking about that, because, just yesterday, I was reading an article. I think it's coming out of Stanford University, almost talking about empathy as a muscle. The way you're describing it is, is that your muscle was developed, and as it developed, it moved from, almost, a cognitive empathy or mentalization where you could try and understand what it was like for the other person down into the deeper emotional empathy where you actually understood because you could feel it. As I was thinking about that, it was leading on to, what you began to explore there was... I imagine that having that emotional empathy with someone with a presentation of psychosis could be quite a complex reality for the empathic person themselves, and I'm just wondering, if you want to talk a wee bit about that, it would be really helpful? Just an idea of what you're talking about in relation to the sensitivity to that emotional presentation on the surface. How you manage that empathy or empathic experience of, for example, I present them to you in a moment of psychosis.

Rory Allott:

Hmm, I think at one level, having to really reinforce the idea that not all people with psychosis are the same. So, we put that to one side. I won't say it too often, but I just need to be really clear that this isn't one group. Yeah. This is a group of individuals, all with their differences. But, putting that to one side, people who share the experience, for instance... an unusual experience that I don't often see, but people often think about when they hear psychosis is, maybe, what some people term Thought Disorder. Yes.

So, where people might be, to the listener, not making much sense, that the words are coming, right, left and center, and they don't seem to actually join up. One minute you can be talking about the podcast, the next minute, I'm talking about the bicycle, and then talking about the cat that's across the road. This is what it can be like listening to somebody who's experiencing Thought Disorder. I think it's quite rare, but it's one of the more unusual experiences that people are often asking me, well, how do you empathize with that?

Rory Allott:

I think, from my own experience and from the research, it's in those moments of acute distress and emotion, people become disordered in their thinking. That, then, comes out as a word salad or disconnected sentences. So, when you're with someone, ironically, sometimes I have to return to where I was when I was a beginner, where I might spend less time emphasizing about the fact that they're distressed by their mother, who was mean to them that week and I might actually stand back and notice that the distress that they experience is leading to them being unable to articulate themselves so I might have to move into a place of talking about the weather for a moment. We might have to talk about something very concrete here for a short period and only do little, small exposures to strong empathy, where there's a risk that it can then lead to lots of Thought Disorder.

Rory Allott:

There's been very little research on that, but there was some at Manchester, looking at whether emotionally salient material leads to more thought disorder in conversations and that is the case. But, even in my own experience, when you test that aid, if you start talking about some very emotional attachment that somebody had to their girlfriend or to their partner or their mother, then, suddenly, you see the Thought Disorder and you think, ah, right, okay. So, empathy involves, both, expressing how someone feels but also understanding when not to as well, I think.

Sebastian Kaplan:

It seems like you're picking up on two different cues there, one, perhaps from the other person, whose language and thinking seems to get a bit disorganized, and, maybe, bounced from one subject to another, but, maybe, there's a cue within you, also, of, maybe, feeling some pressure or frustration or some worry that you're losing them, so to speak, or you're not able to follow them. I don't know if that's true for you, if you're responding to one of those cues, or, perhaps, both of those cues, but something very practical, I guess, for our listeners is, to notice those instances and, as you say, step back and spend a bit more time on concrete subject matter as opposed to trying to delve deeper into a complex reflection or something of that sort.

Rory Allott:

Yeah, and I think it's, probably, in that moment, it's less in me. I'll come back to what happens in me because I think Glenn touched on something that made me think about what it's like to empathize with people who are acutely distressed and psychotic. My

whole team would tell you, we're frequently coming back into the office, you feeling very disconnected in our own heads, when you've been spending a lot of time listening to other people who are also disconnected. So, the action of empathy and listening can, in itself, lead to a change in state in the listener, as it were.

Rory Allott:

But, to come back to what Seb was just saying, even in any consultation... I think you were alluding to this, that in any Motivational Interviewing consultation, there has to be that helicopter view of the two of you talking, and whether you've got enough time to continue this distressing conversation... are you going to end in four minutes? Actually, the peak of this distress or this change talk, or this sustain talk, is in the wrong place. In this arc of a conversation that we often have, yeah. But also, is this actually too much, too soon? I think, often, and, especially in my service, especially when I'm supervising people around Motivational Interviewing... I don't think it's overstating it, to say that most of Motivational Interviewing, but particularly, empathic listening, is a very powerful tool. You have to use it very carefully because people can suddenly offload the most incredible secrets that they've been holding for a long, long time.

Rory Allott:

I guess, this is the other bit of, not unique, but I think the other sensitivity in psychosis is that, we know that people who have had a psychotic episode have probably been exposed to more adversity, both social adversity but also traumatic adversity, abuse and the like, than most other populations. So, empathizing brings with it a risk that although someone feels connected suddenly and feels understood, that there is a risk that they offload too quickly, and they feel, then, unsafe. It's in this place of unsafety, that psychosis flourishes.

Rory Allott:

So, we're needing to create a secure relationship, especially in psychosis, with all that adversity that's gone before, and often interpersonal adversity. So really, I don't think we're doing anything different, but the sensitivity has to be that much greater. Yeah.

Glenn Hinds:

By understanding the experience or the potential experience that your client or patient is having, allows you, then, to respond in the most helpful way and it sounds like that's what's driving you. It struck me that, when you describe the individual who is thought disordered, that that, in itself, may be a presentation of their current distress. Rather than exploring the distress, you contain it and support it. The way you support it is by changing the subject so that their thoughts can realign so they can be connected to themselves again, and it sounded like that was such an act of kindness, and it was being driven by your compassion for their experience, ultimately, to be helpful.

Glenn Hinds:

Whereas, the other example was, it was allowing you to invite the patient to explore or understand or connect to the stress in a way that was manageable for them. So again,

it's all about you supporting the patient or the client to feel you're there with them, holding them in a way that's going to be a benefit to them rather than just allowing you to be very insightful and use empathy to, potentially, cause further distress.

Rory Allott:

Yeah, absolutely. I'm not an expert in non-directive counseling so I may be speaking out of turn here. But, I think, that when I hear people learning Motivational Interviewing, especially counselors, that sometimes the listening can be done without direction, really. So, the listening continues, despite hearing on the tape or seeing on the tape if I'm supervising, seeing the other person becoming more and more distressed. I think the intention there is, that, well, if I have this conversation and really listen to this distress, then it will be overcome and people will have been able to vent things that have been deep inside them.

Rory Allott:

But, unfortunately, I don't think it's always like that. I think it can be, but I think It's also about creating a containment and a secure relationship within that, which that can be explored. But it's hard. That is not easy. You don't know when to stop and when to start. I always asked my clients at the end of therapy, and, often, I will see people... well, if it's just for therapy, I'll often see them for up to a year. But, sometimes, I'll also be a care coordinator. So, just like the nurses in my team, and I'll see them for up to three years. I asked one client at the end, I said, "So, what could have been different, what would be good for someone else?" He said, "I wish you'd got to the heart of the issue sooner in our relationship."

Rory Allott:

That stuck with me because I, probably, was a bit tentative because he had experienced some severe trauma. I felt that the relationship wasn't secure enough, early enough, to go there. In truth, there can be no knowing for, either, of us, whether going there sooner would have been a good idea. Because, maybe, it would have been too soon, and he would have then disengaged. But I do think that we have to have that consideration in mind, especially in psychosis, where trauma is so prevalent.

Sebastian Kaplan:

You speak to something that, perhaps, we can all do more of, that the checking in with the client at the end of the session or, maybe, at the end of the series of sessions. It just strikes me as a powerful take home point, perhaps, for our podcasts though. It seems like people that present with psychotic experiences, they may be treated in such a way by care providers, that because they're thinking is disorganized and they're experiencing reality in ways that we aren't, that they can't really speak to their own experience with much expertise or insight. Actually, your anecdote there, I think, serves to push back on that notion and that, just, because someone is presenting with psychosis, doesn't mean that they don't have ideas about what they need or the direction that they want their therapy to go in or changes that they may want to make in their life.

Rory Allott:

I said in Twitter before, coming on to this podcast, that it would give me an opportunity to reflect on some of the work of Rogers, and I said that my whole career path has been shaped by being person-centered. Rogers did a trial. One of the first big randomized control trials in a state psychiatric facility in 1961, with people with a diagnosis of schizophrenia. If you ever get a chance to read that stuff, it's just incredible, his insights. But, talking to this point that you've just made about, people may be assuming that people don't have a desire or aren't able to express that desire, I think that's true. We know that there's strong stigma in labels such as psychosis, schizophrenia, and along with that stigma goes, the idea that people are dangerous, and that people are incompetent, maybe, unable to make choices, and it is just not true.

Rory Allott:

Would I be okay with sharing a quote that Rogers said on this point, would that be all right? Because, this was in 1961, and here we are in what 2019, about '20, and I just think it's still true, unfortunately. He said, we've come to realize that, almost, none of the individuals with whom we've been working, have ever affirmed themselves. I really like the use of the word affirm and we can come back to that. They have never, in any meaningful way, said, I feel, I live, I have the right to be. They have, instead, being passive receivers of life's hurts, blows and events. It takes, in my experience, great patience to wait for the germination and budding of the will to say, I am, and I deserve to be.

Rory Allott:

I just think that that's really encapsulated my whole approach to Motivational Interviewing with people with psychosis is, they have, unfortunately, been in... not all of them and, again, to repeat, that diverse population, but many have been the recipients of life's hurts and because of that, find it difficult to say that I can be who I want to be. I think Motivational Interviewing with, both, it's techniques like affirmation... and I would always say that, everyone always says when they listen to me doing Motivational Interviewing, how affirming interviews are.

Rory Allott:

I tell my trainees, I say to them, I don't do that by accident, I have to work really, really hard to remember to affirm these people. Every session that I go in, even, after years and years of doing this, I have to actually consciously say to myself, what is it that's so important about this person? What is this person's strengths? In this interview, you've spoken now for 20 minutes, Rory, what strength can you label? Yeah. I'm actually saying that in my head. That's because of these life's hurts that just hit these people. I think that's one of the major contributions that Motivational Interviewing is made to my work with people with psychosis.

Glenn Hinds:

You're very dedicated to being as connected as you possibly can be to those people that you help experience this. It sounds like you've been working very hard to improve

your own experience of yourself being with them. When you read out Rogers quote there, there's an awful lot of sadness, I think, in hearing the way he speaks about the people's experiences. I imagine, there's a lot of people listening to this, will probably identify beyond an individual with a psychosis with some of what Rogers talking about, about their own experiences of life. That life has happened to them without having a sense of themselves.

Glenn Hinds:

It related, back again, to your description of your grandfather's story of the Quaker meeting, where that individual was heard and accepted for who they were, and it sounded almost like the tears that they expressed were just tears of relief, of just been accepted and offered the opportunity to be himself with other people. Again, it sounds like the spirit of Motivational Interviewing for you, is really that everything that you do is germinated from that place, which is, your desire to understand this other person and the true nature of who they are.

Rory Allott:

Absolutely.

Glenn Hinds:

Very often, you are seeing the true nature of who they are, and continuing to see the true nature of who they are until they begin to see it for themselves, and then begin to connect it and then act from that place.

Rory Allott:

Without a doubt. But I would say, and to come back to your point, it made me think that connecting with someone is a risk. Yeah. I might disappear. I might offer some security and then vanish. Yeah. For somebody who's, probably, had people vanishing on them, all their lives, that that is a real risk. So, there is a side effect, I think... and we talked about the Thought Disorder, which is rare, I don't often see people that thought disordered. They're normally in hospital. I'm normally having short interactions with them. Most of my work is in the community, but I do go into hospital as well.

Rory Allott:

But more common, is this really connecting with someone? If you believe that paranoia, that some of these psychotic experiences may be hearing voices, some people would say that they protect against, either, a sense that they themselves are worth nothing, or that people close to them have been abusive. Yeah. So, in order to really tolerate the truth of that, the psychosis might, in some ways, function to externalize it to say, well, it's not about me, it's the FBI chasing me, whatever. So, when you start to connect with someone through reflective listening, through affirming them, through labelling strengths, even, through offering empathy and connecting with their emotion, then, suddenly, that can be quite threatening, and not, infrequently, I would say that that can precipitate further paranoia. Yeah.

Rory Allott:

How are you knowing this about me, is the question? How have you got inside my head to know about this? You must be part of this conspiracy against me. Again, it comes back to that sensitivity to see how your actions, as a worker, as a therapist, as a listener, how they might be having an intended effect on the opposite side of this relationship, and they're not creating security, but instead they're creating threat. Yeah. So, I think that's another caution I have about learning Motivational Interviewing in psychosis, that your empathy doesn't go so far that you end up reading people's minds who already feel like they're being read.

Sebastian Kaplan:

Going back to one of the earlier points you made, a moment to notice that that type of distress or suspicion is coming up and perhaps a time to pull back a bit and become a bit more concrete, perhaps. Or, on the surface, so to speak, to create, more, a sense of safety for the person.

Rory Allott:

Yeah. Or, to become very tentative in your offerings. Yeah. In moments like that, I will be saying, but you know what, I might be wrong here. Or, you know what, I don't know your whole story. Nor, should I, at this stage, because we've only known each other for four sessions or something, I will just become very... take the lower ground to use Bill's more recent language around social hierarchy. Yeah. Trying to really ‘downmanship’ the worker, the therapist, so that they can feel a little bit more secure and know that I'm not there threatening them with some emotional knowledge that they didn't have.

Rory Allott:

But, at the same time, there are opportunities. This is a dance. This is really a dance. The opportunity's there are to say “well, I wonder if we actually know each other so well, that I'm not actually reading your mind, but I just know you quite well, and we've got to know each other.” So, it becomes an opportunity for what Cognitive Behavioral Therapists would be doing, that's testing the veracity of these beliefs, testing whether there's an actual alternative explanation for how I could know that they were feeling anxious. How I could know that they were feeling under threat. It might not be an FBI conspiracy; it might just be that we've got to know each other very well. That in itself is a good learning, isn't it? Because then, hopefully that will generalize to other relationships at home. Yeah.

Glenn Hinds:

So, not everybody that's close to this individual is necessarily going to be dangerous? While, they've had experiences of close relationships that have been harmful, you're perhaps, the first example and, maybe, the blueprint of the experience of, there are close relationships where I can be safe and understood and cared for and valued and, therefore valuable.

Rory Allott:

Absolutely, yeah. You use the word acceptance and I think that that's an acceptance of everything that's in front of you, including people who are expressing some very unusual ideas is a skill. Being able to accept people who are talking about very, very strange ideas, sometimes, can be a challenge, but it's absolutely necessary. I guess, Motivational Interviewing gives you the mechanics for doing that. Yeah.

Sebastian Kaplan:

It actually makes me think of a trap. I suspect that many people, particularly early learners or residents, or early-career professionals, perhaps or maybe experienced professionals get in, when they're in conversation with somebody who believes that the FBI is out to get them, let's say, and because the professional is noticing and hearing a lot of distress on the part of the individual who believes that the FBI is out to get them, our righting reflex as we like to say in MI, would be to try to convince them that that is in fact not true. To challenge those delusions and those sorts of things. Our discussion now about acceptance, and about being more tentative, as you said, Rory, perhaps offers an alternative route to ultimately help the person consider whether in fact, it's the FBI or whether there's some other explanations for some of the experiences that they've had. Maybe, you could speak a little bit to that righting reflex of challenging a delusion and trying to convince somebody that it's not true and how that might be unhelpful or, perhaps, over time, helpful to some extent?

Rory Allott:

Hmm, yeah, I think that's a really tricky one and it's one that, probably, people are trained to not get into conversations about delusions, certainly in psychiatric training. That's, sometimes, an old sort of narrative, really, that trainees have been given. I think it is very tricky. If we're saying that these beliefs, in the same way that all of our beliefs... in the same way that somebody who believes that alcohol is, really, the only thing that can get them through life, and without it, they'd be committing suicide. Well, what would we be doing in Motivational Interviewing with those beliefs? Yeah. These are all tenaciously held beliefs that the therapist probably doesn't believe.

Rory Allott:

So, to a certain extent, delusions are no different. They're tenaciously held beliefs that the opposite partner in this relationship probably doesn't hold so tightly to, so response is exactly the same. I don't want to overplay the term acceptance, but there is some sort of communication there. Well, this is how you're believing things at the moment. I guess, what we would do in both cases, is, we might instead refocus the interview on what's important in their lives, what they value. If the FBI weren't after them, if the alcohol, for whatever reason, wasn't a problem, or the depressed mood that they're trying to solve with alcohol, wasn't a problem or the memories of war, in PTSD, weren't a problem, then what would they be doing with their life? What would be really important in their life to connect with?

Rory Allott:

I guess that all of those, the drink, the depression, the traumatic memories, the delusions, all become barriers to engaging with valued actions. So, they can all be treated in the same way. Well, I wonder if we could tentatively start reconnecting you with those values despite this delusion. Though it doesn't necessarily require challenging head on, and in fact, often won't. Because if you can connect someone with what's important to them, then often the delusion becomes less prominent in their lives. So, actually, I think that is a righting reflex for me, and the trap that I'm often falling into, because I'm often thinking, Oh, I should be doing Cognitive Behavioral Therapy here, because that's the nice guideline recommended approach and that's what I mostly do at work.

Rory Allott:

But, often, I can interpret that to mean, I need to go straight in and challenge these delusional beliefs so that this person can get out into the world. But, the truth is, that getting out into the world is part of Cognitive Behavioral Therapy and connecting with what's important to them is part of Motivational Interviewing. So, that's where I probably would deviate away from strong delusional ideas.

Glenn Hinds:

So, it's about practicing curiosity and hope. The way you're describing it, that you're not necessarily trying to change it. You're trying to get the person to a place where they have different choices or can connect with the world in a different way. But how they arrive at that is open for discussion, rather than, you must do it this way and we're going to take you straight through the barriers. It's what's on the other side of the barrier, and, even, just by looking over the fence, that is an opportunity for them to begin to explore, how else can I get there? I love that idea of, despite the fact that you're having these delusions... rather than, you have to get rid of this before you can get there.

Glenn Hinds:

I'm also struck by just how profound and deep these conversations must be for you, Rory, and your staff. We mentioned, earlier on, in relation to the empathy. What I'm curious about is, for people listening to this, how do you protect your own well-being? When working with individuals who are presenting with this. You described coming back into the office with scattered thinking and, I imagine, that also is true, but on an emotional level… Just for people who are learning to practice, who are developing their empathy, and perhaps, beginning to recognize these presentations themselves, what do you and your staff do to maintain your own well-being as you go in and out of this world with clients?

Rory Allott:

Hmm. Yeah, I'm the clinical lead in my team and we have a team leader and, between us and the psychiatrists, we lead the team. I think there's probably, about 15 of us now in the team and I'm sat here on holiday, in the middle of my holiday... and I've been on holiday now, probably, for six days, I don't think there's been a single day they haven't had on my early intervention WhatsApp group... here's some photos of dogs, of people

walking in the countryside. I don't like dogs, so it annoys the hell out of me. But we realized long ago... we ended up in more austere NHS with less money. We lost the building that we were in so the fabric of security that we had, that we were one team with four walls around us, just vanished, really.

Rory Allott:

So, we created digital security by having these WhatsApp groups where we don't talk about work here, but we talk about our lives, our person, who we are as people. That's one really important aspect is that you can be able to see each other beyond the workplace.

Rory Allott:

The other thing is, we wouldn't survive without supervision. So, everyone working in our service gets supervision, at least monthly. They can be emotional sessions for all of us. There are places where we're frequently talking about the parallel between the relationships that we're having with our clients, and the parallel of the relationships that we're having with our supervisors. So, all of the things that we've said in this podcast for the last 40 minutes or whatever, apply in that supervision setting as well.

Rory Allott:

So, from showing empathy, but knowing when to stop showing empathy so that someone's not walking out in tears into the office. Knowing when someone feels secure enough to talk about difficult moments they've had with clients, but also, I guess, talking about the ambivalence in workers after talking about ambivalence with their clients. So, that's frequently a topic of conversation for supervision. So, I'd say, supervision and informal structures are really absolutely essential. I wouldn't be wanting to be a private practitioner doing this on my own without a team around me. I don't think I could do it. I need a team to come back to. We call them our work family. So, this is our work family and belonging to a family is important to buffer against the distresses that you see in your everyday work life.

Sebastian Kaplan:

Maybe, another reminder that, this disclaimer that we used a lot today, that people with psychosis aren't all the same. Some of your early points about, they're largely no different from either of the three of us or anyone else in our life and the things that we need to stay healthy and to be well and to remain competent as professionals are perhaps the same things that our clients need. Connection with a community, activities that we enjoy, whether it's walking with dogs or clearly something else for you, Rory.

Sebastian Kaplan:

Also, something that we've talked about in other episodes, too, that there's something about the mechanics and the spirit of MI that certainly are helpful in clinical scenarios. However, we can also use some of these same elements and having supervisory conversations that are both impactful from an educational standpoint as well as for our own emotional well-being.

Rory Allott:

Yeah, absolutely. But, at the same time, you can imagine, there's listeners out there and I certainly see them on Twitter that say," Oh, you've never worked in a psychiatric unit then. You've never seen bizarre behavior." Well, I see that every day I go to the wards. I see difficult moments. I don't want to go into too much detail, but I see very disturbing things happening. Even in the most disturbing of moments, on a psychiatric ward where someone is in complete throes of psychosis that in those moments, often actually, language is lost because people are so psychotic, that no matter what you say, it becomes twisted and turned into something else and you're the devil. One client said to me that in those moments, he hardly knows what people have said to him. He hardly remembers anything about what happened on the ward while he was a psychiatric inpatient, but what he does remember, and he has an indelible in an image of this on his mind, which is a kind face. I remembered that and I keep that with me.

Rory Allott:

I think this is why probably doing Motivational Interviewing in psychosis, probably does require a more... I don't know if it's true to say this actually, but certainly it is emotional. But, so should it be in any MI relationship, I would say. But it is especially, emotional because sometimes you're trying to transcend the madness in front of you and connect with the person emotionally.

Rory Allott:

I do remember one moment with someone who hadn't washed for weeks and was detained under the Mental Health Act... and we haven't even talked about that being a special consideration in psychosis is obviously people are frequently, as well as having all the traumas and the abuses in their early life and later life... then they are often, with some strange behaviors in the street, incarcerated and picked up by the police, and that can be a very, very traumatic experience. Sometimes handcuffs, sometimes violently taken into the back of an ambulance and taken to hospital. But anyway, one guy who'd been detained on the ward, I remember he hadn't washed, and I wasn't sure whether I could connect with him, but I always give it a go. He thought some strange things about me, and I didn't think that we'd particularly hit it off. I'd been trying to connect with him, probably for two weeks, and the staff were just really struggling to get him to go and have a shower.

Rory Allott:

So, I saw him just pacing in the corridors and I could see that he was very frightened of lots of things in his head and outside of his head because wards are frightening places, and I stopped with him and walked up and down. I said, "Look, I can see that you're really frightened." So, this was the empathy of Motivational Interviewing. I said, "And, I know that, probably, there are some things that you think about me that are frightening." Taking a bit of a risk getting inside his head, but I said, "Look, I will stand outside this shower door and I will keep you safe from whatever it is that you're fearing." That one day, he went in and had a shower and he talked to me about that afterwards. I guess, that in that moment, he probably would forget the conversation. The fact that somebody

was trustworthy and connected enough to overcome that fear that he had so that he could have a wash. That then becomes a valuable action, doesn't it? We didn't have to challenge his beliefs for that. We just needed to connect with him and try and connect him with what it was that's important to him and, probably being clean was one of them.

Glenn Hinds:

Again, the dedication that you exhibit there, Rory, to the fact that this guy has been on the ward for two weeks, and it sounds like, for those two weeks, you have been endeavouring on every occasion to make the connection and how easy it must be to give up that effort for practitioners. I think, maybe that's a really strong message for us to think about is, how often do we give up when it doesn't happen quickly and how that persistence and that compassion and that care you have for an individual, eventually paid dividends for him. That he found someone who was able to understand from his perspective and, beautifully to articulate in a manner that he felt understood by. That enabled him then to do whatever was necessary, I suppose, from the ward perspective. But again, it was just your willingness not to give up.

Rory Allott:

Hmm. I think that early intervention, the team that I work in, we adopt an Assertive Outreach Approach, so that means no discharge. It doesn't matter how many times you close the door on us, we will persist. Often, sometimes to the annoyance of lots of people. Unfortunately, if we cannot engage people then often, or sometimes, they will end in the legal system. So, that persistence is a matter of liberty really. I guess that that's one of the differences in working in psychosis is, a bit like Rogers said in that quote, it requires patience. It requires persistence and patience.

Rory Allott:

I think the traps that I often fall into and the whole team does and many people, is that when things don't change fast enough, you start thinking that, maybe, you're doing the wrong thing and you try something a bit more, nut crackery... that you're going to crack this nut and, maybe, just go in and challenge some beliefs or raise the medication or do something majorly different, when in fact, what was required, was more persistence and more patience and an acceptance. It's only when acceptance is there, that things really start to change. But that is very hard to do, especially when people are damaging themselves, you do have to intervene.

Sebastian Kaplan:

Yeah, the speed of our work is, of course, it's quite relative, right? So, work fast enough, well enough, relative to what. Oftentimes, it's relative to what the hospital patient data purveyors are saying or maybe, we have some piece of the blame pie there in the MI world because MI is so often touted as a brief intervention. You can do your work faster if you do what we do. That story, Rory, so impactful, but I think important for listeners to not take away the message that, well, if Rory had just said that on day 2 instead of day 10, or whatever, well, it would have happened quicker. Maybe, no, that's not... the message is, maybe it happened exactly the way it was supposed to. Maybe, it was

perfectly timed after two weeks, and it took the time to get there and that time was actually really important for that person to ultimately come to trust you to allow you to stand outside the shower door.

Rory Allott:

Hmm. It is attention, I think that is the major difference, and it's the reason I like working in psychosis. Because, certainly, for me, having relationships with people is the key reason that I go to work. So, having long relationships with people or relatively long compared to say, somebody doing a brief intervention in A&E, is important to me. So, for us, the relationship will normally be anything between one and three years. Three years is our limit. But, sometimes, in our service, the disturbance, the problems that people are facing, the behaviors that they're engaging in, are so serious. There's such a risk to, either people in the community, to people's children or to themselves, that there is the length of time that you can persist and be patient for, is much truncated by the need to protect that person through coercion and through control with the law.

Rory Allott:

I think that is another challenge for working in a person-centered Motivational Interviewing type way, is that, even within… and I'm often saying this to the team, the Mental Health Act, where a social worker and a doctor are turning up to make recommendations to admit someone to hospital, there are choices within that. There are choices about which type of medication you are forced to take. There are choices, within that, about how you spend your time on the ward. So, even with the limited control that a person has, you try to use these person-centered methods to emphasize that they do have some limited autonomy.

Rory Allott:

Even providing information, we teach social workers to use elicit, provide elicit, in these very stressful circumstances where decisions are being made about detention. Well, the chances are that if you can create a climate of autonomy, giving responsibility, respect, then maybe you will avoid the need for a detention. But, unfortunately, these situations become very them and us, very quickly. So, I think, even, within those contexts, there is a role for Motivational Interviewing.

Glenn Hinds:

So, the challenge is, “how do I maintain a kindness and compassion in a mandated situation where I have authority and I'm going to, actually exert my authority to protect you and/or other people.” Almost, like a parent making decisions about a child's behavior, that sometimes I have to not let you do something you want. I know it's going to hurt you; I know it's going to annoy you. But, it's ultimately, for your own good and it's how do you do that with a kindness in your heart rather than an anger or resentment towards you.

Rory Allott:

Absolutely.

Glenn Hinds:

I'm struck by your time, Rory, when we invited people on Twitter to ask questions knowing that you were coming on, and Rob Lyon with Twitter handle @PsychOps, he asked a question, “as for Steinberg's findings in mental health populations, one of them, at least, he says, "How do people with auditory hallucinations perceive statements designed to express empathy, with simple reflections and to what extent are more complex reflections understood by this group, who are also experiencing learning difficulties?"”

Rory Allott:

Hmm. Well, I think, again, we would have to give this proviso that, not all people are the same, but certainly, thinking about people who are hearing voices, we do an exercise and we've done a few MINT forums, maybe two... we've done this exercise where we give people the experience of hearing a voice so we get them into triads and two workers, and I'm sure lots of listeners have, maybe, done this exercise... but, I think the exercise is very telling. So, two people are trying to do MI, and there's a therapist, a client, and then there's a third person who's whispering voices into their ear. Always, the feedback from this exercise from the client, who aren't voice hearers, they're just having this sort of analogous experience, is that they find it nearly impossible to concentrate. That listening to a voice in their ear, and listening to the therapist in front of them, was very taxing.

Rory Allott:

So, what they require, and we redo this with the therapist adapting their methods, is that they require that the therapist is giving lots of silence, but enough structure so that the person can be brought back into the conversation over and over again. So, they often prefer simple reflections that aren't long and drawn out, where they're going to lose the thread while they're listening to another voice as well, but also with frequent summaries, and repeated summaries so that they can keep the thread of the conversation.

Rory Allott:

So, I think on voice hearing, that's probably one adaptation that's important. The same is true, then... and I think he's referring to learning disabilities there, but anyone who's impaired, cognitively, for any reason, be it, alcoholic-related dementia, or even people who are drinking while you're talking to them, the cognitive load is great. So, the therapist needs to be much simpler in the way that they're delivering Motivational Interviewing

Sebastian Kaplan:

Well, one of the threads that seems to have run throughout our conversation today, was being quite mindful to the other person which, in some ways, goes without saying, but some of the examples that you brought up, Rory, really highlight the importance of it in practical terms, the idea that which I guess, I had never really considered but it makes perfect sense, that if you're in conversation with somebody who experiences, in particular, auditory hallucinations, they are trying to distinguish between two different

voices. For them, it's not the case that one is necessarily more important than the other or just because I'm the clinician, I'm talking that they need to listen to me. In some ways, they may not even have a choice in the matter and we need to be very aware of where the other person is in the conversation and adjust our goals for the conversation but the mechanics of them as well, to maximize our benefit.

Rory Allott:

Yeah, absolutely. I think in that exercise that I do with practitioners in training, another feedback that clients, also, have benefited from and benefit from is, that the person who was hearing the voice in these exercises and these role plays, they often say, I just wish the therapist... There's a guy standing next to me, whispering, I wish they just said, “I wonder how hard is with a guy whispering into your ear?” Well, I think it's so obvious that someone's hearing a voice with you, that sometimes, practitioners are fearful of saying that out loud for some reason.

Rory Allott:

So, another adaptation that really is obvious, but really very important, is that you label the elephant in the room, and that you say, I just noticed that you looked off into the corner and I wonder if there's someone here right now talking to you. Sometimes, you'll get it wrong and they'll say, “no, not now, he was talking to me yesterday.” But, sometimes, they'll say “yes. I'll say, right, okay and I wonder if he's telling you not to listen to me because that's often what's happening.” And, they're, just nodding.

Rory Allott:

I can sometimes have whole conversations that are purely reflective listening with the client, just nodding or shaking their head, because they're so overloaded with fear, with voice hearing, with being acutely distressed, that all they can do is nod to my reflections. Obviously, I'm guessing, most of them, but you can see in front of you. I'll often say to trainees, well, what could you see? Not what could you hear, but what could you see in front of you? They say, Well, he looked really distressed. He looked like he was going to get up and hit someone. I say, right, okay. Say it out loud and he'll be relieved, often.

Glenn Hinds:

Yeah, it's that's being noticed. That experience of being noticed without having to articulate it any further than just a recognition or acknowledgement and the head nod.

Rory Allott:

You're becoming their voice when they are unable to use their voice because they're so overwhelmed. You are lending a hand and being their voice for them. You have to be careful because... I, frequently, will use tentativeness and say, don't let me put words into your mouth here. You have to judge whether you're doing that or not.

Glenn Hinds:

Again, the thread throughout it, is just that caring effort, that consideration throughout, to be aware of what it must be like for this other person when I'm being and doing what I'm doing, trying to be helpful. It's been fantastic talk to you, Rory. I'm just conscious of our time and your time and I appreciate that you're talking to us on your holidays and we're both really grateful for that. But, one of the things we often do or always do with our guests, is offer them, just as we come to close, just to talk about, if there's anything that's currently going on for you that is catching your attention, in your world and what you do…

Rory Allott:

We're just currently rolling out a five-day training program for Psychosocial interventions across our entire trust, for all new starters in our entire trust. So, this is for everyone, whether they're a support worker or a psychiatrist, and two days of the five days is Motivational Interviewing. The reason for giving over so much time to MI, is because of its importance in engagement, and engagement is the key to all interventions, whether it's a suicide intervention, or anything.

Rory Allott:

I think that the thing that strikes me is, that often it's not about necessarily being the best empath that you can be, the best Motivational Interviewing that you can be, but it's about not being the worst empath. It's about being non-toxic. It's a sad statement in some respects that I have to say that, but with all my years of experience and looking around and now, with a mounting evidence even in psychosis, that we know that care coordinators that have the least positive things to say. They often don't say mean things on tape when you're doing research, but some research that Katherine Barry's done at the University of Manchester about getting people to talk about their clients, people who have least positive things to say, also have a worst outcome in the future.

Rory Allott:

So, I think that targeting and finding people who find it a struggle, for whatever reason, for their own reasons I'm sure, to be empathic and to be compassionate and helping those people to become more empathic and compassionate, is what's really my journey at the moment. For that reason, we always use an empathy measure in our interviews for new staff. So, we select people... one part of our selection process is, using actually the VASE-R video assessment of simulated encounters that David Rosengren developed. So, people come along and, unfortunately, have to do that. But it gives us an approximation of how empathic our staff are. Find the empathic stuff, that's my end line.

Glenn Hinds:

Hmm.

Sebastian Kaplan:

That paper is really wonderful, is low therapist empathy toxic. Well, we probably can't link the paper itself, the PDF. We can, maybe, put the reference on the episode page

because it really is worth a read. I want to ask one more question before we wrap up, if it's okay. The question of medication for people with psychosis is something that, in my world, anyway, being in a Department of Psychiatry. Is often seen as really the focal point or the most important thing that people who experienced psychosis need. I know it's a huge question, we can, maybe, have a whole other episode on it, but maybe, in a couple minutes, just to share some of your thoughts about how meds fit with MI in this population?

Rory Allott:

I think that the majority of people in our service take medication and it's expected that they do. Even, in my service, where I'd say that psychological interventions are quite a priority, and our social ones, we have employment support workers in our service... But, even in my service, it's the number one treatment. That's the NICE guidelines, it should be offered. There's been two recent trials in our service, multicenter trials. One's called COMPARE by Tony Morrison, at the University of Manchester, and the other one's called MAPS, and that was for younger people. COMPARE, was comparing medication alone, psychotherapy... well, CBT alone and the two together. I don't want to talk to the findings of that, particularly, because it's not my trial, and I'm not an expert on it, but certainly, I would recommend that people went and read that.

Rory Allott:

But, the interesting thing is, just in preparation for this podcast, I read Aaron Beck's 1952 case study of somebody with psychosis that he worked with, in an outpatient setting and I guess, what he was saying in that paper was, there is this attitude around that people can't improve with psychotherapy who have psychosis. Well, we know that they can, and we know that they can also when they're not taking medication as well. But, the findings on that are preliminary.

Rory Allott:

So, I think yes, it's the recommended treatment, first line treatment. I think, sometimes, that people are over-medicated. It's tricky to work with because they can be blunted in their affect, in their emotion. We know that people who experience side effects such as lethargy, weight gain, that these then in themselves, become problems that the psychological therapy have to tackle. They diminish people's self-esteem further. If you believe that psychotic beliefs protect against self-esteem then sometimes, you might be doing more damage with the side effects of medication.

Rory Allott:

But I think that in Britain... well, in my service and beyond, people are becoming much more mindful of the side effects of medication. People are becoming much more emancipated... well, maybe that's too strong a word, but given the information they need to make decisions about medication. Certainly, in our service, assuming that there aren't any risks, we don't demand that people take medication. There are plenty of people, in fact, just thinking through my caseload, at the moment, I'd say about a third are getting

psychological therapy who choose not to take medication, but they're hearing voices and they've got paranoid ideas. So, it's just normal for us. I think it's a mixed bag.

Glenn Hinds:

The word normal, I think is, probably, one of the things that just weaves its way through our conversation. While we're talking about, for most of us, quite bizarre presentations, there's a normality to it. It sounds like the one thing that you've endeavoured to communicate to us is, how to respond to this normality for this other person in a way that they will find helpful. Again, we really appreciate your wisdom and your dedication and the way you describe what you do, Rory. There's no doubt there's much more we could be talking to you about and going into more depth. I guess that there will be people who will be this, maybe, have questions for you. And we often ask our guests if people, after today, were to have questions directly for you, can they contact you and if they were to contact you what would be the best way to do that?

Rory Allott:

Yeah, they can contact me by email at rory.allott@gmmh.nhs.uk. That's my work email.

Glenn Hinds:

Allott is A-L-L-O-T-T?

Rory Allott:

Yeah. Or, on Twitter @rallot.

Glenn Hinds:

@rallot. What we'll do is, we'll post that to the podcast feed. Just drawing it to a close, just to remind people that we've just recently started communicating through Instagram, which is @TalkingToChangePodcast. Our Facebook is Talking To Change, and Twitter is, @ChangeTalking. But, as all good things do, this must now come to an end. With us again be grateful to you Rory, for your time and for your contribution. Seb, can I just thank you for your time again today and wish you all the best.

Sebastian Kaplan:

Thank you so much, Glenn, as always, and, Rory, we really, really appreciate it. This has been a really fascinating conversation.

Rory Allott:

Yeah, thanks very much. Just one more thing, you can watch a video produced by our service users, at #psychosisfilm. If you just put that into YouTube, and it's a three-minute film created by our service users on what it is to experience psychosis.

Glenn Hinds:

Thanks, Rory. Thanks, Seb.