The Lost Art of Engaging Patients with Psychotic Symptoms*

*and Why It Is More Important Than You Might Think!

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Faculty Disclosures

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Learning Objectives

- Review evidence that initial treatment engagement is essential to successful treatment of persons presenting with active psychotic symptoms
- Describe the way in which psychotic symptoms interfere with treatment engagement
- Show some core techniques that are designed to support the engagement and assessment goals early on

Background and Relevance

Okay, Engagement Matters….
But is Training a Good Use of My Time?

- Medications not therapy is what works for psychotic disorders
- You need to wait for medications to kick in before you can engage
- These skills don’t need to be taught; it is intuitive
- I am trained in [fill in your training here]
- Even if you think this is important, you won’t see any benefits
- There is no evidence that initial engagement will help later on

The Role of the Therapeutic Alliance in the Treatment of Schizophrenia

Relationship to Course and Outcome

Arlene F. Frank, PhD, John G. Gunderson, MD

Alliance rating at 6 months*	Outcome at 2 years
Good	77.8%
Poor	25.0%

* $t = 2.35$; $df = 46$; $P<.05$ (two-tailed).

What Patients Tell Us

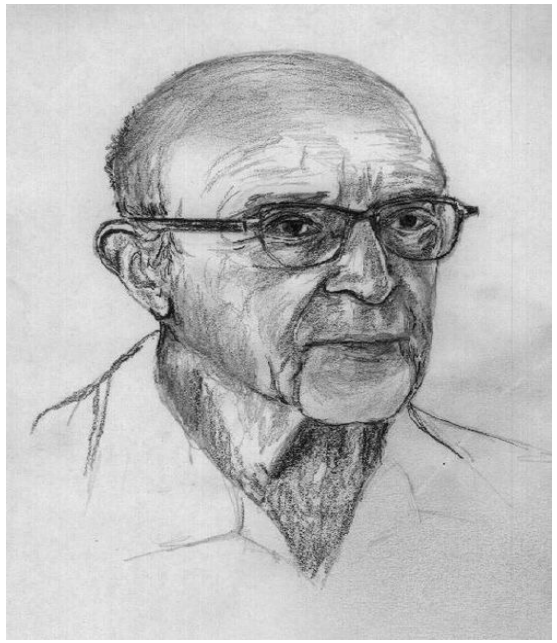
In depth assessment of transcripts of verbal interactions between individuals with psychosis and their clinicians

- Patients actively attempt to talk about the content of their psychotic symptoms
- Clinicians are reluctant and uncomfortable with responding to those concerns
- Frequently caused noticeable tension between patient and clinician

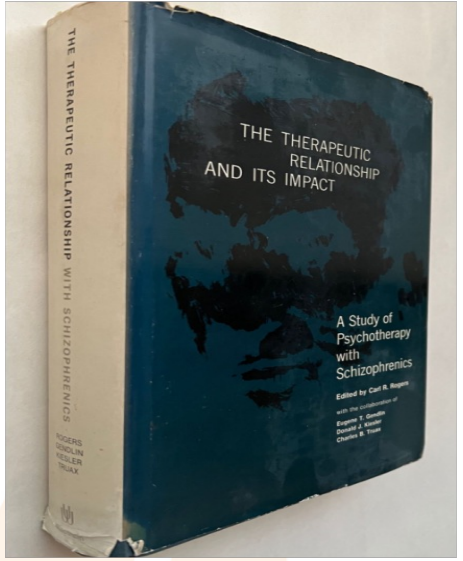
Bottom line: Paying attention to the content of psychotic symptoms may help improve engagement

McCabe R, et al. *BMJ.* 2002;325(7373):1148-1151.

Key Players and Key Concepts



Carl Rogers
Founder of Person-Centered Therapy



Some core principles

- Unconditional positive regard for the other person
- Genuineness of therapist, being authentic
- Acceptance of person's reality

Carl Rogers (1902–1987) was a founder of person-centered psychotherapy and many of the underlying principles and techniques.

For persons with psychosis, emphasis on maintaining acceptance despite challenges imposed by symptoms. Staying genuine from the start and trying to understand psychotic symptoms as a way to connect and start the relationship.

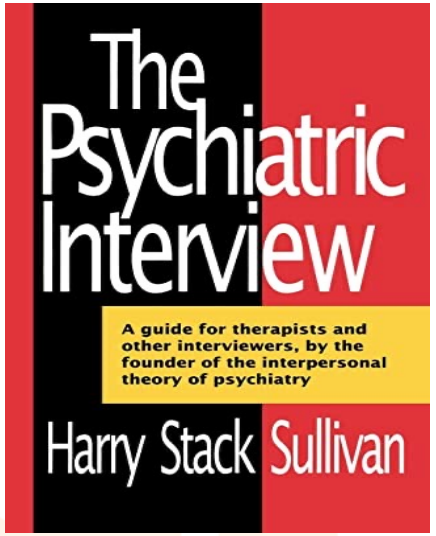
Miller WR, Moyers TB. *J Consulting and Clinical Psychology*. 2017;85(8):757-766. Kirschenbaum H. *The Life and Work of Carl Rogers.* American Counseling Association; 2007. Oberreiter D. *Person-Centered & Experiential Psychotherapies*. 2021;20:152-173.



HS Sullivan (1892–1949) focused on the importance of relationships in treating people with psychotic disorders

Harry Stack Sullivan

Founder of Interpersonal Approach to Treatment of Psychosis



- Viewed symptoms as occurring in relationships
- Interventions based on reducing symptoms in the relationship with others rather than within the individual

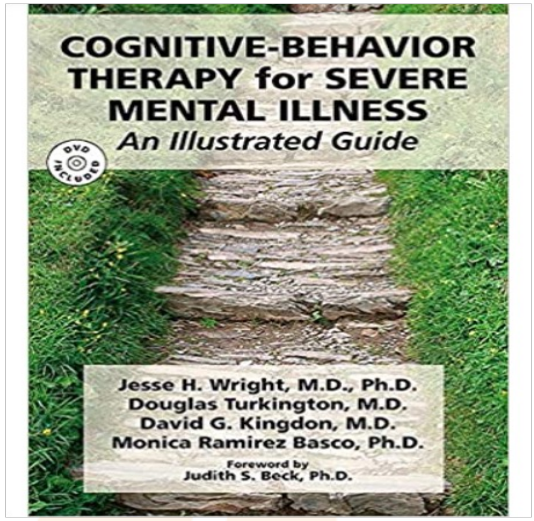
One of the first to emphasize how anxiety, alienation, and loneliness were key issues to address for disorders such as schizophrenia

Sullivan HS. *Academic Medicine*.1962;37(8):800.



Dr. Aaron Beck

Aaron Beck
Founder of CBT

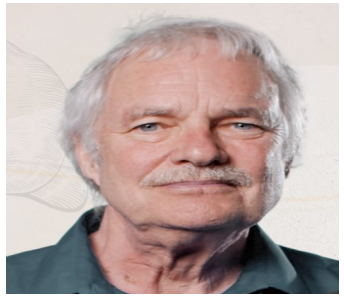


Aaron Beck (1921–2021) is regarded as the father of cognitive therapy and cognitive behavioral therapy (CBT) and was a key supported of developing CBT for persons with schizophrenia and psychosis (known as CBTp).

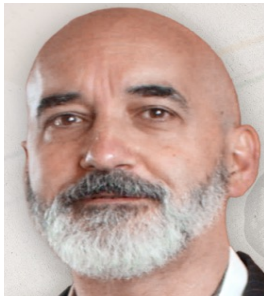
- Used cognitive models to develop an alternative approach to psychoanalytic therapy
- Was the founder and supporter of CBT for psychosis (CBTp) as a core intervention

Showed effectiveness of CBTp for core positive symptoms of schizophrenia and many non-pharmacologic models of intervention developed with this genre of research

Turkington D, Kingdon D, Weiden PJ. *Am J Psychiatry*. 2006;163(3):365-373. Beck AT, Rector NA. *Am J Psychother*. 2000;54(3):291-300.

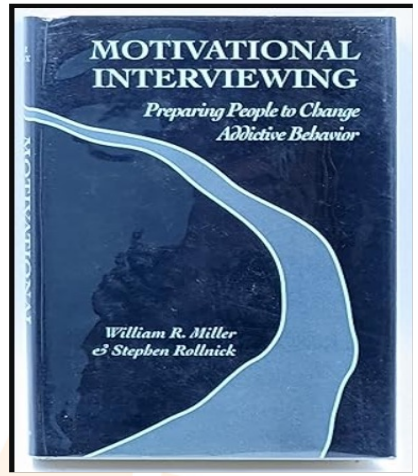


William Miller



Stephen Rollnick

Miller & Rollnick
Founders of Motivational Interviewing



MI designed to promote change for conditions where change is hard

- Influenced by Carl Rogers
  - "unconditional positive regard"
- Stages of change
- Harm reduction approach
- Active listening

For persons with psychosis, active listening, concept of "righting reflex", and unconditional acceptance of person despite their rejection of treatment recommendations

Miller WR, Moyers TB. *J Consulting and Clinical Psychology*. 2017;85(8):757-766. Miller WR. *Behavioural and Cognitive Psychotherapy*. 2023;51(6):616-632.

The Initial Encounter

Psychosis Disrupts Initial Assessment
Too Much or Too Little



Psychosis obvious and disruptive

- Does not want help
- Patient is rude, judgmental, or threatening
- What patient wants to tell you is not what you need



Psychotic symptoms present but hidden

- Withdrawal as a normal response to symptoms
- Interpersonal: Fear of being judged or rejected
- Consequences: Fear of what will happen if disclosed

Initial Encounter:
What comes first? What is top of mind?

ASSESSMENT

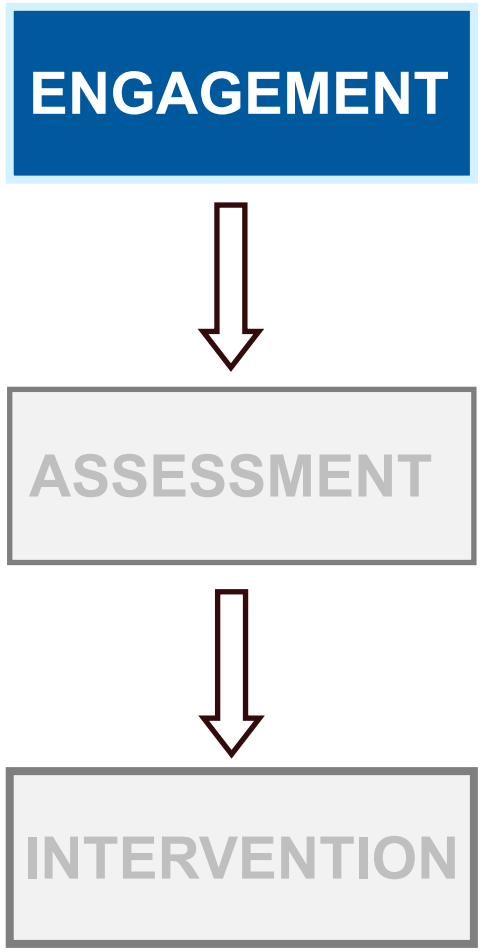
- Information needed for safety and immediate actions
- Understanding symptoms
- Database for intervention

INTERVENTION

- Level of care
- Medical work up
- Mental health referral
- Medication management

Miller WR, Moyers TB. *J Consulting and Clinical Psychology*. 2017;85(8):757-766. Turkington D, Kingdon D, Weiden PJ. *Am J Psychiatry.* 2006;163(3):365-373.

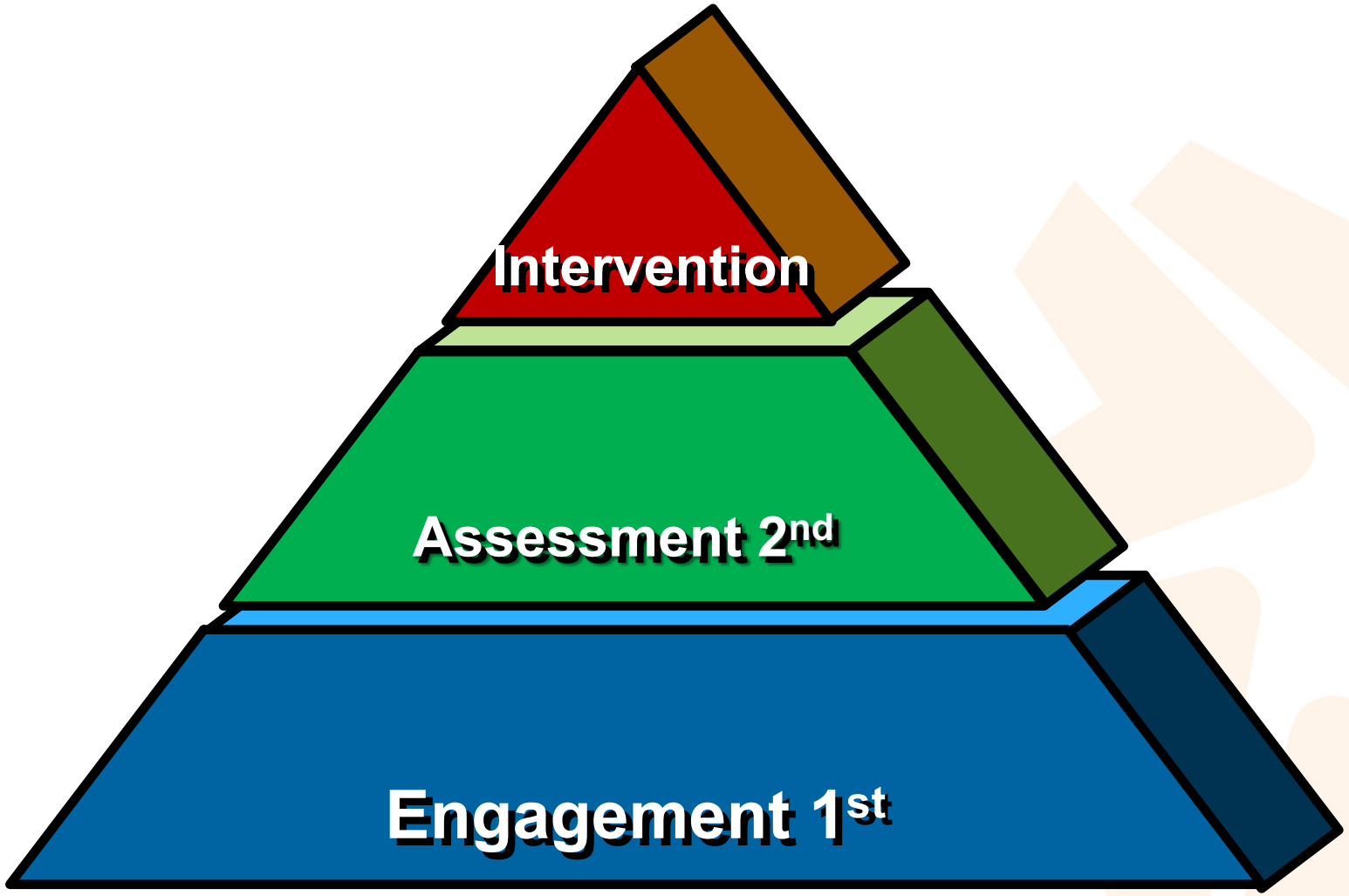
Initial Encounter:
Suggest Shifting to Prioritizing Engagement



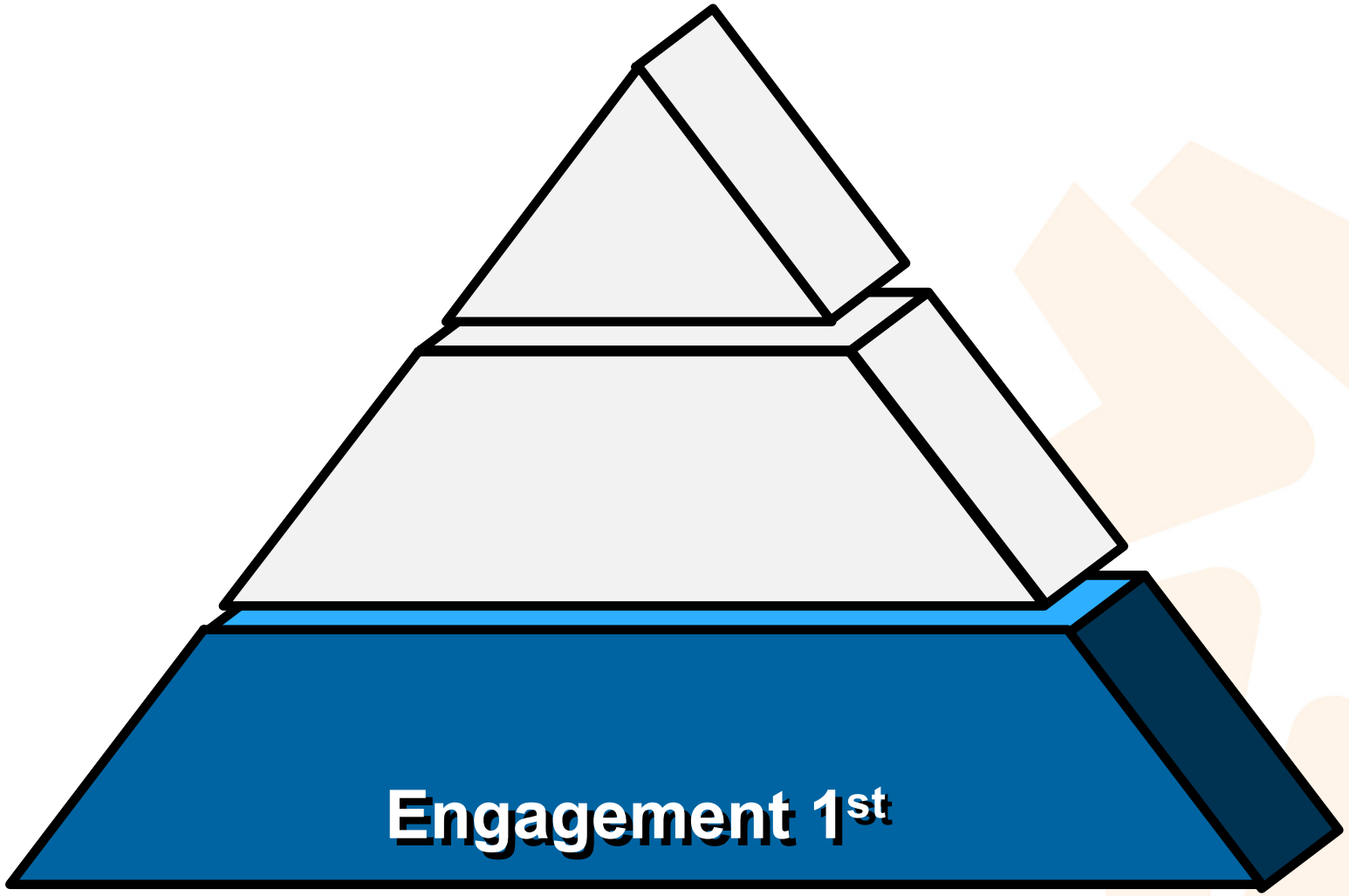
- Engagement comes before assessment
- You will get information for assessment, and it will go better if you engage

Miller WR, Moyers TB. *J Consulting and Clinical Psychology*. 2017;85(8):757-766. Turkington D, Kingdon D, Weiden PJ. *Am J Psychiatry.* 2006;163(3):365-373.

Helpful to Think As Hierarchical Stages



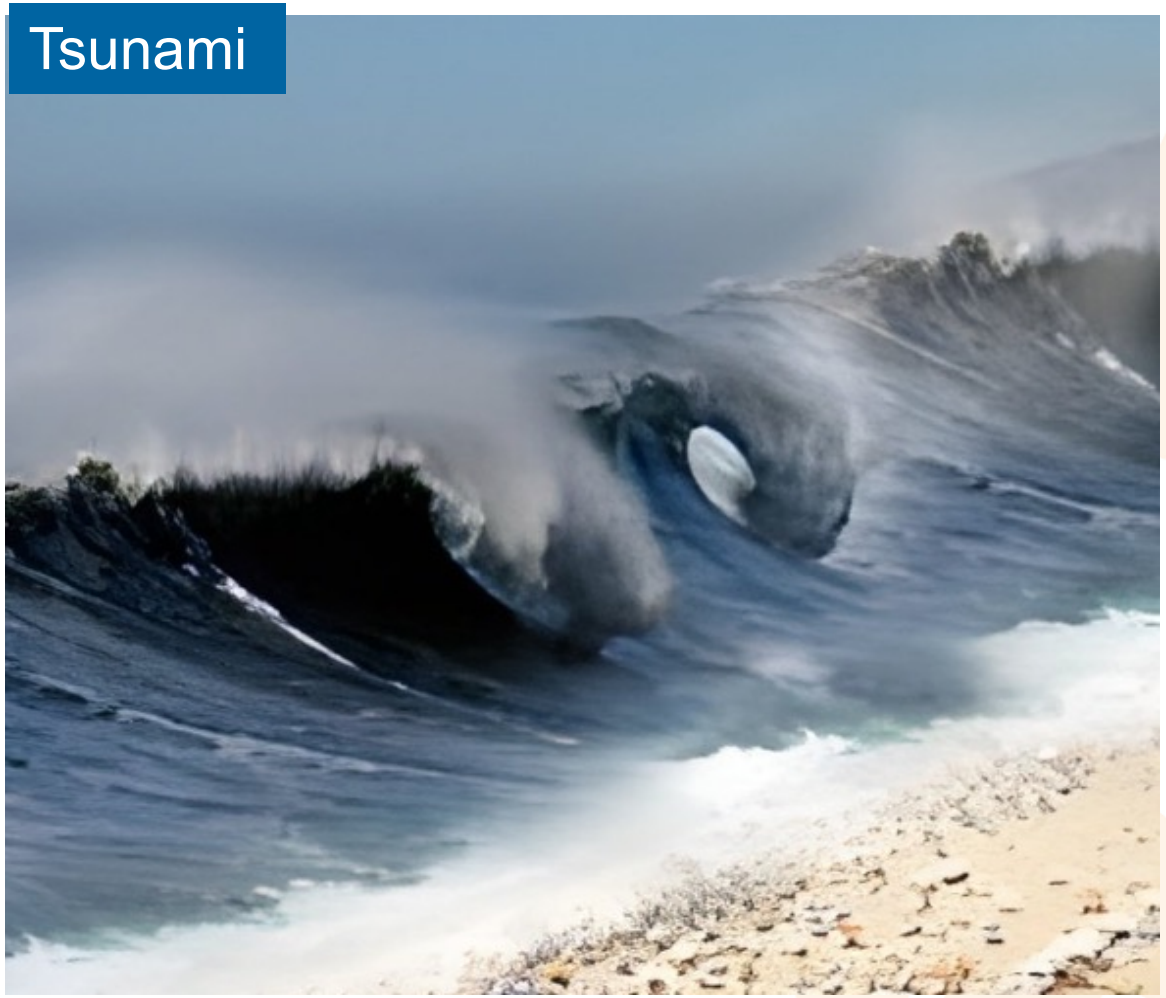
Engagement as the Foundation



ENGAGEMENT

Coping with active positive symptoms

Tsunami



ENGAGEMENT

First Things First

- First impressions matter!
- Small talk or “break the ice”
- State your role
- If you know, say how much time you have
- Provide appropriate structure and context
  - “You are here” sign
  - Review what will happen
- Curse of knowledge → explain the interview

ENGAGEMENT

Respect and Social Courtesies

- Start with patient agenda
  - "How can I help?"
  - Qualify and cross-check
    "It is my understanding that you are here because…did I get that right?
- Try to start with the patient alone, even if briefly
  - Ask what family will say
- Active listening, but modified
  - Don't look bored, look at watch, etc.
  - If family present, ask about perspectives rather than have the family take over

Weiden, PJ, Havens LL. *Hosp Community Psychiatry*. 1994;45(6):549-555. Shea SC. *Psychiatric interviewing: The Art of Understanding*. Elsevier Health Sciences; 2016.

ENGAGEMENT

Managing the Room

Use of Space, Body Positioning

- Increase the distance between you and patient beyond social norms
  - ↑ social distance by a factor of 50% to 100%
- Your height should never be over the patient
  - Example: if you stand and patient is sitting, find a chair and sit
- Everyone needs to be in line of sight
  - Example: Never crowd or stand behind patient, redirect staff
- Try not to sit directly opposite patient
  - Example: skew the chairs so you don't have to look directly at patient

Sullivan HS. *Schizophrenia as a Human Process*. W.W. Norton & Company; 1962. Weiden PJ. *J Psych Practice.* 1996;2:47-50. Weiden PJ, Havens LL. *Hosp Community Psychiatry*. 1994;45(6):549-555.

ENGAGEMENT

Eye Contact

- Differs from usual guidance on active listening
- Calibrate to less direct eye contact than normal
  - Good eye contact may trigger anxiety or paranoid symptoms
- To maintain connection, look in general direction of patient
  - (in other words, stay present and avoid looking at computer screen!)

Weiden P. *J Psych Practice.* 1996;2:47-50.

ENGAGEMENT

Try to Avoid Sensory Overload

- Remember, sensory gating problems may worsen psychosis
  - Remember the patient may have cognitive challenges understanding meaning of talk, including the tone and tactic meaning of the words
  - Try to reduce ambient noises, turn off TV, radio
  - Look for quiet places
  - Ask about lighting and other preferences
  - Ask not to get distracted by cell phone stimuli, but if headphones help with overstimulation, consider offering headphones

ENGAGEMENT

Voice Tone and Speech Cadence

- Why your voice matters
  - Stressful situations tend to heighten volume and speed of voice
  - More interruptions and more reactivity under stress
  - Often need to pause briefly or slow cadence to reduce tension and make sure patient is able to follow (but don’t get into baby talk)
  - If patient replies slowly – long pauses – or is hard to follow, try not to let your voice reveal impatience

ENGAGEMENT

The Patient Did Not Ask for Help

- Establish common agenda and goals
- Try to be genuine in small ways
- Provide rationale for interview
- Do not minimize challenges in unequal power
- Expect pushback
  - They will assume you are as incompetent as the last person
  - They will want to shoot the messenger

ENGAGEMENT

Handling Anger Directed at You

- You are the immediate object of anger for events that came before you
  - "Take statements from patient at face value and use active listening
  - Do not contradict
  - Do not jump to conclusions of fact
- Use passive, impersonal language..
  - Instead of "YOU were breaking up the store; try "it says in the chart that you were breaking things… is that the case? Why would they say that?…"
  - Remind the person you were not there
- Be willing to apologize (need to be sincere) including for bad things in past
  - Remind patient you are new to encounter
  - Gently suggest "don't shoot the messenger"

ENGAGEMENT

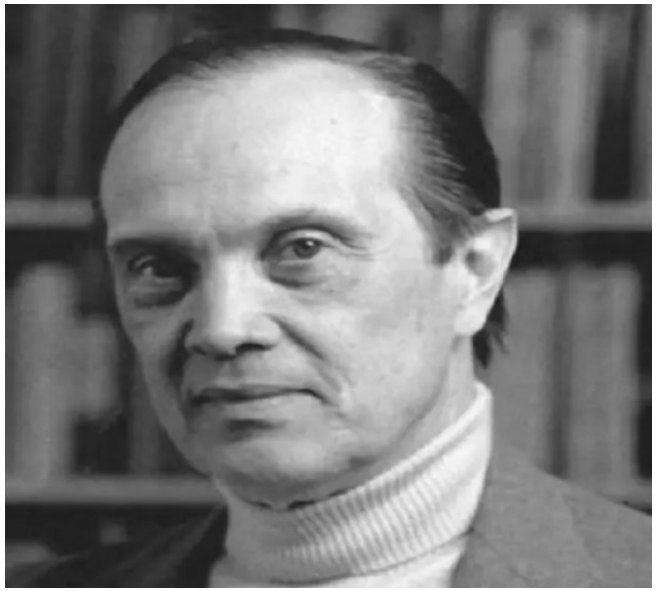
Active Listening despite Psychosis

- Give your full attention: Avoid distractions and focus on the speaker
- Show genuine interest by asking questions, but in a curious and interested manner
  - Avoid being patronizing or dismissive
- Cross-check you understand what the patient said and what was meant
  - Paraphrasing back is a good method. Restate what you just heard in your own words, and then ask if you understood the person correctly
  - Show that you're actively listening by reflecting on what the speaker has said, but avoid direct advice
- If you do respond in a directive way, wait until you feel you fully understand the person's point of view, and respond with respect and open-mindedness
- Listening to what matters to patient → set up a time boundary

For persons with psychosis, this may need some adjustments relative to other conditions

Miller WR, Rollnick S. *Motivational Interviewing: Helping People Change.* Guilford Press; 2012.

Miller's Law



George Miller (1920–2012) was a pioneer of the cognitive revolution in language and memory models

To understand what another person is saying, you have to assume that what they are saying is true

Then, imagine how it is true

Then work backwards, assuming the statement is true. To apply Miller's Law, when you don't understand how the statement is true, work backwards

"Under what circumstances would it be true?"

"What else would I have to believe?"

This can be very helpful in understanding the cognitive or psychological origins of delusions; "The TV is talking to me" → discover it is cognitive overload that happens when watching TV, then explained with hypothesis, tracing to source of problem

Miller GA. *Psychological Science*. 1990;1(1):7-14.

ENGAGEMENT

Applying Miller's Law to Psychotic Symptoms

- Don't dismiss these symptoms out of hand
- The belief that being interested in the psychosis "feeds" these symptoms is WRONG and OUTDATED
- Stay curious without colluding
- Reverse engineer understanding
- Keep control of interview cadence by time boundaries

Consider "Columbo-style" interview approach → who is columbo? → next slide please

“Columbo-Style” Interviewing



Columbo is a detective played by actor Peter Falk in the TV series of the same name that ran from 1968-1978, and then in the 1990s

- Describes a style of interviewing that is useful when person is trying to avoid disclosing key information
- Named after a very popular TV detective show that started with a murder, and audience knows who did it, with killer being accomplished, wealthy, and arrogant
- Detective Columbo would be assigned and came across as a bumbling fool. The narrative would show how his persona helped Columbo eventually unmask the killer

Nonthreatening and slow-paced interview style that combines curiosity with befuddlement that facilitates disclosing of important information

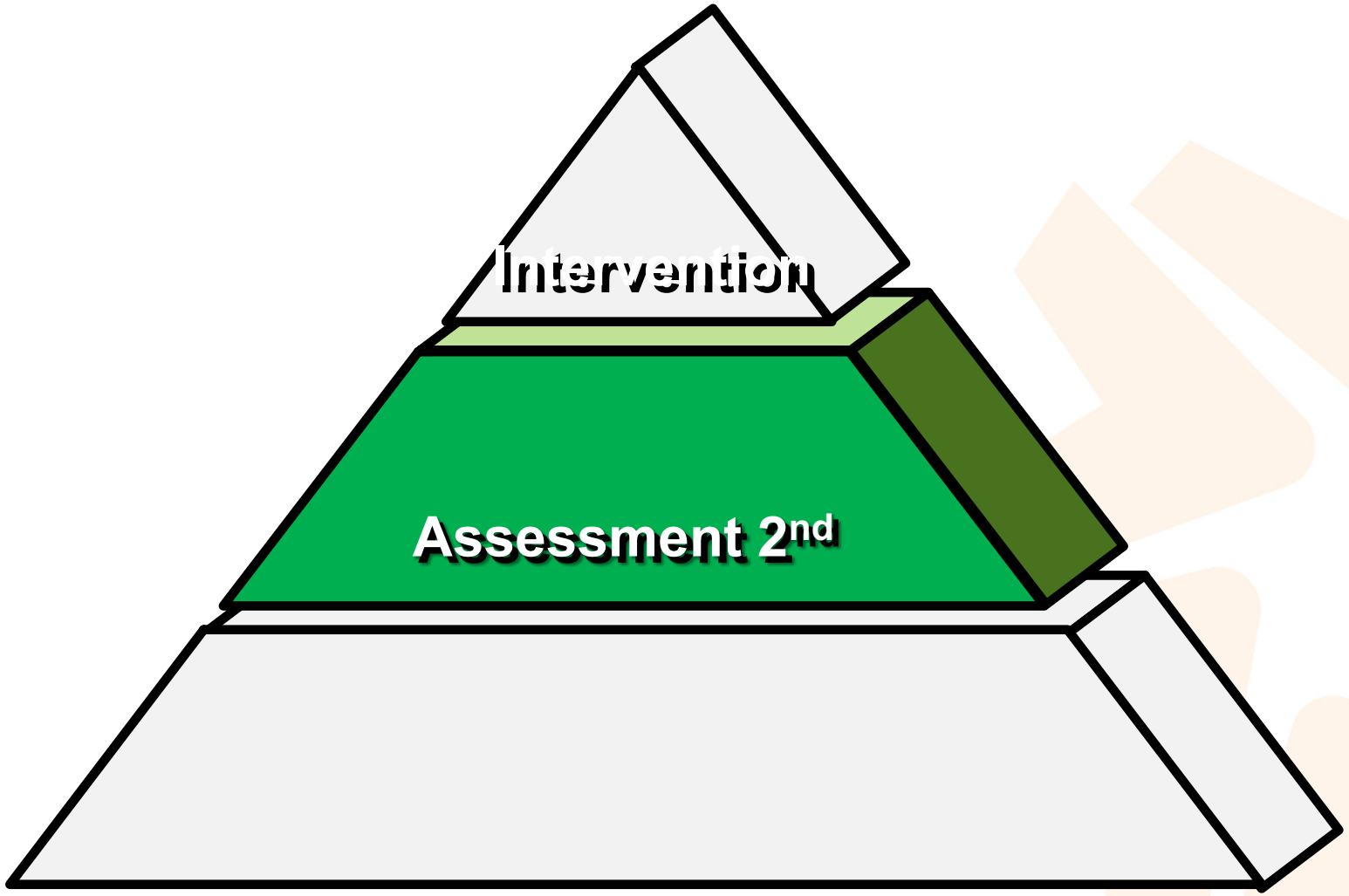
Wikipedia. Accessed September 2025. https://en.wikipedia.org/wiki/Columbo.

ENGAGEMENT

Stuck? Limited Progress?

- Move the topic back to patients' perspective
- Then review the impasse
  - How does this differ from your perspective
  - Be neutral and bureaucratic
    - "I get it. But this is my job to ask you xyx"
  - "Agree to disagree"
- Move on to other areas of agreement
- Find any common goal for alignment

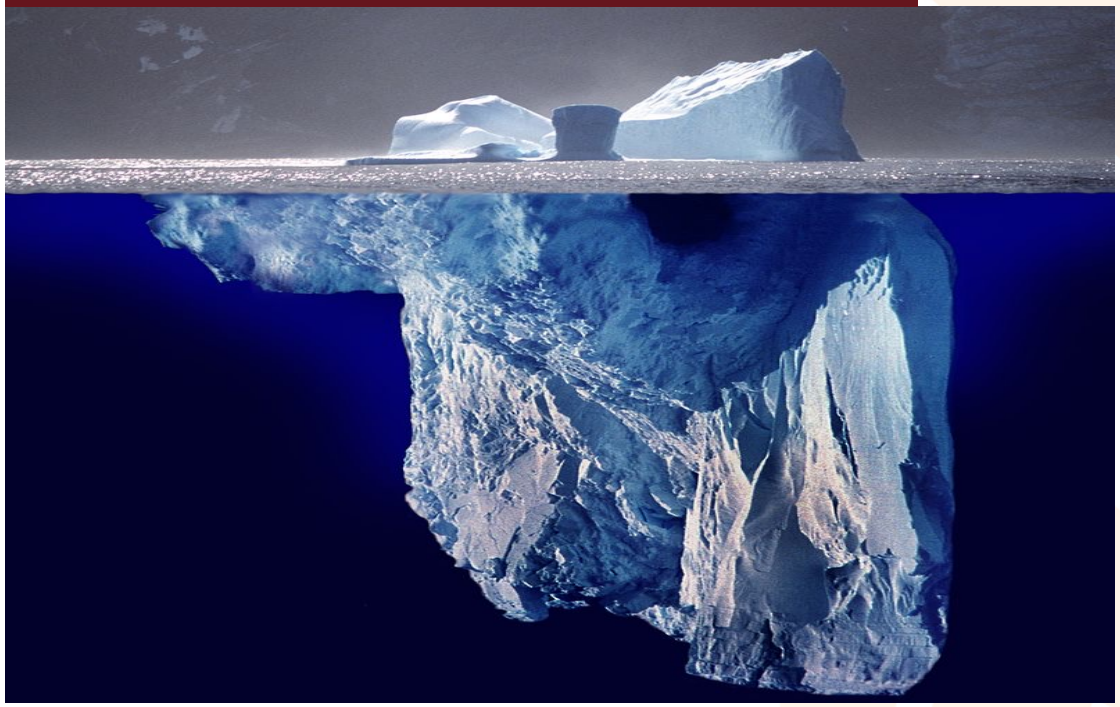
Assessment is Better with Foundation



ASSESSMENT

Coping with hidden positive symptoms that are below the surface

Tip of the iceberg



ASSESSMENT

Uncovering Hidden Symptoms

- Explore behavioral “tells” indirectly
  - If patient seems willing to continue, bring up some possible explanations
  - Introduce as hypotheses based on your experience, is it possible here?
- Example: Patient is startled, then asks you, “Did you just hear that!?”
  - NOT: “No one is around, so you are probably hearing voices”
  - CONSIDER: “Wow, looks like that came out of nowhere for you. Look, I did not hear anything, but I’ve been more focused on our conversation”
- If you ask, use some experience with someone else as example
  - “The way you reacted reminds me of other times when the person said they were hearing voices that no one else could hear.”“ Hmm… has that ever happened to you? Is it possible that just happened to you?”

ASSESSMENT

Eliciting Paranoid Symptoms

- Do not automatically interpret wariness or suspiciousness as paranoia.
  - Trying to mislead or withhold information is not necessarily a symptom
- How to ask about presence of paranoid symptoms
  - Avoid the word “paranoia”
  - If the person seems hesitant to disclose, start with asking about stress symptoms
  - Examples include anxiety, insomnia, avoidance of public places, eating unsealed food,
  - Work backwards “why is it risky for you to go to sleep”?
  - Instead, ask whether person feels safe or feels threatened or in danger. Use language that fits
    - Is it safe for you to [as appropriate]….
      be out in public/take a bus/go to sleep/eat unpackaged food?
    - If safety worries, ask what person does to stay safe

Weiden PJ, Havens LL. Hosp Community Psychiatry. 1994;45(6):549-555. Freeman D, et al. *Psychological Medicine*. 2011;41(5):923-936.

ASSESSMENT

Handling Undisclosed Delusions

- Avoid directly confronting beliefs, but do not collude
- If asked about your perspective, be indirect, “I was told,” or “the chart says,” and stick to facts, “I was not there”
  - Columbo-style surprise: You don’t understand some things and have some questions

    “I don’t get why the government would spend all that money just to follow you” or “I have no idea how someone could put an implant in your brain without any scar”
  - Bring up other situations you had where the person didn’t want to disclose

    “Sometimes people tell me they didn’t want to report these things because they thought they would get hospitalized…let me know if you have any of these worries.”
- If there is an impasse, you can
  - Agree to disagree and move discussion to a shared goal for the assessment
  - Go into bureaucrat mode “I have to follow rules that assume the chart’s version is correct”
  - Agree with general reasons that support being suspicious without taking a position on the specific issue “police have been known to make false accusations” or “I have read about health care systems that push unnecessary treatments just for the money”

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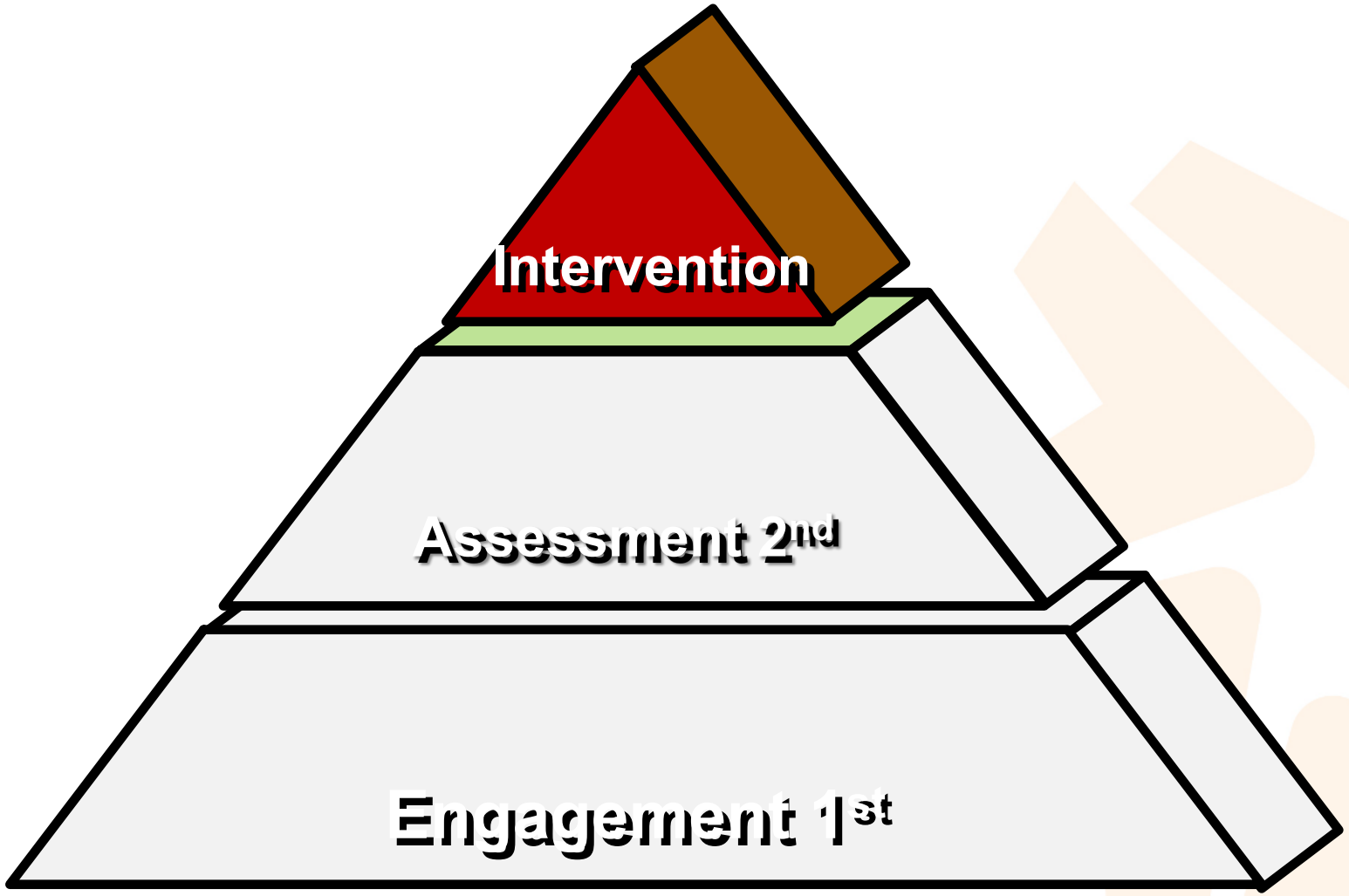
ASSESSMENT

Challenges from Negative Symptoms

Presence of negative symptoms

- may short-circuit normal emotional cues, making it harder for you to emotionally connect with the patient
- long delays between question and response is frustrating, like sitting in a traffic jam
- Poor hygiene or demeanor can be off-putting
- Severe withdrawal means communicating without feedback and needing to make assumptions

Prepping for Intervention



INTERVENTION

Trying to Help a Person who is Mute or Catatonic

- Assume they are able to hear you when you speak even if they can't respond
  - You might be wrong but no harm
  - But incredibly important if you can connect

- Assume they are overwhelmed
- Assume they are frightened by their symptoms or frighted what might happen next
- Be kind and gentle, reassure safety and that others hve gone through this and come out of it ok
- Say what you plan to do and why

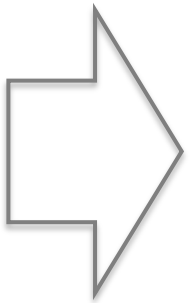
Weiden P. *J Psych Practice*. 1996;2(1):47-50.

INTERVENTION

Assessment to Intervention

What the person has

Withdrawal that seems like a negative symptom



What is going on

Behavior is driven by fear for personal safety “It is not safe for me to leave my house”

INTERVENTION

De-escalating Verbal Conflict

Signs of trouble ahead

- Change in emotional tone and body position
- “Fight or flight” signs of sympathetic overload
- Quick change into power struggles

Verbal de-escalation

- Voice control
- Gently call the person's name
- Agree with something, if possible
  “You might be right about…”
- Check internal sense of safety
  “Do you feel unsafe?”
- Identify a shared experience
  “Looks like we both are frustrated here”
- Take responsibility if possible
  “I’m sorry if I have been confusing”

Remember “flight” in “fight or flight”

“I am getting worried you might hit me. What can you do to help me feel safe, or should we take a break?

INTERVENTION

Person Feeling Alienated, Alone, or Ignored

Normalizing as a technique

- Think of calling a “help desk”
- Greatly reduces anxiety
- Needs to be genuine
- Appropriate use of self-disclosure

Kingdon DG, Turkington D. *J Nerv Ment Dis*. 1991;179(4):207-211.

INTERVENTION

The Righting Reflex



Cat Version (physiology)

- Physiology means tendency to land on one's feet
- Involves vestibular system in the brainstem
- Cats are very good at this

Person Version (psychology)

- Refers to "a built-in desire to set things right"
- This kind of righting reflex is activated when someone tells us about a problem that we want to help them solve
- Our natural inclination is to offer direct guidance or solutions to set things right
- This reflex often leads to the opposite effect; the other person rejects the advice and digs deeper into their way of handling the problem

For persons with psychosis, odds are the person has already heard direct suggestions for fixing the immediate problem, and you should consider holding off

Wikipedia. Accessed September 2025. https://en.wikipedia.org/wiki/Cat_righting_reflex.

INTERVENTION

Aligning With Patient's Concerns and Perspectives

- Remember "righting reflex" and find ways around it
  - Example: "medications are poison" → It is OK to agree with patient that medications suck and that mental health treatment can be terrible (in general terms)
- Do not force agreement on any psychiatric diagnosis
- Focus on distress and track root cause of distress (insomnia traced to fears of harm when sleeping)
- Frame intervention based on shared understanding from engagement and assessment phases

Weiden P. *J Psych Practice.* 1996;2(1):47-50.

Summary

- The assessment is a crucial aspect of treatment
- Engagement is a foundation for successful assessment
- Often skipped or not taken seriously
- May be a lost art that should get more attention

Weiden P. *J Psych Practice*. 1996;2(1):47-50.

1 Connecting

Practical Take-Aways

- After medication, therapeutic engagement is the most important predictor of outcome, and even medication often starts with therapeutic engagement
- Make therapeutic engagement your IMMEDIATE priority! Think of it FIRST, don't leave it for later, or you might lose your chance
- Take ownership of the challenge of connecting when there are active psychotic symptoms. Learn the techniques designed for this situation. Once learned, adapt to your style
- Remember that initial assessments are psychologically invasive and gentle explanation is often needed along the way
- Many patients have been traumatized by a mental health assessment and, as a result, will not feel safe. Counter by anticipating wariness and how you will respond to disclosed information

2 Assessing

Practical Take-Aways

- As you do your assessment, focus on the importance of accurate INFORMATION to guide treatment recommendations in terms of safety and reaching efficacy goals
- Watch out for relationship killers. Watch your tone. Do not interrupt to “correct” something, but listen carefully without contradicting. Take ALL complaints of side effects seriously, no matter what. Do NOT start with medication recommendations and do NOT oversell medication
- Engage while assessing: spend time listening to concerns even if unrelated to your goals, start with non-psychotic symptoms, use less stigmatizing language (e.g., avoid “paranoid” rather, “do you feel safe?”
- Look for small wins to help address patient concerns, no matter how minor

Q&A