Where are we now? Current practices in SLP with adults with mental health disorders?

Jennifer Brophy
Clinical Specialist SLP
Dublin, Ireland
Their Words

“I talk a lot. I don’t like silence. If I stop talking my thoughts will get in too deep. I don’t want to isolate myself. I talk all the time because it’s a distraction. Try to distract my thoughts”
(Mary 20 year old lady with schizophrenia)
Current SLP service provision

- Adults with communication and/or swallowing difficulties
- Acute in onset
- Enduring or chronic in nature requiring residency
- Community based – day centre/day hospital.

- Schizophrenia
- Bi Polar Disorder
- Depressive Illness
- Anxiety Disorders
- Obsessive Compulsive Disorder
- Personality Disorder.
The Team

Client

Psychiatrist

SLP

Nurse

Social Worker

Occupational Therapist

Dietician

Psychologist

Jennifer.Brophy@amnch.ie
Philosophy of Intervention

- Person centred
- Build on strengths to develop impaired or suppressed skills.
- Focus on areas of performance most likely to effect change and maximise communicative competence.

Revealing Ability

Vs.

Treating Disability

Jennifer.Brophy@amnch.ie
Recovery Model

- Focus on increasing the patient’s ability to successfully cope with life’s challenges, and to successfully manage their symptoms. (*American Psychiatric Association*, 2005)

“who and what existed before the illness and who and what endure during and after?”

(*Barham & Hayward*, 1995:2)
Model of Intervention

Person
- Work with individual
- e.g. 1:1 or group basis

Environment
- Work with people, processes or settings
- e.g. training of staff/carers as communication partners

Wider Community
- Influencing attitude, culture or practice
Person & SLP 1:1 Intervention

Environment

Body Structure & Function
- Language
- Cognition
- Nature of mental illness

Activity
- Functional Communication
- Therapy outside the clinic
- Transition from IP to Community

Participation
- ↓ social isolation
- ↑ Quality of life

Personal Factors

Jennifer.Brophy@amnch.ie
Person & SLP
Group Intervention

Social Communication
Skills Based

Social Communication
Experiential
Social Communication Intervention Skills Based

- Social Communication Skills Training (SLP):
  - Traumatic Brain Injury
    - Dahlberg et al (2007)
  - Dysfluency
    - Cook & Fry (2006)
  - Child and Adolescent Mental Health
    - Sim et al (2006)
  - Mental Health

- Issues re.
  - Efficacy vs. real world validity
  - Acquisition
  - Generalisation
  - Cognitive impairment

Jennifer.Brophy@amnch.ie
Evaluations

- ↑ self rating of conversation skills.
- ↑ formal language assessment – not statistically significant.
- ↑ meta communication ‘talking about talk’

**Testimonials**
- “I am more confident talking to people outside of the group”
- “learned how to speak out and relax”
- “being part of a group was good, a bit of a laugh”
- “I’m more observant now when I meet people
- “I have a way to start a conversation now”
Social Communication
Experiential

- Provides opportunity for successful interaction.

- Facilitation by skilled communication partners.
  - In vivo supports necessary to make success of these opportunities

“I could see the way my partner handled himself in a crowd of people I could learn from the way he does it. He talks to people and he’s friendly and it made me feel I could, you know, maybe I could to that too, if I put my mind to it”

(Davidson, 2001:287)

Reduced ability and opportunity to
- Engage in conversation
- Reveal competence

Reduced Communicative Access To Social & Community Life

Reduced Participation in Social & Community Life

Reduced Mental & Social Health

Jennifer.Brophy@amnch.ie
CBT & SLT
A useful combination?
Social Isolation Cycle (Hutchings et al, 1991)

**Thinks**
No-one likes me, no one wants to speak to me

**Feels**
Rejected, unwanted, unpopular

**Behaves**
Avoids starting conversations and interacting,
Does not use body language effectively

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**Avoiding**
Social situations resulting in:
**Less opportunities**
to practice and meet other people resulting in:
**Lack of confidence**
and a fear of rejection, potential embarrassment.

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Social isolation

Can result in
CBT and SLT

- Important to discuss communication difficulty while understanding world from person’s point of view.

- Behavioural Work + concomitant changes in self perception i.e. as a communicator.

- Realisation of changes in communication from a cognitive perspective – can access more accurately the personal meaning of change.

- No awareness = No change.

Jennifer.Brophy@amnch.ie
Environment

- ↓ interaction related stress
- ↓ challenging behavior
- Support clients to access mainstream community services – local leisure facilities.

Jennifer.Brophy@amnch.ie
Environment
Education and Training

- Carers and other professionals
  - Barriers to effective communication
  - Basic communication skills
  - Verbal and non-verbal communication
  - Communication Facilitation Techniques
  - Communication opportunities

- Brindle (2006) - Use of communication scaffolding techniques.

- Kagan (1998) Techniques to
  - acknowledge
  - reveal competence
Wider Community

- Education and Training
- Health Promotion
- Involvement in carers groups

Jennifer.Brophy@amnch.ie
Outcome Measures

- Uniqueness of each individual
- None standardized or tested in this population.
- Functional assessment tools lack reliability/validity.

However.....

- Other domains of practice provide useful tools
  - Cognitive Communication disorders such as TBI, RHLD, Dementia.
- ‘The Missing Voice’ (Kovarsky & Curran, 2007)

Jennifer.Brophy@amnch.ie
Case Vignette

- Client: Mary (20 years)
- Diagnosis: Schizophrenia
- Reason for Referral: Difficulty with social boundaries, difficulty paying attention, interrupts with non-relevant conversation.
Background Information

- First presentation: 16 years
- Previous inpatient and day hospital attendance
- Positive Family History of schizophrenia.
- SLP as a child.
- Chaotic home environment.
- Completed high school. Supported employment.
- Intermittent high anxiety, poor coping strategies, needs reassurance ++
Assessment → Intervention

- **Formal**
  - Breakdown @ different levels of information processing chain
    - paragraph comprehension
    - verbal abstract reasoning
    - controlled fluency
    - naming tasks.

- **Informal**
  - Able to express emotions and opinions
  - Over elaboration of topic with progressive decrease in relevance.
  - Inappropriate topic selection for context.
  - Fast rate of speech
  - Repetitive hand movements - touching hair and face frequently

Jennifer.Brophy@amnch.ie
Intervention

- One to One Therapy

- Social Communication Group Therapy
  - Experiential: ‘in vivo feedback’

- MDT Input – Nursing, Psychology, Work Placement
Evaluation

- Feedback from CPs
- Therapy Blueprint
  - What have I learned about my communication skills?
  - What difference has that made in my social/work life etc?
  - What will make it difficult for me to maintain these skills over the coming months?
  - What can I do about this?

Jennifer.Brophy@amnch.ie
Summary

- Unique needs
  - Engagement & Motivation
  - Unchartered course through their illness.
  - Importance of therapeutic relationship and trust.
  - Recovery model (suppressed skills.)
  - Rate of relapse frequently high.

However ……… given the nature of the language and communication difficulties inherent in mental illness, SLPs already have many of the requisite skills needed to effectively manage intervention in this domain of clinical practice.
References


References


