UNIVERSITÉ DU QUÉBEC À MONTRÉAL

SOCIAL COGNITION AND ANXIETY FOLLOWING A FIRST-EPISODE OF PSYCHOSIS: MARKERS OF CLINICAL REMISSION IN SCHIZOPRENIA AND THE DEVELOPMENT OF A MANUALIZED COGNITIVE-BEHAVIORAL GROUP INTERVENTION FOR SOCIAL ANXIETY

THESIS

PRESENTED

AS A PARTIEL REQUIREMENT

TO THE DOCTORATE DEGREE IN PSYCHOLOGY

BY

TINA MONTREUIL

MARCH 2013

UNIVERSITÉ DU QUÉBEC À MONTRÉAL
Service des bibliothèques

Avertissement

La diffusion de cette thèse se fait dans le respect des droits de son auteur, qui a signé le formulaire *Autorisation de reproduire et de diffuser un travail de recherche de cycles supérieurs* (SDU-522 – Rév.01-2006). Cette autorisation stipule que «conformément à l'article 11 du Règlement no 8 des études de cycles supérieurs, [l'auteur] concède à l'Université du Québec à Montréal une licence non exclusive d'utilisation et de publication de la totalité ou d'une partie importante de [son] travail de recherche pour des fins pédagogiques et non commerciales. Plus précisément, [l'auteur] autorise l'Université du Québec à Montréal à reproduire, diffuser, prêter, distribuer ou vendre des copies de [son] travail de recherche à des fins non commerciales sur quelque support que ce soit, y compris l'Internet. Cette licence et cette autorisation n'entraînent pas une renonciation de [la] part [de l'auteur] à [ses] droits moraux ni à [ses] droits de propriété intellectuelle. Sauf entente contraire, [l'auteur] conserve la liberté de diffuser et de commercialiser ou non ce travail dont [il] possède un exemplaire.»

UNIVERSITÉ DU QUÉBEC À MONTRÉAL

COGNITION SOCIALE ET ANXIÉTÉ À LA SUITE D'UN PREMIER ÉPISODE DE PSYCHOSE: ÉTUDES ÉVALUATIVES DES MARQUEURS DE LA RÉMISSION ET DÉVELOPPEMENT D'UNE INTERVENTION COGNITIVO-COMPORTEMENTALE MANUALISÉE POUR L'ANXIÉTÉ SOCIALE

THÈSE
PRÉSENTÉE
COMME EXIGENCE PARTIELLE
DU DOCTORAT EN PSYCHOLOGIE

PAR

TINA MONTREUIL

MARS 2013

ACKNOWLEDGMENTS

I would like to thank Dr. Claude Bélanger and Dr. Martin Lepage for welcoming me in their respective laboratories and teams at the time where I set off to commence my Ph.D. over four years ago. You have both transmitted me your passion for research and clinical work. Thank you for applying the optimal supervision structure that permitted me to cultivate my skills as a therapist and to foster trust in my own research abilities. Thank you to Dr. Ashok Malla from PEPP-Montreal for giving me the opportunity to work among a highly productive yet truly dedicated team of amazing people. It is there that I discovered a passion and a niche, working with first-episode psychosis clients. A special thank you to the entire PEPP-Montreal family, case managers, psychiatrists, research assistants and clients.

I would like to acknowledge all the participants who took part in the studies. To the socially anxious who built up the courage to face their fears and believed in change. Thank you to all the case managers and psychiatrists for your referrals.

I would like to thank Dr. Gail Myhr for believing in this project and for seeing that it come into being, from helping with location to proofreading proposals. Thank you to Dr. Mathieu Brodeur, Dr. Michael Bodnar, and Clifford Cassidy for the opportunity to publish and collaborate as well as for the insightful exchanges on statistics. To Katrina Messina and Thomas Holmes, I would like to extend my gratitude for assisting me in conducting assessments, as well as data collection and management. To Stephanie, Emilie, Philippe, Larry, Ioanna, Kate, and especially Catherine Otis, for being engaged and enthusiastic co-therapists. I would like to acknowledge Vedrana Ikic and Dr. Stine Linden-Andersen, two colleagues and friends who have provided support and encouragement over the years.

Last but not least, to my amazing family. Mom and dad, thank you for believing in me and for instilling in me the belief that I could achieve anything I set my mind to, but mainly for being a living example of the value of hard work and determination. To Vaughan, thank you for being a man of great wisdom and for exemplifying the qualities of a good listener. To Judy and Melanie, I am so grateful to have the two of you as my sisters and best friends. Thank you for supporting me and inspiring me with your own accomplishments. To Stylianos, who without the constant support, encouragement and love; from late night document binding to reminding me the true reasons why I embarked on this academic journey in the first place, I am forever in debt to you.

TABLE OF CONTENTS

LIST OF FIGURES ix

LIST OF TABLES x

LIST OF ABBREVIATIONS AND ACRONYMS xii

RÉSUMÉ xiv

ABSTRACT xvi

CHAPTER I
GENERAL INTRODUCTION 1

1.1 Preamble 1

1.2 Social Anxiety 2

1.2.1 Non-psychotic social anxiety 2

1.2.2 Social Anxiety in Psychosis 3

1.2.3 Explanatory Models of Social Anxiety in Psychosis 4

1.3 Social Cognition in Schizophrenia 6

1.4 Links between Social Anxiety, Social Cognition and Psychosis 7

1.5 Dual Diagnosis and Comorbidity 10

1.6 Social Recovery in Psychosis 11

1.6.1 The Impact of Comorbid Conditions 11

1.6.2 The Impact of Shame in Psychosis 13

1.6.3 Underpinnings of the Proposed Intervention 14

1.7 Cognitive-Behavioral Therapy 17

1.7.1 Cognitive-Behavioral Therapy for Social Anxiety in Psychosis 18

1.7.2 Incorporating Shame into the Cognitive-Behavioral Model 19

1.7.3 Overview of the Manualized Intervention Program (CBT) 21

1.8 Thesis Project Objectives 21

CHAPTER II
STUDY I - SOCIAL COGNITIVE MARKERS OF SHORT-TERM CLINICAL OUTCOME IN FIRST EPISODE PSYCHOSIS 26

CHAPTER III
STUDY II - ANXIETY SYMPTOMS SEVERITY AND SHORT-TERM CLINICAL OUTCOME IN FIRST-EPISODE PSYCHOSIS 55

CHAPTER IV
STUDY III - MANUALIZED GROUP COGNITIVE-BEHAVIORAL THERAPY FOR SOCIAL ANXIETY IN AT-RISK MENTAL STATE AND FIRST-EPISODE PSYCHOSIS 74

CHAPTER V
GENERAL DISCUSSION 95

5.1 Synthesis and Interpretation of the Results from Studies on Markers of Remission 95

5.1.1 Social Cognitive Markers of Short-Term Clinical Outcome in First-Episode Psychosis 95

5.1.2 Severity of Anxiety Symptoms in First-Episode Psychosis 97

5.1.3 Social Cognition, Anxiety and Clinical Remission in First-Episode Psychosis 98

5.2. Manualized CBGT Intervention for Social Anxiety in First-Episode Psychosis 98

5.2.1 Treatment Outcome Measure Changes 98

5.2.2 Development of Social Anxiety Symptoms in First-Episode Psychosis: An Intervention Targeting Social Anxiety and Shame 100

5.2.3 Attendance and Attrition Rate 100

5.2.31 Social Role Loss and Stigma 102

5.3 Participant-Reported Improvements 102

5.3.1 Improved Self-Esteem and Perceived View of Self 102

5.3.2 Depression and Social Anxiety in First-Episode Psychosis 103

5.3.3 Negative Symptoms and Social Anxiety 104

5.4 Cognitive Model of Social Anxiety and Shame in Psychosis 105

5.4.1 Specific Adaptation to the Intervention Based on the Proposed Developmental Model 106

5.5 Clinical Implications 108

5.5.1 Assessment of Social Anxiety in Psychosis 108

5.5.1.1 A Multifaceted Disorder, a Multidimensional Intervention 108

5.5.1.2 Homogeneity of Group 109

5.5.2 Intervention 110

5.5.2.1 A Manualized CBGT Intervention 110

5.5.2.2 Intervention Manual 111

5.5.2.3 Modification of Maladaptive Relational Patterns through Group Modality 112

5.5.2.4 Reducing Stress Reactivity through Psychoeducation and Reappraisal of Stress 113

5.5.2.5 Alliance, Therapist Treatment Effects and Group Cohesiveness 114

5.6 Limitations of the Manualized CBGT Intervention Project 115

5.6.1. Study Design 115

5.6.2 Assessment of Psychosocial Functioning and Quality of Life 116

5.6.3 Heterogeneity of the Sample 116

5.7 Recommendations – Future Implications 117

5.7.1 Randomized Control Trial 117

5.7.2 Measures of Social Functioning 117

5.7.3 Tailored Treatment Approach 117

5.7.4 At-Risk Mental State 118

5.7.5 Recruitment Difficulties 118

5.7.6 Behavioral Measures or Biomarkers as Predictors of Response to Treatment 119

5.8 Conclusion 120

APPENDIX A
Other scientific writing activities and projects
CASE-MANAGER AND PATIENT-RATED ALLIANCE AS A PREDICTOR OF MEDICATION ADHERENCE IN FIRST-EPISODE PSYCHOSIS 121

APPENDIX B
Model of social anxiety and shame in first-episode of psychosis based on the work of Michail & Birchwood (2009) 141

APPENDIX C
Study Timeline 143

APPENDIX D
Cognitive-Behavioral Group Therapy Intervention Manual 145

APPENDIX E
Clinician Manual French Version 152

APPENDIX F
Clinician Manual English Version 182

APPENDIX G
Participant Manual French Version 237

APPENDIX H
Participant Manual English Version 324

APPENDIX I
Questionnaires and Scales 433

APPENDIX J
Ethics committee approval letter for the Douglas Research Center
and the McGill University Health Centre 524

APPENDIX K
Participant Consent Forms for the Douglas Research Center and
the McGill University Health Centre 530

GENERAL REFERENCES 554

LIST OF FIGURES

FIGURE		PAGE
2.1	Social cognitive profile of poor-outcome, good-outcome, and healthy controls	54
3.1	Between-group comparisons (unremitted versus remitted) of HARS total anxiety rating and (G2) PANSS anxiety rating at baseline and six-months	73
4.1	Effects of intervention as measured by contrasting the measures taken at the all time-points (pre-treatment, post-treatment, follow-up) for all treatment outcomes measures (social anxiety, psychotic and depressive symptomatology)	94

LIST OF TABLES

TABLE		PAGE
2.1	Socio-demographic data of poor-outcome, good-outcome, and healthy control groups	49
2.2	Characteristics and global symptom ratings of poor-outcome and good-outcome groups. Number of participants included (n) for each variable where different from sample	50
2.3	Z-scores (mean, SD, and range) and between-group comparisons of social cognitive tests among good-outcome, poor-outcome, and healthy control groups	51
2.4	Raw data of social cognitive tests for poor-outcome, good-outcome patients, and healthy control groups	52
2.5	P-values of the different group comparisons for the global measure of social cognition and for the different sub-tests.	53
3.1	Socio-demographic data, overall ratings and descriptive data of unremitted and remitted groups. Number of participant included (n) varied across measures	72
4.1	Socio-demographic data of all participants (completers and non-completers) per diagnostic category	90
4.2	Descriptive data (mean, SD) of pre-treatment, post-treatment and follow-up for social anxiety, psychotic symptomatology and general psychopathology ratings	91
4.3	Treatment effect (pre-treatment – post-treatment) for social anxiety, psychotic symptomatology and general psychopathology ratings	92

4.4 Social anxiety, psychotic symptomatology and general psychopathology rating differences between groups (completers versus non-completers) at baseline (pre-treatment) 93

Appendix A

A.1 Descriptive data on alliance and adherence 140

A.2 Comparison of Case Manager-rated and Patient-rated working alliance through course of study 141

A.3 Univariate analyses of Case Manager-rated and Patient-rated working alliance sub domains, and confounding variables over total months of adherence 142

A.4 Linear regression predicting the number of subsequent months of adherence (> 75% of doses taken) based on working alliance scores at study baseline 143

LIST OF ABBREVIATIONS AND ACCRONYMS

BCIS	Brief Cognitive Insight Scale
BSPS	Brief Social Phobia Scale
CBT	Cognitive-Behavioral Therapy
CBGT	Cognitive-Behavioral Group Therapy
CDSS	Calgary Depression for Schizophrenia Scale
DUI	Duration of Untreated Illness
DUP	Duration of Untreated Psychosis
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
FEP	First Episode Psychosis
FES	First Episode Schizophrenia
fMRI	Functional Magnetic Resonance Imaging
G2	General psychopathology scale of the PANSS, item 2 "anxiety"
HARS	Hamilton Anxiety Rating Scale
IPII	Indiana Psychiatric Illness Interview
ISMI	Internalized Stigma in Mental Illness scale
MI	Mental Illness
PANSS	Positive and Negative Syndrome Scale
RCT	Randomized Control Trial
SA	Social Anxiety

SANS	Scale for the Assessment of Negative Symptoms
SAPS	Scale for the Assessment of Positive Symptoms
SCID-I	Structured Clinical Interview for DSM Disorders – Axis I
SIAS	Social Inventory Anxiety Scale
SP	Social Phobia
SZ	Schizophrenia
SPIN	Social Phobia Inventory
WA	Working Alliance
WAI	Working Alliance Inventory

RÉSUMÉ

Évaluation des prédicteurs de la rémission en schizophrénie en lien avec le développement d'une intervention cognitivo-comportementale de groupe pour le traitement de l'anxiété sociale chez les personnes présentant un premier épisode psychotique

Depuis les dernières années, il existe un intérêt croissant pour la notion de comorbidité en psychiatrie. Malgré cette évolution dans la compréhension des problématiques psychiatriques, la relation entre l'anxiété et la schizophrénie demeure toutefois négligée. Cependant, la problématique de la schizophrénie et d'un trouble comorbide à l'axe I du DSM-IV demeure toujours peu explorée dans les écrits scientifiques disponibles. Parmi la recherche existante, portant plus particulièrement sur la comorbidité d'un trouble relié à l'anxiété chez les personnes qui sont atteints de schizophrénie, un très petit nombre d'études ont exploré les liens qui existent entre les symptômes de l'anxiété et la schizophrénie. Le champ des études portant sur la comorbidité chez les personnes présentant plus particulièrement un premier épisode psychotique, demeure davantage inexploré.

L'anxiété sociale est le trouble le plus fréquemment diagnostiqué parmi les troubles qui se retrouvent sur le continuum de l'anxiété. Cette problématique représente aussi l'une des pathologies les plus répandues en ce qui a trait à la comorbidité en schizophrénie. Malgré un intérêt croissant pour l'application de la thérapie cognitivo-comportementale dans le traitement des symptômes reliés à la schizophrénie, très peu d'études ont à ce jour proposé une intervention d'approche cognitivo-comportementale pour l'anxiété sociale spécifiquement adaptée pour les personnes atteintes de schizophrénie. Sur cette base, la présente recherche porte sur une intervention de ce type avec cette population. Nous avons formulé l'hypothèse que les participants qui prendraient part à une thérapie de groupe d'approche cognitivo-comportementale pour l'anxiété sociale qui aurait été adaptée plus particulièrement pour les personnes atteintes de schizophrénie, manifesteraient une réduction significative des symptômes reliés à l'anxiété sociale ainsi que des symptômes psychotiques à la suite de l'intervention. Cette étude portant principalement sur l'efficacité d'un programme d'intervention pour le traitement de l'anxiété sociale en tant que comorbidité en premier épisode de psychose fut développée selon un devis non contrôlé.

Dans le cadre de cette étude, 29 participants ont été recrutés et ont donné leur consentement à participer à l'étude. De ce nombre, 26 personnes ont complété avec succès le programme d'intervention. Les participants ont pris part à la thérapie de groupe d'approche cognitivo-comportementale qui s'est déroulée en 14 séances hebdomadaires de 90 minutes chacune.

L'effet thérapeutique de l'intervention a été évalué à l'aide de tests « t » d'échantillons appariés (T1 pré-test – T2 post-test) pour toutes les mesures de résultats thérapeutiques qui comprennent l'anxiété sociale, les symptômes positifs et négatifs de la psychose et les symptômes de la psychopathologie générale (dépression, insight, stigma).

Le chapitre I de la thèse consiste en une introduction générale qui présente une recension des écrits scientifiques, et plus précisément sur les marqueurs de la rémission clinique en schizophrénie et sur la nature des comorbidités, plus particulièrement l'anxiété sociale chez les personnes présentant un premier épisode psychotique.

Les chapitres II et III présentent deux études empiriques indépendantes qui ont examiné l'impact de la cognition sociale pour l'une des études, et, pour l'autre étude, la fonction de la sévérité des symptômes reliés à l'anxiété sur la rémission clinique chez les personnes présentant un premier épisode psychotique. Les résultats de ces recherches ont révélé que les déficits au chapitre de la cognition sociale et la sévérité des symptômes reliés à l'anxiété sont des marqueurs importants de la rémission clinique chez les personnes présentant un premier épisode psychotique.

Le chapitre IV comprend un troisième article empirique qui vise à évaluer l'efficacité d'une intervention de groupe d'approche cognitivo-comportementale manualisée pour le traitement des symptômes reliés à l'anxiété sociale chez les personnes présentant un premier épisode psychotique. Les résultats de cette étude révèlent que l'intervention semble contribuer à une réduction significative des symptômes d'anxiété sociale, des symptômes négatifs de la psychose, des symptômes dépressifs et du stigma.

Finalement, le chapitre V présente une discussion générale des résultats de la thèse ainsi que des implications cliniques, des considérations méthodologiques et des pistes de recherche future. Les marqueurs de la rémission clinique chez les personnes présentant un premier épisode psychotique sont présentés. Un modèle de l'anxiété sociale en premier épisode psychotique, selon l'intervention de groupe d'approche TCC manualisée, est proposé. Dans l'ensemble, les résultats thérapeutiques de ce programme de recherche suggèrent que l'intervention de groupe d'approche cognitivo-comportementale manualisée doit être soumis à un essai contrôlé randomisé (ECR).

Mots clés : Anxiété sociale, premier épisode psychotique, schizophrénie, thérapie cognitivo-comportementale, intervention psychologique, résultats thérapeutiques, rémission, fonctionnement social, stigma, insight

ABSTRACT

Social Cognition and Anxiety Following a First-Episode of Psychosis: Markers of Remission and Efficacy of a Novel Manualized Cognitive-Behavioral Group Therapy for Social Anxiety

In recent years, there has been a growing interest in psychiatric comorbidity, and despite this development, the relationship between anxiety and schizophrenia remains for the most part overlooked. However, much of the literature found on the comorbidity of schizophrenia and other pathological disorders suggests that Axis I disorders still remain somewhat uninvestigated. Of the existing research that has focused more specifically on comorbid anxiety in schizophrenia, only a scant number of studies shed light on the possible links between symptoms of anxiety and schizophrenia, and even fewer have looked at this association in First-Episode Psychosis (FEP). Social anxiety (SA) is the most commonly diagnosed disorder of the entire anxiety spectrum disorders and it also represents one of the most prevalent comorbid conditions in schizophrenia. Despite growing interest for the application of Cognitive-Behavioral Therapy (CBT) to the treatment of schizophrenia, very few studies have adapted a CBT intervention for social anxiety in schizophrenia. Based on this principle, we hypothesized that participants receiving group CBT for SA in schizophrenia would see a greater reduction of symptoms of social anxiety and symptoms of psychosis after receiving treatment. For this study, 29 participants were recruited and provided consent to take part in the study. From this number, 26 successfully completed the intervention program. This efficacy study was based on an uncontrolled design. Participants took part in the group CBT intervention program for a 90-minute weekly session for 14 weeks. The treatment effect of the intervention was assessed using paired sample t-tests for all outcome measures which included social anxiety, psychotic and general psychopathology symptomatology.

Chapter I consists of a general introduction that presents a relevant literature review on markers of remission and the nature of comorbidities, more specifically social anxiety, in first-episode psychosis.

Chapters II and III present two independent studies that examined the impact of social cognitive abilities and the association between the severity of symptoms of anxiety and achieving clinical remission following a FEP. Results revealed that social cognition deficits and the severity of anxiety symptoms were significant markers of remission in FEP as they were both associated with a poor outcome.

Chapter IV presents the results from the actual efficacy study. A cost-effective manualized cognitive-behavioral approach group intervention program for the treatment of social anxiety in FEP was devised. The results of this study reveal that the intervention appears to lead to a significant reduction in the symptoms of social

anxiety, negative symptoms related to psychosis, symptoms of depression and internalized stigma.

Chapter V represents the general discussion on the results of the thesis research project. A model of social anxiety in FEP is proposed. Overall, the results of the research project suggest that there is an urgent need to apply the findings to a larger scale randomized control trial study. Implications of the current study findings that comorbid social anxiety is a highly prevalent condition in FEP and that treatment approaches in FEP should consider potential comorbidities in order to lead to significant clinical as well as functional improvements are discussed in greater details.

Keywords: Social Anxiety, First-Episode Psychosis, Schizophrenia, Cognitive-Behavioral Therapy, Clinical outcome, Social Functioning, Stigma, Psychological Intervention

CHAPTER I

GENERAL INTRODUCTION

1.1 Preamble

Schizophrenia is a chronic psychiatric illness characterized by delusions, hallucinations, thought disorder, emotional dysfunctions (Freeman & Garety, 2003), social withdrawal and cognitive dysfunctions. The onset of schizophrenia commonly occurs in the late teens or early 20's and can lead to severe academic, occupational and social impairment. Although much attention has been given to the treatment of positive and negative symptoms, other highly prevalent comorbid symptoms such as depression, anxiety and substance abuse, have received much less attention yet are likely to interfere with recovery in schizophrenia. More specifically, social anxiety represents a highly prevalent comorbid condition affecting about 1 in 3 patients (Pallanti et al., 2004). A similar prevalence has been reported for patients with a first episode of psychosis (FEP) (Vogues et al., 2005; Michail & Birchwood, 2009) suggesting that the prevalence of this variable appears to be stable overtime. Targeting social anxiety with a psychosocial intervention following a first-episode of psychosis may be optimal given that these patients are likely to still have a social network, and contact with their families, or friends. This is a very important factor to consider, especially when entering treatment, given that the social network can be used to test and eventually challenge biased or asocial beliefs of shame or fear of rejection. Moreover, a qualitative recovery study (Wendell et al., in press) has shown that a considerable proportion of patients following treatment of FEP consider freedom from anxiety to be an independent and important dimension of recovery. In light of the current pharmacological limitations, future interventions aimed at

improving psychosocial recovery in psychosis will need to consider factors associated with impairments such as potential comorbid conditions (i.e. social anxiety) and cognitive deficits (i.e. social cognition).

1.2 Social anxiety

1.2.1 Non-Psychotic Social Anxiety

Social anxiety is a disabling condition which is characterized by fear of negative evaluation and judgment by others in a social situation. This disorder is the third most prevalent diagnosis among Axis I disorders (Bogels, & Tarrier, 2004), affecting close to 14% of the overall population. People suffering from social anxiety disorder experience an intense fear of embarrassment and shame in particular situations and this despite the fact that they can usually recognize that these fears are disproportionate or irrational, often leading to severe functional impairment that affect many life domains such as education, employment and relationships (Antony, 1997). In its mildest form, social anxiety may be reduced to shyness. However, social anxiety disorder differs from 'shyness' since it involves the presence of a persistent fear of receiving a negative evaluation in a social situation, with or without having to perform before others (Harb, & Heimberg, 2006). Nevertheless, even the mildest form of social anxiety has been shown to interfere with social relationship building (Vertue, 2003). However, those who fall within the upper extreme of the social anxiety continuum may experience severe social functioning impairments marked by a significant level of distress. Individuals who suffer from social anxiety experience persistent fears of social situations where they perceive they may be embarrassed or humiliated. As a result, when a situation is feared, the individual suffering from social anxiety disorder seeks to reduce the level of perceived distress often by avoiding the situation that has become associated with this feared response. This anxiety of social or performance situations frequently interferes with daily activities and everyday life, hindering one's quality of life and overall enjoyment.

1.2.2 Social Anxiety in Psychosis

Social anxiety now represents one of the most prevalent comorbid conditions in schizophrenia. Indeed, a study by Pallanti et al. (Pallanti, Quercioli, & Hollander, 2004) found that about 36% of people with schizophrenia also had a comorbid diagnosis of social anxiety, supporting previous reports (Cassano, et al., 1998; Cosoff & Hafner, 1998; Freeman, Garety, & Kuipers, 2001; Mazeh et al., 2009; Halperin, et al., 2000; Kingsep, & Nathan, 2001; Kingsep, Nathan, & Castle, 2003; Penn, et al., 1994). In the case of first-episode psychosis, social anxiety is one of the most prevalent affective conditions in people with the early manifestation of the illness (Michail & Birchwood, 2011). Recently, social anxiety has received much attention given its association with concurrent functional impairments relatively to social recovery in psychosis. In psychosis, research has revealed that affect instability is a highly prevalent phenomenon early in the course of illness but these affective disturbances would also be highly predictive of illness onset in high-risk samples (Owens et al., 2005; Johnstone et al., 2005). Similar rates of prevalence of social anxiety have been observed in affective psychoses (Freeman et al., 2002).

Schizophrenia patients with comorbid social anxiety often exhibit impaired social functioning as well as an increased risk for relapse (Penn, et al., 1994), in addition to higher rates of suicide (Cosoff & Hafner, 1998). As we have seen for social anxiety, in the case of schizophrenia there is also the presence of a persistent fear of being scrutinized and negatively evaluated during social interaction, which in turn is linked to cognitions on how this perceived anxiety will be revealed as well as interpreted by others (Clark & Wells, 1995). Several studies have suggested that social anxiety and psychosis would share common cognitive processes, where social anxiety and persecutory delusions resulting from psychosis are characterized by an abnormal attention to threat-relevant information (Fear, Sharp, & Healy, 1996; Freeman, Garety, & Phillips, 2000). In the case of psychosis, it is believed that

patients would come to fear judgment as a result of the persecution that may result from the presence of illness. Individuals with social anxiety in psychosis, akin to post-psychosis depression (Birchwood et al., 2000), may be more likely than their counterparts to associate the onset of the illness with self-attributed limitations, and to experience a greater sense of status loss and a heightened level of self-shame. Hence, both psychosis and social anxiety would be associated to early developmental anomalies (Michail & Birchwood, 2012). As it is the case for the development of other anxiety disorders (i.e. panic disorder, generalized anxiety disorder), parental overcontrol and overprotection would play a role in the development of shame proneness (Gross & Hansenn, 2000). This research showed that negative beliefs about the self and psychosis might be associated with the development of concurrent social anxiety disorder (Birchwood et al., 2000).

1.2.3 Explanatory Models of Social Anxiety in Psychosis

Numerous studies have looked at the etiology of anxiety spectrum disorders as a primary diagnosis (Schneider, et al., 1992; Rapee & Heimberg, 1997), while others have looked at the prevalence and nature of specific spectrum disorders such as social anxiety and other anxiety-related disorders alike and their relationship to schizophrenia (Robins et al., 1981; Tien & Eaton, 1992; Jorgensen & Castle, 1998; Davies, et al., 1998). As it has been reported in previous papers (Rietdijk, et al., 2009; Kingsep et al., 2001; Birchwood, et al., 2007) several explanatory models have been proposed to account for the strong association that exists between social anxiety and psychosis. First, some believe that social anxiety would precede psychosis. In earlier works, Leonhard (1957) as referenced in Turnbull & Bebbington (2001) found that the pre-psychotic personality was often anxious or hypomanic. He wrote that anxiety and other affective disorders would sometimes occur as 'accessory symptoms in the acute stage or systematic peripheries' and that these 'paranoid' symptoms are understood as arising from the mood. Based on his work, anxiety would be associated

with typical ideas of reference, and sometimes with illusions and hallucinations. Alike, Mednick (1958) stated in Turnbull & Bebbington (2001) was one to pioneer his view that high levels of anxiety could act as the primary vulnerability factor for schizophrenia. Using the learning theory, he argued that anxiety was a response to precipitating events, which led to thought disorder and delusions. Similarly, Slade (1976) (Turnbull & Bebbington (2001)) used a series of case studies to hypothesize that anxiety may lead to hallucinations in vulnerable individuals. Secondly, other hypothesize that anxiety would occur subsequently to psychosis. Fish (1984) had recognized the occurrence of anxiety in schizophrenia and saw anxiety occurring as a result of the psychiatric symptoms, but also recognized that anxiety could occur prior to the onset of schizophrenic symptoms. It was suggested that anxiety was usually associated with persecutory delusions and hallucinations in acute shift and that the sudden onset of hallucinations seemed to produce depression and anxiety in these patients (Fish, 1984). Although the explanation is not clear or definitive – we now know that the association between the symptoms of anxiety and of schizophrenia posits a high degree of comorbidity. However, in a more recent study, the authors were not able to provide significant data that would support the following model that social anxiety would emerge after the onset of psychosis (Rietdijk, et al., 2009). Finally, a third model suggests that social anxiety would be a comorbid condition to psychosis. Maher (1974) (Turnbull & Bebbington (2001)) in his cognitive account of delusions believed that anxiety arose as a consequence of experiencing abnormal perceptions. In response to the distress resulting, the individual, in an attempt to reduce this intolerable anxiety, would form a delusional explanation in order to make sense of the disturbing experience (Maher, 1974). According to his findings, only once these mechanisms would be eliminated, could it be inferred that anxiety associated with schizophrenia may have been part of the psychotic process. Therefore, there is strong evidence to support the hypothesis that social anxiety would be a psychological reaction to the emergence or co-occurrence of psychotic symptoms (Rietdijk, et al., 2009). The current focus of research in the area of

comorbidity is based on a developmental psychopathology framework, where the goal is to determine the factors that may lead to the manifestation of social anxiety symptom in psychosis.

1.3 Social Cognition Schizophrenia

The scientific literature has long recognized that cognitive impairments are one of the most common characteristics of schizophrenia. In the recent decades, several studies have shown that social cognition is significantly impaired in chronic schizophrenia (Penn et al., 1997; Corrigan & Penn., 2004) as well as in FEP (Addington et al., 2006; Bertrand et al., 2007; Montreuil et al., 2010). More interestingly, these deficits have been related to a poorer functional outcome in both schizophrenia, (Penn et al., 1997; Brekke et al., 2005; Couture et al., 2006) and FEP (13, 14) as defined by poor social and role functioning (Niendam et al., 2006; 2007). Social cognition refers to the ability to perceive and react to one's own emotional experiences as well as to interpret the emotional reactions of others. More specifically, social cognitive abilities enable an individual to respond accordingly to the emotional response and intentions of others (Bowie & Harvey, 2005). Social cognitive abilities include mental abilities such as the perception, interpretation and processing of social information. These abilities are commonly known to be compromised in schizophrenia. Social cognitive impairments go beyond deficits found in more general cognitive functioning and are often present even before the onset of psychotic symptoms, which suggests that these social cognition deficits may persist even after the remission of acute psychotic symptoms (Bentall et al., 2009). Furthermore, these deficits would not be unitary given that psychotic patients may be impaired on one or many cognitive domains. Namely, the cognitive domain 'verbal memory' has been known to be impaired in psychotic patients and these deficits are associated with aspects of functional outcome in chronic patients (Green, 1996; Green et al., 2000) and as well as those experiencing a first-episode psychosis (Malla

et al., 2002; Addington et al., 2005). More specifically, social cognition has received much more interest in the last decade thanks to a group called the MATRICS (Measurement and Treatment Research to Improve Cognition in Schizophrenia) which looked at this feature as part of a diagnostic element to the disorder (Green et al., 2004). Social cognition has since been added to the "cognition consensus' given its relevance to functional outcome in schizophrenia.

1.4 Links between Social Anxiety, Social Cognition and Psychosis

Social impairments represent a core feature of social cognition deficits in psychosis as well as social anxiety. Given that cognitive abilities, more specifically social cognition, are known as the most important predictors of functioning in psychotic individuals (Brune et al., 2007), it suggests a potential relationship between social cognition deficits and comorbid social anxiety in this targeted population. There is evidence that social anxiety usually develops in early infancy and would emerge in middle to late adolescence (Hayward et al., 2008). According to Clark (2001), socially anxious people would behave in a way that would result in a negative social outcome. One possible explanation is that reduced premorbid social competence would result in the development of social anxiety; in turn this "social anxiety" would interfere with or 'inhibit' an individual's level of social experience and thus the "normal" development of social cognitive abilities (Green et al., 2005). The notion of social competence whether "real" or "perceived", appears to mediate the relationship between social cognition and social anxiety. Recently, a study conducted among Icelandic schoolchildren revealed that social cognition deficits were associated with the development and maintenance of social anxiety symptomatology (Hannesdottir & Ollendick, 2012). Another possible explanation on the existing link between the two constructs is that socially anxious people would often be more socially inadequate as they would ascribe greater attention (i.e. hypervigilance) to social cues (Hannesdottir & Ollendick, 2012) as well as the

emotional reactions of others (Ollendick & Hirschfeld-Becker, 2002). In other words, social anxiety may be manifested only when social cognitive cognition is preserved, given that the person would then have the "increased" ability to make inferences about others' mental states (Lysaker et al., 2010). As such, social anxiety and social cognition may share a common process, being both characterized by an information-processing bias (Garety et al., 2007). Research has provided evidence that socially anxious individuals particularly those with high levels of negative affect, experience social cognitive difficulties in understanding the associations of emotions, intentions and beliefs in a given social situation (Banerjee, 2001). Consequently, early interventions targeting this affective dysregulation associated with social anxiety could minimize concurrent social functioning impairments (Chudleigh et al., 2011).

Many of the psychological mechanisms present in psychotic symptoms like paranoia are also found in social anxiety (Rietdijk, et al., 2009) such as: the individual's attention to certain elements found in their surroundings; scanning the environment for threatening social cues; heightened level of self-consciousness; exaggerated negative appraisal of conduct; self-referencing bias; and confirmation bias. However, there is an important distinction that must be made between social anxiety and paranoid delusion/ideation, relatively to the experience of fear (Rietdijk, et al., 2009). During social interaction, the distress associated with social anxiety would stem from a fear of rejection whereas in an individual experiencing paranoid delusion, the threat would arise from fearing persecution. Similarly, greater paranoid ideation has been associated with higher levels of social anxiety, avoidance, and apprehension about evaluation, self-observation and low self-esteem (Martin & Penn, 2001). Lysaker et al. (2010) identified that negative symptoms predicted social anxiety symptoms.

In sum, there is a need to gain a greater understanding on whether social anxiety and psychotic symptoms are truly independent or whether social anxiety is a

manifestation of psychotic symptoms. It has been hypothesized that social cognition impairments would give rise to high levels of social anxiety symptoms and increased risk of developing a comorbid social anxiety disorder (Jacobs et al., 2008). As such, social cognition deficits and social anxiety would represent an important risk factor for social functioning impairments and hence, recovery in schizophrenia. As a result, poorer social cognition competence would be expected in psychotic patients with comorbid social anxiety disorder, and both social anxiety and social cognition may play a role in the development of psychotic symptoms such as paranoia (Lysaker et al., 2010). Conversely, it was suggested that greater paranoia intensity was correlated with stronger social anxiety symptoms and overall better social cognition performances (Lysaker et al, 2010). Nonetheless, based on these findings, two possible interpretations emerge: (1) Social anxiety may be a path to paranoia only in the presence of a good social cognition performance; (2) Paranoid features may cause social cognition deficits or social anxiety depending on the affected individual. In light of these contrasting explanations, a more recent study proposed an interesting perspective on these findings. The study reported that social anxiety symptoms were not strictly dependent on psychotic symptoms, supporting the notion that social anxiety symptoms may differ in patients who have comorbid social anxiety in schizophrenia from those who do not have a "formal" comorbidity (Achim et al., 2013). Though the proposed hypothesis seem logical and have obvious implications for treatment, this study did not look at social cognition abilities or its impact on functioning as a function of a comorbid condition by validating the diagnosis of social anxiety in people who experienced paranoid symptoms related to psychosis. Given that this critical distinction between social anxiety symptomatology and comorbidity was not defined in the reported study, it could account for the lack of concrete results, as it has been the case in most other studies on the subject matter (Achim et al., 2013). These findings further highlight an important distinction that needs to be made in this area of research, the difference between co-occurring diagnoses (i.e. comorbid social anxiety in psychosis) and social anxiety symptom-

severity.

1.5 Dual Diagnosis and Comorbidity

In recent years, there has been a growing interest in psychiatric comorbidity, and yet the relationship between anxiety and schizophrenia has remained practically ignored. Consequently, some have argued that this lack of comorbid diagnosis could be best explained due to the arbitrariness of classification in psychiatry. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994), symptoms are used to establish whether criteria for a given disorder are met. In the case of schizophrenia, patients commonly display an array of markedly different symptoms and manifestations of psychotic symptoms. This existing variability in the manifestation of symptoms in addition to potential overlapping comorbid symptoms makes difficult discriminating conditions or disorders that could perhaps support mutually exclusive classes. Several epidemiological studies have shown that psychiatric comorbidity is frequent in patients suffering primarily from psychotic disorders. However, most of the literature thus far related to the comorbidity of schizophrenia and other pathological disorders mainly looks at its association to post-psychotic depression or alcohol and drug use / abuse. As it was more recently suggested, most other Axis I disorders are being far less investigated (Mazeh et al., 2009). Consequently, in recent years, there has been a growing trend in dual-diagnosis in Canada and the USA, mainly in treating substance use in schizophrenia (Drake, et al., 2008). A common feature to all of these studies is that over half of patients suffering from co-occurring disorders experienced important challenges in their ability to adjust to treatment and recover. Seemingly, the emerging reality involves the pressing need to address eminent comorbidity in mental illness in an attempt to improve course of illness and treatment outcome in order to make functional recovery an achievable goal.

Psychiatric literature provides very few references to the nature of the link between symptoms of anxiety and schizophrenia. Some authors have suggested that the hierarchy model of psychiatric symptomatology or diagnosis (i.e. hierarchically organized primary and secondary disorders) may account for the lack of adjunctive diagnosis of comorbid conditions (Gumley et al., 2004). Despite the existence of much uncertainty, there seems to be a consensus on the notion that clinicians may altogether neglect to elicit or may disregard symptoms of anxiety in their psychotic patients in light of the fact that clinical assessments and evaluation toward the remittance of primary diagnosis is inherently a time consuming task for both patient and clinician alike. Furthermore, as part of the diagnostic criteria stemming from the DSM-IV, a diagnosis of social anxiety cannot be rendered if there is a probability that it may be accountable to another mental disorder (Antony, 1997). Nevertheless, this current growing interest in comorbidity is much needed and appears to be mainly driven by concerns on how these symptoms may impact the severity of symptoms and the patient's clinical outcome.

1.6 Social recovery in Psychosis

1.6.1 The Impact of Comorbid Conditions

Poor social outcome is most common in psychosis. Longitudinal studies suggest that social recovery is achieved by less than 50% of people with non-affective psychosis, and although the majority report that they wish to work (Mueser et al. 2001), only a small percentage of individuals with psychosis (i.e. 10–20%) actually return to work (Johnstone et al. 1990). Poor social outcomes in psychosis tend to emerge early in the course of illness, only to become stable overtime, and ultimately commonly associated with longer-term disability. The development of an effective intervention to improve social recovery in psychosis could contribute to critical long-term benefits, especially for the subgroup of patients who have experienced poor social functioning from the early course of the disorder. Cognitive behavior therapy

(CBT) may provide a useful and basis for developing such an intervention. Several studies have been shown effective to treat anxiety symptoms as well as symptoms related to psychosis. Several studies have reported evidence for the efficacy of CBT on anxiety, depression and negative symptoms (Turkington et al. 2002; Gumley et al. 2003; Wykes et al. 2008).

Currently, psychopharmacological treatments are not sufficient to target the social functional deficits that affect a large proportion of patients especially in the early phase of the illness in large part due to poor medication adherence or resistance to treatment. The attainment of symptomatic or clinical remission in psychosis does not necessarily translate itself into improved social recovery. Social cognition deficits as well as comorbid social anxiety in psychosis have been associated to these functional impairments in recovery, which include poor outcome in occupational (Gureje et al., 2002), social and quality of life domains (Hafner et al., 1995), increased risk for relapse, hospitalization and even suicide (Upthegrove et al., 2009). These impairments are of even greater concern when it comes to the early onset of the illness (FEP) as any disruptions to the 'normal' stage of development may lead to significant social and functional costs. It has been hypothesized that deficits in social information processing might trigger anomalous experiences that in psychotic patients would result in distress which in turn would produce anxiety and lead to the expression of psychotic symptoms (Garety et al., 2007). Similarly, emotion regulation difficulties in anxiety and depression have also been found to influence social functioning in schizophrenia (Kimhy et al., 2012). Hence, there is an urgent need to develop interventions that will target these deficits and comorbid conditions in order to lead to such improvements towards social recovery. However, interventions targeting these deficits in social recovery have only achieved limited success in people with schizophrenia (Muesner, 2000). An extensive number of studies have looked at cognition, more specifically social cognition in psychosis and an increasing number of studies are now exploring the role of comorbid conditions

such as anxiety and mood disorders on clinical / functional outcome in psychosis. A recent study showed that for the purpose of clinical interventions and research evaluations, anxiety disorders seemed to be the most persistent comorbid condition in a FEP sample across time (Pope et al., 2012). It has been suggested that interventions should now aim to treat conditions that limit social recovery (Tarrier, 2010), especially serious comorbidities such as social anxiety.

1.6.2 The Impact of Shame in Psychosis

Studies have shown that increased levels of paranoid ideation (i.e. paranoia) were associated with higher levels of social anxiety and a greater attention to the perception of self by others (Martin & Penn, 2001). Although pertinent, this finding does not shed light on whether paranoia and social anxiety rest on the same continuum or whether they are two independent manifestations of psychotic symptoms. It has been argued that social anxiety represents a phenotypic expression of schizophrenia although it is now believed that social anxiety would instead be an independent dimension of psychosis (Michail & Birchwood, 2010; El-Khouly & El Gaafary, 2011). Furthermore, social anxiety would develop shortly after the onset of psychosis (post-psychotic phenomenon) and would not be related to the presence of positive symptoms in psychosis (Birchwood & Trower, 2006; Michail & Birchwood, 2010). What we now know is that psychosis is considered as a highly stigmatized condition (Thornicroft et al., 2009) and the experience of psychosis is associated with high levels of shamefulness, namely shame about mental illness (Birchwood & Trower, 2006) which would interfere with social recovery. More specifically, the "negative self-evaluation" thoughts are linked to shame appraisals and these thinking patterns would derive from experiencing the psychotic episode itself and the resulting diagnosis of mental illness (Gumley et al., 2003). Consequently, stigma, shame and loss of social role are thought to be involved in the subsequent development of social anxiety (Birchwood et al., 2006; Iqbal et al., 2000). Research has shown that shame

memories are distinctively related to paranoia and social anxiety (Matos et al., 2012). On one hand, external shame would be more highly associated to paranoid ideation while the internal construct would be linked to social anxiety. Despite these findings, the exact nature of the relationship between social anxiety and psychotic symptoms such as paranoia remains unclear. However, there is empirical evidence that social anxiety manifested in psychotic patients is not directly related to paranoia, as a perceived threat by others, but would be an independent dimension of the illness that would ultimately impact recovery outcome in psychosis (Birchwood & Trower, 2006; Michail & Birchwood, 2010). More specifically, paranoid ideation would precede the development of social anxiety in psychosis (Rietdijk et al., 2009). Moreover, paranoia and social anxiety, although distinct, would both be characterized by negative beliefs about the self, indicating that paranoid symptoms in psychosis and social anxiety share a connection at the cognitive level, mediated by how threat is processed (Fowler et al., 2006). However, some argue that unlike paranoia, avoidance of social situations would be a determining factor for the development of social anxiety (Schutters et al., in press).

Given that there is evidence of social impairments in schizophrenia and FEP patients, the possibility that comorbid social anxiety might further exacerbate these difficulties and hence recovery, merits further investigation (El Masry et al., 2009). Furthermore, it has been suggested that social anxiety should not only be investigated but also included in treatment as part of a distinct dimension of the illness (El-Khouly & El Gaafary, 2011). In light of the partial effectiveness of pharmacological-based treatment and its impact on social recovery and the extensively reported benefits of CBT in treating various other psychological and psychiatric conditions, this has consequently led to the development of CBT for psychotic symptoms (Tarrier, 2010).

1.6.3 Underpinnings of the Proposed Intervention

In an attempt to better understand which psychological processes are involved in the emergence of social anxiety in psychosis, some have proposed that it may be the result of stigmatizing negative beliefs related to the illness. This in turn would play an important role in recovery and outcome mainly due to the poor social adjustment (Hofmann, et al., 2007) and lack in functionality that follow as a result of the illness. In schizophrenia, patients often find themselves burdened by various psychosocial difficulties in addition to the onset of the illness itself. Thus, is it believed that the high prevalence of anxiety disorders and more particularly of social anxiety disorder found within this population may be linked to illness-related stigma, a distorted self-image, and a reduction in social functioning. When these are combined, they can greatly and negatively impact the life of the young and older adults who experience psychosis. Hence, the disabling effects of comorbid social anxiety disorder with schizophrenia seem to go far beyond merely negatively impacting social interactions, as it is commonly believed. Rather, this disorder appears to have far greater consequences on many other dimensions of psychopathology, highlighting the crucial need to also establish health service programs for early treatment of comorbid social anxiety in first-episode psychosis patients. Moreover, there is a need to develop a treatment of social anxiety that is specific to people with psychosis. Some studies have suggested that, by reducing anxiety proneness, a patient's resiliency could be increased and therefore prevent future psychotic relapse (Birchwood & Trower, 2006) which would ultimately contribute to recovery.

Similarly, Gumley (Gumley, et al., 2004) proposed that individuals with social anxiety in psychosis, like post-psychosis depression (Birchwood, et al., 2000), might have been more likely than their counterparts to associate the onset of the illness with self-attributed limitations, and to experience a greater sense of status loss and a heightened level of self-shame. This research showed how negative beliefs about self and psychosis might be associated with concurrent social anxiety disorder

(Birchwood, et al., 2000). Likewise, knowing that social anxiety is linked to psychotic symptoms (Rietdijk, et al., 2009), research has provided further evidence, which would support the notion that the psychotic symptomatology may be maintained by safety behaviors also characteristic of social anxiety (Morrison, 2001). In an attempt to reduce the distress associated with a perceived danger or threat and the anticipated related consequences, it is hypothesized that safety behaviors such as avoidance would be utilized both in social anxiety and shame related to psychosis (Michail & Birchwood, 2012). In fact, findings have shown that shameful thinking is linked to the development of social anxiety in psychosis, as it is the case for non-psychotic social anxiety (Michail & Birchwood, 2012).

In view of social anxiety's role in the development of psychotic symptomatology, the present focus of interventions for psychotic symptoms need to be revised. Currently, psychological interventions seeking to foster recovery, like CBT in psychosis are primarily targeting psychotic symptoms and not factoring in affective disturbances such as social anxiety and hence, only treating a fraction of the residual symptomatology that arises from the experience of psychosis (Michail & Birchwood, 2010). Patients who have achieved clinical remission of psychotic symptoms and who experience concurrent poorer quality of life would be at increased risk of developing social anxiety (Kumazaki et al., 2012). According to these same authors, in order to achieve social recovery, interventions need to target social anxiety. More recent research has suggested that therapeutic interventions should target these dysfunctional appraisals and core cognitions related to shame in order to help the individual with psychosis to make sense of what leads to the development of social anxiety and affective disturbances (Michail & Birchwood, 2010); be aimed at reducing avoidance and safety behaviors that are responsible of the development and maintenance of social anxiety (Rietdijk et al., 2009); focus on helping the patient adjust overestimations of social costs associated to social experiences (Hoffman, 2007); and address the shame memories related to the individual's paranoid or

socially anxious past experiences (Matos et al., 2012; Michail & Birchwood, 2010; Birchwood & Trower, 2006).

1.7 Cognitive-Behavioral Therapy

The growth of Cognitive-Behavioral Therapy (CBT) can be traced to the pioneering work of Beck (Beck, et al., 1979). Since then, there have been several theoretical developments in models of cognitive therapy that incorporate a richer understanding of early development, interpersonal processes, and the therapeutic relationship (Addington & Gleeson, 2005). It has been demonstrated that CBT contributes to significant advantages in outcome over routine care and some advantages over supportive therapy (Lewis et al., 2002) for a wide variety of disorders, ranging from anxiety to depression and even psychosis. Broadly, current models of cognitive therapy focus to a varying extent on (i) automatic thoughts, (ii) faulty processing styles and dysfunctional assumptions regarding the self, (iii) core cognitions or self-schemata, (iv) emotional and cognitive development, and (v) interpersonal and interactional factors in addition to cognitions (Vallis, 1998). More simply, cognitive behavior therapy focuses on the links between thoughts, behaviors, and feelings in order to help patients gain a better understanding of and solve their problems. The choice of a CBT intervention for this study was guided by 2 important lines of literature: (1) There is evidence that a cognitive-behavioral therapy specifically for the treatment of social anxiety, whether it is delivered individually or in a group setting, can produce significant outcome when compared to a control group (Mattick & Clarke, 1998; Heimberg, et al., 1990; Halperin, et al., 2000; Kingsep, Nathan, Castle, 2003); (2) CBT has been developed for individuals with social anxiety and has been evaluated in a number of studies. Furthermore, some studies have effectively shown that the individuals receiving group CBT would show more frequent sudden or immediate gains (group setting interactions would immediately result in normalization and exposure for patients) and that these gains

would reveal better treatment response at treatment termination and at follow-up when compared to control groups (Hofmann, et al., 2007; Clark, 2005). CBT, by its philosophy and techniques, is best suited to target these dysfunctional ways of thinking about the self and about social abilities.

1.7.1 Cognitive-Behavioral Therapy for Social Anxiety and Psychosis

As we have seen previously, there is strong evidence that CBT for the treatment of social anxiety is very effective whether it is delivered individually or in a group setting (Halperin, et al., 2000; Heimberg, et al., 1990; Mattick & Clarke, 1998) and studies have shown that a group setting is more effective than individual therapy (Hofmann, et al., 2007; Vittengl, Clark, & Jarrett, 2005). CBT has also been shown to be effective in people with schizophrenia for treatment resistant positive symptoms such as auditory hallucinations and paranoid delusions (Beck, et al., 2009; Garety, et al., 2008; Gaudiano, 2006; Lewis, et al., 2002; Startup, Jackson, & Startup, 2006; Tarrier, et al., 2004; Turkington, et al., 2006; Zimmermann, 2005) and two preliminary studies have already been conducted on social anxiety (Halperin et al., 2000; Kingsep et al., 2003). Furthermore, many individuals with schizophrenia doubt their ability to succeed and often view themselves as less competent as a result of stigma, lowered expectations from family and care providers, and deficits associated with the illness itself (Lysaker, et al., 2005). Hence, providing a CBT intervention for social anxiety is an effective way to empower people suffering from this illness (Lecomte, et al., 1999) a key ingredient to reach recovery in psychosis.

Despite growing interest for the application of CBT to the treatment of schizophrenia, very few studies have adapted a CBT intervention for social anxiety in schizophrenia. Kingsep (Kingsep, et al., 2003) and Halperin (Halperin, et al., 2000) have independently developed CBT interventions for social anxiety in schizophrenia, both finding that a group setting intervention, when being compared to a waitlist

control group, was an effective approach to significantly decrease symptoms of social anxiety. In the case of Halperin and his colleagues, the focus of the intervention was mainly on the behavioral dimension of social anxiety such as the development of social skills and it did not incorporate cognitive elements (Halperin, et al., 2000). The study's outcome measures were social anxiety, quality of life, substance use and depression. Although the study was comprised of a small number of participants (N=20), it nonetheless found some association between variables. On the other hand, Kingsep and his colleagues recruited slightly more participants (N=33) and their intervention program included broader domains than simply social skills training, such as diaphragmatic breathing training and relaxation techniques. Their pioneering approaches suffered however, from some setbacks. In both studies, the intervention mainly focused on behavioral approaches. An important limitation of both studies lies in the fact that the notion of illness-related stigma (psychosis) was not incorporated as a cognitive underpinning in the intervention, which does not take into account the diagnostic specificity of schizophrenia (Birchwood, et al., 2007; Peters, 2000). Instead, in these studies, the proposed interventions were based on treatment of social anxiety developed for non-psychotic populations. According to Tarrier (2010), the application of these "conventional treatments" to individuals with psychosis would be problematic given that they do not account for the issue of shame and dysfunctional cognitions related to the psychotic illness as well as the resulting avoidant behaviors, which are common to FEP. Moreover, the reduction of social anxiety symptoms as defined by the Social Interaction Anxiety Scale (SIAS, (Mattick & Clarke, 1998) was modest in the Halperin study (18%) and moderate (29%) in the Kingsep study. Finally, both studies did not include a measure of the psychotic symptomatology, which did not allow researchers to duly measure the impact of the intervention program on the psychotic outcome.

1.7.2 Incorporating Shame into the Cognitive-Behavioral Model

Recent work has identified specific cognitive processes that could be targeted in a CBT intervention for social anxiety in psychosis. For instance, Birchwood and colleagues (Birchwood, et al., 2007), have observed that individuals with social anxiety experienced greater shame attached to their diagnosis and felt that the diagnosis of schizophrenia set them apart from others. Moreover, Gumley, et al. (Gumley, et al., 2004) found that negative beliefs related to the self and the illness appeared to be related to the development of concurrent social anxiety disorder. Haghihat (Haghighat, 2001) proposes that stigma in illness-related attitudes (psychosis) is comprised of three main components, which are: i) cognitive (e.g. endorsing the view that schizophrenics are violent); ii) affective (e.g. feelings of anxiety); and iii) discriminatory (e.g. refusing to give someone accommodation). Therefore, as a first step, the design of a CBT intervention program for social anxiety in schizophrenia could be specifically adapted to this notion of stigmatization, and incorporate an additional sub-component targeting these cognitive processes such as the dysfunctional thoughts, beliefs and attitudes about the self as related to the illness. Secondly, taking into account that social anxiety may maintain psychotic symptomatology, the intervention program in targeting social anxiety could also aim to improve clinical outcome in these patients through the reduction of social anxiety symptoms (i.e. through a mediating effect).

In addition to potential shame and the related maladaptive core beliefs, a CBT intervention for social anxiety in schizophrenia needs to be tailored to the functional capacity of the participants. As part of their study limitations, Kingsep, et al. (2003) have suggested that a sound CBT intervention program for social anxiety in schizophrenia should take into account the need for a single-task or task-specific approach in addition to slowing down the pace of delivery for this specific population, especially in order to minimize attrition. Hence, cognitive deficits that have been linked to schizophrenia need to be addressed by having a slow pace approach, providing written summaries of key aspects of therapy as part of patient-

manual, and having reading materials intended for high school-level abilities in order to accommodate for this possible neurocognitive variability.

1.7.3 Overview of the Manualized Intervention Program (CBT)

A more complete overview and detailed description of the CBGT intervention program manuals (CLINICIAN AND PARTICIPANT VERSION) can be found in Appendix D Furthermore, the full version of the two manuals is located in Appendices E-H.

1.8 Thesis Project Objectives

The initial goal of this thesis project was to determine markers of clinical remission in a first episode of psychosis population. Subsequent to our manipulations, we were able to identify that both social cognition and the severity of anxiety symptoms were significant predictive markers of the attainment of remission in FEP. In addition, the main goal of this thesis project was to establish the effectiveness of a specific CBGT intervention for social anxiety designed specifically for a psychotic population. This novel manualized intervention varies from its few predecessors (Halperin et al., 2000; Kingsep et al., 2003) given that it is the first intervention in CBGT to the best of our knowledge to propose a treatment for social anxiety in FEP that also targets shame and delusional beliefs about the self and the illness (Birchwood et al., 2007; Peters, 2000). The key purpose of the study is to measure the efficacy of the intervention for the reduction of social anxiety symptomatology and to evaluate the changes in psychotic symptoms and more general psychopathology factors such as depression and internalized stigma by specifically targeting the dysfunctional beliefs (i.e. negative bias) related to the self-following a diagnosis of schizophrenia. As part of this project, thirty-two people will have provided consent and have undergone assessment and a total of twenty-nine participants entered and took part of the intervention. Amongst that number, twenty-six will have gone on to

complete more than 50% of the total number of sessions. The assessment included validation of the two comorbid-conditions on Axis I (i.e. psychosis and social anxiety – SCID-I subsections) as well as the severity of the social anxiety symptom (i.e. SIAS, SPIN, BSPS) and psychotic symptomatology (SANS, SAPS), and the more general psychopathology, which included insight (BCIS), depression (CDSS), and stigma (ISMI).

This project will mark the initial phase of a larger project. Since a very limited number of clinical research projects have looked at the interaction between social anxiety and first-episode psychosis as a comorbidity, our goal for the current study is to subsequently conduct randomized clinical trials, which would compare the effectiveness of our manualized CBGT intervention to an alternative control condition.

Chapter II of the thesis includes the first study "Social Cognitive Markers of Short-term Clinical Outcome in First-Episode Psychosis" which was published in the Journal *Clinical Schizophrenia and Related Psychoses* in 2010. This article was written as a follow-up to an ongoing investigation looking at variables that were associated with remission, defined as "markers of short-term clinical outcome". For example, a previous article had identified that impairments in the two domains of cognition, verbal memory and working memory, were cognitive markers of short-term clinical outcome in FEP-First-Episode Psychosis (Bodnar et al., 2008). Similarly, beside neurocognitive markers of FEP, neuroimaging studies were also completed and it was found that a smaller parahippocampal cortex represented a neural marker in first-episode schizophrenia patients who do not achieve remission one year after treatment (Bodnar et al., 2011). Hence, the first study in this dissertation represented a natural evolution of the work that was already begun and essentially a catalyst to the subsequent studies that would follow. As explained earlier, social cognition has been associated to high social anxiety (Trower &

Chadwick, 1995) and externalizing biases (Garety & Freeman, 1999), a process that appears to be involved in the development of anxiety, primarily social anxiety. A study completed among Icelandic schoolchildren revealed that social cognition deficits were highly associated with the development and manifestation of symptoms of social anxiety (Hannesottir and Ollendick, 2008). Hence, based on these results, studying social anxiety, as a potential mediating factor of social cognition deficits and psychotic symptomatology, appeared to be a logical follow-up to the present study.

Chapter III includes the second study "Anxiety Symptoms Severity and Short-Term Clinical Outcome in First-Episode Psychosis" and this article has been accepted and is currently in press in the journal *Early Intervention in Psychiatry*. Back in 2005, Malla, Norman, and Joober had suggested that research in early intervention in psychosis should aim to improve clinical outcome by examining the effect of "specialized approaches on longer-term outcome as well as considering the cost-effective properties of these treatment options". Thus far, investigation of early markers of FEP had revealed a multidimensional model of schizophrenia comprised of positive and negative symptoms, cognitive deficits and more recently emerging, the notion of comorbidity in psychosis (i.e. mood disorders, anxiety and substance use). The second article materialized from this notion of comorbidity as a marker of early psychosis. From our existing sample of patients, we first looked at the prevalence of comorbid anxiety conditions in FEP. In addition, given that our goal was to study the effect of markers of FEP on the clinical outcome, we wanted to explore if a link could be established between the severity of anxiety symptoms and the attainment of remission (i.e. poor versus good outcome) in a first-episode sample.

Chapter IV presents the third study "Manualized Group Cognitive-Behavioral Therapy for Social Anxiety in First-Episode Psychosis: An Uncontrolled Study" which has been submitted to *Schizophrenia Research*. The CBGT intervention stemmed out of the results from the second study, combined to a thorough literature

review which revealed that people who suffered from a comorbid anxiety disorder in FEP were at increased risk for relapse and hospitalization (Penn, et al., 1994), suicide (Cosoff & Hafner, 1998), and experienced overall poorer quality of life (Lysaker et al., 2010). The presence of social anxiety symptoms was associated to functional and social difficulties that affected employability / occupation, education as well as interpersonal relationships. Going back to Malla, Ross and Joober (2005), we decided to devise a cost-effective cognitive-behavioral approach group therapy for the treatment of social anxiety, more specifically, in a population who experienced a first psychotic episode with the primary aim of yielding longer-term positive outcome effects.

A fourth first author article, which can be found in the Appendix section, emerged from this Ph.D. project. "Early Medication Adherence and Working Alliance in First-Episode Psychosis" was published in 2012 in the *Journal of Clinical Psychopharmacology* (Appendix A). The objective of the study was to evaluate the association between adherence to antipsychotic medication and working alliance in first-episode psychosis and to identify whether other factors such as poor clinical insight, and substance use were also related to poor adherence Therapeutic alliance whether in medication compliance or treatment adherence is a core determinant of the predicted outcome (Lecomte et al., 2008). In our general discussion, the notion of therapeutic alliance and "therapist variables" are further explored and discussed as related to the group CBT intervention. Hence, findings from the present study highlighted key points that were critical in evaluating the scientific contributions of the overall project.

Chapter V constitutes a general discussion on the overall results of the research project. This chapter first proposes a synthesis of the results of all four articles (Chapters II – IV). A model of social anxiety and shame in FEP is proposed and can be found in Appendix B. Subsequently, scientific contributions and theoretical and

practical implications of the study are discussed, along with the strengths and limitations of the research project. Finally, implications of the current study findings for future research will be briefly presented at the end of the dissertation.

CHAPTER II

STUDY ONE

Reference:

Montreuil, T., Bodnar, M., Bertrand, M.C., Malla, A., Joober, R., & Lepage, M. (2010). Social Cognitive Markers of Short-term Clinical Outcome in First Episode Psychosis. Clinical Schizophrenia and Related Psychoses, 4 (2), 105-114.

CHAPTER II

STUDY I - SOCIAL COGNITIVE MARKERS OF SHORT-TERM CLINICAL OUTCOME IN FIRST EPISODE PSYCHOSIS

Abstract

Objective: In psychotic disorders, impairments in cognition have been associated with both clinical and functional outcome, while deficits in social cognition have been associated with functional outcome. As an extension to a recent report on neurocognition and short-term clinical outcome in first episode psychosis (FEP), the current study explored whether social cognitive deficits could also identify poor short-term clinical outcome among FEP patients. Method: We defined the social cognition domain based on the scores from the Hinting Task and the Four Factor Test of Social Intelligence. Data were collected in 45 FEP patients and 26 healthy controls. The patients were divided into good and poor outcome groups based on clinical data at six months following initiation of treatment. Social cognition was compared among 27 poor outcome, 18 good outcome, and 26 healthy control participants. Results: Outcome groups significantly differed in the social cognition domain (z-scores: poor outcome=–2.0 (s.d.=1.4); good outcome=–1.0 (s.d.=1.0); p=0.005); with both groups scoring significantly lower than the control group ($p < 0.003$). Moreover, outcome groups differed significantly only on the Cartoon Prediction subtest (z-scores: poor outcome=–2.7 (s.d.=2.7); good outcome=–0.7 (s.d.=1.8); p=0.001) among the 5 subtests used. Conclusion: Overall, social cognition appears to be compromised in all FEP patients compared to healthy controls. More interestingly, significant differences

in social cognitive impairments exist between good and poor short-term clinical outcome groups, with the largest effect found in the Cartoon Prediction subtest.

Keywords: social cognition, clinical outcome, first-episode psychosis

2.1 Introduction

Individuals, who experience a first episode of psychosis (FEP), vary in their response to treatment (Lieberman et al., 1993; Rosen & Garety, 2005), as well as in their cognitive abilities. Furthermore, there has been growing evidence that cognitive deficits are a core feature of schizophrenia (Gold & Green, 2002; Goldberg, 2002) and other psychotic disorders and that cognitive deficits, namely verbal memory, are associated with aspects of functional outcome in chronic patients (Green, 1996; Green et al., 2000) and as well as those experiencing their first episode (Addington, Saeedi, & Addington, 2005; Malla et al., 2002).

As part of the recent attempt to establish consensus on domains of cognition in schizophrenia, the Measurement and Treatment Research to Improve Cognition in Schizophrenia (MATRICS), social cognition has been added because of its relevance for clinical trials and functional outcome (Nuechterlein et al., 2004). Social cognitive abilities are composed of several mental operations, such as perception, interpretation and the processing of social information. Social cognition is best defined as "the ability to conceptualize other people's beliefs, thoughts and intentions in order to explain and anticipate their behavior (Bertrand et al., 2008).

Over the past two decades, studies have clearly shown that social cognition is significantly impaired in chronic schizophrenia (Corrigan & Penn, 2004; Penn et al., 1997, Corrigan, 2004) and in FEP (Addington, Saeedi, & Addington, 2006; Bertrand et al., 2007; Williams et al., 2007). More interestingly, these deficits have been related to a poorer functional outcome in both schizophrenia (Brekke, Kay, Lee, & Green, 2005; Couture, Penn, & Roberts, 2006; Penn et al., 1997) and in FEP (Addington et al., 2006; Williams et al., 2007). The relationship between social cognition performance and symptomatic or short-term clinical outcome has received little attention so far, although associations have been identified. Deficits in social cognition have been explained by either a lack of development of such abilities pre-

morbidly, as in the case of patients with predominantly negative symptoms, or as result of a loss of such abilities consequent to positive symptoms (Corcoran, Mercer, & Frith, 1995). Whether social cognition is associated with an early reduction of symptoms, similar to what has been reported for verbal memory (Rubinsztein, 2000), still remains unexplored. If such an association does exist it will further increase the significance of assessing the domain of social cognition as part of a cognitive battery of tests given the importance of a full syndromal remission early in the treatment of psychosis (Cassidy et al., 2008).

With past research relating social cognitive deficits to a poor premorbid adjustment in patients with predominantly negative symptoms or resulting from a loss of abilities linked to positive symptomatology (Corcoran et al., 1995) it would be expected that deficits in this domain could significantly affect clinical outcome. Based on this and the abovementioned findings, we hypothesized that all FEP patients would show social cognitive deficits in comparison to matched healthy controls. Furthermore, we hypothesized that deficits in social cognition would be associated with a poor short-term clinical outcome during the initial stages of treatment following a FEP.

2.2 Methods

2.2.1 Participants, treatment setting, and treatment protocol

All participants were part of an ongoing, longitudinal behavioral and imaging study being conducted at the Douglas Mental Health University Institute in Montreal, Canada. All FEP patients were recruited and treated through the Prevention and Early Intervention Program for Psychoses (PEPP-Montreal), a specialized early intervention service with integrated clinical, research, and teaching modules. The program involves a comprehensive approach with intensive medical and psychosocial management. All patients are provided modified assertive case management and

interventions to assist in their recovery (for further details on the program, see (Malla et al., 2003)). Patients aged 14– 30 years from the local catchment area suffering from either affective or non-affective psychosis who had not taken antipsychotic medication for more than one month were consecutively admitted to the program as either in- or out-patients. There is no competing service and treatment is publicly funded.

From PEPP-Montreal we recruited 48 patients for an imaging study who completed supplementary social cognitive tests: the Hinting Task (Corcoran et al., 1995) and the Four Factor Tests of Social Intelligence (O'Sullivan & Guilford, 1976). From our study, three patients were subsequently removed due to a later confirmed diagnosis of substance-induced psychosis. In addition, two poor outcome patients refused antipsychotic medications as treatment option. These clients still received the psychosocial interventions. The remaining 45 patients were subsequently separated into good outcome (n=18) and poor outcome (n=27) groups based on six-month clinical data. As per an earlier report, good outcome was defined by a rating of 2 or less (mild) on all global subscales of the SAPS and 3 or less (moderate) on all global subscales of the SANS excluding the subscale of "attention" (Bodnar et al., 2008). For the present study, all FEP patients were included which was comprised of 39 schizophrenia spectrum disorder (poor outcome=24; good outcome=15), 4 affective psychosis (poor outcome=2, good outcome=2), and 2 psychosis NOS (poor outcome=1; good outcome=1).

Twenty-six healthy controls were recruited through advertisements in local newspapers and took part in social cognitive testing sessions. Controls were included only if they had no current or past history of 1) any Axis I disorders, 2) any neurological diseases, 3) head trauma causing loss of consciousness, and 4) a first-degree family member suffering from schizophrenia or related schizophrenia spectrum psychosis. Controls were also chosen on socio-demographic variables such

as age (at testing), gender, and parental socio-economic status during childhood matched to FEP patients who were taking part in a neuroimaging study.

After a comprehensive description of the study, written informed consent was obtained from all participants. The Douglas Mental Health University Institute review board approved the research protocols.

2.2.2 Clinical and demographic assessments

Patients were diagnosed according to the DSM-IV criteria based on the Structured Clinical Interview for DSM-IV (First et al., 1998) and confirmed through consensus between two senior research psychiatrists (A.M. & R.J). Positive and negative symptoms were assessed with the Scale for the Assessment of Positive Symptoms (SAPS) (Andreasen, 1984b) and the Scale for the Assessment of Negative Symptoms (SANS) (Andreasen, 1984a), respectively. The baseline interview session was conducted within one month of entry into the program (mean=23.4 days, SD=8.6 days, range=4.8-46.2 days). The symptom ratings covered the previous one month and were repeated monthly until the third month and then again at six months, nine months, and twelve months past baseline as shown in Table 2.1. Symptom ratings are performed by research assistants (ICC=0.75 for both the SAPS - Scale for Assessment of Positive Symptoms and the SANS - Scale for Assessment of Negative Symptoms (SANS)) who had received extensive training and supervision with inter-rater reliability measured at least once a year.

Medication adherence was assessed at each of the aforementioned time-points and averaged over the first six-month period to provide an overall adherence score. Medication adherence was based on a 5-point scale ranging from 0 (never adherent) to 4 (fully adherent) on information obtained from patients, family members, case managers, and psychiatrists. Duration of untreated psychosis (DUP) was calculated as the time period from onset of psychotic symptoms judged to be at threshold level

according to DSM-IV criteria until time of adequate treatment with antipsychotics (30 days of continuous treatment or less if remission of positive symptoms occurred). Duration of untreated illness (DUI) was defined as the time period from onset of any psychiatric symptoms to adequate treatment with antipsychotics (Malla et al., 2006).

Parental Socio-economic status (SES) was assessed with the Hollingshead socio-economic status rating scale (Miller, 1991). SES is an estimation that is achieved by considering the occupational status and the highest level of education attained by a parent, including other family assets and resources. Finally, the type of and dosage of antipsychotic taken at the time of the social cognitive evaluation were recorded. All interview sessions acquiring the collection and assessment of pertinent were performed by a trained professional.

2.2.3 Social cognition measures

Patients were assessed after the initiation of treatment and only when in a stable but not necessarily asymptomatic condition. As presented in Table 2.2, there was no difference between patient groups with respect to when evaluations took place following entry into the program (poor outcome: mean=19.8 weeks, SD=9.6; good outcome: mean=18.7 weeks, SD=13.0; t=0.33, d.f.=43, p=0.74).

The two social cognitive tests used were the Hinting Task (Corcoran et al., 1995) and Four Factor Tests of Social Intelligence (O'Sullivan & Guilford, 1976). The hinting task tests the ability of subjects to infer the real intentions behind indirect statements. Ten short passages are read to the subject one at a time presenting an interaction between two characters with one of the characters giving a very obvious hint at the end. The examinee must then tell what the character really meant. If the examinee fails, then he/she is asked what one character wants the other one to do.

The Four Factor Tests of Social Intelligence measures the ability to understand thoughts, feelings, and intentions of other people. There are four different

subtests (Cartoon Prediction, Expression Grouping, Social Translation, and Missing Cartoons) of which three use pictorial stimuli (comic strips and drawings) and one employs printed sentences only. Each question is worth one point yielding four distinct scores (one for each subtest) and a global composite score (by summing up the totals of the subtests) of social cognition.

1. The Cartoon Prediction subtest is a 14-item task that measures the ability to predict social consequences, by showing a cartoon strip where the examinee must be able to anticipate the logical sequence of a given social situation, simply by interpreting the cartoon characters' emotional reactions. The examinee must select, from four alternative cartoon frames, the one that most likely follows from an interpersonal situation depicted in the first cartoon frame. A common example involves a strip where a man is holding on to a roof, while a young boy is standing there, watching the scene. The man's facial expression seems to depict fear. The examinee must be able to conceive that the most logical strip would show the boy being helped by a woman who is carrying a ladder with the intention of helping the man come safely down from the roof (Visser, 2006).

2. The Expression Grouping subtest is a 15-item task that involves the ability to abstract common attributes from different expressive images. Each item of the test consists of a group of three pictures representing either facial expression, hand gestures, or body posture, that correspond to a common thought, feeling or intention. To demonstrate a correct understanding of the situation, the participant must select one picture representing the same emotion from four alternatives.

3. The Social Translation subtest is a 12-item task designed to measure the ability to recognize changes in behavioral meaning. Based on the principle that similar expressional cues can be associated with different meanings as a function of different contexts, the examinee must choose one of three possible sentences having a different meaning from the target sentence.

4. Finally, the Missing Cartoons subtest is a 14-item task measuring the ability to consider social context. Each item consists of an incomplete cartoon strip and, after interpreting each scene; the examinee chooses, from four alternatives, the panel that best completes the cartoon strip, giving the story a logical flow.

2.2.4 Statistical Analysis

All clinical characteristics were normally distributed except for duration of untreated psychosis (DUP) and duration of untreated illness (DUI), which were normalized using logarithmic and square root transformations, respectively. A one-way analysis of variance (ANOVA) was used to examine age (at testing) among the three groups. Independent t-tests were used to compare baseline and six-month total symptom ratings, changes in symptom scores, dosage of antipsychotic medication, medication adherence, DUP, DUI, and Premorbid Adjustment Scale (PAS) scores between the patient outcome groups. Parental SES and Education Level among the three groups were contrasted using a Kruskall-Wallis one-way ANOVA. Gender and type of antipsychotic medication were compared using cross tabulation and Chi-square tests. All of the social cognitive variables were normally distributed. All sub-test scores were transformed into standard equivalents (z-scores) using the mean and standard deviation of the healthy control group.

For the present study, we created a social cognition domain by combining all five of the aforementioned subtests that is the Hinting Task and the four subtests of the Four Factor Test of Social Intelligence. A univariate analysis of covariance (ANCOVA) was used to compare the performance of the social cognition domain among the groups, using group membership (poor outcome, good outcome, and control) as the between-group factor, the global social cognition domain as the within-group factor, and parental SES as a covariate. Post-hoc Fisher's LSD was used to identify any group differences. A subsequent and supplementary within-subject multivariate analysis of covariance (MANCOVA) was used to examine the profile of

the five sub-tests among the three groups using group membership as the between-group factor, the five sub-tests as the within-group factors, and parental SES as a covariate. Post-hoc univariate ANCOVAs along with Fisher's LSD were used to identify any group differences. The critical p-value for this analysis was set to 0.01 following the Bonferroni correction procedure to control for multiple comparisons. This analysis would allow us to observe if there were any differences within each of the 5 sub-tests (that made up our social cognitive domain) among the three groups. Finally, for the entire sample, Pearson's chi-square and Spearman's rho (ρ) examined the independence and correlations, respectively, between the sub-tests and symptom levels at the time of the evaluation. Symptom data at the time of social cognitive testing were estimated from the symptom evaluation closest to administration. Additionally, cross tabulation and Chi-square tests were used to examine if there was an effect of the heterogeneous sample on the social cognitive profile. All statistical tests were two-tailed with the critical p-value set at 0.05, except for the MANCOVA, as previously noted, and were performed using the Statistical Package for the Social Sciences version 12 (SPSS, 2003).

2.3 Results

2.3.1 Clinical and demographic data

The statistical analyses did not reveal any significant differences between the poor outcome, good outcome and control groups with respect to age and gender. The level of education of participants did not significantly differ among the experimental groups (good versus poor outcome) but these groups both differed from the control group. However, Table 2.1 shows how parental SES differed between the poor outcome and good outcome groups and the poor outcome and control groups. In light of these differences, this variable was included as a covariate in our analysis. There were no differences in DUP, DUI, overall medication adherence, and the type of antipsychotic taken during social cognitive testing between the outcome groups.

Finally, there were no between-group differences in both positive and negative symptoms at baseline. At six-months, the poor-outcome group displayed significantly higher negative and positive symptoms, as per design. In addition, over the six-month period, improvements in positive and negative symptoms were significantly better for the good outcome group as presented in Table 2.2.

2.3.2 Social cognition data

The univariate ANCOVA revealed mean differences in social cognition among the groups (F=25.51, df=2,67, p<0.001; ES=0.81). Fisher's LSD revealed the poor outcome group functioned at levels significantly below the good outcome group and that both outcome groups functioned significantly below that of the healthy control group (Table 2.3). The MANCOVA revealed the social cognitive profiles among the three groups were not parallel as indicated by the significant [group x sub-test] interaction (F=5.13, df=10,126, p<0.001; ES=0.64; Figure 2.1). There were significant differences among the three groups on all five sub-tests: hinting task (F=7.35, df=2,67, p=0.001; ES=0.47); cartoon prediction (F=13.06, df=2,67, p<0.001; ES=0.63); expression groupings (F=7.99, df=2,67, p=0.001; ES=0.49); social translations (F=17.83, df=2,67, p<0.001; ES=0.73); and, missing cartoons (F=6.43, df=2,67, p=0.003; ES=0.44). The mean performance of the social cognition subtests reveals these significant differences among the groups (Table 2.4). The good and poor outcome group differed the least on the Hinting Task subtest (mean=15.9, SD=2.6; mean=15.3, SD=3.3 respectively) while they were most discrepant on the Cartoon Predictions task (mean=11.6, SD=1.8; mean=9.5, SD=2.8 respectively). Fisher's LSD revealed the poor outcome group performed significantly lower than the good outcome group in only the Cartoon Prediction subtest. Moreover, compared to the healthy controls, the poor outcome group displayed significant deficits on all five sub-tests while the good outcome group displayed significant deficits in only the Hinting Task and Social Translations subtest as shown in Table 2.3. In our previous

study on non-social cognitive domains and short term clinical outcome (Bodnar et al., 2008) we had observed significant group differences on verbal memory and working memory. We conducted those analyses again (ANCOVA & MANCOVA) and then examined social cognitive performance while covarying each of these non-social cognitive domains but our results remained unchanged for all three groups. In particular, the largest group difference on non-social cognitive domain was observed on the working memory measure and as can be seen in Table 2.5, covarying for it did not alter the results.

Finally, the total positive and negative symptoms at the time of testing were independent of all the social cognitive tests (all $\chi2$ values < 356.6, all P values > 0.10) except for positive symptoms and social translations sub-test ($\chi2=195.3$, $p=0.04$); symptoms were not correlated with any of the tests ($-0.25<\rho<0.07$, all P values $>$ 0.10). Chi-square tests revealed no effect of diagnosis on social cognitive tests (all $\chi2$ values < 19.5, all P values > 0.53) and diagnosis was independent of outcome ($\chi2=0.29$, $p=0.87$).

2.4 Discussion

The present study identified a deficit in social cognition as a marker of short-term clinical outcome in first-episode of psychosis (FEP) patients after six months of treatment. We found a significantly lower performance in the poor outcome patients compared to the good outcome patients at baseline; in addition to both outcome groups functioning below that of the control group. This finding adds to our previous report on non-social cognitive domains in which we reported poorer verbal memory and working memory performance were associated with a poor short-term clinical outcome in FEP patients (Bodnar et al., 2008).

Current trends in research, such as the NIMH-MATRICS, have suggested, that as a seventh domain, social cognition should include multiple measures

including: emotional processing, theory of mind, social perception, social knowledge and attributions (Green et al., 2005) making it comparable to the other cognitive domains (Green et al., 2005). Furthermore, the MATRICS committee has made several recommendations, one of which is to use a single-test evaluation (Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) - Managing Emotions) to evaluate overall social cognitive ability. In contrast, the overall social cognitive domain included multiple measures, and the 1-hour evaluation session for this domain is somewhat time- consuming. Moreover, if one of the subtests, which can be administered in about 12 minutes, could have the same predictive ability as the overall domain, it would make more sense to have a shorter session if one is solely interested in predicting outcome. As such, we decided to investigate if a single test was having an overall effect on the domain. Our results suggested that the Cartoon Predictions subtest was the driving force behind the overall effect of the domain; subsequently, leading to a shortened evaluation if the goal was to predict the clinical outcome. Similarly to the recommendations made by the MATRICS, we are suggesting that Cartoon Predictions, which takes no more than 10 minutes to administer, could possibly be used for evaluating a global deficit in social cognition in a time and cost efficient way.

The observed differences between the good and poor outcome groups with respect to the Cartoon Predictions task can be partially explained by the concept of "theory of mind". Social cognitive abilities are comprised of various mental operations, which include perception, interpretation, and processing of social information, to name only a few (Ostrom, 1984). One of the main features of social cognition is "theory of mind" (Premack, 1978), and it is defined as 'the ability to conceptualize other people's beliefs, thoughts and intentions in order to explain and anticipate their behavior (Bertrand et al., 2007). It is believed that the Cartoon Predictions task best embodies the concept of "theory of mind", in that this subtest measures the ability to predict social consequences by interpreting the intention and

feelings of characters. In fact, severe social cognitive impairments in schizophrenia were found to be the best predictor of illness onset compared to nonsocial cognition and were linked to the duration of the illness and more so to "theory of mind" deficits (Brüne, 2005). Considering that our poor outcome group showed severe social cognitive impairments in the Cartoon Prediction task, one could hypothesize that a deficit in "theory of mind" could lead to an earlier onset of illness which would, in turn, have a negative effect on outcome for a sub-group of patients with a poor prognosis.

Our groups did significantly vary on the level of education. Once we further investigated the relationship amongst groups and level of education we found that they were no significant differences between the good and poor outcome group. However, we did find that these two groups significantly differed from the healthy controls on this variable. Although there is well-established association between low level of education and risk for the development of schizophrenia this association is orthogonal to our research question. Indeed, the focus of our study was to look mainly at the possible existence of differences in social cognition performance among first episode psychosis patients who experience short term good or poor outcome. This association could be further explored but the focus of our study was to look at existing differences in patient course of illness and social cognition. The poor outcome group functioned significantly below the healthy control group on all subtests. Although the good outcome group functioned at levels below that of the healthy controls, these groups differed significantly only on two of the subtests: the Hinting Task and Social Translation subtest. This could suggest those who achieve a quicker and more pronounced resolution of symptoms function better and, in some cases, on par with healthy controls, as far as subtests of social cognition are concerned. Although in contrast with our particular result, a previous study demonstrated that people with remitted schizophrenia functioned on par with healthy individuals on the Hinting Task (Corcoran et al., 1995). At any rate, when compared

to healthy controls, the functional impairments on specific subtests may not be equally compromised for all people suffering from psychosis. Although numerous studies have shown significant social cognitive differences between psychotic and control groups (Addington et al., 2006; Bertrand et al., 2008; Corcoran et al., 1995; Williams et al., 2007), these studies did not account for the heterogeneity of outcome within FEP patients (i.e. good vs. poor outcome). Strangely, this did seem to be the case when examining overall social cognition performance (all subtests included). That is, both good and poor outcome groups functioned below that of the healthy controls. However, we must point out that this overall effect was driven by two tasks in particular: the Hinting Task and Social translations subtest. As such, there appears to be heterogeneity of social cognitive functioning within those suffering from psychosis in relation to short-term clinical outcome with respect to individual subtests. Furthermore, even after re-running all of the analyses covarying for the six non-social cognitive domains, which included working memory, did not significantly change our results. As such, it appears safe to conclude that non-social cognition has no significant effect on social cognitive ability in relation to short-term clinical outcome, which was our main variable of study.

The strengths of our study include a well-characterized sample of first-episode psychosis patients. Consistently, the clinic from which the sample derives is a well-established program, which offers a thorough research protocol that includes systematic follow-up assessments and a consistent re-evaluation and validation of diagnosis. Moreover, by using a healthy comparison group, we controlled for possible demographic differences that may occur with comparisons made to normative data. The heterogeneity of our sample, with respect to diagnosis, provided a more efficient research design for an outcome study (Verdoux et al., 2002). This follows from the idea that baseline diagnoses of first episode patients change rather frequently (Schwartz et al., 2000) which could lead to erroneously drawing conclusions towards a specific diagnostic category.

This study has some limitations. From our study, two poor outcome patients refused antipsychotic medications as treatment option. These clients still received the psychosocial intervention and support allocated through the PEPP clinic and the removal of these clients from the sample did not have any effect on our results. Although our size was adequate to detect highly significant group differences, our smaller sample size diminishes the generalization of our results to the general patient population. As such, replication of our results is needed to verify if there is indeed a true effect of social cognition in relation to clinical outcome.

Furthermore, our assessment of cognitive functioning in clinical settings often takes place at times when the patient is in a stable but not necessarily asymptomatic condition. A stable condition can sometimes be achieved within one or two month post-treatment. Based on these latter findings, having some of the patients tested near the sixth month separation time from entering the program to receiving ongoing treatment for a period of over 6 months, we can assume that psychotic symptoms should have very little to no overall effect on our results. Nonetheless, we cannot entirely reject the possibility that psychotic symptomatology may have had an effect on performance of the social cognition tasks. Social cognition may need to be further investigated, and until then we cannot define the extent of how symptoms, time or clinical stability will affect social cognition.

2.5 Conclusions

Both of our studies have indicated that cognition appears to be a reliable marker of short-term clinical outcome following a first episode of psychosis. The present study found that poor social cognition (or more specifically a deficit in the ability to predict social situations) is a marker of poor short-term clinical outcome after six months of treatment; our previous study identified verbal memory and working memory in the same capacity. Taken together, it would appear that specific impairments in either social cognition or non-social cognition, namely verbal

memory, may be useful for identifying a poor prognosis early on in the treatment process following a FEP.

Social cognitive deficits have been hypothesized to affect the clinical outcome of patients by delaying the response to treatment or by impairing the client's motivation to adhere to treatment as prescribed (Malla et al., 2002). Consequently, it would be important to identify a poor outcome earlier on so, as clinicians, we can pay special attention to this specific subgroup and possibly provide more intensive psychosocial interventions and/or introduce alterative antipsychotics earlier on in the treatment process to better benefit a larger proportion of clients. In addition, studies have found evidence between cognitive improvement and better functional outcome suggesting that cognition should be part of the focus during the treatment of schizophrenia (Gold, 2004). If one operates on the basis that social cognitive deficits are linked to short-term clinical outcome, psychosocial interventions should include elements of psychoeducation about the illness, behavior activation to improve motivation, and cognitive remediation in order to improve overall areas of neurocognition in hope of better outcome.

We have attempted to provide evidence that specific deficits in social cognition are possible markers of poor short-term clinical outcome in FEP and that not all patient's show an equal deficit on all social cognitive measures. That is, patients responding to treatment function at levels similar to healthy individuals on particular subtests. Similarly to the MATRICS, the current study identified a single subtest from the social cognition domain, the Cartoon Prediction task, which appears to be useful for identifying a poor outcome in a short 12-minute evaluation session. However, further studies will be needed in the future in order to support the current findings.

Acknowledgements

This study was supported by operating grants from CIHR (#68961) and the Sackler Foundation to Drs. M. Lepage / A.K. Malla. M. Lepage is supported by a salary award from FRSQ. A.K. Malla is supported by the Canada Research Chairs program. We thank the PEPP-Montréal research staff for their help with recruitment and clinical assessments of patients.

References

1. Addington, J., Saeedi, H., & Addington, D. (2005). The course of cognitive functioning in first episode psychosis: changes over time and impact on outcome. Schizophr Res, 78(1), 35-43.

2. Addington, J., Saeedi, H., & Addington, D. (2006). Influence of social perception and social knowledge on cognitive and social functioning in early psychosis. Br J Psychiatry, 189, 373-378.

3. Andreasen, N. C. (1984a). Modified Scale for the Assessment of Negative Symptoms (SANS). Iowa City: University of Iowa.

4. Andreasen, N. C. (1984b). Scale for the Assessment of Positive Symptoms (SAPS). Iowa City: University of Iowa.

5. Bertrand, M. C., Achim, A. M., Harvey, P. O., Sutton, H., Malla, A. K., & Lepage, M. (2008). Structural neural correlates of impairments in social cognition in first episode psychosis. Soc Neurosci, 3(1), 79-88.

6. Bertrand, M. C., Sutton, H., Achim, A. M., Malla, A. K., & Lepage, M. (2007). Social cognitive impairments in first episode psychosis. Schizophr Res, 95(1-3), 124-133. doi: S0920-9964(07)00245-9 [pii]10.1016/j.schres.2007.05.033

7. Bodnar, M., Malla, A., Joober, R., & Lepage, M. (2008). Cognitive markers of short-term clinical outcome in first-episode psychosis. Br J Psychiatry, 193(4), 297-304.

8. Brekke, J., Kay, D. D., Lee, K. S., & Green, M. F. (2005). Biosocial pathways to functional outcome in schizophrenia. Schizophr Res, 80(2-3), 213-225.

9. Brüne, M. (2005). Emotion recognition, 'theory of mind,' and social behavior in schizophrenia. Psychiatry Res, 132(2), 135-147.

10. Cassidy, C., Rabinovitch, M. Joober, R., & Malla, A. (2008). A comparison study of multiple measures of adherence to antipsychotic medication in first episode psychosis. . Schizophrenia Research, 98(1), 81.

11. Corcoran, R., Mercer, G., & Frith, C. D. (1995). Schizophrenia, symptomatology and social inference: investigating "theory of mind" in people with schizophrenia. Schizophr Res, 17(1), 5-13.

12. Corrigan, P. W., & Penn, D. L. (2004). Social Cognition and Schizophrenia. Washington, DC: American Psychological Association.

13. Couture, S. M., Penn, D. L., & Roberts, D. L. (2006). The functional significance of social cognition in schizophrenia: a review. Schizophr Bull, 32 Suppl 1, S44-63.

14. First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1998). Structured Clinical Interview for DSM-IV Axis I Disorders, Patient Edition (SCID-I/P & SCID-I/NP), Version 2. New York: New York Psychiatric Institute, Biometrics Research.

15. Gold, J. M. (2004). Cognitive deficits as treatment targets in schizophrenia. Schizophr Res, 72(1), 21-28.

16. Gold, J. M., & Green, M.F. (2002). Neurocognition in schizophrenia. In S. V. Sadock BJ (Ed.), Kaplan & Sadock's Comprehensive Textbook of Psychiatry (8th ed. ed., pp. 1426-1448). Batimore: Lippincott, Williams & Wilkins.

17. Goldberg, T. E. a. G., M.F. . (2002). Neurocognitive functioning in patients with schizophrenia: An overview. . Neuropsychopharmacology: The Fifth Generation of Progress, 657–669.

18. Green, M. F. (1996). What are the functional consequences of neurocognitive deficits in schizophrenia? Am J Psychiatry, 153(3), 321-330.

19. Green, M. F., Kern, R. S., Braff, D. L., & Mintz, J. (2000). Neurocognitive deficits and functional outcome in schizophrenia: are we measuring the "right stuff"? Schizophr Bull, 26(1), 119-136.

20. Green, M. F., Olivier, B., Crawley, J. N., Penn, D. L., & Silverstein, S. (2005). Social cognition in schizophrenia: recommendations from the measurement and treatment research to improve cognition in schizophrenia new approaches conference. Schizophr Bull, 31(4), 882-887. doi: sbi049 [pii]10.1093/schbul/sbi049

21. Lieberman, J., Jody, D., Geisler, S., Alvir, J., Loebel, A., Szymanski, S., Borenstein, M. (1993). Time course and biologic correlates of treatment response in first-episode schizophrenia. Arch Gen Psychiatry, 50(5), 369-376.

22. Malla, A., Norman, R., McLean, T., Scholten, D., & Townsend, L. (2003). A Canadian programme for early intervention in non-affective psychotic disorders. Aust N Z J Psychiatry, 37(4), 407-413.

23. Malla, A., Norman, R., Schmitz, N., Manchanda, R., Bechard-Evans, L., Takhar, J., & Haricharan, R. (2006). Predictors of rate and time to remission in

first-episode psychosis: a two-year outcome study. Psychol Med, 36(5), 649-658. doi: S0033291706007379 [pii]10.1017/S0033291706007379

24. Malla, A. K., Norman, R. M., Manchanda, R., & Townsend, L. (2002). Symptoms, cognition, treatment adherence and functional outcome in first-episode psychosis. Psychol Med, 32(6), 1109-1119.

25. Miller, D. C. (1991). Handbook for Research Design and Social Measurement, 5th Edition (5th ed.). Newbury Park, CA: Sage Publications.

26. Nuechterlein, K. H., Barch, D. M., Gold, J. M., Goldberg, T. E., Green, M. F., & Heaton, R. K. (2004). Identification of separable cognitive factors in schizophrenia. Schizophr Res, 72(1), 29-39.

27. O'Sullivan, M., & Guilford, J. P. (1976). Four factor tests of social intelligence (behavioral cognition): Manual of instructions and interpretations. Orange, CA: Sheridan Psychological Services, Inc.

28. Ostrom, T. M. (1984). The sovereignty of social cognition. In R. S. W. T. K. Srull (Ed.), Handbook of social cognition (pp. 1-37). Erlbaum: Hillsdale.

29. Penn, D. L., Corrigan, P. W., Bentall, R. P., Racenstein, J. M., & Newman, L. (1997). Social cognition in schizophrenia. Psychol Bull, 121(1), 114-132.

30. Premack, D., & Woodruff, G. . (1978). Chimpanzee problem-solving: a test for comprehension. Science, 202, 532-535.

31. Rosen, K., & Garety, P. (2005). Predicting recovery from schizophrenia: a retrospective comparison of characteristics at onset of people with single and multiple episodes. Schizophr Bull, 31(3), 735-750.

32. Rubinsztein, J., Michael, A., Paykel, E.S., & Sahakian, J. (2000). Cognitive impairment in remission in bipolar affective disorder. . Psychol Med, 30 1025–1036.

33. Schwartz, J. E., Fennig, S., Tanenberg-Karant, M., Carlson, G., Craig, T., Galambos, N., Bromet, E. J. (2000). Congruence of diagnoses 2 years after a first-admission diagnosis of psychosis. Arch Gen Psychiatry, 57(6), 593-600.

34. SPSS. (2003). SPSS for Windows, Release 12.0.1. Chicago, IL: SPSS.

35. Verdoux, H., Liraud, F., Assens, F., Abalan, F., & van Os, J. (2002). Social and clinical consequences of cognitive deficits in early psychosis: a two-year follow-up study of first-admitted patients. Schizophr Res, 56(1-2), 149-159.

36. Visser, B. A., Ashton, M.C., & Vernon, P.A. (2006). Beyond g : Putting multiple intelligences theory to the test. . Intelligence, 34(5), 487-502.

37. Williams, L. M., Whitford, T. J., Flynn, G., Wong, W., Liddell, B. J., Silverstein, S., Gordon, E. (2007). General and social cognition in first episode schizophrenia: Identification of separable factors and prediction of functional outcome using the IntegNeuro test battery. Schizophr Res, 99(1), 182-191.

TABLE 2.1
Socio-demographic data of poor-outcome, good-outcome, and healthy control groups

	Poor Outcome (n=27)	Good Outcome (n=18)	Healthy Controls (n=26)	Analysis		
				Statistic	df	*p*-value
Age (years)	23.5 ± 3.7	23.9 ± 3.0	24.7 ± 3.6	F=0.81	2, 68	0.45
Parental SES [a]	3.8 ± 1.1	2.9 ± 1.4	3.2 ± 1.0	χ^2=6.82	2	0.03*
Gender (M/F)	19/8	12/6	14/12	χ^2=1.67	2	0.43
Education [b]	11.6 ± 2.8	12.2 ± 2.5	14.4 ± 1.7	F=10.01	2, 68	<0.001*

* significant at 0.05 level

[a] Hollingshead Socio-Economic Status (1=highest and 5=lowest); data was not available for all patients. Mann-Whitney *post-hoc* analyses revealed: poor > good (p=0.03), poor < control (p=0.03), good = control (p=0.52).

[b] Tukey HSD *post-hoc* analyses revealed: poor = good (p=0.68), poor < control (p<0.001), good < control (p=0.01).

TABLE 2.2

Characteristics and global symptom ratings of poor-outcome and good-outcome groups. Number of participants included (n) for each variable where different from sample.

	Poor Outcome (n=27)	Good Outcome (n=18)	Analysis		
			Statistic	d.f.	P
DUP (weeks) [a]	38.3 ± 44.3	93.7 ± 148.2	t=-1.27	43	0.21
median (weeks)					
DUI (weeks) [a]	277.4 ± 250.2	295.3 ± 260.3	t=-0.24	43	0.81
median (weeks)					
Antipsychotic at Testing (mg/day)			χ^2=5.31	5	0.38
Olanzapine	11.8 ± 5.0 (n=11)	10.9 ± 8.0 (n=7)	t=0.40	16	0.77
Risperidone	2.3 ± 0.8 (n=9)	1.5 ± 0.8 (n=5)	t=1.80	12	0.10
Quetiapine	350.0 ± 173.2 (n=5)	775 (n=1)	t=-2.24	4	0.90
Risperidone-Injected	(n=0)	25.0 (n=1)	n/a		
Haloperidol	(n=0)	1.5 (n=1)	n/a		
None	(n=2)	(n=3)	n/a		
Medication Adherence [b]	3.2 ± 1.0	3.5 ± 0.8 (n=16)	t=-1.04	41	0.31
SAPS Total					
Baseline	28.9 ± 16.6	35.1 ± 17.6	t=-1.20	43	0.24
Six-Month	12.1 ± 11.8	1.7 ± 2.8	t=3.66	43	0.001*
Change	16.8 ± 12.4	33.4 ± 17.4	t=-3.75	43	0.001*
SANS Total					
Baseline	28.3 ± 13.6	27.4 ± 13.3	t=0.22	43	0.83
Six-Month	25.3 ± 11.1	14.5 ± 18.7	t=2.44	43	0.02*
Change	3.0 ± 13.2	12.9 ± 17.4	t=-2.18	43	0.04*

Abbreviations: DUP, duration of untreated psychosis; DUI, duration of untreated illness; SAPS, Scale for the Assessment of Positive Symptoms; SANS, Scale for the Assessment of Negative Symptoms

* significant at 0.05 level

[a] DUP and DUI are presented in raw form; however these were analyzed using transformed data.

[b] Medication adherence average over six months: 0 (never adherent) to 4 (always adherent.

TABLE 2.3

Z-scores (mean, SD, and range) and between-group comparisons of social cognitive tests among good-outcome, poor-outcome, and healthy control groups

	Poor Outcome			Good Outcome			Healthy Controls			Fisher's LSD Comparisons		
										Good vs. Poor	Poor vs. Control	Good vs. Control
	Mean	SD	Range	Mean	SD	Range	Mean	SD	Range			
Overall Social Cognition	-2.0	1.4	-5.0 – 0.8	-1.0	1.0	-3.3 – 0.4	0.0	1.0	-0.8 – 1.0	0.005*	<0.001*	0.003*
Hinting Task	-1.9	2.2	-6.8 – 0.7	-1.5	1.8	-6.1 – 1.3	0.0	1.0	-2.0 – 1.3	0.615	0.001**	0.007**
Four Factor Social Intelligence												
Cartoon Prediction	-2.7	2.7	-9.8 – 1.5	-0.7	1.8	-5.1 – 1.5	0.0	1.0	-2.2 – 1.5	0.001**	<0.001**	0.251
Expression Groupings	-1.5	1.8	-5.1 – 2.2	-0.6	0.8	-2.0 – 1.0	0.0	1.0	-2.0 – 2.2	0.036	<0.001**	0.148
Social Translation	-2.7	2.1	-6.5 – 0.6	-1.7	1.5	-4.9 – 0.6	0.0	1.0	-1.8 – 1.4	0.048	<0.001**	0.001**
Missing Cartoon	-1.3	1.3	-3.5 – 1.9	-0.7	1.6	-3.1 – 1.9	0.0	1.0	-2.2 – 1.9	0.122	0.001**	0.097

* *p*-value significant at 0.05.

** *p*-value significant at 0.01 (0.05/5 – corrected for multiple comparisons).

TABLE 2.4

Raw data of social cognitive tests for poor outcome patients, good outcome patients, and healthy control groups.

	Poor Outcome			Good Outcome			Healthy Controls		
	Mean	SD	Range	Mean	SD	Range	Mean	SD	Range
Hinting Task (max 20)	15.3	3.3	8 – 19	15.9	2.6	9 – 20	18.0	1.5	15 – 20
Cartoon Prediction (max 14)	9.5	2.8	2 – 14	11.6	1.8	7 – 14	12.4	1.1	10 – 14
Expression Groupings (max 15)	6.9	2.9	1 – 13	8.3	1.4	6 – 11	9.4	1.6	6 – 13
Social Translation (max 12)	6.8	2.7	2 – 11	8.1	1.9	4 – 11	10.3	1.3	8 – 12
Missing Cartoon (max 14)	5.9	3.0	1 – 13	7.3	3.5	2 – 13	8.8	2.2	4 – 13

TABLE 2.5

P-values of the different group comparisons for the global measure of social cognition and for the different sub-tests. The 'original' columns denotes the p-values observed for the group comparison whereas the 'p with WM' denotes the p-value for the same group comparison after covarying for working memory performance.

	Good vs. Poor		Poor vs. Control		Good vs. Control	
	Original *p*	*p* with WM	Original *p*	*p* with WM	Original *p*	*p* with WM
Social Cognition Domain (average of 5 sub-tests)	0.005*	0.007*	<0.001*	<0.001*	0.003*	0.007*
Sub-tests						
Hinting Task	0.615	0.715	0.001**	0.004**	0.007**	0.017
Cartoon Prediction	0.001**	0.002**	<0.001**	<0.001**	0.251	0.470
Expression Groupings	0.036	0.084	<0.001**	0.002**	0.148	0.198
Social Translation	0.048	0.518	<0.001**	<0.001**	0.001**	0.003**
Missing Cartoon	0.122	0.412	0.001**	0.008**	0.097	0.168

* *p*-value significant at 0.05.

** *p*-value significant at 0.01 (0.05/5 – corrected for multiple comparisons).

Figure Legends

Results are displayed in z-scores with healthy controls defined with a mean of 0 and SD of 1. Error bars are equal to SD.

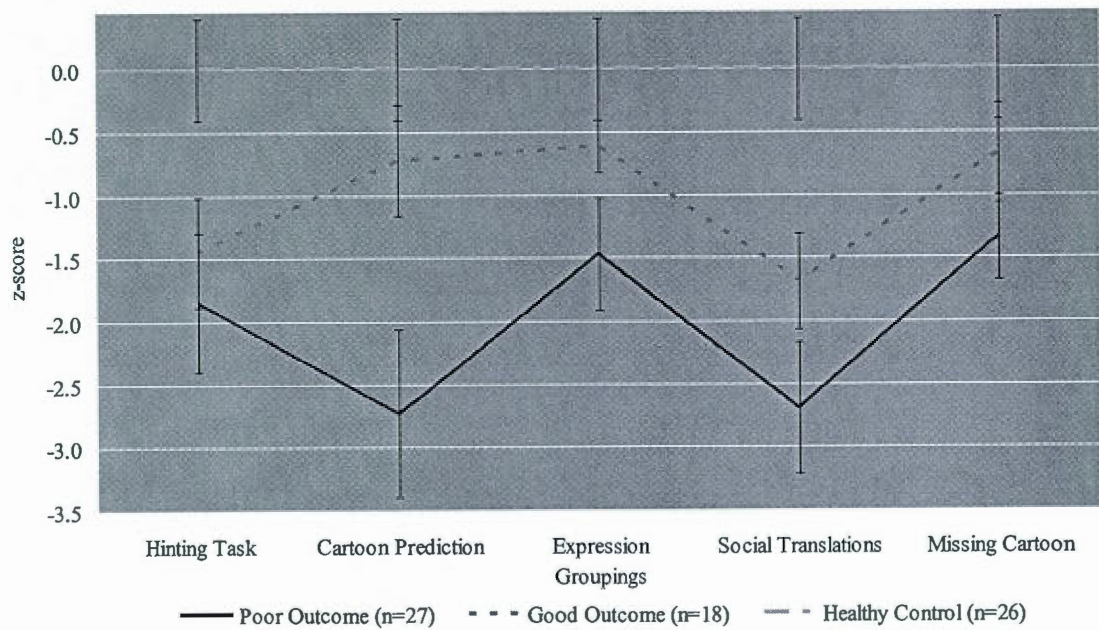


FIGURE 2.1 Social cognitive profile of poor-outcome, good-outcome, and healthy controls.

CHAPTER III

STUDY TWO

Reference:

Montreuil, T., Malla, A., Joober, R., Bélanger, C., & Lepage, M. (2013). Anxiety symptoms severity and short-term clinical outcome in first-episode psychosis. Early Intervention in Psychiatry, 7(1), 5-11.

CHAPTER III

STUDY II - ANXIETY SYMPTOMS SEVERITY AND SHORT-TERM CLINICAL OUTCOME IN FIRST-EPISODE PSYCHOSIS

Abstract

Objective: In psychotic disorders, a limited number of studies have documented the presence of symptoms of anxiety, especially in FEP. There is a growing interest in better understanding how these symptoms may affect the severity of psychotic symptoms and clinical outcome. This study examined the association between symptoms of anxiety, as measured by the HARS and the PANSS, and short-term clinical outcome. We first examined the potential association between anxiety symptom severity among FEP patients and remission. A secondary objective explored the relation between the PANSS single item subscale 'anxiety' item and the total score value of the HARS. Method: Data were collected on 201 FEP patients divided into remitted and unremitted groups based on clinical data at six months. Anxiety ratings were compared between 67 remitted and 99 unremitted patients with the HARS, and for 72 remitted and 103 unremitted patients with the (G2) PANSS. Results: A significant interaction Time X Group was observed on the HARS and on the PANSS G2 item. Looking at the two time points specifically, groups did not significantly differ at baseline on either the HARS or the PANSS. At six-months, these two groups, were significantly different on both anxiety rating scores – HARS [$t(170) = 3.48$, $p=.001$)] and PANSS G2 [$t(173) = 2.51$, $p=.013$)]. Conclusion: Anxiety severity is marked in FEP, and appears to be linked to poor short-term

clinical outcome. The PANSS single item (G2) seems to represent a good indicator of anxiety as it significantly correlated with a more systematic measure of anxiety namely the HARS score. Anxiety severity appears to vary across diagnosis-type.

Keywords: anxiety, symptom-severity, clinical outcome, remission, first-episode psychosis

3.1 Introduction

There is an increased recognition of the deleterious impact of the presence of anxiety symptoms in people suffering from schizophrenia. Several studies have indeed reported the presence of comorbid anxiety disorders in people with schizophrenia (Achim, Maziade, Raymond et al., 2009; McMillan, Enns, Cox et al., 2009). However, the exact nature of the role of this comorbid symptomatology on the remission of psychotic symptoms remains unclear. Furthermore, little is known about the presence of anxiety symptoms in first episode psychosis (FEP) patients. Currently, there is a need to determine to what extent anxiety symptoms decrease with antipsychotic treatment and to better understand the association between anxiety symptoms and early clinical remission in FEP.

In a systematic review of the fifty-two published studies, Achim et al. (2009) reported that the pooled prevalence rate of anxiety disorders in schizophrenia averaged 12.1% for obsessive-compulsive disorders, 14.9% for social phobia, 10.9% for generalized anxiety disorders, 9.8% for panic disorders, and 12.4% for post-traumatic stress disorders. Likewise, a national comorbidity survey in the United States found that the lifetime comorbidity of any anxiety disorder is 71% among subjects diagnosed as suffering from non-affective psychosis (Kendler, Gallagher, Abelson et al., 1996). Others found that the total lifetime frequency of hospitalized schizophrenia spectrum disorder patients with a psychiatric comorbidity was close to 58% (Cassano, Pini, Saettoni et al., 1998). All studies share a common ground; over half of patients suffering from a severe mental illness, the co-occurring disorders appear to impact the ability to adjust to treatment, the course, and outcome of the illness. Tarrier (2010) in a recent paper suggested that there is a need for new practical techniques and theoretical understanding of comorbid conditions in schizophrenia as they can negatively affect remission.

Short-term clinical outcome is defined as symptomatic remission of both positive and negative symptoms. Andreasen et al., (Andreasen, Carpenter, Kane et al., 2005) consensually defined remission as intensity rating of mild or less on all eight cardinal symptoms including delusions, hallucinations, positive formal thought disorder, disorganized behavior; affective flattening, avolition – apathy, anhedonia – asociality, alogia. In addition the absence or mild presence of some of those symptoms need to be sustained for a period of at least six months for a patient to be considered in remission. Recent work from our group has shown that a 3-month temporal criterion for remission is as highly predictive of functional outcome as is six months (Cassidy, Rabinovitch, Joober et al., 2010).

Several factors have been shown to relate to early remission and clinical outcome in FEP. We have already established that several factors are significantly associated with short-term clinical outcome such as cognitive deficits especially verbal memory (Bodnar, Malla, Joober et al., 2008); social cognition (Montreuil, Bodnar, Bertrand et al. 2010); treatment adherence (Malla, Norman, Schmitz et al., 2006; Corriss, Smith, Hull et al., 1999); structural brain measures, including hippocampal and parahippocampal volumes (Bodnar, Malla, Czechowska et al., 2010; Bodnar, Harvey, Malla et al., 2011), and white matter tracks integrity (Luck, Buchy, Czechowska et al., 2011). The presence of symptoms of anxiety has, however, not been systematically examined in relation to early clinical outcome in this population.

The primary objective of the present study was to establish a link between the severity of anxiety symptomatology and early remission in FEP patients. We hypothesized that among the FEP patients, the severity of anxiety symptomatology would be linked to the remission of psychotic and negative symptoms. In other words, patients who would have attained remission, as previously defined, will have lower anxiety ratings. A secondary objective examined whether the Positive and

Negative Syndrome Scale (PANSS) 'anxiety' item (G2) which represents a very brief measure of anxiety could nonetheless be used as a significant probe value to the total score value of the Hamilton Anxiety Rating Scale (HARS) (Hamilton, 1969) and therefore represent a valid, time-and-cost efficient indicator of anxiety in schizophrenia.

3.2 Methods

3.2.1 Criteria for program admission

The PEPP-Montreal's admission criteria include that patients are aged between 14– 35 years; have residence in the local catchment area; that symptoms meet syndromal criteria for a DSM-IV psychotic disorder that would have been present for at least the duration of a week; and have not received pharmacological therapy (antipsychotics) for a longer than one month. Prompt access (48 – 72 hours) to the program was provided upon receiving the referrals from various sources (family relative, guidance counselors, medical health provider / practitioner). There is no competing service and treatment is publicly funded.

3.2.2 Treatment protocol

The program involves a comprehensive approach with intensive medical and psychosocial management. The treatment program at PEPP includes care continuity for all patients by providing modified assertive case management and interventions to assist the patients in the recovery process by specifically addressing the needs of this younger treatment-naïve population (for details see (Malla, Norman, McLean et al., 2003)).

3.2.3 Participants

Data was collected over a period of four years. During this time frame, the

program recruited 198 referred active patients, and from this number there remained 175 participants. As part of their participation within the program, these patients had completed a symptom-evaluation that included ratings on the PANSS scale at baseline and six-months. For the same time points 9 subjects had missing data on HARS resulting in a sample of 166. The entire sample (N=175) was subsequently separated into remitted (n=72) and unremitted (n=103) groups for the purpose of analysis using (G2) PANSS. Respective numbers of remitted and unremitted for analysis using HARS were 67 and 99.

As per an earlier report, remission was defined using the 8-item PANSS remission criteria as proposed by Andreasen et al. (Andreasen, Carpenter, Kane et al., 2005; Andreasen, 1984a, b), which includes: P1 – Delusions; P2 – Conceptual Disorganization; P3 – Hallucinatory Behavior; N1 – Blunted Affect; N4 – Passive/Apathetic Social Withdrawal; N6 – Lack of Spontaneity and Flow of Conversation; G5 – Mannerisms and Posturing; and G9 – Unusual Thought Content). A score of less than or equal to 3 (mild) on the eight key items of the PANSS based on the remission operational criteria (Andreasen, Carpenter, Kane et al., 2005), would be required in order to be included as part of the "remitted" group. After a comprehensive description of the study, written informed consent was obtained from all participants as part of the treatment protocol received at the PEPP clinic. The Douglas Mental Health University Institute review board approved the research protocols.

3.2.4 Symptom and demographic assessments

Trained research personnel performed all of the evaluations for diagnosis and symptom evaluations. The research staff that performed the symptom ratings had received extensive training and supervision with reliability measured at least once a year (ICC=0.79 for PANSS). All patients who were assessed by research personnel first received a diagnosis according to the criteria which are based on the Structured

Clinical Interview for DSM-IV (First, Spitzer, Gibbon et al., 1998) within one month-entry into the program. This diagnosis was then validated through consensus between two senior research psychiatrists (A.M. & R.J). This initial evaluation is considered as the baseline assessment. Following the initial assessment, once consensus by psychiatrists is reached, diagnosis according to DSM-IV codification is assigned to each patient. Baseline interview sessions were conducted within one month of entry into the program (mean=23.4 days, SD=8.6 days, range=4.8-46.2 days). Symptom ratings were repeated monthly until the sixth month and then again at nine months, and twelve months later. The full details regarding the definition of these variables are available in one of our previous study (Bodnar, Malla, Joober et al., 2008). Remission was measured on a monthly basis using the PANSS scale (Andreasen, Carpenter, Kane et al., 2005) from baseline to six months. The PANSS is a widely used scale used for measuring positive and negative symptoms severity along with general psychopathology in schizophrenia and other psychoses and for ascertaining remission. The scale has seven positive-symptom items, seven negative-symptom items as well as 16 general psychopathology symptom items where each item is scored on a seven-point severity scale. More specifically, change in psychotic and negative symptoms were assessed using the total rating score for both the positive and negative scales of the PANSS. Duration of untreated psychosis (DUP) was calculated as the time period from onset of psychotic symptoms to adequate treatment with antipsychotics, while duration of untreated illness (DUI) was defined as the time period from onset of any psychiatric symptoms to adequate treatment with antipsychotics. At baseline, DUP and DUI were calculated based on these definitions using a semi-structured interview, the Circumstances of Onset and Relapse Schedule (Norman, Malla, Verdi et al., 2004).

3.2.5 Anxiety measures

Anxiety was assessed using the HARS (Hamilton, 1969). The Hamilton

Anxiety Rating Scale (HARS) is the most commonly used semi-structured assessment instrument in anxiety treatment outcome studies. The HARS is comprised of 14 items and it was initially designed for patients who received a diagnosis of anxiety neuroses (Hamilton, 1969). Each 5-point scale item is clinician rated. Total score, calculated from adding all item scores ranges from 0 to 70. The reported inter-rater reliability for the HARS total score is of .74 (Shear, Vander Bilt, Rucci et al., 2001). In addition, anxiety was also measured using the "general psychopathology" item on the PANSS scale, (G2) – Anxiety (Kay, Fiszbein & Opler, 1987), where the evaluator rates the patient's ascertained symptoms on the basis of verbal reports made during the course of the interview and corresponding physical manifestations (e.g. "Subjective experience of nervousness, worry, apprehension, or restlessness, ranging from excessive concern about the present or future to feelings of panic"). There was no difference between patient groups with respect to time since entry into the program to the time of the evaluations (unremitted: mean=19.8 weeks, SD=9.6; remitted: mean=18.7 weeks, SD=13.0; t=0.33, d.f. =43, p=0.74). Measures of anxiety were compared between unremitted and remitted participants for the PANSS item G2 and the HARS total score.

3.2.6 Statistical Analyses

Independent t-tests were used to compare baseline and 6-month total symptom ratings (PANSS), changes in symptom scores, DUP, DUI, age of entry and total Premorbid Adjustment Scale scores (PAS) between the outcome groups (remitted and unremitted). Gender and education were compared using cross-tabulation and chi-squared tests. For the purpose of statistical group comparison between the unremitted and remitted participants, the various diagnoses of psychosis were clustered within three categories (schizophrenia spectrum disorder (SSD), schizoaffective disorder (AFF) and psychosis NOS).

Repeated measures (ANCOVA) were performed for both measures of anxiety (HARS and (G2) PANSS) at baseline and 6 months in order to examine differences in anxiety ratings between groups (remitted versus unremitted) over time. Age of entry and the total PAS score were entered as covariates. We performed simple effects analyses to examine if there were any significant group differences between the two time points. These analyses were performed for both the HARS total ratings as well as for the single item (G2) PANSS scores. All analyses were two-tailed with the critical p-value set at 0.05, and were performed using the Statistical Package for the Social Sciences version 18 (Norman & Malla, 1994).

3.3 Results

3.3.1 Clinical and demographic data

From our original sample, (n=117 (67%); poor outcome=78; good outcome=39), individuals were diagnosed with schizophrenia-spectrum disorder; (n=36 (21%) with affective psychosis; poor outcome=14; good outcome=22), and psychosis not otherwise specified/delusional disorder (n=22 (12%); poor outcome=11; good outcome=11). Clinical characteristics were normally distributed with the exception of duration of untreated psychosis and duration of untreated illness, which were normalised using logarithmic and square root transformations, respectively. For the present study, Table 3.1 presents the statistical analyses using independent t-tests which revealed significant differences between the unremitted and remitted groups with respect to age of entry and PAS. However, the repeated measures (ANCOVA) analyses revealed that these interactions were no longer significant, when examining the main effect between anxiety severity measures for both the HARS total score and PANSS (G2) item and group membership (unremitted and remitted).

Between outcome groups, there were no significant differences in overall duration of untreated psychosis (DUP), duration of untreated illness (DUI) scores or level of both positive and negative symptoms at baseline. However, at six-months, based on the PANSS total rating scores for both the positive and negative scales, the unremitted group displayed significantly higher positive and negative symptoms, as per design (Table 3.1). These symptomatic differences reveal that change over time is significant for both negative and positive symptoms.

3.3.2 Anxiety data

3.3.2.1 HARS

A repeated measure ANCOVA revealed a non significant main effect of Group (remitted versus unremitted) [$F(1,164) = 1.62$, $p = .206$]. However, both the main effect of Time and the Interaction between Group and Time were significant with respective values of [$F(1,164) = 83.19$, $p = .001$ and [$F(1,164) = 6.91$, $p = .009$]. Although simple effects analyses revealed no significant group differences at baseline [$t(192) = -.59$, $p = .550$], at six months, a significant difference between the remitted and the unremitted groups in HARS rating was observed [$t(170) = 3.48$, $p = .001$] with the unremitted group displaying higher anxiety ratings.

3.3.2.2 PANSS (G2)

Similar to the main group effect based on the HARS total rating score, the repeated measure ANCOVA also revealed that there was no significant main effect of Group [$F(1,173) = .45$, $p = .503$]. When examining anxiety-severity ratings, our results also revealed a significant main effect of Time [$F(1,173) = 97.09$, $p = .001$] as well as a significant Interaction between the two variables [$F(1,173) = 9.46$, $p = .002$]. Simple effects analyses revealed no significant group differences at baseline [$t(173) = -1.34$, $p = .181$] but at six-months, the groups differed significantly [$t(173) = 2.51$, $p = .013$] with the unremitted group displaying higher anxiety ratings. Figure 3.1

illustrates the HARS and PANSS G2 scores obtained in both remitted and non-remitted group as a function of time of assessment.

3.3.3 Group differences across diagnosis

Additional analyses were completed in order to rule out the possibility that the reported main group differences may be attributable to variability in the diagnosis of psychosis. Upon completing a MannWhitney U test, Table 3.1 shows that group differences between diagnostic categories (e.g. schizophrenia spectrum disorders (SSD), schizoaffective disorders (AFF), schizophrenia NOS) were found between the unremitted and remitted groups [$\chi 2$ (2, N = 175) = 9.587, p = .008)].

3.4 Discussion

The focus of the present study was to examine the impact of anxiety on short-term clinical remission in people with a first episode of psychosis. Results indicated that there were no significant differences between unremitted and remitted groups on anxiety scores at baseline. However, at six-months, significant anxiety score improvements are seen in the remitted group as criteria for remission are also met. Our analysis supported our initial hypothesis that patients who have reached remission of positive and negative symptoms at month six (i.e. remitted group) have lower ratings of anxiety. These findings support the notion that the co-occurrence of anxiety in FEP, also appears to be linked to not achieving remission when comparing course of illness from baseline to six months. However, further analyses could not rule out the possibility that these group differences may vary across diagnosis. This is consistent with the previously reported finding that psychotic symptoms are associated with anxiety and depression concurrently and over time in schizophrenia (Lysaker, Yanos, Outcalt et al., 2010). When it comes to clinical remission, our results suggest that presence and severity of anxiety symptoms is an important factor for achieving short-term clinical remission or not. Hence, it follows that intervention

targeting anxiety symptomatology could potentially promote clinical remission for positive and negative symptoms. This finding becomes increasingly relevant in light of the fact that anxiety severity has been associated to social functional impairments as well as increased risk of relapse (Penn, Guynan, Daily et al., 1994). Given that group differences (remitted versus unremitted) for anxiety ratings were only noticeable at baseline, another possible explanation could be that resolution of anxiety is part of remission and it may reflect a concurrent association of anxiety and depression with positive symptoms, which have been previously reported in schizophrenia (Jones, Rodgers, Murray et al., 1994). Future studies should look at whether symptom-severity in anxiety is associated with variations in functional outcome especially in patients who have remitted from their psychotic and negative symptoms.

In addition, the PANSS single item subscale 'anxiety' item (G2) seems to represent a heuristically useful indicator or "probe value" of anxiety. Indeed, our analyses revealed that like the HARS total rating score base on 14 items, the single PANSS item G2 similarly yielded the same significant interaction between our variables of interest. However, given the multifaceted structure of anxiety, a multi-item questionnaire may provide greater hindsight into the severity and specificity of symptoms. The G2 item, as a probe value, should be used as a preliminary indicator that a more thorough assessment of anxiety may be required.

The present study design cannot be used to determine or propose an explanatory model for the existing interaction between the presence of co-occurring anxiety symptoms in schizophrenia and remission. In addition, one limit of this study is that we were not able to validate whether anxiety symptom-severity accounts for the measured group differences independently of diagnostic-type. This is in part due to limitations regarding the assessment of anxiety symptomatology. Future studies should include more thorough evaluations of the severity of anxiety symptoms.

However, the results of the present study suggest that co-morbidity of anxiety should increasingly become the focus of future studies as others have reported a higher prevalence of anxiety in schizophrenia patients than in non-psychiatric controls (Norman, Malla, Verdi et al., 2004). This points out the specific need for further investigation in the existing relationship of comorbid anxiety in FEP. Although they embody very distinct features, psychosis and anxiety may in fact share some commonalities. Future studies will be necessary for the determination of the true nature of the interaction that exists between these two diagnostic categories. Such research on the co-morbidity of anxiety and schizophrenia, especially in first-episode psychosis, is likely to be of clinical value since schizophrenia patients with co-morbid anxiety spectrum symptoms show impaired social functioning as well as an increased risk for relapse, or conversely, impaired social functioning might predict the future development of schizophrenia as some early studies have shown (Jones, Rodgers, Murray et al., 1994).

In conclusion, our results provide further evidence that the presence of anxiety in schizophrenia is of clinical relevance and the role of co-morbid anxiety needs to be specifically examined among individuals in first-episode psychosis. The current findings highlight that from the onset of illness, in selecting treatment approaches, clinicians may be well advised to consider potential co-morbidity of anxiety symptoms in order to improve the probability of remission. Our findings also suggest the value of ratings of single items such as, the G2 PANSS item as a possible indicator of co-morbid anxiety. In addition, it future research could examine how treating more specific types of anxiety, such as social anxiety, may affect the course of positive and negative symptomatology, thereby affecting functional outcome.

References

1. Achim, A. M., Maziade, M., Raymond, E., Olivier, D., Mérette, C., & Roy, M.-A. (2009). How Prevalent Are Anxiety Disorders in Schizophrenia? A Meta-Analysis and Critical Review on a Significant Association. Schizophrenia Bulletin, 37(4), 1-11.

2. McMillan, K. A., Enns, M. W., Cox, B. J., & Jitender, S. (2009). Comorbidity of Axis I and II Mental Disorders With Schizophrenia and Psychotic Disorders: Findings From the National Epidemiologic Survey on Alcohol and Related Conditions. Canadian Journal of Psychiatry, 54(7), 477–486.

3. Kendler, K. S., Gallagher, T. J., Abelson, J. M., & Kessler, R. C. (1996). Lifetime prevalence, demographic risk factors, and diagnostic validity of nonaffective psychosis as assessed in a US community sample. The National Comorbidity Survey. Arch Gen Psychiatry, 53(11), 1022-1031.

4. Cassano, G. B., Pini, S., Saettoni, M., Rucci, P., & Dell'Osso, L. (1998). Occurrence and clinical correlates of psychiatric comorbidity in patients with psychotic disorders. J Clin Psychiatry, 59(2), 60-68.

5. Tarrier N. (2010). Cognitive behavior therapy for schizophrenia and psychosis: current status and future directions. Clin Schizophr Relat Psychoses, 4, 176–184.

6. Andreasen, N.C., Carpenter, W.T. Jr, Kane, J.M., Lasser, R.A., Marder, S.R., Weinberger, D.R. (2005). Remission in schizophrenia: proposed criteria and rationale for consensus. Am J Psychiatry, 162(3), 441-449.

7. Cassidy C, Rabinovitch, M. Joober, R., & Malla, A. (2010). A comparison study of multiple measures of adherence to antipsychotic medication in first episode psychosis. J Clin Psychopharmacol, 30, 64–67.

8. Bodnar, M., Malla, A., Joober, R., & Lepage, M. (2008). Cognitive markers of short-term clinical outcome in first-episode psychosis. Br J Psychiatry, 193(4), 297-304.

9. Montreuil T., Bodnar M., Bertrand M.C., Malla A., Joober R., Lepage M. Social cognitive markers of short-term clinical outcome in first-episode psychosis, Clin Schizophr Relat Psychoses 2010 Jul; 4(2): 105-114.

10. Malla, A., Norman, R., Schmitz, N., Manchanda, R., Bechard-Evans, L., Takhar, J., et al. (2006). Predictors of rate and time to remission in first-episode psychosis: a two-year outcome study. Psychol Med, 36(5), 649-658.

11. Corriss, D.J., Smith, T.E., Hull, J.W, Lim, R.W., Pratt, S.I., & Romanelli, S. (1999). Interactive risk factors for treatment adherence in a chronic psychotic disorders population. Psychiatry Res, 89, 269–274.

12. Bodnar M., Malla A., Czechowska Y., Benoit A., Fathalli F., Joober R., Pruessner M., Pruessner J., Lepage M. (2010). Neural markers of remission in first-episode schizophrenia: a volumetric neuroimaging study of the hippocampus and amygdala, Schizophr Res, 122(1-3), 72-80.

13. Bodnar M., Harvey P.O., Malla A., Joober R., Lepage M. (2011). The parahippocampal gyrus as a neural marker of early remission in first-episode psychosis: a voxel-based morphometry study, Clin Schizophr Relat Psychoses, 4(1), 217-228.

14. Luck D., Buchy L., Czechowska Y., Bodnar M., Pike G.B., Campbell J.S., Achim A., Malla A., Joober R., Lepage M. (2011). Fronto-temporal disconnectivity and clinical short-term outcome in first episode psychosis: a DTI-tractography study, J Psychiatr Res, 45(3), 369-377.

15. Hamilton, M. (1969). A. Diagnosis and rating of anxiety, Br. J. Psychiatry Special Publication, 3, 76–79.

16. Malla, A., Norman, R., McLean, T., Scholten, D., & Townsend, L. (2003). A Canadian programme for early intervention in non-affective psychotic disorders. Aust N Z J Psychiatry, 37(4), 407-413.

17. Andreasen, N. C. (1984). Modified scale for the assessment of Negative Symptoms (SANS). Iowa City: University of Iowa.

18. Andreasen, N. C. (1984). Scale for the assessment of positive symptoms (SAPS). Iowa City: University of Iowa.

19. Shear, K., Vander Bilt, J., Rucci, P. D., Endicott, J., Lydiard, B., Otto, M. W., Pollack, M.H., Chandler, L., Williams, J., Ali, A., & Frank, D. M. (2001). Reliability and validity of a structured interview guide for the Hamilton Anxiety Rating Scale(SIGH-A). Depression and Anxiety, 13(4), 166-178.

20. Kay, S., Fiszbein, A., Opler, L. (1987). The Positive and Negative Syndrome Scale (PANSS) for Schizophrenia. Schizophrenia Bulletin, 13(2), 261-276.

21. SPSS (2010). SPSS for Windows, Release 12.0.1. Chicago, IL: SPSS.

22. Norman, R. M., & Malla, A. K. (1994). Correlations over time between dysphoric mood and symptomatology in schizophrenia. Comprehensive Psychiatry, 35, 34–38.

23. Lysaker PH, Yanos PT, Outcalt J & Roe D. (2010). Association of stigma, self esteem, negative symptoms and emotional discomfort with concurrent and prospective assessment of social anxiety in schizophrenia spectrum disorders. Clinical Schizophrenia and Related Psychoses, 4(1), 41-49.

24. Penn DL, Guynan K, Daily, T, Spaulding WD, Garbin CP, and Sullivan M. (1994). Dispelling the stigma of schizophrenia: What sort of information is best? Schizophrenia Bulletin, 20, 567-578.

25. Norman RMG, Malla AK, Verdi MB, Hassall LD, and Fazekas C. (2004). Understanding delay in treatment for first episode psychosis. Psychological Medicine, 34, 255-266.

26. Norman RMG, & Malla AK. (1994). A prospective study of daily stressors and symptomatology in schizophrenic patients. Social Psychiatry and Psychiatric Epidemiology, 29 (6), 244-249.

27. Jones P, Rodgers B, Murray R, Marmot M. (1994). Child development, risk factors for adult schizophrenia in the British 1946 Birth Cohort. Lancet, 344, 1398–1402.

TABLE 3.1

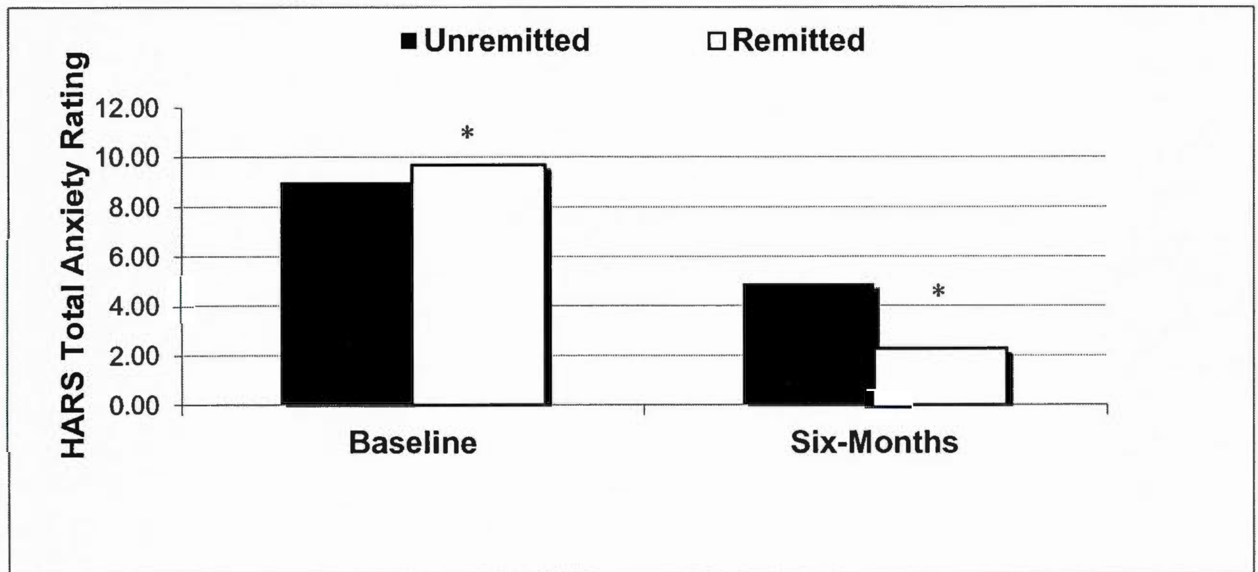
Socio-demographic data, overall ratings and descriptive data of unremitted and remitted groups. Number of participants included (n) varied across measures.

	Unremitted n=103	Remitted n=72	Analysis		
Schizophrenia Spectrum	N= 78	n= 39	Statistic	Df	*P*
Affective Psychosis	N= 14	n= 22	χ^2=9.587	2	0.008* [b]
Del/ Psych NOS [a]	N= 11	n= 11			
	Unremitted	Remitted	Analysis		
			Statistic	Df	*P*
Age at entry (years)	22.5 ± 3.8	23.9 ± 3.8	F=7.13	1, 154	0.023
PAS total score	0.29 ± 0.1	0.22 ± 0.1	F = 4.55	1,154	0.034
Gender (M/F)	52/24	38/20	χ^2=0.126	1	0.723
Education	11.0 ± 2.4	12.6 ± 2.4	χ^2=16.486	11	0.124
			Analysis		
			Statistic	Df	*P*
DUP (weeks) [b]	44.1 ± 56.9	42.3 ± 89.4	T=0.14	131	0.89
median (weeks)					
DUI (weeks) [b]	239.2± 217.2	256.6 ± 273.7	T=-0.41	131	0.68
median (weeks)					
			Analysis		
			Statistic	Df	*P*
PANSS Positive Total					
Baseline	24.3 ± 6.0	23.9 ± 5.5	t=0.461	150	0.65
Six-Month	14.3 ± 4.9	8.8 ± 2.7	t=7.653	132	0.000
Change	-9.9 ± 7.2	-15.2 ± 6.4	t=4.367	132	0.001
PANSS Negative Total					
Baseline	19.5 ± 6.9	14.6 ± 6.2	t=4.564	150	0.000
Six-Month	17.7 ± 6.0	9.9 ± 2.4	t=9.342	132	0.000
Change	-1.7 ± 7.2	-4.7 ± 6.1	T=2.577	132	0.011

Abbreviations: DUP, duration of untreated psychosis; DUI, duration of untreated illness; SAPS, Scale for the Assessment of Positive Symptoms; SANS, Scale for the Assessment of Negative Symptoms

[a] Delusional Disorder / Psychotic Disorder Not Otherwised Specified

[b] DUP and DUI are presented in raw form; however these were analyzed using transformed data.



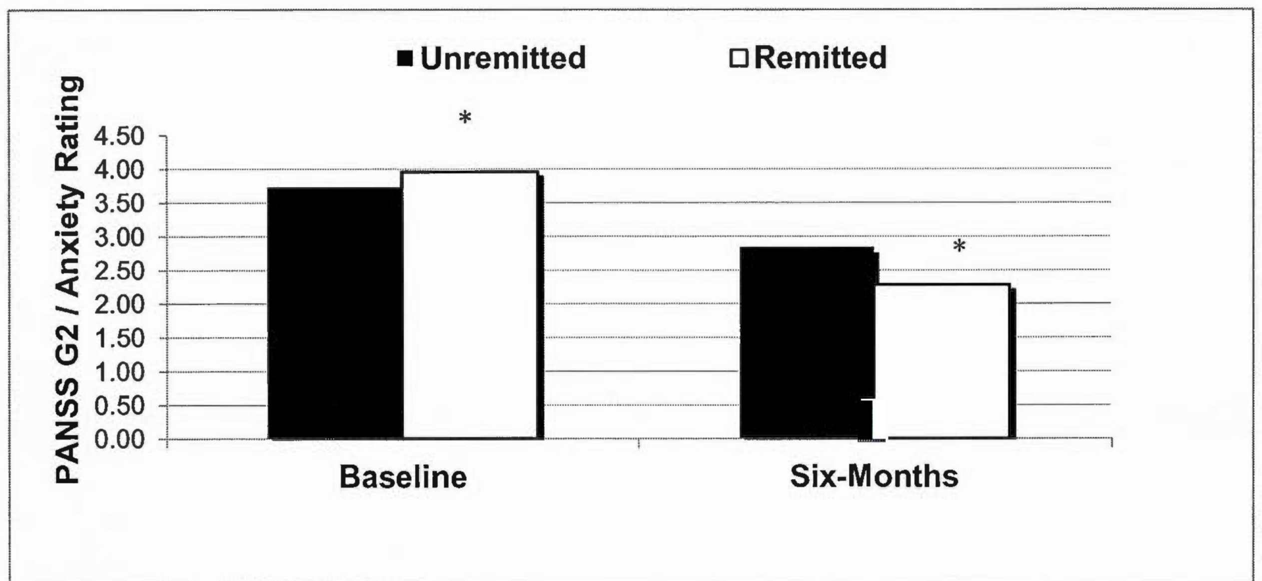


FIGURE 3.1: Between-group comparisons (unremitted versus remitted) of HARS total anxiety rating and (G2) PANSS anxiety rating at baseline and six-months. Covariates included in the ANCOVA were age of entry and PAS total score

* Group differences significant at six-months

* *p*-value significant at 0.05 level

CHAPTER IV

STUDY THREE

Reference:

Montreuil, T., Malla, A., Messina, K., Joober, R., Bélanger, C., Myhr, G., & Lepage, M. (submitted). Manualized Group Cognitive-Behavioral Intervention for Social Anxiety in First-Episode Psychosis: An Uncontrolled Study. Psychosis: Psychological, Social and Integrative Approaches.

CHAPTER IV

STUDY III - MANUALIZED GROUP COGNITIVE-BEHAVIORAL THERAPY FOR SOCIAL ANXIETY IN AT-RISK MENTAL STATE AND FIRST-EPISODE PSYCHOSIS

Abstract

Social anxiety has received only scant attention so far in schizophrenia and related psychoses but some data suggest it represents a significant obstacle to vocational and functional outcome. Objective: This study investigated the efficacy of a novel group-based cognitive-behavioral therapy (CBT) aimed at reducing social anxiety in those at-risk for developing psychosis and in the early phase of psychosis. Method: Twenty-nine patients with first-episode psychosis or at ultra high risk (UHR) for developing psychosis, and co-morbid social anxiety attended a group-based cognitive behavior (CBGT) intervention. The CGBT was provided weekly for 14 weeks in 90-minute sessions. Baseline, post-treatment and follow-up ratings of social anxiety were measured using: the Social Interaction Anxiety Scale, the Social Phobia Inventory, and the Brief Social Phobia Scale. Psychotic symptoms and general psychopathology were also measured before and after the intervention. Results: Participants significantly improved on all three outcome measures of social anxiety after completing this intervention (all p's <.002). Similarly, participants who completed treatment also showed a significant reduction on measures of depression, and negative symptoms. Conclusions: This brief manualized CBGT intervention was

demonstrated to be an effective treatment of social anxiety symptoms in FEP in an uncontrolled pilot study and needs to be tested in a larger RCT.

Keywords: cognitive-behavioral therapy, social anxiety, clinical outcome, remission, first-episode psychosis, at-risk mental state

4.1 Introduction

Despite advances in pharmacological treatments over the past two decades, which have led to symptomatic improvements, many patients with schizophrenia continue to experience chronic difficulties with psychosocial and vocational functioning, which remain largely unaddressed by current pharmacological treatments. Psychopharmacological treatments are not sufficient to target the social functional deficits that affect a large proportion of patients especially in the early phase of the illness, in large part due to poor medication adherence or resistance to treatment. Hence, the attainment of symptomatic or clinical remission in psychosis does not necessarily translate itself into improved social functioning, particularly during the early phase of psychosis. Although the rates of symptomatic remission are relatively higher following treatment of a first episode of psychosis, even with more stringent consensus criteria for remission (Andreasen et al., 2005), the rates of improved social and occupational functioning are far from satisfactory (Cassidy et al., 2010). It has been hypothesized that other highly prevalent comorbid symptoms such as, depression (Smith et al., 2006), anxiety (Montreuil et al., in press) and substance abuse (Green et al., 2003), may contribute significantly to this gap in outcome. In order to achieve complete functional remission, it has been suggested that interventions need to target social anxiety (Kumazaki et al., 2012). High levels of anxiety usually predate the onset of psychosis (Mueser et al., 1998) and anxiety plays a fundamental role in the maintenance of psychotic symptoms (Freeman et al., 2002). Furthermore, in people identified as being at risk for developing psychosis, social anxiety has been identified as a predictor for transition into psychosis (Morrison et al., 2012) and the presence of socio-emotional dysfunction was also among those factors predicting transition to psychosis (Michail & Birchwood, 2012).

Social anxiety (SA) represents one of the most prevalent comorbid conditions in schizophrenia and related psychotic disorders, affecting a high proportion of

patients, ranging from 13 – 36% in all phases of the illness, including patients being treated for a FEP (Birchwood et al., 2011; Cosoff & Hafner, 1998; Michail & Birchwood, 2009; Pallanti et al., 2004) and affective psychosis (Freeman et al., 2002). Moreover, a recent study showed that anxiety disorders seemed to be the most persistent comorbid condition in a FEP sample across time (Pope et al., 2012). These findings and our own data suggest that a comorbid diagnosis of an anxiety disorder shows little change over time. Further, comorbid SA in psychosis has been associated with functional impairments, and poor outcome in occupational (Gureje et al., 2002), social and quality of life domains (Hafner et al., 1995). A recent report suggested that the severity of anxiety in FEP is marked, and appears to be linked to poor short-term clinical outcome (Montreuil et al., in press). It has been proposed that a reduction in the severity of anxiety symptoms may contribute to an improvement in psychotic symptoms and thus could play an important role in remission and promoting functional recovery (Huppert & Smith, 2005).

Despite the importance of SA as a comorbid condition in all phases of psychotic disorders, these problems have received limited attention even within specialized early intervention services. It is very likely that effective and safe interventions to improve SA prior to the onset or very early in the course of the psychotic disorder would significantly improve outcomes beyond symptomatic remissions. For instance, Birchwood and colleagues (Birchwood. et al., 2007) observed that individuals who reported symptoms of social anxiety experienced greater shame of their illness and felt that the diagnosis of schizophrenia set them apart from others. Moreover, Gumley et al. (Gumley et al., 2004) found that negative beliefs related to the self and the illness appeared to be related to the development of a concurrent social anxiety disorder. Hence, the design of a CBT group-based intervention for social anxiety in FEP should incorporate this notion of stigmatization, as well as target these dysfunctional thoughts, beliefs and/or attitudes about the self as related to the illness.

Two previous studies (Halperin et al., 2000; Kingsep et al., 2003) of CBT intervention for social anxiety in schizophrenia were relatively limited in their scope for addressing the complex issues related to social anxiety in patients with psychotic disorders. Halperin and colleagues' (2000) brief intervention incorporated both cognitive and behavioral elements, but did not include social skills training, psychoeducation and normalization of the physiological effects of social anxiety, nor did they make a specific diagnosis of social anxiety disorder, choosing instead to complete a brief pre-screening 'suitability' assessment of social phobia. Kingsep et al. (2003), on the other hand, while addressing some of the above limitations, did not incorporate elements of social skills training although their program did teach the patients about the physiological impact of anxiety. Hence, there is a need for a group-based comprehensive intervention program that will incorporate all of these components. To address these issues, we present an evaluation of a cognitive-behavioral group intervention which we have developed for social anxiety symptoms, specifically for people with psychosis.This intervention factors in dimensions of illness associated with the experience of psychotic symptoms, lacking in previous work reviewed above..

The main objective of our study is to evaluate the effectiveness of a manualized cognitive-behavioral group intervention in a pilot study. We hypothesize that our intervention will lead to a reduction in the severity of social anxiety in patients being treated for ARMS / FEP and concurrent social anxiety. Our secondary hypothesis is that this will consequently be associated with a reduction in the severity of positive and negative symptoms of psychosis.

4.2 Methods

4.2.1 Screening and recruitment of participants

A total of 23 participants were FEP patients receiving treatment as part of the Prevention and Early Intervention Program for Psychoses (PEPP-Montreal) and First

Episode Psychosis Program (FEPP), specialized early intervention services with integrated clinical, research, and teaching modules. The remaining 6 participants were referred from a separate clinic within PEPP-Montréal that provides evaluations and follow-up for youth between 14 and 30 years of age who meet criteria for At Risk Mental State (ARMS) for developing a psychotic disorder. Flyers describing our study, more specifically the "true" nature of social anxiety in order to distinguish between delusion of persecutions and fears of negative evaluation, the inclusion/exclusion criteria, and the research coordinator's contact information, were made readily accessible to referring clinicians (psychiatrists, case managers, psychologists, etc.). For complete details on the treatment protocol of the PEPP-Montreal program, see Montreuil et al. (2010).

4.2.2 Participant

Twenty-three patients receiving treatment for a psychotic disorder were recruited mainly through case manager and psychiatrist referrals. Six participants were at increased risk of developing psychosis. The entire sample (N=29) was subsequently separated into completers (n=26) and non-completers (n=3) (defined as those participants who attended less than 50% of the sessions) groups for the purpose of having taken part of the 14-week intervention program.

4.2.3 Design and procedures

This study is based on an uncontrolled evaluation of the proposed intervention. Participants were evaluated at: baseline (prior to the onset of group therapy); post-treatment (within two weeks of having completed the 14-week intervention program); and follow-up (3-6 months following the post-treatment evaluation).

4.2.4 Treatment outcome measures

Evaluations were conducted by a trained research assistant, who had participated in inter-rater reliability sessions at least once a year. The evaluator was not involved with the actual delivery of the intervention. All diagnoses were based on the Structured Clinical Interview for DSM-IV conducted within one month of entry to the treatment program, validated through consensus between senior research psychiatrists. Three categories of symptoms were systematically examined as part of the clinical assessment: social anxiety; psychotic symptoms; and general psychopathology.

Social anxiety was measured using two self-report scales, Social Phobia Inventory (SPIN) and Social Interaction Anxiety Scale (SIAS); and one rating scale (Brief Social Phobia Scale) administered by the research assistant. Furthermore, these measures were selected to evaluate the distinct domains of social anxiety (i.e. cognitive, behavioral and physiological).

The SPIN is a 17-item scale assessing multiple dimensions of social anxiety including fear, avoidance and physiological discomfort (Connor, 2000). The SIAS, is a 20-item scale measures anxiety in interpersonal encounters (Mattick & Clarke, 1998). Social anxiety scores above 19 for the SPIN or above 34 for the SIAS have been shown to be appropriate cutoff to detect social anxiety disorders and have previously been used in schizophrenia (Connor, 2000).

The BSPS is an 11-item clinician-rated assessment scale measuring fear, avoidance and autonomic physiological responses that are usually associated with most common social situations with a cutoff score of 20.

We used the social phobia subscale of the SCID-I to confirm the diagnosis of social anxiety disorder on Axis I.

The positive and negative symptoms related to psychosis were assessed using the Scale for Assessment of Positive Symptoms - SAPS (Andreasen, 1984a) and the

Scale for Assessment of Negative Symptoms – SANS (Andreasen, 1984b). For the purpose of this study, global scores for the SAPS and SANS were used as comparison for "change" between pre and post as well as follow-up assessments. The Calgary Depression Scale for Schizophrenia (Addington et al., 1990) was used to measure depression.

The participants' anecdotal reports were collected based on the Indiana Psychiatric Interview - IPII (Lysaker et al., 2002), a semi-structured interview that elicits a narrative about one's self and illness, highlight improved self-esteem and perceived view of self at the time of post-assessments and follow-up. This qualitative assessment was collected as a measure of group intervention feasibility.

Global Assessment Scale – GAF (DSM-III modified version of the original "Global Assessment Scale – GAS") (Endicott et al., 1976), was used to assess functioning.

Although not reported in this paper, internalized stigma and cognitive insight were measured as part of this study. The outcome measure results will be reported elsewhere.

4.3 Results

4.3.1 Attrition and attendance

All patients (n=29) participated in at least one session of treatment. From that number, three participants (3 males) dropped out of the study during the course of treatment for various reasons. Dropouts attended an average number of three sessions. The overall attendance rate of completers to the 14-week program was 95%. An average of 11 sessions were attended by participants. The number of attended sessions ranged from 9-14.

4.3.2 Group intervention feasibility

Qualitative data gathered from the IPII, highlights that participants describe the intervention program as useful, practical and enjoyable. Participants were generally satisfied with the intervention and highlighted several perceived benefits such as better mastery over the discomfort associated with the manifestation of anxiety, increased social exposure and becoming more hopeful about the future.

4.3.3 Clinical and demographic data

From our original sample (n=26) who completed the intervention, 9 (31%) had a diagnosis of affective psychosis; 12 (41%) schizophrenia-spectrum disorder; 2 (7%) 'psychosis not otherwise specified'; and 6 participants (21%) met criteria for ARM for psychosis but not for a syndromal level psychotic disorder. At baseline, all participants met DSM-IV criteria for social anxiety. The severity of symptoms varied from moderate to severe. Clinical characteristics were normally distributed. Age and gender were not entered as covariates as they were not significantly correlated with any of the treatment outcome variables (see table 4.1).

4.3.4 Treatment outcomes

4.3.4.1 Social anxiety measures

The paired-samples t-test analyses indicate that the severity of social anxiety symptoms was significantly reduced at post-treatment on all measures of social anxiety. For all 3 measures, respectively, there was significant improvement: [$t(23) = 4.81$, $p < .001$] for the SIAS, [$t(22) = 5.18$, $p < .001$] for the SPIN, and [$t(22) = 5.20$, $p < .001$] for the BSPS (see table 4.2).

4.3.4.2 Positive and Negative symptoms

Following treatment, there was significant change observed in severity of negative symptoms (SANS global scores) and depression (CDSS) [$t(8) = 4.26$, $p =$

.003] [t(13) = 3.62, p = .003] but not in positive symptoms (SAPS) [t(10) =1.38, p = .198]. The overall effect size, for both measures are shown in Table 4.3.

4.3.4.3 Completers versus non-completers

For the present study, Table 4.4 presents the statistical analyses using independent t-tests which revealed no significant differences between our groups (completers versus non-completers) at baseline prior to the intervention on all treatment outcomes measures.

4.3.4.4 Psychotic versus at-risk sample

The at-risk group did display higher levels on social anxiety on all three measures (SIAS, m=49.33 versus m=43.44; SPIN, m=44.33 versus m=40.38; BSPS, m=48.80 versus m=42.19), and there appeared to be no significant differences between our groups based on social anxiety ratings on any of the scales; SIAS [t(20) = -0.98, p = .338], SPIN [t(16) = -.69, p = .500], BSPS [t(19) = -1.00, p = .332].

4.3.4.5 Three-month follow-up

At three months follow-up of 17 participants revealed that symptoms of social anxiety remained significantly lower when compared to baseline (pre-intervention) ratings, yielding [t(12) = 3.03, p = .010] for the SPIN, and [t(11) = 4.04, p =.002] for the BSPS. For the SIAS, the results failed to reach significance [t(12) = 1.98 p = .081], partly due to one participant who scored extremely high on the scale at follow-up (i.e. outlier). In addition, improvements on the CDSS [t(7) = 4,07 p = .005] remained significant at follow-up but not for the SANS [t(6) = 1.33p = .231] (see figure 4.1).

4.4 Discussion

The current study provides some preliminary evidence that, after taking part in a 14-week group CBT intervention, participants with first episode of psychosis and

those at ultra-high risk of developing psychosis showed a significant reduction in the severity of social anxiety symptoms. In addition, significant improvements in the negative symptoms of psychosis and depression were measurable in these same participants following participation in the proposed group intervention. Considering that completers and non-completers did not differ on any of the variables prior to entering treatment, on a preliminary basis, the measured treatment outcome effects appear to derive from our proposed intervention. Furthermore, additional analyses revealed that although the at-risk sample had higher social anxiety scores at baseline compared to the sample of participants who had met criteria for a psychotic disorder (FEP), these differences were not significant. Moreover, following a first-episode of psychosis or even in individuals who are at increased risk of developing psychosis, it may be optimal to target social anxiety with a psychosocial intervention as early as possible given that these patients are likely to still have a social network. This is a very important factor to consider, given that this stage-specific "protective factor" represents a critical intervention period for a likely recovery.

This study has several limitations. Our study did not include an active control condition and hence it is difficult to directly attribute the positive impact of this intervention to the active ingredients of CBT. Furthermore, although we controlled for several potential confounding variables, our design does not allow us to determine how such variables may affect suitability for cognitive therapy and hence, may moderate the effect of the intervention. In addition, our smaller sample may not be representative of the larger population of individuals with a first episode of psychosis or at risk of developing such a disorder. Our results are nonetheless very encouraging, and suggest the utility of a randomized controlled evaluation of this method of treatment in direct comparison to a standard treatment. Finally, another limitation of our study pertains to symptom ratings. Ratings of social anxiety significantly decreased following the intervention but remained somewhat high. Although to our knowledge this has not been examined, the current study suggests

that symptoms of social anxiety in FEP/ARMS may have a greater persistence than in non-psychotic samples. Currently existing non-psychotic social anxiety scales may need to be validated in a population of individuals that are socially anxious who have experienced psychosis.

Nevertheless, in comparison to other studies (Halperin et al., 2000); (Kingsep et al., 2003) our data sample was comprised of a larger number of participants. Furthermore, compared to similar studies, our intervention program included several components that were not available in briefer interventions, such as social skills training, psychoeducation on psychotic symptoms, relapse prevention and more importantly, illness-related stigma by targeting dysfunctional beliefs about the self.

In sum, this manualized group CBT intervention was demonstrated to produce positive effects on measures of social anxiety as well as associated psychopathology prior to the onset of psychosis and in the relatively early phase of psychotic disorders. However, a randomized controlled evaluation of this promising treatment is required to substantiate the positive results reported here.

References

1. Addington, D., Addington, J., & Schissel, B. (1990). A depression rating scale for schizophrenics. Schizophrenia Research, 3(4), 247-251.

2. Andreasen, N. C. (1984). Modified scale for the assessment of Negative Symptoms (SANS). Iowa City: University of Iowa.

3. Andreasen, N. C. (1984). Scale for the assessment of positive symptoms (SAPS). Iowa City: University of Iowa.

4. Andreasen, N.C., Carpenter, W.T. Jr, Kane, J.M., Lasser, R.A., Marder, S.R., Weinberger, D.R. (2005). Remission in schizophrenia: proposed criteria and rationale for consensus. Am J Psychiatry, 162(3), 441-449.

5. Birchwood, M., Peters, E., Tarrier, N., Dunn, G., Lewis, S., Wykes, T., Michail, M. (2011). A multi-centre, randomised controlled trial of cognitive therapy to prevent harmful compliance with command hallucinations. BMC Psychiatry, 11(155).

6. Birchwood et al. (2007). Social anxiety and the shame of psychosis: a study in first episode psychosis. Behav Res Ther, 45(5), 1025-1037.

7. Cassidy C.M., Norman R., Manchanda R., Schmitz N., Malla A. (2010). Testing definitions of symptom remission in first-episode psychosis for prediction of functional outcome at 2 years, Schizophr Bull, 36(5), 1001-1008.

8. Connor, K. M. (2000). Psychometric properties of the Social Phobia Inventory (SPIN).New self- rating scale. Br J Psychiatry, 176, 379-386.

9. Cosoff, S. J., & Hafner, R. J. (1998). The prevalence of comorbid anxiety in schizophrenia, schizoaffective disorder and bipolar disorder. Aust N Z J Psychiatry, 32(1), 67-72.

10. Davidson, J. R., & al. (1991). The Brief Social Phobia Scale. J Clin Psychiatry, 52, 48-51.

11. Endicott, J., Spitzer, R. L., Fleiss, J. L., & Cohen, J. (1976). The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance. . Archives of General Psychiatry, 33, 766-771.

12. Freeman, M. P., Freeman, S. A., & McElroy, S. L. (2002). The comorbidity of

bipolar and anxiety disorders: prevalence, psychobiology, and treatment issues. J Affect Disord,, 68(1), 1-23.

13. Green, A.I., Canuso, C., Brenner, M.J., & Wijcik, J.D. (2003). Detection and management of comorbidity in schizophrenia. Psychiatr Clin N Am, 26, 115-139.

14. Gumley, A., O'Grady, M., Power, K., & Schwannauer, M. (2004). Negative beliefs about self and illness: a comparison of individuals with psychosis with or without comorbid social anxiety disorder. Aust N Z J Psychiatry, 38(11-12), 960-964.

15. Gureje, O., Herrman, H., Harvey, C., Morgan, V., & Jablensky, A. (2002). The Australian National Survey of Psychotic Disorders: profile of psychosocial disability and its risk factors. [Research Support, Non-U.S. Gov't]. Psychol Med, 32(4), 639-647.

16. Hafner, H., Nowotny, B., Loffler, W., van der Heiden, W., & Maurer, K. (1995). When and how does schizophrenia produce social deficits? European Archives of Psychiatry and Clinical Neurosciences, 246, 17-28.

17. Halperin, S., Nathan, P., Drummond, P., & Castle, D. (2000). A cognitive-behavioural, group-based intervention for social anxiety in schizophrenia. Aust N Z J Psychiatry, 34(5), 809-813.

18. Huppert, J. D., & Smith, T. E. (2005). Anxiety and Schizophrenia: The Interaction of Subtypes of Anxiety and Psychotic Symptoms. CNS Spectr, 10(9), 721-731.

19. Kingsep, P., Nathan, P., & Castle, D. (2003). Cognitive behavioural group treatment for social anxiety in schizophrenia. Schizophr Res, 63(1-2), 121-129. doi: S0920996402003766 [pii]

20. Kumazaki, H., Kobayashi, H., Niimura, H., Kobayashi, Y., Ito, S., Nemoto, T.,Mizuno, M. (2012). Lower subjective quality of life and the development of social anxiety symptoms after the discharge of elderly patients with remitted schizophrenia: a 5-year longitudinal study. Comprehensive Psychiatry.

21. Lysaker, P.H., Clements, C.A., Placak Hallberg, C., Knipschure, S.J. & Wright, D.E. (2002). Insight and personal narratives of illness in schizophrenia. Psychiatry,65, 197-206.

22. Mattick, R. P., & Clarke, J. C. (1998). Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. Behav Res Ther, 36(4), 455-470. doi: S0005-7967(97)10031-6 [pii]

23. Michail, M., & Birchwood, M. (2009). Social anxiety disorder in first-episode psychosis: incidence, phenomenology and relationship with paranoia. The British Journal of Psychiatry, 195, 234-241.

24. Montreuil, T., Malla, A., Joober, R., Bélanger, C., & Lepage, M. (2013). Anxiety symptoms severity and short-term clinical outcome in first-episode psychosis. Early Intervention in Psychiatry, 7(1), 5-11.

25. Montreuil,T. M., Bertrand, M.C., Malla, A. K., Joober, R., & Lepage, M. (2010). Social cognitive markers of short-term clinical outcome in first-episode psychosis, Clin Schizophr Relat Psychoses 2010 Jul; 4(2): 105-114.

26. Pallanti, S., Quercioli, L., & Hollander, E. (2004). Social Anxiety in Outpatients With Schizophrenia: A Relevant Cause of Disability. Am J Psychiatry, 161, 53-58.

27. Pope, M., Joober, R., & Malla, A. (2012). One-year stability of primary and secondary diagnosis in patients with first-episode psychotic disorders. Paper presented at the 8th International Conference on Early Psychosis, San Francisco.

28. SPSS. (2010). SPSS for Windows. Chicago, IL: SPSS.

29. Smith, B., Fowler, D.G., Freeman, D., Bebbington, P., Bashforth, H., Garety, P., et al. (2006), Emotions and psychosis: links between depression, self-esteem, negative schematic beliefs and delusions and hallucinations. Schizophr Res. , 86(1–3),181–188.

TABLE 4.1

Socio-demographic data of all participants (completers and non-completers) per diagnostic category

	Completers (n=26)	Non-Completers (n=3)	Analysis		
			Statistic	Df	*p*-value
Age (years)	27.5 ± 9.4	42.2 ± 17.8	F=2.72	2, 27	0.65
Gender (M/F)	18/8	3/0	χ^2=0.26	1	0.61
Education	12.36 ± 2.9	14.7 ± 2.0	F=2.72	2, 27	0.65

* *p*-value significant at 0.05 level

TABLE 4.2

Descriptive data (mean, SD) of pre-treatment, post-treatment and follow-up for social anxiety, psychotic symptomatology and general psychopathology ratings.

	Pre-treatment			Post-treatment			Follow-up		
Measures of Social Anxiety	Mean	N	SD	Mean	N	SD	Mean	N	SD
SIAS	44.42	24	12.18	36.50	24	8.193	37.08	13	9.68
SPIN	40.70	23	11.90	29.04	23	9.70	25.23	13	11.20
BSPS	42.74	23	12.79	31.17	23	9.73	29.50	12	9.44
Measures of Psychotic Symptomatology									
SAPS	11.91	11	10.66	8.10	11	10.47	4.00	6	3.58
SANS	25.86	14	8.63	17.86	14	6.84	15.29	7	5.63
Measures of General Psychopathology									
CDSS	6.33	9	4.69	1.78	9	2.54	4.63	8	4.12

Abbreviations: SIAS, Social Interaction Anxiety Scale; SPIN, Social Phobia Inventory; BSPS, Brief Social Phobia Scale; SAPS, Scale for the Assessment of Positive Symptoms; SANS, Scale for the Assessment of Negative Symptoms; CDSS, Calgary Depression Scale for Schizophrenia.

TABLE 4.3
Treatment effect (Pre-treatment – post-treatment) for social anxiety, psychotic symptomatology and general psychopathology ratings.

Variables	Treatment Outcomes	
	Effect size *d*	**Mean effect size**
Social Anxiety Measures		
SIAS *(N=23)*	1.04	0.97
SPIN *(N=22)*	0.93	
BSPS *(N=22)*	0.95	
Psychotic Symptomatology		
SAPS *(N=10)*	0.17	0.41
SANS *(N=13)*	0.64	
General Psychopathology		
CDSS *(N=8)*	1.25	1.25

* *p*-value significant at 0.05 level

** 2-tailed significance

TABLE 4.4

Social anxiety, psychotic symptomatology and general psychopathology rating differences between groups (completers versus non-completers) at baseline (pre-treatment).

	T	Df	Sig. (2-tailed)
Social Interaction Anxiety Scale- Pre évaluation	.36[a]	26	.723
Social Phobia Inventory- Pre évaluation	.22[a]	26	.826
Brief Social Phobia Scale- Pre évaluation	.20[a]	24	.842
Scale for the Assessment of Positive Symptoms-Pre CBT	.21[a]	15	.836
Scale for the Assessment of Negative Symptoms-Pre CBT	-1.06[a]	20	.302
Calgary Depression Scale- Pre CBT	-.49[a]	14	.634
Global Assessment of Functioning -Pre CBT	.27[a]	11	.793

° [a] Analyses computed based on Completers* (n=26) and Non-completers (n = 3)

° * Completers (participants completed more than 50% of total number of sessions)

° *p*-value significant at 0.05 level

° two-tailed significance

Figure Legends

Abbreviations: SIAS, Social Interaction Anxiety Scale; SPIN, Social Phobia Inventory; BSPS, Brief Social Phobia Scale; SAPS, Scale for the Assessment of Positive Symptoms; SANS, Scale for the Assessment of Negative Symptoms; CDSS, Calgary Depression Scale for Schizophrenia.

° Analyses computed based on Completers (n =26)

° *p*-value significant at 0.05 level for SIAS*, SPIN*, BSPS*, SANS*, CDSS* for T1-T2; SIAS**, SPIN*, BSPS*, SANS**, CDSS*

° *two-tailed significance

° **one-tailed significance

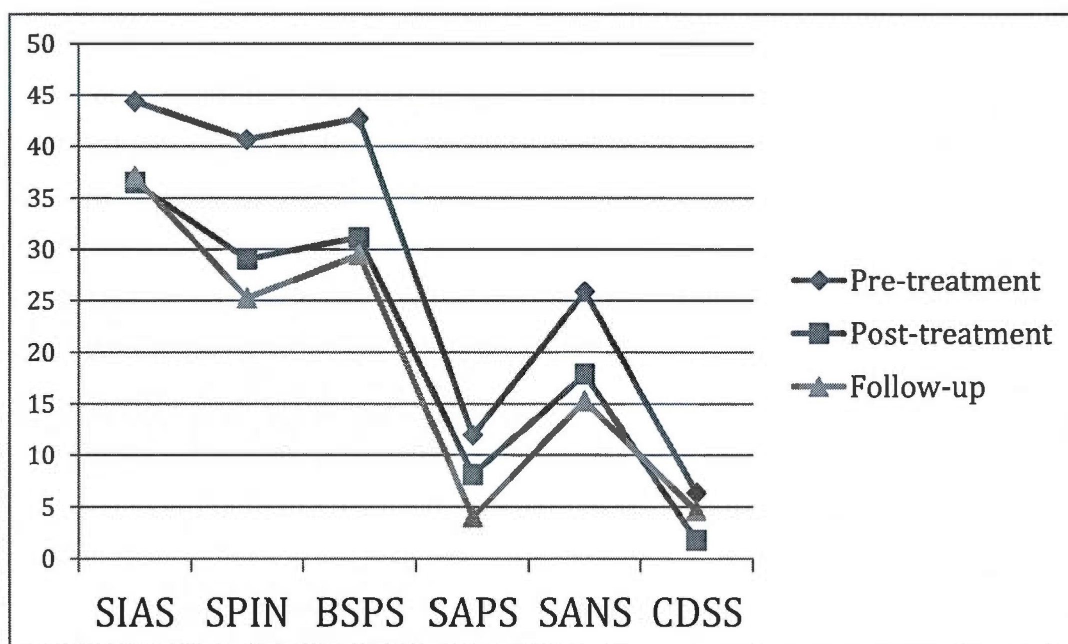


FIGURE 4.1 Effects of intervention as measured by contrasting the measures taken at the all time-points (pre-treatment, post-treatment, follow-up) for all treatment outcomes measures (social anxiety, psychotic and depressive symptomatology)

CHAPTER V

GENERAL DISCUSSION

This chapter will propose a synthesis of the results presented in the articles comprised in this thesis research project. Thereafter, the author will present an etiological model of social anxiety in FEP based on "illness-related" beliefs about the self. The author will also address the scientific contributions of the study, and the strengths and limitations of the research project. Finally, theoretical and clinical implications of the current study findings for future research will be discussed, ending with a brief general conclusion that will highlight the key findings of the research project.

5.1 Synthesis and Interpretation of the Results from Studies on Markers of Remission

5.1.1 Social Cognitive Markers of Short-Term Clinical Outcome in First-Episode Psychosis

The aim of the first study that comprises this thesis project sought to identify social cognitive markers of remission, as defined by 'short-term' clinical outcome in a first-episode psychosis sample. The relationship between social cognition and symptomatic or clinical outcome has received only scant attention so far. However, better cognitive functioning, namely verbal memory, has been associated with lower symptom ratings over a minimum of one year past illness onset and with good clinical outcome after six-months of treatment (Bodnar et al, 2008). Over the past two

decades, studies have clearly shown that social cognition is significantly impaired in chronic schizophrenia (Penn et al, 1997). Hence, it was believed if this domain was the target of treatment, it could improve the outcome of people suffering from schizophrenia.

No other studies in first-episode psychosis population thus far has looked at the potential impact of social cognitive deficits on the clinical outcome of these patients, highlighting the pertinence of our current study. The results of our study revealed that social cognitive deficits in schizophrenia are highly prevalent even during the early phases of the illness. Our study also indicated that social cognition appears to be a reliable marker of short-term clinical outcome following a first episode of psychosis. We found that patients who did not remit from their psychotic symptoms after six months of treatment manifested a concurrent deficit in the ability to predict social situations. In addition, our study provides evidence that patients who did respond to treatment, function similarly to healthy controls. Similar to the MATRICS, the study reveals that a single sub-test from the social cognitive domain appears to be the overall driving force of the measured effect (Green et al., 2004).

Social cognition has also been shown to be an important predictor of functional outcomes in schizophrenia (Couture et al., 2006). It is a domain of cognition that embodies the perception, the interpretation and the processing of social information (Ostrom, 1984). Social cognition deficits in schizophrenia have been associated to information-processing biases (Penn et al, 1997). Although it is true, as we have seen, that social and functional recovery in people with psychosis is limited in light of those social cognitive deficits, it is believed that the emotional / affective sphere, such as social anxiety, may play a mediating role (Birchwood & Trower, 2006). Hence, following this study, we proposed that from the onset of illness, treatment approaches targeted to improve clinical as well as functional outcome, should consider this affective component.

5.1.2 Severity of Anxiety Symptoms in First-Episode Psychosis

Most studies have looked at the etiology of anxiety spectrum disorders as a primary diagnosis. In recent years, we have seen a growing interest in comorbidity, which is driven primarily by concerns on how these symptoms might affect outcome (Gumley et al, 2003). Whether anxiety is occurring as a result of the psychiatric symptoms or that it was manifested prior to the onset of schizophrenic symptoms, there is a growing concern that high levels of comorbid anxiety could negatively impacts patients' recovery and functioning (Birchwood et al., 2006). Despite growing interest and evidence of comorbidity, very little is known about how it relates to the outcome.

The aim of the second study was to provide evidence that there is a link between the severity of anxiety symptomatology and clinical outcome in first-episode psychosis patients by comparing the short-term clinical outcome (based on the psychotic symptoms scores) of these two groups [i.e. poor-outcome (SANS / SAPS ≥ 3) and good-outcome (SANS / SAPS ≤ 3)]. The results of our second study revealed that the poor-outcome group scores were lower on the HARS and the PANSS anxiety-item at baseline compared to the good outcome group. However, at six-months, the good-outcome group anxiety scores were significantly lower than the poor-outcome group. Although, there were no significant differences between the poor-outcome and good-outcome groups on anxiety scores at baseline, at six-months significant anxiety score improvements are seen in the good-outcome group, as criteria for remission are also met for this group of patients. The anxiety ratings on both the PANSS and HARS suggest the presence of moderate symptoms of anxiety in this large cohort of 175 FEP patients, confirming the high prevalence of such symptoms in this clinical population. More importantly, the current findings supported existing literature that from the onset of illness, treatment approaches

should consider potential comorbidity, by providing targeted interventions that would aim to improve patients' functional recovery as well as clinical outcome.

5.1.3 Social Cognition, Anxiety and Clinical Remission in First-Episode Psychosis

Collectively, these two evaluative studies on factors associated with remission clearly show that social cognitive abilities and anxiety severity can influence clinical outcome. At the intersection of these two constructs, there is social anxiety which has been associated with social cognition deficits given that they share cognitive underpinnings. The next study provided a novel intervention for social anxiety that was specifically adapted to people with a first-episode of psychosis. This study targeted specifically social anxiety because of its high prevalence in first-episode psychosis and impact on social functioning.

5.2 Manualized CBGT Intervention for Social Anxiety in First-Episode Psychosis

5.2.1 Treatment Outcome Measure Changes

The existing literature points to the possibility that social anxiety may contribute to poor functional outcome, poor quality of life, unemployment, increased risk for relapse, hospitalization and suicide in FEP. It has been proposed that a reduction in the severity of anxiety symptoms, more specifically social anxiety, may lead to a reduction of psychotic symptoms and hence contribute to recovery. A way to clarify the nature of the relationship between psychosis and social anxiety would be to evaluate whether the treatment of social anxiety leads to changes in psychotic symptoms, more specifically improvements that go beyond symptomatic remission. Consequently, as part of this thesis project, we developed a cognitive-behavioral group intervention aimed at reducing the severity of social anxiety symptoms in a first-episode psychosis population.

The results of our third study indicated that although there were no differences on measures of social anxiety at baseline between completers and non-completers, there was a significant symptomatic reduction following the intervention (T1-T2) on all social anxiety measures (SIAS, SPIN, BSPS) for completers only. Following the intervention, out of 26 completers, 20 participants met DSM-IV criteria for partial remission of their SA symptoms and 2 met criteria for full remission of their SA symptoms. Moreover, we also observed a concomitant decrease in negative symptoms associated with psychosis (SANS) and depressive symptomatology (CDSS). More importantly, most of these improvements were maintained at the time of the follow-up assessment (T1-T3) with the exception of the SIAS that was now marginally significant when looking at the two-tailed significance. Negative symptoms improvements were no longer significant at the time of the follow-up assessment.

At present, the findings from our uncontrolled design study indicate a change in the outcomes measures for social anxiety, negative symptoms, and depression following the 14-week group intervention. Although we were not able to determine empirically that the significance of these improvements is attributable to the effect of the intervention due to the limitations of our design, a future empirically designed study, such as an RCT is warranted based on the reported changes. However, considering the lack of significant differences between completers versus non-completers prior to entering treatment and the feasibility of our intervention, the measured outcomes following our manualized intervention program suggest that it may be an effective intervention to treat social anxiety symptoms in FEP. Interestingly, further analyses revealed that despite the higher social anxiety scores in the at-risk sample at baseline, these differences were not significantly different from the severity of social anxiety symptoms in the FEP sample.

5.2.2 Development of Social Anxiety Symptoms in First-Episode Psychosis: An Intervention Targeting Social Anxiety and Shame

Interestingly, data collected on the SCID-I (Social Phobia subscale) prior to the onset of the CBGT for social anxiety in psychosis, revealed that the development of social anxiety symptoms was preceded by psychotic symptomatology. Although a few participants' account highlighted that at a young age they were already displaying early signs of social anxiety (e.g. shyness, introvert, socially withdrawn), most of them described feeling "shame" or "anxiety" during social interactions. Premorbid shame tendency or shame proneness is a behavioral trait that would manifest itself in early childhood or adolescence and would make an individual more vulnerable to development social anxiety in the future (Dalrymple, 2012). As we have seen, social anxiety and shame although distinct constructs, are both characterized by a "fear of being negatively evaluated and rejected (Gilbert, 2000). A study that investigated the potential phenomenological differences between patients with psychotic social anxiety and their non-psychotic socially anxious counterparts, reported that shameful cognitions played a significant role in the development of social anxiety in psychosis as it does in non-psychotic social anxiety (Michail & Birchwood, 2012), supporting our findings. The group of patients with psychosis reported that difficulties surrounding social anxiety developed after being diagnosed with psychosis (Michail & Birchwood, 2009).

5.2.3 Attendance and Attrition Rate

In terms of attendance, the dropout rate of approximately 10% was slightly below that of other studies. A meta-analysis, which looked at the dropout rates of over seventy-four psychosocial interventions in psychosis, found that the average attrition was 13% (Villeneuve et al., 2010)]. The range of attended sessions by completers was 9 -14 sessions and the average number of sessions attended by

completers was 12 sessions. Qualitative data gathered from the IPII, highlights that participants describe the intervention program as useful, practical and enjoyable. Participants were generally satisfied with the intervention and highlighted several perceived benefits such as better mastery over the discomfort associated with the manifestation of anxiety, increased social exposure and becoming more hopeful about the future.

However, similarly to other studies, the attrition is most significant early in the phase of the intervention (1st – 3rd sessions). Particularly in the case of the present study, several participants never showed up for treatment and this even after having given consent to take part in the study and completing the assessment. Kingsep and colleagues (2003) reported in their study that in the case of social anxiety, it was recommended for clinicians to work on rapport building (i.e. therapeutic alliance). As it was reported in the third study, at the time of assessments, most participants show up extremely anxious. It would appear as though this "first encounter" may represent a "make or break" shifting point. As it has been presented, social anxiety is marked by a fear of judgment and fear scrutiny by others and underlying cognitive biases (Foa et al., 2006) which alters the individual's perception of the social encounter. We suspected that if the patient's experience of assessment was perceived as negative and judgmental, it could result in "no show", refusal to participate or dropout. Interaction or group processes are at the core of social anxiety related difficulties (Bieling et al., 2006). In addition, individuals with social anxiety often underestimate their ability level in contrast to the perceived social standard; believing that their self-attributes fall short of others' expectations of them (Hofmann, 2007). Hence, should participants be given strategies to help them "re-appraise" the perceived level of anxiety and social threat during the first encounter as well as during the early phase of treatment, perhaps this could play a protective role in limiting attrition or refusal to participate in the intervention. It may be of interest for future studies to look into the

factors that may determine participation to intervention or susceptibility to participate based on these observations.

5.2.3.1 Social Role Loss and Stigma

Another process that could explain the early attrition is suggested by the Clark and Wells (1995) model of social anxiety. They have argued that socially anxious individuals would falsely believe that they are in imminent danger of behaving in a way that will be perceived by others as being unacceptable or inappropriate. Even further, this behavior would be perceived as resulting in a loss of status, self-worth and ultimately lead to rejection. This would explain the "negative bias" that is manifested in socially anxious individuals, where they anticipate that negative social outcomes are more likely to occur than positive social outcomes. Likewise, this negative bias in psychosis may be tied to self-blame. Self-blame is required to trigger shame when combined to internalized stigma (Lewis, 1998). The internalization of stigma, which occurs when an individual "believes" the negative beliefs associated to mental illness for example, increases shame (Corrigan & Watson, 2002). It is suggested that shame cognitions associated to internalized-stigma in people with psychosis would be involved in the development of social anxiety. Hence, these cognitive biases not only represent a critical obstacle to social recovery but also for access to treatment on the side of the patient as well as a major recruitment challenge for clinicians and researchers.

5.3 Participant-Reported Improvements

5.3.1 Improved Self-Esteem and Perceived View of Self

The participants' anecdotal reports, based on the Indiana Psychiatric Interview (IPII), a semi-structured interview that elicits a narrative about one's self and illness,

highlight improved self-esteem and perceived view of self at the time of post-assessments and follow-up. These improvements, although not quantitatively measured as part of this research project, appear to have contributed to observable functional improvements in the participants' lives, as reported during the majority of the post-treatment (T2) and follow-up (T3) interviews. The qualitative data provided by the participants through the IPII as well as a more unstructured interview conducted at the post-assessment, revealed that self-esteem improvements may be associated to an overall ability to better manage social anxiety symptoms and the related distress when faced with social situations. Anecdotal reports of participants, at post-assessment and follow-up, highlight this upturn in the individual's perception of self-ability and social confidence following participation in the intervention. Interestingly, studies reveal that CBT can increase levels of self-esteem and social confidence in people who experienced psychosis (Hall & Tarrier, 2003; Good, 2002). Similarly, following participation in a group psychosocial intervention, participants who experienced an increase in self-esteem, also reported a greater sense of empowerment (Lecomte et al., 1999). It is believed that enhanced empowerment and self-esteem are both fundamental components of coping, and essential for recovery in schizophrenia (Anthony, 1993).

5.3.2 Depression and Social Anxiety in First-Episode Psychosis

Our third study results reveal that after treating symptoms of social anxiety, participants manifested an improved mood. Depressive symptomatology has been a core characteristic of schizophrenia that occurs at the height of psychosis and that would decrease over the course of treatment (Koreen et al., 1993; Kingsep et al., 2003). The manifestation of symptoms of depression is associated to an increased negative bias (Fennell, 1989), characteristic of social anxiety, which would further contend with a positive treatment outcome. Depression is reported in 30-50% of individuals who have experienced psychosis (Birchwood et al., 2000). More

specifically, higher levels of depression may be detrimental to treatment of social anxiety as exposure to feared social situations, which is known to be associated to higher levels of social anxiety, may be experienced with lower expectations of success due to the presence of the depressive symptomatology (Kingsep et al., 2003). Hence, in light of these findings, a CBT intervention targeting a comorbid anxiety-related disorder, more specifically social anxiety in psychosis should categorically include treatment of the depressive symptomatology. As we saw in the present research project, improvements relative to the symptoms of depression were still measureable during the follow-up assessment. Consistent with the existing literature, a reduction in social anxiety symptoms may contribute to a concurrent reduction in symptoms of depression, which are associated with the presence of psychotic symptomatology. Nevertheless, future studies may need to consider the severity of the depressive symptomatology of participants as part of their study design. Given the overlapping and coexisting symptoms and/or unitary classification between anxiety and depression however, statistically controlling for depression could potentially also control for social anxiety (Michail & Birchwood, 2012). Hence, careful consideration of the interplay between the two variables is warranted.

5.3.3 Negative Symptoms and Social Anxiety

Unlike other reported findings on social anxiety and psychotic symptoms which did not find any association between social anxiety and negative symptoms (Birchwood et al., 2007; Pallanti et al., 2005), the SANS score revealed that there was a change in the severity of negative symptoms following participation in the group CBT intervention. The distinct nature of positive symptoms and social anxiety have been clearly established, however, few studies have looked into the possibility that social withdrawal, isolation and avoidance may have developed as a result of negative symptoms such as alogia or anhedonia for example (Michail & Birchwood, 2009). Negative symptoms, especially anhedonia, have been strongly associated to impaired

functioning (Herbener et al., 2005) in psychosis. Anhedonia for example, would be linked to deficits in anticipatory pleasure, which has been associated with difficulties in goal-oriented behaviors and social functioning impairments (Horan et al., 2006). Although we cannot determine at this point whether the reduction in the negative symptoms scores is imputable to the intervention directly or whether it would be accountable to an improvement in mood (i.e. reduction of depressive symptoms), the current findings indicate that "targeting" negative symptoms as part of a social anxiety in psychosis intervention may warrant further investigation.

5.4 Cognitive Model of Social Anxiety and Shame in Psychosis

Based on the measured outcomes, participant anecdotal reports during unstructured and semi-structured interviews, observations completed during the multiple intervention groups and the scientific literature, we propose the following explanatory model of the processes involved in the development and maintenance of social anxiety in first-episode psychosis (see APPENDIX B).

Psychotic symptoms precede the development of social anxiety symptoms. The manifestation of positive symptoms (i.e. hallucinations, delusions, paranoid ideations) as well as the presence of negative symptoms (i.e. alogia, anhedonia, social withdrawal) in psychosis would result in social cognition deficits which in turn would contribute to the development of social impairments and poor quality of life. According to the model, social cognition deficits can also be exacerbated by a lack of social skills. When the individual is behaving in a way that isn't socially acceptable or deemed "odd", the individual may subsequently experience rejection from his or her peers or surroundings. This rejection would not only lead to quality of life loss but also consequently reinforce shaming and stigmatizing self-beliefs and thereby increase social anxiety. Besides social skills deficits, similar phenomenological occurrences of social rejection and social status loss can result from beliefs that one is unattractive or unfavorable in comparison to others (Michail & Birchwood, 2012).

Hence, the self-perception of these impairments, whether accurate or negatively appraised, would consequently activate illness-related stigma or shaming beliefs about the self relative to living with a diagnosis of a severe mental illness. Combined to the cognitive biases, attributional biases which derive from both social cognitive deficits and social anxiety vulnerability, this would negatively impact how the individual perceives, interprets and understands others' behaviors relative to them. These cognitive biases (Foa et al., 1996), which were mentioned earlier, would create a negatively perceived response on all three spheres of social anxiety (i.e. cognitive, physiological and affective). The anxiety-related reactions would be filtered through the individual's "heightened self-focused attention", increasing the sensitivity to anxiety symptomatology. The distress perceived would condition the individual to engage in safety behaviors such as avoidance and social isolation in order to reduce the distress associated with exposure to the feared social stimuli. In the case of comorbid social anxiety in psychosis, safety behaviors would serve a "dual purpose"; protecting the "self" from both shame and social anxiety, from the anticipated dangers of humiliation and rejection (Michail & Birchwood, 2012). Safety behaviors would interact with cognitive deficits to create "psychotic misinterpretations and beliefs". In turn, these internalized misinterpretations would reinforce psychotic symptoms as well as the shame beliefs, and as a result maintain the symptoms of social anxiety.

The proposed model of 'development of social anxiety and shame in psychosis will be tested and validated as part of the larger randomized control trial study.

5.4.1 Specific Adaptation to the Intervention Based on the Proposed Developmental Model

The following elements represent the underlying processes, strategies and techniques that have been suggested in the literature as important components for

treatment. The scientific literature has suggested that there are no differences between the cognitive underpinnings of social anxiety, such as "fear of negative evaluation" or "negative interpretation bias" between nonpsychotic and psychotic samples (Birchwood et al., 2007). Hence, the goal of our intervention was to validate that these conventional implications for CBT which are used as the "framework" for therapy for non-psychotic social anxious patients, could also lead to positive outcome measures when applied to a psychotic population.

The complete English and French versions of the clinician and participant manuals can be found in Appendix E and an overview of what each session covers can also be found in Appendix D. The treatment components are as follows:

- Focus on developing a positive view of self and future (cognitive restructuring – identifying and modifying dysfunctional thinking patterns, identifying and modifying attributional, cognitive and attentional biases) as well as the normalization of the psychotic experience, psychoeducation on internalization of stigmatizing beliefs.
- Formulate and establish specific individual goals as well as obstacles for attaining these goals which could lead to social recovery and on the path for change.
- Identify avoidant and safety behaviors as obstacles and resistance to change. Provide psychoeducation on the nature of avoidant behaviors as responsible of the development and maintenance of social anxiety.
- Provide psychoeducation on the nature of stress (i.e. stress versus distress) and normalization of the manifestation of anxiety and anxious responses (i.e. physiological symptoms related to anxiety) by teaching that these sensations are not dangerous and are very common even in non-socially anxious individuals.

- Highlight the anxious individual's tendency to put the focus toward "internal cues" or anxiety symptoms and/or negative cognitions when facing fearful social situations. Participants are provided psychoeducation and reeducation on how: (1) to focus their attention on external cues; (2) develop a better tolerance of the anxious distress associated with exposure to the social encounter.
- Provide participants with in session, in vivo opportunities to test and rehearse and master their newly acquired strategies in a 'safer' group setting. Group feedback can be an effective way of correcting distorted self-perception as well as distorted perception of others.
- Behavioral experiments which allow participants to test and refute their negative appraisal, cost estimates for social events, perceived social standards. These apprehended or anticipated consequences are further challenged by encouraging the participant to "purposefully" engage in a behavior that would go against "social norms" (e.g. walk on the street with a weird-looking hat, go to a store and ask for a refund immediately after making a purchase, ask someone to share their seat on the bus, saying hello to someone unknown to them, etc.).
- Reducing "negative bias" and "catastrophisation bias" in appraisal of feared or avoided social performance as well as reducing post performance ruminations (cognitive restructuring and self-acceptance).

5.5 Clinical Implications

5.5.1 Assessment of Social Anxiety in Psychosis

5.5.1.1 A Multifaceted Disorder, a Multidimensional Intervention

For the present study, we had to develop a thorough evaluation of SA in order to overcome existing limitations in previously designed interventions. SA is a

multifaceted disorder that impacts several domains of functioning and it can especially fluctuate in people living with a severe mental illness. Social anxiety can be manifested across various spheres: cognitively (i.e. hyper self awareness, hypervigilance, uneasiness; feeling of inferiority "I don't measure up"; fear of being negatively evaluated "They won't like me"); physiologically (i.e. blushing, sweating, trembling, shaking; panic attacks may occur during social interactions); and behaviorally (i.e. avoidance, poor eye contact, withdrawn, isolation). As we have seen in the previous section, a systematic intervention program for social anxiety must encompass all factors or components, relying on a combination of variables and techniques that can be implemented to achieve targeted goals by acting on all spheres of the disorder. In order to provide such a target-specific intervention, a proper and rigorous assessment of symptoms must be completed. Thus, a proper and thorough assessment requires an investigation of all dimensions of the disorder, which includes the patient's overall cognitive, emotional and social functioning but also various modality of assessment including self-report and clinician-rated semi-structured interview such as the SCID-I.

5.5.1.2 Homogeneity of Group

After having completed several intervention groups, it became apparent that group "homogeneity" was a critical element to consider for group composition. Homogeneous grouping appeared to be more suitable for our FEP population. Patients with similar psychotic symptom chronicity (ex. paranoia, delirious beliefs, hallucinations, etc.), engagement, level of functioning, personality traits, and especially age appeared to benefit from a homogeneous group. There exists significant debate regarding the pros and cons of relying on a heterogeneous or homogeneous group approach. One of the main arguments in favor of creating homogeneous groups is that it is believed homogeneity would favor group cohesiveness. Concurrently, group cohesiveness becomes an even greater concern in

the case of a "time-limited" and "condensed-content" group intervention, as it is the case with many CBT-based interventions.

To the best of our knowledge, there exist no studies that have investigated the issue of group homogeneity in the social anxiety literature. However, this construct has been studied in hoarding and based on the relative homogeneity of "age", the population seeking treatment were more likely to be cohesive when similar in age (Rose, 2004). Increased homogeneity would lead to increased group cohesiveness and lower attrition (Bieling et al, 2006). Similarly, in the present study, we evaluated the validity of this finding by looking at differences in attrition based on group homogeneity. We found that the rate of dropout and the level of group cohesiveness appeared to benefit from a more homogeneous group. Yalom (1995) suggests that group cohesiveness is to group therapy what therapeutic alliance is to individual therapy. It is the therapist's responsibility to promote group cohesiveness. Cohesiveness would encourage attendance, provide an environment where participants feel free to share and open-up about their experiences and reduces the likelihood that participants stray away from group rules (Yalom, 1995). In social anxiety, the underlying difficulties are defined by a fear of judgment and criticism. A majority of patients, who suffer from social anxiety in FEP, are highly stigmatized and often feel ostracized as a result of the diagnosis of mental illness. This notion of group cohesiveness, although not yet explored for this comorbidity, would appear to be an even greater critical issue to consider for group composition. Consequently, group homogeneity should be considered when designing a CBT group intervention for SA in FEP.

5.5.2 Intervention

5.5.2.1 A Manualized CBGT Intervention

The proposed project represents a novel intervention for a comorbid condition

such as social anxiety in first-episode psychosis. Although many etiological studies on the subject matter investigated the relationship between social anxiety and psychotic symptoms, or determined the prevalence, severity and phenomenology of social anxiety in FEP and SZ, no other studies has treated social anxiety as a comorbid condition, within a "psychosis" framework. However, one commonality shared by all of these studies is that there is an urgent need for a "shift" in the way we deliver treatment to people diagnosed with first-episode psychosis. Other studies (Halperin et al., 2000; Kingsep et al., 2003) have devised interventions that were judged too brief given that they did not include social skills training or psychoeducation on the physiological effects of social anxiety, did not identify whether patients actually met criteria for a comorbid Axis I anxiety disorder, failed to target the issue of dysfunctional beliefs about the self and "shame of illness", and did not include psychotic symptomatology outcome measures as part of the study design. Currently, few studies such as the one we propose, have incorporate the notion of shame and of related dysfunctional cognitions as part of the intervention. The aim of the second phase of this research project is: (1) To conduct a RCT that would test the effectiveness of our manualized intervention in comparison to an alternative condition on reducing shameful cognitions and the associated safety behaviors; (2) To measure the impact of the proposed manualized intervention on functional recovery with the hopes that it will lead to improvements in the patient's quality of life.

5.5.2.2 Intervention Manual

In light of the potential information processing deficits which are associated to both social cognition deficits and social anxiety in addition to reported verbal memory impairments which are characteristic of this "specific population", content delivery should be adapted. Furthermore, information processing deficits play an important in the development and maintaining of psychosocial functioning

impairments, hence program material such as cognitive restructuring or exposure have to be presented slowly and simply and "specifically" (Kinsgep et al., 2003). Consequently, the content of our manual was adapted to a grade-8 reading level to ensure that the material was straightforward in order to be suitable a vast majority of participants.

Current intervention programs are limited in that they are either too brief and hence do not consider the multifaceted nature of social anxiety within their designs. In the case of the current study, the proposed intervention encompassed the most important elements: cognitive restructuring of shame memories and dysfunctional thoughts as well as stigmatizing core beliefs about the self but also incorporating the opportunity to test and regulate social costs appraisal through behavioral experiments. Our intervention program also focused on providing psychoeducation on the prodomal symptoms to prevent future relapse in psychosis. Some studies have shown that working at identifying and normalizing the early signs of psychosis was associated to a reduction in relapse (Gumley et al., 2003). Similarly, working with the dysfunctional and stigmatizing beliefs about the self as related to mental illness was another focus of our group CBT intervention. The intervention targeted the participant's appraisal of the diagnosis of mental illness and the ensuing stigmatizing beliefs. A study looking at the "social ranking model" in a population of individuals diagnosed with schizophrenia actually found that being diagnosed with a MI lead to stigmatizing consequences and a subsequent appraisal of social ranking loss (Iqbal et al., 2000). Moreover, it is believed that omitting to include a measure of self-stigma, as a treatment outcome measure in comorbidity studies, would represent an important methodological limitation (Romm et al., 2011). No other studies investigating the role of comorbid social anxiety in FEP have targeted the issue of dysfunctional self-beliefs, "shame of illness" or stigma.

5.5.2.3 Modification of Maladaptive Relational Patterns through Group Modality

One important advantage of treating social anxiety in a group modality is that the group structure provides an « artificial » yet « representative » depiction of how the participant would interact with others in the external, "natural" world, and hence, a valuable opportunity for the participant to develop more adaptive interpersonal skills. The therapist or group can provide feedback, help the participant to recognize and modify maladaptive appraisals as well as encourage different ways of behaving that may be more adaptive or in line with personal goals and values identified early in the course of treatment (Bieling et al., 2006). The therapist has the ability to convey awareness of these maladaptive relational patterns to the participants and allow them to see how these patterns impact others as well as the group processes.

5.5.2.4 Reducing Stress Reactivity through Psychoeducation and Reappraisal of Stress

Another crucial component of the proposed intervention rests on the notion of increasing tolerance and resiliency to daily stress in order to prevent hospitalization and relapse. Studies have shown that sensitivity to environmental stresses in daily life was a vulnerability marker of psychosis (Myin-Germeys et al., 2005). Hence, improving one's ability to respond to and tolerate stressful situations or life events would appear to be associated with a reduced risk of relapse of psychotic symptoms and concurrent conditions. Although no direct measure of this variable was included as an outcome measure, the qualitative data extracted from the participants anecdotal reports at post and follow-up assessments highlight a perception of having acquired knowledge about "good and bad" stress as well as a certain level of mastery or control over reactivity to stress. Hence, according to them, stress reactivity to events perceived as being stressful appears to have become more "diluted" – given that there was an increased acceptance of the normalcy of "stress". The attributional style corrections may have played a role in helping participants reject the notion that the incidence of stress represented a "personal flaw".

It has been hypothesized that all anxiety disorders share a low perceived control emotional control over negative emotional and bodily reactions (Barlow, 2002). More so in social anxiety, patients often perceive that they cannot exert control over aversive and/or negative events (Barlow, 2002). As part of the group therapy, through psychoeducation and behavioral experiments, participants learned that there are techniques and strategies that they could rely on to help them "adapt" and lower their emotional reaction to these events. Greater personal control has also been shown to be associated with lower reactivity to daily life stressors (Hahn, 2000).

5.5.2.5 Alliance, Therapist Treatment Effects and Group Cohesiveness

Non-adherence to treatment has been associated with impeding treatment success in general by affecting the rate of remission and leading to further psychosocial and functional impairments. With the aim of improving adherence to treatment, studies have attempted to identify variables that would improve this variable. There is strong evidence to support that the quality of the therapeutic alliance is perhaps the most important predictor of positive outcomes in all types of psychotherapies (Martin et al., 2000). A study reported that stronger individual alliance within a group context predicted improved outcomes such as reduced symptoms and lower dropout rates in eleven of thirteen group therapy studies spanning various clinical populations and theoretical orientations (Bernard et al., 2008). Moreover, high treatment engagement and therapeutic alliance have been associated with outcome improvements (Dunn & Bentall, 2007). More specifically, clinician-rated alliance at baseline is a significant predictor of future patient compliance/adherence to treatment in FEP (Appendix A; Montreuil et al., 2012). More importantly, the strongest predictor of a good therapeutic alliance is therapist(s) and participant(s) agreement on the goals for therapy and on the tasks of therapy. In accordance with existing literature, the results of our study on alliance and adherence

revealed that the "task" domain of the Working Alliance Inventory was most significantly correlated with adherence in clinician ratings at baseline (Montreuil et al., 2012).

In the case of the present study, participants were asked to establish their goals for therapy during the initial session of the intervention. At the end of treatment, participants were asked to rate alliance. The majority of participants rated alliance as being good and displayed a great appreciation for therapists. They also shared that they felt safe to self-disclose in the group environment. Some participants even maintained friendships following the end of the group therapy.

5.6 Limitations of the Manualized Intervention CBGT project

5.6.1. Study Design

First, the core of this thesis research project was based on an uncontrolled study design. This represents a study limitation given that it rules out the possibility to draw any causal inferences about the efficacy of our manualized intervention based on the observed outcome measures. In line with principles of clinical trial design, efficacy of a new treatment can only be demonstrated empirically by comparing the response in the treatment group (experimental condition) with that of a control group receiving another alternative treatment. However, in light of the fact that very few studies have looked at comorbid social anxiety in psychosis and that to the best of our knowledge no other studies has measured the effect of a social anxiety intervention on psychotic symptomatology, this uncontrolled study design allowed us: 1) to gather information on "real world" use and practice; 2) detect signals about the benefits and risks of intervention in this sample population; 3) formulate hypotheses that will become the aim of subsequent experiments; 4) provide data needed to design more informative pragmatic clinical trials; and 5) inform clinical practice" (Rosenbaum, 2009). Hence, this study represents the first phase of a more rigorous and ongoing

project that will look at the efficacy of our social anxiety in FEP intervention on functional recovery.

5.6.2 Assessment of Psychosocial Functioning and Quality of Life

Psychosocial functioning evaluation has been shown to be a key component of treatment planning and achieving recovery (Lecomte et al., 2011). Another limitation of the proposed research project lies in the fact no "quantitative" measure of social functioning were included as part of the study design. Given that the goal of the intervention is to target functioning, incorporating these comprehensive measures as part of a future RCT study would provide a more detailed clinical picture of multiple aspects of the participant's psychosocial functioning (Lecomte et al., 2011), hence adding clinical relevance and increasing the external validity of the treatment outcome findings. Therefore, careful consideration of the premorbid functioning should be taken into consideration when devising psychosocial interventions that aim to improve this specific domain of 'remission' given that severity of social anxiety in FEP is associated with poor premorbid functioning (Romm et al., in press).

5.6.3 Heterogeneity of the Sample

While most studies on the subject matter proposed that future research should focus on replicating existing findings in more homogeneous samples, for example in patients with non-affective psychosis (Michail & Birchwood, 2011), our sample not only included affective psychosis patients but also included individuals across the 'course of illness'; from "transitioning into psychosis" to FEP, to the more "crystallized" chronic incidence of the illness. It is important to mention that the chronic cases of SZ, although displaying remarkable improvements, were pruned out of the reported sample in order to sustain a certain level of homogeneity. In line with the reported study design limitation, it has been suggested that current studies should also consider the potential outcome benefit of incorporating non-psychiatric controls.

5.7 Recommendations – Future Implications

5.7.1 Randomized Control Trial

Future research should focus on devising a randomized control trial design (i.e. inclusion of at least one comparative group) in order to test the efficacy of the proposed intervention. Having established the potential benefits of our new psychosocial intervention for social anxiety in first-episode psychosis, the next step is to devise a control condition that can reproduce some of the aspects of our group intervention but that would preclude the active ingredients of group CBT. The added benefits of conducting a RCT as part of a longitudinal study, entails that the participants will be randomly assigned to either treatment condition, hence providing strong evidence of efficacy with limited bias, especially if the evaluator is blinded to the randomization process. Currently, treatment gains need to be explored in larger studies of social anxiety in psychosis within a 'multiple site' model (Halperin et al., 2000).

5.7.2 Measures of Social Functioning

It has been reported that individuals who manifest severe social anxiety had poorer premorbid and current social functioning, lower self-esteem as well as poorer quality of life (Romm et al., in press). Although qualitative reports in the current study revealed that participants' quality of life and overall social functioning had improved, future studies should include quantitative measures of quality of life, enjoyment and satisfaction scores so that we can yield a more accurate assessment of functional remission (Lecomte et al., 2011). It has been suggested that having broader outcome targets such as quality of life in comorbid SA could maximize treatment efficacy (Dalrymple, 2012), especially in the case of a RCT.

5.7.3 Tailored Treatment Approach

It has been suggested that treatment approaches should be tailored specifically for the individual, which would result into better treatment outcomes given that specific changes in the maintaining factors could be closely monitored and treated (Hofmann, 2007). According to Hofmann (2007), in light of the fact that social anxiety is a heterogeneous diagnostic category, the combination of phenotypical symptoms and underlying cognitive processes may vary from one individual to the next. His argument is that depending on this amalgamation or clusters of symptoms, some patients may be more resistant to treatment due to the saliency of the maintaining factors. Future studies should focus on investigating if and how social anxiety in psychosis differs from non-psychotic samples regarding response to treatment.

5.7.4 At-Risk Mental State

Future studies looking at this comorbidity should focus on whether transition into psychosis can be averted through intervention given that highly significant predictors of the development of schizophrenia are detectable years prior to onset. High-risk studies looking at transition into psychosis and/or transition to relapse, found clear evidence of the effect of an affective dimension (i.e. depression, anxiety) as a predictor of outcome. More importantly, social anxiety has been found to be among the strongest predictors of transition into psychosis in this population (Owens et al., 2005). The Edinburgh High-Risk study proposed that anxiety more specifically 'situational anxiety' was the strongest predictor of psychotic conversion (Johnstone et al., 2005). At-risk populations should receive consideration as part of this novel area of research into comorbidities.

5.7.5 Recruitment Difficulties

A commonly reported issue with conducting multi-site randomized control trials is that recruitment difficulties often slow down the anticipated study timeline. Due to the nature of the psychiatric disorder, conducting group intervention

especially for social anxiety in FEP where social impairments and avoidance are highly prevalent; recruitment is even more complex and poses and even greater challenge. In light of the commonly higher than usual attrition or dropout rate, and the diagnostic specificity (i.e. severity of social anxiety in first-episode psychosis), reaching an appreciable sample size can be an arduous task. An additional challenge to consider when devising a group intervention and thereby group composition is the fact that much time may elapse between attrition and unsuitability due in part to misdiagnosis. Therefore, in order to overcome some of these challenges, future research should consider extended recruitment periods, and associated funding, when devising a study protocol. In addition, the clinical trial should address an important research question or area of research and the protocol and data collection method should be as clearly defined and straightforward as possible (Ross et al., 1999). As it is the case with the current study, the recruitment aspects of a larger RCT should be carefully planned and piloted (Ross et al., 1999).

5.7.6 Behavioral measures or biomarkers as predictors of response to treatment

Finally, future research looking into the comorbidity of social anxiety in early psychosis should consider investigating predictors of treatment response using behavioral measures and biomarkers, such as fMRI's. For example, it has been hypothesized that impairments in insight could be a predictor of poor response to treatment and outcome in schizophrenia (Smith et al., 2004). By looking at the brain activity differences in patients with social anxiety disorder, researchers from MIT were able to determine if CBT represented an effective treatment option (Doehrmann et al., 2012). Furthermore, the results of the study, suggested that brain imaging could determine biomarkers that improved predictions for the susceptibility of CBT responsiveness. In accordance with the suggestion that future research should aim to develop tailored intervention, such biomarkers may provide evidence that this

represents an achievable goal and that offering the patients the best treatment option is impending.

5.8 Conclusion

Further research is needed to explore the markers and predictors of social functioning in psychosis. Social anxiety as well as depression may provide exciting research avenues for early interventions of social functioning in FEP. Studies have demonstrated that compliance with psychosocial interventions (13% dropout rate) may be most advantageous compared to medication adherence (42% dropout rate) in light of the lower attrition rate (Villeneuve et al., 2010). If social recovery is to become an attainable goal, it is therefore essential to include these types of intervention as part of treatment given they have been shown to lead to improvements in social functioning (Villeneuve et al., 2010).

Appendix A

Other scientific writing activities and projects

STUDY IV - CASE-MANAGER AND PATIENT-RATED ALLIANCE AS A PREDICTOR OF MEDICATION ADHERENCE IN FIRST-EPISODE PSYCHOSIS

Reference:

Montreuil, T., Cassidy, C., Rabinovitch, M., Pawliuk, N., Malla, A., & Joober, R. (2012). Early medication adherence and working alliance in first-episode psychosis. Journal of Clinical Psychopharmacology, 32 (4), 465-469.

Abstract

Objective: The objective of this study was to evaluate the association between adherence to antipsychotic medication and working alliance (WA) ratings as reported separately by case manager (CM) and patient (P) in first-episode psychosis (FEP) and to identify whether other factors such as poor clinical insight, and substance use, which have been linked to alliance, are also related to poor adherence. Methods: Adherence was evaluated every two months in 81 participants, who met criteria for a DSM-IV psychotic disorder (affective or non-affective) and were treated in a specialized early intervention program. Adherence was measured as the percentage of full doses taken in the past month (0-100%). WA for both CM and P rated alliance was assessed using the Working Alliance Inventory (WAI), which contains three related sub-domains: goal, task domain, and bond. Results: Mean

adherence to antipsychotic medication over the first 3 months following the onset of treatment was 88% of doses taken (s.d. 22). Early treatment adherence was a significant predictor of future adherence in most regressions (p varying from .008—.077), and insight was not predictive in any regression (p's ranging from .32—.99). WA was stable over the course of the study for both P and CM. The "task" domain was most significantly correlated to adherence in CM ratings at baseline. Baseline CM rated WA was a significant predictor of adherence independently of other variables. Conclusion: The results suggest that CM rated working alliance at baseline is a significant predictor of future patient medication compliance/adherence in FEP.

Keywords: first-episode psychosis, adherence, therapeutic alliance, insight, substance use, pharmacology

Introduction

It has been well acknowledged that medication adherence is related to improved clinical outcome (Kampman, Laippala, Vaananen et al., 2002; Malla, Norman & Manchanda, 2002; Novak-Grubic, 2002). Specifically in First-Episode Psychosis (FEP), improved adherence to antipsychotic pharmacotherapy during the early course of treatment was shown to improve the short-term clinical outcome of patients with psychotic disorders (Malla, Norman, Schmitz, et al, 2006). In our previous study, Cassidy et al. (2010) reported that 20 – 56% non-adherence to medication in FEP and that non-adherence was highly correlated to a poorer clinical outcome. The link between poor adherence and poor outcome has been clearly established (Malla & Payne, 2005). Consequently, there is growing interest in finding ways to improve adherence. Some studies have suggested that adherence may be underreported and there may be problems with measurement (Cassidy, Rabinovitch, Schmitz et al. , 2010) while others have focused on patient-specific characteristics (insight, attitude, SES, education, gender, etc.) that could account for improved adherence (Kampman, Laippala, Vaananen et al, 2002; McGorry, Hickie, Yung et al., 2006). While psychosocial interventions have examined multiple determinants of adherence to treatment, (Constantino, Arnow, Blasey et al., 2005; Gleeson, Larsen, McGorry et al., 2003; Zimmermann, Favrod, Trieu et al., 2005) pharmacological interventions have mainly focused on the more technical aspects of treatment such as measurement or mode of delivery. Thus, overlooking the likely important influence of patient-clinician relationship over treatment outcome (Bentall, 2003). Alliance has been linked to treatment outcome (Castonguay, Constantino & Grosse Holtforth, 2006) and so has adherence (Corriss, Smith, Hull et al., 1999; Malla, Norman, Schmitz et al, 2006) although the relationship between the two variables remains unclear. Consistent with findings of studies with other populations, therapeutic alliance in schizophrenia has been linked with treatment adherence and outcome

(Gehrs & Goering, 1994; Lacro, Dunn, Dolder et al., 2002; Svensson & Hansson, 1999).

While adherence to medication is a crucial factor in the attainment of remission, alliance between a patient and his/her clinician is clinically well known to influence outcome. It is possible that alliance and these two determinants of outcome are inter-related. Bentall et al. (2002) found that a link could be established between patient rated therapeutic alliance and the predicted outcome in both cognitive-behavioural therapy as well as with supportive counseling for first-episode psychosis patients. To our knowledge, no other pharmacological-focused study has looked at the role of alliance on medication adherence in FEP. It has been shown that poor quality of life is related to residual psychopathology, longer delays in treatment, and poor premorbid adjustment (Malla & Payne 2005). Hence, early intervention that could lead to improved adherence could also have potential effects on functional outcome and quality of life. As a follow-up to our previous study (Cassidy, Rabinovitch, Schmitz et al., 2010), the aim of the current study is to measure adherence to antipsychotic medication in relation to alliance as rated separately by case manager and patient.

Materials and Methods

Participants

All subjects were being actively treated at the Prevention and Early intervention Program for Psychoses-Montreal (PEPP Montreal), Canada, a specialized early-intervention service which provides assessment and treatment to all cases of first-episode psychosis (FEP) in one sector of a large urban setting. The details of the treatment model have been provided elsewhere. Eligibility criteria for the study included age 18–30 years, presence of symptoms meeting criteria for a DSM-IV psychotic disorder (affective or non-affective), never having received antipsychotic therapy for longer than 1 month prior to entry into the treatment

program, and not being under court-order to take medication. All participants (N=152) were within the first two years of their treatment at the time of study recruitment and from this number, the (N=81) subjects who agreed to participate were recruited at three months following entry into the treatment program. The study protocol was approved by the Research Ethics Board of the Douglas Hospital and patients provided informed consent to participate.

Instruments and Assessment

Medication adherence. Adherence to principal medication (an antipsychotic in 95% of cases and a mood stabilizer in the other 5%) was measured for each patient for each of the 7 months of the study. All measures of adherence were taken between the 9th and 12th week following program entry. This measure was determined through consensus drawing from four sources of adherence data (patients, clinicians, family members when available, and pill counting) at bi-monthly meetings attended by each patient's case manager, the researchers performing patient and family adherence interviews, and a senior investigator not directly involved in the patient's care. In determining the consensus value pill count was given priority followed by clinician report, if the former was missing. If either source was deemed unreliable, team discussions determined which of the four sources was most reliable. If subjects were prescribed multiple antipsychotic medications the average adherence to all antipsychotic medications was taken. Adherence from each source was measured as the percentage of full doses taken in the past month (0-100%). Patients and family members reported adherence in the context of brief interviews with a research assistant not involved in patient care. Clinician report was provided by the case manager responsible for each subject. Case managers are very involved in patient care, systematically ask patients about adherence, and have contact with their patients on a minimum weekly basis over the first 3 months of treatment and a minimum bimonthly basis thereafter. Pill counts were performed by asking subjects to bring their pill bottles to the clinic. The number of missed doses was computed from the

difference between the actual and expected number of pills remaining in the bottle. In the case of patients taking depot medication (n = 4) an injection one day late signified one missed dose. The consensus measure of adherence was also measured as the percentage of full doses taken in the past month (0-100%) and then dichotomized to differentiate whether a patient was adherent (> 75% of full doses taken) or non-adherent (< 75% of full doses taken) for each month of the study. The number of months over the course of the study in which a subject met the adherence threshold were counted and summed (values ranging from 0 to 7) and divided by the total number of months during which the patient participated in the study to provide the fraction of months during which the subject met the adherence threshold. For regression analyses predicting months of adherence based on working alliance the fraction of adherent months subsequent to the measurement of working alliance was calculated and employed in analyses. This measurement did not incorporate information from pill counts but only from patient report and chart review. This measure of adherence was coded at four levels 0 (no doses taken), 1 (< 25% of doses taken), 2 (25-50% doses taken), 3 (50-75% doses taken, and 4 (> 75% doses taken). The average (ranging from 0-4) over the first 3 months of treatment was calculated and used in analyses.

Working Alliance

The Working Alliance Inventory (WAI) (Tracey & Kokotovic, 1989) provides a measure of the strength and quality of helping alliances between patients and clinicians. It contains three related components: patient and therapist agreement on the goals of treatment (goal sub-domain); patient and therapist agreement on the tasks to achieve these goals (task sub-domain); and the development of a personal bond between patient and therapist (bond sub-domain). For this study the WAI-short form (12 items) was used with both the therapists (case managers) and patients completing their respective version at the time of the first assessment for the study. Each sub-

domain contains 4 items which are rated on a 7-point Likert scale. This measure of alliance has a strong internal consistency for both the patient-rated version (= .85) and the clinician-rated version (= .74). Working alliance was measured every month for 7 consecutive months in patients and every 3 months by clinicians. Working alliance was measured at study baseline with a mean of 62.1 for patient-rated questionnaires (s.d. = 1.47) and a mean of 58.3 for the clinician-rated questionnaire (s.d. = 1.16). These values were used in all regression analyses although patient-rated alliance from month 1 or month 2 of the study was employed for patients whose earlier values were missing.

Clinical and Demographic variables

Primary and secondary diagnoses were assessed by trained research staff using the Structured Clinical Interview for DSM-IV (First, Spitzer, Gibbon et al., 1995) followed by a consensus between two senior psychiatrists (A.M. & R.J.). A subject was classified as having a substance use diagnosis if they met criteria for abuse or dependence of drugs or alcohol at any point in their life. Insight was measured using the Scale to Assess Unawareness of Mental Disorder (SUMD) (Amador, Flaum et al., 1994). The first three questions of the SUMD were summed (Q1, Awareness of mental illness; Q2, awareness of response to medication; and Q3, belief that patient needs medication or would benefit from it) with a similar measure used in other studies (Buchy, Bodnar, Malla et al., 2009; Buchy, Czechowska, Chochol et al., 2010). The severity of each aspect of insight is assessed on a five-point scale from 1 (aware) to 5 (unaware).

Substance intake for drugs and alcohol was assessed in order to serve as a possible confounding variable. All patients were administered the Drug Abuse Screening Test (DAST-20) – (Skinner, 1982) as well as the Alcohol Use Disorders Identification Test (AUDIT) – (Saunders, Aasland, Babor et al., 1993). Both of these measures have been validated for a population of first-episode psychosis patients (Cassidy, Schmitz & Malla, 2008).

Data analysis

Correlational analyses were used to evaluate the existing association between months of adherence to antipsychotic medication and alliance as rated by case manager and patient. Pearson correlations were calculated for total scores on case manager-rated and patient-rated working alliance at study baseline as well as at three and six months. In addition to calculating the total working alliance score, Pearson correlations were calculated for each of the sub-domain that comprise the total alliance score (i.e. task, bond and goal) in both patient and case manager working alliance ratings (i.e. scores averaged over all available time points – baseline, three-months, and six-months) in order to evaluate the degree of the relationship between medication adherence and each individual sub-domain of the working alliance over the course of the study timeline. Examination of the working alliance sub-domains allows one to assess if the sub-domains are differentially associated with adherence. Regression analyses were utilized to determine the degree of association between total case manager and patient-rated working alliance at baseline with patient medication adherence. These same analyses were also performed using the 'task' sub-domain of the working alliance case manager and patient-rated working alliance given that amongst all three sub-domains, this sub-domain was found to be the most strongly associated to adherence. All linear regression analyses included the following covariates: substance use diagnosis, insight at study baseline and adherence following treatment onset. These univariate analyses were determined to be significant at ($P < 0.05$). All statistical analyses were performed on SPSS version 15.0 for Windows (SPSS Inc, Chicago, Il, September 2002).

Results

Of the 81 subjects there were 55 males (68%), 67 were single (never married; 83%), 49 had a lifetime SCID diagnosis of substance-use disorder (61%), 63 had a

primary diagnosis of non-affective psychosis and 18 of affective psychosis, the mean age was 23.7 years (s.d. = 3.5), 2 were hospitalized or living in a controlled environment at the time of study baseline (3%) and mean adherence to antipsychotic medication over the first 3 months following the onset of treatment was 88% of doses taken (s.d. 22). Participation rate in the study was fairly high, of 152 consecutive cases admitted to the program who met eligibility criteria for the study, 34 had lost contact with clinical follow-up by the time of recruitment and 30 refused to participate in the study, a further 7 cases participated in the study but were not included in the present report due to missing data. Subjects who refused the study did not differ from participants on any of the above parameters (data not shown, all p's > .22).

Relationship Between Working Alliance and Adherence

Table A.1 shows the descriptive data on the association between patient-rated and case manager-rated alliance scores and adherence. Working alliance is stable over the course of the study as rated by both patients and case managers (within subjects ANOVA $F(2, 49) = .22$; $p = .80$ and $F(2, 31) = .28$; $p = .75$ respectively). Case manager-rated working alliance (WA) and patient-rated WA were substantially inter-correlated at baseline and three months after onset of the study as presented in Table A.2. Univariate analyses show that of the global working alliance scale, the sub-domain "task" was most significantly associated with adherence over all three timepoints (i.e. baseline, month three and month six) with a value of ($R = 0.33$, $p = 0.03$, $N = 79$) for the patient-rated version and ($R = 0.45$, $p < 0.001$, $N = 81$) for the case manager-rated scale. The values for the remaining regressions of sub components and covariates of interest are presented in Table A.3.

Given that the number of participants was greatest at baseline for both shared patient and case manager-rated working alliance and that correlations between scores appeared to be most significant early in the course of the study we used linear regression analyses to assess whether baseline working alliance (i.e. patient and case

manager-rated independently) would predict antipsychotic medication adherence. Results revealed that patient-rated working alliance was not a significant predictor of adherence at baseline, for the total WA score ($\beta = 0.003, p = 0.31, CI_{.95} = -.003, .010$) nor for the WA task domain score ($\beta = 0.014, p = 0.11, CI_{.95} = -.003, .030$). As shown in Table A.4, case manager (CM) rated WA scores do seem to be a valid predictor of adherence, contrary to patient-rated WA. Linear regressions revealed respectively that baseline case manager-rated WA total score and task domain score were both predictive of adherence ($\beta = 0.011, p = 0.020, CI_{.95} = .002, .020$) and ($\beta = 0.031$, $p = 0.027, CI_{.95} = .002, .061$). All regressions found in Table A.3 and Table A.4 included the covariates substance use diagnosis, adherence following treatment onset, and insight at study baseline.

Discussion

This follow-up study asked the question whether adherence was associated to patient and clinician rated working alliance. As it has been reported in previous papers (Lecomte, Spiedel, Leclerc et al., 2008), non-adherence to treatment has been associated with impeding treatment success. Generally speaking, non-adherence has been shown to affect the rate of remission, leading to further psychosocial and functional impairments. The opposite is also true, that improved adherence to antipsychotic therapy, during the early course of treatment, has been strongly associated with outcome success (Malla & Payne, 2005; Malla, Norman, Schmitz et al., 2006; Malla, Norman & Manchanda, 2002). Furthermore, there has been much research that has focused on patient-specific characteristics to better account for treatment outcome (Kampman, Laippala, Vaananen et al., 2002; McGorry, Hickie, Yung et al., 2006). Others have proposed better methods for measuring adherence (Cassidy, Rabinovitch, Schmitz et al., 2010). Some have suggested that pharmacological interventions may have overlooked the importance of patient-

clinician relationship over treatment outcome (Bentall, 2003) unlike many psychosocial interventions. Our study has revealed that clinician-rated working alliance at baseline is a significant predictor of patient medication adherence in FEP. Based on these preliminary findings, it is imperative that future pharmacological research studies include measurement of working alliance, as part of identifying crucial variables. These variables may have a predictive value in improving treatment adherence and consequently, increasing patient engagement in early psychosis services and programs.

Furthermore, our results which indicated that working alliance sub-domain "task" was most strongly associated to adherence throughout the course of the study for both the patient and case manager-rated versions. These findings were in agreement to another study (Kampman, Laippala, Vaananen et al., 2002). The latter has also found a greatest correlation to task domain for working alliance ratings (WAI) (Corriss, Smith, Hull et al., 1999). Although both patients and case manager-rated working alliance were stable over the course of the study, we could not find a similar association between patient-rated working alliance and adherence. This discrepancy may be due to existing differences between patient and clinician raters in how they understand the instrument, in this case, the working alliance scale. Another possible explanation lies in the notion of "desirable outcome". The clinician may perceive a shared alliance with his patients without this being the case from the patients' perspective, even when they are medication adherent. Similarly, it could be that clinicians tend to rate alliance as being higher for patients who are taking their medication.

This study has some limitations. Given that we chose to use the method of pill count to assess adherence and that we did not subsequently supplement our measures, some could perceive this approach as a potential limitation. This measure has been widely disregarded on the basis that it does not constitute a "gold standard" for measuring antipsychotic adherence in terms of reliability. However, a study published earlier this year (Cassidy, Rabinovitch, Schmitz et al., 2010) revealed that pill count

appeared to be a slightly better measure of antipsychotic adherence when compared to patient or clinician reports. In fact, this method was found to be most strongly correlated to clinical improvement. Moreover, all measures were in good agreement with one another (Cassidy, Rabinovitch, Schmitz et al., 2010; Rabinovitch, Béchard-Evans, Schmitz et al., 2009). Finally, given that working alliance scores were obtained from clinician ratings, it is possible that the case managers may have had an 'evaluation bias' towards the patients who were poorly engaged in treatment. However, as we have presented in the 'methods' section of this paper, the WAI (working alliance) scale has been shown to have strong content validity and reliability.

In conclusion, our results provide further evidence of the importance of working alliance in the attainment of pharmacological treatment adherence, early in the course of illness, more specifically in FEP. Clinician-rated alliance appears to be a valid predictor of adherence and is believed to affect treatment outcome. In light of the current findings, there is a need to replicate this study by proposing additional and more rigorous measures of adherence especially in pharmacological study designs.

References

1. Amador, X. F., Flaum, M., et al. (1994). Awareness of illness in schizophrenia and schizoaffective and mood disorders. *Arch Gen Psychiatry, 51*, 826-836.

2. Bentall, R. P. (2003). *Madness explained - Psychosis and human nature.* London: Penguin.

3. Buchy, L., Bodnar, M., Malla, A., Joober, R., & Lepage, M. (2010). A 12-month outcome study of insight and symptom change in first-episode psychosis. *Early Intervention in Psychiatry, 4*(1), 79-88.

4. Buchy, L., Czechowska, Y., Chochol, C., Malla, A., Joober, R., Pruessner, J., & Lepage, M. (2009). Toward a Model of Cognitive Insight in First-Episode Psychosis: Verbal Memory and Hippocampal Structure. *Schizophr Bull*, 1-10.

5. Cassidy, C. M., Rabinovitch, M., Schmitz, N., Joober, R., & Malla, A.K. . (2010). A Comparison Study of Multiple Measures of Adherence to Antipsychotic Medication in First-Episode Psychosis. *Journal of Clinical Psychopharmacology, 30*(1), 64-67.

6. Cassidy, C. M., Schmitz, N., & Malla, A.K. (2008). Validation of the alcohol use disorders identification test and the drug abuse screening test in first episode psychosis. *Canadian Journal of Psychiatry, 53*(1), 26-33.

7. Castonguay, L. G., Constantino, M. J., & Grosse Holtforth, M. (2006). The working alliance: Where are we and where should we go? . *Psychotherapy, 43*, 271-279.

8. Constantino, M. J., Arnow, B. A., Blasey, C., & Agras, W. S. (2005). The association between patient characteristics and the therapeutic alliance in cognitive-behavioral and interpersonal therapy for bulimia nervosa. *Journal of Clinical Psychology, 73*, 203-211.

9. Corriss, D. J., Smith, T.E., Hull, J.W, Lim, R.W., Pratt, S.I., & Romanelli, S. (1999). Interactive risk factors for treatment adherence in a chronic psychotic disorders population. *Psychiatry Res, 89*, 269-274.

10. First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. (1995). Structured clinical interview of DSM-IV axis I. *New York: Disorders (SCID-I) clinical version.*

11. Gehrs, M., & Goering, P. (1994). The relationship between the working alliance and rehabilitation outcomes of schizophrenia. *Psychosocial Rehabilitation Journal, 18*(2), 43-54.

12. Gleeson, J., Larsen, T.K., & McGorry, P.D. (2003). Psychological treatment in pre- and early psychosis. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 31*, 229-245.

13. Kampman, O., Laippala, P., Vaananen, J. et al. (2002). Indicators of medication in first episode psychosis. *Psychiatry Research, 110*, 39 - 48.

14. Lacro, J. P., Dunn, L. B., Dolder, C. R., et al. (2002). Prevalence of and risk factors for medication nonadherence in patients with schizophrenia: a comprehensive review of recent literature. *Journal of Clinical Psychiatry, 63*, 892 –909.

15. Lecomte, T., Spidel, A., Leclerc, C., MacEwan, W., Greaves, C., & Bentall, R. P. (2008). Predictors and profiles of treatment non-adherence and engagement in services problems in early psychosis. *Schizophrenia Research, 102*(1-3), 295-302.

16. Malla, A., & Payne, J. (2005). First-Episode Psychosis: Psychopathology, Quality of Life, and Functional Outcome. *Schiz. Bull, 31*(3), 650- 671.

17. Malla, A., Norman, R., Schmitz, N., et al. (2006). Predictors of rate and time to remission in first-episode psychosis: a two-year outcome study. *Psychol Med, 36*, 649– 658.

18. Malla, A. K., Norman, R. M., & Manchanda, R. (2002). Status of patients with first episode psychosis after one year of phase-specific community oriented treatment. *Psychiatric Services, 53*, 458-463.

19. McGorry, P. D., Hickie, I., Yung, A.R., Pantelis, C. & Jackson, H.J. (2006). Clinical staging of psychiatric disorders: A heuristic framework for choosing earlier, safer and more effective interventions. *Aust. N. Z. J. Psychiatry, 40*, 616–622.

20. Novak-Grubic, V. T., R. (2002). Predictors of noncompliance in males with first-episode schizophrenia, schizophreniform and schizoaffective disorder. *European Psychiatry, 17*, 148-154.

21. Rabinovitch, M., Béchard-Evans, L., Schmitz, N., Joober, R., & Malla, A. (2009). Early predictors of nonadherence to antipsychotic therapy in first-episode psychosis. *La Revue canadienne de psychiatrie, 54*(1), 28-35.

22. Saunders, J. B., Aasland, O. G., Babor, T. F., de la Fuente, J. R., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption — II. *Addiction, 88*, 791–804.

23. Skinner, H. (1982). The Drug Abuse Screening Test. *Addictive Behaviors, 7*, 363–371.

24. Svensson, B., & Hansson, L. (1999). Relationships among patient and therapist ratings of therapeutic alliance and patient assessments of therapeutic process: a study of cognitive therapy with long-term mentally ill patients *Journal of Nervous Mental Disorder, 9*, 579–585.

25. Tracey, T. J., & Kokotovic, A.M. (1989). Factor structure of the Working Alliance Inventory. *J Consult Clin Psychol, 1*, 207–210.

26. Zimmermann, G., Favrod, J., Trieu, V., & Pomini, V. (2005). The effect of cognitive behavioural treatment on schizophrenia spectrum disorders: a meta-analysis. *Schizophr Res, 77*, 1–9.

Table A.1
Descriptive data on alliance and adherence

		N	Mean	Std. dev
Patient-rated working alliance total score	Study baseline (or first available time point	74	62.4	13
	Month 3	56	63.4	12
	Month 6	53	64.4	12
Clinician-rated working alliance total score	Study baseline	76	59.1	9.6
	Month 3	67	59.9	8.9
	Month 6	62	59.5	11
Fraction of months adherent (>75%) over the course of the study		81	.66	.36

Table A.2
Comparison of Case Manager-rated and Patient-rated working alliance through course of study

			Patient-rated total working alliance score		
			Study baseline	Month 3	Month 6
Case manager-rated total working alliance score	Study baseline	Pearson Correlation	0,36		
		Sig. (2-tailed)	0,006		
		N	59		
	Month 3	Pearson Correlation		0,36	
		Sig. (2-tailed)		0,012	
		N		49	
	Month 6	Pearson Correlation			0,196
		Sig. (2-tailed)			0,196
		N			45

Table A.3

Univariate analyses of Patient-rated and Case Manager-rated Working Alliance sub domains, and confounding variables over total months of adherence

		N	Adherent months/total months in study (>75% adherence to principal med study baseline to month-m6)		
			Pearson R	T	P
Patient-rated working alliance scores averaged over all available time points	Task	79	.33		.003*
	Bond	79	.27		.018*
	Goal	79	.27		.015*
	Total	78	.29		.009*
Case manager-rated working alliance scores averaged over all available time points	Task	81	.45		< .001*
	Bond	81	.34		.002*
	Goal	81	.40		< .001*
	Total	81	.44		< .001*
Insight averaged over all available study time points		81	.25		.024*
Adherence following treatment onset		81	.35		.001*
Lifetime substance use disorder		81		1.9	.061

* = p significant at < 0.05

Table A.4

Linear regressions predicting the number of subsequent months of adherence (>75% of doses taken) based on working alliance scores at study baseline

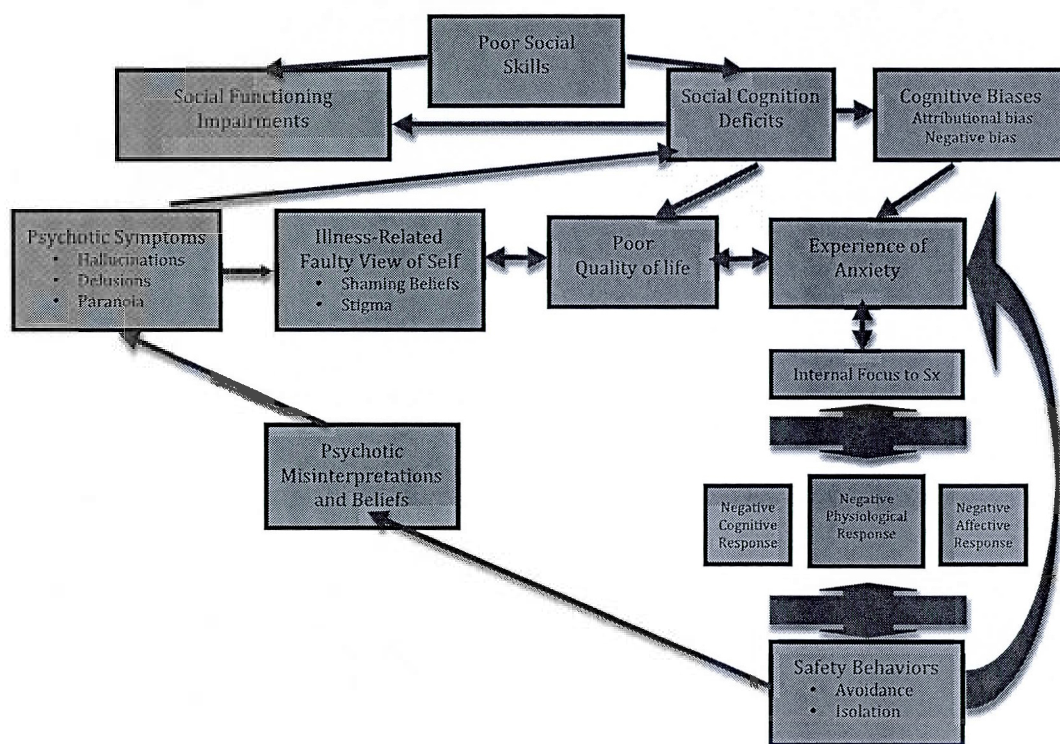
		N	Adjusted R^2 for model	B	95% confidence interval for B	P
Patient-rated	WAI total score at study baseline	74	.19	.003	-.003 – .010	.31
	WAI task domain score at study baseline	75	.21	.014	-.003 – .030	.11
	WAI task domain score at study baseline	68	.25	.015	-.002 – .031	.090
Clinician-rated	WAI total score at study baseline	76	.23	.011	.002 – .020	.020*
	WAI task domain score at study baseline	76	.23	.031	.004 – .058	.027*
	WAI task domain score at study baseline	74	.27	.028	.000 – .056	.054

* = p significant at < 0.05

Analyses include the covariates substance use diagnosis, adherence following treatment onset, and insight at study baseline.

Appendix B

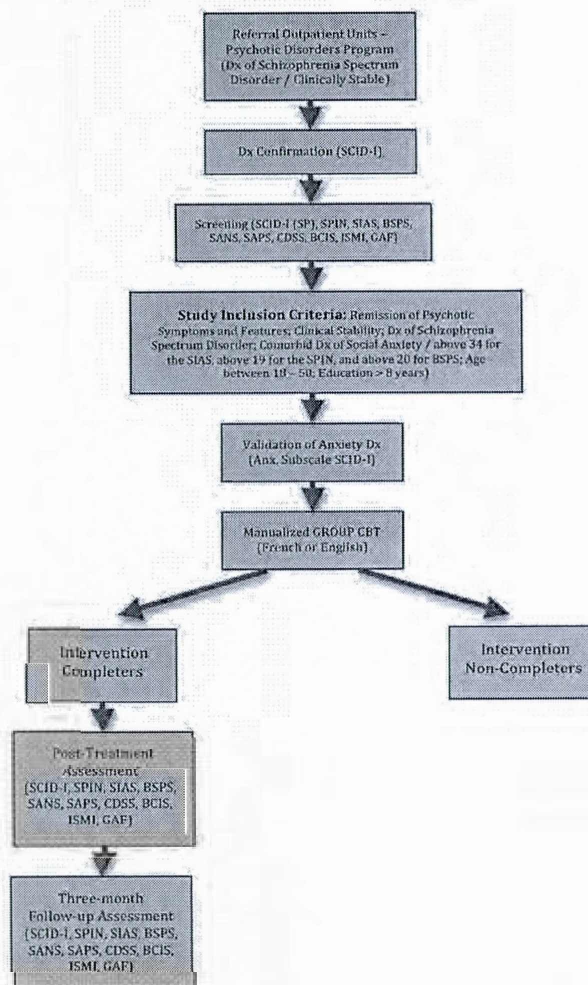
Model of social anxiety and shame in first-episode of psychosis based on the work of Michail & Birchwood (2009)


Poor Social Skills
Social Functioning Impairments
Social Cognition Deficits
Cognitive Biases
Attributional bias
Negative bias
Psychotic Symptoms
• Hallucinations
• Delusions
• Paranoia
Illness-Related Faulty View of Self
• Shaming Beliefs
• Stigma
Poor Quality of life
Experience of Anxiety
Internal Focus to Sx
Psychotic Misinterpretations and Beliefs
Negative Cognitive Response
Negative Physiological Response
Negative Affective Response
Safety Behaviors
• Avoidance
• Isolation

Appendix C

Study Timeline

Timeline of Proposed Trial Design – Preliminary Pilot Study (Intent-to-treat design)



Appendix D

Cognitive-Behavioral Group Therapy Intervention Manual Outline

Session 1: Introduction

Treatment Plan and Rationale

- Familiarize the client to group participation and conduct
- Defining individual and personal goals for therapy
- The CBT principles
- Introduce the CBT interaction model
- Efficacy of CBT for treatment of social anxiety and schizophrenia
- Evidence of effectiveness of CBT for this comorbidity
- Explaining the model of cognitive therapy
- Association between thoughts, behaviors, and feelings.
- Experience of shame in schizophrenia

Assigned Homework

- Ask client to complete the "My goal and objectives for therapy" sheet at home.

Session 2: Psychoeducation on Social Anxiety

Treatment Plan and Rationale

- Nature of fear and social anxiety
- Myths and misconceptions regarding fear and social anxiety
- Cognitive model of social anxiety
- Interaction of the multi-components of fear and distress (e.g. physiological, cognitive and behavioral)
- Overview of treatment plan
- Description and importance of at-home homework compliance

Assigned Homework

- Psychoeducational reading (e.g. self-help, monitoring strategies) on SA
- Anxiety Log or Monitoring grid (daily entry)

Session 3: Psychoeducation on stress

Treatment Plan and Rationale

- The nature of stress
- How does Stress affect me?

- Is Stress always bad for me?
- Signs of stress
- Good and Bad Stress

Assigned Homework

- Ask participant to complete the reading of "My Stress Level" for next week.
- Teaching of Relaxation Techniques and Strategies
- Anxiety monitoring including implementation of relaxation/breathing exercises

Session 4: Psychoeducation on the experience of psychosis

Treatment Plan and Rationale

- Nature of delusions and three symptom_categories in psychosis (e.g. positive, negative and disorganization)
- Myths and misconceptions regarding schizophrenia
- Etiological association of social anxiety and psychosis
- Stigma related to the onset and experience of illness – normalization of experience
- Identification of personal dysfunctional beliefs, stigmas, and delusions
- Overview of treatment plan, including treatment of delusional and stigmatizing beliefs related to the self and the illness

Assigned Homework

- Psychoeducational reading on schizophrenia
- Thought record (e.g. daily log entry of thoughts related to self and the illness)

Session 5: Introduction to Cognitive Distortions

Treatment Plan and Rationale

- Type and description of cognitive distortions (Aaron Beck)
- Application of cognitive distortions to thought record
- Overview of how cognitive distortions influence social anxiety in First-episode psychosis
- Group activity on cognitive distortions where client is taught and practices how to identify his or her own anxious and/or stigmatizing thoughts.

Assigned Homework

- Thought record focused on the cognitive nature of social anxiety and stigma

related to first-episode psychosis

Session 6: Cognitive Restructuring

Treatment Plan and Rationale

- Identification of obstructive thoughts and feelings
- Introducing the links and associations between obstructive thoughts / feelings and behaviors
- Differentiating between thoughts, feelings, situations and facts
- Challenging obstructive thoughts and feelings

Assigned Homework

- Challenging anxiety-provoking thoughts and feelings
- Maintain a record of Cognitive Restructuring

Session 7: Social Skills Training – Part I

Treatment Plan and Rationale

- Presenting the rationale and benefits of social skills training
- Identifying the various types of behaviors targeted in social skills training
- Teaching the specific social skills of interest
    - Nonverbal communication • Conversational skills
- Role play with therapist and other group members
- Introduce the notion of Assertiveness Training

Assigned Homework

- Psychoeducational reading on the nature of Social Skills Training
- List specific social skills that require improvement
- Implementation of the actual rehearsed scenario

Session 8: Social Skill Training Part II / Assertiveness Training

Treatment Plan and Rationale

- Recognizing the presence of an assertiveness problem (signs and indication)
- Explore the various causes and sources of the self-assertiveness difficulties

- Defining the concept of assertiveness
- Identifying and listing the areas (e.g. with who, when, what) where the individual fails to be assertive
- Preparing the scenario for action, engaging in role play
- Implementing the assertiveness training scenario

Assigned Homework

- Psychoeducational reading on assertiveness
- Defining the scenario for the implementation of assertiveness skills

Sessions 9 & 10 : Exposure – Part I

Treatment Plan and Rationale

- Psychoeducation on avoidance as maintaining factor in social anxiety and psychosis
- Psychoeducation on the use of exposure hierarchy
- Elaborate a list of possible obstacles and appropriate responses in the event of failed exposure
- In-session rehearsal of the exposure plan
- Maintain cognitive restructuring during in-vivo exposure
- Feedback following exposure therapy
- Identification of specific behaviors that have been targeted for change

Assigned Homework

- Psychoeducational reading on exposure
- Maintain Cognitive Restructuring (e.g. thought record or log)

Session 11: Exposure – Part II

Treatment Plan and Rationale

- Review the detailed hierarchy of exposure therapy scenario
- Review the list of noted obstacles and appropriate responses in the event of failed exposure
- In-session rehearsal of the exposure plan
- Feedback following exposure therapy
- Identification of specific behaviors that have been targeted for change

Assigned Homework

- Rehearsing the exposure plan and scenario
- Maintain Cognitive Restructuring (e.g. thought record or log)

Session 12: Relapse Prevention

Treatment Plan and Rationale

- Warning signs for relapse in psychosis
- Smaller group activity related to invididual-sharing of prodromal symptoms
- Review consequences and set-backs of relapse of symptoms
- Identification of personal resources / emergency planning in case of relapse
- Consider 'booster' sessions and follow-up visit

Assigned Homework

- Setting up an at-home plan of available resources in the event of a relapse (e.g. family, spouse, friend, case manager, list of phone numbers, etc).
- Reading on Relapse Prevention and filling the Symptom Identification Checklist

Session 13: Maintenance strategies and Termination

Treatment Plan and Rationale

- Maintaining gains and coping skills inventory overview
- Importance of maintaining relaxation techniques, cognitive restructuring, exposure in-vivo
- Identification of remaining personal beliefs, stigmas, and delusions
- Identification of personal strengths, internal resources and personal achievements
- Highlighting the importance of generalization of personal gains attained through therapy

Session 14: Social Activity

Treatment Plan and Rationale

- Highlight the strengths of the participant.

- Provide psychoeducation and validation for the participant's ability to successfully complete something that he/she initiated.
- Empowerment through socialization.
- Exposure to a social situation where interactions are encouraged
- Confrontation of feared situations (i.e. eating in front of others, initiating a conversation in a social setting, etc.).

APPENDIX E

Clinician Manual French Version

INTERVENTION DE GROUPE MANUALISÉE POUR LE TRAITEMENT DE L'ANXIÉTÉ SOCIALE EN SCHIZOPHRÉNIE

Approche cognitivo-comportementale

Protocole du clinicien

Développé par et basé sur les travaux de

Tina C. Montreuil

Révision

Par Dr Martin Lepage, Dr Claude Bélanger, Dre Gail Myhr

Mai 2010

Le contenu de ce manuel comporte une intervention pour l'anxiété sociale en schizophrénie (thérapie cognitivo-comportementale de groupe), est basé sur le protocole de recherche qui a été rédigé par Tina C. Montreuil (2011). Par le fait même tous droits de traduction, d'adaptation et de reproduction d'un extrait quelconque de ces fascicules par quelque procédé que ce soit, et notamment par photocopie ou microfilm, est strictement interdite sans l'autorisation écrite des auteurs.

INTERVENTION DE GROUPE MANUALISÉE POUR LE TRAITEMENT DE L'ANXIÉTÉ SOCIALE EN SCHIZOPHRÉNIE

Thèmes des séances

Semaine 1: Introduction

Semaine 2: Psychoéducation sur l'anxiété sociale

Semaine 3: Psychoéducation sur le stress (bon versus mauvais)

Semaine 4: Psychoéducation sur les symptômes psychotiques

Semaine 5: Introduction aux distorsions cognitives

Semaine 6: Restructuration cognitive

Semaine 7: Entraînement aux habilités sociales – Première partie

Semaine 8: Entraînement aux habilités sociales – Deuxième partie

Semaine 9: Introduction à l'exposition – Première partie

Semaine 10: Exposition – Deuxième partie

Semaine 11: Exposition – Troisième partie

Semaine 12: Prévention de la rechute

Semaine 13: Maintien des acquis

TCC pour l'Anxiété Sociale : INTRODUCTION

Le but de la séance d'aujourd'hui est de se familiariser au contexte de groupe et d'explorer les principes de la thérapie cognitivo-comportementale (TCC). Deuxièmement, nous aurons comme exercice à définir nos besoins individuels ainsi que nos objectifs personnels relatifs à la thérapie. Par ailleurs, les thérapeute et co-thérapeute tenteront de fournir les informations nécessaires sur l'efficacité de la thérapie cognitivo-comportementale pour le traitement de l'anxiété sociale chez les individus ayant vécu une expérience psychotique.

1. Félicitation des participants

Féliciter les participants pour le participant pour sa présence, représente un indice motivationnel important.

2. Présentation des thérapeutes et des participants

On vous demandera de nous présenter brièvement en utilisant votre prénom seulement. Par exemple, le thérapeute va dire: «Bonjour, mon nom est Tina".

3. Présenter les règles du groupe

1. Tous les membres doivent participer à chacune des 14 séances ainsi qu'à prendre part aux activités et discussions de groupe selon leur niveau de confort personnel. La participation au sein du groupe est fortement recommandée puisqu'elle est perçue

Copyright © 2011 Tina C. Montreuil

comme étant une opportunité de socialisation, ce qui est centre même du plan de traitement. De plus, la participation contribue à créer l'unité dans le groupe par l'effet bénéfique de la normalisation qui découle du partage de l'expérience de vie des autres participants.

2. Dû à des circonstances qui sont hors de notre contrôle, il se peut que vous ne puissiez assister à l'une des rencontres. Si en raison de maladie ou en cas d'urgence, nous encourageons le participant à communiquer avec l'un ou l'autre des thérapeutes afin de leur faire part de l'absence le plus tôt possible (au minimum 24 heures à l'avance – avant la tenue de la prochaine séance) dans le but de prévenir les délais à l'intérieur de la séance respective.

3. La confidentialité venant du thérapeute, du co-thérapeute ainsi que du groupe est très fortement recommandée à tout moment durant chacune des séances. Tous les partages d'information confidentielle qui sont livrés durant les séances hebdomadaires, doit demeurer confidentielle et ne pas « quitter les paramètres » de la pièce où auront lieu les séances. Les participants sont encouragés de se restreindre de divulguer des noms, des expériences personnelles ou informations qui leur sont reliés ou reliés à tout autre participant du groupe à l'extérieur du contexte de la thérapie de groupe.

4. Chacun des membres doit être présent à toutes les séances de groupe et se présenter de façon convenable et professionnelle. Ceci signifie qu'il ne sera pas acceptable pour un participant d'être ivre ou intoxiqué aux rencontres, de se présenter à une séance accompagné d'un non-participant, d'utiliser un langage vulgaire ou familier, d'être hostile et agressif ou encore violent à l'égard des autres participants ou thérapeutes.

Copyright © 2011 Tina C. Montreuil

5. Tous les membres sont encouragés à se forger des amitiés au sein du groupe. Les relations amicales sont fortement encouragées par les thérapeutes. Toutefois, il est recommandé que les participants se restreignent d'entrer en liaisons / relations romantiques avec les autres participants du groupe.

6. Il est recommandé que tous les participants demeurent dans la pièce où la séance aura lieu. Les pauses seront désignées à un moment donné durant chacune des séances, à la mi-temps. Certaines séances pourraient déclencher une réaction émotive plus chargée. Toutefois, il est important de demeurer dans la pièce afin de pouvoir recevoir le support et l'expertise provenant des thérapeutes – puisqu'ils ont été formés dans le but de remédier et d'intervenir lors de telles situations.

3. <u>Psychoéducation sur la thérapie cognitivo-comportementale</u>

La TCC se concentre sur la façon dont les gens pensent «cognitive» et agissent «comportementale».

Selon le modèle de la TCC, les pensées qui sont rattachées à une situation affectent la façon dont on se sent (émotionnellement et physiquement) ainsi que la manière dont on se comporte dans cette situation.

Principes TCC. Cette approche comprendra:

i) La psychoéducation sur le trouble d'anxiété sociale

ii) la restructuration cognitive : Identifier les pensées négatives qui se produisent avant, pendant, ou après les situations anxiogènes

iii) l'exposition : Lors d'expériences comportementales, faire la collecte d'informations qui permettra à l'individu de modifier ses appréhensions à l'égard d'une situation redoutée ou évitée

iv) les registres de pensées : Utiliser des registres afin d'identifier, d'explorer et de contester les pensées négatives rattachées aux croyances dysfonctionnelles

Copyright © 2011 Tina C. Montreuil

4. Présenter le modèle cognitivo-comportementale selon Beck

- Les pensées négatives sont responsables des émotions désagréables et des comportements désadaptés (par exemple, l'évitement) qui renforcent nos pensées négatives et ainsi maintiennent le trouble.

5. Présenter l'évidence que la thérapie cognitivo-comportementale est efficace

• La thérapie cognitivo-comportementale met l'accent sur les liens entre les pensées, les comportements et les émotion dans le but d'aider l'individu à acquérir une meilleure compréhension de ses problèmes afin de les résoudre.

• La TCC, par sa philosophie et ses techniques, vise à modifier les comportements et les pensées dysfonctionnels par rapport au soi de sorte à les rendre mieux adaptés.

ACTIVITÉ À LA MAISON

- Compléter la feuille "Mes objectifs de thérapie".

Copyright © 2011 Tina C. Montreuil

Qu'est-ce que l'anxiété sociale ?

La séance d'aujourd'hui nous aidera à mieux comprendre les symptômes associés à l'anxiété sociale. Ces symptômes peuvent affecter la façon dont on pense et se comporte et ils peuvent même avoir un impact sur comment on se sent. Plusieurs de ces symptômes sont plus communs à un bon nombre de gens tandis que d'autres le sont moins. Tout d'abord, il faut se rappeler que quels que soient les symptômes que l'on ressent, ils sont tout a fait normaux. Deuxièmement, il est possible pour nous d'apprendre à exercer un meilleur contrôle sur ces symptômes de sorte à réduire les effets négatifs de l'anxiété dans notre vie.

---

1. Vérifier l'humeur

2. Retour sur l'activité de la semaine dernière

3. Psychoéducation sur l'anxiété sociale

• L'anxiété sociale (AS) est également connue sous le nom de « phobie sociale ».

• L'anxiété sociale est 'une peur persistante et intense d'une ou plusieurs

(1) situations sociales ou bien

(2) des situations de performance

(3) d'être exposé à l'éventuelle observation

Copyright © 2011 Tina C. Montreuil

• L'anxiété associée à la situation redoutée sociale peut même provoquer une attaque de panique (Pas la même chose que "la timidité").

• C'est pour cette raison que plusieurs personnes choisissent de fuir ou d'éviter la situation redoutée.

4. Fournir l'explication de ce qui se produit lors d'une situation sociale.

La réaction d'anxiété qui est associée à la situation sociale (c.-à-d. peur du jugement ou d'être observé) peut se manifester de façon physiologique (symptômes physiques), cognitive (pensées) ou émotionnelle (émotions, sentiments), et ainsi causer de l'embarras, même jusqu'à éviter certaines situations.

> *"Par exemple, supposons que nous devions donner un discours public ou faire une présentation."*
>
> *Si nous éprouvions des symptômes d'anxiété sociale nous aurions probablement peur de parler en public parce que les autres pourraient remarquer que nos mains tremblent ou que notre voix est tremblante, ou encore il se peut que nous aurions peur de faire une erreur telle qu'oublier notre texte.*

Nous appelons ce processus, « anxiété anticipatoire » puisque nous « anticipons » déjà avant même d'avoir été exposé à cette situation, qu'elle provoquera de la détresse, de la peur.

5. Identification des situations sociales qui mènent à une réaction d'anxiété.

Copyright © 2011 Tina C. Montreuil

6. Identifier les symptômes de l'anxiété sociale que vous éprouvez de façon « émotionnelle », en cochant la case.

7. Identifier les symptômes de l'anxiété sociale

8. Résumé de la rencontre

ACTIVITÉ À LA MAISON

- Lire le texte intitulé: « L'anxiété sociale ou la peur des autres »

Copyright © 2011 Tina C. Montreuil

Qu'est-ce que le stress ?

L'objectif de la séance d'aujourd'hui vise à mieux comprendre les stresseurs qui sont présents au quotidien. Il est important de retenir que ces symptômes de stress affectent notre habileté à réfléchir, relaxer et même à interagir avec les autres. Le point le plus important à retenir est que <u>le stress n'est pas toujours ou nécessairement mauvais.</u> La question à se poser est la suivante : « À quel point suis-je stressé (e)? » Non seulement est-il important de réduire notre niveau de stress mais il faut également acquérir des stratégies de gestion du stress de sorte à devenir plus fonctionnel.

---

1. <u>Vérifier l'humeur</u>

<u>2. Retour sur l'activité de la semaine dernière</u>

3. <u>Psychoéducation sur le stress</u>

Le stress se défini comme le suivant:

- Un état résultant d'un stresseur, d'une tension physique ou mentale résultant de facteurs qui peut modifier l'équilibre existant.
- La réponse d'un organisme à des exigences environnementales ou des pressions externes.
- Tension nerveuse, contrainte de l'organisme face à un choc (événement soudain, traumatisme, sensation forte, bruit, surmenage).

Copyright © 2011 Tina C. Montreuil

- Le « stress » est un concept qui a été plus spécifiquement étudié dans les années 1950.
- Le terme a été utilisé pour décrire et encapsuler les causes et les effets des pressions que la personne vie à un moment donné.
- Plus récemment, toutefois, la variance « stresseur » est un mot qui est maintenant utilisé pour représenter le « stimulus » qui provoque une réaction de stress.

- **La réponse à un stresseur aigu, également connu sous le nom « réaction de lutte ou de fuite » fait référence à une réaction psychologique qui se produit en présence de quelque chose qui est perçu comme étant terrifiant. Ce stresseur peut être perçu comme représentant un danger physique ou psychologique.**

4. Explorer la réaction / la réponse au stress du participant

5. Évaluation du niveau de stress

Les signes de stress peuvent être d'ordre cognitif, affectif, physique ou comportemental. Les symptômes communs incluent les inquiétudes excessives, l'irritabilité, l'agitation, une incapacité à se détendre, les tensions musculaires, la diarrhée ou la constipation, la nausée, les étourdissements, les douleurs thoraciques, l'augmentation du rythme cardiaque, des changements au niveau de l'appétit et du sommeil, le retrait social, la procrastination, et voir même l'abus de substances.

6. Psychoéducation sur le bon et le mauvais stress

- NON! Le stress ne représente pas toujours une mauvaise chose pour nous.

Copyright © 2011 Tina C. Montreuil

- Le stress que nous ressentons peut jouer un rôle essentiel à notre survie.
- La réaction à un stress aigu est communément connue sous le nom de la réaction de « lutte » ou de « fuite ».
    - o Essentiellement, la réponse prépare le corps à combattre ou à fuir la menace ou le danger potentiel. Il est également important de noter que la réponse peut être déclenchée en raison de deux dangers : Un danger réel ou une fausse alarme*.

* La « fausse alarme » constitue un danger perçu ou non pas un réel danger.

Il existe deux types de stress :

- Bon stress
- Mauvais stress

Voir ANNEXE 2 de la page 27.

- Un niveau de stress OPTIMAL mène à une productivité maximale. Le graphique ci-dessous nous démontre bien le rationnel de l'intervention : Non pas d'éliminer le stress mais plutôt de nous rendre mieux adapté à faire face au stress.

7. Résumé de la rencontre

ACTIVITÉ À LA MAISON

- Compléter le quiz : «Quel est votre profil personnel de stress?»

Copyright © 2011 Tina C. Montreuil

SYMPTÔMES DE LA PSYCHOSE

Le but de la séance est de nous aider à mieux comprendre les symptômes les plus communément associée à cette expérience inhabituelle. C'est symptômes ne sont probablement présents qu'à certains moment. Notre objectif sera de normaliser cette expérience et nous permettre de mieux comprendre de quelle façon ces symptômes sont en lien avec l'anxiété sociale. La manifestation de ces symptômes peut parfois nous faire sentir différents des autres, résultant en des pensées défaitistes qui nous stigmatisent. Comme nous allons le voir durant la séance, ces symptômes peuvent se manifester dans diverses autres situations.

---

1. Vérifier l'humeur

2. Retour sur l'activité de la semaine dernière

3. Psychoéducation sur l'expérience inhabituelle

- Comme pour plusieurs autres maladies ou troubles, en psychose il y a manifestement toujours la présence de symptômes.
- Les symptômes varient selon chacun. Pour certains, l'expérience de ces symptômes n'aura eu lieu qu'une seule fois durant toute leur vie.
- Il est également possible que pour certains, les symptômes soient si sévères qu'ils interfèrent avec le bon fonctionnement.

Une telle expérience résulte *presque toujours* en un changement marqué au niveau des habiletés et de la personnalité chez cet individu.

Copyright © 2011 Tina C. Montreuil

En général, la détérioration est observable au niveau :

♦ Du travail ou de l'école ♦ Les relations auprès des autres ♦ Hygiène personnelle

4. Psychoéducation sur les symptômes psychotiques

Afin de mieux comprendre cette expérience, il est souvent efficace de grouper les symptômes qui ont des caractéristiques semblables :

(1) **Ajout** de certaines manifestations de symptômes non désirés

-Délires, hallucinations

(2) **Retrait** social (e.g. lié aux symptômes dépressifs et à l'isolement)

-Émoussement affectif, alogie, apathie ou avolition, anhédonie, troubles de l'attention

(3) Difficultés associées à **l'organisation et au fonctionnement**

-Langage désorganisé, comportement désorganisé (moteur et/ou social) ou catatonique (stupeur ou excitation)

L'ensemble de ces symptômes inclue habituellement une combinaison des éléments suivants :

- **Changement au niveau de la personnalité**
- **Trouble de la pensée**
- **Délires**
- **Changements perceptuels**
- **Perception de soi**

5. Présenter le lien entre l'anxiété sociale et l'expérience psychotique

- Plusieurs études ont révélé que chez les personnes atteintes de schizophrénie, environ 36% ont également obtenu un diagnostic de comorbidité d'anxiété sociale.

Copyright © 2011 Tina C. Montreuil

6. Procéder à l'identification des pensées dysfonctionnelles reliées à la maladie mentale

• Inciter les participants à parler des pertes qu'ils auraient vécues depuis l'expérience psychotique

- Porter une attention particulière aux thèmes entourant la honte, la stigmatisation, la perte du statut social, perte du réseau social

- Effectuer une psychoéducation sur le rôle des pensées dysfonctionnelles / stigma dans le développement et maintien de l'anxiété sociale en utilisant le modèle de l'anxiété en premier épisode psychotique (Appendice)

• Valider les émotions et échanges des participants – promouvoir la cohésion sociale en mettant l'accent sur le fait que les expériences partagés « sont communes » à l'ensemble du groupe.

• Encourager les participants en leur partageant qu'il est possible de modifier ses pensées dysfonctionnelles par rapport à soi-même.

7. La normalisation est l'antidote au stigma

- Le but est d'éviter la catastrophisation
- La psychose :
  - Est un problème commun
  - L'apparition des symptômes n'est pas liée à une faute
  - Un bon nombre de gens surmontent les effets des symptômes

• La perception de l'expérience inhabituelle est spécifique contexte culturel.

• Le manque de sommeil et la privation sensorielle peut provoquer l'apparition de symptômes similaires à la psychose

Des études ont révélées que :

- 50% avait vécu du retrait de social et de l'isolement
- 20% avait fait l'expérience d'hallucinations visuelles
- 15% avait eu des hallucinations auditives
  - 100% avait fait l'expérience de symptômes psychologiques inhabituels

7. Résumé de la rencontre

8. ACTIVITÉ À LA MAISON

-Compléter la feuille: "Quels étaient mes symptômes "

Copyright © 2011 Tina C. Montreuil

INTRODUCTION AUX DISTORSIONS COGNITIVES

La séance d'aujourd'hui nous initiera aux stratégies de la thérapie cognitivo-comportementale dans le but de nous aider à faire face à l'anxiété sociale et aux symptômes liés à une expérience inhabituelle. L'objectif de cette session sera également d'identifier et de corriger les pensées dysfonctionnelles qui contribuent au développement et au maintien de l'anxiété sociale en modifiant les distorsions cognitives. D'être en mesure de reconnaître et de modifier les pensées erronées, nous permettra de diminuer l'anxiété d'appréhension, de réduire la détresse ressentie lors de l'exposition à des situations sociales et de limité notre tendance les ruminations (ex. doutes personnels) après une exposition.

1. Vérifier l'humeur

2. Retour sur l'activité de la semaine dernière

3. Psychoéducation sur les distorsions cognitives

- Ces distorsions cognitives ou "filtres" influencent la façon dont nous interprétons une situation donnée. Par exemple, supposons que nous sommes assis dans le métro. Imaginez que la personne assise en face de nous éclate de rire. Une personne qui a tendance à faire de "la lecture de pensées" pourrait automatiquement déduire que cette personne se moque effectivement d'elle. Si l'on croit qu'une personne se moque de nous, il n'est pas difficile d'imaginer à quel point cette situation sociale pourrait être contrariante et nous faire sentir mal à l'aise, timide, humilié, ou même en colère.

- Il est important de pouvoir générer une « explication alternative » puisque nous avons vu durant les dernières séances, que « ce que je me dis », affecte « ce que je ressens » et finalement influence « ce que je fais ». Donc, si nous changeons notre discours interne

Copyright © 2011 Tina C. Montreuil

(pensées) en un discours plus positif, cela aura également un impact positif sur nos émotions ainsi que nos comportements.

On peut modifier nos pensées erronées :

(1) Cibler une situation sociale où nous nous sommes sentis embarrassés, humiliés, en colère ou confus;
(2) Identifier les pensées qui ont été engendrées par l'interaction sociale;
(3) Identifier les distorsions cognitives qui sont associées à ces pensées.

4. Présenter le registre des pensées

-Le registre des pensées ou « tableau » est un outil essentiel lorsqu'il s'agit d'identifier les diverses distorsions cognitives qui se manifestent lors d'interactions sociales

5. Exercice: « La Restructuration Cognitive »

Mise en situation :

Sophie effectue un retour à l'université depuis un long congé d'été. À son entrée dans la salle de cours, Sophie reconnaît une personne qu'elle n'avait pas revue depuis le primaire, prénommée Marie. Lorsque Marie s'assoit, elle se tourne vers Sophie et lui dit : « Est-ce que l'on se connaît ? » Sophie poursuit en répondant qu'elle se rappelle de Marie en 6ième année, puisqu'elles avaient toutes deux participées à un débat où Sophie était ressortie la gagnante. Marie, qui ne semble pas avoir été emballée par cette remarque, répond « Ah oui, je vois » et se retourne brusquement sans rien ajouter. Sophie est vexée par cet incident. Sophie se dit qu'elle fait toujours des gaffes, qu'elle ne peut rien faire de bien. Encore une fois, elle ressent qu'elle ne possède pas d'habiletés de communication et que les gens réagissent ainsi envers elle puisqu'elle est « bizarre » comparativement aux autres individus « normaux ».

1) Identifie les pensées dysfonctionnelles qui pourraient être générées par Sophie à la suite de cet incident.
2) Identifie les émotions négatives que pourraient susciter de telles pensées suite à cet incident.
3) Identifie les distorsions cognitives qui pourraient être associées à cet incident.

Copyright © 2011 Tina C. Montreuil

Le registre de pensées est efficace puisqu'il nous permet de noter les informations suivantes :

(1) **La situation sociale** - Ex. *j'ai laissé un message vocal à mon ami et il ne m'a pas rappelé.*

(2) **Les émotions** –Ex. *tristesse, colère et anxiété et rejet.*

(3) **Les pensées automatiques** –Ex. *« Il doit ne plus vouloir être mon ami »; « J'ai probablement fait quelque chose de mal ».*

(4) **Les distorsions cognitives** – Ex. *Lecture des pensées, raisonnement émotif.*

6. Expliquer le rôle des distorsions cognitives en anxiété sociale

- Les gens qui souffrent d'un trouble anxieux de façon générale, mais plus particulièrement dans le cas de l'anxiété sociale, ont tendance à surestimer le danger potentiel associé à une situation sociale.
- Les gens qui souffrent d'anxiété sociale surévaluent la probabilité d'être évalué, jugé ou ridiculisé.
- Les distorsions cognitives ou pensées erronées sont souvent associées à ces mésinterprétations concernant leurs habiletés à gérer ou tolérer une telle situation. - -
- Ces pensées fautives contribuent à la formation des émotions de honte, d'embarras ou de colère.
- Cette évaluation négative semble être en lien avec la présence de ces pensées erronées.
- Il est donc très important de les modifier si l'on désire réduire ce biais de négativité qui limite nos interactions sociales.

7. Résumé de la rencontre

ACTIVITÉ À LA MAISON

-Compléter le "Registre des pensées" en utilisant une situation sociale vécue.

Copyright © 2011 Tina C. Montreuil

LA RESTRUCTURATION COGNITIVE

La séance d'aujourd'hui nous encouragera à être plus vigilants et finalement à corriger nos pensées erronées ou «schémas de pensée erronés" en apprenant à identifier les erreurs de jugement lorsqu'elles se produisent (Session 5 - distorsions cognitives). Apprendre à identifier mais surtout, à modifier nos pensées automatiques dysfonctionnelles, pourra nous aider à exercer un meilleur contrôle sur nos symptômes d'anxiété. L'objectif vise à nous rendre plus aptes à modifier nos pensées automatiques en des pensées plus rationnelles. Le résultat sera une réduction de la détresse émotionnelle et physiologique qui sont généralement associées à la présence de pensées dysfonctionnelles.

1. Vérifier l'humeur

2. Retour sur l'activité de la semaine dernière

3. Révision - les "distorsions cognitives"

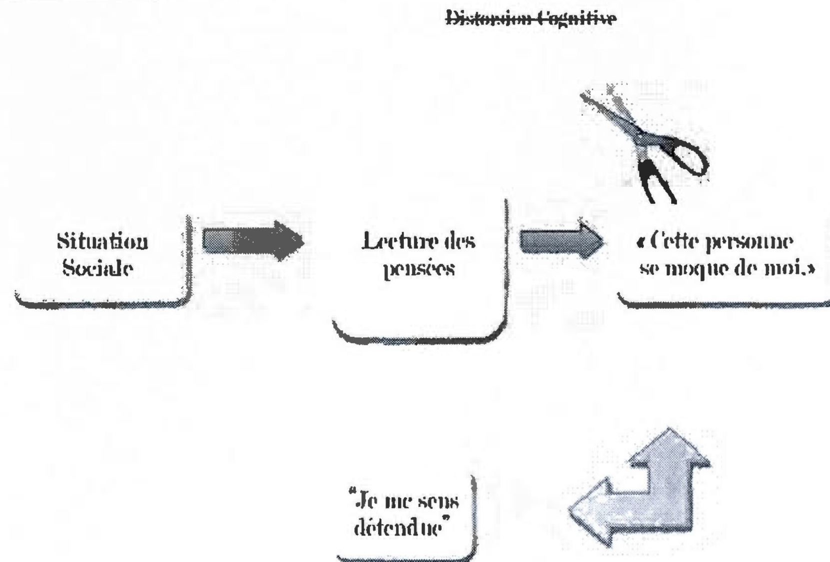
Durant la dernière séance, nous avons vu que les distorsions cognitives ou "filtres" influencent la façon dont nous interprétons une situation donnée.

- Les distorsions cognitives sont:

AUTOMATIQUE, ERRONÉE, INUTILE, PLAUSIBLE, INVOLONTAIRE

Copyright © 2011 Tina C. Montreuil

4. Présentation du modèle



- Il est possible de remédier à ces pensées erronées en « identifiant » et en générant des « explications alternatives » à nos pensées automatiques pour cette même situation.
- Il y aurait-il une explication autre que celle qui nous est venue automatiquement en tête qui pourrait s'appliquer à la situation du métro?
- Il y aurait-il une autre interprétation acceptable qui puisse expliquer les rires de la personne assise près de nous?

5. Extraits vidéo – "Do not judge too quickly" *Ne juge pas trop rapidement!*

6. Présenter le processus de changement

(1) La première étape : Prendre conscience de nos pensées erronées.

(2) La deuxième étape : Tenter de modifier les pensées erronées en pensées plus rationnelles.

Copyright © 2011 Tina C. Montreuil

(1) La situation sociale – *Ex. j'ai laissé un message vocal à mon ami et il ne m'a pas rappelé.*

(2) Les émotions –*Ex. tristesse, colère et anxiété et rejet.*

(3) Les pensées automatiques – *Ex. « Il doit ne plus vouloir être mon ami »; « J'ai probablement fait quelque chose de mal ».*

(4) Les distorsions cognitives –*Ex. Lecture des pensées, raisonnement émotif.*

(5) L'explication alternative, qui nous permet de générer des explications plus adaptées et réalistes de notre expérience.

7. Résumé de la rencontre

8. ACTIVITÉ À LA MAISON

- Compléter le "Registre de pensées" modifié qui inclu L'EXPLICATION ALTERNATIVE en utilisant une situation sociale vécue.

Copyright © 2011 Tina C. Montreuil

ENTRAÎNEMENT AUX HABILETÉS SOCIALES

Ces séances vont nous aider à identifier (1) Quelles sont nos habiletés sociales, (2) Quelles sont quelques exemples d'habiletés sociales utiles, (3) Pourquoi l'entraînement aux habiletés sociales est-elle importante et (4) De quelle façon l'entraînement aux habiletés sociales peut-elle nous être pratique? Les habiletés sociales sont un élément très important de notre fonctionnement psychosocial, de notre vie quotidienne et ils contribuent aussi à notre qualité de vie. Une carence en habiletés sociales peut entrainer des difficultés au plan de notre fonctionnement social. Les effets secondaires des médicaments peuvent contribuer à une réduction des aptitudes sociales. L'entraînement aux habiletés sociales nous aidera à apprendre à communiquer nos sentiments, nos pensées et nos besoins aux autres. De meilleures habiletés sociales peuvent nous aider à atteindre nos objectifs personnels pour le traitement de l'anxiété sociale. Gardez en tête que "la pratique (la répétition)» est essentielle à l'acquisition de ces nouvelles habiletés sociales. C'est alors que l'on parvient à surmonter nos difficultés.

---

1. Vérifier l'humeur

2. Retour sur l'activité de la semaine dernière

3. Définir les habiletés sociales

- Les habiletés sociales comprennent tous les types de comportements que nous utilisons lorsque nous interagissons avec les autres.

- Ces habiletés nous permettent de communiquer et d'entre en relation avec les autres, et sont généralement motivées selon un objectif donné (ex. faire une demande). Les habiletés

sociales ne doivent pas être pris pour acquis, parce que même si certaines sont très simples, comme par exemple de saluer quelqu'un en disant bonjour et au revoir,

Copyright © 2011 Tina C. Montreuil

4. Démystifier l'entraînement aux compétences sociales

5.Définir le mode d'enseignement de l'entraînement aux habiletés sociales par le JEU de RÔLE

- La première étape vise à comprendre pourquoi les habiletés sociales sont importantes.
- La deuxième étape implique les thérapeutes. Ces derniers doivent reproduire, pour les participants, un exemple de l'habileté sociale par le jeu de rôle.
- La troisième étape consiste en l'apprentissage et la pratique de l'habileté par le biais du JEU DE RÔLE. Comme nous l'avons vu dans l'étape précédente, c'est un peu comme être un acteur et de jouer sur la scène devant les autres, ce qui nous mène à l'étape suivante:
- La quatrième étape concerne l'application des participants de l'habileté par le JEU DE RÔLE.

6.Définir les quatre principales habiletés sociales (communication)

7.Résumé de la rencontre

ACTIVITÉ À LA MAISON

- Déterminer l'habileté à travailler afin de procéder au jeu de rôle durant la prochaine séance.

Copyright © 2011 Tina C. Montreuil

L'EXPOSITION

L'objectif des trois prochaines séances sera de diminuer la réponse de fuite ou d'évitement de sorte à ce que nous apprenons à mieux tolérer et s'habituer à l'anxiété générée lorsqu'en présence d'une situation sociale ou d'un contexte social en particulier. Les exercices en séances et à la maison seront centrés sur l'exposition graduelle, prolongée et répétée à la situation redoutée ainsi qu'à d'autres peurs associées, tout en empêchant les comportements d'évitement ou de fuite (cognitifs et comportementaux). L'exposition aux situations anxiogènes fait partie intégrante de la thérapie cognitivo-comportementale. Elle constitue une étape indispensable du plan de traitement pour un trouble d'anxiété sociale.

---

1. Vérifier l'humeur

2. Retour sur l'activité de la semaine dernière

3. Définir l'évitement

L'évitement se définie comme étant un comportement de est un comportement de défense mis en place pour ne pas être confronté avec une situation redoutée qui cause la peur.

4. Présenter et expliquer le modèle de l'anxiété sociale et le rôle de l'évitement

Copyright © 2011 Tina C. Montreuil

L'évitement est souvent manifesté par les comportements sécurisants tels que mentionné plus tôt. Le modèle ci-dessous nous démontre que ces comportements contribuent à stimuler l'activation des croyances dysfonctionnelles et erronées du soi.

5. Donner les consignes de « l'évaluation des comportements sécurisants et de l'évitement »

6. Présenter le rationnel de l'importance de l'exposition

- La principale technique utilisée généralement pour tous les types de troubles anxieux est l'exposition.
- La diminution de l'anxiété ressentie signifie que la personne s'habitue aux diverses réactions et se voit par la suite, davantage confortable avec celles-ci.
- De plus, l'exposition s'applique habituellement de manière graduée et répétée.

7. Décrire comment se passe l'exposition à l'aide de la courbe (voir manuel participant)

8. Définir ce qu'est une hiérarchie d'exposition

9. Résumé de la rencontre

ACTIVITÉ À LA MAISON :
Séance 9 - Compléter "La hiérarchie d'exposition"
Séance 10 - Compléter "Le scénario d'exposition" et un exercice d'exposition
Séance 11 - Compléter "Un nouvel exercice d'exposition"

Copyright © 2011 Tina C. Montreuil

PREVENTION DE LA RECHUTE

Le but de cette séance est de nous aider à prendre connaissance des signes avant-coureurs d'une possible rechute. Il est important de les identifier car ils peuvent nous servir de points de repère en cas de rechute de sorte à éviter une hospitalisation future. Une fois que nous aurons appris à identifier nos indices personnels ou signes précoces de rechute, il sera important d'établir un plan à suivre afin d'être mieux préparé lors d'une éventuelle apparition de ces symptômes indésirables. L'objectif de la session vise donc à nous apprendre à devenir plus confiants, nous fournir un plus grand sentiment de contrôle en prenant les mesures nécessaires afin de rester en bonne santé.

1. VÉRIFIER L'HUMEUR

2. RETOUR SUR L'ACTIVITÉ DE LA SEMAINE DERNIÈRE

3. L'IMPORTANCE DE LA PRÉVENTION DE LA RECHUTE

IL EST DONC ESSENTIEL DE :

1) DE RECONNAÎTRE LES ÉLÉMENTS DÉCLENCHEURS (SITUATIONS).
2) D'IDENTIFIER LES SYMPTÔMES QUI POURRAIENT APPARAÎTRE ET ÊTRE INDICATIFS D'UNE RECHUTE
3) D'ÉTABLIR UN PLAN D'INTERVENTION EN CAS DE RECHUTE

Copyright © 2011 Tina C. Montreuil

4. RECONNAÎTRE LES ÉLÉMENTS DÉCLENCHEURS

5. IDENTIFICATION DES SYMPTÔMES INDICATEURS D'UNE RECHUTE

- Altération subite du comportement
- Négligence de l'hygiène et des soins corporels, de l'alimentation et de l'habillement
- Fatigue marquée et persistante
- Insomnie, l'activité nocturne accrue
- Repli sur soi, l'isolement
- Épisodes de rage
- Intérêt marqué et soudain pour la spiritualité
- Chute du rendement: scolaire, aux études, au travail
- Consommation d'alcool et/ou de drogues et de tabagisme accrue
- Rage d'achats inutiles, impulsivité et comportements excessifs
- Perte de poids rapide;
- Comportements auto-destructifs ou idéations suicidaires;
- Peur ou préoccupation du regard inhabituel

6. NOTER MES SIGNES AVANT-COUREURS

7. ÉTABLIR UN PLAN D'INTERVENTION EN CAS DE RECHUTE

- PERSONNES RESSOURCES
- STRATÉGIES DE COPING
- TRAITEMENT PHARMACOLOGIQUE (CONJOINTEMENT AVEC PSYCHIATRE ET GESTIONNAIRE DE CAS)

8. RÉVISION DES TECHINQUES ACQUISES

9. ACTIVITÉ À LA MAISON

- Completer la feuille: "Mon plan d'intervention"

Copyright © 2011 Tina C. Montreuil

MAINTIEN DES GAINS

Le but de cette session est de nous aider à prendre conscience des compétences, des gains thérapeutiques et des progrès que nous avons fait tout au long de la thérapie. L'objectif est de nous aider à réaliser que nous avons fait l'acquisition d'outils, de connaissances et nous avons établi une liste de ressources disponibles, ce qui contribuera à réduire au minimum le risque d'une éventuelle rechute. Ces compétences sociales nous aurons permis d'exercer un meilleur contrôle sur les symptômes de l'anxiété en nous apprenant à correctement "'identifier et interpréter" les sensations physiques associées à l'anxiété ainsi que les pensées qui y sont associées. Nous devons garder en tête qu'il est possible pour nous d'envisager la thérapie en individuel si nous en évaluons le besoin.

1. Vérifier l'humeur

2. Retour sur l'activité de la semaine dernière

3. Initier la réflexion de fin de traitement

a) Quelles ont été mes acquis et gains thérapeutiques jusqu'à maintenant?
b) Quelles sont les situations sociales qui m'étaient autrefois difficiles que je peux maintenant confronter?
c) Quelles sont les situations sociales qu'il m'est toujours difficile à confronter?
d) Quelles sont les pensées que j'entretiens et qui sont reliées aux symptômes psychotiques qui étaient autrefois présents ou qui le sont toujours, qui affectent la

Copyright © 2011 Tina C. Montreuil

façon dont je me sens en présence des autres? Quels types de pensées me rendent anxieux lors de situations sociales?

e) Lesquelles de ces pensées sont semblables à celles qui me viennent en tête?

___"Je ne suis pas intéressant."
___"Les autres auront des choses plus intéressantes à dire que moi."
___"Je ressens que les autres sont « normaux » en comparaison à moi."
___"Je n'ai rien à offrir."
___"Les gens ne voudront pas me parler."
___"Si j'allais à une fête, je devrais être assis seul puisque personne ne me parlerais."
___"Je ne sais jamais quoi dire."
___"J'ai l'air bizarre"
___"Je parle d'une façon particulière."
___"Je dois toujours faire des efforts pour que les autres m'apprécient."

4. Encourager les participants à compléter mon inventaire d'habiletés

5. Présenter les stratégies apprises qui sont accessibles en cas de rechute

- La restructuration cognitive
- L'identification des croyances erronées
- L'affirmation de soi
- L'exposition

RAPPELONS-NOUS:

- *L'apparition de certains symptômes ne représente pas une rechute totale mais bien une rechute partielle.*
- *Il est normal de vivre des périodes de vie plus difficiles et il est possible que certains symptômes ou comportements apparaissent. Toutefois, ceci ne signifie pas que nous avons échoué – il faut continuer à appliquer les stratégies jusqu'à ce que la situation se stabilise.*

6. Féliciter les participants pour leur courage et détermination!

Copyright © 2011 Tina C. Montreuil

APPENDIX F

Clinician Manual English Version

SOCIAL ANXIETY IN FIRST-EPISODE PSYCHOSIS

Manualized Group Cognitive Behavioral Therapy

Clinician Manual

Developed by and based on the work of

Tina C. Montreuil

Revised

By Dr. Martin Lepage, Dr. Claude Bélanger, Dr. Gail Myhr

May 2009

The contents of this manual consisting of the intervention of social anxiety in first-episode psychosis (group cognitive behavioral therapy), is based on a research protocol that was written by Tina C. Montreuil (2012). All translation, adaptation and reproduction of any unspecified section of these booklets, including photocopy or microfilm, is strictly prohibited without the written authorization of the author.

MANUALIZED INTERVENTION FOR THE TREATMENT OF SOCIAL ANXIETY IN PSYCHOSIS

Themes of Sessions

Session 1: Introduction to the treatment of Social Anxiety in Psychosis.

Session 2: Psychoeducation on Social Anxiety

Session 3: Psychoeducation on Stress

Session 4: Psychoeducation on the experience of psychosis

Session 5: Introduction to Cognitive Distortions

Session 6: Cognitive Restructuring

Session 7: Social Skills Training Part I

Session 8: Social Skills Training Part II

Sessions 9-11: Exposure Part I, II, III

Session 12: Relapse Prevention

Session 13: Maintenance Strategies and Termination

Session 14: Social Activity

SESSION ONE CLINICIAN Manual

Introduction to Group CBT

Purpose of the Session

The purpose of the session is to familiarize the participants to group context and conduct and to explain what is cognitive-behavioral therapy (CBT). Secondly, the participant will be asked to define his or her individual and personal goals for therapy. Furthermore, the therapist and co- therapist will establish and attempt to elicit the participant's desire and motivation to change by providing information on efficaciousness of cognitive-behavioral therapy for the treatment of social anxiety and psychosis.

Goals of the Session

1. Have everyone introduce themselves by only sharing their first name. For example : "Hello my name is Tina".

2. Mood check

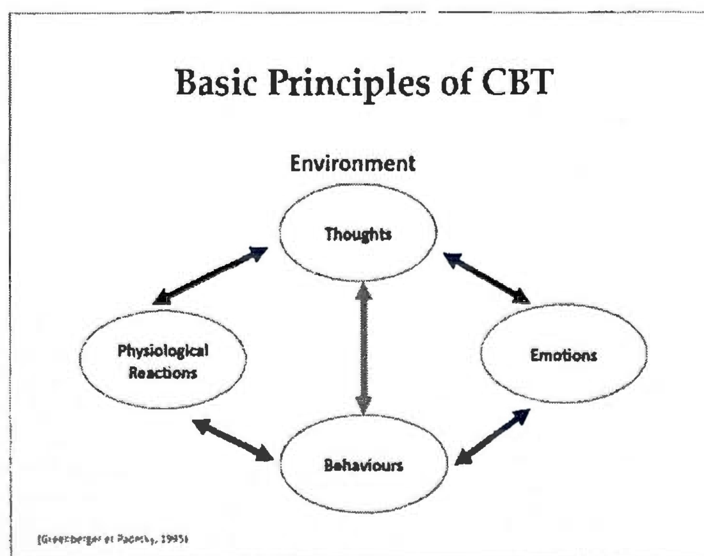
Ask participants to rate their mood (0-100%). Question participants on the level of anxiety felt now in comparison to the beginning of therapy. Validate the anxiety reduction experienced currently. If no changes are reported, inquiry about possible underlying avoidance mechanisms of safety behaviors.

3. Familiarize the participant to group participation and conduct (see Rules and acceptable conduct during group therapy at page 4 of this manual).

The participant will be asked to define his or her individual and personal goals for therapy (see document in Appendix 1 located on page 42 of this manual).

4. Teach the participant about the relevant CBT principles. This approach will include:
i) Psychoeducation on social anxiety disorder;
ii) Cognitive Restructuring: Identify negative thoughts that occur before, during, or after anxiety-provoking situations; Evaluate the accuracy of their thoughts in the light of data derived from Socratic questioning or as a result of so-called behavioral experiments; and derive rational alternative thoughts based on the acquired information;
iii) Exposure component, which focuses on the collection of information that will allow patients to revise their judgments about the degree of risk to which they are exposed in feared situations, challenge their dysfunctional beliefs about the self relative to the illness and their self-efficacy (social status related), and
iv) Use of Thought Records to identify, explore and dispute negative thoughts about dysfunctional self-identity andcore beliefs related to the onset and presence of diagnosis of psyhosis

5. Introduce the CBT interaction model (refer diagram below)



6. Provide information on efficaciousness of cognitive-behavioraltherapy for the treatment of social anxiety and schizophrenia.

- Broadly, current models of cognitive therapy focus to a varying extent on (i) automatic thoughts, (ii) faulty processing styles and dysfunctional assumptions regarding the self, (iii) core cognitions or self-schemata, (iv) emotional and cognitive development, and (v) interpersonal and interactional factors in addition to cognitions (Vallis, 1998).

- More simply, cognitive behaviour therapy focuses on the links between thoughts, behaviours, and feelings in order to help participants gain a better understanding of and solve their problems.

- There is evidence that a cognitive-behavioral therapy specifically for the treatment of social anxiety, whether it is delivered individually or in a group setting, can produce significant outcome when compared to a control group (Mattick & Clarke, 1998; Heimberg et al., 1990; Halperin et al., 2000; Kingsep et al., 2003).

- CBT has been developed for individuals with social anxiety and has been evaluated in a number of studies. Furthermore, some studies have effectively shown that the individuals receiving group CBT (CBGT) would show more frequent sudden or immediate gains (group setting interactions would immediately result in normalization and exposure for participants) and that these gains would reveal better treatment response at treatment termination and at follow-up when compared to control groups (Hofmann, et al., 2007; Clark, & Jarrett, 2005). CBT, by its philosophy and techniques, is best suited to target these dysfunctional ways of thinking about the self and about work.

- Cognitive-behavioraltherapy has been widely used in the treatment of positive symptoms and/or negative symptoms in schizophrenia (Lewis et al., 2002; Tarrier et al., 2004; Zimmerman et al., 2005; Turkington et al., 2006; Gaudiano, 2006; Startup et al., 2006; Garety et al., 2008) and it is now well known that this approach can produce more

positive outcomes in terms of symptom improvement when compared to medication alone or other supportive therapy alike.

- Individuals with social anxiety experienced greater shame attached to their diagnosis and felt that the diagnosis of schizophrenia set them apart from others, incurring a lower social status (Birchwood et al., 2007).

7. Summary of session – Questions – Feedback

Homework

Ask participant to complete the "My goal and objectives for therapy" sheet at home.

Psychoeducation on Social Anxiety

Purpose of the Session

The purpose of the session is to provide the participant with a rationale for intervention using cognitive-behavioral therapy for the treatment of social anxiety. This session will allow opportunities to engage the participants and foster the development of the therapeutic relationship between leader, co-leader, and group members.

Goals of the Session

1. Mood check

Ask participants to rate their mood (0-100%). Question participants on the level of anxiety felt now in comparison to the beginning of therapy. Validate the anxiety reduction experienced currently. If no changes are reported, inquiry about possible underlying avoidance mechanisms of safety behaviors.

2. Thoroughly review the at-home activity schedule last week.

Ensure that each participant is prompted on his or her perception of the activity. Were there any challenges? If so, what were they? Did anything stand out? Did something bother them?

3. Nature of fear and social anxiety

- Watch Video "Etiology of Social Anxiety"

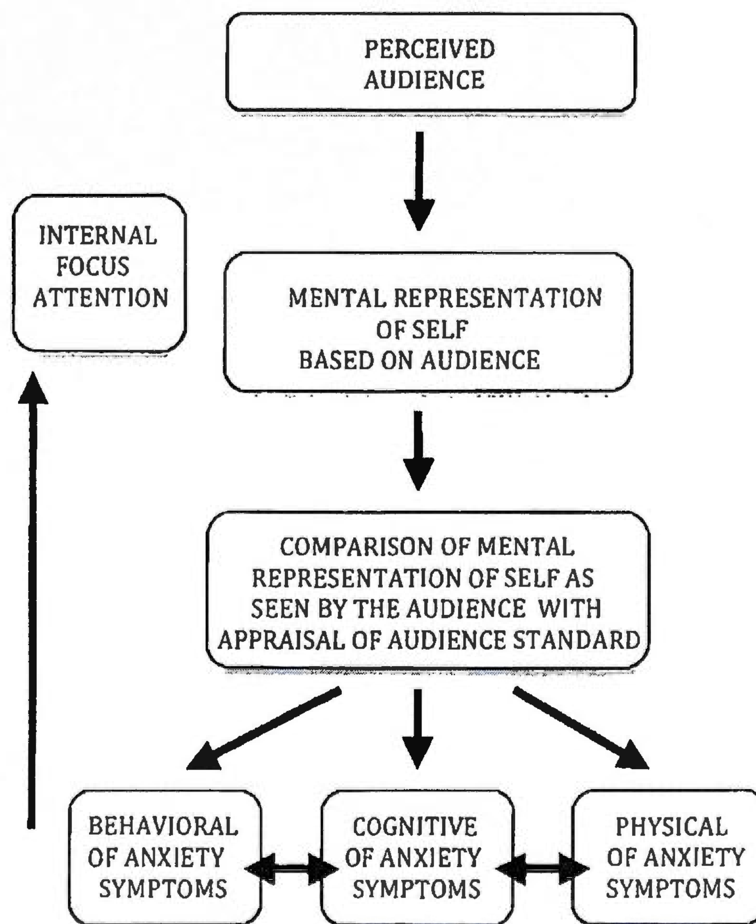
4. Myths and misconceptions regarding fear and social anxiety (Item 1 in Participant manual)

• Social Anxiety (SA) is also known as Social Phobia.
• SA is a disabling condition marked by severe and persistent fear of social situations in which the individual fears humiliation or
embarrassment.
• SA can be a fear of a specific social or work performance situation, such as public speaking, or a generalized fear of most social situations.
• The anxiety associated with the feared social situation may even
provoke a panic attack (dissonant from shyness).
• Given the "dramatic" nature of psychotic symptoms, it should not be surprising that "milder" comorbid conditions such as anxiety can often
go undetected in people with schizophrenia.

5. Cognitive model of social anxiety (refer to the diagram below) – (Items 2 and 3 in Participant manual)

- The leader will present the following model to the participants in the group and explain how the appraised 'negative evaluation from the perceived audience' can play a role in triggering behavioral, cognitive and physical symptoms of anxiety, which play a dual role in the development, and maintenance of the pathology.

FIG. 1. Model of the generation and maintenance of anxiety in social evaluative situations



5. Signs of Social Anxiety

6. Description and importance of at-home homework compliance

The successful outcome of therapy is directly related to the application and the involvement in the completion of at-home weekly homework or assignments.

7. Summary of session – Questions – Feedback

Homework

Ask participant to complete a "Psychoeducational reading" (What is it Like to Live with Social Anxiety Disorder? »).

Psychoeducation on Stress

Purpose of the Session

The third session will focus on helping the group better understand stress and the related stressors. Symptoms of stress affect our everyday functioning; from our ability to think, relax, up to our ability to interact with others. The main message for this session is that not all stress is bad and some stress can serve the function of survival. The question that the patient must ask themselves is: Just how stressed am I; or how does stress really affect my everyday life? Therefore, it is not simply important to reduce stress but also to work on acquiring and developing new skills and abilities to help one handle stress in a better and more functional way.

Goals of the Session

1. Mood check

Ask participants to rate their mood (0-100%). Question participants on the level of anxiety felt now in comparison to the beginning of therapy. Validate the anxiety reduction experienced currently. If no changes are reported, inquiry about possible underlying avoidance mechanisms of safety behaviors.

2. Thoroughly review the at-home activity schedule last week.

Ensure that each participant is prompted on his or her perception of the activity. Were there any challenges? If so, what were they? Did anything stand out? Did something bother them?

3. What is Stress?

Stress is:

- A state resulting from a stressor; a bodily or mental tension resulting from factors that tend to alter an existent equilibrium.

- A strain or a pressure; Stress is defined as an organism's total response to environmental demands or pressures.

When stress was first studied in the 1950s, the term was used to describe both the causes and the effects of these pressures that a person
experiences at a given time. More recently, however, the word stressor has been used for the stimulus that provokes a stress response.

> The acute stress response, also known as the fight-or-flight response, refers to a psychological reaction that occurs in the presence of something that is terrifying, either mentally or physically.

"I am at the end of my rope"

4. How does Stress affect me?

The term 'acute stress response' was first utilized in the 1920s by American physiologist Walter Cannon. Cannon realized that a chain of rapidly occurring reactions inside the body help mobilize the body's resources to deal with threatening circumstances.

In response to acute stress, the body's sympathetic nervous system is activated due to the sudden release of hormones. The sympathetic nervous system stimulates the adrenal glands triggering the release of the hormones, adrenaline and noradrenalin. The table below shows that this results in an increase in heart rate, blood pressure and breathing

rate. The entire body is affected by the release of these hormones. After the threat is gone, it takes between 20 to 60 minutes for the body to return to its pre-arousal levels.

APPENDIX 1 - Turn to page 7

5. Am I Stressed?

Complete the test in order to find out your own current level of stress.

APPENDIX 2 - Turn to pages 8-11

6. Is Stress always bad for me?

NO!!! Stress is not always bad for me.

Sometimes the stress I feel may be essential for my survival. For example, if I was facing a situation where someone a crashing vehicle was coming straight at me on the street. The immediate response would probably be to run out of the way. This response would be very important to ensure that you do not sustain pain or injury - in worst scenarios, ultimately death. Such an automatic response would be called a "flight" response. Similarly, if the clerk of a store was being held at gunpoint by a perpetrator, the clerk may decide to confront him instead of running away. Although this is far more dangerous, it would be referred to as a "fight" response.

The acute stress response is commonly known as the fight-or-flight response. Essentially, the response prepares the body to either fight or flee the threat. It is also important to note that the response can be triggered due to both real and perceived* threats.

* Threats most commonly thought of as being insignificant, not dangerous. For the anxious person, this situation or stressor / stimulus is being PERCEIVED as being a

dangerous threat. To a socially anxious person, the idea or possibility of being evaluated, looked at or judged becomes regarded as being a "REAL" threat although it isn't really LIFE TREATENING. The focus isn't to discover what caused the anxiety to develop in the first place but rather to provide concrete tools that will help you change the way you perceive these situations.

7. How can I know that I am Stress?

Signs of stress may be cognitive, emotional, physical or behavioral. Signs include poor judgment, a general negative outlook, excessive worrying, moodiness, irritability, agitation, inability to relax, feeling lonely, isolated or depressed, aches and pains, diarrhea or constipation, nausea, dizziness, chest pain, rapid heartbeat, eating too much or not enough, sleeping too much or not enough, social withdrawal, procrastination or neglect of responsibilities, increased alcohol, nicotine or drug consumption, and nervous habits such as pacing about, nail-biting and neck pains.

APPENDIX 3 - Turn to page 12

8. What are the differences between good and bad Stress?

There are two types of stress :

- Good stress
- Distress

A certain level of stress actually contributes to a good performance. It stimulates us to prepare accordingly for the task at hand. However, too much stress or "distress" is what leads to a breakdown, which can actually be detrimental to our performance. Good stress management techniques and strategies that can help transform "distress" into "good stress." Therefore, the goal is not to eliminate stress but to better manage it.

9. Summary of session - Questions - Feedback

Homework

Ask participant to complete the reading of "My Stress Level" for next week.

SESSION FOUR CLINICIAN Manual

Psychoeducation on the experience of psychosis

Purpose of the Session

The purpose of this session is to help the client to understand daily symptoms that are associated with the experience of psychosis. The client is to be presented with the various and most common squeal resulting from the illness as it is shared by thousands of others, including the other attending group members. The participant is provided with a theoretical framework that will help him/her identify negative beliefs related to the self and the illness and on how these factors are associated to the development of social anxiety. Internalized-stigma related dysfunctional beliefs are also highlighted and normalization is provided. The overall goal of the session is to empower the participant and challenge these negative biases.

Goals of the Session

1. Mood check

Ask participants to rate their mood (0-100%). Question participants on the level of anxiety felt now in comparison to the beginning of therapy. Validate the anxiety reduction experienced currently. If no changes are reported, inquiry about possible underlying avoidance mechanisms of safety behaviors.

2. Thoroughly review the at-home activity schedule last week.

Ensure that each participant is prompted on his or her perception of the activity. Were there any challenges? If so, what were they? Did anything stand out? Did something bother them?

3. Discuss the nature or the elements surrounding "particular" or "unusual" experience. What key features are characteristic of what took place? How is this similar or different than what you are experiencing now?

4. Identify symptom categories in psychosis (e.g. positive, negative and disorganization)

- The leader would ask the clients to talk about the characteristics surrounding their unusual experience with psychosis. In a "brainstorming period with all clients, the therapists could address some of the clients fears or concerns about what psychosis and about how it relates to them personally." This process may also be achieved or further developed through a period of "Question and Answer". The leader should help client understand that all people may suffer from an illness at one point in their lives (include - "Myths and misconceptions regarding psychosis").

- The therapists are to facilitate conversation among group members, starting from the critical element of "lost of contact with others and reality" During this process, therapists may want to interpret, reiterate or paraphrase these shared experiences in order to ensure that all clients understand, identify with.

- Therefore creating an opportunity to learn - leader as well as co-leader should make sure to monitor the exchange so that every client who feels at ease to share, may have the time to do so.

5. Etiological association of social anxiety and psychosis

- Many studies found that in people with schizophrenia, about 36% also had a comorbid diagnosis of social anxiety, supporting the evidence that had been previously reported. These schizophrenia patients with comorbid social anxiety show impaired social functioning as well as an increased risk for relapse, in addition to higher rates of

suicide. Hence, it appears that the presence of social anxiety in schizophrenia is of clinical relevance.

6. Stigma related to the onset and experience of illness

Normalizing: the antidote to Stigma.

- The goal is to avoid catastrophizing and understand that:

- Virtually everyone faces a significant illness at some point in their life
- Schizophrenia is a common problem that affects many people in many cultures
- The illness is not anyone"s fault
- A large number of people overcome symptoms
- In some cultures it is seen in a positive way

7. Identification of personal beliefs, stigmas, and delusions

- Leader and co-leader must encourage the clients to share their own experiences with stigma and shame resulting from the experience of psychosis and in attempt to make a link on how this sudden lost of social status may have triggered the onset of social anxiety symptoms or traits.

- The example of sensory deprivation
    - 50% type A phenomena
    - 20% type B visual
    - 15% type B auditory
    - 100% mental symptoms of some kind (Slade, 1984)
        - 2 hours of water tank immersion.

8. Overview of treatment plan, including treatment of delusional and stigmatizing beliefs related to the self and the illness

- Identify dysfunctional thoughts related to mental illness
- Encourage participants to talk about the losses they may have experienced as a result of psychosis

- Pay particular attention to the themes surrounding shame, stigma, loss of status, loss of social network
- Complete psychoeducation on the role of dysfunctional thoughts / stigma in the development and maintenance of social anxiety using the model of anxiety in first-episode psychosis (APPENDIX)

• Validate the emotions of participants - Promote group cohesiveness by focusing on the fact that the experiences shared are "common" to the whole group.

• Prompt participants to share what strategies they may have used or relied on to overcome some challenges that they have faced with shame or stigma

• Encourage participants by reinforcing that it is possible to change dysfunctional thinking related to self.

9. Summary of session - Questions - Feedback

Homework

Clients will be given a brief questionnaire to respond on "Stigma related to Mental Illness" and will be asked to complete it.

Introduction to Cognitive Distortions

Purpose of the Session

The purpose of the session is to lay the groundwork for the teaching of cognitive-behavioral techniques for better coping with comorbid social anxiety in schizophrenia and its effects on self-esteem and self-stigma. It is important to mention to the participant that although pharmacotherapy is crucial to control the majority of the symptoms of psychosis and comorbid anxiety, it isn't uncommon for participants to experience breakthroughs of symptoms while still on the medication. Being able to recognize and modify dysfunctional thought content enables the participant to acquire additional coping strategies when medication alone doesn't seem to be able to lead to a fuller functionality.

Goals of the Session

1. Mood check

Ask participants to rate their mood (0-100%). Question participants on the level of anxiety felt now in comparison to the beginning of therapy. Validate the anxiety reduction experienced currently. If no changes are reported, inquiry about possible underlying avoidance mechanisms of safety behaviors.

2. Thoroughly review the at-home activity schedule last week.

Ensure that each participant is prompted on his or her perception of the activity. Were there any challenges? If so, what were they? Did anything stand out? Did something bother them?

3. Type and description of cognitive distortions (Aaron Beck)

- Using the list of "10 cognitive distortions" found in the Appendix, present to the participants the various types of cognitive distortions, along with helpful examples in order to facilitate participant implementation of the nature of cognitive distortions.

1 - All-or-Nothing Thinking

This type of distortion is the culprit when people think in extremes, with no gray areas or middle ground. All-or-nothing thinkers often use words like "always" and "never" when describing things. "I always get stuck in traffic!" "My bosses never listen to me!" This type of thinking can magnify the stressors in your life, making them seem like bigger problems than they may, in reality, be.

2 - Overgeneralization

Those prone to overgeneralization tend to take isolated events and assume that all future events will be the same. For example, an overgeneralizer who faces a rude sales clerk may start believing that all sales clerks are rude and that shopping will always be a stressful experience.

3 - Mental Filter

Those who use mental filtering as their distortion of choice tend to gloss over positive events and hold a magnifying glass to the negative. Ten things can go right, but a person operating under the influence of a mental filter may only notice the one thing that goes wrong. (Add a little overgeneralization and all-or-nothing thinking to the equation, and you have a recipe for stress.)

4 - Disqualifying the Positive

Similar to mental filtering, those who disqualify the positive tend to treat positive events like flukes, thereby clinging to a more negative world view and set of low expectations for the future. Have you ever tried to help a friend solve a problem, only

to have every solution you pose shot down with a "Yeah but..." response? You've witnessed this cognitive distortion firsthand.

5 - Jumping to Conclusions

People do this one all the time. Rather than letting the evidence bring them to a logical conclusion, they set their sights on a conclusion (often negative), and then look for evidence to back it up, ignoring evidence to the contrary. The kid who decides that everyone in his new class will hate him, and 'knows' that they're only acting nice to him in order to avoid punishment, is jumping to conclusions. Conclusion-jumpers can often fall prey to mind reading (where they believe that they know the true intentions of others without talking to them) and fortune telling (predicting how things will turn out in the future and believing these predictions to be true). Can you think of examples of adults you know who do this? I bet you can.

6 - Magnification and Minimization

Similar to mental filtering and disqualifying the positive, this cognitive distortion involves placing a stronger emphasis on negative events and downplaying the positive ones. The customer service representative who only notices the complaints of customers and fails to notice positive interactions is a victim of magnification and minimization. Another form of this distortion is known as catastrophizing, where one imagines and then expects the worst possible scenario. It can lead to a lot of stress.

7 - Emotional Reasoning

This one is a close relative of jumping to conclusions in that it involves ignoring certain facts when drawing conclusions. Emotional reasoners will consider their emotions about a situation as evidence rather than objectively looking at the facts. "I'm feeling completely overwhelmed, therefore my problems must be completely beyond my ability to solve them," or, "I'm angry with you; therefore, you must be in the wrong here," are both examples of faulty emotional reasoning. Acting on these beliefs as fact can, understandably, contribute to even more problems to solve.

8 - Should Statements

Those who rely on 'should statements' tend to have rigid rules, set by themselves or others that always need to be followed – at least in their minds. They don't see flexibility in different circumstances, and they put themselves under considerable stress trying to live up to these self-imposed expectations. If your internal dialogue involves a large number of 'shoulds,' you may be under the influence of this cognitive distortion.

9 - Labeling and Mislabeling

Those who label or mislabel will habitually place labels that are often inaccurate or negative on themselves and others. "He's a whiner." "She's a phony." "I'm just a useless worrier." These labels tend to define people and contribute to a one-dimensional view of them, paving the way for overgeneralizations to move in. Labeling cages people into roles that don't always apply and prevent us from seeing people (ourselves included) as we really are.

10 - Personalization

Those who personalize their stressors tend to blame themselves or others for things over which they have no control, creating stress where it need not be. Those prone to personalization tend to blame themselves for the actions of others, or blame others for their own feelings.

4. Application of cognitive distortions to thought record

5. Overview of how cognitive distortions influence social anxiety in first-episode psychosis

- Leaders may resort to the "Session 3 – Goal Session number 4" – Kingsep's model of how self-deprecating thoughts can generate anxiety and affect the clinical outcome of psychotic symptom outcome.

6. Group activity on cognitive distortions where participant is taught and practices How to identify his or her own anxious and/or stigmatizing thoughts.

7. Summary of session - Questions - Feedback

Homework

The participant will be asked to complete a thought record focused on the cognitive nature of social anxiety and stigma related to psychosis.

Cognitive Restructuring

Purpose of the Session

The purpose of the session is to allow the participant to begin training in monitoring their faulty thinking (negatively biased thoughts) and to identify thinking errors when they occur (based on Session 5 – Cognitive Distortions). Learning to identify their negative automatic thoughts can help participants to monitor their symptoms more closely by relying on a cognitive-based intervention to alter the content of those negative automatic thoughts into more rational ones that will lead to a reduction of the resulting emotional and physiological distress.

Goals of the Session

1. Mood check

Ask participants to rate their mood (0-100%). Question participants on the level of anxiety felt now in comparison to the beginning of therapy. Validate the anxiety reduction experienced currently. If no changes are reported, inquiry about possible underlying avoidance mechanisms of safety behaviors.

2. Thoroughly review the at-home activity schedule last week.

Ensure that each participant is prompted on his or her perception of the activity. Were there any challenges? If so, what were they? Did anything stand out? Did something bother them?

3. Videos to present "Do not judge too Quickly" 4 vignettes

a. Set the stage by explaining to participants that sometimes we jump 'to conclusions "peremptorily without supporting evidence.

b. Present the vignettes, one at a time - in "pause" before the presentation the "true" conclusion is presented.

c. Ask participants to: 1. Gather information that are available at this time 2. Question the participants on the content of the vignette, based on information available to the moment when the sticker was put on pause, it anticipates as a result 3. Continue brainstorming 4. Gather feedback from participants and try to elicit a conclusion of the discussion (if no participants offer a probable conclusion) that "sometimes we jump to conclusion too quickly, hastily without accumulating evidence 'for versus against'

4. Individual activity - "Thoughts Alternatives - Pros and Cons / gather evidence," see attached page for the sheet to be attached to the manual of the participants

a. Participants complete the activity individually from an actual case. They must complete the activity sheet attached by identifying: a) erroneous thoughts, b) the evidence supporting the thoughts c) the evidence between the thoughts and d) healthy behaviors caused by such new evidence.

b. Get participants to generate alternative thoughts over the period.

CHALLENGE OUR AUTOMATIC THOUGHTS: Once you have learned to become aware of your negative/dysfunctional thoughts, the next stage is to try and answer the thoughts back and find more realistic and helpful alternatives.

There are four questions you can use to help you answer your dysfunctional thoughts back:

1. What is the evidence for your thought? Do the facts of the situation back up what you think?

2. What alternative reasons could there be for what has happened? Try and think of as many alternative explanations as you can and look at the evidence for and against them.

3. What is the effect of thinking in the way you do?

4. What are the thinking errors you are making? People who feel depressed tend to jump to the conclusion that things are bad, and they end up feeling guilty and taking responsibility for things that aren't their fault.

** Emphasize that this is not to create "false ideas" or to reference to "positive thinking" but rather to generate thoughts that are more realistic, healthier and lead to feelings (emotions) that cause less distress.*

5. Explain the importance of cognitive restructuring. Submit questions that lead the participant to question his own automatic thoughts. Fill out thought record.

a. Read the prompt questions found in the thought record
b. Fill out the thought record

Introducing the links and associations between obstructive thoughts / feelings and behaviors

- Using the triadic model by Beck, allow the participants to see once again how negative or dysfunctional thinking patterns affect our mood and as a result how we act.
- Apply a specific example to the model.

The participant will have learnt to challenge anxiety-provoking thoughts and feelings. In doing so, the participant will also be required to maintain a record of Cognitive Restructuring (see Appendix).

6. Summary of session - Questions - Feedback

Homework

Identification of obstructive thoughts and feelings - Each participant should write down a situation where they experienced negative or dysfunctional thinking pattern.

Social Skills Training - Part I

Purpose of the Session

The purpose of the session will help us to identify (1) What are Social Skills?, (2) What are some examples of useful Social Skills?, (3) Why Social Skills training is important?, (4) What are some of the possible causes of less developed or a reduction of Social Skills?, and (5) How can Social Skills training help me? Social Skills are a very important component of psychosocial functioning; everyday living and they also contribute to quality of life. Social Skills reduction or impairments can lead to social dysfunction and may lead to other problems. Medication side effects may contribute to a reduction in social skills. Social Skills training helps through learning how to better communicate feelings, thoughts and needs to others and how to better respond to the thoughts, feelings, and needs of others. In addition, better Social Skills can help to become more independent and to meet personal goals and objectives.

Goals of the Session

1. Mood check

Ask participants to rate their mood (0-100%). Question participants on the level of anxiety felt now in comparison to the beginning of therapy. Validate the anxiety reduction experienced currently. If no changes are reported, inquiry about possible underlying avoidance mechanisms of safety behaviors.

2. Thoroughly review the at-home activity schedule last week.

Ensure that each participant is prompted on his or her perception of the activity. Were there any challenges? If so, what were they? Did anything stand out? Did something bother them?

3. What are Social Skills?

The therapists must make sure, through the use of examples that the participant understands the nature and the use/importance of social skills. This reflection may be prompted through the use of questions as well.

- Social skills include all the types of behaviors that we use when we interact with others.
- These skills are what allow us to communicate and interrelate with others, and are usually driven by a specific goal or objective.
- Social skills should not be taken for granted, because although some are very basic and simple, such as greeting someone by saying hello and good-bye, smiling or simply making eye contact with others when we speak; other social skills are more complex and will usually require more practice in order for you to become more skillful.
- These more complex social skills include making a demand or a criticism, negotiating or problem solving in a situation of conflict with someone or disagreeing with someone else's opinion.

The therapists should try to have each participant identify with any one of the following complaints. This process may be achieved through asking participants such questions as: "What are common problems that you experience when being in contact with others (in a social setting/situation)?"; "What qualities or skills do you wish you had when interacting with others?"

Commonly reported complaints include:

- Social isolation
- Limited social network

- Lack of interest in activities
- Making unreasonable demands
- Anger management issues
- Monotone speech / bland conversation
- Difficulty listening and keeping up with others in conversation
- Difficulty disagreeing with others
- Difficulty expressing thoughts / feelings

4. How difficult is it to acquire better Social Skills?

The therapist must "breath hope" into the participant by providing psychoeducation on the efficiency and efficacy of social skills training. Also, let the participant know that it may be challenging – however, making sure that the participant is reminded of the outcome, the aim, the end result which consists of feeling more empowered and competent when it comes to handling social situations.

For some people, learning and acquiring new social skills can be easy, quick, and fun. However, for others that feel more distressed or uncomfortable in a social situation, learning a new social skill may be somewhat more challenging, require more time and practice and you may need to invest a little more conscious efforts.

5. What are some examples of useful Social Skills?

There are many social skills that you could potentially want to work on acquiring. However, here are a few ideas of specific behavioral goals you may want to target in the course of our program:

- CHECK THE ONES YOU WOULD LIKE TO WORK ON:
- Making requests or demands
- Listening to others
- Turning down requests
- Disagreeing with others
- Expressing positive feelings

- Expressing negative or unpleasant feelings
- Beginning and maintaining a conversation
- Ending a conversation
- Keeping up with the flow/content of a conversation
- Problem solving or negotiating a common solution
- Controlling and better managing anger

6. Why Social Skills training is important?

The therapists must make sure that they convey to the participants the importance of taking part of social skills training as part of the reduction of social anxiety when in social context.

- The therapist must ensure that they help the participant realize or make the connection that the improvements in the behavioral domain is tied with an overall improvements of the emotional sphere – through a reduction in "debilitating thought" processes that occur as a result of social skills improvements.
- Social skills training includes a set of techniques that were developed over 25 years ago.
- As you will notice, social skills training involves many steps and varies in length and process depending on your objectives.

o The first step is what we are actually covering in today's lesson; to make sure that the participant understands why social skills are, why they are important and why he or she will need to actually get involved in the social skills training.

o The second step will be for the therapists to demonstrate the model through ROLE PLAY or to act out the social skill to the participants.

o The third step will involve learning and practicing these skills through ROLE PLAY. As we saw in the previous step, it's kind of like being an actor and playing out the scene (in this case the skill scenario) in front of others, which leads to the following step:

o The fourth step where the ROLE PLAY by the participants will allow:

- You may become more comfortable and less anxious about making use of the social skill you will have acquired.
- Get other members from the group and therapist to give you feedback in a safe and constructive environment in order for you to learn how to "make perfect" you newly acquired skill.

o The final step will be for you to go on and try out the newly acquired skill on your own.

These steps will be executed by respecting your own comfort level and tolerance. You will be encouraged to follow the recommendations as these steps have been studied, and tried amongst many other participants before you. These studies have revealed that the method and model is REALLY effective.

ROLE PLAY:

(A) The therapists will first demonstrate this exercise to the participants.

- (I) Both therapists have to engage into a friendly conversation
- (II) One therapist, in addition to taking part in the conversation, has to try to "mentally plan his/her grocery list" all the while maintaining a conversation with the other therapist

- The goal of the exercise is to show the participants, that when our thoughts are focused on something else, inward – on our symptoms, or on what the other is thinking about us (similar to mentally making a grocery list), we are not listening to others. We are being

DISTRACTED given that our attention is divided. Hence, by not following the flow of the conversation, we are unable to focus on the critical conversational elements that fuel our conversations.

(B) Select two participants that will repeat steps I and II as previously executed by both therapists.

7. What are some of the possible causes of less developed or a reduction of Social Skills?

8. How can Social Skills training help me?

The therapists again must remind the participant that although it may be challenging and that it may require much work, "SOCIAL SKILLS TRAINING IS VERY EFFECTIVE!"

9. Summary of session – Questions – Feedback

Homework

Participants will be asked to read the SKILL SHEET: "Listening to others"

SOCIAL SKILLS TRAINING - PART II

Purpose of the Session

The purpose of the session is to teach Assertiveness Training to the client. AT is a form of behavior therapy designed to help people stand up for themselves—to empower themselves. The client will be taught that assertiveness is a response that seeks to maintain an appropriate balance between passivity and aggression. Assertive responses promote fairness and equality in human interactions, based on a positive sense of respect for self and others, while still communicating one's own feelings or thoughts. However, at the core of Assertiveness Training, lies conversational skills and the ability to communicate ones own thoughts and feelings in a an adaptive way. All of these elements should be presented and taught to the client. Remind your client that, "practice (repetition) makes perfect" and "social skills training is truly effective" for overcoming these difficulties.

Goals of the Session

1. Mood check

Ask participants to rate their mood (0-100%). Question participants on the level of anxiety felt now in comparison to the beginning of therapy. Validate the anxiety reduction experienced currently. If no changes are reported, inquiry about possible underlying avoidance mechanisms of safety behaviors.

2. Thoroughly review the at-home activity schedule last week.

Ensure that each participant is prompted on his or her perception of the activity. Ask the participant what he or she recalls from the reading. What elements of the text were more pertinent or representative of them? What is their view of Social Skills Training? How do they feel Social Skills could be useful to them?

3. Recognizing the presence of an assertiveness problem (signs and indication)

- Learning to communicate in a clear and honest fashion usually improves relationships within one's life. Specific areas of intervention and change in assertiveness training include conflict resolution through the use of "conversational or communication skills", realistic goal setting, and stress management. In addition to emotional and psychological benefits, taking a more active approach to self-determination has been shown to have positive outcomes in many personal choices related to health, and mental wellbeing.

4. Defining the concept of assertiveness

- Assertiveness training typically begins with an information-gathering exercise in which clients are asked to think about and list the areas in their life in which they have difficulty asserting themselves. Very often they will notice specific situations or patterns of behavior that they want to focus on during the course of therapy. The next stage in assertive training is usually role-plays (see item Goal for the Session 7) designed to help the client practice clearer and more direct forms of communicating with other members of the group.

As an "ice-breaker", the leader and co-leader should initiate the role-play, demonstrating to the clients how it is done. The role-plays allow for practice and repetition of the new techniques, helping each person learn assertive responses by acting on them. The leader/ co-leader as well as other group members provide feedback in order to improve the response,

and the role-play is repeated within the session and at home as homework. Eventually, as mentioned in the previous session, each client will be asked to practice assertive techniques in everyday life, outside the training setting.

5. Identifying and listing the areas (e.g. with who, when, what, where) the individual is not being assertive.

- Preparation for assertiveness training varies from person to person. For some clients, no preparation will be needed before practicing the techniques; for others, however, more 'individual therapy' may be necessary for that client to be ready for assertiveness training. For clients who may be more shy and feel uncomfortable saying "no" or speaking up for themselves, more individual attention may be required from the part of the leader or co-leader in order for that client to feel at ease with using assertiveness techniques. As part of assertiveness training, for some clients, it may also be beneficial to integrate "Anger Management" strategies in order to increase the probability of successful outcomes.
-

- BREAK –

6. Communication elements/basis for ensuring that "Assertiveness Training" is successful.

<u>COMMUNICATION SKILLS</u>

<u>A) Banal Conversation</u>

A casual conversation is called as such because you will not necessarily talk about very serious and formal topics with others. A casual conversation entails that you may have to engage in "social interaction" with others, by simply being able to maintain a

conversation based on general knowledge topics such as : books, the weather, career, school, politics, geography, economy - mainstream news. Some people put much pressure upon themselves because they feel they have to come up with "strikingly elaborate" content. However, casual conversation refers to nothing that original, common and repeated topics (everyday issues) relating to the majority of people's everyday life.

Start a casual conversation:

- Begin by saluting and greeting the person you are approaching.
- Introduce yourself, and elicit the other person to introduce themselves as well (eg. "Hello my name is Michael, what is your name?"

Ask an open-ended question which requires a detailed answer and "more than a single-word answer" (eg. Ask a question about something you would like to know about them - "What do you do?; Where do you work? How long have you worked for this company?"

- The sentences should start with for example "How or what (it)".
- Avoid closed-ended questions (eg Are you well ... which would lead to a "yes or no" answer.).
- Ask a question or share a personal experience or made a comment on a situation.
- Emphasize non-verbal behavior (eg nod, smile, eye contact, etc.).
- Assess and evaluate whether the person appears interested to communicate or not

To end a conversation:

- Always wait until the other person has finished what they are saying before attempting to end a conversation
- Avoid interrupting them in the process, as it may be perceived as though you find them "uninteresting".
- Make use of "non-verbal" gestures, such as looking away, at someone else or looking at your watch" before you make a "verbal attempt" at ending the conversation.

- Use closing statements such as "Well, I must go; Sorry for having to end this conversation, but I must get going".
- You can choose to either provide no reason as to why you must end the conversation or you may choose to do so in order to smooth the transition if you wish by saying "Sorry, I must really go. I have some errands to run (or I have an appointment)".
- Always finish off by saying "Good bye"
- If you know the person well and you estimate that you will likely see them again, perhaps you could add : "Until next time" or "Looking forward to seeing you soon".

B) Making a request

Before making the request you must:
- Make sure that the other person is listening to you.
- Make sure that you are looking at the person.
- Provide a clear and "to the point" statement about what it is you would like them to do.

When making the request:
- You must speak in the first person tense (eg. "I would like...")
- You must make the request precisely, if necessary support the request by repeating it (Technical broken record, adjust the tone and nonverbal behaviors to the situation).
- Some examples include:
    - "I would like it if you could_______________."
    - "I would really appreciate it if you would _______________."
    - "It is very important for me that you _______________."

Two situations may arise:
- The demand is satisfied or not

- If the request is not satisfied:

  o You must communicate your disappointment or disagreement without complaint or aggression - if you really wish for this request to be executed.

  o If you need to express disagreement, it must be expressed without unnecessary justifications, possibly accompanying an alternative proposal (for example, "Ok, perhaps not today but maybe next week?").

  o If the other still refuses to execute your request, you may decide to stop. However, should you wish to pursue and maintain your request, you may use repetition by relying on the technique of broken record (explain).

  * Keep in mind that this may be perceived as being "aggregating" or "insistent" by the other person - so be sure to evaluate the pros and cons of maintaining your request.

C) Making a criticism

Before making a criticism:

- By definition, making a criticism entails that you will have to express unpleasant feelings to the other person.

- If we must make one, you must have a valid reason for doing so (for example, if someone arrives late repeatedly, you might express to them how it makes you feel when you have to wait for them ("It makes me upset when you do not arrive on time").

Start by:

- Looking at the person directly.

- Speak firmly but calmly.

  - Do not forget that the tone of voice itself may have to be adjusted to the setting or the individual - as some people might be more sensitive to criticism then others. Adjust yourself.

- Begin by the person exactly what made you upset or what you feel they need to change.

- Tell the other person how it may you feel.
- Make a suggestion on how this may be preventable in the future.
- If it is a justified complaint, you have to acknowledge the other person's discomfort without representing them negatively.

D) Positive reinforcement

- You can make a positive reinforcement statement by saying a pleasant thing you noticed in another person.
- It is sometimes very much appreciate by others when we point out certain things that they did or made.
- Also, just like it probably is the case for ourselves, we are more likely to redo something if we know that it pleased others.

First begin by:

- Looking at the person directly in order to make sure that they are listening to you.
- Again, tell the person clearly, what you saw them doing that you appreciated and liked.
- Follow by telling the person how what they did made you feel.

7. Preparing the scenario for action, engaging in role play:

The therapists will divide up the group into smaller group of two's and give them the instructions on "What is Role Play".
Secondly, the therapist will use different example than the one listed in the manual in order to illustrate to the participants how the specific Social Skills should be executed based on the content that was taught in section 4.
Finally, using the groups that were divided up in step one, have the participants engage in the role play an illustrate the social skill.

- Mention to the participant that the "group exercise" role play is effective because we have the advantage of receiving immediate feedback on (1) our overall performance; (2) what we did that was good; and (3) what we need to correct.

- Role-plays usually incorporate specific problems for individual clients, such as difficulty speaking up to an overbearing boss; setting limits to intrusive friends; or stating a clear preference about dinner to one's spouse. Role-plays often include examples of aggressive and passive responses, in addition to the assertive responses, to help clients distinguish between extreme types of response, as they learn a new set of behaviors.

Starting a conversation:

- *You are sitting at a table at lunch with other people and you want to start a conversation.*

Ending a conversation:

- You are talking with a friend over dinner and you have to tell him / her that you have to go back home because you have an early interview in the morning.

Making a request:

- You want to ask someone to go out for lunch with you.

Making a criticism:

- You want to let you friend know how you feel about them cancelling lunch last minute for the second time.

Making a positive reinforcement:

- You want to say something to a family member who gave you a ride to one of your appointments.

8. Summary of session - Questions - Feedback

Homework

The client will be asked to complete a reading on the importance of assertiveness training - conversational skills called "WHAT IS SOCIAL SKILLS TRAINING".

EXPOSURE PART I & II

Purpose of the Session

The purpose of the session will involve presenting anxiety-producing material to the participant (for a long enough time to decrease the intensity of their emotional reaction). The aim is that the feared situation or thing no longer makes the participant anxious. Exposure treatment can be carried out in real situations, which is called in vivo exposure; or it can be done through imagination. There are several variations in the delivery of exposure treatment: participant-directed exposure instructions or self-exposure; therapist-assisted exposure; and group exposure. The basic purpose of exposure treatment is to decrease the participant's anxious and fearful reactions (emotions, thoughts, or physical sensations) through repeated exposures to anxiety-producing content. The reduction of the participant's anxiety response is known as habituation. A related purpose of exposure treatment is to eliminate the anxious or fearful response altogether so that the participant can face the feared situation repeatedly without experiencing anxiety or fear. This elimination of the anxiety response is known as extinction.

Goal of the Session

- Mood Check -

1. Thoroughly review the at-home activity schedule last week.

Ensure that each participant is prompted on his or her perception of the activity. Ask the participant what he or she recalls from the reading. What elements of the text were

more pertinent or representative of them? What is their view of Social Skills Training? How do they feel Social Skills could be useful to them?

2. Types of method for delivery of exposure therapy:

- PARTICIPANT-DIRECTED EXPOSURE:
    - o Patient-directed exposure is the simplest variation of exposure treatment. After the patient makes his or her hierarchy list with the therapist, he or she is instructed to move through the situations on the hierarchy at his or her own rate. The patient starts with the lowest anxiety situation on the list, and keeps a journal of his or her experiences. Patient-directed exposure is done on a daily basis until the patient's fears and anxiety have decreased. For example, if a patient is afraid of leaving the house, the first item on the hierarchy might be to stand outside the front door for a certain period of time. After the patient is able to perform this action without feeling anxious, he or she would move to the next item on the hierarchy, which might be walking to the end of the driveway. Treatment would proceed in this way until the patient has completed all the items on the hierarchy. During therapy sessions, the therapist reviews the patient's journal; gives the patient positive feedback for any progress that he or she has made; and discusses any obstacles that the patient encountered during exposures to the feared situation.

- THERAPIST-ASSISTED EXPOSURE:
    - o In this form of exposure treatment, the therapist goes with the patient to the feared location or situation and provides on-the-spot coaching to help the patient manage his or her anxiety. The therapist may challenge the patient to experience the maximum

amount of anxiety. In prolonged in vivo exposure, the therapist and patient stay in the situation as long as it takes for the anxiety to decrease. For example, they might remain in a crowded shopping mall for four or more hours. The therapist also explores the patient's thoughts during this exposure so that any irrational ways of thinking can be confronted.

- GROUP EXPOSURE:
  - o In group exposure, self-exposure and practice are combined with group education and discussion of experiences during exposure to feared situations. These sessions may last as long as three hours and include 30 minutes of education, time for individual exposure practice, and 45 minutes of discussion. Group sessions may be scheduled on a daily basis for 10–14 days.

3. List noted obstacles and appropriate responses in the event of failed exposure:
Using a separate sheet of paper, allow the participants to note down what they foresee as being potential obstacles or challenges to a successful exposure outcome.

Make the participant aware of the importance of exposure for overcoming "avoidance" and hence maintaining the problem. Despite the potential "rush" or increase in anxiety, the social contact should last for a reasonable amount of time. It may be important for some participants to highlight the potential for some "irrational" fears that may have the participant regarding a future exposure (e.g. fainting, vomiting, dying, etc.) and challenge these fears by letting them know of the very small probability of these more serious consequences to occur.

- Exposure treatment can be more difficult to arrange for treating social phobia, however, because the patient has less control over social situations, which are unpredictable by their nature and can unexpectedly become more intense and anxiety-

provoking. Furthermore, social exchanges usually last only a short time; therefore, they may not provide the length of exposure that
the patient needs.

-BREAK--

Participants may leave the session room for about 15 minutes in order to smoke, stretch or socialize with other group members. The leader and co-leaders are to remain in the room during this period

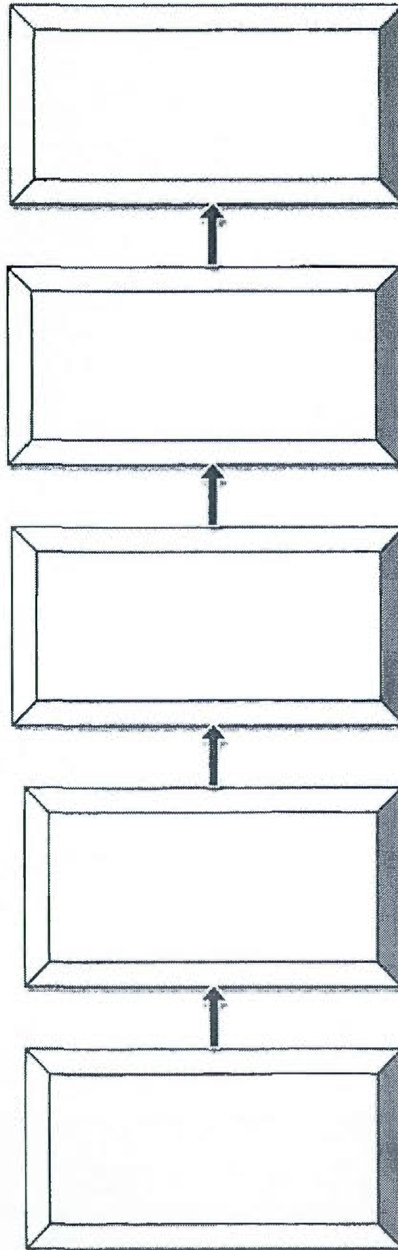
4. What is a Exposure Hierarchy?

5. Establish the Exposure Hierarchy (see attached page)

Identification of specific behaviors or social situations/encounters that have been targeted for change.

Exposure Hierarchy

S T E P B Y S T E P P R O G R E S S



COPYRIGHT
Tina Montreuil, 2010

Homework:

Complete the reading on "Facing your fears"

RELAPSE PREVENTION

Purpose of the Session

The purpose of the session is to inform the clients on the early warning signs and their importance since they can help the client to recognize signs of relapse that are resurfacing, or to reduce the severity of the relapse and avoid future hospital admission and even risk of suicide. Once the client has learned to identify his or her own personal early signs of relapse, it is important that they are taught how to manage those signs and to begin to take responsibility for himself or herself and to identify ways to maintain wellbeing. This involves teaching the client how to develop skills necessary to recognize and control early warning signs of relapse. The aim of the session is also to teach the clients how to become more confident, in control and to trust their own judgment and learns to take action on staying well.

Goal of the Session

- Mood Check -

1. Warning signs for relapse in psychosis (See Annexe 1)

2. Review Stages of psychosis and the consequences and set-backs of relapse of symptoms:

   - Provide information on the three stages of psychosis (Prodrome, Acute, Recovery / Remission). The leader will ask the client to identify the stage in which he or she believes to be in. This exercise allows the therapists to know the level of insight of each group member.

- It may also be useful to have each client share a piece of their personal history with the group on their individual experience with psychosis (Storytelling).

3. Identification of personal resources and emergency planning in case of relapse (See Annexes 2 and 3).

4. Consider 'booster' sessions and follow-up visit.

Homework:

The client will be asked to set up an at-home plan of available resources in the event that symptoms reappear (e.g. family, spouse, friend, case manager, list of phone numbers, etc).

APPENDIX I

Box 3. Early warning signs of psychotic relapse

Thinking/perception
- Thoughts are racing
- Senses seem sharper
- Thinking you have special powers
- Thinking that you can read other peoples minds
- Thinking that other people can read your mind
- Receiving personal messages from the TV or radio
- Having difficulty making decisions
- Experiencing strange sensations
- Preoccupied about 1 or 2 things
- Thinking you might be somebody else
- Seeing visions or things others cannot see
- Thinking people are talking about you
- Thinking people are against you
- Having more nightmare
- Having difficulty concentrating
- Thinking bizarre things
- Thinking you thoughts are controlled
- Hearing voices
- Thinking that a part of you has changed shape

Feelings
- Feeling helpless or useless
- Feeling afraid of going crazy
- Feeling sad or low
- Feeling anxious and restless
- Feeling increasingly religious
- Feeling like you're being watched
- Feeling isolated
- Feeling tired or lacking energy
- Feeling confused or puzzled
- Feeling forgetful or far away
- Feeling in another world
- Feeling strong and powerful
- Feeling unable to cope with everyday tasks
- Feeling like you are being punished
- Feeling like you cannot trust other people
- Feeling irritable
- Feeling like you do not need sleep
- Feeling guilty

Behaviours
- Difficulty sleeping
- Speech comes out jumbled filled with odd words
- Talking or smiling to yourself
- Acting suspiciously as if being watched
- Behaviour oddly for no reason
- Spending time alone
- Neglecting your appearance
- Acting like you are somebody else
- Not seeing people
- Not eating
- Not leaving the house
- Behaving like a child
- Refusing to do simple requests
- Drinking more
- Smoking more
- Movements are slow
- Unable to sit down for long
- Behaving aggressively

APPENDIX 2

Box 2a. Relapse prevention sheet

Name: PF
Date:

Relapse signature
Increased feelings of inadequacy
Preoccupied about self-improvement, including constantly monitoring yourself for faults
Increased feelings of anxiety and restlessness

Racing thoughts/intrusive thoughts
Feelings of elation/spirituality
Do not need to sleep (one night or more)
Suspicious of people close to you
Not wanting to eat

Horrific thoughts and paranoia
Beliefs of being punished by God or possessed by the devil
Severe paranoia
Tactile hallucinations

Keyworker:
Co-worker:
Present medication:
Carer contacts:
Triggers.

Relapse drill
Step 1: stay calm – yoga or meditation
Contact keyworker/services to go out and discuss feelings (PF or partner)
Make time for yourself, use partner and mum for support
Coping with thought/problems

Step 2: Distraction techniques (PTO)
Take mg from emergency supply
Daily contact with services, if necessary (discuss feelings, reality-testing)
Contact doctor regarding recommencing or increasing medication

Step 3: Admission to hospital or respite care

Hours of contact
Mon–Fri (9.00–5.00)
Tel:
Sat–Sun (10.00–5.00)
Tel:

Out-of-hours contact:

APPENDIX 3

Box 2b. Relapse prevention sheet (*contd*)

Name: PF
Date:

Coping with automatic thoughts
What is the thought? – write it down
What is the evidence?
Are there any other explanations/ways of viewing the thought? (evidence to disconfirm this – use others to support) e.g. 'burning up' or 'extremely anxious'

Distraction techniques
Count backwards from 100 in 13s
Concentrate on positive images – nature, greenery

Coping with problems/stressors
State problem – write it down
Write down all possible strategies
Pros and cons of each strategy
Select the best solution

Additional techniques:

MAINTENANCE STRATEGIES AND TERMINATION

Purpose of the Session

The purpose of the session is to help the client become aware of the skills, therapeutic gains and progress that he or she has made along the course of the 14-session therapy program. The aim is to lead to client to realize that he or she has acquired abilities and knowledge with the objective to create a more positive self-image, reduce illness-related self-stigma, improve self-esteem and confidence in one's own abilities and available coping strategies, minimize the risk of potential relapse and the overall anxiety symptomatology. The client will be asked to generate a list of therapeutic gains achieved during the course of the 13-week intervention. The client can be reminded by the leader as well as the co-leader that he or she can have access to individual "booster sessions" in the event where he or she would feel that they would require additional support.

Goals of the Session

-Mood Check-

1. Maintaining gains and coping skills inventory overview
- Clients will be handed a worksheet called "MY - END OF THERAPY - REFLECTION" and be instructed to generate a list of therapeutic gains achieved during the course of the 14-week intervention.

2. Review the importance of maintaining relaxation techniques, cognitive restructuring, exposure in-vivo by noting the progress made through their use.

3. Identification of remaining personal beliefs, stigmas, and delusions

4. Identification of personal strengths, internal resources and personal achievements

5. Highlighting the importance of generalization of personal gains attained through therapy. Complete the sheet called "MY SKILLS INVENTORY"

APPENDIX G

Participant Manual French Version

INTERVENTION DE GROUPE MANUALISÉE POUR LE TRAITEMENT DE L'ANXIÉTÉ SOCIALE EN SCHIZOPHRÉNIE

Approche cognitivo-comportementale

Manuel de traitement

Développé par et basé sur les travaux de

Tina C. Montreuil

Révision

Par Dr Martin Lepage, Dr Claude Bélanger, Dre Gail Myhr

Mai 2010

Le contenu de ce manuel comporte une intervention pour l'anxiété sociale en schizophrénie (thérapie cognitivo-comportementale de groupe), est basé sur le protocole de recherche qui a été rédigé par Tina C. Montreuil (2011). Par le fait même tous droits de traduction, d'adaptation et de reproduction d'un extrait quelconque de ces fascicules par quelque procédé que ce soit, et notamment par photocopie ou microfilm, est strictement interdite sans l'autorisation écrite des auteurs.

THÈMES ET OBJECTIFS DES SÉANCES

Semaine 1: Introduction

Le but de la séance d'aujourd'hui est de se familiariser au contexte de groupe et d'explorer les principes de la thérapie cognitivo-comportementale (TCC). Deuxièmement, nous aurons comme exercice à définir nos besoins individuels ainsi que nos objectifs personnels relatifs à la thérapie. Par ailleurs, les thérapeute et co-thérapeute tenteront de fournir les informations nécessaires sur l'efficacité de la thérapie cognitivo-comportementale pour le traitement de l'anxiété sociale chez les individus ayant vécu une expérience psychotique.

Semaine 2: Psychoéducation sur l'anxiété sociale

La séance d'aujourd'hui nous aidera à mieux comprendre les symptômes associés à l'anxiété sociale. Ces symptômes peuvent affecter la façon dont on pense et se comporte et ils peuvent même avoir un impact sur comment on se sent. Plusieurs de ces symptômes sont plus communs à un bon nombre de gens tandis que d'autres le sont moins. Tout d'abord, il faut se rappeler que quels que soient les symptômes que l'on ressent, ils sont tout a fait normaux. Deuxièmement, il est possible pour nous d'apprendre à exercer un meilleur contrôle sur ces symptômes de sorte à réduire les effets négatifs de l'anxiété dans notre vie.

Semaine 3: Psychoéducation sur le stress (bon versus mauvais)

L'objectif de la séance d'aujourd'hui vise à mieux comprendre les stresseurs qui sont présents au quotidien. Il est important de retenir que ces symptômes de stress affectent notre habileté à réfléchir, relaxer et même à interagir avec les autres. Le point le plus important à retenir est que le stress n'est pas toujours ou nécessairement mauvais. La question à se poser est la suivante : « À quel point suis-je stressé (e)? » Non seulement est-il important de réduire notre niveau de stress mais il faut également acquérir des stratégies de gestion du stress de sorte à devenir plus fonctionnel.

Semaine 4: Psychoéducation sur les symptômes psychotiques

Le but de la séance est de nous aider à mieux comprendre les symptômes les plus communément associés à cette expérience inhabituelle. C'est symptômes ne sont probablement présents qu'à certains moment. Notre objectif sera de normaliser cette expérience et nous permettre de mieux comprendre de quelle façon ces symptômes sont en lien avec l'anxiété sociale. La manifestation de ces symptômes peut parfois nous faire sentir différents des autres, résultant en des pensées défaitistes qui nous stigmatisent.

Comme nous allons le voir durant la séance, ces symptômes peuvent se manifester dans diverses autres situations.

Semaine 5: Introduction aux distorsions cognitives

La séance d'aujourd'hui nous initiera aux stratégies de la thérapie cognitivo-comportementale dans le but de nous aider à faire face à l'anxiété sociale et aux symptômes liés à une expérience inhabituelle. L'objectif de cette session sera également d'identifier et de corriger les pensées dysfonctionnelles qui contribuent au développement et au maintien de l'anxiété sociale en modifiant les distorsions cognitives. D'être en mesure de reconnaître et de modifier les pensées erronées, nous permettra de diminuer l'anxiété d'appréhension, de réduire la détresse ressentie lors de l'exposition à des situations sociales et de limité notre tendance les ruminations (ex. doutes personnels) après une exposition.

Semaine 6: Restructuration cognitive

La séance d'aujourd'hui nous encouragera à être plus vigilants et finalement à corriger nos pensées erronées ou «schémas de pensée erronés" en apprenant à identifier les erreurs de jugement lorsqu'elles se produisent (Session 5 - distorsions cognitives). Apprendre à identifier mais surtout, à modifier nos pensées automatiques dysfonctionnelles, pourra nous aider à exercer un meilleur contrôle sur nos symptômes d'anxiété. L'objectif vise à nous rendre plus aptes à modifier nos pensées automatiques en des pensées plus rationnelles. Le résultat sera une réduction de la détresse émotionnelle et physiologique qui sont généralement associées à la présence de pensées dysfonctionnelles.

Semaines 7-8: Entraînement aux habilités sociales – Première et deuxième parties

Ces séances vont nous aider à identifier (1) Quelles sont nos habiletés sociales, (2) Quelles sont quelques exemples d'habiletés sociales utiles, (3) Pourquoi l'entraînement aux habiletés sociales est-elle importante et (4) De quelle façon l'entraînement aux habiletés sociales peut-elle nous être pratique? Les habiletés sociales sont un élément très important de notre fonctionnement psychosocial, de notre vie quotidienne et ils contribuent aussi à notre qualité de vie. Une carence en habiletés sociales peut entrainer des difficultés au plan de notre fonctionnement social. Les effets secondaires des médicaments peuvent contribuer à une réduction des aptitudes sociales. L'entraînement aux habiletés sociales nous aidera à apprendre à communiquer nos sentiments, nos pensées et nos besoins aux autres. De meilleures habiletés sociales peuvent nous aider à atteindre nos objectifs personnels pour le traitement de l'anxiété sociale. Gardez en tête que "la pratique (la répétition)» est essentielle à l'acquisition de ces nouvelles habiletés sociales. C'est alors que l'on parvient à surmonter nos difficultés.

Semaines 9-11: Introduction à l'exposition – Première, deuxième, troisième parties

L'objectif des trois prochaines séances sera de diminuer la réponse de fuite ou d'évitement de sorte à ce que nous apprenons à mieux tolérer et s'habituer à l'anxiété générée lorsqu'en présence d'une situation sociale ou d'un contexte social en particulier. Les exercices en séances et à la maison seront centrés sur l'exposition graduelle, prolongée et répétée à la situation redoutée ainsi qu'à d'autres peurs associées, tout en empêchant les comportements d'évitement ou de fuite (cognitifs et comportementaux). L'exposition aux situations anxiogènes fait partie intégrante de la thérapie cognitivo-comportementale. Elle constitue une étape indispensable du plan de traitement pour un trouble d'anxiété sociale.

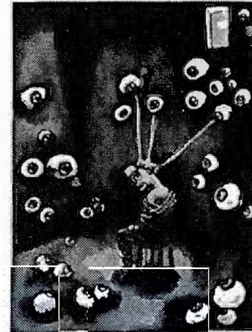
Semaine 12: Prévention de la rechute

Le but de cette séance est de nous aider à prendre connaissance des signes avant-coureurs d'une possible rechute. Il est important de les identifier car ils peuvent nous servir de points de repère en cas de rechute de sorte à éviter une hospitalisation future. Une fois que nous aurons appris à identifier nos indices personnels ou signes précoces de rechute, il sera important d'établir un plan à suivre afin d'être mieux préparé lors d'une éventuelle apparition de ces symptômes indésirables. L'objectif de la session vise donc à nous apprendre à devenir plus confiants, nous fournir un plus grand sentiment de contrôle en prenant les mesures nécessaires afin de rester en bonne santé.

Semaine 13: Maintien des acquis

Le but de cette session est de nous aider à prendre conscience des compétences, des gains thérapeutiques et des progrès que nous avons fait tout au long de la thérapie. L'objectif est de nous aider à réaliser que nous avons fait l'acquisition d'outils, de connaissances et nous avons établi une liste de ressources disponibles, ce qui contribuera à réduire au minimum le risque d'une éventuelle rechute. Ces compétences sociales nous aurons permis d'exercer un meilleur contrôle sur les symptômes de l'anxiété en nous apprenant à correctement "'identifier et interpréter" les sensations physiques associées à l'anxiété ainsi que les pensées qui y sont associées. Nous devons garder en tête qu'il est possible pour nous d'envisager la thérapie en individuel si nous en évaluons le besoin.

SAVIEZ-VOUS QUE...?



- La timidité fait souvent référence à un trait de personnalité et se différencie de l'anxiété sociale. L'anxiété sociale se définie comme étant une peur marquée et persistante des situations sociales ou de performance dans lesquelles un potentiel sentiment de gêne pourrait survenir.

- La timidité quoiqu'elle puisse parfois causer des inconvénients, elle ne s'apparente pas à l'anxiété sociale, qui elle se distingue de par le fait qu'elle occasionne souvent de l'évitement de certains lieux ou situations qui sont associés à la peur ressentie.

<u>Vous arrive-t-il de ressentir de la peur face à :</u>

- Parler avec un ami (ex. au téléphone ou face-à-face)
- Initier une conversation
- Parler avec des étrangers
- Faire une présentation orale ou de parler en public
- Poser une question à un professeur ou autre
- Des situations sociales qui sont peu encadrées (ex. bar, sport, récréation)
- Faire la connaissance de nouvelles personnes
- Assister à des rencontres sociales
- Interagir avec des personnes d'influence ou en position d'autorité
- Regarder une personne dans les yeux
- Présenter à une entrevue

EN PLUS D'ÊTRE ...

- Constamment embarrassé de vous retrouver dans une situation de performance ou sociale dans laquelle vous percevez qu'il existe une possibilité de rejet, de honte ou de jugement de vos habiletés.
- Ressentez-vous presque souvent ou presque toujours des symptômes physiques lorsque vous êtes exposé à de telles situations.
- Reconnaissez-vous que votre peur est irrationnelle ou irraisonnable mais vous ressentez une impuissance face à celle peur.
- Évitez-vous de vous exposer à de telles situations lorsque l'anxiété est trop élevée et/ou lorsqu'elle provoque un certain niveau d'inconfort.

*Si vous avez répondu **OUI** à quelques uns de ces <u>points</u>, il se peut que vous manifestez des symptômes d'**anxiété sociale**.*

Copyright Tina C. Montreuil 2009

TCC pour l'Anxiété Sociale : INTRODUCTION

Le but de la séance d'aujourd'hui est de se familiariser au contexte de groupe et d'explorer les principes de la thérapie cognitivo-comportementale (TCC). Deuxièmement, nous aurons comme exercice à définir nos besoins individuels ainsi que nos objectifs personnels relatifs à la thérapie. Par ailleurs, les thérapeute et co-thérapeute tenteront de fournir les informations nécessaires sur l'efficacité de la thérapie cognitivo-comportementale pour le traitement de l'anxiété sociale chez les individus ayant vécu une expérience psychotique.

---

1. Présentation de mes thérapeutes et des participants

On vous demandera de nous présenter brièvement en utilisant votre prénom seulement. Par exemple, le thérapeute va dire: «Bonjour, mon nom est Tina".

2. Règles du groupe et la bonne conduite

1. Tous les membres doivent participer à chacune des 14 séances ainsi qu'à prendre part aux activités et discussions de groupe selon leur niveau de confort personnel. La participation au sein du groupe est fortement recommandée puisqu'elle est perçue comme étant une opportunité de socialisation, ce qui est centre même du plan de traitement. De plus, la participation contribue à créer l'unité dans le groupe par l'effet bénéfique de la normalisation qui découle du partage de l'expérience de vie des autres participants.

Copyright © 2011 Tina C. Montreuil

2. Dû à des circonstances qui sont hors de notre contrôle, il se peut que vous ne puissiez assister à l'une des rencontres. Si en raison de maladie ou en cas d'urgence, nous encourageons le participant à communiquer avec l'un ou l'autre des thérapeutes afin de leur faire part de l'absence le plus tôt possible (au minimum 24 heures à l'avance – avant la tenue de la prochaine séance) dans le but de prévenir les délais à l'intérieur de la séance respective.

3. La confidentialité venant du thérapeute, du co-thérapeute ainsi que du groupe est très fortement recommandée à tout moment durant chacune des séances. Tous les partages d'information confidentielle qui sont livrés durant les séances hebdomadaires, doit demeurer confidentielle et ne pas « quitter les paramètres » de la pièce où auront lieu les séances. Les participants sont encouragés de se restreindre de divulguer des noms, des expériences personnelles ou informations qui leur sont reliés ou reliés à tout autre participant du groupe à l'extérieur du contexte de la thérapie de groupe.

4. Chacun des membres doit être présent à toutes les séances de groupe et se présenter de façon convenable et professionnelle. Ceci signifie qu'il ne sera pas acceptable pour un participant d'être ivre ou intoxiqué aux rencontres, de se présenter à une séance accompagné d'un non-participant, d'utiliser un langage vulgaire ou familier, d'être hostile et agressif ou encore violent à l'égard des autres participants ou thérapeutes.

Copyright © 2011 Tina C. Montreuil

5. Tous les membres sont encouragés à se forger des amitiés au sein du groupe. Les relations amicales sont fortement encouragées par les thérapeutes. Toutefois, il est recommandé que les participants se restreignent d'entrer en liaisons / relations romantiques avec les autres participants du groupe.

6. Il est recommandé que tous les participants demeurent dans la pièce où la séance aura lieu. Les pauses seront désignées à un moment donné durant chacune des séances, à la mi-temps. Certaines séances pourraient déclencher une réaction émotive plus chargée. Toutefois, il est important de demeurer dans la pièce afin de pouvoir recevoir le support et l'expertise provenant des thérapeutes – puisqu'ils ont été formés dans le but de remédier et d'intervenir lors de telles situations.

3. Qu'est-ce que la thérapie cognitivo-comportementale ou TCC?

Comme son nom l'indique, la TCC se concentre sur la façon dont les gens pensent «cognitive» et agissent «comportementale». Le concept est tout simple. Selon le modèle de la TCC, les pensées qui sont rattachées à une situation affectent la façon dont on se sent (émotionnellement et physiquement) ainsi que la manière dont on se comporte dans cette situation. En tant qu'êtres humains, nous attribuons un sens aux événements qui se passent autour de nous. Cependant, nous ne réalisons pas de façon générale que deux personnes peuvent avoir une signification très différente pour le même événement.

Principes TCC. Cette approche comprendra:

i) La psychoéducation sur le trouble d'anxiété sociale;

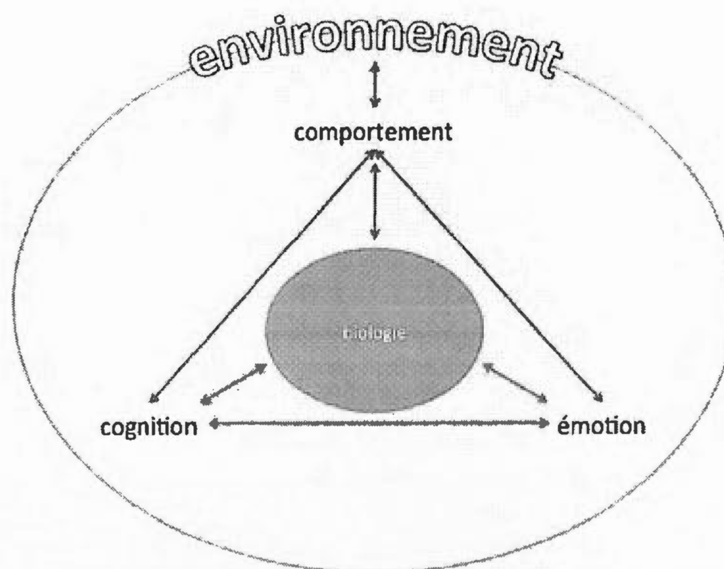
Copyright © 2011 Tina C. Montreuil

ii) la restructuration cognitive : Identifier les pensées négatives qui se produisent avant, pendant, ou après les situations anxiogènes; évaluer l'exactitude des pensées à la lumière des preuves tirées de l'environnement (c.-à-d. par l'interrogation socratique à la suite des expériences comportementales) et élaborer des pensées alternatives basées sur l'information acquise;

iii) l'exposition : Lors d'expériences comportementales, faire la collecte d'informations qui permettra à l'individu de modifier ses appréhensions à l'égard d'une situation redoutée ou évitée (c.-à-d. évaluer le degré de risque de danger réel des situations redoutées, remettre en question les croyances dysfonctionnelles par rapport au soi, aux autres et au monde);

iv) les registres de pensées : Utiliser des registres afin d'identifier, d'explorer et de contester les pensées négatives rattachées aux croyances dysfonctionnelles par rapport au soi, plus précisément suite à l'apparition des symptômes psychotiques.

4. Modèle cognitivo-comportementale selon Beck



Modèle de Beck

Copyright © 2011 Tina C. Montreuil

Tel que vous pouvez le constater, les pensées négatives sont responsables des émotions désagréables et des comportements désadaptés (par exemple, l'évitement) qui renforcent nos pensées négatives et ainsi maintiennent le trouble. En d'autres mots, nos pensées, sentiments et comportements interagissent et s'influencent mutuellement pour créer une « boucle » ou un cercle vicieux. Il nous arrive tous d'avoir des pensées négatives de temps en temps, mais si nous ne modifions pas systématiquement les cognitions négatives liées aux événements, alors nous sommes susceptibles d'éprouver des problèmes d'anxiété et / ou de dépression.

5. Est-ce que la thérapie cognitivo-comportementale est efficace?

• La croissance de la thérapie cognitivo-comportementale (TCC) est attribuable aux travaux du psychiatre et pionnier Aaron Beck (Beck et al.,1979).

• La thérapie cognitivo-comportementale met l'accent sur les liens entre les pensées, les comportements et les émotion dans le but d'aider l'individu à acquérir une meilleure compréhension de ses problèmes afin de les résoudre.

• La TCC a été développé dans le but de venir en aide aux personnes souffrant de trouble tel l'anxiété sociale et elle sont efficacité fut validée auprès d'un bon nombre d'études. En outre, certaines études ont démontré que les individus qui avaient participé dans un groupe de TCC, constataient que leurs symptômes d'anxiété sociale avaient diminués en comparaison au groupe de contrôles. L'exposition à la modalité de groupe aurait eu comme effet de normaliser l'expérience de chacun.

• La TCC, par sa philosophie et ses techniques, vise à modifier les comportements et les pensées dysfonctionnels par rapport au soi de sorte à les rendre mieux adaptés.

• La thérapie cognitivo-comportementale a été largement utilisée pour le traitement des symptômes positifs et négatifs liés à la psychose et cette approche est maintenant très reconnue pour son efficacité à entrainer des bienfaits auprès de cette population et ce en comparaison à la pharmacothérapie seule ou à toute autre forme thérapie de soutien.

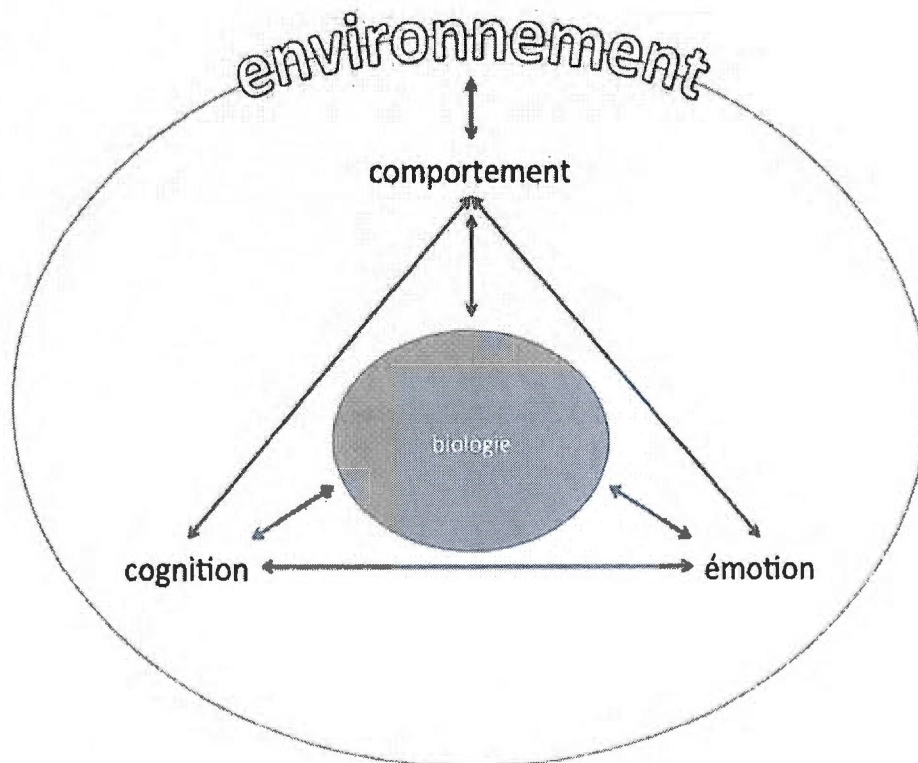
Copyright © 2011 Tina C. Montreuil

"Je crois que je vais y arriver!"

ACTIVITÉ À LA MAISON

Compléter la feuille "Mes objectifs de thérapie".

Copyright © 2011 Tina C. Montreuil



Modèle de Beck

Copyright © 2011 Tina C. Montreuil

MES OBJECTIFS DE THÉRAPIE SONT:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________

Copyright © 2011 Tina C. Montreuil

Qu'est-ce que l'anxiété sociale ?

La séance d'aujourd'hui nous aidera à mieux comprendre les symptômes associés à l'anxiété sociale. Ces symptômes peuvent affecter la façon dont on pense et se comporte et ils peuvent même avoir un impact sur comment on se sent. Plusieurs de ces symptômes sont plus communs à un bon nombre de gens tandis que d'autres le sont moins. Tout d'abord, il faut se rappeler que quels que soient les symptômes que l'on ressent, ils sont tout a fait normaux. Deuxièmement, il est possible pour nous d'apprendre à exercer un meilleur contrôle sur ces symptômes de sorte à réduire les effets négatifs de l'anxiété dans notre vie.

1. Qu'est-ce que l'anxiété sociale?

- L'anxiété sociale (AS) est également connue sous le nom de « phobie sociale ».
- L'anxiété sociale est définie comme étant 'une peur persistante et intense d'une ou plusieurs (1) situations sociales ou bien des (2) situations de performance durant lesquelles une personne est en contact avec des gens non familiers ou bien peut (3) être exposé à l'éventuelle observation attentive d'autrui.
- La personne craint d'agir (ou de montrer des symptômes anxieux) de façon embarrassante ou humiliante.' DSM-IV

Copyright © 2011 Tina C. Montreuil

• L'anxiété sociale peut parfois a crainte d'une situation de performance sociale ou le travail spécifique, comme la parole en public, ou d'une peur généralisée de la plupart des situations sociales.

• L'anxiété associée à la situation redoutée sociale peut même provoquer une attaque de panique (Pas le même que "la timidité").

• C'est pour cette raison que plusieurs personnes choisissent de fuir ou d'éviter la situation redoutée.

• En raison de la nature plus sévère des symptômes psychotiques, les symptômes d'anxiété peuvent souvent passer inaperçus chez les personnes souffrant de schizophrénie.

2. La situation sociale

Tel que nous l'avons vu plus tôt, les gens au pris d'anxiété sociale doivent vivre avec une peur persistante et parfois « écrasante » d'être observé ou jugé par les autres durant une situation sociale ou de performance. De façon générale, la réaction d'anxiété qui est associée à la situation sociale (c.-à-d. peur du jugement ou d'être observé) peut se manifester de façon physiologique (symptômes physiques), cognitive (pensées) ou émotionnelle (émotions, sentiments), et ainsi causer de l'embarras, même jusqu'à éviter certaines situations.

"Par exemple, supposons que nous devions donner un discours

Copyright © 2011 Tina C. Montreuil

public ou faire une présentation."

Si nous éprouvions des symptômes d'anxiété sociale nous aurions probablement peur de parler en public parce que les autres pourraient remarquer que nos mains tremblent ou que notre voix est tremblante, ou encore il se peut que nous aurions peur de faire une erreur telle qu'oublier notre texte.

Imaginons que nous puissions faire la réalisation que nos symptômes d'anxiété sociale sont excessifs mais que nous ne n'arrivions pas à trouver des moyens pour s'en défaire. De façon générale, nous pourrions alors choisir d'éviter ces situations, de sorte à ne pas ressentir cette grande montée de peur. Le problème avec cette alternative, c'est qu'avant même d'être exposé à nouveau à cette situation dans le futur, l'anxiété sera encore une fois manifestée, ainsi nous menant à nouveau à éviter cette situation. Nous appelons ce processus, « anxiété anticipatoire » puisque nous « anticipons » déjà avant même d'avoir été exposé à cette situation, qu'elle provoquera de la détresse, de la peur.

La réaction d'anxiété face à l'exposition à des situations anxiogènes et l'anxiété anticipatoire contribuent à créer des difficultés importantes qui interfèrent avec le fonctionnement de au quotidien.

3. <u>Identifie la ou les situation(s) sociale(s) qui mène(nt) à une</u>

Copyright © 2011 Tina C. Montreuil

réaction d'anxiété?

____

____

____

____

4. Identifier les symptômes de l'anxiété sociale que vous éprouvez de façon « émotionnelle », en cochant la case.

- ☐ *La conscience de soi excessive*
- ☐ *La peur d'être observé*
- ☐ *La peur d'être jugé (e)*
- ☐ *La crainte de l'embarras*
- ☐ *La crainte d'être humilié (e)*
- ☐ *Irrité (e) ou en colère*
- ☐ *Je me sens comme si je voudrais faire du mal à quelqu'un*
- ☐ *Je désire qu'on me laisse seul (e)*

Copyright © 2011 Tina C. Montreuil

- ☐ *Je veux m'enfuir et me cacher*

- ☐ *Je suis si anxieux (euse) que j'ai peine à me contenir*

5. **<u>Identifier les symptômes de l'anxiété sociale que vous éprouvez de façon « physiologique », en cochant la case.</u>**

- ☐ *Engourdissements*
- ☐ *Rougissements*
- ☐ *Transpiration*
- ☐ *Tremblements*
- ☐ *Nausée / bouche sèche*
- ☐ *Difficulté de concentration*
- ☐ *Douleurs / agitations*
- ☐ *Palpitations cardiaques*
- ☐ *Bouffées de chaleurs*

Copyright © 2011 Tina C. Montreuil

☐ *Inconfort gastro-intestinal*

☐ *Étourdissements*

☐ *Tensions musculaires*

☐ *Insomnie*

6. <u>Identifier les symptômes de l'anxiété sociale que vous éprouvez au niveau des « pensées », en cochant la case.</u>

☐ *Sentiment de confusion et doute personnel*

☐ *Les pensées négatives telles que «Les gens pensent que je suis stupide"*

☐ *Une envie de fuir la situation*

☐ *Réalisation que ces sentiments sont irrationnels*

☐ *Mes pensées déferlent dans ma tête*

☐ *J'oublie et je perds le fils de ma pensée*

☐ *J'ai du mal à me concentrer*

Copyright © 2011 Tina C. Montreuil

☐ *Mes pensées sont obscures et je n'arrive pas à faire le vide*

La bonne nouvelle est que l'anxiété sociale est non seulement traitable, mais son traitement est également efficace. Nous n'avons plus à souffrir d'anxiété sociale pour le reste de notre vie.

ACTIVITÉ À LA MAISON

Lire le texte intitulé: « L'anxiété sociale ou la peur des autres »

Copyright © 2011 Tina C. Montreuil

L'anxiété sociale ou la peur des autres

Il est cinq heures du matin et Sébastien ouvre les yeux pour la énième fois de la nuit. L'heure approche. Il doit faire un exposé oral cet avant-midi devant les autres étudiants et étudiantes du groupe et sa professeure. Il a la nausée et il est incapable d'avaler quoi que ce soit. Sébastien tremble à la simple idée de se présenter à l'université ce matin. Il est convaincu qu'il va faire un fou de lui et qu'il se dirige tout droit vers la catastrophe.

Aujourd'hui, c'est jour d'initiation. Annie entreprend ses études universitaires dans un programme où elle ne connaît personne. Elle déteste parler de la pluie et du beau temps et elle craint de n'avoir rien d'intelligent à dire. Annie a peur qu'on la trouve sans intérêt et elle décide de ne pas y aller.

Olivier participe à une réunion de son association étudiante et il ne partage pas le même point de vue que ses collègues. Il aimerait leur en faire part mais Olivier redoute leur réaction. Il choisit donc de se taire.

Karine est au laboratoire et son professeur l'observe tandis qu'elle fait ses manipulations. Elle se sent rougir et elle a peur que ce dernier s'en aperçoive. Karine devient de plus en plus nerveuse, elle se met à trembler et elle n'arrive plus à cacher sa nervosité. Elle souhaiterait se retrouver n'importe où sauf là.

Ces différents scénarios ont une chose en commun, ils mettent en scène des gens qui s'exposent au regard et au jugement des autres. Nous avons tous déjà vécu ce genre de situation. Mais que se passe-t-il donc lorsque le malaise qu'engendrent ces situations nous envahit ?

Qu'est-ce que l'anxiété sociale ?
D'où vient cette peur des autres ?
Comment se manifeste cette peur ?
Comment surmonter sa peur des autres ?
Références

Qu'est-ce que l'anxiété sociale ?

L'anxiété sociale correspond à la peur persistante d'une ou de plusieurs situations dans lesquelles la personne est susceptible d'être observée par autrui et craint d'agir de façon humiliante ou embarrassante. Lorsque nous sommes l'objet de l'attention des autres, il peut arriver que nous ayons peur de ne pas faire bonne impression. Il s'agit là d'un phénomène fort répandu.

L'anxiété sociale comporte plusieurs variantes : le trac, la timidité et la phobie sociale en sont les principales.

Le **trac** est le nom que l'on donne à l'inconfort ponctuel, directement associé à une performance à exécuter devant public. Il est limité à cette situation et n'altère pas, de façon importante, la qualité de vie de l'individu.

Plus généralisée, la **timidité** correspond à un trait personnel, à une manière d'être. Bien qu'elle désire échanger avec son entourage, la personne timide a tendance à se tenir en retrait et à laisser les autres initier la conversation. Elle éprouve habituellement plus d'anxiété sociale que la moyenne. Au fil des rencontres cependant, l'angoisse diminue et la personne timide s'adapte. La timidité comporte d'ailleurs certains avantages. Les personnes timides sont souvent appréciées pour leur discrétion, leur sensibilité, leur sens de l'observation, leur sens critique et leur capacité d'analyse. Le monde d'aujourd'hui valorise l'extraversion mais tout groupe, toute population se doit de compter parmi ses membres des extravertis et des introvertis. Imaginez le brouhaha dans lequel nous nous retrouverions si la société dans laquelle nous vivons ne comportait que des personnes extraverties !

À l'extrême, la timidité devient de la **phobie sociale**. Il s'agit là d'une peur importante et persistante de situations sociales où l'on est exposé au regard et à l'évaluation d'autrui. La personne souffrant de phobie sociale craint d'être humiliée ou embarrassée par sa façon d'agir ou par ses symptômes d'anxiété tels que le rougissement ou les tremblements. Bien qu'elle reconnaisse que sa peur est excessive ou irrationnelle, elle redoute la plupart des situations sociales, qu'elle tente d'éviter ou tolère avec difficulté.

D'où vient cette peur des autres ?

Difficile de répondre en toute certitude à cette question. On peut toutefois identifier certains facteurs tels que l'hérédité, l'environnement familial, l'éducation et des événements marquants. Si, par exemple, vous avez été ridiculisé ou ridiculisée devant toute la classe par un professeur ou une professeure au primaire parce que vous n'avez pas su répondre à une question, il y a de fortes chances que vous ayez de la difficulté à prendre la parole en public. Il est important de mentionner que nous vivons dans une société qui valorise l'individualisme et la performance. Il y lieu de s'interroger sur les effets qu'a cette quête de l'excellence sur nos relations interpersonnelles.

Copyright © 2011 Tina C. Montreuil

Comment se manifeste cette peur ?

Les manifestations de l'anxiété sociale sont diverses. Sous les projecteurs, les gens ressentent souvent des palpitations, des maux de tête. Ils transpirent plus qu'à l'habitude, ils ont l'estomac noué, sont tendus et ont la bouche et la gorge sèches. Les symptômes les plus redoutés sont ceux qui révèlent, contre notre gré, notre nervosité. Le rougissement, le bégaiement et les tremblements en font partie. Les gens ont alors tendance à focaliser davantage sur ces manifestations, ce qui a pour effet de les amplifier et donc d'augmenter, à son tour, le niveau d'anxiété.

L'anxiété nous jette dans l'embarras et nous ressentons de la gêne et de la honte. Cette anxiété peut même se transformer en panique. Nous aurons alors tendance à éviter de façon directe en refusant les invitations, ou de façon plus subtile en ne regardant pas les gens dans les yeux, en ne prenant pas la parole ou en ne faisant que de brèves phrases.

Si nous pouvions entendre les pensées qui traversent l'esprit des personnes qui souffrent de cette phobie avant, pendant et après une situation sociale, nous découvririons un discours intérieur fort négatif. Avant une rencontre, ces personnes anticipent souvent les pires scénarios. Une fois sur place, elles se concentrent sur leur malaise intérieur plutôt que sur la rencontre en cours. De retour à la maison, elles repassent inlassablement le film de cette rencontre, recherchant les erreurs présumées et amplifiant les conséquences de celles-ci.

Non seulement ces autoverbalisations contribuent à augmenter l'anxiété et l'évitement relié à celle-ci, mais elles favorisent l'échec au plan social. La personne qui a peur de l'avion n'augmente pas, par ses pensées, le risque d'écrasement. Cependant, l'individu qui redoute les situations sociales limitera ses interactions et suscitera ainsi moins d'intérêt chez les autres.

Comment surmonter sa peur des autres ?

L'anxiété sociale n'est pas à proscrire. Une petite poussée d'adrénaline n'a jamais nui à personne. Lorsque l'anxiété est trop faible, l'individu est moins motivé et moins mobilisé par la situation et risque ainsi de moins réussir. Lorsqu'elle est présente sans être excessive, l'anxiété stimule et nous permet de faire une meilleure prestation. Nous ne devons donc pas chercher à ne ressentir aucune nervosité mais plutôt chercher à garder un bon contrôle sur soi qui nous permettra d'être alerte et présent aux autres.

L'une des premières étapes pour s'affranchir de la peur des autres consiste à s'habituer progressivement à affronter les situations redoutées. Cette **exposition** doit être graduelle. Il est préférable de commencer par une situation relativement facile puis, une fois qu'elle est surmontée, de passer à une autre un peu plus difficile et ainsi de suite. Si, par exemple, vous n'osez pas adresser la parole à votre voisin ou voisine en classe, vous pouvez commencer par lui sourire, lui dire bonjour, puis lui dire quelques mots en début de cours. Par la suite, vous pouvez discuter avec lui ou elle à la pause et, éventuellement, lui offrir d'aller casser la croûte ensemble après le cours. En répétant ces exercices d'exposition, la personne constate que son anxiété diminue, elle gagne confiance et parvient petit à petit à surmonter son angoisse.

La personne qui a peur des autres doute de ses compétences sociales, parfois avec raison. En évitant les interactions sociales, la personne phobique a moins souvent l'occasion de développer des **habiletés sociales** de base telles que regarder son interlocuteur ou son interlocutrice, sourire et parler de façon audible. En développant des compétences sociales, l'individu améliore son sentiment d'efficacité personnelle et, par conséquent, arrive à faire diminuer son anxiété. Les Clubs Toastmasters, que l'on retrouve dans la plupart des régions, offrent d'excellentes occasions de le faire.

Enfin, nous ne pouvons surmonter notre peur des autres sans modifier notre façon de penser. Nous devons d'abord identifier les perceptions erronées qui découlent de croyances que l'on entretient au sujet de soi-même et d'autrui, puis apprendre à les modifier en étant plus réalistes et en nuançant. Un étudiant ou une étudiante qui croit fermement que les gens surveillent les attitudes des autres et jugent négativement les faibles, par exemple, aura tendance à interpréter comme un signe de rejet le silence de son directeur ou sa directrice de recherche. Il est donc important de se pencher sur nos perceptions et nos propres croyances et de tenter de les remettre en question.

Une bonne partie de l'anxiété sociale vient du fait que l'on se prend trop au sérieux et que l'on veut trop faire bonne

impression. Pourquoi ne pas se prendre tel que l'on est : tantôt malhabile, tantôt timide, parfois drôle et souvent sympathique?

Rédigé par :

Louise Careau, psychologue

Copyright © 2011 Tina C. Montreuil

Qu'est-ce que le stress ?

L'objectif de la séance d'aujourd'hui vise à mieux comprendre les stresseurs qui sont présents au quotidien. Il est important de retenir que ces symptômes de stress affectent notre habileté à réfléchir, relaxer et même à interagir avec les autres. Le point le plus important à retenir est que le stress n'est pas toujours ou nécessairement mauvais. La question à se poser est la suivante : « À quel point suis-je stressé (e)? » Non seulement est-il important de réduire notre niveau de stress mais il faut également acquérir des stratégies de gestion du stress de sorte à devenir plus fonctionnel.

1. Qu'est-ce que le stress?

Le stress se défini comme le suivant:

- Un état résultant d'un stresseur, d'une tension physique ou mentale résultant de facteurs qui peut modifier l'équilibre existant.
- La réponse d'un organisme à des exigences environnementales ou des pressions externes.
- Tension nerveuse, contrainte de l'organisme face à un choc (événement soudain, traumatisme, sensation forte, bruit, surmenage).

Le « stress » est un concept qui a été plus spécifiquement étudié dans les années 1950. Le terme a été utilisé pour décrire et encapsuler les causes et les effets des pressions que la personne vie à un moment donné. Plus

Copyright © 2011 Tina C. Montreuil

récemment, toutefois, la variance « stresseur » est un mot qui est maintenant utilisé pour représenter le « stimulus » qui provoque une réaction de stress.

- **La réponse à un stresseur aigu, également connu sous le nom « réaction de lutte ou de fuite » fait référence à une réaction psychologique qui se produit en présence de quelque chose qui est perçu comme étant terrifiant. Ce stresseur peut être perçu comme représentant un danger physique ou psychologique.**

2. Comment est-ce que je réagis au stress?

Le concept de «réponse au stress aigu» a été utilisé pour la toute première fois durant les années 1920 par le physiologiste américain Walter Cannon. Cannon s'est rendu compte qu'étant face à un danger, une chaîne de réactions « d'alarme » se produisait rapidement à l'intérieur du corps, permettant ainsi au corps de mobiliser les ressources pour répondre à cette situation.

En réponse à un stress aigu, le système nerveux étant activé, il libère un bon nombre d'hormones. Le système nerveux sympathique stimule les glandes surrénales, déclenchant ainsi la libération de deux hormones « l'adrénaline et la noradrénaline ». Le tableau à l'ANNEXE 1 de la page 25 montre que cela résulte en une augmentation de la fréquence

Copyright © 2011 Tina C. Montreuil

cardiaque, de la pression artérielle et la respiration est rendue difficile. Le corps en entier est alors affecté par la libération de ces hormones. Une la menace disparue, on peut compter de 20 à 60 minutes avant que le corps retourne à son niveau de repos.

3. Le stress est-il mauvais pour moi?

NON! Le stress ne représente pas toujours une mauvaise chose pour nous. Parfois, le stress que nous ressentons peut jouer un rôle essentiel à notre survie. Par exemple, imaginions que nous faisions face à une situation où un véhicule roulait en sens inverse sur la rue en notre direction. La réponse immédiate serait probablement de changer de voie. Il n'est pas difficile d'imaginer qu'une telle situation puisse provoquer une intense réaction anxiogène. Toutefois, cette réponse serait très importante puisqu'elle nous mobiliserait « à l'action », assurant ainsi que nous n'ayons pas à subir de blessures – ou encore, dans le pire des scénarios, de trouver la mort. On qualifierait alors ce type de réponse d'alarme comme étant une « fuite ». De même, si nous étions témoin d'un vol, où une dame plus âgée s'était fait prendre son sac par un malfaiteur, nous voudrions probablement lui venir en aide. Bien que ce soit plus dangereux, cette réponse serait considérée comme une « lutte ».

La réaction à un stress aigu est communément connue sous le nom de la réaction de « lutte » ou de « fuite ». Essentiellement, la réponse prépare le

Copyright © 2011 Tina C. Montreuil

corps à combattre ou à fuir la menace ou le danger potentiel. Il est également important de noter que la réponse peut être déclenchée en raison de deux dangers : Un danger réel ou une fausse alarme*.

* La « fausse alarme » constitue un danger perçu ou non pas un réel danger. La survie de l'individu à cette situation ne serait pas compromise par l'exposition à cette situation. Il s'agit de dangers qui sont interprétés par l'individu comme étant dangereux alors que pour une autre personne, ce même stimulus serait perçu comme étant inoffensif. Toutefois, pour la personne anxieuse, cette situation ou stresseur est perçu comme étant une menace dangereuse. Pour une personne socialement anxieuse, l'idée ou la possibilité d'être évalué, observé ou jugé est considérée comme étant une «réelle» menace même si elle ne l'est pas en réalité. La réaction en chaîne que nous avons vu plus tôt est alors activée tout comme dans le cas d'un réel danger. Le but n'est pas de découvrir ce qui a causé cette association erronée en premier lieu, mais plutôt de faire l'acquérir de stratégies concrètes qui nous aiderons à changer notre perception de ces situations.

4. Comment puis-je savoir si je suis stressé (e)?

Les signes de stress peuvent être d'ordre cognitif, affectif, physique ou comportemental. Les symptômes communs incluent les inquiétudes excessives, l'irritabilité, l'agitation, une incapacité à se détendre, les tensions musculaires, la diarrhée ou la constipation, la nausée, les

Copyright © 2011 Tina C. Montreuil

étourdissements, les douleurs thoraciques, l'augmentation du rythme cardiaque, des changements au niveau de l'appétit et du sommeil, le retrait social, la procrastination, et voir même l'abus de substances.

5. Quelles sont les différences entre le bon et le mauvais stress?

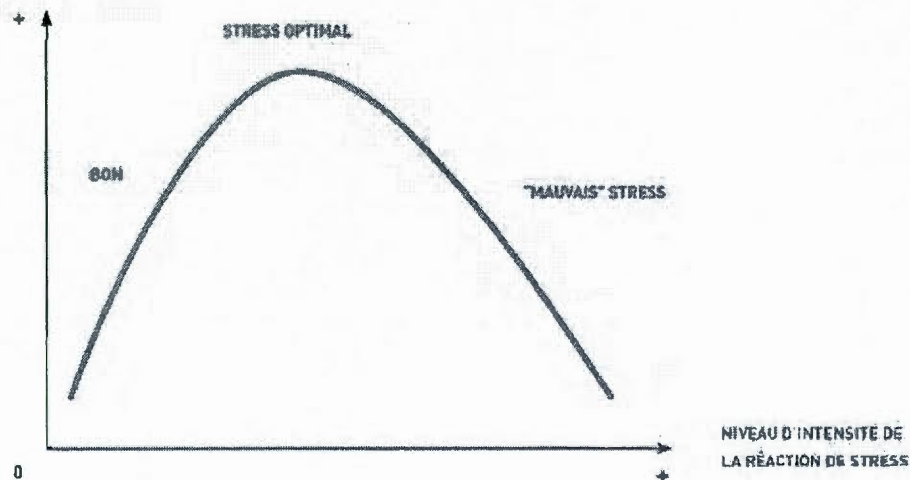
Il existe deux types de stress :

- Bon stress
- Mauvais stress

Un certain niveau de stress contribue effectivement à une bonne productivité telle que le démontre l'ANNEXE 2 de la page 27. Un bon stress nous incite à nous préparer en conséquence de la tâche à accomplir. Toutefois, un niveau de stress trop intense ou le « mauvais stress » peut mener à une surcharge, qui peut incontestablement nuire à notre performance. De bonnes stratégies de gestion du stress peuvent aider à transformer le « mauvais stress » en « bon stress ». Par conséquent, le but de la thérapie n'est pas d'éliminer le stress, mais d'avoir une meilleure gestion du stress.

Un niveau de stress OPTIMAL mène à une productivité maximale. Le graphique ci-dessous nous démontre bien le rationnel de l'intervention : Non pas d'éliminer le stress mais plutôt de nous rendre mieux adapté à faire face au stress.

Copyright © 2011 Tina C. Montreuil



La bonne nouvelle est que l'on peut avoir une meilleure gestion du stress. Nous pouvons développer des stratégies qui nous aiderons à développer une tolérance au stress afin d'améliorer notre capacité à réagir au stress et ainsi minimiser la réaction de « fausse alarme ».

ACTIVITÉ À LA MAISON

Compléter le quiz : «Quel est votre profil personnel de stress?»

Copyright © 2011 Tina C. Montreuil

ANNEXE 1

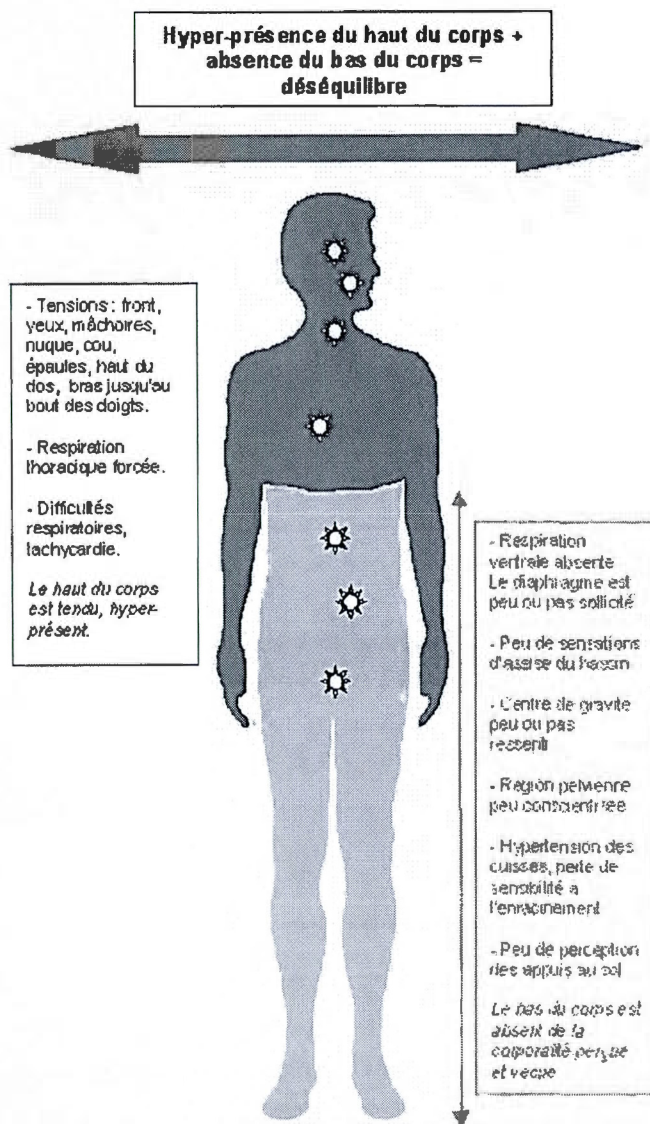


Image gracieuseté *agoraphobie.org*

Copyright © 2011 Tina C. Montreuil

ANNEXE 2

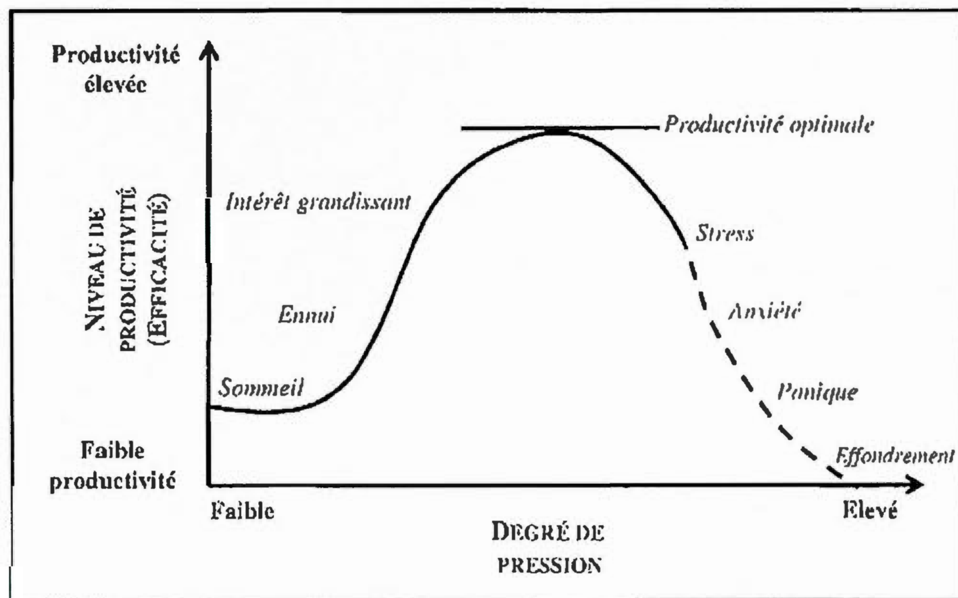


Image gracieuseté *blog.fredericvermeulin.fr*

PASSEPORTSANTÉ.NET

Quel est votre profil personnel de stress?

Si vous avez pour objectif d'exercer un meilleur contrôle sur votre stress, il est important de connaître votre niveau de stress. Certaines situations ou émotions que vous vivez au quotidien en sont fort révélatrices. Pour ce faire, nous vous invitons à répondre aussi honnêtement que possible au test suivant qui comprend vingt énoncés. Réfléchissez et répondez aux énoncés en fonction de ce que vous avez vécu durant le dernier mois.

Pour répondre, indiquez la fréquence à laquelle vous avez vécu les émotions ou situations décrites dans chacun des énoncés : jamais, à l'occasion, fréquemment ou presque continuellement?

Durant le dernier mois, à quelle fréquence avez-vous eu ce sentiment ou vécu cette situation?

1. Je ressens de la tension, de la nervosité, de l'anxiété ou de l'inquiétude.
○ jamais
○ à l'occasion
○ fréquemment
○ continuellement ou presque continuellement

2. Je me sens triste, déprimé, j'ai le cafard ou je suis pessimiste.
○ jamais
○ à l'occasion
○ fréquemment
○ continuellement ou presque continuellement

3. Mon énergie est faible, je me sens exténué, fatigué ou incapable de terminer quoi que ce soit.
○ jamais
○ à l'occasion
○ fréquemment
○ continuellement ou presque continuellement

4. Je n'arrive pas à faire le vide de mes pensées assez longtemps (durant la nuit ou les fins de semaine) pour me sentir détendu et être d'attaque pour une nouvelle journée.
○ jamais
○ à l'occasion
○ fréquemment
○ continuellement ou presque continuellement

5. Je me sens incapable de rester en place, et je dois continuellement bouger.
○ jamais
○ à l'occasion
○ fréquemment
○ continuellement ou presque continuellement

6. Je suis tellement troublé que je me sens en perte de contrôle de mes émotions.
○ jamais
○ à l'occasion
○ fréquemment
○ continuellement ou presque continuellement

7. Un problème personnel important me préoccupe.

○ jamais
○ à l'occasion
○ fréquemment
○ continuellement ou presque continuellement

Copyright © 2011 Tina C. Montreuil

8. Je vis des situations déplaisantes, dans lesquelles je me sens incapable de réagir pour le mieux.
O jamais
O à l'occasion
O fréquemment
O continuellement ou presque continuellement

9. Je me sens fatigué le matin, sans énergie pour me lever ou entreprendre les activités de la journée.
O jamais
O à l'occasion
O fréquemment
O continuellement ou presque continuellement

10. J'ai des problèmes à me concentrer ou à me souvenir de certaines choses.
O jamais
O à l'occasion
O fréquemment
O continuellement ou presque continuellement

11. Je sens que je pourrais prendre nettement mieux soin de moi et de ma santé.
O jamais
O à l'occasion
O fréquemment
O continuellement ou presque continuellement

12. Je sens que je n'ai pas beaucoup de contrôle sur les événements dans ma vie.
O jamais
O à l'occasion
O fréquemment
O continuellement ou presque continuellement

13. Peu importe les efforts que je déploie, il me semble que je suis incapable d'accomplir ce que je veux.
O jamais
O à l'occasion
O fréquemment
O continuellement ou presque continuellement

14. Ma vie est une suite de frustrations causées par la malchance ou par des gens qui ne sont pas à la hauteur de mes attentes.
O jamais
O à l'occasion
O fréquemment
O continuellement ou presque continuellement

15. Mes objectifs personnels sont très élevés.
O jamais
O à l'occasion
O fréquemment
O continuellement ou presque continuellement

16. Lorsqu'une situation difficile ou stressante s'annonce, je me mets à penser à tout ce qui pourrait mal tourner pour moi.
O jamais
O à l'occasion
O fréquemment
O continuellement ou presque continuellement

Copyright © 2011 Tina C. Montreuil

17. Ma vie me semble vide et dépourvue de sens.
- O jamais
- O à l'occasion
- O fréquemment
- O continuellement ou presque continuellement

18. Souvent, je me heurte à des problèmes que je ne peux résoudre.
- O jamais
- O à l'occasion
- O fréquemment
- O continuellement ou presque continuellement

19. Malgré ma volonté, je suis incapable de donner ce que je voudrais aux personnes les plus proches de moi.
- O jamais
- O à l'occasion
- O fréquemment
- O continuellement ou presque continuellement

20. Je ne me sens pas proche de mon entourage ou pas accepté par celui-ci – autant de ma famille que de mes amis.
- O jamais
- O à l'occasion
- O fréquemment
- O continuellement ou presque continuellement

Comment interpréter vos résultats

Ce test est particulièrement utile puisqu'il met en évidence, pour chaque personne, les éléments à cibler dans le travail personnel qu'exige la gestion du stress. Lorsqu'un résultat à un énoncé est élevé, cela vous indique que vous devriez réfléchir à la manière d'améliorer les choses dans votre vie qui se rapportent à l'aire spécifique de l'énoncé (par exemple, l'incapacité à se détendre). Il devient alors plus facile d'établir des objectifs spécifiques et un plan pour améliorer cet aspect de votre vie. Et là réside un aspect important de ce test : en partant de vos résultats, il faut bien identifier ce que vous voulez changer. Sinon, les chances sont grandes que vous entreteniez de manière chronique votre état stressé, sans savoir comment agir pour le diminuer.

Gracieuseté de passeportsanté.net

Copyright © 2011 Tina C. Montreuil

SYMPTÔMES DE LA PSYCHOSE

Le but de la séance est de nous aider à mieux comprendre les symptômes les plus communément associée à cette expérience inhabituelle. C'est symptômes ne sont probablement présents qu'à certains moment. Notre objectif sera de normaliser cette expérience et nous permettre de mieux comprendre de quelle façon ces symptômes sont en lien avec l'anxiété sociale. La manifestation de ces symptômes peut parfois nous faire sentir différents des autres, résultant en des pensées défaitistes qui nous stigmatisent. Comme nous allons le voir durant la séance, ces symptômes peuvent se manifester dans diverses autres situations

---

1. Que s'est-il passé à la suite à mon expérience inhabituelle?

Comme pour plusieurs autres maladies ou troubles, en psychose il y a manifestement toujours la présence de symptômes. Les symptômes varient selon chacun. Pour certains, l'expérience de ces symptômes n'aura eu lieu qu'une seule fois durant toute leur vie. Pour d'autres, il se peut que cette expérience et ces symptômes soient récurrents, mais qu'ils soient tout de même en mesure de mener une vie normale en dépit de la présence de ces manifestations. Toutefois, il est également possible que pour certains, les symptômes soient si sévères qu'ils interfèrent avec le bon fonctionnement.

Une telle expérience résulte *presque toujours* en un changement marqué au niveau des habiletés et de la personnalité chez cet individu. Très souvent, il arrive que ce soit un membre de la famille ou encore des amis qui prennent connaissance que leur être cher ne se « comporte pas comme à l'habitude ». En premier lieu, les symptômes sont normalement moins sévères et ils évoluent jusqu'à ce qu'ils

Copyright © 2011 Tina C. Montreuil

interfèrent de façon plus importante avec le fonctionnement de l'individu.

En général, la détérioration est observable au niveau :

♦ Du travail ou de l'école ♦ Les relations auprès des autres ♦ Hygiène personnelle

2. Quels sont certains des symptômes associés à mon expérience?

Afin de mieux comprendre cette expérience, il est souvent efficace de grouper les symptômes qui ont des caractéristiques semblables :

(1) **Ajout** de certaines manifestations de symptômes non désirés

-Délires, hallucinations

(2) **Retrait** social (e.g. lié aux symptômes dépressifs et à l'isolement)

-Émoussement affectif, alogie, apathie ou avolition, anhédonie, troubles de l'attention

(3) Difficultés associées à **l'organisation et au fonctionnement**

-Langage désorganisé, comportement désorganisé (moteur et/ou social) ou catatonique (stupeur ou excitation)

L'ensemble de ces symptômes inclue habituellement une combinaison des éléments suivants :

- **Changement au niveau de la personnalité :** Souvent considéré comme étant un élément clé dans l'expérience psychotique. En premier lieu, les changements sont plus difficiles à détecter. Éventuellement, ces changements deviennent plus apparents à notre entourage (ex. famille, ami, confrère de classe, collègue, etc.).

  Ces changements se manifestent en une perte au niveau de l'expression des émotions, des intérêts et de la motivation. Une personne active peu parfois se retirer, devenir irritable, timide ou s'isoler. Les émotions deviennent

Copyright © 2011 Tina C. Montreuil

parfois inappropriées au contexte (ex. la personne pourrait rire face à une situation triste ou pleurer s'il s'agit d'une blague) et il arrive que l'individu ne puisse pas démontrer aucune forme d'émotivité.

- **Trouble de la pensée :** Ceci représente le plus important changement vécu lors de cette expérience puisqu'il affecte la « clarté de la pensée » et engendre des difficultés à réagir de façon rationnelle à des situations et problèmes communs. Les pensées peuvent être ralenties, elles peuvent déferler dans notre tête ou encore elles peuvent être complètement absentes. Ainsi la personne peut sauter rapidement d'un sujet à l'autre, avoir l'apparence d'être confuse et avoir beaucoup de difficultés à prendre une très simple décision, chose qu'elle pouvait faire de par le passé.

- **Delires :** Les délires sont principalement de fausses croyances qui ne possèdent aucunes bases fondamentales ou logiques. Les délires peuvent agir comme « filtre » de nos pensées, engendrant ainsi des réflexions dites différentes par rapport à une situation donnée. Certaines personnes ressentent qu'elles sont persécutées, poursuivies, espionnées ou encore que l'on complote contre elles. Il se peut qu'elles soient convaincues que les services secrets ou de police les surveillent. Il peut également y avoir la présence de délires de « grandiosité » où la personne croit qu'elle possède des dons ou habiletés exceptionnelles. Cette grandiosité peut aussi se manifester sous forme de croyances ou ferveurs religieuses intenses chez un individu, où il pourrait avoir l'impression qu'une mission spéciale lui ait été assignée.

- **Changements perceptuels :** Il n'est pas difficile d'imaginer qu'à la suite d'une expérience inhabituelle, la perception du monde d'une personne soit renversée. Les messages sensoriels envoyées au cerveau par tous les sens: les yeux, les oreilles, le nez, la peau ainsi que le goût, deviennent entremêlés et ils peuvent causer chez la personne, la perception de quelques choses qui en réalité, ne l'est pas. Ce phénomène est plus communément appelé « hallucinations » par les psychiatres et psychologues.

Certaines personnes vont entendre des voix. Parfois, il arrive que ces voix

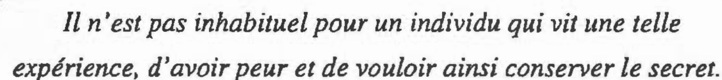
Copyright © 2011 Tina C. Montreuil

soient menaçantes ou dérogatoires. Elles peuvent aussi émettre des ordres ou directives comme par exemple : « Tu ne dois pas faire confiance à cette personne », ou encore « Tu est laid (e) et stupide. »

Certaines personnes font également l'expérience d'hallucinations visuelles, quoiqu'elles soient moins communes. Il arrive que les choses qui avaient disparues, soudainement apparaissent. Ces dernières peuvent aussi affecter la perception des couleurs, des formes et des visages.

L'individu peut aussi faire l'expérience d'une hypersensibilité au son, au gout et aux odeurs. La sonnerie d'un téléphone pourrait être perçue comme étant une alarme à incendie ou encore la voix d'un proche pourrait devenir aussi terrifiante que l'aboiement d'un chien enragé. Le sens du toucher pourrait aussi être affecté de sorte à ce que la personne ait l'impression qu'un insecte ou autre parasite se faufile sous la peau ou qu'un membre de son corps ait changé ou qu'il ne lui appartient pas.

- **Perception de soi:** Lorsque tous les cinq sens sont affectés, il arrive que la personne perde la notion du temps, ou de l'espace, comme si sont esprit « flottait à l'extérieur » d'elle même. Cette expérience peut entrainer la sensation de dépersonnalisation.



3. Quel est le lien entre l'anxiété sociale et l'expérience psychotique?

- Plusieurs études ont révélé que chez les personnes atteintes de schizophrénie, environ 36% ont également obtenu un diagnostic de comorbidité d'anxiété sociale.
- Ces individus ont un risque de rechute plus élevé et des impacts plus sévères

Copyright © 2011 Tina C. Montreuil

sont observables au niveau du fonctionnement. Il semble que la présence d'anxiété sociale suite à une expérience inhabituelle soit plutôt commune. Ce phénomène soulève également l'importance de traiter l'anxiété sociale chez les individus ayant vécu une expérience inhabituelle puisque ces symptômes semblent conséquemment aggravés les symptômes psychotiques.

"La normalisation: L'ANTIDOTE au Stigma."

- Le but est d'éviter la catastrophisation :
  - Presque chaque individu fera face à la maladie à un moment donné au cours de leur vie.
- La psychose :
  - Est un problème commun qui affecte un bon nombre de gens, de diverses cultures, de différentes sphères de vie, indépendamment du statut social.
  - L'apparition des symptômes n'est pas liée à une faute ou nécessairement à des actes répréhensibles.
- Un bon nombre de personnes parviennent à surmonter les effets des symptômes.
- La perception de l'expérience inhabituelle est spécifique contexte culturel.
- Dans certaines cultures, l'expérience inhabituelle est perçue de façon positive.
- Le manque de sommeil et la privation sensorielle peut provoquer l'apparition de symptômes qui ressemblent aux symptômes psychotiques: entendre des voix, des

Copyright © 2011 Tina C. Montreuil

hallucinations visuelles, etc.

• Plusieurs expériences ont été menées afin de déterminer s'il serait possible de reproduire ces symptômes de façon « artificielle ». Les études ont révélées que :

- 50% avait vécu du retrait de social et de l'isolement
- 20% avait fait l'expérience d'hallucinations visuelles
- 15% avait eu des hallucinations auditives
  - 100% avait fait l'expérience de symptômes psychologiques inhabituels

---

ACTIVITÉ À LA MAISON

Compléter la feuille: "Quels étaient mes symptômes"

Copyright © 2011 Tina C. Montreuil

Quels étaient mes symptômes?

Symptômes Psychotiques

Identifie les symptômes qui s'apparent à ton expérience relativement à la psychose

Symptômes Positifs

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________

Symptômes Négatifs

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________

Désorganisation

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________

Copyright © 2010 Tina C. Montreuil

Copyright © 2011 Tina C. Montreuil

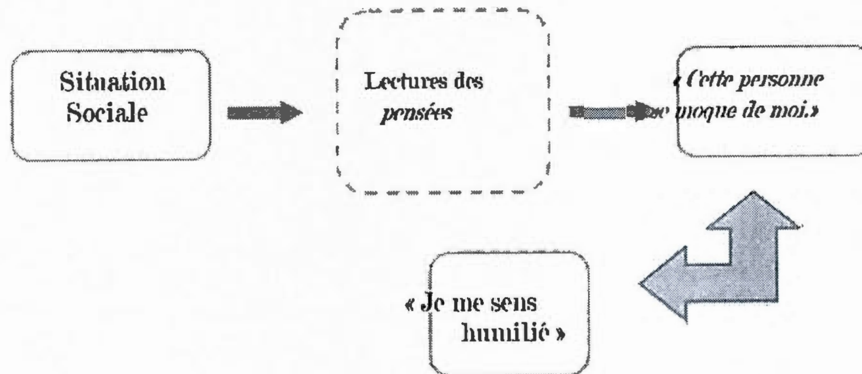
INTRODUCTION AUX DISTORSIONS COGNITIVES

La séance d'aujourd'hui nous initiera aux stratégies de la thérapie cognitivo-comportementale dans le but de nous aider à faire face à l'anxiété sociale et aux symptômes liés à une expérience inhabituelle. L'objectif de cette séance sera également d'identifier et de corriger les pensées dysfonctionnelles qui contribuent au développement et au maintien de l'anxiété sociale en modifiant les distorsions cognitives. D'être en mesure de reconnaître et de modifier les pensées erronées, nous permettra de diminuer l'anxiété d'appréhension, de réduire la détresse ressentie lors de l'exposition à des situations sociales et de limité notre tendance les ruminations (ex. doutes personnels) après une exposition.

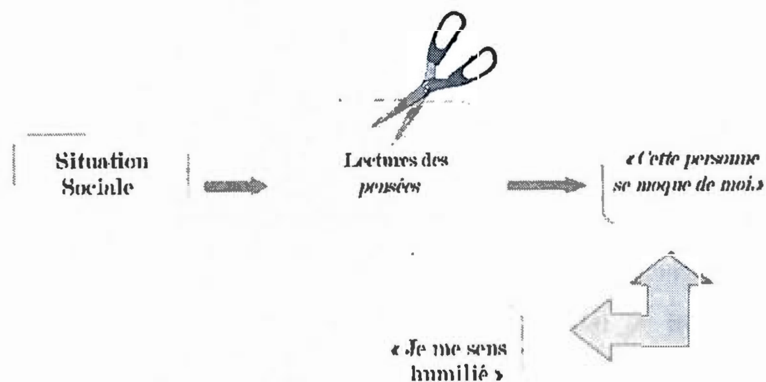
1. Qu'est-ce qu'une "distorsions cognitives"?

Les distorsions cognitives sont définies comme étant des pensées automatiques erronées qui sont en lien avec une situation ou un événement. Aaron Beck a été le premier à utiliser le terme « distorsions cognitives » pour définir ce processus. Ces distorsions cognitives ou "filtres" influencent la façon dont nous interprétons une situation donnée. Par exemple, supposons que nous sommes assis dans le métro. Imaginez que la personne assise en face de nous éclate de rire. Une personne qui a tendance à faire de "la lecture de pensées" pourrait automatiquement déduire que cette personne se moque effectivement d'elle. Si l'on croit qu'une personne se moque de nous, il n'est pas difficile d'imaginer à quel point cette situation sociale pourrait être contrariante et nous faire sentir mal à l'aise, timide, humilié, ou même en colère.

Copyright © 2011 Tina C. Montreuil

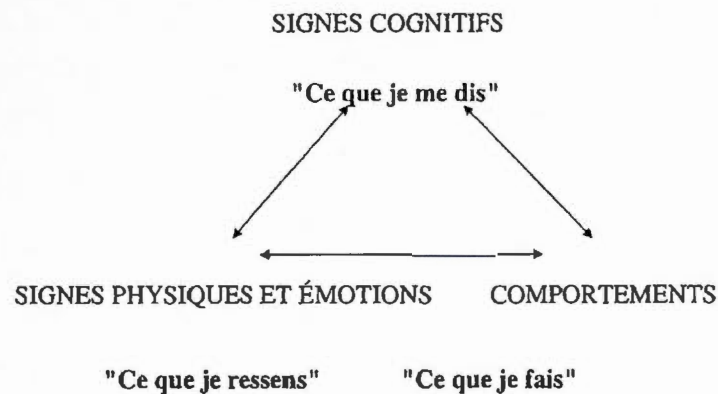


Il est possible de remédier à ces pensées erronées en « identifiant » et en générant des « explications alternatives » à nos pensées automatiques pour cette même situation. Il y aurait-il une explication autre que celle qui nous est venue automatiquement en tête qui pourrait s'appliquer à la situation?



Copyright © 2011 Tina C. Montreuil

Il est important de pouvoir générer une « explication alternative » puisque nous avons vu durant les dernières séances, que « ce que je me dis », affecte « ce que je ressens » et finalement influence « ce que je fais ». Donc, si nous changeons notre discours interne (pensées) en un discours plus positif, cela aura également un impact positif sur nos émotions ainsi que nos comportements.



On peut modifier nos pensées erronées :

(1) Cibler une situation sociale où nous nous sommes sentis embarrassés, humiliés, en colère ou confus;
(2) Identifier les pensées qui ont été engendrées par l'interaction sociale;
(3) Identifier les distorsions cognitives qui sont associées à ces pensées.

Copyright © 2011 Tina C. Montreuil

2. Les différentes distorsions cognitives.

Il existe un bon nombre de distorsions cognitives. De sorte à pouvoir les modifier, il faut tout d'abord les reconnaître. La liste qui se trouve aux pages 41-42, présente chacune des distorsions cognitives. Après en avoir complété la lecture, tentons de voir s'il est possible pour nous d'en identifier quelques unes qui se manifestent durant nos interactions sociales. Rappelons-nous, plus souvent nous en faisons la lecture, plus facile il sera pour nous de les reconnaître.

3. Le registre des pensées.

Le registre des pensées ou « tableau » est un outil essentiel lorsqu'il s'agit d'identifier les diverses distorsions cognitives qui se manifestent lors d'interactions sociales. Ce tableau nous permet également de modifier nos pensées automatiques récurrentes en générant des « explications alternatives ». Durant les prochaines séances, nous allons utiliser cet outil à plusieurs reprises. Nous pouvons trouver un modèle de registre de pensées à la page 46 de notre manuel. Nous complèterons un exemple ensemble durant la séance. Par la suite, ce sera à notre tour d'en faire l'usage à la maison ou encore lors de nos interactions sociales afin de prendre connaissance des distorsions qui se manifestent plus spécifiquement.

Copyright © 2011 Tina C. Montreuil

LES DISTORSIONS COGNITIVES

DAVID D. BURNS[1]

DISTORSIONS COGNITIVES	EXEMPLES
1) LES PENSÉES « TOUT OU RIEN » : Tendance à catégoriser dans les extrêmes - blanc-noir, bon-mauvais, sans nuance. Modes de pensée extrémistes à la base du perfectionnisme, qui amènent la personne à craindre toute erreur ou imperfection et qui incitent à se considérer comme incapable, perdant, déchet, raté.	Un étudiant qui obtient toujours des A dans ses cours et qui obtient un jour un B à un examen arrive à la conclusion suivante : « Maintenant je sais que je suis un raté. » (p. 46)
2) LA GÉNÉRALISATION À OUTRANCE : Tendance à conclure arbitrairement que lorsqu'une chose arrive une fois, elle arrivera toute la vie et entraîne la douleur de rejet.	Un jeune homme timide réussit à faire une invitation à une jeune fille. Cette dernière refusa poliment son offre en lui expliquant qu'elle avait déjà planifié quelque chose ce jour-là. Le jeune homme se dit alors : « Je n'arrivera jamais à sortir avec une fille. Aucune n'acceptera un rendez-vous avec moi. Je serai malheureux et solitaire toute ma vie. » (p. 47)
3) LE FILTRE : Tendance à s'attarder négativement sur un petit détail dans une situation qui fait percevoir négativement l'ensemble de cette situation. C'est un processus de filtrage de la pensée qui fausse la vision de la réalité.	« [...] une étudiante déprimée entendit d'autres étudiantes se moquer de sa meilleure amie. Elle en fut outragée parce qu'elle pensa : « C'est bien la race humaine ! Cruelle et insensible ! » [...] À une autre occasion, après avoir présenté son dernier examen de mi-session, elle fut convaincue qu'elle avait donné une mauvaise réponse à 17 questions sur 100. Obsédée par ces 17 malheureuses questions, elle finit par conclure qu'il ne lui restait plus qu'à abandonner les études universitaires. » (p.47)
4) LE REJET DU POSITIF : Tendance persistante à transformer des expériences neutres ou même positives en expériences négatives. Il ne s'agit plus de se contenter d'ignorer les expériences positives, mais de les transformer très habilement en événements tout à fait cauchemardesques.	Lorsqu'une expérience négative est vécue, une personne retourne le couteau dans la plaie en se disant : « Voilà qui prouve ce que j'ai toujours pensé ». Au contraire, lorsque qu'elle vit une expérience positive, elle se dit : « C'était par hasard, ça ne compte pas. » (p. 48)
5) LES CONCLUSIONS HÂTIVES : A) L'INTERPRÉTATION INDUE OU LA LECTURE DES PENSÉES D'AUTRUI : Tendance à décider arbitrairement que quelqu'un a une attitude négative envers soi sans prendre la peine de procéder à une vérification. Cette attitude défaitiste permet de répondre à des réactions négatives imaginaires par la retraite ou la contre-attaque. Elle permet aussi de justifier des appréhensions. B) L'ERREUR DE PRÉVISION : Tendance à prévoir le pire et à se convaincre que la prédiction est confirmée par les faits. La prédiction est considérée comme un fait même si elle a peu de chances de se réaliser.	A) Une personne croise un ami dans la rue et ce dernier ne la salue pas parce qu'il ne l'a pas vu et qu'il est perdu dans ses pensées. La personne conclue a tort : « Il m'ignore, c'est parce qu'il ne me considère plus comme son ami. » Votre conjoint se montre taciturne un soir parce qu'il a eu des reproches au travail et il se sent trop soucieux pour en discuter. Tout s'écroule autour de vous car, en raison de votre interprétation de son silence, vous vous dites : « Il est en colère contre moi, mais qu'ai-je donc fait de mal ? » (p. 49-50) B) Vous téléphonez à un ami et ce dernier ne retourne pas votre appel dans un délai raisonnable. Vous vous dites : « Il a probablement reçu mon message et il ne s'est même pas donné la peine de me rappeler ! », ce qui vous vexe. En raison de votre interprétation, vous lui en voulez et vous décidez de ne pas le rappeler pour vous en assurer, car vous vous dites : « Il va trouver que je l'importune si je le rappelle et je vais me rendre ridicule. » (p.51)

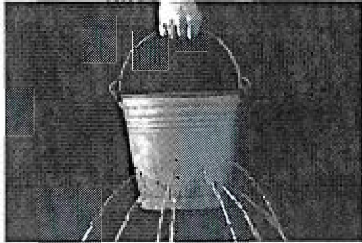
[1] Burns, D. D. (1994). *Être bien dans sa peau*. Les éditions Héritage Inc., pp. 46-56.

Copyright © 2011 Tina C. Montreuil

6) LE PHÉNOMÈNE DE LA LORGNETTE : A) L'EXAGÉRATION OU LA DRAMATISATION : Tendance à amplifier l'importance accordée à ses propres erreurs, ses craintes et ses imperfections. On appelle « dramatiser » le fait de prendre un événement désagréable, mais banal, et en faire quelque chose d'extraordinaire, de cauchemardesque. B) LA MINIMISATION (SON CONTRAIRE) : Tendance à diminuer l'importance de ses points forts en les voyant petits. Ces deux phénomènes amènent à se sentir inférieur aux autres.	« Mon Dieu ! Je me suis trompé. C'est terrible ! C'est effroyable ! Le monde entier va le savoir ! Je vais être déshonoré ! » (p. 51)
7) LES RAISONNEMENTS ÉMOTIFS : Tendance à présumer que les sentiments les plus sombres reflètent nécessairement la réalité des choses. « C'est ce que je ressens, cela doit donc évidemment correspondre à la réalité. » (Burns, 1994, p. 55).	« J'ai l'impression d'être un raté, je suis donc un raté. » « Je me sens coupable, j'ai donc dû faire quelque chose de mal. » « J'ai du vague à l'âme et je n'ai pas le goût de rien faire aujourd'hui. Je suis donc aussi bien de rester au lit. » Je suis fâché contre toi. Cela me prouve que tu t'es mal conduit avec moi, que tu as cherché à abuser de moi. » (p. 51)
8) LES «JE DOIS» ET LES «JE DEVRAIS» : Tendance à essayer de se motiver par des «je devrais» ou des «je ne devrais pas», comme s'il fallait se battre ou se punir pour se convaincre de faire quelque chose, ce qui amène un sentiment de culpabilité. Le fait d'attribuer ces obligations aux autres éveille des sentiments de frustration, de colère et de ressentiment, causant bien des crises émotives et déceptions inutiles dans le quotidien.	Utilisation des phrases suivantes pour se motiver : « *Je devrais* faire ceci... », « *Je dois* faire cela... », « Il faut que je fasse ceci... », « Il faudrait que je fasse cela ou qu'il fasse cela... ». Une personne arrive en retard à un rendez-vous. L'autre personne se dit : « Il *devrait* arriver à l'heure... » (p.52)
9) L'ÉTIQUETAGE ET LES ERREURS D'ÉTIQUETAGE : C'est une forme extrême de généralisation à outrance qui représente la tendance à s'apposer une étiquette négative, à la suite d'une erreur. Elle part d'un sentiment d'imperfection ou de faiblesse, comme «je suis un perdant», plutôt que de qualifier l'erreur. C'est aussi d'accoler une étiquette à une autre personne quand son comportement déplaît. Les erreurs d'étiquetage reposent sur le fait de décrire quelque chose par des mots inexacts, colorés et chargés d'émotions.	Une personne manque un coup au golf et se dit : « Je suis un perdant-né » plutôt que de se dire : « J'ai raté mon dix-huitième trou ». (p. 53)
10) LA PERSONNALISATION : Tendance à assumer la responsabilité d'un événement fâcheux sans en être la cause. C'est l'origine du sentiment de culpabilité.	En lisant le bulletin de son enfant, une mère trouve une note de son professeur qui l'avise que son enfant ne travaillait pas bien à l'école. La mère conclut immédiatement : « Je dois être une mauvaise mère ! Voilà la preuve de mon échec. » (p. 54)

Copyright © 2011 Tina C. Montreuil

Exercice: La Restructuration Cognitive



Sophie effectue un retour à l'université depuis un long congé d'été. À son entrée dans la salle de cours, Sophie reconnaît une personne qu'elle n'avait pas revue depuis le primaire, prénommée Marie. Lorsque Marie s'assoit, elle se tourne vers Sophie et lui dit : « Est-ce que l'on se connaît ? » Sophie poursuit en répondant qu'elle se rappelle de Marie en 6ième année, puisqu'elles avaient toutes deux participées à un débat où Sophie était ressortie la gagnante. Marie, qui ne semble pas avoir été emballée par cette remarque, répond « Ah oui, je vois » et se retourne brusquement sans rien ajouter. Sophie est vexée par cet incident. Sophie se dit qu'elle fait toujours des gaffes, qu'elle ne peut rien faire

1) Identifie les <u>pensées dysfonctionnelles</u> qui pourraient être générées par Sophie à la suite de cet incident.

a. ____

____

b. ____

____

c. ____

____

Copyright © 2011 Tina C. Montreuil

d. ______________________________

____

e. ______________________________

____

2) Identifie les émotions négatives que pourraient susciter de telles pensées suite à cet incident.

a. ______________ d. ______________

b. ______________ e. ______________

c. ______________ f. ______________

3) Identifie les distorsions cognitives qui pourraient être associées à cet incident.

a. ______________________

b. ______________________

c. ______________________

d. ______________________

e. ______________________

Le registre de pensées est efficace puisqu'il nous permet de noter les informations suivantes :

Copyright © 2011 Tina C. Montreuil

(1) **La situation sociale** - Décrire rapidement l'événement ou la situation qui a déclenché la détresse. *Ex. j'ai laissé un message vocal à mon ami et il ne m'a pas rappelé.*

(2) **Les émotions** -Décrire et évaluer le plus précisément possible les émotions ressenties en pourcentages de 0 à 100. *Ex. tristesse, colère et anxiété et rejet.*

(3) **Les pensées automatiques** - Faire la liste de toutes les pensées qui nous passent par la tête et qui nous rendent malheureux, anxieux, ou en colère. *Ex. « Il doit ne plus vouloir être mon ami »; « J'ai probablement fait quelque chose de mal ».*

(4) **Les distorsions cognitives** - Recenser les distorsions qui sont en lien avec les pensées automatiques notées. *Ex. Lecture des pensées, raisonnement émotif.*

4. Le rôle des distorsions cognitives en anxiété sociale.

Les gens qui souffrent d'un trouble anxieux de façon générale, mais plus particulièrement dans le cas de l'anxiété sociale, ont tendance à surestimer le danger potentiel associé à une situation sociale. Les gens qui souffrent d'anxiété sociale surévaluent la probabilité d'être évalué, jugé ou ridiculisé. Les distorsions cognitives ou pensées erronées sont souvent associées à ces mésinterprétations concernant leurs habiletés à gérer ou tolérer une telle situation. Ces pensées fautives contribuent à la formation des émotions de honte, d'embarras ou de colère.

Copyright © 2011 Tina C. Montreuil

Cette évaluation négative semble être en lien avec la présence de ces pensées erronées. Il est donc très important de les modifier si l'on désire réduire ce biais de négativité qui limite nos interactions sociales.

ACTIVITÉ À LA MAISON

Compléter le "Registre des pensées" en utilisant une situation sociale vécue.

Copyright © 2011 Tina C. Montreuil

Situation sociale	Émotions		Pensées Automatiques	Distorsions Cognitives
Décrivez la situation qui a mené à l'apparition de sentiments d'inconfort ou à la détresse.	Tristesse	%	À quoi avez-vous pensé au moment où vous avez été exposé à cette situation? Que vous êtes-vous dit ou répété à l'intérieur de vous-même avant, durant ou après avoir été confronté à cette situation?	En vous basant sur la liste des distorsions cognitives présentée, identifiez le ou les distorsions cognitives qui s'apparent à vos pensées automatiques.
	Colère	%		
	Anxiété	%		
		%		
		%		
	Notez les émotions qui sont apparues au moment où vous avez été exposé à cette situation. Évaluez également en pourcentage de (0 à 100%) votre niveau de détresse émotionnelle.			

Copyright © 2011 Tina C. Montreuil

LA RESTRUCTURATION COGNITIVE

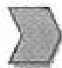
La séance d'aujourd'hui nous encouragera à être plus vigilants et finalement à corriger nos pensées erronées ou «schémas de pensée erronés" en apprenant à identifier les erreurs de jugement lorsqu'elles se produisent (Session 5 - distorsions cognitives). Apprendre à identifier mais surtout, à modifier nos pensées automatiques dysfonctionnelles, pourra nous aider à exercer un meilleur contrôle sur nos symptômes d'anxiété. L'objectif vise à nous rendre plus aptes à modifier nos pensées automatiques en des pensées plus rationnelles. Le résultat sera une réduction de la détresse émotionnelle et physiologique qui sont généralement associées à la présence de pensées dysfonctionnelles.

---

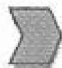
1. Révision - les "distorsions cognitives"

Durant la dernière séance, nous avons vu que les distorsions cognitives ou "filtres" influencent la façon dont nous interprétons une situation donnée.

- **Les distorsions cognitives sont:**



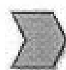
AUTOMATIQUE – Ils apparaissent simplement dans notre esprit, sans effort.



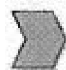
ERRONÉE – Ne sont pas toujours basées sur des faits ou la réalité.

INUTILE – Maintiennent des émotions négatives sur soi.

Copyright © 2011 Tina C. Montreuil

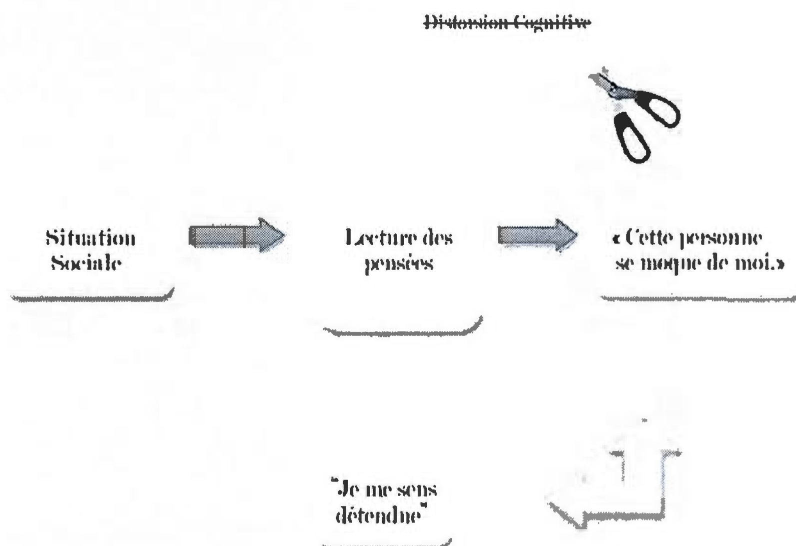


PLAUSIBLE – Ce qui fait en sorte que nous les acceptons comme des faits.



INVOLONTAIRE – Il est très difficile de s'en défaire

2. **<u>Rappelons-nous le modèle?</u>**



Tel que nous l'avons vu, les distorsions cognitives ou pensées erronées sont souvent associées à ces mésinterprétations concernant leurs habiletés à gérer ou tolérer une telle situation. Ces pensées fautives, quoiqu'automatiques et involontaires, contribuent à la formation des émotions de honte, d'embarras ou de colère. Il est donc très important de les modifier si l'on désire réduire ce biais de négativité qui limite nos interactions sociales.

Copyright © 2011 Tina C. Montreuil

Il est possible de remédier à ces pensées erronées en « identifiant » et en générant des « **explications alternatives** » à nos pensées automatiques pour cette même situation. Il y aurait-il une explication autre que celle qui nous est venue automatiquement en tête qui pourrait s'appliquer à la situation du métro? Il y aurait-il une autre interprétation acceptable qui puisse expliquer les rires de la personne assise près de nous?

- **Pensées alternatives: "Il est possible que la personne rigolait avec un(e) ami(e)"**

Le changement d'une pensée erronée en une pensée alternative a un impact positif sur nos émotions et nos sentiments. Comme vous le savez maintenant, nos pensées influencent nos réactions émotionnelles. Par conséquent, il est vraiment important que nous apprenions à évaluer toutes les informations qui sont disponibles autour de nous, avant de passer trop vite à des conclusions. Le prochain exercice "Ne soyez pas trop rapide à juger" a pour objectif de nous encourager à considérer le plus de perspectives ou explications possibles avant de sauter aux conclusions.

3. Extraits vidéo – "Do not judge too quickly" *Ne juge pas trop rapidement!*

Nous allons vous présenter des extraits vidéo. Observez attentivement les images qui y figurent et tentez de suivre l'histoire. Votre travail consistera à rassembler les preuves. Nous vous présenterons les extraits et nous pauserons la bande avant que la conclusion ne soit révélée.

Copyright © 2011 Tina C. Montreuil

Veuillez réfléchir à de possibles réponses pour les questions suivantes:

a. Que ce passe-t-il dans l'extrait?

____

____

____

b. Au moment où l'extrait fut mis en veille, que concluriez-vous de l'histoire en vous basant sur l'information qui vous est disponible à ce moment ?

____

____

____

c. Tentez d'élaborer d'autres potentielles explications ou conclusions pour l'extrait que vous venez de voir (même si elles sont moins probables).

____

____

____

d. Maintenant que l'on vous a présenté la fin de l'extrait, qu'elle conclusion pourriez-vous tirer?

____

____

____

Que l'on peut parfois « tirer une conclusion trop hâtivement » Il est donc important de prendre le soin d'accumuler toutes les preuves et de ne pas présumer que nous possédons les réponses absolues à toutes situations à moins d'avoir accumuler un nombre suffisant de preuves. Il est donc impératif de formuler des EXPLICATIONS ALTERNATIVES.

Copyright © 2011 Tina C. Montreuil

4. Comment initier le changement?

(1) La première étape : Prendre conscience de nos pensées erronées.

a. La meilleure façon de procéder est d'utiliser un REGISTRE DE PENSÉES. Le registre des pensées ou « tableau » est un outil essentiel lorsqu'il s'agit d'identifier les diverses distorsions cognitives qui se manifestent lors d'interactions sociales. Ce tableau nous permet également de modifier nos pensées automatiques récurrentes en générant des « explications alternatives ».

(2) La deuxième étape : Tenter de modifier les pensées erronées en pensées plus rationnelles.

Voici quatre questions que nous pouvons utiliser afin de nous aider à modifier les pensées erronées en explications alternatives.

1. Quelle preuve supporte votre pensée automatique? Est-elle basée sur des faits; la réalité?

2. Quelle serait une explication alternative pour ce qui vient de se passer?

3. Quel impact cette façon de penser a-t-elle sur vous?

4. Quelles sont les types de distorsions cognitives qui se manifestent souvent et qui pourraient être en lien avec cette pensée erronée?

Le registre de pensées est efficace puisqu'il nous permet de noter les informations suivantes :

Copyright © 2011 Tina C. Montreuil

(1) **La situation sociale** - Décrire rapidement l'événement ou la situation qui a déclenché la détresse. *Ex. j'ai laissé un message vocal à mon ami et il ne m'a pas rappelé.*

(2) **Les émotions** -Décrire et évaluer le plus précisément possible les émotions ressenties en pourcentages de 0 à 100. *Ex. tristesse, colère et anxiété et rejet.*

(3) **Les pensées automatiques** - Faire la liste de toutes les pensées qui nous passent par la tête et qui nous rendent malheureux, anxieux, ou en colère. *Ex. « Il doit ne plus vouloir être mon ami »; « J'ai probablement fait quelque chose de mal ».*

(4) **Les distorsions cognitives** - Recenser les distorsions qui sont en lien avec les pensées automatiques notées. *Ex. Lecture des pensées, raisonnement émotif.*

(5) **L'explication alternative,** qui nous permet de générer des explications plus adaptées et réalistes de notre expérience.

ACTIVITÉ À LA MAISON

Compléter le "Registre de pensées" modifié qui inclut L'EXPLICATION ALTERNATIVE en utilisant une situation sociale vécue.

Copyright © 2011 Tina C. Montreuil

Situation sociale	Émotions		Pensées Automatiques	Explication Alternative
Décrivez la situation qui a mené à l'apparition de sentiments d'inconfort ou à la détresse.	Tristesse	%	À quoi avez-vous pensé au moment où vous avez été exposé à cette situation? Que vous êtes-vous dit ou répété à l'intérieur de vous-même avant, durant ou après avoir été confronté à cette situation?	Quelle preuve supporte votre pensée automatique? Est-elle basée sur des faits; la réalité? 2. Quelle serait une explication alternative pour ce qui vient de se passer? 3. Quel impact cette façon de penser a-t-elle sur vous? 4. Quelles sont les types de distorsions cognitives qui se manifestent souvent et qui pourraient être en lien avec cette pensée erronée?
	Colère	%		
	Anxiété	%		
		%		
		%		
	Notez les émotions qui sont apparues au moment où vous avez été exposé à cette situation. Évaluez également en pourcentage de (0 à 100%) votre niveau de détresse émotionnelle.			

Copyright © 2011 Tina C. Montreuil

ENTRAÎNEMENT AUX HABILETÉS SOCIALES

Ces séances vont nous aider à identifier (1) Quelles sont nos habiletés sociales, (2) Quelles sont quelques exemples de habiletés sociales utiles, (3) Pourquoi l'entraînement aux habiletés sociales est-elle importante et (4) De quelle façon l'entraînement aux habiletés sociales peut-elle nous être pratique? Les habiletés sociales sont un élément très important de notre fonctionnement psychosocial, de notre vie quotidienne et ils contribuent aussi à notre qualité de vie. Une carence en habiletés sociales peut entrainer des difficultés au plan de notre fonctionnement social. Les effets secondaires des médicaments peuvent contribuer à une réduction des aptitudes sociales. L'entraînement aux habiletés sociales nous aidera à apprendre à communiquer nos sentiments, nos pensées et nos besoins aux autres. De meilleures habiletés sociales peuvent nous aider à atteindre nos objectifs personnels pour le traitement de l'anxiété sociale. Gardez en tête que "la pratique (la répétition)» est essentielle à l'acquisition de ces nouvelles habiletés sociales. C'est alors que l'on parvient à surmonter nos difficultés.

1. Que sont les habiletés sociales?

Les habiletés sociales comprennent tous les types de comportements que nous utilisons lorsque nous interagissons avec les autres. Ces habiletés nous permettent de communiquer et d'entre en relation avec les autres, et sont généralement motivées selon un objectif donné (ex. faire une demande). Les habiletés sociales ne doivent pas être pris pour acquis, parce que même si certaines sont très simples, comme par exemple de saluer quelqu'un en disant bonjour et au revoir, de sourire ou tout simplement d'établir un contact visuel avec les autres lorsque nous parlons. D'autres habiletés sociales sont plus complexes et ils exigent habituellement plus de pratique et de volonté dans le but d'y être éventuellement plus habile (ex. faire une demande ou une critique).

Copyright © 2011 Tina C. Montreuil

Les plaintes les plus fréquentes sont:

- L'isolement social
- Le réseau social limité
- Manque d'intérêt pour les activités
- Faire des demandes déraisonnables
- La gestion de la colère
- Le discours monotone / conversation banale
- La difficulté à écouter et à maintenir une conversation
- Désaccord avec les autres
- Difficulté à exprimer ses pensées et ses sentiments

2. L'entraînement aux compétences sociales - Est-ce difficile?

Pour certaines personnes, l'apprentissage et l'acquisition de nouvelles compétences sociales peuvent être facile, rapide et amusante. Toutefois, pour les autres qui ressentent une plus grande détresse ou des malaises dans une situation sociale, l'apprentissage d'une nouvelle compétence sociale peut être un peu plus difficile, et nécessité plus de temps et de pratique.

3. Sur quelles habiletés sociales pourrais-je travailler?

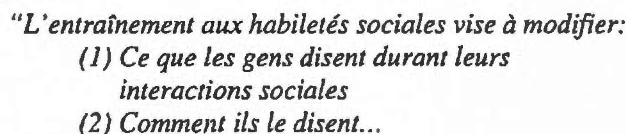
Il y a beaucoup d'habiletés sociales sur lesquelles vous pourriez potentiellement vouloir travailler. Voici, quelques idées:

Copyright © 2011 Tina C. Montreuil

- COCHER CELLES QUE VOUS VOUDRIEZ ACQUÉRIR:

- [ ] Faire une demande
- [ ] Écouter les autres
- [ ] Exprimer un refus
- [ ] Exprimer un désaccord
- [ ] Exprimer des sentiments positifs
- [ ] Exprimer des sentiments négatifs ou désagréables
- [ ] Débuter et entretenir une conversation
- [ ] Mettre fin à une conversation
- [ ] Résolution de problèmes
- [ ] La négociation
- [ ] Gestion de la colère

Copyright © 2011 Tina C. Montreuil



4. Pourquoi l'entraînement aux habiletés sociales est-elle importante?

Entraînement aux habiletés sociales comprend un ensemble de techniques qui ont été développés il y a 25 ans. Comme vous le remarquerez, l'entraînement aux habiletés sociales comporte de nombreuses étapes et varie en longueur et en processus, en fonction de vos objectifs.

- La première étape vise à comprendre pourquoi les habiletés sociales sont importantes.
- La deuxième étape implique les thérapeutes. Ces derniers doivent reproduire, pour les participants, un exemple de l'habileté sociale par le jeu de rôle.
- La troisième étape consiste en l'apprentissage et la pratique de l'habileté par le biais du JEU DE RÔLE. Comme nous l'avons vu dans l'étape précédente, c'est un peu comme être un acteur et de jouer sur la scène devant les autres, ce qui nous mène à l'étape suivante:
- La quatrième étape concerne l'application des participants de l'habileté par le JEU DE RÔLE.

Ceci permet au participant de :

o Se sentir plus à l'aise et moins anxieux face à l'application de la compétence sociale acquise

Copyright © 2011 Tina C. Montreuil

o D'obtenir les commentaires des autres participants et des thérapeutes.

(1) Des éléments positifs et bien maitrisés

(2) Des éléments à modifier

- La dernière étape vise à encourager le participant à mettre en pratique la nouvelle habileté dans une expérience réelle et naturelle.

Cet entraînement est effectué en respectant le niveau de confort et de tolérance de chacun.

5. Comment l'entraînement aux habiletés sociales peut-elle m'aider?

L'entraînement aux habiletés sociales peut vous aider à mieux communiquer avec nos amis, famille, employeur, professeur, etc. Plus important encore, l'entraînement aux habiletés sociales peut nous aider à devenir plus indépendants, afin de nous permettre d'atteindre nos buts et objectifs; quels qu'ils soient (trouver un emploi, rencontrer de nouvelles personnes, d'exprimer nos sentiments et nos pensées, etc.)

"L'ENTAÎNEMENT AUX HABIELETÉS SOCIALES EST TRÈS EFFICACE!"

ACTIVITÉ À LA MAISON

Déterminer l'habileté à travailler afin de procéder au jeu de rôle durant la prochaine séance.

Copyright © 2011 Tina C. Montreuil

"Les avantages de MON ENTRAÎNEMENT AUX HABILETÉS SOCIALES"

Avec QUI voudrais-je être plus affirmatif?

____

____

QUAND voudrais-je plus m'affirmer?

____

____

Dans QUELLE (s) situation (s) voudrais-je plus m'affirmer?

____

____

OÙ voudrais-je plus affirmée?

____

____

Copyright © 2011 Tina C. Montreuil

HABILETÉS DE COMMUNICATION

Discours banal

- Entamer une conversation banale.
- Poser une question « ouverte » qui oblige une réponse circonstanciée.
- Les phrases doivent commencer par exemple par comment ou quel(le).
- Éviter les questions fermées (exemple : vous allez bien… Oui).
- Poser une question ou partager un fait vécu personnel ou d'un commentaire sur une situation.
- Mettre l'emphase sur les comportements non verbaux (ex. hocher de la tête, sourire, contact visuel, etc.)
- Renforcement par le jeu de rôle.

Pour interrompre une conversation, on se place en écoute passive :
- Réponses à faible contenu verbal et non verbal ;
- Puiser dans le discours de l'autre des éléments qui peuvent permettre de banaliser ce qui est dit.

La demande

Avant d'introduire la demande :
- Le sujet doit clarifier anticipativement le matériel à fournir.
- Il doit s'assurer que l'autre est disponible à l'écoute.
- Une demande doit être introduite.

Lorsqu'on formule la demande :
- Il faut parler à la première personne,
- Il faut formuler la demande avec précision, si nécessaire appuyer sa demande en la répétant (techniques du disque rayé, adapter le ton et les comportements non verbaux à la situation).

- Quelques exemples:
  - "J'aimerais que vous_______________."
  - "J'apprécierais si vous _______________."
  - "Il est important pour moi que vous _______________."

Copyright © 2011 Tina C. Montreuil

Deux situations peuvent se présenter :

- La demande est satisfaite ou non
- Dans le cas où la demande n'est pas satisfaite :
    - Il faut livrer sa déception ou son désaccord sans plainte, ni agressivité (veiller au ton).
    - Dans le cas où vous devez exprimer un désaccord, il faut s'exprimer en évitant de se justifier, éventuellement en accompagnant son refus d'une proposition alternative (exemple : pas aujourd'hui mais volontiers la semaine prochaine).
    - Si l'autre insiste, utiliser la répétition du refus selon la technique du disque rayé (expliquer).

Le reproche

- Par définition, un reproche n'est pas constructif.
- Si l'on doit en émettre un, il faut le formuler sous forme d'une demande (exemple : pour quelqu'un qui arrive en retard, j'aimerais que vous arriviez à l'heure).
- On invitera le client à éviter le reproche vague (exemple : tu n'es bon à rien) ou sans solution, ainsi que le reproche culpabilisant.
- On n'oubliera pas que le ton à lui seul peut dans certains contextes avoir valeur de reproche.

Débutez par:

- Regardez la personne directement.

- Parlez de façon ferme mais calme.

- Si je dois subir un reproche, il est bien de demander à l'autre de préciser.
- S'il s'agit d'un reproche justifié, il faut savoir recevoir la critique et reconnaître l'inconfort de j'autre sans se présenter négativement.
- On négocie alors la critique.
- Dites à la personne comment vous vous sentez.
- Faire une suggestion sur la façon dont cela pourrait être évitable dans l'avenir.

Copyright © 2011 Tina C. Montreuil

Le renforcement positif

- On peut construire un renforcement positif en émettant une constatation agréable pour l'autre.
- En l'interrogeant sur un sujet qui le passionne, en transmettant un sentiment.
- On notera en passant que le renforcement positif d'un autre n'exige pas nécessairement une réponse visible de la part du récepteur.

D'abord commencez:

- En regardant la personne directement, afin de s'assurer qu'ils sont à votre écoute.
- Encore une fois, dire à la personne clairement, ce que vous avez remarqué et ce que vous avez apprécié.
- Terminez en disant à la personne ce que vous ressentez à l'égard de ce qu'elle a fait.

Copyright © 2011 Tina C. Montreuil

L'EXPOSITION

L'objectif des trois prochaines séances sera de diminuer la réponse de fuite ou d'évitement de sorte à ce que nous apprenons à mieux tolérer et s'habituer à l'anxiété générée lorsqu'en présence d'une situation sociale ou d'un contexte social en particulier. Les exercices en séances et à la maison seront centrés sur l'exposition graduelle, prolongée et répétée à la situation redoutée ainsi qu'à d'autres peurs associées, tout en empêchant les comportements d'évitement ou de fuite (cognitifs et comportementaux). L'exposition aux situations anxiogènes fait partie intégrante de la thérapie cognitivo-comportementale. Elle constitue une étape indispensable du plan de traitement pour un trouble d'anxiété sociale.

1.Qu'est-ce l'évitement?

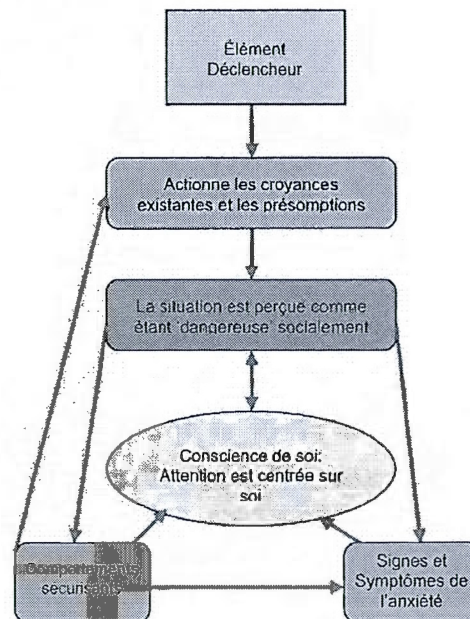
L'évitement se définie comme étant un comportement de est un comportement de défense mis en place pour ne pas être confronté avec une situation redoutée qui cause la peur. L'individu va souvent avoir recours à ces comportements afin de ne pas faire face à cette peur, ou encore à la peur de l'échec. Dans le cas de l'anxiété sociale, les comportements d'évitement se manifestent surtout en l'isolement, le retrait social ou la passivité. Il est important de noter que l'évitement joue un rôle important dans le maintien du trouble puisque ne s'exposant pas aux situations sociales, l'individu ne parvient jamais à confronter ses peurs, ses craintes et ne créer pas d'opportunités afin

de mettre soit en pratique les nouveaux acquis ou de mettre en lumière les éléments à modifier.

Copyright © 2011 Tina C. Montreuil

2. Le modèle de l'anxiété sociale et le rôle de l'évitement

L'évitement est souvent manifesté par les comportements sécurisants tels que mentionné plus tôt. Le modèle ci-dessous nous démontre que ces comportements contribuent à stimuler l'activation des croyances dysfonctionnelles et erronées du soi. En d'autres mots, l'évitement active les distorsions cognitives sur lesquelles nous avons travaillé depuis les dernières semaines.



3. Évaluation des comportements sécurisants et de l'évitement

Copyright © 2011 Tina C. Montreuil

- **VEUILLEZ LIRE LES ÉNONCÉS ET IDENTIFIER CEUX DANS LESQUELS VOUS VOUS RECONNAISSEZ**

________ Il m'est arrivé de refuser des invitations par peur de me sentir mal à l'aise.

________ Ce sont plutôt mes amis qui m'ont choisi(e) et non l'inverse.

________ Dans la conversation, je préfère souvent me taire par peur de dire des choses inintéressantes.

________ Si je me suis senti(e) ridicule devant quelqu'un, je préfère ne jamais plus le revoir.

________ Je suis moins à l'aise en société que la moyenne des gens.

________ Par timidité, j'ai manqué plusieurs occasions dans ma vie personnelle ou professionnelle.

________ Je ne me sens à l'aise qu'en famille ou avec de vieux amis.

________ J'ai souvent peur de décevoir les gens, ou qu'ils ne me trouvent pas intéressant(e).

________ Il m'est très difficile d'engager la conversation avec une nouvelle connaissance.

________ Il m'est arrivé plus d'une fois de prendre un peu d'alcool ou des tranquillisants juste pour me sentir mieux avant de rencontrer des gens.

Si vous avez répondu OUI à l'une ou l'autre des questions, vous connaissez quel(s) est/sont votre (vos) comportement (s) d'évitement.

Tiré de : Lelord et André, " Comment gérer les personnalités difficiles ", p. 295

4. L'importance de l'exposition

Copyright © 2011 Tina C. Montreuil

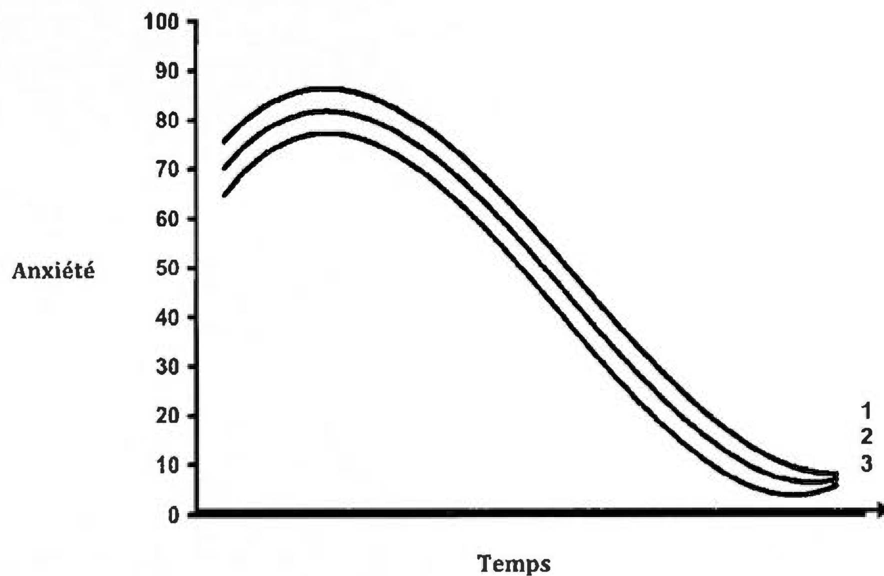
- La principale technique utilisée généralement pour tous les types de troubles anxieux est l'exposition.
- Cette technique consiste principalement à ce que la personne confronte son anxiété en s'exposant aux images mentales, objets et/ou situations générant chez elle de la peur jusqu'à ce qu'elle diminue.
- La diminution de l'anxiété ressentie signifie que la personne s'habitue aux diverses réactions et se voit par la suite, davantage confortable avec celles-ci.
- Il existe divers types d'exposition qui sont utilisées telles que: in vivo, en imagination.
- De plus, l'exposition s'applique habituellement de manière graduée et répétée.

5.Comment se passe l'exposition?

- Dans les séances cinq et six nous avons entamé la première partie du plan de traitement qui visait à modifier les pensées erronées ou distorsions cognitives.
- L'exposition consiste en la deuxième étape complémentaire, qui vise à modifier les cognitions;
  - o Par un travail direct sur les cognitions ou pensées en réalisant des exercices in vivo – dans la vraie vie. Ces expériences nous permettent de nous exercer une fois que les pensées erronées et les comportements sécurisants furent identifiés.
  - o Par l'acquisition et la mise en œuvre de comportements nouveaux, d'expériences nouvelles qui vont modifier les cognitions sous-jacentes.

Copyright © 2011 Tina C. Montreuil

Le graphique ci-dessous nous montre que le niveau d'anxiété diminue au fur et à mesure que l'on s'expose. L'intensité ou la détresse associée est réduite selon le nombre de fois que l'on s'exerce à confronter les situations redoutées en remplacement des comportements sécurisants qui eux constituent un « évitement » et par le fait même, rendent le changement et l'amélioration impossibles.



6.Qu'est-ce qu'une hiérarchie d'exposition?

Lorsque l'on complète un hiérarchie d'exposition on doit classer les situations

Copyright © 2011 Tina C. Montreuil

redoutées par ordre croissant d'intensité de la détresse associée. Il ne suffit que de dresser cette liste, et de faire une évaluation subjective du niveau d'anxiété en assignant une valeur allant de 1 (faible détresse) à 10 (détresse sévère). Une fois cette liste complétée, il faut placer ces items sur la hiérarchie d'exposition en commençant par le comportement ou la situation le moins redouté vers celui qui causerait une plus grande détresse.

ACTIVITÉ À LA MAISON
Séance 9

Compléter "La hiérarchie d'exposition" et un exercice d'exposition

ACTIVITÉ À LA MAISON
Séance 10

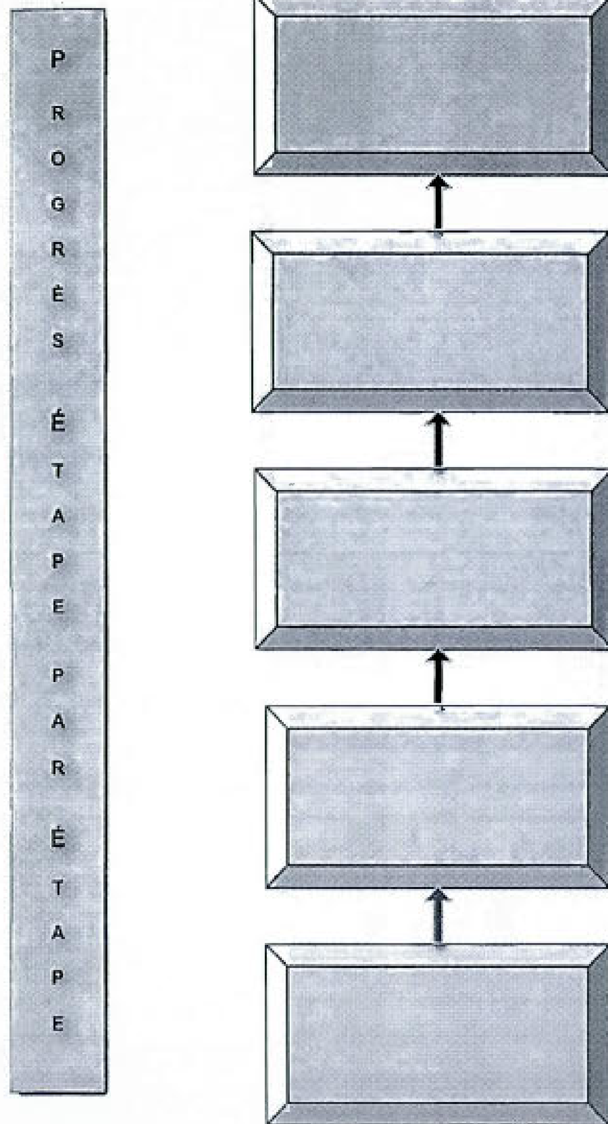
Compléter "Le scénario d'exposition" et un exercice d'exposition

ACTIVITÉ À LA MAISON
Séance 11

Compléter "Un nouvel exercice d'exposition"

Copyright © 2011 Tina C. Montreuil

Hiérarchie d'Exposition



COPYRIGHT
Tina Montreuil, 2010

Copyright © 2011 Tina C. Montreuil

1. Quelle situation avez-vous identifié comme étant toujours difficile à confronter?

2. Comment souhaiteriez-vous affronter cette situation qui est redoutée?

3. Rédigez votre scénario d'Exposition en prenant soin d'y inclure le plus de détails possibles. N'oubliez pas de faire appel à tous vos sens afin de décrire l'expérience que vous souhaitez éventuellement recréer (ex. Que sentez-vous; Que voyez-vous; Qu'entendez-vous; Que pouvez-vous toucher).

4. Identifiez les obstacles qui pourraient potentiellement vous empêcher de réaliser votre scénario d'Exposition.

Copyright © 2011 Tina C. Montreuil

Expérience d'Exposition

Décrire la situation	Vous étiez : 1= Seul (e) 2=Accompagné (e)	Vous avez : 1= Fait face 2= Évité (e) 3= Quitté (e) la situation	Temps d'exposition passé dans la situation?	Niveau d'anxiété (0-10) a) Avant b) Durant c) Après	Ce à quoi vous pensiez : a) Avant b) Durant c) Après
Ex: Rencontre collègue	Ex: 1	Ex: 1	Ex: 10 min.	a) 7 b) 9 c) 5	a) « J'espère qu'elle va m'ignorer » b) « Je ne dois pas rougir » c) « Je suis fier (ère) de lui avoir parlé »

Copyright © 2010 Tina C. Montreuil

Expérience d'Exposition

Décrire la situation	Vous étiez : 1= Seul (e) 2=Accompagné (e)	Vous avez : 1= Fait face 2= Évité (e) 3= Quitté (e) la situation	Temps d'exposition passé dans la situation?	Niveau d'anxiété (0-10) a) Avant b) Durant c) Après	Ce à quoi vous pensiez : a) Avant b) Durant c) Après

Copyright © 2010 Tina C. Montreuil

PREVENTION DE LA RECHUTE

RECHUTE

Le but de cette séance est de nous aider à prendre connaissance des signes avant-coureurs d'une possible rechute. Il est important de les identifier car ils peuvent nous servir de points de repère en cas de rechute de sorte à éviter une hospitalisation future. Une fois que nous aurons appris à identifier nos indices personnels ou signes précoces de rechute, il sera important d'établir un plan à suivre afin d'être mieux préparé lors d'une éventuelle apparition de ces symptômes indésirables. L'objectif de la session vise donc à nous apprendre à devenir plus confiants, nous fournir un plus grand sentiment de contrôle en prenant les mesures nécessaires afin de rester en bonne santé.

1. L'importance de la prévention de la rechute

EN DÉPIT DU FAIT QUE LA RÉMISSION DE PSYCHOSE EST ATTEINTE, IL ARRIVE PARFOIS QUE CERTAINS DES SYMPTÔMES RELIÉS À LA PSYCHOSE RÉAPPARAISSENT. LORSQUE CETTE SITUATION SE PRODUIT, ON PARLE ALORS D'UNE RECHUTE (RECHUTE PARTIELLE).

IL EST DONC ESSENTIEL DE :

1) DE RECONNAÎTRE LES ÉLÉMENTS DÉCLENCHEURS (SITUATIONS).
2) D'IDENTIFIER LES SYMPTÔMES QUI POURRAIENT APPARAÎTRE ET ÊTRE INDICATIFS D'UNE RECHUTE
3) D'ÉTABLIR UN PLAN D'INTERVENTION EN CAS DE RECHUTE

Copyright © 2011 Tina C. Montreuil

2. RECONNAÎTRE LES ÉLÉMENTS DÉCLENCHEURS

SITUATIONS QUI DÉCLENCHENT SYMPTÔMES	MON PLAN POUR GÉRER CES SITUATIONS
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.

3. D'IDENTIFIER LES SYMPTÔMES QUI POURRAIENT ÊTRE INDICATIFS D'UNE RECHUTE.

- Altération subite du comportement
- Négligence de l'hygiène et des soins corporels, de l'alimentation et de l'habillement
- Fatigue marquée et persistante
- Insomnie, l'activité nocturne accrue
- Repli sur soi, l'isolement
- Épisodes de rage
- Intérêt marqué et soudain pour la spiritualité
- Chute du rendement: scolaire, aux études, au travail
- Consommation d'alcool et/ou de drogues et de tabagisme accrue
- Rage d'achats inutiles, impulsivité et comportements excessifs
- Perte de poids rapide;
- Comportements auto-destructifs ou idéations suicidaires;
- Peur ou préoccupation du regard inhabituel

Copyright © 2011 Tina C. Montreuil

Mes signes avant-coureurs :

1.
2.
3.

4. D'ÉTABLIR UN PLAN D'INTERVENTION EN CAS DE RECHUTE

PERSONNES RESSOURCES :

- GESTIONNAIRE DE CAS
  - PSYCHIATRE
  - AMI
  - FAMILLE

STRATÉGIES DE COPING :

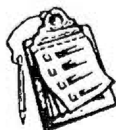
- TECHNIQUES DE RELAXATION
- RÉDUCTION DE LA CHARGE DE TRAVAIL / RESPONSABILITÉS
- ACTIVITÉ PHISIQUE (EX. MARCHE, COURSE, YOGA)
- PARTICIPATION AUX HOBBY, INTÉRÊT (EX. LECTURE, JEUX, ÉCRITURE)

TRAITEMENT PHARMACOLOGIQUE (CONJOINTEMENT AVEC PSYCHIATRE ET GESTIONNAIRE DE CAS):

- AJUSTEMENT DE LA DOSE PRESCRITE
- CHANGEMENT DE MÉDICATION

Copyright © 2011 Tina C. Montreuil

NOTE : JE DOIS ME RAPPELER QU'EN CAS D'URGENCE, MIEUX VAUT ÊTRE BIEN OUTILLÉ(E) ET PRÉPARÉ(E)QUE DÉSEMPARÉ(E)!!!



ACTIVITÉ À LA MAISON

Completer la feuille: "Mon plan d'intervention"

Copyright © 2011 Tina C. Montreuil

<table>
<tr><td colspan="2">MON PLAN DE PRÉVENTION</td></tr>
<tr><td colspan="2">NOM :</td></tr>
<tr><td colspan="2">ÉLÉMENTS DÉCLENCHEURS CIBLÉS :</td></tr>
<tr><td colspan="2">MES SIGNES AVANT-COUREURS SONT :
1.
2.
3.</td></tr>
<tr><td colspan="2">DANS L'ÉVENTUALITÉ D'UNE RECHUTE, JE DOIS M'ASSURER DE:
1.
2.
3.</td></tr>
<tr><td>NUMÉROS DE TÉLÉPHONE DE PERSONNES RESSOURCES PROFESSIONNELLES:
1.
2.
3.</td><td>NUMÉROS DE TÉLÉPHONE DE PERSONNES DE MON ENTOURAGE :
1.
2.
3.</td></tr>
<tr><td colspan="2">EN CAS D'URGENCE JE DOIS :
1.
2.
3.
4.</td></tr>
</table>

Copyright © 2011 Tina C. Montreuil

MAINTIEN DES GAINS

Le but de cette session est de nous aider à prendre conscience des compétences, des gains thérapeutiques et des progrès que nous avons fait tout au long de la thérapie. L'objectif est de nous aider à réaliser que nous avons fait l'acquisition d'outils, de connaissances et nous avons établi une liste de ressources disponibles, ce qui contribuera à réduire au minimum le risque d'une éventuelle rechute. Ces compétences sociales nous aurons permis d'exercer un meilleur contrôle sur les symptômes de l'anxiété en nous apprenant à correctement "'identifier et interpréter" les sensations physiques associées à l'anxiété ainsi que les pensées qui y sont associées. Nous devons garder en tête qu'il est possible pour nous d'envisager la thérapie en individuel si nous en évaluons le besoin.

1 Réflexion de fin de traitement

a) Quelles ont été mes acquis et gains thérapeutiques jusqu'à maintenant?

____
____
____
____
____
____
____
____

Copyright © 2011 Tina C. Montreuil

b) Quelles sont les situations sociales qui m'étaient autrefois difficiles que je peux maintenant confronter?

____
____
____
____
____
____
____

c) Quelles sont les situations sociales qu'il m'est toujours difficile à confronter?

____
____
____
____
____
____
____
____

d) Quelles sont les pensées que j'entretiens et qui sont reliées aux symptômes psychotiques qui étaient autrefois présents ou qui le sont toujours, qui affectent la façon dont je me sens en présence des autres? Quels types de pensées me rendent anxieux lors de situations sociales?

____
____
____
____

e) Lesquelles de ces pensées sont semblables à celles qui me viennent en tête?

___ "Je ne suis pas intéressant."
___ "Les autres auront des choses plus intéressantes à dire que moi."

Copyright © 2011 Tina C. Montreuil

___ "Je ressens que les autres sont « normaux » en comparaison à moi. "
___ "Je n'ai rien à offrir. "
___ "Les gens ne voudront pas me parler. "
___ "Si j'allais à une fête, je devrais être assis seul puisque personne ne me parlerais. "

___ "Je ne sais jamais quoi dire. "
___ "J'ai l'air bizarre "
___ "Je parle d'une façon particulière."
___ "Je dois toujours faire des efforts pour que les autres m'apprécient. "

Autres:
____
____
____
____
____

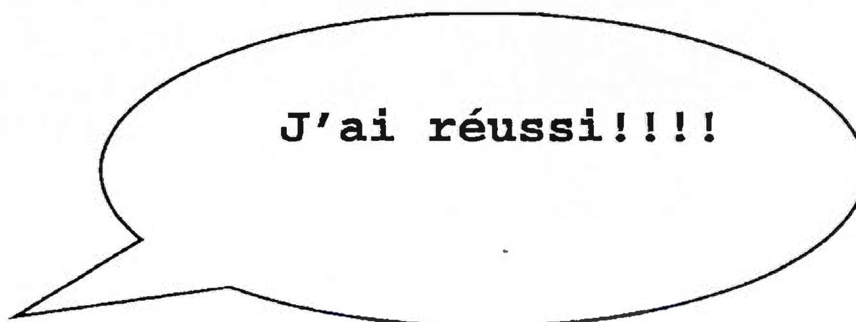
2. Mon inventaire d'habiletés:

1.
2.
3.
4.
5.

Copyright © 2011 Tina C. Montreuil

Les stratégies que j'ai apprises et qui m'aidront à être mieux préparé en cas de rechute :

- La restructuration cognitive
- L'identification des croyances erronées
- L'affirmation de soi
- L'exposition



RAPPELONS-NOUS:

- ***L'apparition de certains symptômes ne représente pas une rechute totale mais bien une rechute partielle.***
- ***Il est normal de vivre des périodes de vie plus difficiles et il est possible que certains symptômes ou comportements apparaissent. Toutefois, ceci ne signifie pas que nous avons échoué – il faut continuer à appliquer les stratégies jusqu'à ce que la situation se stabilise.***

Copyright © 2011 Tina C. Montreuil

APPENDIX H

Participant Manual English Version

SOCIAL ANXIETY IN FIRST-EPISODE PSYCHOSIS

Manualized Group Cognitive Behavioral Therapy

Treatment Manual

Developed by and based on the work of

Tina C. Montreuil

Revised

By Dr. Martin Lepage, Dr. Claude Bélanger, Dr. Gail Myhr

May 2009

The contents of this manual consisting of the intervention of social anxiety in first-episode psychosis (group cognitive behavioral therapy), is based on a research protocol that was written by Tina C. Montreuil (2012). All translation, adaptation and reproduction of any unspecified section of these booklets, including photocopy or microfilm, is strictly prohibited without the written authorization of the author.

THEMES AND OBJECTIVES OF SESSIONS

Session 1: Introduction to the treatment of Social Anxiety in Psychosis.
The purpose of the session is to first familiarize participants to the group context and to provide psychoeducation on cognitive-behavioral therapy (CBT). Second, the client will be asked to define his or her individual and personal goals for therapy. The therapist and co-therapist should try through the exercise of "define goals" to elicit the participants' motivation to change by also presenting information on the efficacy of CBT for the treatment of Social Anxiety and psychosis.

Session 2: Psychoeducation on Social Anxiety
The purpose of the session is to provide the client with a rationale for intervention using cognitive- behavioral therapy for the treatment of social anxiety. This session will allow opportunities to engage the clients and foster the development of the therapeutic relationship between leader, co-leader, and group members.

Session 3: Psychoeducation on Stress
The third session will focus on helping the group better understand stress and the related stressors. Symptoms of stress affect our everyday functioning; from our ability to think, relax, up to our ability to interact with others. The main message for this session is that not all stress is bad and some stress can serve the function of survival. The question that the patient must ask themselves is: Just how stressed am I; or how does stress really affect my everyday life? Therefore, it is not simply important to reduce stress but also to work on acquiring and developing new skills and abilities to help one handle stress in a better and more functional way.

Session 4: Psychoeducation on the experience of psychosis
The purpose of this session is to help the client to understand daily symptoms that are associated with the experience of psychosis. The client is to be presented with the various and most common squeal resulting from the illness as it is shared by thousands of others, including the other attending group members. The participant is provided with a theoretical framework that will help him/her identify negative beliefs related to the self and the illness and on how these factors are associated to the development of social anxiety. Internalized-stigma related dysfunctional beliefs are also highlighted and normalization is provided. The overall goal of the session is to empower the participant and challenge these negative biases.

Session 5: Introduction to Cognitive Distortions
The purpose of the study is to lay the groundwork for the teaching of cognitive-behavioral techniques for better coping with comorbid social anxiety in schizophrenia and its effects on self-esteem and self- stigma. It is important to mention to the client that although pharmacotherapy is crucial to control the majority of the symptoms of psychosis and comorbid anxiety, it is not uncommon for clients to experience breakthroughs of symptoms while still on medication. Being able to recognize and modify dysfunctional

thought content enables the client to acquire additional coping strategies when medication alone does not seem to be able to lead to a fuller functionality.

Session 6: Cognitive Restructuring
The purpose of the session is to allow the client to begin training in monitoring their faulty thinking (negatively biased thoughts) and to identify thinking errors when they occur (based on Session 5 Cognitive Distortions). Learning to identify their negative automatic thoughts can help clients to monitor their symptoms more closely by relying on a cognitive-based intervention to alter the content of those negative automatic thoughts into more rational ones that will lead to a reduction of the resulting emotional and physiological distress.

Session 7: Social Skills Training Part I
The purpose of the session will help identify (1) What are Social Skills?, (2) What are some examples of useful Social Skills?, (3) Why Social Skills training is important?, (4) What are some of the possible causes of less developed or a reduction of Social Skills?, and (5) How can Social Skills training help me? Social Skills are a very important component of psychosocial functioning, everyday living and they also contribute to quality of life. Social Skills reduction or impairments can lead to social dysfunction and may lead to other problems. Medication side effects may contribute to a reduction in social skills. Social Skills training helps teach the patients to better communicate feelings, better understand thoughts and needs of others and how to better respond to the thoughts, feelings, and needs of others. In addition, better Social Skills can help one become more independent and to ultimately meet their personal goals and objectives.

Session 8: Social Skills Training Part II
The purpose of this session is to teach Assertiveness Training (AT) to the client. AT is a form of behavior therapy designed to help people stand up for themselves and empower themselves. The client will be taught that assertiveness is a response that seeks to maintain an appropriate balance between passivity and aggression. Assertive responses promote fairness and equality in human interactions, based on a positive sense of respect for the self and others, while still communicating one's own feelings or thoughts. However, at the core of Assertiveness Training lies conversational skills and the ability to communicate one's own thoughts and feelings in an adaptive way. All of these elements should be presented and taught to the client. The client is reminded that, 'practice (repetition) makes perfect' and 'social skills training is truly effective' for overcoming these difficulties.

Sessions 9-11: Exposure Part I, II, III
This session will involve presenting anxiety-producing material to the client (for a long enough time to decrease the intensity of their emotional reaction). The basic purpose of exposure treatment is to decrease the client1s anxious and fearful reactions (emotions, thoughts, or physical sensations) through repeated exposures to anxiety-producing content. The aim is to help the client to be better able to face and not avoid the feared situation. Exposure therapy can be carried out in real situations, which is called in vivo exposure; or it can be done through imagination. Specifically for the treatment of social

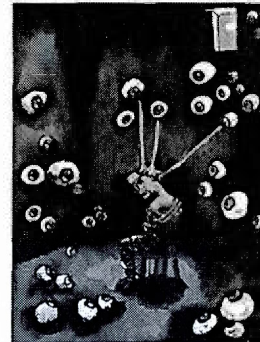
anxiety, our focus will be to incorporate in vivo exposure and behavioral experiments. With the help of therapist-assisted exposure and group-exposure in the form of role-play, the goal will be for the client to learn how to perform self-exposure. This process will be progressive and will respect the level of comfort and tolerance of the client (e.g. through repeated and prolonged exposures to situations that cause anxiety).

Session 12: Relapse Prevention
The purpose of this session is to inform the clients on the early warning signs and their importance since they can help the client to recognize signs of relapse that are resurfacing, or to reduce the severity of the relapse and avoid future hospital admission and even risk of suicide. Once the client has learned to identify his or her own personal early signs of relapse, it is important that they are taught how to manage those signs and to begin to take responsibility for himself or herself and to identify ways to maintain wellbeing. This involves teaching the client how to develop skills necessary to recognize and control early warning signs of relapse. The aim of this session is also to teach the clients how to become more confident and in control, and to trust their own judgment as well as to take action towards staying well.

Session 13: Maintenance Strategies and Termination
The purpose of this session is to help the client become aware of the skills, therapeutic gains and progress that he or she has made along the course of the 13-session therapy program. The aim is to lead the client to realize that he or she has acquired abilities and knowledge with the objective to create a more positive self-image, reduce illness-related self-stigma, improve self-esteem and confidence in one's own abilities and use available coping strategies, minimize the risk of potential relapse and the overall anxiety symptomatology. The client will be asked to generate a list of therapeutic gains achieved during the course of the 13-week intervention. The client can be reminded by the leader as well as the co-leader that he or she can have access to individual 'booster sessions' in the event where he or she would feel that they would require additional support.

Session 14: Social Activity
The purpose of this final session is to highlight the strengths of the participant. Much attention is placed on the ability of the participant to successfully complete something that he/she initiated. The overall take home message is one of "empowerment" through socialization. The participant is exposed to a social situation where interactions will be encouraged and where he/she will be invited to confront once feared situations (i.e. eating in front of others, initiating a conversation in a social setting, etc.).

DID YOU KNOW?



- Shyness is a normally occurring personality style or temperament, which is also a normal human emotion where an individual feels discomfort or inhibition in situations or activities where the focus of attention or evaluation is placed on oneself.

- Shyness and social anxiety cause little problem for most, however, some experience more troublesome levels of social anxiety that can result in fear and avoidance of social and evaluative situations.

<u>Do you ever fear and / or avoid:</u>

- Calling or inviting a friend to get together
- Initiating or starting conversations
- Oral presentations, taking exams or quizzes
- Asking the teacher for help or to explain something
- Unstructured social situations (e.g., free time, recess)
- Meeting new people, socializing, dating
- Attending social events such as dances, parties, sporting events
- Eating in the cafeteria or restaurants
- Answering the telephone or doorbell
- Job or college interviews
- Sticking up for him or herself or asking for assistance (assertiveness)

COMBINED TO...

- Having significant and persistent fear of social or performance situations in which embarrassment, rejection, or scrutiny are possible
- Almost always experiencing the physical symptoms of anxiety when exposed to the feared social situation(s)
- Recognizing that the fear is unreasonable but being unable to do anything about it
- Either avoiding the feared situations or enduring them with intense anxiety, discomfort and / or distress

*If you answered **YES** to several of these <u>points</u>, you may have some symptoms of **Social Anxiety**.*

Copyright Tina C Montreuil 2009

CBT for Social Anxiety: INTRODUCTION

The purpose of today's session is to familiarize each other with group context and conduct and to explore what is cognitive-behavioral therapy (CBT). Secondly, you will be asked to define your individual and personal goals for therapy. Furthermore, the therapist and co-therapist will establish and attempt to provide you with information on the effectiveness and efficacy of cognitive-behavioral therapy for the treatment of social anxiety preceding or following symptoms related to the experience of psychosis.

---

1. My therapists and participants' introduction

Others and I will be asked to introduce ourselves on first name basis only. For example, the therapist will say: *"Hello, my name is Tina"*.

2. Group rules and acceptable conduct

1. Members are required to attend all of 14 sessions and to engage in the group discussions that are provided as their individual level of comfort. However, group participation is highly encouraged as it represents an integral part of the treatment of social anxiety. It acts as an exposure opportunity and also creates a sense of cohesiveness among the group. By sharing one's experience of psychosis, the goal is also to provide help through normalization.

Copyright © 2011 Tina C. Montreuil

2. A client may receive authorization to miss a session in the event of an illness or in case of an emergency. Group members are therefore, encouraged to communicate with the leader or co-leader of the group in other to inform them of any absences as early as possible (at least 24 hours in advance for most cases) in order to avoid any complications or delay pertaining to the daily sessions.

3. Confidentiality from the leader and co-leader as well as group members is highly critical and will be reinforced during individual sessions. All confidential disclosures that are reported during weekly group sessions are required to be kept within the framework of the group's activities. Members are encouraged to refrain from disclosing or reporting names, personal experiences or information related to themselves or any other group attendees at any other time outside of the group context.

4. Each member is expected to attend the sessions under professional and favorable conditions. This means that no attendees will be allowed to take part in weekly group activities should they: present themselves under the influence of illicit and prohibited drugs (including alcohol), accompanied by a non-group member, make use of bad or belligerent language and display hostile, aggressive or violent actions and/or gestures.

5. All members will be advised and encouraged to refrain from engaging in any romantic liaisons or affairs with other group members during the entire 14-session term. These restrictions do not include friendships. Establishing

Copyright © 2011 Tina C. Montreuil

friendships are actually recommended by the leader and co-leader in order to foster group cohesion.

6. It is recommended that all members remain in the room where the group-sessions will be held. Designated breaks will be scheduled throughout the sessions and all members will validate these during the initial session. Some sessions may trigger a greater emotional content. However, it is critical to stay in the room in order to receive or to provide the necessary and needed support to and from fellow members, leader and co-leader.

3. What is Cognitive-Behavioral Therapy or CBT?

As the name suggests, CBT focuses on the way people think ("cognitive") and act ("behavioral"). The concept behind CBT is that our thoughts about a situation affect how we feel (emotionally and physically) and how we behave in that situation. As human beings, we give meaning to events that are happening around us. However, we often don't realize that two people can give two very different meanings to the same event.

CBT principles. This approach will include:

i) Psychoeducation on social anxiety disorder;

ii) Cognitive Restructuring: Identify negative thoughts that occur before, during, or after anxiety-provoking situations; Evaluate the accuracy of their thoughts in the light of data derived from Socratic questioning or as a result of so-called behavioral experiments; and derive rational alternative thoughts based on the acquired information;

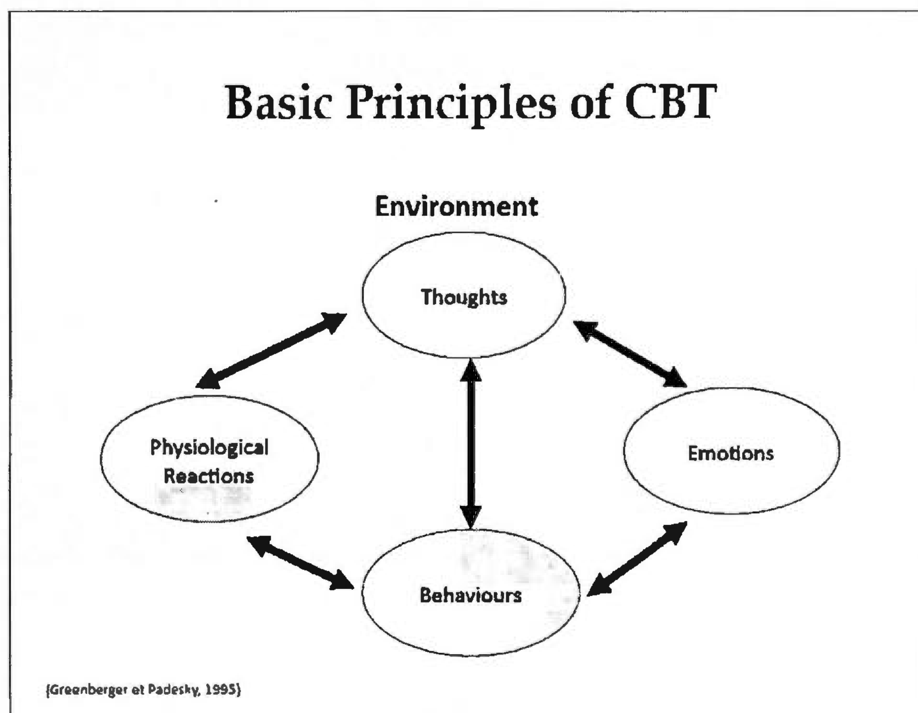
iii) Exposure component, which focuses on the collection of information that will allow patients to revise their judgments about the degree

Copyright © 2011 Tina C. Montreuil

of risk to which they are exposed in feared situations, challenge their dysfunctional beliefs about the self relative to the illness and their self-efficacy (social status related), and

iv) Use of Thought Records to identify, explore and dispute negative thoughts about dysfunctional self-identity and core beliefs related to the onset and presence of diagnosis of schizophrenia.

4. Cognitive-Behavioral Therapy Model



As you can see, unhelpful thoughts lead to unpleasant emotions and unhelpful behaviours (e.g., avoidance) that reinforce our negative thoughts and maintain the problem. In other words, our thoughts, feelings and behaviours can interact and influence each other to create a vicious cycle. We all have negative thoughts every now and then, but if we consistently apply

Copyright © 2011 Tina C. Montreuil

negative meanings to events, then we are likely to experience problems with anxiety and/or depression.

5. Is Cognitive-Behavioral Therapy effective?

• The growth of Cognitive-Behavioural Therapy (CBT) can be traced to the pioneering work of Beck (Beck, Rush, Shaw, & Emery, 1979).

• Cognitive behaviour therapy focuses on the links between thoughts, behaviours, and feelings in order to help clients gain a better understanding of and solve their problems.

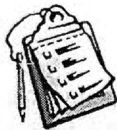
• Since ndividuals with social anxiety experience greater shame attached to their diagnosis and fell that the diagnosis of schizophrenia set them apart from others, there is evidence that a cognitive-behavioral therapy specifically for the treatment of social anxiety, whether it is delivered individually or in a group setting, can produce significant outcome when compared to a control group.

• CBT has been developed for individuals with social anxiety and has been evaluated in a number of studies. Furthermore, some studies have effectively shown that the individuals receiving group CBT (CBGT) would show more frequent sudden or immediate gains (group setting interactions would immediately result in normalization and exposure for clients) and that these gains would reveal better treatment response at treatment termination and at follow-up when compared to control groups. CBT, by its philosophy and techniques, is best suited to target these dysfunctional ways of thinking about the self and about work.

• Cognitive-behavioural therapy has been widely used in the treatment of positive symptoms and/or negative symptoms in schizophrenia and it is now well known that this approach can produce more positive outcomes in terms of symptom improvement when compared to medication alone or other supportive therapy alike.

Copyright © 2011 Tina C. Montreuil

"I think I can do this!



AT-HOME ACTIVITIES

Complete "My goal and objectives for therapy" Sheet.

Copyright © 2011 Tina C. Montreuil

Session 1 Activity ___/___/___

My goals for therapy are:

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

8. ______________________________

9. ______________________________

10. ______________________________

What is social anxiety ?

Today's session will help us to better understand the symptoms associated to *social anxiety*. These symptoms may affect the way you behave, think or feel. Many of these symptoms are common to many people while others are less so. First, remember that whatever the symptoms you may feel, they are normal. Second, there are things you can learn and do to help you have a better control over them and to reduce the impact of anxiety in your life.

1. What is Social Anxiety?

- Social Anxiety (SA) is also known as *Social Phobia.*
- SA is a disabling condition marked by severe and persistent fear of social situations in which the individual fears humiliation or embarrassment.
- SA can be a fear of a specific social or work performance situation, such as public speaking, or a generalized fear of most social situations.
- The anxiety associated with the feared social situation may even provoke a panic attack (Not the same as "shyness").
- Due to the more severe nature of psychotic symptoms,

Copyright © 2011 Tina C. Montreuil

"milder" symptoms of anxiety can often go undetected in people with schizophrenia.

2. The Social Situation.

People that live with social anxiety have a persistent and overwhelming fear of being watched or judged by others in social or performance situation. Mainly, the fear is that because of their anxiety response which can be physical (conduct), cognitive (thoughts) or emotional (emotions, feelings), it may cause embarrassment.

"For example, lets suppose that you were to give a public speech or presentation."

If you were experiencing symptoms of social anxiety you would probably fear public speaking because others may notice that your hands are shaking or that your voice is trembling, or you may fear talking in front of others because you fear you may stutter.

While you may come to realize or not that your social anxiety symptoms are excessive; you may find it difficult to deal with them. Instead, you may choose to avoid these situations, feel a great

Copyright © 2011 Tina C. Montreuil

amount of fear or anxiously anticipate the situation that may in return lead to important difficulties that interfere with your daily functioning.

3. **What is an important social situation that causes you to become anxious?**

____

____

____

____

4. **Identify the symptoms of Social Anxiety that you experience emotionally by checking the box.**

- ☐ *Excessive self-consciousness*
- ☐ *Fear of being watched*
- ☐ *Fear judging by others*
- ☐ *Fear of embarrassment*
- ☐ *Fear of humiliation*

Copyright © 2011 Tina C. Montreuil

- [ ] *I feel irritated or angry*
- [ ] *I feel like I would want to hurt someone*
- [ ] *I just want to be left on my own*
- [ ] *I want to run away and hide*
- [ ] *I am so anxious that I can barely contain myself*

5. Identify the symptoms of Social Anxiety that you experience physically by checking the box.

- [ ] *Numbness*
- [ ] *Blushing*
- [ ] *Sweating*
- [ ] *Trembling*
- [ ] *Nausea dry mouth*
- [ ] *Difficulty talking*

Copyright © 2011 Tina C. Montreuil

- [ ] *Tremors · aches can't stop moving around*
- [ ] *Palpitations*
- [ ] *Sweating*
- [ ] *Gastrointestinal discomfort I have to go to the bathroom*
- [ ] *Hot or cold flashes*
- [ ] *Excess muscle tension*
- [ ] *Insomnia*

6. **Identify the symptoms of Social Anxiety that you experience in your mind by checking the box.**

- [ ] *Feeling of confusion and self-doubt*
- [ ] *Negative thoughts such as "People think I am stupid"*
- [ ] *An urge to flee from the situation*
- [ ] *Knowledge that these feelings are irrational*

Copyright © 2011 Tina C. Montreuil

- ☐ *Feeling trapped*
- ☐ *My thoughts are racing*
- ☐ *I forget a lot more my ideas   thoughts*
- ☐ *I have difficulty concentrating*
- ☐ *My thoughts are clouded and I cannot clear up my mind*

> The good news is that social anxiety is not only treatable, but the treatment is also successful. Social anxiety no longer needs to be a life-long, devastating condition.

AT-HOME ACTIVITIES

Read the text called: «<u>What is it Like to Live with Social Anxiety Disorder?</u> »

Copyright © 2011 Tina C. Montreuil

FACT SHEET 1

Social Anxiety Disorder

What Is Social Anxiety Disorder?

This disorder is also known as social phobia. Social anxiety disorder is a common anxiety disorder that affects about 7 to 14 percent of people at some time during their lives. People with this disorder are intensely anxious about some or all of the social interactions and public events of everyday life. They understand that their fears are excessive, but nevertheless are unable to overcome their anxiety around other people. Everyday events like making a phone call, purchasing items at a store, attending a meeting or party, or speaking to others can be extremely difficult and stressful. People with this disorder are constantly worried that others are watching them or judging them negatively. They often avoid social situations and only feel comfortable at home either alone or with family members. Unfortunately, they may also feel lonely because they want contact with others, even though it makes them feel anxious.

What Social Anxiety Disorder Is Not

Having social anxiety disorder is not the same as being an introvert—a person who simply prefers to spend time alone rather than with others. Nor is it the same as performance anxiety or stage fright, which are temporary symptoms related to specific situations such as giving a speech, playing a musical instrument, or acting in a play (although such problems can be debilitating for musicians, actors, and others whose livelihoods depend on performance). And, although some people in recovery may feel socially detached and isolated, those feelings do not constitute an anxiety disorder. After months or years of using drugs or alcohol to artificially facilitate their social lives, some people may find it awkward to get back into social situations and relationships now that they are in recovery. These problems are associated with the consequences of addiction; they do not indicate social anxiety disorder.

What Are the Primary Symptoms of Social Anxiety Disorder?

Symptoms of social anxiety disorder include

- intense anxiety in social situations and consequent avoidance of them
- excessive fear of being scrutinized or negatively judged by others
- physical symptoms of anxiety, including confusion, pounding heart, sweating, shaking, blushing, muscle tension, upset stomach, and diarrhea

© 2008 by Hazelden Foundation. All rights reserved. Duplicating this material for personal or group use is permissible

Common anxiety-producing situations for people with this disorder include

- eating or drinking (any beverage) in front of others
- writing or working in front of others
- being the center of attention
- interacting with other people, including dating or going to parties
- asking questions or giving reports in groups
- using public toilets
- talking on the telephone

What Is the Cause of Social Anxiety Disorder?

There is no single known cause of social anxiety disorder, but it is believed that biological, physical, and environmental factors play a significant role.

What Are the Usual Treatments for Social Anxiety Disorder?

Effective treatments include cognitive-behavioral therapy (CBT), medications, or both. CBT works by helping people identify and replace negative thoughts and behaviors with more positive and useful ones. Emphasis is placed on developing new coping skills, reducing avoidance of social situations, and learning to modify negative thoughts and feelings about social interactions.

The most effective medications for this disorder are antidepressants.* Benzodiazepines are sometimes prescribed, but they are less effective for treating the disorder. Beta-blockers, often used to treat heart conditions, may also be used to minimize certain physical symptoms of anxiety, such as rapid heartbeat and shaking.**

Research has shown that gains made in CBT are lasting, even after the therapy sessions have ended: typically, the person is less anxious in social situations, and thus avoids them less. However, the gains made with medications revert to near baseline if the medication is discontinued. Sometimes CBT and medications are combined.

How Does the Use of Alcohol and Other Drugs Affect Social Anxiety Disorder?

Many people use drugs or alcohol to reduce the symptoms of anxiety in social situations. Although these substances often provide short-term relief from anxiety, they often worsen

* More information on antidepressants can be found in Handout 1, Antidepressant Medications.

** More information on benzodiazepines and beta-blockers can be found in Handout 4, Antianxiety and Sedative Medications.

© 2008 by Hazelden Foundation. All rights reserved. Duplicating this material for personal or group use is permissible.

it in the long run. In addition, using substances to deal with anxiety can impede people from developing better coping skills and may lead to addiction.

The benzodiazepine medications sometimes prescribed for this disorder are themselves addictive. This can compound the challenges of recovering from co-occurring social anxiety and substance use disorders. For a person with a vulnerability to an alcohol or drug addiction, the best choice may be CBT, an antidepressant medication, or both.

How Does Social Anxiety Disorder Affect Addiction Treatment and Recovery?

For people with both social anxiety disorder and addiction, one major problem is that their fear of social situations may prevent them from seeking professional help. People may feel anxious about entering into a professional relationship and exposing themselves to the scrutiny of other people. They may also have mistaken ideas about addiction treatment programs, such as negative stereotypes from popular media and film. The prospect of group therapy or an AA meeting in a crowded, poorly lit church basement can be terrifying to a person who is anxious about groups of strangers. But these safe places, once entered, can be highly therapeutic, and the "strangers" quickly become allies.

And, as with other anxiety disorders, once the person stops using drugs or alcohol, the anxiety symptoms may reappear and even worsen, possibly increasing the risk of relapse. Addiction treatment will help with management of these symptoms, but the person may become impatient with his or her progress or feel anxious, tempting him or her to return to substance use.

Moreover, benzodiazepine medications have addictive potential. Although these medications are frequently prescribed for social anxiety disorder, they are less effective than antidepressants. If a benzodiazepine has already been prescribed, a switch to an antidepressant may be in order.

CBT, a non-medication-based solution, is one of the best treatments for social anxiety disorder for a person with addiction. Furthermore, in studies of people with this disorder, the benefits of CBT are shown to be more lasting, surpassing those of medications beyond the end of treatment.

Treatment for Co-occurring Social Anxiety and Substance Use Disorders

For a person with a co-occurring substance use and social anxiety disorder, it is important to get treatment for both disorders. Trying to deal with the substance use disorder

© 2008 by Hazelden Foundation. All rights reserved. Duplicating this material for personal or group use is permissible

without addressing the social anxiety can place the person at risk for relapse. On the other hand, addressing the social anxiety disorder—through medication or CBT—while the person is still actively using substances is less effective. The best treatment is integrated: that is, it focuses on both disorders at the same time. For a person in an addiction treatment program where group therapy is the main modality, all health care providers should understand how the social anxiety disorder might affect the person's participation and contribution. Likewise, if peer support group meetings in the community are recommended (AA meetings, for example), it will be imperative for the social anxiety disorder to be addressed, either with CBT or medication.

As noted previously, benzodiazepines are potentially addictive themselves, and antidepressants are a more effective medication for social anxiety disorder. In general, antidepressants may be a better choice for social anxiety disorder. As a non-pharmaceutical option, CBT is the most conservative, effective, and durable approach for developing more confidence in social situations. People with social anxiety disorder can ultimately benefit from attending peer support groups, and also can benefit from connecting with others who have these co-occurring disorders and are in recovery.

Resources

Antony, M. M. 2004. *10 simple solutions to overcome shyness: How to overcome shyness, social anxiety & fear of public speaking.* Oakland, CA: New Harbinger.

Hilliard, E. B. 2005. *Living fully with shyness and social anxiety: A comprehensive guide to gaining social confidence.* New York: Marlowe & Company.

Markway, B., and G. Markway. 2003. *Painfully shy: How to overcome social anxiety and reclaim your life.* New York: Thomas Dunn Books.

National Institute of Mental Health. "Social phobia (social anxiety disorder)." Available at www.nimh.nih.gov/health/publications/social-phobia-social-anxiety-disorder.shtml.

National Institute on Alcohol Abuse and Alcoholism. "FAQ for the general public." Available at www.niaaa.nih.gov/FAQs/General-English/default.htm.

National Institute on Drug Abuse. "Drugs of abuse information." Available at www.nida.nih.gov/drugpages.html.

Stein, M. B., and J. B. Walker. 2002. *Triumph over shyness: Conquering shyness and social anxiety.* New York: McGraw-Hill.

WebMD. "Mental health: Social anxiety disorder." Available at www.webmd.com/anxiety-panic/guide/mental-health-social-anxiety-disorder.

© 2008 by Hazelden Foundation. All rights reserved. Duplicating this material for personal or group use is permissible.

What is stress ?

Today's session will help us to better understand stress and the related stressors. These symptoms of stress affect our everyday functioning; from our ability to think, relax, up to our ability to interact with others. The main thing to remember is that not all stress is bad – some stressors actually serve a function of survival. The question is: "Just how stress am I; or how does stress really affect my everyday life?" Therefore, it is not simply important to reduce stress but also to work on acquiring and developing new skills and abilities that will help us handle stress in a better and more functional way.

1. What is Stress?

Stress is:

- A state resulting from a stressor; a bodily or mental tension resulting from factors that tend to alter an existent equilibrium.
- A strain or a pressure
- *Stress is defined as an organism's total response to environmental demands or pressures.*

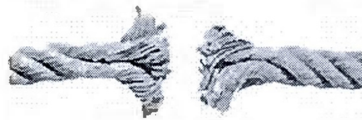
When stress was first studied in the 1950s, the term was used to describe both the causes and the effects of these pressures that a person

Copyright © 2011 Tina C. Montreuil

experiences at a given time. More recently, however, the word stressor has been used for the <u>stimulus that provokes a stress response.</u>

- The acute stress response, also known as the fight-or-flight response, refers to a psychological reaction that occurs in the presence of something that is terrifying, either mentally or physically.

"I am at the end of my rope"



2. **<u>How does Stress affect me?</u>**

- The term 'acute stress response' was first utilized in the 1920s by American physiologist Walter Cannon. Cannon realized that a chain of rapidly occurring reactions inside the body help mobilize the body's resources to deal with threatening circumstances.

In response to acute stress, the body's sympathetic nervous system is activated due to the sudden release of hormones. The sympathetic nervous systems stimulates the adrenal glands triggering the release of the hormones, adrenaline and noradrenaline. The table below shows that this results in an increase in heart rate, blood pressure and breathing rate. The entire body is affected by the release of these hormones. After

Copyright © 2011 Tina C. Montreuil

the threat is gone, it takes between 20 to 60 minutes for the body to return to its pre-arousal levels.

ANNEXE 1 – Turn to page 7

3. Am I Stressed?

Complete the test in order to find out your own current level of stress.

ANNEXE 2 – Turn to pages 8-11

4. Is Stress always bad for me?

NO!!! Stress is not always bad for me. Sometimes the stress I feel may be essential for my survival. For example, if I was facing a situation where someone a crashing vehicle was coming straight at me on the street. The immediate response would probably be to run out of the way. This response would be very important to ensure that you do not sustain pain or injury – in worst scenarios, ultimately death. Such an automatic response would be called a "flight" response. Similarly, if the clerk of a store was being held at gunpoint by a perpetrator, the clerk may decide to confront him instead of running away. Although this is far more dangerous, it would be referred to as a "fight" response.

The acute stress response is commonly known as the **fight-or-flight response.** Essentially, the response prepares the body to either fight or flee the threat. It is also important to note that the response can be triggered due to both **real and perceived* threats.**

Copyright © 2011 Tina C. Montreuil

* Threats most commonly thought of as being insignificant, not dangerous. For the anxious person, this situation or stressor stimulus is being PERCEIVED as being a dangerous threat. To a socially anxious person, the idea or possibility of being evaluated, looked at or judged becomes regarded as being a "REAL" threat although it isn't really LIFE TREATENING. The focus isn't to discover what caused the anxiety to develop in the first place but rather to provide concrete tools that will help you change the way you perceive these situations.

5. How can I know that I am Stress?

Signs of stress may be cognitive, emotional, physical or behavioral. Signs include poor judgment, a general negative outlook, excessive worrying, moodiness, irritability, agitation, inability to relax, feeling lonely, isolated or depressed, aches and pains, diarrhea or constipation, nausea, dizziness, chest pain, rapid heartbeat, eating too much or not enough, sleeping too much or not enough, social withdrawal, procrastination or neglect of responsibilities, increased alcohol, nicotine or drug consumption, and nervous habits such as pacing about, nail-biting and neck pains.

ANNEXE 3 – Turn to page 12

6. What are the differences between good and bad Stress?

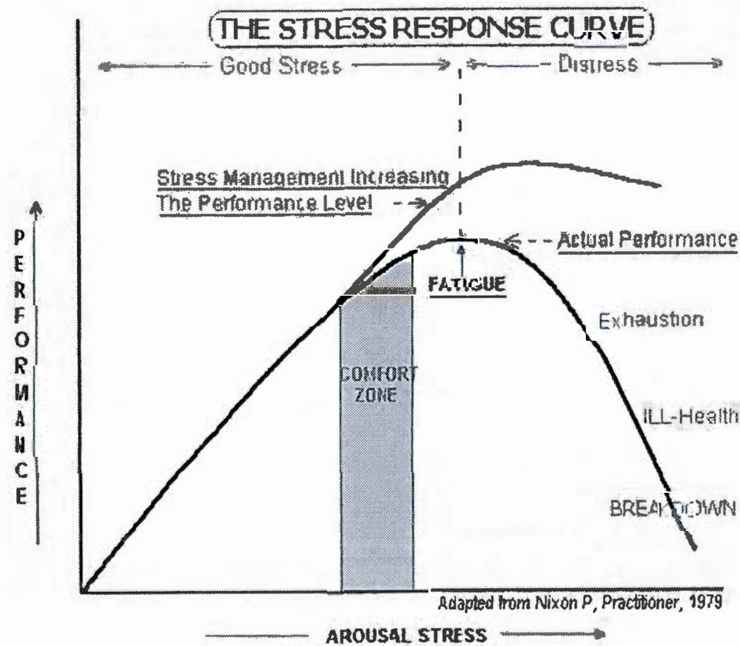
There are two types of stress :

- Good stress

Copyright © 2011 Tina C. Montreuil

- Distress

A certain level of stress actually contributes to a good performance. It stimulates us to prepare accordingly for the task at hand. However, too much stress or "distress" is what leads to a *breakdown*, which can actually be detrimental to our performance. Good stress management techniques and strategies that can help transform "distress" into "good stress." Therefore, the goal is not to eliminate stress but to better manage it.

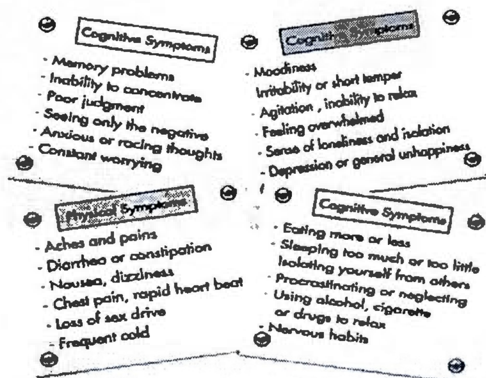


See ANNEXE 4 and 5 – Turn to pages 13-14

Copyright © 2011 Tina C. Montreuil

The good news is that stress can be managed. We can all aim to work within our "comfort zone" in order to improve our ability to better cope with stress and its related stressors.

"HOW STRESS AFFECTS ME" POST IT ©

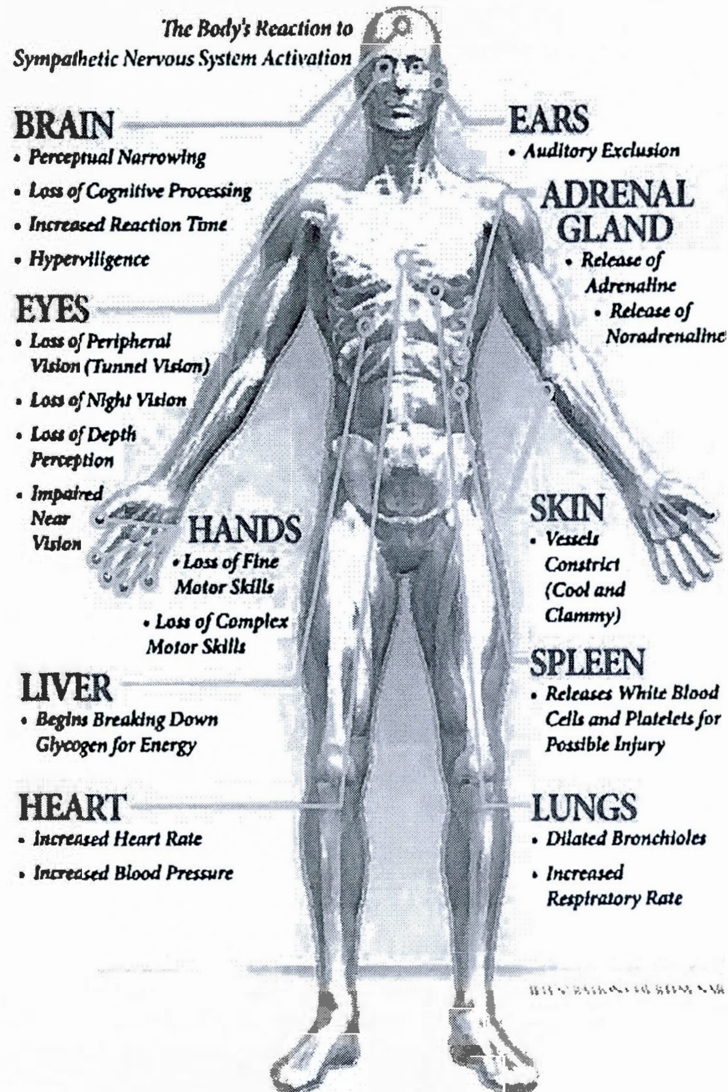


AT-HOME ACTIVITIES

Read the rating scale called: «My Stress Level»

Copyright © 2011 Tina C. Montreuil

ANNEXE 1



Copyright © 2011 Tina C. Montreuil

ANNEXE 2

<u>Are you stressed? Find out by taking the test below.</u>

(This test is not meant to replace a clinical assessment.)

Answer these twenty questions: Yes or No.

1. Do you frequently neglect your diet?

○ Yes

○ No

2. Do you frequently try to do everything yourself?

○ Yes

○ No

3. Do you frequently blow up easily?

○ Yes

○ No

4. Do you frequently seek unrealistic goals?

○ Yes

○ No

5. Do you frequently fail to see the humor in situations others find funny?

○ Yes

○ No

6. Do you frequently get easily irritated?

○ Yes

○ No

7. Do you frequently make a "big deal" of everything?

○ Yes

○ No

8. Do you frequently complain that you are disorganized?

○ Yes

○ No

9. Do you frequently keep everything inside?

○ Yes

○ No

10. Do you frequently neglect exercise?

- Yes
- No

11. Do you frequently have few supportive relationships?

- Yes
- No

12. Do you frequently get too little rest?

- Yes
- No

13. Do you frequently get angry when you are kept waiting?

- Yes
- No

14. Do you frequently ignore stress symptoms?

- Yes
- No

15. Do you frequently put things off until later?

- ◯ Yes
- ◯ No

16. Do you frequently think there is only one right way to do something?

- ◯ Yes
- ◯ No

17. Do you frequently fail to build relaxation into every day?

- ◯ Yes
- ◯ No

18. Do you frequently spend a lot of time complaining about the past?

- ◯ Yes
- ◯ No

19. Do you frequently race through the day?

- ◯ Yes
- ◯ No

20. Do you frequently feel unable to cope with all you have to do.

- ◯ Yes
- ◯ No

INTERPRETING YOUR SCORE

- Add up all of the "YES" as 1 point and "NO" as 0.

Your score is = __________

Scores of 1-6: *Few Hassles*

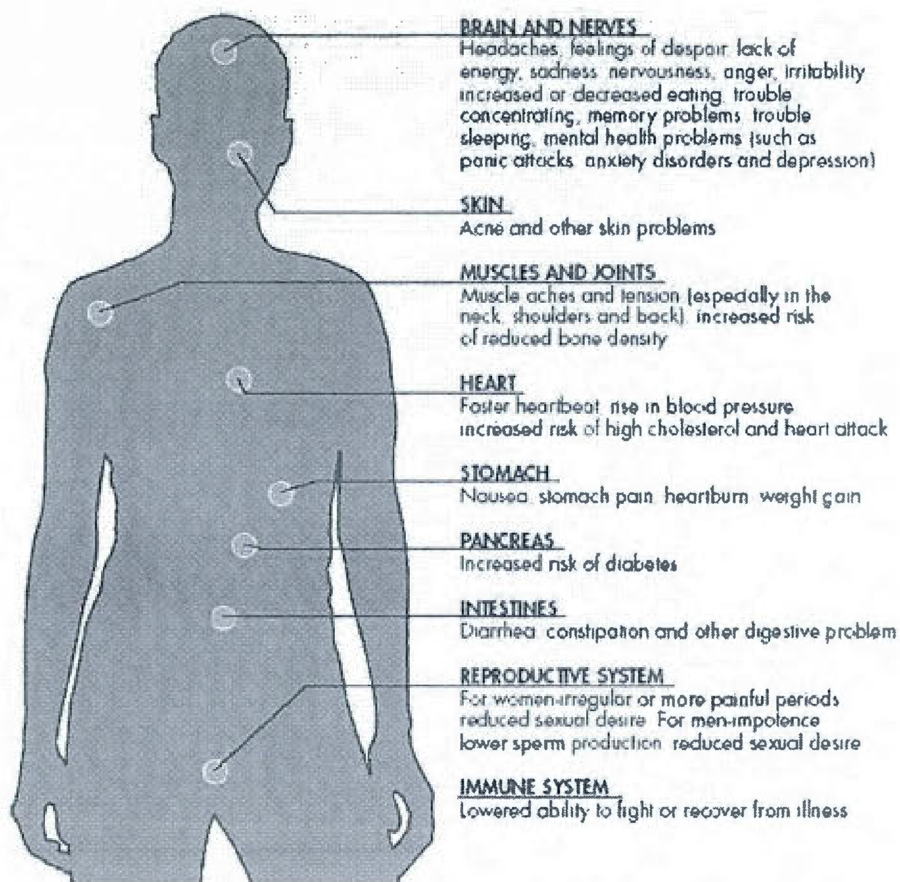
Scores of 7-12: *Pretty Good Control*

Scores of 13-17: *Danger Zone. Watch out!*

Scores of 18+: *Stressed Out. "I need help."*

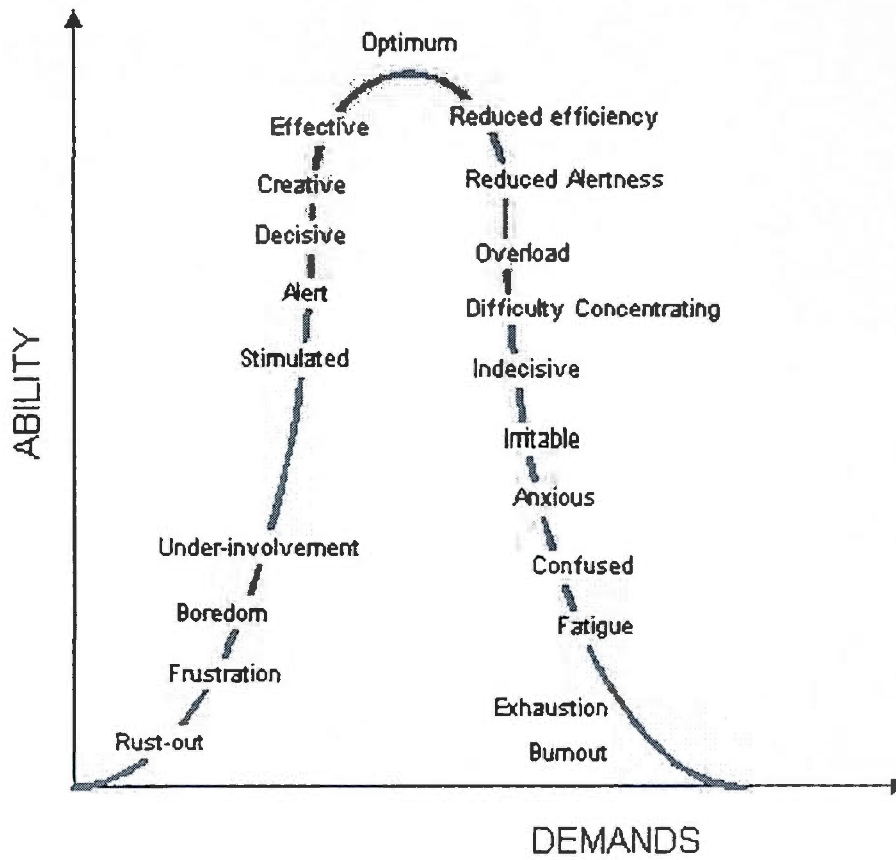
Test courtesy of http://www.lessons4living.com/stress_test.htm

ANNEXE 3



Copyright © 2011 Tina C. Montreuil

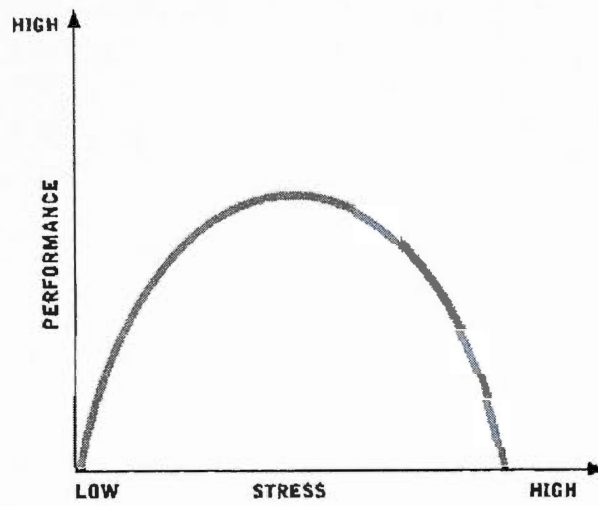
ANNEXE 4



Copyright © 2011 Tina C. Montreuil

ANNEXE 5

STRESS MANAGEMENT



Copyright © 2011 Tina C. Montreuil

SYMPTOMS OF PSYCHOSIS

Today's session will help us to identify the types of symptoms that were present during your unusual experience. These symptoms may still be present at certain times. The purpose of the session is to provide normalization of this experience and allow you to understand how these symptoms may be tied to social anxiety. The appearance of these symptoms can also make us feel "different" from others, often resulting in self-defeatist and stigmatizing thoughts. As you will see, unusual experiences are common.

1. What happens to me following an unusual experience?

Just as it is the case with many other illnesses, there are always signs or symptoms, so does psychosis. Symptoms are not the same for everyone. Some people may have experienced unusual mental symptoms only onece in their lifetime. Others may have recurring experiences or symptoms, and yet still be able to live rather normal lives despite these symptoms. While others may also maintain severe symptoms, as a result of their unusual experience throughout all their life.

Such an unusual experience usually *always* involves a change in one's ability and personality. It's usually family members and friends that notice that their loved one is not "behaving the same way." At first, the symptoms are usually milder and they usually grow until they increasingly interfere significantly with our functioning. Deterioration is usually observed in:

♦ Work or academic activities ♦ Relationships with others ♦ Self care and hygiene

Copyright © 2011 Tina C. Montreuil

2. What are some of the symptoms associated with my experience?

To understand this experience, it is useful to group together some of the more characteristic symptoms:

(1) Additions and manifestation of unwanted symptoms

(2) Loss of touch with the outside world (e.g. related to depression and isolation)

(3) Difficulties related to organization and functioning

These group of symptoms usually include a combination of the following:

- **Personality change** is often a key to recognizing the experience of psychosis. At first, changes may be subtle, minor and go unnoticed. Eventually, these changes become more obvious to our surroundings (ex. our family, friends, classmates or co-workers).

  There is a loss or lack of emotion, interests, and motivation. A person that is usually outgoing may become withdrawn, quiet, moody or even isolated. Emotions may be inappropriate for a given context (ex. the person may laugh in a sad situation, or cry over a joke) or the person may also be unable to show any emotion at all.

- **Thought disorder** is the most important change, since it prevents "clarity of thoughts" and primarily a rational response to common situations or problems. Thoughts may be slowed down, or become rapid, or may be completely absent. The person may jump from one topic to another, appear to be confused, or experience great difficulty in making very simple decisions that were once more easily achieved

- **Delusions** are primarily false beliefs that have no foundational or logical basis. Delusions can act as a "filter" to our thoughts and make us think differently about a given situation. Some people may feel that they are being persecuted, followed, spied on or plotted against. They may be convinced the

Copyright © 2011 Tina C. Montreuil

CIA, FBI or police are after them and watching them. Or they may have "grandiose delusions" where they believe that they possess super powers or have been given all-powerful, special abilities, or that there are even immune to danger. They may also have a strong religious drive, believing they have a personal mission to "fix" or do right for all the wrongs in the world.

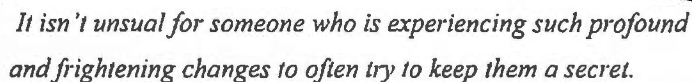
- **Perceptual changes** which turn the world of the person who lives through an unusual experience upside down. The sensory messages that are sent to the brain from all the sensory organs; the eyes, ears, nose, skin, and taste buds, become confused and cause the person to actually hear, see, smell or feel sensations that are in reality not truly there. These are what psychiatrist usually call *hallucinations*.

People will often hear voices. Sometimes the voices are threatening or condemning; they may also give commands such as: *"You cannot trust this person", "You are so stupid, ugly or incompetent."*

Some people will also have visual hallucinations though it is less common. Things or people that were once there may all of a sudden appear. These may also affect colors, shapes, and faces that may change before the person's eyes.

There may also be hypersensitivity to sounds, tastes, and smells. A ringing telephone might seem as loud as a fire alarm bell, or a loved one's voice as threatening as a barking dog. Sense of touch may also be affected. Someone may literally "feel" that something is crawling on his or her skin or a part of their body may also appear to be different or not belong to them.

- **Sense of Self:** When one or all five senses are affected, the person may feel out of time, out of space "free floating" and "*bodiless*" and all of a sudden that there are no longer themselves.



Copyright © 2011 Tina C. Montreuil

3. What were my symptoms?

Symptoms of Unusual Experience

Identify some of the sumptoms that you experienced

Manifestation of unwanted symptoms

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______

Loss of touch with others/withdrawal

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______

Difficulties with organization and functioning

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______

Copyright © 2011 Tina C. Montreuil

4. What is the link between the symptoms associated with my experience and social anxiety?

- Many studies found that in people who experienced an unusual experience, about 36% also had associate social anxiety.

- These individuals were at an increased risk for relapse, and had a more severely impacted daily functioning. Hence, it appears that the presence of social anxiety following an unusual experience is common. Also, this acts as evidence that we need to treat social anxiety as it may be linked to worsening of symptoms that occur following an unusual experience.

- The link between the symptoms of an unusual experience and social anxiety may be best understood by one of these two possible scenarios:

    o Social anxiety may have been present prior to the unusual experience and have (a) continued on more or less the same course following the unusual experience; (b) have increased since the unusual experience.

    o Social anxiety may have surfaced following the unusual experience

- In either of these cases, social anxiety has been shown lead to the worsening or increase of the symptoms related to the unusual experience.

    - (1) Additions and manifestation of unwanted symptoms
    - (2) Loss of touch with the outside world (Sx related to depression and isolation)
    - (3) Difficulties related to organization and functioning

5. Stigma related to the unusual experience and the illness.

- There is often a strong need to deny what is happening, and to avoid other people and situations where the fact that one feels "different" and that others may discover it. The symptoms resulting from an unusual situation may cause changes in the perception of reality, which are often linked to feelings of panic, fear, and

Copyright © 2011 Tina C. Montreuil

anxiety, which are natural reactions to such a terrifying experience. Psychological distress is intense, but the person will often try to keep it hidden due to a strong sense of either denial of fear.

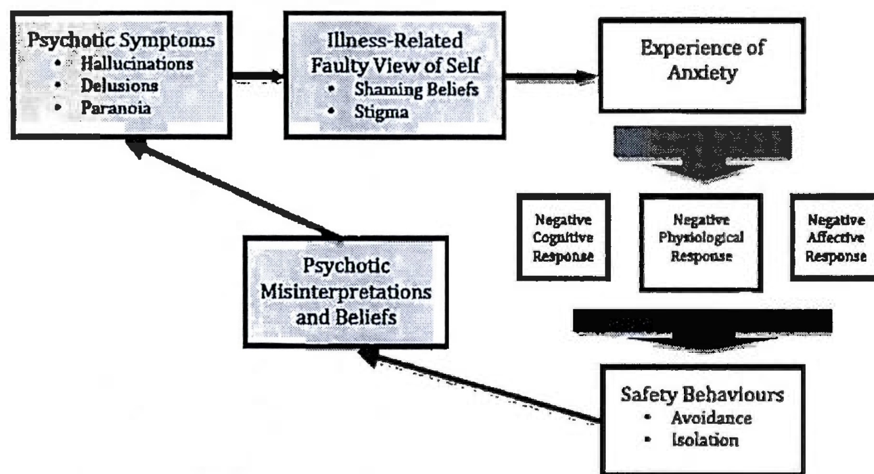
"Normalizing: Is the ANTIDOTE to Stigma."

- The goal is to avoid catastrophizing and understand:
    - Virtually everyone faces a significant illness at some point in their life.
    - Psychosis is a common problem that affects many people, in many culture, from different spheres of life and social status.
    - The appearance of any of these symptoms is not due to one's or anyone's fault or wrongdoing.
        - A large number of people actually overcome symptoms
        - The perception of the unusual experience is context and culture specific
            - As a matter of fact, in some culture, the unusual experience is perceived in a positive way
        - Sleep and sensory deprivation may provoke the appearance of symptoms that would resemble or include: hearing voices, visual hallucinations, etc.

Copyright © 2011 Tina C. Montreuil

- 50% social withdrawal/isolation/delusion
- 20% visual hallucinations
- 15% auditory hallucinations
- 100% had some unusual mental symptoms of some kind

Social Anxiety and the Experience of Psychosis Explanatory Model



AT-HOME ACTIVITIES

Read the text "Early Warning Signs"

Copyright © 2011 Tina C. Montreuil

INTRODUCTION TO COGNITIVE DISTORTIONS

Today's session will help us to lay the groundwork for the teaching of cognitive-behavioral techniques for better coping with social anxiety and symptoms related to an unusual experience. The goal of this session is also to develop better self-esteem by correcting dysfunctional thinking pattern and reducing self-stigma through the teaching of these CBT techniques. Keep in mind that although CBT techniques work well to reduce symptoms associated with social anxiety and any other symptoms that may derive from an unusual experience, research has shown that the combination of CBT and pharmacological intervention (i.e. medication) remains the best option for symptom reduction. Being able to recognize and modify any dysfunctional thought content will enable you to acquire new coping strategies that will allow you to retrieve additional information about your surroundings, even when medication alone does not appear to lead to improved functioning.

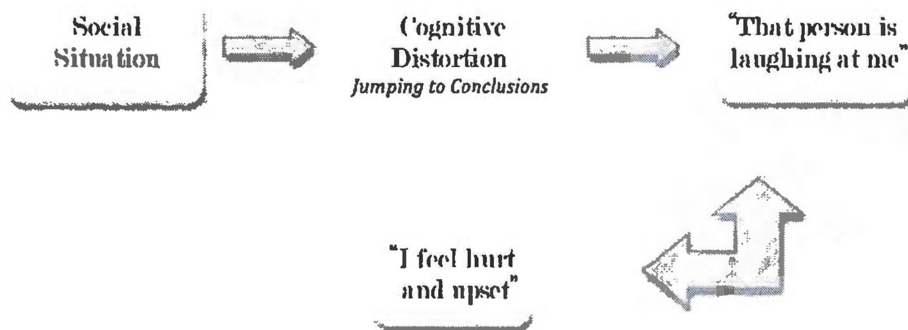
---

1. What are "cognitive distortions"?

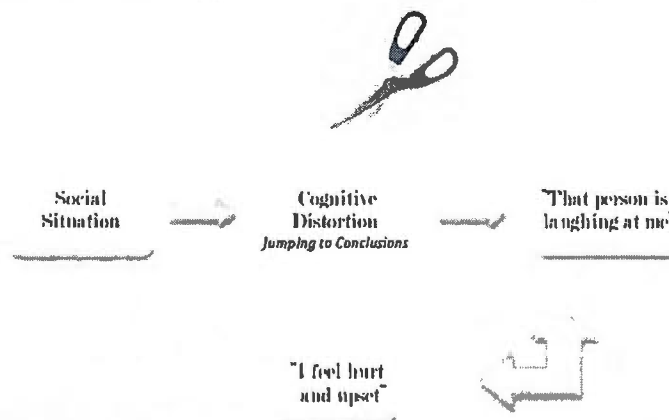
Cognitive distortions are defined as a 'skewed' yet automatic way of thinking related to a situation or event. Aaron Beck was the first to propose the theory behind cognitive distortions. David Burns was however responsible for promoting the notion of cognitive distortions by attributing more common names and examples for the distortions. These cognitive distortions "filter" the

Copyright © 2011 Tina C. Montreuil

way we interpret a given situation. For example, let's suppose that you are sitting in the bus. Imagine that the person across from you starts laughing. A person that has a tendency to "jump to conclusion" might automatically assume that the person is actually laughing at them. If you think that a person is laughing at you, it is easy to understand how this social situation might make you feel uncomfortable, upset, shy, humiliated, or even angry.



The idea behind working on "modifying" our cognitive distortions is done through actually "cutting access" to that automatic assumption by proposing a different or "alternate" explanation for the situation that just took place.



Copyright © 2011 Tina C. Montreuil

This alternate way of thinking about the situation might be to say: "What are other possible reasons that might explain why this person laughed?". We will actually take a closer look into 'how to generate these alternative thoughts' during a future session. However, at this point in time, it is crucial for us to be able to first (1) target a social situation where we may have felt embarrassed, shy, upset, distraught or angry; (2) identify the thoughts that resulted from this social interaction and; (3) identify the cognitive distortion that is associated with that thought pattern.

2. The different types of cognitive distortions.

Here are the ten different types of cognitive distortions. In order to better understand what each refers to, some examples and applications have been included for each type. Please read through each one of these examples very carefully. Remember, the more you read, the better you will remember them and the easier it will become for you to identify them.

1 - All-or-Nothing Thinking

This type of distortion is the culprit when people think in extremes, with no gray areas or middle ground.

All-or-nothing thinkers often use words like "always" and "never" when describing things. "I always get stuck in traffic!" "My bosses never listen to me!" This type of thinking can magnify the stressors in your life, making them seem like bigger

Copyright © 2011 Tina C. Montreuil

problems than they may, in reality, be.

2 - Overgeneralization

Those prone to overgeneralization tend to take isolated events and assume that all future events will be the same.

For example, an overgeneralizer who faces a rude sales clerk may start believing that all sales clerks are rude and that shopping will always be a stressful experience.

3 - Mental Filter

Those who use mental filtering as their distortion of choice tend to gloss over positive events and hold a magnifying glass to the negative. Ten things can go right, but a person operating under the influence of a mental filter may only notice the one thing that goes wrong. For example, a person may have gotten 5 very good marks (A's) on their report card and only one average mark (B) but the person who has mental filter as a cognitive distortion will be saddened and focus solely on the less than perfect mark, despite the other 5.

By adding a little overgeneralization and all-or-nothing thinking to the equation, and you have a recipe for stress.

4 - Disqualifying the Positive

Similar to mental filtering, those who disqualify the positive tend to treat positive events like flukes, thereby clinging to a more negative world view and set of low expectations for the future.

Have you ever tried to help a friend solve a problem, only to have every solution you pose shot down with a "Yeah but..." response? You've witnessed this cognitive distortion firsthand.

Copyright © 2011 Tina C. Montreuil

5 - Jumping to Conclusions

People do this one all the time. Rather than letting the evidence bring them to a logical conclusion, they set their sights on a conclusion (often negative), and then look for evidence to back it up, ignoring evidence to the contrary.

The kid who decides that everyone in his new class will hate him, and 'knows' that they're only acting nice to him in order to avoid punishment, is jumping to conclusions.

Conclusion-jumpers can often fall prey to mind reading (where they believe that they know the true intentions of others without talking to them) and fortune telling (predicting how things will turn out in the future and believing these predictions to be true). Can you think of examples of adults you know who do this? I bet you can.

6 - Magnification and Minimization

Similar to mental filtering and disqualifying the positive, this cognitive distortion involves placing a stronger emphasis on negative events and downplaying the positive ones.

The customer service representative who only notices the complaints of customers and fails to notice positive interactions is a victim of magnification and minimization.

Another related form of this distortion is known as catastrophizing, where one imagines and then expects the worst possible scenario. It can lead to a lot of stress.

7 - Emotional Reasoning

This one is a close relative of jumping to conclusions in that it involves ignoring certain facts when drawing conclusions. Emotional reasoners will consider their emotions about a situation as evidence rather than objectively looking at the facts.

For example: "I'm feeling completely overwhelmed, therefore my problems must be completely beyond my ability to solve them," or, "I'm angry with you; therefore, you must be in the wrong here," are both examples of faulty emotional reasoning.

Acting on these beliefs as fact can, understandably, contribute to even more problems

Copyright © 2011 Tina C. Montreuil

to solve.

8 - Should Statements

Those who rely on 'should statements' tend to have rigid rules, set by themselves or others that always need to be followed -- at least in their minds. They don't see flexibility in different circumstances, and they put themselves under considerable stress trying to live up to these self-imposed expectations.

If your internal dialogue involves a large number of 'shoulds,' you may be under the influence of this cognitive distortion.

9 - Labeling and Mislabeling

Those who label or mislabel will habitually place labels that are often inaccurate or negative on themselves and others.

Examples of this include: "He's a whiner." "She's a phony." "I'm just a useless worrier."

These labels tend to define people and contribute to a one-dimensional view of them, paving the way for overgeneralizations to move in. Labeling cages people into roles that don't always apply and prevent us from seeing people (ourselves included) as we really are.

10 - Personalization

Those who personalize their stressors tend to blame themselves or others for things over which they have no control, creating stress where it need not be.

Those prone to personalization tend to blame themselves for the actions of others, or blame others for their own feelings.

3. The thought record.

A thought record is an essential tool when it comes to identifying cognitive

Copyright © 2011 Tina C. Montreuil

distortions and modifying our thought patterns, as we will see in the next coming sessions. For the next few sessions, we will be using the thought record quite often. It is okay. As we mentioned before, in order to easily identify the cognitive distortions that are most prevalent in your own thought patterns, you will need to repeat this step more than once. Here is an example of a 'thought record'.

Dysfunctional Thoughts Record

Date

Situation	Automatic Thoughts (What keeps running through your head?)	Emotions felt (Intensity Rating 0-100%)	Objective situation (What are the basic, objective FACTS. No interpretations)	Distortions (Give names, from Burns or Beck)

Copyright © 2011 Tina C. Montreuil

Thought records are useful since they allow the user, you, to write down the following information:

(1) **The social situation,** which provoked the emotional and/or behavioral reaction;

(2) **The automatic thought(s)** that were triggered by the situation

Copyright © 2011 Tina C. Montreuil

(3) **The feelings** that were associated with the situation

(4) **The behavior**, which refers to how I reacted when confronted with the situation I identified in point 1.

(5) **The cognitive distortion(s)** that match the thought pattern(s) I identified in point 2.

4. Let's practice filling out the thought record.

Going back to the situation "on the bus", let's use this example in order to fill out the thought record that found above.

(1) **The social situation** = *Sitting on the bus, a person is laughing and you make eye contact with him/her.*

(2) **The automatic thought(s)** = *"That person is laughing at me; I must look ridiculous, etc."*

(3) **The feelings** = *Shyness, shame, uncomfortable, angry, sad, etc.*

(4) **The behavior** = *I walk off the bus upset, I look at the person and I tell them off – telling them they have no business laughing at other people, etc.*

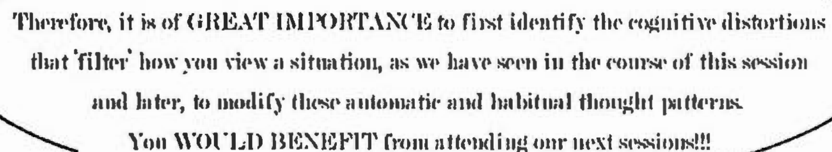
(5) **The cognitive distortion(s)** = *Mislabeling, emotional reasoning, personalization*

5. The role of cognitive distortions in social anxiety.

Each anxiety disorder, especially social anxiety disorder is associated with a specific tendency to overestimate the danger inherent in particular social situations, more specifically situations that may lead to judgment or reprisal. Cognitive distortions

Copyright © 2011 Tina C. Montreuil

may lead to misperceptions you may have about your own abilities and self-worth, which may ultimately lead to guilt, embarrassment, or anger. Studies have shown that compared non-socially anxious controls, people that were socially anxious tended to have a more negative estimate of a given situation. These 'negative appraisal', amongst other variables, appeared to be linked to the presence of cognitive distortions.



AT-HOME ACTIVITIES

Complete the "Thought Record" using your own personal experience of a social situation or encounter.

Copyright © 2011 Tina C. Montreuil

Dysfunctional Thoughts Record

Date__________________

Situation	Automatic Thoughts (What keeps running through your head?)	Emotions felt (Intensity Rating 0-100%)	Objective situation (What are the basic, objective FACTS. No interpretations)	Distortions (Give names, from Burns or Beck)

Copyright © 2011 Tina C. Montreuil

Copyright © 2011 Tina C. Montreuil

INTRODUCTION TO COGNITIVE RESTRUCTURING

Today's session will allow you to begin training in monitoring and correcting the erroneous thoughts or "faulty thinking patterns" by learning to identify thinking errors when they occur (Session 5 – Cognitive Distortions). Learning to identify and most importantly to modify your dysfunctional automatic thoughts can help you to monitor your anxiety symptoms more closely. You will be learning how to rely on a cognitive-based intervention to alter the content of those dysfunctional automatic thoughts. In doing so, you will be able to modify these automatic thoughts into more rational ones. This will eventually lead to a reduction of the emotional and physiological distress that is usually associated with standing by dysfunctional thoughts.

1. Review on "cognitive distortions"?

During the last session, we saw that "cognitive distortions" are defined as a 'skewed' yet automatic way of thinking related to a situation or event.

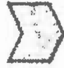
- **What you need to remember is that "Cognitive Distortions" are:**

AUTOMATIC – They just appear in your mind without any effort.

SKEWED – They are not always supported by reality or what is known to be true.

Copyright © 2011 Tina C. Montreuil

UNHELPFUL – They keep you feeling bad about yourself and make it difficult for you to change and be less rigid.



PLAUSIBLE – Which makes you accept them as face value or as facts and do not question or discredit them – but they don't always reflect reality.

INVOLUNTARY – You have not chosen to have them and they are very difficult to deal with or to stop.

2. **Remember the model?**

~~Cognitive Distortion~~

Social Situation

Alternative THOUGHT

"That person is laughing with her friend"

"I feel okay and relaxed"

Copyright © 2011 Tina C. Montreuil

As we saw, the idea behind working on "modifying" our cognitive distortions is done through actually "cutting access" to that automatic assumption by proposing a different or "alternate" explanation for the situation that just took place. This alternate way of thinking about the situation might be to say: "What are other possible reasons that might explain why this person laughed?".

- **Alternate Thought: "She was laughing with her friend"**

This change in dysfunctional thought also has an impact on our emotions and our feelings. As you know by now, these dysfunctional emotions impact and have an effect on how you then behave in social settings. They make you feel as though you do not fit in, that you are different from others or that you will never be able to overcome some of these situations. Therefore, it is really important that you learn to evaluate all the information that is available around you, and not jump too fast to conclusions or simply assume that you know what the other person is thinking. The next exercise will explain exactly what it is that we mean by "Don't be too quick to judge".

3. Video – "Do not judge too quickly"

We will be showing you four little clips or videos. Watch carefully as your job will be to gather facts from what you are watching. We will play the video montage and pause it before the ending is revealed.

Copyright © 2011 Tina C. Montreuil

You may want to think about the following questions:

a. What appears to be taking place in the clip?

____

____

____

b. Using the available information, if you were to make a judgment from the moment the clip was paused, what would you conclude?

____

____

____

c. Try to come up with a different explanation, different from the one you just wrote that could also be possible (even though you may think it's less probable).

____

____

____

d. Now that you saw the ending, what have you learned?

____

____

____

That "sometimes we jump to conclusion too quickly – concluding that we have all the answers based on what we know, doing so hastily without accumulating evidence. We also have to practice to find evidence 'against' in order to generate an ALTERNATIVE EXPLANATION.

Copyright © 2011 Tina C. Montreuil

4. How do I initiate change?

(1) The first step is to : Become aware of your dysfunctional thoughts.

First of all, you need to become aware of what your dysfunctional thoughts are, and how they affect you. Dysfunctional thoughts can make us feel; anxious, sad, depressed, upset, hopeless, guilty, and angry. It is actually useful for us to use these emotions as cues in identifying our dysfunctional thoughts. It is recommended that you try and notice when your mood changes, and think about what was running through your mind at that moment. Doing this will help you become more aware of changes in the way you are feeling and therefore, become a useful tool in helping you to identify the thoughts that are underlying these feelings.

a. The best way to do this is to write them down as soon as they occur, you can do this using the THOUGHT RECORD attached in your participant manual. Try to record the thoughts that were running through your head as accurately as you can.

b. It may be challenging for us to write down our dysfunctional thoughts, because we do not want to face the thoughts, or might be frightened. It is important to remember that ignoring the thoughts will not make them go away.

(2) Once you have learned to become more aware of your dysfunctional thoughts, **the second step is to: Try to modify the thoughts and find more realistic and helpful alternatives.**

Copyright © 2011 Tina C. Montreuil

There are four questions you can use to help you modify the dysfunctional thoughts.

1. What is the evidence for your thought? Do the facts of the situation back up what you think?

2. What alternative reasons could there be for what has happened? Try and think of as many alternative explanations as you can and look at the evidence for and against them.

3. What is the effect of thinking in the way you do?

4. What are the thinking errors you are making? People who feel depressed tend to jump to the conclusion that things are bad, and they end up feeling guilty and taking responsibility for things that aren't their fault.

5. The thought record.

A thought record is an essential tool when it comes to identifying cognitive distortions and modifying our thought patterns. As we saw last session, the thought record includes key elements. Now that you are ready to start questioning your own thoughts, we will add this final element: ALTERNATIVE EXPLANATION.

(1) **The social situation,** which provoked the emotional and/or behavioral reaction;

(2) **The automatic thought(s)** that were triggered by the situation;

(3) **The feelings** that were associated with the situation;

(4) **The behavior**, which refers to how I reacted when confronted with the situation I identified in point 1;

Copyright © 2011 Tina C. Montreuil

(5) **The cognitive distortion(s)** that match the thought pattern(s) I identified in point 2;

(6) **The alternative explanation,** that you will generate more positive and realistic ways of viewing your experiences, and then to test these out in action.

At first, this will probably be hard. Modifying your dysfunctional thoughts is like any other skill, it takes time, effort and practice to get it right. The next few pages will provide you with a guide to help you challenge your dysfunctional automatic thoughts.

Here is an example of a 'thought record' that includes the ALTERNATIVE EXPLANATION:

EXERCISE 7.2 AUTOMATIC THOUGHT RECORD

As soon as you feel your mood worsening fill in the chart below by asking yourself, "What am I thinking and feeling right now?"

Date, Time	Situation	Automatic Thought/s	Feeling/s	Your Response	Results
	• What event led to the distressing feelings?	• Record the thoughts or images that went through your mind • Rate how strong you believed each thought (0-100%) • Which Thinking Styles apply?	• What feelings did you have? • How intense were they? (0-100%)	• Respond to each thought using questions below • Rate how much you believe each response (0-100%)	• Rate intensity of feeling/s • Rate belief in thought/s • Write a more balanced thought. Rate your belief in this thought (0-100%)

Respond to each of your Automatic Thoughts using the following questions. (See Table 7.1 for further explanations)

(1) What is the evidence your thought is true? Not true? (Two sides should total 100%)
(2) Would others agree that your thought is true?
(3) What are some alternative explanations for your thought?
(4) What's the worst thing that could possibly happen? The best? Most realistic?
(5) If a friend in this situation had that thought, how would you respond?
(6) What are benefits of this thought? The costs? (Two sides should total 100%)

[illegible]

6. Let's practice filling out the REVISED Thought Record.

AUTOMATIC THOUGHT RECORD

When you notice your mood getting worse, ask yourself, **"What's going through my mind right now?"** As soon as possible, fill in the table below.

Date, Time	Situation	Automatic Thoughts	Emotion	Adaptive Response	Outcome
	• What led to the unpleasant emotion? • What distressing physical sensations did you have?	• What thought/s or image/s went through your mind? • How much did you believe the thought at the time (0-100%)?	• What emotion/s did you feel at the time? • How intense was the emotion (0-100%)?	• Which thinking styles did you engage in? • Use questions below to respond to the automatic thoughts/s. • How much do you believe each response (0-100%)?	• How much do you now believe your ATs (0-100%)? • What emotion(s) do you now feel? At what intensity?

Questions to compose an Adaptive Response: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) What's the worst that could happen? What's the best that could happen? What's the most realistic outcome? (4) If a friend were in this situation and had this thought, what would I tell him/her?

Copyright © 2011 Tina C. Montreuil

Don't expect your beliefs in the negative thoughts to disappear completely or all at once.
Learning to modify your negative and dysfunctional thoughts well,
will require that you take time to practice regularly.

AT-HOME ACTIVITIES

Complete the "Thought Record" that includes ALTERNATIVE EXPLANATION using your own personal experience of a social situation

Copyright © 2011 Tina C. Montreuil

SOCIAL SKILLS TRAINING – PART I

Today's session will help us to identify (1) What are Social Skills?, (2) What are some examples of useful Social Skills?, (3) Why Social Skills training is important?, (4) What are some of the possible causes of less developed or a reduction of Social Skills?, and (5) How can Social Skills training help me? Social Skills are a very important component of our psychosocial functioning, of our everyday living and they also contribute to our quality of life. Social Skills reduction or impairments can lead to social dysfunction and may lead to other problems. Medication side effects may contribute to a reduction in social skills. Social Skills training will help you to learn how to better communicate your feelings, thoughts and needs to others around you and how to better respond to the thoughts, feelings, and needs of others. In addition, better Social Skills can help you to become more independent and to meet your personal goals and objectives.

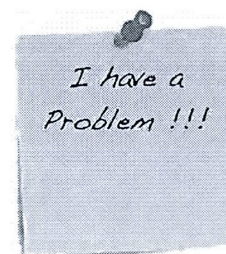
1. What are Social Skills?

Social skills include all the types of behaviors that we use when we interact with others. These skills are what allow us to communicate and interrelate with others, and are usually driven by a specific goal or objective. These very skills are what enable us to get along with others. Social skills should not be taken for granted, because although some are very basic and simple, such as greeting someone by saying hello and good-bye, smiling or simply making eye contact with others when we speak; other social skills are more complex and will usually require

Copyright © 2011 Tina C. Montreuil

more practice in order for you to become more skillful. These more complex social skills include making a demand or a criticism, negotiating or problem solving in a situation of conflict with someone or disagreeing with someone else's opinion.

Commonly reported complaints include:



- Social isolation
- Limited social network
- Lack of interest in activities
- Making unreasonable demands
- Anger management issues
- Monotone speech bland conversation
- Difficulty listening and keeping up with others in conversation
- Difficulty disagreeing with others
- Difficulty expressing thoughts / feelings

2. How difficult is it to acquire better Social Skills?

For some people, learning and acquiring new social skills can be easy, quick and fun. However, for others that feel more distressed or uncomfortable in a social situation, learning a new social skill may be somewhat more challenging, require more time and practice and you may need to invest a little more conscious efforts.

3. What are some examples of useful Social Skills?

There are many social skills that you could potentially want to work on acquiring. However, here are a few ideas of specific behavioral goals you may want to target in the course of our program:

- CHECK THE ONES YOU WOULD LIKE TO WORK ON:

Copyright © 2011 Tina C. Montreuil

- ☐ • Making requests or demands
- ☐ • Listening to others
- ☐ • Turning down requests
- ☐ • Disagreeing with others
- ☐ • Expressing positive feelings
- ☐ • Expressing negative or unpleasant feelings
- ☐ • Beginning and maintaining a conversation
- ☐ • Ending a conversation
- ☐ • Keeping up with the flow-content of a conversation
- ☐ • Problem solving or negotiating a common solution
- ☐ • Controlling and better managing anger

"Social Skills training aims at improving:
(1) What people say to others during their social interactions, and
(2) How they say it"

Copyright © 2011 Tina C. Montreuil

4. Why Social Skills training is important?

Social skills training includes a set of techniques that were developed over 25 years ago. As you will notice, social skills training involves many steps and varies in length and process depending on your objectives.

- *The first step is what we are actually covering in today's lesson; to make sure that the participant understands why social skills are, why they are important and why he or she will need to actually get involved in the social skills training.*

- *The second step will be for the therapists to demonstrate the model through ROLE PLAY or to act out the social skill to the participants.*

- *The third step will involve learning and practicing these skills through ROLE PLAY. As we saw in the previous step, it's kind of like being an actor and playing out the scene (in this case the skill scenario) in front of others, which leads to the following step:*

- *The fourth step where the ROLE PLAY by the participants will allow:*

    - *You may become more comfortable and less anxious about making use of the social skill you will have acquired*
    - *Get other members from the group and therapist to give you feedback in a safe and constructive environment in order for you to learn how to "make perfect" you newly acquired skill.*

- *The final step will be for you to go on and try out the newly acquired skill on your own.*

These steps will be executed by respecting your own comfort level and tolerance. You will be encouraged to follow the recommendations as these steps have been studied, and tried amongst many other participants before you. These studies have revealed that the method and model is REALLY effective.

Copyright © 2011 Tina C. Montreuil

5. What are some of the possible causes of less developed or a reduction of Social Skills?

There are many explanations as to why some people have less developed or reduced social skills. These difficulties may be explained by the fact that some individuals may have grown up in environment that did not have good role models. Some may have acquired these skills overtime, depending on their life experiences or social network. Another possible explanation is that some people may have become ill and as a result, they may have withdrawn from others. Of course, any combinations of these various elements may have contributed to social skill deficits.

6. How can Social Skills training help me?

Social Skills training may be useful by teaching you how to communicate more effectively with others so that you may relate more with your social environment. It can help you better communicate with you friends, family, employer, teacher, etc. More importantly, Social Skills training will help you become more independent with the main aim to allow you to reach your goals and objectives; whatever they may be (find a job, meet a significant other, meet new people, convey your feelings and thoughts, etc.).

"SOCIAL SKILLS TRAINING IS VERY EFFECTIVE!"

AT-HOME ACTIVITIES

Read the SKILL SHEET: "Listening to others"

Copyright © 2011 Tina C. Montreuil

SKILL: Listening to Others

RATIONALE: Whenever you are in a conversation, it is important to show the other person that you are listening, that you are paying attention When the other person can tell you are listening, he or she is more likely to want to continue talking to you There are some specific things you can do to show your interest to the other person.

STEPS OF THE SKILL:

1. Look at the person.
2. Let him or her know that you are listening by either nodding your head OR saying something like "Uh-huh" or "OK" or "I see."
3. Repeat back what you heard the other person saying.

SCENES TO USE IN ROLE PLAYS:

1. Listening to someone who is talking about a favorite hobby.
2. Listening to someone who is talking about a favorite TV show.
3. Listening to a staff member who is talking about the rules at the community residence.
4. Listening to your doctor telling you about your medication.
5. Listening to a friend talk about a recent outing.

SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:

1. Role plays should be set up using two people: One person talks about a topic, while the person who is practicing the skill follows the steps.
2. Clients often have difficulty paying attention when someone is speaking to them. It is important to keep the role plays short (30 seconds or less) and simple when first prac ticing the skill

Copyright © 2011 Tina C. Montreuil

SOCIAL SKILLS TRAINING – PART II

The purpose of today's session is to teach you "Assertiveness Training". AT is a form of behavior therapy designed to help people stand up for themselves—to empower themselves. You will be taught that assertiveness is a response that seeks to maintain an appropriate balance between passivity and aggression. Assertive responses promote fairness and equality in human interactions, based on a positive sense of respect for self and others, while still communicating one's own feelings or thoughts. However, at the core of Assertiveness Training, lies conversational skills and the ability to communicate ones own thoughts and feelings in a an adaptive way. All of these elements will be presented to you today. Keep in mind, "practice (repetition) is key" and "social skills training is truly effective" for overcoming these difficulties.

1. How do I know whether I would benefit from Assertiveness training?

Learning to communicate in a clear and honest fashion usually improves relationships within one's life. Specific areas of intervention and change in assertiveness training include conflict resolution through the use of "conversational or communication skills", realistic goal setting, and stress management. In addition to emotional and psychological benefits, taking a more active approach to self-determination has been shown to have positive outcomes in many personal choices related to health, and mental wellbeing.

Copyright © 2011 Tina C. Montreuil

2. What is assertiveness?

Assertiveness training typically begins with an information-gathering exercise in which clients are asked to think about and list the areas in their_life in which they have difficulty asserting themselves. Very often they_will notice specific situations or patterns of behavior that they want to_focus on during the course of therapy. The next stage in assertive training_is usually role-plays (see item Goal for the Session 7) designed to help the_client practice clearer and more direct forms of communicating with other_members of the group.

As an "ice-breaker", the leader and co-leader should initiate the role-play, demonstrating to the clients how it is done. The role-plays allow for practice and repetition of the new techniques, helping each person learn assertive responses by acting on them. The leader/ co-leader as well as other group members provide feedback in order to improve the response, and the role-play is repeated within the session and at home as homework. Eventually, as mentioned in the previous session, each client will be asked to practice assertive techniques in everyday life, outside the training setting.

3. Identifying and listing the areas (e.g. with who, when, what where) I am not being assertive.

Preparation for assertiveness training varies from person to person. For some clients, no preparation will be needed before practicing the techniques; for others, however, more 'individual therapy' may be necessary for that client to be ready for assertiveness training. For clients who may be more shy and feel uncomfortable

Copyright © 2011 Tina C. Montreuil

saying "no" or speaking up for themselves, more individual attention may be required from the part of the leader or co-leader in order for that client to feel at ease with using assertiveness techniques. As part of assertiveness training, for some clients, it may also be beneficial to integrate "Anger Management" strategies in order to increase the probability of successful outcomes.

MY ASSERTIVENESS TRAINING "How I would benefit from it" LIST:

With WHO would I want to become more assertive?

____

____

WHEN would I want to be more assertive?

____

____

In WHICH situation (s) would I want to become more assertive?

____

____

WHERE would I want to be more assertive?

____

____

4. What are communication skills in Assertiveness Training?

The following four COMMUNICATION SKILLS are the most basic and

Copyright © 2011 Tina C. Montreuil

fundamental ones you should acquire: (A) Engaging in casual conversation; (B) Making a request; (C) Making a criticism; and (D) Making a positive reinforcement (compliment).

Here we explain them to you in greater details.

A) Engaging in casual conversation

A casual conversation is called as such because you will not necessarily talk about very serious and formal topics with others. A casual conversation entails that you may have to engage in "social interaction" with others, by simply being able to maintain a conversation based on general knowledge topics such as : books, the weather, career, school, politics, geography, economy – mainstream news. Some people put much pressure upon themselves because they feel they have to come up with "strikingly elaborate" content. However, casual conversation refers to nothing that original, common and repeated topics (everyday issues) relating to the majority of people's everyday life.

How do I start a casual conversation?

- Begin by saluting and greeting the person you are approaching.
- Introduce yourself, and elicit the other person to introduce themselves as well (eg. "Hello my name is Michael, what is your name?"

Ask an open-ended question which requires a detailed answer and "more than a single-word answer" (eg. Ask a question about something you would like to know

Copyright © 2011 Tina C. Montreuil

about them – "What do you do?; Where do you work? How long have you worked for this company?"

- The sentences should start with for example "How or what (it)".

- Avoid closed-ended questions (eg Are you well ... which would lead to a "yes or no" answer.).

- Ask a question or share a personal experience or made a comment on a situation.

- Emphasize non-verbal behavior (eg nod, smile, eye contact, etc.).

- Assess and evaluate whether the person appears interested to communicate or not

To end a conversation:

- Always wait until the other person has finished what they are saying before attempting to end a conversation

– Avoid interrupting them in the process, as it may be perceived as though you find them "uninteresting".

- Make use of "non-verbal" gestures, such as looking away, at someone else or looking at your watch" before you make a "verbal attempt" at ending the conversation.

- Use closing statements such as "Well, I must go; Sorry for having to end this conversation, but I must get going".

- You can choose to either provide no reason as to why you must end the conversation or you may choose to do so in order to smooth the transition if you wish by saying "Sorry, I must really go. I have some errands to run (or I have an appointment)".

- Always finish off by saying "Good bye"

Copyright © 2011 Tina C. Montreuil

- If you know the person well and you estimate that you will likely see them again, perhaps you could add : "Until next time" or "Looking forward to seeing you soon".

B) Making a request

Before making the request you must:

- Make sure that the other person is listening to you.
- Make sure that you are looking at the person.
- Provide a clear and "to the point" statement about what it is you would like them to do.

When making the request:

- You must speak in the first person tense (eg. "I would like...")
- You must make the request precisely, if necessary support the request by repeating it (Technical broken record, adjust the tone and nonverbal behaviors to the situation).
- Some examples include:
    - "I would like it if you could___________________."
    - "I would really appreciate it if you would ________________."
    - "It is very important for me that you ___________________."

Two situations may arise:

- The demand is satisfied or not
- If the request is not satisfied:
    - o You must communicate your disappointment or disagreement without

Copyright © 2011 Tina C. Montreuil

complaint or aggression - if you really wish for this request to be executed.

o If you need to express disagreement, it must be expressed without unnecessary justifications, possibly accompanying an alternative proposal (for example, "Ok, perhaps not today but maybe next week?").

o If the other still refuses to execute your request, you may decide to stop. However, should you wish to pursue and maintain your request, you may use repetition by relying on the technique of broken record (explain).

* Keep in mind that this may be perceived as being "aggregating" or "insistent" by the other person – so be sure to evaluate the pros and cons of maintaining your request.

C) Making a criticism

Before making a criticism:

- By definition, making a criticism entails that you will have to express unpleasant feelings to the other person.

- If we must make one, you must have a valid reason for doing so (for example, if someone arrives late repeatedly, you might express to them how it makes you feel when you have to wait for them ("It makes me upset when you do not arrive on time").

Start by:

- Looking at the person directly.

- Speak firmly but calmly.

Copyright © 2011 Tina C. Montreuil

- Do not forget that the tone of voice itself may have to be adjusted to the setting or the individual = as some people might be more sensitive to criticism then others. Adjust yourself.
- Begin by the person exactly what made you upset or what you feel they need to change.
- Tell the other person how it may you feel.
- Make a suggestion on how this may be preventable in the future.
- If it is a justified complaint, you have to acknowledge the other person's discomfort without representing them negatively.

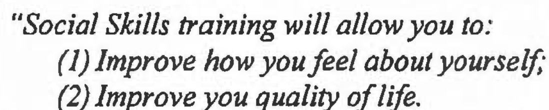
D) Positive reinforcement

- You can make a positive reinforcement statement by saying a pleasant thing you noticed in another person.
- It is sometimes very much appreciate by others when we point out certain things that they did or made.
- Also, just like it probably is the case for ourselves, we are more likely to redo something if we know that it pleased others.

First begin by:

- Looking at the person directly in order to make sure that they are listening to you.
- Again, tell the person clearly, what you saw them doing that you appreciated and liked.
- Follow by telling the person how what they did made you feel.

Copyright © 2011 Tina C. Montreuil



5. Now that I am all "geared up" – let's do some role play.

Role-plays usually incorporate specific problems for individual clients, such as difficulty speaking up to an overbearing boss; setting limits to intrusive friends; or stating a clear preference about dinner to one's spouse. Role-plays often include examples of aggressive and passive responses, in addition to the assertive responses, to help clients distinguish between extreme types of response, as they learn a new set of behaviors.

Starting a conversation:

- *You are sitting at a table at lunch with other people and you want to start a conversation.*

Ending a conversation:

- You are talking with a friend over dinner and you have to tell him / her that you have to go back home because you have an early interview in the morning.

Making a request:

- You want to ask someone to go out for lunch with you.

Copyright © 2011 Tina C. Montreuil

Making a criticism:

- You want to let you friend know how you feel about them cancelling lunch last minute for the second time.

Making a positive reinforcement:

- You want to say something to a family member who gave you a ride to one of your appointments.

"SOCIAL SKILLS TRAINING IS VERY EFFECTIVE!"

Repetition, repetition, repetition...

AT-HOME ACTIVITIES

Read the "What is Social Skills Training (SST)?"

Copyright © 2011 Tina C. Montreuil

What is Social Skills Training (SST)?

A major goal of social skills training is teaching persons about the verbal as well as nonverbal behaviors involved in social interactions. There are many people who have never been taught such interpersonal skills as making "small talk" in social settings, or the importance of good eye contact during a conversation. In addition, many people have not learned to "read" the many subtle cues contained in social interactions, such as how to tell when someone wants to change the topic of conversation or how to initiate a conversation.

Social skills training (SST) helps participants to learn to interpret these and other social signals, so that they can determine how to act appropriately in the company of other people in a variety of different situations. SST proceeds on the assumption that when people improve their social skills or change selected behaviors, they will raise their self-esteem and increase the likelihood that others will respond favorably to them. Trainees learn to change their social behavior patterns by practicing selected behaviors in individual or group therapy sessions. Another goal of social skills training is improving a participant's ability to function in everyday social situations.

Social skills training can help participants to work on specific issues—for example, improving one's social abilities—that interfere with their jobs, relationships, or daily lives. Many studies have showed that social skills training is a really effective intervention for improving social skills. Improved social skills means that you will achieve a better quality of life and take pleasure in engaging in activities that you were once able to do or have desired to engage in.

Copyright © 2011 Tina C. Montreuil

EXPOSURE – PART I

The purpose of today's session is to teach about "Exposure Therapy" in treating fears linked to social anxiety. The aim is to help you to be better able to face and not avoid the feared situation. Exposure therapy can be carried out in real situations, which is called in vivo exposure; or it can be done through imagination. There are several variations on how to deliver exposure therapy: client-directed exposure instructions or self-exposure; therapist-assisted exposure; and group exposure. The basic purpose of exposure therapy is to decrease anxious and fearful reactions (emotions, thoughts, or physical sensations) through repeated and prolonged exposures to anxiety-producing situations or context.

1. Exposure therapy – SOME FACTS:

A- Exposure Therapy aims seeks the reduction of the "learned" anxiety response. This process is better known as habituation ("getting used to something").

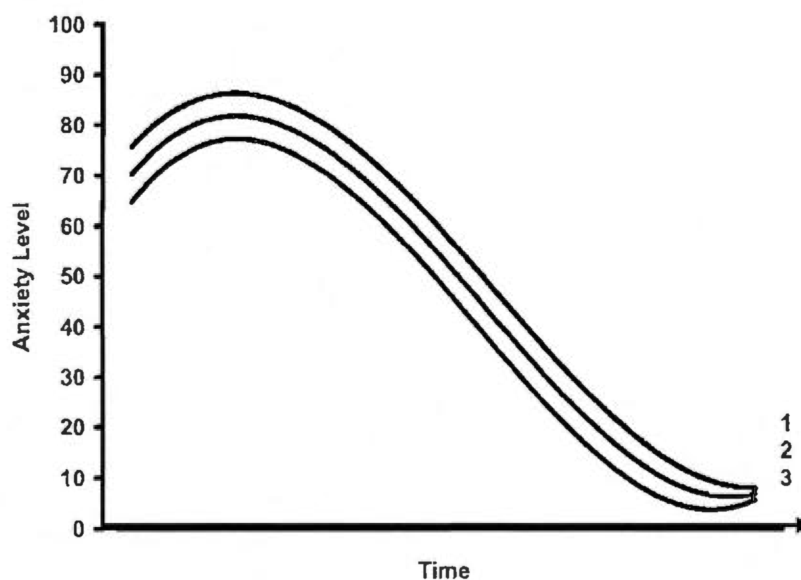
B- A related purpose of exposure therapy is to eliminate the anxious or fearful response altogether so that you can face the feared situation repeatedly without experiencing an unmanageable level of anxiety or fear.

C- The elimination of the anxiety response is known as extinction.

Copyright © 2011 Tina C. Montreuil

2. How can I understand how "Habituation" works in Exposure Therapy?

Looking at the graph below, you notice that the more you expose or face the situation you fear as opposed to avoiding it, the less intense is the anxiety. Overtime, when you expose yourself to an anxiety-provoking situation, the anxiety you feel is reduced.



3. What are the various types of method for delivery of exposure therapy?

-1- CLIENT-DIRECTED EXPOSURE:

- Client-directed exposure is the simplest variation of exposure therapy. After the person makes his or her hierarchy list with the

Copyright © 2011 Tina C. Montreuil

therapist, he or she is instructed to move through the situations on the hierarchy at his or her own rate. The person starts with the lowest anxiety situation on the list, and keeps a journal of his or her experiences. Client-directed exposure is done on a daily basis until the person's fears and anxiety have significantly decreased.

For example, if a person is afraid of leaving the house, the first item on the hierarchy might be to stand outside the front door for a certain period of time. After the person is able to perform this action without feeling anxious, he or she would move to the next item on the hierarchy, which might be walking to the end of the driveway. Treatment would proceed in this way until the person has completed all the items on the hierarchy. Another example could be that a person which fears making a demand to her boss about being able to leave early from work, might want to start practicing asking someone for directions, or asking for the price of an item at the grocery store.

-2- THERAPIST-ASSISTED EXPOSURE:

o In this form of exposure therapy, the therapist goes with the person to the feared location or situation and provides on-the-spot coaching to help the person manage his or her anxiety. The therapist

Copyright © 2011 Tina C. Montreuil

may challenge the person to experience the maximum amount of anxiety.

In prolonged in vivo exposure, the therapist and person stay in the situation as long as it takes for the anxiety to decrease. For example, they might remain in a crowded shopping mall for four or more hours. The therapist also explores the person's thoughts during this exposure so that any irrational ways of thinking can be confronted.

-3- GROUP EXPOSURE:

o In group exposure, self-exposure and practice are combined with group psychoeducation / training and feedback of experiences during exposure to feared situations in the form of role play.

4. Some misconceptions about how SOCIALLY SKILLED individuals feel in social situations.

1° Socially Skilled people do not feel anxious.

2° Socially Skilled people feel completely comfortable.

3° Socially Skilled people know exactly what they are going to say.

4° Socially Skilled people do not feel awkward.

5° Socially Skilled people do not worry at times about how others will perceive them.

Copyright © 2011 Tina C. Montreuil

5. What is an Exposure Hierarchy?

The principle of exposure is based on the principle of exposing or placing yourself in a situation that causes fear and anxiety. Psychologists have developed the 'exposure hierarchy' as a tool to help you face this overwhelming anxiety. An exposure hierarchy is defined as a list of your very own anxiety-provoking situations starting from the least challenging to the most challenging based on the associated anxiety level.

6. Establishing the Exposure Hierarchy.

dentify the specific behaviors or social situations/encounters that have been targeted for change. Again, remember to begin by listing the easiest, most achievable situations first and end with the most difficult at the top.

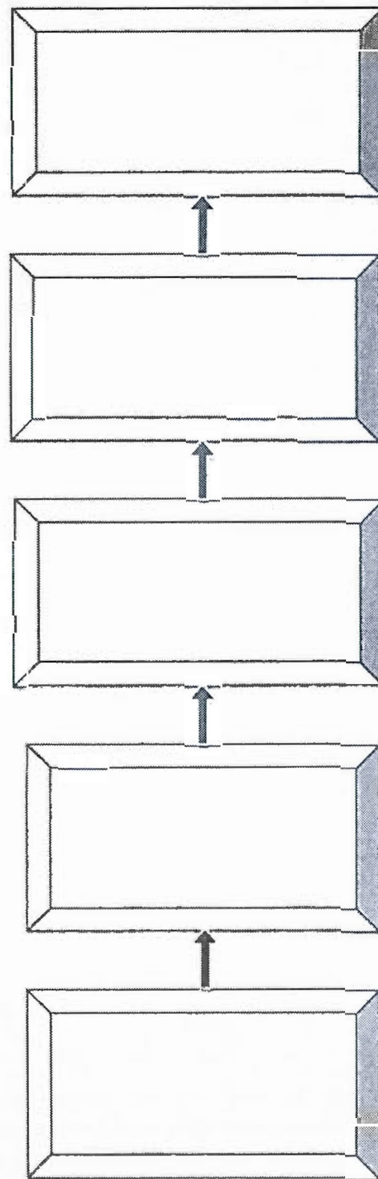
AT-HOME ACTIVITIES

Complete "The Exposure Hierarchy"

Copyright © 2011 Tina C. Montreuil

Exposure Hierarchy

S T E P B Y S T E P P R O G R E S S



COPYRIGHT

Copyright © 2011 Tina C. Montreuil

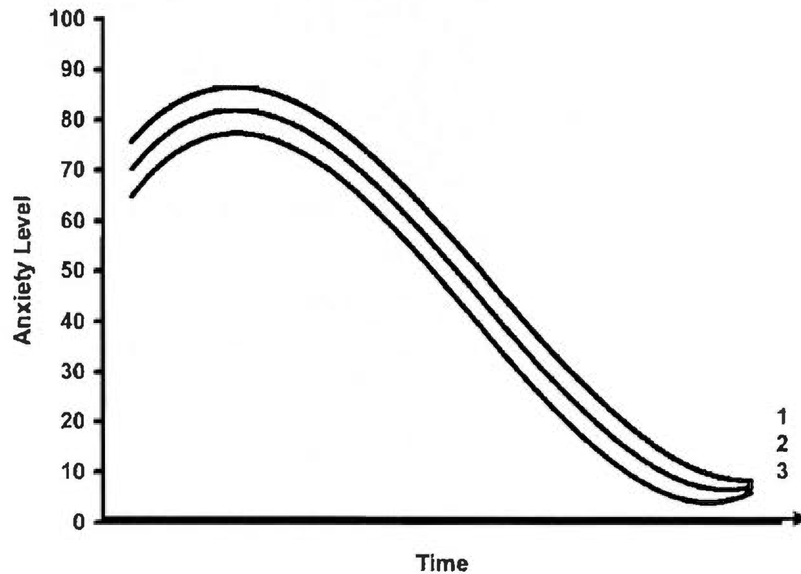
EXPOSURE – PART II

The purpose of today's session is to teach about "Exposure Therapy" in treating fears linked to social anxiety. The aim is to help you to be better able to face and not avoid the feared situation. As we saw, Exposure therapy can be carried out in real situations, which is called in vivo exposure; or it can be done through imagination. Specifically for the treatment of social anxiety, our focus will be to incorporate in vivo exposure and behavioral experiments. With the help of therapist-assisted exposure and group-exposure in the form of role-play, the goal will be for you to learn how to perform self-exposure. This process will be progressive and will respect your personal level of comfort and tolerance. Once again, the basic purpose of exposure therapy is to decrease anxious and fearful reactions (emotions, thoughts, physical sensations) through repeated and prolonged exposures to situations that may you anxious.

1. Exposure therapy and "Habituation".

As we saw during the last session, the graph below reveals that the more you expose yourself to your fears as opposed to avoiding them, the less intense your anxiety will become. Overtime, when you expose yourself to an anxiety-provoking situation, the anxiety you feel is reduced. Hence, the second time you expose yourself, the anxiety you feel will be less intense than the first time, the third time will be even less intense than the second and so forth. You get the idea! Practice makes it better.

Copyright © 2011 Tina C. Montreuil



2. Why do I feel anxious when I am in social situations?

Nature has helped us in guaranteeing our survival innately by making sure that our nervous system releases adrenaline in our system, so that we instinctively stray away from a "dangerous situation". However, sometimes the same reaction takes place even when the situation is not really dangerous or not as threatening to our survival or wellbeing. Similarly, the person still has the same response as if it were dangerous – often leading to that person leaving the situation or avoiding it altogether.

But, as we saw before, if you stay in the situation longer or repeat the Exposure often, as illustrated in the curve above, the anxiety will progressively decrease. It is as if by getting over the initial hurdle, you end up learning that there is in fact no real danger.

Copyright © 2011 Tina C. Montreuil

What to expect? As we saw, eventually your fear will go away. Again, the technical term is Habituation. Therefore, if you do not expose yourself to the anxiety-provoking situation, there will be very little hope of becoming habituated to the fear. So one of the keys to overcoming fears is to learn **not to avoid**.

3. Why is it so important to "avoid" avoidance.

Avoidance is the root of the problem when it comes to better understanding the development and treating Anxiety Disorders. When you avoid a situation, you cannot habituate yourself or become used to this fear. If you do not habituate, you will continue to wrongfully perceive non-threatening or neutral situations as being dangerous.

There are three additional problems with avoidance:

- *It reinforces what can become a vicious cycle of helplessness.* The anxious avoiding person "learns" that the way to reduce the distress associated with a situation is to run away from it. This only lead to greater avoidance. A socially anxious person avoids going to a social event in order not to feel any anxiety and consequently might conclude that she does not like social events or that social events aren't for him or her. The person ends up fearing that he/she might look ridiculous, be judged by others or not fit in by fear of not knowing what to say or do. The fear then becomes a reality.

- It inhibits the possibility of learning needed social skills. A person never develops

Copyright © 2011 Tina C. Montreuil

good social skills because by avoiding, they never get the opportunity to develop these core skills. The person never learns to challenge their anxiety and does not practice theses skills frequently enough in order to being able to learn them.

- It prevents "testing the evidence" which are necessary to overcome cognitive distortions and negative beliefs. You must have the opportunity to challenge these thoughts and beliefs in order see that they are false, that they are not real.

    - For example: "I will stumble over my words and make a fool of myself" is never challenged because the person completely avoids social gatherings. He or she never discovers that:
        - He or she can talk without stumbling and,
        - People will still accept him or her even if he or she does make a mistake.

- HOW DO I OVERCOME AVOIDANCE? By exposing yourself to your fears, using an Exposure Hierarchy.

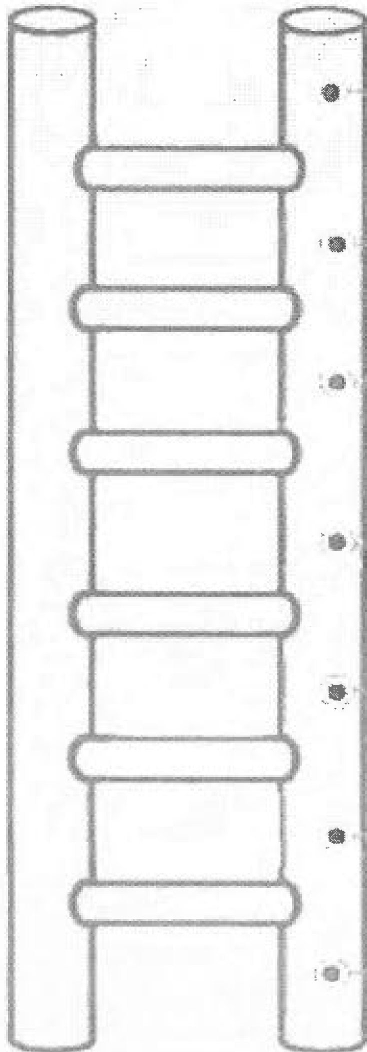
4. What is an Exposure Hierarchy?

As we saw during the last session, an exposure hierarchy is defined as a list of your very own anxiety-provoking situations starting from the least challenging to the most challenging based on the associated anxiety level. Remember, the purpose of exposure is to decrease avoidance and develop a greater habituation to the physical symptoms of anxiety.

Copyright © 2011 Tina C. Montreuil

5. My very own Exposure Hierarchy.

List the situations starting from the easiest (bottom) to the most difficult (top).



Copyright © 2011 Tina C. Montreuil

6. What are some of the potential obstacles or challenges to my successful exposure?

- Exposure therapy can be seen as difficult or too challenging to overcome. It is true that social situations can be quite unpredictable by their nature and can unexpectedly become more intense and anxiety-provoking. However, do remember that social exchanges usually last only a short time – THE DISCONFORT WILL NOT LAST FOREVER. More importantly, you must "remain" in the situation LONG ENOUGH to make sure that the exposure time was SUBSTANTIAL long enough for YOUR ANXIETY LEVEL TO REDUCE SIGNIFICANTLY – so that it is manageable and that you feel somewhat comfortable.

Copyright © 2011 Tina C. Montreuil

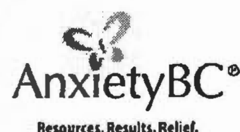
On one side of the grid, list noted obstacles and on the other, the appropriate responses even in the event of a failed exposure.

POSSIBLE OBSTACLES AND CHALLENGES	*APPROPRIATE RESPONSE*

AT-HOME ACTIVITIES

Read the "Facing your Fears?"

Copyright © 2011 Tina C. Montreuil



FACING YOUR FEARS: EXPOSURE

An important step in managing anxiety involves facing feared situations, places or objects. It is normal to want to avoid the things you fear. However, avoidance prevents you from learning that the things you fear are not as dangerous as you think.

The process of facing fears is called **EXPOSURE**. Exposure involves gradually and repeatedly going into feared situations until you feel less anxious. Exposure is not dangerous and will not make the fear worse. And after a while, your anxiety will naturally lessen.

Starting with situations that are less scary, you work your way up to facing things that cause you a great deal of anxiety. Over time, you build up confidence in those situations and may even come to enjoy them. This process often happens naturally. A person who is afraid of the water takes swimming lessons every week and practises putting their feet and legs in the water, then the whole body and, finally, diving underwater. People with a fear of water can learn to love swimming. The same process occurs when people learn to ride a bike, skate, or drive a car.

> ***Doubts about the helpfulness of exposure?***
>
> *You may have tried exposure in the past and found that it did not work. However, you may have tried to face something too scary too soon, which can be overwhelming. Or, you didn't have the chance to practise repeatedly in order to get the benefits of exposure. If done correctly, exposure can be VERY effective in overcoming fears. Be willing to try again! Follow the steps below to get the most out of exposure.*

Exposure is one of the most effective ways of overcoming fears. However, it takes some planning and patience.

Copyright © 2011 Tina C. Montreuil

How To Do It

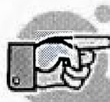
STEP 1. Make a list

Make a list of situations, places or objects that you fear. For example, if you are afraid of dogs, the list may include: looking at pictures of dogs; standing across the park from a dog on a leash; standing in the same room as a dog on a leash; standing a few feet from a dog; or petting a puppy. If you are afraid of social situations, the list may include: saying "hi" to a co-worker; asking a stranger a question; making small talk with a cashier; or calling a friend on the phone.

HELPFUL HINT: Group Fears Together. Some people have a lot of different fears, so it can help to group similar fears or specific fear themes together. For example, you may have a fear of bugs, as well as a fear of heights. Make different lists for different fear themes.

STEP 2. Build a Fear Ladder

Once you have made a list, arrange things from the <u>least scary</u> to the <u>most scary</u>. You can do this by rating how much fear you have for each situation on the list, from "0" (No fear) to "10" (Extreme fear). Once you have rated each situation, use the **Fear Ladder** form to make a final list.



HELPFUL HINTS: When making a fear ladder, identify a specific goal (such as having a meal in a restaurant), and then list the steps needed to achieve that goal (e.g., go to a restaurant and get a coffee to go; have a coffee at the restaurant and sit near the door; have a snack at the restaurant and sit near the door; have a snack at the restaurant and sit at a table in the middle of the room; have a meal at the restaurant and sit near the door; have a meal at the restaurant and sit in the middle of the room). See **Examples of Fear Ladders** for some ideas on building your fear ladder.

If you have a lot of different fears, build separate ladders for each fear theme.

Each ladder should include a whole range of situations. The ladder should include some steps you can do now with mild anxiety, some that you can do now with moderate anxiety and, finally, the steps you find too difficult to do now. It is important to start really small and take gradual steps.

Some steps on the ladder can be broken down into smaller steps. For example, if you are afraid to talk to co-workers, facing this situation could be broken up into a number of steps such as saying "hi" to a co-worker, asking a quick question, and then talking about your weekend.

Copyright © 2011 Tina C. Montreuil

Because it is sometimes difficult to come up with steps on the fear ladder that cause only moderate anxiety (that is, somewhere between a little and very scary), you can consider other factors that might make it easier or harder for you to do.

Some examples include:

- **Length of time**: for example, talking to someone for 30 seconds is probably less scary than talking for five minutes.
- **Time of day**: for example, driving over a bridge in the middle of the afternoon versus evening rush hour.
- **Environment**: for example, swimming at a local pool versus swimming in a lake.
- **Who is with you**: for example, going to the mall with your spouse versus alone.

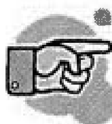
See Examples of Fear Ladders for some ideas about building your fear ladder.

STEP 3. Facing fears (exposure)

Starting with the situation that causes the least anxiety, **repeatedly** engage in that activity (e.g., saying "hi" to the bus driver everyday) until you start to feel less anxious doing it. If the situation is one that you can remain in for a **prolonged** period of time (such as standing on a balcony), stay in the situation long enough for your anxiety to lessen (e.g., standing on the balcony for 20-30 minutes). If the situation is short in duration, try "looping" it, which involves doing the same thing over and over again for a set number of times (e.g., repeatedly driving back and forth over a bridge until you start to feel less anxious or making consecutive phone calls until you feel more comfortable doing it).

If you stay in a situation long enough (or continue engaging in a specific activity), your anxiety will start to reduce. This is because anxiety takes a lot of energy and at some point it "runs out of gas". The longer you face something, the more you get used to it and the less anxious you will feel when you face it again.

Copyright © 2011 Tina C. Montreuil



HELPFUL HINT: It can help to track your fear level during exposure exercises and to try and remain in those situations (or continue engaging in a specific activity) until your fear level drops by about 50%. For example, if you rated holding a needle as a 6/10 on the fear scale (remember that "0" = no fear and "10" = extreme fear) then you want to continue holding the needle until your fear level drops to a 3/10.

It is important to **plan** exposure exercises in advance; that way you feel more in control of the situation. Identify what you are going to do and when you plan to do it.

Remember - Exposures should be **planned, prolonged, and repeated!**

Make sure to track your progress. See the Facing Fears form, which will help you identify how anxious you were before and after facing the feared situation, and what you learned. Make copies and fill one out each time you face a fear.

Once you are able to enter a specific situation on several separate occasions without experiencing much anxiety you can move on to the next thing on the list.

KEY: Don't Rush! It can be very scary facing the things you fear. Be patient and take your time. Go at a pace that you can manage!

Step 5. Practise

It is important to practise on a regular basis. Some steps can be practised daily (e.g., driving over a bridge, taking an elevator, saying "hi" to a stranger, touching doorknobs), while other steps can only be done once in a while (e.g., giving a formal presentation to a large group or taking a plane trip). However, the more often you practise the faster the fear will fade.

Don't forget to maintain the gains that you have made. Even if you have become comfortable doing something, it's important to keep exposing yourself to it from time to time, so your fears don't creep back. For example, if you have overcome a fear of needles, you should schedule routine blood tests or donate blood every six months so that your fear of needles does not return.

Re-rate your entire fear ladder every once in a while; that way, you can see the progress you have made, and identify the steps on the ladder you still need to tackle.

© AnxietyBC

Copyright © 2011 Tina C. Montreuil

Remember, you will experience anxiety when facing fears - this is normal.

Step 6. Reward brave behaviour

It's not easy facing fears. Reward yourself when you do it!

It may be helpful to use specific rewards as a motivation to achieve a goal. For example, plan to purchase a special gift for yourself (DVD, CD, book, treat) or engage in a fun activity (rent a movie, go to the movies, go out for lunch or dinner, plan a relaxing evening) after you reach a goal.

Don't forget the power of positive self-talk (e.g., "I did it!").

TIP: Don't be discouraged if your fears start creeping back. This can happen from time to time, especially during stressful periods or transitions (for example, starting a new job or moving). This is normal. It just means that you need to start practising using the tools – plan some exposures! Remember, coping with anxiety is a lifelong process.

For more information on how to maintain your progress and how to cope with relapses in symptoms, see **How to Prevent a Relapse**.

Copyright © 2011 Tina C. Montreuil

RELAPSE PREVENTION

RELAPSE

The purpose of the session is to inform you about the early warning signs and their importance since they can help you to recognize signs of relapse that are resurfacing, or to reduce the severity of the relapse and avoid future hospital admission. Once you learn to identify your personal early signs of relapse, it is important that establish a plan in order to better cope with these unwanted symptoms. The aim of the session is also to teach you how to become more confident, in control and to trust your own judgment and learn to take action on how to stay well.

1. Importance or Relapse Prevention.

DESPITE HAVING SUCCESSFULLY ACHIEVED REMISSION, IT IS SOMETIMES POSSIBLE FOR SYMPTOMS TO PARTIALLY REAPPEAR. WHEN THIS OCCURS, WE REFER TO THIS AS A PARITAL RELAPSE. A PARTIAL RELAPSE IS THE SAME AS A FULL RELAPSE.

IN ADDITION, EVEN IF SOME SYMPTOMS SHOULD REAPPEAR, BECAUSE I HAVE RESOURCES AND A SUPPORT NETWORK, I WILL BE MUCH BETTER EQUIPPED TO DEAL WITH THE SYMPTOMS. THEREFORE, WHATEVER HAPPENS, I WILL BE MUCH BETTER PREPARED THEN WHEN I EXPERIENCED MY FIRST PSYCHOSIS. GIVEN THAT I HAVE THIS SUPPORT SYSTEM, THAT I AM ADHERENT TO MY

 Copyright © 2011 Tina C. Montreuil

TREATMENT AS RECOMMENDED BY MY DOCTOR AND THAT I HAVE LEARNED SKILLS TO HELP MYSELF - I AM WELL PREPARED FOR ANY EVENT.

THEREFORE, IT IS ESSENTIAL THAT I:

1) RECOGNIZE THE TRIGGERS (SITUATIONS) OF MY SYMPTOMS,
2) IDENTIFY AND LIST THE SYMPTOMS THAT ARE ASSOCIATED WITH A POTENTIAL PARTIAL RELAPSE,
3) ESTABLISH A CLEAR AND DEFINITE PLAN IN THE EVENT OF A PARTIAL RELAPSE.

2. Recognizing the triggers.

SITUATIONS THAT TRIGGER MY SYMPTOMS	HOW I PLAN TO MANAGE THESE SITUATIONS
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.

3.Identifying the symptoms or events that could point to a potential partial relapse.

- Sudden alteration of behavior;
- Neglect of hygiene and personal care, food and clothing;
- Marked and persistent fatigue;
- Insomnia, increased nocturnal activity;
- Withdrawal, isolation;

 Copyright © 2011 Tina C. Montreuil

- Episodes of rage;
- Strong and sudden interest in spirituality;
- Fall in performance: school, education, work;
- Alcohol and or drugs and smoking ;
- Rage of unnecessary purchases, impulsive and excessive behavior ;
- Dramatic and rapid weight loss;
- Taking off by, rail, air, or long walks at random;
- Crises ups, excessive, inappropriate to the context;
- Discussions with irrational content, stubborn, claimant, dogmatism;
- Self-destructive behaviors or suicidal ideation;
- Fear or concern that others are watching

4. My triggers.

1.
2.
3.

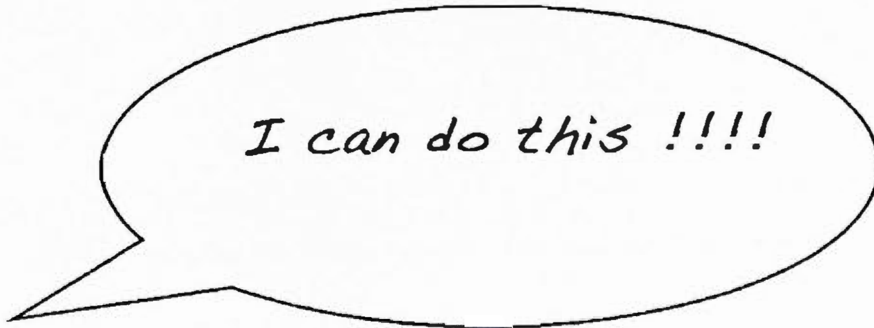
NOTE: I MUST REMEMBER THAT, EVEN IF REGRETABLE, IN CASE OF AN EMERGENCY, IT IS BETTER TO BE ORGANIZED THAN SORRY!!!

 Copyright © 2011 Tina C. Montreuil

5. My very own Intervention Plan.

My Intervention Plan
Name :
TRIGGERS
My triggers are :
1.
2.
3.
IN THE EVENT THAT SOME OF MY SYMPTOMS RETURN AND BECOME MORE SEVERE, THESE ARE THE STEPS I NEED TO TAKE :
1.
2.
3.
PHONE NUMBERS OF RESOURCEFUL PEOPLE (HEALTH PROFESSIONALS):
1.
2.
3.
PHONE NUMBERS OF RESOURCEFUL PEOPLE (FAMILY AND FRIENDS):
1.
2.
3.
IN CASE I NEED IMMEDIATE ATTENTION, THIS IS MY PLAN:
1.
2.
3.
4.

 Copyright © 2011 Tina C. Montreuil



AT-HOME ACTIVITIES

Complete "My Intervention Plan" Worksheet

 Copyright © 2011 Tina C. Montreuil

APPENDIX I

Box 3. Early warning signs of psychotic relapse

Thinking/perception	*Feelings*	*Behaviours*
Thoughts are racing	Feeling helpless or useless	Difficulty sleeping
Senses seem sharper	Feeling afraid of going crazy	Speech comes out jumbled filled with odd words
Thinking you have special powers	Feeling sad or low	Talking or smiling to yourself
Thinking that you can read other peoples minds	Feeling anxious and restless	Acting suspiciously as if being watched
Thinking that other people can read your mind	Feeling increasingly religious	Behaviour oddly for no reason
Receiving personal messages from the TV or radio	Feeling like you're being watched	Spending time alone
Having difficulty making decisions	Feeling isolated	Neglecting your appearance
Experiencing strange sensations	Feeling tired or lacking energy	Acting like you are somebody else
Preoccupied about 1 or 2 things	Feeling confused or puzzled	Not seeing people
Thinking you might be somebody else	Feeling forgetful or far away	Not eating
Seeing visions or things others cannot see	Feeling in another world	Not leaving the house
Thinking people are talking about you	Feeling strong and powerful	Behaving like a child
Thinking people are against you	Feeling unable to cope with everyday tasks	Refusing to do simple requests
Having more nightmare	Feeling like you are being punished	Drinking more
Having difficulty concentrating	Feeling like you cannot trust other people	Smoking more
Thinking bizarre things	Feeling irritable	Movements are slow
Thinking you thoughts are controlled	Feeling like you do not need sleep	Unable to sit down for long
Hearing voices	Feeling guilty	Behaving aggressively
Thinking that a part of you has changed shape		

 Copyright © 2011 Tina C. Montreuil

MAINTENANCE STRATEGIES AND TERMINATION

The purpose of the session is to help you become aware of the skills, therapeutic gains and progress that you have made along the course of the 14-session therapy program. The aim is to help you come to the realization that you have acquired abilities, knowledge of self and established a list of available resources, which will contribute to minimizing the risk of a potential relapse. These skills will also lead to a better control over symptoms of anxiety by you learning how to accurately "identify and interpret" the physical sensations associated with anxiety. Keep in mind that you do have access to individual therapy or "booster sessions" in the event where you would feel that additional support would be required.

1. MY « END OF THERAPY » REFLECTION

a) What skills or abilities have I achieved up until now?

____
____
____
____
____
____
____
____

 Copyright © 2011 Tina C. Montreuil

b) What past social situations were difficult for me to confront, which I can now face?

c) What social situations remain difficult for me to confront?

d) Relative to my experience of psychosis, what are some of the thoughts that I still struggle with when in the presence of others? What kinds of beliefs do I tend to have that make me anxious in social situations? Do I tend to have any of the following thoughts and beliefs?

_____"I am not interesting to others."
_____"Other people have more interesting things to say than I do."
_____"I feel that others are 'normal' in comparison to me."
_____"I do not have anything to offer to others."
_____"People will most likely not want to speak to me."
_____"If I were to go to a party, I would end up sitting alone and not interacting."
_____"I usually don't know what to say."
_____"I look odd or funny (or I look funny when I eat, when I walk...)"
_____"I talk in a funny, odd way."
_____"I need to make efforts or do something special for others to not get tired of me."

Other:

 Copyright © 2011 Tina C. Montreuil

____
____
____

2. MY SKILLS INVENTORY:

1.
2.
3.
4.
5.

Strategies and skills that I have acquired which will help me to become better organized and suited to face challenges and a potential resurgence of psychotic symptoms:

- Relaxation Techniques
- Cognitive Restructuring

 Copyright © 2011 Tina C. Montreuil

- Exposure
- Identification of skewed/negative thoughts and beliefs
- Identification of my skills/abilities and available resources

REMEMBER:

A study did find that the "patient's expectations" was one of the most powerful predictor of a successful post-treatment outcome in the treatment of social anxiety.

- This means that:
    - If you are hopeful about your future, your quality of life will be improved.
    - You will have a more positive outlook on your own social abilities.
    - If you normalize your own situation and challenges by identifying that everyone experiences anxiety – YOU WILL HAVE MORE CONTROL
    - Your self-esteem will also be improved.

 Copyright © 2011 Tina C. Montreuil

APPENDIX I

Questionnaires and Scales

CBT for Social Anxiety in Schizophrenia

Sujet: ______________________

Check list pour projet

	Fait (✓)	Commentaires
Consent Form		
SCID (Overview +Social Phobia)		
SAPS		
SANS		
CDS		
SIAS		
SPIN		
BSPS		
Indiana Psychiatric Illness Interview		
BCIS		
ISMI		
GAF		

Échelle D'Appréciation Des Symptômes Négatifs (Déficitaires)
(SANS)
0= Absent 1=Incertain 2=Léger 3=Moyen 4=Important 5=Sévère

Identification du sujet: ______________________

Date: ______________________

ÉMOUSSEMENT AFFECTIF

1. Expression figée du visage
L'expression faciale apparaît rigide, figée, mécanique. On note une absence, ou une diminution, des changements d'expression en rapport avec le contenu du discours. — 0 1 2 3 4 5

2. Diminution des mouvements spontanés
Le patient est assis, immobile durant l'entretien et présente peu, ou pas de mouvements spontanés. Il ne change pas de position, ne bouge pas ses membres, etc. — 0 1 2 3 4 5

3. Pauvreté de l'expression gestuelle
Le patient n'utilise pas les mouvements de son corps pour l'aider à exprimer de ses idées, tels que des gestes des mains ou une posture penchée en avant. — 0 1 2 3 4 5

4. Pauvreté du contact visuel
Le patient évite de regarder l'autre dans les yeux. Son regard peut aussi sembler perdu dans le vide même lorsqu'il parle. — 0 1 2 3 4 5

5. Absence de réponses affectives
Ne rit ou ne sourit pas lorsqu'il y est incité indirectement. — 0 1 2 3 4 5

6. Affect inapproprié
L'affect exprimé est inapproprié ou incongru et non simplement pauvre et émoussé. — 0 1 2 3 4 5

7. Monotonie de la voix
Lorsqu'il parle, le patient ne présente pas les modulations vocales normales. Le discours et monotone. — 0 1 2 3 4 5

8. Évaluation globale de la pauvreté affective
L'évaluation globale prend en compte la gravité de l'ensemble de l'émoussement affectif. Une importance particulière doit être donnée au noyau représenté par l'absence de réactivité, une diminution globale de l'intensité émotionnelle, ou de son caractère inapproprié. — 0 1 2 3 4 5

ALOGIE

9. Pauvreté du discours
C'est la réduction de la quantité de propos spontanés, aboutissant à des réponses aux questions qui sont brèves et non élaborées. — 0 1 2 3 4 5

10. Pauvreté du contenu du discours (idéique)
Bien que les réponses soient suffisamment longues pour que le discours soit normal en quantité, il comporte peu d'informations. Le langage tend à être vague, souvent trop abstrait, répétitif, stéréotypé. — 0 1 2 3 4 5

11. Barrage
Le patient indique spontanément, ou à partir d'une question, une interruption du cours de sa pensée. — 0 1 2 3 4 5

12. Augmentation de la latence des réponses
La durée qui s'écoule avant que le patient ne réponde aux questions est plus longue que la normale. Il peut sembler « ailleurs ». Il a cependant compris la question. — 0 1 2 3 4 5

13. Évaluation globale de l'alogie
Les principaux signes de l'alogie sont la pauvreté du discours et celle de son contenu. — 0 1 2 3 4 5

AVOLITION-APATHIE

14. Toilette- hygiène
Vêtements négligés ou sales, cheveux graisseux, odeur corporelle... — 0 1 2 3 4 5

15. Manque d'assiduité au travail ou à l'école
Le patient a des difficultés à trouver ou garder un emploi ou une insertion scolaire en rapport avec son âge, à effectuer les travaux ménagers. S'il est hospitalisé, il ne participe pas de façon durable aux activités du service. — 0 1 2 3 4 5

16. Anergie physique
L'inertie est physique : le sujet peut rester des heures assis sur une chaise, sans entreprendre spontanément une activité. — 0 1 2 3 4 5

17. Évaluation globale
Un poids important peut être accordé à un ou deux symptômes prédominants dans l'évaluation globale s'ils sont particulièrement frappants. — 0 1 2 3 4 5

ANHEDONIE-RETRAIT SOCIAL

18. Intérêt et activités de loisirs
Le patient présente peu de centres d'intérêts, peu d'activité ou de « hobbies ». L'évaluation doit prendre en compte les aspects qualitatifs et quantitatifs de ces intérêts/activités. — 0 1 2 3 4 5

19. Intérêts et activités sexuels
Le patient peut présenter une diminution des intérêts et activités sexuels ou du plaisir associé.
0 1 2 3 4 5

20. Incapacité à vivre des relations étroites ou intimes
Le patient présente une incapacité à développer des relations étroites ou intimes, en particulier avec sa famille ou des sujets du sexe opposé.
0 1 2 3 4 5

21. Relations avec les amis et collègues
Le patient peut avoir peu, ou pas d'amis et faire peu d'efforts pour y remédier, choisissant d'être pratiquement tout le temps seul.
0 1 2 3 4 5

22. Évaluations global de l'anhédonie et du retrait social
L'évaluation global doit rendre compte de la sévérité de l'ensemble symptomatique anhédonie-retrait social en tentant compte des normes attendues selon l'âge, le sexe, le statut familial.
0 1 2 3 4 5

ATTENTION

23. Inattention dans les activités sociales
Le patient parait inattentif lors de l'entretien. Il semble « perdu » ou « dans la lune ».
0 1 2 3 4 5

24. Inattention durant un test
Pour l'évaluer on peut demander d'épeler le mot « MONDE » à l' envers ou demander de faire un compte à rebours à partir de 100 et en soustrayant « 7 » à chaque fois (au moins 5 soustractions correctes). Score 0 = 0 erreur, Score 1= 0 erreur, mais il/elle hésite, Score 2 = 1 erreur, Score 3 = 2 erreurs, Score 4 = 3 erreurs, Score 5 = 4 erreurs ou plus.
0 1 2 3 4 5

25. Évaluation globale
L'évaluation globale des possibilités d'attention ou de concentration; doit tenir compte des éléments cliniques et de la performance aux tests.
0 1 2 3 4 5

Échelle D'Appréciation Des Symptômes Positifs (Productifs)
(SAPS)
0= Absent 1=Incertain 2=Léger 3=Moyen(ne) 4=Important(e) 5=Sévère

Indentification du sujet: ______________________

Date: ______________________

HALLUCINATIONS

1. Hallucinations Auditives Le patient rapporte entendre des voix, des bruits, ou d'autres sons que personne d'autre n'entend.	0 1 2 3 4 5
2. Commentaires des actes et de la pensée Le patient fait mention d'une voix qui commente son comportement et ses pensées.	0 1 2 3 4 5
3. Hallucinations de conversation Le patient rapporte entendre deux ou plusieurs voix parler entre elles.	0 1 2 3 4 5
4. Hallucinations somatique ou tactiles Le patient fait mention de sensations physiques bizarres au niveau de son corps.	0 1 2 3 4 5
5. Hallucinations olfactives Le patient sent des odeurs inhabituelles que personne d'autre n'a remarquées.	0 1 2 3 4 5
6. Hallucinations visuelles Le patient voit des formes ou des personnes qui ne sont pas réellement présentes.	0 1 2 3 4 5
7. Évaluation globale des hallucinations Cette évaluation doit prendre en compte la durée et la sévérité des hallucinations et l'impact sur la vie du patient.	0 1 2 3 4 5

IDEES DELIRANTES

8. Idées délirantes de persécution Le patient pense qu'il est, d'une façon ou d'une autre, persécuté ou victime d'un complot.	0 1 2 3 4 5
9. Idées délirantes de jalousie Le patient pense que son conjoint a une relation amoureuse avec quelqu'un d'autre.	0 1 2 3 4 5
10. Idées délirantes de culpabilité ou de péché Le patient croit qu'il a commis un terrible péché ou fait quelque chose d'impardonnable.	0 1 2 3 4 5

11. Idées délirantes de grandeur Le patient pense qu'il est détenteur de pouvoirs spéciaux ou doué de capacités exceptionnelles.	0 1 2 3 4 5
12. Idées délirantes religieuses Le patient est préoccupé par des croyances erronées de nature religieuse.	0 1 2 3 4 5
13. Idées délirantes somatiques Le patient est convaincu que d'une façon ou autre son corps est malade, anormal ou modifié.	0 1 2 3 4 5
14. Idées délirantes de référence Le patient a le sentiment que des remarques ou des événements sans importance le concernent ou possèdent une signification spéciale.	0 1 2 3 4 5
15. Idées délirantes d'influence Le patient a le sentiment que ses sentiments ou ses actions sont contrôlées par une force extérieure.	0 1 2 3 4 5
16. Idées délirantes de lecture de la pensée Le patient croit que les autres sont capables de lire ou de connaître ses pensées.	0 1 2 3 4 5
17. Divulgation de la pensée Le patient croit que ses pensées sont divulguées de telle sorte que lui-même ou les autres peuvent l'entendre.	0 1 2 3 4 5
18. Idées délirantes de pensée imposée Le patient croit que des pensées qui ne sont pas les siennes ont été introduites dans son cerveau.	0 1 2 3 4 5
19. Idées délirantes de vol de la pensée Le patient pense que des pensées lui ont été dérobées.	0 1 2 3 4 5
20. Évaluation globale de la sévérité des idées délirantes L'évaluation globale doit prendre en compte la durée et la persistance des idées délirantes et de l'impact sur la vie du patient.	0 1 2 3 4 5

COMPORTEMENT BIZZARRE

21. Habillement et présentation Le patient s'habille de façon inhabituelle ou fait des choses étranges pour modifier son apparence.	0 1 2 3 4 5
22. Conduite sociale et sexuelle Le patient se comporte d'une façon inappropriée par rapport aux normes sociales en cours (par exemple se masturbe en public)	0 1 2 3 4 5
23. Comportement agressif ou agité Le patient peut être agressif ou agité de façon souvent imprévisible.	0 1 2 3 4 5

24. Comportement répétitif ou stéréotypé
Le patient met en place des séries d'action ou de rituels répétitifs qu'il est obligé de faire et refaire. 0 1 2 3 4 5

25. Évaluation globale du comportement bizarre
Cette évaluation doit prendre en compte le type de comportement et sa déviance par rapport aux normes sociales. 0 1 2 3 4 5

TROUBLES DE LA PENSÉE ET DU LANGAGE

26. Relâchement des associations
Modalité de discours où les idées dévient vers d'autres sujets n'ayant avec elles que des rapports lointains (voire inexistants) 0 1 2 3 4 5

27. Tangentialité
Le patient répond fréquemment à une question de manière indirecte ou non pertinente. 0 1 2 3 4 5

28. Incohérence
Le discours est, à certains moments, incompréhensible. 0 1 2 3 4 5

29. Pensées illogiques
Le discours ne respecte pas une organisation logique de la pensée. 0 1 2 3 4 5

30. Discours circonlocutoire
Type de discours prenant des voies très indirectes et tardant à atteindre son objectif. 0 1 2 3 4 5

31. Logorrhée
Le discours du patient est rapide et difficile à interrompre, la quantité de discours produite spontanément est plus importante que de coutume. 0 1 2 3 4 5

32. Distractibilité du discours
Le patient est distrait pas des stimuli de l'environnement qui interrompent son discours. 0 1 2 3 4 5

33. Association par assonances
Type de discours dans lequel ce sont les sons plutôt que les relations sémantiques qui gouvernent le choix des mots. 0 1 2 3 4 5

34. Évaluation globale du trouble de la pensée et du langage
Cette évaluation doit prendre en compte la fréquence de l'anomalie et son impact sur la capacité du patient à communiquer. 0 1 2 3 4 5

Identification du sujet : ______________________

Date : ______________________

SCID – I / P

French version

Modified for use in:

Insight et schizophrénie: Déterminants psychologiques et neuronaux

OVERVIEW

Maintenant je vais vous poser des questions concernant vos expériences ainsi que les problèmes ou les difficultés que vous pouvez avoir rencontrés au cours de votre vie. Je vais prendre des notes tout au long de l'entrevue. Avez-vous des questions à me poser avant de commencer?

DONNÉES DÉMOGRAPHIQUES

Êtes-vous marié(e)?

SI NON: L'avez-vous déjà été?

Statut Marital
1 marié(e) ou conjoint(e) de fait de > 1 ans
2 veuf(ve)
3 divorcé(e) ou mariage annulé
4 séparé(e)
5 célibataire

Avez-vous des enfants?

SI OUI: Combien? Quels âges ont-ils? ____________________

Où demeurez-vous? ____________________

Avec qui vivez-vous? ____________________

HISTOIRE DE SCOLARITÉ ET DE TRAVAIL

Quel est votre niveau de scolarité le plus haut?

Éducation:
1 6ième année de primaire ou moins
2 secondaire 7 à 11 (sans obtenir diplôme)
3 secondaire complété(e) ou équivalent
4 partie de cégep
5 cégep complété(e)
6 université complété(e)
7 partie des études gradués/professionnelles
8 études graduées/professionnelles complété (e)

S'IL N'A PAS COMPLÉTÉ UN DIPLOME POUR LEQUEL IL S'ÉTAIT INSCRIT:
Pourquoi ne l'avez-vous pas terminé? ____________________

Code: (for data entry)		
	Elementary School	1 – 6 years
	High School	7 – 11 years (or 7 – 12 for outside Quebec)
	Cégep (Québec)	12 – 13 years
	University (Québec)	14 – 16 years (may be more depending on the program)
	University (outside Qc)	13 – 16 years (may be more depending on the program)
	Graduate/Professional School	17 – 22+ years

Avec qui avez-vous grandit: a) 2 parents b) mère c) père d) autre : ____________________

Si autre, éducation ____________ Occupation : ____________

Niveau d'éducation du père :____________ Occupation: ____________

Niveau d'éducation de la mère: ____________Occupation: ____________

Travaillez-vous présentement? Quel genre de travail faites-vous? ____________________

SI OUI: Depuis quand travaillez-vous à cet endroit?
Avez-vous toujours fait ce genre de travail? ____________________

SI MOINS DE 6 MOIS: Pourquoi avez-vous quitté votre dernier emploi? ____________________

SI NON: Pourquoi? ____________________

Quel genre de travail faisiez-vous avant? ____________________

Comment subvenez-vous à vos besoins? ____________________

SI INCONNU: Y a-t-il eu un moment où vous étiez incapable d'aller à l'école ou de travailler?

SI OUI: Quand? Pourquoi? ____________________

VUE GLOBALE DE LA MALADIE ACTUELLE

Etes-vous hospitalisé en ce moment? ____________________

Nombre de semaines depuis l'admission à la clinique
1 < 1semaine
2 1-4 semaines
3 > 4 semaines

SI PRÉSENTEMENT EN TRAITEMENT :
DATE D'ADMISSION À L'HOPITAL OU À LA CLINIQUE EXTERNE POUR LE PROBLÈME ACTUEL

Quand êtes-vous venu à (l'hôpital, la clinique)? ____________________

HISTORIQUE DES TRAITEMENTS

Quand avez-vous eu pour la première fois des problèmes émotionnels ou psychiatriques? (âge/année) ____________________

Quand êtes-vous venu à l'hôpital la première fois? ____________________

Pour quelle raison? ____________________

____

<u>À vérifier dans le dossier du patient:</u>
1. Nombre d'hospitalisation et la durée de chaque (ajouter une page si besoin):

____

____

____

____

____

____

2. Médication reçue

___

___

___

___

___

Êtes-vous déjà allé à l'hôpital pour soigner un problème médical? ___

SI OUI: C'était pour quelle raison? ___

Comment est votre santé physique? (Avez-vous des problèmes médicaux?) ___

(UTILISER CETTE INFORMATION POUR COTER L'AXE III) ___

Diagnosis **Lifetime Prevalence of Psychopathology**

Mood Disorders

Dépression

Vous êtes-vous déjà senti attristé ou malheureux pendant une longue durée de temps (e.g. 2 semaines ou plus)?

OUI NON (en encercler un)

SI OUI: Parlez-moi en. ___

___

CRITÈRES (cinq ou plus doivent être présents durant la même période de temps – cochez les cases)

☐ Humeur triste **pendant la plupart de la journée, presque chaque jour** *
(Est ce que vous ressentiez cela à chaque jour ou presque?)

___

☐ Grosse perte d'intérêt ou de plaisir pour la plupart des activités **durant la plupart de la journée, presque chaque jour** *
(Avez-vous trouvé que vous aviez perdu l'intérêt ou le plaisir à faire les activités que vous aimiez faire auparavant? Ressentiez-vous cela à chaque jour ou presque? Pendant la plupart de la journée?)

___

☐ Perte de poids importante (sans diète), prise de poids, ou diminution de l'appétit, **presque chaque jour** ___

☐ Insomnie ou hypersomnie **presque chaque jour** *(Aviez-vous de la difficulté à dormir ou dormiez-vous plus que d'habitude? Est-ce que cela se passait à chaque jour ou presque?)*

___

☐ Agitation psychomoteur (tracas) ou retardement **presque chaque jour** *(Aviez-vous eu des tremblements ou vous êtes-vous senti agité ou incapable de relaxer? Est-ce que vous vous sentiez comme si vos mvmts étaient beaucoup plus lents ou difficiles à exécuter qu'avant? Chaque jour?)*

____

☐ Fatigue ou diminution d'énergie, **presque chaque jour** ______________________________

☐ Sentiments de dévalorisation ou de culpabilité excessive *(Est-ce que vous vous sentiez comme si vous ne méritiez pas d'être heureux? Est-ce que vous vous blâmiez pour des évènements passés?)*

____

☐ Difficultés à penser, se concentrer ou prendre des décisions ______________________________

☐ Pensées récurrentes sur la mort ou des idées de suicide, plan pour se suicider ou avoir essayé de se suicider *(Est-ce que vous pensiez que la vie ne valait pas la peine d'être vécue? Avez-vous déjà pensé au suicide ou même essayé de vous blesser?)*

____

NOTES: ______________________________

ET

☐ Les symptômes créent du stress ou des difficultés dans la vie sociale, de travail ou autres parts *(Est-ce que cela a modifié votre capacité à accomplir vos activités quotidiennes ou votre travail normalement? Est-ce que cela (sxs) a créé des problèmes avec vos amis, collègues, famille?)*

____

Bipolaire

Vous êtes vous déjà senti si bien (comme sur un « high »), à un tel point que d'autres personnes vous en ont fait la remarque?

OUI NON

SI OUI: Parlez-moi en (doit durer > 4 jours): ______________________________

SI OUI : Pendant ces moments là étiez-vous facilement distrait ou agité? Aviez-vous beaucoup d'idées? ______________________________

Dormiez-vous moins que d'habitude? ______________________________

Avez-vous participé dans des activités que vous avez regretté plus tard? ______________________________

Est-ce que votre humeur affectait votre appétit, votre sommeil ou votre capacité à travailler? ______________________________

Vous êtes vous déjà senti si irritable que vous pouviez crier, vous disputer ou vous battre avec les gens?

OUI NON

SI OUI: Parlez-moi en (doit durer > 4 jours): ______________________________

Dysthymic Disorder

Durant les deux dernières années, avez-vous eu une humeur dépressive pratiquement toute la journée et ce, plus d'un jour sur deux? (Plus de la moitié du temps?)

OUI NON

SI OUI: Pendant cette période, est ce que votre appétit à changé? Aviez vous de la difficulté à vous endormir? Aviez-vous moins d'énergie/plus fatigué? Étiez-vous attristé? Étiez-vous désespéré? ______

- Mood Disorder Due to a General Medical Condition

Avant de ressentir (mood sxs), souffriez-vous de malaise physique? ______

SI OUI: Pensez-vous que (mood sxs) étaient reliés à (condition médicale comorbide)? ______

SI OUI: De quelle façon? Est-ce que les (sxs) ont débutés ou se sont empirés après que (condition médicale comorbide) a commencé? ______

- Substance-Induced Mood Disorder

Lorsque vous ressentiez (sxs), preniez-vous des médicaments en même temps? ______

SI OUI : Pensez-vous que ces (sxs) étaient en parti reliés à (ABUS DE SUBSTANCE)? ______

Lorsque vous ressentiez (sxs), consommiez-vous de l'alcool ou des drogues en même temps? ______

SI OUI: Pensez-vous que ces symptômes (expériences) étaient en parti reliés à (ABUS DE SUBSTANCE)? ______

SI OUI: De quelle manière? Est-ce que ces (sxs) ont débutés ou se sont empirés après que (ABUS DE SUBSTANCE) a commencé? ______

Substance Use Disorders

Alcool

Combien de verres d'alcool consommez-vous en général (Passé)? ______

Combien de verres d'alcool consommez-vous en général (3 derniers mois)? ______

Avez-vous déjà consommé plus que cinq boissons en une seule occasion?

SI OUI : Quand? ______________________

3 derniers mois? ______________________

Pendant ce temps:	**Passé**	**3 derniers mois**
À quelle fréquence buviez-vous?		
Est-ce que boire vous causait des problèmes? Avez vous déjà manqué de travailler ou d'aller à l'école parce que vous étiez trop intoxiqué?		
Avez-vous déjà eu de la difficulté à prendre soins de vos enfants ou de garder votre domicile propre?		
Avez-vous déjà bu dans une situation où c'était peut être dangereux de boire?		
Est-ce que le fait de boire créait des problèmes avec d'autre gens (famille, amis, collègues)?		
Est-ce que cela arrivait qu'une fois avoir commencé à boire que vous buviez beaucoup plus que prévu?		
Avez-vous déjà essayé de diminuer votre consommation ou d'arrêter de boire entièrement?		
Avez-vous déjà remarqué que vous deviez boire de plus en plus afin de ressentir les mêmes effets que vous ressentiez au début?		
Avez-vous déjà ressenti des symptômes de sevrage?		
Avez-vous déjà suivi des traitements pour l'alcool?		

Drogues et Autres Substances (utiliser une autre page si besoin)

Liste des drogues :

- **Sédatifs, hypnotiques et anxiolytiques (« Downers »)** : Quaalude (« ludes »), Seconal (« reds »), Valium, Xanax, Librium, Barbituriques, Miltown, Ativan, Dalmane, Halcion, Restoril, autres : ______________
- **Cannabis** : Marijuana, hashisch (« Hasch »), THC, « pot » herbe, mari, joint, autre: ______________
- **Stimulants ("uppers")**: Amphétamine, "speed", Méthamphétamine ("Crytal", "ice"), Dexedrine, Ritalin, Autre: ______________
- **Opiacés** : Héroïne, morphine, opium, méthadone, Darvon, Codéine, Percodan, Demerol, Dilaudid, Autre : ______________
- **Cocaïne** : Par prise intranasale, IV, « freebase », crack, « speedball », autre : ______________

- **Hallucinogènes (psychédéliques)/ PCP** : LSD (acide), Mescaline, peyotl, psilocybine, DOM (diméthoxyméthylamphétamine ou « STP »), champignons, ecstasy, MDA, PCP (Poudre d'ange), autre : ____________

- **Autres** : Stéroides anabolisants, « colle », chlorure d'éthyles (fréon), solvants pour peinture, solvants volatiles, oxyde nitreux (gaz hilarant), nitrite d'amyle (« poppers »), somnifères (pilules pour dormir) et anorexigènes (pilule pour maigrir) en vente libre, Autre : ____________

	Passé	**3 derniers mois**
Avez-vous déjà été dépendent à un médicament prescrit ou pris plus que la dose suggérée?	____	____
Avez-vous consommé des drogues au cours de votre vie?	____	____

Pendant ce temps :

Quand et à quelle fréquence preniez-vous ces drogues? (Était-ce plus que 10 fois en un seul mois?) ____________

Est-ce que cela arrivait qu'une fois avoir commencé à consommer que vous en preniez beaucoup plus que ce que vous aviez l'intention de prendre? ____________

Avez-vous déjà essayé de diminuer ou d'arrêter de consommer entièrement? ____________

Passiez-vous beaucoup de temps à essayer d'obtenir les drogues? ____________

Avez-vous déjà passé votre temps à prendre des drogues au lieu de faire des activités avec votre famille ou avec vos amis? ____________

Aviez-vous remarqué que cela prenait de plus en plus de drogue pour obtenir le même effet qu'au début de votre consommation? ____________

Avez-vous déjà ressenti des symptômes de sevrage? ____________

Avez-vous déjà été traité pour un problème de drogue? ____________

Summary – Notes

____

____

____

____

____

____

____

Symptômes psychotiques : Passé

(Symptômatologie présente sera documentée dans SAPS/SANS)

Documenter début du symptôme, durée et type d'hallucination/délire.

Hallucinations:

Délires:

PHOBIE SOCIALE

CRITÈRES DIAGNOSTIQUES

Y a-t-il des choses que vous avez peur de faire en public ou que vous n'osez pas faire en public, comme parler, manger ou écrire ?

Pourriez-vous me décrire ce genre de situation ?

Qu'est-ce qui vous faisait peur quand ____ ?

SI LE SUJET A SEULEMENT PEUR DE PARLER EN PUBLIC : (Pensez-vous que vous êtes plus mal à l'aise que la plupart des gens dans une telle situation ?)

A. Peur marquée et persistante d'une ou de plusieurs situations publiques ou sociales dans lesquelles le sujet est en contact avec des gens qu'il ne connaît pas ou est exposé à l'éventuelle attention d'autrui, et dans lesquelles il craint d'agir de façon humiliante ou embarrassante (ou de montrer des signes d'anxiété).

? 1 2 3 — F47

SITUATIONS PHOBOGÈNES (Cocher) :

- Parler en public ___ F48
- Manger en présence d'autrui ___ F49
- Écrire en présence d'autrui ___ F50
- Général (la plupart des situations sociales) ___ F51
- Autres (Préciser : ____________) F52

Remarque : Les adolescents doivent pouvoir entretenir des relations sociales avec leurs proches; l'anxiété doit se manifester non seulement en présence d'adultes, mais aussi en présence de jeunes du même âge.

PASSER À LA PAGE F.18 (PHOBIE SPÉCIFIQUE)

Avez-vous toujours éprouvé de l'anxiété lorsque vous deviez (NOMMER LA SITUATION PHOBOGÈNE) ?

B. L'exposition au(x) stimulus(li) phobogène(s) provoque presque toujours de l'anxiété; celle-ci peut prendre l'aspect d'une attaque de panique provoquée ou favorisée par une situation donnée.

Remarque : Chez l'enfant, l'anxiété peut se manifester par des pleurs, des crises, une attitude figée ou la fuite.

? 1 2 3 — F53

PASSER À LA PAGE F.18 (PHOBIE SPÉCIFIQUE)

Pensiez-vous que votre peur était exagérée ou injustifiée ?	C. Le sujet reconnaît la nature excessive ou irrationnelle de sa peur. Remarque : Cette caractéristique peut être absente chez les enfants.	? 1 2 3 ↓ (1) PASSER À LA PAGE F.18 (PHOBIE SPÉCIFIQUE)	F54
SI LA RÉPONSE N'EST PAS CLAIRE : Faisiez-vous des efforts particuliers pour éviter ___________ ? SI NON : Quelle difficulté cela représente-il pour vous de ___________ ?	D. La ou les situations phobogènes sont évitées; sinon, elles sont vécues avec une grande anxiété.	? 1 2 3 ↓ (1) PASSER À LA PAGE F.18 (PHOBIE SPÉCIFIQUE)	F55
SI L'IMPORTANCE DES PEURS N'EST PAS ÉVIDENTE : À quel point cette peur vous empêchait-elle de vivre une vie normale ? SI LE SUJET PEUT QUAND MÊME VIVRE UNE VIE NORMALE : À quel point cela vous a-t-il dérangé(e) d'avoir ce genre de peurs ?	E. La conduite d'évitement, la peur anticipée ou la détresse éprouvée au cours des situations phobogènes interfèrent de façon marquée avec les activités habituelles du sujet ou avec son rendement professionnel (ou scolaire), ses activités sociales ou ses relations avec autrui, ou il existe un sentiment important de détresse à l'idée d'avoir ce genre de peurs.	? 1 2 3 ↓ (1) PASSER À LA PAGE F.18 (PHOBIE SPÉCIFIQUE)	F56
SI LE SUJET EST ÂGÉ DE MOINS DE 18 ANS : (Depuis combien de temps éprouvez-vous ce genre de peurs ?	F. Sujets de moins de 18 ans : les peurs existent depuis 6 mois au moins.	? 1 2 3 ↓ (1) PASSER À LA PAGE F.18 (PHOBIE SPÉCIFIQUE)	F57

Quelque temps avant l'apparition de ce genre de peurs, preniez-vous des médicaments, de la caféine, des pilules pour maigrir ou de la drogue ?

(Quelle quantité de café, de thé ou d'autres boissons contenant de la caféine consommez-vous chaque jour?)

C. Les peurs ou la conduite d'évitement ne sont pas directement attribuables aux effets physiologiques d'une substance (p.ex., d'une drogue ou d'un médicament) ni à une maladie physique.

? 1 3 F58

S'IL EXISTE UN LIEN ENTRE LES PEURS ÉPROUVÉES PAR LE SUJET ET UNE MALADIE PHYSIQUE (MAL. PHYS.) OU UNE INTOXICATION (INTOX.), PASSER À LA PAGE F 40 ET REVENIR À LA PRÉSENTE SECTION POUR ATTRIBUER UNE COTE DE "1" OU DE "3".

ATTRIBUABLE À UNE MAL. PHYS. OU À UNE INTOX.

PASSER À LA PAGE F.18 (PHOBIE SPÉCIFIQUE)

Lorsque vous avez commencé à éprouver ce genre de peurs, souffriez-vous d'une maladie physique ?

SI OUI : Qu'a dit votre médecin ?

TROUBLE ANXIEUX PRIMAIRE

Exemples de maladie physique : hyperthyroïdie, hypothyroïdie, hypoglycémie, hyperparathyroïdie, phéochromocytome, insuffisance cardiaque, arythmies, embolie pulmonaire, bronchopneumopathie chronique obstructive, pneumonie, hyperventilation, carence en vitamine B12, porphyrie, tumeurs du S.N.C., troubles vestibulaires et encéphalite.

Par intoxication, on entend : l'intoxication par le cannabis, par un hallucinogène, par le PCP, par l'alcool ou par un psychotonique (cocaïne, amphétamines, caféine) ou le syndrome de sevrage à la cocaïne ou à un dépresseur du S.N.C. (alcool, sédatif ou hypnotique).

CONTINUER

... de plus, on peut écarter les autres troubles mentaux comme causes possibles des peurs éprouvées (p. ex. : trouble panique sans antécédent d'agoraphobie, angoisse de séparation, peur d'une dysmorphie corporelle, trouble envahissant du développement ou personnalité schizoïde).

? 1 2 3 F59

PASSER À LA PAGE F.18 (PHOBIE SPÉCIFIQUE)

		?	1	2	3	
SI LE DIAGNOSTIC N'EST PAS ENCORE ÉTABLI : REVENIR À LA PRÉSENTE SECTION UNE FOIS L'INTERROGATOIRE TERMINÉ.	H. S'il existe une maladie physique ou un autre trouble mental, la peur décrite en A n'y est pas reliée, p.ex., il ne s'agit pas de la peur de bégayer ou de trembler (chez un sujet atteint de la maladie de Parkinson) ou de révéler un comportement alimentaire anormal (chez les sujets atteints d'anorexie mentale ou de boulimie).	?	1 → PASSER À LA PAGE F 45 (TROUBLE ANXIEUX NS)	2	3	F60
	LES CRITÈRES A, B, C, D, E, F, G ET H DE LA PHOBIE SOCIALE SONT COTÉS "3".	?	1 → PASSER À LA PAGE F.18 (PHOBIE SPÉCIFIQUE.)		3 → PHOBIE SOCIALE	F61

CHRONOLOGIE DE LA PHOBIE SOCIALE

DANS LE DOUTE : Au cours des 6 derniers mois, est-ce que cela vous a dérangé de devoir (SITUATION PHOBOGÈNE) ?

Le sujet a répondu aux critères diagnostiques de la phobie sociale au cours des 6 derniers mois. ? 1 3 F62

INDIQUER LE DEGRÉ DE GRAVITÉ ACTUEL DU TROUBLE : F63

1 Léger : Peu, voire aucun autre symptôme à part ceux requis pour poser le diagnostic; les symptômes ne sont guère invalidants sur le plan social ou professionnel.

2 Moyen : Les symptômes ou l'incapacité fonctionnelle sont de degré « léger » à « sévère ».

3 Sévère : Il existe beaucoup plus de symptômes que ceux requis pour poser le diagnostic ou il y a plusieurs symptômes particulièrement graves ou encore, les symptômes sont très invalidants sur le plan social ou professionnel.

PASSER À LA SECTION INTITULÉE « ÂGE DE SURVENUE DU TROUBLE » (CI-DESSOUS).

SI LE SUJET NE RÉPOND PAS COMPLÈTEMENT (OU PAS DU TOUT) AUX CRITÈRES DE PHOBIE SOCIALE : F64

4 En rémission partielle : Le sujet a déjà répondu à tous les critères de la phobie sociale mais à l'heure actuelle, seuls certains signes ou symptômes persistent.

5 En rémission totale : Les signes et les symptômes ont disparu, mais il est encore pertinent de noter l'existence de ce trouble — par exemple, chez une personne ayant déjà eu des épisodes de phobie sociale dans le passé, mais prenant un anxiolytique et n'ayant éprouvé aucun symptôme depuis trois ans.

6 Antécédents de phobie sociale : Le sujet a déjà répondu aux critères, mais il s'est rétabli.

Quand avez-vous éprouvé (SYMPTÔMES DE PHOBIE SOCIALE) pour la dernière fois ?

Nombre de mois écoulés depuis les derniers symptômes de phobie sociale : ___ ___ ___ F65

ÂGE DE SURVENUE DE LA PHOBIE SOCIALE

QUESTION À POSER AU BESOIN : Quel âge aviez-vous quand vous avez commencé à (CITER LES SYMPTÔMES DE PHOBIE SOCIALE ÉPROUVÉS PAR LE SUJET) ?

Âge de survenue de la phobie sociale (SI LE SUJET NE SAIT PAS, INSCRIRE 99) ___ ___ F66

PASSER À LA PAGE F 18 (PHOBIE SPÉCIFIQUE)

Version Française – « Social Interaction Anxiety Scale - SIAS »

1. **Je deviens nerveux (se) lorsque je dois parler avec quelqu'un en position d'autorité (enseignant, patron, etc.).**

   Pas du tout 0
   Légèrement 1
   Modérément 2
   Beaucoup 3
   Extrêmement 4

2. **J'éprouve de la difficulté à établir un contact visuel avec les autres.**

   Pas du tout 0
   Légèrement 1
   Modérément 2
   Beaucoup 3
   Extrêmement 4

3. **Je me sens tendu(e) si j'ai à parler de moi-même ou de mes sentiments.**

   Pas du tout 0
   Légèrement 1
   Modérément 2
   Beaucoup 3
   Extrêmement 4

4. **J'ai de la difficulté à socialiser avec les gens avec qui je travaille.**

   Pas du tout 0
   Légèrement 1
   Modérément 2
   Beaucoup 3
   Extrêmement 4

5. **Je parviens facilement à me faire des amis de mon âge.**

   Pas du tout 0
   Légèrement 1
   Modérément 2
   Beaucoup 3
   Extrêmement 4

6. **Je me sens tendu(e) lorsque je croise une connaissance dans la rue.**

Pas du tout	0
Légèrement	1
Modérément	2
Beaucoup	3
Extrêmement	4

7. **Je suis inconfortable en situations sociales.**

Pas du tout	0
Légèrement	1
Modérément	2
Beaucoup	3
Extrêmement	4

8. **Je me sens tendu(e) lorsque je me retrouve seul(e) avec une personne.**

Pas du tout	0
Légèrement	1
Modérément	2
Beaucoup	3
Extrêmement	4

9. **Je suis à l'aise de rencontrer des gens dans les fêtes, etc.**

Pas du tout	0
Légèrement	1
Modérément	2
Beaucoup	3
Extrêmement	4

10. **J'ai de la difficulté à parler avec les gens.**

Pas du tout	0
Légèrement	1
Modérément	2
Beaucoup	3
Extrêmement	4

11. **Je parviens facilement à trouver des sujets de conversation.**

Pas du tout	0
Légèrement	1
Modérément	2
Beaucoup	3
Extrêmement	4

12. Je suis inquiet(ète) lorsque j'ai à m'exprimer car je crains d'avoir l'air maladroit.

Pas du tout 0
Légèrement 1
Modérément 2
Beaucoup 3
Extrêmement 4

13. J'ai de la difficulté à m'opposer au point de vue d'une autre personne.

Pas du tout 0
Légèrement 1
Modérément 2
Beaucoup 3
Extrêmement 4

14. J'ai de la difficulté à parler aux personnes du sexe opposé que je trouve attirantes.

Pas du tout 0
Légèrement 1
Modérément 2
Beaucoup 3
Extrêmement 4

15. Je m'inquiète de ne pas savoir quoi dire lorsque je me retrouve en situations sociales.

Pas du tout 0
Légèrement 1
Modérément 2
Beaucoup 3
Extrêmement 4

16. Je suis nerveux (se) en présence de gens que je connais peu.

Pas du tout 0
Légèrement 1
Modérément 2
Beaucoup 3
Extrêmement 4

17. J'ai le sentiment que je vais dire quelque chose d'embarrassant si je parle.

Pas du tout	0
Légèrement	1
Modérément	2
Beaucoup	3
Extrêmement	4

18. Je crains d'être ignoré (e) lorsque je dois m'intégrer à un groupe.

Pas du tout	0
Légèrement	1
Modérément	2
Beaucoup	3
Extrêmement	4

19. Je suis tendu (e) lorsque je dois m'intégrer à un groupe.

Pas du tout	0
Légèrement	1
Modérément	2
Beaucoup	3
Extrêmement	4

20. Je suis incertain (e) si je dois saluer quelqu'un que je connais peu.

Pas du tout	0
Légèrement	1
Modérément	2
Beaucoup	3
Extrêmement	4

Inventaire de la phobie sociale

[illegible] Cochez une boîte seulement pour chaque énoncé [illegible]

	Pas du tout (0)	Un peu (1)	Quelque peu (2)	Beaucoup (3)	Extrêmement (4)
1. J'ai peur des personnes en position d'autorité					
2. Cela m'ennuie de rougir devant les autres					
3. Je redoute les soirées et les activités mondaines					
4. J'évite de parler aux gens que je ne connais pas.					
5. Je crains beaucoup les critiques.					
6. La peur d'être embarrassé m'empêche de faire des choses ou de parler aux gens					
7. Le fait de transpirer devant les autres est pour moi très pénible.					
8. J'évite les soirées ou réceptions.					
9. J'évite les activités où l'attention est centrée sur moi					
10. J'ai peur de parler à des étrangers.					
11. J'évite d'avoir à prononcer des discours					
12. Je ferais n'importe quoi pour éviter les critiques					
13. J'ai des palpitations en compagnie d'autres gens.					
14. J'ai peur de faire des choses quand quelqu'un pourrait m'observer.					
15. L'une de mes plus grandes craintes c'est d'être embarrassé ou d'avoir l'air bête					
16. J'évite de m'adresser à toute personne en position d'autorité.					
17. Cela m'est très pénible de trembler devant les autres.					

Connor KM, Davidson JRT, Churchill E, et coll. Psychometric properties of the social phobia inventory (SPIN): A new self-rating scale. Affiche présentée lors du [illegible] congrès annuel de NCDEU tenu à Boca Raton, en Floride, du 1er au 4 juin 1999

Un score d'au moins 19 points évoque un diagnostic de phobie sociale qui peut être confirmé cliniquement par les critères du DSM-IV

À l'usage du médecin

Initiales :

Numéro d'identification :

Date :

Notes :

Section I: Peur - Évitement

A quel point craignez vous et évitez-vous les situations suivantes? S'il vous plaît, donnez des évaluations distinctes pour la peur et l'évitement.

Évaluation de la peur	**Évaluation de l'évitement**
0 = Pas du tout	**0 = Jamais**
1 = Un peu	**1 = Rarement**
2 = Modérément	**2 = Quelquefois**
3 = Beaucoup	**3 = Souvent**
4 = Énormément	**4 = Toujours**

	Peur	Évitement
1. Parler en public devant les autres.		
2. Parler à des personnes en autorité.		
3. Parler à des étrangers.		
4. Être embarrassé(e) ou humilié(e).		
5. Être critiqué(e)		
6. Rencontres sociales.		
7. Faire quelque chose lorsque l'on vous observe (à l'exception de parler en public).		

Section II: Physiologique (P)

Lorsque vous êtes dans une situation qui exige de rencontrer des gens, ou lorsque vous êtes en train de penser à une telle situation, ressentez-vous les symptômes suivants:

0 = Pas du tout
1 = Un peu
2 = Modérément
3 = Beaucoup
4 = Énormément

8. Rougissement:	
9. palpitations:	
10. Tremblements	
11. Transpiration:	

DAVIDSON ET AL., 1991: The Brief Social Phobia Scale, J. Clin. Psychiatry 52 (11, supp) novembre 48-51; traduit et adapté par Gilles Gaudette et Ariel Stravynski, Centre de recherche Fernand-Séguin.

Calgary Depression Scale (CDS)
(Traduction de Addington, D. & Addington, J. (1990)

Identification du sujet: ______________________ Projet :___________

Date : ____________

	Absent	Léger	Modéré	Sévère
1. Dépression	0	1	2	3
2. Désespoir	0	1	2	3
3. Auto-dépréciation	0	1	2	3
4. Idées de référence associées à la culpabilité	0	1	2	3
5. Culpabilité pathologique	0	1	2	3
6. Dépression matinale	0	1	2	3
7. Éveil hâtif	0	1	2	3
8. Suicide	0	1	2	3
9. Dépression observée	0	1	2	3

ÉCHELLE DE DÉPRESSION

DE CALGARY

D. ADDINGTON & J. ADDINGTON (C)

1990

L'ÉCHELLE DE DÉPRESSION DE CALGARY
GUIDE D'UTILISATION GÉNÉRALE

L'échelle de dépression de Calgary est spécifiquement construite pour l'évaluation du degré de dépression chez des patients souffrant de schizophrénie. Elle s'inspire originalement de deux outils d'évaluation clinique largement utilisés, le Present State Examination et l'échelle de dépression de Hamilton. Pour ce faire, on a utilisé des analyses factorielles et de fiabilité. La fiabilité et la validité ont été testées de plus sur un échantillon séparé en utilisant des analyses factorielles de confirmation et de discrimination.

Cette échelle est conçue pour refléter la présence de dépression à l'exclusion d'autres dimensions psychopathologiques chez des schizophrènes à des stades aigus ou résiduels de la maladie. Elle est sensible au changement et peut-être utilisée à différents intervalles.

L'évaluateur devrait avoir l'expérience des patients schizophrènes et la fiabilité interjuge devrait être vérifiée avec un autre évaluateur déjà expérimenté dans l'utilisation d'instruments d'évaluation structurée. Une bonne fiabilité inter-juge devrait être acquise en 5-10 entrevues de pratique.

L'interview consiste en 8 questions structurées suivie d'un item d'observation. Ce dernier item est fondé sur l'observation du patient durant l'entretien complet.

Pour des informations additionnelles,
contactez le
Dʳ D. Addington,
Département de psychiatrie
Foothills Hospital
1403, 29 St. N.W.
Calgary, Alberta
T2N 2T9

GUIDE DE L'ENTRETIEN
POUR L'ÉCHELLE DE DÉPRESSION DE CALGARY
POUR SCHIZOPHRÈNES

A L'intention de l'interviewer

Poser la première question telle qu'écrite. Par la suite, vous pouvez utiliser d'autres questions d'exploration ou d'autres questions pertinentes à votre discrétion.

Le cadre temporel concerne les deux dernières semaines à moins qu'il ne soit stipulé autrement.

N.B. Le dernier item, #9, se base sur des observations fondées sur l'ensemble de l'entretien.

1. DÉPRESSION

Comment pourriez-vous décrire votre humeur durant les 2 dernières semaines : avez-vous pu demeurer raisonnablement gai ou est-ce que vous avez été très déprimé ou plutôt triste ces derniers temps? Durant les deux dernières semaines, combien de fois vous êtes-vous senti ainsi, tous les jours? toute la journée?

0. Absent

1. Léger : exprime une certaine tristesse ou un certain découragement lorsque questionné.

2. Modéré : une humeur dépressive distincte est présente, persistant pendant au moins 50% du temps au cours des 2 dernières semaines; présente tous les jours.

3. Sévère : une humeur dépressive marquée persistant tous les jours, plus de la moitié du temps affectant le fonctionnement normal, psycho-moteur et social.

2. Désespoir

Comment entrevoyez-vous le futur pour vous-même? Est-ce que vous pouvez envisager un avenir pour vous? Ou est-ce que la vie vous apparait plutôt sans espoir? Est-ce que vous avez tout laissé tomber ou est-ce qu'il vous apparait y avoir encore des raisons d'essayer?

0. Absent

1. **Léger :** à certains moments, il s'est senti sans espoir au cours de la dernière semaine mais il y a encore un certain degré d'espoir pou l'avenir.

2. **Modéré :** une perception persistante mais modérée de désespoir au cours de la dernière semaine. On peut cependant le persuader d'acquiescer à la possibilité que les choses peuvent s'améliorer.

3. **Sévère :** un sentiment persistant et éprouvant de désespoir.

3. Auto-dépreciation

Quel est votre opinion de vous-même en comparaison avec d'autres personnes? Est-ce que vous vous sentez meilleur ou moins bon, ou à peu près comparable aux autres personnes en général? Vous sentez-vous intérieur ou même sans aucune valeur?

0. Absent.

1. **Léger :** une légère infériorité; n'atteint pas le degré de se sentir sans valeur.

2. **Modéré :** le sujet se sent sans valeur mais moins de 50% du temps.

3. **Sévère :** le sujet se sent sans valeur plus de 50% du temps il peut être mis au défi de reconnaître un autre point de vue.

4. Idées de référence associée à la culpabilité

Avez-vous l'impression que l'on vous blâme pour certaines choses ou même qu'on vous accuse sans raison? A propos de quoi? (ne pas inclure ici des blâmes ou des accusations justifiés. Exclure les délire de culpabilité).

0. **Absent.**

1. **Léger :** le sujet se sent blâmé mais non accusé, moins de 50% du temps.

2. **Modéré :** un sentiment persistant d'être blâmé et/ou un sentiment occasionnel d'être accusé.

3. **Sévère :** un sentiment persistant d'être accusé. Lorsqu'on le contredit, il reconnaît que cela n'est pas vrai.

5. Culpabilité pathologique

Avez-vous tendance à vous blâmer vous-même pour des petites choses que vous pourriez avoir faites dans le passé? Pensez-vous que vous méritez d'être aussi préoccupé à propos de cela?

0. **Absent.**

1. **Léger :** le sujet se sent coupable de certaines peccadilles mais moins de 50% du temps.

2. **Modéré :** le sujet se sent coupable habituellement (plus de 50% du temps) à propos d'actes dont il exagère la signification.

3. **Sévère :** le sujet sent habituellement qu'il est à blâmer pour tout ce qui va mal même lorsque ce n'est pas de sa faute.

6. DÉPRESSION matinale

Lorsque vous vous êtes senti déprimé aux cours des 2 dernières semaines, avez-vous remarqué que la dépression était pire à certains moments de la journée?

0. Absent.

1. Léger : dépression présente mais sans variation diurne.

2. Modéré : le sujet mentionne spontanément que la dépression est pire le matin.

3. Sévère : la dépression est de façon marquée pire le matin avec un fonctionnement perturbé qui s'améliore en après-midi.

7. Éveil hâtif

Vous réveillez-vous plus tôt le matin qu'à l'accoutumée? Combien de fois par semaine cela vous arrive-t-il?

0. Absent : pas de réveil précoce.

1. Léger : à l'occasion s'éveille (jusqu'à 2 fois par semaine) une heure ou plus le moment normal de s'éveiller ou l'heure fixée à son réveil-matin.

2. Modéré : s'éveille fréquemment de façon hâtive (jusqu'à 5 fois par semaine) une heure ou plus avant son heure habituelle d'éveil ou l'heure fixée par son réveil-matin.

3. Sévère : s'éveille tous les jours une heure ou plus avant l'heure normale d'éveil.

8. Suicide

Avez-vous déjà eu l'impression que la vie ne valait pas la peine d'être vécue? Avez-vous déjà pensé mettre fin à tout cela? Qu'est-ce que vous pensez que vous auriez pu faire? Avez-vous, effectivement, essayé?

0. Absent

1. Léger : des idées qu'il serait mieux mort ou des idées occasionnelles de suicide.

2. Modéré : il a envisagé délibérément le suicide avec un plan mais sans faire de tentative.

3. Sévère : une tentative de suicide apparemment conçue pour se terminer par la mort (c'est-à-dire une découverte accidentelle ou un moyen qui s'est avéré inefficace).

9. DÉPRESSION observée

Basée sur les observations de l'interviewer durant l'entretien complet.

La question "est-ce que vous ressentez une envie de pleurer"? utilisée à des moments appropriés durant l'entretien peut stimuler la production d'informations utiles à cette observation.

0. Absente

1. Léger : le sujet apparait triste et sur le point de pleurer même durant des portions de l'entretien touchant des sujets effectivement neutres.

2. Modéré : le sujet apparait triste, près des larmes durant tout l'entretien avec une voix monotone et mélancolique, extériorise des larmes ou est près des larmes à certains moments.

3. Sévère : le patient s'étrangle lorsqu'il touche à des sujets amenant de la détresse, soupire profondément, fréquemment et pleure ouvertement, ou est de façon persistante dans un état de souffrance figée.

Nom : ________________
Date : ________________

Beck Insight Scale

	Totalement en désaccord	Légèrement en accord	Fortement en accord	Totalement en accord
Parfois, j'ai mal compris l'attitude des autres à mon égard.				
Mes interprétations de mes expériences sont définitivement correctes.				
Les autres peuvent mieux comprendre que moi-même la cause de mes expériences inhabituelles				
J'ai sauté aux conclusions trop rapidement				
Certaines des expériences que j'ai eues qui m'ont semblé très réelles pourraient avoir été causées par mon imagination				
Certaines des idées que je croyais vraies se sont avérées fausses.				
Si quelque chose semble correct, cela veut dire que ce l'est				
Bien que je crois fortement avoir raison, je pourrais avoir tord.				
Je sais mieux que quiconque quels sont mes problèmes.				
Lorsque les gens ne sont pas d'accord avec moi, ils ont généralement tord				
Je ne peux pas me fier à l'opinion des autres à l'égard de mes expériences.				
Si quelqu'un m'indique que mes croyances sont incorrectes, je suis disposé(e) à le considérer.				
Je peux faire confiance à mon jugement en tout temps.				
Il y a souvent plusieurs façons d'expliquer pourquoi les gens agissent de telle manière				
Mes expériences inhabituelles peuvent être dues au fait que je sois contrarié(e) ou stressé(e)				

Internalisation des Stigmas en Santé Mentale (ISMI)

ID :______

Date :______

Pour chaque énoncé, SVP cochez la case qui représente le mieux votre opinion; Fortement en désaccord, en désaccord, d'accord, ou fortement d'accord.

Énoncés	Fortement en désaccord	En désaccord	D'accord	Fortement d'accord
1. J'ai l'impression de ne pas être à ma place dans ce monde parce que je suis atteint d'une maladie mentale.				
2. Être atteint d'une maladie mentale a gâché ma vie.				
3. Les personnes qui ne sont pas atteintes d'une maladie mentale ne peuvent pas me comprendre.				
4. Je me sens gêné ou honteux d'être atteint d'une maladie mentale.				
5. Je suis déçu de moi-même parce que je suis atteint d'une maladie mentale.				
6. Je me sens inférieur par rapport à ceux qui ne sont pas atteint d'une maladie mentale.				
7. Les stéréotypes vis-à-vis la maladie mentale s'appliquent à moi.				
8. L'on peut voir en me regardant que je suis atteint d'une maladie mentale.				
9. Les personnes qui sont atteintes d'une maladie mentale ont tendance à être violents.				
10. Parce que je suis atteint d'une maladie mentale, j'ai besoin que les autres prennent la plupart des décisions à ma place.				
11. Les personnes atteintes d'une maladie mentale ne peuvent pas vivre une vie belle et gratifiante.				
12. Les personnes atteintes d'une maladie mentale ne devraient pas se marier.				
13. Je ne peux pas contribuer à la société parce que je suis atteint d'une maladie mentale.				
14. Les gens font de la discrimination à mon égard parce que je suis atteint d'une maladie mentale.				
15. Les autres pensent que je ne peux pas réaliser beaucoup de choses dans la vie parce que je suis atteint d'une maladie mentale.				

Boyd Ritsher, J., P. G. Otilingam, et al. (2003). "Internalized stigma of mental illness: psychometric properties of a new measure." Psychiatry Research 121(1): 31-49.

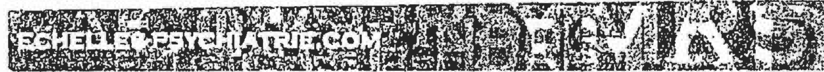
Internalisation des Stigmas en Santé Mentale (ISMI)

ID :______

Date :______

Énoncés	Fortement en désaccord	En désaccord	D'accord	Fortement d'accord
16. Les gens m'ignorent ou ne me prennent pas au sérieux parce que je suis atteint d'une maladie mentale.				
17. Les gens sont souvent condescendants à mon égard, ou me traitent comme un enfant, seulement parce que je suis atteint d'une maladie mentale.				
18. Personne n'est intéressé à être proche de moi parce que je suis atteint d'une maladie mentale.				
19. Je ne parle pas beaucoup de moi parce que je ne veux pas ennuyer les autres avec ma maladie mentale.				
20. Je ne socialise pas autant qu'auparavant parce qu'être atteint d'une maladie mentale pourrait me donner un air ou me faire agir de façon « bizarre ».				
21. Les stéréotypes négatifs à propos de la maladie mentale me tiennent à l'écart du monde « normal ».				
22. J'évite les situations sociales pour ne pas gêner ma famille et mes amis.				
23. Être avec des personnes qui ne sont pas atteintes d'une maladie mentale me rend inconfortable ou me donne le sentiment d'être inadéquat.				
24. J'évite de me rapprocher des personnes qui ne sont pas atteints d'une maladie mentale pour ne pas être rejeté.				
25. Je me sens à l'aise d'être vu en public avec des personnes étant visiblement atteintes d'une maladie mentale.				
26. En général, je suis capable de vivre ma vie comme je le veux.				
27. Je peux avoir une vie belle et enrichissante, malgré que je sois atteint d'une maladie mentale.				
28. Les personnes qui sont atteintes d'une maladie mentale apportent une contribution importante à la société.				
29. Vivre avec la maladie mentale a fait de moi une personne pouvant passer au travers d'épreuves difficiles.				

Boyd Ritsher, J., P. G. Otilingam, et al. (2003). "Internalized stigma of mental illness: psychometric properties of a new measure." Psychiatry Research 121(1): 31-49.



Evaluer le fonctionnement psychologique, social et professionnel sur un continuum hypothétique allant de la santé mentale à la maladie. Ne pas tenir compte d'une altération du fonctionnement due à des facteurs limitants d'ordre physique ou environnemental.

Utiliser des codes intermédiaires lorsque cela est justifié : p. ex : 45, 68, 72.

100-91
Niveau supérieur de fonctionnement dans une grande variété d'activités. N'est jamais débordé par les problèmes rencontrés. Est recherché par autrui en raison de ses nombreuses qualités. Absence de symptômes.

90-81
Symptômes absents ou minimes (p. ex., anxiété légère avant un examen), fonctionnement satisfaisant dans tous les domaines, intéressé et impliqué dans une grande variété d'activités, socialement efficace, en général satisfait de la vie, pas plus de problèmes ou de préoccupations que les soucis de tous les jours (p. ex., conflit occasionnel avec des membres de la famille).

80-71
Si des symptômes sont présents, ils sont transitoires et il s'agit de réactions prévisibles à des facteurs de stress (p. ex., des difficultés de concentration après une dispute familiale) ; pas plus qu'une altération légère du fonctionnement social, professionnel ou scolaire (p. ex., retard temporaire du travail scolaire).

70-61
Quelques symptômes légers (p. ex., humeur dépressive et insomnie légère) ou une certaine difficulté dans le fonctionnement social, professionnel ou scolaire (p. ex., école buissonnière épisodique ou vol en famille) mais fonctionne assez bien de façon générale et entretient plusieurs relations interpersonnelles positives.

60-51
Symptômes d'intensité moyenne (p. ex., émoussement affectif, prolixité circonlocutoire, attaques de panique épisodiques) ou difficultés d'intensité moyenne dans le fonctionnement social, professionnel ou scolaire (p. ex., peu d'amis, conflits avec les camarades de classe ou les collègues de travail).

50-41
Symptômes importants (p. ex., idéation suicidaire, rituels obsessionnels sévères, vols répétés dans les grands magasins) ou altération importante du fonctionnement social, professionnel ou scolaire (p. ex. absence d'amis, incapacité à garder un emploi).

40-31
Existence d'une certaine altération du sens de la réalité ou de la communication (p. ex., discours par moments illogique, obscur ou inadapté) ou déficience majeure dans plusieurs domaines, p. ex., le travail, l'école, les relations familiales, le jugement, la pensée ou l'humeur (p. ex., un homme déprimé évite ses amis, néglige sa famille et est incapable de travailler ; un enfant bat fréquemment des enfants plus jeunes que lui, se montre provocant à la maison et échoue à l'école).

30-21
Le comportement est notablement influencé par des idées délirantes ou des hallucinations ou troubles graves de la communication ou du jugement (p.ex., parfois incohérent, actes grossièrement inadaptés, préoccupation suicidaire) ou incapable de fonctionner dans presque tous les domaines (p. ex., reste au lit toute la journée, absence de travail, de foyer ou d'amis).

20-11
Existence d'un certain danger d'auto ou d'hétéro-agression (p. ex., tentative de suicide sans attente précise de la mort, violence fréquente, excitation maniaque) ou incapacité temporaire à maintenir une hygiène corporelle minimale (p. ex., se barbouille d'excréments) ou altération massive de la communication (p. ex., incohérence indiscutable ou mutisme).

10-1
Danger persistant d'auto ou d'hétéro-agression grave (p. ex., accès répétés de violence) ou incapacité durable à maintenir une hygiène corporelle minimale ou geste suicidaire avec attente précise de la mort.

0
Information inadéquate.

Références :
DSM-IV-TR, éd. Masson, 2004

Entrevue Indiana des Troubles Psychiatriques

L'entrevue consiste en 5 questions qui sont demandées au cours de l'entrevue.

1. Dites-moi l'histoire de votre vie.

2. Pensez-vous avoir une maladie mentale (trouble psychiatrique)?

3. À cause de ceci, qu'est-ce qui a et n'a pas changé?

4. De quelle façon le fait d'avoir une maladie mentale vous affecte-t-il/ affecte-t-il les autres?

5 .Que contrôlez-vous / Qu'est-ce qui vous contrôle?

6. Que voyez-vous dans l'avenir?

Inventaire de la phobie sociale

[illegible] Cochez une boîte seulement pour chaque [illegible] des 17 énoncés.

	Pas du tout (0)	Un peu (1)	Quelque peu (2)	Beaucoup (3)	Extrêmement (4)
1. J'ai peur des personnes en position d'autorité					
2. Cela m'ennuie de rougir devant les autres					
3. Je redoute les soirées et les activités mondaines					
4. J'évite de parler aux gens que je ne connais pas.					
5. Je crains beaucoup les critiques.					
6. La peur d'être embarrassé m'empêche de faire des choses ou de parler aux gens					
7. Le fait de transpirer devant les autres est pour moi très pénible					
8. J'évite les soirées ou réceptions.					
9. J'évite les activités où l'attention est centrée sur moi					
10. J'ai peur de parler à des étrangers.					
11. J'évite d'avoir à prononcer des discours					
12. Je ferais n'importe quoi pour éviter les critiques					
13. J'ai des palpitations en compagnie d'autres gens.					
14. J'ai peur de faire des choses quand quelqu'un pourrait m'observer.					
15. L'une de mes plus grandes craintes c'est d'être embarrassé ou d'avoir l'air bête					
16. J'évite de m'adresser à toute personne en position d'autorité.					
17. Cela m'est très pénible de trembler devant les autres.					

Connor KM, Davidson JRT, Churchill E, et coll. Psychometric properties of the social phobia inventory (SPIN): A new self-rating scale. Affiche présentée lors du 39e congrès annuel de NCDEU tenu à Boca Raton, en Floride, du 1er au 4 juin 1999

Un score d'au moins 19 points évoque un diagnostic de phobie sociale qui peut être confirmé cliniquement par les critères du DSM-IV

À l'usage du médecin

Initiales :

Numéro d'identification :

Date :

Notes :

Section I: Peur - Évitement

À quel point craignez vous et évitez-vous les situations suivantes? S'il vous plaît, donnez des évaluations distinctes pour la peur et l'évitement.

Évaluation de la peur	**Évaluation de l'évitement**
0 = Pas du tout	**0 = Jamais**
1 = Un peu	**1 = Rarement**
2 = Modérément	**2 = Quelquefois**
3 = Beaucoup	**3 = Souvent**
4 = Énormément	**4 = Toujours**

	Peur	Évitement
1. Parler en public devant les autres.		
2. Parler à des personnes en autorité.		
3. Parler à des étrangers.		
4. Être embarrassé(e) ou humilié(e).		
5. Être critiqué(e)		
6. Rencontres sociales.		
7. Faire quelque chose lorsque l'on vous observe (à l'exception de parler en public).		

Section II: Physiologique (P)

Lorsque vous êtes dans une situation qui exige de rencontrer des gens, ou lorsque vous êtes en train de penser à une telle situation, ressentez-vous les symptômes suivants:

0 = Pas du tout
1 = Un peu
2 = Modérément
3 = Beaucoup
4 = Énormément

8. Rougissement:	
9. palpitations:	
10. Tremblements	
11. Transpiration:	

DAVIDSON ET AL., 1991: The Brief Social Phobia Scale. J. Clin. Psychiatry 52 (11, supp) novembre 48-51; traduit et adapté par Gilles Gaudette et Ariel Stravynski, Centre de recherche Fernand-Séguin.

Calgary Depression Scale (CDS)

(Traduction de Addington, D. & Addington, J. (1990)

Identification du sujet: ____________________ Projet :__________

Date : __________

	Absent	Léger	Modéré	Sévère
1. Dépression	0	1	2	3
2. Désespoir	0	1	2	3
3. Auto-dépréciation	0	1	2	3
4. Idées de référence associées à la culpabilité	0	1	2	3
5. Culpabilité pathologique	0	1	2	3
6. Dépression matinale	0	1	2	3
7. Éveil hâtif	0	1	2	3
8. Suicide	0	1	2	3
9. Dépression observée	0	1	2	3

– Tania Pamboulova

ÉCHELLE DE DÉPRESSION

DE CALGARY

D. ADDINGTON & J. ADDINGTON (C)

1990

L'ÉCHELLE DE DÉPRESSION DE CALGARY
GUIDE D'UTILISATION GÉNÉRALE

L'échelle de dépression de Calgary est spécifiquement construite pour l'évaluation du degré de dépression chez des patients souffrant de schizophrénie. Elle s'inspire originalement de deux outils d'évaluation clinique largement utilisés, le Present State Examination et l'échelle de dépression de Hamilton. Pour ce faire, on a utilisé des analyses factorielles et de fiabilité. La fiabilité et la validité ont été testées de plus sur un échantillon séparé en utilisant des analyses factorielles de confirmation et de discrimination.

Cette échelle est conçue pour refléter la présence de dépression à l'exclusion d'autres dimensions psychopathologiques chez des schizophrènes à des stades aigus ou résiduels de la maladie. Elle est sensible au changement et peut-être utilisée à différents intervalles.

L'évaluateur devrait avoir l'expérience des patients schizophrènes et la fiabilité interjuge devrait être vérifiée avec un autre évaluateur déjà expérimenté dans l'utilisation d'instruments d'évaluation structurée. Une bonne fiabilité inter-juge devrait être acquise en 5-10 entrevues de pratique.

L'interview consiste en 8 questions structurées suivie d'un item d'observation. Ce dernier item est fondé sur l'observation du patient durant l'entretien complet.

Pour des informations additionnelles,
contactez le
Dr D. Addington,
Département de psychiatrie
Foothills Hospital
1403, 29 St. N.W.
Calgary, Alberta
T2N 2T9

GUIDE DE L'ENTRETIEN
POUR L'ÉCHELLE DE DÉPRESSION DE CALGARY
POUR SCHIZOPHRÈNES

A L'intention de l'interviewer

Poser la première question telle qu'écrite. Par la suite, vous pouvez utiliser d'autres questions d'exploration ou d'autres questions pertinentes à votre discrétion.

Le cadre temporel conceme les deux demières semaines à moins qu'il ne soit stipulé autrement.

N.B. Le dernier item, #9, se base sur des observations fondées sur l'ensemble de l'entretien.

1. DÉPRESSION

Comment pourriez-vous décrire votre humeur durant les 2 dernières semaines : avez-vous pu demeurer raisonnablement gai ou est-ce que vous avez été très déprimé ou plutôt triste ces derniers temps? Durant les deux dernières semaines, combien de fois vous êtes-vous senti ainsi, tous les jours? toute la journée?

0. Absent

1. Léger : exprime une certaine tristesse ou un certain découragement lorsque questionné.

2. Modéré : une humeur dépressive distincte est présente, persistant pendant au moins 50% du temps au cours des 2 demières semaines; présente tous les jours.

3. Sévère : une humeur dépressive marquée persistant tous les jours, plus de la moitié du temps affectant le fonctionnement normal, psycho-moteur et social.

2. Désespoir

Comment entrevoyez-vous le futur pour vous-même? Est-ce que vous pouvez envisager un avenir pour vous? Ou est-ce que la vie vous apparait plutôt sans espoir? Est-ce que vous avez tout laissé tomber ou est-ce qu'il vous apparait y avoir encore des raisons d'essayer?

0. Absent

1. Léger : à certains moments, il s'est senti sans espoir au cours de la dernière semaine mais il y a encore un certain degré d'espoir pou l'avenir.

2. Modéré : une perception persistante mais modérée de désespoir au cours de la dernière semaine. On peut cependant le persuader d'acquiescer à la possibilité que les choses peuvent s'améliorer.

3. Sévère : un sentiment persistant et éprouvant de désespoir.

3. Auto-dépreciation

Quel est votre opinion de vous-même en comparaison avec d'autres personnes? Est-ce que vous vous sentez meilleur ou moins bon, ou à peu près comparable aux autres personnes en général? Vous sentez-vous intérieur ou même sans aucune valeur?

0. Absent.

1. Léger : une légère infériorité; n'atteint pas le degré de se sentir sans valeur.

2. Modéré : le sujet se sent sans valeur mais moins de 50% du temps.

3. Sévère : le sujet se sent sans valeur plus de 50% du temps il peut être mis au défi de reconnaître un autre point de vue.

4. Idées de référence associée à la culpabilité

Avez-vous l'impression que l'on vous blâme pour certaines choses ou même qu'on vous accuse sans raison? A propos de quoi? (ne pas inclure ici des blâmes ou des accusations justifiés. Exclure les délire de culpabilité).

0. **Absent.**

1. **Léger :** le sujet se sent blâmé mais non accusé, moins de 50% du temps.

2. Modéré : un sentiment persistant d'être blâmé et/ou un sentiment occasionnel d'être accusé.

3. Sévère : un sentiment persistant d'être accusé. Lorsqu'on le contredit, il reconnaît que cela n'est pas vrai.

5. Culpabilité pathologique

Avez-vous tendance à vous blâmer vous-même pour des petites choses que vous pourriez avoir faites dans le passé? Pensez-vous que vous méritez d'être aussi préoccupé à propos de cela?

0. **Absent.**

1. Léger : le sujet se sent coupable de certaines peccadilles mais moins de 50% du temps.

2. Modéré : le sujet se sent coupable habituellement (plus de 50% du temps) à propos d'actes dont il exagère la signification.

3. Sévère : le sujet sent habituellement qu'il est à blâmer pour tout ce qui va mal même lorsque ce n'est pas de sa faute.

6. DÉPRESSION matinale

Lorsque vous vous êtes senti déprimé aux cours des 2 dernières semaines, avez-vous remarqué que la dépression était pire à certains moments de la journée?

0. Absent.

1. Léger : dépression présente mais sans variation diurne.

2. Modéré : le sujet mentionne spontanément que la dépression est pire le matin.

3. Sévère : la dépression est de façon marquée pire le matin avec un fonctionnement perturbé qui s'améliore en après-midi.

7. Éveil hâtif

Vous réveillez-vous plus tôt le matin qu'à l'accoutumée? Combien de fois par semaine cela vous arrive-t-il?

0. Absent : pas de réveil précoce.

1. Léger : à l'occasion s'éveille (jusqu'à 2 fois par semaine) une heure ou plus le moment normal de s'éveiller ou l'heure fixée à son réveil-matin.

2. Modéré : s'éveille fréquemment de façon hâtive (jusqu'à 5 fois par semaine) une heure ou plus avant son heure habituelle d'éveil ou l'heure fixée par son réveil-matin.

3. Sévère : s'éveille tous les jours une heure ou plus avant l'heure normale d'éveil.

8. Suicide

Avez-vous déjà eu l'impression que la vie ne valait pas la peine d'être vécue? Avez-vous déjà pensé mettre fin à tout cela? Qu'est-ce que vous pensez que vous auriez pu faire? Avez-vous, effectivement, essayé?

0. Absent

1. Léger : des idées qu'il serait mieux mort ou des idées occasionnelles de suicide.

2. Modéré : il a envisagé délibérément le suicide avec un plan mais sans faire de tentative.

3. Sévère : une tentative de suicide apparemment conçue pour se terminer par la mort (c'est-à-dire une découverte accidentelle ou un moyen qui s'est avéré inefficace).

9. DÉPRESSION observée

Basée sur les observations de l'interviewer durant l'entretien complet.

La question "est-ce que vous ressentez une envie de pleurer"? utilisée à des moments appropriés durant l'entretien peut stimuler la production d'informations utiles à cette observation.

0. Absente

1. Léger : le sujet apparait triste et sur le point de pleurer même durant des portions de l'entretien touchant des sujets effectivement neutres.

2. Modéré : le sujet apparait triste, près des larmes durant tout l'entretien avec une voix monotone et mélancolique, extériorise des larmes ou est près des larmes à certains moments.

3. Sévère : le patient s'étrangle lorsqu'il touche à des sujets amenant de la détresse, soupire profondément, fréquemment et pleure ouvertement, ou est de façon persistante dans un état de souffrance figée.

Nom : ____________
Date : ____________

Beck Insight Scale

	Totalement en désaccord	Légèrement en accord	Fortement en accord	Totalement en accord
Parfois, j'ai mal compris l'attitude des autres à mon égard.				
Mes interprétations de mes expériences sont définitivement correctes				
Les autres peuvent mieux comprendre que moi-même la cause de mes expériences inhabituelles				
J'ai sauté aux conclusions trop rapidement				
Certaines des expériences que j'ai eues qui m'ont semblé très réelles pourraient avoir été causées par mon imagination				
Certaines des idées que je croyais vraies se sont avérées fausses				
Si quelque chose semble correct, cela veut dire que ce l'est				
Bien que je crois fortement avoir raison, je pourrais avoir tord.				
Je sais mieux que quiconque quels sont mes problèmes				
Lorsque les gens ne sont pas d'accord avec moi, ils ont généralement tord				
Je ne peux pas me fier à l'opinion des autres à l'égard de mes expériences.				
Si quelqu'un m'indique que mes croyances sont incorrectes, je suis disposé(e) à le considérer				
Je peux faire confiance à mon jugement en tout temps.				
Il y a souvent plusieurs façons d'expliquer pourquoi les gens agissent de telle manière				
Mes expériences inhabituelles peuvent être dues au fait que je sois contrarié(e) ou stressé(e)				

CBT for Social Anxiety in Schizophrenia

Sujet: ______________________

Check list pour projet

	Fait (✓)	Commentaires
Consent Form		
SCID (Overview +Social Phobia)		
SAPS		
SANS		
CDS		
SIAS		
SPIN		
BSPS		
Indiana Psychiatric Illness Interview		
BCIS		
ISMI		
GAF		

SANS: Scale for the Assessment of Negative Symptoms
(SANS)
0= None 1=Questionable 2=Mild 3=Moderate 4=Marked 5=Severe

Subject ID Number: ______________________________

Date: ____

AFFECTIVE FLATTENING OR BLUNTING

Item	Rating
1.Unchanging Facial Expression The patient's face appears wooden-changes less than expected as emotional content of discourse changes.	0 1 2 3 4 5
2. Decreased Spontaneous Movements The patient shows few or no spontaneous movements, does not shift position, move extremities, etc.	0 1 2 3 4 5
3. Paucity of Expressive Gestures The patient does not use hand gestures or body position as an aid in expressing his ideas.	0 1 2 3 4 5
4. Poor Eye Contact The patient avoids eye contact or "stares through" interviewer even when speaking.	0 1 2 3 4 5
5. Affective Nonresponsivity The patient fails to laugh or smile when prompted.	0 1 2 3 4 5
6. Inappropriate Affect The patient's affect is inappropriate or incongruous, not simply flat or blunted.	0 1 2 3 4 5
7. Lack of Vocal Inflections The patient fails to show normal vocal emphasis patterns, is often monotonic.	0 1 2 3 4 5
8. Global Rating of Affective Flattening This rating should focus on overall severity of symptoms, especially unresponsiveness, inappropriateness and an overall decrease in emotional intensity.	0 1 2 3 4 5

ALOGIA

Item	Rating
9. Poverty of Speech The patient's replies to questions are restricted in amount, tend to be brief, concrete, unelaborated.	0 1 2 3 4 5
10. Poverty of Content of Speech The patient's replies are adequate in amount but tend to be vague, over concrete or over generalized, and convey little in information.	0 1 2 3 4 5

11. Blocking
The patient indicates, either spontaneously or with prompting, that his train of thought was interrupted. 0 1 2 3 4 5

12. Increased Latency of Response
The patient takes a long time to reply to questions, prompting indicates the patient is aware of the question. 0 1 2 3 4 5

13. Global Rating of Alogia
The core features of alogia are poverty of speech and poverty of content. 0 1 2 3 4 5

AVOLITION-APATHY

14. Grooming and Hygiene
The patient's clothes may be sloppy or soiled, and he may have greasy hair, body odor, etc. 0 1 2 3 4 5

15. Impersistence at Work or School
The patient has difficulty seeking or maintaining employment, completing school work, keeping house, etc. If an inpatient, cannot persist at ward activities, such as OT, playing cards, etc. 0 1 2 3 4 5

16. Physical Anergia
The patient tends to be physically inert. He may sit for hours and not initiate spontaneous activity. 0 1 2 3 4 5

17. Global Rating of Avolition/Apathy
Strong weight may be given to one or two prominent symptoms if particularly striking. 0 1 2 3 4 5

ANHEDONIA-ASOCIALITY

18. Recreational Interests and Activities
The patient may have few or no interests. Both the quality and quantity of interests should be taken into account. 0 1 2 3 4 5

19. Sexual Activity
The patient may show decrease in sexual interest and activity, or no enjoyment when active. 0 1 2 3 4 5

20. Ability to Feel Intimacy and Closeness
The patient may display an inability to form close or intimate relationships, especially with opposite sex and family. 0 1 2 3 4 5

21. Relationships with Friends and Peers
The patient may have few or no friends and may prefer to spend all his time isolated. 0 1 2 3 4 5

22. Global Rating of Anhedonia/Asociality
This rating should reflect overall severity, taking into account the patient's age, family status, etc. 0 1 2 3 4 5

ATTENTION

23. Social Inattentiveness
The patient appears uninvolved or unengaged. He may seem "spacey". 0 1 2 3 4 5

24. Inattentiveness During Mental Status Testing
Refer to tests of "serial 7s" (at least five subtractions) and spelling "world" backwards. Score 0 = 0 error, Score 1 = 0 error but a lot of hesitation, Score 2 = 1 error, Score 3 = 2 errors, Score 4 = 3 errors, Score 5 = 4 errors or more 0 1 2 3 4 5

25. Global Rating of Attention
This rating should assess the patient's overall concentration, both clinically and on tests. 0 1 2 3 4 5

SAPS: Scale for the Assessment of Positive Symptoms
(SAPS)
0= None 1=Questionable 2=Mild 3=Moderate 4=Marked 5=Severe

Subject ID Number: ______________________________

Date: ____

HALLUCINATIONS

Item	Rating
1. Auditory Hallucinations The patient reports voices, noises, or other sounds that no one else hears.	0 1 2 3 4 5
2. Voices Commenting The patient reports a voice which makes a running commentary on his behavior or thoughts.	0 1 2 3 4 5
3. Voices Conversing The patient reports hearing two or more voices conversing.	0 1 2 3 4 5
4. Somatic or Tactile Hallucinations The patient reports experiencing peculiar physical sensations in the body.	0 1 2 3 4 5
5. Olfactory Hallucinations The patient reports experiencing unusual smells which no one else notices.	0 1 2 3 4 5
6. Visual Hallucinations The patient sees shapes or people that are not actually present.	0 1 2 3 4 5
7. Global Rating of Hallucinations This rating should be based on the duration and severity of the hallucinations and their effects on the patient's life.	0 1 2 3 4 5

DELUSIONS

Item	Rating
8. Persecutory Delusions The patient believes he is being conspired against or persecuted in some way.	0 1 2 3 4 5
9. Delusions of Jealousy The patient believes his spouse is having an affair with someone.	0 1 2 3 4 5
10. Delusions of Guilt or Sin The patient believes that he has committed some terrible sin or done something unforgivable.	0 1 2 3 4 5

Item	Rating
11. Grandiose Delusions The patient believes he has special powers or abilities.	0 1 2 3 4 5
12. Religious Delusions The patient is preoccupied with false beliefs of a religious nature.	0 1 2 3 4 5
13. Somatic Delusions The patient believes that somehow his body is diseased, abnormal, or changed.	0 1 2 3 4 5
14. Delusions of Reference The patient believes that insignificant remarks or events refer to him or have special meaning.	0 1 2 3 4 5
15. Delusions of Being Controlled The patient feels that his feelings or actions are controlled by some outside force.	0 1 2 3 4 5
16. Delusions of Mind Reading The patient feels that people can read his mind or know his thoughts.	0 1 2 3 4 5
17. Thought Broadcasting The patient believes that his thoughts are broadcast so that himself or others can hear them.	0 1 2 3 4 5
18. Thought Insertion The patient believes that thoughts that are not his own have been inserted into his mind.	0 1 2 3 4 5
19. Thought Withdrawal The patient believes that thoughts have been taken away from his mind.	0 1 2 3 4 5
20. Global Rating of Delusions This rating should be based on the duration and persistence of the delusions and their effect on the patient's life.	0 1 2 3 4 5

BIZARE BEHAVIOUR

Item	Rating
21. Clothing and Appearance The patient dresses in an unusual manner or does other strange things to alter his appearance.	0 1 2 3 4 5
22. Social and Sexual Behavior The patient may do things considered inappropriate according to usual social norms (e.g., masturbating in public).	0 1 2 3 4 5
23. Aggressive and Agitated Behavior The patient may behave in an aggressive, agitated manner, often unpredictably.	0 1 2 3 4 5
24. Repetitive or Stereotyped Behavior The patient develops a set of repetitive actions or rituals that he must perform over and over.	0 1 2 3 4 5

25. Global Rating of Bizarre Behavior This rating should reflect the type of behavior and the extent to which it deviates from social norms.	0 1 2 3 4 5

POSITIVE FORMAL THOUGHT DISORDER

26. Derailment A pattern of speech in which ideas slip off track onto ideas obliquely related or unrelated.	0 1 2 3 4 5
27. Tangentiality The patient replies to a question in an oblique or irrelevant manner.	0 1 2 3 4 5
28. Incoherence A pattern of speech that is essentially incomprehensible at times.	0 1 2 3 4 5
29. Illogicality A pattern of speech in which conclusions are reached that do not follow logically.	0 1 2 3 4 5
30. Circumstantiality A pattern of speech that is very indirect and delayed in reaching its goal idea.	0 1 2 3 4 5
31. Pressure of Speech The patient's speech is rapid and difficult to interrupt; the amount of speech produced is greater than that considered normal.	0 1 2 3 4 5
32. Distractible Speech The patient is distracted by nearby stimuli which interrupt his flow of speech.	0 1 2 3 4 5
33. Clanging A pattern of speech in which sounds rather than meaningful relationships govern word choice.	0 1 2 3 4 5
34. Global Rating of Positive Formal Thought Disorder The frequency of this rating should reflect the frequency of abnormality and degree to which it affects the patient's ability to communicate.	0 1 2 3 4 5

Subject # : ______________________

Date : ________________________

SCID – P

English version

Modified for use in:

Insight and schizophrenia: Psychological and neuronal determinants

Overview

Now I'm going to ask you about your experiences and some problems or difficulties you may have had in the past, and I'll be taking notes as we go along. Do you have any questions before we begin?

DEMOGRAPHIC DATA

Are you married?

If NO: Were you ever?

Marital Status
1 married or living with someone as if married
2 widowed
3 divorced or annulled
4 separated
5 never married

Do you have any children?

If YES: How many? What are their ages? ____________________

Where do you live? ____________________

Who do you live with? ____________________

EDUCATION AND WORK HISTORY

How far did you get in school?

Education:
1 grade 6 or less
2 grade 7 to 11 (without graduating high school)
3 graduated high school or high school equivalent
4 part college (cégep)
5 graduated 2 year college (cégep)
6 graduated 3 or 4 year university
7 part graduate/professional school
8 completed graduate/professional school

IF FAILED TO COMPLETE A PROGRAM IN WHICH THEY WERE ENROLLED:
Why didn't you finish? ____________________

____

Code:
(For data entry)

Elementary School	1 – 6 years
High School	7 – 11 years (or 7 – 12 for outside Quebec)
Cégep (Québec)	12 – 13 years
University (Québec)	14 – 16 years (may be more depending on the program)
University (outside QC)	13 – 16 years (may be more depending on the program)
Graduate/Professional School	17 – 22+ years

Who did you grew up with: a) both parents b) mother c) father d) other: __________

If other, education: __________ Occupation: __________

Father's highest level of education: Occupation: __________

Mother's highest level of education: Occupation: __________

Are you working now? What kind of work do you do? ____________________

IF YES: How long have you worked there?
Have you always done that kind of work? ____________________

IF LESS THAN 6 MONTHS: Why did you leave your last job? ____________________

IF NO: Why is that?
What kind of work have you done? ____________________

How are you supporting yourself now? ____________________

Has there ever been a period of time when you were unable to work or go to school?

IF YES: When? Why was that? ____________________

OVERVIEW OF PRESENT ILLNESS

Are you an inpatient at this moment? ____________________

Number of weeks since admission to facility

1 < 1week
2 1-4 weeks
3 > 4 weeks

IF CURRENTLY IN TREATMENT·
DATE ADMITTED TO INPATIENT OR OUTPATIENTS FACILITY FOR PRESENT ILLNESS

When did you come to the (hospital, clinic?) ____________________

TREATMENT HISTORY

When was the onset of your problem (year/age)? ____________________

When did you first come to the hospital? ____________________

What was it for? ____________________

To verify in patient's file:
1. # of hospitalisation and length of each (add extra page if needed):

____
____
____
____
____
____

2. Medication received

____
____
____
____
____

HAVE YOU EVER BEEN IN A HOSIPTAL FOR TREATMENT OF A MEDICAL PROBLEM?

IF YES: what was that for? ____

____

How has your physical health been? (Have you had any medical problems?) (USE THIS INFORMATIONS TO CODE AXIS III)

____

____

Diagnosis **Lifetime Prevalence of Psychopathology**

Mood Disorders

Major Depressive Disorder

Have you ever felt sad or down for a long period of time? YES NO (circle one)
(e.g. 2 weeks or more)

Have you ever experienced a significant loss of interest or pleasure in doings things you used to enjoy?

YES NO

IF YES: Tell me about it: ____

____

____

CRITERIA (five or more of the following have been present during the same 2 week period – check boxes)

- ☐ Depressed mood most of the day, almost every day*
  ____
- ☐ Large decrease in interest or pleasure in most activities most of the day, almost every day*
  ____
- ☐ Significant weight loss (when not dieting) or weight gain, or decreased appetite nearly every day
  ____
- ☐ Insomnia or hypersomnia almost every day ____________________
- ☐ Psychomotor agitation (restless, fidgety) or retardation almost every day ____________________
- ☐ Fatigue or loss of energy almost every day ____________________
- ☐ Feelings of worthlessness or excessive guilt ____________________

☐ Diminished ability to think, concentrate or take decisions ____________________

☐ Recurrent thoughts of death or suicidal ideation, plan to commit suicide or actual suicide attempt
____

AND

☐ Symptoms cause distress or impairment in social, occupational or other areas of functioning
____

Bipolar

Have you ever felt so good, high or hyper that other people thought you weren't your normal self?

YES NO

IF YES: Tell me about it (must last > 4 days): ____________________

IF YES: During this time did you notice yourself being easily distracted or full of ideas (thoughts racing)? ____________________

Did you sleep less than normal? ____________________

Were you involved in any activities that you later regretted getting involved in? ____________________

Did your mood affect your appetite, your sleep, or you ability to work? ____________________

Have you ever felt so irritable that you found yourself shouting at people or starting arguments? ____________________

IF YES: Tell me about it (must last > 4 days): ____________________

Dysthymic Disorder

For the past 2 years, have you been bothered by depressed mood most of the day, more days than not? (More than half of the time)
YES NO

IF YES: During this period, did you experience a difference in your appetite? Did you have trouble sleeping? Did you have little energy to do things or feel tired a lot? Did you feel down on yourself? Did you feel hopeless? ____________________

Mood Disorder Due to a General Medical Condition

Just before you started feeling (sxs) were you physically ill? ____________________

IF YES: Do you think your (mood sxs) were in any way related to (comorbid GMC)? ____________________

IF YES: Tell me how? Did the (mood sxs) start or get much worse after (comorbid GMC) began? ____________________

Substance-Induced Mood Disorder

Just before you started feeling (sxs) were you using any meds? ____________

IF YES: Do you think your (mood sxs) were in any way related to (comorbid GMC)? Any change in the amount you were using? ____________

Just before you started feeling (sxs) were you drinking or using any street drugs? ____________

IF YES: Do you think your (mood sxs) were in any way related to your (substance use)? ____________

IF YES: Tell me how? Did the (mood sxs) start or get much worse after your (substance use) began? ____________

Substance Use Disorders

Alcohol

What are your drinking habits like (Past)? ____________

What are your drinking habits like (Last 3 months)? ____________

Has there ever been a time in your life when you had five or more drinks one on occasion?

IF YES: When? ____________

Last 3 months? ____________

During that time: **Past** **Last 3 months**

How often were you drinking? ____________

Did your drinking cause problems for you? (any problems with the law?) ____________

Did you ever miss work or school because you were very intoxicated or hung over? ____________

Did you ever have problems taking care of your children or keeping your house clean? ____________

Did you ever drink in situations in which it might have been dangerous to be drinking? ____________

Did your drinking cause problems with other people (family, friends, coworkers)? ____________

Did you often find that when you started drinking you ended up drinking much more than you were planning to? ____________

Past **Last 3 months**

Did you ever try to cut down or stop drinking altogether? ______________________

____

Did you find that you had to keep drinking more and more to get the same feeling you had when you started drinking? ______________________

____

Have you ever experienced any withdrawal symptoms? (nausea, sweating, insomnia...) ______________________

Have you ever taken treatment for alcohol? ______________________

Drugs and Other Substances (use extra page if needed)

List of drugs:
- **Sedatives – hypnotics – Anxiolytics:** Quaalude, Seconal, Valium, Xanax, barbiturates, Miltown, Ativan, Dalmane, Halcion, Restoril, other: ______________

- **Cannabis:** Marijuana, hashish, THC, other: ______________

- **Stimulants:** Amphetamine, "speed", crystal meth, dexadrine, Ritalin, "ice", other: ______________

- **Opioids:** Heroin, Morphine, opium, methadone, darvon, codeine, Percodan, Demerol, Dilaudid, unspecified or other: ______________

- **Cocaine:** intranasal, IV, freebase, crack, "speedball", unspecified or other: ______________

- **Hallucinogens/PCP:** LSD, mescaline, peyote, psilocybin, STP, mushrooms, PCP ("angel dust"), extasy, MDMA, or other: ______________

- **Other:** steroids, "glue", paint, inhalants, nitrous oxide ("laughing gas"), amyl or butyl nitrate ("poppers"), non-prescription sleep or diet pills, unknown, other: ______________

	Past	Last 3 months
Did you ever get hooked on a prescribed drug or take more of it than you were supposed to?		
Have you ever used street drugs?		
When were you using (DRUG) the most (how much)? (Did they take the drug more than 10 times in a one-month period?)		
Did you ever find that when you started using a drug you ended up using much more of it than you were planning to?		
Did you ever use drug in situations in which it might have been dangerous to be under the influence of a drug?		
Did you ever want to stop or cut-down?		
Did you ever spend a lot of time trying to get the drug?		
Would you ever spend time using drugs rather than		

spend time with family or friends or engaging in other activities you used to do before? ______________________

Did you find that you had to keep using more and more of the drug to get the same feeling you had when you first started using it? ______________________

Have you ever experienced any withdrawal symptoms? ______________________

Have you ever taken treatment for drugs? ______________________

Summary – Notes

Psychotic symptoms : Past

(Present symptomatology to be documented in SAPS/SANS)

Document time of onset, duration and type of hallucination or delusion.

Hallucinations:

Delusions:

SOCIAL PHOBIA **SOCIAL PHOBIA CRITERIA**

SCREENER: YES / NO

→ SCREENING QUESTION #6 ANSWERED "NO," SKIP TO *SPECIFIC PHOBIA,* F. 16.

IF NO GO TO *SPECIFIC PHOBIA* F. 16

→ IF QUESTION #6 ANSWERED "YES": You've said that there are things that you were afraid to do in front of other people, like speaking, eating, or writing . . .

→ IF SCREENER NOT USED: Was there anything that you have been afraid to do or felt uncomfortable doing in front of other people, like speaking, eating, or writing?

Tell me about it.

What were you afraid would happen when ______________?

IF PUBLIC SPEAKING ONLY: (Do you think that you are more uncomfortable than most people are in that situation?)

A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.

? 1 2 3

GO TO *SPECIFIC PHOBIA* F. 16

PHOBIC SITUATION(S) Check:

___ public speaking
___ eating in front of others
___ writing in front of others
___ generalized (most social situations)
___ other (Specify: ______________)

Note: In adolescents, there must be evidence of capacity for age-appropriate relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.

Have you always felt anxious when you (CONFRONTED PHOBIC STIMULUS)?

B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack.

? 1 2 3

GO TO *SPECIFIC PHOBIA* F. 16

Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

Interview question	Criterion	Rating	Code
Did you think that you were more afraid of (PHOBIC ACTIVITY) than you should have been (or than made sense)?	C. The person recognizes that the fear is excessive or unreasonable. Note: in children, this feature may be absent.	? 1 2 3 (1: GO TO *SPECIFIC PHOBIA* F. 16)	F5[illegible]
IF NOT OBVIOUS: Did you go out of your way to avoid _____________? IF NO: How hard is it for you to _______________?	D. The feared social or performance situations are avoided, or else endured with intense anxiety or distress.	? 1 2 3 (1: GO TO *SPECIFIC PHOBIA* F. 16)	F55
IF UNCLEAR WHETHER FEAR WAS CLINICALLY SIGNIFICANT: How much did _______ interfere with your life? IF DOES NOT INTERFERE WITH LIFE: How much has the fact that you have this fear bothered you?	E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.	? 1 2 3 (1: GO TO *SPECIFIC PHOBIA* F. 16)	F56
IF UNDER AGE 18: (For how long have you had these fears?)	F. In individuals under age 18 years, the duration is at least 6 months.	? 1 2 3 (1: GO TO *SPECIFIC PHOBIA* F. 16)	F57

Just before you began having these fears, were you taking any drugs, caffeine, diet pills, or other medicines?

(How much coffee, tea, or caffeinated soda do you drink a day?)

Just before the fears began, were you physically ill?

IF YES: What did the doctor say?

G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

? 1 2 3 F58

DUE TO SUBSTANCE USE OR GMC

GO TO "SPECIFIC PHOBIA" F.16

PRIMARY ANXIETY DISORDER

IF THERE IS ANY INDICATION THAT THE ANXIETY MAY BE SECONDARY (I.E., A DIRECT PHYSIOLOGICAL CONSEQUENCE OF THE GMC OR SUBSTANCE, GO TO "GMC / SUBSTANCE," F. 36, AND RETURN HERE TO MAKE A RATING OF "1" OR "3."

Etiological general medical conditions include: hyper- and hypothyroidism, hypoglycemia, hyperparathyroidism, pheochromocytoma, congestive heart failure, arrhythmias, pulmonary embolism, chronic obstructive pulmonary disease, pneumonia, hyperventilation, B-12 deficiency, porphyria, CNS neoplasms, vestibular dysfunction, encephalitis.

Etiological substances include: intoxication with central nervous stimulants (e.g., cocaine, amphetamines, caffeine) or cannabis, hallucinogens, PCP, or alcohol, or withdrawal from central nervous system depressants (e.g., alcohol, sedatives, hypnotics) or from cocaine.

CONTINUE

. . . and is not better accounted for by another mental disorder (e.g., Panic Disorder Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).

? 1 2 3 F59

GO TO "SPECIFIC PHOBIA" F. 16

IF NOT ALREADY CLEAR: RETURN TO THIS ITEM AFTER COMPLETING INTERVIEW.

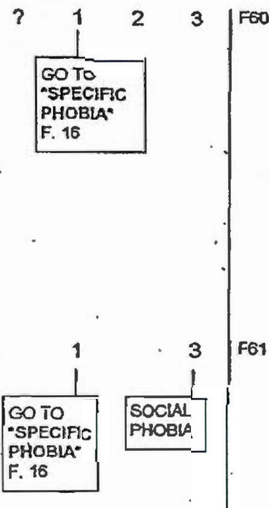
H. If a general medical condition or other mental disorder is present, the fear in A is unrelated to it, e.g., the fear is not of stuttering, trembling (in Parkinson's disease) or exhibiting abnormal eating behavior (in Anorexia Nervosa or Bulimia Nervosa).

? 1 2 3 F60

NOTE: Social anxiety related to a general medical condition or other mental disorder may be indicated as Anxiety Disorder NOS (page F. 40)

SOCIAL PHOBIA CRITERIA A, B, C, D, E, F, G, AND H ARE CODED "3"

1 3 F61



"SOCIAL PHOBIA CHRONOLOGY"

IF UNCLEAR: During the past month, have you been bothered by (SOCIAL PHOBIA SITUATION)?	Criteria have been met for social Phobia during past month	? 1 3	F62

INDICATE CURRENT SEVERITY: (F63)

1 - **Mild:** Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.

2 - **Moderate:** Symptoms or functional impairment between "mild" and "severe" are present.

3 - **Severe:** Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

CONTINUE WITH "AGE AT ONSET", BELOW

IF CURRENT CRITERIA NOT FULLY MET (OR NOT AT ALL): (F64)

4 - **In Partial Remission:** The full criteria for the disorder were previously met, but currently only some of the symptoms or signs of the disorder remain.

5 - **In Full Remission:** There are no longer any symptoms or signs of the disorder, but it is still clinically relevant to note the disorder--for example, in an individual with previous episodes of Social Phobia who has been symptom free on an antianxiety agent for the past three years.

6 - **Prior History:** There is a history of the criteria having been met for the disorder, but the individual is considered to have recovered from it.

When did you last have (ANY SX OF SOCIAL PHOBIA)?	Number of months prior to interview when last had a symptom of Social Phobia	___ ___ ___	F65

"AGE AT ONSET"

IF UNKNOWN: How old were you when you first started having (SXS OF SOCIAL PHOBIA)?	Age at onset of Social Phobia (CODE 99 IF UNKNOWN)	___ ___	F66

GO TO "SPECIFIC PHOBIA" F. 16

Social Interaction Anxiety Scale (SIAS)

Patient Name: ______________________ **Date:** ____________

Instructions: For each item, please circle the number to indicate the degree to which you feel the statement is characteristic or true for you. The rating scale is as follows:

0 = **Not at all** characteristic or true of me.
1 = **Slightly** characteristic or true of me.
2 = **Moderately** characteristic or true of me.
3 = **Very** characteristic or true of me.
4 = **Extremely** characteristic or true of me.

CHARACTERISTIC	NOT AT ALL	SLIGHTLY	MODERATELY	VERY	EXTREMELY
1. I get nervous if I have to speak with someone in authority (teacher, boss, etc.).	0	1	2	3	4
2. I have difficulty making eye contact with others.	0	1	2	3	4
3. I become tense if I have to talk about myself or my feelings.	0	1	2	3	4
4. I find it difficult to mix comfortably with the people I work with.	0	1	2	3	4
5. I find it easy to make friends my own age.	0	1	2	3	4
6. I tense up if I meet an acquaintance in the street.	0	1	2	3	4
7. When mixing socially, I am uncomfortable.	0	1	2	3	4
8. I feel tense if I am alone with just one other person.	0	1	2	3	4
9. I am at ease meeting people at parties, etc.	0	1	2	3	4
10. I have difficulty talking with other people.	0	1	2	3	4
11. I find it easy to think of things to talk about.	0	1	2	3	4
12. I worry about expressing myself in case I appear awkward.	0	1	2	3	4
13. I find it difficult to disagree with another's point of view.	0	1	2	3	4
14. I have difficulty talking to attractive persons of the opposite sex.	0	1	2	3	4
15. I find myself worrying that I won't know what to say in social situations.	0	1	2	3	4
16. I am nervous mixing with people I don't know well.	0	1	2	3	4
17. I feel I'll say something embarrassing when talking.	0	1	2	3	4
18. When mixing in a group, I find myself worrying I will be ignored.	0	1	2	3	4
19. I am tense mixing in a group.	0	1	2	3	4
20. I am unsure whether to greet someone I know only slightly.	0	1	2	3	4

Document is in the public domain. Duplicating this material for personal or group use is permissible.

Social Phobia Inventory

Initials _____ Age __________ Sex ____________ Date _____ ID# ______

Please check how much the following problems have bothered you during the past week. Mark only one box for each problem, and be sure to answer all items.

	Not at all	A little bit	Somewhat	Very much	Extremely
1. I am afraid of people in authority.	0	1	2	3	4
2. I am bothered by blushing in front of people.	0	1	2	3	4
3. Parties and social events scare me.	0	1	2	3	4
4. I avoid talking to people I don't know.	0	1	2	3	4
5. Being criticized scares me a lot.	0	1	2	3	4
6. Fear of embarrassment causes me to avoid doing things or speaking to people.	0	1	2	3	4
7. Sweating in front of people causes me distress.	0	1	2	3	4
8. I avoid going to parties.	0	1	2	3	4
9. I avoid activities in which I am the center of attention.	0	1	2	3	4
10. Talking to strangers scares me.	0	1	2	3	4
11. I avoid having to give speeches.	0	1	2	3	4
12. I would do anything to avoid being criticized.	0	1	2	3	4
13. Heart palpitations bother me when I am around people.	0	1	2	3	4
14. I am afraid of doing things when people might be watching.	0	1	2	3	4
15. Being embarrassed or looking stupid are my worst fears.	0	1	2	3	4
16. I avoid speaking to anyone in authority.	0	1	2	3	4
17. Trembling or shaking in front of others is distressing to me.	0	1	2	3	4

From Connor K., Davidson J., Churchill L., Sherwood A., Foa E., Weisler R., "Psychometric properties of the Social Phobia Inventory" Br J Psychiatry.2000 176:379-86

©2000 J R. Davidson

Protocol ________ Visit ______ Pt. Initial ______ ID# ______ Date ______

BRIEF SOCIAL PHOBIA SCALE (BSPS)

INSTUCTIONS

The clinician will rate the time period covering the previous week. If a patient has not been exposed to the feared situation in the past week, the clinician should rate the fear, avoidance and physiological symptoms according to how the patient would feel now if faced with each situation.

PART I (Fear/Avoidance)
How much do you fear and avoid the following situations? The clinician will give separate ratings for fear and avoidance by recording in each box below a score corresponding with the following clinical anchor points.

	FEAR	AVOIDANCE
1. Speaking in public or in front of others.	☐	☐
2. Talking to people in authority.	☐	☐
3. Talking to strangers.	☐	☐
4. Being embarrassed or humiliated.	☐	☐
5. Being criticized.	☐	☐
6. Social gatherings.	☐	☐
7. Doing something while being watched (this does not include speaking).	☐	☐

Clinical Anchor Points
Fear:

0 = None
1 = Mild = Infrequent and/or not distressing
2 = Moderate = Frequent and/or some distress
3 = Severe = Constant, dominating a person's life and/or clearly distressing
4 = Extreme = Incapacitating and/or very painfully distressing

Avoidance:

0 = Never (0%)
1 = Rare (1 - 33%)
2 = Sometimes (34 - 66%)
3 = Frequent (67 - 99%)
4 = Always (100%)

PART II (Physiology)
When you are in a situation which involves contact with other people, or when you are thinking about such a situation, do you experience the following symptoms? Record in each box below a score corresponding with the following anchor points.

	PHYSIOLOGICAL
1. Blushing	☐
2. Palpitations	☐
3. Trembling or shaking	☐
4. Sweating	☐

Clinical Anchor Points
Physiological

0 = None
1 = Mild = Infrequent and/or not distressing
2 = Moderate = Frequent and/or some distress
3 = Severe = Constant, dominating a person's life and/or clearly distressing
4 = Extreme = Incapacitating and/or very painfully distressing

TOTAL SCORES

Part I Fear items 1-7 Total ______ (F)
Avoidance items 1-7 Total ______ (A)
Part II Physiological items 1-4 Total ______ (P)

Calgary Depression Scale (CDS)

(Addington, D. & Addington, J. (1990)

Subject identification : ____________________ Project :__________

Date : __________

	Absent	Mild	Moderate	Severe
1. Depression	0	1	2	3
2. Hopelessness	0	1	2	3
3. Self depreciation	0	1	2	3
4. Guilty ideas of reference	0	1	2	3
5. Pathological guilt	0	1	2	3
6. Morning depression	0	1	2	3
7. Early wakening	0	1	2	3
8. Suicide	0	1	2	3
9. Observed depression	0	1	2	3

Calgary Depression Scale

Type	Symptom Scale.
Subject	Assessment of depressive symptoms separate from positive, negative and extrapyramidal symptoms in people with schizophrenia.
Administration	Observer scale, semi-structured, goal directed interview.
Time Axis	Two weeks unless otherwise specified.
Item Selection	Factor analysis from Present State Examination and Hamilton Depression Rating Scale.
Number of Items	Nine.
Scoring	The CDSS depression score is obtained by adding each of the item scores. To select a cut off point refer to the attached power point slides. A score above 6 has an 82% specificity and 85% sensitivity for predicting the presence of a major depressive episode. CDSS Scoring
Definition of Items	All ratings of the items are defined according to operational criteria from 0-3.
Psychometric Validity	Construct validity has been confirmed by correlations with other depression rating scales and by the prediction of a major depressive episode. Divergent validity from positive, negative and extrapyramidal symptoms has been established by the absence of correlations with measures of these symptoms. In addition, the level of depression assessed by CDSS and the level of negative symptoms differentially predict outcome.
Reliability	Internal reliability of the scale has been shown to be good, as has inter-rater reliability.
Copyright �	The Scale is copyrighted and the copyright is held by Dr. Donald Addington and Dr. Jean Addington. The Scale may be used free by any student or non profit organization. Permission to use the Scale will be given to for profit organizations upon request to Dr. Donald Addington by e-mail or in writing.
Comments	The CDSS has been specifically developed for the assessment of the level of depression in schizophrenia. It has been extensively evaluated in both relapsed and remitted patients and appears sensitive to change. Translations have been made into many languages. In comparison to the Hamilton Depression Scale, it has fewer factors and less overlap with positive and negative symptoms. This lack of overlap is present both at the time of relapse and at the time of remission. The rater should have experience with people with schizophrenia and should develop inter-rater reliability with another rater experienced in the use of structure assessment instruments. An experienced rater should develop adequate inter-rater reliability within 5 practice interviews.

Interviewer: Ask the first question as written. Use follow up probes or qualifiers at your discretion. Time frame refers to last two weeks unless stipulated. N.B. The last item, #9, is based on observations of the entire interview.

1. Depression: How would you describe your mood over the last two weeks? Do you keep reasonably cheerful or have you been very depressed or low spirited recently? In the last two weeks how often have you (own words) every day? All day?

0. Absent	
1. Mild	Expresses some sadness or discouragement on questioning.
2. Moderate	Distinct depressed mood persisting up to half the time over last 2 weeks: present daily.
3. Severe	Markedly depressed mood persisting daily over half the time interfering with normal motor and social functioning

2. Hopelessness: How do you see the future for yourself? Can you see any future? - or has life seemed quite hopeless? Have you given up or does there still seem some reason for trying?

0. Absent	
1. Mild	Has at times felt hopeless over the last two weeks but still has some degree of hope for the future.
2. Moderate	Persistent, moderate sense of hopelessness over last week. Can be persuaded to acknowledge possibility of things being better.
3. Severe	Persisting and distressing sense of hopelessness.

3. Self Depreciation: What is your opinion of your self compared to other people? Do you feel better, not as good, or about the same as others? Do you feel inferior or even worthless?

0. Absent	
1. Mild	Some inferiority; not amounting to feeling of worthlessness.
2. Moderate	Subject feels worthless, but less than 50% of the time.
3. Severe	Subject feels worthless more than 50% of the time. May be challenged to acknowledge otherwise.

4. Guilty Ideas Of Reference: Do you have the feeling that you are being blamed for something or even wrongly accused? What about? (Do not include justifiable blame or accusation. Exclude delusions of guilt.)

0. Absent	
1. Mild	Subject feels blamed but not accused less than 50% of the time.
2. Moderate	Persisting sense of being blamed, and/or occasional sense of being accused.
3. Severe	Persistent sense of being accused. When challenged, acknowledges that it is not so.

5. Pathological Guilt: Do you tend to blame yourself for little things you may have done in the past? Do you think that you deserve to be so concerned about this?

0. Absent	
1. Mild	Subject sometimes feels over guilty about some minor peccadillo, but less than 50% of time.
2. Moderate	Subject usually (over 50% of time) feels guilty about past actions the significance of which he exaggerates.
3. Severe	Subject usually feels s/he is to blame for everything that has gone wrong, even when not his/her fault.

6. Morning Depression: When you have felt depressed over the last 2 weeks have you noticed the depression being worse at any particular time of day?

0. Absent	No depression.
1. Mild	Depression present but no diurnal variation.
2. Moderate	Depression spontaneously mentioned to be worse in a.m.
3. Severe	Depression markedly worse in a.m., with impaired functioning which improves in p.m.

7. Early Wakening: Do you wake earlier in the morning than is normal for you? How many times a week does this happen?

0. Absent	No early wakening.
1. Mild	Occasionally wakes (up to twice weekly) 1 hour or more before normal time to wake or alarm time.
2. Moderate	Often wakes early (up to 5 times weekly) 1 hour or more before normal time to wake or alarm.
3. Severe	Daily wakes 1 hour or more before normal time.

8. Suicide: Have you felt that life wasn't worth living? Did you ever feel like ending it all? What did you think you might do? Did you actually try?

0. Absent	
1. Mild	Frequent thoughts of being better off dead, or occasional thoughts of suicide.
2. Moderate	Deliberately considered suicide with a plan, but made no attempt.
3. Severe	Suicidal attempt apparently designed to end in death (i.e.: accidental discovery or inefficient means).

9. Observed Depression: Based on interviewer's observations during the entire interview. The question "Do you feel like crying?" used at appropriate points in the interview, may elicit information useful to this observation.

0. Absent	
1. Mild	Subject appears sad and mournful even during parts of the interview, involving affectively neutral discussion.
2. Moderate	Subject appears sad and mournful throughout the interview, with gloomy monotonous voice and is tearful or close to tears at times.
3. Severe	Subject chokes on distressing topics, frequently sighs deeply and cries openly, or is persistently in a state of frozen misery if examiner is sure that this is present.

© Dr. Donald Addington and Dr. Jean Addington.

THE CALGARY DEPRESSION SCALE

GENERAL INSTRUCTIONS

The Calgary Depression Scale is specifically designed for assessment of level of depression in people with schizophrenia. It was originally derived from two widely used instruments, the Present State Examination and the Hamilton Depression Rating Scale, using factor and reliability analysis techniques. Its reliability and validity was further tested on a separate sample using Confirmatory Factor Analysis and Discriminatory Analysis techniques.

The scale is designed to reflect the presence of depression exclusive of other dimensions of psychopathology in schizophrenics at both the acute and residual stages of the disorder. It is sensitive to change, and can be used at a variety of intervals.

The rater should have experience with schizophrenics and should develop inter-rater reliability with another rater experienced in the use of structured assessment instruments. An experienced rater should develop adequate inter-rater reliability within 5-10 practice interviews.

The interview consists of eight structured questions followed by one observation item. This last item depends on the observation of the entire interview.

For further information contact :
Dr. D. Addington
Department of Psychiatry
Foothills Hospital
1403 - 29 St. N.W.
Calgary, Alberta T2N 2T9

3. SELF DEPRECIATION

What is your opinion of yourself compared to other people?
Do you feel better or not as good or about the same as most?
Do you feel inferior or even worthless?

0. Absent

1. Mild — Some inferiority; not amounting to feeling of worthlessness.

2. Moderate — Subject feels worthless, but less than 50% of the time.

3. Severe — Subject feels worthless more than 50% of the time. May be challenged to acknowledge otherwise.

4. GUILTY IDEAS OF REFERENCE

Do you have the feeling that you are being blamed for something or even wrongly accused? What about? (Do not include justifiable blame or accusation. Exclude delusions of guilt).

0. Absent

1. Mild — Subject feels blamed not accused less than 50% of the time.

2. Moderate — Persisting sense of being blamed, and/or occasional sense of being accused.

3. Severe — Persistent sense of being accused. When challenged acknowledges that it is not so.

5. PATHOLOGICAL GUILT

Do you tend to blame yourself for little things you may have done in the past?
Do you think you deserve to be so concerned about this?

0. Absent

1. Mild — Subject sometimes feels over guilty about some minor peccadillo, but less than 50% of time.

2. Moderate — Subject usually (over 50% of time) feels guilty about past actions the significance of which he exaggerates

3. Severe — Subject feels s/he is to blame for everything that has gone wrong, even when not his/her fault.

9. OBSERVED DEPRESSION

Based on interviewer's observations during the entire interview

The question "Do you feel like crying?" used at appropriate points in the interview, may elicit information useful to this observation.

0. Absent

1. Mild — Subject appears sad and mournful even during parts of the interview involving affectively neutral discussion.

2. Moderate — Subject appears sad and mournful throughout the interview, with gloomy monotonous voice and is tearful or close to tears at times.

3. Severe — Subject chokes on distressing topics, frequently sighs deeply and cries openly, or is persistently in a state of frozen misery.

Name : ________________
Date : ________________

Beck Insight Scale

	Do not agree at all	Agree slightly	Agree a lot	Agree completely
At times, I have misunderstood other people's attitudes toward me.				
My interpretations of my experiences are definitely right.				
Other people can understand the cause of my unusual experiences better than I can.				
I have jumped to conclusions too fast				
Some of my experiences that have seemed very real to me may have been due to my imagination.				
Some of the ideas I was certain were true turned out to be false				
If something feels right, it means that it is right.				
Even though I feel strongly that I am right, I could be wrong.				
I know better than anyone else what my problems are				
When people disagree with me, they are generally wrong.				
I cannot trust other's people opinion about my experiences.				
If somebody points out that my beliefs are wrong, I am willing to consider it.				
I can trust my own judgment all the times.				
There is often more than one possible explanation for why people act the way they do.				
My unusual experiences may be due to my being extremely upset or stressed.				

Internalized stigma of mental illness (ISMI)

We are going to use the term 'mental illness' in the rest of this questionnaire, but please think of it as whatever you feel is the best term for it. For each question, please mark whether you strongly disagree (1), disagree (2), agree (3) or strongly agree (4).

Alienation	strongly disagree (1)	disagree (2)	agree (3) or	strongly agree (4).
I feel out of place in the world because I have a mental illness				
Having a mental illness has spoiled my life				
People without mental illness could not possibly understand me				
I am embarrassed or ashamed that I have a mental illness				
I am disappointed in myself for having a mental illness				
I feel inferior to others who don't have a mental illness				
Stereotype Endorsement				
Stereotypes about the mentally ill apply to me				
People can tell that I have a mental illness by the way I look				
Mentally ill people tend to be violent				
Because I have a mental illness, I need others to make most decisions for me				
People with mental illness cannot live a good, rewarding life				
Mentally ill people shouldn't get married				
I can't contribute anything to society because I have a mental illness				
Discrimination Experience				
People discriminate against me because I have a mental illness				
Others think that I can't achieve much in life because I have a mental illness				
People ignore me or take me less seriously just because I have a mental illness				
People often patronize me, or treat me like a child, just because I have a mental illness				
Nobody would be interested in getting close to me because I have a mental illness				

Boyd Ritsher, J., P. G. Otilingam, et al. (2003). "Internalized stigma of mental illness: psychometric properties of a new measure." Psychiatry Research 121(1): 31-49.

Social Withdrawal				
I don't talk about myself much because I don't want to burden others with my mental illness				
I don't socialize as much as I used to because my mental illness might make me look or behave 'weird'				
Negative stereotypes about mental illness keep me isolated from the 'normal' world				
I stay away from social situations in order to protect my family or friends from embarrassment				
Being around people who don't have a mental illness makes me feel out of place or inadequate				
I avoid getting close to people who don't have a mental illness to avoid rejection				
Stigma Resistance (reverse-coded items)				
I feel comfortable being seen in public with an obviously mentally ill person				
In general, I am able to live life the way I want to				
I can have a good, fulfilling life, despite my mental illness				
People with mental illness make important contributions to society				
Living with mental illness has made me a tough survivor				

Stigma resistance items were reverse coded by subtracting each item's score from 5.

Boyd Ritsher, J., P. G. Otilingam, et al. (2003). "Internalized stigma of mental illness: psychometric properties of a new measure." Psychiatry Research **121**(1): 31-49.

Global Assessment of Functioning (GAF) Scale*

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code	(Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)
100 - 91	**Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is ought out by others because of his/her many positive qualities. No symptoms.**
90 - 81	**Absent of minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).
80 - 71	**If symptoms are present, the are transient and expectable reactions to psycho-social stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in schoolwork).
70 - 61	**Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful relationships.**
60 - 51	**Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).
50 - 41	**Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).
40 - 31	**Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 - 21	**Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home or friends).

* All of this information was pulled from the DSM IV-TR.

20 | **Some danger of hurting self or others** (e.g., suicidal attempts without clear expectation of death; frequent violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).
11

10 | **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**
1

The rating of overall psychological functioning on a scale of 0 – 100 was operationalized by Luborsky in the Health-Sickness Rating Scale (Luborsky, L: "Clinician's Judgments of Mental Health." *Archives of General Psychiatry* 7:407 – 417, 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J, Spitzer RL, Fleiss JL, Cohen J: "The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance." *Archives of General Psychiatry* 33:766-771, 1976). A modified version of the GAS was included in DSM-III as the Global Assessment of Functioning (GAF) Scale.

The Indiana Psychiatric Illness Interview

Interview consists of 5 sets of prompts which are offered as the interview progresses.

1. Tell me the story of your life.

2. Do you think you have a mental illness?

3. Because of this what has and has not changed?

4. How does having a mental illness affect/ is affected by others?

5 .What do you control/what controls you?

6. What do you see in the future?

APPENDIX J

Ethics committee approval letter for the Douglas Research Center and the McGill University Health Centre

SOIGNER.
DÉCOUVRIR.
ENSEIGNER.

Douglas

INSTITUT UNIVERSITAIRE EN SANTÉ MENTALE
MENTAL HEALTH UNIVERSITY INSTITUTE

CARING.
DISCOVERING.
TEACHING.

March 17th, 2010

Dr Martin Lepage
Douglas Research Center
F.B.C. Pavilion

Subject: **Protocol 10/10** Manualized group cognitive-behavioral intervention for social anxiety in schizophrenia: An efficacy pilot study
New protocol – REB Issues

Dear Mr. Lepage;

At its meeting held on March 9th, 2010 the REB examined the protocol you submitted for approval. As you will see from the extract from the minutes of the meeting that is enclosed with this letter, the REB raised some issues which need to be addressed.

The REB agreed that the response from the researcher does not need to be examined by the whole Committee, but can receive expedited approval if the response is found satisfactory by the assigned reviewers.

Please send one original and two copies of your reply for approval by the REB. Please make sure to include a cover letter explaining the changes and highlight the changes made in the new version of the protocol and in the new version of the consent form to allow the reviewers to easily identify them.

Thank you for your cooperation.

Sincerely yours,

for:
J. Bruno Debruille, M.D., Ph.D.
Chairperson
Douglas Institute Research Ethics Board
/ec

EXTRACT FROM THE MINUTES OF THE DOUGLAS HOSPITAL RESEARCH ETHICS BOARD

Held on March 10, 2010, at 12:00 p.m.
in Room B-2151, Dobell Pavilion

6.2 Protocol 10/10 *Manualized group cognitive-behavioral intervention for social anxiety in schizophrenia: An efficacy pilot study*
New protocol
Principal investigator: Dr. Martin Lepage
Douglas Hospital Research Centre
Financing: CIHR

Protocol summary: The main objective of this research is to contrast the impact of a CBT Intervention for the treatment of social anxiety in schizophrenia with standard care (care as usual) on reducing symptoms of social anxiety.

The REB examined this protocol and raised the following issues which need to be addressed:

- The committee suggests that an additional measurement tool should be applied instead of the retest method unless the test-retest reliability can be demonstrated ;

- The Committee is wondering if there is also a method to evaluate social anxiety objectively without relying on self-report;

- The researcher refer specifically to Kingsep & Halperin &Al. in study design; the reference must be provided;

- The committee feels that using a waiting list with standard care as a control is no longer appropriate given pre-existing evidence. At that stage of the knowledge, a control intervention appears needed. (see for instance Depress Anxiety. 2008;25(6):542-53;

- A randomized trial of interpersonal therapy versus supportive therapy for social anxiety disorder;

- Lipsitz JD, Gur M, Vermes D, Petkova E, Cheng J, Miller N, Laino J, Liebowitz MR, Fyer AJ.);

- No references are provided.

Consent form:

The consent form needs to be adapted to the model FRSQ consent form available at the following web address:
http://ethique.msss.gouv.qc.ca/site/download.php?012d68d66ab55c8ab54ba7ea534dd40f

More specifically corrections are needed to the following headings:

- Section 5 – Participation, Section 6 – Responsibilities of the researcher, Section 7 – Conflict of interest, Section 8 – Benefits and Section 10 – Confidentiality;

- In section «Who can you call in case of questions or difficulties?» The names of Dr Martin Lepage and Dr Bélanger should be replaced with the names of the Emergency Room member's names with their phone numbers;

- The language in the consent form should be easier to understand for the participants.

The REB agreed that the response from the researcher does not need to be examined by the whole Committee, but can receive expedited approval if the response is found satisfactory by the assigned reviewers.

Centre universitaire de santé McGill
McGill University Health Centre
Les meilleurs soins pour la vie
The Best Care for Life

Bureau d'éthique de la recherche
Research Ethics Office

June 8, 2011

Dr. Gail Myhr
MUHC – RVH
Room P2.085C

Re: "Manualized Group Cognitive-behavioral Intervention for Social Anxiety in Schizophrenia: An Efficacy Pilot Study"

Dear Dr. Myhr:

The research proposal entitled above received Full Board review at the convened meeting of the PSY Committee on January 25, 2011 and was found to be within ethical guidelines for conduct at the McGill University Health Centre, and entered accordingly into the minutes of the Research Ethics Board (REB) meeting. At the MUHC, sponsored research activities that require US federal assurance are conducted under Federal Wide Assurance (FWA) 00000840.

Final approval for the study which includes the Study Protocol (May 2011), the Informed Consent (June 2011) and the study poster (undated) was provided on June 8, 2011.

All research involving human subjects requires review at a recurring interval and the current study approval is in effect until December 20, 2011. It is the responsibility of the principal investigator to submit an Application for Continuing Review to the REB prior to the expiration of approval to comply with the regulation for continuing review of "at least once per year".

It is important to note that validation for the translated version of the consent document has been certified by an MUHC translator As the translated text was potentially modified, the document must be reviewed by the study sponsor prior to its use. Any further modification to the REB approved and certified consent document must be identified by a revised date in the document footer, and re-submitted for review prior to its use.

The Research Ethics Boards (REBs) of the McGill University Health Centre are registered REBs working under the published guidelines of the Tri-Council Policy Statement, in compliance with the "Plan d'action ministériel en éthique de la recherche et en intégrité scientifique" (MSSS, 1998) and the Food and Drugs Act (7 June, 2001), acting in conformity with standards set forth in the (US) Code of Federal Regulations governing human subjects research, and functioning in a manner consistent with internationally accepted principles of good clinical practice.

...2

687, avenue des Pins ouest, S11, Montréal (Québec) H3A 1A1, Tél.: 514 934-1934, Postes : 36077, 34323, 34720

We wish to advise you that this document completely satisfies the requirement for Research Ethics Board Attestation as stipulated by Health Canada.

The project was assigned MUHC Study Number 10-273-PSY that is required as MUHC reference when communicating about the research Should any revision to the study, or other unanticipated development occur prior to the next required review, you must advise the REB without delay. Regulation does not permit initiation of a proposed study modification prior to REB approval for the amendment.

We trust this will meet with your complete satisfaction.

Sincerely,

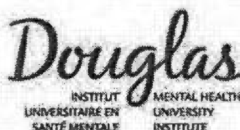
Lawrence Annable

Lawrence Annable, BSc, Dip. Stat.
Chair,
PSY Committee

Cc: 10-273-PSY

APPENDIX K

Participant Consent Forms for the Douglas Research Center and the McGill University Health Centre



FORMULAIRE DE CONSENTEMENT

Il est important que vous compreniez bien toutes les informations contenues dans ce formulaire de consentement. N'hésitez pas à poser des questions s'il y a un mot ou une phrase que vous ne comprenez pas ou si une information n'est pas claire.

TITRE DU PROJET DE RECHERCHE

« Intervention cognitive-comportementale de groupe manualisée pour le traitement de l'anxiété sociale chez les personnes schizophrènes : Une étude préliminaire »

CHERCHEURS RESPONSABLES DU PROJET DE RECHERCHE

Chercheur(s)e principal CUSM: **Dr Gail Myhr, M.D., C.M. M.Sc., FRCPC, Psychiatre (Centre Universitaire Santé McGill, Département Psychiatrie - Université McGill)**

Chercheur(s)e principal : Dr Martin Lepage, Ph.D., Psychologue (Institut Universitaire en Santé Mentale Douglas – Centre de Recherche Douglas, Département Psychiatrie - Université McGill)

Les co-chercheurs sont:

-Dr Claude Bélanger, Ph.D., Psychologue (UQÀM – Université du Québec à Montréal, Institut Universitaire en Santé Mentale Douglas, Département Psychiatrie - Université McGill)
-Dr Ashok Malla, M.D. FRCPC, Psychiatre (Institut Universitaire en Santé Mentale Douglas, Département Psychiatrie - Université McGill)
- -Dr Norbert Schmitz, Ph.D., (Institut Universitaire en Santé Mentale Douglas – Centre de Recherche Douglas, Département Psychiatrie - Université McGill)
-Tina Montreuil, M.Ed. Psy., Candidate au doctorat (Institut Universitaire en Santé Mentale Douglas – Centre de Recherche Douglas, Département Psychologie Clinique – Université Québec à Montréal)

NATURE ET OBJECTIF DU PROJET DE RECHERCHE

Nous vous invitons à participer à ce projet de recherche qui porte sur les problèmes reliés à l'anxiété sociale pour les personnes souffrant de schizophrénie. L'étude aura lieu à l'Institut Allan-Memorial et sous la direction chercheurs cliniciens. L'objectif du projet de recherche vise à mesurer l'efficacité thérapeutique d'une intervention psychologique de groupe, de courte durée (13 semaines) selon une approche cognitivo-comportementale (TCC). Veuillez prendre le temps de lire, de bien comprendre et de considérer très attentivement les renseignements qui suivent, avant d'accepter de participer à ce projet et de signer le formulaire d'information et de consentement.

Ce formulaire peut contenir des mots que vous ne comprenez pas. Nous vous invitons à poser toutes les questions au chercheur responsable du projet ou aux autres membres du personnel affecté au projet de

recherche que vous jugerez utiles. Vous êtes libre de leur demander de vous expliquer tout mot ou renseignement qui n'est pas clair.

Votre participation à cette étude est entièrement volontaire et vous pouvez cesser de participer à tout moment.

1. Organisme subventionnaire

Cette étude est subventionnée par le laboratoire de Dr Martin Lepage (CIHR) et la clinique PEPP (Clinique Prévention Psychose Premier-Épisode). Le chercheur principal est le Dr Martin Lepage, Ph.D., Psychologue (Institut Universitaire en Santé Mentale Douglas – Centre de Recherche Douglas, Département Psychiatrie - Université McGill).

2. Objectif du projet

Cette étude vise à examiner l'utilité d'une intervention psychologique de groupe de courte durée. L'intervention porte sur la thérapie cognitivo-comportementale, mieux connue sous l'acronyme TCC. L'objectif principal du traitement vise à réduire les symptômes reliés à l'anxiété sociale chez les individus qui souffrent de schizophrénie. Le but de l'étude vise à améliorer le fonctionnement social de ces individus. L'étude compare l'efficacité de cette intervention d'approche TCC au traitement standard. Ce type de psychothérapie est utilisé depuis plusieurs années. De plus, la TCC a été démontré efficace dans le traitement de divers troubles anxieux. Cependant, très peu d'études se sont intéressées spécifiquement à l'efficacité du traitement à la fois pour l'anxiété sociale et la schizophrénie comme le propose cette étude. Les participants qui décideront de participer à l'étude recevront l'intervention proposée soit : (1) immédiatement ou, (2) ils seront mis sur une liste d'attente pour recevoir le traitement à la fin du premier groupe.

3. Description du projet

Évaluation

Lors de la première rencontre, l'évaluateur va mesurer la sévérité de vos symptômes anxieux. Cette évaluation sera complétée par un assistant de recherche. L'évaluation comprend une entrevue ainsi que l'administration de quelques questionnaires que vous devrez compléter si vous acceptez de participer. Ces questionnaires serviront à identifier vos symptômes. En identifiant des symptômes d'anxiété sociale, cette évaluation servira donc à déterminer si vous êtes un bon candidat pour l'étude. L'entrevue d'évaluation durera environ 90 minutes (incluant une pause si vous le désirez). En ce basant sur les symptômes identifiés lors de l'évaluation, l'assistant de recherche vous informera si vous êtes en mesure de participer à l'étude. Si vous décidez de participer à l'étude, vous serez alors assigné au hasard à l'une ou l'autre des deux conditions de l'expérience. Soit que vous participerez à la thérapie immédiatement ou que vous prendrez part à la thérapie à la fin du premier groupe. Si vous êtes choisi au hasard à faire partie du deuxième group, vous serez placé sur une liste d'attente.

Intervention

Dans l'un ou l'autre des cas, l'intervention immédiate ou la liste d'attente, vous participerez à une thérapie de groupe une fois par semaine. La durée approximative d'une rencontre est d'environ deux heures. Les rencontres à chaque semaine se dérouleront sur 13 semaines consécutives. Dans le cas d'intempéries ou d'un congé férié, la séance sera reprise et reportée à la semaine suivante. À la fin des

13 semaines, il y aura une évaluation d'environ 90 qui visera à mesurer les bénéfices de la thérapie, s'il y a lieu. Une dernière évaluation finale aura aussi lieu trois mois après la fin du traitement. Cette évaluation dura environ 30 – 45 minutes.

Que ce soit pour l'intervention immédiate ou la liste d'attente, la thérapie sera offerte en groupe. Le groupe sera animé par une thérapeute accompagnée d'une co-thérapeute. Les groupes de thérapie seront animés en français ou en anglais. Le client choisira la langue avec laquelle il juge être le plus à l'aise.

Si vous êtes d'accord, les entrevues seront enregistrées (audio) afin de s'assurer que le thérapeute applique correctement le bon type de thérapie. Parmi les enregistrements, on sélectionnera des cassettes au hasard et celles-ci seront écoutées par des thérapeutes du projet. Cet enregistrement servira au contrôle de la qualité des services offerts. Si vous n'êtes pas à l'aise avec le fait d'être enregistrés, vous pouvez participer au projet et être libre de refuser l'enregistrement. Vous pourrez le mentionner à la fin du formulaire de consentement et/ou en faire part au thérapeute.

4. Participation

Si vous acceptez de participer au projet, il est recommandé de ne pas participer en même temps à d'autres projets de recherches. Il est également recommandé de ne pas prendre part à une autre forme de thérapie avant d'avoir complété le projet de recherche suivant.

Votre participation à ce projet de recherche est volontaire. Vous êtes donc libre de refuser d'y participer. Vous pouvez également vous retirer de ce projet à n'importe quel moment, sans avoir à donner de raisons. Vous pouvez mettre fin à votre participation en faisant connaître votre décision au chercheur responsable du projet ou à l'un des membres du personnel du projet.

Votre décision de ne pas participer à ce projet de recherche ou de vous en retirer n'aura aucune conséquence sur la qualité des soins et des services auxquels vous avez droit. De plus, votre décision de vous retirer n'entrainera pas de conséquences sur votre relation avec le chercheur responsable du projet ni les autres intervenants.

Les chercheurs associés au projet de recherche peuvent mettre fin à votre participation, sans votre consentement. Ceci pourrait se produire si de nouvelles découvertes ou informations indiqueraient que votre participation au projet n'est plus dans votre intérêt. De plus, si vous ne respectez pas les consignes du projet de recherche ou s'il existe des raisons administratives, vous pourriez être forcé à cesser votre participation dans le projet.

5. Responsabilités du chercheur principal

Au cas où une réaction négative se produisait suite à une procédure incluse dans cette étude, il est de la responsabilité du chercheur de vous offrir les services nécessaires. Ses soins seraient couverts par l'assurance de l'hôpital et leur couverture d'assurance santé. En acceptant de signer le formulaire de consentement, vous ne compromettez pas vos droits légaux. Les chercheurs doivent honorer leurs propres responsabilités légales et professionnelles.

6. Conflit(s) d'intérêt

Il n'existe aucun conflit d'intérêt associé à ce projet de recherche qui implique des cliniciens-chercheurs ni le centre de recherche.

7. **Avantages**

Il n'y a pas d'avantages à participer à cette étude. Toutefois, votre participation à ce projet de recherche pourrait contribuer à aider de futurs participants, en raison des connaissances qui découleront de cette étude.

8. **Risques**

En participant à cette recherche, vous ne courez aucun risque prévisible. Il n'y a pas de risques médicaux ni psychologiques importants qui sont associés au présent projet de recherche. Cependant, il est envisageable que chez certains participants, certaines questions puissent raviver des émotions désagréables liées à une expérience vécue. Vous êtes libre de ne pas répondre à une question que vous jugez embarrassante. Vous n'avez pas à vous justifier si vous choisissez de ne pas répondre. De plus, à tout moment, vous avez le droit de quitter la séance si vous ressentez un inconfort. De plus, vous avez le droit de poser des questions afin de partager vos inquiétudes.

9. **Confidentialité**

À moins qu'il n'en soit autrement requis par la loi toutes les informations que vous communiquerez resteront confidentielles. Les réponses aux questions des entrevues ne seront pas communiquées à qui que ce soit autre qu'aux professionnels impliqués dans cette étude. Afin d'assurer cette confidentialité, nous utiliserons un numéro à la place de votre nom pour identifier les feuilles qui serviront à la cueillette des informations. Ainsi, toutes les informations resteront anonymes. Nous n'utiliserons aucune information permettant d'identifier une personne ou l'autre. La liste de tous les participants et participantes sera gardée dans un endroit sécuritaire. Elle ne sera utilisée que par les membres de l'équipe de recherche.

Toutes mesures nécessaires seront entreprises afin de protéger la confidentialité et l'anonymat des participants au cours de la recherche. Les données cliniques recueillies seront traitées dans la plus stricte confidentialité. De plus, toutes les informations que vous devez fournir seront codées et maintenues sous clés dans un classeur.

Si vous acceptez que les entrevues soient enregistrées, une fois que les entrevues vérifiées, les enregistrements audio seront détruits l'année suivant les dernières publications, jusqu'à un maximum de cinq ans suivant la fin de l'étude.

10. **Compensation**

Les frais de transport en commun qui s'avèreront nécessaires pour des visites supplémentaires à celles de votre suivi habituel vous seront remboursés.

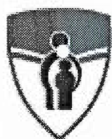
Dans le cas où vous décideriez d'interrompre votre participation dans cette étude, nous vous rembourserons les coûts associés à votre participation antérieure.

11. **Qui puis-je appeler si j'ai des questions ou des difficultés?**

Si vous avez des questions concernant le projet de recherche ou si vous éprouvez un problème que vous

croyez relié à votre participation au projet de recherche, vous pouvez communiquer avec: les responsables du projet au numéro (514) 934-1934 (ext. 35533) pour la coordonatrice du projet, Mme Sylvie Lafleur qui est située à l'Institut Allan-Memorial, 1025 Avenue des Pins Ouest, P2.086. Le comité de recherché éthique impliquant des humains du Centre de Recherche Douglas ainsi que l'UQÀM ont tous deux approuvés le projet de recherche dans lequel vous accepteriez de participer.

Pour toute question sur vos droits à titre de participant à la recherche, vous pouvez communiquer avec l'Ombudsman du CUSM au numéro suivant : (tél.) 514-934-1934, poste. 48306.



Centre universitaire de santé McGill
McGill University Health Centre

FORMULAIRE DE CONSENTEMENT

Il est important que vous compreniez bien toutes les informations contenues dans ce formulaire de consentement. N'hésitez pas à poser des questions s'il y a un mot ou une phrase que vous ne comprenez pas ou si une information n'est pas claire.

TITRE DU PROJET DE RECHERCHE

« Intervention cognitive-comportementale de groupe manualisée pour le traitement de l'anxiété sociale chez les personnes schizophrènes : Une étude préliminaire »

CHERCHEURS RESPONSABLES DU PROJET DE RECHERCHE

Chercheur (s) e principal CUSM : **Dr Gail Myhr, M.D., C.M. M.Sc., FRCPC, Psychiatre (Centre Universitaire Santé McGill, Département Psychiatrie - Université McGill)**

Chercheur (s) e principal : Dr Martin Lepage, Ph. D., Psychologue (Institut Universitaire en Santé Mentale Douglas – Centre de Recherche Douglas, Département Psychiatrie - Université McGill)

Les Co chercheurs sont :

— Dr Claude Bélanger, Ph. D., Psychologue (UQÀM – Université du Québec à Montréal, Institut Universitaire en Santé Mentale Douglas, Département Psychiatrie - Université McGill)
-Dr Ashok Malla, M.D. FRCPC, Psychiatre (Institut Universitaire en Santé Mentale Douglas, Département Psychiatrie - Université McGill)
- -Dr Norbert Schmitz, Ph.D., (Institut Universitaire en Santé Mentale Douglas – Centre de Recherche Douglas, Département Psychiatrie - Université McGill)
— Tina Montreuil, M.Ps., Candidate au doctorat (Institut Universitaire en Santé Mentale Douglas – Centre de Recherche Douglas, Département Psychologie Clinique – Université Québec à Montréal)

NATURE ET OBJECTIF DU PROJET DE RECHERCHE

Nous vous invitons à participer à ce projet de recherche qui porte sur les problèmes reliés à l'anxiété sociale pour les personnes qui souffrent de schizophrénie. L'intervention porte sur la thérapie cognitive-comportementale, mieux connue sous l'acronyme TCC. Le projet de recherche a pour but de mesurer l'efficacité thérapeutique d'une intervention psychologique de groupe, de courte durée (13 semaines) selon une approche cognitive-comportementale (TCC). L'étude aura lieu à l'Institut Allan-Memorial.

Prenez le temps de lire, de vous assurer que vous comprenez bien les renseignements qui suivent, avant

d'accepter de participer à ce projet.

N'hésitez pas à poser toutes vos questions au chercheur responsable du projet. Vous pouvez également lui demander de vous expliquer tout mot ou renseignement qui n'est pas clair.

Votre participation à cette étude est totalement volontaire. Vous pouvez arrêter de participer à n'importe quel moment sans que ceci nuise au traitement que vous recevez à cet hôpital.

1. Organisme accordant la subvention

Cette étude est subventionnée par des fonds de recherche qui furent attribués au laboratoire de Dr Martin Lepage par l'Institut de Recherche en Santé Mentale du Canada (IRSC) et la clinique PEPP (Clinique d'Intervention et de Prévention Psychose Premier-Épisode). Le chercheur principal est le Dr Martin Lepage, Ph. D., Psychologue (Institut Universitaire en Santé Mentale Douglas – Centre de Recherche Douglas, Département Psychiatrie - Université McGill).

2. Objectif du projet

Cette étude tente d'examiner l'utilité d'une intervention psychologique de groupe de courte durée. La TCC est une approche psychothérapeutique très structurée qui vise à l'identification et la modification des comportements et émotions qui entraine des difficultés en changeant les pensées dysfonctionnelles qui leur sont associées. L'objectif principal de l'intervention vise à voir si la TCC de groupe peut réduire les symptômes reliés à l'anxiété sociale chez les gens qui souffrent de schizophrénie, et ce dans le but d'améliorer le fonctionnement social de ces personnes ainsi qu'à réduire les symptômes psychotiques associés. L'étude compare l'efficacité d'une intervention d'approche TCC au traitement standard.

La TCC est utilisée depuis plusieurs années et elle a été démontrée efficace pour le traitement de divers troubles mentaux surtout les troubles reliés à l'anxiété. Cette étude s'intéresse à l'efficacité de la TCC pour le traitement de l'anxiété sociale chez les gens souffrant de schizophrénie. Si vous acceptez de participer à cette étude, vous recevrez de la TCC de groupe en plus d'avoir accès aux services habituels offerts par votre médecin et votre personnel de soutien à votre clinique. Vous recevrez l'intervention proposée soit immédiatement ou vous serez mis sur une liste d'attente afin de recevoir le traitement plus tard durant l'année. Le groupe auquel vous ferez partie vous sera assigné au hasard.

3. Description du projet

Évaluation

Si vous acceptez de prendre part à cette étude, nous communiquerons avec vous dans le but de vous offrir un rendez-vous afin de : (1) discuter de l'étude, répondre à vos questions concernant l'étude et signer le formulaire de consentement, ainsi que de (2) rencontrer l'un des chercheurs qui vous posera des questions détaillées dans le but de mieux comprendre le type de symptômes reliés à l'anxiété qui sont présents chez vous et de déterminer à quel point ils sont sévères. Le chercheur, Thomas Howells, vous posera certaines questions provenant d'un questionnaire qui aide à mieux comprendre les difficultés que vous cause l'anxiété. Le questionnaire aide le chercheur à déterminer si vous possédez le type de symptômes qui sont en lien avec cette étude ou s'il est question de tout autre symptôme qui pourrait être mieux traité selon une différente approche. Dans l'éventualité où vos symptômes sont différents de ceux ciblés par l'étude, nous vous en aviserons. Les questionnaires durent environ une heure et demie à deux heures. Si vous décidez de ne pas vouloir participer, l'évaluation n'aura pas lieu. À la fin de l'entrevue, nous vous informerons si vous pouvez participer à l'étude et nous vous

demanderons si vous souhaitez y participer. Vous pouvez cesser de participer à l'étude (retirer votre consentement) à tout moment. Si vous décidez que vous voulez toujours participer à l'étude, vous participerez soit à la thérapie immédiatement ou vous serez placé sur une liste d'attente. Être placé sur une liste d'attente signifie que vous allez tout de même recevoir le même traitement. La seule différence est que votre groupe débutera dès que le premier groupe aura terminé.

Intervention

Qu'il s'agisse de l'intervention TCC de groupe immédiate ou la liste d'attente, vous participerez à une rencontre de deux heures à chaque semaine pour une durée de 13 semaines. La TCC peut accommoder de 8 -10 participants par groupe. Si l'une des rencontres doit être annulée, elle sera fixée à un autre moment déterminé afin qu'un nombre total de 13 rencontres soit atteint. À la fin de la dernière rencontre, on vous assignera une rencontre de suivi d'environ 90 minutes. On vous posera des questions concernant vos symptômes d'anxiété dans le but de déterminer s'ils se sont améliorés ou non à la suite de l'intervention TCC. Trois mois après cette date, on vous demandera de vous présenter pour une brève évaluation qui dura environ 30 – 45 minutes afin de voir comment vous allez.

Toutes les séances de thérapie auront lieu en groupe incluant d'autres participants qui souffrent d'anxiété sociale et elles seront animées par une thérapeute, étudiante au doctorat en psychologie clinique, ainsi qu'une co-thérapeute qui est résidente en psychiatrie. Les groupes seront offerts en français ou en anglais. Vous pourrez choisir si vous désirez participer au groupe offert en français ou en anglais.

Si vous êtes d'accord, les entrevues seront enregistrées (audiovisuel) afin de s'assurer que la thérapie se déroule selon les règles. Parmi les enregistrements, on sélectionnera des cassettes au hasard et celles-ci seront écoutées par des thérapeutes du projet afin de voir au contrôle de la qualité des services offerts. Si vous n'êtes pas à l'aise avec le fait d'être enregistrés, vous pouvez participer au projet et être libre de refuser l'enregistrement. Si vous acceptez de participer à l'étude, nous vous demanderons si vous acceptez de nous donner accès à votre dossier médical dans le but probable de vérifier l'historique médical et la clinique ou l'équipe traitante.

4. Participation

Votre participation à ce projet de recherche est volontaire. Vous êtes donc libre de choisir si vous désirez participer à cette étude. Vous pouvez également vous retirer de ce projet à n'importe quel moment. Votre décision de ne pas participer à ce projet de recherche ou de vous en retirer n'aura pas de conséquences sur la qualité des soins et des services auxquels vous avez droit.

Les chercheurs associés au projet de recherche peuvent mettre fin à votre participation, sans votre consentement pour les motifs suivants : s'ils perçoivent que votre participation pourrait vous être dommageable; si vous ne respectez pas les consignes de l'étude tel que recommandé par les chercheurs; ou si les organismes qui accordent la subvention de l'étude décidaient de mettre fin à l'étude.

5. Responsabilités du chercheur principal

Nous n'envisageons pas que cette étude provoque des effets négatifs. Toutefois, si une telle situation se produisait nous nous engageons à vous offrir les soins nécessaires sans aucuns frais. Toutefois, si cette situation se produisait à la suite de votre participation à cette étude, il est de la responsabilité du chercheur de vous offrir les soins nécessaires, et ce sans frais pour vous. En acceptant de signer le formulaire de consentement, vous ne mettez pas en jeux vos droits légaux.

6. Conflit (s) d'intérêts

Il n'existe aucun conflit d'intérêts associé à ce projet de recherche qui n'implique des cliniciens-chercheurs ni le centre de recherche.

7. Avantages

Il n'y a pas d'avantages à participer à cette étude. Toutefois, votre participation à ce projet de recherche pourrait contribuer à aider de futurs participants, en raison des connaissances qui pourraient découler de cette étude.

8. Risques

Il n'y a pas de risques médicaux connus qui seraient associés à votre participation au projet de recherche. Les risques associés à cette étude ne sont pas plus élevés que pour ceux qui sont associés au traitement habituel. Cependant, il est possible que pour certains participants, certaines parties de l'intervention puissent raviver des émotions désagréables liées à une expérience passée. Au fil de l'étude, il est suggéré que vous nous informiez si vous désirez continuer à prendre part à l'étude. Vous n'avez pas à vous justifier si vous choisissez de ne pas répondre. Nos thérapeutes sont qualifiés pour offrir une aide aux participants qui vivraient un inconfort.

9. Confidentialité

À moins que la loi l'oblige, toutes les informations que vous communiquerez resteront confidentielles. Les réponses aux questions des entrevues ne seront pas communiquées à qui que ce soit autre qu'aux professionnels impliqués dans cette étude. Afin d'assurer cette confidentialité, votre nom n'apparaitra pas sur les documents relatifs à l'étude, à la place de votre nom nous utiliserons un numéro pour identifier les feuilles qui serviront à la cueillette des informations. Ce numéro nous permettra d'identifier les documents que vous aurez complétés durant l'étude. Nous n'utiliserons aucune information permettant d'identifier une personne ou l'autre. La liste de tous les participants et participantes sera gardée dans un endroit sécuritaire. Elle sera seulement utilisée que par les membres de l'équipe de recherche.

Ce projet est confidentiel. Ceci signifie que seuls les chercheurs ainsi que les assistants à la recherche de ce projet pourront avoir accès à l'information que vous avez fournie. Ceci inclut les informations qui auront été recueillies durant les séances de thérapie, les enregistrements ou toute autre retranscription de leur contenu, incluant votre dossier médical. Toutes informations que vous aurez fournies seront enregistrées et elles seront mises sous clé dans un classeur. Si vous êtes d'avis à ce que les entrevues soient enregistrées, ces enregistrements seront détruits une fois que les entrevues auront été vérifiées, visionnées et retranscrites dans un cahier. Les enregistrements audio seront détruits à l'intérieur de cinq ans suivant la fin de l'étude. Les représentants du Comité d'Éthique de la Recherche du CUSM pourraient effectuer une inspection dans le but de vérifier l'intégrité et la qualité des informations qui sont recueillies dans le cadre de cette étude.

10. Compensation

On vous remboursera les frais de transport en commun qui seront associés aux visites supplémentaires à celles de votre suivi habituel.

Dans le cas où vous décideriez de ne plus participer dans cette étude, nous vous rembourserons les coûts qui sont associés à votre participation depuis le début.

11. Qui puis-je appeler si j'ai des questions ou des difficultés?

Si vous décidez de participer à cette étude, vous recevrez une copie de ce formulaire de consentement.

Si vous avez des questions concernant le projet de recherche ou si vous éprouvez des difficultés à cause de votre participation au projet de recherche, vous pouvez communiquer avec la coordonnatrice du projet, Mme Sylvie Lafleur au numéro (514) 934-1934 (ext. 35533). Mme Lafleur est située à l'Institut Allan-Memorial, 1025 Avenue des Pins Ouest, P2.086.

Pour toute question sur vos droits à titre de participant à la recherche, vous pouvez communiquer avec l'Ombudsman du CUSM au numéro suivant : (tél.) 514-934-1934, poste. 48306.

Centre universitaire de santé McGill
McGill University Health Centre

CONSENTEMENT

Avant de signer ce document

Je, ______________________________ reconnais avoir lu le formulaire de consentement suivant et j'accepte volontairement de participer à ce projet de recherche. Je reconnais que les chercheurs ont pris le temps nécessaire afin de m'expliquer l'objectif et la démarche de l'étude à laquelle je souhaite donner mon consentement à y participer. J'ai eu suffisamment de temps afin de bien réfléchir à ma décision de prendre part à cette étude. Toutes mes questions ont été répondues de façon satisfaisante. J'ai lu le formulaire de consentement et je comprends les avantages et les risques impliqués par ma participation à ce projet.

Je comprends que je peux me retirer de ce projet à n'importe quel moment. Si je souhaite ne plus participer à cette étude, ce retrait n'entrainerait pas de conséquences négatives. Si je décide de me retirer, cela ne nuira pas aux soins et services que je recevrai dans le futur.

Par la présente, je consens que j'accepte de participer à cette étude et je certifie que l'on m'a remis une copie du formulaire de consentement.

J'accepte________ je refuse_________ que mes entrevues soient enregistrées. Je comprends que les enregistrements seront détruits à l'intérieur de cinq ans suivant la fin de l'étude.

DOSSIER MÉDICAL

J'autorise l'accès ________ / Je refuse l'accès_________ à mon dossier médical du CUSM.

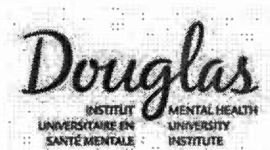
______________________________ ______________________
Signature du participant Date

____
Nom

______________________________ ______________________
Signature de la personne qui obtient le consentement Date

____
Nom

Veuillez conserver le premier exemplaire de ce formulaire de consentement pour votre usage personnel futur et veuillez remettre le deuxième à l'interviewer.



CONSENT FORM

It is essential that you understand all the information contained in this consent form. Do not hesitate to ask questions if there is a word or a phrase that you do not understand or if an information is unclear.

TITLE OF THE RESEARCH PROJECT

"Manualized group cognitive-behavioral intervention for social anxiety in schizophrenia: An efficacy pilot study"

THE RESEARCHER IN CHARGE OF THE RESEARCH PROJECT

Principal investigator : **- Dr Martin Lepage, Ph.D., Psychologue (Institut Universitaire en Santé Mentale Douglas – Centre de Recherche Douglas, Département Psychiatrie - Université McGill)**

The co-investigators are :

-Dr Claude Bélanger, Ph.D., Psychologue (UQÀM – Université du Québec à Montréal, Institut Universitaire en Santé Mentale Douglas, Département Psychiatrie - Université McGill)
-Dr Ashok Malla, M.D. FRCPC, Psychiatre (Institut Universitaire en Santé Mentale Douglas, Département Psychiatrie - Université McGill)
-Dr Gail Myhr, M.D., C.M. M.Sc., FRCPC, Psychiatre (Centre Universitaire Santé McGill, Département Psychiatrie - Université McGill)
-Dr Norbert Schmitz, Ph.D., (Institut Universitaire en Santé Mentale Douglas – Centre de Recherche Douglas, Département Psychiatrie - Université McGill)
-Tina Montreuil, M.Ed. Psy., Candidate au doctorat (Institut Universitaire en Santé Mentale Douglas – Centre de Recherche Douglas, Département Psychologie Clinique – Université Québec à Montréal)

THE PROTOCOL'S NUMBER

You are invited to participate in this research project, which consists of an intervention for social anxiety in schizophrenia. The objective of this study is to examine the effectiveness in social anxiety symptom reduction of a 13-week group CBT for social anxiety adapted for people with schizophrenia. The study will be conducted at the Douglas Institute by clinical investigators. Please be sure to read the following document carefully and in order to ensure that you have understood all the information it contains prior to accepting to participate and signing the current consent form.

You are free to participate to this study and you may withdraw your participation at any time.

2. Sponsors and researchers

This study is funded by Dr Martin Lepage's lab (CIHR) and the PEPP clinic. The principal investigator is Dr Martin Lepage, Ph.D., Psychologue (Institut Universitaire en Santé Mentale Douglas – Centre de Recherche Douglas, Département Psychiatrie - Université McGill)

3. Purpose of the research

We hypothesize that individuals receiving the brief manualized CBT intervention will show a reduction in symptoms associated with social anxiety (as determined with the Social Interaction Anxiety Scale (SIAS) and the Social Phobia Inventory (SPIN) after therapy. Furthermore, this study will explore the utility of a brief psychological group intervention utilizing the specific approach of cognitive-behavioral therapy, better known by its acronym CBT. The main goal of treatment is to reduce the symptoms related to social anxiety in individuals with schizophrenia in order to improve their social functioning and clinical prognosis in early remission of psychotic symptoms. The study compares the effectiveness of adding CBT to standard therapy. This approach to psychotherapy has been used for several years and its effectiveness was demonstrated extensively for the treatment of various psychopathologies, especially anxiety- related disorders. However, very few studies have looked specifically at the effectiveness of CBT for the treatment of comorbid social anxiety and schizophrenia, as proposed by this study. The study participants will receive the proposed intervention in addition to the usual care as offered by their respective clinic. Group membership will be randomly assigned on the basis of immediate intervention versus waiting list. This study will last approximately 2 years and will include over 80 participants that will be divided into 2 groups (intervention group receiving immediate treatment (40) and group on the waiting list, receiving the intervention at the end of the original group (40).

4. Description of the research

A randomized clinical trial will be conducted comparing the experimental group, which will be receiving CBT for social anxiety in addition to usual care, whereas the control group will be assigned to usual care alone and be placed on a waiting list in order to receive the treatment once the experimental group intervention is completed. The randomization process will take into account that the repartition of participants will be the same on the basis of social anxiety severity in order to avoid any initial group inequality.

Evaluation

The purpose of the initial meeting will aim at establishing a preliminary assessment relative to the nature and severity of your anxiety symptoms. The research assistant, Thomas Howells, will conduct the psychological evaluation. The psychological evaluation includes a diagnostic interview and the administration of several questionnaires designed to determine the more specific nature of the anxious symptomatology. This evaluation has the objective to also seek to determine if you meet the

selection or inclusion criteria in order to be granted participation in the study, which has been designed to treat social anxiety disorder. The assessment interview will last approximately 90 to 120 minutes (interrupted by a break if it is necessary) and will mainly help experimenters determine whether you qualify to become eligible to take part in this study and receive the group cognitive-behavioral therapy.

Following this interview, the research assistant will contact you to inform you if you meet the eligibility criteria regarding the severity of anxiety symptoms. If you decide to participate in the study, you will be randomly assigned to one of two experimental conditions: the group receiving immediate intervention and the group that is placed on the waiting list.

Intervention

In either case, immediate intervention or waiting list, treatment intervention involves that the participate engage in a weekly group intervention program, which will last approximately two hours and this for 13 consecutive weeks unless weather does not permit. In the event where one or more of the sessions should require cancellation, each missed session will be postponed to the following week in order to complete all 13 sessions. In addition, in order to measure the benefits of therapy if any, there will be a follow-up appointment that will last approximately 90 to 120 minutes at the end of your participation in the psychological intervention. Three-months following the termination of the group CBT intervention program, you will be asked to return for a brief follow-up evaluation. This session should not take more than 30 – 45 minutes.

All therapy sessions will be delivered in a group format by a therapist along with a co-therapist. The participants will be assigned the bilingual therapy group, which will be conducted in French and English. If you accept, the interviews will be recorded (audio-visual) to ensure that the therapists correctly apply the principles of cognitive-behavioural therapy. Among the records, the videotapes will be randomly selected and they will be reviewed by therapists and supervisors involved in the project in order to perform this quality-control measure. If you are not comfortable with being recorded, you are free to participate in the project and to refuse videotaping. Should this be the case, experimenters will take note of this in the consent form and / or inform the therapists.

5. Participation

If you wish to withdraw from this research project, you may do so at any time.
Your participation in this project is voluntary. This means that you agree to participate in the project without any coercion or external pressure. Also, you are free to terminate your participation from the project at any time during this study, without penalty or without it impacting your relationship with your doctor or treatment team and without affecting the quality of care or attention.

Similarly, at any time the researchers may also decide to terminate partial or full participation in the study, if they feel it is necessary for any health concerns.

6. Responsibilites of the researcher

In case of adverse reaction resulting from procedures required for this research, you will receive all the necessary care you need which are covered by the hospital insurance and health insurance plans. By signing this consent form, you are not giving up any of your legal rights. Furthermore, the researchers are not being discharged from their legal and professional responsibilities.

7. Conflict of interest

There is no conflict of interest related to this research project neither for the clinicians-researchers nor for the research centre.

8. Benefits

There are no known benefits to you associated with your participation in this research.

However, your participation in this study will help us improve in the future, services offered to individuals suffering from social anxiety and schizophrenia. Also, if you meet the selection criteria for the study you will receive a free 13-week psychotherapy for the treatment of social anxiety specifically adapted for the schizophrenia clientele.

9. Risks

There are no known harms associated with your participation in this research. The risks associated with this study are no higher than those associated with standard treatment or usual care, which you will continue receiving at your respective clinic. It is true that there are no risks of medical or physiological discomfort associated with your participation in this therapy. However, you should be aware that certain issues could revive unpleasant emotions or memories related to personal experience. You remain free to withdraw yourself from answering a question that you feel would be awkward and this without having to provide any justification. In addition, at any time, you can withdraw from the therapy session to relax, and are encouraged to ask questions in order to express your concerns.

10. Confidentiality

Unless it is otherwise required by law, *(in rare instances it will not be possible to ensure confidentiality because of mandatory reporting laws (e.g., suspected child abuse, reportable communicable diseases)* all the information that you will provide will remain confidential. Answers to questions from interviews will not be disclosed to other participant or any other professional. In order to ensure confidentiality, instead of your name we will be using numbers to identify the documents which will be used to collect data. This way, all information will remain confidential. We will not be using any information, which could lead to the identification of one person or another. The list of all participants will be kept in a secured place and will be used exclusively by members of the research team.

This project is confidential, which means that only the researchers and research assistants for this project will have access to information that you provided during the therapy sessions, recordings or any transcriptions of its content, including your medical record. All necessary measures will be taken to protect the confidentiality and anonymity of participants during the study. Clinical data collected will be treated with the strictest confidentiality. Consequently, all study participants will be assigned an alphanumeric identification number in lieu of their name, and no other personal information will be made available. Moreover, all the information you provide will be encrypted and kept under key in a workbook. If you agree to the recorded interviews and therapy sessions, it is with the

understanding that once these are viewed and encoded, that any video recordings will be destroyed one year after the latest publications. [1]

Furthermore, a copy of the signed consent form, as well as an updated list of all patients participating a in a research project needs to be sent to the medical records department; this procedure excludes projects of less than a one month duration. [1]

11. Compensation

The costs of transit, which are necessary for any additional visits to those of your regular monitoring, will be refunded. Although no financial compensation is provided through your participation in this study, it is important that you take notice that you will nonetheless receive an effective psychological treatment.

Withdraw from the research will not affect any reimbursement of costs that may have been incurred prior to withdrawal.

12. Who can you call in case of questions or difficulties?

If you decide to participate in this study, you will receive a copy of this consent form.

To obtain more information about this study, you can contact:

For additional questions on the research project or your rights as a research participant, you can contact the project number (514) 761-6131 (ext. #4393 for Dr Martin Leapge, or (514) 987-3000 (ext. #1777 for Dr Claude Bélanger). The Committee on Ethical Research Involving Humans, UQAM has approved the research project in which you are agreeing to take part.

For any question related to your rights as a research participant or for any ethical problem concerning the conditions in which this research project is being conducted, you may contact the Ombudsman of the Douglas Mental Health University Institute, 6875 Lasalle blvd., Montreal (Quebec) H4H 1R3, telephone : (514) 761-6131 local 3287, e-mail : Ombudsman@douglas.mcgill.ca

We would like to thank

Your cooperation was essential to the realization of our project and the research team would like to thank you.

I hereby consent, and agree to participation in this study and I accept_______ I refuse________ to have my interviews be recorded for verification in order to ensure the quality of the rendered psychotherapy services. I have been informed that the records will be destroyed no later than one year following the latest publications.

MEDICAL FILE

I authorize access to my medical record of the Douglas ________

I refuse access to my medical record of the Douglas _________

Participant signature   Date

Name (script)

Signature of the person who explained the study   Date

Name (script)

Please keep the first copy of this consent form for possible communication with the research team and the second to give the interview.

Centre universitaire de santé McGill
McGill University Health Centre

CONSENT FORM

It is essential that you understand all the information contained in this consent form. Do not hesitate to ask questions if there is a word or a phrase that you do not understand or if information is unclear.

TITLE OF THE RESEARCH PROJECT

"Manualized group cognitive-behavioral intervention for social anxiety in schizophrenia: An efficacy pilot study"

THE RESEARCHER IN CHARGE OF THE RESEARCH PROJECT

MUHC Principal Investigator: - Dr Gail Myhr, M.D., C.M. M.Sc., FRCPC, Psychiatrist (McGill University Health Centre, Department of Psychiatry – McGill University)

Principal investigator : **- Dr Martin Lepage, Ph.D., Psychologist (Douglas Mental Health Institute, Department of Psychiatry – McGill University)**

The co-investigators are :

-Dr Claude Bélanger, Ph.D., Psychologist (UQÀM – Université du Québec à Montréal, Douglas Mental Health Institute, Department of Psychiatry – McGill University)
-Dr Ashok Malla, M.D. FRCPC, Psychiatrist (Douglas Mental Health Institute, Department of Psychiatry – McGill University)
-Dr Norbert Schmitz, Ph.D., (Douglas Mental Health Institute, Department of Psychiatry – McGill University)
-Tina Montreuil, M.Ps., Doctoral Candidate (Douglas Mental Health Institute, Douglas Research Centre, Department of Clinical Psychology – Université Québec à Montréal)

THE RESEARCH PROJECT

You are invited to participate in this research project, which studies a treatment for social anxiety in schizophrenia. This treatment approach is called cognitive behavioural therapy or "CBT". This study examines the effectiveness of a 13-week CBT group treatment for social anxiety that has been designed for people with schizophrenia. The group will be at the McGill University Health Centre.

Please read this document carefully to make sure you understand all the information before you accept to participate and sign the consent form.

Your participation in this study is completely voluntary and you can leave the study at any time. Your participation or withdrawal will not affect your treatment at this hospital.

1. **Sponsors and researchers**

This study is funded by research funds granted to Dr Martin Lepage's lab (Canadian Institute of Health Research) and the Prevention and Early Intervention Program for Psychosis (PEPP-Montréal) clinic. The principal investigator is Dr Martin Lepage, Ph.D., Psychologist (Douglas Mental Health Institute – Douglas Research Centre, Department of Psychiatry – McGill University)

2. **Purpose of the research**

This study will explore the helpfulness of a short psychological group treatment called cognitive-behavioral therapy, or *CBT*. CBT is a form of therapy that is very structured and it aims to improve difficulties that are related to behaviors and emotions by first working on identifying and changing negative inaccurate thoughts. The main goal of this intervention is to see if group CBT reduces the symptoms of social anxiety in people with schizophrenia so that they can improve their social functioning and help their psychotic symptoms. The study compares the usefulness of adding CBT to standard services.

CBT has been used for several years and is helpful in the treatment of various mental disorders, especially anxiety-related disorders. This study looks at the helpfulness of CBT in treating social anxiety in people with schizophrenia. If you agree to be in this study, you will receive group CBT in addition to the usual care given to you by your doctors and caregivers in your clinic. You will either get treatment immediately or be on a wait list to get your treatment later in the year. The group you start with will be assigned on the basis of chance.

3. **Description of the research**

Evaluation

If you agree to be in this study, we will contacted you for an appointment to: (1) talk about the study, answer any questions you have about the study, and sign a written consent form, and (2) meet with one of the researchers who will ask detailed questions to understand what kinds of anxiety symptoms you have and how bad they are. The researcher, Thomas Howells, will ask you some questions from a questionnaire that helps better understand the problems anxiety causes for you. It also helps decide if you have the types of symptoms that this study is about or if you have other symptoms that should be treated in a different way. If your symptoms turn out not to be the kind this study is looking at then this study is not for you and we will let you know that. The questionnaire takes between and hour and a half and two hours. If you decide not to participate, it will not be done. You will be told after the interview is over if you can take part in the study and asked if you would still like to participate. You can stop the study (withdraw your consent) at any time. If you decide that you still want to take part in the study you will either start the group right away or you will be placed on the waiting list. Being on the waiting list means that you will still get the same treatment as if you were getting it immediately. The only difference is that your group will start after a first group has already been done.

Intervention

Whether you start the CBT group right away or are on the waiting list, you will meet for a 2 hour group therapy meeting every week for 13 weeks. In CBT, groups can easily accommodate between 8 – 10 participants. If a meeting has to be cancelled, it will be rescheduled so that you will have 13 sessions in total. After the last session, you will be given a follow-up appointment that lasts about 90 minutes. Questions about your anxiety symptoms will be asked to see if they got better or not with the CBT treatment. Three months after this, you will be asked to come back for a short interview of 30-45 minutes to see how you are doing.

All therapy sessions will be done in a group with other people with social anxiety and led by a therapist, a clinical psychology doctoral student, along with a co-therapist, a psychiatry resident. The groups will be in English or French. You can choose if you would like to be in the English or French group.

If you accept, the evaluations will be recorded (audio-visual) to check that the therapists are doing cognitive behavioural therapy correctly. The videotapes will be randomly chosen for review by therapists and supervisors involved in the project to make sure that the therapy is of good quality. If you are not comfortable with being recorded, you are free to participate in the project and to say no to videotaping. If you accept to participate, you will be asked whether you will allow the investigator to view your medical records. Information such as medical history and treating team/clinic may be looked at.

4. **Participation**

Your participation in this project is voluntary. This means that you are free to choose whether or not to take part in the study. Also, you are free to stop taking part in the treatment at any time during this study. This will not affect your relationship with your doctor or treatment team and will not change the quality of care or attention you receive from them.

The study doctors also may decide that you should no longer participate in this study for any of the following reasons: If they feel it would be dangerous for you to continue; in case you do not follow study procedures or rules as recommended by the study doctors; or because the sponsor of the study decides to end the study.

5. **Responsibilities of the researcher**

We do not expect that you will experience any harm or injury as a result of participating in this study. However, if this should happen, you will receive all the care and services needed to treat you without any cost to you. By signing the consent form, you are not giving away any of your legal rights.

6. **Conflict of interest**

There is no conflict of interest related to this research project involving the clinicians-researchers nor for the research centre.

7. **Benefits**

There are no known benefits to you from taking part in this study. However, your participation may help others in the future because of the knowledge gained from the study.

8. **Risks**

There are no known physical harms associated with your participation in this research. The risks associated with this study are no higher than for regular treatment or usual care. You will continue to receive the same care from your clinic. However, for some participants, parts of the treatment could stir up unpleasant emotions or memories related to past personal experiences. As the study moves forward, we suggest that you let us know if you wish to continue taking part in the study. Our therapists are qualified and have been trained to assist participants in coping with these unpleasant potential unpleasant emotions or memories.

9. **Confidentiality**

All the information that you share with us will remain confidential, unless we were forced by law to do otherwise. Answers to questions from evaluations will not be shared with any other participant or any other professional. In order to make sure that your personal information stays confidential, your name will not be written on any study forms (we use a number instead). This number will be used to identify the documents that you will have filled out during the study. We will not be using any information which could identify you or anyone else taking part in the study. The list of all participants will be kept in a secured place and will only be used by members of the research team.

This project is confidential. This means that only the researchers and research assistants for this project will be able to access the information that you provide. This includes the information collected during the therapy sessions, the recordings or in any transcriptions of its content, including your medical record. All the information you provide will be recoded and locked in a filing cabinet. If you agree to take part in the recorded interviews and therapy sessions, any video recordings will be destroyed once these are viewed and written down in a workbook. This information will be destroyed within five years after the study is completed. Representatives of the MUHC Research Ethics Board may inspect the information collected in order to ensure the integrity and quality of the research.

10. **Compensation**

We will refund the costs of transit, if you need it to attend any of the evaluations or treatment sessions.

If you choose to leave the study, we will still reimburse you for any money you had to spend to participate before you left.

11. **Who can you call in case of questions or difficulties?**

If you decide to participate in this study, you will receive a copy of this consent form.

For additional questions on the research project or your rights as a research participant, you can contact the project number (514) 934-1934 (ext. 35533 for the study recruitment coordinator, Mrs. Sylvie Lafleur) who is located at the Allan Memorial Institute, 1025 Pine Avenue West, P2.086.

If you have any questions regarding your rights as a study participant, you should contact the Ombudsman at the following number: (tel.) 514-934-1934, ext. 48306.

Centre universitaire de santé McGill
McGill University Health Centre

CONSENT

Before signing this document

I, ____________________________ have read this consent form and I freely give my consent to participate in this study. The researchers have clearly explained to me the goals and the procedures of the study to which I am giving my consent to participate. I have been given enough time to think about my decision to participate in this study. All my questions were clearly answered. I have read this consent form and I understand that there are possible benefits and risks that may be associated with my participation in this study.

I understand that I can choose to stop taking part in the study at any time. If I no longer want to participate in the study, there would not be any negative consequence in stopping. If I decide to stop, the care and services I will receive in the future will not be affected.

By signing this document, I agree to participate in this research project and I confirm that I was given a copy of the consent form that I signed.

I accept________ I refuse_________ to have recorded interviews. I am aware that the records will be destroyed within five years after the study is completed.

MEDICAL FILE

I accept________ I refuse_________ access to my medical record of the MUHC.

____________________________________ ________________________________
Participant signature Date

____
Name

____________________________________ ________________________________
Signature of the person who explained the study Date

____
Name

The interviewer will give you a copy of this consent form for possible communication with the research team and another copy will be given to the investigator.

GENERAL REFERENCES

Achim, A. M., M. Maziade, E. Raymond, D. Olivier, C. Mérette, et M.A. Roy, M.- 2009. «How Prevalent Are Anxiety Disorders in Schizophrenia? A Meta-Analysis and Critical Review on a Significant Association». Schizophrenia Bulletin, vol. 37, no 4, p. 1-11.

Addington, J., H. Saeedi et D. Addington. 2005. «The course of cognitive functioning in first episode psychosis: changes over time and impact on outcome». Schizophr Res, vol. 78, no 1, p. 35-43.

Addington, J., H. Saeedi et D. Addington . 2006. «Influence of social perception and social knowledge on cognitive and social functioning in early psychosis». Br J Psychiatry, vol. 189, p. 373-378.

Addington, J. et J. Gleeson, 2005. «Implementing cognitive-behavioural therapy for first-episode psychosis». Br J Psychiatry Suppl, vol. 48, p. 72-76.

Addington, D., J. Addington et B. Schissel. 1990. «A depression rating scale for schizophrenics.». Schizophr Res, vol. 3, no 4, p. 247-251.

Amador, X.F., Flaum, M., et al. 1994. «Awareness of illness in schizophrenia and schizoaffective and mood disorders». Arch Gen Psychiatry, vol. 51, p. 826-836.

Anderson, R. A. et C.S. Rees, C. 2007. «Group versus individual cognitive-behavioural treatment for obsessive-compulsive disorder: a controlled trial». Behav Res Ther, vol. 45, no 1, p. 123-137.

Andreasen, N.C. 1984a. *Modified Scale for the Assessment of Negative Symptoms (SANS)*. Iowa City: University of Iowa.

Andreasen, N.C. 1984b. *Scale for the Assessment of Positive Symptoms (SAPS)*. Iowa City: University of Iowa.

Andreasen, N.C., W.T. Carpenter Jr, J.M. Kane, R.A. Lasser, S.R. Marder et D.R. Weinberger. 2005. «Remission in schizophrenia: proposed criteria and rationale for consensus». Am J Psychiatry, vol. 162, no 3, p. 441-449.

Antony, M.M. 1997. «Assessment and treatment of social phobia». Can Journal of Psychiatry, vol. 42. no. 8, p. 826-834.

Anthony, W. A. 1993. «Recovery from mental illness: The guiding vision of the mental health service system in the 1990's». Psychosocial Rehabilitation, vol. 16, no. 4, p. 11-23.

Banerjee, A. 2001. «Social Cognitive Factors in Childhood Social Anxiety : A Preliminary Investigation». Social Development, vol. 10, no. 4, p. 558-572.

Barlow, D. H. 2002. *Anxiety and its disorders: The nature and treatment of anxiety and panic* (2nd ed.). New York: Guilford Press.

Barrowclough, C., G. Haddock, F. Lobban, S. Jones, R. Siddle, C. Roberts et L. Gregg. 2006. «Group cognitive-behavioural therapy for schizophrenia». British Journal of Psychiatry, vol. 189, p. 527-532.

Beck, A.T., E. Baruch, J.M. Balter, R.A. Steer et D.M. Warman. 2004. «A new instrument for measuring insight: The beck cognitive insight scale». Schizophrenia Research, vol. 68, no 2-3, p. 319-329.

Beck, A.T., N.A. Rector, N. Stolar et P. Grant. 2009. *Schizophrenia: Cognitive Theory, Research and Therapy*. New York: Guildford Press.

Beidel, D.C., et al. 2005. «Social effectiveness therapy for children: three-year follow-up». J Consult Clin Psychol, vol. 74, no 3, p. 721-725.

Bieling, P. J., R.E. McCabe et M.M. Antony. 2006. *Cognitive-Behavioral Therapy in Groups*. New York: Guilford Press.

Bentall, R. P. 2003. *Madness explained - Psychosis and human nature*. London: Penguin.

Bernard, H., G. Burlingame, P. Flores, L. Greene, A. Joyce, J.C. Kobos et al. 2008. «Clinical practice guidelines for group psychotherapy». International Journal of Group Psychotherapy, vol. 58, p. 455–542.

Bertrand, M. C., A. M. Achim, P. O. Harvey, H. Sutton, A. K. Malla et M. Lepage. 2008. «Structural neural correlates of impairments in social cognition in first episode psychosis». Soc Neurosci, vol. 3, no 1, p. 79-88.

Bertrand, M. C., H. Sutton, A. M. Achim, A. K. Malla et M. Lepage. 2007. «Social

cognitive impairments in first episode psychosis». Schizophr Res, vol. 95, no 1-3, p. 124-133.

Birchwood, M. , E. Peters, N. Tarrier, G. Dunn, S. Lewis, T. Wykes, L. Davies, H. Lester et M. Michail. 2011. «A multi-centre, randomised controlled trial of cognitive therapy to prevent harmful compliance with command hallucinations». BMC Psychiatry, vol. 11, no 155.

Birchwood, M., Z. Iqbal, P. Chadwick et P. Trower. 2000. «Cognitive approach to depression and suicidal thinking in psychosis. 1. Ontogeny of post-psychotic depression». [Research Support, Non-U.S. Gov't]. Br J Psychiatry, vol. 177, p. 516-521.

Birchwood, M., Trower P., Brunet K., Gilbert P., Iqbal Z. et Jackson C. 2007. «Social anxiety and the shame of psychosis: a study in first episode psychosis». Behav Res Ther, vol. 45, no 5, p. 1025-1037.

Birchwood, M. et P. Trower. 2006. «The future of cognitive-behavioural therapy for psychosis: not a quasi-neuroleptic». [Editorial]. Br J Psychiatry, vol. 188, p. 107-108.

Blanchard, J. J., K.T. Mueser et A.S. Bellack. 1998. «Anhedonia, positive and negative affect, and social functioning in schizophrenia». Schizophr Bull, vol. 24, no. 3, p. 413-424.

Bodnar, M., A. Malla, R. Joober et M. Lepage. 2008. «Cognitive markers of short-term clinical outcome in first-episode psychosis». Br J Psychiatry, vol. 193, no 4, p. 297-304.

Bodnar M., A. Malla, Y. Czechowska, A. Benoit, F. Fathalli, R. Joober, M. Pruessner, Y. Pruessner et M. Lepage. 2010. « Neural markers of remission in first-episode schizophrenia: a volumetric neuroimaging study of the hippocampus and amygdala ». Schizophr Res, vol. 122, no 1-3, p. 72-80.

Bodnar M., P.O. Harvey, A. Malla, R. Joober et M. Lepage. 2011. «The parahippocampal gyrus as a neural marker of early remission in first-episode psychosis: a voxel-based morphometry study». Clin Schizophr Relat Psychoses, vol. 4, no 1, p. 217-228.

Bogels, S. M. et N. Tarrier. 2004. « Unexplored issues and future directions in social phobia research». Clin Psychol Rev, vol. 24, no 7, p. 731-736.

Brekke, J., D. D. Kay, K. S. Lee et M. F. Green. 2005. «Biosocial pathways to functional

outcome in schizophrenia». Schizophr Res, vol. 80, no 2-3, p. 213-225.

Brüne, M. 2005. «Emotion recognition, 'theory of mind,' and social behavior in schizophrenia.». Psychiatry Res, vol. 132, no 2, p. 135-147.

Buchy, L., Bodnar, M., Malla, A., Joober, R., et Lepage, M. 2010. «A 12-month outcome study of insight and symptom change in first-episode psychosis». Early Intervention in Psychiatry, vol. 4, no 1, p. 79-88.

Buchy, L., Czechowska, Y., Chochol, C., Malla, A., Joober, R., Pruessner, J., et Lepage, M. 2009. «Toward a Model of Cognitive Insight in First-Episode Psychosis: Verbal Memory and Hippocampal Structure». Schizophr Bull, vol. 36. no. 5, p. 1040-1049.

Cassano, G. B., S. Pini, M. Saettoni, P. Rucci et L. Dell'Osso. 1998. «Occurrence and clinical correlates of psychiatric comorbidity in patients with psychotic disorders». J Clin Psychiatry, vol. 59, no 2, p. 60-68.

Cassidy C, M. Rabinovitch, R. Joober et A. Malla. 2010. «A comparison study of multiple measures of adherence to antipsychotic medication in first episode psychosis». J Clin Psychopharmacol, vol. 30, p. 64–67.

Cassidy, C. M., N. Schmitz et A.K. Malla. 2008. «Validation of the alcohol use disorders identification test and the drug abuse screening test in first episode psychosis». Canadian Journal of Psychiatry, vol. 53, no 1, p. 26-33.

Cassidy C.M., R. Norman, R. Manchanda, N. Schmitz et A. Malla. 2010. «Testing definitions of symptom remission in first-episode psychosis for prediction of functional outcome at 2 years». Schizophr Bull, vol. 36, no 5, p. 1001-1008.

Castonguay, L. G., M.J. Constantino et M. Grosse Holtforth. 2006. «The working alliance: Where are we and where should we go? ». Psychotherapy, vol. 43, p. 271-279.

Clark, D. M., et A. Wells. 1995. *A cognitive model of social phobia*. In R. G. Heimberg, M. Liebowitz, D. Hope & F. Scheier (Eds.), Social Phobia: diagnosis, assessment, and treatment (pp. 69-93). New York: Guilford.

Clark, D. M. 2001 *A cognitive perspective on social phobia.* In Handbook of Social Anxiety: Concepts Relating to the Self and Shyness (eds R. Crozier & L. E. Alden), pp. 48-97. Chichester: John Wiley & Sons.

Clark, D. A. 2005. *Intrusive thoughts in clinical disorders: Theory, Research & Treatment*. New York: Guilford Press.

Connor, K.M. 2000. «Psychometric properties of the Social Phobia Inventory (SPIN).New self- rating scale». Br J Psychiatry, vol. 176, p. 379-386.

Constantino, M. J., B.A. Arnow, C. Blasey et W.S. Agras. 2005. «The association between patient characteristics and the therapeutic alliance in cognitive-behavioral and interpersonal therapy for bulimia nervosa». Journal of Clinical Psychology, vol. 73, p. 203-211.

Corcoran, R., G. Mercer etC. D. Frith. 1995. «Schizophrenia, symptomatology and social inference: investigating "theory of mind" in people with schizophrenia». Schizophr Res, vol. 17, no 1, p. 5-13.

Corrigan, P. W. et D. L. Penn. 2004. Social Cognition and Schizophrenia. Washington, DC: American Psychological Association.

Corrigan, P. W. et A.C. Watson. 2002. «Understanding the impact of stigma on people with mental illness». World Psychiatry, vol. 1. no 1, p. 16-20.

Corriss, D.J., T.E. Smith, J.W. Hull, R.W. Lim, S.I Pratt et S. Romanelli. 1999. «Interactive risk factors for treatment adherence in a chronic psychotic disorders population». Psychiatry Res, vol. 89, p. 269-274.

Cosoff, S. J., et R. J. Hafner. 1998. «The prevalence of comorbid anxiety in schizophrenia, schizoaffective disorder and bipolar disorder». Aust N Z J Psychiatry, vol. 32, no 1, p. 67-72.

Couture, S. M., D. L. Penn et D. L. Roberts. 2006. «The functional significance of social cognition in schizophrenia: a review». Schizophr Bull, vol. 32 Suppl 1, p. S44-63.

Dalrymple, K. L. 2012. «Issues and controversies surrounding the diagnosis and treatment of social anxiety disorder». Expert Reviews in Neurtherapy, vol. 12, no 8, p. 993-1009.

Davidson, J.R., et al. 1991. «The Brief Social Phobia Scale». J Clin Psychiatry, vol. 52, p. 48- 51.

Davies, N., A. Russell, P. Jones et R.M. Murray. 1998. «Which characteristics of schizophrenia predate psychosis»? J Psychiatr Res, vol. 32 no 3-4, p. 121-131.

Doehrmann, O., S.S. Ghosh, F.E. Polli, G.O. Reynolds, F. Horn, A. Keshavan et J.D. Gabrieli. 2012. «Predicting Treatment Response in Social Anxiety Disorder From Functional Magnetic Resonance Imaging». Arch Gen Psychiatry, vol. 70, no 1, p. 87-97.

Drake, R. E., E.L. O'Neal et M.A. Wallach. 2008. «A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders». Journal of Substance Abuse Treatment, vol. 34, no1, p. 123-138.

Dunn, G. et R. Bentall. 2007. «Modelling treatment-effect heterogeneity in randomized controlled trials of complex interventions (psychological treatments)». [Multicenter Study Randomized Controlled Trial Stat Med, vol. 26, no. 26, 4719-4745.

Endicott, J., R.L. Spitzer, J.L. Fleiss etJ. Cohen. 1976. «The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance». Archives of General Psychiatry, vol. 33, p. 766-771.

El-Khouly, G., & El Gaafary, M. (2011). «Social anxiety in schizophrenia: a clinical quantitative and qualitative analysis». Middle East Current Psychiatry, 18(1), 37–44.

El Masry, N., N. Abdel Fattah, N. et al. 2009. «Comorbidity of Social Phobia in a Sample of Out-patients with Schizophrenia». Current Psychiatry [Egypt], vol. 16, no 4, p. 397-402.

Foa, E. B., M.E. Franklin, K.J. Perry et J.D. Herbert. 1996. «Cognitive biases in generalized social phobia». J Abnorm Psychol, vol. 105, no 3, p. 433-439.

Fear, C., H. Sharp et D. Healy. 1996. «Cognitive processes in delusional disorders». Br J Psychiatry, vol. 168, no 1, p. 61-67.

Fish, F. (1984). *Schizophrenia*, 3rd ed. Hamilton, M. (ed) Williams & Wilkins, Baltimore.

First, M. B., R. L. Spitzer, M. Gibbon et J. B. Williams. 1995. «Structured clinical interview of DSM-IV axis I». New York: Disorders (SCID-I) clinical version.

First, M.B. , R.L. Spitzer, M. Gibbon et J.B.W. Williams. 1998. Structured Clinical Interview for DSM-IV Axis I Disorders, Patient Edition (SCID-I/P & SCID-I/NP), Version 2. New York: New York Psychiatric Institute, Biometrics Research p.

Freeman, M.P., S.A. Freeman et S.L. McElroy. 2002. «The comorbidity of bipolar and anxiety disorders: prevalence, psychobiology, and treatment issues». J Affect Disord, vol. 68, no 1, p. 1-23.

Freeman, D., P.A. Garety et M.L. Phillips. 2000. «An examination of hypervigilance for external threat in individuals with generalized anxiety disorder and individuals with persecutory delusions using visual scan paths». Q J Exp Psychol A, vol. 53, no 2, p. 549-567.

Freeman, D., P.A. Garety et E. Kuipers. 2001. «Persecutory delusions: developing the understanding of belief maintenance and emotional distress». Psychol Med, vol. 31, no 7, p. 1293-1306.

Freeman, D. et P.A. Garety. 2003. «Connecting neurosis and psychosis: the direct influence of emotion on delusions and hallucinations». Behav Res Ther, vol. 41, no 8, p. 923-947.

Garety, P. A. et D. Freeman. 1999. «Cognitive approaches to delusions: A critical review of theories and evidence». British Journal of Clinical Psychology, vol. 38, p. 113-154.

Garety, P., E. Kuipers, D. Fowler, D. Freeman et P. Bebbington. 2001. «Theoretical paper: A cognitive model of the positive symptoms of psychosis». Psychol Med vol. 31, p. 189–195.

Garety, P. A., P. Bebbington, D. Fowler, D. Freeman et E. Kuipers. 2007. «Implications for neurobiological research of cognitive models of psychosis: a theoretical paper». Psychol Med, vol. 37, no 10, p. 1377-1391.

Garety, P.A., D.G. Fowler, D. Freeman, P, Bebbington, G. Dunn et E. Kuipers. 2008. «Cognitive behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: randomised controlled trial». Br J Psychiatry, vol. 192, no 6, p. 412-23.

Gaudiano, B.A. 2006. «Is symptomatic improvement in clinical trials of cognitive-behavioral therapy for psychosis clinically significant»? J Psychiatr Pract, vol. 1, p. 11-23.

Gehrs, M., & Goering, P. 1994. «The relationship between the working alliance and rehabilitation outcomes of schizophrenia». Psychosocial Rehabilitation Journal, vol. 18, no 2, p. 43-54.

Gleeson, J., T.K. Larsen et P.D. McGorry. 2003. « Psychological treatment in pre- and early psychosis». Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, vol. 31, p. 229-245.

Gold, J. M. 2004. «Cognitive deficits as treatment targets in schizophrenia». Schizophr Res, vol. 72, no 1, p. 21-28.

Gold, J.M. et M.F. Green. 2002. *Neurocognition in schizophrenia*. In Kaplan & Sadock's Comprehensive Textbook of Psychiatry, 8th ed., S. V. Sadock BJ, p. 1426-1448. Batimore: Lippincott, Williams & Wilkins.

Goldberg, T.E. et M.F. Green. 2002. «Neurocognitive functioning in patients with schizophrenia: An overview». Neuropsychopharmacology: The Fifth Generation of Progress., p. 657–669.

Good, J. 2002. «The effect of treatment of a comorbid anxiety disorder on psychotic symptoms in a patient with diagnosis of schizophrenia: A case study». Behavioural and Cognitive Psychotherapy, vol. 30, p. 347-350.

Green, M. F. 1996. «What are the functional consequences of neurocognitive deficits in schizophrenia?». Am J Psychiatry, vol. 153, no 3, p. 321-330.

Green, M. F., R. S. Kern, D. L. Braff et J. Mintz. 2000. «Neurocognitive deficits and functional outcome in schizophrenia: are we measuring the "right stuff"?». Schizophr Bull, vol. 26, no 1, p. 119-136.

Green, M. F., B. Olivier, J. N. Crawley, D. L. Penn et S. Silverstein. 2005. «Social cognition in schizophrenia: recommendations from the measurement and treatment research to improve cognition in schizophrenia new approaches conference». Schizophr Bull, vol. 31, no 4, p. 882-887.

Green, A.I., C. Canuso, M.J. Brenner et J.D. Wijcik. 2003. «Detection and management of comorbidity in schizophrenia». Psychiatr Clin N Am, vol. 26, p. 115-139.

Gross, C.A. et N.E. Hansenn. 2000. «Clarifying the experience of shame: the role of attachment style, gender and investment in relatedness». Personality and Individual Differences, vol. 28, p. 897–907.

Gumley, A., M. O'Grady, K. Power et M. Schwannauer. 2004. «Negative beliefs about self and illness: a comparison of individuals with psychosis with or without comorbid social anxiety disorder». Aust N Z J Psychiatry, vol. 38, no 11-12, p. 960-964.

Gureje, O., H. Herrman, C. Harvey, V. Morgan et A. Jablensky. 2002. «The Australian National Survey of Psychotic Disorders: profile of psychosocial disability and its risk factors». Psychol Med, vol. 32, no 4, p. 639-647.

Hafner, H., B. Nowotny, W. Loffler, W. van der Heiden et K. Maurer. 1995. «When and how does schizophrenia produce social deficits?». European Archives of Psychiatry and Clinical Neurosciences, vol. 246, p. 17-28.

Haghighat, R. 2001. «A unitary theory of stigmatisation: pursuit of self-interest and routes to destigmatisation». Br J Psychiatry, vol. 178, p. 207-215.

Hahn, S. E. 2000. «The effects of locus on daily exposure, coping and reactivity to work interpersonal stressors: A dairy study». Personality and Individual Differences, vol. 29, p. 729-748.

Hall, P. L. et N. Tarrier. 2003. «The cognitive-behavioural treatment of low self-esteem in psychotic patients: a pilot study». [Clinical Trial Randomized Controlled Trial]. Behav Res Ther, vol. 41. no 3, p. 317-332.

Halperin, S., P. Nathan, P. Drummond et D. Castle. 2000. «A cognitive-behavioural, group-based intervention for social anxiety in schizophrenia». Aust N Z J Psychiatry, vol. 34, no 5, p. 809-813.

Hamilton, M. 1969. « A. Diagnosis and rating of anxiety ». Br. J. Psychiatry Special Publication, vol. 3, p. 76–79.

Hannesdottir, D. K. et T.H. Ollendick. 2007. «Social Cognition and Social Anxiety among Icelandic Schoolchildren». Child & Family Behavior Therapy, vol. 29, no 4, p. 43-58.

Harb, G. C., & Heimberg, R.G. (2006). *Social anxiety disorder*. New York: Springer.

Harrison, G., K. Hopper, T. Craig, E. Laska, C. Siegel, J. Wanderling et D. Wiersma. 2001. «Recovery from psychotic illness: a 15- and 25-year international follow-up study». Br J Psychiatry, vol. 178, p. 506-517.

Hart, S. L. et T.A. Hart. 2010. «The future of cognitive behavioral interventions within behavioral medicine». Journal of Cognitive Psychotherapy: An International Quarterly, vol. 24. no 4, p. 344-353.

Hayward, P. et J. Bright. 1997. «Stigma and mental illness : a review and critique». Journal of Mental Health, vol. 6, p. 345-354.

Heimberg, R. G. (2002). «Cognitive-behavioral therapy for social anxiety disorder: current status and future directions». Biol Psychiatry, vol. 51, no 1, p. 101-108.

Heimberg, R. G., D.A. Hope, C.S. Dodge et R.E. Becker. 1990. «DSM-III-R subtypes of social phobia. Comparison of generalized social phobics and public speaking phobics». J Nerv Ment Dis, vol. 178, no 3, p. 172-179.

Heimberg, R. G., M.R. Liebowitz, D.A. Hope, F.R. Schneier, C.S. Holt, L.A. Welkowitz, et D.F. Klein. 1998. «Cognitive behavioral group therapy vs phenelzine therapy for social phobia: 12-week outcome». Arch Gen Psychiatry, vol. 55, no 12, p. 1133-1141.

Herbener, E.S., M. Harrow et S.K. Hill. 2005. «Change in the relationship between anhedonia and functional deficits over a 20-year period in individuals with schizophrenia». Schizophr. Res., vol. 75, p. 97–105.

Hofmann, S. G. (2007). «Cognitive Factors that Maintain Social Anxiety Disorder: a Comprehensive Model and its Treatment Implications». Cogn Behav Ther, vol. 36, no 4, p. 193-209.

Huppert, J.D, et T.E Smith. 2005. «Anxiety and Schizophrenia: The Interaction of Subtypes of Anxiety and Psychotic Symptoms». CNS Spectr, vol. 10, no 9, p. 721-731.

Jones, P., B. Rodgers, R. Murray et M. Marmot. 1994. « Child development, risk factors for adult schizophrenia in the British 1946 Birth Cohort ». Lancet, vol. 344, p. 1398–1402.

Johnstone, E.C., K.P. Ebmeier, P. Miller, D.G. Owens et S.M. Lawrie. 2005. « Predicting schizophrenia: findings from the Edinburgh High-Risk Study». Br J Psychiatry, vol. 186, p. 18-25.

Jorgensen L et D.J. Castle. 1998. « Anxiety and Psychosis». Comment on Aust N Z J Psychiatry, vol. 32, no 1, p. 67-72.

Kampman, O., Laippala, P., Vaananen, J. et al. 2002. «Indicators of medication in first episode psychosis». Psychiatry Research, vol. 110, p. 39 - 48.

Kay, S., A. Fiszbein et L. Opler. 1987. « The Positive and Negative Syndrome Scale (PANSS) for Schizophrenia ». Schizophrenia Bulletin, vol. 13, no 2, p. 261 276.

Kendler, K. S., T.J. Gallagher, J.M. Abelson et R.C. Kessler. 1996. «Lifetime prevalence, demographic risk factors, and diagnostic validity of nonaffective psychosis as assessed in a US community sample». The National Comorbidity Survey. Arch Gen Psychiatry, vol. 53, no 11, p. 1022-1031.

Kimhy, D., J. Vakhrusheva, L. Jobson-Ahmed, N. Tarrier, D. Malaspina et J.J. Gross. 2012. «Emotion awareness and regulation in individuals with schizophrenia: Implications for social functioning». Psychiatry Res. doi: 10.1016/j.psychres.2012.05.029

Kingsep, P., P. Nathan et D. Castle. 2003. «Cognitive behavioural group treatment for social anxiety in schizophrenia». Schizophr Res, vol. 63, no 1-2, p. 121-129.

Kingsep, P. et P.R. Nathan. 2001. Social Anxiety in Schizophrenia: A Cognitive Behavioural Group Therapy Programme. (Therapist Treatment Manual). Nedlands, Western Australia: Riobay Enterprises.

Koreen, A. R., M.D. Samuel, S.G. Siris et al. 1993. «Depression in first-episode schizophrenia». American Journal of Psychiatry, vol. 150, p. 1643– 1648.

Kumazaki, H., H. Kobayashi, H. Niimura, Y. Kobayashi, S. Ito, T. Nemoto et M. Mizuno. 2012. «Lower subjective quality of life and the development of social anxiety symptoms after the discharge of elderly patients with remitted schizophrenia: a 5-year longitudinal study». Comprehensive Psychiatry, in press.

Lacro, J. P., L.B. Dunn, C.R. Dolder. et al. 2002. «Prevalence of and risk factors for medication nonadherence in patients with schizophrenia: a comprehensive review of recent literature». Journal of Clinical Psychiatry, vol. 63, p. 892 – 909.

Lecomte, T., A. Spidel, C. Leclerc, W. MacEwan, C. Greaves et R.P. Bentall. 2008. «Predictors and profiles of treatment non-adherence and engagement in services problems in early psychosis». Schizophrenia Research, vol. 102, no 1-3, p. 295-302.

Lecomte, T., Corbière, M., & Briand, C. 2011. «Cognitive functioning in schizophrenia. In K. T. Mueser & D. V. Jeste (Eds.), Clinical Handbook of Schizophrenia New York: Guilford Press.

Lecomte, T., M. Cyr, A.D. Lesage, J. Wilde, C. Leclerc, C. et N. Ricard. 1999. «Efficacy of a self-esteem module in the empowerment of individuals with schizophrenia». J Nerv Ment Dis, vol. 187, no 7, p. 406-413.

Lewis, M. 1998. *Shame and stigma.* In P. Gilbert & B. Andrews (Eds.), Shame: Interpersonal Behaviour, Psychopathology and Culture (pp. 126-140). New York: Oxford University Press.

Lewis S, N. Tarrier, G. Haddock, R. Bentall, P. Kinderman, D. Kingdon et al. 2002. «Randomised controlled trial of cognitive-behavioural therapy in early schizophrenia: acute-phase outcomes». Br J Psychiatry Suppl, vol. 43, p. 91-97.

Lopez, A.D., C.D. Mathers, M. Ezzati, D.T. Jamison et C.J. Murray. 2006. «Global and regional burden of disease and risk factors, 2001: systematic analysis of population health data». Lancet, vol. 367, p. 1747–1757.

Lieberman, J., D. Jody, S. Geisler, J. Alvir, A. Loebel, S. Szymanski, M. Woerner et M. Borenstein. 1993. «Time course and biologic correlates of treatment response in first-episode schizophrenia». Arch Gen Psychiatry, vol. 50, no 5, p. 369-376.

Luck D., L. Buchy, Y. Czechowska, M. Bodnar, G.B. Pike, J.S. Campbell, A. Achim, A. Malla, R. Joober et M. Lepage. 2011. « Fronto-temporal disconnectivity and clinical short-term outcome in first episode psychosis: a DTI-tractography study ». J Psychiatr Res, vol. 45, no 3, p. 369-377.

Lysaker P.H., P.T. Yanos, J. Outcalt et D. Roe. 2010. « Association of stigma, self esteem, negative symptoms and emotional discomfort with concurrent and prospective assessment of social anxiety in schizophrenia spectrum disorders ». Clinical Schizophrenia and Related Psychoses, vol. 4, no 1, p. 41-49.

Lysaker, P. H., L.W. Davis, M.J. Gatton et S.M. Herman. 2005. «Associations of anxiety-related symptoms with reported history of childhood sexual abuse in schizophrenia spectrum disorders». J Clin Psychiatry, vol. 66, no 10, p. 1279-1284.

Maher, B. A. 1988. *Anomalous experience and delusional thinking: The logic of explanations.* In T. F. Oltmanns & B. A. Maher (Eds.), Delusional Beliefs (pp. 15–33). New York: Wiley.

Malla, A. K., R. M. Norman, R. Manchanda et L. Townsend. 2002. «Symptoms,

cognition, treatment adherence and functional outcome in first-episode psychosis». Psychol Med, vol. 32, no 6, p. 1109-1119.

Malla, A., R. Norman, T. McLean, D. Scholten et L. Townsend. 2003. «A Canadian programme for early intervention in non-affective psychotic disorders». Aust N Z J Psychiatry, vol. 37, no 4, p. 407-413.

Malla, A., R. Norman, N. Schmitz, R. Manchanda, L. Bechard-Evans, J. Takhar et R. Haricharan. 2006. «Predictors of rate and time to remission in first-episode psychosis: a two-year outcome study». Psychol Med, vol. 36, no 5, p. 649-658.

Malla, A. et J. Payne. 2005. «First-Episode Psychosis: Psychopathology, Quality of Life, and Functional Outcome». Schiz. Bull, vol. 31, no 3, p. 650- 671.

Malla, A. K., R.N. Norman et R. Manchanda. 2002. «Status of patients with first episode psychosis after one year of phase-specific community oriented treatment». Psychiatric Services, vol. 53, p. 458-463.

Matos, M., J. Pinto-Gouveia et P. Gilbert. 2012. «The effect of shame and shame memories on paranoid ideation and social anxiety». Clinicial Psychology and Psychotherapy, in press.

Mattick, R. P. et J. C. Clarke. 1998. «Development and validation of measures of social phobia scrutiny fear and social interaction anxiety». Behav Res Ther, vol. 36, no 4, p. 455-470.

Mazeh, D., E. Bodner, R. Weizman, Y. Delayahu, A. Cholostoy, T. Martin et Y. Barak. 2009. «Co-Morbid Social Phobia in Schizophrenia». Int J Soc Psychiatry, vol. 55, no 3, p. 198-202.

McGorry, P.D., I. Hickie, A.R.Yung, C. Pantelis et H.J. Jackson. 2006. «Clinical staging of psychiatric disorders: A heuristic framework for choosing earlier, safer and more effective interventions». Aust. N. Z. J. Psychiatry, vol. 40, p. 616–622.

McMillan, K. A., M.W. Enns, B. J. Cox et. S. Jitender. 2009. «Comorbidity of Axis and II Mental Disorders With Schizophrenia and Psychotic Disorders: Findings From the National Epidemiologic Survey on Alcohol and Related Conditions». Canadian Journal of Psychiatry, vol. 54, no 7, p. 477–486.

McRoberts, C., G. Burlingame et M. Hoag. 1998. «Comparative efficacy of individual and group psychotherapy: A meta-analytic perspective». Group Dynamics: Theory, Research and Practice, vol. 2, p. 101-117.

Michail, M. et M. Birchwood. 2012. «Social anxiety disorder and shame cognitions in psychosis». Psychol Med, p. 1-10. doi: 10.1017/S0033291712001146

Michail, M. et M. Birchwood. 2011. *Understanding the Role of Emotion in Psychosis: Social Anxiety Disorder in First-Episode Psychosis*, in Handbook Of Schizophrenia Spectrum Disorders, Volume II2011, Springer Netherlands: Dordrecht. p. 89-110.

Michail, M., et M. Birchwood. 2009. «Social anxiety disorder in first-episode psychosis: incidence, phenomenology and relationship with paranoia». The British Journal of Psychiatry, vol. 195, p. 234-241.

Miller, D.C. 1991. Handbook for Research Design and Social Measurement, 5th Edition, 5th. Newbury Park, CA: Sage Publications.

Montreuil, T.M. , A.K. Malla, R. Joober, C. Bélanger et M. Lepage. 2013. «Anxiety symptoms severity and short-term clinical outcome in first-episode psychosis». Early Intervention in Psychiatry, vol. 7, p. 5-11.

Montreuil,T. M., M.C. Bertrand, A.K. Malla, R. Joober et M. Lepage. 2010. «Social cognitive markers of short-term clinical outcome in first-episode psychosis». Clin Schizophr Relat Psychoses, vol. 4, no 2, p. 105-114.

Morrison, A. P., P. French, S.L. Stewart, M. Birchwood, D. Fowler, A.I. Gumley, A. I. et G. Dunn. 2012. «Early detection and intervention evaluation for people at risk of psychosis»: multisite randomised controlled trial. BMJ, vol. 344, e2233. doi: 10.1136/bmj.e2233

Mueser, K. T. 2000. *Cognitive functioning, social adjustment and long-term outcome in schizophrenia.* In T. Sharma & P. Harvey (Eds.), Cognition in Schizophrenia (pp. 157-177). New York: Oxford University Press.

Myin-Germeys, I., P. Delespaul et J. van Os. 2005. «Behavioural sensitization to daily life stress in psychosis». Psychol Med, vol. 35, no 5, p. 733-741.

Norman, R. M. et A.K. Malla. 1994. « Correlations over time between dysphoric mood and symptomatology in schizophrenia ». Comprehensive Psychiatry, vol. 35, p. 34–38.

Norman, R.M.G., A.K. Malla, M.B. Verdi, L.D. Hassall et C. Fazekas. 2004. « Understanding delay in treatment for first episode psychosis ». Psychological Medicine, vol. 34, p. 255-266.

Norman, R.M.G. et A.K. Malla. 1994. « A prospective study of daily stressors and symptomatology in schizophrenic patients ». Social Psychiatry and Psychiatric Epidemiology, vol. 29, no 6, p. 244-249.

Novak-Grubic, V. et R. Tavcar. 2002. «Predictors of noncompliance in males with first-episode schizophrenia, schizophreniform and schizoaffective disorder». European Psychiatry, vol. 17, p. 148-154.

Nuechterlein, K. H., D. M. Barch, J. M. Gold, T. E. Goldberg, M. F. Green et R. K. Heaton. 2004. «Identification of separable cognitive factors in schizophrenia». Schizophr Res, vol. 72, no 1, p. 29-39.

O'Sullivan, M., et J.P. Guilford. 1976. Four factor tests of social intelligence (behavioral cognition): Manual of instructions and interpretations. Orange, CA: Sheridan Psychological Services, Inc.

Ostrom, T.M. 1984. «The sovereignty of social cognition». In Handbook of social cognition, R. S. W. T. K. Srull, p. 1-37. Erlbaum: Hillsdale.

Pallanti, S. , L. Quercioli et E. Hollander. 2004 «Social Anxiety in Outpatients With Schizophrenia: A Relevant Cause of Disability». Am J Psychiatry, vol. 161, p. 53-58.

Penn D.L., K. Guynan, T. Daily, W.D. Spaulding, C.P. Garbin et M. Sullivan. 1994. « Dispelling the stigma of schizophrenia: What sort of information is best »? Schizophrenia Bulletin, vol. 20, p. 567-578.

Penn, D. L., P. W. Corrigan, R. P. Bentall, J. M. Racenstein et L. Newman. 1997. «Social cognition in schizophrenia». Psychol Bull, vol. 121, no 1, p. 114-132.

Pope, M., R. Joober et A. Malla. 2012. «One-year stability of primary and secondary diagnosis in patients with first-episode psychotic disorders». 8th International Conference on Early Psychosis. San Francisco, Early Intervention in Psychiatry, vol. 6, p. 70.

Premack, D., et G. Woodruff. 1978. «Chimpanzee problem-solving: a test for comprehension». Science, vol. 202, p. 532-535.

Rabinovitch, M., L. Béchard-Evans, N. Schmitz, R. Joober et A. Malla. 2009. «Early

predictors of nonadherence to antipsychotic therapy in first-episode psychosis». La Revue canadienne de psychiatrie, vol. 54, no 1, p. 28-35.

Rapee, R. M. et R.G. Heimberg. 1997. «A cognitive-behavioral model of anxiety in social phobia». Behav Res Ther, vol. 35, no 8, p. 741-756.

Rietdijk, J., J. van Os, P. Delespaul et M. van der Gaag. 2009. «Are social phobia and paranoia related, and which comes first»? Psychosis, vol. 1, no 1, p. 29-38.

Robins, L.N., J.E. Helzer, J.L. Croughan et K.S. Ratcliff. 1981. «National Institute of Mental Health Diagnostic Interview Schedule: its history, characteristics and validity». Arch Gen Psychiatry, vol. 38, no 4, p. 381–389.

Romm, K.L., I. Melle, C. Thoresen, O.A. Andreassen et J.I. Rossberg. 2011. «Severe social anxiety in early psychosis is associated with poor premorbid functioning, depression, and reduced quality of life». Compr Psychiatry, vol. 53, no 5, 434-440.

Rosenbaum, P. 2009. «Putting child development back into developmental disabilities» [Editorial]. Developmental Medicine & Child Neurology, vol. 51, p. 251.

Rose, D. 2004. *Cognitive-behavioral group work.* In C. D. Garvin & L. M. Gutierrez (Eds.), Handbook of social work in groups (pp. 111-135). New York: Guildford Press.

Rosen, K., et P. Garety. 2005. «Predicting recovery from schizophrenia: a retrospective
comparison of characteristics at onset of people with single and multiple episodes». Schizophr Bull, vol. 31, no 3, p. 735-750.

Ross, S., A. Grant, C. Counsell, W. Gillespie, I. Russell et R. Prescott, R. 1999. «Barriers to participation in randomised controlled trials: a systematic review». J Clin Epidemiol, vol. 52, no. 12, p. 1143-1156.

Rubinsztein, J., A. Michael, E.S. Paykel et J. Sahakian. 2000. «Cognitive impairment in remission in bipolar affective disorder. ». Psychol Med, vol. 30 p. 1025–1036.

Saunders, J. B., O.G. Aasland, T.F. Babor, J.R. de la Fuente, J. R. et M. Grant. 1993. «Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption — II». Addiction, vol. 88, p. 791–804.

Schwartz, J. E., S. Fennig, M. Tanenberg-Karant, G. Carlson, T. Craig, N. Galambos, J. Lavelle et E. J. Bromet. 2000. «Congruence of diagnoses 2 years after a first-admission diagnosis of psychosis». Arch Gen Psychiatry, vol. 57, no 6, p. 593-600.

Shear, K., J. Vander Bilt, P.D. Rucci, J. Endicott, B. Lydiard, M.W. Otto, M. H. Pollack, L. Chandler, J. Williams, A. Ali et D.M. Frank. 2001. « Reliability and validity of a structured interview guide for the Hamilton Anxiety Rating Scale(SIGH-A) ». Depression and Anxiety, vol. 13, no 4, p. 166-178.

Skinner, H. 1982. «The Drug Abuse Screening Test». Addictive Behaviors, vol. 7, p. 363–371.

Smith, B., D.G. Fowler, D. Freeman, P. Bebbington, H. Bashforth, P. Garety et al. 2006. «Emotions and psychosis: links between depression, self-esteem, negative schematic beliefs and delusions and hallucinations». Schizophr Res., vol. 86, no 1–3, p. 181–188.

SPSS. 2010. SPSS for Windows. Chicago, IL, SPSS. Release 12.0.1.

Svensson, B. et L. Hansson. 1999. «Relationships among patient and therapist ratings of therapeutic alliance and patient assessments of therapeutic process: a study of cognitive therapy with long-term mentally ill patients ». Journal of Nervous Mental Disorder, vol. 9, p. 579–585.

Tarrier N. 2010. «Cognitive behavior therapy for schizophrenia and psychosis: current status and future directions». Clin Schizophr Relat Psychoses, vol. 4, p. 176–184.

Tarrier, N., S. Lewis, S., G. Haddock, R. Bentall, R. Drake, P. Kinderman et al. 2004. «Cognitive-behavioural therapy in first-episode and early schizophrenia. 18-month follow-up of a randomised controlled trial». Br J Psychiatry, vol. 184, p. 231-239.

Thornicroft, G., E. Brohan, D. Rose, N. Sartorius et M. Leese. 2009. «Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey». Lancet, vol. 373, no 9661, p. 408-415

Tien, A.Y. et W.W. Eaton. 1992. «Psychopathologic Precursors and Sociodemographic Risk Factors for the Schizophrenia Syndrome». Arch Gen Psychiatry, vol. 49, no 1, p. 37-46.

Tracey, T.J. et A.M. Kokotovic. 1989. «Factor structure of the Working Alliance Inventory». J Consult Clin Psychol, vol. 1, p. 207–210.

Turkington, D., D. Kingdon, S. Rathod, K. Hammond, J. Pelton et R. Mehta. 2006. «Outcomes of an effectiveness trial of cognitive-behavioural intervention by mental health nurses in schizophrenia». Br J Psychiatry, vol. 189, p. 36-40.

Turnbull G. et P. Bebbington. 2001. «Anxiety and the schizophrenic process: clinical and epidemiological evidence». Social Psychiatry and Psychiatric Epidemiology, vol. 36, no 5, p. 235-243.

Upthegrove, R., M. Birchwood, K. Ross, K. Brunett, R. McCollum et L. Jones. 2010. «The evolution of depression and suicidality in first episode psychosis». Acta Psychiatr Scand, vol. 122, no 3, p. 211-218.

Vallis, T. M. 1998. *When the going gets tough: Cognitive therapy for the severely disturbed.* In Perris & P. McGorry (Eds.), Cognitive psychotherapy of psychotic and personality disorders (pp. 37-63). Chichester: Wiley.

Verdoux, H., F. Liraud, F. Assens, F. Abalan et J. van Os. 2002. «Social and clinical consequences of cognitive deficits in early psychosis: a two-year follow-up study of first-admitted patients». Schizophr Res, vol. 56, no 1-2, p. 149-159.

Villeneuve, K., S. Potvin, A. Lesage et L. Nicole. 2010. «Meta-analysis of rates of drop-out from psychosocial treatment among persons with schizophrenia spectrum disorder». [Meta-Analysis]. Schizophr Res, vol. 121, no 1-3, p. 266-270.

Visser, B.A., M.C. Ashton et P.A. Vernon. 2006. «Beyond g : Putting multiple intelligences theory to the test». Intelligence, vol. 34, no 5, p. 487-502.

Vogues, M. et J. Addington. 2005. «The association between social anxiety and social functioning in first episode psychosis». Schizophrenia Research, vol. 76, no 2-3, p. 287-292.

Washburn, D. 2012. *Theory of Mind Decoding and Reasoning Abilities in Depression, Social Phobia, and Comorbid Conditions*. (Master), Queen's University.

Wendell, D. R., R. Norman et A. Malla. in press. «The personal meaning of recovery among individuals treated for a first-episode of psychosis». Psychiatry Service.

Williams, L. M., T. J. Whitford, G. Flynn, W. Wong, B. J. Liddell, S. Silverstein, C. Galletly, A. W. Harris et E. Gordon. 2007. «General and social cognition in first episode schizophrenia: Identification of separable factors and prediction of functional outcome using the IntegNeuro test battery». Schizophr Res, vol. 99, no 1, p. 182-191.

Yalom, I. D. 1995. *The Theory and Practice of Group Psychotherapy*. New York: Basic Books.

Yung, A., L.J. Philips et P.D. McGorry. 2001. *Comprehensive Assessment of At-Risk Mental States (CAARMS)*. Melbourne: PACE Clinic: University of Melbourne.

Zimmermann, G., J. Favrod, V. Trieu, V. et V. Pomini. 2005. «The effect of cognitive behavioural treatment on schizophrenia spectrum disorders: a meta-analysis». Schizophr Res, vol. 77, p. 1–9.