

IX. Study unit: A psychotherapeutic approach to psychotic disorders

Patrícia Polgár

Aim

In this chapter students will become acquainted with the communicational techniques and psychotherapeutic methods necessary for the treatment of psychotic disorders. Subsequent to mastering the knowledge contained in this chapter, students will become acquainted with the communicational forms that help improving the compliance of psychotic patients to pharmacological treatment, and will find out about the cognitive behavioural therapy of psychosis.

Introduction

Introduction

In this chapter you will become acquainted with those simpler non-pharmacological treatment methods, through which psychotic disorders may be approached in general medical practice.

Target group: general practitioners, psychologists, psychology undergraduates and medical students

Task

Suggested study methods:

Read the texts.

Following this, answer the comprehension questions.

If you were not able to answer all the questions, survey the problematic parts in the texts again.

Total amount of study-time necessary: 6 hours

Literature

Recommended literature

Key words: Psychosis, schizophrenia, acceptance of illness, cognitive behavioural therapy

Content of chapter

IX./1. General characteristics of psychotic disorders

IX./1.1. The notion of psychosis and schizophrenia, their characteristics

IX./1.2. General principles of treatment

IX./1.3.: Summary

IX./2.: Facilitation of compliance

IX./2.1.: The significance of not accepting the illness

IX./2.2.: Basics of the LEAP method

IX./2.3.: The establishment of the relationship

IX./2.4.: Listening, empathy

IX./2.5.: Motivating the patient

IX./2.6.: Establishment of partnership

IX./2.7.: Summary

Summary

Which are the characteristic symptoms of schizophrenia?

The **characteristic symptoms** of schizophrenia can be divided into four groups. Thus we can identify the **positive symptoms** (hallucinations, delusions, disorganized speech and behaviour, catatonic symptoms), the **negative symptoms** (emotional-dispositional impoverishment, motivational decline, social withdrawal, decrease in the ability of joy), and the **affective symptoms** (anxiety, depression). Moreover in schizophrenia **cognitive symptoms** are also important (disorders of the attention, the work memory, and the executive functions).

[P_3_figure_XI_1_chapter.doc]

Legend: *Figure 3.: The diagnostic criteria of schizophrenia (American Psychiatry Association 1994.)*

Important
Treatment of acute psychosis

IX./1.2.: General principles of treatment

Acute psychotic conditions are to be treated pharmacologically by antipsychotic medications. Antipsychotic treatment in most instances *must be commenced immediately* after the patient's perception of the disease, for a delayed introduction of the therapy increases the risk of the development of emergencies and may extend the time span of symptomatic remission.

The **selection of the place of the treatment** is preceded by the assessment of the patient and the consideration of risks. It is important for the psychotic patient to be placed into a safe environment which entails the least possible restrictions on him, but where the conditions for the treatment can be ensured. There is a need for **acute psychiatric ward** treatment, if the behaviour of the patient is severely disorganized, if there is a directly threatening condition – the patient, on account of his hallucinations or delusions, is unable to attend to his own needs he requires permanent care. If the patient has a satisfactory ability to decide, then he has to **be informed** of the necessity and particulars of the treatment, his compliance has to be gained, and his approval of the therapy has to be asked for. If the patient, on account of his condition, constitutes **a direct threat to himself or for others**, then, within the bounds of a restricting measure, the patient may be hospitalized in an acute psychiatric ward, even against his will. In acute psychoses caused by psychoactive substances, when selecting the place of the treatment, the conditions of detoxification must also be considered. If, co-existent with the symptoms of acute psychosis, there exists some life-threatening somatic or neurological disease, then consultation with the competent specialists or the referral of the patient to these specialists may become necessary.

Important
Long-term treatment of a psychotic patient

In the case of schizophrenia, medicinal therapy is to be continued even subsequent to the passing of the psychotic condition (for years or even for life), as antipsychotic therapy is able to prevent **further relapses** For a long term medicinal treatment regular psychiatric control and a good collaboration between patient and doctor are necessary.

The role of the psychotherapeutic methods and the psychosocial interventions in the acute phase is more of a crisis intervention and psycho-education, whereas in the course of chronic care their aim is the decreasing of symptoms, the development of social skills and the preservation of an adequate compliance.

Summary

X./1.3.: Summary

The **psychotic state is a symptomatological diagnosis**, in the background of

Literature	<p>which several diseases may be found. The most characteristic disease that leads to a psychotic state is schizophrenia, which may develop as a result of the joint effect of genetic and environmental factors. In the case of schizophrenia, psychotic episodes and symptom-free periods may alternate with each other. The frequency and severity of the psychotic episodes is reducible or preventable by a preserving antipsychotic treatment.</p> <p>Acute psychotic conditions are generally to be treated by antipsychotic medications in psychiatric wards. The role of the psychotherapeutic interventions in this case is to improve compliance, and provide psycho-education and crisis intervention.</p> <p>In the course of the maintenance treatment of schizophrenia psychotherapeutic interventions, along with antipsychotic treatment, also plays a role in the alleviation of symptoms, in skill-development, and in the development of a long-term doctor-patient relationship.</p> <p>Literature</p> <p>American Psychiatric Association, DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, fourth ed. American Psychiatric Association, Washington, DC. 1994.</p> <p>The Professional College of Psychiatrists has issued a methodological circular about the treatment of psychotic conditions, which may be accessed on the homepage of the Hungarian Psychiatric Association: http://www.mpt.iif.hu/pages/4/page10.htm</p>

<p>Aim</p> <p>Important</p> <p>Question Why is it important, to have a long-term treatment of schizophrenia?</p> <p>How frequent is the lack of acceptance of illness?</p>	<p><i>IX./2.: Facilitation of compliance</i></p> <p>In the course of the reading of the chapter the student will become acquainted with communicational techniques that are useful in the treatment of psychotic disorders.</p> <p>IX./2.1.: The significance of not accepting the illness</p> <p>In the long-term treatment of schizophrenia patients the maintenance of antipsychotic treatment is of fundamental importance, since this is how further psychotic episodes may be prevented. According to the results of the majority of surveys, however, about half of the people suffering from severe mental diseases, do not take their medication. The most general cause of this is the partial or deficient acceptance of illness. For example, the result of a survey involving 400 patients show that approximately 60% of schizophrenia patients are not aware of their suffering from some illness (Amador 1994). A significant proportion of patients involved in the survey were not even aware of their symptoms (e.g. hallucinations, delusions, dulled emotions, asocial behaviour), while those around them were clearly aware of these symptoms. The lack of acceptance of illness frequently leads to the abandonment of medications and that, in turn, leads to further psychotic episodes. Psychotic episodes, on the one hand, may actually</p>
--	--

listening?

- The employment of open-ended and half open-ended questions; advancing from open-ended questions towards close-ended ones
- Feedbacks reflecting attention: “Mmm”, “I see”
- Paraphrases: Repeating the patient’s communication with different words
- Summary: Summarizing the patient’s communications with different words

IX./2.4.: Listening, empathy

An advantage of **empathic listening** is that when we feel empathy and we make the patient aware of it, he will have the experience that we understand him. Through this he will become more open to learning our opinion and to our joint work. It is important to display empathy **towards the following emotions** of the patient (Amador 2008):

- Frustrations (on account of his unattained goals and that others want to force him to accept treatment or medications)
- Fears (from failure, from stigmatization, from medications)
- Feeling of discomfort (which the patient may occasionally attribute to the medications; e.g. slackening, putting on weight, decrease of creativity)
- Wishes (not to have to go to hospital, to get married, to have a job, to study, to have children).

We do not have to agree with the patient’s delusions in order to understand him and be able to relate to him empathetically.

Example:

Patient: *“I have a feeling that I’m followed everywhere in the streets, and that I’m watched by cameras.”*

Therapist: *“This must be dreadful, you must be really frightened because of this.”*

Its elements:

- The method of reflective listening itself reflects empathy
- **Emotional reflection**, that is we word feelings the patient did not express with words, but from the words he did say, one may deduce these feelings (like in the above example)
- **Normalization**: expressing the natural and universal nature of certain feelings (“It is but natural that you are worried about having lost your job. In such a situation everyone would be worried.”)

IX./2.5.: Motivating the patient

Question:
Which are the elements
of empathic listening?

Question:
Which are the elements
of the inspiration of
motivation?

Inspiring motivation for the treatment may cause difficulty in the case of numerous diseases, for example in the case of addicted patients. A lacking or partial acceptance of illness brings about similar difficulties in the motivation of the patient. Usually it is a common feature of the motivational interviews that first we **define the aims of the patient** (e.g. he would like to go to college), then by the means of questions we point out the discrepancy between his aims and his current situation (in order to be able to go to college, it is important for him not to get back to the hospital again and again / not to hear the voices).

For the motivation of patients suffering from psychotic diseases Amador recommends the following (Amador 2008):

- Normalization (“I would have similar feelings in your place”)
- We should only mention symptoms and problems which are perceived also by the patient (e.g., if he says that his inability to sleep and his anxiety is because of the upstairs neighbour who is planing to murder him, then we should speak to him about anxiety and sleeping disorders but we should not, by any means, use the expression: “paranoid delusion”)
- **Let us summarize those advantages and drawbacks of the treatment which** were perceived by the patient too. If the patient approves of it, let’s make a list of the advantages and the drawbacks.
- **Let us correct the misunderstandings** (e.g. antipsychotic medications do not cause addiction), and present the advantages of the suggested treatment (I’ve chosen this medicine because it can help you stop being so nervous, and according to the researches this does not increase appetite.)
- Let us reflect and emphasize those advantages of the treatment which are perceived by the patient as well. Whenever it is possible, we should highlight the advantages the patient has already experienced.
- If we are not of the same opinion in everything, let us make an agreement that we do not need to be of the same opinion in everything

Example:

Patient: *“I feel ashamed of taking medicatons, and since I’ve been taking them, I’ve put on 5 kilos.”*

Therapist: *“Have you noticed any advantages in taking those medications?”*

Patient: *“Well... not anything in particular... Perhaps that if I don’t take them, my parents will sooner or later bring me back to the hospital, and while I’m here, I cannot work.”*

Therapist: *“Well, then summing up what we’ve just discussed: the drawback of the pills is that you feel ashamed of taking them and that you feel you’ve gained weight, and the advantage is that if you take them, you won’t be brought to hospital and you can work.”*

IX./2.6.: Establishment of partnership

The majority of the patients comply with the therapy only if they themselves have the chance to take part in the development of plans concerning the treatment. For this reason we should strive for **joint decision-making** in all essential questions of the therapy. We should also determine the framework of therapy together: together with the patient we should decide the frequency and date of the appointments. It is

<p>Question: What does partnership mean?</p>	<p>important that the doctor and patient should have a joint aim. In most cases this is positively so, since both persons aim for the recovery of the patient or the avoidance of psychotic episodes and hospitalization, but it is worth clarifying in detail and more accurately who means what by that, and likewise it is worth formulating and stating this joint aim. We should connect the treatment plan with the aim: that is we should explain to the patient how our suggested treatment would lead to the aim we both wish to reach.</p> <p>Example: <i>Therapist: "The medication helped you before not to hear the voices and also helped you to be able to work. If I understand correctly, our aim hasn't changed: we don't want you to need hospitalization, we don't want you to hear voices and we want you to be able to go about your work. I would like to recommend you a medicine that would help you to reach these aims."</i></p>
<p>Summary</p>	<p>IX./2.7.: Summary</p> <p>A frequent characteristic of psychotic diseases is a lack or only a partial acceptance of illness. More than half of the patients suffering from schizophrenia are not aware of their disorder. This fact usually encumbers both short- and long-term compliance. Since untreated psychotic conditions impair the long-term outcome of the disease and they may entail numerous risks; it is of fundamental importance that the difficulties arising in compliance should be treated. The LEAP method has been developed to facilitate the compliance of psychotic patients. The method consists of four elements. These are the establishment of the relationship through reflective listening; listening and empathy, frequent elements of which are normalization and emotional reflection; strengthening motivation through the classification of advantages and drawbacks mentioned by the patient; as well as the establishment of partnership in the course of the joint decision-making about the treatment-plan.</p>
<p>Literature</p>	<p>Literature</p> <p>Amador X, Flaum M, Andersen NC, Strauss DH, Yale SA, Clarc SC, Gorman JM. Awareness of illness in schizophrenia and schizoaffective and mood disorders. <i>Arch Gen Psychiatry</i>, 1994;51:826-836.</p> <p>Marshall M, Lewis S, Lockwood A, Drake R, Jones P, Croudace T. Association Between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients. <i>Arch Gen Psychiatry</i>. 2005;62:975-983.</p> <p>Young DA, Davila R, Scher H. Unawareness of illness and neuropsychological performance in chronic schizophrenia. <i>Schizophrenia Research</i>, 1993;10:117-124.</p>

	<p>IX./3.: The psychotherapeutic approach to psychotic disorders</p>
--	---

<p>Aim</p>	<p>While reading this chapter the student will become acquainted with those non-pharmacological techniques that may be employed in the treatment and rehabilitation of patients suffering from psychotic disorders, and especially from schizophrenia.</p>
<p>Important</p>	<p>IX./3.1.: The place of psychotherapeutic methods in the treatment of schizophrenia</p> <p>The treatment of psychotic disorders happens primarily by means of antipsychotic medication. For the purpose of treating certain symptoms of the disease, improving quality of life, rehabilitation and skill-development psychotherapeutic techniques have also been found useful. It is important to mention, however, that in the case of psychotic patients psychotherapeutic treatment does not substitute pharmacological therapy, it is not an alternative to it. Below we briefly introduce the psychotherapeutic techniques currently found efficient by therapists.</p>
<p>Question</p> <p>Which are the phases of social communication?</p>	<p>IX./3.2.: Developing social skills</p> <p>By social skills we mean those aptitudes and behaviours by which we interpret the emotions and intentions of others and by which we communicate our own emotions, intentions and needs appropriate to our environment. The process of social communication can be divided into three phases.</p>
<p>Important</p>	<p>[P_1_figure_IX_3_chapter] Legend: <i>Figure 1.: The phases of social communication (Liebermann 2010)</i></p> <p>Social skills, and through them social competence, are influenced by several personal, clinical and environmental factors. According to literature data, the disorder of social perception (recognition of emotions, the appraisal of others' intentions) is prevalent among schizophrenia patients; moreover, cognitive and behavioural deficits also occur. The aim of the social skill developing trainings is the strengthening of interpersonal competence: that is the structured development of skills with the help of behavioural therapeutic learning theory techniques. The training consists of steps built on each other, and are adjusted to the extant and lacking aptitudes of the patient. It is important that acquired skills should become generalized: that is the patient should be able to employ what he has acquired not only during the trainings but in real life situations as well. The giving of home assignments, the involvement of the family, friends and acquaintances of the patient, and the teaching of the patient to instruct, evaluate and reinforce himself are all of great help in this. Social skill development has several types depending on which skill the given type focuses on and what technical framework it happens in. In the case of schizophrenia patients the most frequently used method is social problem-solving training. Both the personal therapy developed for the rehabilitation of schizophrenia patients and the cognitive remediation therapies contain several social skill developing elements.</p>
<p>Important</p>	<p>IX./3.3.: Social problem solving training</p> <p>Poor problem-solving skills make the adequate rehabilitation of the patients more difficult. In the course of the training patients are taught a sequence of steps which can be generalized and employed in connection with almost any kind of interpersonal problem situation. Social problem solving trainings in most cases take place in group settings.</p>

Question:

Which are the basic steps of a social problem-solving training?

The elements comprising the sequence of steps:

1. Identification of the problem
2. Finding alternatives by brainstorming, which are suitable for solving the problem: we identify all possible ways of the solving of the problem
3. Considering the alternatives: let us consider one by one the possible consequences of each alternative
4. Selecting one or more interactions that may solve the problem and help in reaching our goal
5. Employment of the selected interaction

IX./3.4.: Personal therapy

Personal therapy (PT) has specifically been developed for the rehabilitation of schizophrenia patients. According to research, the method efficiently helps patients in getting employment, in integrating and in the meaningful use of leisure time. Personal therapy is employed twice in each month for three years **in three consecutive phases that are built upon each other**. The patient advances with the successful completion of each successive step. The therapy adjusts flexibly to the phase of the disease the patient is currently in (psychotic, post-psychotic, partial or full remission). (Hogarty 2002).

Question:

What skills does the patient acquire during personal therapy?

1. **First phase:** psycho-education, teaching the recognition of symptoms, teaching the basic social skills, teaching the connection between stress situation and symptoms.
2. **Second phase:** adaptation to the disease, outlining the competence and responsibility of the patient, teaching further social skills, further psycho-education regarding a stable medicinal preserving treatment.
3. **Third phase:** further development of the elements of earlier phases: relaxation, stress treatment, teaching the treatment of criticism, conflict treatment in social and working environment.

IX./3.5.: Cognitive remediation

Research in recent years has repeatedly underscored **cognitive dysfunction as a core characteristic of schizophrenia**. The cognitive dysfunction shows more stability than positive and negative symptoms; it **displays a close connection with the longitudinal course** and with the level of the psychosocial functioning as well (Green 1996). The deficit may be present before the beginning of the disease, prior to the first psychotic episode, already at a young age. Its treatment may open up a possibility for the improvement of the psychosocial functions and of the quality of life, and if it is diagnosed early enough it may be prevented as well. In schizophrenia cognitive deficit means the impairment of several neuropsychological functions.

Question

Which cognitive functions are impaired in schizophrenia?

[P_2_figure_IX_3_chapter]

Legend: *Figure 2.: Cognitive deficit in schizophrenia*

Question:
What is the aim of cognitive behavioural therapy in the case of schizophrenic patients?

The aim of remediation programmes is to improve specifically, **through a directed development of basic skills**, the life-quality of the patient. Some cognitive remediation programmes focus on the development of **attention, memory and the executive functions**, while others focus on the improvement of **social cognition** and the **recognition of emotions**. Heterogenic programmes belong here, among which individual, group, paper-pencil based and computerized training programmes can equally be found. According to research results, **cognitive skills significantly improve** among patients participating in these programmes (Medalia 2009). These programmes are successful mainly as parts of work therapy or complex rehabilitation programmes, where special attention is paid to the arousing and preserving of the motivation of the patients. Programmes directed explicitly at **the improvement of social cognition skills** constitute a relatively new subdivision of the cognitive remediation programmes. These computerized training programmes aim at acquiring **skills playing a key role in social functions**: that is at the recognition of emotions and the intentions of others (Horan 2009).

IX./3.6.: Cognitive behavioural therapy

Cognitive behavioural therapy was originally developed for the treatment of depressive symptoms, and is based on the identification of negative automatic thoughts and cognitive distortions. According to research, this method may be useful even in psychotic diseases for the purpose of **decreasing positive symptoms, reducing distress caused by psychosis, and the improvement of the quality of life** (Bechdolf 2010, Lynch 2010). The method is primarily employed in the case of stable, treatment resistant, chronic, positive symptoms (that is hallucinations and delusions), in individual or group therapy settings. The therapist does not confront the patient with the incredibility of the delusions, rather he **relates acceptingly** to these delusions and hallucinations, then reveals the proofs behind the beliefs. Subsequent to this they look for **alternative explanations** for the delusions and hallucinations, and within the scope of the thought-provoking questions of a joint investigation, they examine the validity and acceptability of these (Libermann 2010).

IX./3.7.: Family therapeutic interventions

Although a dysfunctional family environment does not play a role in the development of schizophrenia, the dysfunction perceivable in the families of schizophrenic patients, however, causes patients increased stress. Research has identified the “**Expressed Emotion**” (EE) factor, the high level of which in the family leads to **the rise in the number of psychotic relapses**.

The three components of EE are the following:

1. Frequent critical feedbacks
2. Hostility
3. Extreme emotional involvement

In the course of dealing with the families, family members are given psycho-education related to the disease, and this, through the **reduction of the level of Expressed Emotion**, leads to fewer relapses (Tényi). Family interventions are to be employed together with medicinal treatment, disease management, crisis

Question:
What does the term “expressed emotion” mean?

intervention and other supporting services. Several researches have proven the usefulness of family interventions related to the families of schizophrenic patients (Falloon, 1999). Family interventions reduce the number of psychotic episodes, improve the self-esteem and disposition of the patient and his family members, and reduce emotional burdens, the result of which is a decrease in the number of hospitalized treatments and an improvement of expense efficiency (Libermann 2010).

IX./3.8.: Non-verbal therapies

Music therapy, art therapy and movement therapy are all to be classified as nonverbal therapies. These methods may be of help in establishing eye-contact with patients having difficulties with this, and in improving their creativity, in their socialization within individual and group therapeutic frameworks. There hasn't been enough clinical research to verify their efficiency (Ruddy 2005), but these are methods of great past tradition and can be found in modern therapeutic recommendations as well. The essence of art therapies lies in the process of creation, in the course of which the feeling of creativity and self-efficacy may increase. We call art psychotherapies those methods, where creation serves as a means of becoming acquainted with the world of experiences of the patient, and there are further psychotherapeutic interventions to be built on this. Works of fine art made by psychiatric patients are classified as **Art Brut** (literally: crude, brutal, unpolished art), which, from the second half of the 20th century on, receives an ever growing attention both from the side of arts, and art historians and that of psychiatry.

[P_3_figure_IX_3_chapter]

Legend: *Figure 3.: Heni Árvai: Flowers. A work of art made during a programme called Psychart24, organized by Art Brut Galéria, Budapest (Source: www.artbrut.hu)*

[P_4_figure_IX_3_chapter]

Legend: *Figure 4.: Jakab Gusztávné Ella, S. Erzsébet: Gipsy skirt. A work of art made during a programme called Psychart24, organized by Art Brut Galéria, Budapest (Source: www.artbrut.hu)*

IX./3.9.: Summary

The treatment of schizophrenia is primarily comprised of the employment of **antipsychotic medications**. However, **psychosocial and psychotherapeutic interventions** also play a role in symptom reduction and in rehabilitation. Trainings directed at the **development of social skills** resting on the basic concepts of learning theory; their aim is the improvement of social perception, of problem-solving and of interpersonal behaviour. **Personal therapy** has been developed specifically for psychotic patients. The three-year individual therapy consists of psycho-education, stress treatment, and social skill development. The development of the elementary cognitive skills (such as attention, memory, executive functions, social cognition, and the recognition of emotions) is possible by the help of **cognitive remediation programmes**. **Cognitive behavioural therapy** – which has so far been employed successfully in several psychiatric diseases – and **family therapeutic interventions** have both been found effective in symptom reduction. In involving patients who are not easily involved in verbal therapies, **nonverbal therapies** may be of great help: art therapy, music therapy and movement therapy may be pursued in both individual and group settings.

Question:
What nonverbal therapies are you familiar of?

Summary

Literature

Literature

Bechdolf A, Knost B, Nelson B, Schneider N, Veith V, Yung AR, Pukrop R. Randomized comparison of group cognitive behaviour therapy and group psychoeducation in acute patients with schizophrenia: effects on subjective quality of life. *Aust N Z J Psychiatry*. 2010 Feb;44(2):144-50.

Falloon IRH, Held T, Coverdale JH, Roncone R, Laidlaw TM. Family Interventions for Schizophrenia: A Review of Long-term Benefits of International Studies *Psychiatric Rehabilitation Skills*, 1999;3(2):268 – 290

Green MF: What are the functional consequences of neurocognitive deficits in schizophrenia? *Am J Psychiatry* 1996; 153(3):321-330

Hogarty EG. Personal Therapy for Schizophrenia and Related Disorders: A Guide to Individualized Treatment. New York, Guilford Press, 2002.

Horan WP, Kern RS, Shokat-Fadai K, Sergi MJ, Wynn JK, Green MF. Social cognitive skills training in schizophrenia: An initial efficacy study of stabilized outpatients. *Schiz Res* 2009;107:47–54

Lynch D, Laws KR, McKenna PJ. Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials. *Psychol Med*. 2010 Jan;40(1):9-24

Medalia A, Choi J. Cognitive Remediation in Schizophrenia *Neuropsychol Rev* 2009;19:353–364

Ruddy R, Milnes D. Art therapy for schizophrenia or schizophrenia-like illnesses. Cochrane Database of Systematic Reviews 2005, Issue 4. Art. No.: CD003728. DOI: 10.1002/14651858.CD003728.pub2

<http://www.artbrut.hu/>