5. Psychotherapeutic approaches in the treatment of schizophrenia

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Summary

The author gives a critical overview of various psychotherapeutic approaches used with persons with schizophrenia and their families. It is emphasized that these approaches are to be used in conjunction with pharmacological treatment and should always be individualized for each patient depending on the phase and severity of illness.

Individual psychotherapy, particularly cognitive–behavioural modality, group therapy, and family therapy are described in some detail. Special attention is given to compliance therapy.

5.1. Introduction

Schizophrenia is usually a chronic disorder characterized by a continuing or episodic course with symptomatic exacerbations followed by full or partial remissions. A major goal in the treatment of schizophrenia is to develop clinically effective and cost-effective methods of enhancing functional abilities and of preventing and managing relapse. Relapse and rehospitalisation rates

can best be reduced when antipsychotic medications are used in conjunction with other individual, family, and community treatment approaches.

Schizophrenia is a disorder with many symptoms, impairments, and psychosocial consequences; it is therefore hard to expect that one single treatment would be capable of ameliorating it. For most patients, a comprehensive and individualized program of therapeutic efforts that makes use of a variety of treatment modalities is required. Individual, group, and family therapies should be tailored for each of the patients depending on the phase and severity of illness, unique aspects of individual cases, patient interest, the availability of treatment resources, and the motivation of families (Fenton and Cole, 1996).

5.2. Individual psychotherapy

A variety of individual psychotherapy approaches have been used in the treatment of schizophrenia. These approaches differ along many dimensions, including the degree to which prevention of relapse is emphasized as a primary goal of treatment.

5.2.1. Insight-oriented psychotherapy

Studies of individual psychotherapy in schizophrenia using psychoanalytically oriented approaches for the most part failed to demonstrate an advantage when compared with supportive therapy (Bookhammer et al,1966;, Grinspoon et al, 1968; Karon and VandenBos, 1972)). The Boston Psychotherapy Study (Gunderson et al, 1984) compared the efficacy of exploratory insight-oriented psychotherapy with that of reality-adaptive supportive psychotherapy, which focused on the practical issues of daily living. Patients, randomly assigned to two psychotherapeutic approaches for 2 years, also received psychotropic medications during the study. The principal findings of this study were that the reality-adaptive supportive psychotherapy group spent significantly less time in the hospital and had better occupational functioning compared with the insight-oriented group. Despite the small sample size and other methodological problems, the results also suggested a relationship between psychodynamic exploration and improvement in negative symptoms (Glass et al, 1989).

A review of the experimental literature showed that intensive, insight-oriented psychotherapy was not appropriate for most patients with schizophrenia (Mueser and Berenbaum, 1990). On the other hand, reality-adaptive psychotherapy and other types of supportive psychotherapies should be regarded as the individual psychotherapeutic approach of choice for most people with schizophrenia. The type of psychotherapy should always be determined by the characteristics and needs of the patient. In conducting supportive psychotherapy, it is desirable for the therapist to have a comprehensive understanding of the patient. Such understanding may include knowledge of the patient's intrapsychic conflicts and defences, coping skills, and strengths, as well as the interpersonal, social, cultural, and biological factors affecting the patient's life. The clinical literature supports the use of a pragmatic and broad-based psychotherapy that relies at various times on supportive, directive, educational, investigative, and insight-oriented strategies applied flexibly depending on the individual patient's type and phase of illness (Dingman and McGlashan, 1989;, Martindale et al., 2002, Krausz and Naber, 1999). This approach, termed flexible psychotherapy, has defined a set of assumptions concerning the nature of schizophrenia, a hierarchy of clinical tasks and interventions that are likely to be required during different phases of illness, and a set of general technical strategies with which the therapist aims to guide treatment and strengthen collaboration. This type of psychotherapy includes a wide range of activities occurring within a physician–patient relationship that provide continuity of care over a period of time (Herz and Lamberti, 1996).

5.2.1. Cognitive–behavioural therapy

Cognitive–behavioural therapy for psychosis is undergoing rapid development. First, its focus is shifting from the treatment of individual positive symptoms, especially delusions and hallucinations, to therapy with people who present with complex and diverse difficulties, which include these symptoms among an array of other problems. Second, the previously restrictive use of cognitive approaches to the treatment of people with relatively stable positive symptoms that had not responded to antipsychotic medication has given way to more recently developed forms of therapy for people in acute episodes (Drury et al, 1996) and for young people experiencing their first episode of psychosis (McGorry, 1998). Finally, the research evaluations of the effectiveness of this approach have become more sophisticated and now include randomized controlled trials (Garety et al, 2002).

Cognitive–behavioural psychotherapy is based on the assumption that the vulnerability-stress model provides the best available integration of data pertinent to the aetiology, course, and outcome of schizophrenia. This model states that the individual has an enduring vulnerability to psychosis, possibly but not necessarily of genetic or neurodevelopmental origin, a vulnerability that may be heightened by childhood experiences, whether social, psychological, or biological. The stress side of this model assumes that a variety of environmental stressors can precipitate the emergence or recurrence of symptoms in vulnerable persons. Research supports an association between, on the one hand, stressful life events, cultural milieu (egocentric vs. sociocentric), social class, social network size and density, and the emotional quality of the living environment, and, on the other, the onset and course of schizophrenia (Brennan and Walker, 2001). The specific stresses associated with illness onset or exacerbation are often highly individualized. They may be primarily biochemical (e.g., stimulant or hallucinogen abuse), developmental (e.g., leaving for college, joining the armed forces), social (e.g., breaking up with a girlfriend, family or work tension), or environmental (e.g., poverty, unemployment, eviction) (Harvey, 2001).

The broad aims of cognitive–behavioural therapy for people with psychosis are first, to reduce the distress and disability caused by psychotic symptoms; second, to reduce emotional disturbance; and third, to help the person to arrive at an understanding of psychosis in order to promote the active participation of the individual in reducing the risk of relapse and levels of social disability. The general approach is concerned with understanding and making sense of the patient's experiences working to achieve collaboration between the person with psychosis and the therapist, rather than using didactic, interpretative, or confrontational styles (Garety et al, 2001).

The foundation of cognitive–behavioural therapy, as with other types of psychotherapy, is the therapeutic relationship. Continuity of care with one therapist who engages in a collaborative nonauthoritarian relationship is most beneficial in establishing a therapeutic alliance. While establishing a therapeutic alliance is an important predictor of therapeutic success in the treatment of any disorder (Horvath and Symonds, 1991), it is of particular relevance to working with people with psychosis.

Cognitive–behavioural therapy is a structured and time-limited therapy although the duration and frequency of therapy sessions will vary according to the nature and severity of the person's problems. The average num-

ber of sessions is about 20. The therapy is conceptualized as a series of six stages, although this should be seen as a guiding framework to be applied flexibly (Fowler et al., 1995): building and maintaining a therapeutic relationship, inculcating cognitive–behavioural coping strategies, developing a new understanding of the experience of psychosis, addressing delusions and hallucinations, addressing negative self-evaluations, anxiety, and depression, and managing risk of relapse and social disability.

5.3. Medication adherence

Medication nonadherence is common in illnesses for which long-term maintenance treatment is required. Medications can cause uncomfortable side-effects, and discontinuing medication makes the patient initially feel better (Diamond, 1984). Rates of noncompliance in schizophrenia may be as high as 75% over several years of treatment (Corrigan et al, 1990). The assessment of noncompliance must be individualized and include attention to (1) the dysphoric side-effects of neuroleptics and realistic concerns about the risk of tardive dyskinesia and other serious side-effects; (2) practical barriers such as transportation, financial problems, unappealing clinic settings, and overly complex medication regimes; (3) the patient's cognitive disorganization or forgetfulness; (4) the quality of the physician–patient relationship; and (5) particular psychological meanings the patient attaches to the medication.

The psychotherapist should assume that most patients at some time will take more or less medication than prescribed, and should work toward creation of a therapeutic relationship in which such experimentation can be openly discussed, rather than hidden. Showing an active interest in medication by asking how much is being taken and attending to side-effects is of value. During periods of clinical stability, allowing patients to self-regulate medication dosage within bounds can substantially enhance the therapeutic alliance (Diamond, 1984). When denial is a major factor, enlisting the assistance of family and friends and arranging for the supervision of medication taking can be useful. When incorrect beliefs about mental illness are judged to be operative, psychoeducation with patient, family, and friends is called for. When disorganization or cognitive deficits interfere with compliance, specific behavioural interventions may be of value (Falloon and Liberman, 1983).

Hayward et al. (Hayward et al, 2002) describe three phases of compliance therapy, which should be only intended as guidelines indicating the tasks the

therapist will be trying to undertake. In the first phase of therapy, the goal is to establish the patient's stance towards medication. Due credence is given to any negative views that the patient may have about medication: These are not challenged at this point, but instead gentle enquiry is used to establish as many of the facts as possible about what happened. In the first instance, patients will seldom opt for a medical explanation of their problems: They may focus on delusional explanation, and they may also blame stress, trauma, and various other external factors. If a link can be made between non-compliance and relapse, this association should be gently pointed out to the patient, without emphasizing it unduly at this point; the therapist should not be too quick to challenge a patient for "not following doctor's orders". However, the disadvantages of being unwell should be highlighted as well as the direct and indirect advantages of staying well, such as better relationships with loved ones or being able to remain at work. Negative aspects of medication must be acknowledged, explained, and discussed with the patient.

In the second phase of the therapy, the key technique is to ask the patient to examine the pros and cons of medication use. This is the heart of the compliance therapy intervention and is in keeping with the model of the patient as capable of rational choice. Having in mind the possibility of forced medication during involuntary hospitalisation, it is worth making the effort to convince the patient that deciding to comply with the prescribed medication is in no way an attempt to minimise a person's freedom and individuality. Again, the pros and cons of the medication have to be discussed, and the therapist may have to deal with those aspects of medication use that the patient perceives as negative. One cannot promise that the patient will not experience side-effects or other unpleasant effects of treatment, only that every effort will be made to minimise them.

During the third phase of therapy, the benefits and drawbacks of continued, long-term compliance are discussed. This phase is only possible if the patient thinks that there may be some benefit in medication. The goal here is to offer arguments in favour of accepting, or, at the very least, trying out a long-term course of medication. Rather than seeing medication as something imposed from outside, the patient is encouraged to view it as a long-term strategy to improve personal functioning.

5.4. Group therapy

Group therapy was originally developed to enhance self-esteem and to alter attitudes and behaviour through a corrective experience of supportive community feeling and positive reflected appraisals by group members.

Persons with schizophrenia experience deficits in attention focusing, information processing, and concept formation that can be remediated through cognitive, communication, and problem-solving training in a group setting (Brenner et al, 1989, van den Bosch et al, 1992). Participation in interaction-oriented group therapy can assist isolated patients with schizophrenia who are unresponsive to the concerns of others and unable to use social praise and attention to generate supportive social networks.

As Selzer at al. (Selzer et al, 1992) reported, group therapy can provide insight into unconscious processes, such as transference, resistance, and motivation. Patients test reality by distinguishing between gross distortions and consensually validated perceptions or beliefs and control psychotic experiences through the development of effective strategies of self-control (Breier and Strauss, 1983). The group setting is also appropriate to coordinate medication management and the prompt response to the reemergence of symptoms of psychotic relapse (Kahn and Kahn, 1992). In groups, it is much easier to prescribe activities around the pursuit of a specific task or project (Anthony and Liberman, 1986) and to improve skills in communication, social relations, and problem-solving through a structured group process emphasizing disclosure, group discussion, feedback, and between-session task assignment (Kanas, 1991). Last but not least, members of self-help groups can render mutual aid, sharing experiences of a common, stigmatized condition, and give each other encouragement and advice.

Having realized many advantages of group therapy, Drury et al. (Drury et al, 1996) included a structured cognitive–behavioural group in their cognitive therapy programme for acute episodes, in addition to individual cognitive therapy. They considered that the group was an important component of treatment, enabling peer-group relating and providing a setting of solidarity for bolstering self-regard through the challenging of negative social stereotypes (Birchwood et al, 1998).

5.5. Family treatment

Family expressed emotion (EE), an operational measure of family criticism and emotional overinvolvement that is considered a mediating variable associated with relapse in severely ill patients with poor premorbid functioning, may represent either a normal reaction to the stress of coping with a schizophrenic member (Lefley, 1992) or a stable marker of preexisting emotional instability (Goldstein et al, 1992). Psychoeducational family management approaches can help to lower EE and reduce patient relapse. These methods teach patients and their family members to cope with the illness through a pragmatic understanding of the disease, of symptom and behaviour management strategies, and of the local health-care system. Group therapies help patients to develop skills to deal more effectively with relatives who have high EE (Bellack et al, 1992).

Psychoeducation typically includes formal training sessions for a family or families in an effort to teach as much as is currently known about the illness and to encourage their continued involvement with the treatment of their relative. For example, families are taught about negative symptoms of schizophrenia: that long periods of lethargy, anhedonia, passivity, and social withdrawal typically follow an episode of more active, positive symptoms. With such knowledge, families can better create a more low-key convalescent environment within which the patient can more naturally recuperate from a major psychotic episode. Clinicians work collaboratively with the family or families in resolving difficulties that are naturally generated by the illness (McFarlane, 2002).

There are four major themes of family therapy:

1) Families learn to set realistic expectations for the patient, based on a clear understanding of the disorder;
2) families learn how to respond to often-exasperating patient behaviour in a low EE manner;
3) families learn that they are not to blame for the patient's disorder;
4) families learn to include in their social networks other families with a schizophrenic member when they meet in multifamily treatment or support groups. These meetings foster the sharing of experience, knowledge, practical advice, and advocacy (Anderson, 1983). The recommended techniques and strategies incorporate elements of behavioural, structural, problem-oriented, and strategic family therapies (Falloon, 1984).

5.6. Conclusions

The range of services needed for people with schizophrenia is diverse and needs to be tailored to individual circumstances. Psychological and psychosocial treatments should be an indispensable part of the treatment options available for the patients and their families in the effort to promote recovery, prevent relapse, and reduce symptoms.

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