

EARLY AND SUSTAINED DYNAMIC INTERVENTION IN SCHIZOPHRENIA

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SUMMARY

This paper is based on the Danish National Schizophrenia Project manual for psychodynamic individual psychotherapy with persons in states of schizophrenia. The methods for engaging with and treating a patient with schizophrenia in a supportive, psychodynamic way are described.

Key words: *psychodynamic psychotherapy – schizophrenia - supportive techniques - countertransference*

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Introduction

The Danish National Schizophrenia Project is a large scale, prospective, longitudinal, comparative, multicentre study of the treatment of persons with a first-episode schizophrenia diagnosis. Outcomes for patients who receive psychodynamic psychotherapy or assertive community treatment are compared with those of patients who receive treatment as usual (Rosenbaum 2005, 2006). The following is based on the project's manual for psychodynamic individual psychotherapy with persons in states of schizophrenia. The methods for engaging with and treating patients with schizophrenia in a supportive, psychodynamic way are described.

The Meaning of 'Psychodynamic'

Many definitions of supportive, psychodynamic psychotherapy exist, and a short outline of some main points are therefore necessary. In our manual the term 'psychodynamic' implies establishing a working alliance that is so stable that it continues its function even in the presence of psychotic or negative transference. Furthermore, the term 'psychodynamic' requires the use of the interactions in the therapeutic space to understand communication processes outside this space. Emotions and thoughts communicated in the therapy illustrate what may happen in daily life situations in which the patient experiences communication with others. The term 'psychodynamic'

also implies the acceptance of the work of unconscious processes, and the relevance of empathizing with the patient's subjective conditions and conflicts and link this empathy with a theoretical understanding of it. Working psychodynamically also means accepting the role of countertransference in the distortion of the therapist's understanding and responding. This work recognises and respects the co-existence of both psychotic and non-psychotic aspects of the personality. And finally, working psychodynamically acknowledges the importance of developing symbolformation into mature forms, i.e. 'turning the raw sense impressions into thoughts' and 'thoughts into thinking' (Rosenbaum & Harder 2007).

The meaning of 'Supportive'

In the context of the manual, also 'supportive' has several implications. 'Supportive' means acknowledging that the patient's defence mechanisms encompass both helpful and the destructive aspects, i.e. mental stability, understanding of self and others, integrating emotions and thoughts, are both facilitated and severely inhibited by the defence mechanisms in use. Being 'supportive' also implies helping orienting the patient's mind in its defence against and recovery from the losses it has experienced (by reformulating the patient's- story of development). Finally, 'supportive' implies applying a long array of necessary modifications of the technique,

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Prof. Rosenbaum gave the slides to be put in the Abstract Book and they have been reconstituted into a piece of text by Dr Mark Agius

including: clarifications, affirmations, suggestions, proposals, exemplifications from general life experience, responding to questions after having examined their possible meanings, and showing explicit empathy with the patient's painful state of mind. Each of these modifications occurs in the here-and-now situations, and of course need further definition and description.

From an ethical standpoint, the supportive psychodynamic therapy accepts the ethics of shared responsibility for the work to be done.

Some general Points

The overall aims of treatment are to focus on the fact of having become ill and the course of its development, to focus on healthy functioning, to focus on re-orientation in connection with actual loss and changes in social, psycho-social, and interpersonal conditions, and to focus on developing the capacity for entering into a therapeutic alliance.

The general method of treatment is that the psychotherapy must be a dialogue that has a structure, and this structure is supposed to counter-balance dissolution and breakdown. The contents of the therapy should be focussed and with clear reference to what issues are to be talked about. It is believed that persons in states of schizophrenia are helped by practicing what they discover in the course of therapy. The psychotherapy must always focus on the development of the self. The therapist should not remain emotionally indifferent but authentically empathic.

The Initial Phase of the Therapy

In the initial sessions significant points in the history of the patient's life, development, and the course of illness are determined. This includes hypotheses about the dynamics of the patient's current life problems, and the associated pathological grieving processes.

It is important to give the patient a feeling that the therapist has an eye for aggression, suicidal impulses, other self-destructive and violent thoughts and acts, and that the therapist is not afraid of these phenomena and is prepared to help the patient tolerating them, and to avoid them being carried out.

It is also important that the awareness and sense of illness be acknowledged. The patient must realise that the therapist regards mental illness as part of a condition of life, and as a condition for which treatment is needed. The therapist should

expect to be challenged on this and should have facilitating answers in mind, e.g. pointing at the patient's creative capacities and resources.

Clarification of the possibilities of, and the obstacles against, creating a therapeutic alliance with the patient and stimulating the patient's hope of recovery, is of great importance when ending the initial sessions. Psycho-biographical and conflictual 'highlights' that may serve as a focus during the therapy process are emphasised.

The Middle Phase

The course of this phase may follow different tracks.

Hopefully, a creative therapeutic relationship has developed. Work is being done on one or several psychological problems, and though not all of the patient's symptoms have disappeared, the patient may feel attached to the therapy and to the experience of being helped. New and more comforting editions of ones life narratives starts emerging.

However, an opposite course may also appear. A destructive or difficult therapeutic relationship may exist where the patient from time to time is mentally absent, does not collaborate, or does not at all manage to work with the therapeutic material. The patient does not by himself bring problems to therapy and may be totally preoccupied by his symptoms or fragments of his life. The same narratives are repeated many times without giving meaning to the patient's self-understanding.

There may be also intermediate forms of the therapeutic relationship. 'Ups' and 'downs' of the therapy may create many countertransference feelings in the therapist whose initiatives and containing ability may swing between hope and hopelessness. Other outcomes are difficult in so far as they are static, e.g. working with specific themes has stopped, and the intensity of the dialogue has dropped significantly, but neither catastrophes nor progress appear. These situations demand from the therapist an excessive containing capability of the patient's projective processes.

During the middle phase, it is sometimes important to relieve the patient of the experiences of imminent crisis by advising and guiding the patient in a concrete way as to how he should tackle, and not allow himself to be governed by, his symptoms; anxiety, phobia, obsessive and depressive thoughts, hallucinations and delusions. An equilibrium may also be re-established by

explaining to the patient the positive and negative sides of his defence mechanisms.

It is important to deal with statements about aggression. Psychodynamically working psychotherapists know how rage and murderousness against the self is simultaneously rage against an internalised object which may be directed at an outside object at any suitable moment. The patient may experience his world-body relations according to models like: 'I live in a world of terror, and I must constantly either avoid the world or fight against it' and 'Giving up the fight against others is giving up the aim of changing my life'. At times downplaying the psychotic experiences and anxiety-provoking conflicts in order to achieve better resocialisation is necessary. At other times confronting the patient with the aggressive mechanisms in his internal and external object relations is the best option. This may be achieved by mobilising the healthy sides of the patient's personality, which includes helping the patient define his reality, enhancing perspectives and guidelines, and supporting available defence mechanisms.

The Termination Phase

Three to six months prior to ending, the therapist summarises what has been worked with in the period thus far and what the therapist finds likely that the patient will still have to deal with, think about, and may encounter after termination.

The therapist and the patient must allow for time to talk about how the patient might be able to handle remaining 'symptoms', and to illuminate which strategies may be used and what precautions might be taken. The therapist has to proceed

carefully, as many patients fear that if they talk too much about the 'symptoms', the unpleasant effect of the symptoms will return.

The therapist should give the patient the possibility of commenting on the therapist's ways of being helpful or not-helpful, and about different ways of listening, etc. With a sense of humour and warmth, the therapist may highlight some 'blunders' that may have affected the patient, and from which the therapist has learnt something from the patient.

During the entire termination phase, it is important for the therapist to maintain empathy with the patient's experience of shortcomings and lack of progress.

The therapist should mainly comment on the creative and life-affirming aspects of the personality. Admonishments are in themselves useless unless they are understood as caring encouragement.

The termination phase should have the character of a joint project coming to a close, that both parties have learned from it, and that the patient is now about to find new ways for himself.

REFERENCES

1. Rosenbaum B et al. *The Danish National Schizophrenia Project: Design and 1 year follow-up. British Journal of Psychiatry*, 2005; 186: 394-399.
2. Rosenbaum B et al. *Treatment of patients with first-episode psychosis: two-year outcome data from the Danish National Schizophrenia Project. World Psychiatry*. 2006 June; 5(2): 100-103.
3. Rosenbaum B, Harder S. *Psychosis and the dynamics of the psychotherapy process. International Review of Psychiatry*, 2007; 19/1: 1-12.

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