



THEME

Psychosis



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Contemporary psychosocial treatment of psychosis

Not simple, but many opportunities

BACKGROUND

The range of needs of people experiencing schizophrenia or other psychotic illnesses is great, this however provides those treating them with many opportunities for effective intervention. Psychotic medications, while often providing significant benefit, are not the complete answer for patients with psychotic illness.

OBJECTIVE

This article outlines approaches to building and maintaining a therapeutic relationship with a patient with psychosis, provides a guide to assessment to assist in treatment planning, identifies some current trends in psychological treatments to augment medication, and examines family support requirements.

DISCUSSION

To maximise patient outcomes in relation to symptom remission, psychological adjustment and return to premorbid functioning, a range of interventions over a period of time may be required. Central to recovery from psychosis may be the support and guidance of a primary care physician who can recruit the assistance of a range of professionals in a timely manner.

The successful treatment of psychosis is a matrix of psychological, social and biological interventions.¹ We have never been better equipped to assist those with psychosis, and the range of needs, rather than being a plethora of issues, provides us with a number of opportunities to intervene, aide recovery, and improve quality of life. Identifying the needs and accessing services is greatly aided by the ongoing care of an informed and involved general practitioner. In spite of the various benefits of medication, antipsychotics have not yet proven to be the complete answer for all patients with psychotic illnesses. Nonpharmacological interventions such as psychological therapies, family, social and vocational interventions are increasingly used to ameliorate psychotic symptoms themselves, to counter, or lessen the effect of associated disabilities or secondary disorders such as depression and anxiety.

With comprehensive treatment in the early years, good outcomes in both syndromal and functional recovery can be achieved for a significant proportion of patients with schizophrenia and other psychoses. Whitehorn et al¹ found, in an evaluation of an early intervention program, that after 1 year of treatment 67% of patients had symptomatic recovery for both positive and negative symptoms, 50% achieved overall functional recovery, and about 50% achieved recovery in all dimensions. Features of the program included:

- strong therapeutic alliance with patient and family
- use of second generation antipsychotics
- extensive education to patient and family
- case management, and
- coordination of social support and occupational reintegration.

Relationship

Central to the relationship with a patient with psychosis is trust, support, and a willingness to work with the patient over time. The relationship can be greatly aided by the use of active listening.² Helpful attitudes and behaviours that can assist in the relationship are listed in *Table 1*.

At times, restrictive treatment/interventions may be required. The therapeutic relationship can usually be maintained if the patient understands it was done out of care and concern. Things that can convey this include:

- reviewing the patient behaviours which were worrying (eg. not sleeping, being very frightened, others being frightened)
- expressing concern as your motivator rather than saying: 'You were psychotic so you had to go to hospital'
- frequently expressing empathy for the patient's concerns
- stating that you have different opinions on some things, and a working relationship can be maintained anyway
- arranging joint meetings with case managers or family members, if involved, to indicate that others shared the concerns.³

Assessment

The value of comprehensive assessment should not be underestimated. Assessment gives a focus and individualises treatment, ensuring that interventions occur in a timely fashion. Assessment informs prognosis and sets goals for overall recovery. Areas to include are:

- psychiatric (mental state, psychiatric history, family history, history of presenting problem)
- psychological (coping style, premorbid personality, relational style, self image, self esteem)
- vocational (capacity to access and engage in meaningful daily activities, work history, current interests)
- social (support networks, ability to access these, capacity to advocate for self, ability to care for others where relevant)
- drugs of addiction (quantity used, diagnosis, pattern of use, impact of use on various life domains)
- risk (to self and others including direct and indirect, harm to reputation).

Over the course of the illness, assessments will need to be repeated as the picture changes, and new strategies need to be developed to keep the recovery process alive or to deal with new problems.

Psychological interventions

While medication will be effective for many, for those who experience persistent positive symptoms, psychological therapy can assist by lessening the impact of the symptoms, encouraging reality testing and experimentation to test beliefs, as well as identifying and managing factors which exacerbate symptoms.⁴ Contributing factors may be specific situations, the patient's appraisal of situations, or emotional states. Types of cognitive behavioural therapy (CBT)⁵⁻⁷ and befriending⁸ have been found to be useful in the treatment of hallucinations. In one study, those who received CBT continued to improve at the 9 month follow up, whereas those receiving befriending did not improve beyond the treatment period.⁸

While it may be highly desirable for patients with persistent positive symptoms to have access to CBT, the value of supportive relationships in general should not be underestimated. Psychological studies frequently use befriending, supportive therapy or structured activities and informal support as controls and find it has a significant benefit on a range of symptoms associated with psychosis.^{8,9}

In spite of the growing support for the role of CBT in treating psychosis, there are factors associated with the experience of psychosis that do not readily lend themselves to this framework.⁴ These include issues of reintegration, feeling out of control, and alteration to the sense of self. What is emerging is the concept of flexible psychotherapy.^{10,11} This approach requires a therapist to conceptualise the patient's issues in a number of ways and adapt the therapeutic strategies to the patient's needs. Therapeutic orientations may also be integrated. For example, when assisting with psychological adjustment following the first or second episodes, increased adjustment and reduced secondary morbidity (depression and anxiety) has been found if they received a hybrid therapy based on CBT and self psychology principles called 'cognitively oriented psychotherapy for early psychosis'.¹²

Even when syndromal recovery is progressing, there is often a role for nonpharmacological interventions. Lewis et al⁵ found in first or second episode psychosis patients those who received psychological interventions improved more quickly over an 18 month period. The augmenting therapies were CBT and supportive counselling. These were equally effective. This suggests that the use of psychological interventions should be considered as a matter of course, alongside medication, to enhance outcomes early in treatment.

Table 1. Helpful attitudes and behaviours to assist the doctor-patient relationship

- Being nonjudgmental
- Being sympathetic to the patient's suffering
- Optimism that things can be better
- Collaborative treatment planning and problem solving
- Repeated explanations if required
- Normalising experiences (eg. speaking of fear rather than paranoia)
- Avoiding jargon that patients may find persecuting or pejorative (eg. 'Can't get your head together/feeling confused' rather than 'thought disorder')
- Identify outcomes for the patient (eg. 'Let's contact some people who might give you more support' rather than 'I'm going to call the CAT team because you're psychotic')
- Strategic use of neutrality (ie. avoiding confronting psychotic symptoms directly)
- Address whatever patient concerns you reasonably can
- Have regular if not frequent appointments scheduled at each visit. This provides a supportive structure that may lessen anxiety in general, allows some day-to-day problem solving to occur, as well as providing a regular opportunity to review and work on issues before crises arise

Substance use

Substance use disorders are prevalent among those with a diagnosis of schizophrenia (47% lifetime prevalence¹³) and in Australia lifetime prevalence of dependence has been found to be 59.8%.¹⁴ The use of drugs of addiction for people with schizophrenia is associated with greater risk for poor outcome, both syndromal and functional.^{15,16} A comprehensive review of correlates and effects on mental health and outcome can be found in Maslin.¹⁷ An integrated approach for those with comorbid substance use and psychotic illness has been found useful in improving general functioning, reducing positive symptoms and symptom exacerbation and in increasing the number of abstinence days from drugs or alcohol.¹⁸ The program, in addition to usual psychiatric care, included motivational interviewing, CBT and family intervention.

Relapse prevention

Psychotic relapse is highly disruptive to a patient's life in the short term and in a proportion of patients (about 30%) each episode will result in a worsening of both residual symptoms and impairment.¹⁹ For these reasons, reducing the likelihood of relapse is highly desirable.

Adherence with medication as well as avoidance

of drugs of addiction are important in reducing relapse rates as well as early intervention in the relapse via the identification of early warning symptoms. A comprehensive review²⁰ of the role of relapse prevention in schizophrenia concludes that nonspecific symptoms (altered sleep, appetite, dysphoria and anxiety) as well as sub-threshold psychotic symptoms, should be monitored as part of a relapse profile. Monitoring should also be carried out by a network of people (clinicians and family) as well as the patient wherever possible. Identifying the early warning signs, based on previous experience, can facilitate insight in patients and understanding of the illness in families. Monitoring needs to be frequent, a challenge when people are stable and resources limited. By involving several parties who communicate well, and where a formal plan identifying relapse symptoms, risk situations/times and a plan of action, some of these difficulties can be overcome.²⁰

Families – dealing with the fallout

Even if only temporary, the changes to the mind when someone has psychosis can effect behaviour, emotions, sense of self, the ability to relate to others, and the capacity to engage in the usual activities of living. People may be regressed, with their behaviour being confusing, challenging or rejecting. This can evoke a range of emotions including guilt, anger, resentment and fear, leaving families and friends confused as to what has come over their loved one (not to mention the confusion of accessing help). These problems are compounded when there have been premorbid relationship problems.

Families usually benefit greatly from detailed and specific information regarding the patient's condition, prognosis, and appropriate treatment from reconstructing the onset of the illness, and information about the services available to assist the patient and themselves. Such information may need to be delivered on multiple occasions, as the complexity and level of distress may hinder the absorption of information. There are advantages to delivering psychoeducation (illness information and support/assistance with coping) on an individual and group basis.²¹ Education, as distinct from family therapy, with families of people with schizophrenia has been found to increase knowledge and optimism concerning the family's role in treatment, and reduce relatives' stress.²²

Before the most obvious symptoms emerged there may have been misattribution of the behaviours exhibited.²³ Social withdrawal or lack of motivation may have been seen as laziness due to substances

of addiction or normalised as 'adolescence' or 'their personality'. To deal with these behaviours, and to help the person, families may react either with over involvement or criticism; sometimes both. These coping styles combined have come to be known as expressed emotion (EE). These patterns of involvement have been well documented and researched and there is strong evidence to indicate that they have a powerful effect on the outcomes for those with psychosis.^{24–26} For example, approximately 50% of those returning to live in high EE families will relapse within 9 months compared with 21% who return to low EE families. Intervention with relatives of people with schizophrenia has also been found to reduce relapse rates by as much as 20%, with a marked effect if the treatment is longer than 3 months.²⁷ It is notable that these patterns of relating may also be exhibited by professionals as well as families. High EE has been found to be independent of social functioning and symptoms in patients but associated with relatives' appraisal of the deficits of their family member,²⁸ and with specific coping strategies such as behavioural disengagement, mental disengagement, and alcohol/drug disengagement.

Interventions aimed at families developing constructive problem solving strategies (management of day-to-day problems and stressful life events), less avoidant coping strategies, and communication training (to encourage clear communication with patient and professionals) are likely to assist families reduce EE.^{29–31}

Families may need guidance in adjusting the level of care depending on the patient's needs at a given phase. At times there may be a higher level of support and intervention required, and then as the patient recovers, reassurance that they can step back allowing the patient to re-establish their independence.

Conclusion

The needs of people with psychosis may be met in a range of ways by a number of people. One of the key elements to successful treatment is having a central professional who over time comes to know the patient, the family, and the illness. Knowing the patient and being aware of the possibilities for care, the primary care physician can effectively access services and other professionals as required.

Summary of important points

- To be comprehensive and effective the treatment of psychosis should include interventions in the biological, psychological, social, and occupational domains.

- Interventions with family members should include support, education, and assessment of family function in relation to the illness.
- Adherence with medication regimen, avoidance of drugs of addiction and monitoring of nonspecific as well as subclinical psychotic symptoms will aid relapse prevention.
- A relationship with an informed GP may be central to the effective treatment of psychosis.

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