Psychosis

Philadelphia Center of Psychoanalysis
Psychotherapy Program
Fall 2020

Agnes Martin. *With My Back to the World.* 1997.

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Course Description

This seminar serves as an introduction to the constellation of human experiences and behavior sometimes referred to as "schizophrenia" or "psychosis." This course is presented from a trauma-informed and recovery-oriented perspective, and one that is deeply consonant with many humanistic, psychodynamic, and existential ideas and sensibilities. The varied lived experiences of people who experience psychosis and other extreme states will be encountered, along with biopsychosocial explanations, empirical research, and empirically-supported psychosocial interventions. Students will be introduced to case studies and other literature on psychotherapeutic approaches that reflect respectful, facilitative participation in the lives of people who experience psychosis. Finally, and very importantly, students will be encouraged to explore their own experiences with people experiencing psychosis, or diagnosed with a schizophrenia-type disorder, in weekly readings as well as open group dialogue and discussion.

Goals and Objectives

Upon completion of this course, participants will be able to: describe some subjective and interpersonal experiences associated with psychosis; discuss a psychoanalytic conceptualization of psychosis that relates to contemporary neurodevelopmental research; identify several ways to work psychotherapeutically with people who experience psychosis, in a way that promotes their personal recovery and growth.

Course Schedule

WEEK 1

What is Psychosis? *Nothing About Us, Without Us.*

Readings

- Britz, B. (2017). Listening and hearing: A voice hearer's invitation into relationship. *Frontiers in Psychology*, *8*, 387, 1-4.
- Deegan, P. (1996). Coping with: Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, *19*, 3, 91-97.
- Carey, B. (October 22, 2011). A high-profile executive job as defense against mental ills. *The New York Times*.
  - https://www.nytimes.com/2011/10/23/health/23lives.html
- Myrick, K. (2012). The New York Times and all that…*Mad in America*.
  - https://www.madinamerica.com/2012/01/the-new-york-times-and-all-that-2/

WEEK 2

Towards a Genuine Biopsychosocial Explanation of Psychosis.

"The real understanding is not a simple abstraction, but specific understandings of specific patients in detail"

(*B. Karon, personal communication, 07/26/2012*)

Readings

- Read, J., Fosse, R., Moskowitz, A., & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry*, *4*, 1, 65-79.
- Freud, S. (1924). The loss of reality in neurosis and psychosis. The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIX (1923-1925): The Ego and the Id and Other Works, 181-188.
- Klein, M. (1946). Notes on some schizoid mechanisms. *The International Journal of Psychoanalysis*. *27*, 99-110.

Can People Recover? Yes.

Readings

- Addendum to Psychosis Course Syllabus, 4-8.

WEEK 3

What Can Help? Being With.

Readings

- Fromm-Reichmann, F. (1939). Transference problems in schizophrenia. *The Psychoanalytic Quarterly*, *8*, 412-426.

*About FF-R: Joanne Greenberg, author of I Never Promised You a Rose Garden and patient of Fromm-Reichman discussed with McAfee her experience of their therapy: "the personalities have to fit in therapy and if the symptoms are metaphors, the therapist has to be someone who understands those metaphors or at least is amenable to learning them so that when they appear in the therapeutic dialogue, the right amount of weight

is given to them" (p. 523). She says Fromm-Reichmann told her "you must take me with you," that she, Frieda, knew nothing about mental illness and that Greenberg had to be her teacher (pp. 515-516). Greenberg speaks also of the danger of being understood by another person: "People would tell you what perceptive things a patient had said. The thing is I want to choose my perceptions. I don't want them to come out of some kind of unconscious soup. I want it to be something I choose to say, not something that says me." She adds that being understood in that state felt horrifically dangerous: "I don't know how Frieda got around that. I remember the danger. … It's bigger than you are. It's more powerful. It can kill" (p. 528). "Maybe the strongest thing I'd like to say ever to anybody is that creativity and mental illness are opposites, not complements. It's a confusion of mental illness with creativity. Imagination is, includes, goes out, opens out, learns from experience. Craziness is the opposite: it is a fort that's a prison" (p. 527).

*Excerpt from McAfee, L.I. (1989). Interview with Joanne Greenberg. In *Psychoanalysis and Psychosis*, ed. A.-L. S. Silver. Madison, CT: International Universities Press, pp. 513-533

- Laing, R. D. (1967). *The politics of experience.* p. 46-56.

WEEK 4
What Can Help? Thinking With.
Readings

- Whitaker, L. (2013). Resolving the trouble with schizophrenic thinking. *Ethical Human Psychology and Psychiatry*, *15*, 1, 50-58.
- Lysaker, P. , Buck, K., Fogley, R., Ringer, J., Harder, S., Hasson-Ohayon, I., Olesek, K., Grant, M., & Dimaggio, G. (2013). The mutual development of intersubjectivity and metacognitive capacity in the psychotherapy for persons with schizophrenia. *Journal of Contemporary Psychotherapy, 43,* 2, 63-72.
- Prouty, G. (2003). Pre-Therapy: A newer development in the psychotherapy of schizophrenia. *Journal of the Academy of Psychoanalysis and Dynamic Psychiatry*, *31*, 1, 59-73.

WEEK 5
What Can Help? Making Meaning With.
Readings

- Karon, B. (2003). The tragedy of schizophrenia without psychotherapy. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *31*, 1, 89-118.
- Searles, H. (1961). Schizophrenic communication. *Psychoanalytic Review*, *48A*, 3-50.

ADDENDUM TO PSYCHOSIS COURSE SYLLABUS

Can People Recover? Yes.

	Onset	Course Type	End State	Percent (n = 228)[1]	Burghölzli Hospital Study[2] (%)	Vermont Longitudinal Research Project[3] (%)
1.	Acute	Undulating	Recovery or mild	25.4	30-40 25-35	7
2.	Chronic	Simple	Moderate or severe	24.1	10-20	4
3.	Acute	Undulating	Moderate or severe	11.9	5	4
4.	Chronic	Simple	Recovery or mild	10.1	5-10	12
5.	Chronic	Undulating	Recovery or mild	9.6	–	38
6.	Acute	Simple	Moderate or severe	8.3	5-15	3
7.	Chronic	Undulating	Moderate or severe	5.3	–	27
8.	Acute	Simple	Recovery or mild	5.3	5	5

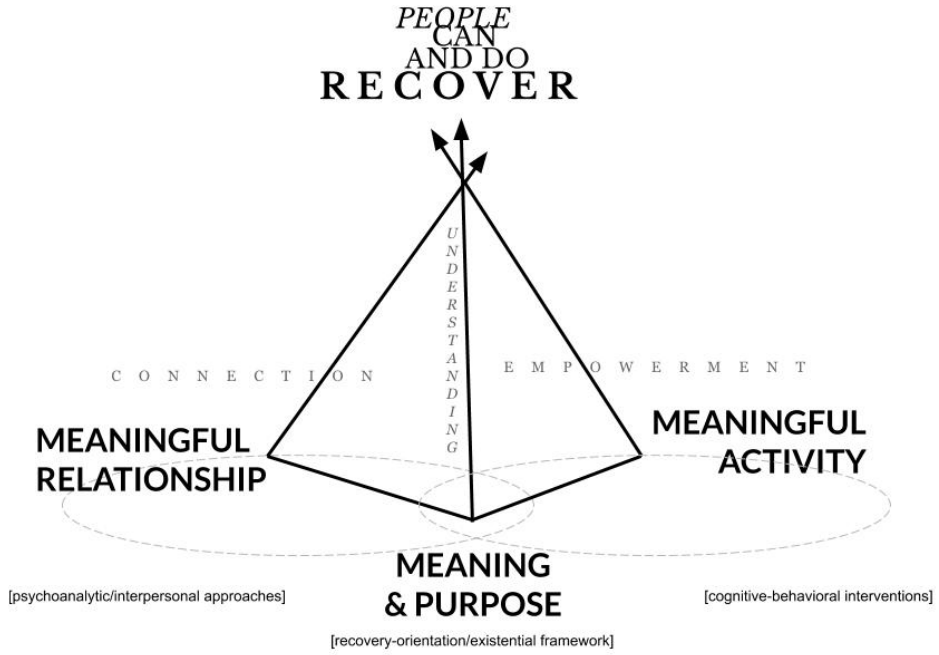
Harding, C. (1988). Course Types in Schizophrenia: An Analysis of European and American Studies. *Schizophrenia Bulletin*. *15*, 4, 633-643

1. Bleuler, M. (1972) Die schizophrenen Geistesstörungen: im Lichte langjähriger Kranken und Familiengeschichten. New York: Intercontinental Medical Book Corporation (U.S. distributor)
    - Followed 208 subjects for 23 years following inpatient hospitalization in 1942-1943

2. The Harding Longitudinal Studies
    - Harding, C., Brooks, G., Ashikaga, T., Strauss, J., & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *The American Journal of Psychiatry*, *144*, 6, 727-735.

        - long-term look at course of illness for “schizophrenia” patients; found heterogeneity of course
            - Vermont State Hospital
                - program of psychosocial rehabilitation; social psychiatry, medicine, vocational rehabilitation; organized around self-sufficiency
                - “blurring of roles...intensified relationships, and new expectations for patients and staff” (unit description from DeSisto, Harding, et al, 1995)
                - involved many “profoundly ill, back-ward, chronic patients”
                    1. 62-68% showed no signs of schizophrenia 32 years later
                        - 50% of these were found not to use psychotropic medication
            - Maine (Augusta State Hospital)
                - comparison group of chronic schizophrenic patients
                - followed biological, medical model of treatment
                    2. 48% recovery showed no signs of schizophrenia 32 years later
    - DeSisto, M., Harding, C., McCormick, R., Ashikaga, T., & Brooks, G. (1995). The Maine and Vermont Three-Decade Studies of Serious Mental Illness. I. Matched comparison of cross-sectional outcome. *British Journal of Psychiatry*, *167*, 331-342.
        - remaining subjects matched by age, sex, dx, chronicity
        - Vermont participants were found to be more productive, have fewer symptoms, and with better community adjustment and GAF scores
            - Authors propose that the differences in outcome were due to difference between the Vermont and Maine approaches to care, as well as a policy in Vermont of allowing people to return to community life more quickly

People Can and Do Recover. How?



1. The Empathic Ward
    - Whitaker, L. & Deikman, A. (2009). The empathic ward: Reality and resistance in mental health reform. *Ethical Human Psychology and Psychiatry*, *11*, 50-62.
        - see also: Deikman, A. & Whitaker, L. (1979). Humanizing a psychiatric ward: Changing from drugs to psychotherapy. *Psychotherapy Theory, Research and Practice*, *16*, 2, 204-214.
        - Whitaker and Deikman opened an "experimental" inpatient ward consisting only of psychosocial interventions for one year
        - Rather than focusing on reduction of psychotic experiences and medication compliance as discharge criteria, the goal of this ward was to help residents of the ward gain psychological strength, and become more actively and creatively engaged with their own experiences and in helping others. With time, staff and residents developed a truly therapeutic milieu and sensibility in the ward, cultivated through empathy, camaraderie, and the sharing of power and responsibility.
        - At the end of one year, the "empathic ward" boasted fewer elopements (even with the ward being unlocked), fewer incidents of violence towards others and self-harm, and lower rates of readmission at follow-up than comparable units in the hospital with psychiatric treatment as usual

2. More on the effects of social environments: Soteria House
    - Mosher, L.R. (1999). Soteria and other alternatives to acute hospitalization: A personal and professio- nal review. Journal of Nervous and Mental Diseases, 187, 142–149.
3. Leff et al (1992)
    - Original WHO study (1979) showed better outcomes for people diagnosed with schizophrenia in low or middle income countries; at 5 year follow-up, most powerful predictor of better outcomes for sz patients in "developing v. developed" countries (best in India and Nigeria centers)
4. Karon's Michigan State Psychotherapy Project
    - Karon, B. & VandenBos, G. (1994). *Psychotherapy of schizophrenia: The treatment of choice*. New York, NY: Aronson.
        - Three experimental groups: psychotherapy without medication, psychotherapy with medication, only medication no therapy
        - After two years:
            - medication only group - 2:1 chance of being rehospitalized
            - psychotherapy group (particularly with experienced therapists) - 2:1 chance of not being rehospitalized
5. Open Dialogue (Finland, Western Lapland)
    - Seikkula, J., Alakare, B., & Aaltonen, J. (2011). The comprehensive open-dialogue approach (II). Long-term stability of acute psychosis outcomes in advanced community care: The Western Lapland Project. *Psychosis*, 3, 1–13.
        - Open Dialogue is a recovery-oriented psychosocial approach that emphasizes patient-centered care and engaging an individual's family and social network
        - improved outcomes for acute psychosis: fewer and shorter hospitalizations, less recidivism, reduced neuroleptic medication dosage, improved likelihood of employment, and greater improvements in functioning
6. Recovery-Oriented Cognitive Therapy (CT-R)
    - Grant PM, Huh GA, Perivoliotis D, Stolar NM, Beck AT. Randomized Trial to Evaluate the Efficacy of Cognitive Therapy for Low-Functioning Patients with Schizophrenia. *Archives of General Psychiatry*, *69*, 2, 121-127.
    - Grant PM, Bredemeier K, and Beck AT. (2017). Six-Month Follow-Up of Recovery-Oriented Cognitive Therapy for Low-Functioning Individuals with Schizophrenia. *Psychiatric Services*, *68*, 10, 997-1002.
        - In a randomized clinical trial, CT-R improved community participation, motivation, and positive symptoms to a greater extent than treatment as usual (Grant et al., 2012); improvements were maintained 6-months after treatment ended (Grant et al., 2017). Gains were experienced regardless of the individuals' duration of illness.
7. Supportive Psychodynamic Psychotherapy
    - Rosenbaum, B., Harder, S., Kundsen, P., Koster, A., Lindhart, A., Lajer, M., Valbak, M., & Winter, G. (2012). Supportive psychodynamic psychotherapy versus treatment as usual for first-episode psychosis: two-year outcome. *Psychiatry*, *75*, 4, 331-341.
        - Danish schizophrenia project (DNS) compared psychodynamic psychotherapy for psychosis with standard treatment in patients with a first-episode schizophrenia spectrum disorder; intervention group improved significantly on measures of both PANSS and GAF scores, with large effect sizes at two years follow-up after inclusion. Further, improvement on GAF(function) ($p = 0.000$)

and GAF(symptom) ($p = 0.010$) significantly favored SPP in combination with TaU over TaU alone.

8. Harrow et al (2014)
    - longitudinal study of outcomes of use of antipsychotic medication
        - those who used less antipsychotic medication over time had fewer psychotic symptoms
9. Volavka et al (2018)
    - "very long-term" outcomes for people diagnosed with schizophrenia and related disorders
        - shows highly variable course for people with same diagnosis
        - use of low-dose antipsychotic medication associated with better outcomes than higher maintenance dose
        - early interventions associated with better long-term outcomes