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ROLE OF INDIVIDUAL PSYCHOTHERAPY OF PERSONS DIAGNOSED WITH SCHIZOPHRENIA IN THE POLISH PSYCHIATRIC CARE SYSTEM

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Summary: This paper takes up the subject of the place and role of individual psychotherapy of people diagnosed with schizophrenia in the Polish system of psychiatric care. It describes various therapeutic contexts in which such psychotherapy can take place: inpatient ward, outpatient ward, ambulatory care, community care team. It also touches upon the issue of psychotherapy in contact with a chronically ill patient who participates in his rehabilitation at the occupational therapy workshops or at a day care center. It discusses various needs of patients at specific stages of illness: acute psychosis, post-psychotic depression, symptomatic remission and a possible response to these needs offered by psychiatric treatment. The paper emphasizes the importance of long-term therapeutic contact for the recovery process, which includes the patient's self-knowledge and awareness of the capability to influence their own life, gained during psychotherapy. The central idea of this paper is the connection of psychotherapy and organizational solutions which would enable its broadest and most effective usage in daily practice. An important element is a reflection concerning the relationships between psychotherapy of people suffering from schizophrenia and usually concurrently administered pharmacotherapy .

Key words: **schizophrenia, individual psychotherapy, organization of treatment**

Existing works on individual psychotherapy for people with a diagnosis of schizophrenia, accessible in Polish literature, has been focused on theoretical conceptions [1–4] or on casuistic description [5, 6], in some cases of autobiographical character [7]. In this work I would like to propose a combined examination of psychotherapy issues with organizational matters. At the root of this idea is my conviction that while it is, of course, possible to provide therapy to people with a schizophrenia diagnosis in a private practice, the vast majority of cases are treated in other therapeutic contexts. Psychiatric inpatient wards in psychiatric or general hospitals, outpatient wards, walk-in centres, or community care teams are also treatment settings in which psychotherapy for people with a schizophrenia diagnosis may – and in many cases should – be available. What is more, in the Polish setting, institutions formally designated for rehabilitation, such as community care homes and occupational therapy workshops, are also (successfully) used for therapy of chronically ill patients, for whom they are often the only accessible therapy venue option. The context in which the therapy is conducted has a very significant impact on its course.

Patients at different stages of treatment and rehabilitation usually have widely divergent needs, potential and motivation to take advantage of therapy. A patient with acute psychosis undergoing inpatient treatment requires a different approach than one in stable remission under a long-term walk-in treatment regime, and a different approach again is needed for a patient with persistent attendant symptoms who has been treated for six years in the community, in a community care home. But it is not only the patient who can influence the course of the therapy – issues connected with general acceptance of psychotherapy as a form of treatment, in particular by directors of individual institutions, and technical matters, such as a suitable place, and time restrictions, which are problematic above all in inpatient and day units, will also affect the provision and efficacy of psychotherapy.

Two issues must be defined more clearly – first: what the term "schizophrenia" means (for the author); and second: what the psychotherapy is. With regard to the former issue, I must emphasize that I preserve a certain distance to the term "schizophrenia". Like many other doctors and therapists [8], I feel that it is a word that is overused in the colloquial language, usually in a stigmatizing way. Using it with care, what I have in mind are more chronic non-affective psychoses that remain with patients for months, sometimes years.

The concept of psychotherapy for people with a diagnosis of schizophrenia goes far beyond the narrow definition required in the case of those with personality or anxiety disorders. In this instance a greater flexibility is necessary, as well as the recognition as potentially therapeutic (psychotherapeutic) of influences and relationships that could formally be qualified as sociotherapy. In other words, the dividing line between psychotherapy and other forms of psychosocial assistance seems more fluid, more permeable.

When psychotic symptoms appear, especially ones that are not self-limiting to 2–3 days, both the patient and his environment begin to succumb to instability. From the perspective of this paper, the most significant issue is that there may come a time when previous coping strategies of both the patient and his environment – usually the family system – cease to be adequate to the problems. In the Polish context the place where people in phases with acute psychotic symptoms will most usually find help is a psychiatric inpatient ward.

We should perhaps preface our discussion on the place of individual therapy for patients with psychotic disturbances undergoing treatment on an inpatient ward by asking if this combination is possible at all. There are difficulties of at least two types: ideological and technical.

The ideological difficulties are related above all to the issue whether those in decision-making capacities on the ward – the head doctor, head psychologist and head nurse – accept that psychotherapy can be useful in treating people with a schizophrenia diagnosis. In practice this

varies widely. There are wards where not only talking, but also psychotherapy, both individual and in groups of people diagnosed with schizophrenia, is a normal part of the everyday routine. There are, however, others where there is no consent either to psychotherapy or even to talk. In such conditions, without the acceptation or support of superiors, it is hard to introduce new methods of therapy.

Technical difficulties are connected with place and time. On some inpatient wards there are no rooms for individual conversations – there are the doctors' and nurses' stations, the main ward, a shared space such as a dining room, the corridor, and nothing else. None of these spaces, of course, offer the conditions necessary to conduct therapy. In terms of time, there are wards on which one doctor has twenty, thirty or even more patients. The professional duties involved and the various types of formalities that must be discharged take up so much time that there is none left for psychotherapy. In this respect cooperation between the psychologist and the doctor can be a solution – the psychologist conducts therapy while the doctor takes charge of the more biological aspect of treatment. But not every psychologist wants or is able to conduct therapy with patients with psychotic disorders, and not every doctor is skilled at cooperating effectively with psychotherapists.

If both the ideological and technical conditions to conduct a therapy are in place on an inpatient ward, the next question is as follows: what do patients at this stage of the treatment process need? Reclaiming their sense of security is paramount, and individual therapy can contribute to this if at least two conditions are met.

First, the therapist should assume the "observation ego" [9] in order to achieve the optimal distance between himself/herself and the patient. Excessive closeness heightens the risk of aggravating the patient's anxiety or even of the therapist becoming a part of the delusional system. If the distance is too big, the patient will probably experience the therapist as uninterested or even repulsive. This will often be an echo of traumatic, insufficient relationships from the past. The optimum degree of closeness will, of course, evolve as time goes on. It will be different at the beginning of the relationship, on admission to the hospital, and different again (ideally greater) after a few weeks of talking.

The second condition is that this individual relationship should be concordant with the wider context of what goes on in the rest of the ward. It will be difficult for the individual therapist to generate a sense of security if the other members of the treatment team do not cooperate and help to create that feeling.

Another extremely important task facing the therapist at this stage of the therapy is undoubtedly containment. The extremely powerful emotions being experienced by the patient –

anxiety, anger, a sense of emptiness, guilt, remorse, hurt, bewilderment, fascination and euphoria – will also be felt to some extent by the therapist. And his/her readiness to accept these feelings and the attendant frustration, and to process them constructively, is crucial to his/her being able to help the patient. This is described very colourfully by Maria Selvini-Palazzoli [after: 2]. Something that may help the therapist in this situation is the awareness that in accepting these difficult feelings he/she is probably bringing relief to his/her patient. There are some immensely valuable descriptions of the process of entering the psychotic world in the works of Kępiński [10] and Zadęcki [11].

This is also a time for building a relationship that has a chance to become a bridge between the psychotic world of the patient and the extra-psychic real world. There is a range of theoretical constructs and practical experiences showing what should happen in order for that bridge-building process to work. I shall cite Arnhild Lauveng [12], a description of a situation in which she experienced intense visual hallucinations – seeing wolves attacking her, to which she, naturally, responded with intense anxiety. For the most part, the people around her reacted with denial – "there are no wolves here" – but this did nothing to help the patient. During one night shift she got talking to a male nurse, who said: "I can't see your wolves, but if I did, I would be totally terrified. Are you afraid?" That therapeutic intervention proved very helpful. Without validating the reality of her psychotic world, he showed a similarity and in doing so bridged part of the gap separating the patient's world from his own. The admission that if we were to experience psychotic symptoms we would feel similar emotions helps to build a bridge of understanding and empathy between the two worlds. Consent to verbalization – allowing the patient to talk about the psychotic symptoms he/she is experiencing – may also be useful. Sometimes it can help to reduce the fear, for what is named and described can be less terrifying. It is also a starting point for work on insight. As already noted, therapy is not restricted to formal sessions. The way relationships are built between therapy meetings, during gatherings of the community, or when preparing a meal to share, generates a friendly atmosphere not only "for special occasions" but on a day-to-day basis, and this can be key to build a trust-based relationship.

In relationships with patients in acute psychosis with symptoms of considerable psychomotor agitation or verbal/physical aggression it will sometimes be necessary to protect both them and their environment from the consequences. Use of direct force – restraint, or medication without consent – might seem rather at odds with the ideas behind psychotherapy, but in practice both situations may be connected with the same therapist. Even if they are not, the recollection of experienced force will surface in the therapeutic relationship. Itt is important for the use of direct force to be an expression of concern for the patient and of human benevolence, as Antoni Kępiński

[13] stressed so long ago, and not of a desire to punish or of sadistic tendencies. If both the patient and the therapist have the feeling that the use of force was justified, there should be no problems continuing the psychotherapy process. If, however, it is experienced as inappropriate or traumatic, there will be no cooperation in the treatment process despite all the therapist's will and efforts.

The average stay on a psychiatric ward in Poland is around one month [14]. Even seriously ill persons rarely spend longer than 10 weeks on inpatient wards. When their time on the ward is drawing to a close, the question of what's next should come up. Should, but alas not always does, often reduced to the superficial annotation "further treatment in local mental health clinic". Often, patients do not know where their local mental health clinic is, how to access it, or are unwilling or afraid to register there, for reasons including fear of stigmatization. It is often the case that they never go, and fail to continue both psychotherapy and pharmacotherapy. This lack of provision of realistic follow-on care often leads to relapses and the "revolving door" syndrome of frequent re-admissions to inpatient wards.

One realistic and in many cases appropriate form of continuation is time on an outpatient ward, ideally as an immediate follow-on from inpatient care. What challenges and tasks face the patient at this stage, and how can psychotherapy help? This phase of the treatment process is on the one hand a continuation of the previous phase, with the same elements of containment, optimum distance and relationship building, while on the other various new aspects come in, as the psychotic world fades and reality becomes more of a factor. The fading of the psychotic world often brings with it symptoms of profound sadness, depression and emptiness, which may be understood as a grieving reaction, a process described superbly by Aneta Kalisz [5].

In this period there may be signs of a desire to return to the world of the psychosis, to experience the same intense feelings again, even if the price to be paid is high. This decision of whether to make the effort to tackle reality, often a very difficult one, or the less attractive option from the patient's point of view, or to return to the world of the psychosis – or indeed not to leave it – is crucial to the further course of the therapy. Frankl's considerations on the importance of human decisions are fully applicable here [15]. Naturally, in order to produce long-term effects, the decision, once taken, must be supported consistently.

So what can convince the patient to choose the path back to health? Without a doubt, a sense of support and understanding shown by the individual therapist and felt by the patient will be a helpful experience. The therapist should become a kind of trainer – someone who will analyse the patient's coping mechanisms, assess their efficacy, and suggest potential modifications. The patient will fall repeatedly; what is important is that he has sufficient support to get up again. This sporting

metaphor may be useful for both the therapist and the patient. It shows the patient's ability to influence his own life, and the role of determination and will to regain his health.

Another important factor is taking optimum advantage of the therapeutic potential of the group and the therapeutic team [5]. Participation in group therapy on the ward is often a patient's first positive experience of "being in a group" in his life. Creation of an atmosphere of security on the outpatient ward can make the real world seem less painful, and thus ease the decision to leave the world of the psychosis. In this task, the therapist, in her role as "supportive ego", can ease the path to health, help to recognize successes along the way, analyse the reasons for failures, seek new solutions, and discover new ways of looking at reality. There is also a range of interventions of a more sociotherapeutic nature that can help to render the reality of the non-psychotic world more attractive.

The outpatient ward is also a place where work on insight can be tackled more effectively than on the inpatient ward. This effectiveness is a result on the one hand of the lesser intensity of positive symptoms and on the other of the possibility of reducing drug doses and sedation. Insight is a key element in building the long-term therapeutic covenant, but it is important to remember that it should not be treated as an aim in itself. Attempts to build insight too fast carry a significant risk of rupture of the therapeutic relationship and of suicide attempts.

At this stage in the treatment process the question "Why did I become ill?" surfaces with greater awareness. The quest for an answer may be undertaken both in dedicated psychoeducation classes [16] and during individual therapy sessions – this latter offers the chance to reach very sensitive areas connected with traumatic events, conflicts, feelings, and ways of reacting that are hard to reveal in the group context. When the patient sees that his life history influences his/her current situation, and that at least some of the factors that contributed to his/her illness can be modified, this can increase his/her sense of agency in his/her own life. The awareness that it is possible to take specific action to reduce the risk of relapse helps him to feel more confident – that "something depends on me".

Time well spent on an outpatient ward can ensure that someone who had been returning again and again to hospital can break the vicious circle of relapses and embark on the process of returning to health. But not even both these stages of treatment, from a few weeks on an inpatient ward to upwards of ten in an outpatient setting, are usually enough to be able to consider a sick person fully healed and not requiring further help. Therapy of people with schizophrenia-related psychoses requires more time, owing to their chronic nature. Kostecka writes that the minimum period assumed for this therapeutic process is two years [3]. Thus, towards the end of therapy on a day ward, the question again arises: What's next?

Often, the answer can be to continue outpatient treatment. I am firmly convinced that the walk-in clinic is the most important element of the whole system. If psychotherapy does not begin on the inpatient or outpatient wards, but at the walk-in clinic, help, though delayed, is nevertheless there. The opposite situation – psychotherapy is accessed on the inpatient and/or outpatient wards but is not pursued at a walk-in clinic – represents premature termination of therapy, and this, at best, risks impermanent treatment outcomes. Given the lack of time constraints, the patient's state of health, and the potential to confront developmental tasks, the walk-in clinic is arguably the most effective place for therapy. It is optimal if the patient has the chance to continue the therapeutic process begun previously on the inpatient or outpatient ward. Familiar therapists, continuity of contact, a trust-based relationship, and the fact that the patient does not need to retell his story over again are all factors that save both the patient's and the therapist's time, and the effort of building a new bond.

Continuity of therapy also permits pursuit of strands begun at previous stages. In view of the changes that will be occurring in the patient's life, however, such as new roles, and the opening up of previously inaccessible areas of life, there will often be new themes arising: problems connected with work, study, the return to old circles of friends or the forging of new relationships, the issue of closeness and forming erotic relationships, or the dilemmas inherent in the possibility of becoming a parent. All these strands become more common, and are analysed more deeply than at previous stages of the therapy

The same is true of themes that open up very sensitive issues, such as the patient's own sexuality, mental traumas, and spirituality. These are, of course, sometimes addressed in acute psychosis, but in an uncontrolled manner hard to integrate with the rest of his life story. The time constraints and mental state of patients at previous stages of the therapy can prevent access to these issues. Addressing them in long-term outpatient psychotherapy can work like extracting a splinter from a festering wound. Returning to difficult feelings, such as sadness, injury, anger, and shame, without the accompanying psychotic symptoms, helps to assimilate them and release them in a controlled manner, so reducing the risk of their accumulation and explosion in the form of a relapse into psychosis. This risk of accumulation of unwanted, unassimilated feelings was described very accurately by Antoni Kępiński [10].

Another subject that tends not to feature at previous stages of the therapy is the revelation of attendant personality disorders. When the psychotic symptoms are at their height, or during the period of post-psychotic depression they tend not to be perceptible. When those symptoms abate, both the therapist and the patient's environment may be confronted by difficult behaviours that are rooted in the patient's personality structure. In the excellent documentary "Room 4070", which

profiles a seminar on psychosis, there is one strand about a patient named Andreas. His unwillingness to act, and his exploitation of his illness as justification for his behaviours provokes anger and reproach from his sisters and parents, who have major doubts as to what extent it is the illness and to what extent "taking the easy way out" that is the reason for his indolence. This dilemma, sometimes known as the "bad or mad dilemma", is particularly challenging for the therapist, and demands careful supervision and countertransference analysis.

Another issue that may arise at this stage of the therapy is that of pharmacotherapy, and in particular the possibility and desire to stop taking the drugs. The significance of the drug as object in the psychological sense is addressed by Murawiec [17, 18], who emphasizes matters including the importance of the transference and countertransference relationship in the context of the pharmacotherapy. Something that has a seminal influence on this is the definition of health as formulated by the patient for his/her own use. There are patients to whom "recovery" means not taking medications. They will seek to achieve that goal by taking action on their own initiative, without consulting their doctor or therapist, and without regard for the potential consequences. Such steps often end with the return of symptoms and rehospitalisation. Psychotherapy conducted in parallel with pharmacotherapy can be helpful in redefining the patient's notion of health and redirecting his activeness towards improving his social functioning and developing areas of health.

This strategy does not preclude the possibility of ending pharmacotherapy, but it does broaden the context of such a decision. It can make the patient more aware of the beneficial changes that have occurred over the period he has been taking the drugs, and can help him to weigh up the potential benefits and risk connected with the decision to stop taking them. If the person using the psychotherapy changes the ways he/she deals with stressful situations to make them more effective, if his/her defensive mechanisms become more mature [19], and if he/she learns to be more aware of his/her feelings, all these changes will increase his/her chances of ending his/her pharmacotherapy successfully. In a study conducted in the Krakow community treatment system this was achieved by a group of 11% of patients (recovery, drug free, after first episode) assessed at 20 years catamnesis [20].

The intensity and duration of therapy may, of course, start to change at this stage of the treatment. They will depend on the patient's motivation, intellectual capabilities, time, organizational skills, amount of material to be worked through, and health. There is a subgroup of patients who for various reasons have problems using walk-in treatment. Some may be afraid of stigmatization should they be seen in the local clinic. Others may be so fearful, lost and disoriented on discharge from hospital that they are unable or afraid to leave the house. Finally there is a group of patients who, although they were never hospitalized and represent no immediate danger to their

own lives or the lives or health of others, are nevertheless in psychosis and need treatment. They will not consent to go to the doctor, but do consent to talk if a doctor comes to them. For all these people, community treatment teams can be a helpful form of therapy. This form of treatment has been described in considerable detail by Prot and Murawiec [21]. For my part I would like to add my thoughts on the dynamic growth in numbers of community treatment teams and their increasing role in areas including provision of therapy services. Over recent years their number has grown, from 33 in 2008 (clustered in cities) to 118 in 2013 [22]. These teams are far more evenly deployed throughout the country, and are accessible even in small towns. For many people this is the only available form of therapy, including psychotherapy. Therapists with experience of this type of work stress the great diagnostic value of visits to patients' homes, both for meeting members of their families and observing their natural environment. Moreover, the type of therapeutic bond and trust that grows out of a home visit is unique, and hard to replicate in a psychiatric institution.

A separate issue is psychotherapeutic work with the chronically ill patients that attend the many occupational therapy workshops and community care centres and homes. These are of immense value for patients, many of whom are unable to access psychotherapy elsewhere, in other contexts. Work with chronically ill patients demands special skills. Learning not to expect rapid results, endurance, the ability to notice minor changes and successes – all these combine to create a construct that I propose to call "the long-distance mentality".

At this stage of the therapy, elements of the existential approach could prove useful, with particular emphasis on exploration of the theme of the meaning of life. Viktor E. Frankl wrote [15] of three possible sources of meaning: relationships, work/creativity and spirituality. Many of those who attend psychiatric rehabilitation are not able to work, maintain a long-term relationship, or achieve other objective successes. But does this mean that their life is devoid of meaning? Absolutely not. The experience of work in a community care centre shows that both group work and individual therapy help people with chronic symptoms to develop, aim to be healthy, and discover meaning in life. Even if a person is not capable of forging a relationship, he/she can fall in love, even if someone is not able to work, he/she can do voluntary work, or study, or pursue an interest. A separate issue addressed in the Polish literature [23] is that of the spirituality of people with mental health problems, including those with a diagnosis of schizophrenia. This dimension is especially important, as on the one hand it can be the root of disorders and extremely severe symptoms [24], yet on the other it can be a fundamental source of meaning, offering protection from suicide, a moment of relief from the torture of the illness, and a place within a community. Elements of psychotherapy can have a beneficial effect not only in occupational and social rehabilitation settings [25] but also in the context of rehabilitation through work [26].

There is insufficient accessibility of various forms of psychotherapy for patients with schizophrenic psychoses in Poland. More good solutions are needed to make complex, psychotherapy-focused, community models of treatment more widely accessible. Although examples of good practice are to be found in a number of centres around the country [27, 28], it is important to develop local solutions and methods that will enable patients with schizophrenia diagnoses to access psychotherapy more extensively than has previously been possible.

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