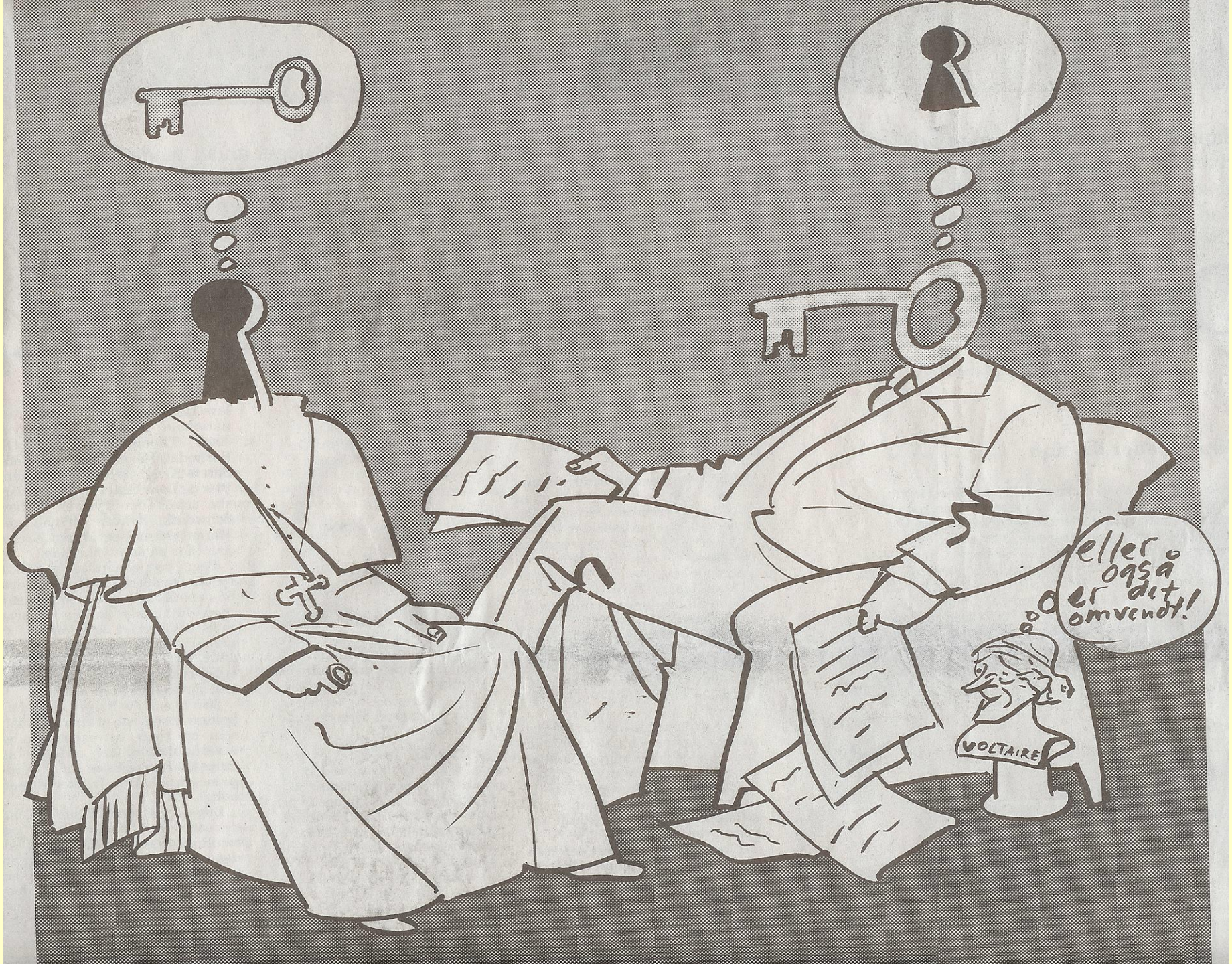
Guidelines for psychodynamic psychotherapy for psychoses

The Merging of Two Worlds – Health and Social Care

Pilsen, September 16-18, 2021


eller også er det omvendt!
VOLTAIRE

The meaning of ’psychodynamic’

- The work of unconscious processes, and the relevance of both experiental/subjective andtheoretical understanding;
- The co-existence of the working alliance and psychotic or negative transference;
- The use of the interactions in the therapeutic space (transference) to understand communication processes outside this space;
- The role of countertransference in the distortion of the therapist’s understanding and responding;
- Recognizing and respecting the co-existence of both psychotic and non-psychotic aspects of the personality;
- Acknowledging symbolformation as “turning the raw sense impressions into thoughts”, and “thoughts into thinking”.

The meaning of ’supportive’

- A consistent non-polarizing attitude
- Acknowledging both the helpful and the destructive aspects of the defence mechanisms in use;
- Orienting the patient’s mind in its defence against and recovery from the losses it has experienced (reformulating your story of development and its future perspectives);
- Applying the necessary modifications of the technique: clarifications, affirmations, suggestions, proposals, relevant exemplifications and generalisations from life experience, responding to questions after having examined their possible meanings, showing explicit empathy with the patient's painful state of mind;
- The ethics of shared responsibility for the work to be done.

Overall aims of treatment

- Focus on the fact of having become ill
- Focus on healthy functioning
- Focus on re-orientation in connection with actual loss and changes in social, psycho-social and interpersonal conditions
- Focus on developing the capacity for entering into a therapeutic alliance

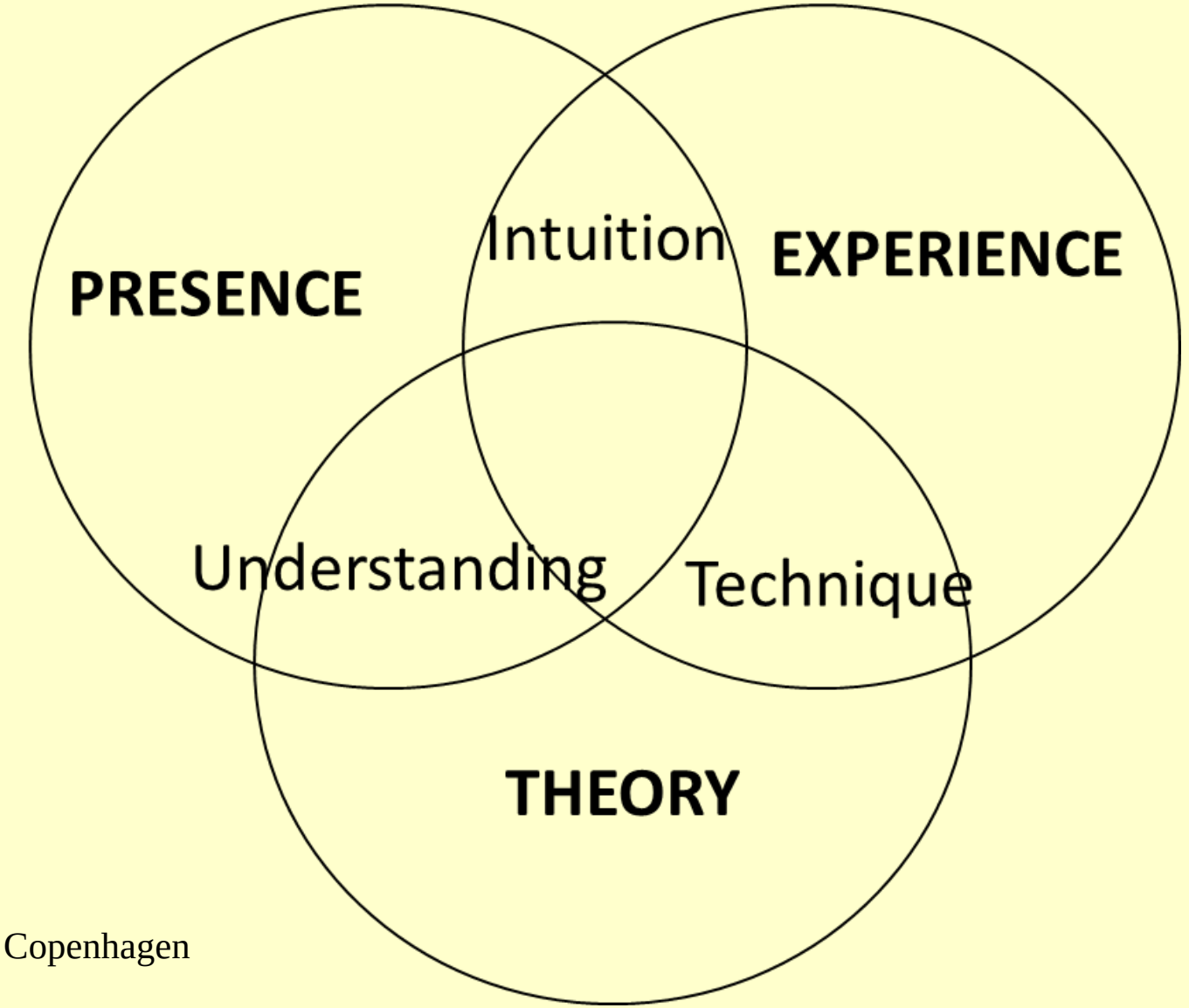
General method of treatment

- The psychotherapy must be a dialogue that has a *structure*, and this structure is supposed to counter-balance dissolution and break-down
- The contents of the therapy should be *focused* and with *clear reference* to what issues are to be talked about.
- The patient's enunciations – regardless their "normality" or "pathology" - are conceived as subjective truths that shall be clarified and investigated
- 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*

Desired therapist abilities

- Taking pleasure in the growth of another person, and being able to accept a slow pace of growth
- The ability to care and refuse to give up while not needing the patient or his devotion
- Tolerance of attachment and dependency
- Permitting another person to live in his own way
- Capacity to cooperate in a team, enduring accompanying envy, competition, anger and affection

Elements of listening



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DNS
DET NATIONALE SKIZOFRENIPROJEKT

Ending the initial sessions

- It is important together with the patient to go through what the therapist has noted as *the psycho-biographical and conflictual 'highlights' that may later serve as a focus*.

- The psychotherapist must reflect and formulate a set of hypotheses concerning:

a) The presence of suicidal and/or violent thoughts and impulses, currently and in the course of the illness;

b) The the obstacles against creating a therapeutic alliance

Ending the initial sessions

- Recreating the history of life and illness. 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 you, as a therapist, have an eye for aggression, suicidal impulses, other self-destructive and violent thoughts and acts, and that you are prepared to help the patient avoiding them being carried out.

Ending the initial sessions

- The awareness and sense of illness. The patient must realise that the therapist regards the present state of mind as a condition for which treatment is absolutely needed. The therapist should expect to be challenged on this and should have facilitating answers in mind.
- Clarification of the possibilities of - and the obstacles against - creating a therapeutic alliance with the patient.
- Never forget to investigate the patient's creative capacities and ressources and to use these in an instillation of hope.

Additional assessment of the severely psychotic patient

- What significance does the patient attribute to the psychotherapy?
- The patient's overall capacity to share personal questions and conflicts with another person
- The patient's understanding of how his/her condition affects others
- The patient's capacity for containing uncertainty, suspense, doubts
- To what extent has the perception of the therapist a delusional base?

Keywords when addressing the patient

- ***Getting better (and better)***
    - Changes never come by themselves. Being in psychotherapy means that you yourself will have to make an active effort to create changes.
    - Psychotherapy is an aid for you to function as best as possible with others and function well when you are alone.
- ***Understanding more (and more)***
    - In psychotherapy you may talk about the problems that are important right now and difficulties you have had before .
    - During therapy you may use me to try to understand the experiences you have with others and which may be difficult to understand.
- ***Staying in treatment (as long as necessary)***

The middle phase

- A creative therapeutic relation. 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

- A destructive/difficult therapeutic relation where the patient is mentally absent or does not at all manage to work with the therapeutic material. The patient does not by himself bring problems to therapy. The patient appears totally preoccupied by his symptoms or details, but no meaning seems to be gathering for the patient

The middle phase

- Intermediate forms which are difficult in so far they are static, e.g. working with specific themes has stopped, the intensity of the dialogue has dropped. The situation is only “good” insofar as there are no catastrophes, and the hope of a more creative process is still preserved.

- The situation demands excessive containing of the projective processes

The middle phase

- Relieving 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.

- Re-establishing an equilibrium by explaining to the patient the positive and negative sides of his defence mechanisms.

The middle phase

- At times downplaying the psychotic experiences and anxiety-provoking conflicts in order to achieve better resocialisation (risk of countertransference); at other times confronting the patient with the aggressive mechanisms in his internal and external object relations.

- Mobilising the healthy sides of the patient's personality which includes: helping the patient define his reality, enhancing perspectives and guidelines, supporting available mature defence mechanisms.

The middle phase

- The way the patient handles attachment and loss
- A move towards a capacity to risk relatedness for those patient who keep their distance to avoid the attachment for fear of fusion and loss of their sense of self
- Improved self-esteem
- Improved coping capacity with symptoms still present
- Creative changes in the transference and the way this is made use of in previously difficult social interaction

Termination phase

- 3-6 months prior to ending, the therapist summarises what has been worked with in period thus far and what the therapist finds likely that patient will still have to deal with, think about, and may encounter after termination

- Therapist and patient must allow for time to talk about how the patient might be able to handle remaining ‘symptoms’: Which strategies may be used, what precautions might be taken?

Termination phase

- The therapist should give the patient the possibility of commenting on the therapist's way of being helpful/non-helpful, about ways of listening, etc. The patient who has stayed in therapy will obviously be hesitant criticising the therapist. With a sense of humour and/or warmth, you may highlight some 'blunders' that may have affected the patient, and from which you have learned something from the patient.

- The therapist has to proceed carefully, as many patients fear that if they talk too much about the 'symptoms', the unpleasant effect of symptoms will return.

Termination phase

- During the entire termination phase it is important to keep your 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.