

Psychotherapies in Acute and Transient Psychoses¹

Manuel González de Chávez*

Abstract:

From a comprehensive and global view -psychological, biological and social- acute and transient psychoses could be considered identity breakdowns with fragmentation of its structure, paranoid mechanism and cognitive regression.

Psychotherapies favour evolution of psychotic identity through disorder awareness and knowledge of aspects of patients that make them more vulnerable to psychotic experiences.

We underline the key role of group psychotherapy to improve therapeutic relationships and best use of patient's coping strategies in the chronology of therapeutic interventions and recovery process of these patients.

KeyWords: Acute and Transient Psychoses; Identity Crisis; Psychotherapy; Group Psychotherapy; Therapeutic Relationship; Coping Strategies; Recovery.

We believe that a comprehensive and global view - psychological, biological and social - of acute transient psychoses and in general psychoses of the patients and the patient's disorders must be stressed, using broad approaches such as those developed by some authors in recent years^{1,2,3,4}. From a global perspective as those mentioned, we could easily consider the psychotic episode as an identity crisis of the subject, considering identity as the self in a biographic continuity.

Identity, or the self-view of a subject, is the product of a biological substrate and biographic history in a social context and familial dynamics that gives rise to a personality shaped by usual behavior patterns, defense mechanisms or coping strategies, with projects, adjustments, maladjustments, achievements and failures in multiple aspects: social, political, religious, racial, group or class, cultural, educational, work roles or subidentities as well as those of the family, body, affective, sexual, etc.^{5,6}.

For the purposes of trying to understand the psychotic crisis, identity is also the combination of more or less different subidentities: accepted, public, private, intimate, hidden, rejected or denied in addition to ideal and grandiose identities and others that are introjected from childhood in relationship with parental figures and significant persons.

In general lines, all the biographic process of conception and evolution of the identity is guided by the principles of uniqueness, continuity, independence and self-esteem, to assimilate, adapt and evaluate reality⁷. Biographic episodes, that suppose qualitative negative changes, are crises that lead to reflection and questioning of reality and ones own identity. They are painful processes of resistances, self-deception and coping strategies to save the identity and achieve its adaptation to the new reality. They entail a dynamics of readjustment of the subidentities that make the identity more vulnerable.

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* Director de Serviço: Serviço de Psiquiatria do Hospital General Universitario Gregorio Marañón. Tfno: 915868132. Secretaria: 915868131. Fax: 914265110. mchavez.hgugm@salud.madrid.org

When the coping strategies fail in the defense of uniqueness, continuity, independence and self-esteem of the identity, breakdown occurs. The psychotic episodes are identity breakdowns^{8,9} with splitting and fragmentation of its structure, paranoid mechanisms and a process of cognitive regression in the inverse road to that of normal cognitive development, which now carries the patient from the formal logic to the operational and preoperational, to perceptive egocentrism and finally to magic thinking, where all solutions are possible^{10,11}.

In the fragmentation of vulnerable identity, grandiose or feared subidentities acquire predominance in the patient and are transformed into psychotic identities.

The hidden, rejected or denied subidentities could be experienced in a paranoid way as delusions of feeling observed, known, transparent, watched, persecuted, discredited or insulted. Those introject from the significant object relationships that are presently alienated and unrecognized as one's own, could appear in the mind of the psychotic subject as hallucinations of control and criticism or support and consolation.

In the recovery process of the psychotic episode, we observe the following **evolution of identity**:

1) A **psychotic identity** exists in the middle of the episode, with a subjective transformation of the idea of oneself and the reality experienced.

2) After, many of them acquire disease awareness, and accept the psychopathological character of the experiences lived. It can be said that they have **identity of patient**.

3) At a later time in the psychotherapeutic process, they may acquire knowledge of the aspects of themselves and their reality that makes them more vulnerable to psychotic experiences. This is what we call **vulnerable identity**.

4) The purpose of psychotherapy is for the patient to be able to understand the sense or meaning of their disorders and the integration of their experiences and subidentities, to achieve an **integrating identity**.

The pathways that a patient may cover after a psychotic episode vary greatly. These go from continued permanence in their psychotic identity to a more or less contradictory awareness of disease. During the psychotherapy process, many patients acquire self-knowledge of psychological and biographical aspects that underlie and influence their disorders. A few, hardly 13% in some studies of psychotherapy follow-up¹², achieve this integration of identity and understanding of the psychotic experiences they have had, that can make them less vulnerable.

The **therapeutic relationship** with the psychotic patients follows a sequence of stages¹³, which is parallel to the evolution of their identity, as we have described:

- 1) In the beginning, in the relationship of **contact**, the therapist does not exist as such and is included in the patient's psychotic world. It is the time of personal contact, to give the patient a containing relationship, one of safety and trust, of our presence, patience and persistence always preserving the respect and dignity of the patient.
- 2) Later, we establish a **link**, a very primitive, insecure, ambivalent and unstable relationship. For the patient, this is a relationship that only exists in the present. There is no collaboration or project for the future for the patient but there is a strong presence of unconscious aspects and psychotic transferences.
- 3) Only later does the patient establish a **personal relationship** of evaluation and respect, with some confidentiality and possibilities of influence, but without a clear therapeutic meaning.
- 4) Later on, we can establish a **therapeutic relationship**, that is stable and consistent, with motivation, commitment, empathy, trust and therapeutic work, that may only be a therapeutic relationship of support or may be one of support and insight.

Our objective in the group dynamics is to favor the best **coping strategies** of the patient which are simultaneously intrapsychic, interpersonal and group ones and that can be falsifying, avoidant, reevaluating or integrat-

ing. We should help them to begin to discard, suppress or modify the most pathological strategies in order to favor the most integrating ones because:

- A) With the **falsifying strategies**, the patient distorts reality to maintain their image and identity in crisis. These strategies are fantasies or constructions of a false self that may lead to the creation of a psychotic identity. They are splitting, projection and externalization mechanisms. The delusion is the subjective falsification of the reality experienced.
- B) With the **avoidant strategies**, the subject avoids confronting a painful reality that questions and threatens him/her. The strategies are denial, rejection, forgetfulness, withdrawal, negativism mechanisms or distraction and occupation in other activities. Alcohol abuse and abuse of other toxics are common. The use of the third conditional, imagining how the present would be if the past had been different, is also common.
- C) The **reevaluating strategies** attempt to modify the analysis of the threatening reality, focusing it on partial aspects or banalizing it, comparatively devaluing the others, reevaluating oneself, whether with grandiosity and unfounded optimism, or in a catastrophic, fatalistic or resigned way, with disproportioned pessimism.

D) Favoring the **integrating strategies** helps the patients to verbalize, communicate, accept and cope, seek information and advice, receive help, mutually review, re-define and restructure their identity again, correcting the most vulnerable aspects and anticipating the possible most stressing situations or factors.

All psychotherapies revolve around the best use of coping strategies and group psychotherapy uses the group context and dynamics, mirroring and group therapeutic factors for it. The chronology of psychotherapy interventions from the psychotic episode to recovery initiates with group therapy for in-patients and with joint work of all the team in order to obtain better understanding and help from different professional perspectives and therapeutic interventions, not only group but also individual, familial and institutional^{14,15}.

During the acute psychotic crises or episodes, not all the patients fulfilled the conditions to be included in a psychotherapy group. There is a pregroup stage conditioned by the intensity of the psychotic experiences and non-reflective mirroring¹⁷. In the more intense moments, some patients may have a marked psychotic distortion in the perception of the context they are experiencing. It is necessary to wait for them to overcome, with the help of neuroleptic treatment, the disorganization, excitation, hostility, anguish or perplexity in order to establish a minimum relationship

and communication in the group context. The patient's condition should allow for a certain degree of control and minimum capacity of "reflective mirroring." In the first group stage, their mirroring reactions are egocentric and sometimes they try to convert the group into a psychotic participant in defense of their delusional convictions. The group dynamics acts by correcting the perceptive egocentrism and allows for cognitive decentering. Often, the group members reflect better by projecting than by disclosure. They reflect that which they are unaware of, that which they deny, their unconscious conflicts. The group makes it possible to act out the defense mechanisms of its members and this acting out increases the patient's observation and awareness and then self-reflection and self-questioning. The groups in the in-patient units are open with frequent sessions held daily or every other day. The therapists are always more active and directive, helping in the cognitive organization of the speech, correcting the perceptive egocentrism, paranoidization and psychotic reinforcement^{15,18,19}.

In the first therapeutic interventions, including groups as well as individual and familiar ones, our objective will be to listen, examine and favor self-disclosure of the patient. We should reconstruct together with the patient and the patient's family his/her biographic history and psychotic history, premorbid personality and all the context, relationships and precipitating factors that have lead to the

identity crisis that is revealed with his/her psychotic manifestations. This is the time to offer help, without humiliation, frustration or rejection of the patient, know the mechanisms of this transaction which is to help and be helped.

The group context should be respectful and safe, in order to help the patients to leave aside the defensive withdrawal, distrust and insecurity and favor self-disclosure and desingularization of the psychosis. In this stage, the purpose is for the patients to know that they are not the only ones who have unique realities and identities. It is to clarify, specify and focalize, and to help express feelings and experiences, sequence them and place them in a context in the biography. It is to separate facts from interpretations, consensually validate the reality and introduce other possible hypotheses and perspectives, such as those of the close significant persons and the pathways that have led the patient to the hospital, with all the dynamics experienced in the "untreated period" of psychosis. We attempt to know the internal world and external reality of the patient, his/her relationships and also the attitudes and reactions of the others regarding the patient's behavior, for example, discrediting and rejecting him/her or trying to understand and help him/her, and to know how the patient hides, expresses or verifies his/her psychotic experiences, what supports the patient has and in what obstacles and distortions we need to intervene therapeutically.

Our purpose will now be to motivate both the patient and his/her family to follow a therapeutic program with out-patient group psychotherapy that will facilitate the therapist relationship and compliance of the psychotherapy and drug treatment²⁰. This is the time to inform and "psychoeducate" the patient and his/her family on the psychotic disorder, with realistic hopes and expectations, explain the reason for the drug prescribed, deal with the subjective pharmacological experiences and reduce their possible adverse effects. It is also the time to explain the components of the program, its purposes and approximate duration. The mean duration of our program is approximately 4 to 5 years, with a weekly session of 90-120 minutes of group psychotherapy and with individual and family sessions that are established according to needs^{19,21}. All the psychotherapy programs have stages, that should not be short-circuited or skipped, in order to achieve the evolution of the identity of the schizophrenic patients. This must first go from the psychotic identity to the acceptance of the patient's identity, then to knowledge of the patient's vulnerability and finally to the integration of his/her identity.

The purpose of all the initial interventions of the psychotherapeutic process is that the patient, after his/her own contradictory internal debate, begins to accept the subjective character of his/her psychotic experiences, to accept the psychopathological character of the experiences lived, acquire awareness of

the disease and identity of patient. The group functions by contrasting and questioning the psychotic identities and blocking the development of delusion convictions or beliefs in the past truthfulness of the psychotic experiences lived.

We use both examination as well as confrontation, establishing an interlacing of crossed interventions where the similarities and differences help to advance the disclosure of the objective and subjective worlds, stimulate cohesion and facilitate the observations, analyses and reflections. We support independence and not regression, clear focal communication and not the verbalization of free associations or vague, abstract, elusive or inferred speech. We avoid long silences and situations of marked anxiety that generate group defenses and cognitive disorganization. We analyze the resistances and transferences when they obstruct the therapeutic process. We make few interpretations and prefer to note questions, contradictions or alternatives, associate sequences and connections or take an interest in the horizontal observations, opinions or interpretations of the other group members, always oriented at improving the degree of the patients' insight.

As the groups are open, with gradual incorporation of new patients, the stages are not the same in all the group members, but rather for each patient. The most veteran patients serve as guidance and support in the self-knowledge of those who enter the group after having suf-

fered a crisis. Mutual identifications permit prospective hope of some and retrospective insight of the others. All of them acquire the sense of continuity of the therapeutic process, the pathway to be covered and that covered.

In the chronology of group dynamics, we soon encounter the reactions following the psychotic crisis, its impact on the patient and his/her family members and the stigma that more isolation may cause. The group provides a socializing, motivating and altruistic support that makes it possible to analyze and approach these problems and help to fight against depression, demoralization and stigma. The patient also has a reference group in the other group members. This helps the patient to have a more objective view of him/herself and of his/her progress in a recovery that goes from readaptation to reality, to social, familial, work relationships and also to intimate relationships. Living, in the activity and practice, is where the patients reconstruct their identity and become less vulnerable.

Family help and understanding, which is made possible by using different techniques and perspectives, is essential in the recovery process of the patient and also in some way in that of the family that we must work with in order to receive adequate support. We should obtain the motivation of our patients for the others and for life, their interest for new behaviors and interaction patterns to have relationships, to trust and to intimate.

Group dynamics of knowledge, validation, reconstruction and redefinition through others²² is no more than therapeutically-led reactivation and reinitiation of the personal and biographic mirroring process of the subject, that has been created and continues to be made in his/her external-group matrix lived, the development of the patient's own image, personality and identity.

Since childhood, the familial mirroring reactions and then those of other reference groups shape self-observation and self-knowledge together with interpersonal observation and knowledge and of all the reality. It is a process that is parallel to the subject's cognitive development, to his/her differentiation and individuation of the others, to the capacity to observe, distinguish and reflect on external and internal duality of the subject's world and to know the characteristics and limits of one's awareness and reality.

This child goes through the process of overcoming the perceptive egocentrism and achieves cognitive decentering with the capacity of having empathy with the perspective and place of the others. The child's cognitive development advances through different stages of logical thinking, also overcoming the objective and subjective primitive fusion of magic thinking. Cognitive development and the development of the subject's identity are parallel and are integrated in the same continuous interpersonal mirroring process that the subject has lived since childhood and that

allows him/her to know the reality and know him/herself through others^{23,24,25}.

Altered and conflictive familial dynamics are involved in schizophrenia and other psychoses^{10,11,26,27,28}. Symbiotic, egocentric, hostile, biased, irrational or contradictory dynamics may unfavorably affect cognitive development in one's own image and self-esteem and the attitudes, relationships and understanding of the world surrounding us. This instability, inconsistency and incoherence are reflected in the vulnerable identity and the underlying resort to perceptive egocentrism and cognitive regression against stress factors, circumstances or demands that may break the precarious balance of the poorly integrated subidentities.

Group psychotherapy creates a new mirroring process to know and recognize oneself in the others and with the help of others who suffer or have suffered themselves the breakdown of the identity that gives rise to fragmentation and alienation of subidentities in psychotic experiences. It is a unique therapeutic context that uses the capacity of insight over others who have also lived or live the subjective transformation of oneself and their own reality. It facilitates a new process of interpersonal and intrapersonal relearning that makes it possible to first accept and recognize the crisis and then that of one's own vulnerability in order to be able to thus make a more realistic, more stable and more integrated redefinition of one's own identity.

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