Episode 070: The Interview & Therapeautic Alliance: Session 7 The Psychotic Patient

David Puder, M.D, Joseph Wong

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There are no conflicts of interest for this episode.

In this episode of The Psychiatry and Psychotherapy Podcast, Dr. Puder talks about the importance of therapeutic alliance in the psychiatric interview, specifically in regards to psychosis. Without a strong therapeutic alliance, the patient will have low rates of continuing medications.

Introduction

For the acutely psychotic patient typically seen in the inpatient setting, medications are an essential part of treatment to help to get the patient out of a psychotic state. However, even in the inpatient setting (and especially the outpatient setting) poor medication compliance is an important issue for mental health professionals in treating psychosis.

The CATIE and EUFEST trials looked at medication compliance in chronic schizophrenic patients and found that 74% discontinued their study meds before 18 months (Czobor et al., 2015). Certain factors that contribute to poorer medication compliance include:

- Substance use (Ascher-Svanum et al., 2006; Owen et al., 1996; Pristach & Smith, 1990),
- Medication side-effects (e.g. extrapyramidal symptoms) (Van Putten, 1974; McCann et al., 2008)
- Higher hostility levels (Czobor et al., 2013; Lindenmayer et al., 2009)
- Poor cognitive functioning and insight (Ascher-Svanum et al., 2006; Hofer et al., 2007; Perkins et al., 2006)
- Difficulties in establishing a therapeutic alliance (Barrowclough et al., 2010; Velligan et al., 2009).

The clinical implication of these studies suggest that we can improve medication adherence if we improve the patient's insight into their psychotic condition, address their comorbid substance use, lower the patient's hostility levels towards us during sessions, and build a therapeutic alliance with the patient.

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How can we help patients adhere to their treatment?

There are six factors that can contribute to improved medication adherence: (Cañas et al., 2013)

1. Know that most patients with schizophrenia are at risk of partial or non adherence.
2. Good therapeutic alliance.
3. Tailored treatment plans that consider the patient's needs, including the most suitable delivery of medication.
4. Involving key people in the patient's life (e.g. family) in the care of the patient.
5. Ensuing optimal effectiveness of care.
6. Ensuing continuity in the care of the patient.

Therapeutic Alliance

One of the biggest determining factors in psychotic patients adhering to their treatments is a positive therapeutic alliance. Developing a therapeutic alliance with a psychotic patient can be more challenging than it would be with someone who is not experiencing psychosis. For this reason, I wanted to cover how to develop a connection with and help patients experiencing a psychotic episode.

How do we connect? We try to set up a quality attachment and practice empathy. I believe that patients, even when severely psychotic, can experience your empathy, calmness, confidence and steadfastness. This helps them feel more calm. Once the patient is able to communicate coherently, we can begin developing a therapeutic alliance that will help them adhere to treatments.

First, we need to remember that everyone is most comfortable with people like ourselves; we are inclined not to attune to depression, aggression, hostility. Also, the patient is more like us than not like us when we really consider all of our own humanness. We've all had dreams that are psychotic, we've all had that twilight experience when we are barely awake when things aren't completely as they seem to be. Those things alone are frightening for us to feel, so understanding this will help us accept the patient with all of their strange and frightening symptoms.

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Through taking their history and listening to their hallucinations or delusions, you will also hear about their strengths. Ask yourself: What do you think are the patient's expectations of the interview and of the treatment? What would their wishes, aspirations, and fears be? If they can answer, know that most patients want you to understand what is going on inside of them, and they will try their best to communicate that. For many patients, it is more important to them to be understood than to hear what others have to say about them.

During the interview, avoid being hurried, use calm inquiry and convey a calm body language so that the patient can calm down.

- I like to say things like:
    - "Do you feel more or less agitated while I am here with you?"
    - "If you ever feel like you want me to leave, just let me know."
    - "I would like to help you feel safe and secure from _____."
    - "Is there anything I can do to make you feel more at ease?"

These types of statements gives them a feeling of power and safety when they're with me.

During and after a psychotic episode, there is a **strong sensitivity to rejection**. Patients can easily feel like we are looking down on them, that they're crazy and worthless. Understand that sensitivity to esteem maintenance is vital. Listen attentively, respectfully, and find meaningfulness in everything about the patient (e.g. their fears). I like to read microexpressions in order to better attune to their emotional state so that I can better respond to it. All these things will diminish fears of rejection and unacceptability, and enhance worthwhileness and positive self-regard.

Remember that **the patient is entitled to their emotions**. What is the patient experiencing—are there any particular emotions? How does he or she understand it? What does the emotion mean for him/her? Focus on the emotion; focus on the here and now and the present more than the past. Focus on the immediate precipitating stressors and current adaptive challenges and tasks and the opportunities and benefits of mastery. Remember that some patients may take years to be forthcoming with their emotions, and it is important to meet that openness with gratitude.

When we listen to their stories, it's important to remember that in psychosis, sometimes the treatment process involves being put on an involuntary hold, taking medication against their will, being put in front of the court, and even being put in restraints. These can all feel like traumatic events to them. Thus, we need to listen in an empathetic way, which can be healing in and of

itself, and to let the patient know that "we're doing the best we can to help them." Acknowledge all patient's entitlement to their ambivalent feelings, particularly the involuntary patient.

Tailored Treatment Plans

Although our initial treatment plan may involve giving the patient medications against their wishes on an involuntary hold, as the treatment progresses, it's important to allow the patient to be part of the decision making process. There may be several different options for medications, which present the patient with the opportunity to direct their care and share with us their concerns and fears. It is important to tell the patient about all the possible side-effects that each option presents as the fear of unexpected side-effects has been shown to lead to poor medication compliance (Velligan et al., 2009).

Importance of Family

Once a good therapeutic alliance is established, we can begin to increase the patient's insight into the disease, which in turn will increase adherence to treatment. One important aspect of improving the patient's insight into their condition involves bringing in the family into the process of understanding the patient's condition and increasing their insight. Although you may have to deal with high emotions in the family and taking the time to build respect and trust between you, the patient, and their family, I've experienced many success stories where the family were champions of the patient's health (e.g. brought the patient to visits, took them to get weekly blood draws for clozapine).

Optimizing Care

One of the things that can better optimize patient care are well-scheduled appointments, which includes little waiting time in the waiting room, and enough time during the appointment for the patient to express their concerns. One of my patients told me about his experience in a clinic waiting room where he had to wait 3-4 hours to see the psychiatrist. After 40 minutes of waiting, he became so stressed and agitated that he got up and left.

Continuity of Care

Everyone that has worked in the inpatient setting shares the frustration of not knowing whether their patient got the outpatient follow-up care they needed. As discussed earlier, bringing in family can improve continuity of care as even if the patient isn't motivated to seek the treatment they need, their family can become the determining factor in their positive growth. In certain

practices, being able to discharge the patient from inpatient so they can complete their own follow up through outpatient care can build on the therapeutic alliance you've already developed, increase continuity of care and thus, medication compliance.

The psychotic patient's behavior:

Disorganized speech
Blurred ego boundaries occur in psychosis (where I start and others begin, as well as between my internal world and the external world around me). When malevolence of caregivers and others becomes too painful to tolerate, the ability to reflect on mental states of self and others is not possible. Disorganized communication can be used defensively to avoid communicating with others.

Hallucinations and delusions
Psychotic patients demonstrate a bias towards **external attribution** of thoughts and internal events. **Hallucinations and delusions are creations with significant emotional and idiosyncratic meaning to the patient.** Be sure to have the patient state their story first so you can attune to their point of view. Their delusions embody core wishes and concerns, and like dreams, they are a royal road to understanding the unconscious.

- Delusions are fixed belief systems that are clung to in spite of evidence to the contrary.
- Approach delusions with curiosity about their content and their larger meanings for patients, without co-authoring the patient's delusions.
- Ask questions concerning the details of the delusion as though the delusion were reality.
- Demonstrate genuine interest in the content of delusions and hallucinations, as well as what they might symbolize is desirable.
- Hallucinations can be unintegrated and inconsistent representations of their central relationships.
- Decrease external attributional bias.
- Help them come up with a plan to cope with their hallucinations

Confusion
If the patient is confused, you may need to check in to see what they are processing and comprehending. Check to see their working memory: ask them to spell "world" backwards, count down from 72 by 7s, and to draw a clock.

Anger and violence

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Although there is a known correlation between patients with schizophrenia and violent behavior, only about 5-10% of offenders of homicide and non-fatal violence have schizophrenia (Mullen, 2006). So if a patient does look violent, obviously keep yourself safe, but understand that violence in these patients should be not expected to be the norm.

Several factors that can lead to anger and violence in these patients include:

- Feeling devalued
- Not being understood
- Being held against their will/not being in control
- Fear
- History of violence
- Delusions
- CAH (Rogers, 2008)

The quality of the therapeutic alliance is one of the major factors in predicting inpatient violence, so it is important to distinguish agitation that decreases a patient's stress and that which is a reflection of increasing frustration. That is why it is important to listen to why they were violent, empathize with what they said, and to give instructions in a non-confrontational manner, "Hey, why don't you sit here so we can have a conversation."

If you would like to learn more about reducing inpatient violence, refer to Ep. 040 of the podcast.

Fearfulness and Paranoia

Explain to the patient that you are wanting to help them feel safe and secure, and that you also want to feel safe and secure along with them. It is essential to reassure the fearful patient, to empathize with their situation.

Physically, there are some things you can do to reduce fear for you and your patient:

- Reduce your physical profile (be at the same height, or lower than the patient. Don't loom over the patient)
- If the patient is sitting down, also take a seat
- Keep your hands in front of you and visible, not behind the back or high up
- Make sure both you and the patient have a way to safely leave the interview if need be
- Take more time to talk about the importance of safety in the environment
- Check in with the patient frequently about how secure/insecure/frustrated they are feeling and whether their fearfulness is increasing or decreasing

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The Involuntary Hold

To help the patient understand their involuntary hold, try to work to reduce the patient's sense of coercion by:

- Putting the hold out of concern and care for the patient
- Acknowledging their ambivalence about having been forced
- Treating them with respect
- Not using deception (what you say should be true)
    - Give them a chance to tell their story (express your belief that their story, their feelings, and their hopes are extremely important to you)
- Considering what patients have to say as you make treatment decisions together—collaboration is of the essence!
- Clearly explaining your role in their treatment
- Conveying optimism about treatment and its effectiveness
- Explaining the patient's condition, the treatment, and its possible side effects

Limit setting

Limit setting occurs within a therapeutic relationship to help the patient. The limits will ideally reflect a respectful, least-restrictive approach. It is mainly for the preservation of treatment as it does not improve treatment outcomes.

The treatment provider pressures a client to change behavior that is disturbing, dangerous, or destructive in order to be engaged in treatment. Don't hesitate to give verbal encouragement or admonition such as, "that behavior keeps getting you into trouble." Also, give contingent support or contracting such as, "once you manage your medications reliably, we'll see about getting you that job." You can suggest the involvement of others by saying things such as, "you seem to need help managing your money."

Another way to set a limit is to state an informal coercion such as, "you can enter the hospital voluntarily, or we will have to commit you." If you need to instate a formal coercion, state it clearly: "I am putting you on a 5250, and you can appeal to the judge if you want to."

Learning what is normal from studies:

Notes from "Clinical Assessment of Malingering and Deception" 3rd Edition edited by Richard Rogers.

Genuine Hallucinations:

- 88% of hallucinations are associated with delusions
- They are intermittent rather than continuous

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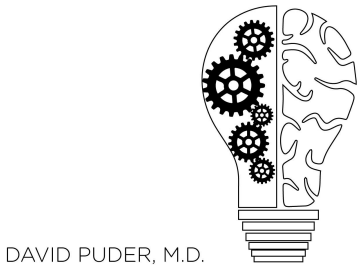

- Olfactory and tactile hallucinations are uncommon except when associated with medical causes or latent onset schizophrenia
- Immediate improvement is unlikely (median days that they clear before the first hallucination is 27 days)
- 75% hear both genders
- 88% hear both familiar and unfamiliar voices
- Only 7% are vague or inaudible (usually it is clear)
- Many psychotic patients hear voices both internally and externally, and this should not be used to determine their genuineness
- Themes relate to culture (Saudi patients had religious/superstitious nature, English had running commentary)

Themes of hallucinations:

- Hallucinated voices are omnipotent and omniscient (voices know the patient's thoughts and able to predict the patient's future)
- Benevolent voices: usually provoke positive emotions which patients respond to by elective listening, willing compliance, doing things to bring on the voices
- Malevolent voices: usually provoke negative emotions (**fear**) which patients respond to by shouting, arguing, noncompliance, avoidance of cues that trigger voices
- 81% are worried or upset about their hallucinations

In schizophrenia, they are usually persecutory or instructive

- They are insulting, obscene, accusatory or insulting
- Schizophrenic hallucinations tend to be ego-dystonic, derogatory comments about the patient or the activities of others
- Chastising rather than information seeking
- Negative hallucinations may focus on sexuality, with women being described as sluts and men as gay, which is stigmatizing and therefore usually not faked
- Hallucinations associated with music are rare except with organic brain pathology

Genuine Command Hallucinations:

- 38% of those with AH also have CAH
- 50% of mood disorders and schizophrenia have CAH
- 30-40% of alcoholic withdrawal hallucinations are CAH
- Of those with CAH, 85% also have non-command hallucinations
- Of those with CAH, 75% also have delusions
- Some who hear will act on them and compliance with dangerous commands are less

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likely to be obeyed

Coping with hallucinations:

- 66% of patients reported ways of managing their symptoms (involvement in activity, working, listening to music, watching TV, changes in posture, seeking interpersonal contact, taking medications). Learning to successfully distract oneself is a huge coping skill.
- 69% of patients reported some success with these strategies.
- Sometimes when the voice commands them to do something, the person will debate and the voices will rephrase their requests, speak louder, curse the patient for being non-compliant. In contrast malingerers are more likely to claim that they were compelled to obey the commands without further discussion
- 98% reported experiencing adverse effects from the hallucinations: holding jobs, emotional distress, feeling threatened
- 50% expressed some positive effects: companionship, relaxation, and more ease in receiving disability benefits
- 80% reported being alone worsened hallucinations
- Listening to the radio and watching TV (especially new shows) worsened hallucinations
- Genuine AH have a wide range of intensity from whispers to shouting, and the range is sometimes experienced within the same person
- The cadence of speech is typically normal

In summary

Through our affective empathy we can feel our patient's paranoia, which can make us feel more fearful than we really need to be. We may put our own narratives on the emotion, for example when we start to fear that they may hurt us. They have strong feelings of shame and sensitivity to rejection. Listening non-judgmentally, not counteracting delusions (but rather listening to their meaning), empathizing with their distress and desires, and being able to calm our own body are powerful tools.

Therapeutic Alliance Part 1

Therapeutic Alliance Part 2: Meaning and Viktor Frankl's Logotherapy

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PSYCHIATRY & PSYCHOTHERAPY

Therapeutic Alliance Part 3: How Empathy Works and How To Improve It

Therapeutic Alliance Part 4: What is Transference and Countertransference?

Therapeutic Alliance Part 5: Emotion

Therapeutic Alliance Part 6: Attachment Types and Application