Psychotherapy for Psychosis with Dr. Michael Garrett

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In this week's episode of the podcast, we interview Dr. Michael Garrett, Professor Emeritus of Clinical Psychiatry and former Vice Chair and Director of Psychotherapy Education at SUNY Downstate Medical Center, Brooklyn, NY. He also wrote a book called, *Psychotherapy for Psychosis: Integrating Cognitive-Behavioral and Psychodynamic treatment.* He is husband to the prior beloved presenter, Dr. Nancy McWilliams. In this episode, we will discuss how psychotherapy can be effective for patients experiencing psychosis.

Introduction

Psychosis—an alteration in one's perception of reality—is often misunderstood, leading to misconceptions about those experiencing it. These individuals navigate a unique world, inhabited by voices and sensations others cannot comprehend. Yet, their experiences are not entirely disconnected from the 'normal' human experience. In truth, they demonstrate an extreme variant of feelings and perceptions that we all encounter. As we delve into the complex world of psychosis, we'll explore how it can be understood, empathized with, and treated through a combination of cognitive behavioral therapy, psychodynamic therapy, and pharmacology, fundamentally redefining the conventional view of this condition.

Psychosis and a variance of human experience

“Psychosis is grounded in a subjective change of being” (Garrett, p.199). The pathogenesis of psychosis includes experiencing thoughts with an increased “acoustic quality,” characterized as disruptions in one’s self-perception and relationship with one’s body. Psychosis consists of delusional beliefs that appear to be true claims about the world that are literally false but are figuratively true metaphorical statements that aptly capture the patient’s experience. It presents as changes in the subjective experience of consciousness, known as *hyperreflexive self-awareness*. Psychotic patients are hyper-reflexively self-aware, with the ability to hear and track their own thoughts. The psychotic patient loses their sense of personal agency and their mental processes become objects of perception. These patients record their own stream of consciousness without realizing it and their experiences feel as if they are observing themselves from outside of their own body. For example, a patient hears voices arguing and commenting on the actions of the patient, while the patient “watches” from the outside, being the third-person subject of the debate (Garrett, p.33).

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Psychosis is frequently misunderstood as the absence of cognitive capacity; however, it is described as the presence of a belief or reality that is more compelling than an individual's previous experiences or logic. Dr. Garrett suggests that psychiatrists should respect the patient's altered subjective reality as a version of the world that the patient strongly believes (Garrett, p. 137). If the therapist can understand how real the patient's altered reality is, similar to how real the therapist's reality is to the therapist, then they can better empathize with the patient's distress.

Dr. Garrett discusses how he tries to explain to his patients that their experiences are variants of normal human experience. There are times where non-psychotic individuals feel that attention is focused on them. For example, if someone spills something on their clothes or has a messy hair day during a presentation, they feel that people around them are hyper focused on that one flaw. "When we overreact to an event, we are imagining that something we unconsciously fear has already happened or about to happen" (Garrett, p. 137). When the reality of feeling is translated into conviction, the experience feels real. In situations similar to what is mentioned above, most individuals are able to come to the realization that they have *overreacted.* The psychotic patients are not able perceive their emotion as overreacting. They don't have the intuition to understand that their imaginative fear is not actually an existing reality because to them it is real.

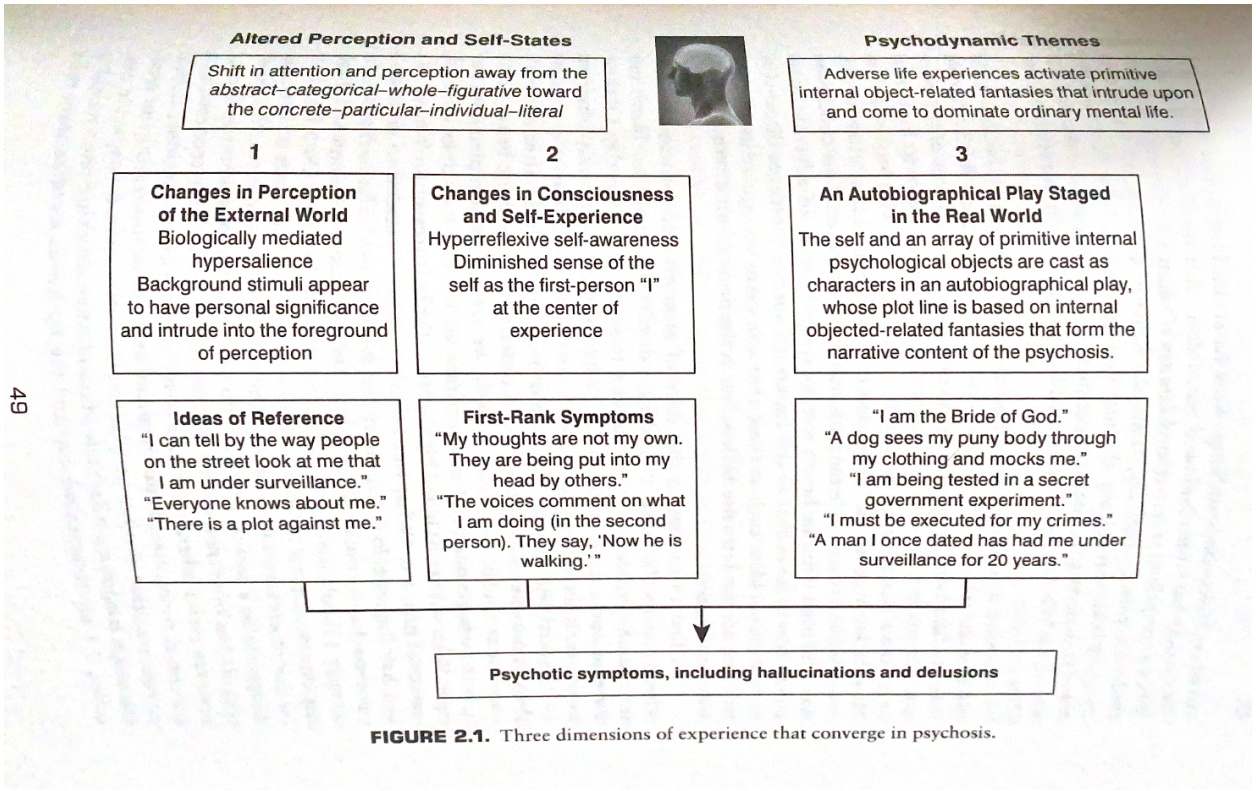

FIGURE 2.1. Three dimensions of experience that converge in psychosis.

It is really challenging for an adult to imagine that their minds are open to anyone to access their thoughts. This relates to the disturbances in self-experience, because as the “I” diminishes and the person becomes an observer to themselves, it becomes a two-dimensional state. When the patient is under the circumstance that they have a thought and it doesn't feel like they thought it, this leads them to believe that someone else is putting thoughts in their head.

Dr. Garrett describes psychotic symptoms as a form of expression of the person’s mental life. “Step on a crack and break your mother’s back” is related to psychic equivalence. For example, a child believes that if they avoid the cracks of the sidewalk, then they won’t hurt their mother. The child is frightened of thinking negative thoughts about their mother, but the child is angry. This phrase implies don’t step on a crack and you save your mother from your own aggression. Their fears get projected outwards, and the sidewalk becomes part of the patient's mind. They believe that the safety measure is to avoid the lines of the sidewalk. We all have some ideas of superstition. For example, in medical school a student might wear the same exact shirt to each medical exam because they believe it is good luck.

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Current Biological Theories of psychosis:

In his book, Dr. Garrett discusses the current theories that explain the potential causes of psychosis.

The Traumagenic Neurodevelopmental Model

- This model emphasizes the changes in the brain due to adverse effects and experiences.
- The trauma or adverse events that a patient has experienced cause significant neuroanatomical changes that “sculpt” the brain into different shapes that are visible on brain scans.
- Childhood maltreatment is an example of how experiences are directly related to changes in brain structure, function, and overall connectivity.
- Not all cases of child maltreatment will show signs of psychosis, even though there are physical changes in the brain.
- This model puts emphasis on childhood adverse events as an underlying cause of psychosis.

The Biological Neurodevelopmental Model

- This model incorporates genetics and biological effects that play a role in the development of schizophrenia in individuals that present at an earlier age.
- The “two-hit” model proposed by Keshavan states that insults that occur prenatally or perinatally are combined with later disturbances from experiences and the environment that play a role in neuronal development of adolescence (p. 36).

The Dopamine Theory of Schizophrenia

- This theory incorporates the positive and negative symptoms of psychosis that are attributed to dopamine excess in the limbic system or dopamine deficiencies in the frontal cortex.

- There is a “presynaptic dopaminergic abnormality” that results in a large increase in dopamine synthesis.

The Dysconnectivity Model

- This model incorporates the main pathology of schizophrenia with the idea that some circuits in the brain may be overactive or underactive.
- This idea was suggested after it was found that certain regions in the brains of schizophrenics, particularly the frontal lobe and other areas of the brain, had decreased brain connectivity.

How to get a resistant patient to agree to psychotherapy?

There are certain patients that are beyond the reach of engagement and not easy to approach. However, there are some approaches that can be used to help a patient transition into psychotherapy.

- Scandinavian countries and a few regions in the U.S. use the Open-Dialogue approach.
    - This approach aims to avoid admitting the patient into a hospital.
    - The goal is to incorporate the family and openly discuss worries or concerns of the family
    - It is an open dialogue with the family in which the person of concern is invited to contribute equally as a participant
    - The discussion is respectful and the family expresses their feelings and explores the dilemma together.
    - This kind of interaction plays an important role in the recovery process of the patient because it eases communication within the members of the group/family.
- A family consultation in the absence of the patient aims to target the member of the family that likely has a greater emotional influence on the patient.
    - In this approach, the psychiatrist works with that specific family member whom the patient trusts. The psychiatrist learns from their perspective and builds an alliance.

    - Family members are directly affected when their loved ones are the psychotic patient. Dr. Garrett tries to explore the concerns and empathize with their worries regarding the patient.
    - The goal of this approach is not necessarily to cure the patient's symptoms, but to open a conversation that allows the patient to express his/her most concerning distress.
    - Example: A patient hears voices and is greatly distressed. His distress is not regarding what the voices are saying, but that his family does not believe or understand. He feels alienated because his family does not have the same experience as him.
- Giving the patient an ultimatum if they are not behaving in a *civil* manner and posing a threat to the family.
    - In this approach, patients are coerced into treatment because they are not safe to go untreated.
    - In some cases, the patient can still develop a meaningful relationship with the psychiatrist.

The Working Formulation of the CBT and Psychodynamic Components

In Dr. Garrett's book, he discusses approaching patients who experience psychosis with cognitive behavioral therapy and psychodynamic therapy. The combination of cognitive behavioral therapy, psychodynamic therapy, and pharmacology is a fully integrative approach that aims to learn about the underlying events related to the patient's "mythic narrative perspective" in order to combat the most distressing aspect. Combining these therapies allows for openness and exploration with curiosity regarding the patient. It is the therapist's job to understand the patient's perception of their suffering in order to better formulate the patient's treatment plan.

The working formulation for cognitive behavioral therapy serves as a guide for the psychiatrist when approaching the patient. This includes learning about the patient's upbringing, familial or interpersonal issues, strengths, weaknesses, and significant life events. Dr. Garrett described the A-B-C sequence which is used to investigate the patients thoughts, feelings, and perceptions critical in their maladaptive beliefs.

The first step determines the “A” of the patient, which is typically an anomalous conscious experience that captures the patient’s attention. It is the starting point in therapy that allows the therapist to find a “cognitive hook” when beginning treatment. For example, a girl that was physically abused by her parents might hear a voice telling her “You’re pathetic!” in which case the voice is “A.” In this situation, the therapist might interpret that as the patient blaming herself for what happened by telling herself she isn’t good enough. “In the A-B-C sequence, C is the emotional and/or behavioral consequence of the belief B activating event A”(Garrett, p. 162). The A-B-C sequence is not permanent and changes over the course of therapy, as it is the working formulation.

The working psychodynamic formulation is the blueprint of the core psychological conflict, interpreting the symbolism underlying the patient’s psychotic symptoms. The sources of information for the psychodynamic work formulation are (Garrett, p. 163):

1. The psychological and social triggers of the first psychotic episode, and following episodes, in the psychosis
2. The subject or content of the psychotic symptoms, which convey the person’s unconscious psychological conflicts

The minds of humans create symbols naturally and it is the job of the therapist to help expose the organizational work the patient’s mind has already done through psychodynamic therapy (Garrett, p. 164). This model is therapeutic because it is the intent to understand the patient that is ultimately successful in the recovery process. The patient is able to appreciate this and feel they are worth understanding.

The addition of a pharmacological approach, such as adding neuroleptics to the patient’s regimen, helps modulate the affective zone and help the patient remain in a stable zone. The psychiatrist meets the patient with not only a medical mind, but also a curious mind to explore the patient as a person.

Exploring the Patient’s Symptoms & Using Combination Therapy

It is common for patients to feel resistant to treatment due to past traumas from previous hospital experiences. In some cases, where safety concerns are not withstanding and the patient is capable of engaging in a conversation, Dr. Garrett might say to a patient “It is not my intent to prescribe any medication for you as a requirement

of our meeting. I am happy to see you without taking medication as we get to know each other and we see how our conversation goes." The idea is to give the patient the condition that they won't be forced to take medication. Over a period of time, the patient can evolve into building their own interest in pharmacological treatment.

For example, Dr. Garrett discusses how one of his patient's refused to ever take psychiatric medication after she went through a traumatizing experience. This patient was involuntarily admitted to the hospital and treated with the medication depakote, which led her to lose all of her hair. The combination of being involuntarily held and forced to take medication that caused a horrible adverse effect led her to swear that she would never take psychiatric medications again.

When the patient started psychotherapy, it was on the condition that she wouldn't have to take medication. Over time in psychotherapy, Dr. Garrett was able to discuss the voices she was hearing and investigate a deeper meaning of her worries. The patient was hearing voices that were telling her someone was going to die. This led her to spend hours a day looking for clues to find out how this person was going to die. Dr. Garrett helped normalize the voices she was hearing by helping her understand it was a variant of normal human experience. After many sessions, she was able to share how she suffered many losses in her life. These losses had a great impact on her because she was starting to feel that death and loss were approaching her soon. Psychosis is a stress-related condition and, in this situation, may have been the cause of her voices.

Together, they concluded that the defense of her psychological experience was to investigate the puzzle of who was going to die next because, in her delusion, it was not going to be her. However, she came to understand in the end that it was her. By getting to this point in psychotherapy, Dr. Garrett established a sense of trust with the patient. He was able to offer a low-dose aripiprazole for medication to help taper the voice-hearing experiences. She agreed to medication, which led to the end of the voice-hearing experience.

This treatment method was a combination of CBT, psychodynamic therapy, and pharmacology. The CBT helped the patient normalize the voice-hearing experience. The psychodynamic/psychoanalytic approach helped the patient understand the conflict regarding her losses and grief. The incorporation of pharmacology helped close the biological window. Overall, this combination therapy worked together to properly assess

and treat the patient. She was able to re-enter normal life by working and making an income for herself, which helped boost her self esteem.

Empathizing with the Psychotic Experience

The therapist is responsible for understanding how the patient's lived experience of psychosis demonstrates itself as an altered state of consciousness. In these altered states of consciousness, external stimuli become exceptionally important and pertinent, while changes in self-experience eliminate the first person, becoming the lived experience of psychosis (Garrett, p. 199).

A patient may describe unspeakable tortures that may have never occurred, but the delusion may be consistent with the feeling the patient was experiencing. Therapists can accomplish a personal empathetic understanding into the patient's psychosis by the expression of metaphors to help recognize their altered states.

The empathic door into psychotic experience can be achieved by reflecting on one's own hyper-reaction to certain situations. Reflecting on the tension between what is rational and irrational can help a therapist better empathize with the patient's lived experiences.

Ambitious Psychotherapy in the Public

Dr. Garrett discusses the importance of implementing psychotherapy training in the current residency and outpatient programs. He advises that there should be protected time for 1-2 long-term patients selected for an ambitious effort at psychotherapy. Within the clinic, the program can identify a few patients that would be good candidates for psychotherapy and work with them long-term. The trainees would be supervised by experts in psychotherapy to provide guidance and teaching lessons. The goal of the training would be that once the psychiatrist feels more comfortable with psychotherapy with a couple people, they will improve their skills and their level of empathic engagement with all their patients.

Real change is needed in the way care is provided. The four main limitations, according to Dr Garrett, are numbers of staff, funding, guild allegiance and interdisciplinary

politics. Psychiatrists who are knowledgeable and skilled in psychotherapy in a program and support therapists and social workers in implementing psychotherapy are needed.

Summary

Navigating the labyrinthine world of psychosis is no simple task. Yet, through a blend of cognitive behavioral therapy, psychodynamic therapy, and pharmacology, clinicians can achieve a deeper understanding of their patients' experiences and provide more effective treatment. This multifaceted approach not only helps in managing symptoms, but also promotes empathy, bridging the gap between the patient's reality and our own. Ultimately, achieving change in mental health care for individuals with psychosis calls for a shift in our therapeutic approaches, a reimagining of treatment protocols, and a re-evaluation of our training models. By doing so, we can ensure that each patient's unique world is not just recognized, but also truly understood.

You can continue to learn more from Dr. Garrett's book, Psychotherapy for Psychosis: Integrating Cognitive Behavioral and Psychodynamic Treatment.