

Influence of individual psychological support on the severity of psychopathological symptoms in patients with paranoid schizophrenia

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Summary

Aim. The aim of the study was to investigate the relationship between psychological therapeutic interactions and the severity of psychopathological symptoms in patients diagnosed with paranoid schizophrenia during their hospitalisation.

Sample and method. The study involved 60 patients hospitalised for paranoid schizophrenia. They were divided into two groups of 30. The first group consisted of patients actively using psychological assistance and the second group of patients not benefiting from such aid. The PANSS and the author's own questionnaire were used to conduct the assessment. In the survey, patients were asked to determine the frequency and quality of contact with a psychologist.

Results. The results show that at the beginning of hospitalisation, patients in both groups did not differ significantly from one another in terms of the severity of psychopathological symptoms measured with PANSS. The group actively using psychological support during hospitalisation received significantly lower scores in general PANSS. Also, all subscales of PANSS indicate a significant decrease in scores. This means that in patients of the first group there was a significant weakening of positive, negative and general symptoms as compared with the second group.

Discussion. The results confirm the validity of the inclusion of psychotherapy in treatment of people with paranoid schizophrenia.

Conclusions. Patients in the group actively using psychological support during hospitalisation achieved significantly greater reduction in the severity of psychopathological symptoms compared with patients in the group not participating in therapy. Persons in contact with therapists became significantly healthier (symptomatic improvement) than those in the second group.

therapeutic influence / positive symptoms / negative symptoms / paranoid schizophrenia / recovery

One may wonder whether, at the time of dynamically developing neuroscience, seeking the significance of psychotherapy in the treatment of schizophrenia is justified. Although scientists have made great advances in the knowledge of the functions of the brain, we still do not know

the precise answer to the most important questions regarding the causes of schizophrenia and its treatment. As suggested by Pérez-Álvarez and colleagues [1], the search for the most effective treatment of schizophrenic disorders is not necessarily associated with neuroscience and antipsychotics. Evaluation of the effectiveness of psychological support, including psychotherapy, in the treatment of schizophrenia gradually changes. In the past century the importance of psychotherapy has evolved: it used to be practi-

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cally overlooked, as a method whose effectiveness is difficult to verify empirically, or occupied an important place among the other treatments of schizophrenic disorders [2]. The adoption of a holistic, biopsychosocial model in the approach to the aetiology of schizophrenia allowed acknowledging the importance of psychological and social factors in its treatment. Still, the biological aspect seems to be dominant in thinking about the causes of schizophrenia [3]. Clinicians with biomedical orientation for many years denied the importance of psychological and social support in the treatment of this group of mental disorders. Medical aid of patients with schizophrenic disorders is based on pharmacological treatment, but psychological support is an equally important part of this process.

Nearly 50 years ago, psychotherapy was placed in the canon of treatment of mental disorders alongside biological and pharmacological methods. The standard in helping individuals suffering from schizophrenic disorders should be comprehensive treatment. It includes both pharmacological and psychotherapeutic procedures and early and late rehabilitation [4]. According to Aleksandrowicz [5], psychotherapy can significantly help patients diagnosed with schizophrenia, and pharmacotherapy combined with psychotherapy is more effective than using only medications. Having no conclusive criteria for the aetiology of schizophrenia prompted Kępiński [6] many years ago to adopt its multifactorial origins. He held that the consequences of this view should be taken into account in developing treatment programmes. Years later, Alanen [7] similarly pointed to the diversity of issues involving people with schizophrenic disorders. He emphasised the need to consider in the process of treatment the individual needs of a patient, manifested in the selection of adequate pharmacological methods combined with psychotherapy, family therapy and social interactions. Empirical studies available in literature indicate that currently the most favourable therapeutic results in the treatment of individuals with schizophrenia are achieved by adapting an integration model, according to which clinical practice combines various forms of treatment, including psychotherapeutic interactions [3].

Inclusion of psychological help in the therapeutic process of people with schizophrenic dis-

orders results from the expectations indicated by patients (conversation, trust, hope) as well as the belief that people with mental disorders should be provided with new, corrective experience helpful in overcoming a mental crisis [8]. A positive relationship with a therapist will improve the quality of life of people diagnosed with schizophrenia. Establishing good contact, an understanding expressed by the therapist, the ability to accompany and be accessible to the person at the time when they are going through an acute mental crisis, are crucial in the patient's return to health. Clinical practice and a growing number of studies confirm the improved efficiency of the treatment of schizophrenia through incorporating the psychosocial element. Any psychotherapist is able to discern in the delusional content revealed by the patient also his psychological problems. Already in the early stages of the disease, the therapist can strengthen the patient's sense of security, accompany him in his suffering, offer support, provide positive experiences and information to help overcome the psychological crisis, introduce elements of psychological education about the disease, give the patient the space to express himself and name his experiences associated with psychotic sensations. Individual, direct, therapeutic contact allows the identification and resolution of significant emotional problems the patient is experiencing.

The objectives of psychotherapeutic interactions with people affected by schizophrenia are not clearly defined and are usually individualized. The general objectives formulated in literature come down to two: establishing therapeutic contact and maintaining levels of personal and interpersonal functioning. Studies on the effectiveness of psychotherapeutic methods in the treatment of schizophrenia include the main trends of psychotherapy. Psychotherapy of the psychoanalytic orientation was never leading in the treatment of schizophrenia, but it has more than a century-old tradition in this regard. Assumptions of psychoanalysis are employed in individual psychotherapy of patients with schizophrenia, but classical psychoanalytic techniques are rarely used. Such treatment is defined as a psychoanalytically or psychodynamically oriented psychotherapy [7]. The aim in psychodynamic therapy is to provide support to patients afflicted with schizophrenia spectrum disorders

and to enable them to undergo corrective treatment and avoid situations that could cause regression. When working with patients affected by schizophrenic disorders, the techniques of cognitive-behavioural therapy are aimed at reducing symptoms, improving self-esteem, improving social functioning and increasing insight. Research on the effectiveness of cognitive-behavioural therapy initially did not provide conclusive results. However, a meta-analysis of several studies from the years 1990–2004 has shown that cognitive-behavioural therapy is an effective method to assist in the treatment of positive symptoms in schizophrenia spectrum disorders. The effectiveness of interactions based on cognitive-behavioural techniques was greater in patients with an acute psychotic episode than in those in a chronic state [9]. Another study based on a meta-analysis of cognitive-behavioural therapy was published by Newton-Howes & Wood [10]. They did not detect significant differences between the groups treated with cognitive-behavioural methods compared with supportive therapy in terms of increased severity of patient psychopathology. The authors did not suggest that this type of therapy is not effective in treating psychotic patients, but have shown that it is not more efficient. Cognitive methods are directed more towards factors maintaining persistent symptoms of schizophrenia than those related to the psychological sources. In turn, family therapists working with the family of the person who has suffered a psychotic disorder focus on changes in the family system to the extent that it is beneficial for the patient and his relatives. A person with mental illness and his family receive support and helpful information within the framework of psychological education. Research on the effectiveness of interventions carried out on the basis of a family therapy system indicate its beneficial effects, if the duration of the intervention is sufficiently long [11, 12], but there are also studies demonstrating the effectiveness of short-term interactions [13]. Psychotherapy as one of the methods in the comprehensive treatment of people diagnosed with schizophrenia is more effective if it is tailored to the individual needs of the patient. This seems a matter of course, however, clinical practice demonstrates that it is still difficult to achieve because of insufficient resources being allocated to the treat-

ment of people with mental disorders [3]. In the process of helping a patient who suffers from schizophrenia, the most important seems to be not only the selection of adequate psychotherapeutic methods, but the role and characteristics of the therapist and the therapeutic relationship which is formed between the therapist and the patient. The factors that determine the success of psychotherapy are: the relationship between the patient and therapist, the therapeutic setting and the patient's susceptibility to therapist interventions. Representatives of different schools of psychotherapy are in agreement that the psychological treatment of psychosis is possible and even necessary [14].

The effectiveness of psychotherapy in the treatment of people with schizophrenia is generally difficult to evaluate clearly. Alanen [7] identified three fundamental limitations.

1. Clinical heterogeneity of schizophrenia - patients in psychotherapy differ significantly in terms of motivation for treatment and psychotherapeutic needs. Individual psychotherapy brings positive effects in some patients and lack of satisfactory results in individuals diagnosed with schizophrenia, for which it is an inadequate method. In this context, psychotherapy cannot be considered as an unsuitable form of treatment if it brings a marked improvement to the mental health of some patients. Rather, it should lead to further research that would accurately indicate the patients for whom psychotherapy would be effective.

2. Treatment of the majority of patients suffering from schizophrenia requires an integrated approach. For this reason, the study of a single method of interaction may not reflect the capabilities of a comprehensive, psychotherapeutic treatment of schizophrenic disorders.

3. The personality of the therapist is a very significant factor in the treatment of schizophrenia. In the process of treatment of schizophrenic disorders, which are chronic in nature, motivation of both patient and therapist is of vital importance to the success of psychotherapy. Alanen [7] emphasises the importance of matching the personality of the patient and the therapist, especially in the initial period of treatment.

SAMPLE AND METHOD

The study involved 60 patients hospitalised 24 hours a day. The selection criteria for the groups were as follows: (1) diagnosed with paranoid schizophrenia (ICD-10 diagnosis); (2) systematic, repeated use of individual psychological support, or the lack of it during the current hospitalisation; (3) treatment with second-generation antipsychotics; (4) at least a third hospitalisation, but no more than a tenth; (5) lack of a clear damage to the central nervous system; (6) lack of dependence on alcohol or psychoactive substances; (7) logical verbal contact during the completion of the survey (Table 1).

Individual contact with a clinical psychologist consisted of psychological support, psychological education, acquiring skills to cope with symptoms, and conversations aimed at getting insight into the disease. Therapeutic meetings were held regularly, on average twice a week, but their frequency could be increased if the patient signalled the need for it or if his mental crisis intensified. The Positive and Negative Syndrome Scale (PANSS) [15] and a questionnaire created by the author (B.W.) were used to conduct the studies. The PANSS is one of the most

the first 2 days after admission and on the day of discharge. The level of symptomatic improvement was determined on the basis of the difference in PANSS scores. In the questionnaire, patients were asked to specify the frequency and quality of contact with a psychologist. Participation in the study was voluntary. Each patient had been informed about the scientific aim and anonymous character of the study. They also received information that they could withdraw their consent to participate in the study at any stage without giving any reasons and without any consequences.

RESULTS

The mean scores obtained by patients in group I on all subscales of PANSS (PANSS N, PANSS P, PANSS G) and the result of the total PANSS T are higher than in group II at the beginning of hospitalisation (Table 2). The results of both groups do not differ significantly at the first measurement in terms of severity of psychopathological symptoms measured with PANSS. Symptoms with which the two groups of patients began their hospitalisation were compa-

Table 1. Characteristics of the two study groups

	Group I (n=30)	Group II (n=30)
	Patients using intensive psychological support during the current hospitalisation	Patients not using intensive psychological support during the current hospitalisation
Gender	14 women, 16 men	16 women, 14 men
Age, years	26–55 (mean 37, 03; s.d. 7, 20)	25–53 (mean 36, 03; s.d. 9, 10)
Age at onset, years	10–31 (mean 25, 40; s.d. 6, 36)	16–34 (mean 24, 10; s.d. 6, 01)
Hospitalisations, n	3–10 (mean 5, 77; s.d. 2.66)	3–10 (mean 5, 07; s.d. 2, 20)
Days hospitalised, n	22–170 (mean 59, 43)	15–153 (mean 53, 86)
Place of residence		
City	13 persons (43, 33%)	21 persons (70%)
Country	17 persons (56, 67%)	9 persons (30%)

widely used tools for assessing the clinical state of patients with schizophrenic disorders. It allows specifying a multidimensional psychopathological symptom severity in the form of a structured interview.

Clinical psychologists evaluated the mental state of the patients using the PANSS twice: in

the first measurement (at admission) and the second measure (at discharge) the group actively using psychological support during hospitalisation received statistically significantly lower scores in total PANSS. Also, all subscales of PANSS indicate a significant decrease in scores. This means that in patients of the first

group there was a significantly larger weakening of positive, negative and general symptoms than in the second group.

Positive symptoms occurring in schizophrenic disorders are referred to as fabricated symptoms [8]. They include: hallucinations, delusions, formal thought disorders, psychomotor agitation and the attitude of grandeur – self-importance, suspicion, hostility. Negative symptoms include: reduced emotional reactivity, emotional withdrawal, social withdrawal, poor contact, impaired abstract thinking, lack of spontaneity and fluidity of conversation, stereotypical thinking. Within the general range of symptoms of schizophrenia disorders in PANSS G are, among other things: anxiety, tension, mannerisms, inhibition of movement, disorientation, lack of insight,

increased, but remained at a level indicating an exacerbation of symptoms of schizophrenia. Results from both groups in the second measurement, i.e. during patient discharge from hospital, differ significantly.

DISCUSSION

A marked improvement in mental state was observed in both groups studied - significantly higher in group I (people actively using psychological support). This may indicate a beneficial effect of individual psychological support in the treatment of patients with schizophrenic disorders. Many researchers obtained similar results indicating a significant role of psychotherapy in

Table 2. Level of severity of psychopathological symptoms and the use of psychological help

PANSS	GROUP I, n=30 Mean (s.d.)	GROUP II, n=30 Mean (s.d.)	t	d.f.	P
1PANSS P	26.93 (8.12)	25.33 (5.82)	0.88	58	0.384
1PANSS N	25.07 (6.82)	22.47 (6.16)	1.55	58	0.127
1PANSS G	54.90 (12.43)	48.97 (12.20)	1.87	58	0.067
1PANSS T	106.57 (24.10)	96.10 (19.14)	1.86	58	0.068
2PANSS P	10.77 (3.83)	16.23 (5.98)	-4.22	58	<0.001
2PANSS N	13.43 (5.41)	18.57 (5.36)	-3.69	58	<0.001
2PANSS G	26.47 (6.67)	35.27 (9.16)	-4.25	58	<0.001
2PANSS T	50.67 (14.29)	70.07 (18.67)	-4.52	58	<0.001
1-2 PANSS P	16.07 (7.76)	9.10 (5.36)	4.04	58	<0.001
1-2 PANSS N	11.63 (6.78)	3.90 (4.20)	5.31	58	<0.001
1-2 PANSS G	28.30 (13.25)	13.70 (10.11)	4.80	58	<0.001
1-2 PANSS T	55.90 (25.35)	26.03 (15.48)	5.51	58	<0.001

Group I actively using psychological support; Group II not using psychological support; PANSS P, positive symptoms; PANSS N, negative symptoms; PANSS G, general psychopathological symptoms; PANSS T, total score; 1-2 PANSS, difference between the first and second result on the PANSS.

poor impulse control. Further quantitative analysis indicated that the greatest improvement in the symptoms measured with PANSS concerned positive symptoms. This pattern applies to both groups. The smallest improvement occurred in negative symptoms in both groups. The analyses show that the total PANSS score obtained in the second measurement in group I falls within the standards of a norm and indicates the disappearance of, or significant improvement in, symptoms in patients with schizophrenic disorders. In the second group this result also de-

the treatment of schizophrenia [16, 17]. In recent years the preferred form of treatment of psychosis in the USA and the UK is cognitive-behavioural therapy (CBT) and meta-analyses carried out by British researchers have confirmed its effectiveness, especially in reducing the positive symptoms of schizophrenia [18].

The studies presented here most commonly focus on the evaluation of the effectiveness of specific programmes of psychotherapy used in the treatment of people with schizophrenia. It should be noted that the present study did not

evaluate the effectiveness of any specific type of psychotherapy, but drew attention to the intensity of contact with a clinical psychologist and the ability to maintain a therapeutic relationship. In further analyses it would be desirable to look at factors that contribute to effective psychological counselling. No less important is to identify the factors that impede the therapeutic contact and prevent the use of psychological help by people diagnosed with schizophrenia.

One of the limitations of the study is its small sample size as well as the failure to consider the equal length of hospitalisation of patients. Therefore, it would be interesting to conduct a similar research on a larger group. The study demonstrated significant effectiveness of psychological therapy in reducing the severity of psychopathological symptoms in patients hospitalised with schizophrenic disorders.

CONCLUSIONS

Based on the study results, it can be concluded that patients in the group actively using psychological support during hospitalisation achieved significantly greater reduction in the severity of psychopathological symptoms than patients in the group not participating in therapy. Persons in contact with therapists became significantly healthier (symptomatic improvement) than those who did not have such contact. Verification of this dependence confirms the validity of a comprehensive treatment of schizophrenic disorders by pharmacotherapy combined with systematic psychological assistance.

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