

UK Charter

- The primary member of staff should be
 - someone **intending to work in the service for at least 18 months**
 - because the stability and continuity of a good relationship is crucial to recovery.

UK Charter

- **The assessment should lead to a formulation**
that aims to ‘make sense’
 - of the information gathered,
 - **of what has lead to the person’s ‘break’ with reality,**
 - and aims to elicit the meaningful personal issues contained in the psychotic manifestations.

ISPS UK Charter

- Those nearest to the person should also be offered a sensitive assessment of their own needs and be offered appropriate psychological help.
- In many cases families may both want and benefit from being helped **together with** the member who has had or is still experiencing psychosis.
- Family meetings should be offered at least monthly and more frequently at times of crisis, and these meetings should continue as long as needed.

UK Charter

- All people who have experienced psychosis should have access to long-term psychological therapy, which might last **for a period of up to five years**, that helps them in their recovery.
- The therapist should be experienced and regularly supervised.

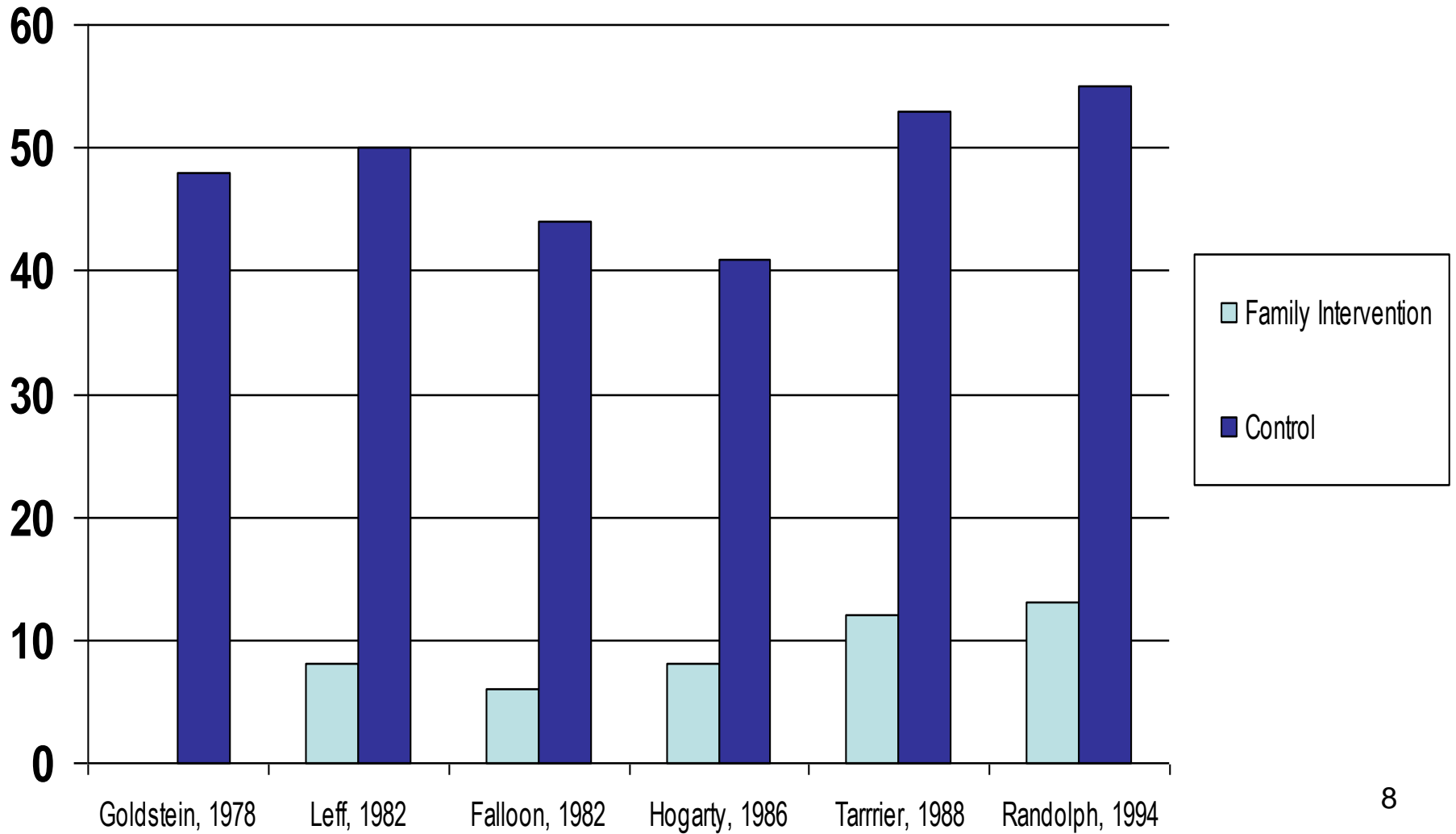
Aims of Lecture

- Why work with families
- Dynamic perspectives
- The problem of guilt (plural) and blame
 - Case example
- Open Dialogue –principles and outcome
- Discussion
 - Break
- Real world case presentation and discussion

Why work with families: Outcomes

- 38 family intervention RCTs (3,134 participants)
- Family interventions significantly reduced the risk of relapse up to 12 months following treatment **compared to TAU or any other control.**
- Significant reduction in hospital admissions and severity of symptoms for up to 24 months
- Cost effective: overall saving (reduced hospitalisation) £1,195 - £3,741 / patient

Intervention Studies: Relapse Rates



NICE UK Recommendations

Offer family interventions to **all families** of people with schizophrenia who live with or are in close contact with the service user.

This might be particularly useful for those who:

- Recently relapsed or at risk of relapse.
- Have persisting symptoms

What happens in practice

- Less than 7% offered any family interventions
- Only 1/2 of these were given
 - more than 10 sessions or
 - given an intervention that lasted more than 6 months (the recommended amount)

Why work with families where there is psychosis? (1)

- The individual: denial, rationalisation and paranoia will often be a major feature
- The family: usually more in touch with the change and deterioration in functioning of the individual and ask for help
- The family have important resources as well as problems sometimes relevant to the psychosis

Why work with families where there is psychosis? (2)

- HEE, 'over-involvement' and projective identification
- The many faces of guilt and blame
- Erroneous ideas such as 'laziness'

Why work with families where there is psychosis? (3)

- Assessment within the stress vulnerability model in a family context
- The great value of multiple perspectives from multiple persons
- Past and recent experiences of family members of mental health services

Why work with families where there is psychosis? (4)

- Psychodynamic practitioners more accepting of complexity and therefore tolerant of longer term work
- The importance of relapse prevention and families assistance with this
- Family work leads to support for individual therapy

Why work with families where there is psychosis? (5)

- No problems with confidentiality
- Better understanding of nature nurture

Psychosis, guilt and the family:

We do know that schizophrenia is not caused by

- bad parenting,
- trauma,
- abuse,
- or personal weakness”

(Consensus Guideline Series, 1999).

Guilt and Psychosis

- **Reparative Guilt,**
- **Punitive Guilt**
- **Projected Guilt**

Reparative guilt

- Concern for the other for possibility of harm done
- Motivates the wish to assist the other

Punitive Guilt

- Guilt is retained and punishment is an internally directed phenomena
- Energy is absorbed in some form of self punishment
- No reparative energy directed towards the other
- Depression is common

Projected Guilt

- Responsibility is projected / made into a not me phenomena
- The recipient of the projection is mercilessly attacked to induce ‘responsibility’ and to punish
- Psychotic in that a new reality is created,
 - *it is not the projector who feels guilty; it is the other who is / should be*

Michael: History

- Michael has turned up as an emergency stating:
 - My mouth wash has been replaced by street drugs
 - He is treated as someone with paranoid schizophrenia for three years
 - During this time mother gets into frequent battles with the services complaining of their inadequacy leading to two transfers to other teams
 - Mother becomes prominently involved in the local lay organisation herself offering family education as to the (biological) causes of schizophrenia and its optimum medical treatment
 - No family meetings are offered in three years. Father has never been seen

Mother:

Michael has received a present for some voluntary work he has done with children.
Michael – you should follow this work up.

Analyst:

(a few exchanges later and based on non-verbal cues)

Michael, am I correct that you seemed perturbed by the idea of something that you have done being recognized and valued - and as mother suggests -pursued?

Michael:

(Without hesitation) Yes, I would immediately be under pressure to pursue something that was not really 'me'!!.

(remember the mouth wash being replaced by street drugs)

Mother:

(clearly not acknowledging what Michael had said at all)

Michael would like working with children -everyone does. I enjoyed it so much.

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Michael:

(neutrally) That was not my impression
mother.

*(The family atmosphere immediately
changed.)*

Mother:

(getting indignant) –Don't try that on – you know it was only in the latter years I did not enjoy work. **You** need to find work that is enjoyable.

(again mouth wash replaced by street drugs)

Michael:

Mother: I was simply voicing my experience that you had not enjoyed your work.

- **Mother:**

(getting very uptight indeed and now accusing Michael)

Don't you start – you are trying to manipulate me.

Michael:

(feeling accused retaliates with counter accusation)

Why is everything my fault? What about Saturday?

You (mother) –simply lost it. You went completely wild blaming me.

Mother: What are you talking about – nothing happened on Saturday.

- **Father:**

I don't think I was there on Saturday.

- **Michael:**

Mother you were in a rage accusing me of being responsible for everything(!) that goes wrong.

- **Mother:**

(now recalling but again unable to consider her effect on others)

But I went out of the house after that and when I came back it was 'forgotten' it was nothing - it was water off a duck's back.

- **Michael:**

For me it was not ‘nothing’. Your outburst disturbed me a lot. You went berserk – and I had done nothing. I was simply telling you that Larissa –*[a therapist that Michael was seeing individually]*– had said something about a positive change in me recently. You said what a load of rubbish and you got into a fury saying my sessions were a waste of time.

- Mother

became even more defensive and attacking.

The idea that this other woman could help Michael change was perhaps very challenging to mother, who now must have felt very uncomfortable that her rivalrous attack on helpful clinic staff being exposed.

- **Father**

(now joining in the attack on Michael; recalling that he had been there on Saturday !!).

Why are you bringing this up – nothing has been said since Saturday?

You are deliberately manipulating the situation **trying to blame us** –well we are not going to take it.

- In summary
 - Mother is unable to accept any difficulty she poses for Michael (*no self punitive or reparative guilt*)
 - Michael is exclusively the cause of problems who is projected into, the one that needs to change and who should feel guilty
 - There is no paternal support for Michael in his self development
 - Michael could not complain about the change of domestic atmosphere when he broke down, (the mouth and poison) displacement and condensation

Why does work NOT happen with families where there is psychosis?

- The previous example?
- The fear of being accused of blaming and of guilt
- Individual training
- In-patient units not welcoming
- Nurses and others like to care and do caring things (Opus)
- Lack of systemic approach to change

The Open Dialogue Approach

- Immediate allocation of all new referrals to a team.
- The team includes an employment advisor
- The team visit the patient and his family and friends within 24 hours of referral
- The visit takes place in the patients home

The Open Dialogue Approach

- The visits happen as frequently as needed if there is a crisis
- The dialogue involves the team in the presence of the family so that the family get the experience of thinking about things, differences
- There is far less emphasis on diagnosis, but much more on formulating /putting into words matters for which for which there have not previously been words

The Open Dialogue Approach

- All members of the team are trained to national qualification levels in family (80%+) or individual therapy
- The training is integrated into the team's diary so that it is whole team training

Open Dialogue – outcomes (1)

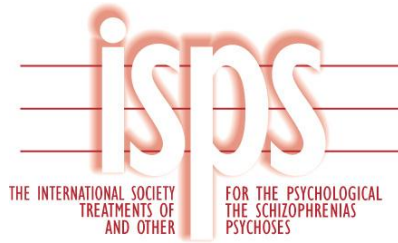
- Possibly the best in the world for psychosis
- No new long stay patients (in-patient for more than one year)
- Great reduction in duration of untreated psychosis as project developed (community knowledge and good experience of the approach leading to early referral) 3.5months to 15 days
- Considerable **Reduction** in incidence of schizophrenia (42% to 22%)
- Considerable **Increase** in brief psychotic episodes (2% to 14%)

Open Dialogue (outcomes 2)

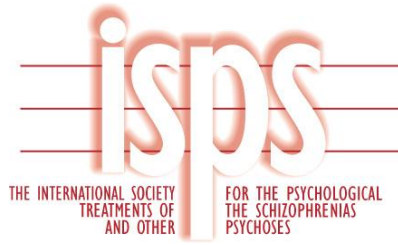
- **Less than 28%** taking regular neuroleptic medication
- More than 80% without psychotic symptoms at 2 year follow up
- 84% studying, employed, or actively seeking employment
- Most of these factors stable at 10 year follow up

References

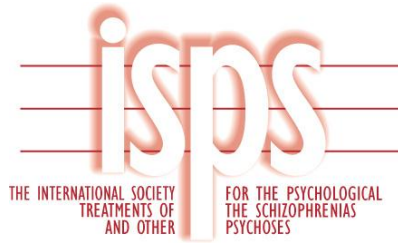
- Open Dialogue results
 - Psychosis 2011: Volume 3, Issue 3
- Guilt – types of
 - Martindale: 2008 The rehabilitation of psychoanalysis and the family: recovering from blaming in Psychotherapies for Psychosis eds Gleeson et al. Routledge (ISPS book series)
- Nice Guidelines for Schizophrenia
 - <http://www.nice.org.uk/nicemedia/pdf/CG82FullGuideline.pdf>
- Expert Consensus Guidelines Series (1999) The treatment of schizophrenia. Journal of Clinical Psychiatry 60 s8-80, p2
 - Thanks to Alison Brabban and Graigine Fadden for information used in some of t



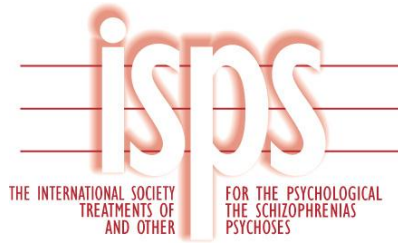
- Aims
 - Illustration of ‘ordinary’ family meetings evolving into therapy
 - In the home
 - Systemic / dynamic formulation as basis of work
 - Some understanding of dynamics of the psychosis
 - Developmental perspective
 - Counter transference
 - Limits of the work
 - Benefits to next generation (children)



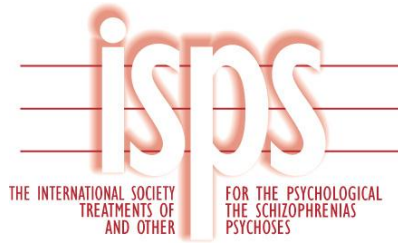
- Mark and Mary and 3 children
- Mark: ‘idyllic childhood –certainly not
- Shame, fear and abuse
- Fear of ‘being gotten rid of’
- Epilepsy / cotton wool
- The Angel? The Devil!
- Brother Arthur –feared identifications



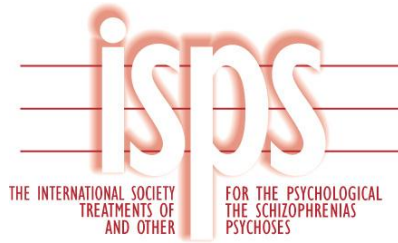
- Referral pseudo-epilepsy, depression
- The attack on the publican
- The son falling out of a window
- The neighbours
- Spyware,
- Hallucinations



- Presentation
 - Multiple Overdoses: consequences
- CBT, medication and supportive family work

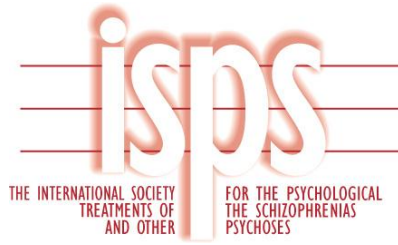


- Formulation
 - Mary’s History:
 - Mary’s behaviour
 - Mark’s dilemma’s and behaviours
 - » The Angel or the Devil
 - » Fear of his and other’s violence (physical and psychological)
 - Effect on children



- Therapy
 - Another overdose
 - Big Mark and Little Mark
 - Cruel Voices increased

 - Increased involvement with his children
 - Paedophile accusations
 - Hiding and mocking



- Consolidation
- Outside the home
- Stupid
- Reparative Guilt re children and his overdoses
- Limitations of the therapy
- Training opportunity