



Adapting psychotherapy to psychosis

Richard Lakeman

Townsville Homeless Outreach Psychiatry Service, Townsville, Queensland, Australia

Abstract

The tradition in many schools of psychotherapy has been the exclusion of people experiencing psychosis or the suspension of psychotherapy when psychosis emerges. In this paper it is argued that those who experience psychosis have a need for psychotherapeutic assistance. Health professionals involved in the care of people with psychosis ought to interact in a psychotherapeutic manner and develop psychotherapeutic skills. The purposes and some selected techniques of psychotherapy along the supportive-exploratory continuum are reviewed and pragmatic considerations when selecting psychotherapeutic interventions are discussed.

Keywords

psychotherapy, psychosis, schizophrenia, interventions, cognitive behavioural therapy, narrative therapy, family therapy

The need for psychotherapy in psychosis

Psychosis may be associated with a wide range of conditions and have a range of underlying causes. Consequently, the experience of psychosis may be transient, episodic, or chronic, and may vary in intensity and the extent to which it causes distress or disability. The discussion here focuses on psychosis but places particular emphasis on psychosis associated with schizophrenic syndromes.

Psychosis may be considered as an alteration in the capacity to test reality. According to Schwartz, Bleiberg and Weissman (1995, p.146): *Altered reality testing is intimately connected with a regression in the spheres of thinking and of self-object representation and differentiation. The regression in thinking - otherwise known as a thought disorder - is to a level that is less organised and differentiated; for example, the rules of logic may be*

suspended, parts may stand for the whole, associational pathways may become loose and fragmented or blocked completely, and perception and memory may be distorted.

The experience of schizophrenia is frequently accompanied by a diminished or altered sense of self: *Conscious and unconscious mental images of the self and of important objects in the individual's life may become less coherent or fragmented and the differentiation of these self and object representations may become blurred or fused (Schwartz et al., 1995, p.146).*

Not only is the relationship with the external world affected but the person's relationship with him or herself. According to Laing (1959, p.17): *... in the first place, there is a rent in his relation with his world and, in the second, there is a disruption in the relation with himself. Such a person is not able to experience himself 'together with' others or 'at home in' the world, but on the contrary, he experiences himself in despairing aloneness and isolation.*

-
- Contact:** Richard Lakeman, Team Leader, Townsville Homeless Outreach Psychiatry Service, c/o Townsville Integrated Mental Health Services, PO Box 1596, Thuringowa Central, Townsville, Queensland 4817
Richard.Lakeman@health.qld.gov.au
- Citation:** Lakeman, R. (2006). Adapting psychotherapy to psychosis. *Australian e-Journal for the Advancement of Mental Health* 5(1) www.auseinet.com/journal/vol5iss1/lakeman.pdf
- Published by:** *Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet)* – www.auseinet.com/journal
Received 16 March 2005; Revised 18 May 2006; Accepted 22 May 2006

Schizophrenia, considered to be one of the main psychotic illnesses, is thought to affect 0.4 percent of the population (World Health Organization, 2001). Despite a prevalence of less than 5 in 1,000, it accounts for 5% of the burden of disease in Australia (Mathers, Vos, Stevenson & Begg, 2000). A recent study of disability in 14 countries found that the general population ranked psychosis the third most disabling condition after paraplegia and blindness (Üstün, Rehm, Chatterji et al., 1999). In Australia the economic costs associated with psychosis are extremely high and as the authors of an Australian cost analysis point out (Carr, Neil, Halpin & Holmes, 2002) the bulk of expenditure is on hospitalisation, which predominantly provides pharmacological treatments and places relatively little emphasis on the other therapies which may be more beneficial. In 2002-2003 schizophrenia was the most common diagnosis reported for mental health hospitalisation and accounted for more patient days (471,204) than any other diagnostic grouping in Australia (Australian Institute of Health and Welfare, 2004).

Despite costly, frequent and sometimes lengthy hospitalisations, a large number of people living in the community with psychosis have been found to have unremitting symptoms and high levels of disability. In the largest Australian survey of people living in the community with psychosis (Jablensky, McGrath, Herrman et al., 1999) it was found that 83 percent found medication helpful but 63 percent felt impaired in their daily life due to side effects and for 47 percent some symptoms did not remit. Sixteen percent had deliberately overdosed or self harmed in the preceding 12 months. Many people experience homelessness, live on the margins of society, are socially alienated, and only a minority enjoy meaningful employment. Forty percent of those diagnosed with schizophrenia attempt suicide at some time and 10-13 percent complete suicide (SANE, 2002). This disturbing profile obscures the reality that many people achieve personal and clinical recovery. However, it does highlight the need for services to offer something different and more to assist people with psychosis.

Neil, Lewin and Carr (2003) propose that what is needed are interventions that can be carried out by skilled practitioners, to most people who need treatment, in a way that is acceptable to those most in need. Whilst some schools of psychotherapy require years of training and intensive supervision to gain competence, many techniques are accessible to the supervised novice or beginning practitioner. This paper aims to explore some of the psychotherapeutic techniques that may be available to helpers, with particular emphasis on those drawn from the supportive end of the supportive-exploratory continuum.

The nature of psychotherapy

Psychotherapy can and has been construed in many ways. There is by no means consensus on what this term means and how to differentiate it from counselling or indeed other forms of interpersonal helping. As Yalom (1995) points out, psychotherapy takes place in diverse settings, with diverse groups, utilising a bewildering array of techniques and styles, informed by a vast array of theories and ideologies.

Barker and Kerr (2001, p.5) propose that psychotherapy involves:

... psychological treatment of problems of living by a trained person, within the context of a professional relationship, involving either removing or modifying specific emotional, cognitive or behavioural problems and/or promoting social adaptation, personality development and/or personal growth.

Gibney (2003, p.49) suggests "... the therapeutic endeavour works best in the same 'safe space' week after week, session after session". However this may not be feasible for some that have the greatest need for psychotherapeutic interventions, and for those people that spend the greatest time with them. For example those who grapple with schizophrenia due as much to their circumstances as to their symptoms or suitability for a particular brand of psychotherapy may be very unlikely to attend fixed sessions at regular intervals in an office. Furthermore, this population already receives a significant proportion of face-to-face care via community 'case management' or assertive community

treatment. Encounters with mental health professionals ought to be psychotherapeutic.

Peplau (1952, p.62) presaged this idea over 50 years ago, asserting that counselling was the most important role that nurses could fulfil, meaning by this a “relationship that provides satisfaction for needs unmet in the past through which continuing growth becomes possible”. Peplau acknowledged that nurses who provided a round-the-clock relationship with people, and assumed numerous roles, could not function in the same manner as a dedicated psychotherapist who might conduct sessions at a specific place and time. Peplau held that phenomena such as hearing voices were “... illusionary figures, autistically invented for the twin purposes of avoiding anxiety and mitigating loneliness” (Peplau, 1989, p.323) and recommended a range of specific interpersonal psychotherapeutic responses. Any intervention or approach should be chosen and undertaken judiciously with an understanding of the person’s current capacity, desires and with a purpose in mind.

The supportive–exploratory continuum

Therapy in practice may be considered on a continuum from supportive to expressive/exploratory. Figure 1 illustrates a number of psychotherapeutic approaches as they might appear on the continuum (although the order of these is speculative). Supportive therapy encompasses various activities intended to prevent relapse or deterioration and to overcome symptoms. In supportive therapy, positive efforts are made to minimise anxiety and to enhance self-esteem (Pinsker, 1998). Luborsky (in Barber, Stratt, Halperin & Connolly, 2001, p.168) list the following techniques as supportive:

1. demonstration of support, acceptance, and affection toward the patient;
2. emphasis on working together with the patient to achieve results;
3. communication of a hopeful attitude that the goals will be achieved;
4. respect of the patient’s defences; and
5. focus on the patient’s strengths and acknowledgement of the growing ability of the patient to accomplish results.

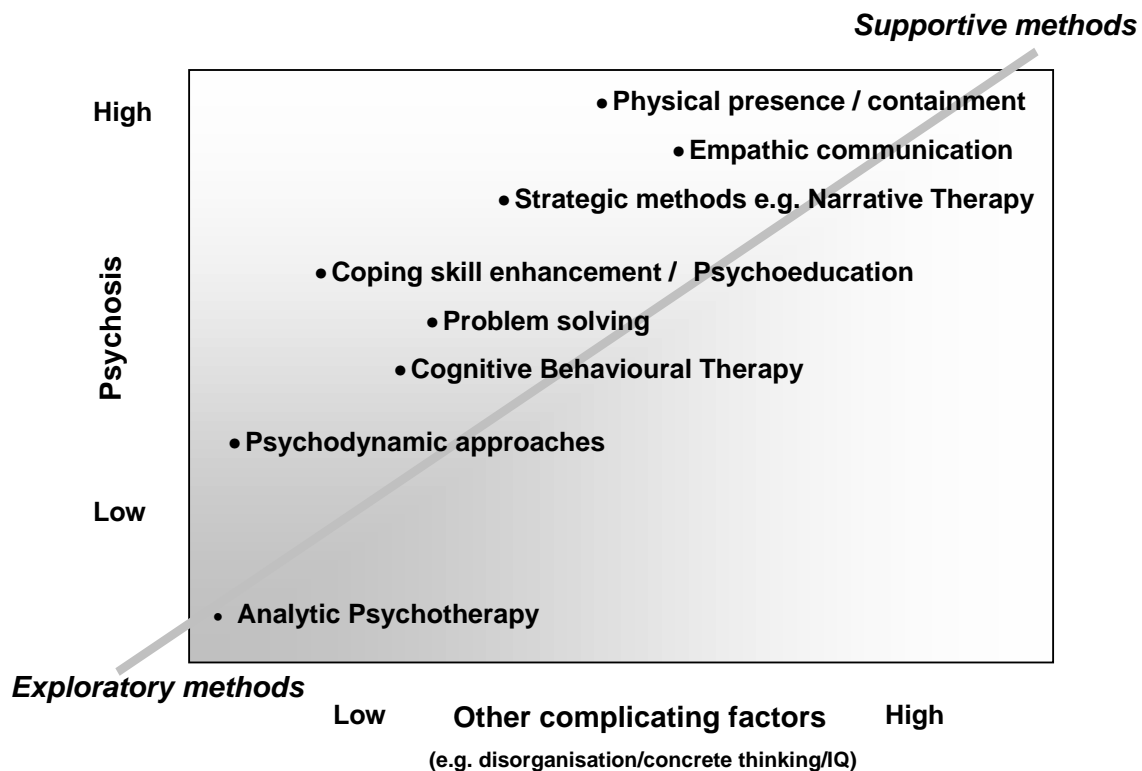


Figure 1. A continuum of psychotherapeutic approaches to psychosis

Supportive techniques have been found to be useful in many forms of therapy (Barber et al., 2001). Supportive techniques may include empathic communication, reassurance, encouragement, advice, guidance, problem solving, or simply the conveyance of positive regard (see Ogrodniczuk & Piper, 1999). Exploratory therapy may seek to bring about personality change or entail deeper reflection, makes more demands on the person who may need to tolerate anxiety and requires greater meta-cognitive capacity. Techniques may include probing questioning, silence, or analysis. In practice most therapies have both supportive and exploratory elements, although a greater emphasis may be placed on some techniques over others generally or at different stages of the therapeutic relationship. A supportive relationship characterised by acceptance, respect and interest is essential for therapy to take place (Pinsker, 1998).

Goldstein (1998) suggests that for "... psychotic patients, to whom intense transferences can be clearly disruptive ... supportive interventions predominate over insight-oriented ones." For many schools of psychotherapy, psychosis or the propensity towards it, is one definitive exclusion criteria. For example Knapp (cited in Coltart, 1993, p.25) considered "psychotic signs or behavioural trends" and "schizoid borderline psychotics" as categories deemed unsuitable for psychoanalysis. For schools of psychotherapy on the supportive end of the continuum, such as narrative therapy, schizophrenia appears to be their *raison d'être* (see Vassallo, 2002). The principle questions that need to be asked when selecting interventions are: what does the person ask for and need, and what is their present capacity to endure the therapeutic process? Pragmatic considerations also include the skill of the therapist, and their role and commitment to ongoing work with the person.

Gibney (2003) proposes that there are at least four levels of psychotherapeutic engagement:

1. Engagement – negotiation around whether or not therapy is required;
2. Problem solving or Solution Focused Therapy;

3. The therapeutic relationship as the consciously perceived nexus of change; and
4. Transformative therapy in the presence of an implicated witness.

Therapy is often 'prescribed' up to Level 2, which includes Cognitive Behavioural Therapy (CBT) and Narrative Therapy, for anyone with a history of psychosis. This would be a mistake if the person craved self-understanding, personal insight, and was deeply interested in uncovering their motivations. Gibney (2003, p.81) points out that the level of engagement cannot be chosen but develops in the relationship and is in part a function of the creativity and resistances of both therapist and patient. A practitioner may be limited in their capacity and creativity to recognise and respond to a deeper level of engagement with the person who is psychotic.

Recognising capacity and matching interventions in psychosis

When a person is actively psychotic, interventions on the supportive end of the continuum are probably not only helpful, but ethically demanded of professional helpers. The person will need to feel some sense of connection with others, understanding and hope. The professional helper can act as a life buoy which the person can grasp onto and feel secure from the currents that push and pull her or him, and that are seemingly beyond control at that moment. Such times are not the best for exploring how the person came to that point. However, most people can and do reach a point of anchorage or firm ground when the psychosis is quiescent (although delusions and disturbing thoughts may still be present) and such exploration is then possible.

Syndromes such as the schizophrenic spectrum of disorders also affect people in profound ways quite aside from symptoms of psychosis. Apathy, withdrawal, anhedonia, cognitive problems such as memory and attention deficits, concrete thinking, ambivalence, autistic preoccupation and iatrogenic treatment effects may all contribute to problems of living whilst psychosis may wax and wane. The therapist needs to be cognisant of and sensitive to how these potential problems may affect the

individual. Thus when selecting interventions the therapist needs to be mindful of not only whether or not psychosis is active but of other factors that might affect the capacity of the person to engage at a given point in time. When there is a high level of activated psychosis and a high level of other complicating factors (see Figure 1) the interventions available will be more constrained. As the psychosis and other complicating factors diminish a greater repertoire of interventions will be available.

Empathy and connection

Nelson (1997) elaborates on a general model of cognition that offers an explanation of how delusions are formed and maintained (see Figure 2). Psychosis is hypothesised to arise at a physiological level, which activates the basic biosocial system, which is ordinarily only activated by external events. This in turn leads to a psychotic mood state which is made sense of in light of pre-existing beliefs about the world and influenced by the human tendency to select evidence that is consistent with the prevailing mood state (emotional reasoning) and existing beliefs (selective attention). A delusion may then develop arising from a misattribution of the psychotic mood that further reinforces the mood directly and via biases in cognition. It is much easier to modify (as is the intent of CBT) the belief system, misinterpretation of events or delusion itself if the psychotic activity is not continuing to generate the potent affective state.

There is evidence that delusions and indeed other phenomena such as the content of voices tend to be mood congruent (Freeman & Garety, 2003). For example, a depressed mood tends to be associated with beliefs with themes around guilt, persecution or catastrophe; anxiety tends to be associated with referential ideas and persecution; expansive moods with grandiosity; and disgust with hypochondriacal and somatic themes. Nayani and David (1996) found that affective states, bodily sensations, and cognitive cues could be identified by the majority of 100 people surveyed, as antecedents to hearing voices. Heightened anxiety has been found to be a typical antecedent to dramatic relapses into psychosis (O'Connor, 1991). Exploring, these

antecedent or current feelings is a pivotal point for the development of strategies for 'relapse prevention', or to assist the person making the distinction between feeling and knowing. More importantly, however acknowledgement of such feelings forms the basis of empathic connection with the person and enables them to feel understood.

Therapeutic engagement when people are actively psychotic poses a great challenge to health professionals. Professionals continue to be influenced by edicts such as 'don't argue with' or 'don't reinforce' delusional content. Many may continue to shy away from exploring the content of delusions, or the detailed utterances of voices, or indeed to explore the person's feelings in relation to these experiences in any detail. For example, McCabe, Heath, Burns and Priebe (2002, p.1148) analysed the conversations of 32 psychiatric consultations and found:

Patients actively attempted to talk about the content of their psychotic symptoms in consultations by asking direct questions, repeating their questions and utterances, and producing these utterances in the concluding part of the consultation. In response, doctors hesitated, responded with a question rather than with an answer, and smiled or laughed (when informal carers were present), indicating that they were reluctant to engage with patients' concerns about their psychotic symptoms.

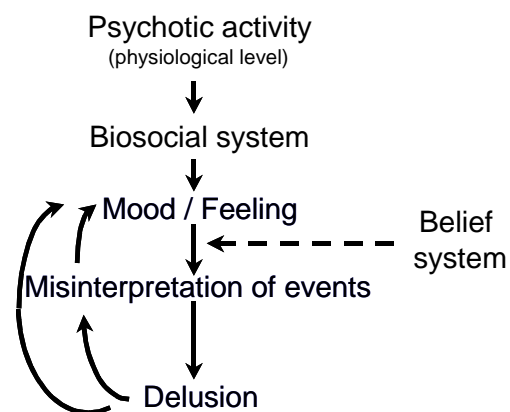


Figure 2. A simplified working model for the formation and maintenance of a delusional belief (Source: Nelson, 1997)

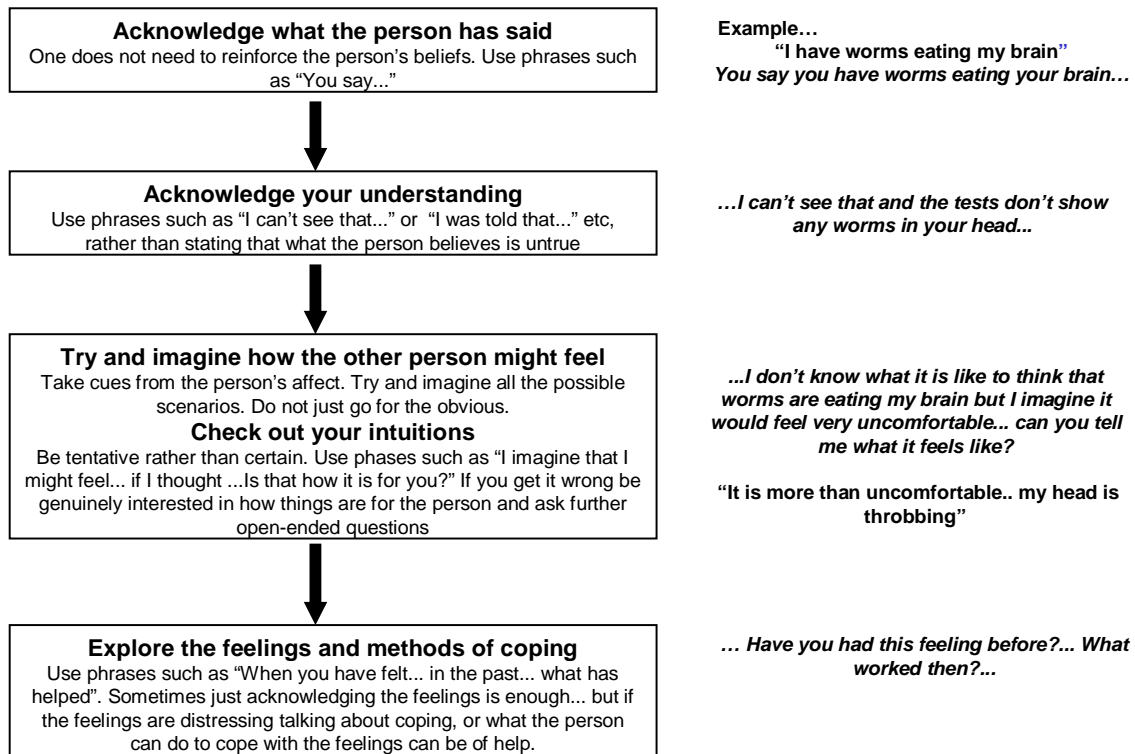


Figure 3. A model of empathic communication (adapted from Harper & Klue, 1991).

Perhaps the most basic supportive therapeutic intervention in psychosis is empathic communication; that is, communication that conveys a sense of understanding of how that person feels in relation to their situation (see Egan, 1997). Figure 3 illustrates how a basic empathic response might be framed in response to a delusional statement. Such a response acknowledges the person, conveys a sense of desiring to understand, attempts to connect with the emotions that arise from the delusion, and creates an opening to explore what might work to alleviate the distressing emotion.

Expressed emotion

One clinical construct that is germane for consideration when working with people who are psychotic is expressed emotion (EE). A robust research finding is that exposure to high EE (i.e. critical comments, hostility and over involvement within family groups) can

contribute to acute relapse in schizophrenia (Butzlaff & Hooley, 1998). These findings have led to a sustained focus on psychoeducation and problem solving in families under the rubric of 'psychosocial interventions' (Brooker, 1990a, 1990b; Lopez, Nelson Hipke, Polo et al., 2004), although the effects of family interventions may be variable (Pharoah, Rathbone, Mari & Streiner, 2003). There is however a sound case to help relatives adopt less blaming and more flexible beliefs about the nature of a person's problems (Barrowclough & Hooley, 2003). There is some evidence that at least in some cultural groups, 'family warmth' may be protective against relapse (Lopez et al., 2004). Principles that arise from the EE and attribution research apply equally to health professionals and families. That is, the health professional should be mindful of conveying warmth and reducing critical comments and moderating over-exuberant responses.

Phases of acuity and recovery

Whilst schizophrenia may be unpredictable there are different ways to consider its course. It has been proposed that there are at least four distinct phases of symptomatology and adaptation and it is useful to tailor interventions to these phases (Miller & Mason, 1999). The length of time between the first behavioural signs of schizophrenia and first (medical) treatment may be lengthy (sometimes years). In this 'prodromal' phase, early intervention programs and group therapy have come to predominate as there is some evidence that early recognition and treatment leads to better outcomes (Albiston, Francey & Harrigan, 1998; Birchwood, 2000; Birchwood, Todd & Jackson, 1998; Black, Peters, Rui et al., 2001; Carbone, Harrigan, McGorry et al., 1999; Hafner, 2000). The prodromal period may be followed by an acute phase in which psychosis and disorganisation predominates. During this time the person may be hospitalised, and drug treatment implemented. The next phase is stabilisation in which rehabilitation and psychosocial interventions may commence. This is followed by a maintenance and healing phase, the success of which may be judged by the return to ordinary community living, and the prevention of acute relapse.

The above reflects a clinical model of recovery, but increasingly there are calls for a greater emphasis to be placed on personal recovery. Andresen, Oades and Caputi (2003) suggest that there are five stages to recovery: (i) moratorium; (ii) awareness; (iii) preparation; (iv) rebuilding; and (v) growth. They suggest that the critical ingredients to realising recovery are finding hope, re-establishing identity, finding meaning in life, and taking responsibility for recovery. Not surprisingly, a relationship has been observed between recovery orientation and lower severity of depressive symptoms (Resnick, Rosenheck & Lehman, 2004). Psychotherapeutic interventions that address depression, by bolstering hope, assisting in the discovery of meaning, and empowering (or staving off a sense of powerlessness), are crucial to personal recovery and also to reducing morbidity (clinical recovery).

Beyond empathy

As already stated, most therapeutic approaches combine supportive and expressive elements. It is hard to imagine that exploration would be possible without the person feeling supported and safe. As in therapy with people experiencing other problems, the quality of the therapeutic alliance is likely to account for most of the treatment effectiveness. For example Bambling and King (2001) suggest that the working alliance is responsible for up to 30 percent of all treatment outcomes across approaches. In working with people with schizophrenia a positive alliance is considered essential by all health professionals. A positive therapeutic alliance is posited to promote treatment compliance (Oehl, Hummer & Fleischhacker, 2000), improve outcomes of hospital treatment (Clarkin, Hurt & Crilly, 1987), and improve global functioning and reduce symptom severity in assertive community treatment (Neale & Rosenheck, 1995). It is beyond the scope of this paper to explore the plethora of specific psychotherapeutic interventions for psychosis. According to Bachmann, Resch and Mundt (2003), the most influential therapies have been psychoanalytic / psychodynamic, cognitive behavioural (CBT), and supportive therapies. The following is just a précis of some promising areas on the supportive end of the continuum.

Strategic family interventions

There is no question that improving the relational functioning of families in which a member has schizophrenia will have positive flow on effects for all members. Interventions aimed at reducing expressed emotion are widely recommended (Bustillo, Lauriello & Keith, 1999; Peuskens, 1996).

Arising from the traditions of strategic family therapy is Narrative Therapy. This is a modality that has little empirical evidence to support it, but nevertheless is growing in popularity. Narrative Therapy involves the selection of carefully planned strategic questions and statements with the goal of constructing an alternative discourse of self that empowers the person against externalised problems. The practices in Narrative Therapy (according to White, in Carr, 1998, p.488) includes adopting

“... a collaborative co-authoring position” and listening for liberating stories. Externalising is a technique that establishes a context where people experience themselves as separate from the problem, rather than having a problem or being the problem. Once externalised the person’s relationship to the problem is explored and a ‘preferred alternative’ is constructed collaboratively. Stories of success, learning, strength, courage, resilience, competence and resistance are actively constructed (Stacey & Hills, 2001). The capacity for change lies in the client’s ability to operationalise a radically new perspective on his or her life and problems. The Narrative Therapy viewpoint however holds that personal narratives and shared discourse shape and create reality and this is their focus. Narrative Therapy may be particularly helpful for people in whom symptoms are distressing and unremitting. In such circumstances, people may feel better and more hopeful if their struggle and resistance is acknowledged.

Coping strategy enhancement

Literature is accruing on coping strategies for specific symptoms of psychosis. For example, a considerable body of research exists on coping with and controlling hallucinatory experiences through the use of headphones (Feder, 1982; Hustig, Tran, Hafner & Miller, 1990; McInnis & Marks, 1990); wearing earplugs (Birchwood, 1986; Done, Frith & Owens, 1986; Luchins, Dyson, Hanrahan et al., 1992); or varying the type of auditory stimulation and task engagement (Collins, Cull & Sireling, 1989; Gallagher, Dinan & Baker, 1994, 1995).

Such practices are promoted in the self-help literature (see Watkins, 1993). Coping strategy enhancement is a strategic aim of family work and CBT (Penn & Mueser, 1996). Sophisticated programs are in development, which target negative symptoms. For example cognitive enhancement therapy for first-episode schizophrenia combines supportive therapy with social skills and cognitive remediation training and aims at ameliorating cognitive and negative symptoms in a purposefully motivational format (Miller & Mason, 2004). Psychotherapeutic strategies that help people cope with the social pressures to which they are particularly

vulnerable augment pharmacological treatments (Peuskens, 1996)

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) in schizophrenia appears to have amassed a reasonable body of research demonstrating its efficacy (Haddock, Tarrier, Spaulding et al., 1998). The central premise of CBT is that a person’s responses to events (i.e. their feelings and behaviour) are mediated by their beliefs, images, inferences and evaluations (Chadwick, Birchwood & Trower, 1996; Nelson, 1997). Psychotherapeutic processes and practices, which may be considered ‘specific’ to CBT, encompass those congruent with CBT theory that aim to modify self-defeating, irrational or negative beliefs in order to produce more desirable consequences.

Elaborate models have been theorised and researched to describe how beliefs are formed, maintained and influence behaviour in response to specific events, although these are less developed for CBT in psychosis than for other disorders (Haddock et al., 1998). For example Chadwick and Birchwood (1994, 1995) have demonstrated how people’s reactions to hearing voices are mediated by beliefs about the voices’ identity, power and purpose. Voices perceived as malevolent were shown to be associated with fear, anger and resistance behaviour, whereas voices perceived as benevolent were shown to be associated with positive affect and engagement behaviour (Birchwood & Chadwick, 1997). They suggested that voice form and topography did not show any link with behaviour or affect, although intrusiveness of voices was found in a smaller sample (Lakeman, 2000) to be linked to beliefs about malevolence and poorer coping. In the case of hearing voices, the goals are unlikely to be the amelioration of voices, but rather undermining beliefs about the voices being all-powerful and all-knowing, thereby reducing distress and enhancing coping. The development of CBT in schizophrenia has largely focused on models and treatment for hallucinations, delusions and to a lesser extent, problems of mood (Rector & Beck, 2001).

The range of CBT approaches used in the treatment of psychosis is diverse and there is a

plethora of models and research which practitioners draw upon to inform practice. However, coping strategy enhancement is promoted in CBT as a means to "... empowering clients and weakening the voice's omnipotent grip" (Chadwick et al., 1996, p.98). Treatment specific effects of CBT ought to include a reduction in targeted beliefs, rather than just improvement in coping or global symptom reduction.

Conclusions

Existing theoretical explanatory models of psychosis only shed light on the margins of an extraordinarily complex and poorly understood range of phenomena. The yardstick of a 'good enough' model of psychotic phenomena ought to be its capacity to lead to interventions which help realise the aims of psychotherapy (as described by Barker & Kerr, 2001) and that have utility in the world of everyday clinical practice. Falloon, Held, Roncone et al. (1998, p.43) observe that, "treatment for schizophrenia is best provided by integrating the various and specific psychosocial intervention strategies in addition to the optimal use of medication".

Consideration of the degree to which a person is affected by psychosis, and other factors which impinge upon the person's capacity to engage psychotherapeutically, will be helpful to select an appropriate intervention from the supportive-exploratory continuum. Supportive approaches are by no means less important than exploratory strategies and indeed may be crucial to the person's survival and future psychotherapeutic prospects. These may also be more accessible to the novice practitioner and sustainable over time. A recent Cochrane review of CBT (Cormac, Jones & Campbell, 2002) found that it held promise, but current evidence does not suggest significant advantages over supportive psychotherapy. Empathic communication that acknowledges the person and their feelings, conveys hope, and opens a door to exploring and enhancing coping, is a basic starting point to effective helping. Once the person's psychosis begins to resolve, a supportive therapeutic alliance will enable the helper to undertake more focused work, utilising techniques from a range of schools or approaches - as negotiated with the person and within the capacity of the

practitioner. Psychotherapy is the business of all those who profess an interest in addressing the needs of people who experience psychosis and the skills needed to help effectively are within the grasp of most.

References

- Albiston, D. J., Francey, S. M. & Harrigan, S. M. (1998). Group programmes for recovery from early psychosis. *British Journal of Psychiatry Supplement*, 172(33), 117-121.
- Andresen, R., Oades, L. & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry*, 37(5), 586-594.
- Australian Institute of Health and Welfare. (2004). *Australian Hospital Statistics 2002-03*. Canberra: AIHW (Health Services Series no. 22).
- Bachmann, S., Resch, F. & Mundt, C. (2003). Psychological treatments for psychosis: History and overview. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 31(1), 155-176.
- Bambling, M. & King, R. (2001). Therapeutic alliance and clinical practice. *Psychotherapy in Australia*, 8(1), 38-43.
- Barber, J. P., Stratt, R., Halperin, G. & Connolly, B. M. (2001). Supportive techniques: Are they found in different therapies? *Journal of Psychotherapy Practice and Research*, 10(3), 165-172.
- Barker, P. & Kerr, P. (2001). *The Process of Psychotherapy: A Journey of Discovery*. Oxford: Butterworth Heinemann.
- Barrowclough, C. & Hooley, J. M. (2003). Attributions and expressed emotion: A review. *Clinical Psychology Review*, 23(6), 849-880.
- Birchwood, M. (1986). Control of auditory hallucinations through occlusion of monoaural auditory input. *British Journal of Psychiatry*, 149, 104-107.
- Birchwood, M. (2000). Early intervention and sustaining the management of vulnerability. *Australian and New Zealand Journal of Psychiatry*, 34 Suppl, S181-184.
- Birchwood, M. & Chadwick, P. (1997). The omnipotence of voices: Testing the validity of a cognitive model. *Psychological Medicine*, 27(6), 1345-1353.

- Birchwood, M., Todd, P. & Jackson, C. (1998). Early intervention in psychosis. The critical period hypothesis. *British Journal of Psychiatry Supplement*, 172(33), 53-59.
- Black, K., Peters, L., Rui, Q., Milliken, H., Whitehorn, D. & Kopala, L. C. (2001). Duration of untreated psychosis predicts treatment outcome in an early psychosis program. *Schizophrenia Research*, 47(2-3), 215-222.
- Brooker, C. (1990a). The application of the concept of expressed emotion to the role of the community psychiatric nurse: A research study. *International Journal of Nursing Studies*, 27(3), 277-285.
- Brooker, C. (1990b). Expressed emotion and psychosocial intervention: A review. *International Journal of Nursing Studies*, 27(3), 267-276.
- Bustillo, J. R., Lauriello, J. & Keith, S. J. (1999). Schizophrenia: Improving outcome. *Harvard Review of Psychiatry*, 6(5), 229-240.
- Butzlaff, R. L. & Hooley, J. M. (1998). Expressed emotion and psychiatric relapse: A meta-analysis. *Archives of General Psychiatry*, 55(6), 547-552.
- Carbone, S., Harrigan, S., McGorry, P. D., Curry, C. & Elkins, K. (1999). Duration of untreated psychosis and 12-month outcome in first-episode psychosis: The impact of treatment approach. *Acta Psychiatrica Scandinavica*, 100(2), 96-104.
- Carr, A. (1998). Michael White's narrative therapy. *Contemporary Family Therapy*, 20(4), 485-503.
- Carr, V., Neil, A., Halpin, S. & Holmes, S. (2002). *Costs of Psychosis in Urban Australia: A Bulletin of the Low Prevalence Disorders Study*. Canberra: Commonwealth of Australia.
- Chadwick, P. & Birchwood, M. (1994). The omnipotence of voices: A cognitive approach to auditory hallucinations. *British Journal of Psychiatry*, 164, 190-201.
- Chadwick, P. & Birchwood, M. (1995). The omnipotence of voices. II: The Beliefs About Voices Questionnaire (BAVQ). *British Journal of Psychiatry*, 166, 773-776.
- Chadwick, P. D., Birchwood, M. J. & Trower, P. (1996). *Cognitive Therapy for Delusions, Voices and Paranoia*. London: Wiley.
- Clarkin, J. F., Hurt, S. W. & Crilly, J. L. (1987). Therapeutic alliance and hospital treatment outcome. *Hospital and Community Psychiatry*, 38(8), 871-875.
- Collins, M. N., Cull, C. A. & Sireling, L. (1989). Pilot study of treatment of persistent auditory hallucinations by modified auditory input. *British Medical Journal*, 299(6696), 431-432.
- Coltart, N. (1993). Diagnosis and assessment for suitability for psychoanalytic psychotherapy. *Slouching Towards Bethlehem and Further Psychoanalytic Explorations* (pp15-26). London: Free Association Books.
- Cormac, I., Jones, C. & Campbell, C. (2002). Cognitive behaviour therapy for schizophrenia. *Cochrane Database of Systematic Reviews Online Update Software(1)*, CD000524.
- Done, J. D., Frith, C. D. & Owens, D. C. (1986). Reducing persistent auditory hallucinations by wearing an ear-plug. *British Journal of Clinical Psychology*, 25, 151-152.
- Egan, G. (1997). *The Skilled Helper: A Systematic Approach to Effective Helping*. New York: Brooks Cole.
- Falloon, I. R., Held, T., Roncone, R., Coverdale, J. H. & Laidlaw, T. M. (1998). Optimal treatment strategies to enhance recovery from schizophrenia. *Australian and New Zealand Journal of Psychiatry*, 32(1), 43-49.
- Feder, R. (1982). Auditory hallucinations treated by radio headphones. *American Journal of Psychiatry*, 139(9), 1188-1190.
- Freeman, D. & Garety, P. (2003). Connecting neurosis and psychosis: The direct influence of emotion on delusions and hallucinations. *Behaviour Research & Therapy*, 41(8), 923-947.
- Gallagher, A. G., Dinan, T. G. & Baker, L. J. V. (1994). The effects of varying auditory input on schizophrenic hallucinations: A replication. *British Journal of Medical Psychology*, 67(Part 1), 67-75.
- Gallagher, A. G., Dinan, T. G. & Baker, L. V. (1995). The effects of varying information content and speaking aloud on auditory hallucinations. *British Journal of Medical Psychology*, 68(Part 2), 143-155.
- Gibney, P. (2003). *The Pragmatics of Therapeutic Practice*. Melbourne: Psychoz Publications.
- Goldstein, W. N. (1998). Analytic vs. dynamic psychotherapy in the era of managed care. *Psychiatric Times*, 15(11), www.psychiatrictimes.com/p981151.html
- Haddock, G., Tarrier, N., Spaulding, W., Yusupoff, L., Kinney, C. & McCarthy, E. (1998). Individual cognitive-behavior therapy in the treatment of hallucinations and delusions: A review. *Clinical Psychology Review*, 18(7), 821-838.
- Hafner, H. (2000). Onset and early course as determinants of the further course of schizophrenia. *Acta Psychiatrica Scandinavica. Supplementum*, 102(407), 44-48.

- Harper, I. & Klue, L. (1991). *A Model of Empathic Communication*. Material distributed at staff workshop, Lake Alice Hospital, Palmerston North, New Zealand.
- Hustig, H. H., Tran, D. B., Hafner, R. J. & Miller, R. J. (1990). The effect of headphone music on persistent auditory hallucinations. *Behavioural Psychotherapy*, 18(4), 273-281.
- Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Morgan, V. & Korten, A. (1999). *People Living with Psychotic Illness: An Australian study 1997-98*. Canberra: Department of Health and Aged Care.
- Laing, R. D. (1959). *The Divided Self*. Harmondsworth, England: Penguin.
- Lakeman, R. (2000). Helping people cope with voices. Paper presented at *Mental Health Nurses for a Changing World: Not Just Surviving*. Broadbeach, Queensland (3-7 September).
- Lopez, S. R., Nelson Hipke, K., Polo, A. J., Jenkins, J. H., Karno, M., Vaughn, C. & Snyder, K. S. (2004). Ethnicity, expressed emotion, attributions, and course of schizophrenia: Family warmth matters. *Journal of Abnormal Psychology*, 113(3), 428-439.
- Luchins, D. J., Dyson, V., Hanrahan, P., Marks, R. & Blake, L. (1992). Failure of a binaural comprehension deficit to select responders to earplug use in schizophrenia. *British Journal of Psychiatry*, 161, 397-398.
- Mathers, C. D., Vos, E. T., Stevenson, C. E. & Begg, S. J. (2000). The Australian Burden of Disease Study: measuring the loss of health from diseases, injuries and risk factors. *Medical Journal of Australia*, 172(12), 592-596.
- McCabe, R., Heath, C., Burns, T. & Priebe, S. (2002). Engagement of patients with psychosis in the consultation: Conversation analytic study. *British Medical Journal*, 325, 1148-1151.
- McInnis, M. & Marks, I. (1990). Audiotape therapy for persistent auditory hallucinations. *British Journal of Psychiatry*, 157, 913-914.
- Miller, R. & Mason, S. E. (1999). Phase-specific psychosocial interventions for first-episode schizophrenia. *Bulletin of the Menninger Clinic*, 63(4), 499-519.
- Miller, R. & Mason, S. E. (2004). Cognitive enhancement therapy: A therapeutic treatment strategy for first-episode schizophrenia patients. *Bulletin of the Menninger Clinic*, 68(3), 213-230.
- Nayani, T. H. & David, A. S. (1996). The auditory hallucination: a phenomenological survey. *Psychological Medicine*, 26, 177-189.
- Neale, M. S. & Rosenheck, R. A. (1995). Therapeutic alliance and outcome in a VA intensive case management program. *Psychiatric Services*, 46(7), 719-721.
- Neil, A. L., Lewin, T. J. & Carr, V. J. (2003). Allocation of resources and psychosis. *Australian and New Zealand Journal of Psychiatry*, 37(1), 15-23.
- Nelson, B. (1997). *Cognitive Behavioural Therapy with Schizophrenia: A Practice Manual*. Cheltenham, UK: Stanley Thornes.
- O'Connor, F. W. (1991). Symptom monitoring for relapse prevention in schizophrenia. *Archives of Psychiatric Nursing*, 5(4), 193-201.
- Oehl, M., Hummer, M. & Fleischhacker, W. W. (2000). Compliance with antipsychotic treatment. *Acta Psychiatrica Scandinavica. Supplementum*, 102(407), 83-86.
- Ogrodniczuk, J. S. & Piper, W. E. (1999). Measuring therapist technique in psychodynamic psychotherapies. Development and use of a new scale. *Journal of Psychotherapy Practice and Research*, 8(2), 142-154.
- Penn, D. L. & Mueser, K. T. (1996). Research update on the psychosocial treatment of schizophrenia. *American Journal of Psychiatry*, 153(5), 607-617.
- Peplau, H. E. (1952). *Interpersonal Relations in Nursing*. New York: G.P. Putnam.
- Peplau, H. E. (1989). Theoretical constructs: Anxiety, self, and hallucinations. In A. W. O'Toole & S. R. Welt (Eds.), *Interpersonal Theory in Nursing Practice: Selected Works of Hildegard E. Peplau* (pp. 270-326). New York: Springer.
- Peuskens, J. (1996). Proper psychosocial rehabilitation for stabilised patients with schizophrenia: The role of new therapies. *European Neuropsychopharmacology*, 6(Suppl 2), S7-12.
- Pharoah, F. M., Rathbone, J., Mari, J. J. & Streiner, D. (2003). Family intervention for schizophrenia. *Cochrane Database of Systematic Reviews Online Update Software* (4), CD000088.
- Pinsker, H. (1998). The supportive component of psychotherapy. *Psychiatric Times*, 15(11), www.psychiatrictimes.com/p981160.html
- Rector, N. A. & Beck, A. T. (2001). Cognitive behavioral therapy for schizophrenia: An empirical review. *Journal of Nervous and Mental Disease*, 189(5), 278-287.
- Resnick, S. G., Rosenheck, R. A. & Lehman, A. F. (2004). An exploratory analysis of correlates of recovery. *Psychiatric Services*, 55(5), 540-547.

SANE (2002). *Schizophrenia: Costs. An Analysis of the Burden of Schizophrenia and Related Suicide in Australia*. Melbourne: Access Economics for SANE.

Schwartz, H. J., Bleiberg, E. & Weissman, S. H. (Eds.). (1995). *Psychodynamic Concepts in General Psychiatry*. Washington, DC: American Psychiatric Press.

Stacey, K. & Hills, D. (2001). More than protest: Further explorations of alternative metaphors in narrative therapy. *Australian and New Zealand Journal of Family Therapy*, 22(3), 120-128.

Üstün, T. B., Rehm, J., Chatterji, S., Saxena, S., Trotter, R., Room, R. & Bickenbach, J. (1999). Multiple-informant ranking of the disabling effects of different health conditions in 14 countries. WHO/NIH

Joint Project CAR Study Group. *Lancet*, 354(9173), 111–115.

Vassallo, T. (2002). *Narrative Group Therapy with the Seriously Mentally Ill: A Case Study*. Retrieved 15 November 2004 from www.narrativeapproaches.com/narrative%20papers%20folder/mentalill.htm

Watkins, J. (1993). *Hearing Voices: A Self Help Guide and Reference Book*. Melbourne: Richmond Fellowship of Victoria.

World Health Organization (2001). *The World Health Report 2001 - Mental Health: New Understanding, New Hope*. Geneva: World Health Organization.

Yalom, I. D. (1995). *The Theory and Practice of Group Psychotherapy* (4th ed.). New York: BasicBooks.