

Rethinking the Treatment of Psychotic Disorders

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The hallmark features of psychotic disorders such as schizophrenia are hallucinations, delusions, and disordered thinking. Most clinicians approach treatment of these patients by using medications and occasionally “supportive psychotherapeutic” techniques. However, few clinicians have applied a cognitive model of psychotherapy for patients suffering from schizophrenia or schizoaffective disorders simply because they feel it cannot be done. Yet, many windows of opportunity are lost that could have a dramatic impact on these patients.

CASE PRESENTATION

The patient is a 48-year-old divorced African American woman who was referred to the clinic by her primary care physician for the treatment of symptoms related to an earlier diagnosis of schizoaffective disorder. Approximately 20 years earlier, the patient was diagnosed with schizophrenia, which was later modified to a diagnosis of schizoaffective disorder, depressed type. She described a past history of paranoia and disordered thoughts with occasional auditory hallucinations. Along with these psychotic symptoms, the patient noted a predominately depressed mood for a large part of her illness. She had had a period of psychotic symptoms lasting at least 2 weeks in the absence of depression, which meets criteria for a DSM-IV diagnosis of schizoaffective disorder.

The patient’s longtime psychiatrist, whom she was seeing for medication management, retired, and her primary care physician wanted to ensure continued outpatient psychiatric care. She had spent much of the last several years in and out of psychiatric hospitals. On presentation to the clinic, the patient was taking an atypical neuroleptic (risperidone), an antidepressant (sertraline), and a minor tranquilizer (chlordiazepoxide). Medication compliance had been sporadic, and the patient was complaining of muscle stiffness most likely related to a bedtime dose of 2 mg of risperidone.

She was also complaining of a depressed mood, with episodic and vague paranoid ideas. She denied auditory or visual hallucinations and any other psychotic symptoms.

“Out of reality” is how the patient described her past. Personal hygiene was a marker that the patient and her physicians had used in the past to monitor how well she was doing with treatment. When her hygiene declined, hospitalization was often imminent.

In describing her history and current situation, the patient continually made cognitive errors, including overgeneralization, selective abstraction, and polarization. She described being “depressed in the past,” therefore assuming she would “never be happy.” She made statements such as, “Everyone is cruel” and “I can never learn to function in this world.” Statements such as these suggest the value of a cognitive model of psychotherapy. If she were able to examine critically the meanings she applied to situations and relationships and replace them with more adaptive meanings, she might be able to lessen her depression as well as the burden of schizophrenia.

According to the patient, the past 20 years were spent living a lonely, quiet existence. She remained in the house except for running errands and had few friends providing social support. Financial support came in the form of a disability check. Despite suffering from psychiatric illness, the patient had been relatively free of major medical problems, except for being treated for hypertension with hydrochlorothiazide. She denied a history of substance use in the past, except for occasional social alcohol consumption.

At the initial intake, the patient appeared slightly nervous. Her personal hygiene was fair, and speech and motor activity were normal. The patient’s mood was “sad and empty,” and her affect was blunted. Her thought content revealed no suicidal or homicidal ideation, but she had some vague paranoid ideas. The patient’s thought process was slightly disordered, but, overall, it was comprehensible. We discussed medication management initially and agreed to substitute ziprasidone for risperidone. Sertraline and chlordiazepoxide were continued at the current doses. At this point, we contracted for a few medication management visits. Although I suspected the patient might benefit from a cognitive approach to treatment, I refrained from discussing psychotherapy options initially.

The patient began the second session by describing modest improvement in paranoia and minimal change in depressive symptoms. She had no overt signs of disordered thinking. She continued to exhibit cognitive errors in the context of her description of events during the past week. I increased her sertraline dose and continued the same dose of clordiazepoxide for generalized anxiety. For the majority of the second and third sessions, we focused on medication management.

PSYCHOTHERAPY

By the end of the fourth session, the patient appeared considerably better (her hygiene and grooming were improved). She reported no paranoia, but moderate continuing depressive symptoms. At this point, we discussed adding biweekly psychotherapy sessions to address the patient's "depressive thinking." Given her history of chronic mental illness, we did not contract for a specific number of sessions, but planned to revisit progress at the tenth session. She identified as current goals the remission of her depressed mood and an improvement in overall functioning.

During the fifth session, we focused on identifying negative automatic thoughts such as, "I've always been unhappy, so I can never be happy," "I've been out of reality for so long that I can never learn to function," "Everyone in the world is cruel," and "I can never learn to do things normal people can do." With some collaborative work, the patient was able to generate alternatives to her "depressed" way of thinking.

Although I did not present the traditional triple-column format to the patient as homework, we incorporated these principles into each session. The patient readily presented numerous situations and thoughts to guide most of our discussions. Despite her tendency to dwell on the past, I continually refocused treatment on the present. Humor and analogies were used to help the patient begin to make a "shift of set" so that she might identify a cognitive error or find a more suitable meaning.

By the sixth session, the patient reported a significant improvement in depressive symptoms. She became adept at examining her thoughts, with little prompting from me. I continually challenged her to reframe her views of life situations (consider alternatives) when her beliefs did not serve a strategic purpose for her. The family told me that she was doing "somewhat better." The patient stated that she was, once again, hearing voices, and this was addressed successfully by increasing her dose of ziprasidone.

Overall, the patient's depressive symptoms nearly remitted. She occasionally experienced transient psychotic symptoms. She was now attending church and church groups regularly and becoming involved in volunteer work. Throughout the next several sessions, we utilized cognitive principles to "reintroduce" the patient to reality. The patient told me she was "feeling a lot less lonely." Over the next 2 months of treatment, the patient continued to be more functional, and her depression remained essentially in remission. Her psychotic symptoms were limited to an "occasional voice." Medication compliance has been very good, and the patient has remained out of the hospital. At session 10, we reviewed her progress to date and concluded that additional cognitive therapy sessions were warranted. These sessions focus on helping her learn to "function in reality."

COMMENT

Psychotic disorders are defined as "thought disorders," and, because of this, many clinicians do not consider psychotherapy for patients who have these disorders. Ironically, especially when symptoms are well controlled with medications, these patients often benefit from cognitive therapy. Patients who have improved on treatment with medications are more likely to relapse without psychotherapy to aid their adaptation to the real world in healthy ways. Medication compliance generally improves with successful psychotherapy. In the right patient at the right time, cognitive therapy can be a useful adjunct in the management of these difficult patients.

Editor's note: Dr. Pelic is in the third year of psychiatric residency training at the Medical University of South Carolina. Dr. Schuyler is Clinical Associate Professor of Psychiatry and teaches cognitive therapy to psychiatry residents at the Medical University of South Carolina.