About 2% of the population will suffer from schizophrenia in their lifetime. Treatment often consist of medication alone, but psychotherapy can be an important component to help maintain the remission and increase the quality of life.

Keywords: schizophrenia, psychotherapy, treatment
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Introduction

About 2% of the population will suffer from schizophrenia in their lifetime. This may not seem much, but there are two reasons why schizophrenia is maybe the preeminent psychiatric condition. One is that it can cause immense suffering and has, with some exceptions, only really become treatable over the last decades. The other reason is that it produces some of the strangest symptoms, which have found their way repeatedly into literature and film. It is a condition which sheds light on the necessary distinction between the internal and external worlds of the individual. If this barrier breaks down, a patient may hear internal thoughts as they were external voices and perceive external events as if they were interfering with internal thought processes.

Schizophrenia

Schizophrenia is a chronic and severe mental disorder that affects how a person thinks, feels, and behaves. People with schizophrenia may seem like they have lost touch with reality. Although schizophrenia is not as common as other mental disorders, the symptoms can be very disabling.

Signs and Symptoms

Symptoms of schizophrenia usually start between ages 16 and 30. In rare cases, children have schizophrenia too.
The symptoms of schizophrenia fall into three categories: positive, negative, and cognitive.

Positive Symptoms

“Positive” symptoms are psychotic behaviours not generally seen in healthy people. People with positive symptoms may “lose touch” with some aspects of reality. Symptoms include:

- Hallucinations
- Delusions
- Thought disorders (unusual or dysfunctional ways of thinking)
- Movement disorders (agitated body movements)

Negative symptoms

“Negative” symptoms are associated with disruptions to normal emotions and behaviours. Symptoms include:

- “Flat affect” (reduced expression of emotions via facial expression or voice tone)
- Reduced feelings of pleasure in everyday life
- Difficulty beginning and sustaining activities
- Reduced speaking

Cognitive symptoms

For some patients, the cognitive symptoms of schizophrenia are subtle, but for others, they are more severe and patients may notice changes in their memory or other aspects of thinking. Symptoms include:

- Poor “executive functioning” (the ability to understand information and use it to make decisions)
- Trouble focusing or paying attention
- Problems with “working memory” (the ability to use information immediately after learning it)
Universality

The risk of developing schizophrenia is roughly similar across cultures and continents. Schizophrenia, a form of psychosis, is a severe mental health condition, which in previous centuries usually meant a complete withdrawal from social life and life-long commitment to a mental institution, where treatment was in the best case largely ineffective and in the worst cases barbaric and inhumane.

Schizophrenia and Genius

There have been famous individuals, like the impressionist painter Vincent Van Gogh, who used his art to communicate how differently he saw the world and some of the suffering that came with it. Many have tried to write or express themselves in other ways. I have seen a patient who thought of himself as the king of Sweden and his room had become an office to write correspondence to various members of the European high aristocracy, politicians and others he deemed worthy of corresponding with.

Development of Psychotherapy for Schizophrenia

For the past 20 to 30 years the use of medication has dominated mainstream approaches to the treatment of psychotic disorders with little credibility or resources being allocated to psychological interventions. However, more recently, interest in psychological interventions aimed at ameliorating the impact of psychosis on the lives of individuals has increased.

Current research evidence shows that psychological interventions including cognitive-behavioural, psychodynamic, and dialogical approaches to psychotherapy are effective in the treatment of people diagnosed with schizophrenia, both in the early and chronic stages of the disorder (Lysaker, Buck, & Ringer, 2007; Rosenbaum et al., 2012; Wykes, Steel, Everitt, & Tarrier, 2008; Yung et al., 2011).
Reignited interest in psychotherapy for people with schizophrenia has occurred within the context of a growing emphasis in mental health services on recovery from severe mental illness and advances in the phenomenological understanding of schizophrenia (Bellack, 2006; Davidson, 2003; Sass & Parnas, 2001).

An Individual Process

Recovery from mental illness is “a deeply personal, unique process [which] ... involves the development of new meaning and purpose as one grows beyond the catastrophe of mental illness” (Anthony, 1993, p. 527). Recovery is no longer viewed solely in terms of symptom cessation. Instead, recovery incorporates two specific domains: objective and subjective recovery (Bellack, 2006; Lysaker & Buck, 2008). The objective aspects of recovery relate to the reduction of illness-related problems while the subjective aspects of recovery relate to a person’s subjective experience of their life and mental health difficulties.

Research suggests a bi-directional relationship between objective and subjective aspects of recovery, linking objective measures of recovery such as paid employment and symptom severity, with subjective aspects such as empowerment, self-experience, quality of life, and hope (Lloyd, King, & Moore, 2010; Lysaker, Buck, Hammoud, Taylor, & Roe, 2006). While psychopharmacotherapy and vocational rehabilitation focus on the objective aspects of recovery from psychosis, there has been a lack of interventions that address sufferers’ sense of self and subjective experiences of their difficulties.

Communication

Already in the processes which give rise to schizophrenia, communication plays a significant role. There are two distinct areas where communication take place:

- Internal communication
- External communication

Internal communication is the exchange of messages within the organism, especially the brain, where there is a direct high-speed connection. External communication, on the other hand, occurs between the
organism and the environment, such as between people talking to each other. In schizophrenia, the labelling of what is external and what is internal communication seems to get lost.

The Self

The self is where one feels that the communication with the environment and with oneself takes place. It is entirely subjective, and we cannot see or observe it from the outside.

Research that has considered the subjective experience of people with mental illness has suggested that recovery involves processes that cannot be attained passively, such as the recapturing of a sense of personhood and meaning.

For many, recovery often means becoming an active agent in charge of one’s own life, making meaning of one’s own life, constructing narratives about past events, and ultimately using that metacognitive knowledge to decide what to do as a being in the world (Lysaker, Roe, & Buck, 2010; Roe & Davidson, 2005). This is important in defining one’s own social role, interacting with others and finding the right amount of time spent with others and by oneself. This goes back to the finding the right quality and quantity of internal and external communication.

Meaning

Making sense of the schizophrenic condition is important to integrate it into one’s life history and oneself. When someone sees meaning in an illness, one can also see more meaning in oneself. This does not mean seeing the condition as ‘good’, but seeing meaning in the own thought processes and emotions it triggers.

The other side of making meaning is to focus on communication, but the external one with the environment and the internal one with oneself. Making one’s interactions with others meaningful, or selecting the ones that are meaningful, helps to build a better sense of self.
Active Involvement

The need for active participation by the person in recovery points directly to the necessity for the development of integrative treatments. Because recovery is attained through active involvement, requires meaning making, and is more than symptom remission or skill acquisition, no single intervention alone or eclectic collections are likely to meet the needs of people with unique backgrounds, strengths, weaknesses, histories, and cultures. Interventions that are integrative by contrast seem uniquely positioned to bring together disparate work under a larger theoretical frame to promote recovery among people with a severe mental illness (SMI) such as schizophrenia. But what would an integrative psychotherapy for SMI involve? A range of very specific and detailed interventions have been rapidly developed in the mental health field for people with SMI (Mueser & Roe, in press); however, outside of a few commentaries (e.g., Hamm, Hasson-Ohayon, Kukla, & Lysaker, 2013), little has been written about how each individual approach might fit into the larger picture. In many venues, treaters are even directed to use specific interventions to maximize chances for recovery. However, this is often without consideration of the larger purpose of getting to know each client as a unique human being.

Treatment

Communication actually plays a large role in the development of the condition, as well as it should in its treatment. Someone suffering from schizophrenia does not seem to communicate in a normal way with the environment or himself or herself. Unfortunately, in many cases the communication environment provided in many institutions does not help the patient or those who provide treatment.

Compassion Focused Therapy

CFT can provide an alternative approach to help regulate affect and build a better sense of self. Compassion, coupled with mindfulness and emotion regulation techniques, can help generate the courage to address the worst symptoms of psychosis. CFT can provide the means to help develop the more grounded kinds of sense of self needed to manage emotional distress.
Integrative Psychotherapy

There are a number of combination treatments which have been tried, such as:

- An emphasis on recovery that includes a number of conceptual elements such as interpersonal processes, personal narrative, and metacognition.
- A framework that deals with the double challenge of low self-reflectivity among clients with an at-risk mental state in a prison setting, an intense and stressful social environment with reduced opportunities for a person to engage in self-reflectivity. First identify the degree to which a client is able to self-reflect and avoid trying to form ideas that are too complex for the client in that moment.
- Combining metacognition-oriented therapy, cognitive behavioral therapy, and psychiatric rehabilitation, personalized to the needs of a middle-aged man with chronic schizophrenia and a mood disorder. These three different approaches can be used in a sequential and complementary fashion to foster recovery by improving the ability to understand self and others, and using this information to work toward the attainment of personal goals and greater insight. One of the central goals of this approach is to improve a client’s agency—that is, helping an individual to view him- or herself as an active participant in the world and as a central character in his or her personal narrative. The authors show how, through the journey of therapy, the client gradually develops a more coherent narrative about his life, establishes a more stable sense of self, and becomes more of an active agent in the world.

Metacognitive reflection and insight therapy (MERIT)

MERIT is considered to be an integrative form of psychotherapy and entails the use of cognitive, behavioral, humanistic, or psychodynamic techniques with the aim of promoting the synthesis of an integrated sense of self and others. Further, MERIT requires a focus on reflection as opposed to correcting beliefs or teaching skills. The authors present a description of 12 sessions, recounting eight interrelated processes (and activities) that should occur in each session in order to stimulate and increase
metacognitive ability. In their article, they carefully describe each MERIT element along with the observed clinical and metacognitive gains. Using a step by step approach, they show how the described procedures facilitated the client’s transformation from a state of having no complex ideas about himself (or others) to one featuring a more integrated and realistic sense of self and others, as well as a growing ability to use this capacity to think and try to respond to life challenges.

**Metacognitive Narrative Psychotherapy**

Recognizing the centrality of sense of self and human subjectivity in the recovery process for people with psychotic symptoms, Lysaker and colleagues (Lysaker et al., 2011) developed Metacognitive Narrative Psychotherapy, an adaptation of a psychotherapeutic approach to the treatment of personality disorders (Dimaggio et al., 2012; Dimaggio, Semerari, Carcione, Nicolò, & Proacci, 2007).

Metacognitive Narrative Psychotherapy draws upon dialogical narrative understandings of self-experience and schizophrenia, and is influenced by multidimensional conceptualizations of recovery from mental illness (Lysaker & Buck, 2008; Lysaker, Lysaker, & Lysaker, 2001). The approach was also designed to specifically target impaired metacognitive capacity, recognizing it as a stable and independent feature of schizophrenia, which is linked to increased symptom severity and poor social functioning (Brune, Dimaggio, & Lysaker, 2011; Harrington, Langdon, Siegert, & McClure, 2005; Lysaker, Carcione, et al., 2005; Lysaker et al., 2009; Lysaker & Lysaker, 2004; Nicolò et al., 2012; Roncone et al., 2002). Metacognition refers to a spectrum of activities which involves thinking about thinking and stretches from consideration of discrete psychological phenomenon to the synthesis of discrete perception into an integrated representation of self and others (Lysaker, et al., 2011).

Case-study evidence has demonstrated that the approach yields positive effects on metacognitive capacity, narrative structure and content, quality of life, symptom severity, and insight in the treatment of people with schizophrenia (Buck & Lysaker, 2009; Lysaker, et al., 2007; Lysaker, Davis, et al., 2005; Lysaker & Hermans, 2007; Salvatore et al., 2012; Salvatore et al., 2009). Metacognitive Narrative Psychotherapy is also the only intervention to date, with the exception of a case study of mentalization-based therapy (Brent, 2009), that has been designed specifically to target metacognitive deficits in people with schizophrenia.
Most individual with severe mental illnesses can work, cope with the domination of symptoms, and find ways to have personally meaningful and productive lives (Lysaker & Buck, 2008; Roe, 2001; Silverstein & Bellack, 2008).

Quality of Life

Schizophrenia is a condition which can severely reduce an individual’s quality of life over long periods of time, frequently a lifetime. Fortunately, new generations of medication and new lines of psychotherapeutic treatment have alleviated much of the suffering and allowed many patients to lead normal lives with families and professional careers. In fact, the advances on the medical side have in some respects sent more patients into psychotherapy because communication and self-reflection have become easier. The psychosis is still apparent, but therapy can be provided in more ‘normal’ intensity and frequency, which has been regarded as an important economic aspect.

Merger of Two Worlds

A central theme of schizophrenia is that an individual can no longer distinguish between the world on the inside and on the outside. For example, thoughts become voices, while other people seem to influence one’s thoughts. Medication allows many individuals with schizophrenia to clearly distinguish again between what happens on the inside and what happens on the outside. However, it does not remove the issues encapsulated in the content of the voices and many unusual experiences. A sleeping pill can make someone sleep, and it might even affect one’s dreams in a global way, but it does not provide the information for a specific dream content. Psychotherapy can help with the content, which is very useful if the psychosis comes with paranoid and frightening thoughts. They do come from somewhere.
Relationships

Any psychosis both affects and is maintained on the relationship level. Messages and people are interpreted differently by someone suffering from psychosis. Often this interpretation is related to a patient’s emotions. If there is fear a patient might believe that the other person is a secret agent tracking him, even if the fear is not directly related to the other person and objectively there is no reason to assume that the other person is a secret agent. Associations made in one’s mind in a psychosis can be experienced as facts in the real world.

Evers paranoid or schizophrenic symptom has a profound impact on the patient’s ability to communicate and interact with other people. But at the same time, it is in the interaction between therapist and patient were some of the negative effects of the condition are treated.

Many individuals suffering from psychosis are very sensitive to the messages they receive from the world around them. Since their borders are more fluid, they often try to find structure and explanations for their own emotions and what they observe in the world around them. This can give rise to paranoid ideas and even hallucinations in an attempt to make sense of their perceptions on the inside and the outside. Medication can reduce or even eliminate these symptoms significantly, but therapy still requires a strong and empathic working relationship between therapist and patient.

Understanding

Notably, as suggested by Gerson (1996), the therapist expresses a fundamental interest in the process of knowing. This enables an intersubjective space for mutual exploration of the agenda. Mutual exploration of the patient’s agenda can frame potential psychological problems and allow for the patient to assert his own subjectivity and agency early in session.
Life Story

Narrative episodes should involve the patient relating a sequence of events involving specific people and places that have occurred for either a clear or unclear reason, have antecedent and consequent events, and have relevance for the patient (Dimaggio et al., 2012a; Dimaggio et al., 2012b). The eliciting of narrative episodes is likely to require action on the therapist’s part and has to be pursued with the goal of understanding what has happened. The narratives that are produced, either as individual narrative episodes or as multiple narrative episodes that have been strung together, should be understood by therapists as a universal part of how people make sense of immediate experience in the light of past experience. The creation and consideration of narrative episodes are a common human activity that we all use to lay out ideas about ourselves so they can be shared with others and ultimately adapted and revised in the face of continued participation in the world.

Eliciting narrative episodes is likely to be closely tied to the next element, which is the naming of the psychological problem. Of note, in seeking a narrative episode the ultimate goal is to think with patients about themselves as beings in the world and as such the goal in obtaining a narrative episode is not to collect a history but to think with the patients about the contexts within which they are experiencing certain mental activities.

Common barriers include eliciting narratives in which therapists ask for memories without offering adequate scaffolding when some patients at best can only offer fragments of experience. Therapists may also neglect to explore narrative episodes when those episodes have been previously discussed, thinking nothing new will come from reviewing events in potentially increasing depth, potentially missing a chance for a richer understanding. Conversely, therapists may follow narratives that are not related to the patient’s experience and may serve as a diversion from thinking about narratives relevant to the patient’s agenda and mental activities.

Element 5: Reflecting on Interpersonal Processes Occurring Within the Session

This element holds that sessions should contain a discussion of some of the interpersonal processes occurring within the session between the therapist and patient that support or limit metacognitive activities. We suggest that there are at least four different general aspects of the interpersonal processes occurring within and between sessions that could be discussed within session as they occur. These
interpersonal aspects that could be discussed include the possible role or roles the therapist, as an addressee, may be playing in the ongoing dialogue with the patient. Once identified, a second aspect to be potentially addressed concerns why it is important for the therapist to function in these roles and how it may be and/or not be beneficial to the process of psychotherapy for the therapist to function in these roles. The third aspect that can be addressed concerns how well or poorly the therapist is performing his or her role. Finally, the fourth concern is the patient’s reaction to the therapist’s performance of the role.

The primary purpose in considering the interpersonal processes is not necessarily for the patient or therapist to make more appropriate use of the session. However, that may be one consequence. The therapist subjectivity is addressed in order to promote patients’ subjectivity (Safran and Muran, 2000).

Thus, thinking about how the patient positions the therapist role and all that follows should be seen as an opportunity for the therapist and patient to understand how the patient is experiencing the therapist as being present and having a mind which could potentially understand him or her and hence to think about the context within which thinking about thinking is being generated. The primary purpose is to utilize the interpersonal, intersubjective context thusly as another subject for reflective activity. It is a set of mental activities occurring that the patient can form ideas about and hence practice metacognitive activities.

Performing this element may aid in the generation of a narrative episode, psychological problem and/or elucidation of the agenda. Common barriers to performing this element include therapists’ unawareness of their own thoughts and feelings and hence difficulties intuiting what patients are experiencing. Therapists may also be personally uncomfortable with patients’ strong reactions to them including both positive feelings such as love and sexual attraction as well as more negatively toned responses such as anger and jealousy.

Stimulating Self-Reflectivity and Awareness of the Other

This element concerns the direct stimulation of patients to think about their own thinking, either about themselves or thinking about others. This requires that therapists first assess the patient’s metacognitive level both in terms of self-reflectivity and then in terms of awareness of the other. For this purpose, we recommend the use of the MAS-A, which allows for an assessment of patients’ maximum metacognitive capacity in the moment. This instrument has been described in Chapter 6 (Metacognition in

Once therapists have assessed self-reflectivity and awareness of others, therapists should then intervene and ask patients about their thoughts about themselves and others in light of that assessment, asking patients to exercise their maximal level of metacognitive capacity. For instance, if a patient is at best able to notice that they have memories but are unaware of their emotions or subjectivity of thought, it would be best to notice they are having memories rather than asking them to identify an affect or question their thinking.

The assumption is that metacognitive capacity will increase with exercise either in a single session or in multiple sessions, hence patients will become able to perform more complex metacognitive acts and therapists will intervene differently over time. Of note, it is possible that metacognitive capacity may also decline within a session as painful material arises, interventions are too taxing, or general levels of life stress increase. In such cases therapists should adjust their interventions accordingly. As a complete discussion of these issues is beyond the scope of this chapter, narrative tasks and interventions per level of the MAS-A Self-Reflectivity and Understanding the Mind of Others are presented in Tables 12.1 and 12.2.

Stimulating Mastery

In parallel to the seventh element, this calls for an assessment using the MAS-A of patient’s level of Mastery or the ability to use knowledge of oneself and others in order to respond to social or psychological problems. Therapists should then offer interventions appropriate to that level. As in the case of SelfReflectivity and Understanding the Mind of Others, it is assumed that Mastery scores will change over time in either a positive or negative direction, and therapists should adjust their interventions accordingly.
Medication

Many people on medication can lead normal lives as managers, scientists, salespeople, husbands and wives. Individuals on the new neuroleptic agents (and sometimes older ones) have become virtually symptom free and indistinguishable from their ‘healthy’ counterparts. A trained mental health professional may still spot the odd little detail that gives the condition away, but it is remarkable that a condition which was untreatable for most of human history has over the last decades become manageable in most cases. Unfortunately, in an attempt to save costs, the emphasis is often put on medication alone. Many studies, however, have borne out clearly that medication alone is significantly inferior to a combination of psychotherapy and medication, especially when it comes to relapse prevention. Adequate psychotherapy thereby saves the much higher social and individual costs of permanent disability, repeated inpatient treatment and the unquantifiable reduction in the human quality of life.

The Therapeutic Relationship

The therapist needs to establish with the patient a stable working relationship that is strong enough to absorb and process the fears and doubts the patient may have. This requires empathy and an openness to accompany patients in their exploration of new perspectives and their own thought processes, while giving them the support necessary in dealing with everyday life. The shared world between therapist and patient should convey safety and be a platform for exploration. This is important because as the patient communicates more of the inner world in this space into the outer (real) world, it stabilizes a sense for the real world.

Freedom in Therapy

The therapist, while retaining the analytical and intervention tools of the trade, should give the patient the necessary freedom to choose a focus so that important areas of the patient’s life can be reflected upon. It not only helps the therapist to better understand the client, but also builds the absolutely critical therapeutic working relationship between patient and therapist. Especially in cases of paranoia and deep
mistrust against society or institutions there is a need to carve out a secure platform from which to work therapeutically. Through the interaction with the therapist the patient learns to distinguish between the internal world of the mind and the external world we all live in. In the interaction with an experienced therapist the patient can so acquire a feeling for the boundaries between the inner and outer world. The patient’s interactions with other people help solidify and reinforce these boundaries, provided they are built on mutual respect and genuine interest.

Schizophrenia is a severe mental health disorder that affects approximately 0.7% of the population.1 Symptoms include positive symptoms such as hallucinations, disordered thinking and delusions, and negative symptoms that include expressive deficits such as blunted affect and impoverished speech, and experiential deficits such as asociality, anhedonia, and avolition.2,3 Negative symptoms have been found to have a profound impact on long-term outcomes,4,5 but current treatment options are limited. In a review by the National Institute for Health and Care Excellence (NICE) in the UK,6 arts therapies – an umbrella term for all non-verbal creative therapies such as art therapy, music therapy and body psychotherapy – were identified as the only type of therapy with justified claims to reduce negative symptoms. Consequently, it was recommended that clinicians should consider referring people with schizophrenia for arts therapies.6,7 However, the review was based on only six small-scale trials, meaning more evidence is needed. Since the publication of NICE guidelines one large trial of conventional art therapy has been completed (MATISSE) that found no significant treatment effect on negative symptoms.8 Following MATISSE, the aim of the present study was to evaluate the effectiveness of a different type of arts therapy, namely body psychotherapy, as a treatment for negative symptoms of schizophrenia. Body psychotherapy is a form of therapy that involves an explicit theory of body–mind functioning designed to improve emotional, cognitive, physical and social integration. In an earlier trial where this therapy was evaluated,9 a significant reduction in negative symptoms was detected in the body psychotherapy group in comparison with a supportive counselling control group. The effect size was large, and was maintained months later. However, this study was relatively small (45 participants), did not control for the non-specific effects of supported group physical activity, and all body psychotherapy groups were conducted by the same therapist. Three earlier trials on body-oriented psychotherapy not included in the NICE review suggested improvements in various outcomes including negative symptoms,10–12 however, all had significant methodological shortcomings.
There are a number of advantages to evaluating this particular form of arts therapy as a treatment for schizophrenia. First, it is recognised that patients with schizophrenia can experience a range of body disturbances such as desomatisation, abnormal bodily sensations and motor impairments. Consequently, providing a form of therapy that focuses on the body may help to address such disturbances. Second, to our knowledge this is the only form of arts therapy where a treatment manual specific to the treatment of negative symptoms has been produced that details a theoretical model, mode of action and a standardised therapy structure. Beyond its possible clinical effectiveness, body psychotherapy is relatively inexpensive, can be combined flexibly with other treatment methods, and may appeal to patients who are difficult to engage in other treatments given its novel approach. In order to examine the effectiveness of body psychotherapy as a treatment for negative symptoms we conducted a full-scale, randomised controlled trial (RCT) comparing a manualised form of the intervention with a well-defined, physically active control condition, namely Pilates.

Pilates is a structured physical fitness programme involving stretching and controlled movement. The specific components of body psychotherapy under investigation were the focus on body experience at a cognitive and emotional level, the facilitation of emotional group interactions, and the link between movement and emotion. The components common to both interventions include the non-specific effects on non-emotional group interactions, group facilitator attention and physical activity.

Clearing Away Stress

Stressful issues should be cleared away in a psychotherapy away and involving partners and family can be of benefit. A special emphasis should be placed on transparency and clarity. The patient should be supported in developing own resources, but also in knowing their limits and establishing healthy boundaries. Medication supports this process because it can create a distance to stressful emotions and thoughts, so that the patient is less likely to feel overwhelmed or threatened by them. After all, it is the fear triggered by a patient’s own thoughts and feelings which leads to the paranoia vis-à-vis other people and institutions, such as being spied on by the mob, a government conspiracy, and the like.
Sensitivity and Perception

Quite regularly patients suffering from schizophrenia seem to have very perceptive antenna for the emotional state of other people. On the other hand, this heightened sensitivity can lead to the projection of own emotions into another person’s otherwise relatively meaningless small gestures and remarks. This often requires helping patients in their approach to appropriate communication patterns with their environment, while recognizing the factors in the patient that might maintain paranoid believes, such as negative emotions caused by life events or unfulfilled needs and aspirations.

A Fulfilled and Happy Life

The goal in the treatment of schizophrenia is no longer for the patient to ‘function’ but to lead a fulfilled and happy life. This requires particular attention also be paid to the relationships and interactions the patient has with his or her environment, while working with the patient towards greater clarity on the values, needs and aspirations the patient holds.

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References


assessments of work performance over six months. [Corrected Proof]. Schizophrenia Research. doi: 10.1016/j.schres.2009.04.024


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