Dialogue therapy in psychosis 2020

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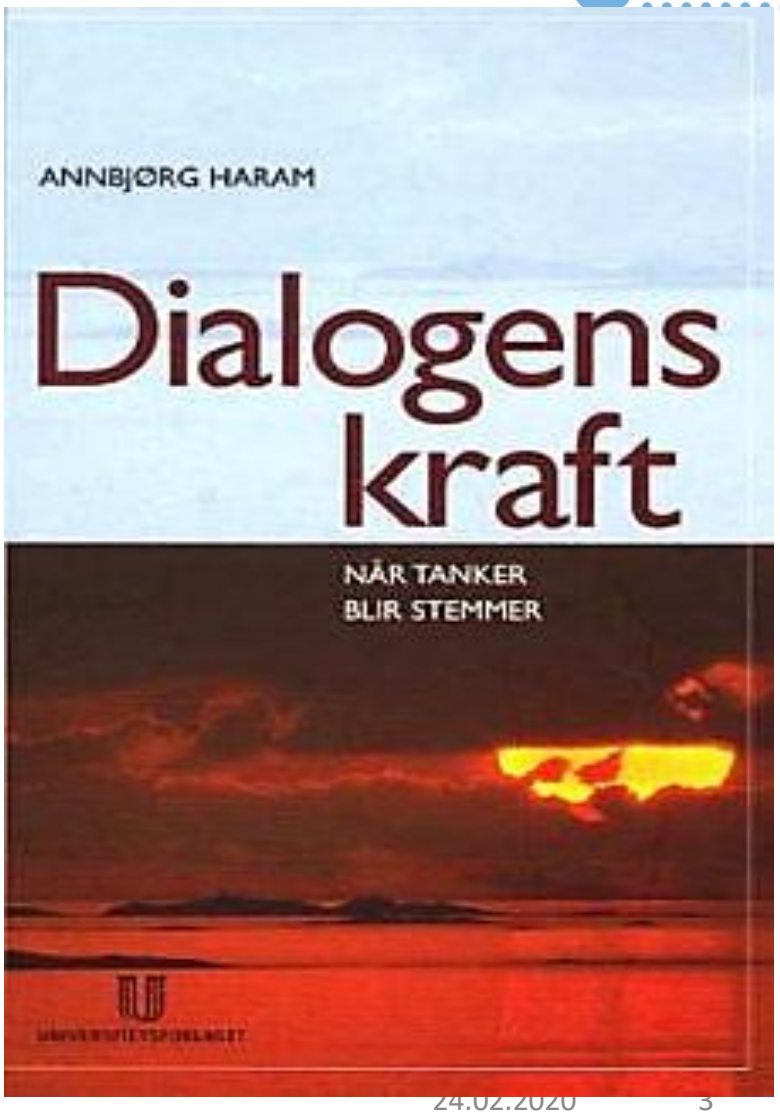
Schedule

1. Background & Foundations
2. Theory Perspectives & Attitudes
3. The DT-figure model - Methods organized in three tables
4. Central findings of analysis from a local project, Ålesund hospital, Ålesund
5. Questions

Dialogens kraft 2004

- As in a therapeutic collaboration, the book is structured in three stages. Plans of research is referred to in the preface by Tom Andersen.
- Patients are invited as co-researchers and theirs's statements appear in italics.
- In Cullberg's book from 2000, pages 191-193, the sketch from the dialogue therapy model and case illustrations from Haram's therapy are shown.
- The dialogue therapy model was first presented by Haram in a family therapy workshop in Asker, 1996.



DT is a philosophical-ethical approach

- and has a pragmatic attitude to tailor the treatment to each person
- key sources of inspiration are found in humanistic traditions
- specific concepts from language and narrative approaches, familiy therapy, intersubjectivity and mentalization-based treatments

Perspectives and Attitudes

- DT offers a psychotherapy that emphasizes the opportunity for cure and restoring health in psychosis
- this type of highlighting in itself may promote change by positively influencing the patients' motivation

Characteristics in DT

- is to ask how you as the therapist would like to be met in a similar situation, and the perception that a human being cannot be changed from the outside
- the therapist can only help the patient to see opportunities
- and an option to choose to make use of them

Perspectives & Methods

- there is an agreement among several theories that the dialogue represents a powerful landscape of communicative processes
- essential in DT is to move focus from monologue and disease thinking to dialogue and contexts of causal relationship

Essential aspect

- a central aspect is that treatment questions are dealt with in dialogue, and the therapist is not analyzing behind the words
- if anything is interpreted, this is done together with the patient and not by the therapist alone

The power of the dialogue

- the dialogue is applied as a powerful therapeutic instrument to open doors into rooms for free conversations
- dialogue therapy is *here* and *now*-oriented and emphasises use of *curiosity*, to wonder; what do we not know in what we know?

Attitudes & Practice

- dialogue therapy has a strong attitude on restoring health, with an emphasis on contexts
- history and experiences is natural, unique and subjective
- the illness and healthy properties are dealt with in parallel in psychoterapy

Central perspectives

- if the disordered parts are primarily attended to, this may maintain the illness and lead to a chronic disease state
- to be genuine, muster empathy, involvement and
- respectful listening to all utterances are highlighted

Emotional self-growth

- the therapist inspires to a process of reciprocity and emotional self-development
- a starting point to empower the patient's healthy features is to create an atmosphere of safety, inclusion, hope, dialogue and a collaborative process

As in music with interest in the spaces between the notes (Steve de Shazer)

- create an atmosphere of safety, inclusion, hope, dialogue and a collaborative process

Stimulate the patient's own efforts

- the therapist is meeting moments spontaneously to promote opportunities for positive change
- the therapist encourages the patient to find keys to solutions in fighting the illness

Invite the patient into dialogue

- Is there something I should do different ?
- Is there something I forgot to ask you about ?
- So well, how did you do it?
- Empower the patient
- Give compliment
- The therapist wonders, small-talks, tuning in and seeks advice along the way

Attitude & Language

- the therapist has a critical eye on how language constitutes attitudes an influences how we meet the patients
- psychosis is not primarily regarded as a biological illness

- In spite; a consequence of several small or large life stresses, trauma, caused by identity harm in interpersonal relationships

Knowledge of their own psychosis

- the patients are invited to participate in a collaborative, mutual relationship with their own specific knowledge
- symptoms are considered as informative in providing opportunities to talk and understand the patient's history and causal explanations

Reflecting methods – small-talk

- experiences from the psychotic world are seen as opportunities for better understanding of the patients real life problems
- small-talk and frequent summing up in order to reduce anxiety and ease the atmosphere

Sort out misunderstandings

- the patient is assisted to revise history to see nuances and sort out misunderstandings
- this intends to reduce confusion and feelings of chaos from the psychosis
- it implies that the psychotic language should not be considered as a single-sided sign of biological illness that first of all must be remediated by antipsychotic medication

New history in dialogue

- instead, symptoms are seen to involve deposits or tracks that give important information and show connections to real life-events
- this implies that to share the patient's stories might lead the psychotic world to loose its paralyzing power

Specific Methods of DT

- DT is provided in one hour sessions each week. It has three phases, and the length of treatment usually varies from three months to three years
- the therapist goes along with the patient and moves within and between the different phases, and, if necessary, stops and moves back to previous phases

Methods of DT

- focus is on authorizing the patients in regaining self-regulation (figure1).
- the essence of self-regulation is to deal with and master own emotions and behavior, which implies to regain mental control and direct focus on one thing and ignore others

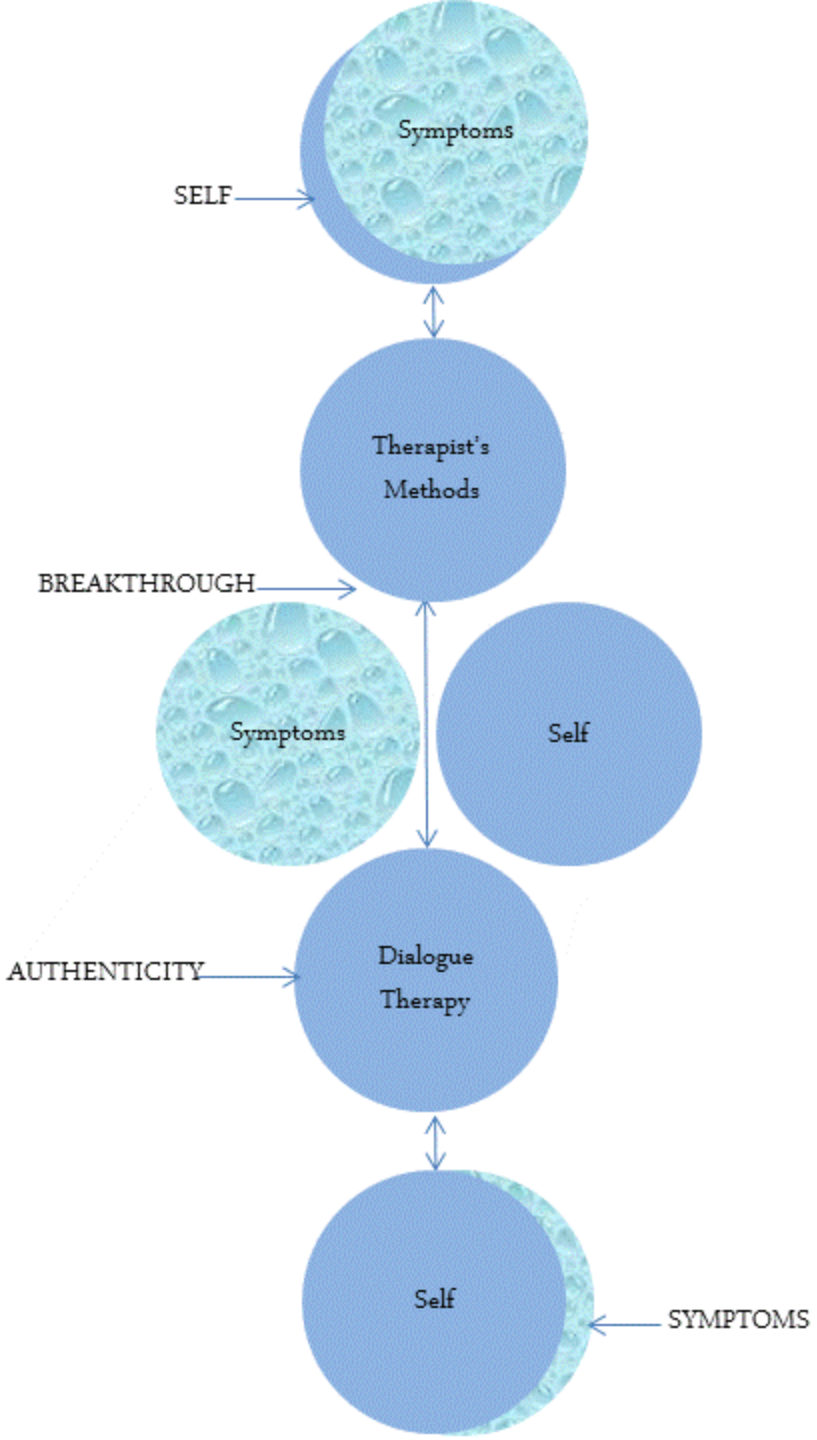

Symptoms
SELF
Therapist's Methods
BREAKTHROUGH
Symptoms
Self
AUTHENTICITY
Dialogue Therapy
Self
SYMPTOMS

Figure text:

The model in fig. 1 illustrates the patient's development of self-regulation along with therapeutic interactions in DT (Haram, 2004). The circle at the top of the model shows the patient's degree of symptoms at start of treatment. The hidden circle pictures the patient's healthy functioning. The third circle displays the therapist's total competence. The line between the two circles symbolizes the therapeutic competence in action. The two circles in the middle of the model symbolize the breakthrough, where the patients have succeeded in pushing/splitting the symptoms themselves. This step is crucial and opens for the patient's gradually co-evolving participation in the dialogue, even if voices or other delusions persist. The circle second to bottom states that psychotherapy has evolved to a stage where the patient more fully participates. Finally, the large bottom circle displays the self after changing from captivity in psychosis to freedom with self-control and direction in life. The small piece of the hidden circle shows possible remaining symptoms but that no longer are threatening to the patient.

Therapeutic Steps of DT

- initial therapeutic steps in DT put weight on creating an atmosphere of safety and predictability
- Important elements are inclusion, hope, and to invite the unique patient to a co-creating treatment process

The clinical themes and specific interventions

in the three phases of DT are specified in

tables 1-3 below

Table 1. Specific methods in the first treatment phase

Therapeutic theme	**Central interventions**
(1) Create a safe therapeutic relationship	The therapist small-talks about the situation without necessarily expecting answers to make herself/himself known and predictable
(2) Prospects of emotional knowledge	The therapist is aware of quality moments and moves along with the emotional flow or the wordless signs to promote development of emotional growth
3) Impart enthusiasm, tune in and share language	The therapist tunes into contact with compassion, enthusiasm and empathy, shares language, varies tone of voice and tonality, is doing small-talk and asks questions about what comes up in therapy, invites to dialogue and collaboration
(4) Authenticity and give response	The therapist seeks resonance, themes and ways of relating oneself, is authentically committed, and gives responses along the way in words and in body language
(5) Reduce mystery and fear	The therapist assists the patient to sort out mix-ups in the chaos of psychosis, giving small-talks and summing up to reduce confusion and mystery, increase safety and calm down the patient's fear
(6) Compliment improvements and give hope	The therapist thinks and communicates prospects of improvements, nourishing hope and opportunities, and in this fashion seeks to increase the patient's sense of freedom and safety

First stage of DT

- the therapist uses emotional presence to take hold of good moments in locating the appropriate contact and meeting point with the patient
- being aware of signals and utterances, meet shifting needs - using interventions such as *small-talk* and *reflecting activity*

Illustrations of therapeutic talks

«I’m glad you decided to meet me here today, even if it’s hard for you to talk; you don’t know me yet and the entire situation can be experienced very intimidating to you; would you like that I start and talk about my experiences as your therapist so that you can get a little familiar with me?; you don’t have to answer me if you don’t feel it naturally; how does that sound to you?; I see how you struggle and understand it might be difficult to find your own voice in the chaos, but you are doing so well, we’ll figure it out together.»

Movements in DT

- the therapist seeks emotional resonance, themes and ways of relating in being authentically, truly engaged
- central is the importance of intuition, emotional resonance of an experience together with shared understanding and reciprocity

Reclaim a lost or deficient self

- encouraging the patient along the way in words and in body language, emphasizes to use the patient's language
- exchange a variety of perspectives to help the patient sort out misunderstandings caused by symptoms from the psychotic world

Demystifying frightening symptoms

- the therapist assists the patient in seeing connections between psychotic symptoms and real life-events, to reduce fear
- signalize a strong belief in the patient's ability for change to restore health and have an enduring open eye for different methods that might be better

Clinical vignette: *“When admitted, I was trapped and left alone, which was completely the opposite of what I needed. Psychiatry stops asking questions when you’ve got a diagnosis like schizophrenia.”*

Humility for the unknown

- the therapist shows humility for unknown elements, and puts weight on creating an atmosphere where new opportunities are welcomed rather than restricted
- visualizes prospects of improvement, nourishing hope and reinforce what works now and has worked before to increase the patient's sense of freedom

Table 1: Baseline demographic characteristics for patients in Dialogue therapy and Standard treatment

	Dialogue Therapy (n=54)	Standard Treatment (n=54)
Age, Mean (SD)	29.4 (10.3)	27.9 (9.6)
Female	23 (43 %)	23 (43 %)
Diagnosis (ICD 10)		
Schizophrenia (F20.0-9)	24	24
Paranoid Psychoses (F22.0-9)	10	10
Acute Polymorph Psychoses (F23.0-9)	5	5
Schizoaffective Psychoses (F25.0-9)	5	5
Bipolar Affective Disorder (F31.0-9)	5	5
Severe Depression with Psychotic Symptoms	5	5

FIGURE 1. GAF SCORES AT BASELINE AND FOLLOW UP FOR PATIENTS IN DIALOGUE THERAPY AND STANDARD TREATMENT

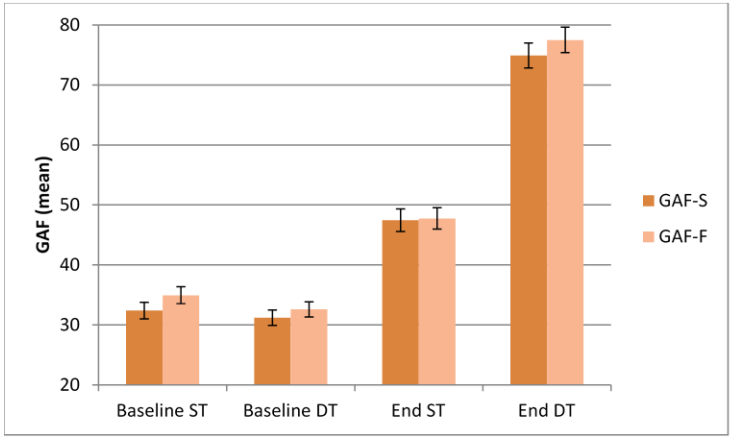


Table 2: Changes in GAF scores over the treatment course in Dialogue therapy and Standard treatment

	Baseline		Follow-up	
	Dialogue Therapy	Standard treatment	Dialogue Therapy	Standard treatment
All patients (n=108, 54 in each treatment group)				
GAF-S, mean (SD)	31.2 (9.3)	32.4 (10.2)	74.9 (15.2)	47.5 (13.8)
GAF-F, mean (SD)	32.6 (9.4)	35.0 (10.5)	77.7 (15.6)	47.7 (13.0)
Schizophrenia (n=48, 24 in each treatment group)				
GAF-S, mean (SD)	26.8 (9.2)	29.5 (9.3)	75.4 (15.1)	45.4 (12.8)
GAF-F, mean (SD)	28.3 (9.6)	31.6 (8.2)	77.7 (15.5)	44.7 (13.0)
Other psychoses (n=60, 30 in each treatment group)				
GAF-S, mean (SD)	34.7 (8.0)	34.7 (10.5)	74.5 (15.6)	49.1 (14.6)
GAF-F, mean (SD)	36.0 (7.9)	37.6 (11.4)	77.3 (16.0)	50.7 (13.7)

* In both t-tests and regression analyses, at follow up, both GAF-S and GAF-F were significantly ($p < 0.001$) higher in patients in Dialog Therapy compared to patient in Standard treatment. In regression analysis, these group differences were not moderated by whether patients had schizophrenia diagnoses or diagnoses for other psychosis

Effect sizes (Cohen's d) were large; 1.8 for GAF-S and 2.1 for GAF-F.

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Effect sizes (Cohen's d) were large; 1.8 for GAF-S and 2.1 for GAF-F.

FIGURE 2. CHANGES IN GAF SCORES FROM BASELINE TO FOLLOW UP FOR TWO DIAGNOSTIC SUBGROUPS IN DIALOGUE THERAPY AND STANDARD TREATMENT

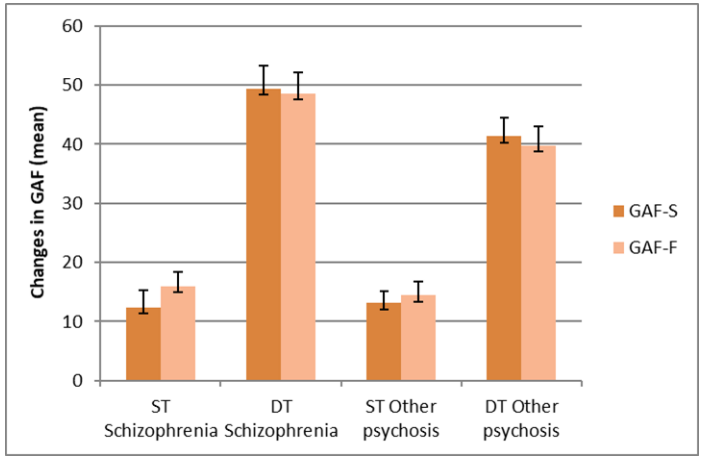


FIGURE 4. USE OF HIGH-DOSE NEUROLEPTICS AT BASELINE AND FOLLOW UP IN THE TWO TREATMENT GROUPS

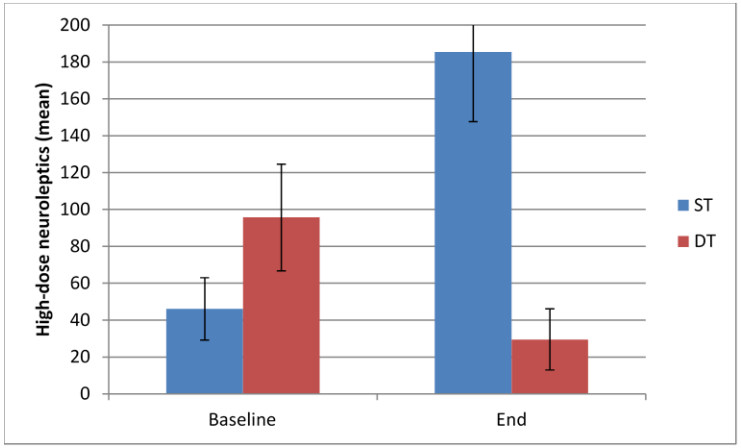


FIGURE 3. USE OF LOW-DOSE NEUROLEPTICS AT BASELINE AND FOLLOW UP IN THE TWO TREATMENT GROUPS

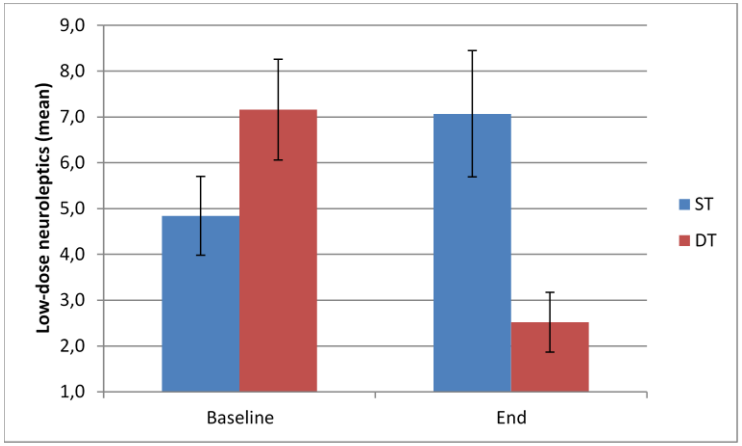


Figure 1. Schizophrenia and other Psychosis N=108 Months of Therapy

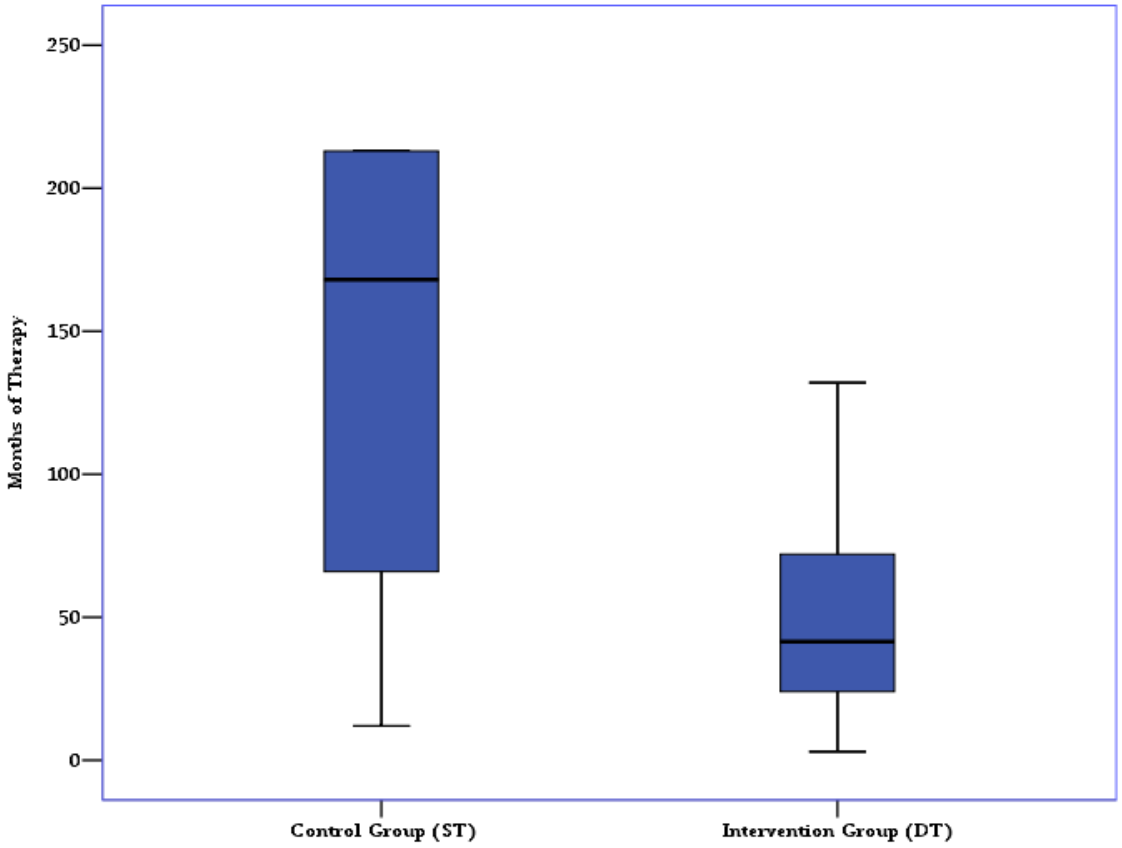
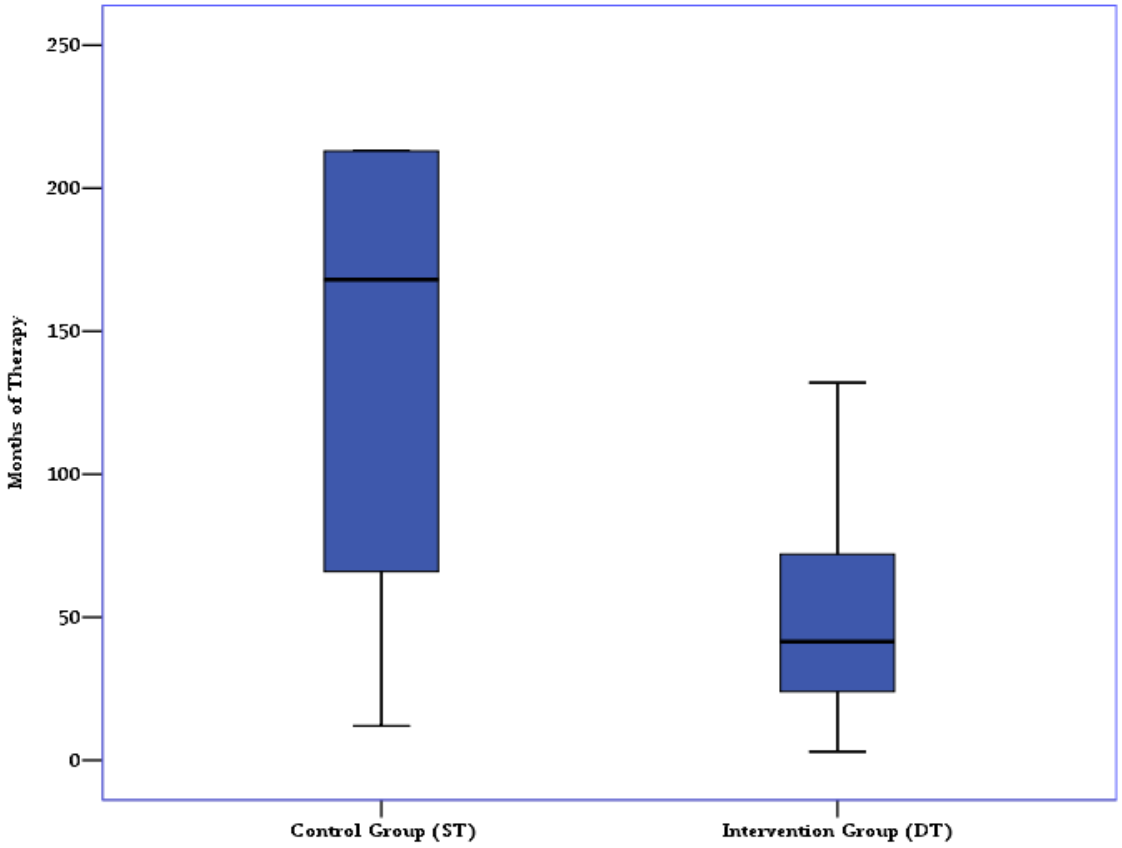


Figure 2. Schizophrenia Group N=48
Months of Therapy



Second part of treatment

- the attention is devoted to expand reciprocity and collaboration and to maintain an authentic predictable therapeutic relationship
- the patient is helped to reach a greater understanding of own feelings and thoughts to be able to control and regulate emotions, authorizing identity and self-regulation

Table 2. Specific methods in the second treatment phase

Therapeutic theme	**Central interventions**
(1) Maintain a safe therapeutic relationship	The therapist highlights confidence and a trustworthy, predictable relationship with the patient
(2) Curiosity and the therapist's entire competence	The therapist is personally and professionally engaged in parallel, and shows curiosity in asking questions along these lines; who is involved in this, when, where and how?
(3) See the whole human being	The therapist seeks contact with parts of the patient's self that are not dominated/ overshadowed by the illness
(4) Get in between	The therapist moves attention to the patient's healthy self-identity and emotions and assists the patient in generating a breakthrough/splitting, pushing the symptoms aside to increase freedom and reciprocity in the dialogue
(5) Restore the self	The therapist authorizes the patient's healthy identity and gives compliments to new and previous achievements in life
(6) Personify the symptoms	The symptoms are personified and visualized to be subjects of joint exploration in psychotherapy

A characteristic of DT

- including the patient as an active mutual participant
- providing possibilities to influence their own situation
- awaken the patient's interest to engage in dialogue
- explore new efforts on their own

Central intervention

- show *curiosity*
- *ask questions*
- widen the perspective

- let the patient's unique history and experiences influence the psychotherapy

Push the symptoms aside

- the therapist assists the patient in pushing aside the symptoms by holding firm contact with the person's healthy functioning
- the symptoms are personified, for example by calling them “ghosts”, which provides the patient with tools to differ the symptoms out and into the therapy

«LØPENDE OG SKYGGER» 1990. 167 x 210 cm.

«LANDSKAP / RYTTER» 1988. 104 x 155 cm.

Create a breakthrough

- the therapist highlights not losing sight of the whole picture of the patient, in seeing both healthy properties and the illness in parallel
- crucial is to connect with the part of the patient's self that is not overshadowed by the illness
- the purpose is to create a break-through - a splitting

Engaged in a broader dialogue

- the patient is assisted to engage in a broader dialogue in distinguishing between the alien symptoms and healthy functioning
- the aim is to help the patient feel freer and more able to push the symptoms outside themselves and split off the psychotic world

Central Concept & Methods

- a central concept in DT is authentic commitment and empathic concern
- support the patients own talents an build a sustainable relation

- an essential method is to personalize the symptoms in giving them expression in drawings, a poem, a written history or possible other utterances

Essential intervention

- twist and turn the distorted psychotic picture to make it obvious and understandable
- put light on contexts and different explanations
- in such a way promote a healing process where the patient can become free and obtain normal life functioning

Creating new and better histories and identities

- give ways to deal with contents from the psychotic world and broadening the understanding of what has happened in the person's life
- the therapist makes associations and empowers the dialogue to revise the negative influence of the patient's relationship with the symptoms

Third part of treatment

- assist the patient in a process of returning to a normal life in the family and community
- make methods become the patient's private instruments / tools

Table 3. Specific methods in the third treatment phase

Therapeutic theme	**Central interventions**
(1) Encourage independence	The therapist emphasizes to maintain a safe relationship with the patient and seeks to evolve the dialogue to a broader field of action
(2) Free from burden	The therapist offers the patient opportunities to learn from theories and methods used in the psychotherapy and develop insight
(3) Find explanations and re-authoring lives	The therapist assists the patient to search for causes and explanations for the illness and to find new histories and ways of understanding
(4) Support own power	The therapist supports the patients in developing their own efforts to find back to a meaningful life
(5) Give the patient tools	The therapist provides tools to prevent new illness signs, preserve self-regulation and mental control
(6) Return to normal life	The therapist encourages the patient to future occupations, such as starting in a new job or education or other meaningful activities in the society

The therapeutic interventions illustrated above, show ways to inspire the patients to re-think or re-evaluate their experiences in psychotherapy. The aim is to increase the patient’s insight and competence for the future management of symptoms as well as to empower healthy properties.

Evaluating changes

- invite the patient to have influence upon decision making about diagnostic evaluations and possibilities of change during the treatment process
- inform and explain the patient about theories and knowledge used in therapy
- this intends to prevent new illness after psychotherapy

Clinical vignette: *“I used four different types of neuroleptics without any real rehabilitation or improvement. In fact, I got worse. When the symptoms no longer were able to generate fear and tether my feelings, I was not so afraid as before. I felt my ability to concentrate improved.”*

Clinical vignette: *"When I managed new things in social connections you often said, how well, how did you do it, and what did you do? It was important that you as my therapist showed me that I could do something myself, and I remember how you encouraged me all the time. You took my story seriously and showed clearly that you were interested in helping me, which made a great impact on me. I suppressed my feelings and then the psychosis came over me. Life was so unbearably painful."*

Links to references

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Impact of Psychotherapy in Psychosis: A Retrospective Case Control Study
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