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Negative Symptoms and Social Functioning in Schizophrenic Patients Addressed alongside Medication by Psychosocial Interventions

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Abstract

Negative symptoms and impaired social functioning are aspects of schizophrenia that are particularly difficult to treat. Psychosocial interventions play a major part in attempting success in treating both these areas of schizophrenic illness, together with medication. Psychoanalytic psychotherapy is the form of treatment which, though long term, may potentially bring about the greatest healing accessible patients, *i.e.* those who are receptive and responsive in their communications with their therapist, a psychoanalytic psychotherapist, can achieve. Their negative symptoms, which are very resistant to treatment, may sometimes improve, and their social functioning is likely to respond eventually in most patients, particularly those who are accessible in their communications with therapists. Hard work with the patients is required to bring about both these improvements, and psychoanalytic therapeutic work must be sustained for years before its effects are clearly seen. But when progress occurs this will imply definite shifts in accessible patients' minds towards improved consciousness, understanding, awareness of other people and, eventually, a degree of autonomy. Dr Michael Robbins has identified 7 Stages of this recovery [1], though not with patients manifesting negative symptoms. CBT may be used in place of psychoanalytic psychotherapy but is less effective in the long term, both for negative symptoms and social functioning. Cognitive Remediation Therapy (CRT) and Social Cognition and Interaction Training (SCIT) are, however, particularly effective forms of CBT. Psychodynamic group therapy, family therapy, and anticipatory skills training may all be used as adjuncts to psychoanalytic psychotherapy, with good effect. Need-Adapted treatment is quite effective for improving social functioning in milder forms of schizophrenia, but only within the family [2]. Negative symptoms respond less significantly well to all forms of treatment than social functioning, which may improve with adjunctive therapy once the underlying illness has been addressed with psycho-

analytic psychotherapy.

Keywords

Schizophrenia, Psychosocial Interventions, Negative Symptoms, Social Functioning

1. Introduction

The pathogenesis of schizophrenia commonly involves prodromal dysphoria. Negative symptoms, *i.e.* avolition, anhedonia, asociality, alogia and blunted affect, may be a consequence of this state of mind, or reflect a common aetiology. Psychoanalytic psychotherapy and CBT may be used to counteract negative symptoms alongside medication with varying success. Motivational interviewing does not help negative symptoms but may help social functioning. Schizoaffective and paranoid schizophrenic patients are those most accessible to psychotherapy, their forms of schizophrenia responding best to their therapist.

Psychoanalytic psychotherapy is known to be sometimes successful in resolving schizophrenia in accessible patients, those with negative symptoms less so than those with positive symptoms. Different techniques are used, depending on the patient's stage of recovery from the illness. Early in therapy the patient may only be able to connect with difficulty with the words her psychoanalyst is presenting to her. It has been stated that a mental state examination should be done every 5 minutes when treating a schizophrenic patient with analytic therapy so that psychotic symptoms may be appropriately managed. Later, the recovering patient may be treatable almost like any other patient suffering from milder, though significant, psychological difficulties. CBT tends not to be successful in the long term for treating schizophrenic illness, but CRT and SCIT may help some patients' functioning.

Social functioning may improve with specific treatments, especially after positive and negative symptoms have been resolved as far as possible, with the best outcomes resulting from psychoanalytic psychotherapy. Social skills training, anticipatory skills training and family therapy are the most successful specific treatments here. Need-Adapted treatment, developed by Yrjo Alanen and colleagues in Turku, Finland [2], improves patients' social functioning, but only within the context of their family and with other families which have a relative with schizophrenia, in a wider community. The experience of negative symptoms has been documented, but improvement in reducing them and in the patient's social functioning requires a long period of intensive treatment.

2. Discussion

Psychoanalytic psychotherapy is the most effective therapy for schizophrenic patients found to be accessible during conversation with them, but requires a heavy

investment in clinical expertise, time and financial resources. Patients with negative symptoms tend to be less accessible in response to therapy than those with positive symptoms. One psychoanalytic technique practised by psychoanalysts is effected by the psychoanalyst producing an ambience of kindness, cheerfulness and interest through a continuum of kind, cheerful and interested words, in a kind tone of voice, in the consulting room with the analysand (the patient). The patient's mind, stultified and poorly responding due to her negative symptoms, for example avolition and alogia, latches on to some of the words, and speaks. His or her words are analysed by the psychoanalyst, which shapes the continuing ambience of kind words and kind tone of voice so that the patient's mind is stimulated from its negative symptoms, and begins to think: the patient can in due course join in the conversation with the analyst, Stage 2, Engagement, of Dr Michael Robbins' 7 Stages of recovery from schizophrenic illness using psychoanalytic psychotherapy [1]. Thus, the patient with negative symptoms may be stimulated. These patients respond less well to psychoanalytic psychotherapy than those with positive symptoms; Dr Robbins worked with paranoid schizophrenic patients who had positive symptoms. Further sessions in the long term continue to enliven accessible and responsive patients, who can then access his/her memories and experiences, and think about their own self as a person. This develops during ongoing therapy with the analyst's evenly suspended positive regard and his cheerfulness and kindness, and eventually this may produce self esteem in the patient. If she responds well, this process ensures that her insight gradually improves due to contact with the psychoanalyst's perceived warm and engaging personality and communications. She achieves better interaction with him, thus increasing her self-confidence, and more appreciative perceptions of the world around herself. These influences reduce their negative symptoms in accessible and responsive patients; the patient, unconsciously, increasingly accesses within herself what Freud identified as her life drive, *i.e.* her unconscious personal resources of natural energy; and she overcomes her inertia and negative symptoms with active responses and in due course, initiatives.

Cognitive Behaviour Therapy (CBT) is practised through gaining access to the patient's cognition and encouraging her to perceive and think differently towards fresh goals. Psychoanalytic psychotherapy, by comparison, makes contact with the deepest parts of the patient's mind, and makes changes at this level in the patient's experiences of themselves in their own life, and of other people who they may relate to only with difficulty. Cognitive behaviour therapy aims to resolve the patient's practical difficulties through communicating with her cognitively. Negative symptoms, particularly avolition, anhedonia and asociality, may result from longstanding beliefs. Cognitive therapy addresses these beliefs by replacing them with a new set of goals [3].

Goal-directed cognitive therapy, devised by Aaron T Beck [4], constructs plausible long term goals, then short term goals. An extended period of specific, direct questioning to access the patient's goals may be required. Difficulties may be en-

countered, for example apathy, an extended time frame, repeated questioning, and all of these requiring much patience; open-ended questions may need to be followed by direct, closed questions, in helping the patient to identify her chosen goals. Thus, her negative symptoms, in particular her avolition, asociality and her anhedonia, which are most likely to change as a response to treatment, are addressed cognitively [3].

But this is an experience which depends on memory to be effective, and negative symptoms in schizophrenic illness afflict cognitive function so severely that memory is poor, limiting goal-directed cognitive therapy's efficacy. Trials by Rector and colleagues [5] and Sensky and colleagues [6], showed cognitive therapy to cause significant reduction in negative symptoms, but only a 9-month follow-up period was studied in each case. Similarly, Turkington and colleagues [7], studied negative symptoms treated by cognitive therapy and found these to be reduced, but only a 5-year follow-up period was studied [3]. By contrast, psychoanalytic psychotherapy for schizophrenia is practised over a far longer period, commonly 5 - 9 years, but when successful enables the patient subsequently to live thereafter a largely independent life. There have been no studies of CBT followed after an interval by psychoanalytic psychotherapy.

Cognitive Remediation Therapy (CRT) may be an exception to the somewhat temporary benefit of other forms of CBT. Cognitive impairments in schizophrenic patients, such as are notably found with negative symptoms (avolition, asociality and alogia) have, among other consequences, the effect of being rate-limiting factors in social functioning. They also affect work performance [8].

It has been found that due to this association between cognitive impairment and vocational disability remediation of these cognitive deficits improves social and vocational outcomes. Cognitive remediation through using simple computer-based cognitive exercises, and achieving more complicated problem-solving, causes patients to employ cognitive processes that otherwise they would avoid, and so in this way reversing learned non-use. Thus, actively exercising their cognitive functions appears to facilitate use-dependent cortical reorganization. The social functioning of patients with negative symptoms may thus be improved by intense application of cognitive exercising; the ground work of improving cognitive functioning may help patients' alertness in recognizing emotional facial expressions as demonstrated in psychological testing, for example, and this may then be observed in successful interpersonal interactions [8].

Social Cognition and Interaction Training (SCIT) may also facilitate social functioning in patients with negative symptoms. In schizophrenia, the ability to adaptively infer the thoughts and feelings of others, *i.e.* social cognition (seen as mentioned above, in the context of elementary facial emotional recognition during psychological testing, which is usually adversely affected) is strongly associated with community functioning [9].

SCIT, a form of CBT, improves social cognition as a means of improving outcomes of social functioning in people suffering from schizophrenia. It has three

phases: emotion training; "figuring out" situations; and integration. Emotion training is carried out by 1 or 2 therapists over 24 weekly sessions each lasting 50 minutes. It provides information regarding the patient's emotions and their relationship to thoughts and situations; defines basic emotions; and improves emotion perception. Patients are then encouraged to "figure out" situations, and then integrate this learning from SCIT by putting it into practice in their daily lives. The effects of SCIT can help patients engage emotionally with other people, with improved interactions [9].

Motivational interviewing may reveal the schizophrenic patient's potential regarding his or her social functioning. The patient's potential social rapport may be evidenced by her readiness to engage with the motivational interviewer. In motivational interviewing, goals are identified by the patient. The therapist's technique is to enhance the patient's choices, finding reasons and advantages to support the patient's perspectives. Fresh options or new choices are not introduced by the therapist. Encouragement, confidence-building, and reinforcement of the patient's plans are intended to help the patient become more active, thereby overcoming her negative symptoms. However, schizophrenic patients are found during psychological testing to be unable to improve their performance at doing tasks; motivational therapy does not significantly help schizophrenic patients' negative symptoms, which impede their practical functioning, but may help their social skills.

As mentioned, schizophrenic patients, especially those with negative symptoms, may not be able to progress very far in doing practical tasks, ("improve their performance"), but if their confidence can be developed by other psychosocial approaches, for example by encouraging them to join a psychodynamic community group, then they may benefit more from motivational interviewing and find a modest but entirely acceptable milieu for themselves through making friends. Psychodynamic group therapy enables individuals who may be suffering from different psychological deficits to bring these to mind and share them, so that they themselves can learn fresh ways of managing them. The patients in a group volunteer personal views which the group may each consider, and then in a social and coordinated way share these so that the other group members may consider them and then discuss them together.

Other psychosocial approaches which may improve social functioning in addition to psychodynamic group therapy and motivational interviewing as mentioned above include social skills therapy, anticipatory skills training and family therapy, as well as psychoanalytic psychotherapy and CBT. Need-Adapted therapy (Alanen, 1997) is practised in Turku, Finland. It does not specifically help negative symptoms in schizophrenic patients, but does improve their social functioning.

The maximal level of improvement in social functioning achievable through psychoanalytic psychotherapy and CBT is not usually observed before these treatments are completed. Steps towards this may however be observed during a pro-

longed treatment such as psychoanalytic psychotherapy; the patient may be keen to try out and experiment using some of the improvements she has discovered in herself due to her therapeutic progress. She may make friends during the course of her treatment. CBT, except for CRT and SCIT as described, does not involve her emotions as much as psychoanalytic psychotherapy and so her affect, involving such qualities as kindness, patience, generosity and friendliness, all involved in social functioning, does not develop in a practical way with most CBT as much as with psychoanalytic psychotherapy.

Need-Adapted therapy, a social psychotherapy, is tailored to a patient's needs, but through the family's needs as a whole. It helps the whole family and not simply the ill patient. The afflicted families join a community of similar families, and undergo socially facilitated growth and development. Patients' social functioning improves with the family's functioning, but not as independent individuals outside their families.

Family therapy may help younger patients with schizophrenia, which in this age-group is commonly that with negative symptoms, to function slightly better in their family, and their family more so in coping with them. This needs careful observation to discern whether the family is essentially well disposed towards the patient, or not. If it is not, then, the treatment centre must arrange alternative management, for example, in a hostel, where teenagers may progress, or long term in a sheltered community centre for recovering schizophrenic patients similar to those that exist for Downs Syndrome patients. It is not known how much schizophrenic patients may potentially improve in the years following therapy, because this situation is too uncommon to be clear; Downs Syndrome patients may recover socially to a remarkable extent, previously not expected at all.

Social skills therapy commonly achieves considerable progress for the schizophrenic patient in encouraging her to utilize good and rewarding features of her own personality, of which she may be aware and enjoy in small measure from her contact with other people. The more she can extend development of her ability to engage with other people, due to her social skills therapy, the better her social functioning will become.

Anticipatory pleasure skills training is sometimes given to schizophrenic patients, and helps them appreciate more the available pleasures that they may have access to, improving their anhedonia. If they are shown how to enjoy their life the deeper parts of their personal psyche may develop in a psychologically positive direction; even with negative symptoms this treatment may access whatever elements of personality remain with the patient. Sir Aubrey Lewis in 1967 quotes a young man aged 18 with severe negative symptoms who writes extremely lucidly about his profoundly distressing negative symptoms:

> "I am more and more losing contact with my environment and with myself. Instead of taking an interest in what goes on and caring about what happens with my illness, I am all the time losing my emotional contact with everything including myself. What remains is only an abstract knowledge of what goes

> on around me and of the internal happenings in myself… Even this illness which pierces to the centre of my whole life I can regard only objectively. But, on rare occasions, I am overwhelmed with the sudden realization of the ghastly destruction that is caused by this creeping uncanny disease that I have fallen a victim to… My despair sometimes floods over me. But after each such outburst I become more indifferent, I lose myself more in the disease, I sink into an almost oblivious existence. My fate when I reflect upon it is the most horrible one can conceive of. I cannot picture anything more frightful than for a well-endowed cultivated human being to live through his own gradual deterioration fully aware of it all the time. But that is what is happening to me." [10]
>
> (Reproduced by permission of Taylor and Francis Group)

If he had received any intensive treatment at all it is entirely possible his hidden and attractive-sounding personality could have been accessed and retrieved. Anticipatory pleasure skills training is one of the finer and more subtle psychosocial interventions for schizophrenic patients, and would almost certainly have improved the social functioning of this patient, for example, especially following any of the interventions described herein and with carefully tailored medication. Schizophrenia is so severe a mental illness that achievement of anything approaching normality will always require intensive treatment for a long period of time. Long term maintenance and improvement in the patient's life will, through knowledge and treatment of the ongoing physiological, psychological and emotional processes of the illness, require long term interventions that are coordinated effectively. If these are tailored to the individual patient they may potentially bring about some social relief for the patient to enjoy.

3. Conclusions

Negative symptoms are difficult to treat. Medication is always required, and when carefully prescribed will assist psychotherapy during many years of intensive work to achieve successful emergence of the patient's personality. The young man whose predicament with negative symptoms has been quoted above is likely, it would appear, to have responded to any psychological intervention at all; he was entirely accessible. Psychoanalytic psychotherapy for all patients and especially those with negative symptoms is slow to be effective but its good results commonly benefit the patient for the rest of her life. CBT takes less time to achieve its best results, but it is possible that progress may tend to fade if the cognitive memories reached by the patient are no longer retained: although changes in cortical reorganization as proposed in SCIT (see above) may be an exception.

Social functioning helps the patient, when effectively interacting with other people, to feel more confident and able to achieve worthwhile personal attainments in her life. If this quality of life can be experienced by her she will feel that she is overcoming the heavy restrictions of her severe illness. By no means is this level of functioning to be expected after therapy; very few patients have reached

it. But this is because very few schizophrenic patients have been treated with this degree of intensity. A proof of concept study is needed to ascertain what is possible from psychoanalytic psychotherapy among this patient population. If details of optimal therapeutic technique for schizophrenic patients' recovery are established during a proof of concept study this would open the door for more patients to find some peace and solace from their terrible suffering. Intelligent patients such as University students are among those who have already been studied. A pioneer of this treatment, Dr Michael Robbins, chose to treat a very debilitated schizophrenic woman, Sara, who was beset with hallucinations, delusions and odd behaviour, because she was "intelligent and had a wide vocabulary" [11]. She entirely recovered in his care with psychoanalytic psychotherapy and medication. The young man quoted above with negative symptoms is likely to have responded very well to carefully prescribed medication and skilled psychoanalytic psychotherapy. A proof of concept study would resolve questions of suitability for patients most likely to be helped; it could provide details of optimal therapeutic techniques including medication prescription, and the lengths of treatment that may be required for the best results possible in this selected patient population.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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