

Psychodynamic contributions to early intervention in psychosis

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Abstract This article considers the contribution that psychodynamics can make to the work of teams providing early intervention in psychosis. Psychodynamic understanding enriches the stress and vulnerability psychosis model; can contribute to resolving the issues involved in relapse prevention; informs individualised formulations; and can make sense of patients' reactions to prescribing in psychosis. A rationale is given for longer-term individual, group and family dynamic psychotherapies within early intervention teams.

Teams for early intervention in psychosis, assertive outreach and crisis/home treatment are three cornerstones of the UK modernisation of clinical adult mental health services.

The framework for services providing early intervention in psychosis was set out in the *Mental Health Policy Implementation Guide* (Department of Health, 2001) and early intervention teams now operate in many UK trusts. In its foreword, the policy implementation document states 'This is a guide not a prescription' (p. 3) and it actively encourages local flexibility in creating the settings and circumstances in which teams improve the chances that a young person who has experienced their first episode of psychosis will return to a meaningful life of relationships and occupation.

This article offers an introductory illustration of how psychodynamics can contribute to the work of early intervention teams by improving their understanding of patients and families and informing interventions. References are given to more extensive clinical and theoretical accounts.

Early intervention services in Scandinavia

Early intervention in psychosis has a much longer history in Scandinavia than in the UK. Psychodynamic and systemic understandings of psychosis are often routinely incorporated into a needs-adapted and family-dialogue approach to treatment, with encouraging results (Alanen, 1997; Cullberg *et al*,

2006; Seikkula *et al*, 2006). In some Scandinavian areas, 75% of mental health staff have nationally approved qualifications in psychotherapy (Seikkula *et al*, 2006). In the UK, perhaps because of the separation of specialist training for psychotherapy from adult and community psychiatry, psychodynamics is rarely integrated into the psychiatry of psychosis. The practices described by Garelick & Lucas (1996) and Jackson & Cawley (1992) are exceptions. This impoverishment is in danger of being carried into the new early intervention services.

The aims of early intervention

Box 1 summarises the main aims of early intervention teams and is consistent with the Department of Health's (2001) implementation guide. Services are usually aimed at people between 14 and 35 years of age. The importance of reaching patients early cannot be overemphasised. Several surveys have indicated that the usual time between onset of psychosis and treatment is 1–2 years (Johannessen *et al*, 2000: p. 213). During this prolonged period preventable psychosocial deterioration often occurs (Melle *et al*, 2004, 2006).

The stress–vulnerability model of psychosis

Practitioners in early intervention teams usually work within the stress–vulnerability model of psychosis (Zubin & Spring, 1977). Recent stresses

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Box 1 Key features of early intervention services

- Teams reach into the community so that people aged 14–35 with their first episode of psychosis receive specialist help far earlier than usual
- The teams engage in a way that supports and assists families
- To support psychosocial recovery, care coordinators with low case-loads offer a stable continuous relationship over a 3-year period
- Recovery involves developing effective relapse prevention plans with the patient and immediate friends and family
- Recovery aims to achieve a developmental trajectory of meaningful personal relationships for younger patients that involve leisure, education and work
- The teams attend to individuals' comorbid psychiatric disturbances
- Antipsychotic medication is prescribed at the lowest effective dose and there is 'zero tolerance' of side-effects
- Residential and in-patient facilities are adapted to the needs of young people, minimising trauma and stigma

in the individual's life are identified and underlying personal vulnerability clarified. The long-term aim is to maximise psychosocial recovery. This is a considerable change of emphasis from services focusing mainly on reduction of psychotic symptoms. The stress–vulnerability model is inherently dynamic, even when unconscious processes are not specifically being considered.

Protection from, and vulnerability to, psychosis stems from complex interactions of biological and formative experiences (Tienari *et al*, 1994). Listening to the patient and the family from a psychodynamic perspective can contribute considerably to further clarification of the very personal nature of 'toxic' stresses. It is important to identify emotions that have previously overwhelmed the individual and are now being circumvented. Destructive urges, previous abuse and other trauma, sexual identity issues, punitive guilt, shame, loss, feelings of failure and loneliness are commonly expressed in distorted forms through psychodynamic mechanisms, especially projection. It is important to pay attention to the content of delusions and hallucinations for clues.

Gathering a full picture of the personality prior to the psychosis will inform understanding of how

stress and vulnerability have interacted in the individual. This picture can then be used as a key to recognising the psychotic mechanisms that the individual is using to avoid thoughts of particular painful or difficult issues. Vignette 1 illustrates the interrelatedness of current stress and antecedent vulnerability.¹

Vignette 1

A woman in a psychotic state was initially in denial of her pregnancy. The ward team provided a good physical environment and waited for 3 months for the prescribed antipsychotics to work. However, the woman remained seriously suicidal. She experienced preoccupations, seemingly disconnected from her pregnant state, that took a psychotic form with jumbled content that sometimes included the word alien. The specific meaning of this was not explored until a psychodynamically experienced member of staff joined the team and called a family meeting that included the patient. Shame about both the circumstances of the conception and the father of the child was the key unbearable and unspeakable dynamic for the whole family (and the staff). Once a regular, safe family setting was created to contain and discuss this very painful shame, progress was made and the psychosis quickly remitted.

The shame had immense implications for whether the family could tolerate the (alien) baby in their home or whether 'excommunication' was the only acceptable solution. These issues were easily available if interest had been taken in the content of the psychotic ideation and family context of the patient. This illustrates the importance of looking for meaning in the form and content of psychosis to identify unbearable affects and ideation in the current stresses.

Further family meetings revealed long-standing issues of shame and embarrassment. The family was from a traditional Bangladeshi background and had faced emotive intergenerational and cross-cultural issues since arriving in the UK. Being the oldest child, the daughter (pregnant with the first grandchild) had been the first to experience these issues, making her vulnerable. These factors might explain the woman's vulnerability to psychotic thoughts about an alien.

Engagement requires therapist flexibility. Therapeutic work with the family took place on the ward and then moved to the family home.

Relapse prevention in the stress–vulnerability model

An important component of early intervention is work with the patients – and those close to them – to identify early warning signs of psychotic

1. All the cases in this article are fictitious but based on everyday experience of work in a first-episode psychosis service.

relapse particular to each individual (the relapse signature). Factors that are helpful or exacerbating at such times are identified and strategies devised for implementation of ameliorating factors. Gumley *et al* (2003) and J. Smith (2004, personal communication) have demonstrated convincingly the effectiveness of such measures.

A psychodynamic assessment may complement relapse assessments made using other perspectives.

Vignette 2: relapse prevention

Tim had achieved little since leaving school, passively dropping out of an apprenticeship. He delayed seeking help when he became psychotic. He heard denigrating voices commenting that he was a waste of time. He had been bullied at school; he had no conscious memories of anyone at home speaking up for him. The psychosis settled and some potentially useful relapse prevention measures were identified. However, a psychodynamic assessment led staff to recognise that every effort they made on Tim's behalf made them feel useless. This threw fresh light on Tim's voices: he treated others as a waste of time, but disowned this knowledge of himself, and it is likely that the persecuting voices that he heard expressed aspects of that unacceptable knowledge. For relapse prevention and achievement of interpersonal functioning, Tim would need to watch out for and effectively contain both the anticipated destructive tendencies of others but – as important – those stemming from himself towards others.

Tim's case illustrates the potential complexity of relapse prevention and of care planning. It was important that everyone (the early intervention team, his family and friends and, in time, his employer) began to discuss these tendencies with him regularly to help him face them. In the prepsychotic period these issues had been destructively active but unacknowledged, leading to his increasingly impoverished and isolated life.

Psychodynamic contributions to understanding psychosis

Integration and expulsion of reality

Normal mental functioning takes into account and integrates reality. In psychodynamic terms, reality has both internal and external components. External reality refers to both inanimate and animate reality, including the reality of other peoples' minds and culturally accepted rules governing the functioning of the inanimate and animate external world. Internal reality refers to the inner world of personal emotions connected with loving, hating, sexuality, loss and loneliness, among other creative and destructive thoughts and fantasies, as well as the reality of communications from the super-ego (conscience). The

intact mind treats thoughts, fantasies, emotions and symbols for what they are.

By contrast, in psychosis, the mind does not integrate some of these normal aspects of mental and external reality. When psychogenic factors are at work in psychosis, psychodynamics conceives of the unconscious mind as trying to expel from itself aspects of internal or external reality that are too unbearable, too unacceptable or too overwhelming, so that the person carries on as if aspects of reality did not exist. For some, projection (away from the self), denial and various kinds of splitting off of reality may be a habitual way of dealing with unwelcome affects (i.e. revealing psychotic aspects of that personality); in others this only happens in overwhelming circumstances. Modern psychodynamic theory considers that both the form and the content in psychosis can be partially determined by unconscious psychological forces. This is quite compatible with a constitutional vulnerability.

Vignette 3

A woman, K., had longstanding insecurities as to whether she could make a stable relationship. She was heartbroken when someone she had fallen for did not reciprocate her feelings, and the experience exacerbated both her negative images of herself and her fears for her future, which she found very difficult to bear. After 2 weeks of inconsolable misery, K. awoke with the persistent delusional belief that she was engaged to a young lord (who had recently been prominent in the newspapers).

An understanding of psychodynamics allows hypotheses to be generated regarding the unwanted personal meaning (reality) contained in psychotic distortions. In this example, K.'s unwanted 'heartbroken' internal reality has been expelled and a new pain-free reality created (which does not, of course, correspond to external reality). She would tell the news of her (imagined) engagement in a way that consistently made others feel that they were lacking by comparison, providing evidence of some success of the expulsion of the 'lack' into others.

Freud (1924) wrote that:

'a delusion is found applied like a patch over the place where originally a rent had appeared in the ego's relation to the external world ... If this pre-condition of a conflict with the external world is not much more noticeable to us than it now is, that is because in the clinical picture of the psychosis, the manifestations of the pathogenic process are overlaid by manifestations of an attempt at a cure or a reconstruction' (p. 151).

K. exemplified Freud's insight. It required painstaking therapeutic work to make noticeable what had been going on in the weeks before the sudden onset of psychosis. Those not familiar with psychological

splitting processes in psychosis might erroneously see this apparent absence of connection with the person's life as evidence that the psychosis has a biological cause.

In psychiatry, psychosis is diagnosed on the basis of the presence of certain mental phenomena. Theory is not involved. Psychodynamics contributes to a psychological theory of some psychoses, where the unconscious aim is to eliminate or bypass the normal 'reality' of mental experience and create a new reality. In non-psychotic mental disorders reality is painfully retained and suffered. In psychosis, certain thoughts and feelings are treated not as mental phenomena with symbolic significance (meaning) but as real, dangerous 'matter' or 'things' to be dealt with by physical means.

More on psychotic defence mechanisms

This section enlarges on psychodynamic understandings of phenomena experienced by people during first-episode psychosis so that the rationale for possible approaches to treatment can be better understood.

Psychodynamic clinicians have now delineated a wider range of psychological mechanisms in psychosis than were recognised earlier. Information reaches the mind from many sensory sources – such as eyes, ears and skin – and is the product of the mind itself, in the form of thoughts and memories. If the self is threatened by that information (if it has unacceptable meaning or produces overwhelming affect) or the self has already been overwhelmed, unconscious mechanisms try to rid the self of the reality of the information, resulting in the bizarre symptoms and signs of psychosis.

The sensory and mental apparatus itself (normally sources of information) are used by the psychotic aspects of the mind as routes by which information about reality, including the 'reality' of the unacceptable thoughts and feelings, can be eliminated from awareness. Hence the vast range of scenes in psychosis: auditory and visual hallucinations, tactile phenomena, disorders of thought and ideation attributed to other minds or inanimate objects trying to force ideas back in (resulting in persecutory psychotic phenomena). These mechanisms are available to all of us in our dreams.

Some aspects of the mind and personality remain intact in psychosis, whereas others are taken over by the psychotic process. Both coexist in complex relation with one another, often competing for supremacy (Sinason, 1993), as in the following simplistic vignette.

Vignette 4

An elderly widow believed that people were trying to enter her flat through gas pipes and floorboard cracks to steal her possessions. (She could not emotionally tolerate thoughts of progressive impoverishment.) However, she went to the mental hospital to complain rather than the police station.

An important psychodynamic mechanism in psychosis is the active splitting of links between elements of information or thoughts (Bion, 1959) and (in fantasy) expelling the resulting fragments in a desperate attempt to create safety. These phenomena are called fragmentation or splitting (off) and projection. A simplified example of hallucinatory voices may clarify this.

Vignette 5

John was hallucinating – hearing others speaking in a denigrating and accusatory fashion about him. The voices started after an impulsive holiday he had taken following a row with his partner. The argument had been about John's long-standing insensitivity to his partner's feelings. On holiday he had been sexually promiscuous.

The voices may be understood as coming from an unconscious attempt to break the link and in fantasy eliminate the unbearable reality of his own thoughts that he was perhaps uncaring and self-centred. (He externalised his conscience.) By unconscious identification, the thoughts of being uncaring now projected onto the minds of others were unacceptable to those minds too; hence the 'voice persons' were trying to force the unwelcome ideas back onto him. In psychosis, such phenomena are experienced as real, in concrete external space (just as we all experience in dreams), not as internal thoughts.

Some support for this psychodynamic formulation of John's symptoms came from a psychosocial group in which John was inappropriately placed. John was very condemning towards anyone who diplomatically tried to alert him to his insensitivity to other group members.

'Benign' hallucinations

In some psychoses, hallucinations have a comforting quality.

Vignette 6

An African woman's background left her with understandable reasons to be fearful of the intentions of men and hopeless about finding a caring relationship. She filled her days nurturing back to health damaged birds. During the nights, she hallucinated a camera in her bedroom keeping guard.

Although the camera was experienced as a benign presence, the seriousness of her loss of trust and attribution of malign intent to all men should not be minimised. It took early intervention staff considerable skill to gain her trust and get her to see how this link with her past abuse was seriously limiting her adult life. She was encouraged to re-evaluate her own mind's capacity to protect herself and slowly allow some care for herself like that she offered the injured birds (with which she was identified).

The manic defence and grandiosity and denial

Both mania and grandiosity can serve defensive psychological functions in people who find certain feelings difficult to tolerate.

Vignette 7

A married woman had endured, seemingly stoically, prolonged humiliation by her husband. She could not stand up for herself or take care of her own emotional life but unquestioningly met the needs of others. Eventually she broke out of this role, becoming manic and sexually disinhibited. This behaviour might be seen as an attempt to prove that she was acceptable to men and better than other women. When the manic defence lessened, she felt more shame, humiliation and depression from her awareness of her behaviour. As might be predicted from her usual personality, she was excessively tolerant of her psychiatrist's limitations in relieving her of her depressive torment.

The psychodynamics of expressed emotion

The psychodynamic model of psychosis makes a useful contribution to understanding interpersonal processes in psychosis. For example, research has long established that high 'expressed emotion' in a household carries a greater risk of psychotic relapse (Leff & Vaughn, 1985). Family therapy that leads to containment of such emotions reduces the relapse rate.

Migone (1995) has made links between the empirical findings of expressed emotion and the three phases of projective identification. First, a family member projects unwanted or threatening mental content (e.g. guilt, inadequate feelings or fears of the criticism of other family members) onto the psychotically vulnerable individual. They criticise that person or become excessively involved to compensate for the unwelcome feelings. Second, they exert 'interpersonal pressure' (expressed emotion) so that the individual appears to fit the

projection as deserving criticism (e.g. 'She's just lazy'). Third, the individual cannot contain the projections and decompensates and/or projects it back onto the relatives, arousing further unwanted or threatening feelings.

These ideas, based on careful observations, are valuable for improving understanding of psychotically vulnerable individuals, but they are vulnerable to misinterpretation as blaming of family members.

Psychodynamic pharmacology

The judicious use of antipsychotics is a key therapeutic intervention in most early intervention services. People experiencing first-episode psychosis are very sensitive to antipsychotics, so the lowest doses necessary are used. The ideal is that side-effects are not accepted but this is problematic as only belatedly are we becoming aware of troubling consequences of longer-term use of atypical antipsychotics (Lieberman *et al*, 2005).

Many patients will not persist with medication. Rational reasons for not taking medication that has unwelcome side-effects should not be underestimated but interaction is common between the patient's objective awareness of troublesome side-effects and disturbing subjective meaning.

Vignette 8

Jack grew up with conflicting feelings about being a boy and he envied his sister, who had bettered him academically and socially. His psychosis started after he found his first girlfriend in bed with another young man. Jack responded to olanzapine but was intolerant of the weight gain around his buttocks, which fuelled his gender identity conflicts, and he stopped the medication.

Transference to the prescriber

The following vignettes show the need for alertness to transference manifestations towards the prescriber.

Vignette 9

A young Asian woman came close to death from self-immolation following command hallucinations. She came under the care of an early intervention team. For months she felt sedated through most of the day but she did not push her care coordinator for a medication review. Her psychiatrist tried to understand her prolonged tolerance of these side-effects. She revealed a fixed idea that it was the psychiatrist's intention to sedate her to keep her quiet, and she thought that complaining would be dangerous. She had been extensively abused in childhood and threatened with dangerous consequences of not maintaining silence.

Patients in the grip of a paranoid psychosis may be very suspicious of both the prescriber and the associated medications. This suspiciousness may lead to refusal to take medication or stopping it at any hint of a side-effect.

Vignette 10

A man twice allowed the doctor in an early intervention team to initiate a low dose of antipsychotic medication, but precipitately stopped taking the medication in panic at what he thought was a side-effect and fearing a catastrophic outcome. He smiled with relief when the doctor suggested a break from the 'poisons' and relaxed when the doctor recognised that his long-standing panics reflected his fear of repeating the 'falling to pieces' that he had experienced at the original onset of psychosis. Following this revelation he welcomed lorazepam and psychological help for his disabling panics (which is what he had wanted help for but – in his transference relationship with the doctor – had lacked confidence to ask).

Psychiatrists need to be alert to recognising and managing common psychotic and non-psychotic ideation that patients have about them and the medication they prescribe. Patients can feel not only paranoia about prescribed drugs; some bestow on medication magical powers to change their mental state that do not correspond to its physical properties.

Are antipsychotics always needed?

Evidence is available from Finland that, for the majority of patients, outcome in first-episode psychosis treated solely with expert psychosocial interventions is as good as that achieved with antipsychotics (Lehtinen *et al*, 2000; Seikkula *et al*, 2006). A psychodynamically plausible explanation for this is that teams containing expertise in the psychological interventions in psychosis can address the unconscious issues leading to the patient's psychotic evasive reactions and, through psychological containment, can facilitate their integration over time. The pregnant woman described in vignette 1 is an example where psychological containment and integration of shame led to remission of her psychosis.

The contribution of psychodynamic therapies

Psychological approaches such as cognitive and family therapy play an important part in the treatment of psychosis (Martindale *et al*, 2000). In this section I hope to show how psychodynamic understanding can complement and contribute to psychological

Box 2 The place of psychodynamic approaches in treating psychosis

Incorporated into generic early intervention practice, psychodynamic perspectives can:

- help in identifying psychological stressors and underlying developmental vulnerability to psychosis (especially by finding the meaning within symptoms)
- reveal the psychodynamic mechanisms operating in psychosis to avoid painful realities
- contribute to case formulation and the choice of focus for a psychotherapeutic approach
- inform the phasing of recovery and steps to tackle underlying vulnerability, thus contributing to relapse prevention
- inform prescribing by revealing the patient's subconscious beliefs about medication
- identify and contain interpersonal and institutional consequences of psychosis for family and individual staff and teams

(Johannessen *et al*, 2006)

therapies as well as offering the stand-alone approach of psychodynamic therapy in carefully selected cases. For an example of the complementary function of psychodynamics see my commentary on an article on cognitive therapy for delusions in this journal (Turkington & Siddle, 1998).

Incorporating psychodynamic approaches into early intervention

Areas in which psychodynamics can contribute to the work of early intervention services are outlined in Box 2.

A coordinator in an early intervention team will usually work with a patient for 3 years, and it is inevitable that the patient's psychotic tendency to avoid thinking about difficult or limiting aspects of their life will affect this work. Since a key objective is to help the patient to engage in as full a life as possible, mindfulness of the psychodynamics of the ongoing relationship is vital, whatever therapeutic modality is used.

An experienced psychodynamic practitioner can facilitate team discussions on case formulation, helping to incorporate psychodynamics and an understanding of the evolving relationship between the team and the patient and/or family. National guidelines on the treatment of schizophrenia (National Institute for Clinical Excellence, 2002:

p. 13) recommend this as a principle of good practice. Such meetings can minimise maladaptive defences that often arise in teams working with psychosis (Hinshelwood, 2004). Professionals are often aware that their own feelings and reactions are important sources of information about patients, but they may lack a setting that legitimises voicing and thinking about such reactions.

Vulnerable personalities

The Department of Health's (2001) policy implementation guidelines do not adequately consider the therapeutic resources for the underlying personality vulnerability in psychosis. Some patients respond well to a care coordinator's regular sensitive contact and assistance with mastering a range of anxieties, engagement in confidence-boosting activities and relationships, and linking them with resources that aid educational and vocational development. These individuals are responding to the non-specific therapeutic ingredients of psychotherapy (Paley & Shapiro, 2002) that engage and strengthen non-psychotic aspects of the personality. However, many patients do not respond and continue to be hampered by the pull of psychodynamic psychotic activity. This may be 'silent': missing sufficient appointments so that nothing changes, secretly not taking medication, rarely going out, procrastinating and avoiding help in managing.

Many staff in early intervention services, including psychiatrists, have little training in therapies that attend to the vulnerable personalities and relationship difficulties preceding psychosis. Unrealistic expectations can be made of them unless such training needs and inexperience are recognised. The need becomes particularly clear after the patient's psychosis has settled. Instead of reducing contact at this stage (as in traditional services), care coordinators in early intervention teams are expected to engage with patients in improving the quality of their lives and relationships. In the continuing development of early intervention services, attention should be paid to equipping staff with the skills needed to provide longer-term individual, group and family psychodynamic therapies adapted for people whose personalities make them vulnerable to psychosis. This is an area in which little research has been undertaken, a situation that must be remedied (Simonsen, 2006).

Individual psychodynamic therapy

Resources for psychodynamic therapy have been incorporated into many first-episode services in Scandinavia. In recent decades there have been

substantial developments in understanding psychodynamic psychotic mechanisms and recognition of a need to adapt standard technique substantially if patients are to be well engaged in psychodynamic therapies. Many misunderstandings result from lack of awareness of the developments in psychodynamic therapy specific to work with psychosis, and I recommend the following sources of information.

The specific qualities needed in psychodynamic therapies for people vulnerable to psychosis have been summarised by Gabbard (1994). Lotterman (1996) has described with clarity the techniques used in clinical situations encountered in dynamic therapy with patients with schizophrenia. Cullberg (2006) gives a masterly account of the integration of psychodynamic approaches with understandings from other disciplines in psychosis. The writings of Jackson and Robbins are replete with clinical material from their extensive psychoanalytic experience (Robbins, 1993; Jackson & Williams, 1994; Jackson, 2001).

Recent research from Denmark provides some evidence of the potential superiority of supportive psychodynamic approaches over treatment as usual even after just 1 year (Rosenbaum *et al*, 2005). More substantive differences would be expected after a longer interval. Careful reviews of the research literature from the 20th century indicate that, although short-term outcome studies do not reveal impressive results, the effectiveness of psychotherapy increases when longer-term studies are reviewed and indicators of the quality of therapy are included (Karon, 1989; Gottdiener & Haslam, 2002).

Dynamic and interpersonal group therapies

People with psychosis often lose, to varying degrees, their capacity to form meaningful interpersonal relationships and tend to become more isolated and withdrawn. Many had limited interpersonal skills before the onset of psychosis. Group therapies have been shown to be of value, but need to be carefully structured and graded according to a number of factors, including the phase of recovery. Kanas (2000) has produced a useful account of such approaches, together with research evidence.

Psychodynamic family work

Few families ask for family therapy. However, an understanding of psychodynamics and systemic approaches can usefully be brought to family meetings in which the aim is to understand the stresses and strains families face, improve communication and improve containment. Initially, the professional

should be concentrating less on educating the family about psychological issues and more on allowing themselves to be educated about the strengths and vulnerabilities of the family. Concern about blame must be taken very seriously and fully respected. Here the psychodynamic understanding of two kinds of guilt can be most helpful. Families feeling reparative guilt (concern that there may be things they could do or could have done differently) can make good use of exploratory psychodynamic family meetings. Families of people like John (vignette 5), who is pervaded by persecutory guilt, may also benefit from other family approaches (National Institute for Clinical Excellence, 2002).

Implications for psychiatrists

I hope that this article will encourage early intervention psychiatrists without training in the psychodynamics of psychosis to seek out resources to incorporate such knowledge and skills into daily practice. An appreciation of psychodynamics will increase their capacity to understand patients and their families. The nature of psychosis means that concerns are expressed in what initially appears to be a bizarre way. McCabe *et al* (2002) provide evidence that patients actively seek help to make psychological sense of their symptoms and that the current training of psychiatrists does not equip them well to respond. Lack of training may be one of the reasons why psychiatrists do not actively champion the introduction of family work into psychosis teams (Baguley *et al*, 2000). The Royal College of Psychiatrists actively supports enlarging the interface between the Faculty of General and Community Psychiatry and the Faculty of Psychotherapy (<http://www.rcpsych.ac.uk/college/faculties/psychotherapy.aspx>). If advantage were taken of the specific recommendations of that report, psychiatrists and medical psychotherapists could extend their skills and overcome the institutional impediments that currently interfere in psychosis.

Understanding of the relevance of psychodynamics to psychosis may encourage intervention teams to include (or have access to) staff with special training in the individual, group and family psychodynamics of psychosis. Their insight would complement the contributions that cognitive and family specialists of other orientations bring to such services (National Institute for Clinical Excellence, 2002) and encourage further research and audit in this area.

Declaration of interest

None.

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*Recommended further reading.

MCQs

1 Early intervention teams:

- a originated in the UK
- b focus on patients aged 40–60
- c have as their main purpose the active rapid removal of symptoms
- d do not regard the duration of untreated psychosis as important
- e aim to work with families from the outset.

2 Psychodynamic understanding:

- a helps in identifying personal significance in psychotic symptoms
- b is not of much use in clarifying underlying vulnerability
- c is contraindicated in engaging families
- d has not been associated with blaming families
- e has no relevance to prescribing.

3 Psychodynamic mechanisms in psychosis:

- a do not alter the experience of ‘reality’
- b aim to retain subjective contact with unwanted feelings
- c include repression and sublimation
- d often lead to transference and countertransference phenomena.
- e are fundamentally different from the psychological mechanisms of dreams.

4 In early intervention in psychosis:

- a teams aim to reduce the vulnerability of patients to relapse
- b it is unrealistic to aim at helping patients recover a meaningful life
- c staff are usually well trained to work with the character vulnerabilities found in their patients
- d in the UK teams usually work with patients for 5 years
- e the content of hallucinations is regarded as of no useful psychological significance.

5 Psychodynamic expertise:

- a in understanding patients is not a good practice point in the NICE guidelines on schizophrenia
- b is commonly found in early intervention teams
- c has no place in the running of therapeutic groups for people with psychosis
- d there is little clinical and theoretical literature on psychodynamics and psychosis
- e is an integral part of Scandinavian early intervention teams.

MCQ answers

1	2	3	4	5
a F	a T	a F	a T	a F
b F	b F	b F	b F	b F
c F	c F	c F	c F	c F
d F	d F	d T	d F	d F
e T	e F	e F	e F	e T