
Theses, Dissertations, and Projects

2011

The integration of ego psychological and cognitive behavioral interventions for first episode psychosis : strengthening the self and treating the symptoms

Megan Mary Czaja

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Czaja, Megan Mary, "The integration of ego psychological and cognitive behavioral interventions for first episode psychosis : strengthening the self and treating the symptoms" (2011). Masters Thesis, Smith College, Northampton, MA.

<https://scholarworks.smith.edu/theses/1061>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact scholarworks@smith.edu.

Megan Czaja
The Integration of Ego
Psychological and Cognitive
Behavioral Interventions for
First Episode Psychosis:
Strengthening the Self and
Treating the Symptoms

ABSTRACT

This theoretical study is an exploration of the use of ego psychological and cognitive behavioral interventions as an integrative treatment for the beginning phase of schizophrenia known as first episode psychosis. Schizophrenia develops as first episode psychosis in young adults who are navigating complex developmental tasks. Current research on schizophrenia treatment indicates that appropriate and prompt care following first episode psychosis improves prognosis and allows individuals to regain and maintain developmentally appropriate levels of functioning. This study was undertaken in an effort to identify the holistic treatment needs of young adults experiencing first episode psychosis.

The clinical phenomenon of schizophrenia and first episode psychosis was described. Then schizophrenia was conceptualized from an ego psychological and cognitive behavioral orientation. Treatment methods associated with each methodology were detailed and each theory was applied to first episode psychosis. The two theoretical orientations, ego psychology and cognitive behavioral treatment, were applied to a first episode psychosis case. A discussion follows which highlights the importance of utilizing interventions from both modalities to ensure treatment needs are met for first episode psychosis clients.

THE INTEGRATION OF EGO PSYCHOLOGICAL AND COGNITIVE
BEHAVIORAL INTERVENTIONS FOR FIRST EPISODE PSYCHOSIS:
STRENGTHENING THE SELF AND TREATING THE SYMPTOMS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Megan Czaja
Smith College School for Social Work
Northampton, Massachusetts 01063

2011

ACKNOWLEDGMENTS

This thesis could not have been accomplished without the assistance of many people whose contributions are gratefully acknowledged.

I wish to thank both research advisors who guided me through this process, Joyce Everett for her patience, understanding and acceptance of my choices and Jean LaTrez for motivating me, following my pace and providing me with unwavering encouragement.

Thanks to the staff at the Family Resource Center, you inspired me to take risks, taught me the importance of the relationship and allowed me to follow my bliss. This research would not have happened without your support and motivation.

Thank you also to Jason, for your consistent support, patience and partnership along this journey. Thank you for never doubting me. You and me together, we can do anything!

And gratitude towards the first episode psychosis clients, thank you for allowing me the honor of bearing witness to your tears, smiles and stories of healing and hope in the face of a storm. You can tolerate the intolerable and enjoy the whimsy of life.

TABLE OF CONTENTS

ACKNOWLEDGMENTS	i
TABLE OF CONTENTS.....	ii
LIST OF TABLES	iii
LIST OF FIGURES	iv
CHAPTERS	
I. INTRODUCTION.....	1
II. THE PHENOMENON	11
III. THEORY ONE.....	32
IV. THEORY TWO.....	59
V. DISCUSSION AND CONCLUSIONS	76
REFERENCES	98

LIST OF TABLES

Table	Page
1. CBT interventions for Specific Symptoms of Schizophrenia	73

LIST OF FIGURES

Figure	Page
1. Cognitive Model Individual with Auditory Hallucinations	61

CHAPTER ONE

INTRODUCTION

Imagine being 19 years old, after a whirlwind senior year of high school, involving arguments with parents, tearful goodbyes to peers and the last days of a summer job. You are moved into your dorm room, it is your first time away from home. You have packed your books, IPOD, that old teddy bear, and the good and bad memories you have encountered throughout your life. You are struggling to connect with any new friends. Suddenly, you are a different person and don't really feel comfortable leaving your room. At the same time it seems as though you are experiencing a lot of coincidences; it seems as though people are following you and a sense of doom creeps over your mind.

Who you once were seems to have disappeared overnight; in fact you are not even sure you exist anymore. You begin to panic and wonder if you do not exist then, how are you supposed to be like the other 19 year olds? You should be discovering life goals and growing up. Instead there are beings that are sending you messages on how to find a way to an alternate dimension in which they say you belong. You cannot go to class anymore, it is not safe and the beings may not be able to find you there. You do not want to miss the messages; the beings tell you the only way to the other dimension is to drink a bottle of cleaning fluid.

There is a knock on the dorm room door; your parents are there, along with the police and an ambulance. You are taken to a hospital, you scream, you cry you are told to take pills. You take them and go numb and the beings settle down a bit. The doctors tell you that you will

now be seeing a therapist; you must move back home and you have to keep taking the pills. The therapist tells you that you have schizophrenia, and she wants to help you recover. You are not you anymore and you do not know who you will become. You wonder: “Do I need to recover? Do I want to recover? Is it possible to recover?”

The above describes the process of a young adult developing *first episode psychosis* (FEP), or in other words, the first psychotic break and initial diagnosis of schizophrenia. It is a time of fear, disappointment, trepidation and loss. The safety the FEP client once felt is gone, along with a sense of self. However, with appropriate treatment that acknowledges specific needs of young adults, an FEP client’s chance of recovery from schizophrenia will improve and the young person will be able to re-engage with life. This study examines the treatment needs of a unique population, young adults with FEP, from a cognitive behavioral and ego psychological perspective, with an aim at developing a holistic treatment modality to help FEP clients process the experience of mental illness and learn to live despite the diagnosis.

FEP requires special clinical attention as the needs of young adults experiencing their first psychotic break are different than the needs of individuals who deal with chronic schizophrenia (Cullberg, 2006). In the 1990’s, treatment programs emerged that focused on early intervention for FEP (Compton & Broussard, 2009). It is believed that young adults approximately 18 to 26 in age benefit from specialized phase specific treatment that is designed to help young adults achieve developmental milestones as they transition to adulthood and adapt to a diagnosis of schizophrenia. Phase specific treatment programs offer a range of services including pharmacotherapy, individual psychological and family interventions, case management, group therapy and vocational rehabilitation (Addington & Addington, 2008).

Australia and the United Kingdom require the availability of programs especially designed for FEP clients (Sin, Moone & Wellman, 2005). Other countries are expanding specialized treatment as well. However, the United States does not have many programs for FEP due to the current managed care system. Many of the services offered through specialized programs; such as long term case management, and family, individual and group therapy are not paid for by insurance companies (Kuller, Ott, Goisman, Wainwright, & Rabin, (2010). Furthermore, most people cannot afford the out of pocket costs of such services Therefore, young adults who have experienced a first psychotic episode do not receive the necessary level of care that would promote high levels of recovery.

The focus of this study is to examine two treatment approaches that are applied to the young adult, FEP population. The first treatment approach, ego psychology has been given little empirical attention. Ego psychology aims at strengthening selfhood in order to enhance the understanding of the self and to increase functioning in society. On the other hand, cognitive behavioral therapy (CBT) has been highly researched and is the modality of choice by many FEP programs (Addington & Gleeson, 2005). CBT seeks to change the way individuals with FEP react to the symptoms of schizophrenia in hopes that young adults with FEP develop coping skills that will help them function in society. Many clinicians working with FEP clients utilize interventions from ego psychology and CBT on a regular basis; however, an integration of the two theories has not been clearly articulated in academic literature.

Clinical social workers have an opportunity to expand upon, develop and share knowledge about phase specific care for FEP and enhance the specific treatment that is already being provided. It seems as though clinical social workers and other mental health professionals would often be the first to encounter FEP patients across all levels of care including but not

limited to: schools, emergency rooms, inpatient psychiatric hospitals and community mental health agencies. If a social worker is aware of the importance of the phase specific care for FEP, he or she will have the opportunity to intervene in a timely manner and likely improve the client's prognosis. Furthermore, an in-depth understanding of the various methodologies to treat FEP enables the clinician to plan and implement those interventions necessary to effectively work with young adults experiencing the beginnings of schizophrenia.

This study will add to the existing literature on FEP treatment by reviewing the specific phase of schizophrenia known as FEP in conjunction with a focus on two differing theoretical orientations – ego psychology and CBT. As the following exploration of illness and healing unfolds throughout this study, the use of the healing powers of the human relationship (ego supportive psychology) and the adaptive properties of structured intervention (CBT) will take shape, leading to an integrative method that can be used to address the suffering associated with the change in perception and the loss of the self that young adults experience during a first psychotic break.

Conceptualization

Within this section the theoretical framework for this study will be discussed. As previously stated the focus of this study is on the phenomenon of first episode psychosis (FEP), the beginning phase of schizophrenia wherein psychotic symptoms initially emerge in young adults. In order to better understand the treatment of FEP, two psychological theories will be reviewed: ego psychology and CBT. These theories will be defined and applied to FEP as possible, concurrent treatment modalities.

Definition of Terms

As with any study there are specific terms that should be defined in order to enhance the reader's understanding of the phenomenon and theories. A brief explanation of schizophrenia, ego psychology and CBT will be provided in this chapter in order to orient the reader. An in-depth and expanded definition of terms pertinent to the study will be provided in Chapters Two, Three and Four.

Schizophrenia: with a focus of the first episode of psychosis

Schizophrenia will be defined in detail in Chapter two, the Phenomenon chapter. The criteria for diagnosis, epidemiology and the experience of having the illness will be highlighted. Symptoms of schizophrenia will be thoroughly explained and exemplified. Furthermore, schizophrenia will be described as occurring in phases and the phase of first episode psychosis will be the focal point throughout the study.

Receiving a diagnosis of schizophrenia is akin to being diagnosed with cancer. It is considered to be one of the most serious psychiatric diagnoses (Lavertsky, 2008). Individuals who experience schizophrenia are often stigmatized by society (Torrey, 2006). The word "schizophrenia" tends to evoke the image of a bag lady wearing layers of clothing in the middle of summer, pushing a carriage and singing to herself. This is Hollywood's version of the typical person with schizophrenia. In reality, someone with schizophrenia looks like the teller at your bank, your lawyer, the person you sit next to in class and even yourself. People with schizophrenia are average human beings who are suffering from a tragic illness that alters their thoughts and perceptions.

Many mental health professionals avoid working with people diagnosed with schizophrenia. It is not an illness that can be fully cured and small changes in a client's

functioning must be celebrated as large gains (McWilliams, 1994). Moreover, when working with an individual with schizophrenia, therapists are exposed to a raw, primitive, frightening and sad form of human functioning and a therapist may fear of losing her own connection to reality (McWilliams, 1994). On the other hand, great joy can be experienced when specializing in the practice of therapy with people diagnosed with schizophrenia. Joining someone on a journey of discovering the self is a gift and it is a privilege to watch someone grow from a complete breakdown of the self to a person with hopes and dreams.

Work with the FEP population is particularly rewarding because it is an opportunity to help young adults adapt to the diagnosis of schizophrenia and develop the skills necessary to maintain a good quality of life. FEP typically occurs in late adolescence and early adulthood, approximately between the ages of 17 and 26 (APA, 1994). Young adults experience FEP while they are navigating a complex transition point in life. They are exploring who they are and moving on from their families. Treatment for FEP involves a comprehensive understanding of the developmental tasks associated with late adolescence and young adulthood; as well as, knowledge of family systems and treatment of schizophrenia in general. Young people who have just experienced a first psychotic break require care that will meet them where they are in life and help them take the next steps in the face of the adversity that is schizophrenia.

Theorists, geneticists, neurologists and other clinical professionals have spent decades trying to determine the cause of schizophrenia and a subsequent cure. However, there remains no clear explanation as to why one individual may develop schizophrenia over another and there is no treatment that will provide full recovery from the illness (Lavretsky, 2008). What is clear is that with the continued dedication of professionals to the pharmacological, psychological and psychosocial treatment of schizophrenia, it is possible people diagnosed with the illness may

experience recovery, go to school, maintain employment, fall in love, have families and and experience fulfilling lives.

Ego psychology.

Ego psychology is a theoretically based treatment model that provides methods of assessment and a conceptualization of psychological functioning. Ego psychology is a psychodynamic theory with origins in Freud's original structural theory (Goldstein, 1995). According to ego psychological theory, the ego is the core of the self that functions to organize and synthesize experiences with the goal of creating a stable structure of self that interacts with the external world (Goldstein, 1995; Schamess, 2008). Furthermore, the ego employs specific defenses to protect the self against overwhelming anxiety (Goldstein, 1995; McWilliams, 1994; Schamess, 2008). The type of ego functions and defenses a person utilizes indicates a developmental level of psychological functioning. Individuals with schizophrenia are conceptualized as experiencing developmentally low or primitive functioning. A person with schizophrenia has regressed ego functioning and a weak to nonexistent sense of self (McWilliams, 1994).

Ego supportive therapy is the treatment modality associated with ego psychology; thus a focus of this study. Ego supportive treatment does not have structured interventions. The therapeutic relationship is the foundation of ego supportive therapy. Interventions occur within the context of the therapeutic relationship in order to enhance client's ego strength and improve the client's functioning (Goldstein, 1995). Ego supportive treatment of schizophrenia requires the therapist to lend ego strength in order to encourage higher developmental levels of ego functioning.

This study focuses on ego psychology in conjunction with CBT because it provides an alternate lens in which to approach treatment of FEP. Ego psychology and CBT have roots in very different theoretical frameworks and the form of therapeutic interventions differ. Applying ego psychological theory to the treatment of schizophrenia allows for exploration of the non-dominant approach to treatment of schizophrenia; perhaps highlighting an alternate yet effective way to work with those experiencing FEP.

Cognitive behavioral theory.

Cognitive behavioral therapy (CBT) is also a theoretically based model that includes a method of conceptualization and a set of specific therapeutic intervention strategies and techniques. The CBT model states that difficulties in functioning occur as a result of the way people think, behave and feel in reaction to life events (Wright, Basco & Thase, 2006). Therefore, the aim of cognitive behavioral interventions to help a person react to a situation in a way that does not cause psychological difficulty. This therapeutic modality was initially established to treat depression and anxiety but has been further developed to treat schizophrenia.

From a cognitive behavioral perspective, people with schizophrenia have vulnerabilities to the illness and develop symptoms of schizophrenia when triggered by various forms of stress (Kingdon & Turkington, 2005). People with schizophrenia experience difficulties in functioning as a result of their reactions to having the illness and reactions to symptoms. Therefore, treatment of schizophrenia from a cognitive behavioral perspective involves specific interventions that alter the maladaptive reactions a person has to the symptoms of the illness.

CBT was chosen for review in this study because of its popularity and effectiveness in treating schizophrenia. Research on the efficacy of CBT has shown the modality's utility in the treatment of schizophrenia and FEP (Addington & Gleason, 2005; Kuller, Ott, Goisman,

Wainwright & Rabin, 2010). Because CBT is such a widely implemented treatment strategy for schizophrenia, it is important to continuously review the theoretical background to ensure that the theory is appropriately applied to schizophrenia treatment. It is additionally important to determine whether CBT for FEP can be enhanced through integration of cognitive behavioral interventions with other methods of conceptualization and treatment modalities, such as ego psychology - specifically ego supportive therapy.

Methodology

Within this study ego psychology and CBT will be explored as integrated treatment modalities for FEP. The purpose of the study is to closely examine both theoretical orientations, demonstrating how each may be applied to therapeutic work with FEP clients. An exploration of the two separate theories will shed light upon how the theories may be combined to create an integrated methodology for FEP treatment. Chapter Two, the Phenomenon, begins by describing schizophrenia in order to understand the illness's origins, diagnostic criteria and possible causes. The illness will be described as occurring in phases with specific attention on the phase of FEP, and the rationale for specialized care. Following the presentation of schizophrenia and FEP the study, Chapters Three and Four will address the two different theoretical perspectives: ego psychology and. The theoretical perspectives will be considered in regards to FEP and exemplified as possible treatment modalities. Chapter Five, the Discussion, will present the application of both theories to case material and discuss the applicability of both theoretical orientations through an integrated treatment modality.

Study Bias and Limitations

The most significant bias within this study is the researcher's professional dedication to the field of phase specific care for FEP. The researcher is engaged in clinical work with the FEP

population and participates in the development of services for FEP clients. Therefore, along with the review of the literature, personal experiences within the field have resulted in a subjective presentation of information. Furthermore, the researcher's theoretical orientation towards psychodynamic interventions emphasizes the utility of the therapeutic relationship. This potentially prejudices the presentation of information as a result of the author's greater understanding of and personal inclination towards psychodynamic methodologies.

In regards to limitations, this study lacks the validity of an empirical study which would provide information directly sampled from clinicians specializing in FEP treatment and/or information from FEP clients directly. This study is a review of the literature and a synthesis and critique of two theoretically based treatment approaches opposed to an empirical exploration of treatment for FEP. A lack of phase specific care is a barrier to finding a large enough sample of clinicians to report on treatment modalities for FEP. Furthermore, the vulnerability of the population presents ethical barriers to directly interviewing or obtaining data from FEP patients. However, a theoretical approach to the study of FEP treatment provides the opportunity to apply two differing theoretical orientations to the same phenomenon and describe how the methodologies may be blended to form a different style of treatment for FEP.

CHAPTER TWO

SCHIZOPHRENIA

Each day mental health care providers devote time to a diverse range of people who happen to be diagnosed with schizophrenia. Over 20 million people worldwide have the illness and their quality of life is impacted by the symptoms of schizophrenia (Silverstein, Spaulding & Menditto, 2006). Although many mental health professionals are dedicated to being present for and providing support to the people who experience the illness a general understanding of schizophrenia is lacking. As a result of the deficit of knowledge the illness is often feared opposed to understood. The definition, prognosis and general understanding of schizophrenia has evolved over time, therefore, a current understanding of the illness will aid in the evaluation and applicability of various treatment methodologies. Schizophrenia must be understood as a mental illness and a human experience.

History of Schizophrenia

Prior to the availability of set diagnostic criteria, mental illness was not always recognized. Many individuals may have suffered from the symptoms of what we now call schizophrenia prior to its recognition as a mental illness. When reading ancient literature, one might surmise that some of our ancestors were psychotic as historical accounts are filled with tales that seem to transcend reality, such as Greek legends and biblical verses. However, schizophrenic symptoms could not be diagnosed as a mental illness prior to the 19th century; simply because, no diagnosis existed.

Psychiatrists in the 1800's began to notice symptoms of what was later called schizophrenia as a mental health condition. People were observed with hallucinations, disorganized behavior and thought process, lack of insight and lack of emotion (Vahia & Cohen, 2008). This experience was thought to be a premature deterioration of the mind and at that time the illness was seen a form of early dementia. Benedict Augustine Morel called the disorder *dementia praecox*. At this point the illness was recognized as a disease of biological deficit characterized by deterioration of the mind (Lavretsky, 2008).

Psychiatry continued to develop an interest in dementia praecox, and Emil Krapelin and his colleagues worked to further identify, describe and classify this illness. Krapelin identified ten forms of the illness and defined these “as a series of clinical states that have as their common characteristic a peculiar destruction of the internal connections of the psychic personality” (Lavretsky, 2008, p.4). Krapelin additionally classified the course and onset and outcome of the illness while also being the first to distinguish between dementia praecox and manic depressive psychosis on the basis of eventual outcome. Dementia praecox was described as a permanent condition; whereas, manic depressive psychosis was episodic (Kaplan, 2008). Although his early conclusion regarding the projection of schizophrenia is now viewed as inaccurate, according to Kaplan (2008), Krapelin's work in classification continues to guide current clinical practice and research.

In 1911, Eugen Bleuler looked beyond the neuropathological lens of his predecessors and identified the psychological aspects of dementia praecox. Bleuler introduced the term *schizophrenia* to classify symptoms. Schizophrenia encompasses a condition that is often described as the cancer of mental illness and literally means; “a mind that is torn asunder” (Lavretsky, p. 4, 2008). Bleuler viewed schizophrenia as “an extension of normal personality

which could, with perseverance, be understood and ultimately provide an insight into human nature” (Kaplin, p.309, 2008).

Psychiatrists continue conducting research to further understand the symptomology, etiology, and outcome of the illness. The understanding and treatment of schizophrenia continues to evolve with the advancement of technology and theoretical understanding. However, images of deterioration and breakage described in early characterization of schizophrenia remain visible within the person diagnosed today. The mind is like a completed puzzle and schizophrenia is the breeze that scatters the pieces.

Diagnostic Criteria and Symptomology

Schizophrenia belongs to a subset of mental health diagnoses classified as *psychotic disorders*. These diagnostic categories include; schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder due to a general medical condition, substance induced psychotic disorder, and psychotic disorder not otherwise specified (APA, 1994). Although each disorder listed above includes psychosis as a featured symptom, adjunctive symptoms and appropriate interventions differ; therefore, schizophrenia is the diagnostic category of interest in this study.. Furthermore while schizophrenia is broken down to various classifications or types to be discussed further in this section, a common symptom picture persists throughout all forms of schizophrenia.

The clinical symptom picture of schizophrenia is described in the DSM-IV (1994). In order to for a person to be diagnosed with schizophrenia they must exhibit two or more of the following symptoms for a significant portion of a month for six or more months: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior. Negative symptoms such as, flattened affect, alogia or avolition must also be present for a diagnosis to be

considered. Furthermore, functioning must be impaired and mood, medical, substance induced and pervasive developmental disorders must be ruled out before diagnosis of schizophrenia (APA, 1994).

Positive Symptoms

During the *acute phase* of schizophrenia, a person may experience highly active positive symptoms such as delusions, hallucinations and/or disorganized behavior. Symptoms are labeled as positive because they add something to the person's beliefs or sensory experiences. *Delusions* are characterized as an excess or dysfunction of ideas and beliefs not based in reality (Berzoff, 2008). Delusions exceed strongly held beliefs that persist despite clear evidence of falsity. A client diagnosed with schizophrenia may experience many different themes within delusions such as persecutory, referential, somatic, religious and or grandiose themes (APA, 1994). Furthermore, delusions impact a person's behavior often impeding functioning and causing emotional anguish.

Delusions

Persecutory delusions are the most common delusion beliefs. People experiencing persecutory delusions believe "he or she is being tormented, followed, tricked, spied on, or ridiculed" (APA, 1994, p. 299). For example a person may always be alert and ready to fight because a gang is after him. Furthermore, when the individual walks down the street he may feel people are planning a violent attack against him or her. As a result of the intensity of these beliefs, a person's life may be focused on maintaining safety from harm and actions may be taken against the persecutor. School, work and social interaction may provoke intense fear and thus, be avoided.

When an individual experiences *referential delusions* he or she believes that “certain gestures, comments, passages from books, newspapers, song lyrics or other environmental cues are specifically directed at him or her” (APA, 1994, p. 299). A young woman may have referential delusions that interfere with her ability to attend high school. When boys look at her, even a passing glance she experiences them as thinking negatively about her. A quick glance indicates the boy thinks she is ugly. When she sees the same boy talking to his friends at a different time, she knows they must be talking about her. The school day is spent in discomfort as she tries to determine what is being said about her. Furthermore, the young women may often experience depression or anger in response to her beliefs.

Somatic delusions involve false beliefs or misinterpretations about the body and or physical sensations (Bowie, 2010). A person may believe they have a physical illness or experienced some bodily harm. The intensity of the delusion varies. One individual may think he is being scratched all over their arms; whereas, a different individual is terrified because he feels as his lungs are melting and his entire body will eventually disintegrate.

Delusional beliefs that contain religious material beyond the norms of an individual’s cultures are considered *religious delusions* (Bowie, 2010). For example, a person may believe her life mission is to become a God. If she does not want to fulfill this mission she must commit suicide. As a result of this belief, the person may feel she has to kill herself in order to avoid the feared task to be God.

Grandiose delusions are beliefs where one possesses a special ability or power, has accomplished something extraordinary, or has an affiliation with a person of power and prestige” (Bowie, 2010, p. 1). Someone may think his life is a popular television show and therefore everyone must want to date or be his friend and he is invincible. When a person experiencing

grandiosity emerges from acute psychosis, he may be faced with consequences of the grandiosity. A person may have spent all of his money or hurt the people he cares about by over evaluating his importance. Furthermore when the psychosis lifts a previously grandiose individual may become depressed as he no longer feels important. The disappointment of being ordinary opposed to extremely important may result in externalizing behavior such as substance abuse.

If a delusion is “clearly implausible and not understandable and does not derive from ordinary life experiences” (APA, 1994, p.299) it is classified as *bizarre*. Delusions of any of the previously described themes may have bizarre content; however delusions involving loss of control such as thought insertion, thought withdrawn and delusions of control are always classified as bizarre.

Thought withdrawal occurs when a person feels her thoughts are being taken from her mind from an outside force. For example, a man who experiences the world as seeing his thoughts and reading his mind in attempt to take over his life is experiencing is a bizarre, paranoid delusion of thought withdrawal. On the other hand, *thought insertion* is experienced when thoughts are put into a person’s mind and *delusions of control* occur when an outside force is manipulating or controlling the body’s action. A person who stops eating because she states the president of the United States is directing her to commit suicide by means of starvation illustrates bizarre delusions of thought insertion and control.

Hallucinations.

Differing from delusions, *hallucinations* are an excess or dysfunction of sensory experiences (Berzoff, 2008). Hallucinations are characterized based on the senses in which they are experienced. Types of hallucinations include auditory, olfactory, gustatory, and tactile (APA,

1994). *Auditory hallucinations* are the most commonly experienced form of uncontrolled sensory experiences (Weisholtz, Epstein, Stern, & Silbersweig, 2010). Auditory hallucinations are often in the form of voices which may severely impact an individual's ability to function. The constant sounds inside the mind makes it difficult to focus on external stimuli; thus, hindering concentration (Cullberg, 2006). Furthermore the quality of auditory hallucinations varies; sounds or voices may be louder during acute stages. Content also differs, at times voices may command action, be humorous, nagging, or symbolic.

Other positive symptoms.

Disorganization of speech and behavior are additionally associated with a diagnosis of schizophrenia. *Disorganized speech* takes the form of loose associations, tangential speech or complete incoherence (APA, 1994). A conversation with someone whose speech is disorganized may be difficult to follow as the person demonstrates an "inability to fully and coherently elaborate on any theme or topic" (Hoffman, 2010). With severe incoherence, which is described as *word salad*, it may be impossible to understand anything a person says because the words used have no connection to one another.

Disorganized behavior can occur in conjunction with or separate from disorganized speech. Disorganized behavior may present as silliness, unpredictable agitation, difficulties with goal directed behavior and activities of daily living (APA, 1994). Disorganized behavior may be sexually dis-inhibited and be observed by others as frightening or obscene, such as public masturbation or sudden unprovoked shouting (Cullberg, 2006). However, disorganized behavior is not always a threat to the self or others. For example, a person wearing multiple jackets, hats, gloves and snow boots in July may be demonstrating disorganized behavior.

Catatonia is a severe form of disorganization wherein the individual experiences motor system disturbance such as a stupor, excitability or posturing (Cullberg, 2006). People with catatonia do not react to their environment and may seem completely unaware of what is occurring around them. A person in a catatonic stupor will remain still and unresponsive when a fire alarm goes off inside the building they occupy. Additionally, if you attempt to move a person's arm and he actively resist the person may be experiencing catatonic rigidity. If he does not respond to verbal instructions to move, it is a display of catatonic negativism. Catatonic posturing occurs when a person holds an odd posture for a lengthy period of time. Catatonia also includes catatonic excitement, such as an individual excessively moving an arm around. Catatonic experiences make people seem as though they are completely withdrawn from their surrounding environments.

Negative Symptoms

Throughout the experience of acute positive symptoms an individual may also be enduring what are termed *negative symptoms* including "apathy, indifference, difficulties initiating tasks or speech, negligible emotional contact, social withdrawal and introversion" (Cullberg, 2006). Furthermore, once positive symptoms dissipate, a person with schizophrenia may continue to experience negative symptoms and lack motivation to engage in daily activities, socialize or be unable experience pleasure. The negative symptoms, which take away from the person's behavior often continue, causing despair throughout recovery from schizophrenia.

A common negative symptom that can be visually observed is *affective flattening*, an experience that renders an individual unable to express emotion through facial expression or body language (APA, 2004). A person may be excited about an upcoming vacation; however, she does not smile or show any joy. This impacts an individual's ability to socially communicate.

A person's peers have difficulty understanding the emotional state of a person with a flat affect, or perceive the affect as disinterest.

Alogia additionally impacts social communication, and is defined as poverty of speech (APA, 2006). The symptom is characterized by a decrease in thoughts and brief replies to verbal inquiry. When speaking with someone experiencing alogia the person lacks fluency or productivity in his speech.

An additional negative symptom is *avolition*, or difficulty motivating. A person experiencing this symptom will have difficulty initiating activity (APA, 2004). Although people may have the opportunities to socialize, work or attend school, they cannot encourage themselves to get out of bed and participate. The lack of participation in activities may be additionally explained by *anhedonia*, or the inability to experience pleasure (APA, 2004). People with schizophrenia may no longer enjoy activities that previously gave them joy. Therefore, people no longer attempt to engage in what once occupied their time, such as sports, school or hobbies.

Subtypes

When a person's negative and positive symptoms are first evaluated the diagnosis of schizophrenia is given subtyped as: paranoid, disorganized, catatonic, undifferentiated or residual (APA, 2004). The subtypes may change as symptoms may present differently throughout treatment. Furthermore, prognosis may be determined based upon the subtype of schizophrenia a person is diagnosed with.

Paranoid and disorganized subtypes are often the least severe types of schizophrenia and have a better prognostic outcome. The main features of paranoid schizophrenia include persecutory and/or grandiose delusions and/or auditory hallucinations that relate to the theme of

the delusion (APA, 2004). A person diagnosed with this subtype has a minimal presence of decreased cognitive functioning and impaired affect.

Delusions and hallucinations may also be present in the disorganized subtype; however, they are not centered on a particular theme. Instead this subtype is characterized by disorganized behavior, speech, flat or inappropriate affect (APA, 2004). An individual with disorganized schizophrenia may have odd behaviors or mannerisms. Behaviors associated with catatonia are not prominent in individuals with disorganized schizophrenia.

An individual who is diagnosed with catatonic schizophrenia has an illness dominated by psychomotor disturbance. The individual's motor movements may be immobile or excessive. She may experience rigid posturing and mutism. Additionally, the individual may present with *ecolalia* which is the constant repetitive imitation of words or phrases spoken by others; or *echopraxia* the repetitive imitation of the movement of others (APA, 2004). This form of the illness may be dangerous, as individuals who are acutely symptomatic may be at risk of injuring the self or others.

The final subtypes of schizophrenia are those not meeting particular criteria. The *undifferentiated* type of schizophrenia notes that an individual has experienced the positive and/or negative symptoms of the illness but does not fit the category for any of the previously described subtypes (APA, 2004). *Residual* schizophrenia indicates that an individual has experienced at least one schizophrenic episode but at the time of evaluation and diagnosis only experiences negative symptoms or mild positive symptoms (APA, 2004). Undifferentiated or residual schizophrenia may be a transition period between a psychotic episode and remission.

No matter what symptoms a person experiences or how their diagnosis is subtyped, individuals with schizophrenia have developed an illness that has left them suffering and

possibly lost from the world they once knew. In order to understand and help an individual diagnosed with schizophrenia it is important to understand why the illness may have emerged in the first place.

Etiology of Schizophrenia: A Biological Lens

Although the causes of schizophrenia are continually being explored, biological theories dominate the current understanding of the illness. Despite psychological explanations of the development of the disorder, technological advances have shown a biological foundation for schizophrenia. Biological theories do not define the cause of the illness. Instead, the theories identify the biological risk factors that predetermine the possible onset of schizophrenia (Green, 2003). Schizophrenia can be defined as a “disease of the brain” (Torrey, 2006, p. 118). Thus, examining the biological precursors to the illness requires exploration of neurological, developmental, and genetic features of the illness.

Neurological Precursors

Neurochemical analysis indicates abnormalities in particular neurotransmitters that may signify the onset of schizophrenia. Neurotransmitters are messengers of the brain. They are released from one nerve cell and bind to another (Green, 2003). Fluctuations in the neurotransmitter dopamine are correlated with symptoms of schizophrenia as observed by the impact of particular drugs on dopamine levels and psychotic symptoms (Downar & Kapur, 2008). For example, amphetamines increase the production and release of dopamine causing symptoms related to schizophrenia. On the other hand, antipsychotic medications block dopamine from binding to neurons, reducing the amount of dopamine in the brain and symptoms of schizophrenia, (Torrey, 2006). As a result of studies examining the function of antipsychotics on dopamine levels and symptoms it is hypothesized that an excess of dopamine accounts for

schizophrenia. (Downar & Kapur, 2008; McDonald & Schulz, 2009; Torrey, 2006; Walker, Kestler, Bollini & Hochman, 2004).

Glutamate is an additional neurotransmitter linked to schizophrenia. The nerve cell receptor associated with glutamate is abnormal in people with schizophrenia (Walker, Kestler, Bollini & Hochman, 2004). Similar to the dopamine hypothesis, conclusions about the relationship between schizophrenia and glutamate have been reached through the analysis of effects of drugs and antipsychotic medications on symptoms associated with schizophrenia. Drugs such as phencyclidine (PCP) cause symptoms similar to schizophrenia and block nerve cell receptors from receiving glutamate (Torrey, 2006). Medications that reduce symptoms aid nerve cell receptors in the reuptake of glutamate.

By studying the brain itself, biological risk factors have been identified. Structural and functional brain abnormalities have been discovered through the use of multiple types of brain imaging software. Magnetic resonance imaging (MRI) has demonstrated that people with schizophrenia have smaller brains (Downar & Kapur, 2008; Walker, Kestler, Bollini & Hochman, 2004). Furthermore, functional MRI's (fMRI) ; wherein, a person is completing a task during an MRI, have highlighted metabolic and blood flow deficits in certain areas of the brain that impede functioning in those with schizophrenia (Downar & Kapur, 2008). Reduced brain activity in those with schizophrenia is additionally observed during fMRIs (Walker, Kestler, Bollini & Hochman, 2004). Through the comparison of a healthy brain and the brain of a person with schizophrenia, it is clear that differences exist; thus highlighting a biological cause of the disorder.

Developmental Precursors

Developmental theorists postulate that certain obstetric complications during fetal brain development may contribute to abnormal brain structure and function. As the brain develops it undergoes a pruning process wherein excess neurons are eliminated. Many factors could cause problems during pruning and if an error occurs during the developmental process abnormalities may arise (Torrey, 2006).

Viruses in utero may affect an individual's brain predisposing them for schizophrenia later in life (Silverstein, Spaulding & Menditto, 2006; Torrey, 2006). For example, influenza during pregnancy may inhibit neurodevelopment, eventually leading to schizophrenia (Green, 2003). This theory may explain why more people with schizophrenia are born in the winter months as their mothers may have had greater exposure to the influenza virus (Torrey, 2006). Although being exposed to influenza prior to birth is a possible indicator of later development of schizophrenia, not all people who experience viral exposure develop the illness.

Other obstetric complications include fetal malnutrition and hypoxia. Malnutrition prior to birth and hypoxia prior to or during birth may contribute to brain differences in people with schizophrenia (Ellman & Cannon, 2008; Torrey, 2006). Similar to the impact of influenza on development, the complications inhibit brain development increasing the vulnerability to the later development of schizophrenia (Torrey, 2006).

Genetic Precursors

An additional biological understanding of the illness comes from the study of genetics, including the presence, absence and placement of particular genes. Family, twin and adoption studies have all noted a genetic link in the development of schizophrenia. Family studies highlight an "elevated risk among relatives of affected individuals, with the degree of risk

contingent upon the degree of biological relation to the patient” (Glatt, 2008, p. 60).

Furthermore, twin studies indicate a 60-70% chance of genetically inheriting schizophrenia (Glatt, 2008). Research does not imply that genetics are linked to causality. Instead the data indicates that a person’s genetic background makes a person more susceptible to developing schizophrenia (Glatt, 2008; Torrey, 2006).

Phases of Schizophrenia

There has been an increased interest in the development of schizophrenia and the illness has been further classified as occurring in phases. An individual will experience a premorbid, prodromal and psychotic phase throughout the onset of schizophrenia (Frudenreich, Holt, Cather & Goff, 2007). Each phase is characterized by various symptoms and has multiple treatment implications.

People start in the *premorbid* phase of the illness, wherein they do not have difficulty functioning nor experience symptoms. The *prodromal* phase usually occurs after puberty and continues for multiple years prior to a psychotic episode (Frudenreich, Holt, Cather & Goff, 2007). As the illness begins to develop and an individual moves into the prodromal phase, alterations in behavior and individual subjective experience occur (Birchwood, Fowler & Jackson, 2002). The person may appear depressed, anxious, become increasingly withdrawn and lose interest in academic or social activities. Furthermore, as the individual approaches an initial first psychotic break, cognitive and emotional difficulties may become more apparent, along with a decline in energy and ability to tolerate stress (Frudenreich, Holt, Cather & Goff, 2007).

The presence of frank psychotic symptoms indicates the end of the prodromal phase and the illness is now classified FEP (Compton & Broussard, 2009). FEP usually occurs in late adolescence and early adulthood (APA, 2004). If the psychotic symptoms associated with FEP

are not a result of substance use or a medical issue, a diagnosis of schizophrenia or an alternate psychotic disorder is applicable.

Delineation of phases has enabled the development of phase specific treatment for schizophrenia. Knowledge of the prodromal phase has heightened the interest in preventative treatment. However, intervention in the prodromal phase remains controversial because individuals would begin treatment for schizophrenia prior to experiencing psychotic symptoms (McGorry, 2002). Emphasis is additionally placed on early intervention for schizophrenia, through treatment tailored specifically to the needs of young adults experiencing FEP. In fact, mental health policies for Australia and England mandate phase specific treatment for FEP (Sin, Moone & Wellman, 2005).

Phase Specific Treatment for First Episode Psychosis: Rationale

Similar to the onset of a major medical illness, the first time an individual experiences psychotic symptoms his or her life is turned upside down. All that was once the familiar and safe is foreign, including one's own mind. The experience impacts the developing self and family relationships and produces a range of difficult feelings. Further if left untreated, FEP may quickly develop into chronic schizophrenia, causing long term difficulties in functioning. The specific impact of psychosis and subsequent unique needs of FEP clients differs from the experiences and needs of individuals with chronic schizophrenia (Miller & Mason, 1998) - thus, highlighting the importance of phase specific treatment for FEP opposed to the application of standard schizophrenia treatment to all phases of the illness.

FEP and Psychosocial Development

FEP clients are usually adolescents or young adults and in the midst of navigating complex developmental. Hence, treatment should account for the impact psychosis has on

achieving developmental milestones. Individuals in late adolescence or early adulthood use peer relationships to develop a personal identity separate from parents (Newman & Newman, 2006). Social relationships are necessary for the formation of the self, and it is a societal norm for young people to partake in interpersonal relationships (Grazebrook, Siddle, Leadley, Everitt, Benn, Haddock & Tarrier, 2004). Young adults are also exploring and establishing romantic relationships. They are learning to love and trust another individual (Newman & Newman, 2006). An interruption of the transition period, social development and interpersonal experiences results in future developmental difficulties (MacDonald, Sauer, Howie & Albiston, 2005).

Symptoms associated with FEP cause individuals to isolate from friends and have difficulty initiating and maintaining social and romantic relationships (MacDonald, Sauer, Howie & Albiston, 2005). Furthermore, relationships formed before psychosis often diminish as the person continues to socially withdraw. Isolation from friends and romantic partners “can affect confidence and the opportunities for the development of social relationships, causing a lag in comparison with one’s peers.” (Addington & Haarmans, 2006, p.44). Additionally, the presence of social relationships is correlated with high quality of life (Thorup, Petersen Jeppesen, Ohlenschlaeger, Christensenm Krarup, Jorgensen & Nordentoft, 2006). Therefore, individuals with FEP who have socially withdrawn may negatively evaluate their lives.

Phase specific treatment directly acknowledges that young adults have become disconnected from their social environment following a first psychotic break. Interventions aim at increasing the opportunities for individuals to engage in formative relationships with peers. Malla, Norman and Joober (2005) indicate that that social functioning of FEP clients increases with phase specific treatment; thus enabling young people to better meet their ongoing social needs.

During late adolescence and early adulthood an individual is either attending high school or college and is in the process of formulating further educational and vocational plans (Newman & Newman, 2006). The lack of social interactions along with the symptoms and behaviors associated with FEP hinders an individual's ability to function in educational environments and meet goals related to career development (Malla, Norman & Joobar, 2005). When FEP occurs, the acutely symptomatic individual frequently has to miss school and falls behind in academic work, causing developmental setbacks. Phase specific interventions acknowledge the impact of psychosis on educational and vocational development and aid young people in the transition back to school or into the workforce (Addington & Addington, 2008).

Relationships, educational and occupational development contributes to an individual's development of personal identity during late adolescence and early adulthood (Newman & Newman, 2006). In essence the young person is in the process of developing a sense of self when FEP occurs (Grazebrook, Siddle, Leadley, Everitt, Benn, Haddock, Kinderman & Tarrier, 2004). Psychotic symptoms interrupt this developmental process and young people struggle to determine who they are and what they will become. Phase specific treatment provides support for a young person whose quest for individuality and independence is shattered by psychosis. Treatment for FEP helps the individual develop into a "normal" young person who can achieve goals and dreams, not a "sick schizophrenic" who is doomed to a life of institutions and isolation.

FEP and the Family

Young adults experiencing FEP are more likely to be connected to their families due to their age. It is common for FEP clients to still be living with their parents and relying on them for financial support and other basic needs (Moone & Wellman, 2005). This situation differs from

those individuals experiencing chronic schizophrenia who may be disconnected from family due to an achievement of developmental milestones or long term involvement with mental healthcare. Treatment for individuals with chronic schizophrenia may minimally include the family; whereas, phase specific treatment for FEP recognizes the need for high levels of family involvement to help the directly inflicted individual overcome the experience of FEP.

Family systems theory explains that an individual's pathology impacts the whole family. What happens to one - happens to all - meaning that although one family member is actually experiencing FEP, the entire family is experiencing that person's response to the illness. Family members are connected and impacted by interactions they have with one another (Nichols, 2009). When a young adult family member experiences psychosis, interactions with parents and siblings change, altering the way the family previously functioned. The family has to adapt to the change in the individual and to a loss of relationships they once knew. Because FEP impacts the entire family, all members should be involved in treatment with the individual. Nichols (2009) stressed the family context as, "The whole is always greater than the sum of its parts" (pg. 64). Therefore, treatment will make the most impact if the focus is on the whole family as opposed to just the diagnosed individual.

When a young person first experiences psychosis, the family is likely the first a) to observe the individual's change in behavior and b) to respond to a crisis situation. Family members of FEP clients experience distress associated with FEP. Family members may have their own psychiatric difficulties or may feel burdened in response to caring for a psychotic family member (Tennakoon, Fannon, Doku, O'Ceallaigh, Soni Santamaria, Kuipers & Sharma, 2000). The family's reaction to the individual's psychosis has the potential to impact the FEP client's recovery and vulnerability for relapse

Expressed emotion (EE) in families may cause more distress to the person with psychosis. *High EE* is described as intense expression of either positive or negative emotion around or towards the individual experiencing psychosis (McFarlane, 2002). High amounts of EE have been correlated with an exacerbation of psychotic symptoms (Bebbington & Kuipers, 2008). Lowering the level of expressed emotion within the family of a person with psychosis reduces the risk of relapse. Barrowclough and Lobban (2008) indicate that high EE within families result from a lack of knowledge about schizophrenia. Families may not have experience with psychosis and therefore do not know how to help or live with the FEP client. Therefore, family interventions within phase specific care provide psychoeducation about schizophrenia, including the role of EE in maintaining remission from symptoms. Family interventions also include supportive therapy for family members of an FEP client. Supportive therapy helps the family process the experience of having a mentally ill family member and provides an outlet for any strong emotional reactions; thus, lowering the amount of EE within the family system.

Specific Risks associated with FEP

Young adults experiencing FEP have different risks than individuals who have had the illness for a long period of time. Developmental level and societal pressures make the experience of the illness different for young people causing them to respond in different ways. A FEP client may develop co-morbid symptoms of depression, anxiety and trauma in reaction to experiencing psychosis (McGorry, 2001). The development of psychotic symptoms may be experienced as a loss. Furthermore, symptoms may be frightening and subsequent hospitalization has the potential to be traumatic for the FEP person.

Young people with psychosis have higher rates of co-occurring substance use disorders (Kavanagh, 2008) A young person with FEP may initially begin use drugs to fit in with friends,

feel normal or lessen the intensity of symptoms (Compton & Broussard, 2009). Further, an addiction may have already been present before the first psychotic episode and the person continues using after the episode. Drug use is more dangerous in FEP clients because the drugs themselves may exacerbate some or all of the FEP symptoms (Kavanagh, 2008). The young person gets trapped in a cycle of substance abuse possibly developing an addiction to the drug(s) of choice. The young person uses mind-altering substances at first to feel better for a little while. However, the aftereffects often make the symptoms worse so the FEP person increases the dosage in hopes of feeling better once more. Substance abuse in FEP clients is also dangerous because it may interfere with prescribed medication or impair a person's ability to remember to take medication. If a young person is using and forgets to take medication, symptoms may rapidly return - causing more distress and possibly the need for hospitalization.

Although suicide is a risk for many individuals with mental illness, "people with psychosis are at a much higher risk for suicide attempts and completed suicide than the population as a whole." (Compton & Broussard, 2009, p.30). Risk for suicide is especially high in the early phases of the illness (Robinson, Harris, Harrigan, Farrelly, Prosser, Schwartz, Jackson & McGorry, 2009). FEP clients may feel hopeless about their life situation and experience more depressive symptoms (Heisel, 2008). Hopelessness may lead to despair that psychotic symptoms will not improve and the client may decide that taking his own life is the only way to end the discomfort. Phase specific treatment that is sensitive to the risks associated with FEP clients prevents further decomposition into to the illness or in some cases future suicide attempts.

Duration of Untreated Psychosis

Duration of untreated psychosis (DUP) refers to the amount of time a young person may be experiencing psychosis before receiving treatment (Addington & Addington, 2008).

Intervening in the early stages of schizophrenia shortens the DUP, improving the prognosis of the illness, reducing the risk of relapse while also allowing for improved social functioning and a greater quality of life (Tarrrier & Bobes, 2000). In the past, when a young person presented with symptoms of psychosis, mental health professionals would often wait before diagnosing the individual with schizophrenia; as doctors did not want to risk giving incorrect medication. The illness went untreated and the young person continued to experience psychotic symptoms. Thus, the young adult fell further behind developmentally, experienced additional stress within the family and had an increased risk for substance abuse and/or suicide.

Ongoing untreated mental illness is detrimental to the future wellbeing of the FEP client as “delays in treatment are associated with slower and less complete recovery” (Tarrrier & Bobes, 2000, p. 44). Providing rapid treatment specific to FEP clients provides young adults with the opportunity to regain their quality of life and plan for a future in spite of having an illness characterized as causing massive deterioration to the life and mind of inflicted individuals (Tarrrier & Bobes, 2000). People experiencing a first psychotic episode do not have to cease living their lives or pursuing their goals as long as they are given the opportunity for appropriate phase specific treatment.

CHAPTER THREE

EGO PSYCHOLOGY AND SCHIZOPHRENIA

Ego psychology is considered one of the four psychodynamic theories. The theory of ego psychology emerged as Freud began to shift his ideas away from his original topographic theory, which described the mind as consisting of unconscious, conscious and preconscious regions. In 1923 Freud developed his structural theory and began to refer to the mind as being comprised of three parts which are in constant conflict with one another the ego, id and superego. Anna Freud (1936) continued to expand Freud's structural theory, identifying ego defenses as adaptive and relating these defenses to particular developmental phases. At this time, the concept of the ego remained connected to the other structures of the mind; the id and superego.

Hartmann (1939) moved beyond structural theory and began to define the ego as developing separate from the id and superego. Hartmann (1939) emphasized the ego functioning independently from the other parts of the mind. As ego psychology evolved out of structural theory the notion of conflicting parts of mind was put aside and the theory focused on the

...ego's innate, conscious, rational, and adaptive capacities, the autonomous or conflict free areas of ego functioning, the adaptive role of defense, the importance of interpersonal and environment factors and the capacity for growth and change all through the life cycle (Goldstein, 1995, p.34).

The ego was now recognized as the part of the mind that organizes parts of the self into an integrated whole which interacts with the external world. Hartmann (1939) further noted the

ego's ability to adapt in order to cope with the environment, and the importance of interpersonal relationships for ego development. The ego was now thought of a positive force with functions that could be supported or built through relationships.

Within this chapter, ego psychology will be further explored. The chapter will provide a description of how ego psychology came to be its own theory and details regarding two of the main concepts associated with ego psychology, ego functioning and ego defenses. Furthermore, schizophrenia will be conceptualized from an ego psychological perspective. Ego psychological treatment in the form of ego supportive therapy will also be defined and exemplified with special emphasis on how ego supportive therapy is used in the treatment of schizophrenia. The chapter will end with an exploration into the use of ego supportive therapy for young adults experiencing FEP.

Ego Psychology: A Theory of its Own

Current understanding of ego psychology remains driven by Hartmann's (1939) notion of the ego as independent. The *ego* is now conceptualized as the "preeminent psychic agency" (Schamess & Shilkret, 2008), or the most important part of the mind. It is a theoretical construct that is defined by its functions (Cullberg, 2006). The ego functions in a way that organizes and synthesizes mental experiences resulting in a whole, stable, character structure that engages with the external world (Goldstein, 1995; Schamess, 2008). Ego psychology holds that the ego develops and changes throughout the lifespan via interaction with the external social and physical world (Schamess & Shilkret, 2008). Therefore, the focus of intervention from an ego psychological perspective considers the individual's psyche as well as his or her environment. Furthermore, because interactions with the environment can change the ego, it is now believed that through intervention the ego can be supported and strengthened resulting in increased

adaptive functioning. Before the ego psychological interventions are explored in further detail, the specific functions and defenses process of the ego must be explained.

Ego Functions

Ego functions are the means in which the ego organizes and synthesizes internal and external stimuli so an individual can adapt and function in the external environment (Goldstein, 1995; Schamess & Shikret, 2008). Ego functions should be assessed in all clients as a way to understand an individual's ego strengths and areas that need further support. Furthermore, regularly monitoring ego functions evaluates the progress of treatment. Bellak, Leopold, Hurvich and Gediman (1973) identified 12 ego functions as the major organizing principles of the mind, these include: reality testing, judgment, sense of reality of the world and of the self, regulation and control of drives, affects and impulses, object relations, thought processes, adaptive regression in the service of the ego, defensive functioning, stimulus barrier, autonomous functioning, mastery-competence and synthetic-integrative functioning. These functions will now be briefly defined including a description of how they appear when functioning properly and improperly. Furthermore, ego functions impacted by schizophrenia will be discussed later in this chapter.

Reality testing.

The ego function that allows a person to discern between fantasy life and the objective world is *reality testing*. This ego function is essential for all forms of adaptive behavior (Goldstein, 1995). Reality testing is absent during infancy but develops over time as awareness of world external to the self increases. In order to function well, a given stimulus must be perceived as internal or external. A person with good reality testing knows his ideas are within his or her own mind. Furthermore, a person may hear a voice or noise and know whether or not it

is in his or her mind or if others in the external world are having the same experience. On the other hand, individuals who experience delusions and/or hallucinations demonstrate a complete inability to engage in reality testing. A client may hear a voice that only exists inside his mind; however, he feels it is really occurring in the external environment.

Judgment.

This ego function speaks to an individual's capacity to assess situations and determine the best action to take. *Judgment* is the ability to explore decisions, anticipate and consider the consequence of the decision and discern the option that will result in desired goals and minimal consequences (Goldstein, 1995). This ego function develops as individuals practice making judgments and receive feedback from the environment regarding the appropriateness of the decision. A person who displays good judgment will not drive a car fast in an ice storm when she is late to work. A person with bad judgment will drive fast, not understand the risk of crashing the car.

Sense of reality of the world and the self.

The ability to accurately experience the world and the self is the ego function of *sense of reality of the world and self*. This ego function involves an individual's ability to feel connected to the world that is apart from her body. Furthermore, this function indicates the ability to determine that a separation exists between the self and the other (Goldstein, 1995). This ego function develops as the infant begins to experience himself as separate and unique. When someone feels as though they are in a dream or distant from his own body the ego function is considered weak. However, the ego function is strong when the person knows he has an identity separate from other people.

Regulation and control of drives, affects and impulses.

The capability to control the expression of ones impulses and feelings is the *regulating* ego function (Goldstein, 1995). All individuals experience strong feelings and have an urge to act a certain way. However, it is important to be able to tolerate feelings and stop oneself from reacting on impulse. Furthermore, it is important to not overregulate oneself as a balance must exist between control and expression of feeling and impulses. Someone who has poor regulation and impulse control will walk out of a group therapy session when a topic is difficult or the person has a desire to go outside. The individual with good control will stay in the group, waiting until the end before satisfying a desire for fresh air.

Object relations.

In order to have mature relationships with others a person must have good object relations functioning. *The term, object relations*, is defined as “the development of one’s own internalized sense of self and others and the evolution of the capacity for mature interpersonal relationships” (Goldstein, 1995, p. 60). Strong functioning in this area is indicated by the individual’s ability to have mental representations of the self and other as separate. People who are socially withdrawn and isolated have a weakness in the area of object relations. The people are unable to form relationships because they may fear losing the self by engaging with the other person.

Thought processes.

The ego function of *thought process* is a person’s ability to engage in secondary mature process thinking. In other words, thought process can be an ego strength if a person’s thinking is grounded in reality, directed towards goals and is organized (Goldstein, 1995). An individual

whose thinking regularly involves fantasies, gratifications of instincts, is illogical and has no concept of time can be identified as utilizing primary process thinking. People who have maladaptive thought processes are unable to connect one thought to another.

Adaptive regression in the service of the ego.

At times it is necessary for a person to engage in behavior associated with an earlier developmental stage in order to protect the mind from intolerable feelings. When this occurs, a person is adaptively regressing in order to serve their ego (Goldstein, 1995). It is important for individuals to allow themselves to regress as a means of coping with a difficult situation. The regression is considered adaptive if it enables the person to move forward with their task. If taking a nap provides someone with the energy to complete a project the nap is adaptive. If a person sleeps all day to avoid work the regressive act is maladaptive.

Defensive functioning.

Ego defenses are the unconscious functions an individual uses as a means of protection from intolerable feelings or frightening situations (Goldstein, 1995). Evaluating a person's ego defenses is an important part of assessment and treatment. Therefore, ego defenses will be discussed at length later in this chapter.

Stimulus barrier.

The stimulus barrier is the function that regulates internal and external activity so it does not become overwhelming (Goldstein, 1995). A strong functioning stimulus barrier will allow an individual to maintain functioning in a high stimulus environment such as a noisy restaurant. When someone's stimulus barrier is poor they may become stressed when they are trying to place an order in the loud restaurant.

Autonomous functioning.

Particular ego functions that are not impacted by conflict within the mind are considered *autonomous functions*. Concentration, memory, learning, perception and motor functions are all part of autonomous functioning (Goldstein, 1995). At times people become stressed and autonomous functioning suffers. For example, a person may experience difficulty concentrating if she worries about all the tasks to complete by the end of the day.

Mastery-competence.

People need to feel good and confident about their abilities in order to be autonomous, and experience pleasure and confidence about ones role in the world (Goldstein, 1994). *Mastery – competence* is the ability to feel good about what one does. A young adult who gets into college develops confidence in her intellectual abilities, integrates this confidence into her sense of self and demonstrates mastery-competence as an ego strength. Someone who is always putting themselves down experiences an area of ego weakness.

Synthetic-integrative function.

As previously stated one of the largest roles of the ego is its ability to organize all mental process into a whole which enables a person to successfully interact with the world (Goldstein, 1995). When an individual has a well-integrated self he or she will have a clearly defined self. On the other hand, the thoughts of individuals with poor integrative functioning are “contradictory, fragmented, inconsistent, unpredictable, or chaotic” (Goldstein, 1995, p. 70). When a person’s behavior appears incoherent they are likely internally incoherent.

Ego Defenses.

When the ego functions act as a means of protecting the mind from impulses and threats, the ego is said to be implementing defensive functioning. Ego defenses work to keep

uncomfortable thoughts and experiences out of the mind. All individuals unconsciously use ego defenses and continue functioning. However, ego defenses occasionally become maladaptive and impair other ego functioning. All ego defenses are connected to a particular level of personality development including: developmentally early defenses, immature defenses, neurotic defenses and mature defenses (Vaillant, 1992). The defenses exist along a continuum. The lower level defenses such as developmental early and immature defenses impair functioning. Neurotic defenses are less disruptive to functioning and mature defenses improve functioning (Schamess & Shikret, 2008). Although 26 major and 26 minor defenses have been identified by Laughlin (1979), what follows is a description of the major defenses usually seen in clinical practice. The defenses are grouped by their associated developmental level. Special attention should be paid to the defenses associated with the lower level of the continuum as they are associated with schizophrenia, the diagnostic category of focus in this study.

Developmentally early ego defenses.

When developmentally early defenses are active, other ego functions are negatively impacted resulting in difficulties tolerating internal and external stimuli. Some defenses are classified as *early developmental* because they have qualities associated with the preverbal phase of development and they involve difficulty with the boundary between the self and the external world. These defenses are also referred to as primary or primitive defensive functioning and are associated with psychotic or borderline personality issues (McWilliams, 1994). The functions of early developmental defenses are described and exemplified below and include: primitive withdrawal, denial, omnipotent control, primitive idealization and devaluation, projection, introjection, projective identification and splitting.

Primitive withdrawal. The ego defense that allows individuals to escape discomfort is *primitive withdrawal*. The use of this defense is similar to an infant who falls asleep to avoid over stimulation or distress. Primitive withdrawal is the isolation and withdrawal of the self into a different level of consciousness to avoid the stress of interaction (McWilliams, 1994). An example of this defense is when a person with schizophrenia is preoccupied with an internal delusional world in order to avoid interacting with the external world. A classic presentation of primitive withdrawal is a catatonic state, wherein a client may sit perfectly still and silent because they are wrapped up in their delusions as though the delusions are a movie distracting the client from daily life.

Denial. When a person has a total lack of acceptance of what they are experiencing or what is actually occurring in the external world the person is utilizing *denial* (McWilliams, 1994). For example a person with schizophrenia who reports no symptoms and therefore does not take medication is experiencing denial. By denying symptoms and not taking the medication, the client continues to believe he does not have a mental illness. The lack of acknowledgement of the actual situation enables the person to believe the uncomfortable situation is not occurring at all.

Omnipotent control. Sometimes defense functioning takes the form of a person who thinks he can manipulate the world with his or her mind. *Omnipotent control* occurs when a client has an exaggerated sense of self and feels all powerful behaving as though his thoughts control the external environment (Goldstein, 1995; McWilliams, 1994). When a client with schizophrenia has a delusion that he causes people to lose their car keys by thinking people are going to lose their keys, the client's ego is utilizing omnipotent control as a defensive function.

Primitive idealization and devaluation. This defense occurs when an individual either over or undervalues other people. When a client *idealizes* someone, the individual is making the other person more important than themselves as a means to feel safe (McWilliams, 1994). This process is similar to that of small children who believe their mothers can do anything and have superhuman powers. On the other hand, *devaluation* occurs when a client has an extreme negative view of other people. This defense may be utilized to protect the mind from feelings of disappointment (Goldstein, 1995). Furthermore, strong idealization may lead to even stronger devaluation when the idealized does not live up to expectations. For instance, a client who has a delusion that all men wearing hats are going to abduct her thoughts may think that her therapist is the only person that can protect her from the men in hats. However, when the therapist eventually disappoints the client in some way, the therapist may be perceived as just as dangerous as the men. The client may begin to think the therapist is in partnership with the hat wearing men. The therapist goes from being loved and valued to being hated and feared.

Projection. The mind defends itself from unconscious thoughts that are unacceptable by attributing the thoughts to others. This indicates a lack of a psychological boundary between the self and the outside world. Therefore, what is occurring internally in the self is actually experienced as occurring externally (Goldstein, 1995). For example, a person who experiences delusions that everyone in the world is dangerous is projecting the feeling that the self is dangerous. Furthermore, people who experience paranoid symptoms of schizophrenia likely use projection as their main psychological defense (McWilliams, 1994).

Introjection. This method of defense occurs when an individual psychologically takes another person into the self to avoid experiencing strong emotions towards the other person (Goldstein, 1995). Instead of the intense feelings such as love or hate being directed at the

external individual the feelings are redirected and felt towards the self. For example, a client who is being self-deprecating may have negative feelings towards his mother who disappointed the client in some way. Opposed to being angry at his mother, the client introjects his mother and is angry at himself.

Projective identification. When projection and introjection occur simultaneously a person is using the defense of *projective identification* (McWilliams, 1994). This primitive defense occurs “when a person continues to have an impulse [or feeling], generally an angry one, that, at the same time, is projected onto another person, who then is feared as an enemy who must be controlled. Projective identification is seen as the most challenging defense in in clinical work because clients behave in a way that causes the therapist to behave a certain way. In short, the client feels fear (or an alternate feeling), rejects the feeling and projects it onto the therapist. The client then sees the therapist as frightened, identifies with the fear and tries to get rid of the fear by distancing herself from the therapist

For example, a client may have the delusional belief that the therapist can see the client’s thoughts. Consequently, the client is fearful of the therapeutic relationship. The client further believes that the therapist is frightened by the thoughts being seen and the client tries to leave the relationship. The client expresses this fear but also believes the clinician is frightened as well. In reaction, the therapist fears the client leaving the therapy and goes to great lengths to make the client stay. The therapist responds to the client’s projection by becoming fearful and identifying with the clients feelings; thus, experiencing the client’s projective identification.

Splitting. Similar to projective identification, splitting is a defense mechanism that is primitive in nature and causes angst in the therapeutic relationship (McWilliams, 1994). *Splitting* occurs to keep contradictory feelings such as love and hate or good and bad apart (Goldstein,

1995). An individual unconsciously uses splitting as a defense when they cannot tolerate the ambivalence of good and bad occurring simultaneously (McWilliams, 1994). For example, a child is unable to experience his need gratifying mother as having bad attributes. Therefore, the badness of mother is split away leaving only the goodness behind. As a defense mechanism splitting may occur when a client experiences the therapist as all good until the therapist angers the client. Then the therapist becomes all bad. The client cannot tolerate that the therapist may, by human nature, be inconsistent in their goodness and badness, the therapist has to be one or the other. An example of splitting occurring in schizophrenia is when a therapist has to hospitalize a client and the client reacts by thinking the therapist is pure evil.

Immature ego defenses.

Immature ego defenses negatively impact other ego functions less severely than developmentally early defenses. Furthermore, immature defenses mechanisms can sometimes be adaptive in helping the ego maintain functioning. The defense mechanisms that are classified as immature ego defenses do not relate to the boundary between the internal self and the external world. Instead these defenses occur within the ego itself. The following immature defenses will be defined and exemplified: acting out and regression.

Acting out. All individuals experience tension associated with particular impulses. At times, this tension becomes too much to bear and the ego defends it self by acting out the impulses. *Acting out* is “the direct expression of wishes, impulses, and fantasies through overt behavior” (Schamess & Shilkret, 2008, p. 80). The action allows the individual to avoid any discomfort associated with containing a feeling. A person who is struggling to accept the diagnosis of a mental illness may abuse drugs as a means to avoid the negative feelings he or she experiences regarding the situation.

Regression. The defense of regression is another way to protect oneself from high levels of stress or anxiety. *Regression* involves the return to a lower developmental level of functioning to cope with environmental stress (Shchamess & Shilkret, 2008). When someone behaves in a way that was previously given up in the face of stress, they are experiencing regression. For example an 18 year old moves away from home for the first time. Upon going to sleep her first night alone, she is suddenly afraid of the dark and uses a nightlight - something she has not done since she was five years old. Everyone experiences the continuum of regression, returning to what was once soothing. However, if people utilize regression as a regular defense their functioning is impaired and they may be characterized as infantile (McWilliams, 1994).

Neurotic ego defenses.

This set of defenses is associated with a high level of functioning and is often seen in individuals who are emotionally healthy (McWilliams, 1994). Therefore, it is not common for an individual with schizophrenia to be unconsciously utilizing neurotic defenses. Similar to immature defenses, neurotic level defenses maintain functioning. What differs between the two defenses levels is that neurotic defenses at times promote better functioning. There are many more neurotic ego defenses than what will be described in this study. A complete exploration of all neurotic defenses is beyond the scope of this paper as their relevance to the treatment of schizophrenia is limited. The following defenses are commonly seen in ego defense literature; however, they are not characteristic to schizophrenia. Instead, the following defenses represent healthier levels of functioning: repression, reaction formation, displacement and undoing.

Repression. When an individual unconsciously forgets thoughts, memories or feelings that are painful, his ego is utilizing the defense of repression to protect himself from the pain. *Repression* is “keeping unwanted thoughts or feelings out of awareness, or unconscious”

(Goldstein, 1994, p. 77). For instance, a person was recently hospitalized for an increase in psychiatric symptoms; however, she cannot remember how she got to the hospital because details of the trip would be too painful to keep in awareness.

Reaction formation. The defense of *reaction formation* occurs when the wishes or ideas a person consciously experiences are the exact opposite to the actual unconscious wish or idea they have (Schamess & Shilkret, 2008). Essentially, the mind is turning what it perceives as bad into good. An example of reaction formation is when a mother thinks her young adult daughter is mentally healthy even though the daughter attempted suicide by drinking a cup of bleach two days earlier. The mother is being overly optimistic about her daughter's wellbeing to replace painful unconscious feelings related to the seriousness of the situation.

Displacement. *Displacement* emerges as a defense when wishes or feelings that are unconsciously unacceptable to be felt towards one person are directed at a different person. This defense often occurs in the therapeutic relationship in the form of transference (Schamess & Shikret, 2008). The client who is angry at her father may actually express her anger towards the therapist. It is unconsciously more acceptable for the client to be angry at her therapist than it is to be mad at her father.

Undoing. This defense occurs when an individual is trying to rectify prior thoughts, feelings or behaviors that provoked a sense of guilt. *Undoing* "means exactly what one would think: the unconscious effort to counterbalance some affect—usually guilt or shame—with an attitude or behavior that will magically erase it" (McWilliams, 1994). A client who misses an appointment may arrive early for the next appointment. The client feels guilty for missing the initial appointment and is trying to make up for the behavior as a means of ridding herself of the guilty feelings.

Mature ego defenses.

The final set of ego defenses are those which actually enhance a person's ego functioning. *Mature defenses* are the healthiest defenses a person can employ to cope with internal discomfort. Similar to neurotic defenses it is uncommon to see the defenses active in people who experience schizophrenia. The following mature ego defenses will be described: sublimation and humor.

Sublimation. When people act in a way to make a socially unacceptable behavior acceptable they are using the defense of *sublimation*. This defense is considered to be one of the healthiest defense mechanisms and represents "a creative, healthful, socially acceptable or beneficial resolution of internal conflict" (McWilliams, 1994, p. 142). An example of sublimation is when an individual may feel a lot of internal aggression and instead of fighting as a means to expel the aggression the individual becomes an athlete. He then uses sports, a socially acceptable activity, as a means to rid himself of his anger.

Humor. The expression of painful feelings or socially unacceptable behavior through jokes and humor is an additional socially acceptable and even valued ego defense (Schamess & Shilkren, 2008). When someone is able to laugh in times of emotional pain the person is better able to function and adapt to the painful situation. For instance, if a client's dog dies they may make jokes about the dog or find an alternate humorous way to deal with the situation. This rids the person's mind of some of the pain allowing her to continue with daily functioning.

The Relationship between Ego Psychology and Schizophrenia: A Lens of Assessment and Conceptualization

This section of the chapter is a discussion of schizophrenia from an ego psychological perspective, highlighting the importance of utilizing ego psychological concepts such as ego functions and defenses to assess individuals with schizophrenia. Ego psychology provides a way

of understanding what a person with schizophrenia experiences psychologically as well as the individual's developmental level of functioning. Within an ego psychology model, schizophrenia is conceptualized as a regression in ego functions and defenses. The individual with schizophrenia is considered to have an ego that is weak, severely disrupted and unable to cope with the dilemmas associated with everyday reality (Freud, 1924; Goldstein, 1995; McWilliams, 1994). It is as though the ego is a bridge and all the weight of stress on the mind causes the ego to collapse into psychotic thinking, much like a bridge would collapse under the weight of so many cars (Cullberg, 2006). Due to intense discomfort in the mind, primitive defenses are employed and ego functioning is disrupted, leaving the individual with schizophrenia unable to manage both internal and external stimulus. In order to understand how the ego has regressed and the level of functioning a person with schizophrenia demonstrates, it is important to explore how ego functions and defenses present in a person with schizophrenia.

Ego Functions and Schizophrenia

When a person experiences schizophrenia the ego is negatively impacted resulting in poor ego functioning. Exploring the ego functions that are altered during psychosis aids in the understanding of what a person with schizophrenia is feeling and how they are processing information. The ego functions most impaired in schizophrenia are: reality testing, sense of reality of the world and the self, object relations, thought process and the synthetic integration function. These ego functions are primary for an individual to function in the external world. The ego functions are usually so profoundly hindered that other ego functions not directly impacted by schizophrenia also perform inadequately. The following describes how schizophrenia directly impacts core ego functions.

Reality testing.

To begin, reality testing is the ego function most severely impaired in schizophrenia. Schizophrenia is characterized as a break from reality (Goldstein, 1995). When an individual is experiencing delusions and hallucinations, they are unable to distinguish external reality from internal stimuli. Similarly, a person's sense of reality of the world and the self is also impaired. According to McWilliams (1994) those with schizophrenia may question their existence in the external world.

Object relations.

Schizophrenia also diminishes an individual's object relations. Meaningful relationships are difficult and people with schizophrenia are frequently unable to have relationships because the person with symptoms is unable to define their existence (McWilliams, 1994). Furthermore, positive object relations requires a person to feel they are a separate individual from other people, this is not possible in schizophrenia because a characteristic of the illness is the person's uncertainty or inability to feel they have a boundary between themselves and others.

Thought process.

Thought processes are additionally impacted in people experiencing schizophrenia, particularly, the disorganized type of the illness. In fact "severe impairments in thought processes are common among individuals with schizophrenic conditions" (Goldstein, 1994, p. 63). The thoughts of people with schizophrenia are at times disconnected from reality and do not make logical sense. Primary process thinking is the dominant level of thought process for those diagnosed with schizophrenia.

Synthetic integrative function.

When people experience schizophrenia, the ability to integrate their personality into a unified structure breaks down (Cullberg 2006; Goldstein, 1995). The fragmentation of the mind, characteristic of schizophrenia, results in the individual's inability to feel a sense of personhood. A person with schizophrenia lacks a sense of continuity of the self and often experiences her identity and internal coherence as confused (Cullberg, 2006). The breakdown of the synthetic integrative function leads the individual to lose a sense of wholeness and feel no identity (Cullberg, 2006; Hertz, 2008).

Defensive Ego Functions and Schizophrenia

Apart from the ego deficits present in someone with schizophrenia, the defenses characteristic of the disorder further impact an individual's ego functioning. People with schizophrenia experience *annihilation anxiety*. That is, the person is in constant fear that he or she will cease to exist (Hertz, 2008; McWilliams, 1994). As a result of this intense anxiety and fear of loss of the self, and in order to process internal and external stimuli, the ego's functions break down causing the mind to call up specific defenses. It is as though "the mind retreats from reality in order to avoid the painful experience and the affects" (Adler, 1978). When the world becomes too painful and scary, the only choice for the ego is to withdrawal via the early developmental primitive defenses.

The ego defenses present in those with schizophrenia are those which do the greatest damage to the person's ability to function - the primitive defenses. The primitive defenses characteristic to schizophrenia include: primitive withdrawal, denial, omnipotent control, primitive idealization and devaluation, projection, projective identification and splitting (Hertz, 2008; McWilliams, 1994). Because these defenses were discussed at length in the previous

section with examples given related to schizophrenia, a secondary discussion will not occur in this section. Furthermore, a case example in chapter five will further demonstrate an individual's experience with primitive ego defenses.

Ego Psychological Treatment of Schizophrenia: Ego Supportive Therapy

Treatment of schizophrenia from an ego psychological perspective usually takes the form of ego supportive therapy. As noted in the previous section, individuals with schizophrenia have severe ego impairments and utilize defenses that further hinder adaptive functioning. An ego supportive approach is recommended for individuals with severe and chronic ego deficits, such as people who are diagnosed with schizophrenia (Goldstein, 1995). Within *ego supportive therapy* therapeutic techniques support positive ego functions and build ego strengths within individuals with schizophrenia.

Ego supportive therapy differs from CBT in that ego supportive treatment is less structured. Additionally, all ego supportive interventions are based upon the therapeutic relationship (Goldstein, 1995). In other words the therapeutic relationship itself, from the initial encounter on, is seen as the change agent in ego supportive therapy. On the other hand, in CBT, specific interventions are what cause change and growth. Within the following section ego supportive therapy will be further defined and ego supportive interventions for the treatment of schizophrenia will be discussed.

Ego Supportive Therapy and Schizophrenia

Ego supportive therapy “aims at supporting, restoring, maintaining, or enhancing the individual's adaptive [ego] functions as well as strengthening or building ego where there are deficits or impairments” (Goldstein, 1995, p. 166). Through ego supportive therapy, an individual is helped to regain previous functioning and build higher levels of functioning. Within

ego supportive therapy, an individual's ego functions and defenses are assessed; and the ego supportive therapist works with the client in a way to strengthen ego functioning and promote the use of higher levels of ego defense. An ego supportive therapist would assess someone with schizophrenia and determine treatment would include helping the client strengthen the ability to reality test, improve thought processes, enhance object relations and help the client experience a better integrated sense of self. Furthermore, upon review of an individual's defenses, the ego supportive therapist would help the client with schizophrenia use more mature levels of defense. For example a therapist may note at times client is able to use humor to cope with auditory hallucinations. If the client begins to experience hallucinations and appears to be withdrawing in defense, the therapist might remind the client of a joke the client made about hallucinations during the previous session. This intervention would draw the client away from the primitive defense and promote the use of a higher level defensive functioning.

Ego Supportive Intervention: The Therapeutic Relationship.

In order for a client to experience ego growth within ego supportive therapy, a therapeutic relationship must exist between the client and the therapist. In fact, the therapeutic relationship is strongly emphasized in ego supportive work and seen as the "medium in which help is given and received" (Goldstein, 1995, p. 200). The change a client experiences is a result of what occurs within the connection between therapist and client. In ego supportive therapy the human relationship is healing.

Most therapeutic modalities require a therapeutic alliance in order to implement intervention. In traditional psychodynamic psychotherapy the therapist must take a neutral stance within the relationship in order for the client to recreate earlier formative relationships through transference. Ego supportive therapy differs in that the therapist's own ego is the intervention

and therefore must be present in the relationship. The therapist actively presents herself to the client allowing individual and personal aspects of the self to enter the relationship. The openness of the relationship is crucial when treating schizophrenia because when working with “more troubled [psychotic] clients, one must be willing to be known” (McWilliams, 1994, p.73).

People experiencing schizophrenia need a trustworthy relationship with a human being to help them recover (Hertz, 2008). The development of a trusting relationship may be difficult depending on the client’s symptomatology. For instance, it may be hard to earn the trust of someone who has a paranoid delusion that everyone is out to hurt him. Therefore, it is imperative that the therapist remain true to the tenets of supportive therapy and offer self-authenticity and equality within the relationship. The client with schizophrenia will develop trust in the therapist when the clinician is emotionally honest with the client in the form of emotional self-disclosure and acceptance of the client as an equal (McWilliams, 1994). The therapist must not be afraid to disclose to the client in order for the client not to be afraid to disclose to the therapist. As a result of the trusting relationship a genuine human connection is built in which the client can draw upon the therapist’s ego strength. The client is able to grow as the therapist lends ego or acts as an auxiliary ego to the client (Vaillant, 1992). In other words the client builds ego functioning by drawing from the therapists ego functioning.

Although the therapeutic relationship is based upon mutuality and openness, professionalism and ethics are necessary in the therapeutic relationship. Within the relationship, the therapist is a real person with an individual personality and emotions; however, the focus of the relationship is on the client (Goldstein, 1995). The therapist’s needs are not a focus. Instead, the therapist uses herself to address the client’s needs. For example, a therapist may be experiencing stress from an interpersonal conflict. At the start of the session, the client may

comment on the therapist seeming stressed. The therapist should not deny the stress, as that is not genuine; nor should the therapist get into detail about what triggered the stress as that is not professional. Instead the therapist should talk with the client about the impact of the therapist's current emotional state on the client and help the client tolerate the interaction. Perhaps the therapist can use the situation to show the client he or she is not always responsible for what others are feeling. Furthermore, within the interaction the therapist uses the opportunity to model to the client that stress can be dealt with maturely, demonstrating and sharing ego strength with the client. Being open and real with the client while at the same time maintaining focus on the client's needs enhances trust in the therapeutic relationship and stays within ethical bounds.

Even though the development of transference and countertransference is not the aim of the therapeutic relationship in ego supportive psychotherapy, transference does occur. If the client develops an intense transference reaction to the therapist, either positive or negative, it should be noted and diffused (Goldstein, 1995). If the transference continues, the client may begin to regress to an earlier level of functioning and such a regression is the opposite of the aims of ego supportive therapy. On the other hand, a positive transference on behalf of the client towards the therapist may be helpful. The client may experience the therapist as a compassionate parental figure who naturally helps the client build ego strength.

The ego supportive therapist must develop a relationship with the client and in doing so assess the client's ego strengths, sustain hope and motivation for the client, enhance the client's independence, provide a role modeling or corrective experience, promote personality change, mobilize resources for the client, modify the client's environment and act of behavior of the client (Goldstein, 1995). The psychological and environmental interventions undertaken by the therapist in order to achieve the above tasks will now be explored.

Psychological techniques of intervention.

When working from an ego supportive context, certain psychological techniques are utilized that differ from other forms of psychotherapy. Ego supportive therapists use psychological techniques to help the client develop ego strength, feel less alone, diminish unpleasant emotions, increase self-esteem, confidence and hope and increase independence. Also, the therapist may employ techniques that enhance the client's awareness of maladaptive behaviors thoughts and feelings (Goldstein, 1995). Individuals with schizophrenia benefit from the type of growth just described and are able to tolerate techniques utilized in ego supportive psychotherapy without becoming overwhelmed or regressing to primitive ego defenses.

Hollis (1972) describes psychological techniques utilized in ego supportive psychotherapy. To start, the therapist must work to sustain the client. This is done through listening sympathetically, providing the client with reassurance and encouraging and accepting the client. For example, the therapist will listen and not pass judgment as a client describes her frightening delusional world. The therapist will also offer the client comfort and support, helping the client to feel accepted even after sharing something others may view as bizarre.

At times the therapist must also offer the client direct advice in order to act as a supplementary ego (Hollis, 1972). For example a client's judgment may be impaired as a result of psychotic symptoms and the client may be considering stopping medication because she thinks the medication is poison. The therapist assures the client that the medication is not poison and recommends the client continue taking the medication as prescribed. Another example is when a client is unsure if he should buy a new car. The therapist may offer the client some advice on what the car buying process is like and what steps should be taken in order to prevent the client from making an impulsive decision.

Often individuals with schizophrenia have trouble understanding or expressing feelings. The ego supportive therapist may draw out what the client is feeling, identify the feeling for the client and help the client understand what the feeling means (Hollis, 1972). A client may be crying upon hearing news of a death of a friend, she may become distraught as a result of her reaction and become overwhelmed by the intensity of emotion. Before the client has an opportunity to engage in primitive defensive functioning, the therapist describes the grief process to the client, telling her that she is sad about the loss of a friend and that feeling sadness when someone dies is normal and accepted. The therapist may then explore other feelings with the client, helping the client to acknowledge the reaction she is having to a loss.

Exploratory techniques should be used cautiously when working with people experiencing schizophrenia. This is because they may create intolerable anxiety in the client, causing the person to experience an increase in psychotic symptoms (Goldstein, 1995). In exploratory techniques the therapist may help the client explore their current life situation and relationships. Additionally, the therapist may observe patterns of maladaptive behavior in the client and help the client understand the impact of the behavior. For instance a client always sits alone during group activities. The therapist makes the client aware of this behavior; gently informing the client that it may be contributing to his isolation. The therapist and the client may also work together to explore the client's past, helping the client to understand how it may be impacting the client's current behavior. Although the above interventions may help the client enhance self-understanding the interventions should not be done if the client does not have the ego strength to tolerate the exploration.

Environmental techniques of intervention.

The therapist's ego is used to help the client psychologically as well as make changes in the client's social environment (Goldstein, 1995). Through use of the self outside the therapeutic relationship, the therapist acts on behalf of the client in practical ways within the social environment. The role of therapist as the client's ego in the environment is to act as a broker, mediator and advocate (Grinnell, Kyte & Bostwick, 1991). For instance, the therapist may help the client mobilize resources and opportunities like obtaining insurance benefits or signing up for college courses. The work done in the environment aids the client's functioning and teaches the client how to make change themselves. The therapist does what the client cannot do for themselves while enhancing the client's ability to independently act on the environment.

Ego Supportive Therapy and First Episode Psychosis

As a therapeutic modality used to treat individuals with schizophrenia, ego supportive therapy should be explored as a form of treatment for young adults experiencing FEP. Regardless of a mental health diagnosis, young adults are in the process of ego development and often require ego support from parents, teachers, mentors and other adults who can lend ego strength as the young adult develops more mature independent ego functioning (Goldstein, 1994). However when a young person experiences FEP, the person's ego functioning regresses and further ego development is thwarted by the illness. Thus, the young adult has a greater need of someone who will help him or her regain the level of functioning the person had prior to the FEP and develop further functioning as the person moves toward adulthood.

The nature of the relationship in ego supportive therapy seems to fit the relational and treatment needs of young adults experiencing FEP. The openness on behalf of the ego supportive therapist is essential in therapy with young adult clients. The FEP client will thrive from the

therapist's high level of involvement and the mutuality of the relationship. Furthermore, a relationship in which the therapist may be experienced as a warm, accepting parental figure who provides ego strengthening and environmental support will be helpful to the young adult client. The parents of FEP clients may have difficulty adapting to their child's illness and at times may act in ways that worsen the FEP client's symptoms. Therefore, the FEP client needs an ego supportive figure to help him or her navigate the illness and the transition to adulthood. For example, the supportive therapist may need to help the FEP client fill out a college application and ensure the school provides reasonable accommodations to help the client succeed in school. Thus, both psychological and environmental interventions are beneficial for the FEP client.

The techniques associated with the therapeutic relationship from an ego supportive modality also appear to be an appropriate way in which to enhance FEP client's ego functioning. Cullberg (2006), identifies how healing can occur following FEP, noting that hope needs to be rebuilt in the young person, the feelings associated with the trauma of the psychosis need to be explored, and impaired relationships with family and friends must be restored in order to combat loneliness. Ego supportive interventions will allow for all the aspects of healing needed for the FEP client to rebuild ego strength.

Additionally, ego supportive therapy for schizophrenia offers a "relationship in which a person's daily struggle is recognized and shared, where tears are shed for the dreams not realized and new hopes are construed for the life yet to be led (Hertz, 2008, p. 304). Young adults experiencing schizophrenia for the first time are mourning the loss of self and the diminishment of ego functioning. Further, FEP clients face what is often a painstaking task of becoming a person. The young adult must now navigate the dual transition of separating and individuating from family of origin and getting accustomed to a life that includes mental illness. FEP clients

may need to put some dreams on hold, waiting to go away to college or not starting full time work. The FEP client needs help putting words to this loss and a venue in which they may mourn the situation and develop plans to overcome the adversity. The relationship offered through ego supportive therapy helps the young FEP client process the experience in a way that builds adaptive ego functioning and provides strength for future development.

The following chapter shifts away from the psychodynamic theory of ego psychology and focuses on CBT with an emphasis on schizophrenia and FEP. Similar to ego psychology, CBT provides a lens in which to conceptualize and assess schizophrenia; as well as, offers a treatment modality for the illness. However, the interventions associated with CBT are more structured than ego psychology. The following chapter provides greater detail of CBT psychological lens and highlights the utility of CBT in the treatment of FEP.

CHAPTER FOUR

COGNITIVE BEHAVIORAL THERAPY AND SCHIZOPHRENIA

Cognitive behavioral therapy (CBT) was originally developed by Aaron Beck in the 1960's. Beck was a psychoanalytically trained therapist who became interested in furthering his understanding of depression and anxiety. While observing and working with his patients, Beck noticed the patients' ways of thinking about life events impacted their behaviors and created mental health difficulties. He developed the CBT model which suggests that the way we "interpret events has consequences for how we feel and behave, and that such interpretations are often maintained by unhelpful thinking biases and behavioral responses" (Morrison, 2008, p. 226). The goal of CBT is to think about thinking, and to alter thinking and behaviors that cause difficulty in a person's life.

Differing from traditional psychodynamic therapy, CBT is present focused and utilizes structured interventions to improve functioning as opposed to exploring the past to understand present behavior. The modality is a theory along with a set of strategies and utilizes specific techniques to address pathological cognitions (Corsini & Wedding, 2008). The structured nature of CBT has enabled the modality to be widely researched and it is described as an evidenced based practice; meaning, clinical research has confirmed CBT's efficacy in treating mental health difficulties. CBT has moved beyond its origins of treating depression and anxiety, has been adapted into other contemporary theories and is utilized to treat a variety of diagnosis in current psychotherapy, including schizophrenia and FEP.

This chapter describes CBT, highlighting the use of the modality to treat schizophrenia. The theoretical foundation of CBT will be discussed along with definitions of common terms used in CBT. Next, the chapter will focus on CBT for the treatment of schizophrenia beginning by highlighting a cognitive behavioral conceptualization of the illness followed by a discussion of how assessment should occur within the context of CBT. CBT interventions will be described and interventions identified to treat the symptoms of schizophrenia will be explained. The chapter will end by reviewing the techniques of CBT for schizophrenia as applied specifically to the treatment of FEP.

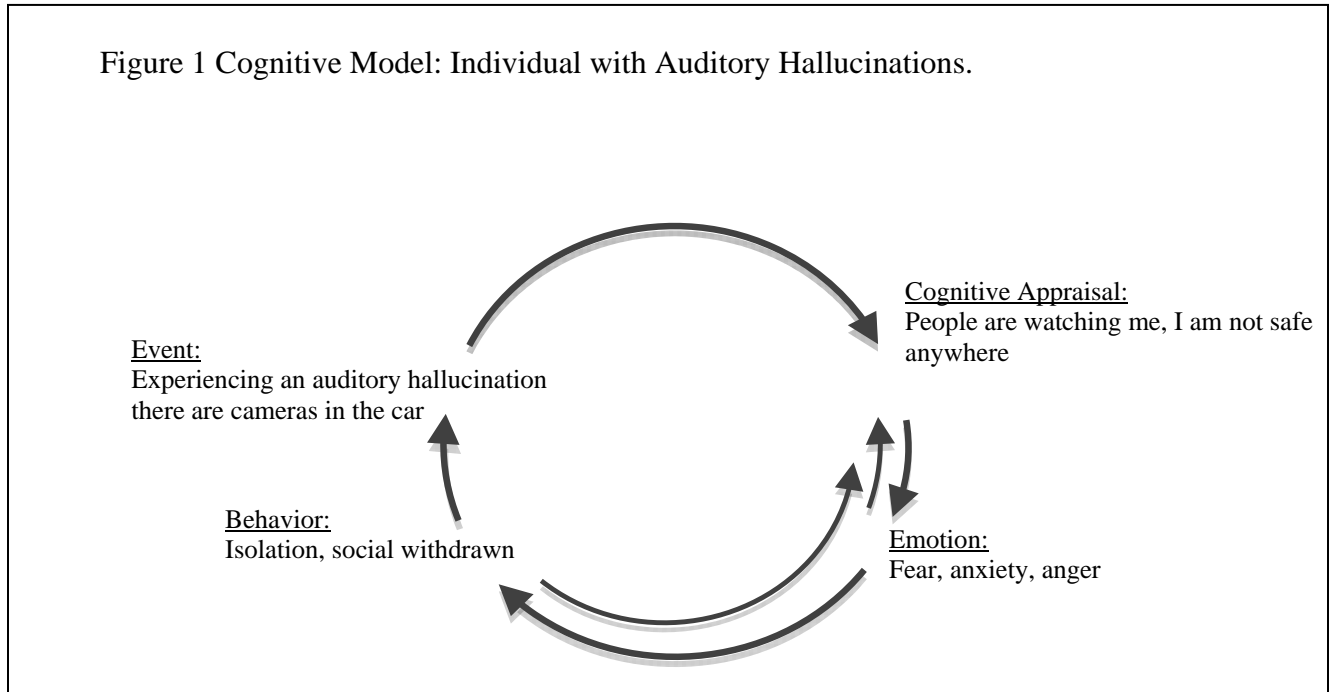
Foundations of CBT

The following section reviews the cognitive model of CBT in detail, indicating how difficulties in functioning are understood from a CBT perspective. Furthermore, the section will review and define specific terms associated with CBT. An understanding of the CBT conceptual model and key terms will aid in understanding the rest of the chapter.

Cognitive Model

CBT utilizes a conceptual model to explain pathological functioning in individuals. The major premise of this model is that people cognitively appraise (think about) and react to all events in a particular way (Wright, Basco & Thase, 2006). The cognitive appraisal of the event leads to an emotional reaction and a particular behavior. The CBT model identifies relationships between an event, cognition about the event, an emotional reaction to the cognition and behavioral reaction to the emotion (Wright, Turkington, Kingdon & Basco, 2009). Furthermore, a strong emphasis is placed on the relationship between cognition and behavior as these are the points of pathological functioning that may be addressed with the CBT methods discussed later in this chapter.

The graphic below shows an individual's reactions to an event. Figure 1 shows the relationships between event, cognition, emotion and behavior.



Definition of Terms

CBT identifies three levels of cognitive processing individuals' experience:

consciousness, automatic thoughts and schemas (Beck, Rush, Shaw & Emery, 1979).

Consciousness is a state of awareness and is the highest level of cognition. A goal of CBT is to bring other levels of thought into consciousness where rational decisions can be made (Wright et al., 2006). Cognitive behavioral interventions are designed to increase awareness of the lower levels of cognitive processing such as automatic thoughts and schemas. Therefore, an understanding of these terms is critical to the understanding of CBT.

Automatic thoughts are the cognitions that immediately come to mind when people are in the middle of a situation or remembering past events. Within the CBT model, this is the cognitive appraisal an individual experiences after an event. This level of thought is just below

consciousness and is typically irrationally analyzed (Wright et al., 2009). Furthermore, automatic thoughts occur rapidly, are not always verbalized but often elicit strong emotional reactions (Wright et al., 2006).

Automatic thoughts are natural and occur in everyone. However, individuals who experience mental health difficulties frequently experience *cognitive errors* also known as *cognitive distortions*. The error occurs within the logic of the automatic thought (Wright et al., 2006). Cognitive errors can result in maladaptive emotions or behaviors, causing discomfort for an individual and impacting a person's ability to function. CBT interventions aim to help people recognize the cognitive errors experienced in response to an event. Beck and his colleagues (1979) identified six types of cognitive errors that continue to be utilized in CBT. The errors are selective abstraction, arbitrary inference, overgeneralization, magnification and minimization, personalization and absolutistic thinking. A thorough understanding of each error is important and each will be described in detail later in this chapter as they specifically relate to schizophrenia.

The deepest levels of conscious are called *schemas*. Everyone develops schemas throughout life as a way to organize information and life experiences. Schemas are “enduring principles of thinking that start to take shape in early childhood and are influenced by a multitude of life experiences...”(Wright et al., 2006). Schemas, also referred to as *core beliefs*, may be understood as fixed ways of understanding information as it relates to self-esteem. For example, as a result of experiences throughout life a person may develop a core belief that they are worthless. All individuals have positive and maladaptive schemas that strongly impact self-esteem and individual behavior. The *stress-diathesis hypothesis* holds that negative schemas

may not impact a person's life until a stressful event triggers the core belief which in turn produces more cognitive errors within automatic thoughts (Wright et al., 2006).

Foundations of CBT for Schizophrenia

In 1952 Beck used his cognitive behavioral model to treat a man who had been experiencing chronic paranoid schizophrenia for seven years. He sought to help the man overcome the disruption in his life caused by paranoid delusions. Beck undertook this work with a psychodynamic understanding of paranoid delusions but utilized cognitive behavioral techniques (Kingdon & Turkington, 2005). Beck's treatment of this patient did not eliminate his delusions. Instead, the delusions were modified such that the man was able to live with less fear and suspicion. Beck's patient utilized the skills he learned working with Beck and was able to "reason himself out of" (Beck, 1952, p.310) impending paranoid thoughts.

Research continued beyond Beck's initial study and CBT methods were adapted to treat schizophrenia. The CBT model for schizophrenia suggests that the "way people interpret psychotic phenomena rather than the psychotic experiences themselves accounts for distress and disability" (Morrison, 2008, p. 226). CBT interventions for schizophrenia are aimed particularly at the positive symptoms of schizophrenia, focusing on the modification of the way people think about hallucinations and delusions (Kingdon & Turkington, 2005). Research on CBT has shown evidence supporting its efficacy in the treatment of schizophrenia and is therefore currently routine treatment for individuals with schizophrenia in the United Kingdom and is growing in popularity in the United States (Kuller, Ott, Goisman, Wainwright & Rabin, 2010). The specific interventions described further in this chapter have been researched and identified as appropriate, useful and necessary treatments for schizophrenia (Kingdon & Turkington, 2005; Wright et al., 2009).

Cognitive Behavioral Conceptualization of Schizophrenia

This section will focus on CBT specifically in regards to schizophrenia. The CBT model of conceptualization for schizophrenia will be explored. Furthermore the CBT understanding of both positive and negative symptoms of schizophrenia will be detailed.

Vulnerability Stress Model

CBT incorporates a biopsychosocial approach with a focus on the *vulnerability stress model* to conceptualize schizophrenia. Emphasis is placed on the different biological, social and psychological vulnerabilities a person experiences along with the stresses in their lives.

“Vulnerabilities and stresses combine to produce the symptoms characteristic of the disorder [schizophrenia]” (Kingdon & Turkington, 2005). Furthermore, the higher level of vulnerability a person has, the less stress it takes for symptoms to be activated (Kingdon & Turkington, 1994). An individual may have a high level of vulnerability to schizophrenia; however, he may never experience the level of stress needed to ignite symptoms.

Each set of vulnerabilities within the biopsychosocial model are unique; thus, requiring explanation. Examples of biological vulnerabilities include all the neurological, developmental and genetic factors discussed in chapter two. Social vulnerabilities may be the geographic region a person lives in, as schizophrenia is more common in cities (Kingdon & Turkington, 2005). Limited support, racism and social alienation may be additional social vulnerabilities. Within the cognitive behavioral model, psychological vulnerabilities include cognitive distortions elicited by particular experiences and the inability to experience powerful emotion.

Vulnerabilities alone do not lead to schizophrenia. The CBT conceptualization notes the impact of vulnerability combined with stress. Various events throughout one’s life may be characterized as stressful. Some events such as trauma and loss are obvious stressors and are

likely to stimulate high levels of stress in the majority of the population. Other events, such as changing jobs or ending a relationship may produce varying levels of stress in different people (Kingdon & Turkington, 2005). Either way, the more stress a person experiences combined with multiple vulnerability factors increases an individual's risk of developing schizophrenia.

Specific Symptoms of Schizophrenia

Positive symptoms.

Specific symptoms of schizophrenia are also conceptualized from a cognitive behavioral framework. Kingdon and Turkington (1994, 2005) define *delusions* as strongly held beliefs that cause distress and interfere with functioning and interpersonal relationships. Within CBT, delusions are thoughts that need to be understood and the consequences of those thoughts need to be explored (Kingdon & Turkington, 2005). Furthermore, delusions are believed to develop from previous schemas about the self, which have become activated by a particular event and result in automatic thoughts that are delusional in nature (Garety, Kuipers, Fowler, Freeman & Bebbington, 2001).

Cognitive errors explain delusional beliefs (Kingdon & Turkington, 1994, 2005).

Personalization, occurs when someone relates an external event to herself without any evidence of the relationship (Wright et al., 2006). For example, a delusion exists wherein someone thinks the television character is talking specifically to him or her. *Selective abstraction* happens when evidence about a situation is ignored (Wright et al., 2006). Therefore, the individual does not consider that the television character does not know the individual. A similar cognitive error is *arbitrary inference* wherein the belief continues despite contradictory evidence (Wright et al., 2006). The cognitive error of *minimizing* is making less of a situation; whereas, *maximizing* is exaggerating the situation (Wright et al., 2006). The individual thinks that the television

character is in love with her because the character is talking to the individual.

Overgeneralization occurs when an individual thinks that all television characters talk to him or her. The final cognitive error associated with delusions is *absolutistic thinking*; also known as, *all or nothing thinking*, wherein beliefs are placed into one of two categories (Wright et al., 2006). It is possible for multiple cognitive errors to be occurring simultaneously and not all cognitive errors may be understood as being delusions.

Hallucinations are cognitively behaviorally understood as an individual's automatic thoughts perceived as occurring externally. In other words, hallucinations are "the person's own thoughts—which, to them, seem to come from *outside* their mind (Kingdon & Turkington, 2005, p. 22). Someone may think he is going to die and he experiences the thought as an auditory hallucination of the president telling the individual he will die. Furthermore, the way individuals interrupt hallucinations leads to some of the distress in schizophrenia (Morrison & Renton, 2001). For instance, if an individual experiences a maladaptive automatic thought in the form of a cognitive error in response to a hallucination, the hallucinatory experience causes a negative experience for the individual.

The symptoms of disorganized thought and behavior are conceptualized within CBT as *disordered communication* (Kingdon & Turkington, 2005). People with disordered communication attempt to convey a particular message that seems logical to them but is expressed in an illogical manner. For instance, a person with loose associations may think he is communicating clearly and it is the person receiving the message who does not understand. If an individual is always misunderstood when he communicates with others, he may develop a negative core belief that his communication skills are terrible. As a result of his negativity he may stop trying to communicate all together. The person with schizophrenia whose attempts at

communication continue to be misunderstood may cease communication and develop a core belief about their ability to communicate.

Negative symptoms.

As noted in chapter two negative symptoms include: difficulty expressing emotion, an inability to engage in social behavior, problems with motivation and a decreased ability to experience pleasure (APA, 1994). Negative symptoms of schizophrenia are not extensively conceptualized from a CBT model. Kingdon and Turkington (2005) wrote that negative symptoms are a result of a myriad of psychosocial sources based upon an individual's experience. Negative symptoms may be learned behaviors or a consequence of particular core beliefs (Kingdon & Turkington, 2005). Furthermore, negative symptoms may be behavioral reactions to certain events and utilized as coping mechanisms. For example, *anhedonia* may result from a situation in which a person felt demoralized; and withdrawal may occur when a person's environment is over stimulating. From a CBT perspective negative symptoms are understood as resulting from biological and psychosocial issues (Kingdon & Turkington, 2005). Within CBT, it is important to not only see negative symptoms as resulting from biological issues; but negative symptoms should also be scrutinized for a psychosocial explanation (Kingdon & Turkington, 2005).

Assessment of Schizophrenia from a CBT Perspective

Similar to other modalities, CBT treatment for schizophrenia begins with a thorough assessment of the client and their presenting issues. A cognitive behavioral model of assessment helps the therapist: 1) develop a deeper and more thorough understanding of an individual's background, 2) develop a formulation of the client's experience based upon the vulnerability stress model and 3) guides intervention (Kingdon & Turkington, 2005). Cognitive behavioral

assessment for schizophrenia follows the same tenets as cognitive behavioral assessment for other mental health conditions. However, assessment completion may be more difficult with clients with schizophrenia as symptoms of their illness, such as paranoia, may hinder the process of gathering information.

The assessment process essentially occurs during the initial engagement with the client at the beginning of the therapeutic relationship. The therapist works directly with the client to gather information needed to complete a thorough assessment. The therapist and client work together to understand what has brought the client to treatment (Kingdon & Turkington, 2005). Although assessment involves a review of collateral information, the majority of information obtained comes from direct, collaborative interaction with the client (Kingdon & Turkington, 2005). The assessment should include a mental health diagnosis and a focus on information about symptoms, childhood experiences, formative influences, situational and interpersonal issues, biological, genetic and medical factors as well as the client's strengths and assets. Furthermore, typical automatic thoughts, behaviors, emotions and underlying schemas should be identified through the assessment process (Wright et al., 2006, 2009).

Constructing a working hypothesis and developing a treatment plan are the next steps in the assessment process. A working hypothesis "pulls together the most important observations from the formulation [assessment] into a proposed explanation for the development and maintenance of the patient's symptoms" (Wright et al., 2009). In other words, the hypothesis utilizes the assessment data to explain what the client is going through and why it may be happening. Furthermore, additional information is obtained throughout the treatment process. Therefore, the hypothesis is "working" and may change over time with increased understanding of the client. The treatment plan details CBT interventions that will best help the client (Wright

et al., 2009). Within the treatment plan, the interventions should be described in relation to the specific issues the client experiences. Details regarding CBT interventions will be discussed later in this chapter.

Upon completion of the initial assessment, the various elements of the assessment should be organized into a case formulation worksheet. The worksheet simply provides a structured way to review the details obtained through assessment and help determine where to target interventions (Wright et al., 2006). Once the data is organized into the case formulation worksheet it may be shared with the client as a therapeutic intervention (Kingdon & Turkington, 2005). Incorporating the subsequent feedback provided by the client may increase the client's awareness and insight into his or her difficulties; thus beginning the CBT process.

Cognitive Behavioral Treatment for Schizophrenia

CBT for schizophrenia follows a similar model of CBT for other mental health conditions. Treatment is applied through a series of specific steps, with interventions timed to occur at particular phases of treatment. The basic steps of treatment, although standardized, may require specialized implementation when applied to individuals with schizophrenia. The first and most vital step of CBT is the *engagement process* and the *development of the therapeutic relationship*. The therapist and the patient must get to know each other and develop a relationship of mutual trust within the boundaries of a professional relationship. Emphasis is placed upon developing a sense of collaboration, warmth and mutual respect within the relationship before proceeding with treatment (Kingdon & Turkington, 2005). This phase may be complicated when treating individuals with schizophrenia because paranoid symptoms may impede the client's ability to form an intimate trusting relationship. Therefore, the development

of the relationship may need to occur at a slow pace and be non-confrontational in nature (Wright et al., 2009).

Psychoeducation and normalization are the next stages of treatment and sometimes occur simultaneously. *Psychoeducation* involves educating the client about the process of CBT, schizophrenia, symptoms and medication (Kingdon & Turkington, 2005). The client should also be educated regarding the stress vulnerability model so he or she may explore what may trigger symptoms. Psychoeducation should not be delivered didactically. Instead, information is demonstrated or shared in a conversational manner allowing the client to ask questions about the information he or she is learning (Kingdon & Turkington, 2005). Informational handouts are frequently provided in the therapeutic session for the therapist and client to review together. This written material maintains the mutuality of the therapeutic relationship. Psychoeducation continues throughout treatment as concepts may be further explained and illustrated at varying times.

Normalization often occurs throughout psychoeducation. This is “the process by which thoughts, behaviors, moods and experiences are compared and understood in terms of similar thoughts, behaviors, moods and experiences attributed to other individuals who are *not* diagnosed as ill—especially mentally ill” (Kingdon & Turkington, 2005, p. 87). When participating in the CBT normalization process, a person with schizophrenia will hopefully develop an understanding that people without a psychotic illness may sometimes have experiences similar to psychosis. The explanation may help clients begin to feel less stigmatized for having schizophrenia; the client may start to realize they are not suffering alone. The normalization process additionally helps the client to realize that the therapist understands what the client is experiencing (Wright et al., 2009).

Once a relationship is established and the client has a better understanding of the illness and the treatment process, the work of helping the client alter reactions to specific situations begins. This phase includes three basic strategies. The first is *modification of automatic thoughts*. To begin this process, the client must be helped to identify the automatic thoughts and cognitive errors that emerge. Modification of automatic thoughts may be done in session as the therapist probes for emotions or engages in role playing (Wright et al., 2006). Automatic thoughts may also be identified by the client doing homework outside of session, keeping a record of thoughts or using a thought checklist.

When specifically treating schizophrenia, delusions may be identified as automatic thoughts and cognitive errors (Wright et al., 2009). For example, the delusional belief that every time the client thinks of driving someone will get in a car accident is an example of personalization. After the thoughts are identified, the therapist and the client work together to modify them. This may be done through a process of examining evidence for and against the belief and generating rational alternatives. The process of discovering that car accidents occur regardless of what the client thinks may help the individual see there is no connection between her thoughts and car accidents.

The next CBT intervention strategy is the *modification of schemas or core beliefs*. The schemas must first be identified similar to the way automatic thoughts are identified. Then, modification can occur through techniques that move the person away from their maladaptive views and help the client develop new core beliefs. The client may explore the advantages and disadvantages of her beliefs or generate alternatives to current beliefs. Modifying schemas with an individual with schizophrenia may involve exploring and modifying an individual's belief about the illness or the safety of the world around them (Wright et al., 2009). For instance, the

client may believe he is worthless because of the illness. Alternatives to this schema may be generated by helping the client notice what he contributes to his community. Once the client sees all the evidence against the schema of worthlessness, he may start practicing a new core belief that he is helpful and needed in the world.

The last strategy includes interventions aimed at *behavior modification*, which is changing behaviors that cause distress. Behavioral interventions are utilized either to improve activity levels or decrease anxiety about a specific situation (Wright et al., 2006). A therapist may help a client who is experiencing negative symptoms activate behavior, such as getting out of bed or doing chores. When trying to activate behavior the therapist may have the client develop do-able goals to engage in one or two specific activities. The success the client has reaching the goal may stimulate a sense of change and hope in the client, motivating the person to keep achieving more goals (Wright et al., 2006). Devising an activity schedule wherein the client is able to document how she feels about a particular activity additionally helps motivate the client. Through activity scheduling, the client may be able to develop some mastery of the types of activities that are pleasurable (Wright et al., 2006).

A different set of behavioral interventions helps clients change anxious reactions to particular events. This type of intervention is based on learning theory which stipulates that people become conditioned to respond to situations in a particular way. For example, a client may become conditioned to fear leaving the house because the voices she hears tell her she is being watched each time she goes out. A behavioral intervention such as *graded exposure* would help the client confront the situation and use coping skills or relaxation techniques to tolerate the discomfort (Wright et al., 2006). Slowly having the client leave the house, be exposed to the voice and not have a negative experience teaches the client that although the voice

occurs when they leave the house nothing bad happens. Therefore, the client becomes re-conditioned to not have a negative reaction to the situation.

CBT Interventions for Specific Symptoms of Schizophrenia

The interventions described above may be implemented specifically in the treatment of schizophrenia. More examples of interventions for specific symptoms are provided in Table 1. However, a thorough description of each intervention is beyond the scope of this study as learning and understanding each strategy takes time, demonstration and collaborative learning. For further explanation of specific strategies please see Kingdon and Turkington (1994; 2005), Wright, Basco and Thase (2006) and Wright, Turkington, Kingdon and Basco (2009).

Table 1: CBT Interventions for Specific Symptoms of Schizophrenia

Hallucinations	Delusions	Disorganized Thinking	Negative symptoms
<ul style="list-style-type: none"> • Reality test hallucinations • Use the basic CBT model to develop understanding of symptoms • Generate a problem list and targets for treatment • Develop rational explanations for symptoms • Keep a voice diary • Build coping strategies • Use graded exposure • Construct coping cards 	<ul style="list-style-type: none"> • Treat delusions as if they are cognitive errors • Take a different perspective regarding the thought • Use the ABC technique to understand the relationship between the activating event, belief, and consequence of the belief • Use a thought record to explore automatic thoughts and correlating realistic thoughts • Modify schemas related to delusions by exploring the evidence for or against the schema 	<ul style="list-style-type: none"> • Help the client clearly communicate • Model clear, precise communication • Help the client link their ideas • Teach the client to focus on the underlying emotion of the communication • Practice summarizing and structuring communication 	<ul style="list-style-type: none"> • Reduce pressure and expectations on the individual • Set reasonable goals • Build motivation through behavioral methods • Practice behavior activation • Activity scheduling • Graded task assignment

CBT and First Episode Psychosis

CBT is the preferred and often expected intervention to be utilized when treating schizophrenia (Kuller, Ott, Goisman, Wainwright & Rabin, 2010). Therefore, CBT is also the intervention of choice for FEP (Addington & Gleeson, 2005). There are approximately 158 early psychosis programs that specifically treat FEP clients throughout the world. The programs developed through research continued to indicate the efficacy of specialized phase specific care. Programs in the United Kingdom and Australia run under a government mandate and implement cognitive behavioral methods to treat FEP clients. CBT is utilized in such programs because the intervention is evidenced based and may be tailored to address the needs of a young person (Addington & Haarmans, 2006).

The use of CBT for FEP follows a similar method of conceptualization, assessment and intervention as CBT for chronic, ongoing schizophrenics. But, the major focus is on the presenting concerns of a young person who has developed a psychotic illness (Valmaggia, Tabraham, Morris & Bouman (2008). The different needs of FEP clients have already been discussed and CBT interventions have been modified as to meet those specific needs. Addington and Gleenson (2005) note that CBT for FEP focuses

...not only the symptoms of the illness, but the impact of the illness on an individual. This includes isolation from families and friends, damage to social and working relationships, depression and demoralization and an increased risk of self-harm, aggression and substance misuse. (p. 73)

Specific CBT interventions are formed around the above stated needs of FEP client in order to help the young person to experience recovery from a first episode. CBT helps the young FEP client develop an understanding of psychosis, experience adaptation to the illness, increase self-

esteem and decrease emotional reactions to the illness. CBT interventions help the client decrease distress associated with hallucinations and delusion while developing strategies to function in daily life (Addington & Haarmans, 2006). Furthermore, CBT for FEP emphasizes relapse prevention. Psychoeducation regarding the illness, symptoms and the stress vulnerability model are tools used to help the FEP client avoid a relapse of psychotic symptoms (McGorry, 2009). FEP for CBT will be reviewed in chapter five through the presentation of a case vignette and the application CBT concepts.

CHAPTER FIVE

TREATING THE SYMPTOMS AND BUILDING THE SELF: AN INTEGRATED THEORETICAL APPROACH TO TREAT FIRST EPISODE SCHIZOPHRENIA

This final chapter is an application of the two theoretical concepts to an FEP case. The aim of the chapter is to show that both ego psychology and cognitive behavioral therapy can be used in conjunction with one another to effectively treat FEP. The chapter begins with a description of an FEP case, highlighting the specific issues associated with being a young adult with psychosis. Next, the case will be reviewed from theoretical perspectives, first ego psychology and then CBT. Each theory section will include a brief assessment and example of the treatment approach for the given theory. The chapter will conclude with a discussion of how the theories should be used together to provide holistic care for young adults with FEP.

The Case of Dani: A Young Woman's Experience with FEP

The following is a glance into the life of Dani, a 22 year old, young women who has been receiving specialized FEP treatment for approximately two years. This section includes a description of Dani's first psychotic episode and presentation in treatment. Furthermore, the section exemplifies the impact FEP has had on Dani's psychosocial development and family relationships. Although the case of Dani is based upon the researcher's clinical experience, all identifying information has been disguised to protect client confidentiality.

History of Present Illness

Dani began treatment at the specialized FEP program following an inpatient hospitalization for a first psychotic episode. Dani was in the midst of finishing her senior year of high school when the first symptoms emerged. She was an honor student who was already taking college level math. Academics were Dani's life; she had already been accepted to the prestigious college of her choice and had ambitious career goals, which mirrored her father's occupation. Dani spent most of her free time studying and tutoring math, it was her life. She had a few close friendships and was described as very personable.

In regards to her home life, Dani felt caught in a difficult situation. Her parent's marriage was falling apart, her father was having an affair and Dani was the only one who knew. She kept this a secret from her mother and felt obligated to protect her younger brother. Dani began to hate her father for putting her in this position and she became increasingly withdrawn from family and friends. Dani became increasingly paranoid without anyone noticing a change in her behavior. She began to hear voices telling her different ways to kill herself. Dani thought she was supposed to listen to the voices so she attempted an overdose and was hospitalized.

Once she was in the hospital, it was clear that Dani was psychotic. She was diagnosed with schizophrenia, paranoid type and put on an antipsychotic medication. When she was no longer actively suicidal, Dani was discharged from the hospital and began attending the FEP program where she currently receives treatment. Dani struggles to accept the illness and is in a difficult college program even though she actively experiences psychotic symptoms and has extreme difficulty concentrating. Dani was once an A student, but she has not gotten a grade above a C since she developed psychosis. Dani's identity was her ability to be a good student and the schizophrenia took that away from her.

Current Mental Status and Symptoms

Dani currently presents with a constricted affect and anxious mood. She avoids eye contact keeping her head down during social interactions. When she does lift her head up, it is in response to internal stimuli. Dani continues to experience positive symptoms of schizophrenia on a daily basis, including auditory hallucinations and paranoid delusions. What follows is a brief example of Dani's symptoms. A more comprehensive description of her symptomology will be provided throughout the theoretical application sections of this chapter

In regards to auditory hallucinations, Dani hears voices telling her ways to kill herself and that other people are planning to harm her. One of Dani's regular auditory hallucinations is that the Queen of England is insulting Dani and telling her she should not be alive. At times Dani will also hear gun shots or explosions and become fearful that she will be shot. Dani also experiences ongoing paranoid delusions. She fears the FBI is after her and they are going to punish her for a crime she did not commit. She will complain about cameras being in the bathroom of her dorm room and that a car is always parked outside her window with people in it watching her.

Dani also experiences negative symptoms of schizophrenia. She has difficulty expressing emotion, finding pleasure in activities and is socially withdrawn. Further, Dani has struggled with suicidal ideation throughout treatment, at times she feels dying is the only way her symptoms will stop. She will concoct plans to hurt herself but does not follow through. Dani's previous suicidal plans have included: putting raw meat into an open wound on her body, crashing her car into a snow bank, taking all of her medication and hanging herself. It is important to continue to monitor Dani's suicidal behavior because of the high suicide risk associated with young adults with FEP (Robinson, et al., 2009).

Impact of Schizophrenia on Dani's Development

As indicated in chapter two, FEP and the initial diagnosis of schizophrenia have a unique influence on a young adult's life. Dani's psychosocial development and family relationships have been negatively impacted by her psychotic symptoms. In particular, she has struggled to develop a personal identity. When Dani first experienced psychosis, she had a solid identity as a student. She knew her strengths and had a plan for what she wanted to become in life based upon her academic abilities. That plan was not abandoned when she was diagnosed with schizophrenia; instead the plan became more difficult to pursue.

Dani is no longer a highly successful student; she cannot study without being distracted by her symptoms. Furthermore, due to her symptoms Dani is only able to take one class per semester, something she is very ashamed of. Dani no longer knows who she wants to be and feels like a failure for not having a career plan. She is considering becoming a math teacher. However, her father once told her, "Those who cannot do, teach." Therefore, Dani is terrified that if she becomes a teacher, she is admitting she cannot "do" math anymore. Dani is horrified by this change in her academic ability and in almost every therapy session she expresses a wish to "be the person I used to be." When she is told that she is still smart, Dani responds by saying "not as smart as a once was." Dani is mourning the loss of a self she knew and a self she never had the opportunity to develop.

Dani also lacks social relationships, which as indicated in chapter two, further impacts her development (Addington & Haarmans, 2006). She is ashamed of her illness and is fearful of developing new friendships. Furthermore, Dani is embarrassed because she is no longer a good student and she does not want her peers to know how much she is struggling to keep up academically. Dani has had one romantic relationship since her developing psychosis. However,

Dani felt it was unfair for her partner to be involved with someone who has a mental illness. So, she ended the relationship.

Dani's family has also been impacted by the illness. Her mother has been Dani's primary caretaker since she developed mental illness. Like many other FEP clients, Dani relies on her mother for financial support. Dani's mother is petrified that Dani will hurt herself. Her mother becomes very emotional when Dani discusses her symptoms, indicating a high level of expressed emotion (McFarlane, 2002). When her mother displays intense emotions, Dani often becomes more symptomatic. Dani's parents have divorced and Dani's relationship with her father remains tenuous. She continues to be angry about her father's affair and has kept that relationship secret from her mother and brother. Dani thinks her schizophrenia is a punishment for not telling her mother about the affair. Dani remains protective of her brother and is concerned that she is not a good role model. Her brother will be attending the same college in the fall and Dani feels it is her responsibility to ensure he succeeds in school.

Dani struggles with both psychotic symptoms and her concept of self on a daily basis. She is well motivated to participate in treatment and wants to regain her former level of functioning and move forward in her life. In the next section ego psychology will be applied to the case of Dani and ego supportive interventions to help Dani with her developing self will be identified.

Ego Psychology and Treatment of Dani: Support of the Self

Dani is suffering from an illness that has caused her to lose her sense of self. From an ego psychological perspective, Dani has experienced a regression in functioning and exhibits multiple areas of ego weakness as well as, primitive levels of defense. As a result of her decreased level of functioning, Dani lacks a coherent internal sense of self. What follows is a

brief assessment based upon ego psychological concepts of ego functions and defenses. Once an ego psychological understanding of Dani's presenting problem is described, the section will provide details of how ego supportive treatment should be undertaken to assist Dani's developing self.

Assessment of Ego Functions

Dani lacks an ego which can handle the task of organizing and synthesizing internal and external information, thus making it difficult for her to tolerate her own thoughts and the world around her. Weakness in one area of Dani's ego functioning results in weakness in all Dani's ego functioning; thus, Dani struggles to manage the developmental tasks and relationships she previously successfully accomplished. The most apparent weakness is Dani's difficulty with *reality testing* as indicated by her ongoing experience of hallucinations and delusions. Dani has difficulty acknowledging her hallucinations are internal stimuli and symptoms of an illness; instead she believes that these experiences and beliefs are real. Due to her symptomatology Dani's thinking is not reality based; therefore, she is classified as having a primary level of *thought processing*.

Dani also has weak *object relations*. She has very few friendships, cannot maintain romantic relationships and is emotionally disconnected from her family. Although Dani has engaged in treatment, it seems as though she is unable to form any new relationships or maintain old relationships. Furthermore, Dani occasionally thinks that she will cause someone to die if she develops a relationship with the person. Perhaps Dani, herself, feels dead. Due to a weak differentiation between self and other, Dani thinks the other person will cease to exist because Dani herself does not exist. Dani's recurring suicidal ideation further highlights Dani's inability to feel like a cohesive self indicating a difficulty within *the synthetic integrative function*. In

therapy Dani regularly talks about killing herself and continues to have auditory hallucinations telling her ways to die. She may feel like she has no reason to live because she perceives herself as not being a whole person who is engaged in life.

Dani also has weaknesses in other areas of functioning. She has a low *stimulus barrier* indicated by her inability to tolerate long periods of silence without an increase in auditory hallucinations. She also does not have a sense of *mastery or competence* due to her low self-esteem. Furthermore, Dani has poor autonomous ego functioning. She has difficulty concentrating, experiences impaired memory and struggles to learn new concepts. Despite ego weaknesses, it is important to note that Dani does demonstrate areas of ego strength. She has good *judgment* and she is able to *control her impulses*. Treatment methods to utilize Dani's ego strengths and enhance other functioning will be described later in the chapter. For now, it is important to explain Dani's level of defensive ego functioning.

Assessment of Ego Defenses

Based upon Dani's diagnostic presentation, it may be conceptualized that she is experiencing annihilation anxiety. Dani has constant fear that people are going to kill her or she wants to end her own life. Primitive defenses are characteristic of individuals who experience annihilation anxiety and often indicate difficulty seeing the self as separate from the other (McWilliams, 1994). Dani fits the ego psychological conceptual profile of defensive functioning and employs primitive level defenses to cope with intolerable fear and anxiety.

Dani does not engage with other people in group therapy and in social situations. She does not follow and only minimally participates in conversation or respond when called upon. Furthermore, Dani spends the majority of her free time alone in her room, unable to connect with the external world. This behavior indicates a *primitive withdrawal* from the external world. Life

outside of Dani's internal reality is too difficult for her to tolerate; therefore, she becomes withdrawn. She also experiences a level of primitive denial. Dani sometimes does not believe her hallucinations and delusions are a result of schizophrenia. Therefore, she does not think medication will work and then refuses to take a therapeutic dosage of medication. Furthermore, Dani continues to try and maintain the same level of academic activity from before she developed the illness which may seem like ambition; however it is a form of denial because she does not accept that her functioning has become impaired.

Omnipotent control further protects Dani from intolerable feelings. At times Dani has described delusions wherein she is a god meant to fulfill certain tasks. She also believes she causes car accidents by imagining the accident will happen. Dani utilizes projective identification to rid herself of her fear of nonexistence. She will be very provocative in therapy sessions and with family members, describing in detail ways in which she wants to die. Dani is unable to recognize her own fear or desire for death. So she projects it outward through the delusional belief that people in the world are out to kill her. Dani's expression of her fear ignites fear in her therapist and family members. Dani is able to see the fear in others and withdraws from others as a way to withdraw from her own fear.

Although Dani is utilizing primitive defenses the majority of the time, she also demonstrates some higher levels of defensive functioning. She utilizes humor regularly making jokes about her symptoms as a way to tolerate their presence. Dani has also exhibited repression in that she has been unable to recall therapy sessions wherein the content focused on losses she has experienced as a result of the illness. Higher levels of defensive functioning should be strengthened in Dani. The more mature defensive functioning Dani uses to tolerate anxiety, the better her ego functioning will become in general.

Ego Supportive Therapy with Dani

Upon review of Dani's presenting difficulties, it is clear that CBT cannot address all of Dani's treatment needs as she is still trying to process who she is now that she has developed schizophrenia. Therefore, ego supportive therapy is an appropriate way to help Dani recover her sense of self from the experience of FEP. The goals for ego supportive treatment with Dani are 1) to help her strengthen her ego functions and 2) to develop a stronger sense of self. As an FEP client, Dani needs help processing the feelings associated with her illness, support in rebuilding hope and guidance as she works to restore family and social relationships (Cullberg, 2006). Ego supportive therapy meets Dani's needs through the use of therapeutic techniques that strengthen Dani's ego functioning, help her cope with difficult emotions, and increase her self-esteem and hope (Goldstein, 1995). As Dani's functioning improves, she develops a more coherent self and may experience relief from her psychosis. Ego supportive therapy ensures Dani is not alone on her quest to rebuild herself.

Within the ego supportive model the main intervention used to assist Dani is the therapeutic relationship. Through the relationship, the therapist lends ego strength and at times will serve as an ego for Dani. In essence, the therapist functions for and with Dani until she can function on her own. The therapist models more adaptive ego functioning by using her own ego functions and mature levels of defense when working with Dani. Dani takes in the therapist's strong ego functions and defenses as a way to build up her own functioning.

The relationship between the therapist and Dani will be different from the traditional psychotherapeutic relationship as it requires less formality and increased flexibility on the part of the therapist. The therapeutic relationship is one of equality. The therapist must develop the relationship in a way that mirrors an equal human relationship, opposed to a professional

relationship. Multiple and specific actions by the clinician will occur with Dani. For instance, a therapy session may not always occur in a regular office setting as this setting does not reflect natural relationships and may not be the most comfortable situation for Dani. Instead, a therapy session may occur outside while taking a walk or getting a cup of coffee. Dani enjoys sitting outside with her therapist. She likes to take a brief walk to get some exercise and then usually settles down at a picnic table in a park like setting. On hot days Dani likes to visit the local ice cream shop and talk with her therapist over a treat. The therapist frequently meets with Dani on her college campus. Dani likes to show the therapist where she lives and walk with the therapist around the campus.

Therapy outside of the office exposes Dani to everyday situations that usually present a struggle for her. This exposure provides the opportunity for Dani to use the therapist's support as she practices interacting with the external environment. For example, when walking around her college campus, the therapist would point out different activities around campus that Dani could participate in. The therapist then asks Dani to make some observations herself about campus activities Dani may sign up for. A second example might occur when they get coffee or ice cream. The therapist models casual conversation with the server and demonstrates to Dani that it is safe to engage in social interaction. Another situation occurs when meeting outside. Dani may spot a car that she thinks has been following her and expresses her fear to the therapist. This situation provides an opportunity for the therapist to strengthen Dani's reality testing. The therapist tells Dani the car is always parked there because the owner of the car works nearby. This reality test helps Dani disengage with her delusions and connect to the real situation.

Therapy sessions with Dani are limited to an hour once a week as more time is needed to develop a strong therapeutic relationship. Dani might have additional sessions as needed and she

was also encouraged to call or email the therapist in between sessions. These arrangements do not mean the therapist is available 24 hours a day, as professional boundaries are necessary. But it does show Dani the therapist is willing to be flexible and provide Dani with support when needed. This level of flexibility is necessary to maintain the relationship with Dani. At times, Dani may struggle to make a scheduled appointment due to her psychotic symptoms. She may be too paranoid to leave the house or her auditory hallucinations may tell her the therapist is in on a conspiracy against her. This flexibility shows Dani that people will be available for her, even when she is not available to herself. In other words, the therapist's ego will be accessible to Dani when her own ego is not.

Dani experiences paranoia, including beliefs that others will harm her; therefore, the therapist must demonstrate that she will not harm Dani. In order to help Dani feel safe, the therapist shows Dani transparency by allowing for more disclosure than usual (McWilliams, 1994). By asking questions of the therapist, Dani can reality test and disconfirm any delusions she has about the therapeutic relationship. Once Dani develops a sense of safety, she may no longer feel anxiety regarding the relationship and her use of primitive defenses may diminish. Sometimes, the therapist needs to volunteer information about herself to Dani in order to model ego functioning. The following transcript of therapeutic process demonstrates how the therapist would use herself to strengthen Dani's ego functioning.

Dani: I am such an idiot I got a C on my advanced calculus exam; I used to always get A's before, when I was better.

Therapist: Oh man Dani; I am sorry you have to go through this. Getting a C is very difficult, especially when you are used to being an A student. I remember the first time I got a lower grade than I wanted, it was real blow, I felt awful. (The therapist discloses a

personal story to validate Dani's feelings, essentially giving Dani the opportunity to be upset and express discomfort before Dani has the opportunity to unconsciously defend against her pain in a maladaptive way).

Dani: I used to be awesome, now I suck. I hate this!

Therapist: What are you talking about used to be awesome?! I honestly do not know how many people who could pass advanced calculus; gosh I barely understand what calculus is! Even though you did not get an A you are still passing, that seems pretty awesome to me! (The therapist is trying to boost Dani's confidence in order to help Dani feel a sense of mastery and competence regarding her academic abilities).

The therapist demonstrates that she has also been upset over a similar issue and describes how she could tolerate those feelings - showing Dani it is alright to do the same.

Another important element of the therapeutic relationship with Dani is the therapist's ability to listen, no matter what she is saying. If the therapist is frightened by Dani's delusions, the therapist must continue to maintain the relationship and deal with her own feelings outside of the session. If the therapist ends the relationship, Dani may feel she destroyed the therapist and herself. Rather, the therapist listens to Dani explain frightening feelings and symptoms. For example, Dani once stated that the voices were telling her to wrap a phone cord around her mother's throat while she was sleeping. The therapist did not become frightened by Dani's comment and have her involuntarily admitted to the hospital. Instead, the therapist shows her understanding of Dani's projective identification, hearing Dani's need to kill her own pain. The therapist continues to tolerate Dani's pain and maintain a self despite the horror of Dani's symptoms. This therapeutic stance can increase Dani's ability to handle difficult emotions, enable her to have a coherent self and possibly decrease hallucinations regarding suicide.

Therapy with Dani should also focus on assisting her along the developmental path of helping her establish independence from her family. It is normal for Dani to want to move forward in developing a life apart from her family (Newman & Newman, 2006). However, Dani's ability to do so is thwarted by her illness. Therefore, the therapist serves as a transition between dependence on her mother and complete independence. This transition is often done through direct advice giving and environmental interventions. For example, the therapist advises Dani on how she should handle a mean professor. She helps Dani apply for disability benefits. Dani eventually learns to handle tasks on her own by observing the therapist do things for and with her. Although Dani still has someone handling responsibilities, she has the opportunity to develop independence from her mother.

Developing and maintaining relationships with others is crucial for Dani to continue with age appropriate psychosocial development (Addington & Haarmans, 2006). Within treatment, Dani's object relations needs to be strengthened, preventing her from becoming more socially withdrawn and improving her ability to engage in relationships. Maintaining the therapeutic relationship with Dani shows her that she is capable of having a relationship with another person without the person becoming a threat to her. The therapist also models those feelings associated with relationships, and helps Dani through any discomfort a relationship may provoke. Moreover, the therapist regularly co-leads a support group with Dani and other FEP clients. The clients, including Dani are encouraged to interact with one another. The therapist aids the interaction by noting similarities and prompting conversation. Often times the co-leaders interact with each other in front of the Dani and the other clients before, during and after the group. These interactions show the clients how meaningful regular social interaction can be.

Dani's feelings regarding her mental illness need be explored and validated within the treatment relationship. Dani experienced a traumatic event the first time she was hospitalized and her life has dramatically changed since the onset of symptoms. The therapist can help Dani understand what she may be feeling in response to these changes and her illness. Based upon her feelings of low self-worth and her wish to be the way she was before schizophrenia, it seems as though Dani is mourning what she has lost as a result of the illness. The goal with Dani is to help her identify her grief and allow her to be upset in a safe way without retreating to primitive defenses or regressed functioning.

The therapist supports Dani as she recognizes what she has lost in herself and helps Dani know and accept the person she is now. The therapist uses exploratory techniques and puts words to Dani's feelings around the loss of her identity as a math genius. The therapist tells Dani it is alright and normal to be upset. If Dani is better able to tolerate her feelings regarding loss or have someone else process difficult emotions with her, she can then build stronger ego functioning, more mature defenses and an increased ability to tolerate reality. The therapist also works to instill hope in Dani, helping Dani to meet the person she has become: a smart young woman who has great skill to teach math. As Dani's ego is strengthened so is her sense of self and she is able to develop adaptive functioning that is associated with her new definition of self.

Cognitive Behavioral Therapy and Treatment of Dani: Diminishing the Symptoms

Along with those conflicts associated with the self, Dani experiences psychotic symptoms daily; often the symptoms are so intense that she is unable to function. From a CBT perspective Dani's psychological distress is a result of the way she thinks about and reacts to her psychotic symptoms (Wright, Basco & Thase, 2006). Therefore, interventions are directed towards the way Dani thinks about a situation, with the aim to reduce the negativity of the reaction. Within the

upcoming section, a CBT understanding of Dani's suffering will be provided in the form of a condensed assessment of Dani's automatic thoughts, cognitive errors and schemas about the self. Following an understanding of Dani's difficulties in thinking, a description of CBT interventions for Dani is presented.

Cognitive Behavioral Assessment of Dani

Dani is caught in a cycle of experiencing symptoms, having a stressful reaction to symptoms and then having even more symptoms as a result of her initial reactions. As previously stated in Chapter Four, psychotic symptoms on their own do not cause distress. It is the way people understand and react to the symptoms that causes suffering (Morrison, 2008). Dani interprets her symptoms in a way that causes her to suffer. For instance, Dani reacts to auditory hallucinations with maladaptive thoughts and behaviors. When she hears the sound of gunshots all around her, Dani reacts with fear and hides under her bed. Dani will not leave her dorm room for days following these auditory hallucinations. She is frightened and believes she must do everything possible to remain safe from the gun fire. If Dani thought about the hallucinations differently, perhaps she would not isolate herself and instead continue with her daily life.

Dani is also bothered by the delusions that she experiences. Delusions are cognitive behaviorally conceptualized as errors in the logic of automatic thoughts known as cognitive distortions (Kingdon & Turkinton, 1994; 2005; Wright et al., 2006). Some of Dani's delusions may be thought of as *cognitive distortion personalization*. Dani has recently felt as though men wearing hats in the library are gathering data about her for the FBI. Dani is creating a situation that has nothing to do with her (people wearing hats in the library) personally. These men may be wearing hats because it is cold and they are in the library to study. However, Dani believes that the men are in the library to focus on her. Dani also has automatic thoughts that are classified as

selective abstraction, the cognitive error of ignoring evidence disconfirming a particular situation (Wright et al., 2006). Dani is certain there are cameras in the shower drains at school, even after she takes the drain apart and does not find a camera. Although evidence exists to disprove Dani's delusion she continues to think it is true.

Dani also suffers because she has developed a deeply held belief about herself known as a *schema* (Wright, et al., 2006). Dani has a core belief that she is dumb and she will never be successful. This belief may have been formed prior to the onset of the illness but did not become activated until Dani became symptomatic. Since developing schizophrenia, Dani's core belief has been strengthened. When Dani began taking challenging college courses she was also preoccupied with her psychotic symptoms. Dani has since struggled to focus in class and has received poor grades. However, Dani does not recognize the challenges that prevented her success. Instead, she negatively evaluates herself and feels as though should have been able to overcome the adversity of symptoms and difficult courses. She now has low self-esteem and feels worthless.

Cognitive Behavioral Therapy with Dani

Dani has strong reactions to her symptoms and would benefit from CBT interventions to help her reduce the distress associated with FEP. The goals of CBT with Dani involve interventions that would help Dani understand and adapt to the illness, decrease her intense emotional reactions to symptoms and increase her self-esteem. CBT works to specifically address Dani's treatment needs so she is better able to function despite experiencing a psychotic break and being diagnosed with schizophrenia. As CBT decreases Dani's suffering, she is better able to re-engage in the developmental tasks associated with young adulthood.

The first CBT intervention with Dani is the establishment of the therapeutic relationship. It is essential for the therapist and Dani to have a relationship before the implementation of CBT interventions. The relationship within CBT is similar to the relational intervention associated with ego supportive therapy. However, in CBT the confines of the relationship are more clearly defined. The therapist and Dani are working collaboratively to change the way Dani reacts to symptoms. The task of therapy is distinctly understood by both parties and the relationship remains focused on goals of CBT and on the client.. The therapist is warm towards Dani but does not share much if any of herself. This is not to say the therapist cannot share herself, it is simply not the normal practice in CBT. Furthermore, transference reactions of any kind are discouraged. Moreover, to keep the relationship safe and demonstrate the therapist's respect for Dani, the therapist does not force Dani to engage in any conversations or interventions that cause Dani discomfort..

Psychoeducation and normalization are appropriate interventions to implement during the development of the therapeutic relationship. Dani becomes less suspicious of the therapist as the therapist teaches Dani about the CBT process. Furthermore, Dani and the therapist engage in collaborative learning while they educate each other. The therapist uses psychoeducation to teach Dani about schizophrenia and Dani teaches the therapist about her experience having the illness. As the relationship further develops, the therapist and Dani learn together that Dani's experiences are symptoms of schizophrenia. It is difficult for Dani to identify her hallucinations and delusions as symptoms because she fluctuates between understanding she has schizophrenia and believing she has unique powers. The psychoeducation process has further helped Dani understand that taking medication and participating in treatment will diminish some of the symptoms Dani experiences, causing her less distress.

Normalization is an additional component of psychoeducation that helps Dani understand she is not the only person who has disturbed thoughts and perceptions (Kingdon & Turkington, 2005). The therapist shares literature about other young adults experiencing psychosis. Dani is additionally encouraged to participate in a group for FEP clients. By engaging with the group members, Dani is able to see that her experiences are not different than others; thus reducing the shame she may feel regarding her diagnosis. The therapist also helps Dani see that even people not diagnosed with schizophrenia may have symptoms related to psychosis. For instance the therapist tells Dani that many people see or hear things that are not real as they are falling asleep at night. This normalization helps Dani feel less stigmatized and also proves to Dani that the therapist understands what Dani is going through.

Relapse prevention is an integral part of CBT with psychosis and is utilized in treatment with Dani (McGorry, 2009). Psychoeducation about relapse helps Dani learn what may trigger a psychotic episode. Dani identifies that she becomes more symptomatic around final exams. She notes that the stress of taking an exam along with the quiet that accompanies studying, results in increased auditory hallucinations. Now that Dani knows when she will have more symptoms, she can prepare ahead of time to prevent distress and a need for hospitalization. Dani requests more time on exams from professors, studies with music on and takes extra medication to reduce the likelihood of increased symptoms.

When Dani feels comfortable in the relationship and understands more about CBT and schizophrenia, she may begin to take the steps necessary to change her reactions to symptoms. Modifying her automatic thoughts that are cognitive distortions will help Dani develop adaptive reactions to her symptoms. Dani has hallucinations and delusions that she is supposed to die, she reacts with the automatic thought that someone is going to kill her and she is never safe. Dani

spends every day thinking she is going to be killed. She is always hyper-vigilant and will avoid certain situations out of fear. She rarely experiences a relaxing moment due to her automatic thought. It is not the hallucinations and delusions that do not allow her to relax, it is the way she thinks about the hallucinations and delusions.

In order to be relieved of the disturbing belief that she is going to die, Dani needs to develop a different automatic thought. This is done through the examination of the belief she is going to die. Dani and the therapist deduce that there is no evidence that someone is trying to kill Dani. They discuss that Dani has lived for 19 years so far and no one has yet to make an active attempt to take her life. Furthermore, the therapist and Dani review statistics about accidents related to death and find the likelihood of this happening to Dani is low. As Dani discovers ongoing concrete evidence disproving her hallucinations and delusions she starts to think the voices are wrong. Her automatic thought changes, her reaction now is that the voices are incorrect and she will live a long time. Due to this change Dani is able to go about her day in a more relaxed way, focus on her classes and have a social life without fear of death.

Dani can also create a rationale alternative to her automatic thoughts. Dani sees the same person walk by her dorm room window every day and believes the person is the FBI spying on her. Dani and the therapist brainstorm other reasons why the person walks by every day. Dani identifies there is a church next door and perhaps the person works there. She also begins to think that perhaps this person takes a daily walk to stay in shape or take a break. Dani is able to identify alternate reasons as to why this person is around and her distress decreases.

Modifying core beliefs about herself helps increase Dani's self-esteem. As previously stated, Dani has developed a schema that she is dumb. This core belief prevents Dani from achieving her developmental goals because she doubts her abilities to move forward. Therefore

the goal would be to help Dani see that she is still smart. This schema revision is done by reviewing alternatives to her belief. For instance, when Dani gets down on herself stating she is of lower intelligence are that she is worthless, the therapist reminds Dani that she attends a highly prestigious college known for its rigorous math program and that she has strong skills teaching and tutoring children in math. Over time with regular feedback regarding her abilities, Dani will be able to develop a new belief that she is intelligent and she has good math skills.

Dani also has a core belief that any suffering on behalf of her family is her fault. She feels that she bears responsibility for the end of her parent's marriage. This schema, that she ruined her family, prevents Dani from having healthy relationships with family members and stops her from pursuing romantic interests. In order to change this belief, the therapist and Dani generate alternative reasons why her parents divorced, identifying reasons that do not directly involve her actions. Furthermore, Dani is encouraged to explore the negative and positive impact of this belief on her own life. As she sees the detriment caused by the belief, Dani may be more willing to let it go.

As Dani continues to experience psychosis, different symptoms may emerge causing her to continue reacting with automatic thoughts and negative schemas. Thus, CBT interventions will be ongoing and Dani will be taught to utilize CBT skills herself outside of session. While Dani continues to develop different reactions to all of her symptoms she becomes less bothered by her symptoms and increases her ability to function and achieve life goals.

Conclusion

The application of ego supportive therapy and CBT to the treatment of Dani shows that a singular theory, on its own, does not meet all of Dani's needs. Ego supportive therapy helps with the development of the self but does not directly provide relief from symptoms. On the other hand, CBT helps Dani adaptively react to symptoms but Dani does not have the opportunity to discover her sense of self now that she has developed schizophrenia. Therefore, an integration of interventions from both theoretical models is needed to address the relational and behavioral needs of Dani and other FEP clients. Young adults, such as Dani, have suffered a loss of the self as well as distress related to disturbing symptoms. FEP clients need help determining who they are as well as skills to move forward in the social, occupational and vocational areas of their lives despite of the presence of psychotic symptoms. Therefore, it is necessary to address all the needs of the FEP client for treatment to be considered appropriate and effective.

The first step of both ego supportive therapy and CBT is the engagement process and establishment of the therapeutic relationship. Therefore, an integrated treatment would begin with ego supportive interventions to build a healing relationship. Once a strong therapeutic relationship is established therapy can alternate between ego psychological and cognitive behavioral interventions based upon what the client needs at a particular time. An FEP client may come to a session one day having intense symptoms and need help modifying the cognitive errors they have in reaction to the symptoms. The next session the same client may be struggling with the loss of relationships and need support during the mourning process. Therefore, the therapist needs to have flexibility and know a client's needs at a given time will mandate which interventions should be utilized, ego supportive or cognitive behavioral.

An integrative model to treat FEP does not provide a concrete process by which interventions should be provided. Instead the young adult is helped with various issues within the context of a healing therapeutic relationship. By connecting with another individual who provides the FEP client with support, strength and tools for coping with symptoms the FEP client will have an opportunity for success and perhaps become more powerful than the illness of schizophrenia.

References

- Addington, D., & Addington, J. (2008). First episode psychosis. In K. Mueser & D. Jeste (Eds.), *Clinical handbook of schizophrenia* (367-379). NY: The Guilford Press.
- Addington, J., & Gleeson, J. (2005). Implementing cognitive-behavioural therapy for first-episode psychosis. *British Journal of Psychiatry*, *187*(48), 72-76. doi: 10.1192/bjp.187.48.s72
- Addington, J., & Haarmans, M. (2006). Cognitive-behavioral therapy for individuals recovering from a first episode of psychosis. *Journal of Contemporary Psychotherapy*, *36*(1), 43-49. doi: 10.1007/s10879-005-6
- Adler, G. (1978). The psychotherapy of schizophrenia: Semrad's contribution to current psychoanalytic concepts. *Schizophrenia Bulletin* *5*(11), 11-137.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Barrowclough, C., & Lobban, F. (2008). Family intervention. In K. Mueser & D. Jeste (Eds.), *Clinical handbook of schizophrenia* (214-225). NY: The Guilford Press.
- Beck, A. T. (1952). Successful outpatient psychotherapy of a chronic schizophrenic with a delusion based on borrowed guilt. *Psychiatry: Journal for the Study of Interpersonal Process*, *15*(3), 305-312.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. NY: The Guilford Press.

- Bebbington, P., & Kuipers, E. (2008). Psychosocial factors. In K. Mueser & D. Jeste (Eds.), *Clinical handbook of schizophrenia* (74-81). NY: The Guilford Press.
- Bellak, L., Hurvich, M., & Gediman, H. (Eds.). (1973). *Ego functions in schizophrenics, neurotics, and normals*. NY: John Wiley & Sons.
- Berzoff, J., Flanagan, L. M. & Hertz, P. (2008) *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (2nd ed.). Lanham, MD: Jason Aronson.
- Bowie, C. R. (2010). Delusional disorder. In I. Weiner & W. Craighead (Eds.), *Corsini Encyclopedia of Psychology* (1–3). Malden, MA: John Wiley & Sons
DOI: 10.1002/9780470479216.co_rpsy0255
- Compton, M. T. & Broussard, B. (2009). *The first episode psychosis: A guide for patients and their families*. NY: Oxford.
- Corsini, R. J., Wedding, D. (2008). *Current psychotherapies 8th ed.* Belmont, CA: Thomson Brooks/Cole.
- Cullberg, J. (2006). *Psychoses: An integrative perspective*. NY: Routledge.
- Downer, J., & Kapur, S. (2008). Biological theories .In K. Mueser & D. Jeste (Eds.), *Clinical handbook of schizophrenia* (25-34). NY: The Guilford Press.
- Ellman, L. M., & Cannon, T. D. (2008). Environmental pre- and perinatal influences in etiology. In K. Mueser & D. Jeste (Eds.), *Clinical handbook of schizophrenia* (65-73). NY: The Guilford Press.
- Frued, A. (1936). *The ego and the mechanisms of defense*. NY: International University Press.
- Frued, S. (1923). The ego and the id. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19.). London: Hogarth Press.

- Frued, S. (1924). Neurosis and psychosis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19.). London: Hogarth Press.
- Freudenreich, O., Holt, J. H., Cather, C., & Goff, D. C. (2007). The evaluation and management of patients with first episode schizophrenia: A selective, clinical review of diagnosis, treatment, and prognosis. *Harvard Review of Psychiatry*, *15*(5), 189-211.
doi:10.1080/10673220701679804
- Garety, P. A., Kuipers, E. E., Fowler, D. D., Freeman, D. D., & Bebbington, P. E. (2001). A cognitive model of the positive symptoms of psychosis. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences*, *31*(2), 189-195. doi: 10.1017/S0033291701003312
- Glatt, S. J. (2008). Genetics. In K. Mueser & D. Jeste (Eds.), *Clinical handbook of schizophrenia* (55-64). NY: The Guilford Press.
- Goldstein, E. G. (1995). *Ego psychology and social work practice* (2nd ed.). NY: The Free Press.
- Grazebrook, K. A., Siddle, R., Leadley, K., Everitt, J., Benn, A., Haddock, G., Tarrier, N. (2004). First episode psychosis: Two cases to illustrate the role of cognitive behavior therapy in making sense of unusual experiences. *Behavioural and Cognitive Psychotherapy*, *32*, 341-345. doi: 10.1017/S1352465804001390
- Green, M. F. (2003). *Schizophrenia revealed*. NY: Norton.
- Grinnell, R. M., Kyte, N. S., & Bostwick, G. J. (1981). Environmental modification. In A. N. Maluccio (Ed.), *Promoting competence in clients: A new/old approach to social work practice* (152-184). NY: Free Press.
- Hartmann, H. (1939). *Ego psychology and the problem of adaptation*. NY: International Universities Press.

- Heisel, M. (2008). Suicide. In K. Mueser & D. Jeste (Eds.), *Clinical handbook of schizophrenia* (491-504). NY: The Guilford Press.
- Hertz, P. (2008). The psychosis, with a special emphasis on schizophrenia. In J. Berzoff, L. M. Flanagan, & P. Hertz (Eds.), *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (2nd ed.). (281-310). Lanham, MD: Jason Aronson.
- Hoffman, R. E. (2010). Loose associations. In I. Weiner & W. Craighead (Eds.), *Corsini Encyclopedia of Psychology* (1–2). Malden, MA: John Wiley & Sons
DOI: 10.1002/9780470479216.c orpsy0255
- Hollis, F. (1972). *Casework: A psychosocial therapy* (2nd ed.). NY: Random House.
- Kaplan, R. M. (2008). On being Bleuler: The second generation of schizophrenia. *Australasian Psychiatry*, 16(5), 305-311. doi: 10.1080/10398560802302176
- Kavanagh, D. (2008). Management of co-occurring substance use disorders. In K. Mueser & D. Jeste (Eds.), *Clinical handbook of schizophrenia* (459-470). NY: The Guilford Press.
- Kingdon, D. G., & Turkington, D. (1994). *Cognitive –behavior therapy of schizophrenia*. NY: The Guilford Press.
- Kingdon, D. G., & Turkington, D. (2005). *Cognitive therapy of schizophrenia*. NY: The Guilford Press.
- Kuller, A. M., Ott, B. D., Goisman, R. M., Wainwright, L. D., & Rabin, R. J. (2010). Cognitive behavioral therapy and schizophrenia: A survey of clinical practices and views on efficacy in the United States and United Kingdom. *Community Mental Health Journal*, 46(2), 2-9. doi: 10.1007/s10597-009-9223-6
- Laughlin, H. P. (1979). *The ego and its defenses* (2nd ed.). NY: Jason Aronson.

- Lavertsky, H. (2008). History of schizophrenia as a psychiatric disorder. In K. Mueser & D. Jeste (Eds.), *Clinical handbook of schizophrenia* (3-13). NY: The Guilford Press.
- MacDonald, A. W., & Schulz, S. (2009). What we know: Findings that every theory of schizophrenia should explain. *Schizophrenia Bulletin*, 35(3), 493-508. doi:10.1093/schbul/sbp017
- MacDonald, E., Sauer, K., Howie, L., & Albiston, D. (2005). What happens to social relationships in early psychosis? A phenomenological study of young people's experiences. *Journal of Mental Health*, 14(2), 129-143. doi: 10.1080/09638230500060052
- Malla, A. K., Norman, R. M., & Joober, R. (2005). First episode psychosis, early intervention and outcome: What have we learned. *Canadian Journal of Psychiatry*, 50(14), 881-891.
- McFarlane, W. R. (2002). *Multifamily groups in the treatment of severe psychiatric disorders*. NY: Guilford Press.
- McGorry, P. D. (1995). Psychoeducation in first-episode psychosis: A therapeutic process. *Psychiatry: Interpersonal and Biological Process*, 58(4), 313-328.
- McGorry, P. D. (2002). The scope for preventive strategies in early psychosis: Logic, evidence and momentum. In M. Birchwood, D. Fowler, & C. Jackson (Eds.), *Early intervention psychosis: A guide to concepts, evidence and interventions* (3-27). NY: Wiley Press.
- McGorry, P.D. (2001). The detection and optimal management of early psychosis. In M. Birchwood, D. Fowler & C. Jackson (Eds.). *Early Intervention in Psychosis*, (3-27). Chichester, UK: John Wiley & Sons Ltd.
- McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical practice*. NY: The Guildford Press.

- Miller, R., & Mason, S. E. (1998). Group work with first episode schizophrenia clients. *Social Work with Groups*, 2(1/2), 19-33. doi: 10.1300/J009v21n01_03
- Morrison, A.P. (2008). Cognitive-Behavioral therapy. In K. Mueser & D. Jeste (Eds.), *Clinical handbook of schizophrenia* (226-239). NY: The Guilford Press.
- Morrison, A. P., & Renton, J. C. (2001). Cognitive therapy for auditory hallucinations: A theory-based approach. *Cognitive and Behavioral Practice*, 8(2), 147-160. doi 10.1016/S1077-7229(01)80020-1
- Newman, B. M., & Newman, P.R. (2006). *Development through life: A psychosocial approach* (9thed.). Belmont, CA: Thomson Wadsworth.
- Nichols, M., P. (2009). *The essentials of family therapy* (4th ed.). Boston, MA: Pearson Education, Inc.
- Robinson, J., Harris, M. G., Harrigan, S. M., Henry, L. P., Farrelly, S., Prosser, A., McGorry, P. D. (2010). Suicide attempt in first episode psychosis: a 7.4 year follow-up study. *Schizophrenia Research*, 116, 1-8. 10.1016/j.schres.2009.10.009
- Schamess G. (2008). Structural theory. In J. Berzoff, L. M. Flanagan, & P. Hertz (Eds.), *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (2nd ed.). (49-62). Lanham, MD: Jason Aronson.
- Schamess, G., & Shilkret, R. (2008). Ego psychology. In J. Berzoff, L. M. Flanagan, & P. Hertz (Eds.), *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (2nd ed.). (63-98). Lanham, MD: Jason Aronson.
- Silverstein, S. M., Spaulding, W. D., & Menditto, A.A. (2006). *Schizophrenia: Advances in psychotherapy evidenced based practice*. Cambridge, MA: Hogrefe & Huber.

- Sin, J., Moone, N., & Wellman, N. (2005). Developing services for the careers of young adults with early-onset psychosis—listening to their experiences and needs. *Journal of Psychiatric and Mental Health Nursing*, *12*, 589-597. doi:10.1111/j.1365-2850.2005.00883.x
- Tarrier, N., & Bobes, J. (2000). The importance of psychosocial interventions and patient involvement in the treatment of schizophrenia. *International Journal of Psychiatry in Clinical Practice*, *4*(1), 35-51. doi: 10.1080/13651500050518028
- Tennakoon, L. A., Fannon, D., Doku, V., O’Ceallaigh, S., Soni, W., Santamaria, M., Sharma, T. (2000). Experience of caregiving: Relatives of people experiencing a first episode of psychosis. *British Journal of Psychiatry* *177*, 529-533. doi: 10.1192/bjp.177.6.529
- Thorup, A., Petersen, L., Jeppsen, P., Ohlenschlaeger, J., Christensen, T., Krarup, G., ... Nordentoft, M. (2006). Social network among young adults with first-episode schizophrenia spectrum disorders: Results from the Danish OPUS trial. *Social Psychiatry and Psychiatric Epidemiology*, *41*, 761-770. doi: 10.1007/s00127-006-0098-3
- Torrey, E. F. (2006). *Surviving schizophrenia: A manual for families, patients and providers* (5th ed.). NY: Collins Living.
- Vahia, I. V., & Cohen, C. I. (2008). Psychopathology. In K. Mueser & D. Jeste (Eds.), *Clinical handbook of schizophrenia* (82-90). NY: The Guilford Press.
- Vaillant, G. F. (1992). *Ego mechanisms of defense*. Washington, DC: American Psychiatric Press.
- Valmaggia, L. R., Tabraham, P., Morris, E., & Bouman, T. K. (2008). Cognitive behavioral therapy across the stages of psychosis: Prodromal, first episode, and chronic

- schizophrenia. *Cognitive and Behavioral Practice*, 15(2), 179-198. doi:10.1016/j.cbpra.2007.007
- Walker, E., Kestler, L., Bollini, A., & Hochman, K. M. (2004). Schizophrenia: Etiology and Course. *Annual Review of Psychology*, 55, 401-430. doi:10.1146/annurev.psych.55.090902.141950
- Weisholtz, D., Epstein, J., Stern, E. and Silbersweig, D. (2010). Hallucinations. In I. Weiner & W. Craighead (Eds.), *Corsini Encyclopedia of Psychology* (1–3). Malden, MA: John Wiley & Sons DOI:10.1002/9780470479216.corpsy0255
- Wright, J. H., Basco, M. R., & Thase, M. E. (2006). *Learning cognitive-behavior therapy: An illustrated guide*. Arlington, VA: American Psychiatric Publishing Inc.
- Wright, J. H., Turkington, D., Kingdon, D., & Basco, M.R. (2009). *Cognitive-behavior therapy for severe mental illness: An illustrated guide*. Arlington, VA: American Psychiatric Publishing Inc.