

ATTACHMENT AS A PREDICTOR OF THERAPEUTIC OUTCOME

A case study of a young patient with psychosis

Janja Mihoci & Marjeta Blinc Pesek

Psychiatric clinic Rudnik, Rudnik II / 4, 1000 Ljubljana, Slovenia

SUMMARY

Therapeutic alliance is one of the predictors of a successful therapy. In the current case study of the 26 year old male student diagnosed with paranoid schizophrenia we discuss the possible consequences of a short break in the therapeutic process on the treatment outcome.

The client was appointed to an assistant psychologist for study support sessions and to work on his social skills and anxieties. The therapy continued regularly for a month and a half with some visible results in motivation, engagement and mood. After a break in the sessions due to the psychologist's absence, the client did not attend the sessions regularly. He became more withdrawn, his compliance with medical treatment was diminished and he did not meet his study goals.

Key words:

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Introduction

A lot of attention has been given to the importance of therapeutic alliance in psychotherapy and how it at least modestly correlates with outcome (Horvath & Symonds 1991; in Wittor et al. 2010). Secure attachment needs to be established before a good therapeutic alliance can be formed.

Methodology

A self-report questionnaire was administered (1) in order to assess drug attitude of the patient. The questionnaire was translated into Slovene.

1. Drug Attitude Inventory (DAI-10) by Daniel J. Dugan (7). *The questionnaire consists of statements about the perceived effects and benefits of antipsychotic medication. Higher scores indicate a more positive attitude towards medication.*

Case report

The 26 years old male student diagnosed with paranoid schizophrenia (American Psychiatric Association 2005) started attending therapy and support sessions with an assistant psychologist in May 2010. The sessions were aimed to prepare him for his upcoming exams and to improve his social skills and deal with anxieties in that area.

The client first saw a psychiatrist in October 2006. He was diagnosed as having suspected psychosis with a depressive disorder and was treated with olanzapine 5 mg, aripiprazole 10 mg and paroxetine 20 mg per day. He was noncompliant with medication and after his fourth visit he terminated treatment.

In May 2007 he first made an appointment with his current psychiatrist. He presented then with delusions of being observed, auditory hallucinations, insomnia and oversleeping during the day, difficulty deciding, thoughts about death, but no attempt to commit suicide. He was restless and would walk around the house a lot.

He has been prescribed aripiprazole, the treatment has been changed to Risperdal Consta 25 mg every two weeks because of poor compliance. From August 2007 on has been attending group therapy every two weeks. He has never been hospitalised.

On the Drug attitude inventory DAI-10 (Dugan 2006) he had a low positive score. Implying he has a low compliant attitude towards medication.

He is the second of three children; 3 years older sister and 8 years younger brother. He has strict, authoritative and emotionally cold parents. His mother is highly protective. Without any particular reason his father would get physically aggressive towards him and his sister. From his childhood on he was afraid of him; he first spoke to him in 2006 in his first psychotic episode, before that he only answered what he was asked. The only person in his family with whom he has a good relationship is his younger brother.

As a child he suffered a lot from asthma attacks. He has been hospitalized for a few weeks at age 1 and a half and withdrew into sleep as he has been told by his mother afterwards.

He refused to attend primary school at the beginning. He was a very good pupil. His marks dropped in Secondary school. He started to feel very anxious and started avoiding social situations. In his second year he started experiencing thought blockage. He had to repeat his second year. In 2001 he consumed marijuana every day for a week than only once a month. It had a calming effect. He has stopped using it after some paranoid feeling developed and is not using it any longer for more than five years. After high school he entered the university the Department of physics. He did not pass any exams in the first year and stayed at home the following year. After that he entered the Department of Geology.

His social interaction in primary school was good. He played tennis and was cycling a lot with two of his friends. In Secondary school he was more withdrawn.

At this point he had only one person who he occasionally meets outside his family or therapeutic setting, a young man who he met in group therapy.

At first his sessions with the psychologist were study orientated due to lack of concentration at home. He usually came into the office for two hours. The session started with a short motivational conversation with the therapist. Then he studied for 45 minutes. He met the therapist during his 15 minutes break and then studied for 45 minutes again.

He attended regular therapy sessions from end of May till middle of July 2010, every 4 days on average. He hasn't come for 8 working days because of a school trip. In middle of July the therapist was absent for 10 working days. The therapist announced her absence two sessions in advance and arranged for him to come for sessions with the psychiatric nurse that he knew, she was also the person who gave him intramuscular medication. He also got a diary where he was supposed to write his study progress and emotions connected to studying. This was supposed to be presented to the nurse on every session. He attended only one of these sessions and did not bring the diary.

The frequency of his sessions decreased to every 7 days after the therapist returned, with 15 days being the longest absence. He missed 4 of his appointments and did not schedule new ones without the recommendation of his psychiatrist. He did not finish his exams and was not able to enrol into the second year of his studies.

On the basis of his psychiatrist's recommendation he asked for a new appointment with the therapist.

Interpretation

The question is whether a good therapeutic alliance was established. Was there a strong enough emotional bond between the client and therapist (Maritin et al. 2000; in Wittorf et al. 2010), which could lead to a good alliance. During the sessions it was not easy for the client to share his feelings about situations, experiences and perceptions. It was difficult for him to take a perspective on his own observations, thoughts and feelings (Rosenbaum & Harder 2007). He has put great hope in the 'new therapy' and the immediate effects of this were seen in his motivation, success in some exams and better mood. He also became more compliant with medical treatment and accepted a small dosage of Leponex that has improved his condition further.

He temporarily lost protection and security that has been represented by the sessions that he had with the psychologist. Because of the insecure and tender attachment he could not perceive the loss as temporary. He has had some blocks in studying at home and the anxiety level increased.

Correspondence:

Janja Mihoci
Psychiatric clinic Rudnik
Rudnik II / 4, 1000 Ljubljana; Slovenia
E-mail: psih.ord.r@siol.net

He has failed a few exams and has not attended a few.

His insecure attachment to his main symbiotic person, his mother, could also be one of the reasons that the delicate therapeutic alliance did not withstand the absence of the therapist.

It is well known that people with persisting psychotic disorders need adequate and continuing treatment in a stable, safe and stimulating environment (Herrman, Hawthorne and Thomas, 2002). Safety and stability were two important factors in therapy that were disrupted at an early stage in therapy and could have lead to an unfavourable outcome. The structure of the sessions was also interrupted. It has been argued that structure has a lot of influence in creating a therapeutic alliance, as have the personal qualities of the therapist (Rosenbaum & Harder 2007).

Every break in therapy should be announced well in advance. This could decrease the separation anxiety that has interrupted the therapeutic process.

When talking about therapeutic alliance it is important to note the implications it can have in a clients' life (e.g. improved global and social functioning, fewer symptoms, higher life quality, and greater medication compliance) (Frank & Gunderson 1990, Gehrs & Goering 1994; Neale & Rosenheck 1995, Solomon et al. 1995, Svensson & Hansson 1999; Hansson et al. 2008, in Wittorf et al. 2010).

Considering the vast implications of therapeutic alliance mentioned above for a good therapeutic outcome and what the outcome of the present case was it is important to have it in mind for further therapy sessions with the client.

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