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Ryszard Chłopek, Anna Kominek

PSYCHOTHERAPY OF A COUPLE WITH LONG-STANDING EXPERIENCE OF PSYCHOSIS

Couple and Family Therapy Clinic

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Summary

The aim of this article is to consider whether marital or couple therapy can be a useful method of supporting biological treatment, which seems to have been overlooked so far in specialist literature and research. A 21-month process of marital therapy carried out by a couple of psychotherapists was analysed. The sessions lasted one and a half hours and for most of the therapy, they were held once every two weeks. The results of the therapy are promising. The number of relapses and hospitalizations has decreased. For the last four years before the psychotherapy started, the patient had been experiencing one to two fits of psychosis per year and it always involved many months of hospitalizations. For the two years of therapy and one year after its completion, the patient did not experience a relapse of acute psychotic phase and she was not hospitalized. In addition, the quality of the relationship has improved. It seems that marital and couple therapy can become an important part of the treatment of patients struggling with psychoses. To the authors' knowledge, this method is rarely offered to patients of psychiatric institutions.

Introduction

Specialists from different countries and presenting various therapeutic paradigms agree that psychotherapy of patients struggling with psychosis is a challenge, but it also brings hope for improving their functioning and returning to family, professional and hobby activities [1-8]. The literature describes individual [9], group [10] and family therapies [2]. The heroic efforts of clinicians to undertake psychotherapy of people suffering from schizophrenia and to organise the whole system of support institutions are often recognised [3]. However, the authors of this study did not come across a description of the couple therapy in which one of the couple suffers from schizophrenia. Hence the idea of presenting such a work.

The fact of diagnosing a mental illness in one of the partners can be understood as a traumatic event, permanently affecting the family homeostasis [11]. A separate question is how psychosis affects the relationship and the marital bond and how the quality of marriage can affect the course of the disease. A mental illness can destabilise or even destroy a marital relationship. Therefore, the support provided by the spouse is of great importance but so is the support provided for the couple during and immediately after hospitalisation.

Below is a description of a marital therapy lasting 21 months, conducted within a private therapy centre. There have been twenty session lasting an hour and a half each. Most of the time, the meetings were held every two weeks. In the last period of the therapy, sessions were held less frequently. Psychotherapy was carried out by a pair of therapists (male and female) integrating the systemic, psychodynamic and psychoeducational approaches [11].

The case description is based on the therapists' memories and post-session notes. The patients were consulted about the description by letter, they gave their consent to publishing it and added that the effects of the therapy persisted. The letter contact was made about a year after the end of the therapy.

Case description

The phase of establishing the therapeutic alliance and of making the contract (sessions 1-3)

A couple - M. (age 51) and R. (age 52) - being married for thirty years came for marital therapy. The initiator of the meeting was Mrs. M. - she was the one who contacted the therapist on the phone, she was also the first to speak at the sessions. The inspiration to look for marital therapy came from two sources:

1) from an addiction treatment centre where Mrs. M. went with her husband worried about his alcohol use. However, the addiction therapist – according to both Mr. and Mrs. X – was not able to diagnose or exclude the addiction syndrome and suggested that the couple be treated;
2) from the daughter, who was in treatment for depression at the time and gave them contact details directly to the therapists.

Mrs. M. was a tall, well-groomed woman. She had a higher education in teaching, and the first 7 years she worked in health care. The development of a mental illness (the first in-patient hospitalisation in her life took place after the birth of her youngest daughter) made it impossible for M. to return to work. She liked spending time with her husband, preferably in the theatre, at concerts, or with friends. At the time of the first consultation, she was a few weeks after the end of another psychiatric hospitalisation, she complained about too strong drugs causing, according to her account, concentration disorders, stupefaction, and muscle stiffening. In fact, during that conversation this stiffening was visible *e.g.* in "limited" facial expressions and frequent blinking.

Mr. R. was a warm, though somewhat withdrawn man. He graduated from an artistic university and in the past, he was involved in social activities. At the time of the therapy, he was very successful in business activities in various industries. He described his interests in the same way as his partner – he liked spending time with her in the theatre, cinema, opera, or philharmonic and meeting with friends. In the description of his interests, he included a sentence that raised the therapists' concerns – for twenty years, he had been trying to drink at least one bottle of wine every day. When questioned about, he said that he was a wine gourmet – in his opinion, he did not suffer life losses due to the use of alcohol. Mrs. M. disagreed with that opinion, pointing to her husband's periodically bad morphology.

R. and M. had three daughters – all of them moved out of the house and led an independent life.

The youngest worked with her father in one of the companies. All three daughters were treated for depression, the oldest one also for addiction.

After the birth of her youngest daughter, Mrs. M. went through an acute psychotic episode and was hospitalised for the first time. Since then, she had frequent recurrences that were dramatic and required hospitalisation. Mr. and Mrs. X. also had a seven-year remission period in Mrs. M.'s disease, which was in the "family with teenagers" phase. Mr. R. associated that time of good coping with the disease with the fact that his wife decided to take a depot drug during that period.

The disease exacerbated 4 years before the couple came to therapy. In Mrs. M.'s opinion, this was related to menopause. In turn, in the minds of the therapists, there were hypotheses about the connection between the worsening of her mood and the "empty nest" phase, mourning after her daughters left home and she lost the sense of being needed by others. Mrs. M. expressed ambivalent feelings about psychiatric treatment – on the one hand, she admitted that medicines helped her and that she felt good about the contact with her attending physician. On the other hand, the very diagnosis of paranoid schizophrenia and the course of her admissions to hospitals and hospitalisations themselves was dehumanising. For Mr. R., the acute phases of his wife's disease were associated with a loss of sense of security – she was then aggressive towards him, and once she wrote a report to the Tax Office (fortunately without any consequences). Psychiatric hospitalisation could only start when Mrs. M.'s condition was already deteriorating to such an extent that she had to be taken to an inpatient ward by force and treated against her will. As a result, most of the hospitalisations (which were over a dozen) started dramatically for both partners.

The couple had previously attempted therapy with different therapists three times. From the descriptions of previous therapeutic contacts one could get the impression that what made it difficult for Mr. and Mrs. X. to be in a therapeutic relationship was that in their comments and reactions, the previous therapists omitted the most difficult issues brought by the couple to therapy. This made Mr. and Mrs. X. feel misunderstood and they lost motivation to continue the therapy. These issues were particularly clearly highlighted by Mr. R., saying that the previous therapist did not comment on his wife's aggressive behaviour and therefore he felt abandoned. Also, the previous therapist's praise for their family life occurred to him like omitting the painful topics and so he felt abandoned again. These stories were at the same time a guideline for the current therapists – what their patients needed (empathic tuning and room as well as responding to real events – perhaps with a temporary suspension of neutrality in the systemic sense), and what was better to be avoided at least in the first stages of therapy (working on resources, positive connotation) – as this could be experienced as disregard for the suffering of Mr. and Mrs. X.

At the first meetings, the way the spouses behaved with each other was a mixture of attachment, distance, hostility, and fear. Mrs. M. was afraid that her husband would use her diagnosis as an excuse to control her, criticise her and deprive her of the right to decide about herself. Mr. R. was afraid of the acute phases of his wife's psychosis – when they started, he would live for several days and sometimes for several weeks under one roof with a person who was hostile towards him and out of control. He waited in tension

for his wife's behaviour to become so aggressive that he could call an ambulance. He was afraid that if Mrs. M. wrote an allegation letter to some institution again, this would bring actual inspections on his companies. Mr. R. also expressed his anxiety and annoyance that his wife did not take advantage of her long experience of psychiatric treatment, which would eventually end up in a relapse.

Mr. and Mrs. X. formulated their expectations regarding the therapy goals as follows:

Mrs. M. wanted more openness in the relationship and more time spent together, she also expected her husband to drink less.

Mr. R. wanted to get an insight into his wife's treatment – he further explained that this was basically an interim goal to his main objective, which was to reduce the number of recurrences of the acute phase of the disease and the associated aggressive behaviour and hospitalisations.

At the same time, the partners did not want to agree to each other's goals. Mrs. M. did not want to be controlled by her husband, and Mr. R. did not want to give up drinking wine.

With regard to both the above expectations and the disagreement about the goal of the therapy, a therapeutic contract was made with Mr. and Mrs. X. for an indefinite period of work, at a frequency of 1.5 hours every two weeks, the objectives of which were: 1) talking about schizophrenia and thinking about how to prevent the relapses of psychosis; 2) discussion about the function, role and importance of alcohol in the life of family X; 3) building emotional closeness. The contract did not contain any behavioural goals, such as: what is to change in the life of the couple. The role of the therapists was to moderate and enable conversation.

The phase of talking about problems as well as looking for changes and implementing them (sessions 4-16)

The middle phase of the therapy comprised 13 sessions and lasted 7 months. At that time, the spouses were adopting such an attitude towards each other that could be called negotiating. Mr. R. wanted to deal with his wife's illness, and Mrs. M. wanted to talk about her husband's drinking. The solution that Mr. and Mrs. X. developed over time to make their work during sessions possible was to distribute the time evenly. And so at one point the structure of the session started to look like this: 1) The initial phase, in which they talked about how the time had passed since the last meeting and what they remembered best from the last session (about 10 minutes), 2) the time for an issue brought by one of the partners, and then the same time for an issue brought by the other partner (about 50 minutes – 2 times 25 minutes each) – in this part of the session, the role of the therapists was to moderate the conversation in such a way that each of the spouses participated in the discussion on the topic brought by the partner to the same extent, 3) summarising the comments of the therapists - using the reflecting team technique (about 10 minutes), 4) the spouses' comments on the comments of the therapists, concluding and opening conversation, making another appointment and saying goodbye.

The couple discussed the following problematic issues: 1) the recurrence of the acute phase of

the disease, the dynamics of symptoms, the treatment and the impact of the disorder on the partners; 2) alcohol – its good and bad sides in family life; 3) distribution of power and dependence in the marriage; 4) intimate life; 5) family histories - working with the genogram.

Talks about schizophrenia

For both Mr. and Mrs. X. and for the therapists, the analysis of the dynamics of symptoms and the development of more effective methods to prevent the recurrence of the acute phase of the disease were an important issue. Before coming to therapy, the couple experienced very frequent and long hospitalisations – they happened once or twice a year and lasted several months. Analysing the history of the disease, Mr. and Mrs. X. said that, in fact, the symptoms appeared eight years before the first hospitalisation and were untreated, and the situation between them at that time (hostility, separation) was difficult for them to define and they tended to experience it as intensified marital problems. It was not until the first hospitalisation of Mrs. M. (after the birth of their youngest daughter) that a medical narrative was introduced into Mr. and Mrs. X's thoughts about their family.

Hospitalisations were preceded by weeks of increased tension in mutual relations, which was connected with the intensification of delusional thinking and hostility of Mrs. M. towards her husband. At that time, Mr. R. usually suffered verbal aggression from his wife and anxiously awaited an event that would allow him to call an ambulance.

During one of the sessions devoted to developing a psychoeducational map of the dynamics of the symptoms, Mrs. M. said that when the acute phase of the disease was approaching, she would first feel hostility towards her husband and start to be interested in esotericism. Mr. R. added that this was accompanied by chaos in his wife's thinking and acting. Both Mr. and Mrs. X. thought this was the best and actually the only time for Mrs. M. to react and do something to avoid aggravation of the symptoms and hospitalisation. Mr. R. expressed his anger that his wife, although she knew what drugs might help her at that point, was not taking them. On the contrary, it sometimes happened that at this moment, she would take drugs that she knew their activating effect would paradoxically accelerate the development of psychotic symptoms. Mrs. M. was initially angry with her husband's statements and wanted to deny them, but after a while, she went silent and quietly admitted that "psychosis absorbs you." When asked for a more detailed description, she said that she experienced her life – especially in the periods after psychotic episodes – as empty and colourless. Therefore, the euphoria that she begins to experience on the verge of delusions is something so attractive that she does not want to interrupt it. Further conversation concerned the consequences of a psychotic episode for Mrs. M. and revolved around the question of whether a few weeks of pleasant psychosis was worth a few months of humiliating and unpleasant hospitalisation and a few months of post-psychotic state in which Mrs. M. experienced overwhelming feelings of emptiness, lack of energy, anhedonia and lack of sense. This session ended with Mrs. M. being convinced that she wanted to prevent relapses of the acute phase of the disease.

Despite this declaration, Mr. and Mrs. X. came for the next session upset. Mr. R. in his first words said that according to him, his wife was starting to fall into psychosis, the physician could not see it and had no chance of seeing it (because Mrs. M. was hiding it from him), and he had no chance of sharing his observations with the physician because his wife did not allow him to contact her psychiatrist. Mr. R. felt helpless and angry – he expected that the meeting would lead to unblocking his ability to contact the physician. Mrs. M. was angry with her husband, accusing him of tyranny and a desire to control her completely, at times she seemed to have lost the plot, she also seemed to be in a slightly increased drive. It seemed like the "psychosis was just absorbing her"...

At that point, the therapists began to experience the fear of hospitalisation, which would be another traumatic experience in the life with the disease, and that it would stop the therapy for several months. And if the spouses considered the therapists to be unable to help them, they could end the therapy prematurely and without any effect.

The response to the therapists' fears, Mr. R.'s fear, and the threat of the acute phase of the disease developing was the introduction of a strategic intervention in the form of a ***Health Contract*** [14th session].

The Health Contract
Mrs. M. undertakes to strictly follow the instructions of the psychiatrist in terms of pharmacotherapy, in particular: 1) not to modify the recommended dosages without consulting the physician; 2) not to include additional psychiatric drugs without consulting the physician; 3) consulting the physician on the inclusion of additional tranquilizers and herbal medicines in the therapy. Mr. R. undertakes to visit the psychiatrist regularly with Mrs. M. so that: 1) the psychiatrist has an opportunity to obtain information about the observed symptoms and effects of treatment also from Mr. R; 2) Mr. R. is clear about the recommended drugs, their doses and the psychiatrist's recommendations. The therapists undertake to ask at each subsequent session whether the contract was being observed.

After this contract was concluded, the therapists became worried that they were interfering too much with the physician-patient relationship. In the therapists' notes, there is an entry: "you have to contact the physician," which, however, they did not do.

During subsequent sessions, it turned out that the contract was being observed – though Mrs. M. was angry with it, rightly raising the issue of inequality, as the contract forced something mainly on her. It resulted in joint visits at the psychiatrist's, modification of pharmacotherapy and extinguishing the initial symptoms of an acute psychotic episode. During joint visits at the physician's, the spouses worked out a

scheme of pharmacological reactions to the first heralds of an episode.

Talks about alcohol

The subject of alcohol was raised very consistently by Mrs. M. She was worried that her husband was destroying his health but she also wanted to be closer to him – and she felt that alcohol made it difficult. Mr. R. disagreed with such a description, arguing that you could talk over wine and be close.

The therapists' thoughts during that period of the therapy revolved around describing Mr. R. in nosological terms – alcohol-dependence syndrome. What prevented them from relying on such a description was the fact that it was difficult to point out significant life losses (professional, family, health) in Mr. R.'s life caused by the use of alcohol and the fact that Mr. R. did not increase the doses of alcohol, although the period of intensive use of wine by Mr. R. had already lasted almost 20 years.

During the conversations about alcohol, it turned out that a significant problem for Mrs. M. was that when her husband was drinking, she would drink with him (about two glasses of wine a day), in spite of taking psychiatric medications simultaneously. During this phase of therapy, the spouses tried to find solutions at the behavioural level by introducing "Monday without alcohol". Despite initial problems – mainly from Mr. R. – with maintaining abstinence on one day of the week, over time Mr. and Mrs. X. began to introduce a second day without alcohol.

On the intra-psychological level, such intensive use of alcohol by Mr. R. could be understood as a way to alleviate fear, anxiety, tension, and a sense of helplessness associated with the trauma of mental disease in the family and its dramatic course. For Mrs. M., alcohol was associated with a sense of closeness, pleasant memories from the first years of marriage, and with pleasure in general – so it may have been a substitute for the couple's erotic life, which had faded.

In the therapists' thinking, the problem of alcohol was paradoxically a good resource for therapeutic contact. Thanks to it, it was possible to conduct therapeutic conversations in a way that was close to neutral, without marking one of the partners as the "carrier of the disease" and to avoid a situation where "three therapists" (the psychotherapists and Mr. R.) and only one patient were working on the reported problem. The balance of problems, developed by the system, allowed the spouses to treat each other as partners in the search for solutions and was perhaps an unconscious expression of Mr. R.'s need to stay in a partnership relation with his wife.

The issue of power, meaning and family relations

The spouses did not raise the issue of distribution of power and dependence as a separate topic for the sessions but this theme appeared quite often when discussing other problems. Mrs. M.'s disease and the subsequent leaving of their daughters from home had a significant impact on the structure of the family – Mrs. M. felt frustrated by her insignificance in the home and lack of influence *e.g.* on the household income. Even though Mrs. M. considered returning to professional activity, after an over-twenty-year break from

work and a decrease in self-confidence in social relations, she was rather thinking about working as a volunteer.

Mrs. M. communicated her frustration caused by not being able to realise herself in this sphere of life, in the form of resentment and reproach addressed to her husband. At a deeper level, probably, he felt guilty (this assumption could only be identified in the last, supportive phase of the therapy), and in communication, he reacted defensively emphasizing his contribution to family life, which was in fact very large. Mr. R. did not only support the family at a high financial level and often helped his adult daughters, but he also took over his wife's household duties for months. However, in marital conversations, noticing Mr. R.'s merits made Mrs. M. feel even less important. In her statements addressed to the therapists, she reported a sense of guilt and a sense of being a drag on her husband, but in her statements addressed to her husband, she only expressed anger and dissatisfaction.

These dynamics led to arguments between the partners – also outside the sessions. This was of great concern to Mr. R. The irritability and anger of his wife over the past two decades would herald the onset of the acute phase of the disease. Now, the partners had to accept the argument back as part of family life but also to learn how to distinguish between a simple argument and a psychotic one.

Issues concerning the couple's erotic life

In the fifth session, the couple indirectly signalled a problem in erotic life. When questioned about it, they presented this aspect of life from their own perspective each. Mrs. M. said she had been having trouble with sex and reaching orgasm since the beginning of her treatment. She thought it was related to the influence of the drugs and she wanted to ask the psychiatrist a few times – but she always felt embarrassed. She said that she had "not been attracted to sex" at all for four years. Mr. R. believed that their erotic life was returning when they felt comfortable with each other in everyday life. Both spouses found this topic too embarrassing to discuss during the sessions, probably due to the fact that the therapists were clearly younger than the couple – but it was not discussed during the session. Perhaps the reasons for the lack of such a discussion were unreflected fears of the therapists that they would turn out not to be competent/experienced enough. The therapists rather decided to respect the clients' clear declaration that they wanted to use the sessions to talk about other issues. The topic of erotic life never returned during the sessions.

Family histories – working with the genogram

From the 7th to the 10th session, the therapists worked with the genogram. The introduction of this technique was not associated with any specific, defined goal of the therapists; it was rather a permanent element of the workshop, helping to get to know the family better.

Mrs. M. recounted a painful and dramatic story of herself and her family – including experiences of violence, alcohol abuse, tragic, premature death of a loved one and emotional distance in the relation with

her mother. During the session, Mrs. M. was very moved – the traumas were still emotionally alive in her inner world.

Mr. R. presented his family of origin in terms of resources – as family people, supporting one another, caring and well-functioning socially.

An important hypothesis for the therapists – derived, among other things, from the work on the genogram – was the assigning of the following dynamics to the couple: If Mr. R. moves away emotionally from Mrs. M., then she ”does not want to be healthy” and does not find motivation to stop ”attractive” relapses of psychosis. And when Mrs. M. enters into delusional symptoms, then Mr. R. moves away emotionally. Such dynamics was based on feedback and therefore self-deepening by nature.

Observations on the therapeutic relationship

Mr. R. built a relationship with the therapists through distance. For the first eight months of working together, he was reluctant to talk about himself, and much more willing to cooperate with the therapists in analysing his wife’s problems. The therapists’ fantasies about the reasons why he kept hiding himself all revolved around the fact that Mr. R.: 1) could have been afraid of evaluation and criticism – as the social message and medical language related to problems with alcohol are clearly pejorative, so they may evoke feelings of guilt and shame; 2) could have been afraid that his needs regarding a therapeutic change would not be taken into account during the session and/or he might feel misunderstood – such experience was gained from previous attempts of marital therapy.

Compared to her husband, Mrs. M. was very open – she was the one who called the therapists to arrange the first meeting, she also contacted them to reschedule a session if needed. She was the first to speak in sessions and she brought in topics that were important to her and that she wanted to discuss. She also disagreed with the therapists with great ease and communicated her anger openly (but constructively) if she was not satisfied with something that was happening during the therapy (*e.g.* the ”Health Contract”).

A crisis in the relationship between the therapists and Mrs. M. occurred at the 12th session. It partly shifted from what the client was experiencing in her treatment in the day ward, which she had started twelve weeks earlier and was about to part with the group. Throughout the whole period of therapy in the day ward, the patient felt well and praised the treatment – but in the last week, she engaged in a conflict with another person from the group, and then with one of the therapists who tried to remind Mrs. M. about the rules in the ward. On the last day of her treatment in the day ward – the day she was to say goodbye to the group, the patient did not come to the facility.

On the wave of these emotions, the client came to the 12th session of her marriage therapy after drinking one beer and she was irritated. The therapists conducting the session had the impression that Mrs. M., for the most part unconsciously, was trying to provoke them to hostility (this is what the therapists imagined the alcohol before the session was supposed to do). Guided by the hypothesis that in this way, Ms. M. was defusing the tension associated with the parting, the therapists – as part of the reflecting team

technique – started to tell ideas about the fear and pain that she could experience with every parting, about feelings so acute and penetrating that it was easiest to cover them with hostility and part in anger, and that all this could be associated with the traumas and losses described while working with the genogram. Mrs. M. was moved by these comments, close to tears. The therapists felt that this session did not only help Mrs. M. stay in therapy, but it also helped Mr. R. open up a little bit more.

Maintenance phase, consolidation of changes and bringing the therapy to an end (sessions 17-20)

The last phase of the therapy lasted one year and included four sessions. During the 17th session, the therapists inspired a conversation about the course of the therapy so far and the expectations of Mr and Mrs X. regarding further therapy. Mrs. M. said that the problem left to be solved was alcohol. However, Mr. R. expressed the opinion that alcohol was not a problem and he did not feel like working on it. He did not see other goals of further therapy, as the goal he cared about most – to work out ways to prevent the recurrence of the acute phase of the disease – was achieved in his opinion. When the spouses were leaving after this session, the therapists suggested that by the next session, the couple could think about what to do with the therapy.

At the 18th session, the couple reported that in spring, Mrs. M. had an onset of a psychotic crisis, which the spouses managed to overcome (largely thanks to the attention of their daughter, who expressed concern about her mother's condition in a talk with her father). The clients and the therapists rewrote the therapeutic contract for maintenance sessions scheduled by telephone each time they needed support.

Sessions 19 and 20 took place after a six-month break. Mr. and Mrs. X. came persuaded by one of their daughters who was worried about the fact that her parents were arguing more and more and her mother was growing more irritated. In fact, just a month earlier, the couple had struggled with the threat of recurrence of the acute phase of the disease but they dealt with the problem on their own before the meeting.

Mr. R. was concerned that his wife modified the *Health Contract* so that a part of the physician's appointments were done by herself, before Mr. R. managed to get to the clinic: The visits started a few minutes before the scheduled time. Mrs. M. went into the physician's office without her husband, and Mr. R. was not invited in until after a while. Mrs. M. wanted her visits at the psychiatrist's to be this way – she wanted to be able to talk to the physician like that, without her husband hearing it. Mr. R. was concerned that this was some kind of a breach of contract and that one such breach would make the next one easier, which would devastate the whole contract and result in the recurrence of psychosis. For Mrs. M., it was a step in the consistent pursuit of increasing her autonomy.

Between the 19th and 20th sessions, the therapists, after the clients gave their consent, contacted Mrs. M.'s psychiatrist. After apologizing to the physician for the previous unauthorised interference in his relationship with the patient, it was agreed that the psychiatrist would continue to modify the contract with his patients on his own. The physician found the very introduction of the *Health Contract* useful.

In addition to developing their skills in preventing psychotic crises, the spouses boasted of having

introduced (on their own) significant changes in the use of alcohol in their home. For several months, they had been using wine only on weekends and abstained from drinking on weekdays. They also reduced its amount.

Mrs. M. took up individual psychotherapy.

During the support sessions, the partners also deepened their dialogue on the need for Mrs. M.'s independence. During these discussions, Mr. R. discovered that, in fact, from the beginning of the disease, he felt somehow guilty deep inside. This feeling of guilt made it difficult for him to listen to his wife's messages and needs, as they often moved his feelings and he reacted to them defensively.

No formal termination of the therapy was established: 1) partly because of the emotions that Mrs. M. could experience; 2) partly to make it easier for the spouses to attend consultation sessions, should they need them.

Later on, the couple occasionally used consultations.

Conclusions

Successive stages of the therapy relied on various models and techniques used in family therapy [11] – reflecting team, analysis of transgenerational transmission using the genogram, psychoeducational, and strategic intervention, as well as elements of narrative therapy. In the therapists' opinion, each of the mentioned techniques was useful and brought a new, invigorating perspective to the dialogue between the clinicians and their clients. At a crisis moment of the therapy, when the work alliance seemed to be at risk, the therapists used the transference analysis (psychodynamic model), which allowed them to continue the work. An effective transference analysis was only possible thanks to the previous analysis of the genogram.

In working with couples affected by psychosis, it seems important to understand the significance of the problem – but in such a way that the problem does not overshadow other aspects of the relationship. We ca say that throughout the entire duration of the therapy, the therapists together with their clients consistently tried to mainly identify and strengthen the non-psychotic areas of the relationship. So on the one hand, the work focused on the couple's resources and their strengthening. On the other hand, an important part of the work was to constantly encourage the clients to get to know and observe the schizophrenia that had entered their lives. In the opinion of all those involved in the therapy, the biggest problem was not the psychosis itself but the fact that it would regularly get out of control. Through confrontations, externalisation of the problem, psychoeducational and strategic interventions, the couple's power over the disease was strengthened. One of the decisive factors was the good relationship with the psychotherapists and the attending physician. Although the psychotherapists and the psychiatrist only contacted each other once during the therapy, both treatments complemented and strengthened each other well.

The results of the therapy are promising. The number of relapses and hospitalisations decreased. For the last four years before the psychotherapy started, the patient had been experiencing one to two fits of

psychosis per year and it always involved many months of hospitalisations. For two years of the therapy and one year after its completion, the patient did not experience a relapse of the acute psychotic phase and she was not hospitalised. In addition, the quality of Mr. and Mrs. X's relationship improved.

Schizophrenia is a disease that drives one into solitude. People affected by psychosis often lose their bonds with their loved ones. For this reason, support not only for families but also for couples, provided already at the level of a psychiatric hospital and day wards, can have an impact on the reconstruction of relations but also on the course of the disease. And although examination of this hypothesis would require separate studies, it seems that couple therapy may become an important part in the treatment of patients struggling with psychoses. According to the authors' knowledge, this method is unfortunately rarely available to patients of psychiatric institutions.

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e-mail: ryszard.chlopek@wp.pl