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MOTIVATIONAL INTERVENTION IN THE INITIAL PHASE OF SCHIZOPHRENIA

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Many studies have shown the effectiveness of early intervention programs for schizophrenia and their impact on illness outcome. In fact, preventive intervention in the prodromal period and after the first episode of psychosis has come to play a crucial role in research on the treatment of schizophrenia and in clinical procedures. The initial phase of schizophrenia affects many activity and relational areas that must be addressed by patients in their recovery, so that patient motivation in this early period is of the utmost importance for treatment. This article presents a review of the literature and a general consideration of motivational interventions in schizophrenia.

Key words: *schizophrenia, initial phase, early intervention, motivational intervention*

Son muchos los estudios que en los últimos quince años han demostrado la efectividad de los programas de intervención precoz en la esquizofrenia y su impacto sobre el pronóstico de la enfermedad. De hecho, la intervención preventiva en la fase prodrómica y posterior al primer episodio se ha convertido en una de las líneas principales de investigación y de aplicación clínica para el abordaje de la esquizofrenia. Durante el la fase inicial de la esquizofrenia, quedan paralizadas muchas áreas de actividad y relacionales a las cuales el paciente deberá enfrentarse durante la fase de recuperación. Su grado de motivación en esta fase será de vital importancia para el tratamiento. En el presente trabajo se presenta una revisión y algunas consideraciones acerca de las intervenciones motivacionales en la esquizofrenia.

Palabras clave: *esquizofrenia, fase inicial, intervención precoz, intervención motivacional*

EARLY PHASES OF SCHIZOPHRENIA: FIRST EPISODES

During the 1990s there was increasing optimism with respect to the prognosis of schizophrenic disorders. Much of this optimism was due to the emergence of second-generation neuroleptic drugs that were more effective and had fewer side-effects. Another reason for such optimism was the growing conviction that special attention in the early phases of psychosis could substantially reduce morbidity, influence the prognosis, increase quality of life in patients and their families and lead to high levels of clinical improvement.

The present study reflects how published reports of controlled clinical trials over the last ten years on the efficacy of cognitive-behavioural interventions in schizophrenia have totally confirmed that effective psychological treatments combined with neuroleptics have a high impact on the illness (Perona, Cuevas, Vallina & Lemos, 2003).

Thus, recent and current early intervention programmes opt for psychotherapy comprising interventional approaches that have demonstrated their efficacy in patients with schizophrenia.

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EMOTIONAL IMPACT OF THE FIRST PSYCHOTIC EPISODE AND A CONSIDERATION OF INTERVENTION

The psychopathological experiences of the first episode and the initial phase can have a truly disturbing and lasting effect on the person (McGorry et al., 1991). Undoubtedly, people tend to be more sensitive to treatment than in subsequent episodes and later phases, but relapses are also more frequent during the first five years (the so-called *critical period*) (Birchwood et al., 1998). It could be said that this period provides us with highly fertile ground for our intervention, though the matter is greatly complicated by the large quantity of variables to take into account during the onset of the first episode (McGorry, 2005).

Standard cognitive-behavioural therapy focuses on delusional beliefs, beliefs about voices and negative self-assessment, dealing in a more collateral fashion with subjective experience of the disorder and patients' coping with both their own difficulties and with their adaptation to the use of the new coping tools provided by the therapist.

From this perspective, and from the review of the effectiveness of interventions in patients suffering from psychosis, it emerges that combined intervention is essential for the correct treatment of the illness, but is not yet complete.

In this process of the initial phase there is a sudden break with everything that made up the person's self-concept, increasing confusion, affecting self-esteem levels and prompting the progressive disintegration of the identity (Ridgway, 2001; Birchwood et al., 1992).

It is at this point that the person realizes that everything that defined him or her as a unique and individual person is undergoing a process of change. Without doubt, the multiple and progressive losses the person experiences strongly affect his or her overall functioning (Harrop & Trower, 2001).

We can suppose that the process of adaptation to these changes might form part of a process of mourning, whose purpose would be the reconstruction of one's identity based on the integration or assimilation of each one of these losses (Palma, Ferrer, Farriols & Cebrià, 2006).

The patient's experience is commonly one of "paralysis"; the areas of global functioning have become blocked by the onset of the first episode, often having gradually deteriorated during the prodromal phase. The difficulties of the illness itself, with which the patient is burdened throughout the recovery phase, substantially reduce the person's functioning at the work, social, family, affective and recreational levels.

Thus, it would seem that the pathways of emotional unease are not concentrated in prodromal conditions or post-psychotic depressive symptoms, nor in effects secondary to the symptomatology of schizophrenia. After the onset of a first psychotic episode on the schizophrenic spectrum, the person will go through a series of complex processes in which emotional management and motivation will constitute the mainstay of their coping.

It should be borne in mind that the onset of the disorder most commonly occurs between adolescence and early adulthood, a time when one's personal identity is become consolidated (Ridgway, 2001), and this contributes to making it such a complex and onerous problem.

AFFECTIVE ASPECTS AND MOTIVATION: TWO KEY ELEMENTS IN TREATMENT

During this period, then, a series of emotional needs emerge that are not considered by the cognitive-behavioural therapy (CBT) treatments described. From an integrational perspective, the emotional component should be understood as a heuristic, a global construct covering both biological and psychological/psychosocial aspects of the individual. The person-centred approach stresses the value of the personal experience, the capacity to experience life events fully and consciously, the attitude of getting to know and valuing the being who one "really is" –as Rogers (1961) puts it –, which implies an attitude of being open to one's own complexity, to accepting oneself and accepting others. This is, moreover, an optimistic attitude, of openness to change, since experience is never static. And the emotional aspect is the basic structure underlying that experience.

Emotional treatment and accompaniment are clearly fundamental, and come into play in motivational intervention. Patients' motivation to start their own mechanisms of change is an essential requirement of the therapeutic process, but precisely in a context in which there has been a rupture and blockage of the person's areas of global functioning it becomes difficult to find motivations for change. And it is here where we find the principal difficulties of the therapeutic exercise with patients suffering from schizophrenia.

In spite of this complexity, since the mid-1990s researchers have been carrying out studies and trials in which they have incorporated motivational interventions into treatments for schizophrenia (not necessarily in the first episodes). We shall continue by looking at some of the principal results of these types of intervention.

The majority of studies have attempted to show the effectiveness of motivational or combined interventions on treatment compliance in people with psychotic disorders (Coffey, 1999; Gray, Robson & Bressington, 2002; Hayward, Chan, Kemp & Youle, 1995; Kemp, Kirov, Everitt, Hayward & David, 1998; Randall et al., 2002; Rusch & Corrigan, 2002; Swanson, Pantalon & Cohen, 1999; Walitzer, Dermen & Connors, 1999; Zygmunt, Olfson, Boyer & Mechanic, 2002) or on compliance with treatment for substance abuse (Baker et al., 2002a; Baker et al., 2002b; Barrowclough et al., 2001; Bellack & Diclemente, 1999; Brown et al., 2003; Etter, Mohr, Garin & Etter, 2004; Graeber, Moyers, Griffith, Guajardo & Tonigan, 2003; Haddock et al., 2003; Kavanagh et al., 2004; Martino, Carroll, O'Malley & Rounsaville, 2000; Martino, Carroll, Kostas, Perkins & Rounsaville, 2002; Pantalon & Swanson, 2003; Steinberg, Ziedonis, Krejci & Brandon, 2004; Tsuang et al., 2004; Van Horn & Bux, 2001; Zhang, Harmon, Werkner & McCormick, 2004).

The main difficulty for assessing results concerns the variation in what different authors understand by motivational intervention. Little research has been carried out in this area, and although some guidelines have been drawn up, particularly in pioneering works such as those of Miller and Rollnick (1991), there are no manuals for motivational intervention in psychotic disorders. This shortcoming in this particular field of intervention makes it difficult at the present time to draw firm conclusions from reviews.

For the present article we selected the thirteen works with *good quality* criteria, with descriptions of the methodological aspects in relation to selection, random assignment, blinding and losses (Jadad, 1998). The purpose is to observe the results and consider the principal conclusions of the studies (see Table 1).

In general, better results are observed in relation to the objectives set in 90% of studies that compare motivational intervention with another therapeutic technique. Nevertheless, this difference in improvement was only statistically significant in 55% of the studies.

As regards clinical results, some studies endorse the effectiveness of motivational intervention for improvements in relation to level of *insight,* attitude towards medication, relationship with services, symptomatology and global functioning, substance use, and relapses.

On the other hand, it would be highly advantageous to consider the heterogeneity of the term "motivational intervention" – with a view to achieving some kind of consensus – so as to avoid confusion about the type of intervention involved in each study. From this starting point there emerges a need to carry out more studies in this line in order to draw more consistent conclusions.

THE CONCEPT OF MOTIVATIONAL INTERVENTION

We shall continue by examining the content of motivational interventions. Some studies understand motivational intervention as a set of strategies making up a style (and themselves interwoven) in specific interventions such as social skills training or problem-solving therapy (Kemp, Kirov, Everitt, Hayward & David, 1998; Swanson, Pantalon & Cohen, 1999; Bellack & Diclemente, 1999; Barrowclough et al., 2001; Haddock et al., 2003; Tsuang et al., 2004). Other studies start out from a view that understands motivational intervention as a model in itself (rather than merely an intervention style) (Baker et al., 2002, Graeber, 2003, Brown et al., 2003; Steinberg, Ziedonis, Krejci & Brandon, 2004).

SOME GENERAL PREMISES OF MOTIVATIONAL INTERVENTION

Coinciding with the former point of view, we believe the climate in the therapist-patient relationship to be based largely on the style of the therapist him/herself, to the extent that the pioneers of the motivational interview (MI) have used the term *motivational spirit* (Rollnick et al., 1995) to refer to this form of relating to the patient. From these bases, motivational intervention could be defined according to the following principles (see Table 2):

Thus, the professional's task is essentially to identify the intrinsic values that stimulate change in the patient, facilitate the verbal expression of ambivalence, employ strategies for provoking ambivalence, clarify and resolve that ambivalence in a framework of respect and unconditional acceptance and promote patients' freedom of choice and independence with regard to their behaviour (Cebrià & Bosch, 1999,2000).

Psychotherapeutic changes feed off an empathic and authentic relationship with the professional, and the motivation for these changes is developed by the patient; the professional respects the person's independence and freedom of choice (Palma, Cebrià, Farriols, Cañete & Muñoz, 2005).

The crucial aspect is the therapist's belief in patients' own resources and in their independence for experiencing, directing and managing their own process of recovery and adaptation.

The therapist, during the intervention, tries to get patients to position themselves and accumulate reasons for adopting more functional attitudes or behaviours, increasing their commitment and determination; in this way they will be able to resist the psychological suffering involved in all types of change (Cebrià & Bosch, 2000). This idea is also derived from one of the principles of cognitive therapy, whereby if a person has a mistaken belief about reality it is because they have accumulated sufficient present and contextual reasons for doing so; thus, unless they find a valid alternative to their beliefs, they will be unlikely to develop mechanisms for changing them (Sassaroli & Lorenzini, 2004).

Motivational intervention is underpinned by some theoretical principles described by Miller and Rollnick (1991), on which the pertinent techniques are articulated.

- ✔ *The expression of empathy*: empathy is by definition an acquired ability involving "putting yourself in the other person's place". In the framework of the relationship with the patient, in addition to understanding

TABLE 1
RESULTS OF THE STUDIES ON MOTIVATIONAL INTERVENTIONS IN THE TREATMENT OF SCHIZOPHRENIA

Studies	N	Comparison groups	Principal results
(Hayward et al., 1995)	25	- Drug compliance therapy (Motivational Interview, MI) - Control group	Changes are observed in attitude to medication and improvement at the level of *insight*. However, in comparison with the control group the improvement is not statistically significant.
(Kemp, Kirov, Everitt, Hayward & David, 1998)	74	- Drug compliance therapy (motivational interview strategies) - Counselling	For the group on compliance therapy an improvement is observed in attitude towards medication, and there is better fulfilment of therapeutic instructions and an improvement in *insight*.
(Swanson et al., 1999)	121	- Standard treatment (pharmacological, individual and group psychotherapy, leisure activities) - Standard treatment + motivational intervention.	The proportion of patients that linked up adequately with services during the follow-up was greater in the MI group ($p<0.01$). The same applied to the patients with dual diagnosis (42% of the group that received MI, compared to 16% of the standard treatment group; $p<0.01$).
(Barrowclough et al., 2001)	36	- Motivational intervention + cognitive-behavioural therapy + family intervention + standard treatment. - Standard treatment.	Statistically significant improvement in the first group at the level of global functioning after 12 months' intervention ($p=0.001$). The improvement in positive symptomatology is also significant in the first group compared to the second at 12 months ($p=0.01$), as it is in negative symptomatology ($p<0.02$). Differences are also observed in relapse rates in favour of the first group ($p<0.05$)
(Baker et al., 2002a and b)	160	-Motivational intervention (n=79) -Standard treatment (n=81)	No statistically significant differences were observed between groups in relation to reduction of substance use or to treatment compliance
(Haddock et al., 2003)	36	- Motivational intervention + cognitive-behavioural therapy + family intervention + standard treatment. - Standard treatment.	Statistically significant improvement in the first group at the level of global functioning at 12 months. No differences are observed in relation to reduction in carers' needs or in health system costs for either group.
(Graeber et al., 2003)	30	- Psychoeducational intervention - Motivational intervention.	Statistical differences are observed in abstinence rates in favour of the group that received motivational intervention.
(Brown et al., (2003)	191	- Motivational intervention - Brief advice	Motivational intervention was more effective than brief advice for abstinence from smoking in people with schizophrenia. It was more effective in adolescents, whether or not they had the intention to change their habit. However, it was not effective in adolescents with a history of attempts to give up.
(O'Donnell *et al.*, 2003)	94	- Motivational therapy for compliance - Counselling	One year after the intervention, therapeutic compliance did not differ between the intervention and control groups. No differences were found in improvement of symptoms or in quality of life.
(Steinberg et al., 2004)	78	- Motivational intervention - Counselling - Brief advice	The researchers observed a higher proportion of people in the first group that gave up smoking (32%) with respect to the groups receiving counselling (11%) and brief advice (0%) in a single session.
(Kavanagh et al., 2004)	25	- Motivational intervention - Standard treatment	All the participants in the first group gave up consumption after 6 months of therapy, compared to 58% of control group participants. Changes were maintained at 12-month follow-up
(Haddock et al., 2003)	36	- Motivational intervention + cognitive-behavioural therapy + family intervention + standard treatment. - Standard treatment.	The first group showed a maintenance of improvement in global functioning and negative symptoms 18 months after the intervention. However, differences were not notable in either relapses or number of days of abstinence (though the rates were lower).
(Bellack, Bennett, Gearon, Brown & Yang, 2006)	129	- Motivational intervention + social skills training - Control group (support therapy)	The results show significant effects in the first group in post-treatment at 6 months in the measures of management of community resources, rehospitalizations and quality of life.

with unconditional acceptance what the client is expressing, the professional should be capable of transmitting by means of verbal or non-verbal facilitators that the emotion presented is received and taken on board.

- ✔ *Helping to develop discrepancy*: the professional attempts to get patients to identify and verbalize the conflict or discrepancy between their present behaviour and their desired behaviour*: "I would love to go to the driving school, even just three days a week,… but when the time comes…".*

  The professional's objective is to increase the level of conflict in order to help the patient express emotions that generate discomfort (in a verbal or non-verbal fashion).

  The discomfort of some emotions that are repeated in different situations reported by the patient is the principal motor of change. In this context the therapist has to be alert to these emotions for facilitating expression, since the verbal expression of an uncomfortable situation in our own words is one of the principal motivations for a change of position (auditory self-conviction).
- ✔ *Avoiding attempts to persuade*: psychoeducational advice and recommendations provoke *rejection* (psychological reactance) (Bosch & Cebrià, 1999). Persuasion is not a good tool for convincing someone about the usefulness of a change, insofar as it can lead to resistance. Patients may feel that their freedom to choose is being controlled by some kind of authority.
- ✔ *Working with resistance*: the best tool for dealing with resistance is avoiding its appearance, though it sometimes emerges without the clinician's having intervened inappropriately. Resistance forms part of any natural process of change, but it is advantageous to have strategies for dealing with it. These would include:

  a) Empathy: The principal strategy for managing resistance is the verbal and non-verbal expression of empathy.

  b) Paradox: resistance often appears as a natural expression of psychological reactance. The paradox technique utilizes this reactance inversely, in favour of "no change", so that patients react in the opposite direction, actively seeking change themselves.

  c) Exploration of beliefs: most of the time, resistance goes hand in hand with the person's belief system. It is very difficult to promote a change if it is incongruent with one's belief system. Therefore, in the face of resistance it is generally useful to explore this system, ask the patient what he/she thinks about certain things and point out to him/her, if deemed necessary, any distortion that is maintaining the constructs. The objective is to deactivate those beliefs that block the processes of change and hinder the therapeutic task. In this regard, the *restructuring of ideas* technique can be useful.

  d) Refocusing on objectives: this is a strategy that can be employed when the patient avoids some issues and "beats about the bush", continually blocking the communication processes. Whenever clinicians consider it appropriate to intervene directly on the symptom they can use this strategy for dealing with resistance.

  e) Double pact: this is a strategy of negotiation with the patient that can be used when resistance is activated by a patient's need associated with the process of change.

  f) Exploration of values: this involves inquiring in detail about things that are important for the person and how they influence their current state.

  g) Balanced decision: the objective of this strategy is for the patient to weigh up the positive and negative aspects of the target behaviour. It is recommended to begin by asking about the positive aspects and eventually move on to those that are giving the patient some difficulty (focusing on the behaviour).
- ✔ *Enhancing and reinforcing the feeling of self-efficacy.* The principal motor of change is determined by three main elements: self-esteem, internal locus of control and belief in the possibility of change. The therapist's

TABLE 2
PRINCIPAL ELEMENTS OF MOTIVATIONAL INTERVENTION

- It is a patient-centred intervention style
- The therapist decides which elements it should reflect from the patient's discourse
- The therapeutic relationship is one of collaboration between experts (professional-patient), rather than of expert-patient
- The intention is to promote changes in behaviour through statements of commitment drawn up by the patient.
- The method involves helping patients to explore and resolve their own ambivalence (Miller & Rollnick, 1991)
- It is based on the cross-theoretical model of stages of change (Prochaska & Diclemente, 1992)

role here is to encourage the feeling of **ability** by carefully reinforcing all of the person's abilities that denote control over one's behaviours. Patients have to experience small sensations of success in the framework of the therapeutic relationship in order to feed their self-esteem and strengthen their self-efficacy in the proposed behaviours. The patient connects with his or her deepest and most powerful motivations. At a psychophysiological level, the fronto-limbic connections are reinforced.

On the basis of these principles, patient and therapist, in their expert-to-expert relationship, will begin their journey through the different stages of change set out in Prochaska and Diclemente's (1992) cross-theoretical model: pre-contemplation, contemplation, preparation, action, maintenance and relapse. Nevertheless, the motivational strategies described by pioneers Miller and Rollnick in 1991 must be adapted to the patient in question. In the case of patients with schizophrenia we find certain common difficulties that must be borne in mind, such as cognitive deterioration, information-processing difficulties, deficits in the perception or interpretation of affective stimuli, thinking disorders or awareness of the illness.

In this context, motivational strategies should be specifically adapted to the implicit difficulties of communication with the schizophrenic patient (Palma et al., 2005).

EFFECTIVENESS OF MOTIVATIONAL INTERVENTIONS IN THE INITIAL PHASE OF SCHIZOPHRENIA

In the light of the results from the selected studies on motivational intervention, in which 90% obtain better results than the control or comparison groups, 55% of which are statistically significant, we could deduce that it is an effective type of intervention for helping patients with schizophrenia to change their behaviours.

Moreover, given that the majority of this research has been carried out with schizophrenic patients in advanced phases, we can infer that in the early phases the results of motivational intervention might be more sensitive, since there is a lesser presence of elements of elements of deterioration, relapses, pharmacological treatments, and so on.

Indeed, we believe this phase of the illness to be the ideal point to use this type of intervention. But we cannot ignore some aspects that will make it difficult, and which we must bear in mind in order to be able to use this approach in an integrated, appropriate and focused manner. The motivational style acts as a backdrop, but can we use the tools to work in all contexts and at all times? The answer is no. Our experience is that during the initial phase schizophrenic patients do not, generally, have as many difficulties as a person many years into the disorder, but that they present difficulties which block some abilities essential for the use of motivational strategies. The main one of these, and the most common in patients who recover after their first episode (as outpatients, beyond the hospital context) is difficulty with introspection. This will greatly reduce the field of activity if we do not focus clearly on the objective pursued.

These patients' efforts are usually short-lived and infrequent, influenced by a pronounced external locus of control and by a rigid perception, so that they commonly have expectations of a negative type (Hodel & Brener, 2004). Therefore, progressive reinforcement of behaviours and insistence on recalling the objectives set is fundamental, as is collaboration and support from the family. In therapeutic practice, problem-solving techniques facilitate active behaviour in these people, as well as highlighting what they learn from their own experiences (Palma et al., 2005).

The aim of motivational strategies is not for patients to become more aware of their illness or to make sophisticated reflections on their life; rather, it is to progressively mobilize some of the areas affected by sudden rupture and secondary blockage at the onset of the first episode (including the prodromal stage).

We consider that the increase in **awareness of the illness** must be related basically with the taking of medication in the most independent way possible, and with involvement in psychosocial intervention programmes. A sudden awareness implying patients' identification with their often substantial limitations may hinder improvement due to the depressive symptoms this may bring with it (Palma et al., 2005).

Thus, without being too presumptuous about the potential of motivational intervention, we could set out the following four premises with regard to its suitability (see Table 3).

It should be borne in mind that the emotional impact on the person who has suffered a first psychotic episode is highly complex. This means that the therapist must pay particular attention to the process employed, given the likelihood of the patient's resistance when dealing with emotionally-charged issues. As mentioned above, the

emotional dimension involves the very life fabric of the person, including the awareness and acceptance of their experience and their problem.

This is the main reason why the intervention should be tailor-made, without the objectives marking the rhythm or pace of the process for patient. The emotional tempo is in the person experiencing the unease, not in the intervention; and in the course of the treatment patients will deal with each objective as and when they are emotionally prepared to do so. This "journey" constitutes a veritable learning-for-life process, made possible by attitudinal training, and which patients must undertake at their own pace. Among its objectives is that of increasing awareness about one's personal responsibilities and about the meaning of the experience of change, within a broad biographical context. Each and every behaviour acts as an indicator of change.

The therapist must therefore be alert to verbal and non-verbal signals – including behavioural ones, such as failure to keep session appointments, arriving late for sessions, talking about banal subjects in an attempt to avoid dealing with one's true concerns, etc. – and be able to adjust to the patient's rhythm.

Awareness of the illness, included as just one of the objectives of the intervention, at the suitable moment, could be considered as what Frankl describes on referring to the treatment of psychosis – the capacity to "go beyond the condition of the illness towards an image of the man", to discover for oneself the meaning of one's own suffering, which, more than an illness, can become a way of describing one's own being, one's own identity (Frankl, 1979, 1992).

For their own well-being, it is as important that therapists be able to respect the intervention process as it is for the patients themselves to be able to tolerate the frequent slowness with which small changes occur. This is why, on the basis of a sound alliance, the therapist must be a model of tolerance to processes of change, reinforcing each small success, since, in a patient with schizophrenia recovering from an episode, it is a great step forward to be able to approach the illness in a more constructive way, with a more conscious and rounded attitude.

REFERENCES

Baker A, Lewin T, Reichler H, Clancy R, Carr V, Garrett R, Sly K., Devir H. & Terry M. Evaluation of a motivational interview for substance use within psychiatric in-patient services. Addiction 2002; 97(10):1329-1337.

Baker A, Lewin T, Reichler H, Clancy R, Carr V, Garrett R, Sly K., Devir H. & Terry M. Motivational interviewing among psychiatric in-patients with substance use disorders. Acta Psychiatr Scand 2002; 106(3):233-240.

Barrowclough C, Haddock G, Tarrier N, Lewis SW, Moring J, O'Brien R et al. Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. Am J Psychiatry 2001; 158(10):1706-1713.

Barrowclough C, Haddock G, Tarrier N, Lewis SW, Moring J, O'Brien R et al. Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. Am J Psychiatry 2001; 158(10):1706-1713.

Bellack AS & Diclemente CC. Treating substance abuse among patients with schizophrenia. Psychiatr Serv 1999; 50(1):75-80.

Bellack AS & Diclemente CC. Treating substance abuse among patients with schizophrenia. Psychiatr Serv 1999; 50(1):75-80.

Bellack AS & Diclemente CC. Treating substance abuse among patients with schizophrenia. Psychiatr Serv 1999; 50(1):75-80.

Birchwood M. & Tarrier N. *El tratamiento psicológico de la esquizofrenia*. Ariel Psicología. 1995, Barcelona.

Birchwood, M. (1992). Early intervention in schizophrenia: Theoretical background and clinical strategies. *British Journal of Clinical Psychology, 31,* 257-278.

Birchwood, M., Todd, P. & Jackson, C. (1998). Early

TABLE 3
CONSIDERATIONS IN MOTIVATIONAL INTERVENTION FOR SCHIZOPHRENIA

- The motivational style promotes a suitable climate for change, and a lack of changes does not imply failure. This style helps set the scene for work on emotional dysfunction resulting from a reaction to psychosis (Birchwood & Trower, 2005).
- It increases personal control of behaviour.
- The person's capacity for introspection must be valued.
- The behaviours to be changed must be specified. Among the commonest behaviours worked on by means of motivational interventions are:
- The taking of medication in the most independent way possible.
- Drug use.
- Compliance with psychological treatment and with therapeutic schedules.
- Doing activities.
- Task-planning habits.
- Hygiene habits.

intervention in psychosis. The critical period hypothesis. *British Journal of Psychiatry* (Suppl. 172), 53-59.

Birchwood, M. & Trower, P. (2006). The future of cognitive-behavioral therapy for psychosis: not a quasi-neuroleptic. *British Journal of Psychiatry, 188,* 107-108.

Bosch JM & Cebrià J. Reactancia psicológica : "Fumar es un placer". FMC 1999; 6:59-61.

Brown RA, Ramsey SE, Strong DR, Myers MG, Kahler CW, Lejuez CW et al. Effects of motivational interviewing on smoking cessation in adolescents with psychiatric disorders. Tob Control 2003; 12 Suppl 4:IV3-IV10.

Brown RA, Ramsey SE, Strong DR, Myers MG, Kahler CW, Lejuez CW et al. Effects of motivational interviewing on smoking cessation in adolescents with psychiatric disorders. Tob Control 2003; 12 Suppl 4:IV3-IV10.

Cebrià J & Bosch JM. La peregrinación por la rueda del cambio tiene indulgencia sanitaria plena. FMC 2000; 7:233-236.

Cebrià J & Bosch JM. Querer y no querer. El dilema de la ambivalencia. FMC 1999; 6(393):395.

Coffey M. Psychosis and medication: strategies for improving adherence. Br J Nurs 1999; 8(4):225-230.

Etter M, Mohr S, Garin C & Etter JF. Stages of change in smokers with schizophrenia or schizoaffective disorder and in the general population. Schizophr Bull 2004; 30(2):459-468.

Frankl, V.E. *Teoría y terapia de las neurosis*. Herder, 1992 Barcelona.

Frankl, V.E. *El hombre en busca de sentido*. Herder, 1979 Barcelona.

Graeber DA, Moyers TB, Griffith G, Guajardo E & Tonigan S. A pilot study comparing motivational interviewing and an educational intervention in patients with schizophrenia and alcohol use disorders. Community Ment Health J 2003; 39(3):189-202.

Gray R, Robson D & Bressington D. Medication management for people with a diagnosis of schizophrenia. Nurs Times 2002; 98(47):38-40.

Greenberg, L.S. Un análisis del caso de Jim Brown desde la perspectiva de los procesos experienciales y la Gestalt. In: Farber, B.A., Brink, D. & Raskin, P.M. *La psicoterapia de Carl Rogers. Casos y comentarios*. Desclee de Brouwer. 2001, Bilbao.

Haddock G, Barrowclough C, Tarrier N, Moring J, O'Brien R, Schofield N et al. Cognitive-behavioural therapy and motivational intervention for schizophrenia and substance misuse. 18-month outcomes of a randomised controlled trial. Br J Psychiatry 2003; 183:418-426.

Haddock G, Barrowclough C, Tarrier N, Moring J, O'Brien R, Schofield N et al. Cognitive-behavioural therapy and motivational intervention for schizophrenia and substance misuse. 18-month outcomes of a randomised controlled trial. Br J Psychiatry 2003; 183:418-426.

Harrop, C. & Trower, P. (2001). Why does schizophrenia develop at late adolescence? *Clinical Psychological Review, 21,* 241-265.

Hayward P, Chan N, Kemp R & Youle S. Medication self-management: A preliminary report on an intervention to improve medication compliance. J Ment Health 1995; 4(5):511-517.

Hodel, B. & Brenner, H.D. (2004). Enfoques presentes para el tratamiento de los trastornos del procesamiento de la información en la esquizofrenia. In: C. Perris & P. McGorry. Psicoterapia cognitiva para los trastornos psicóticos y de personalidad. Bilbao: Descleé de Brower.

Jadad, A. R., Moore, R. A., Caroll, D., Jenkinson, C., Reynolds, D. J. M. & Gavaghan, D.

J. (1996). Assessing the quality of reports of randomized clinical trials: is blinding necessary? Controlled Clinical Trials, 17, 1-12.

Kavanagh DJ, Young R, White A, Saunders JB, Wallis J, Shockley N et al. A brief motivational intervention for substance misuse in recent-onset psychosis. Drug Alcohol Rev 2004; 23(2):151-155.

Kemp R, Kirov G, Everitt B, Hayward P & David A. Randomised controlled trial of compliance therapy. 18-month follow-up. Br J Psychiatry 1998; 172:413-419.

Kemp R, Kirov G, Everitt B, Hayward P & David A. Randomised controlled trial of compliance therapy. 18-month follow-up. Br J Psychiatry 1998; 172:413-419.

McGorry, P., Chanen, A., McCarthy, E., Van Riel, R., McKenzie, D. & Singh, B. (1991). Post-traumatic stress disorder following recent onset psychosis: An unrecognised post-psychotic syndrome. *Journal of Nervous and Mental Disease, 179,* 253-258.

McGorry, P. (2005). Un resumen de los antecedentes y del alcance de las intervenciones psicológicas en psicosis temprana. In J.Gleeson & P. McGorry (Eds.). *Intervenciones psicológicas en la psicosis temprana* .

Bilbao: Desclée de Brower.

Martino S, Carroll K, Kostas D, Perkins J & Rounsaville B. Dual Diagnosis Motivational Interviewing: a modification of Motivational Interviewing for substance-abusing patients with psychotic disorders. J Subst Abuse Treat 2002; 23(4):297-308.

Martino S, Carroll KM, O'Malley SS & Rounsaville BJ. Motivational interviewing with psychiatrically ill substance abusing patients. Am J Addict 2000; 9(1):88-91.

Miller WR & Rollnick S. La entrevista motivacional. Preparar para el cambio de conductas adictivas. Paidós. 1991, Barcelona.

Palma, C., Cebrià, J., Farriols, N., Cañete, J. & Muñoz, E. (2005). La intervención motivacional en el paciente esquizofrénico. *Psiquis, 26,* 109-120.

Palma, C., Ferrer, M., Farriols, N. & Cebrià, J. (2006). La recuperación en la psicosis temprana: los procesos de duelo y el sentido de la experiencia psicótica. *Anales de Psiquiatría*, 22 (6), 296-305

Pantalon MV & Swanson AJ. Use of the University of Rhode Island Change Assessment to measure motivational readiness to change in psychiatric and dually diagnosed individuals. Psychol Addict Behav 2003; 17(2):91-97.

Perona, S., Cuevas, C., Vallina, O. & Lemos, S. (2003). *Terapia cognitivo-conductual de la esquizofrenia.* Madrid: Minerva Ediciones.

Prochaska JO & Diclemente CC. Stages of change in the modification of problem behaviors. Prog Behav Modif 1992; 28:183-218.

Randall F, Wood P, Day J, Bentall R, Rogers A & Healy D. Enhancing appropriate adherence with neuroleptic medication: Two contrasting approaches. In: Morrison A, editor. A casebook of cognitive therapy for psychosis. New York: Brunner-Routledge, 2002: 281-297.

Ridgway, P. (2001). Restoring psychiatric disability: learning from first person narratives. *Psychiatric Rehabilitation Journal, 24,* 335-343.

Rogers, C.R. *El proceso de convertirse en persona.* Paidós. 1961 Barcelona.

Rollnick S & Miller WR. What is IM? Behav Cogn Psychoth 1995; 23:325-334.

Rusch N & Corrigan PW. Motivational interviewing to improve insight and treatment adherence in schizophrenia. Psychiatr Rehabil J 2002; 26(1):23-32.

Sassaroli S & Lorenzini, R. Patogenia y terapia. In: C. Perris & P. McGorry, P. *Psicoterapia cognitiva para los trastornos psicóticos y de personalidad.* Desclee de Brouwer. 2004, Bilbao.

Steinberg ML, Ziedonis DM, Krejci JA & Brandon TH. Motivational interviewing with personalized feedback: a brief intervention for motivating smokers with schizophrenia to seek treatment for tobacco dependence. J Consult Clin Psychol 2004; 72(4):723-728.

Swanson AJ, Pantalon MV & Cohen KR. Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. J Nerv Ment Dis 1999; 187(10):630-635.

Tsuang J & Fong TW. Treatment of patients with schizophrenia and substance abuse disorders. Curr Pharm Des 2004; 10(18):2249-2261.

Van Horn DH & Bux DA. A pilot test of motivational interviewing groups for dually diagnosed inpatients. J Subst Abuse Treat 2001; 20(2):191-195.

Walitzer KS, Dermen KH & Connors GJ. Strategies for preparing clients for treatment. A review. Behav Modif 1999; 23(1):129-151.

Zhang AY, Harmon JA, Werkner J & McCormick RA. Impacts of motivation for change on the severity of alcohol use by patients with severe and persistent mental illness. J Stud Alcohol 2004; 65(3):392-397.

Zygmunt A, Olfson M, Boyer CA & Mechanic D. Interventions to improve medication adherence in schizophrenia. Am J Psychiatry 2002; 159(10):1653-1664.