A Framework for the Analysis of Psychotherapeutic Approaches to Schizophrenia

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Received October 11, 1984

A conceptual framework is articulated which clarifies the importance of psychotherapy as part of the treatment armamentarium in working with individuals carrying schizophrenic diagnoses. The author looks at the goals and appropriate role relationships for understanding and treating schizophrenic individuals from multiple psychotherapeutic perspectives. The goal is to present an overview within which different psychotherapeutic approaches to schizophrenia can be understood and compared and then reconnected in actual practice.

In this paper the author will articulate a conceptual framework to clarify the importance of psychotherapy as part of the treatment armamentarium in working with individuals carrying schizophrenic diagnoses. There is marked disagreement and often bitter controversy about the validity of different theories, and the value and even the legitimacy of various treatment approaches to schizophrenia. I shall look at the goals and appropriate role relationships for understanding and treating schizophrenic individuals from multiple psychotherapeutic perspectives. The goal here is not to evaluate specific concepts and techniques, nor to argue that one perspective is more legitimate than any other. It is, instead, to present an overview within which different psychotherapeutic approaches to schizophrenia can be understood and compared and then reconnected in actual practice. When the distinctions have been further clarified, it will be possible to pursue more effectively the goal of combining these approaches in new treatment methods.

Historically, psychiatry has been committed to four major tasks. As described in previous work [1,2,3], these interconnected tasks have been sanctioned by society and are relevant to the problem of schizophrenia. The tasks and their related perspectives are: (1) diagnosing, curing and limiting illness—the Medical Perspective; (2) reducing defect, enabling those with defect to live their lives as best they can—the Rehabilitative Perspective; (3) fostering growth and competence—the Educatively-Developmental Perspective; and (4) controlling socially deviant behavior—the Societal-Legal Perspective.

Treatment of the schizophrenic syndromes is one of the most central and time-honored concerns of psychiatry. While there is no way to do justice in a brief exposition to the role of psychotherapy in treating schizophrenia, a comprehensive approach to psychotherapy of schizophrenic individuals must take into account the many ways in which the schizophrenias are at the same time a disease state, a defect, a cluster of behaviors labeled as deviant, and a developmental impairment.

219
THE MEDICAL PERSPECTIVE: SCHIZOPHRENIA AS ILLNESS

Central to the medical perspective is the concept of schizophrenia as a disease. Diagnosis, psychopharmacology, and psychotherapy are used within social structures designed for the treatment of the schizophrenic illness. Some biological quality of the organism is involved, although underlying causes may in part be functional. Major concepts include differential diagnosis, symptomatology, pathology, etiology, and natural course. From differential diagnosis evolves formulation, treatment planning, and a prognostic statement regarding the probable course of the disease. The appraisal of outcome and ongoing follow-up of the patient's disease constitute the focus of psychotherapy within this task area.

Psychotherapy from the medical perspective is based on a clinical medical model which has as its core the reciprocal dyad of doctor and patient [4,5]. The conduct of patients and physicians is ordered by the nature of the sick role, the codes of medical ethics, and the construct of Aesculapian authority [5]. Treatment takes place "under the supervision" of the physician. The expert physician confers a sick role [6] which prescribes rules of conduct for the patient: to seek help, to accept treatment, to be exempted from normal responsibilities. It also involves aspects of adaptive regression and ambivalent dependency. Physician/patient relationships often reflect a benign paternalism.

Case A: Mr. A is a 27-year-old single man who works as a cook, lives with his family, and carries the diagnosis of chronic paranoid schizophrenia. He was recently discharged from his third brief hospitalization in six years, a hospitalization precipitated by the loss of a significant female relationship. Mr. A has been followed by his psychiatrist for the past four years. Hospitalization was initiated after outpatient therapeutic measures failed to affect psychotic symptoms both Mr. A and his family recognized as signaling decompensation. The three-week hospitalization led to symptom remission, allowed for some further exploration of the current loss, and reaffirmed the utility of the current treatment plan—in short, reestablished equilibrium. Four months after discharge, Mr. A had resumed his usual activities. He is seeing his psychiatrist weekly to further integrate this latest regression into his life, with plans to cut back to less frequent visits in the near future. Mr. A and his family have found the psychiatrist's availability and flexibility within a benevolent paternalistic role helpful.

As can be inferred from Case A, from this perspective the psychiatrist attempts to simplify the chaos attending acute psychotic decompensation and then to reawaken the patient's hopes, to clarify the nature of the illness, to work on the conflicts that may have contributed to a retreat into psychosis, and to merit the patient's trust. The clinician's awareness of psychodynamics facilitates psychotherapeutic interactions with his or her patient. Examination of the physician/patient relationship and issues of transference usually are avoided in such psychotherapy. The patient's dependency is acknowledged, and some mastery of the experience is incorporated into treatment planning.

In contact beyond the acute psychotic episode, a psychotherapeutic interaction may help maintain a trusting relationship so that the clinician can in a regular way assess current level of functioning and monitor and facilitate the psychopharmacotherapy.
Psychotherapy furthers awareness of problematic issues in the patient's life and is preparatory to rehabilitation. The physician, like his or her counterpart in physical medicine, may choose to refer the patient for appropriate rehabilitative work rather than undertake such activities himself (e.g., the patient might be referred to a group treatment and vocational rehabilitative program with psychiatric contacts from every two weeks to once every few months in order to monitor current state, medication compliance, and side effects). He or she would be available to the patient in crisis and would expect to be called. He or she would use psychological understanding to help identify, if possible, precipitants for the crises and would draw upon the patient's trust in order to recommend appropriate treatment. A shift in focus from the control of illness (with reference to the organic state) to the management of defect (with reference to the adequacy of functioning) reflects a more basic shift from a medical perspective to a rehabilitative one.

THE REHABILITATIVE PERSPECTIVE: SCHIZOPHRENIA AS DEFECT

Within a rehabilitative perspective, the primary condition to be dealt with in patients diagnosed as schizophrenic is an adaptive defect. A rehabilitative view draws heavily on psychological, social-psychological, and sociological theory. It is based upon a careful evaluation which attempts to assess the extent of defect, the influence of defect upon functioning, the social and psychological responses to defect, the areas of individual strength and capacity to function, and the identification of treatment based on and geared to the individual's specific skill(s)/deficits [7]. It also takes into account economic incentives and disincentives to a return to functioning. The aims of rehabilitation are to bring about the best possible psychosocial, medical, and economic adaptation within the limits of the individual's handicap. Interventions are thus related to restoration of functioning within a shared sociocultural value system. Independence, work, and achievement are valued, whereas dependence, non-productivity, and stasis are to be avoided. The patient's difficulties are seen as resulting from impairment with some permanent damage. Even when the source of defect is disease, the rehabilitative perspective does not focus chiefly on the disease as such; indeed, the patient may not be seen as having a disease.

From the rehabilitative perspective the conduct of therapist and schizophrenic patient in psychotherapy is understood within an impairment model. Psychotherapeutic interventions on the part of the therapist in his or her role as benevolent expert allow the therapist to guide the patient in a cooperative endeavor [8]. Efforts are directed toward preventing further deterioration and restoring function to as great a degree as possible. The residual defects are evaluated together with compensatory assets, and restorative goals are identified. The goals of the psychotherapeutic endeavor include the repairing of functional limitations, the restoration of lost skills, the fostering of some improved adaptive capacity, or the acquisition of new, compensatory goals. Rehabilitation usually requires extensive commitment to the disabled person. It is labor-intensive and requires extensive practitioner training. The conduct of patients is also addressed within the impaired role. The impaired role has its own implied rules of conduct, which include acting as normally as possible and seeking rehabilitation to prevent further deterioration and/or to minimize impairment. The schizophrenic patient is an active participant, and treatment effect is highly influenced by the degree to which the patient participates and partakes of the treatment(s).
Case B: Ms. B is a 31-year-old single woman who lives in a halfway house, attends a psychiatric day treatment program, and is maintained on neuroleptic medication. She has carried a chronic schizophrenic diagnosis for six years, during which time she has had three brief and one long-term hospitalization, but none since she accepted the recommendation of long-term rehabilitation in the day program. During the year Ms. B has been in the day treatment program, she herself sees progress in her ability to care for herself, interact more appropriately and effectively with others, and begin to look toward sheltered work as a reentry step into the work force. The therapeutic relationship with her case administrator has deepened over time. Ms. B finds herself comfortable with her therapist/administrator's approach of combining a concrete focus, consistency, and support. In recent months Ms. B has shifted the focus of their weekly meeting to begin to address the impact of her schizophrenia on her self-esteem. In addition, she has joined a psychotherapy group of chronically ill psychiatric patients to further her adjustment as well as acceptance of her internal psychotic state.

Although many psychotherapies aspire toward a value-free orientation, this is rarely accomplished. Indeed, since a major object of repair is to facilitate functioning in the face of defect, adjustment is a legitimate goal. As is seen in Case B, psychotherapeutic techniques are utilized to limit, reverse, or compensate for defect and its intrapsychic and behavioral consequences. Structural change within the individual is not necessarily the focus of treatment. Insight into conscious and unconscious thoughts, affects, and behaviors may be peripheral to the treatment goals. The therapist may be more "real" and direct in his or her interactions and responses to the patient. Goals include helping the schizophrenic patient learn new methods of coping with seemingly insoluble life problems and replacing psychotic solutions with more adaptive ones. The reparative work may shore up the schizophrenic's defenses, providing additional necessary support for the individual who cannot sustain him or herself. Rehabilitation can take place even when the patient does not understand or only poorly understands the cause of the disability, provided that the schizophrenic process is not rapidly progressive.

THE EDUCATIVE-DEVELOPMENTAL PERSPECTIVE: SCHIZOPHRENIA AS IMPEDED GROWTH

In this area, persons seeking services are engaged in the search to become more as they wish to be, to attend to one's self-concept and ability, to experience a more complete view of self, with less attention to what society per se values. Individuals are interested in self-knowledge, further insight into their psychological makeup, and enriching their lives. The person is seen as an individual with sufficient ego strength and motivation to pursue his or her own development.

From the educative-developmental perspective, the therapeutic relationship is seen within an educative framework. The therapist uses his or her knowledge as participant observer and interpreter in a relationship that requires empathic listening and mutual participation [8]. Psychological treatment is viewed as a form of education, aiming toward individual development and integration. This development is made possible by the educative/experiential, therapeutic interaction of therapist and individual. The individual wishes to learn more about his or her self through self-understanding. He or she is the active agent, and growth is related to the individual's motivation and resistances.
Psychotherapy is used to stimulate exploration and resolution of internal conflict by rendering conscious early patterns of behavior which have interfered with life in the present. The focus of treatment is the psyche and its defensive structure. The primary aim is to correct problems in development that have led to psychosis and to stimulate growth through the exploration and resolution of conflict [9]. Specific forms of illness, pathology, and defect are acknowledged; they are regarded not as the primary focus of treatment but as constraints upon development. Through a broad range of techniques the individual comes to appreciate his or her own strengths and weaknesses and to explore new possibilities.

Case C: Ms. C is a 29-year-old woman who lives in a cooperative apartment and works as a teller in a local bank. She had the first of three schizophrenic breaks six years ago but has been largely symptom-free for the past two years. She began long-term individual psychotherapy when she was a day hospital patient at a university hospital and has continued in twice-weekly psychotherapy with her psychiatrist. The nature of the treatment has shifted in the past several years to focus on her traumatic childhood and her retreat into psychosis as a way of coping with the unconscious conflict she has felt. The therapy has gone through several stormy regressive periods in which the exploration of transference issues became necessary. At this time Ms. C has been able to bring to better resolution some of her previously unbearable affects and look more hopefully to the possibility of more satisfying interpersonal relationships in the future.

This example illustrates how increased understanding leads to significant changes in the individual's internal psychological structure, as well as improved social functioning and the goals of autonomy. There is an emphasis upon engaging the individual in therapy that explores individual psychology or social functioning and insists upon enhancing individual responsibility for behavior regardless of possible biological determinants. In the case of schizophrenic patients, treatment from an educative-developmental perspective increasingly has become a luxury available to those who are wealthy or who have access to training institutions. Such treatment may be given after there has been partial recovery of function through treatment from the medical and rehabilitative perspectives as discussed in Case C.

THE SOCIETAL-LEGAL PERSPECTIVE: SCHIZOPHRENIA AS SOCIALY DEVIANT BEHAVIOR

Psychotherapeutic practice in this area encompasses both medical and rehabilitative perspectives. Differential diagnosis is basic and critical to developing a formulation. The determination of the extent to which any treatment plan requires collaboration is a crucial question. The issue of lack of mutual trust must be confronted: a situation quite different from the other task perspectives. Both a social deviance model and a moral model [10] reflect on therapist and patient roles with psychotherapeutic interventions directed largely toward rehabilitation of the schizophrenic patient into more socially acceptable behaviors.

In the social control task area, the utilization of psychotherapy brings the clinician into direct confrontation with the dual mandate of safeguarding society (protective detention) and caring for individuals unable to care adequately for themselves (parens patrie). The law has the power to state what is within the clinician's prerogative; the
clinician has the responsibility to speak for good clinical care and to seek more adequate ways of providing such care, especially when the patient does not see it as in his or her own interests. In identifying the work of this area, it is important to identify both the parens patriae and social control functions. Society exerts control not only to protect itself but also to protect those who need care. While the concept of treatment with the patient who has been defined as deviant by the legal system needs more examination than it has yet received, it is an ever-present issue in the treatment of schizophrenic patients, as evidenced by Case D.

Case D: Mr. D is a 25-year-old schizophrenic man who has drifted about the country since his first psychotic break six years ago. He has done his best to avoid the mental health system, often living on the streets and begging or prostituting to survive. In the past year repeated encounters with the police led to his arrest and legal commitment to treatment. During his first prolonged hospitalization, Mr. D did take antipsychotic medications on a regular basis and met consistently with one staff member whom he began to trust. After discharge he was placed in a community residence with a court-appointed legal guardian managing his finances. Mr. D meets regularly with a therapist as part of the continuing court-mandated treatment. Though he remains delusional much of the time, Mr. D has begun to make use of the therapy as a place to address the impact of his psychosis on his life.

The social control function creates many dilemmas in the treatment of the schizophrenic patient. Those who are acutely disturbed need contact, but they are often incompetent to give informed consent. Many schizophrenic individuals, at least in certain phases of their life course, do not perceive themselves as needing care; thus practitioners often require the state's coercive power to involve the patient in treatment. When psychotherapy is utilized in this context, the clinician is buffeted by several equally compelling and mutually exclusive demands: the need to be trustworthy, the patient's need to test the therapist, and society's insistence on preventing antisocial behavior. While coercion can help hold someone in psychotherapy, it also may interfere with the development of the therapeutic relationship.

DISCUSSION

To some extent in separating the four tasks and their relevant perspectives, I have caricatured the work in each area. While clearly it is possible to separate the different psychotherapeutic perspectives, the demands of the clinical situation in a given psychotherapy require an ability to move with fluidity from perspective to perspective. This may change at different points in a given individual's life as well as within a given psychotherapy, so that at one time one approach may be more appropriate in a particular circumstance or within a therapy. I am not implying that an individual psychotherapy must necessarily be limited to one of the perspectives, nor that one perspective is more important than the others. A flexible therapist must be able to understand, differentiate, and shift perspectives as indicated.

My goal here has been to sharpen the distinctions among the four task areas and their associated perspectives as they apply to the utilization of psychotherapy as part of the treatment armamentarium for schizophrenia. The goals and role relationships between therapist and patient are different from each perspective. One emphasis of this paper has been that technique does not define an area of psychotherapeutic work
even or especially with schizophrenic patients. For example, if the focus of treatment is on disturbed functioning, then the work is more often rehabilitative, whether the techniques used are exploratory or supportive. Restoring the individual to an adaptive equilibrium, maintaining control, alleviating symptoms, as well as strengthening existing defenses, are goals of treatment. The relationship between therapist and patient is utilized to promote functional improvement. Interviews require a reality involvement with schizophrenic patients and may deal with symptoms, external factors that may contribute to stress or disturbance, or discerning patients' self-object needs and providing them with necessary supports. This may lead to the therapist being a real and permanent object in the patient's life. From the educative-developmental perspective, the therapist/patient interaction is scrutinized, the development of transference issues encouraged and then analyzed as a way of developing insight into unconscious conflicts.

Adaptation to life with a chronic mental illness such as schizophrenia is a complex process. In addition to type and severity of illness, satisfactory adjustment depends upon the individual's behavior, attitudes, and personality, financial resources, and social supports. Furthermore, this process takes place in the context of a particular culture, community, health care system, and family [11]. The role of psychotherapy in treating such individuals is influenced by all these factors as well as where in the life course an individual is. Like the rest of us, schizophrenic patients have diverse values, skills, goals, and support. Prescribing therapeutic goals congruent with individual skills and with life satisfaction may too easily be missed.

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