

Preparing the Schizophrenic Patient for Treatment by J. Rosberg, and A. A. Stunden

A major problem confronting psychotherapists who treat schizophrenia is how to make successful therapeutic contact with the patient. Too often the patient's bizarre behaviour drives the therapist away especially when the illness intrudes on the patient's ability to use ordinary human, communication. This problem can be so frustrating to both patient and therapist that each is unable to respond to the potential inherent in the therapeutic encounter. Therapists most often adopt this stance because they are not familiar with these problems and how to work with them. Few training institutions encourage therapists to engage the patient with schizophrenia in human terms so that a sense of relatedness can be established. Direct confrontation psychotherapy helps the therapist understand and quickly overcome the patient's psychological barriers to treatment. Treatment can begin with the rapid disruption of the patient's defensive patterns.

INTRODUCTION:

Because of the dramatic way it calls attention to itself, and the enormous amount of human misery and despair associated with its presence, schizophrenia has always been a special kind of illness that cannot easily be ignored. It demands treatment and it will not wait while we search for better answers. It urgently insists that we find swift solutions to its unique problems and forces us to apply all of our advance biological and technical resources even though we cannot be sure of their outcome. It challenges us to measure our professional commitment to treatment by the rapidity with which we provide maximum relief for the symptoms of its illness. In fact, effective treatment for schizophrenia has almost become synonymous with symptom relief. Still, this is not just a modern-day issue. One has only to look at the variety of treatments our society has sanctioned for schizophrenia over the years to appreciate how long this problem has been with us.

Within this framework of necessity and conflict many of us have become honestly confused about how best to cope with the pressure of developing appropriate treatment for our schizophrenic patients. In this harried state we find it easy to ignore the person who is ill in our urgency to treat the illness. In our efforts to be responsive we allow ourselves to go back and forth in our treatment approach. We offer one thing only to change it and offer something else. We usually focus first on medication. If this is successful, and we have some experience with other forms of treatment, we may then try to help our patients learn how to cope with the psychological effects of their illness.

The moment, however, we believe that our patient is not responding well to treatment, we look to the patient as the source of our failure. We no longer concern ourselves with improving our treatment plan but, instead, we begin to explore how our patient might be thwarting our treatment efforts. Finally, we label our patient intractable or treatment resistant. This argumentum ad hominum permits us, with the exquisite illogic of which only humans are capable, to discharge our frustration by blaming our patients for our lack of success. When this occurs frequently enough we begin to expect treatment failure. We start to program ourselves and our patience so that no one treatment is successful. We begin to behave in ways that insures that treatment failure takes place. Some aspect of the illness called schizophrenia has become iatrogenic.

With difficult, long-term patients, this problem is more distressing. The types of treatment these patients receive are seldom fixed by their needs or potential to respond. The length and character of their clinical

history determine what they are offered. After patients who seek treatment, with this kind of history in their clinical charts, are almost certainly doomed to receive no treatment that will help them. No treatment will be offered that will realistically address their potential for change and thus their strengths as human beings. These patients will only find a reaffirmation of their already well documented and all too obvious weaknesses. They will be told, once more, that they cannot benefit from treatment because they are schizophrenic.

If we are to overcome this pessimistic outlook, we must first accept that many of the dysfunctional consequences of schizophrenia can be changed by influencing or modifying the emotional and behavioural reactions of the patients to their illness. We must concede that the illness does not exist in the absence of the person who is sick. We must acknowledge that the dysfunctional behaviour we see in our patients is associated with but not necessarily caused by the condition. And, most important, we must admit that these behavioural and emotional patterns exist in a form unique to each patient.

Consider, for example, the patient who withdraws from others. This behaviour is not analogous to the rise in temperature that is pathognomonic for a specific disease. Social isolation is not a symptom of schizophrenia. It is better understood as a personal choice that is determined by the patient's interpersonal style or character development. Social withdrawal is a protective reaction made by the patient in the face of their illness and is not an inevitable consequence of the illness itself.

Therapists who believe in the importance of changing the patient's dysfunctional behaviour must be aware of these basic ideas if they are to approach their patients with any hope of success. They must have some appreciation for the psychological character of the illness as it exists within the unique interpersonal framework of the individual patient. As stated in our paper on Stephanie:
"Regardless of etiology, however, no one is ever justified in assuming that the ultimate consequences of the illness- that is, the maladaptive psychologic and interpersonal behaviour- are intractable and therefore not subject to change or modification. These issues of intractability are seldom related to any biologic reality but, instead, are more often a function of the inability of the treating professional to believe that psychologic treatment can be effective".

PREPARING THE PATIENT FOR TREATMENT

The idea of "preparing the patient" for treatment, is a logical extension of these concepts. Some psychological assessment must be made of the patient's needs and ability to respond to the treatment relationship. This evaluation must include an exploration of the patient's psychological resources, both positive and negative sufficient to decide how they can be integrated into the treatment process. Thus, in this first contact the therapist must search out what the patient will permit the clinician to access and influence. That is, the therapist must discover the patient's behaviours that can most easily be changed.

The case of Stefanie, as described by us in 1989 offers an interesting opportunity to examine these ideas in the context of real clinical material. What follows is a brief process analysis of this consultation. This analysis, some of which is in Rosberg's own words, describes how he used direct confrontation psychotherapy to prepare the patient for treatment.

Rosberg was invited to consult regarding Stefanie in the autumn of 1987. At the time of the consultation she was a 32-year-old, never married, caucasian female with no children who was an inpatient in a Swedish psychiatric hospital. Never able to attend school, she had been taught to read and write in the

institutions providing her with treatment. At age four, she started psychotherapy and was described by her first therapist as “so frightened I couldn't get her to sit in my lap”. From the age of 13 she was treated in hospitals and institutions primarily in Sweden. She had been treated with phenothiazines without effect.

When first seen, Stefanie was confined to bed in five point restraints. Rosberg gives his present recollections of that meeting as follows:

“It was clear she was not going to allow me to join with her. She viciously rejected me when I said “hello” by spitting on me until I was drenched. Then, when that didn't work, she yelled at me to kill her, to hit her, to cut her head off and, most important, to leave her alone.

When she raged at me to leave her alone she offered me the entrée into her life I was looking for. She had given me a way to access her psychosis and her life. When she told me she wanted to be alone she had acknowledged the presence of our relationship. When she told me she didn't want me in her world, I knew I had finally forced her to leave the consuming narcissism of her psychosis and join the reality of my world”.

In this first contact, Stefanie's desire to be left alone gave Rosberg the diagnostic information he needed to begin treatment. She had revealed that she needed to protect the equilibrium of her psychotic, psychological world by keeping out everyone. She implied that if she was to be safe she needed to be alone. She conveyed that she could enforce her will if she made the risk to the therapist to great for treatment to continue. And, she behaved as if she could best shield herself from Rosberg's intrusion by trying to terrorize him as she herself had been terrorized.

Rosberg recognized that if he was persistent he could penetrate her unique psychological response to her illness and force her to change. He also realizes that if he was to influence Stefanie successfully he had to persuade her that he could outlast her without violating her. He continues: “To convince her of this I became angry. Not the artificial anger of the actor, but the genuine and realistic anger of someone who has been outrageously violated and vilified. I raged at her that she was a dictator and a miserable beast. She began telling me what a rotten person she was and that I should kill her because of it. We began sharing with each other our thoughts and feelings about her condition. She became convinced of my desire to outlast her no matter how hard she tried to drive me away. She began to listen to me and to pay attention to this crazy man (Rosberg) who might really be more powerful than she was. During her contact with me, she moved from a psychotic queen autocratically ruling their fantasy castle, to a psychotic queen under siege who recognizes the need to come out to negotiate with her besieger. I had established a sense of relatedness with her”.

Rosberg had forced Stefanie to take the first step toward establishing a sense of relatedness. At this stage she had no idea that the compromise that had been extracted from her might be the beginning of the treatment relationship. She only knew that her well practiced interpersonal style had been ineffective and that she had been required to access other, different behaviours to cope with the interpersonal demands placed on her by Rosberg. She had started to change. Together, out of their respective needs, they had forged the beginnings of a relationship that could be beneficial to both. They had begun to create what Lidz and Lidz have described as “a relationship in which the patient can examine his life together with the therapist and begin to assume responsibility for him”.

CONTACTING THE PERSON WITH SCHIZOPHRENIA

Though we do not know the cause of schizophrenia we can still treat it effectively and with predictable outcomes. As little as we know about the condition, however, we know even less about how to modify it in isolation from the psychological influence of the person who carries it. Because of this we must conclude that the diagnoses “schizophrenia” cannot be applied in isolation from the individual who hosts the illness and, that treatment cannot begin without a careful assessment of the person in whom the illness is housed. When the diagnosis of schizophrenia is used it must refer to a process that occurs between patient and condition in which one influences the other: that each, the illness and patient, exists in an independent, existential framework, with unique needs and demands. All of which must be met understood and integrated by the therapist if the patient is to survive or get better.

When we look on treating the patient with schizophrenia in this way we are faced with an enormous task. How can we possibly develop effective treatment for the infinite combinations potential between the illness and the person who has it? How can we expect to find and apply a common denominator to the treatment process such that some treated will be better than no treatment regardless of the patient?

If we are to solve this puzzle we must stay focused on the interaction between patient and illness. We must remember that much of the behaviour called schizophrenic is the patient’s psychological response to the illness itself. And, that the patient does not want to be sick but no longer knows how to get better. If we are to impact this dilemma effectively the therapist must intrude uniquely into the life of the patient so the fundamental choice faced by all patients can be made; whether to maintain a false sense of psychological equilibrium and comfort that supports the dysfunctional behaviour or, with the therapist’s help, to struggle to achieve whatever change is possible.

With this approach the initial contact with the schizophrenic patient becomes the most important and revealing part of the treatment process. The therapist quickly uncovers the essence of the patient's psychological disorder and the direction that must be taken if treatment is to be beneficial. Most important, the patient rapidly discovers that change is possible when the therapist and therapy are an effective and safe reality in their lives.

As we have suggested elsewhere, treating schizophrenia is different from treating any other kind of disorder. Yet, because we are dealing with human beings, the principles underlying behavioural and emotional change through psychotherapeutic intervention are the same. The major problem facing us today is how to teach these tactics to others so that our patients may be redirected into a life more consistent with what is normal. Though a cure for schizophrenia is not yet possible, we must recognize that patients can change and the quality of their lives improve with the tools we have available.