Recovery in Schizophrenia:

The Viability of Recovery and Can Psychoanalysis Play a Role?

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Abstract

This paper reviews the idea of schizophrenia as a chronic, progressive, incurable, genetic defect of the brain; this view being promoted by mainstream media, pharmaceutical companies, psychiatric professionals, and the government (Breeding, 2008). However, in examining the research it would appear that there is merit to the concept of recovery in schizophrenia. This paper addresses recovery rates of persons with schizophrenia, concluding that based on the research; recovery is possible and should be a goal of patients. Additionally, this paper looks at psychoanalysis and its role in treating persons with schizophrenia. The paper concludes with findings consistent with Gottdiener (2006) that there are inconsistencies in the literature. Because of these inconsistencies declaring a moratorium is premature and more empirical studies are required.

Key Words: schizophrenia, recovery, psychoanalysis, psychosis

Recovery in Schizophrenia: The Viability of Recovery and Can Psychoanalysis Play a Role?

A prominent and accepted view of schizophrenia is that it is a chronic, progressive, incurable, genetic defect of the brain; this view being promoted by mainstream media, pharmaceutical companies, psychiatric professionals, and the government (Breeding, 2008). Fowler and Celenza (2008) indicate that schizophrenia is increasingly viewed as a chronic, biological illness. The American Psychiatric Association states that a return to full pre-morbid function is not common with schizophrenia (Karon, 2008). Shean (2008) states that since the diagnosis of schizophrenia was first introduced, schizophrenia has been thought of as a chronic debilitating disorder with a deteriorating course and little to no hope for sustained recovery. This pessimistic viewpoint arguably dates back to the time of Kraepelin, who was the first to classify symptoms with predicted outcomes, stating that in dementia praecox 75% of patients could be expected to deteriorate to end stage dementia (Whitaker, 2003). A review of the literature, however, would lend a different impression of schizophrenia's recoverability. Davidson (2008) concludes that a majority of people with schizophrenia are seen to improve. Moreover, recovery and wellness should be the goal of each patient (Smith & Bartholomew, 2006), as opposed to pathology, symptomology and illness. Recovery rates of persons suffering from major mental illness shed light on the seemingly incurability of schizophrenics. Harding, Zubin and Strauss (1987) find that between 60% and 70% of persons with schizophrenia were able to become self sufficient over time. This paper will review the concept of recovery as related to the mental health system and the literature related to recovery rates of persons with schizophrenia. Additionally, psychoanalytic approaches to treating schizophrenia will be reviewed and proposed.

Recovery in Schizophrenia

Beers (1908) stated that "Most sane people think that no insane person can reason logically. But that is not so" (p. 57). As early as the 18th and 19th centuries, recovery principles were promoted to patients in asylums or hospitals in the form of moral (psychological) treatment (see Pinel, 1806) leading to a discharge rate of 60% to 80% (Bockoven, 1972). When moral treatment was abandoned for medical based systems of care, discharge rates dropped helping to reinforce the idea of the chronicity of psychosis and other major mental illnesses. It was not until the 1990's that the recovery movement began to gain momentum (Anthony, 1993). Smith and Bartholomew (2006) state that the recovery model promotes the idea that recovery is possible and should be the goal of all patients and it empowers patients to strive toward therapeutic goals and wellness. To contrast this, many hospitals and treatment centers operate under a medical model, which promotes the identification of symptoms, pathologies, and illness as well as a rigid control (Smith & Bartholomew). Furthermore, Smith and Bartholomew (2006) suggest that for recovery to be effective, hierarchies must be toppled and doctors must relinquish power so that they may empower the patient toward recovery. Anthony (1993) adds that recovery from mental illness involves more than recovery from the illness itself and may include dealing with the stigma patients have incorporated into their very being, side effects of unemployment, and crushed dreams.

The idea of recovery is the new trend in the mental health sector, being the subject at conferences, presentations, and of publications (Silverstein & Bellack, 2008). In the literature, however, there is no consensus about how to even define recovery (Liberman & Kopelowicz, 2005; Roe, Rudnick, & Gill, 2007). Furthermore, Davidson, O'Connell, Tondora, Staeheli, and Evans (2005) state that the word recovery has a variety of uses without having any meaningful implications. Such ambiguity and vagueness allow for ease of use by the clinician, consumer,

and researcher but provide little merit for its use. Given the elusive nature of the concept of recovery it is difficult to assess the degree to which recovery principles are translated into actual practice and the extent to which this can even be assessed (Davidson et al., 2005). Nevertheless, recovery practices are being assessed and this occurrence is not new.

Given the exorbitant cost of their operation, asylums, from their construction were under careful scrutiny to illustrate the success of the institution at curing the insane. It was not, until the middle of the 20th century that this data was scrutinized and peer reviewed for efficacy. Bleuler (1972/1978) conducted a 23 year follow-up study with a sample (n=208) finding that 53% were recovered or significantly improved. Huber, Gross and Schuttler (1975) found that of their sample (n= 502) 55.9% of participants were socially recovered. Ciompi (1980) reported results from a 40 year follow study in Switzerland beginning in 1900 and concluded that the long term course of schizophrenia was favorable in 50% of the cases. Harding, Zubin and Strauss (1987) found that 30% of persons with schizophrenia fully recovered in the long run, and that 60% to 70% became self-sufficient. Ogawa et al. (1987) found that 56% significantly improved or recovered. Their sample (n=140) was followed-up between 21 to 27 years ($\overline{X}$ = 23.6 years) post discharge (Harding & Keller, 1998). Lysaker and Buck (2008) summarized that most people with schizophrenia achieve long and meaningful periods of recovery, optimistic outlook on life and a sense of self worth. In a more recent study, Alem et al. (2009) concluded that 70% of patients achieved a complete remission in rural Ethiopia. The authors furthermore concluded that a third (30.8%) had continuous illness suffering, 5.7% had near-continuous remission, and less than a fifth (17.3%) experienced remission for about half of the follow-up period (Alem et al., 2009).

Lastly, Harrow, Grossman, Jobe, and Herbener's (2005) 15 year multi-follow-up research design found both promising and disappointing features associated with outcome and recovery in schizophrenia. Harrow et al. (2005) conclude that outcomes can be relatively positive but most people tend to have an episodic course. Davidson and McGlashan (2005) add that many longitudinal studies have a lack of clear criteria for diagnosis, unclear definitions of recovery, sampling bias, have no controls, and fail to address social and cultural contexts. Despite a clear definition of recovery (Silverstein & Bellack, 2008) and seemingly questionable research methods, at the National level there is a push to transform the mental health system to a consumer focused, recovery system (Harrow et al., 2005). Given the drive for recovery focused treatment, Katz and Gunderson (1990) assessed the overall treatment effects across psychoanalytic and supportive therapies, concluding that persons with schizophrenia can benefit from psychotherapy regardless of theoretical orientation and therapeutic technique. Persons with schizophrenia can improve and despite its seemingly unpopular approach, psychoanalysis may provide an effective medium to facility treatment and recovery of persons with schizophrenia.

Psychoanalytic Contributions to Schizophrenia

Psychoanalysis is now over one-hundred years old (Stone, 1999). The psychoanalytic treatment methods taught today are practically unchanged since the time of Freud and the other psychoanalytic founders (Alexander, 2004). It was not popular to be a reformer among the pioneers of psychoanalysis and those that tried were labeled dissenters and excommunicated creating an environment that did not support change from the beginning (Alexander). Early on, Freud did not believe in the possibility of treating schizophrenia patients with psychoanalysis and not wanting to be labeled separatists, only a few psychoanalysts attempted to treat persons with schizophrenia (Stone). Around 1907 to 1908, some of Freud's inner circle, Federn, Jung,

and Abraham, began to express that psychoanalysis could be applied effectively to schizophrenia (Stone). After this time practitioners began applying psychoanalysis to persons with schizophrenia and published their results in the form of case studies. Ferenczi and Meyer in particular helped to popularize psychoanalysis as a viable treatment option (Stone).

Leffel (1999) stated that one of the arguments about psychoanalytic treatment and schizophrenia is centered on whether schizophrenia is a deficit or a defense. The deficit stance states that a schizophrenic person is qualitatively different from others, whereas the defense model places a schizophrenic on the same continuum with other people (Leffel). The latter model argues essentially that a person with schizophrenia is comparable, by using a continuum to a person without schizophrenia. In the deficit model, because of the deficits, a schizophrenic person is not comparable to one without the illness, which appears dehumanizing. Leffel further elaborated on the deficit model by adding that from childhood, a pre-schizophrenic person because of deficient perceptual abilities or learning ability does not normally internalize a sense of self and through stress what internalizations the persons does have disappear. This model does not exclude a biological or medical influence but does not require it.

Today, current perspectives recognize that early psychodynamic approaches to the treatment of schizophrenia were probably misguided and lacked rigorous study because of the heavy use of case reports (Rosenbaum & Harder, 2007). The case study approach makes replication difficult, if not impossible, as well as affecting the ability to generalize any results obtained. More recent research on the efficacy of individual psychodynamic psychotherapy for people with schizophrenia has produced contradictory findings (Gottdiener, 2006).

Karon and VandenBos (1981) randomly assigned schizophrenic patients to an average of 70 sessions of psychoanalytic psychotherapy, medication used effectively, or both. They found

that psychotherapy alone, or with initial medication that was withdrawn as soon as the patients could tolerate being without it, led to earlier discharge from the hospital, low recidivism, and improved their thought disorders more than medication alone. Gottdiener and Haslam's (2002) meta-analysis of 37 studies published between 1954 and 1999, found that individual psychodynamic psychotherapy was associated with significant improvement in persons with schizophrenia (r = .31). They also compared cognitive behavioral and non-psychodynamic therapies to psychodynamic approaches and found that all three produced similar results but they found significant improvements when medication was combined with psychodynamic therapy.

Using randomized controlled clinical trials, May (1968) concluded the contrary of Karon and VandeBos (1981). May found that patients treated only with medication and those treated with individual supportive psychodynamic psychotherapy and conjoint antipsychotic medication had significantly greater improvement rates than patients who received only supportive psychodynamic psychotherapy. This study illustrated that a psychodynamic approach alone was not enough to bring about recovery and decrease symptoms, as well as medication being able to produce the same results without analysis. Additionally, Drake and Sederer (1986) found detrimental effects of psychoanalytic treatment. They conclude that intensive treatment has negative effects, focuses on rapid changes, and fails to appreciate the importance of the treatment alliance. Further, they offer several suggestions some of which include focusing on long-term adjustment, establish a therapeutic alliance, and to let the patient have an active role in treatment.

When summarizing the available research from 1960-1970, Katz and Gunderson (1990) conclude that treatment by dynamically oriented therapist provides no assurance of additional improvement for schizophrenic patients. The authors also conclude that any improvements attributed to psychotherapy are rarely obvious or dramatic. Despite conflicting findings in the

literature, Gottdiener (2006) argues that with a close examination of outcome data, a pessimistic viewpoint is unfounded in relation to psychodynamic psychotherapy and schizophrenia. This viewpoint is easily seen, however, if one looks at case studies when evaluating outcomes of psychoanalytic approaches. Given these findings, practitioners continue to apply psychoanalytic techniques today to persons with schizophrenia.

Additions to Psychoanalysis

Psychoanalytic practices continue today with new modifications and additions to the theory. Alexander (2004) comments about Sandor Rado who published several writings starting in 1948. Rado criticizes current psychoanalytic practices but not the underlying theory. Rado stresses to work with present life conditions as well as to build the self-confidence of the patient as opposed to illustrating the therapists power (Alexander, 2004). This idea relates highly to the ideas of promoting recovery in patients and by empowering the patient, the patient is more likely to succeed in treatment. Another addition to psychoanalytic practice comes from Richards (2007). Richards takes Sinason's (1993) concept of internal cohabitation, or two minds or egos, one step further by applying psychoanalysis to it. In cohabitation there is a psychotic and a non-psychotic mind cohabitating in one body perhaps since birth; the psychotic mind is often experienced as an advice giver who expresses criticism and ridicule if the advice is not taken and often if it is (Richards, 2007). It is then necessary to conduct a dual-track analysis of both coexisting minds knowing that one mind can relate to the therapist while the other wishes to remain hidden (Richards).

Discussion

Conclusions

In reviewing the research it would appear that there are indeed conflicting reports of the efficacy of applying psychoanalytic theories to the treatment of schizophrenia. It is clear however, that whether one uses a psychoanalytic approach or cognitive behavioral approach, there is merit to talk therapy. Recovery of persons with schizophrenia is possible (Huber, Gross, & Schuttler, 1975; Harding, Zubin, & Strauss, 1987; Lysaker, & Buck, 2008) and should be the goal of each patient. Chadwick (2006) reported that one of the problems with biomedical approaches to schizophrenia is that patients feel that clinicians are not listening to their experiences and results in patients having little faith in psychiatrists to aid them in their recovery. This theme relates directly to the recovery model. If a patient has little faith in their clinician, he or she is less likely to feel empowered and be actively involved in their treatment, making recovery tenuous. Gray (2009) adds that people with mental health problems at the very least want their stories, narratives, and voices to be valued and taken into consideration. Katz and Gunderson (1990) indicated that careful selection of patients/participants, as opposed to random selection, specific use of technique and the alliance between the patient and therapist will all contribute to success in treatment of persons with schizophrenia. Shean (2008) adds that a comprehensive, well-integrated spectrum of psychosocial and rehabilitative services along with psychotropic medications, continued medication compliance, and access to comprehensive pharmacological management services can improve the efficacy of recovery. Mojtabai, Fochtmann, Chang, Kotov, Craig and Bromet (2009) add that recovery in this group of patients cannot be fully realized until ease of access to services and improvement of existing services is completed. Lastly, McWilliams (2008) concluded that there is hope for the continued practice of

psychoanalysis and that for the theory and technique to survive it may be reinvented in an alternate form.

Implications

Because of the inconsistent findings when looking at psychoanalytic approaches to treating schizophrenia, declaring a moratorium (Meuser & Berenbaum, 1990; Dolnick, 1998) is premature. It is clear, however, the use of case studies must be abandoned as a means of illustrating psychoanalytic successes in treating schizophrenia. Furthermore, more current empirically based research studies are needed before a moratorium should be declared. Practitioners and researchers must work together to begin new original research studies to assess the efficacy. Fowler and Celenza (2008) write that unless outcome research identifies specific benefits of various modes of talk therapy in the treatment of schizophrenia, it is unlikely these treatments and especially psychoanalytic forms of treatment will be included in treatment guidelines and third-party-payer policies. Given the longer requirements of a psychoanalytic approach, this is a critical step if psychoanalysis is to continue to be used to treat schizophrenia. It must be able to work with the managed care system for it to survive. Furthermore, it must be ascertained through research how viable this approach is in the first place given these conflicting findings (May, 1968; Karon & VandenBos, 1981; Drake & Sederer, 1986; Gottdiener, & Haslam, 2002). Lastly, practitioners must utilize and not underestimate the effectiveness of the therapeutic relationship when working with persons with schizophrenia.

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Acknowledgments: A special thanks to Kyung-Hee Kim, PhD for the opportunity to write this manuscript and for assisting in the submission of it for publication.