Counseling Schizophrenics in Transitional Living

by

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Abstract

This paper examines literature regarding the origins of schizophrenia and utilizes that literature as a lens through which to assess therapies and concepts that have been applied in the past to treat the disorder. This analysis leads to a description of my own model of counseling, which is designed to improve the quality of life for schizophrenics. This broad goal relies on the achievement of two specific sub-goals: (1) to prepare clients for living independently within the community, and (2) to equip them for success in gaining lasting employment. The model stresses the importance of the therapeutic alliance. It integrates aspects of many therapeutic philosophies, but relies most heavily on psychoanalytic, person-centered, and behavioral and cognitive behavioral therapies.
Counseling Schizophrenics in Transitional Living

I have outlined an approach to counseling that blends existing methods shown to effectively treat symptoms of schizophrenia, with counseling approaches that align with my philosophy of counseling. Due to the complexity of schizophrenia, multiple approaches have been developed to deal with specific aspects of the disorder. It is my belief that quality of life can be drastically improved for schizophrenics by helping them achieve independent living status and stable employment. Doing so requires an in-depth understanding of the schizophrenia population, the barriers that exist in obtaining these goals, and how best to deal with these barriers.

My philosophy of counseling largely reflects psychoanalytic and person-centered therapy. Due to the nature of schizophrenia, however, these philosophies will have to be tempered with some of the elements more in line with the behavioral and cognitive behavioral approaches, of which there are many variations.

Schizophrenics are significantly more likely to commit suicide, more likely to be homeless, more likely to abuse drugs, to end up in the criminal justice system, and to be unemployed (Ramsay, Stewart, & Compton, 2012; Lieberman, 2001; National Institute on Drug Abuse, 2012; “Stony brook medicine,”, 2012; Palmer, Pankratz & Bostwick, 2005). I believe schizophrenia has been written off as a condition wherein there is little hope for a high quality of life. Schizophrenia has come to be viewed as a problem to be solved through medicating patients and little else. I believe a model of counseling can be developed that will greatly increase quality of life.
My Counseling Application Area: Schizophrenics in Transitional Living

Schizophrenia is a disorder that affects .3 - .7 percent of the population (depending upon how it is measured). It affects men and women equally (Saha, Welham, & McGrath, 2005). What causes the disorder is not entirely understood. Some studies point to evidence of a clear genetic component (Murray, Reveley, & McGuffin, 1986). Other studies either downplay or refute entirely this notion of a genetic propensity in schizophrenia (Read, Mosher, & Bentall, 2004). Research is ongoing regarding contributing factors. Interestingly, it is a disorder that appears to disproportionately affect those of low socio-economic status (Link, Dohrenwend, & Skodol, 1986), and those who have been victims of discrimination (Karon, 1975). This finding suggests that stress level may play a role in the development of the disorder. This suggestion is echoed in some of the alternate theories that try to explain the development of schizophrenia.

The theory I find most compelling is the conceptualization of schizophrenia as a chronic terror syndrome. This view characterizes all the symptoms of schizophrenia as either features of the terror syndrome or defenses against it (Karon, 2007). Karon concluded that all schizophrenics have endured excessive levels of trauma throughout their lives, leading them to reside in a state of chronic terror. There is support for Karon’s conclusions about the relationship between trauma and development of schizophrenia. Childhood exposure to trauma is significantly correlated to the development of schizophrenia (Spence, Mulholland, Lynch, McHugh, Dempster, & Shannon, 2006).

Treating schizophrenia is a multi-faceted task due to the range of “positive” and “negative” symptoms. Positive symptoms include auditory hallucinations, thought broadcasting, somatic hallucinations, delusional perception, and ideas of passivity. Negative symptoms include flat affect, loss of enjoyment in life, and not speaking (Leberman, 2006). Impairment of
cognitive functioning is a core feature of schizophrenia, manifesting as problems with attention, memory, and problem solving. These cognitive deficits are believed to be major contributing factors to the social maladjustment common in schizophrenia. Areas specifically impaired are social cognition/perception, social problem solving skills, social skills, behavior in treatment setting, and community functioning (Penn, Corrigan, & Racenstein, 1998).

These wide-ranging, erratic symptoms lead to complications in everyday functioning. The unemployment rate for schizophrenics is much higher than the general population, at 65 percent (Ramsay, Stewart, & Compton, 2012). Prevalence of substance abuse among schizophrenics is between 40 and 60 percent (Lieberman, 2001), compared to 8.7 percent in the general population (National Institute on Drug Abuse, 2012). Thirty-three to fifty percent of all homeless adults are schizophrenic ("Stony brook medicine," 2012). Of those diagnosed with schizophrenia, 10 percent will commit suicide, with a much higher percentage attempting (Palmer, Pankratz, & Bostwick, 2005). It is clear there is a need for interventions that improve the quality of life within this population.

The goal of counseling is to improve the quality of life for schizophrenics. This is contingent on two sub-goals: (a) preparing clients for living independently within the community, and (b) equipping them for success in gaining lasting employment. Employment status has been shown to be positively correlated with quality of life for schizophrenics (Hsiao, Hsieh, Tseng, Chien & Chang, 2012). Improving social skills is possibly the most important factor in achieving these goals, and obtaining a higher quality of life. Numerous studies have demonstrated improvement of cognitive functioning is a vital step in improving social skills in schizophrenics.
Therapies Used in the Past

Treatment of schizophrenia usually includes the use of antipsychotic drugs, often in combination with some form of therapy. While medication continues to be viewed by the larger medical and therapeutic community as an important component of symptom regulation, its actual effect on symptoms is categorized in the “medium-effect size range.” Over the duration of treatment, at least 50 percent of patients stop taking their medication (Moritz, Veckensyedt, Ransjbar, Vitzthum, & Woodward, 2011). Research indicates the most effective treatment for schizophrenia is psychotherapy without medication, with the condition that the therapist, patient and setting are able to tolerate it (Karon, VandenBos, & O'Grady, 1981). One study showed that all of the fully recovered schizophrenic patients in the study had been in the 50 percent of patients who had discontinued their medication (Harding, 1988).

Cognitive Remediation Therapy (CRT) has been shown to improve cognitive functioning (Wykes, Reeder, Landau, Everitt, Knapp, et al., 2007). It is a behavioral therapy that employs drill and practice and emphasizes compensatory and adaptive strategies. Improvements in working memory were found, which is predicted to lead to improved social functioning. Improvements in behavioral performance in attention and reasoning have also been produced (Bor, d’Amato, Costes, Saua-Chagny, Saoud, & Poulet, 2011). A particular type of CRT, called Neuropsychological Educational Approach to Remediation (NEAR) was shown to significantly improve verbal and visual memory, sustained attention and executive functioning. There was improvement in social and occupational outcomes as well (Hodge, Siciliano, Withey, Moss, Moore, et al., 2010). NEAR aims to increase motivation and task engagement by applying educational techniques designed to promote learning.
Cognitive Behavioral Therapy (CBT) has been shown to be effective in reducing the severity of both positive and negative symptoms of schizophrenia (Sensky, Turkington, Kingdon, et al., 2000). CBT is a therapy based on the idea that feelings and behavior are caused by thoughts, as opposed to external things. It has been shown effective even in cases of schizophrenia resistant to medication. Metacognitive Training (MCT) is classified as a variant of CBT. It is a relatively new method that largely targets delusions (Kumar, Ul Haq, Dubey, Dotivala, et al., 2010). MCT works by attempting to make the patients aware of their delusional biases, and then to change those delusions through education and training. It is typically carried out in a group setting.

Group Body Psychotherapy has shown promise in reducing negative symptoms of schizophrenia (Rohricht, Papadooulos, Holden, Clarke, et al., 2011). This therapy focuses on the relationship between mind and body, and attempts to access deeper levels of the psyche through greater awareness of the body. Art therapy, though it has not been shown to have any significant effect on patient outcomes on its own, has been useful as a supplement to the therapeutic process (Spaniol, 2012). Personal Therapy is an evidence-based psychotherapy that has produced significant outcomes in terms of personal and social adjustment. It has been shown to be effective in reducing relapse rates and enhancing patient adjustments (Hogarty, 2002).

Psychoanalytic techniques have been shown to be effective in facilitating meaningful understanding of hallucinations and delusions. Interpreting transference (Pollack, 1989) and interpreting hallucinations as waking dreams (Karon, 1992) are important tools in deciphering what might otherwise be considered incoherence on the part of the client. Emphasis on unconscious processes and repression is employed when using this model to treat schizophrenia.
The model is shown to work best when modified to be a more personal, involved, and active approach (Jennings, 1987).

Aside from these detailed therapy models, there are less specific factors that affect counseling outcomes. Positive (as opposed to neutral) staff-patient relationships can have a real impact of patient outcomes (Berry, Gregg, Vasconcelos, Haddock, et al., 2012). Along similar lines, it has been shown that success of therapy can be predicted by assessing the strength of the therapeutic alliance (Mihoci & Pesek, 2010). Hill, Mayes, and McConnell (2010) outlined three processes believed to greatly increase success rates in transitioning schizophrenics to independent living: developing a sense of control, establishing a relationship between illness and place, and attaining a sense of belonging.

Schizophrenia is a complex disorder, to which are attached many differing, and often conflicting, theories regarding origin and treatment preference. What cannot be argued is the extent to which this population suffers. One of the major findings of this review is the evidence of positive outcomes without the use of medication. Just as significant are the findings that cast doubt on genetics as the determining factor in the emergence of the disorder. Both findings will play a large role in directing the development of my therapy model.

**My Approach to Counseling Schizophrenics in Transitional Living**

The primary goal of my therapy model is to improve the quality of life for schizophrenics. This main goal can be broken into two sub-goals: (a) to prepare clients for living independently within the community, and (b) to equip them for success in gaining lasting employment. In most cases, obtaining these goals will be dependent upon controlling or eliminating symptoms (positive and negative), and improving social skills.
Assumptions and Goals

My model is based on two assumptions: (a) a person can fully recover from schizophrenia, and (b) medication is not necessary, and can actually impede progress. Both assumptions, though appearing controversial, are grounded in scientific research. What is implicit in these assumptions is my belief that schizophrenia is not a predetermined genetic fate, but a condition that arises as a response to adverse life events or life conditions. I believe we are all potential schizophrenics.

Distinguishing Characteristics

My model places an enormous emphasis on the importance of the therapeutic alliance. Well-established trust is important in any counseling relationship, but especially so with schizophrenics, who have developed a particularly vigorous distrust of everything around them. While building this trust, the client must be reassured the therapist can always be reached. The therapeutic alliance can be further strengthened by being helpful, as opposed to neutral (Karon, 2008). Directly challenging the client’s beliefs during counseling is discouraged, especially in the early stages of therapy, when trust is still being earned. Even later in therapy, directly challenging beliefs often leads to client distress and discontinuation of therapy (Garety, Fowler, & Kuipers, 2000). Important to building the therapeutic alliance is the ability of the therapist to tolerate client incoherence, and to tolerate not understanding.

My model is based on the interpretation of symptoms as meaningful, as opposed to being merely products of a mental illness. It incorporates techniques and principles from a wide-range of approaches, but relies most heavily on psychoanalytic theory, person-centered therapy, and behavioral and cognitive behavioral therapy.
The model borrows from psychoanalytic therapy in its emphasis on the process of making the unconscious conscious. Recent studies have shown that symptoms (hallucinations and delusions) can be eliminated simply by making the client aware of their source or significance (Kivlighan, Multon, & Patton, 2000). Recognizing and interpreting transference is an important psychoanalytical aspect adapted to my model, and is the primary mode of discovering the source/significance of hallucinations and delusions. Similar to how psychoanalytic therapists interpret dreams, hallucinations can be interpreted to gain insight into the unconscious.

Several aspects of my model are based on the philosophies of person-centered therapy (Corey, 2009). As clients experience therapist acceptance, they learn to accept themselves. Schizophrenics have likely had many painful experiences of not being accepted by society. By showing acceptance, the therapist is preparing the client for healthy social engagement in the future. Unconditional positive regard is essential to the relationship because of the readiness of schizophrenics to distrust.

Behavioral and cognitive behavioral techniques are blended, with a bias toward philosophies outlined in Beck’s model of cognitive therapy (Corey, 2009). The main focus, in terms of the behavioral and cognitive behavioral components of the model, is the improvement of social skills.

**Stages of Counseling Model**

The initial stage of the counseling model consists of accumulating as clear a case history as possible, focusing specifically on possible traumatic experiences. This is an ongoing process throughout therapy. This may be an arduous process if relying mainly on the client for
information. Much of this information may be repressed and may only come to be revealed through transference.

It may be difficult to determine where to start when counseling a schizophrenic. It may, however, be as easy as starting with the most pressing symptom (e.g. the client is violent, the client is not eating), or, with something of particular pertinence in the accumulated case history. While in these first stages of therapy it is important to diligently establish a strong therapeutic relationship.

Once trust is established work can begin in sorting out delusions and hallucinations, accomplished by interpreting transference, exploring with the client pertinent case history information, and over time, coming to better understand how to interpret what the client is trying to say. Having the client draw that they are thinking, then asking them to explain the drawing can lead to significant insight. I work with a client named James who is schizophrenic. I asked him what he was drawing one night. He said it was pigeon in a carousel whirlwind, and he proceeded to say “life is a carousel whirlwind.” I asked him how life was a carousel whirlwind, and he told me a story from his childhood that, I believe, was of significance in terms of his development of schizophrenia. Once the unconscious source of the delusions and hallucinations are brought into awareness, symptoms should begin to decrease.

Once symptoms are manageable, the therapist can begin to introduce techniques that blend various aspects of behavioral and cognitive behavioral therapy. Treatment goals can be developed with client/therapist corroboration. The central aim of these goals should be to change thoughts and behavior and reduce stress, which will lead to improved social skills and more control over symptoms. This stage of therapy should remain entirely collaborative, with the counselor maintaining an inquisitive and interested stance.
Because one of the main goals of my model is to improve social skills, social skills training should factor prominently into goal formation. Studies have shown social skills training to be highly effective in improving social adjustment and independent living among schizophrenics (Kurtz, & Mueser, 2008). Social skills training can be implemented using psychoeducation, modeling, reinforcement, behavioral rehearsal, role playing, and feedback. The specific method used will be dependent upon the client and the situation.

There should be an in-depth exploration of the client’s dysfunctional beliefs and the origins of these beliefs. These beliefs can then be challenged and modified using a combination of skills training, behavioral rehearsal, and exposure therapy determined by therapist and client.

New behavioral and cognitive coping strategies should be introduced and practiced in an effort to reduce stress and increase the client’s sense of control. Implementing these strategies will generally take the form of a homework task, such as recording the occurrence of the target symptom.

**Counselor’s Role**

The counselor has various roles within this model that evolve as the therapy progresses. At the outset of therapy the central role of the counselor is to be a trustworthy and helpful confidant who encourages and facilitates exploration of delusions by creating a safe environment for the client. This is accomplished using various methods of analysis (e.g. interpreting transference, compiling and interpreting a client’s case history, interpreting stories that may serve as metaphors) and by asking questions.

At all stages of therapy counselors have the responsibility of modeling a healthy, accepting relationship that the client will hopefully internalize as a model of how to treat himself. Though various psychoanalytic techniques are used, the “blank screen” approach should never
be used with schizophrenics, as it produces a distressing amount of negative transference (Karon, 2008). The counselor should not be confrontational, but should be explicitly helpful (as opposed to neutral) in response, pointing out possible inconsistencies and aiding the client in understanding the world and other people. The counselor should be tolerant of incoherence, and should exhibit unconditional positive regard.

Once symptoms are reduced to a reasonable level, the role of the counselor shifts slightly to accommodate the evolving goals of the therapy. Even at this later stage of therapy, the strength of the therapeutic alliance is important. The counselor, having developed intimate familiarity with the client over time, can decide how best to go about implementing a blend of behavior and cognitive behavioral therapy that relies most heavily on the philosophy of Beck’s model of cognitive therapy.

Client’s Role and Experience

Initially the client’s role is simply to consistently attend therapy sessions and engage with the counselor in conversation. Verbalization, whether coherent or not, is key at the outset of therapy. Clients are encouraged to cooperate and take an active role in exploring their symptoms as they are guided by their own considerations and by the counselor. Later in therapy, clients work with the counselor to form goals which clients are expected to focus on and work toward during, and outside of, the therapy session.

The client is encouraged to take an active role in determining goals for therapy, to engage in the agreed-upon behavioral techniques, and to be responsive to feedback and suggestions from the counselor.

Perhaps the most important aspect of this therapy model is how a safe, positive environment is created for the client. This allows the client to experience a healthy, safe
relationship aimed at facilitating an open exchange between client and counselor. This exchange is what will lead to the client's understanding of symptoms in terms of the functions they serve and how they came about.

**Assessing Progress and Effectiveness**

Progress will most likely be slow in the first stages of this model. In the initial stages it is measured by the level of symptom reduction. This can be gauged using formal checklists or other assessment devices, by therapist observation, client reporting, and reporting by those close to the client outside of therapy. Specifically progress at this stage may mean reduction in delusions, reduction in hallucinations, more coherent speech, more appropriate/organized speech, and more animated or appropriate affect. Progress in the later stage of the model will be gauged by assessment of the established goals.

**Summary**

Research has shown schizophrenia to be an incapacitating disorder that is characterized by a range of complex primary symptoms, and many subsequent disadvantages. It is also a disorder that, research has shown, can be recovered from through the use of psychotherapy, with an essential component of that therapy being a strong therapeutic alliance.

This counseling model integrates elements of psychoanalytic therapy, person-centered therapy, behavioral therapy, and cognitive-behavioral therapy. Specifically, this model aims to improve social skills and eliminate client symptoms, which will enable the client to achieve the ultimate goals of this model, which are to prepare for (1) living independently and (2) obtaining steady employment. This model stresses the importance of the therapeutic alliance and relies heavily on counselor/client collaboration. It is a model intended to be flexible and evolving, allowing both client input and counselor discretion.
References


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