

Vemos, por aqui, só alguns dos aspectos da complexidade da acção CL. Trabalhar em equipa apela a sentimento de grupalidade e ao conhecimento das forças dinâmicas de grupo, sempre presentes, que nem todos os psiquiatras e psicólogos estão aptos a reconhecer ou a aceitar quer por insuficientes bases teórico-práticas, quer por interferirem no poder decisório dum pretensa onisciência científica.

Um estudo brasileiro³ referiu que quem trabalha em Psiquiatria CL é o "profissional que se sente motivado por sua vocação, bem como pela possibilidade de renovar conhecimentos e de expandir seu relacionamento profissional". Quanto a nós, no trabalho CL há constante superação prática da dicotomia cartesiana entre a res extensa e a res cogitans – a integração humana do soma com a psique. Este é um fundamento que o Consultor CL verifica constantemente no seu trabalho e lhe causa a íntima satisfação, na praxis, de estar perante o ser uno e não artificialmente dividido.

Entendeu a actual Direcção Grupo Português de Psiquiatria CL em promover junto dos psiquiatras e dos psicólogos clínicos um Curso de Formação Pós-Graduado⁴ na sua área de intervenção.

Psiquiatria de Ligação e Modelos Teóricos;
Comunicação na Consulta CL;
Avaliação e Diagnóstico na interface Doença Somática/ Psiquiátrica;
Intervenções Psicoterapêuticas;
Psicofarmacologia e Interações Medicamentosas;
Particularidades de Intervenção nos Cuidados Primários e Hospitalares;
Psicologia da Saúde;
Psicopedagogia Terapêutica (Psicoeducação) na Intervenção CL;
Investigação em CL;
Ética em CL.

Raul Guimarães Lopes

¹ Consiliar (escrita com "s" e não com "c") vem do conselho (que não se confunde com concelho), consulta, consultadoria (ou consultoria no Brasil).

² Como na ocorrência das reuniões de serviço com apresentações de casos clínicos.

³ Consultoria psiquiátrica em hospital geral: inviável ou promissora? Botega, N. J. et al, Rev. Bras. Psiquiatr. vol. 22 n. 3 São Paulo Sept. 2000.

⁴ Vêde mais pormenores e condições de inscrição no sítio da web: www.psiquiatria-cl.org.

New Visions of Schizophrenia: psychotherapeutic advances

Hipólito, J., M.D., Ph.D.*

sumário

Com a introdução dos neurolépticos, as abordagens psicoterapêuticas, perderam muito da sua importância no tratamento da esquizofrenia, até serem por vezes consideradas como má prática, na ausência de neurolépticos. Contudo, uma revisão cuidadosa da literatura, mostra que a psicoterapia guarda toda a sua importância no arsenal terapêutico da esquizofrenia e que em contrapartida a sua ausência pode ser uma má prática. A Terapia Centrada no Cliente oferece uma abordagem terapêutica importante da esquizofrenia, sobretudo na perspectiva de Gary Prouty. A qualidade e o rigor da formação dos psicoterapeutas aparecem como elementos chave para o seu sucesso.

palavras-chave

Psychotherapy, Client Centered Therapy, Schizophrenia

summary

With the introduction of the neuroleptics, the psychotherapeutic approaches lost much of their importance in the treatment of the schizophrenia, being even sometimes considered as bad practice in the absence of neuroleptics. Nevertheless a careful review of the literature shows that psychotherapy maintains all of its importance in the therapeutic arsenal of schizophrenia and that its absence can be bad practice. Client Centered Therapy offers an important therapeutic approach to schizophrenia especially from the perspective of Pre-Therapy and the work of Gary Prouty. The quality of the training of the psychotherapists appears one of the key elements for its success.

key- words

Everyday; Mental disease; Concepts; Consequences.

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There can be no doubt that the introduction of chlorpromazine in 1957, and especially of haloperidol in 1959, were the bases of the spectacular reduction in the number of psychiatric beds all over the world. For example, The Julio de Matos Hospital in Lisbon, projected in 1911 with 800 beds, had 1200 in 1952 and has approximately 478 beds presently. The Malevoz Hospital in Switzerland, which was involved in a training exchange programme with the Julio de Matos Hospital at the time of the latter's activation, had 450 beds in 1970, which were reduced to 120 in time for its centennial celebration in 1999.

One may, however, be left with the impression that up to this time the therapy of the psychoses, and of schizophrenia in particular, was limited to the custody of patients, following the "Grand Enfermement" (The Great Internment), a movement publicly denounced by Michel Foucault in 1961. (Foucault, 1976/2001).

Some attempts at applying effective treatments, especially biological, physical or even surgical had already been made. Julius Wagner-Jauregg had introduced malaria therapy for the treatment of neuro-syphilis in 1917, a feat which won him the Nobel Prize 10 years later. The success of this treatment led to its later use in the treatment of psychotic illnesses.

The Swiss physician Jakob Klaesi proposed in 1922 the so-called "sleeping-cures", associated with a psychotherapeutic approach strongly influenced by Psychoanalysis. Manfred J. Sakel introduced in 1927 insulin shock therapy or Sakel's cure; this consisted of an insulin-induced coma together with a strong psychotherapeutic ambience, and was for many years applied with relative success.

The erroneous belief of the incompatibility between epilepsy and schizophrenia motivated the search and development of artificial methods of inducing convulsions. It was thus that Ladislaus von Meduna introduced convulsive therapy with injections of metrazol in 1934, and Ugo Cerletti and Lucio Bini introduced electroconvulsive therapy in 1937. If metrazol-induced seizures disappeared

from the therapeutic armamentarium, the same does not apply to electroconvulsive therapy. ECT is used today for many precise indications and is especially efficacious in the treatment of psychotic depression.

As is common knowledge, Egas Moniz introduced the pre-frontal lobotomy in 1935, being later awarded the Nobel Prize in 1949 for his contribution to the study of brain function and the "treatment" of the schizophrenias.

Nevertheless, the treatment of psychotic disorders via more psychological approaches hasn't been abandoned since the time of Phillipe Pinel.

Bockoven (quoted in Karon, 2003), claims that much prior to the introduction of the antipsychotics and since the time of Pinel, "moral therapy" had shown excellent results, allowing 60 to 80% of patients to leave hospital. The abandonment of "moral therapy" in the mid 19th Century resulted in the reduction in the number of patients that were discharged from hospital down to 20 to 30%.

"Moral therapy" was based on four pillars: 1) the non-utilization of force or humiliation on patients, with the exclusive use of force to protect the patient from himself or to prevent harm to others, but never as punishment; 2) the taking of an as elaborate clinical history as possible; 3) the encouragement of social relations and work, and 4) a bringing together of all the efforts and commitment of the caregivers in such a way as to understand the patient as a human being.

With the development of Freud's psychoanalytical model, the psychological treatment-approach to the psychoses became marked with an effort towards some clinical investigation, but primarily by theorising based on clinical cases studies, the most famous of which is the case of Judge Schreber (Freud, 1911). Freud has subsequently been criticised for his elaborate interpretations of someone he never met, and for ignoring the role Schreber's highly unusual and traumatic past might have played in his illness (Storr A. 1989)

Racamier, one of the psychoanalysts that has most dedicated himself to the treatment

of the psychoses, produced an article that, despite its age, continues to be relevant in this field, namely an excellent review of the psychoanalytical approach to the psychoses. (Racamier, 1974)

To illustrate this point we would like to refer to the work of Rosen (1953 or 1960), on the development of specific psychotherapeutic tools. Also, Sechehaye's (1954) psychoanalytical work seems a good introduction to the comprehension of this problem. Finally, reading the description of a case study with a favourable outcome, such as the relatively recent one described by Dorman (1999), may be extremely helpful.

Apart from psychoanalysis, other schools have shown interest in researching this area. This is notably the case of the Person-Centered Approach, extensively documented in the work of Carl Rogers and his associates. Within the Person-Centered field we consider it salient to refer to a work published in 1964 by Virginia Axline (Axline, 1964), which is a case study of a purportedly psychotic child's therapy, and which remains a best seller in the field still today.

With the introduction of the neuroleptics, the importance of psychotherapy began to wane in favour of a greater and faster efficacy offered by medication. However, a clear comparison of the two treatment approaches was never really made. The disadvantages mentioned relative to psychotherapy are largely due to the great difficulty in developing competences in the therapists; these require a high level of personal and professional investment, and both therapist training and therapy itself are long and time-consuming.

A study carried out by Bockoven and Solomon, in 1975 (Bockoven & Solomon, 1975) compares the evolution of two groups over 5 years. Subjects in both groups were chosen randomly. One group consisted of 100 hospitalized patients, in a community-orientated psychiatric hospital in 1947. The other group was composed of 100 patients admitted to a community-centred mental health centre in 1967, posterior to

the introduction of the neuroleptics for the treatment of schizophrenia.

Although the first group did not receive neuroleptics, the results for both groups were similar leading the authors to conclude that perhaps neuroleptics are not indispensable for treatment of schizophrenia. However, no mention was made of the quality of life in the two populations, and the study is anterior to the introduction of the atypical antipsychotics, the first of which, clozapine, was introduced in 1970, to be followed by the so-called second wave of atypicals with risperidone becoming available in 1994, olanzapine in 1996, quetiapine in 1997 and ziprasidone in 2000.

Nevertheless, the long-term advantages of psychopharmacology over psychotherapy are far from consensual.

Bertram P Karon studied the long-term evolution of schizophrenia. According to him, the analysis of Harding, Zubin and Strauss (1987) carried out on 5 reviews of published papers of various researchers showed that 30% of patients recovered completely over the long term, and 60 to 70% became self-sufficient, without a clear role of the introduction of the neuroleptics being evident in these findings.

This same author also states that the results of the Michigan state Psychotherapy Project, which compared a group of patients that received 70 individual analytical psychotherapy sessions with a group that received medication and with a third group treated with both types of therapy, showed that the third group had better outcomes than the medication group, but inferior to the psychotherapy-only group or of patients that received medication for a short period or abandoned it (Karon & VandenBos, 1981).

Likewise, Lambert, based on his own experience, had already mentioned that the use of the lowest possible dose of neuroleptic was one of the essential conditions for a psychoanalytical cure (Lambert, 1986).

A presently much propounded idea is that in the early stages of the schizophrenic disorder, the non-utilization of neuroleptics in adequate doses is a bad practice, and that

experience shows that the mid and long-term evolution of the disorder will be better the earlier that treatment is initiated.

Mosher re-analysed the Soteria Project and focussed on the new admissions. He compared the results obtained by those therapeutic communities, which are based on a practice of minimal or no neuroleptic usage, with the results obtained at traditional psychiatric hospitals, and found that after a 2 year follow-up, the subjects treated in the therapeutic communities showed better results (Mosher, 1999; Bola & Mosher, 2003). These results had previously been confirmed by the work of Luc Ciompi and his team, at the University of Berne, during the development of the Soteria Project Berne (Ciompi et al, 1993).

Ciompi claims that "in a therapeutic setting and with a caring style especially focussed on anxiety reduction, emotional relaxation, interpersonal support, and protection against cognitive-affective over-stimulation, psychotic symptoms may disappear in weeks without neuroleptics or with only minimal medication" (Ciompi, 1997)

There seems therefore to be sufficient evidence to claim that the absence of psychotherapy in the treatment of psychosis is bad clinical practice.

Since Engels (1977) introduced the concept of the bio-psycho-social approach (the Portuguese psychiatrist Barahona-Fernandes spoke of bio-psycho-socio-anthropological approach.) the idea of associating drug therapy to different socio-therapeutic approaches and offering the patient and his family psycho-education, as well as the so-called contextual and systemic therapies has become widespread. However, psychotherapeutic approaches have regained some importance, most especially cognitive-behavioural therapy (Haddock, G., & Lewis, S. 2005; Tarrier, S. & all. 2004; Valmaggia, L. R., & all 2005), with its focus on symptoms, as well as the analytically based therapies. An extensive review of these modalities is however beyond the scope of this paper.

The biomedical model has come to

dominate most treatment approaches, whether psychopharmacological or psychotherapeutic, implying a previous diagnosis of an aetiological nature, followed by, in the majority of cases, a specific intervention based on the chosen theoretical model.

We consider it important at this point to mention another form of psychotherapeutic intervention, namely that developed by Carl Rogers, based on a holistic perspective, and known as the Person-Centred Approach.

Rogers postulated the existence of a tendency towards complexification, present at all levels of the universe, and which he called the Formative Tendency (Rogers, 1977). In the case of life, this tendency accelerates, and Rogers called it The Actualising Tendency (Rogers, 1980). This tendency toward complexification or "hypercomplexification" has two corollaries: one, it considers the existence in the universe, from the inanimate level up to the level of social organisms of an auto-organisation; second, the tendency towards self-cure of the organism, as long as the necessary and sufficient conditions are met. This confidence in the self – auto organizing and self-curative capacities of organisms led Rogers to develop a conceptualisation he named the Non-Directive Attitude, the name by which his therapeutic approach was initially known.

Towards the end of the 50s and beginning of the 60s Rogers carried out research work at the university of Wisconsin that came to be known as the Wisconsin Project, and which he later described in his book "The Therapeutic Relationship and Its Impact" (Rogers, 1967).

Carl Rogers and his team tested various hypotheses related to the three basic attitudes of the therapeutic relationship, namely congruence, unconditional positive regard and empathic understanding. They developed a study that compared the evolution in psychotherapy of a group of patients diagnosed as suffering from chronic schizophrenia, a group diagnosed as having acute schizophrenia, a group with neuroses, a group of so-called normal people and a control group.

Of the various hypotheses of the study, the second claimed that "the same variables of process movement will characterize the in-therapy behaviour of more acute schizophrenics, more chronic schizophrenics, normals, and neurotics" (Rogers, 1967 pp.17). "In so far as we were able to test this hypothesis", writes Rogers, "the evidence was generally confirmatory. The major change which emerged from our findings is that schizophrenics initially focuses more on relationship formation than self-exploration, and thus some of the most characteristic elements of process for the neurotic are not initially present for the schizophrenic. Indeed, such self-exploratory behaviour may never occupy as prominent a position in the therapy of the schizophrenic as it does in the therapy of the neurotic." (Rogers, 1967 pp.90).

Rogers said the therapists found themselves confronted with an unexpected difficulty: "they were new to the task of relating to individuals who had not asked for help. (...) therapists were less expressive, less skilled in initiating a significant relationship than they later became (...) we failed to communicate to the normal subjects the possibilities which we had hoped they would discover in an expressive relationship (...) [the therapists] were faced with many difficult problems in establishing a relationship with the hospitalized schizophrenics and likewise the normals, both of the groups being composed of individuals who were not seeking help" (Rogers, 1967, pp. 67).

Gendlin, a collaborator of Rogers on this project and the founder of experiential-focussing therapy, commented that "the initiation of therapy is extremely difficult with discouraged, frightened, withdrawn, suspicious patients. Such patients need to see and hear the therapeutic relating with other patients and withdraw from it repeatedly before they can bear to try out such a relationship themselves" (Rogers, 1967, pp. 526)

Carl Rogers, (1957), based on his research work proposed six necessary and sufficient conditions for therapeutic change. They are 1)

that two people are in psychological contact, 2) that the first, who is called the client, is in a state of incongruence, being vulnerable or anxious, 3) that the second, who is called the therapist, is congruent or integrated in the relationship, 4) that the therapist experiences an unconditional positive regard for the client, 5) that the therapist experiences an empathic understanding of the client's internal frame of reference and communicates this to the client, and 6) that the communication to the client of the unconditional positive regard and empathic understanding is minimally achieved.

Rogers claimed that if these 6 conditions were present, then constructive change would occur in the client; if one or more were absent, then change would not occur. Furthermore, the dimension of the positive change would be proportional to the degree to which the six conditions were present.

Seen from this holistic perspective, the psychological diagnosis, although very important in issues such as research and communication within the scientific community, ceases to be important in determining the indications for psychotherapy. This is instead substituted by a new "diagnostic apparatus" (Hipólito, 1992) based on the presence or absence of these six necessary and sufficient conditions for therapeutic change. The actualization of the capacity for self-cure, and the attitude of confidence in the capacity for self-organization of the organism, stem directly form these six conditions.

We see that in many patients (whom the rogerian school prefers to refer to as clients (Caldeira, 1979), even those diagnosed as schizophrenic, the six conditions are present and therefore it is not necessary for the therapist to assume a particular or specific attitude, except perhaps the greater importance of his training and therapeutic experience.

Inspired by the anthro-poly-analytical model, Caldeira, pretended to operationally define client-based practice, and complete it with an original theoretical reflection. He

thus contributed in a significant way towards the practice and investigation in the field of the psychotherapy of schizophrenia (Dias & Caldeira, 1982).

In this paper it is our intention to concentrate on one of the more specific and frequent difficulties encountered with schizophrenic patients, namely the absence of psychological contact, the first of the aforementioned conditions.

Carl Rogers did not elaborate on the idea of psychological contact as clearly and completely as he did for the so-called three basic attitudes of the therapist, mentioned beforehand. Rogers said that psychological contact meant the presence of the essential minimum of the relationship, namely that each person made a perceived (or subceived) difference in the experiential field of the other. This presence could be minimal and may not be immediately apparent to an observer.

Gendlin considered some of the difficulties encountered when trying to establish contact with some of the participants in the Wisconsin Project. He describes some of the attitudes he assumed in order to develop contact, such as "touching, [but in] a mode that won't be confusing, sexual-like or frightening" (Rogers, 1967, pp. 384). As an example he describes how, at a given moment, the therapist, at the patient's request, offered him a cigarette although later he refused that same request; on another occasion he lent the patient money without asking why, but later he made demands concerning a new loan (Rogers, 1967 pp. 388).

Garry Prouty (1990) has carried out an extensive and interesting analysis of the Wisconsin Project and has re-evaluated its results. He points out that Tsanika mentions that "the severely disturbed individuals have difficulty in being aware of the empathic understanding and unconditional positive regard of the therapist. Consequently, empathic contact is not established and the therapeutic process is stalled" (Tsanika, 1987).

Prouty also stresses that Rogers spoke of the tendency of schizophrenics to the

relationship either by almost complete silence, (...) or by a flood of words, equally effective in preventing a real encounter" (Rogers, 1972, pp. 188), and introduces the necessity of methods, permitting "a pre-relationship or a pre-experiencing".

In this article, and following on Peters (1986) and Merleau-Ponty (1962), Prouty (1990) develops the idea of psychological contact by defining it as a set of therapeutic techniques (contact reformulations), of psychological functions necessary for the therapy to happen and of emerging measurable behaviours.

Regarding schizophrenic patients Prouty says that there "exists a deficiency in reality contact which prevents the sharing with the therapist of a mutual *"hic et nunc"*; a deficiency in the "contact of communication" which prevents verbal expression".

Seen from this point of view, a "reality contact (with the world), a communicative contact (with another) and an affective contact (with the self) are "pre-conditions for the therapy to become functional", and consequently it is the psychological contact that permits the essential opening up to the world, the self, and to others.

Whenever this contact is absent in psychotic patients, the author proposes that it be developed with an approach he called "Pre-Therapy" (Prouty, 1994:2003). This is based on a theory and methodology of intervention that permits the restoration of the psychological contact necessary for therapy.

Prouty classified as five the therapeutic techniques used, which he called contact reformulations, as follows:

1. Situational reflections, facilitating the restoration and development of contact with reality, permitting the patient to enter into the context of his immediate reality;

2. Facial reflections, developing and restoring affective contact by means of making explicit the affect implicit in the client's face;

3. Verbal or word-for-word reflections, developing and restoring communicative contact by making use of the client's own verbal output;

4. Body reflections, developing a generalization of contact in the "here and now", through the body-felt sense and in the reformulation of more or less bizarre movements and postures;

5. Reiterative reflections, developing contact through the repetition of reformulations that proved effective before.

With regard to these contact functions we believe we can say that the contact with reality (with the world) defines peoples' conscience, as well as things places and events; on the other hand, affective contact (with the self) defines the consciousness of feelings, states of mind and emotions; and contact of communication defines the capacity to symbolize for (the benefit of) others the consciousness the client has of reality and affectivity.

The emergence of contact behaviours should then be the logical continuation of the aforementioned developments, as the client expresses a progressively greater contact with his Inner-world (affective), with the reality of the Outer-world and with the reality of the Other-world. The desired evolution would be the construction, or re-construction, of psychological contact, permitting the movement from a first phase of pre-therapy to a second phase of conventional client-centered therapy, if the other five conditions are deemed to be present.

This proposal of psychological intervention has as objective the establishment of the indispensable element called psychological contact. This is a necessary prior condition for the carrying-out of any psychological intervention, a fact also recognised by other schools of therapy. However, this does not exclude the necessity for the eventual complementary use of neuroleptics. These permit a better discrimination between reality and fantasy, facilitating the development of contact and, consequently, the establishment of the relationship, something considered as the cornerstone of the six necessary and sufficient conditions as proposed by Rogers.

Based on all the research work mentioned before, we conclude that in the psychiatric

treatment of schizophrenia, the absence of psychotherapy is a bad practice, since through it patients benefit, unquestionably, from a process of maturation and elaboration that permits them a better integration in their "being-in-the-world".

Without wanting to minimise the contributions of other psychotherapeutic models, we believe that the holistic model of Client-Centered Therapy has clearly shown its potential, a fact that justifies its presence in a wide network of European psychiatric institutions.

Finally we wish to state our belief of the importance of personal training in psychotherapy for psychiatrists during their specialist training.

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