New Contributions on the Psychoanalytic Approach to Psychotherapy and Comprehensive Treatment of Family of Schizophrenic Patients

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The authors present a way of psychotherapeutic treatment of schizophrenia patients that highlights parents’ participation in the cure and emphasizes their involvement in, the psychotic trauma. An out-patient department for parents and their children was equipped and organized, in which the therapeutic relationship is planned in order (a) to meet the questions of patients and their parents, (b) to fit the different relational ways of individuals, and (e) to provide an uninterrupted service. This setting allowed to develop the therapeutic relationship from tentative to more permanent and structured modalities in a psychotherapeutic meaning. Data of the 4-year work are offered: the therapeutic relationship with children appears significantly correlated with the stability of the therapeutic relationship of their parents. The hospitalization of frequently admitted patients is significantly reduced only within the patients from intact families.

Key words: Family, Schizophrenia, Treatment.

Since the 1950’s a number of important changes in psychiatric perspectives have taken place, especially on the way of dealing with the family during the schizophrenic patient’s treatment. Recently Wynne (1988), one of the researchers who supported the theory of the “schizophrenogenic” mother and family, has expressed his disappointment about all the misunderstandings created in theoretic work and the therapeutic projects following his hypothesis. These changes in psychiatry were and still have been an expression of the deep family and couple crisis of our time in the face of that particular growing-up phase that represents

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the entrance of young people in the world of adulthood. If at the beginning of our century this transitions was clear, as well-defined somatic changes and social customs occurred in a short period of time, the maturation of late phase has changed deeply and its length increased: adolescence begins much earlier while adulthood is postponed.

The deep changes and the difficulties related to the generational transition from parents to children are expressed in the turbulence and myths that permeate youth in this long expectation, where the childish phases of separation-individuation are relived. This psychological process covers man’s existence with its problems, and it was called by Freud the Oedipus myth. Most authors correlate this growing phase with a parallel evolution phase toward which the parents themselves move, and this marks the beginning of schizophrenia (Racamier, Sens, & Carrettier, 1961; Winnicott, 1953). The root of disease affects parents in many different ways: biological genetic, constitutional, childish and historical, environmental-educational, and also communicative and emotional.

The therapeutic relationship with schizophrenic patients inevitably involves, even in psychiatrists, the comparison between the parenthood complex and the influence of one’s origin, varied according to personal growth and emancipation experiences, with the social and cultural models taken as references. How psychiatric science rationalized and privileged some of these generational bonds in the different and opposed ethno-logical theories on schizophrenia is show in the behavior with the patient’s relatives also at a therapeutic level. The family was sometimes under suspicion, kept away from the patient, accused, considered as a victim or perhaps completely ignored: therapeutic strategies correlated to different defensive choices that characterized the approach to such a disturbing pain expressed in schizophrenia and in the attempt to understand the meaning of the family’s participation in this sorrow, which involves one of the deepest narcissistic wound.

Within these different therapeutic ways of psychiatry, followed procedures already taken by the patients or their parents, like a “therapeutic” family novel (even at the request of the therapists themselves to regain their own narcissism, sometimes even showing themselves; substitute parents). Even if the “schizophrenogenic” mother’s theory could seem opposed to the genetic hereditary one, as a matter of fact parents paid with even more sorrow and responsibility (Wynne & Singer, 1965). The application of the system’s theory to the family, and the enhancing of the type of communication that exists within the family itself when one of the member is ill, turned out some therapeutic solutions meant to cure the whole family system considered “salomonically” entirely ill, and able to produce as a symptom the “designated patient” to keep its precarious equilibrium: the transactional schizophrenic family (Bateson, Jackson, & Weakland, 1956; Haley, 1972; Watzlawick, Beavin, & Jackson, 1967).

These clinical experiences, sometimes guided or inspired by researchers external to the medical and psychiatric science, linguists or communicative experts, start to take into account the family aspect in schizophrenic pathology and introduce it in the psychiatric debate not only in the internal considerations on schizophrenic pathology, but even as a therapy phases that cannot be given up. Therefore even if the systemic therapy was considered in psychiatry any “external body”, and because of its own origins could join the clinical practice only as a rare and momentary characteristic, it has anyway the credit of renewing attention and interest in the relational and family aspect.

For a few years now, psychiatric research has as object the therapeutic functionality of the patient’s treatment, and, especially in the USA and Great Britain, therapeutic programs have been used and verified in combination with psycho-educational treatment to relatives. These programs have shown the usefulness of the treatment of parents together with all the others on the schizophrenic patient. These studies clearly demonstrate the parallelism between the relative’s behavior towards the patient, in the meaning of Expressed Emotion, and in the disease course, in the meaning of symptomatologic, relapses (Leff, 1988; Faloon et al., 1985).

Today, in psychiatry, an empirical approach is preferred. It follows interdisciplinary
models, giving up hypotheses that deal with only one type of methodology, and preferring prognosis to etiology, and clinical practice to theory. This allows the unification of different theoretic positions: the treatment seems more compact than therapeutic myths seem to diverge, and there is the sensation, clearly expressed in the literature, that independently of the type of treatment used, involving parents in schizophrenic therapy has a strong positive meaning. In this new perspective, the importance of family participation in the schizophrenic patient's treatment is generally recognized, both as an aid to a strong therapeutic alliance with the patient, thus maximizing compliance with all the treatment in use, and to promote family “therapeutic” factors, which can help the evolution of the disease. The family seems to emerge as the best therapeutic surrounding, and the "power source” of the therapist, and if it is well sustained, for many patients may represent the best support, difficult to be substituted with other institutions (Leff, 1989).

This time there are no doubts on giving to the psychiatrist the duty to treat even the patient's parents who are since the beginning very demanding: there is a common agreement in the literature about this, regardless of the theoretic models taken as references.

**New developments of the psychoanalytic theory**

The period that is easily considered critical for psychoanalysis shows, instead, some signs indicating very important clinical and theoretical developments. These signs can be summarized in the recognition, from a different point of view, of the reality of the mutual parent-child, teacher-pupil, analyst-patient generational or relational bond, and of its importance in the symbolic and cultural construction, and in the analytic process.

Within a theoretical discussion, this recalls the meaning of empathy, counter transferance, or analyst's transference; it brings back the debate on the historic real-childish fantasy, showing once again the trauma concept; it is an expression of the origins and of the myths connected to it, through the diffusion of publications not censored or filtered about the history of the psychoanalytic movement and the persons who were its pioneers, starting from the less institutional Freud’s biography, and in particular, Fliess’s letters and Ferenczi’s Clinical Journal, which enables to historically possibility, the less known matrix, the context where the psychoanalytic theory was born.

Moreover, the present convergence and comparison between different theoretical models move together with the recognition of the therapeutic expectations and their prejudices in the analytic process. Therefore in some cases they may rationalize some difficulties starting only from the patient’s point of view – negative transference and death instinct, endlessness (Schwaber, 1992). These conditions should be taken into account as chronic aspects of that analytic relation. We see a revelation to the analyst who dreams and projects for his/her patient.

The psychosis’ approach may find here some new perspectives: after the development of the acquisitions attained in the analytic treatment of children and the analysis of narcissism and pathology of the Self, thinking back to analytic relation as a mutual construction of identity and representation might offer some precious instructions about what seems to be a specific parenthood, traditional, thought transmission disorder (schizophrenia) which starts precociously in the relation between parents and children, within emotions, gestures and words (Pierri, 1991). Even in clinical work this disorder has to be seen in a more complex way including the psychiatrist and the institution, giving rise to a painful chronic experience, which increasingly reveals itself as a relational and cultural reality.

From this point of view, the subjective experience of insanity reflects in the tragic aspect of exclusion-desertion, reclusion or social treatment, in which not only the ability of cultural comprehension of an era, but also the individual and collective expense for a certain type of progress are measured. If schizophrenia is indeed a pathology found in all cultures, the best prognosis occurs in primitive cultures, and this expresses a greater ability to re-establish individual and collective health.
in those contexts where normality standards are not so rigid (idealized and persecuted) and the pressure towards progress and maturation is not so strong and alienated.

**Working with parents in schizophrenic patients’ treatment**

At the Psychiatric Department of Padua University, we are carrying out a research on the clinic application of the psychoanalytic model to psychotherapy and rehabilitation of institutionalized schizophrenic patients. We follow an original model that involves relatives and especially both parents. This type of clinical and research work started about ten years ago, and has led to establishment of a *Counseling and Psychotherapy Outpatient Service for Parents and Their Children*, specifically addressed to parents of teenagers and young adults who show psychotic disorders.

There are a lot of studies on schizophrenic patients involving parents in the treatment, but only a few of them contemplate a continuous and lasting treatment: we think this aspect is very important for the psychoanalytic perspectives, as every change in the individual and the family relation requires achievement of a stability that only a long and orderly therapy can give. Even the most positive studies see the usefulness of a psychotherapeutic or educational treatment, especially on the family, which should last no more than a few months. This should prevent incidence of symptomatologic relapses in the ensuing year (Vaccaro, Joung, & Glynn, 1993); the follow-up after two years does not reveal any differences with the control group. There are studies on the relation between psychotherapy and rehabilitation in schizophrenia that start to take into account the importance of the treatment continuity.

Our Outpatient Service offers parents not only counseling, but also individual or group psychotherapeutic experiences, which last quite a long time and are organized in a parallel way to the children’s treatment as an integrated model: the collaborators who work with the parents and the children hold a meeting twice a week. This work is based on past experiences and is characterized by a better continuity, organization and flexibility. This leads to the possibility of responding to the various family re-quests in different ways depending on how much they can stand, and it is supported by a permanent service of individual counseling or emergency requests. There is also the possibility of a psychotherapeutic elaboration in a more precise context with limits to its setting, as an experience of individual or group psychotherapy for both parents and patients.

**Basic assumptions**

We want to formalize two assumptions of the theoretic psychoanalytic model which characterizes our work with schizophrenic patients and their relatives:

1. Interpretation of the schizophrenic symptoms as an expression of non-adaptation and current regression or blockage of the development in the parent-child relationship. This deals with the external and internal maturation requests peculiar to youth and initiation phase (maturational phase of both child and parents). Hence, the consideration of schizophrenia as a specific disease concerning parenthood and involving parents and children on a hereditary, neurobiological, constitutional, environmental, social, experiential, emotional, comprehensive basis and that expresses itself in the external and internal psychic reality.

2. Interpretation of the specific parental pathology as a complementary regression to the children’s. The inner goal of this regression is to stimulate the maturity process and to search for the old communicative level of experience, even if primitive. This regression again shows both sides of the misunderstanding related to the first traumatic parent-child relation, which did not achieve meaningfulness in the common and communicative reality. Better still, it shows the disowning of the other as different but similar, as subject and object of needs and desires. This trauma or misunderstanding blocks feelings and thoughts within the autistic-
symbiotic dilemma and stops the possibility of encounter and separation.

Sometimes this regression within a psychotherapeutic treatment can help the couple or each parent to re-establish recognition of a child, with his/her image altered due to the illness, and even to see themselves again as parents again, able to re-construct home and family feelings, even if it might be painful. In other cases psychotherapeutic treatment may help parents during the separation from their child, and therefore even from their own regressive conditions. On the other hand, they still have to continue supporting their child with love when the latter is in an institution to be cured. Moreover, the work with the parents can give an answer to some of the schizophrenic patient’s needs, as well as serving, within the treatment itself, as a facilitation mechanism, a specialized method for the reconstruction of the origins of affections.

Key concepts of treatment

From the basic assumptions, we can go on to some key concepts for the treatment.

The importance of the therapist’s ability, and of the therapeutic treatment, of “regression”. We do not think that therapists or institutions, their climate and functionality can be evaluated as neutral, and we therefore try to create a “facilitating” therapeutic institution. The therapist should have very high technical ability, but also the skill to adjust the therapeutic relation, with both parents and child, to their specific requests and language level. This must be done with flexibility, continuous presence and within a therapeutic relation development project. The whole work must follow a well-defined therapeutic setting, adjusted to the parents’ and patients’ needs and requests.

The reconstruction of a communicative language in both parents-child and therapeutic relations, starts from therapeutic gestures and concrete actions, in a way to transform the traumatic aspects into events related to an emotional story that can be lived. Therefore symbolic fragments must be collected and pieced together as puzzle pieces between parents and child, patient and therapist, and their shapes redefined: to do so we need a great therapeutic ability and flexibility in the realization of the regressive “movement towards”, in such a way that mutual recognition is realized and a necessary separation of the search for new forms of encounter made possible.

A continuous Outpatient Service looks essential, since it appears from statistics that in this way both parents and patients are more involved in the treatment, the latter in a more indirect and stable way. From this perspective a parent’s outpatient service might constitute a meeting space, a "filter", sometimes even before the beginning of the child's treatment; psychotherapeutic work with one or both parents, within group or as an individual experience, might be helpful and useful for the child’s therapeutic treatment in all aspects; care, psychopharmacological, rehabilitative, or analytic. The continuity of the Outpatient Service turns out to be very important with psychotic patients’ parents and even more important than the treatment itself. This aspect marks the difference between our model and all the others that suggest a rigid standard therapeutic treatment, even from a pharmacological, educational or systemic point of view. Moreover, usually the treatment is mostly of limited duration (three months, one year, two years, etc). Our follow-up takes place during the treatment and lasts differently for each patient.

Only in this particular perspective we think that the different phases of treatment can play their essential roles and we think that only when the outpatient service is free to change the therapeutic setting as requested by the patient it is possible to construct; some interpretations based on the history of the developing relationship.

The development of the therapeutic work within the institution must be done with care: all the therapists must cooperate and participate in a clinical discussion group, on top of which there must be one or more coordinators and supervisor expert enough to be the “tutors” of the operation.

The therapist and the institution should understand that there is always a possible risk of
deterioration, not only for the patient (in the relation with the parents), but also for their own customary and cultural well-being. Automatism, identity loss, thoughtlessness, delirium, perverse relations, destructivenesses permeate into the institutional life and their health. The achievement of significant encounters with the patient and his/her relatives affects the institution’s culture and health.

The parents -children counseling experience

We have seen, and had in treatment since 1991, the parents of 48 patients: 25 males and 23 females. Eighty-three percent of the patients live with their parents, and 55% are below the age of thirty. In the Outpatient Service, we have seen 70 parents: 25; fathers and 45 mothers; 20 came together, 5 fathers and 25 mothers alone. Patients’ mothers are more involved in the therapeutic treatment. We found that 27% of the families were broken households (due to separation, divorce or death of the father).

The flexibility in the parents-child counseling service experience could show us two main relational methods of treatment: one without a structured and definite setting; the other with a rhythmic and stable structure, with pre-defined spaces and times of setting like individual or group psychotherapy for the couple, mother or father singularly, or for the patient. During the treatment patients and parents might select their own way of relation (with one or more therapists). Sometimes both methods are chosen, or one of them follows the other. This shows different communicative levels and reflects a specific patient’s request that must be accepted. Both ways are related to two main request of the Self – autonomy against dependence – which parents may present in a confused way: therefore they need to be recognized and integrated. The less structured method of treatment (A) might be the only way of contact with the institution, or the starting point of movement towards the more definite one (B). Anyway, the condition of no-contact in serious pathologies, such as schizophrenic ones, should be avoided to reach the treatment goal, while clinical contact represents the best condition, a therapeutic alliance.

The type of treatment relations with parents was unstable in 29% of cases, stable in 71%. Within the stable relation: 25% chose the treatment mode! of structure A, and 46% the model of structure B. Let’s look at the course of outpatient treatment of the children as compared to the one of the parents (Table 1). A two-way log-linear analysis between parents’ treatment type and parent-child contact shows (a) a positive statistical significance between a stable contact and a stable treatment (Z = 2.87, p = .002), and (b) a negative statistical significance between an unstable contact and an unstable parente\textsuperscript{1} treatment (Z = 2.87, p = .002), that is children of parents with stable clinical relationships tend to hold a stable contact with their parents.

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<th>Table 1. Two way Frequency Matrix</th>
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<td>Parents’ Treatment Type:</td>
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Hospital admittance is sometimes seen simply as a symptomatologic relapse. We have some doubts about it; as we have verified, admissions combined with a clinical support might represent a well-defined phase within the treatment project. However, if they are the only relationship with the service, they may take on the meaning of a failing therapy, just like the no-contact condition.
In the group of our patients already pluri-hospitalized, the hospital re-admissions are correlated with their family’s coalition: more common in broken homes, they go to zero in intact homes. In fact, 72.72% of patients from intact homes, and 14.28% from broken homes have no more hospitalizations; 27.27% of patients from intact homes and 14.28% from broken homes have only one re-admission; 71.44% of patients from broken homes and not even one patient from intact homes have more than one hospital re-admission.

References


