

Schizophrenia: psychodynamic explanations

| You are learning how to... | In the context of... |
|---|---|
| <ul style="list-style-type: none"> Describe psychodynamic explanations for abnormality Comment critically on psychodynamic explanations Present information in ways that make it easy to learn | <ul style="list-style-type: none"> Schizophrenia |

The psychodynamic view of schizophrenia

The psychodynamic approach views schizophrenia as the result of the disintegration of the ego. It is the ego's job to keep control of the id's impulses and strike a compromise between the demands of the id and the moral restrictions of the superego. According to the Freudians, some types of abnormal upbringing (particularly if there is a cold, rejecting 'schizogenic' mother) can result in a weak and fragile ego, whose ability to contain the id's desires is limited. This can lead to the ego being 'broken apart' by its attempt to contain the id, leaving the id in overall control of the psyche.

If this happens, the person loses contact with reality as they can no longer distinguish between themselves and others, their desires and fantasies and reality (you need an ego to be able to do this). They regress to a state of 'primary narcissism' little different from that of a newborn infant, dominated by their animal instincts, incapable of organizing their own behaviour and hallucinating as a result of their basic inability to distinguish between their imaginations and reality.

The psychodynamic view is not highly regarded any more, for several reasons. The development of effective antipsychotic drugs in the 1950s and 1960s gave the biological view of schizophrenia a boost from which the psychological theories have never really recovered. As mainstream psychology turned away from Freud's tripartite model of the psyche under the influence first of behaviourism and then of the cognitivists psychodynamic theories generally fell from favour. Research showed that the mother's personality was not a reliable predictor of mental illness and the schizogenic mother approach came to be regarded as an embarrassing, sexist holdover from a less enlightened time (although much research continues to implicate a disturbed upbringing as a risk in schizophrenia onset and relapse). Finally, the apparent failure of psychodynamic therapies successfully to treat psychotic patients led to the abandonment of this approach by all by the most committed psychodynamicists.

You are the teachers

- Each group has information that everyone needs to learn
 - You have **fifteen minutes** to prepare
 - You have **six minutes** to teach your information to the others
 - You can take any approach you like *except* standing at the front and talking

- How will you make it *interesting*?
- How will you make it *accessible*?
- How will you ensure that your students are *learning*?

Schizophrenia: psychodynamic treatments

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The psychodynamic treatment of schizophrenia

Freud did not think there was much point in trying to treat schizophrenic patients with his talk based therapy. Psychoanalysis involves the cathartic release of repressed material, a facing up to its true significance and a restructuring of ego-defence mechanisms to allow the person to understand and deal with their past more effectively. If the patient's ego has collapsed there is nothing there for the therapist to engage with: the patient needs to have some basic awareness of reality but in schizophrenia the division between fantasy and reality has broken down.

Post-Freudians were a little more hopeful. Rosen (1946) advocated a 'direct analysis' approach in which the patient was brutally confronted with the nature of his own problems and inadequacies. The therapist attempted to bring about a regression to early childhood, and then would take on the role of parent/nurturer, thereby coaxing the patient to develop for a second time, the return to adulthood bringing with it a corresponding redevelopment of the ego, reconnecting them with reality.

Rosen and others claimed quite a high success rate but this has been questioned by later researchers. It isn't that Rosen is thought to have faked any data but rather that the successes claimed by Rosen would no longer be regarded as schizophrenia cases as we now understand the disorder. More recent research has suggested that psychodynamic type therapies, far from making schizophrenia better, may actually make them worse. Drake and Sederer (1986) found that therapies that involved a close client-therapist relationship, age regression and high levels of emotionality led to a worsening of symptoms and longer hospitalization.

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Schizophrenia: behaviourist explanations

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The behaviourist view of schizophrenia

Behaviourists believe that apart from a few innate reflexes, behaviour is learned as a result of a person's interactions with their environment. The behaviours we call psychological symptoms are no different and to a behaviourist all symptoms can be explained in terms of classical, operant and social learning processes.

It is not immediately obvious how a person could learn to behave like a schizophrenia patient although it is worth remembering that the disorder tends to run in families so it is possible that people may learn to exhibit symptoms through observing other people who do. It may also be the case that a person who first exhibited a symptom for no obvious reason may maintain it through operant processes. It might be positively reinforced, through the attention of others or it might be negatively reinforced if a consequence of symptomatic behaviour was the avoidance of aversive situations ('we'll leave him alone – he's crazy').

What is clear is that once a person has been classified as schizophrenic and moved to an institution full of other people similarly classified there is ample opportunity for the learning of new symptoms and the maintenance of old ones.

Clearly, this approach cannot really account for what we agree are the core features of schizophrenia: hallucinations, delusions and disorganization of thinking. To a hardline behaviourist this doesn't really matter – the patient's inner experiences are irrelevant. However, learning accounts have a hard time explaining why so many people with schizophrenia exhibit similar symptoms regardless of where they originate or whether they have ever spent any time with another sufferer. Finally, experiments with behaviour modification for schizophrenia have indicated that, whilst symptoms can be modified, the accompanying experiences tend to persist, which suggests that the 'all surface' view associated with the behaviourist outlook is deficient.

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Schizophrenia: behaviourist treatments

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The behaviourist treatment of schizophrenia

Behaviourism is committed to the view that all psychological disorders are clusters of learned behaviour that have arisen and are maintained as a result of a person's experiences and transactions with their environment. It follows that if the patient can be made to unlearn each individual symptom then they will eventually be made 'well'.

Schizophrenia is no exception. To the behaviourist the question of whether a patient *really is* hearing voices is irrelevant. What matters is whether the patient is *behaving as if* he is hearing voices. If he can be made to behave as if he isn't then he will be cured.

Some behaviour therapists have attempted systematically to reinforce coherent speech and punish incoherent. Nydegger (1972) reported some success in reducing apparent hallucinations and delusions in psychotic patients but it is open to question whether symptoms actually disappeared or patients just learned not to talk about them.

Institution-wide token economies in which 'well' behaviour is reinforced with tokens that may be exchanged for positive reinforcers (and 'crazy' behaviour may be punished with the removal of tokens) led to some success. Paul & Lentz (1977) found that they could be successful in promoting reduction in bizarre motor behaviour and improvements in social interactions but did not have an impact on hallucinations and delusions. Subsequent reassessments of these schemes have also questioned whether similar improvements can be brought about merely by improving the ways in which staff in institutions interact with patients. It has frequently been found that any improvements that do occur tend not to last once the patients are released. Furthermore, the withholding of basic goods like chocolate and cigarettes in order to increase their reinforcement value raises ethical implications.

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