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Towards a more humanistic psychiatry: Development of need-adapted treatment of schizophrenia group psychoses

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The group of schizophrenic psychoses is clinically and prognostically very heterogeneous. Contradictory views about etiology have had a major negative effect of the development of treatment, especially psychotherapeutic methods. There is an obvious need for more integrated approaches. We should study the development and precipitating factors of every person's psychosis individually and plan his/her treatment on this knowledge.

This has been done in the need-adapted treatment of schizophrenia group psychoses, developed gradually by the author and his co-workers in Finland over 40 years ago. Our aim is a comprehensive and psychotherapeutically oriented treatment approach for public psychiatric health care. A crucial step forward was the initiation of treatment with therapy meetings, including the treatment team, the patient, and his/her family members (or sometimes other persons close to him).

During the last few decades, several projects applying the need-adapted model have been developed. The author describes the experiences and results of some projects and also deals with the use of neuroleptic drugs in connection with the need-adaptive orientation.

Keywords: early intervention; family therapy; integrative approaches; psychodynamic psychotherapy; schizophrenia; treatment planning

Philippe Pinel, while working as Medical Director at the Salpetriére and Bicétre Hospitals in Paris in the 1790s, released mentally ill patients from their chains and worked actively to develop and humanize psychiatry. Some of his contemporaries were working towards similar goals, but Pinel emerged as the universally recognized symbol of humanistic psychiatry[1].

Psychiatric practices, and the position of mentally ill patients, are now quite different from what they were two centuries ago. The number of psychiatric hospital beds, too, has fallen as a result of efforts to develop outpatient care, and the prejudice and stigma related to mental illness have slowly begun to wear off. The majority of even long-term patients live outside hospitals with some degree of community care. Nevertheless, there is still very much to be done toward further reforming and humanizing treatment practices.

In the following I intend to focus on my own main professional interest, the study and treatment of psychoses classified as the "schizophrenia group" (Bleuler, 1911). The psychoses that belong to this group are clinically and prognostically so heterogeneous that we can ask whether it is even justifiable to speak of an illness called

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"schizophrenia". Diagnostic boundaries are vague and based on criteria agreed on by convention, and the clustering of markedly different patients in a single entity hampers research in a way that is seldom acknowledged sufficiently. It is also a serious burden to those who, after recovering from their psychosis, still have the label of schizophrenia imposed on them.

Schizophrenia research should develop towards better integration

Ideas concerning the etiology of schizophrenia group psychoses are still divergent. Both the neurobiological and the psychological approaches have their proponents, and they still share too little mutual understanding and even less cooperation. Combined with the disproportionately dominant position of biological–pharmacological approaches, this dichotomy has had a major negative impact on the development of treatment, especially psychotherapeutic methods. I hope that the significant innovative efforts undertaken by the *Psychiatry for the Person* initiative, established by Juan Mezzich (2007), may alleviate this antagonism in the future.

The remarkable progress in brain research and molecular genetics over the past couple of decades has been expected to shed crucial light on the pathogenesis of schizophrenia. Despite intensive neurobiological research, however, no factors have been discovered that explain specifically the origins and onset of schizophrenia-group psychoses – at least not in a way generally accepted by researchers. The role of genetic traits as the most solidly established etiological factor in schizophrenia has been confirmed by numerous international projects, but the existence of any specific "schizophrenia genes" is now considered unlikely. Instead, there are likely to be several chromosomal regions, mutant genes and/or genetic aberrations that may contribute to a predisposition to schizophrenia and related psychoses (cf. Allen et al. 2008; Stefansson et al. 2008). The heterogeneous nature of schizophrenic psychoses is also reflected by neurobiological and genetic findings.

On the other hand, recent developments in the field of integrated neurobiological research into the factors underlying the normal or disturbed development of human personality are very interesting, especially those presented by Kandel (1998) 10 years ago. He underlines the holistic plasticity and adaptability of cerebral functions and their constant interaction with the environment, which shapes the development and functionality of the neural web. Early interaction with caregivers has been recognized as a prerequisite of human development: it is not merely psychology, but – I would say – part of human biology as well (Alanen, 1997). This notion is supported by the observations on "wolf children", i.e. human children who, in warm climates, have survived in the care of animals. They do not learn to speak, their facial expressions remain undeveloped and even their instinctual drives remain rudimentary (cf. the excellent Dutch review by Rang, 1987).

Interesting findings will most probably be generated by the study of the brain's mirror neurons – or, perhaps more accurately, *mirror neuron functions* – discovered by Rizzolatti and Gallese (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996; Rizzolatti, Fadiga, Gallese, & Fogassi, 1996). These are assumed to be significant for the development of a capacity for mutual empathy as well as for early identification processes between infant and mother (or other caretaking person). Impaired mirror neuron functions have been found in persons with Asperger's syndrome (Nishitani, Avikainen, & Hari 2004), and are assumed to be a major factor in the genesis of infantile autism (Gallese, 2006). They may also appear relevant to the further study of schizophrenia

vulnerability. However, here again it is a question not simply of innate characteristics but of an *interplay* between individual genetic characteristics and early emotional interaction (Gallese, 2006; Olds, 2006).

Can we assume that the interdependence between gene expression and interaction with the human environment, which was highlighted by Kandel, also underlies the development of vulnerability to schizophrenia – something he himself regarded as doubtful? The most convincing evidence for this comes from the extensive study on adoptive children conducted by Tienari and his team in Finland (Tienari et al. 2003, 2004; Wynne et al. 2006a, 2006b). According to their findings, the children of mothers with schizophrenia-group psychosis who were adopted away at an early age did have more psychotic disorders than matched control subjects, although the difference became statistically significant only when closely related non-psychotic disorders were also included ("schizophrenia spectrum"; Kety, Rosenthal, Wender, & Schulsinger 1968). But the adoptees' disorders were also closely associated with the disorders prevalent in the mental atmosphere of the growing environment provided by the adoptive family, although a significant difference only emerged in the group of children genetically at risk, not among the controls (Wahlberg et al., 2004). The project hence demonstrated that a significant role in the development of schizophrenia-spectrum disorders is played by the interaction between genetic factors and a dysfunctional growing environment. A healthy growing environment in the adoptive family in turn seemed to protect from illness even children at risk. The adoptive parents' individual disorders were less significant than the overall psychological family atmosphere.

Another line of study pointing to the importance of environmental factors in the manifestation of schizophrenic psychoses arises out of findings as to the frequency of traumatic child abuse (physical and sexual) and neglect in schizophrenia group patients, compared with controls. Particularly noteworthy are the specific connections between hallucinations (especially commenting voices and command hallucinations) and childhood experiences (Read, van Os, Morrison, & Ross, 2005).

I consider the pathogenesis and development of schizophrenia group psychoses to be a multi-faceted and multi-level process, in which both biological and psychosocial factors –as well as their mutual interaction – play a part (Alanen, 1997, the figure on p. 108). The heterogeneous nature of schizophrenia group psychoses is not only obvious at the symptomatic level, but also requires a comprehensive and yet individualized treatment context.

Can schizophrenic psychoses be approached through psychological understanding?

My own experience of schizophrenia-group disorders derives on the one hand from family research and family therapy (Alanen, 1958, 1976, 1980), and on the other from psychodynamically oriented individual psychotherapies from the mid-1950s until the late 1990s (Alanen, 1962, 1997). This experience has confirmed my views of both the heterogeneity of this group of psychoses and the association between the onset of psychosis and the patient's serious and usually long-term psychological problems.

We can briefly define psychotic symptoms – at least in most cases – as a consequence of a regressive change in the psychic functions of a personality with inadequate psychological individuation. The symptoms are triggered by intense internal anxiety

and result in partial loss of logical control, but they are still relevant to the patient's internal psychological functions as first pointed out by Freud (1911) in his famous essay on the "Schreber case". However, Freud's pessimism as to the possibility of establishing a transference relationship with schizophrenic patients regressed to early narcissism (as he saw it) also had a notable negative impact on professional interest in the psychotherapeutic treatment of these patients.

Since then, the possibility of a psychological understanding of the nature of schizophrenic psychoses has been confirmed by numerous psychoanalysts working with schizophrenic patients. We know that it is possible to approach and gain understanding into a psychotic patient and his or her delusional representational world, and that it is often also possible to influence it psychologically (e.g. Benedetti, 1976; Jackson, 2001). Prognostically, schizophrenia-group psychoses constitute a continuum. At the more favourable end, this continuum consists of patients who are easily able to establish a therapeutic relationship, with features of symbiotic interdependence, while the less favourable end consists of patients deeply withdrawn into their autistic world.

Here I would like to cite from my book, *Schizophrenia: Its Origins and Need-Adapted Treatment* (Alanen, 1997), the following brief example of the concretized thinking typical of psychotic regression, and its interpretation. My patient Paula believed delusionally that part of her brain had been removed in the hospital ward. When I said that she might be thinking this because she felt that now that she was ill and in the hospital she was unable to think as clearly as earlier, the delusion disappeared. However, it should be added that one precondition for the success of this "interpretation upwards" was her instinctual acceptance of my empathic attitude; this helped her to relinquish her delusion, characterized by an accusatory and projectively hostile attitude towards us, the hospital people.

Why is the psychological understanding still so difficult to adopt, even for psychiatrists and other mental health workers? Table 1 sums up the cultural, social and psychological factors that may cause a negative attitude towards psychological involvement and therapy with patients with a schizophrenia-group psychosis.

One important point should be added: to understand a patient of the schizophrenia group, the researcher or therapist should have, first of all, the will and in fact the practical possibility for this; secondly, the appropriate training; and thirdly, a good

Table 1. Factors which have promoted antagonism against psychotherapeutic approach to psychoses.

- Commitment in medical research and training to natural-scientific way of thinking → undervaluing of work representing different theoretical outlook.
- Boom in brain research → view of schizophrenia as organic disorder not connected to psychological factors
- Great influence of drug manufacturers on psychiatric practices
- Belief that wide application of psychotherapeutic methods with psychotic patients would be impossible in public health care due to need for extensive staff resources
- Unpromising results of rigidly planned controlled trials
- Pessimistic attitude towards psychotherapeutic treatment of schizophrenic patients ← Freud's belief in irreversible narcissistic regression
- Studies of psychological etiology of schizophrenia → anxiety and resistance; particularly when perceived as blaming parents for their child's illness
- Individual and shared defense mechanisms emphasizing difference between "us" and "our patients" → favor superficial drug treatment; help us avoid encountering their deep-rooted problems

capacity for empathy. The situation is best in a working community where the therapist can share his or her experience with colleagues (Benedetti, 2006).

Development of the need-adapted treatment approach

Forty years ago, in the city of Turku, which has slightly less than 200,000 inhabitants, we launched a long-term project to develop a comprehensive and psychotherapeutically oriented treatment approach to schizophrenia-group psychoses, one which could be applied in public psychiatric health care. I was fortunate to get a group of enthusiastic and innovative co-workers, whose contribution to the development of our treatment approach has been highly significant all along. I consider that the Pinel Prize awarded to me should not be considered only my personal merit, but rather a sign of recognition for our whole team. I would like to mention especially the psychiatrists Viljo Räkköläinen, Klaus Lehtinen and Jukka Aaltonen, and the ward nurse Riitta Rasimus.

Our initial goals are shown in Table 2.

Our first aim was to develop our psychosis ward into *a psychotherapeutic community*, one which would be characterized by a shared empathic attitude towards patients, open communication, frequent group activities and meetings, and personal nurse relationships between staff and patients. Individual therapy was developed through on-the-job training and supervision. One of our main conclusions was that specialized psychiatric nurses, who work on the ward and become profoundly familiar with the patients' problems, constitute a therapeutic resource that is far too seldom made use of. Many nurses are capable of therapeutic relationships that significantly support the patients and even promote their internal development (Aaku, Rasimus, & Alanen, 1980). In our team their work became more fulfilling than in communities with a more rigidly hierarchical organization, and many of our nurses chose to improve their psychotherapeutic skills through further training.

One of our objectives was to work with families, especially in cases where such work was obviously needed. In the early 1980s, the systemic-psychodynamic family therapy training that we had started led to a change considered by many individual therapists to be almost revolutionary. Our teams began to hold therapy meetings with newly admitted schizophrenia-group patients immediately after admission together with their families, or sometimes other persons close to them. Especially in acute cases, this often helped to eliminate or alleviate the symptoms quickly.

Prognostic improvement was evident in the five-year follow-up study, where Klaus Lehtinen (1993) compared newly referred patients to an earlier cohort primarily

Table 2. Turku schizophrenia project: goals.

- Basic psychotherapeutic attitude
- Development of hospital wards into psychotherapeutic communities
- Development of individual therapeutic relationships
- Development of family therapies and other forms of family-centered work
- Pharmacotherapy regarded as treatment mode supporting psychosocial therapies
- Establishment of comprehensive training and supervision activities to support active participation of all professional groups in therapeutic work
- Development of rehabilitative activities
- Follow-up studies of cohorts, including all first-admitted schizophrenia group patients from catchment area

treated with individual therapy. There was a clear difference in prognosis between the cohorts gathered in 1976–1977 and in 1983–1984 including all first-admission patients from our catchment area diagnosed as schizophrenic disorder, schizophreniform disorder or schizo-affective psychosis (according to DSM-III R). The number of patients now without psychotic symptoms increased from 40 to 60%, and the patients' average need for inpatient care within five years decreased by half. The gradual development of outpatient care could not explain the difference, nor were there changes in drug treatment (besides diminishing it); what was new was our practice of joint *therapy meetings* (as we soon began to call them), and our increased emphasis on family-oriented activities. We did not have a specific preference for either an individual or a family-oriented way of working; individual therapies of different intensities were still conducted in many cases where the appropriate indications were present. But the development of therapy meetings helped to integrate therapeutic practices, and it was possible to bring within the sphere of psychotherapeutically oriented treatment many patients who lacked the motivation for individual therapy. Families were very willing to discuss matters when a family member was first admitted to treatment: in our 1983–1984 cohort, therapy meetings could be arranged in 87% of cases. There was thus an obvious need for family support.

The functions of therapy meetings are threefold: informative, diagnostic and therapeutic (Alanen, 1997). A crucial part of their therapeutic impact is obviously attributable to the support offered to the patient's self-esteem by giving each patient a chance to take part in discussing the situation and in planning his or her care on an equal footing with the others. Another important factor is the support given in a crisis both to the patient and to the family members, corresponding to the symbiotic needs often typical of interactions in schizophrenia-prone families. A successful psychodynamic family therapy may actually help parents who have unconsciously cherished overly symbiotic relationships with their children to support the latter's developmental process toward a more integrated personality and independent life. Preconditions for a successful individual therapy are often promoted by family contacts included in the preceding therapy meetings.

In the course of this development, our approach began to be known as *need-adapted treatment of schizophrenia group psychoses* (Alanen, 1997; Alanen, V. Lehtinen, K. Lehtinen, Aaltonen & Räkköläinen, 2000; Alanen, K. Lehtinen, Räkköläinen, & Aaltonen, 1991; Alanen, Räkköläinen, Laakso, Rasimus, & Kaljonen, 1986). We defined its *central elements* as follows:

(1) Therapeutic activities are planned and carried out flexibly and individually in each case, to meet the real, changing needs of both patients and those forming their personal interactional networks (usually the family).
(2) Examination and treatment are dominated by psychotherapeutic attitude.
(3) Different therapeutic activities supplement each other rather than either/or approach.
(4) Treatment should become and remain a continuing process.
(5) Follow-up is important both at individual level and in development of treatment units and treatment system as a whole.

Patients often undergo several treatments at the same time – for instance, each patient in a psychotherapeutic community has individual contact with his or her personal nurse. In the most serious cases the initial focus is usually on family sessions, often

with a subsequent shift towards individual therapy or support, whereas patients with less severe symptoms often start individual therapy right after the therapy meeting, if possible outside the hospital ward.

During the course of the nationwide Finnish schizophrenia project, coordinated by me in the 1980s (Alanen et al. 1990; Tuori et al., 1998), the need-adapted approach was applied in many other parts of the country. It was especially common to set up multi-professional *psychosis teams*, which focused on the evaluation and treatment of newly admitted psychosis patients. Family therapy training, which became available in different parts of Finland, served as a crucial stimulus for this. One of the most significant and successful new projects was the Western Lapland Project, established by Jukka Aaltonen and Jaakko Seikkula in the Tornio region (Seikkula et al., 2003). In Sweden our treatment approach was applied in modified form (however, without regular therapy meetings) in the Parachute Project, consisting of 17 centers and coordinated by Johan Cullberg (Cullberg et al., 2006).

Psychodynamic or cognitive psychotherapy?

The use of psychotherapy with schizophrenia-group patients has recently received new impetus from the development of cognitively based methods. Some of the proponents of cognitive–analytical and psychodynamic schools have also begun to approach one other, usually to their mutual benefit. Some cognitive–behavioral and psychoeducational therapists, however, continue to view schizophrenia as an organic disease requiring constant medication, with the aim of supporting patients and improving their ability to control their symptoms. Psychodynamic therapy has the additional aim of reactivating the incomplete internal development of the patient's personality and promoting its further development.

However, in the case of many patients with schizophrenia-group psychoses, the motivation for a psychodynamic therapy relationship is lacking or extremely ambivalent. In Finland, Eeva Iso-Koivisto (2004) studied the subjective treatment-related experiences of newly admitted psychotic patients and their families. She concluded that psychodynamic therapy is best suited to patients with a "depressive position" in Kleinian psychoanalytic terminology (for instance "I lost my mental health because I made some wrong choices in life"). Patients with a paranoid–schizoid position, who externalize the causes of their illness, in contrast benefit most from a psychoeducative approach. However, the motivation for self-examination often emerges gradually in the course of the therapeutic relationship. In a psychotherapeutic community, the psychodynamic approach is an indispensable foundation that increases all the participants' understanding of their work, and hence their ability to identify and achieve the relevant objectives in each patient's treatment in a need-adapted way.

Use of neuroleptic drugs and need-adapted treatment

I am not opposed to neuroleptic treatment; however, I strongly oppose their far too dominant position in the treatment of schizophrenia group psychoses. With many patients these drugs, in small doses, can provide important support for psychotherapeutic treatment. But an empathic approach often helps acutely psychotic patients to calm down just as effectively as antipsychotic medication. And we have to remind

ourselves of the fact that meta-analyses have shown no improvement in the long-term outcome of schizophrenia during the neuroleptic era (Hegarty, Baldessarini, Tohen, Waternaux & Oepen, 1994; Warner, 2004).

The need for neuroleptic treatment for first-admission patients with non-affective psychoses receiving need-adapted treatment was studied in six different districts in Finland in connection with the Acute Psychosis (API) Project (Lehtinen, Aaltonen, Koffert, Räkköläinen, & Syvälahti, 2000). The results for the experimental group, consisting of three districts, were equal to or better than those for districts carrying out need-adapted treatment with habitual use of neuroleptics, even though nearly half of the patients in the experimental group did not receive neuroleptics during the following two-year period (Bola, Lehtinen, Cullberg & Ciompi, 2009).

In some psychotherapeutic ward communities the introduction of neuroleptics is now postponed by two or three weeks, and the patient's anxiety and agitation controlled temporarily with benzodiazepine medication (Räkköläinen & Aaltonen, 2009). This time should be used to establish an intensive working relationship with the patient and those close to them. In all treatments, neuroleptic doses should be kept small or moderate at most. High doses should be avoided, not only because of the possible adverse effects of even new neuroleptic derivatives, but also because of their negative impact on the patient's creativity and ability to learn, including the capacity to get benefit from a psychotherapeutic relationship.

The NIPS project on the treatment of first-admission schizophrenia group patients, conducted jointly in the four Nordic countries – Denmark, Finland, Norway and Sweden (Alanen et al., 1994) – clearly showed that the need for pharmacotherapy declined with the progress of psychotherapeutic treatment. At the end of the five-year follow-up, 56% of the patients were not taking neuroleptics; 49% of all patients, and 39% of those with a DSM III R diagnosis of "schizophrenic disorder", showed no psychotic symptoms.

An eye to the future

The development and results of need-adapted treatment, originally established in Finland, have recently attracted increasing attention outside Scandinavia as well. As I see it, its principles, in particular the use of family-oriented therapy sessions, could serve as a significant resource in the treatment of other serious psychic disorders as well. Turku now has a specialized team for patients with psychotic mood disorders. In many Finnish districts, psychosis teams currently also deal with other than psychotic crises, such as suicide attempts.

The current global cultural atmosphere, as I have indicated at the beginning of this review, is not consistently favorable for the development of need-adapted treatment. This treatment orientation cannot be created instantly or by fiat. It is always based on a gradual development, in which local resources have to be taken into account as the starting-point of further development. On-the-job staff training with supervision activities as well as psychotherapy training programs play a central role in this process (cf. Aaltonen, Alanen, Keinänen, & Räkköläinen, 2002).

Although the emphasis is on outpatient care, many first-admission psychosis patients need to spend a fairly long time in a psychotherapeutically oriented ward community before they can establish a therapeutic relationship. A busy hospital ward is not necessarily a suitable milieu for this. One solution to this problem is offered by the establishment of treatment environments such as the "Bern Soteria", developed as

part of the public health care system in Bern by Luc Ciompi (Ciompi et al., 1992). The Swedish "Parachute Project" followed the same pattern. Indeed a recent analysis of five such projects demonstrated a range of clinical and research benefits compared to treatment as usual (Bola, et al., 2009).

More studies should be developed of the indications for neuroleptic medication in connection with the need-adapted orientation. Räkköläinen and Aaltonen (2009) dealt with this question while presenting a clinically relevant classification determined by patients' premorbid psychosocial development and reactions to the clinical interview. Cooperation between psychotherapeutically and biologically oriented researchers would here be especially important.

The pendulum in the development of psychiatry has always alternated between the biological and psychological schools of thought. There are some signs hopefully indicating that an integrative development may now have begun to strengthen. I sincerely hope that in the not too distant future we will experience a change in our attitudes and practices, gradually making psychiatry more humanistic, while at the same time facilitating the integration of different approaches.

Note

1. This review is based on the author's address connected with the inaugural WPA Philippe Pinel Prize for Psychiatry for the Person, in the XIV WPA Congress in Prague, September 2008.

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