

11 Schizophrenia – Therapy and Pastoral Care

The treatment of schizophrenia has changed dramatically in the last fifty years. When I look through the case notes of my patients I am always moved by the terrible impasse in which schizophrenic patients found themselves prior to 1950. There was hardly any means to ease their restless anxiety and delusive ideas. Doctors and medical staff grasped at doubtful straws in the attempt to make life more bearable for these patients who frequently would become so absorbed in their psychotic inner world, that conversation from outside no longer reached them. The thought of a return to their family was out of the question.

Even mild schizophrenic episodes which nowadays subside in a matter of weeks used to last months or years without medication. Hannah Green gives a striking picture of this period in her book »I never promised you a rose garden«. Today the time when patients were calmed down by being wrapped in wet sheets or sat in covered hip baths is long since past.

In our time most patients with schizophrenia live outside the hospital. Their care is the responsibility not only of psychiatrists and caring professionals, but of pastoral counsellors and the relatives who live with them. In the following pages I will show some possible approaches to the care of schizophrenic patients, which take account of medical and social as well as pastoral aspects. The best possible care can only be achieved when all work together for the best of our patients.

Three Pillars in the Treatment of Schizophrenia

The multitude of different approaches to the treatment of schizophrenia can be divided into three main groups:

1. Medication (with neuroleptic drugs)
2. An ordered daily routine
3. An emotional climate conducive to improvement.

1. Medication

Since disturbances in the neurobiology of the brain play an important role in schizophrenia, medication has a fundamental influence on the condition. Neuroleptic drugs are the medication of choice (such as Halidol, Risperidone or Zyprexa, to name a few). They generally lead to a calming and ordering of the thought processes. Continued medication under the supervision of a doctor is the most important pillar in the prevention of a relapse.

Unfortunately, not all problems can be solved even by the regular intake of medication. To be honest, severe and insidious forms of schizophrenia are only affected to an unsatisfactory extent. Nevertheless, if the schizophrenic patient is only rendered a little calmer, it can make it easier for relatives to take care of him at home, instead of having to have him treated at the hospital.

Neuroleptic drugs, like all drugs have side effects. Muscle cramps, drowsiness, and restlessness in the legs are the most common in the »first generation neuroleptics« (e.g. Halidol). However, these can be controlled by additional medication in the majority of cases. The newer drugs often cause major weight problems (e.g. Zyprexa). As a general rule of thumb, the drugs are given in the correct dosage if the acute symptoms are under control and normal sleep patterns are maintained.

2. Daily Structure

Patients with schizophrenia frequently find it difficult to order their day. For this reason, modern psychiatric practice will be to encourage a program of occupational therapy during the week, whether in the hospital or outside in a sheltered workshop. They need protection from stress on the one hand, but training for their remaining abilities as well as contact with other people on the other. A regular daily routine is important for the following reasons:

- a) A clear timetabled programme helps the patient to be orientated and breaks up the monotony of a long day.
- b) It communicates to the patient the sense that he is needed and can do something useful.
- c) It provides a break for relatives and spreads the burden of care so that it rests on more shoulders.

3. Emotional Climate

People who suffer from schizophrenia are generally less able to cope with pressure than others. The reaction of their environment, especially that of their relatives, can contribute to the prevention of a relapse. It is necessary to accept the patient with his limitations, without taking all responsibility away from him.

That is not always easy. A few years ago now, researchers thought they had established that the reaction of relatives was an important factor in coping with the illness. »E.E. research« (expressed emotions) confirmed that the relatives of patients who made a good recovery accepted them better, criticised them less and gave them more independence. The conclusion was drawn from this observation that patients recovered well because their relatives behaved in this way. However, it is becoming increasingly clear today that the opposite was the case. The relatives found it easier to behave in this way because the patient was improving so well. Nevertheless the relatives and carers need continual encouragement to show the sick person love in the right way, and to set appropriate boundaries.

A Word about the Psychotherapy of Schizophrenia

In support of the three pillars mentioned above, supportive conversations and sympathetic advice can be very valuable for the patient. Particularly in times of crisis, they are grateful for the support of a professional person who can help them overcome the problems they face.

However, psychotherapy in the strict sense has not proved valuable with schizophrenic patients. For most schizophrenic individuals psychotherapy is an excessive burden, indeed it can cause a great deal of damage. Attempts to release feelings, and to work through hidden motives are particularly dangerous. I have observed several relapses and even suicides which have been triggered by psychodynamic group therapies, transactional analysis, primal scream therapy and similar approaches.

At this point it needs to be said that intensive approaches to pastoral

care can have the same results. Treatment of schizophrenia belongs properly in the hands of the psychiatrist, supported by sympathetic carers, pastoral counsellors included, who know their limitations. What contribution can be made to the therapy of schizophrenia patients by biblically orientated pastoral care?

Pastoral Care for the Schizophrenic Person

Counselling depends on the ability of a person to take part in a conversation, on his ability to understand, properly interpret and apply the things that are said. However, when it comes to people suffering from schizophrenia – particularly during an active phase – the severe illness-related disturbance to their thought processes means that there are severe limits to what can be achieved through counselling sessions.

The conversational ability of schizophrenic people can be differentiated in accordance with the various phases through which the illness passes. A patient is least capable of receiving benefit from counselling during an acute psychotic episode. In the times between episodes normal conversation is often possible. The same applies to the spiritual life. This is severely disrupted by the disturbed thought processes but can nevertheless become completely normal again, and when it returns, it can be an important support for the patient.

In view of this I would like to deal with the possibilities and limitations in the pastoral care of schizophrenic people in two sections, namely

- a) in the acute phase and
- b) during the residual phase (including the residual intermediate phase).

How to Respond to Acute Symptoms

1. Keep calm and try to keep bringing the person back all the time to the level of reality, in other words, talk to them about the real situation, even when they find it hard to receive what you are saying. The circumstances under which admission to a hospital becomes necessary, can be very dramatic. As a result the pastoral helper can easily get left out of the picture at this point.
2. Be logical and do everything to motivate the sick person to receive medical treatment. These sick people basically need to be cared for by a medical specialist. Only rarely can someone with an acute episode of

schizophrenia be successfully treated as an outpatient. As a rule these people have no insight into their illness. For this reason in certain circumstances it is necessary for this decision to be taken out of the hands of the sick person. If you have to do this you should not show any sign of personal uncertainty. Since these patients have been disorientated, as counsellors we have to give them clear direction.

3. Behave in a natural and unobtrusive way. Don't put on a kind of protective patronising manner, but behave in a friendly way to the sick person, talking as naturally as possible with them.
4. Visit the sick person during their stay in hospital so that they doesn't lose contact with the normal world. It is important, in this connection, that during his hospital stay the sick person is prepared for the time after discharge. It will be important both during the stay in hospital, and even more so afterwards, to talk in an encouraging way about God's love and the love of the people at church, and to stress God's ability to carry him through.

One word of caution is needed, however: Visits should be arranged, to begin with, in careful consultation with the medical staff. For a sick person whose psychological condition is weakened, visits can be very stressful and lead to a further worsening of his condition.

Pastoral Care on the Return From Hospital

Medical treatment does not render careful pastoral support unnecessary. On the contrary, the very thing a believer needs when he or she has gone through the distressing experience of a psychosis, is to understand and work through the illness in the light of their faith. What questions will they be likely to bring to the pastoral counsellor? In the consultations I have had, the questions I have encountered fall into three groups:

1. Questions of meaning and of faith
2. Questions about the illness: its causes, prognosis, medication, etc.
3. Questions about coping with life:
 - a) Coping with reduced ability to endure stress
 - b) Practical arrangements for living
 - c) Advice and comfort for relatives

Questions of Meaning and Faith

The experience of a psychosis raises questions for the believing patient and his relatives, which they are not usually able to voice to the psychiatrist. Here are a few examples:

- Why has God let this happen?
- Where does the illness come from? Is there sin or occult bondage involved?
- We have tried everything. Why isn't prayer working?
- Why is the spiritual life so disturbed?
- (Dora, a 23-year old clerk): »I don't have any assurance of faith any more! It seems as if my neighbour has stolen it. She's always looking at me with a dark expression on her face.«
- (Richard, 32, a former teacher): »I'm often so tired that I can't make sense of the Bible any more. I just lie around all the time. Can God really still help me?«
- and finally: »Is there still hope?«

You will notice that there is no simple answer to any of these questions. We often have to struggle with the suffering of the schizophrenic patient in much the same way as with that of the cancer victim. In this phase pastoral care needs to be characterised by compassion and patience. Not in a resignative kind of waiting, but actively »helping the weak« in the knowledge and certainty of God's Word. Christians have a hope which reaches beyond such things as health, the ability to work, or riches and happiness!

There is no need to pay too much attention to religious delusions, because in most cases they will fade away of their own accord. The best thing you can do is to hold the patient to the biblical facts in simple words, full of conviction. For example, you could respond to Dora's question in this way: »Maybe sometimes you're not able to hold on to your faith the way you used to. But Jesus is faithful. He is stronger than all the powers of darkness. He holds us even when we don't have the strength to hold on to Him any more. You will get your joy back again. It just needs time for you to get better.«

Richard used to be a teacher, who has already been unfit for work for eight years (residual state). He needs continual reassurance that his value to God does not depend on his career. For him the promise is especially relevant which says »The Spirit of God comes to our aid. We are weak and do not know how we should pray. For this reason the Spirit approaches

God on our behalf with groans which cannot be expressed in words«.

The answers in these situations are similar to those in the care of people who suffer from severe physical disabilities. I have continually experienced how patients in the weakness of a residual schizophrenic state learn to trust God and draw strength from His Word. Of course, it goes without saying that pastoral counselling should not stand in isolation from practical support and advice for the patient and his relatives.

Questions About The Illness

As schizophrenia is so difficult to understand, the pastoral counsellor, no less than medical personnel, will be confronted with questions about the illness, and will need to be in a position to give well-informed answers. If you have read this book carefully, you will be able to answer the most important questions about the causes, understanding, and course of schizophrenia.

Often the sufferer will also want to hear what the pastoral counsellor thinks about the medication. »Do I still have to take tablets?« they may ask, »I don't want to become an addict!« Under no circumstances should someone seeking advice be encouraged to stop taking neuroleptic drugs. Always direct them towards their doctor and explain to them how helpful medication can be, even when it means putting up with a few side effects.

It is better to be able to live, work and attend church outside the hospital, than to slip into a psychosis without tablets or injections. Regular use of neuroleptic drugs should not be compared with an addiction. A better comparison is with the regular administration of insulin to a diabetic, who also suffers, of course, from a disturbance of the body's metabolism. As a general rule, the ability to regularly get sufficient sleep is a good sign that the time may be right for a reduction of the medication. If you notice that a schizophrenic person is suddenly sleeping less and is more strongly driven, get in touch with their doctor.

Compassion and Patience

Relatives often need to talk as well. How often they find themselves in the dilemma of asking »To what extent is the patient's behaviour caused by the illness, and to what extent is it intentional? How should we respond? And at what point does it become necessary to admit the afflicted person to hospital again?« Even experts are not always able to answer these ques-

tions. Often it is not, in the first instance, a matter of right and wrong, but more a question of how much the carers can cope with in a particular situation.

Pastoral counsellors who care for schizophrenic people need a great deal of patience and a willingness to carry the burdens of sick people and their families, without seeing spectacular changes. Nevertheless, this does not imply that there is any reason to lose hope. Do not forget that, with correct treatment, 75 per cent of all cases improve, though it takes considerable time. Those who share these burdens should be encouraged by the promise, »so will you fulfil the law of Christ!« It isn't enough to give them admonitions from the Bible. If you really want to help people who have a chronic psychiatric illness, you will need to discover afresh the meaning of comforting and supportive pastoral care.

Rehabilitation: Support or Burden?

Often well-meaning pastoral counsellors (not to mention behaviourally orientated social workers and psychologists) tend to overstretch the patient and his family. I once asked a doctor who was a committed Christian, »What is your goal in the treatment of schizophrenic patients?« I was dismayed by his answer: »For them to be as healthy as I am!«

Why was I dismayed? Is this request unreasonable? Certainly, the wish is good, but the effect of it can be that you expect too much from the patient, and hence from yourself. In the long term, the result is always disappointment, for the patient as much as the helper.

Schizophrenic patients who already have gone through several episodes and show an obvious reduction in their general performance are less capable of handling pressure, even in their »good« times. The personality of a chronic schizophrenic patient is sometimes described as »silted up«. That is a good way to describe these emotionally flattened people who are incapable of handling pressure and have little self initiative. Such people can be activated to a pronounced degree through the kind of committed care that can be provided in residential homes and communities.

Nevertheless, it is essential to recognise the boundary between encouragement, and making excessive demands. It is certainly possible to train these patients to a certain degree and spur them on to a higher performance, but in the process they are often placed under an uncomfortable pressure to succeed, a tension which can lead to a further relapse. Without constant supervision they do not have the power within them to apply

independently what they have learned before. They are like crumbling sandstone, which cannot be returned to its former shape.

Therapists who do not recognise these boundaries remind me of children, who apply themselves to build a sandcastle with enthusiasm and effort, but almost as soon as their work is left to the wind and the waves the signs of decay begin to show. The beautiful towers and carefully excavated gateways are washed away.

This is why we need to ask »Where are the limits of what can be attained in our chronically ill patients? And which is of more value: A person who lives within their limits and is content with them, or a chronically overtaxed patient who can only maintain his level through the constant efforts of a number of carers?« If attempts at rehabilitation have shown that a patient is pushing his limitations, we have to accept these and help him to make the best of them. It can no longer be the carer's job to groom him to be a star performer in a competitive society. We are not called to build impressive sandcastles, but to lovingly create a context in which the fragile sandstructures of the chronic schizophrenic person can survive. To protect them, care for them and carry them, in the full knowledge of their weakness.