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Clinical philosophy in the treatment of paranoid schizophrenia and obsessive–compulsive disorder

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Summary

Aim: Clinical philosophy (CP) is an approach to the treatment of mental disorders. The goal of the present study is to put CP to a first empirical testing.

Method: I present a case of a patient with paranoid schizophrenia comorbid with obsessive–compulsive disorder (OCD) that did not respond to conventional, standard cognitive–behavioural therapy (CBT). Using a single-case pre-test/post-test design, a CP approach was developed drawing heavily on existentialist and philosophy-oriented writers.

Results: The client responded well to this novel treatment approach. Above all, levels of intolerance of uncertainty improved greatly from pre – to post-treatment. A decrease in overall illness severity as well as specific psychopathological variables such as obsessive–compulsive symptoms, depression and anxiety could be observed.

Conclusion: Results are discussed in terms of the underlying mechanism of the CP approach. An account of the underlying mechanism of efficacy, understood as a tripartite function, is introduced. CP as a philosophy-oriented method within the broader framework of third wave CBT and existential analysis is considered.

obsessive–compulsive disorder/paranoid schizophrenia/clinical philosophy/philosophical therapy/existential cognitive–behavioural therapy

INTRODUCTION

Humans are capable of many extraordinary things. We think about ourselves and our place in the world we live in. We feel love, hate and are afraid. We act, do things and behave in a certain way. We are aware of bodily processes, such as tense muscles, accelerated heartbeat and an upset stomach. At times, our cognitive, emotional, behavioural and bodily aspects go awry, get side-tracked, and thereby leave us at best in an irritating situation and at worst in a severely disabling state of mind. The latter might result in a full-blown mental disorder in need of an adequate psychiatric and psychological treatment.

Speaking of empirically validated non-pharmacological treatment options, cognitive–behavioural therapy (CBT) is still the first-line treatment for a wide range of mental disorders [1]. Typically in CBT, falsely held beliefs and irrational interpretations on the cognitive, emotional, behavioural and physiological level are addressed and consequently corrected. While old-school first wave CBT focused exclusively on behavioural aspects, second wave CBT incorporated cognitive processes and a few decades

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later, the third wave of CBT started to add further elements. Among these third wave CBT approaches, the acceptance and commitment therapy (ACT [2]) centres around the acceptance of mental processes, above all one's own experiences, and the commitment to one's own values by pursuing them through appropriate behaviour change.

Notwithstanding the fact that the legacy of CBT is unbroken, other treatment options are available and much needed for patients who turn out to be hard to treat with standard treatment approaches. The extension of classical CBT through third wave enhancements might be one way of achieving that goal. The need for thinking outside the box and pursuing alternative options thus arises.

Among these alternative options, philosophy-oriented approaches might be considered. For instance, Marquard [3] placed philosophical practitioners close to health professionals in the sense of therapy-like counselling, when philosophical methods are used to work through philosophy-relevant topics related to the client's current problems. Similarly, practitioners in the field see their work in prompting questions and a joint assessment of different answers the client gives [4] by means of an open dialogue about issues that preoccupy the client [5].

One way to use philosophy within the clinical context has been put forward in the pioneering work by Poltrum ([6, 7]; see also Poltrum & Musalek [8]). He coined the term 'clinical philosophy' (CP), which can be understood as applied philosophy adapted for the treatment of mental disorders. Poltrum & Musalek [8] reported preliminary data on the influence of CP on their patients suffering from substance abuse. As part of the treatment plan, patients were required to regularly participate in philosophical group meetings where philosophical topics were discussed and patients read excerpts from the relevant literature. Upon completion of the therapy the patients were asked how they were affected by philosophizing during their hospitalization and could allocate points to each suggested category. The results showed that 45% of the points were given to the category 'engagement and reflection', 23% to 'knowledge acquisition and expanding one's views' and 16% to 'willingness to act'. These findings showed that the incorporation of philosophy into the treatment plan is beneficial for the patients.

Poltrum and Musalek recognized CP as a much needed approach in the treatment of mental disorders. According to them, the differentiating factor between philosophy and evidence-based psychiatry and psychotherapy is the client's pathology. If there is an existential crisis of any kind, then philosophy enters the picture. If there is more than an existential crisis and a full-blown mental disorder is prevalent, then evidence-based psychiatry and psychotherapy are the first-line treatment. The more clinically relevant the symptoms are, the more philosophy fades out of the picture.

Contrary to that point of view, several authors argued for a closer relationship of philosophy and psychopathology. For instance, Mills [9] argued that psychology and philosophy are interwoven, such that philosophy is an insight-oriented approach used as a tool within psychological treatment. Within the tradition of existential psychotherapy and logotherapy [10], the big question of the meaning of one's personal life is the key ingredient in every treatment plan. The search for an answer in the light of a debilitating and seemingly meaningless situation becomes at least as important as behaviour change itself. Everyone encounters situations where previously developed coping mechanisms cannot be employed and it feels as if one's existence may be shattered by an overwhelming amount of suffering, pain, guilt, anxiety and other unsavoury gifts life has to offer, with death as the ultimate consequence. These *Grenzsituationen*, as Jaspers [11] calls them, are inevitable. However, what is open for debate is the nature of the incorporation of philosophy into the treatment plan. This incorporation might either be regarded as an additional factor, 'nice to have', as argued by Poltrum and Musalek, or as a substantial, necessary factor, as suggested by others. It might be argued that CP provides a recontemplation of one's life and the current path one is on. It gives a metaphysical and theoretical underpinning to lean on. Guidelines for a good life are developed and life's big questions such as the search for the meaning of life itself are at its heart. Exactly these issues might be the ones that need to be worked through by the client with the therapist. In that case, CP does not constitute an adjuvant factor, but rather the main factor in the overall treatment plan.

In order to tackle that question, the single case study of 'Arnold' is presented. In the treatment of Arnold, interventions drew heavily on existentialist philosophical writings and this CP approach was put to a first empirical testing in the present pre-test/post-test single-case design. The outcome measures were self-report questionnaires assessing the client's most prominent psychopathological variables.

METHOD

Client

Arnold was referred for the treatment of his aggressive obsessions and delusions. Prior to the first therapy session, he had undergone extensive classical CBT for the management of his paranoid schizophrenia and obsessive–compulsive disorder (OCD), but with little treatment success. He was offered weekly treatment sessions.

Arnold had extensive experience with different mental healthcare providers and psychiatric clinics resulting in a respectable patient file. His psychopathology had been shifting throughout his history and imperative voices with an associated diagnosis of paranoid schizophrenia have been alternating with obsessional thoughts with an associated diagnosis of OCD.

Starting a few years before the beginning of our treatment sessions, Arnold has been maintained on 15 mg aripiprazole and 150 mg venlafaxine as well as 150 mg trazodone. During our first few sessions, he revealed obsessive thoughts and was afraid that his aggressive obsessions and imperative voices would re-occur and overpower him. Most notably, he revealed that he could not stand the uncertainty of not knowing whether his aggressive obsessions and imperative voices would recur or not. Thus, his paranoid schizophrenia had temporarily abated and yielded to OCD as the primary diagnosis.

Self-report measures

Intolerance of Uncertainty Scale

The Intolerance of Uncertainty Scale-12 (IUS-12 [12]) was used. The validated German version assesses intolerance of uncertainty with 12 items rated on a 5-point Likert scale. The two subscales, 'blocking anxiety' (six items, e.g. 'Uncertainty makes life intolerable', 'When it's time to act, uncertainty paralyzes me') and 'prospective anxiety' (six items, e.g. 'I should be able to organize everything in advance', 'One should always look ahead so as to avoid surprises') exhibits good internal consistency of α=0.81 and α=0.78, respectively.

Brief Symptom Inventory

In order to assess a wide range of psychopathological variables and to get a measure of general illness severity, the Brief Symptom Inventory (BSI [13]) was administered. The BSI is a short form of the Symptom Checklist (SCL [14]) and measures different psychopathological variables. It consists of 53 items rated on a 5-point Likert-scale. The nine subscales, with corresponding internal consistencies, are the following: somatization (α=0.67), obsessive–compulsive (α=0.75), interpersonal sensitivity (α=0.75), depression (α=0.82), anxiety (α=0.70), hostility (α=0.59), phobia (α=0.65), paranoia (α=0.64), and psychoticism (α=0.70). The re-test reliability (1 week) ranges between r=0.73 (phobia) and r=0.92 (obsessive–compulsive). Summing up those nine subscales plus additional items capturing appetite, difficulty falling asleep, suicidal ideation and feelings of guilt, amounts to the total score of the BSI, reflecting psychological distress. Regarding the total score, the internal consistency is 0.95 and re-test reliability (1 week) is 0.90.

Procedure

Treatment plan

The treatment plan targeted intolerance of uncertainty and existential needs that arose during therapy sessions. In several sessions, Arnold was given different reading assignments addressing his specific needs as well as his strategies to cope with uncertainty. The reading assignments drew nearly exclusively on existentialist and philosophy-minded authors, although parables from Arnold's favourite non-philosophical writers were also used as well and other writers that the therapist decided to fit into the treatment plan.

The client completed his reading assignments between therapy sessions. The focus was to present the client with an understanding attitude and to offer some guidance in finding solutions to existential questions.

At the heart of this CP approach lies the assumption that developing one's point of view of the world, arguing for that view and constructing a consistent theory of why things are the way they are, are the crucial active ingredients of the treatment plan. The focus is on discovering a metaphysical underpinning of one's very being and building a sound basis of one's very existence, which in turn facilitates positive changes on the cognitive, emotional, behavioural and physiological level.

Material

In sessions 1 to 4, a thorough psychological assessment took place. Part of sessions 4 and session 5 consisted of a discussion of Friedrich Schiller's poem 'Über das Erhabene', resembling the Serenity Prayer adopted by Alcoholics Anonymous. Arnold's assignment was to argue what situations must be accepted as they are and what situations can actually be changed.

Part of session 6 and session 7 used an excerpt from Paulo Coelho's *The Alchemist* about a traveller who was looking for the secret of happiness. The wise man gave him a task where holding on the previous things (i.e. spoon filled with oil) is incompatible with experiencing new things (i.e. the wise man's palace and wealth therein). Arnold's assignment was to analyze the text and consider what it is all about, and what things must be kept in mind when some change is inevitable.

Parts of session 8 and session 9 engaged with the last chapter of Albert Camus' *The Myth of Sisyphus*. Sisyphus has been condemned by the gods to roll a stone up a mountain, but the stone rolls downhill and he has to start the task again, in all eternity. This text addressed the meaning of one's life in the light of a recurring event. Arnold's assignment was to think of what a meaningful life was to him.

The most discussed reading assignment began at the end of session 10, carried over to sessions 11, 13 and 14 and targeted Franz Kafka's *The Trial*. One chapter was discussed in detail. Kafka's protagonist Josef K. was put to trial for a crime he does not even know he committed. In that specific chapter, Josef K. sought the help of a priest in a cathedral. Arnold's assignment was to thoroughly examine many different view points related to Josef K.'s trial.

Finally, parts of session 15 and session 17 focused on Karl Jaspers' existential philosophy, especially his conceptualization of *Grenzsituationen*. The last assignment concerned an excerpt from Karl Jaspers' and his introduction of *Grenzsituationen*, which are thought of as inevitably negative life events. Arnold was asked to develop his own view of how the good and the bad might be viewed as essential to our world. In session 18, relapse prevention took place and the therapy was officially concluded.

Data analysis

For the IUS-12, *z*-scores were derived using the means and standard deviations of the normative data provided, whereas for the BSI, *t*-scores were used according to the test manual; *t*-transformed scores higher than 62 indicate clinical significance. After session 8, the pre-treatment self-report measures were administered and after session 18, the post-treatment self-report measures were handed out.

RESULTS

Self-report data

Pre-treatment

Pre-treatment (Table 1), Arnold showed significantly elevated levels of intolerance of uncertainty in both the total IUS-12 score and in its two subscales.

The analysis of the BSI revealed a clinically significant psychological distress based on the total score of the BSI. Regarding the BSI subscales, clinically significant levels of somatization, obsessive–compulsive symptoms, depression and anxiety were observed. However, somatization levels remained clinically significant. Arnold's interpersonal sensitivity, hostility, levels of phobic anxiety, paranoia and psychoticism were all in the normal range.

Table 1 Self-report measures, normative data with means (M) and corresponding standard deviations (SD), pre-treatment scores and corresponding z-value or T-value, post-treatment scores and corresponding z-values or T-values.

Scale	Normative data	Pre-treatment		Post-treatment	
	M (SD)	Score	z-value	Score	z-value
IUS-12	24.53 (6.99)	54	4.216 ***	26	0.210, ns
IUS-BA	10.95 (3.04)	27	5.280 ***	13	0.674, ns
IUS-PA	13.59 (4.77)	27	2.811 **	13	-0.124, ns
		Score	T-value	Score	T-value
BSI-Total	-	38	67	31	62
BSI-Som	-	4	63	6	66
BSI-OC	-	9	68	6	61
BSI-Social	-	2	56	2	56
BSI-Depr	-	9	73	3	59
BSI-Anx	-	5	64	4	62
BSI-Host	-	1	50	2	57
BSI-Phob	-	1	56	0	45
BSI-Para	-	2	55	3	58
BSI-Psych	-	1	54	1	54

Note. IUS = Intolerance of Uncertainty Scale, IUS-BA = subscale "blocking anxiety", IUS-PA = subscale "prospective anxiety", BSI = Brief Symptom Inventory, BSI-Total = total score, BSI-SOM = subscale "somatization", BSI-OC = subscale "obsessive-compulsive", BSI-Social = subscale "interpersonal sensitivity", BSI-Depr = subscale "depression", BSI-Anx = subscale "anxiety", BSI-Host = subscale "hostility", BSI-Phob = subscale "phobia", BSI-Para = subscale "paranoia", BSI-Psych = subscale "psychoticism", *** = $p < .001$, ** = $p < .01$.

Post-treatment

Post-treatment (Table 1), Arnold's levels of intolerance of uncertainty decreased and did not significantly differ from the normative sample. This holds true for the total score of the IUS-12 as well as both IUS-12 subscales.

BSI scores revealed a moderate to small reduction from pre-test to post-test. However, the decrease was enough to result in lower scores than the clinical cut-off scores. In particular, the total BSI score as well as the subscales 'obsessive–compulsive', 'depression' and 'anxiety' were in the sub-clinical range. All other subscales that were clinically non-significant pre-treatment remained as such post-treatment.

DISCUSSION

The main goal of the present study was to test a novel philosophy-oriented treatment approach to therapy that incorporates philosophy as a substantial factor in the overall treatment plan. Arnold's intolerance of uncertainty was reflected in significantly elevated IUS-12 scores pre-treatment, which subsequently decreased and did not differ from the normative population post-treatment. Throughout therapy, many different views on uncertainty were developed, discussed, revised, and an account of how uncertainty may fit into one's world has been formulated by Arnold. I suggest that the philosophical reading assignments prompted Arnold to change his perspective on uncertainty, so he was able to see it as a normal part of life.

Furthermore, a reduction of overall illness severity post-treatment could be observed. This was mostly due to a decrease in OCD symptomatology, depression levels and anxiety levels. The client's illness severity as measured by the BSI total score decreased and post-treatment fell below the clinical cut-off score. It should be

noted that pre-treatment, the score was clearly above the cut-off score and post-treatment it was slightly below. Similarly, a clinically relevant decrease in OCD symptomatology as measured by a subscale of the BSI could be observed from pre – to post-treatment. This finding might be tied to lower IUS-12 scores. Although no firm conclusion regarding the causal direction can be made, there are data shedding light on the causal direction of intolerance of uncertainty to another distorted thought process, namely worrying. As is the case with obsessional thoughts, worrying is directed towards events that are expected to turn out negative [15] and individuals engage in this distorted thought process over and over again [16]. Evidence suggests that an experimental manipulation of intolerance of uncertainty led to a corresponding change in worry level [17, 18]. In addition to this experimental manipulation, similar effects have been observed in the therapeutic setting in the treatment of pathological worriers, where a decrease in intolerance of uncertainty was followed by a decrease of worry [19]. Given these findings, it may be suspected that a greated capability of handling uncertainty led to a decreased OCD symptomatology in Arnold. Also, this explanation gets support from the treatment plan which targeted foremost the intolerance of uncertainty.

In addition, a decrease of depressive symptoms as well as a drop in anxiety levels as measured by the corresponding BSI subscales was observed. Elevated depression scores in schizo-obsessive individuals have been reported previously [20, 21] and get further support from the present case study. Also, it is well known that depressive symptoms are highly comorbid with anxiety symptoms (e.g. Kessler et al. [22]). Arnold endorsed clinically relevant feelings of depression and anxiety pre-treatment and fell in the normal range post-treatment. The main reason of his mood improvement might be his newly gained independence and mastery of his life.

Underlying mechanism of CP

To explain the effects observed in Arnold in more detail and to facilitate the possibility of generalizing the observed efficacy to other cases and patient groups, I propose the following sketch of a framework for CP. The underlying mechanism of CP efficacy can be understood as a tripartite function.

The first part consists of the abstraction of the personal problem. For instance, Arnold's catastrophic expectations of how his family would react on seeing him in his current lament got reformulated in a more general way. In particular, instead of asking what his family would think about him, he was asked how anyone comes to a point of view in the first place. Thereby the development of different perspectives was discussed, the epistemic basis of one's specific perspective, and the subject-dependency in any given situation. Through abstraction, the client is able to face the problem in a new way, stripped from all the personal baggage he is carrying. The therapeutic use of this first step has also been acknowledged by philosophical practitioners. According to Amir [4], moving from a personal question to an abstract question can create a much-needed space and time to reflect: 'The abstract as an inward space where thought can be expanded and freedom gained without the tyranny of personal fear is one of the great therapeutic interventions of philosophy' (p. 37).

The second part comprises the reading assignment, chosen on the basis of the identified abstract problem. This more abstract problem of adapting a point of view got further elaborated and illuminated by excerpts from Kafka's *The Trial*. During this stage, the therapist might also choose to use short video clips or recorded interviews as a substitute for reading assignments. However, what is crucial is to allow enough time and reflection for the client to develop his own thoughts in response to the philosophical input. In the following session, the discussion should only be restricted to the reading assignment itself and a maintainable position should be developed. For instance, Arnold's interpretation was that Kafka's protagonist found himself in an absurd situation which can be viewed from many different angles, as demonstrated by the specific excerpt of that book. Arnold continued arguing that despite the seemingly meaningless and devastating situation, Kafka's protagonist should not get side-tracked and should continue striving for answers.

The third and last part focuses on the application of the insight gained from the reading as-

signment to the personal problem. After Arnold came up with an interpretation of Josef K.'s situation, his original, personal problem we started out with was taken up again. He applied to the uncertain situation and subsequent catastrophic expectations of his family's reactions the insight that one situation can be viewed from many different perspectives. It is important to stress that Arnold had already developed his own opinion and solution regarding the abstract problem prompted by the philosophical reading assignment. Hence, the analysis of the personal problem should merely constitute a special case of the abstract problem which has already been sufficiently analyzed.

CP and related disciplines

Whether CP should be understood as a standalone approach or rather a philosophy-oriented method as part of other treatment approaches, is open for debate. On the one end of the spectrum, philosophy as a therapeutic tool is insight-oriented, focusing on the development of a sound theoretical and metaphysical underpinning. Addressing the big questions of life, such as human existence, self-actualization, freedom and responsibility, and using philosophy to find answers, it might be placed close to existential analysis [10] or even other humanistically oriented approaches [23].

On the other end of the spectrum, such a maintainable position is of value only if it can be translated into changes in the cognitive, emotional, behavioural and physiological architecture. People restructure their thoughts which are directed at the world and they primarily pursue the goal of a symptom-free life. Hence, CP might be viewed as a method belonging to the third wave of CBT, possibly dubbed as existential CBT. Combining different approaches in therapy might help clients to gain insight via conceptual (philosophical) reasoning on the one hand and to facilitate desired changes on the other hand [24].

Conclusions and limitations

In conclusion, this was the first study that reports a successful treatment of an individual with paranoid schizophrenia and comorbid OCD with predominantly obsessional thoughts using CP. However, it is not free of limitations. First, the results must be handled with caution and await replication in another study, preferably with a larger sample size. In doing so, further refinements and elaboration of the sketch of the tripartite function of CP should take place. Second, the quantitative results might have been weakened, because pretreatment data for the analyses of self-report measures were gathered after session 8. If they had been collected after the first session, both the decrease and increase of scores from pre – to post-treatment might have been more pronounced. Third, the relation to other psychotherapy approaches must be addressed in more detail in further studies.

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