

A Relational-Contemplative Model of Counselor Practice with Schizophrenia

Andrew J. Davis¹
Robert C. Schwartz

The University of Akron, Akron, Ohio, United States

Jon M. Cefus

New Philadelphia, Ohio, United States

The treatment of schizophrenia has historically focused on symptom elimination while overlooking the affective, existential, and intrapersonal aspects of suffering from a holistic wellness perspective. Research highlights the therapeutic relationship and the client's subjective experience as part of a comprehensive model of recovery, thereby supporting the need for a paradigm shift in the ways mental health practitioners work with clients suffering from schizophrenia. To address this need, the authors present a relational-contemplative model of counselor practice for clients with schizophrenia. This model emphasizes the therapeutic counseling relationship as a basis for developing mindfulness and self-compassion to increase client self-awareness, self-acceptance, and a positive self-narrative. Comparisons with traditional biomedical approaches are provided through a case vignette and analysis in order to highlight a holistic approach that offers potential benefits compared with traditional approaches alone.

Keywords: schizophrenia, mindfulness, compassion, therapeutic relationship, contemplative practice

Schizophrenia is one of the leading causes of disability in the United States, its etiology remains poorly understood, and its treatment remains costly, long-term, and often invasive (National Institute of Mental Health [NIMH], 2009). Over 2.5 million persons (i.e., 7 to 8 persons out of 1000) live with schizophrenia (NIMH, 2016), and in 2013 the total direct and indirect costs of schizophrenia in the United States was \$155.7 billion (Cloutier et al., 2016). Stages of symptoms of schizophrenia differ for each person, and

¹ Address correspondence to Andrew J. Davis, School of Counseling, The University of Akron, 27 S. Forge Street, Akron OH 44325-5007. Email: ajd60@uakron.edu

may include: prodromal or initial but less apparent symptoms (e.g., ideas of reference rather than delusions, odd sensations rather than hallucinations); a more active phase of psychosis causing marked impairments characterized by delusional beliefs, hallucinations, disorganized speech or behaviors, and reductions in affect, fluency of speech, and goal oriented behaviors (i.e., negative symptoms); and residual symptoms wherein full criteria for the disorder are no longer met but some distorted beliefs, odd perceptual experiences, and cognitive deficits remain (American Psychiatric Association [APA], 2013). Despite the pervasive symptomatology and debilitating course of schizophrenia, recent empirical findings have shown that with appropriately tailored treatment, most persons with schizophrenia can experience meaningful partial or full recovery from active symptoms (Silverstein & Bellack, 2008). To facilitate the recovery process counselors need more sophisticated models of treatment that takes into consideration the whole person, the diversity of presentations, and a personalized model of recovery.

This article reviews traditional treatments and current developments in holistic and humanistic approaches for schizophrenia to provide a basis for a relational-contemplative model (RCM) of counseling. RCM is then detailed and compared with a traditional approach through a case vignette and discussion including potential benefits, limitations and recommendations for future development. In addition to being holistic and humanistic the RCM aligns with the Substance Abuse and Mental Health Services Administration's (SAMSHA, 2012) working definition of recovery, which specifically includes person-centered care, a relational component, and consumer strengths and hope.

Traditional Schizophrenia Treatments

History and Rise of a Biological Treatment Model

Counseling has historically been one of the schizophrenia treatment options. In earlier psychoanalytic practice, Carl Jung (Jung, Peterson, & Brill, 1909; Lysaker & Silverstein, 2009) suggested that persons suffering with schizophrenia could benefit from psychoanalysis, provided that attention was given to their self-narrative and affect. Lysaker and Roe (2012) explained that this view was counter to Sigmund Freud's opinion that schizophrenia was not treatable through any form of counseling available during the early 1900's. However, with the introduction of the first antipsychotic drug in the 1950s (chlorpromazine, also known as Thorazine) the predominant use of pharmacotherapy was employed to eliminate or alleviate symptoms of schizophrenia such as hallucinations and disorganized thinking (Mueser & VandenBos, 2011; Tandon, Nasrallah, & Keshavan, 2010). Biologically-based treatment helped many persons, while also serving to entrench a predominant biomedical model that continues to exist in mental health care (Tandon et al., 2010).

Limitations of a Biological Approach and Additional Treatment Needs

While many persons with schizophrenia benefit from medications, there are serious physical side effects which may include obesity, metabolic syndrome, cardiovascular disease, diabetes, drowsiness, muscle spasms, and tremors (National Institute for Health Care and Excellence [NICE], 2014; Tandon et al., 2010). Many persons do not adequately respond to drug treatments, and some persons with schizophrenia recover from active symptoms without any medication (Tandon et al., 2010). Emphasis solely on the physical aspects of schizophrenia and a sole focus on elimination of symptoms can distract from effective and self-determined holistic alternatives (Lysaker, Glynn, Wilkness, & Silverstein, 2010). Therefore, we advocate that counselors should consider a more comprehensive treatment approach. For example, leading health organizations such as SAMSHA (2012) have provided guidelines that advocate for more comprehensive treatment. Also in the United Kingdom, NICE (2014) published guidelines for the treatment of schizophrenia, noting concern that antipsychotic medications may induce serious health problems, recommending psychosocial and dietary treatments before medication for persons at risk of developing psychosis. For persons experiencing active psychotic symptoms a combination of psychotherapy, family interventions, and medication may be recommended (NICE, 2014).

In a major review of evidence-based practice (Tandon, Nasrallah, & Keshaven, 2009), it was found that many practitioners were not considering a client's stage of schizophrenia and her or his unique symptom manifestation during case conceptualization. However, researchers have explained that treatments for schizophrenia should be stage-specific so interventions can be individualized (Tandon et al., 2009). A more individualized approach toward mental health care, rather than a focus solely on symptom reduction, seems to align with a more person-centered and holistic model tailored to clients' unique subjective needs and is advocated for by theorists (Chadwick, 2006; Glasser, 2004; Lysaker & Silverstein, 2009) and governmental organizations (SAMSHA, 2012).

A Holistic and Humanistic Approach to Conceptualizing Schizophrenia

Scholars (Keshavan, Nasrallah & Tandon, 2011; Tandon, Keshavan, & Nasrallah, 2008) have noted that developing effective treatment for schizophrenia is challenging due to the complex and biopsychosocial nature of the illness. For example, heterogeneous presentations of symptoms can lead practitioners to misunderstand client needs (Silverstein & Bellack, 2008; Tandon et al., 2010). Therefore, the phenomenology of psychosocial issues unique to persons with schizophrenia must be understood by counselors (Lysaker, Buck, & Lysaker, 2012). Phenomenologically, persons with schizophrenia present with diverse perceptual distortions about the external world (e.g., delusions and hallucinations) which must be considered during conceptualization and development of a holistic treatment approach. A client's stage of illness is another factor that affects the treatment process because an acute psychotic episode may require more

immediate interventions related to personal or others' safety, compared with maintenance interventions focused on functional and relational skills in persons with stable yet chronic schizophrenia (Tandon et al., 2010). Recently, schizophrenia has thus been reconceptualized as a conglomerate of related but slightly differing syndromes all having etiologies that include biological, psychological, and sociological factors (Tandon et al., 2009). In this article, schizophrenia is conceptualized as a spectrum disorder with different stages and unique individual presentations that has psychosocial and existential ramifications affecting one's sense of self (e.g., fear, self-loathing, demoralization, and hopelessness) and one's perspective of reality leading to fragmented self-other relations and ultimately maladaptive behaviors. Thus, persons in recovery from schizophrenia, or those attempting to reduce the psychosocial consequences of the illness should be understood from a psychosocial-existential perspective and treated using a holistic, empathic, compassionate and relational counseling approach (SAMSHA, 2012).

Holistic and Humanistic Evidence-Based Treatments for Schizophrenia

Early noted authors in the mental health field viewed effective schizophrenia treatments as including aspects of client affect (Sullivan, 1928), interpersonal skills (Fromm-Reichmann, 1958), human survival skills (Rosen, 1950), and existential growth (Arieti, 1960). Contemporary psychosocial evidence-based treatments (EBTs) include social skills training, assertive community treatment, family psychoeducation, supported employment, social learning and token economy programs, and structured cognitive-behavioral therapy (CBT) (Mueser & VandenBos, 2011). CBT is one of the primary psychosocial treatments for schizophrenia in the world (Gaebel, Reisbeck, & Wobrock, 2011). However, there are still unanswered questions regarding the efficacy of traditional CBT with schizophrenia. For example, a large-scale review by Sivec and Montesano (2012) of seven meta-analyses using CBT for psychosis showed only small to moderate CBT-related effect sizes, indicating that CBT treatment has some effectiveness, but there is still need to improve treatment efficacy. Moreover, the authors found that while the studies reviewed did report some benefits at the end of treatment, longer-term follow-up revealed few global treatment gains. The authors suggested that certain common factors be utilized which may be of greatest influence for clinical outcomes, such as the therapeutic relationship, instilling a sense of hope, empathy, and reinforcing factors outside counseling sessions (e.g., positive relationships).

A recent shift has therefore begun to unfold in which some clinicians, including CBT therapists, are advocating for helping clients recognize symptoms as part of the spectrum of human behavior, conceptualizing symptoms in a less stigmatizing way (e.g., viewing auditory hallucinations as intrusive thoughts), symptom reduction versus elimination, and emphasizing a collaborative therapeutic relationship as primary (Chadwick, 2006; Lysaker et al., 2012; Pinto, 2010). There has also been a surge in schizophrenia research involving mindfulness, meta-cognition, and compassion-based psychotherapies in addition to standard CBT approaches (Tai & Turkington, 2009). According to Lysaker, Glynn, Wilkness, and Silverstein (2010), reinterpretation of self-

experience “changes how persons think and experience themselves in the world, changes that occur regardless of whether persons experience other gains in symptoms or function” (p. 76). Although symptom reduction is an important component of treating schizophrenia, a holistic approach including insight into the illness and its consequences (Schwartz & Smith, 2004), self-empowerment, self-acceptance, and self-compassion within a therapeutic relationship are equally important for long-term recovery.

The Therapeutic Relationship and Schizophrenia

Hewitt and Coffey (2005) noted that the therapeutic relationship received less attention compared to specific techniques and pharmaceutical interventions. Despite its recognition, few empirical studies have focused on the therapeutic relationship with persons recovering from schizophrenia. For example, Hewitt and Coffey (2005) explained that the therapeutic relationship appeared to positively impact motivation for change, medication adherence, and overall client satisfaction to the extent that “the combination of relationship and process may prove to be the most effective treatment for people with schizophrenia” (p. 568).

However, Lecomte and Lecomte (2012) pointed out that a biomedical model continued to largely define the treatment of psychotic symptoms, and that clinicians should also consider how sociological and psychological factors contribute to successful outcomes. In this regard, the importance of a strong collaborative relationship has been described as integral in the successful counseling outcomes (Bachelor & Horvath, 1999), and accounts for a large proportion of client change (Duncan, Miller, Wampold, & Hubble, 2010). A more egalitarian approach can enhance the therapeutic relationship with clients having schizophrenia. Chadwick (2006) called this way of relating radical collaboration, described as “a process of allowing clients to find their own goals within a supportive, collaborative relationship that is free from therapist demands about how therapy should progress” (p. 25). Perhaps the most important aspect of radical collaboration is placing the primary choice of being in a collaborative relationship with the client. Persons with schizophrenia commonly experience distrust in others as their illness unfolds (Lysaker & Roe, 2012), including involuntary hospitalizations, physical restraints, medication against one’s will, loss of social relationships and public rights, and social stigma (Lysaker et al., 2010; Mueser & VandenBos, 2011). Recent theorists suggested that, if consciously incorporated, the counseling relationship and use of empathy may help in the recovery process by facilitating clients’ connection with themselves in a more positive way and with others (de Waal, 2012).

Contemplative Practices and Schizophrenia

Overview of contemplative practices. Contemplative approaches to counseling have been gaining attention in the literature as a practical means for helping those with severe mental illness such as schizophrenia (Braehler et al., 2013). These approaches

include practices are intended to produce positive mental skills and socio-emotional states (Davidson et al., 2012). Contemplative practices may include various forms of meditation and yoga, and have a history in Eastern spiritual traditions (Waters, Barsky, Ridd, & Allen, 2015) that have been practiced for thousands of years within certain cultures but only recently have been incorporated into Western counseling interventions (Khoury, Lecomte, Gaudiano, & Paquin, 2013). Mindfulness professionals (e.g., Campbell & Christopher, 2012; McCown, Reibel, & Micozzi, 2010) assert that contemplatively trained counselors should therefore gain skills a current mindfulness or compassion-based counseling approach and maintain an active personal practice of meditation.

Mindfulness has been defined as “the awareness that emerges through paying attention on purpose, in the present moment and non-judgmentally, to the unfolding of experience moment to moment” (Kabat-Zinn, 2003, p. 145). Mindfulness-based approaches began in the 1980’s, and some of the current approaches include mindfulness-based stress reduction (MBSR; Kabat-Zinn, 2005), mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2013), acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 2012), and dialectical behavior therapy (DBT; Linehan & Wilks, 2015). Mindfulness can be developed through practice and has been associated with such qualities as equanimity, wisdom and non-judgmental acceptance of one’s experiences whether positive or negative (Kabat-Zinn, 2003). These practices can therefore be very valuable in the schizophrenia recovery process.

Compassion and loving-kindness, two closely related constructs, have often been linked in both practice and research. Compassion meditation practices focus on awareness and alleviation of suffering while loving-kindness practices focus on developing a loving and kind concern toward oneself and others (Hoffman, Grossman, & Hinton, 2011). Self-compassion has been conceptualized as self-kindness and connecting with a common humanity (Germer & Neff, 2013). These approaches include models such as compassion focused therapy (Gilbert, 2009), compassionate mind training (Gilbert & Procter, 2006), and mindful self-compassion (Neff & Germer, 2013). It is believed that while self-compassion may be one of the benefits of mindfulness training, in practice it has a unique and additive benefit above mindfulness training alone (Neff & Germer, 2013) and can be particularly salient for schizophrenia recovery.

Contemplative practice and client care. Practicing mindfulness (Khoury et al., 2013) and compassion (Braehler et al., 2013; Johnson et al., 2011) may be a means for alleviating suffering and developing necessary coping skills for clients with schizophrenia. Importantly, mindfulness and compassion practices in schizophrenia treatment have been shown to reduce hospitalizations, reduce anxiety (Brown, Davis, LaRocco, & Strasburger, 2010), decrease believability of hallucinations (Abba, Chadwick, & Stevenson, 2008; Strauss, Thomas, & Hayward, 2015), and increase positive emotions (Gumley, Braehler, Laithwaite, MacBeth, & Gilbert, 2010). Mindfulness has been shown to foster a calm and decentered awareness of symptoms as another transitory psychological state (Abba et al., 2008) so clients are less reactive to their own symptoms and

responses of others. Clients engaging in compassion practices may experience an increase in warmth, positive emotions, self-soothing, positive interpersonal relationships, resilience, and motivation (Gilbert & Procter, 2006; Gumley et al., 2010). A client can then begin to explore negative experiences and self-concepts non-judgmentally and integrate them as part of a more positive self-concept (Chadwick, 2006; May, Strauss, Coyle, & Hayward, 2014). Accompanied by less reactivity is less suffering and a less constricted view of one's symptomatology (Chadwick, Kaur, Swelam, Ross, & Ellett, 2011; Dannahy et al., 2011). With mindfulness practice the self can be examined as changeable, having both positive and negative aspects that are part of being human (Pinto, 2010). For the client, mindfulness and compassion practices foster core conditions of self-acceptance and a reconnection within oneself and with others.

In a parallel process with client care, mindfulness and compassion practices help the counselor develop greater self-awareness and self-acceptance (Pinto, 2010). Counselors who themselves develop mindfulness and self-compassion can become more attuned to their clients, and therefore demonstrate increased empathy (McCollum & Gehart, 2010) and therapeutic collaboration (Lappalainen et al., 2007). As noted above, these qualities are key features of a successful outcome with persons suffering from schizophrenia. Findings have shown positive client satisfaction outcomes when working with contemplatively trained counselors (Grepmaier et al., 2007; Lappalainen et al., 2007) because the counselor may be more centered and less reactive to the client's symptoms fostering calmness and space for making wise choices regarding how to proceed with treatments (Pinto, 2010).

A Relational-Contemplative Model with Schizophrenia

To advance a more humanistic and holistic approach using the principles described above with persons suffering from schizophrenia, we propose a relational-contemplative model (RCM) for schizophrenia treatment. The RCM is a conceptual model based on humanistic counseling, current mindfulness and compassion-based interventions, as well as aspects of CBT for schizophrenia. It is an integrated model in that it highlights the interconnectedness of the relationship between counselor and client, and the counselor's own contemplative practices. The RCM is complimentary to other evidence-based approaches in the treatment of schizophrenia, intends to address limitations of traditional treatment approaches, and can be adapted depending on a client's stage of illness. Below is a description of the RCM, its therapeutic processes, and how it is applied using a case vignette illustration.

The RCM Therapeutic Processes

The RCM is shown as a Yin - Yang figure with concentric circles in order to highlight the interconnection of its therapeutic processes (see Figure 1). The Yin - Yang figure represents the egalitarian yet interdependent relationship between counselor and client. Each concentric circle represents facets of treatment with a core of compassion, then

mindfulness-based interventions, and finally specific evidence-based treatments. As a conceptual model, the RCM provides a representation of four key elements for humanistic and holistic treatment and their relation to one another. As a humanistic model the therapeutic relationship is conceptualized as egalitarian, reciprocal, and the space in which treatment should occur. The model is holistic, emphasizing the interconnection of the biopsychosocial aspects of a person's life, engaging basic human capacities of compassion and mindfulness along with specific treatments such as pharmacotherapy, CBT, and psychoeducation.

RELATIONSHIP - Yin Yang

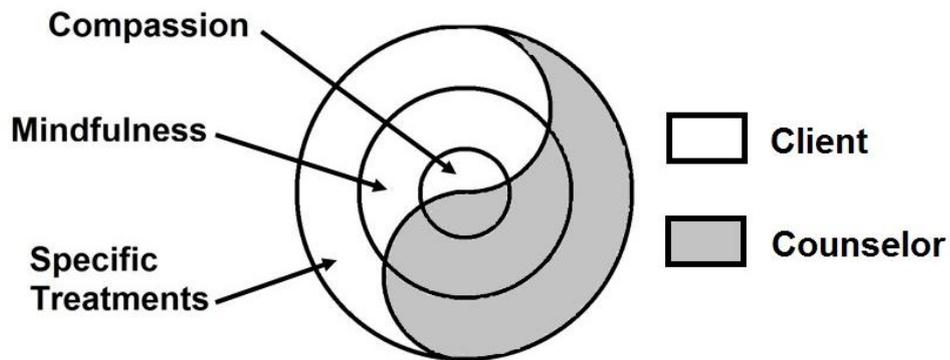


FIGURE 1

Relationship – Yin Yang

Figure 1. Relational-Contemplative Model showing inter-relationships of compassion, mindfulness, and specific treatments within the context of a collaborative egalitarian therapeutic relationship.

The RCM relationship. In the RCM, the counselor works toward building a therapeutic counseling relationship by fostering warmth, trust, collaboration, and self-acceptance. This is particularly important for persons with schizophrenia because as described above developing and maintaining genuine interpersonal relationships and an internal sense of self are core aspects of the recovery process. The therapeutic relationship becomes a safe environment where trust is built and emotional warmth and positive affiliation can be cultivated. A felt sense of genuine caring registers with the client who may have previously experienced fear, paranoia, depression, and self-defeating cognitions. For this process to occur, the counselor must be aware of common countertransference reactions toward clients having psychotic experiences (e.g., prejudices, fears, a sense of pity) in order to transmit warmth, safety, and unconditional positive regard (Schwartz, Smith, & Chopko, 2007).

Counselors should be committed to collaboration by facilitating a relationship that is egalitarian and empowers the client to choose their own values, goals, and terms of

engagement in counseling. Together, the client and counselor take a more compassionate view in that persons with schizophrenia may have unique experiences and have a potential for recovery toward a more healthful life. Using the RCM counselors should therefore have an orientation toward understanding the person's source of distress broadly while not solely focusing on the etiology of psychotic symptomatology. Developing active listening, supported discovery, and having clear and open discussions about personal choice in the treatment process are vital.

The RCM and compassion. Establishing the therapeutic counseling relationship and demonstrating compassion provides the necessary conditions to begin contemplative practices. Compassion and mindfulness in the RCM can be incorporated into any stage of treatment. The compassion-based component of the RCM includes the counselor being committed to embodying self-compassion as a helping professional, and modeling compassion toward the client (Gilbert & Procter, 2006; Neff & Germer, 2013). As the client's symptoms stabilize and therapeutic trust is built, more explicit compassion practices can be introduced such as loving-kindness meditation, or kind actions toward oneself. Use of guided discovery or guided imagery can be used to instill positive images and help the client make friends with themselves in order to generate positive affect and increased self-compassion. Compassionate letter writing can help the client process hallucinations or self-criticism and shame. Then, ongoing diaries of responding compassionately toward one's self may be useful for noting thoughts or hallucinations involving self-criticism and shame. In this regard, counselors should recognize that resistance to self-compassion may be a client's learned way of self-protection. Including psychoeducation about the concept of self-compassion as well as normalizing symptoms as common and recoverable may help lessen compassion-based resistance.

The RCM and mindfulness. In the RCM mindfulness is a practice based on a foundation of compassion, with both a broad perspective but specific techniques. At a later stage of treatment when a client's symptoms stabilize, the counselor can introduce a more explicit introduction of mindfulness exercises. In a trusting therapeutic relationship and through generating self-compassion modeled by the counselor, the client can begin adopting their own mindfulness practice. We propose that mindfulness practice allows the client to increase self-soothing, self-awareness, openness, and a nonjudgmental approach toward their own recovery. Such practices include meditation and development of acceptance toward oneself, openness to one's experiences as neither right or wrong, and eventual contemplation of the experience and one's own sensations (including psychotic experiences). These practices can be cultivated either simultaneously or individually over time.

In this regard, using adapted meditations within sessions that are shorter, with less silence and more frequent feedback according to the skill and comfort level of the client can be helpful. For example, counselors may start sessions with short mindfulness practices to help establish calmness and concentration (e.g., mindfulness of breath).

Incorporating adapted body scans, sitting meditation, walking and movement meditation, and mindfulness of daily activities (e.g., eating) will facilitate contemplation in the present moment. However, it may be helpful to not require contemplative homework outside of sessions before first practicing in sessions in order to ensure acceptance of and desensitization toward the exercises.

Additional specific treatments aligned with RCM. As counseling progresses, other evidence-based treatments can be introduced, tailored to benefit the client depending on their stage of recovery. Specific treatments may include CBT for psychosis, depression, and anxiety. Screening and treatment as necessary for trauma and substance abuse should be a routine part of counseling due to their frequent comorbidity with schizophrenia (APA, 2013). Social support and family psychoeducation can be utilized as well. Counselors should also develop a positive working relationship with prescribing doctors or nurses and case managers in order to both coordinate care and reinforce a RCM-based approach to recovery.

The RCM and commitment to practice. The contemplative component of the RCM involves a professional commitment to regular contemplative practice as a helping professional. This practice helps counselors embody and model what is being shared with the client (Chadwick, 2006; Pinto, 2010). As such, this approach allows counselors to draw on their own experience when training clients, and enhances therapeutic presence within sessions. It is important to note that, when utilizing the RCM, it is insufficient to simply work from a prescribed curriculum or rely on conveyance of intellectual knowledge alone. We recommend that counselors interested in this approach seek out training in mindfulness and compassion meditation practices such as Mindfulness-Based Stress Reduction (Kabat-Zinn, 2005), Mindfulness-Based Cognitive Therapy (Segal et al., 2013) or the Mindful Self-Compassion program (Neff & Germer, 2013). The RCM characteristics described in this section are summarized in Table 1. In order to demonstrate the utility of the RCM for counselors, a case vignette and discussion regarding case conceptualization is presented below.

TABLE 1

Relational-Contemplative Model Components

Component	Characteristics
Relationship	Primacy of therapeutic relationship; warmth, trust, unconditional positive regard; collaborative; egalitarian
Compassion	Model self-compassion; loving-kindness practices; positive imagery; guided discovery; normalize symptoms; kind action towards self; letter writing

Mindfulness	Brief mindfulness exercises; non-judgmental awareness of present moment experiences
Specific Treatments	Pharmacotherapy; CBT; Psychoeducation; Social Skills; Supported Employment

Application of RCM

Case Vignette

A 24-year-old White male has been recently admitted to a psychiatric hospital after locking himself in his apartment alone for approximately one week. He reports that the “devil sucked all emotions out of his body.” He is distressed and feels punished for prior wrongdoings to others. He stopped going to work or talking to family members approximately one month prior. He reports that he used to be very creative, “he could feel colors in the outside world,” and had lots of innovative ideas. But now he has no connection with others and cannot work. He relates this deadening feeling to being punished for several arguments he had with family members approximately one year ago. While in the hospital he voiced a vivid description of a cloud over his bed pulling at his body each night for days until all the emotion was “transferred out his body.” He claims a family history of depression, and has an uncle that was reportedly diagnosed with schizoaffective disorder. He is currently not in an intimate relationship, and is engaging in a partial hospitalization program having been diagnosed with schizophrenia.

Case Conceptualization

A variety of approaches can be used to conceptualize this client’s distress. The conceptualization used will significantly impact a counselor’s treatment decisions because it will color which interventions are chosen and in what form they are delivered. More broadly, the conceptualization will also guide how a counselor interacts with the client and their perceived role as a helping professional. A traditional biomedical model and the RCM are compared below as different methods of conceptualizing this client’s biopsychosocial concerns. Note that we are purposefully describing these different perspectives in order to highlight two ends of a treatment continuum. Although no single, pure, or homogenous biomedical viewpoint is generalizable to treating all persons with schizophrenia, the approach described below is based on a traditional medical model perspective, as opposed to a more holistic, wellness, relational, and compassion-based approach (i.e., the RCM).

Biomedical conceptualization. From a biomedical perspective, the client is exhibiting positive psychotic symptoms, such as persecutory delusions and tactile hallucinations evidenced by supernatural forces causing him and “feeling colors.” His social withdrawal and blunted affect are viewed as evidence of negative psychotic symptoms.

His lack of ability to maintain intimate relationships is conceptualized as marked social impairments, and his personal distress and depressive symptoms may lead to concerns about possible self-harm. The traditional biomedical approach would include listing each form of maladaptive behavior as illness symptomatology to be eliminated. After completion of a diagnostic assessment the standard first-line intervention would be prescription of antipsychotic medications to reduce positive symptoms and associated depression and anxiety (i.e., psychophysiological tranquilization). Additional medications would then typically be prescribed to help offset physiological side effects of the psychiatric medication regimen. After symptom stabilization was achieved, manualized CBT interventions would be initiated focused on therapist-directed psychoeducation and behavioral symptom maintenance. Follow-up services would be considered, such as community-based case management, focusing on medication compliance and social skills training. The goals of treatment would be directed by the professional through a primary role focused on evaluating and eliminating biologically-conceptualized symptoms (e.g., hallucinations and delusions). Secondly the professional would usually focus on reducing psychosocial impairments through psychoeducation about symptomatology and behavioral modification.

RCM conceptualization. The RCM is best seen as integrative and adaptive, placing a priority on conceptualizing suffering from a holistic framework in order to augment any necessary traditional methods with a foundation that is relational, mindful, and compassionate (Chien & Thompson, 2014). Although the RCM would recognize this individual's distress as being linked to experiencing psychosis, the approach would begin by allowing the client to openly share his thoughts, feelings, images, and fantasies in order to show compassion and purposefully build rapport. The first priority would be establishing a therapeutic alliance. Respect and a supportive response would be used to build a therapeutic relationship in order to help the individual feel safe in the presence of a caring and compassionate helping professional. The common therapeutic factors of hope and expectancy of positive change would be reinforced as the individual and counselor conversed within a safe environment to promote a holistic person-centered healing atmosphere.

The counselor would show nonjudgmental acceptance of the client's distress, including his fears and confusion. Compassion would be modeled through loving-kindness and patience, as more mindful awareness was reinforced with the client in the present moment. An attempt would be made to actively promote self-compassion in the client through the use of empathy. After building a foundation of self and other compassion, mindfulness-based strategies (e.g., mindfulness-based stress reduction) would be incorporated to build relaxation and self-awareness. Simple activities that invite the client to gain self-awareness of present-moment experiences, desensitize to emotional stress resulting from psychosis, and accept rather than avoid their internal experiences would be introduced (Schwartz, 2015a). One of the goals would be to help the client develop a fuller and more holistic sense of self while acknowledging existential dilemmas.

After symptom stabilization, when the client demonstrated the ability to maintain concentration, mindfulness practices aimed at cultivating contemplation would be introduced. The client would be invited to conceptualize hallucinations as messages brought to awareness rather than frightening and stigmatizing psychological intrusions. One goal would be to help him develop fuller understanding in order to gain a more concrete and in-depth picture of meanings behind the experiences (Schwartz, 2015b). An outcome of this process would be a nonjudgmental attitude toward one's own experiences, and a reduction in fear and shame due to conscious responding rather than symptom-based non-mindful reacting. The process of treatment includes two persons engaging in an atmosphere of openness and trust in order to understand the client's unique experience of suffering mindfully and compassionately, thereby reinforcing positive neuroplasticity and social relatedness while also decreasing distress.

Discussion

Table 2 outlines some primary aspects of each conceptualization. Note that the perspectives and techniques outlined are purposefully describing two different perspectives along a treatment continuum based on a more traditional medical model perspective contrasted with a more wellness, relational, and compassion and mindfulness-based perspective. In practice these seemingly dichotomous approaches can be integrated. Counselors should test these ideas to see how they can be integrated into practices at their workplace.

TABLE 2

Comparison of Traditional Biomedical Conceptualization and Relational-Contemplative Model Conceptualization

Phase	Biomedical Model	Relational-Contemplative Model
Acute Care	Use of anti-psychotic medication to reduce most florid psychotic symptoms.	Focus on showing compassion and empathy for client's distress; begin building therapeutic relationship. Maintain a nonjudgmental environment for client to share thoughts, feelings and fantasies. Normalize psychotic experiences as part of range of human experiences (self-compassion).
Stabilization	Step-down from inpatient to partial hospitalization program.	Introduce mindfulness exercises for both self-soothing and self-awareness. Introduce short compassion exercises to

		generate warmth towards self and others.
Recovery	Focus on eliminating biological factors related to psychotic symptomatology.	Focus on working with psychotic symptoms that may reoccur with acceptance, self-compassion, and skillful action.
	Focus on non-psychotic symptom reduction (e.g., depression and anxiety) using psychotropic medications and CBT.	Focus on developing contemplative skills to manage stress and reduce anxiety and depression.
	Intermittent use of short-term CBT interventions emphasizing psychosocial coping skills.	Use mindfulness and self-compassion practices work toward more satisfying relationships with others and self.
	Long-term medication compliance and symptom management.	Feel safe and supported; mindfulness/ acceptance of distressing experience; learn relational skills through counselor support and modeling.
	Case management services as needed.	Instill hope for the future and securing compassionate support from others.

Adopting the RCM when counseling persons with schizophrenia offers different advantages compared with traditional treatments alone. The RCM does not discount the potential benefits of biologically-based treatments or other evidence-based psychosocial treatments (e.g., traditional CBT), but does place primacy importance on the therapeutic counseling relationship as a basis for healing. The RCM also incorporates mindfulness and compassion-based approaches to expand the limits of traditional interventions, conceptualizing these as partial and symptom-limited practices that may not result in long-term or self-guided recovery. Mindfulness compassion training can provide awareness and skills to compassionately recover from symptoms of schizophrenia toward longer-term benefits (Chien & Thompson, 2014), while addressing the more humanistic goals of improved self-identity and personal relationships.

The RCM can address both multicultural and client advocacy concerns. For example, incorporating mindfulness-based and contemplative treatments may promote suitability for different (e.g., non-Western) cultures aligned with a constructivist epistemology. Relatedly, Chien and Thompson (2014) showed the efficacy of mindfulness-based interventions with Chinese clients experiencing schizophrenia. There is also growing evidence of mindfulness-based intervention acceptability among Western

clients. From an advocacy perspective, the RCM validates and empowers clients versus stigmatizes symptoms of illness as biological abnormalities to be eliminated. Contrasted with traditional approaches the RCM promotes self-understanding or self-compassion, and lessens the conflicting messages of distrust in and dependence on the medical system for external evaluation and expert interventions. Rather, symptoms are normalized as part of the individual's experience, and a highly collaborative therapeutic stance is fostered from the outset of treatment. Advocacy of this more holistic and person-centered stance may be especially important for counselors working in environments with demands for traditional evidence-based treatments that often require manualized approaches, as these approaches may unintentionally lead to a culture of client objectification and depersonalization.

RCM Limitations and Future Development

Limitations of the RCM are that it is a newly conceptual model integrating Eastern and Western approaches. The model builds on a vast array research and theory focused on mindfulness, compassion, contemplation and the therapeutic relationship. However, the RCM as an integrated approach needs further research to determine its efficacy for counselor effectiveness and client treatment outcomes. In the current literature, treatment of schizophrenia including humanistic and contemplative approaches are still in development. The RCM as presented provides a framework to suggested interventions, but a further refinement including specific training and detailed techniques are needed as they are drawn from other approaches.

For further development of RCM research is needed in the various contemplative practices and their effectiveness in schizophrenia; counselors' effectiveness in relation to the amount and type of contemplative training to provide; counselor training on mindfulness and compassion practices; experiences of counselors and clients as they progress through the RCM stages; and an analysis of the four RCM components to determination the relative importance to one another and clients' overall recovery outcomes.

Conclusions

The RCM is a counseling approach consistent with the humanistic and relational philosophy of the profession, incorporating contemporary evidence-based and holistic interventions. The RCM therefore provides a different framework for counselors to work from in treatment with a person experiencing symptoms of schizophrenia. The RCM is not intended to subvert other traditional approaches. Rather, this approach aims to maintain a primary concentration on each unique client's suffering in order to instill compassion, mindfulness, and positive personal relational experiences. The RCM not only offers unique benefits, but can also benefit counselors as a means to improve therapeutic relationship and empathy skills, while reinforcing multicultural and advocacy mandates of the profession. The RCM also aligns well with a newer definition of

counseling as “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (Kaplan, Tarvydas, & Gladding, 2014, p. 366). As a new conceptual model with potential benefits for clients and counselors, the RCM warrants further research.

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