An Adaptation of Ego Function Assessment Techniques During Transactions With A Schizophrenic Existence

Doris Matherny Modly, R.N., M.S.N. is an Instructor, Psychiatric-Mental Health Nursing, Case Western Reserve University, Cleveland, Ohio.

The changing patterns of mental health services have rendered the “mothering role” of the nurse insufficient and have necessitated that the nurse therapist approach her client purposefully, with the practice focus on assessing the client’s health status, assets and deviations from health, and to assist the client in attaining or regaining his optimum mental health potential. This role definition of the nurse clearly delineates two central functions for the nurse therapist in a psychiatric setting: the assessment function and the function of assisting the client therapeutically to attain optimal levels of mental health.

To fulfill these functions the nurse therapist has to proceed systematically, basing her actions on theoretical constructs and principles of intervention developed by other disciplines and to modify these interventions thus making them congruent with nursing needs of clients. The nurse therapist further has to proceed to evaluate the effectiveness of the therapeutic interventions by evaluating the observable behavior change of the client and the client’s expression of satisfaction with the outcome of therapy.

Basically, the functions of the nurse therapist do not differ from those of any other psychotherapist whether that be a social worker, psychologist or psychiatrist. All bring to the clinical situation the “self” of the therapist, the technique and the scientific basis on which technique is based. Truax and Carkhuff’s research showed that the three personal characteristics of an effective therapist were: (1) accurate empathy, (2) nonpossessive warmth, and (3) genuineness. Their research has received acclaim and general acceptance. Conversely, Strupp makes a strong argument for the importance of technique in psychotherapy. Technique “implies the deliberate employment of skill and introduces from a different vantage point objectivity and science into the relationship.” Yet, it is difficult to believe that either the behavioral characteristics of the therapist or the skill, judgment, and technique employed by the therapist singly can produce change on part of the client. It is more probable
that the salient characteristics of the personality of the therapist interact with the technical skill to make possible a new emotional experience, cognitive learning and the gradual acquisition of new attitudinal patterns.

The ideas discussed in this paper were generated during a short-term therapeutic contact of a nurse therapist with a client hospitalized for diagnostic purposes on a psychiatric inpatient unit. The twice-weekly therapy sessions extended over eight weeks. The goal for the sessions set by the client were to “talk to somebody and prove once and for all that I am not sick so that I should be left alone.” This goal was congruent with the therapist’s goal which was to contribute to the diagnostic profile of the client. Techniques of intervention were based on data obtained about the client through the use of Bellak’s Ego Function Assessment Guide. Changes were noted on the Ego Function Profile. Continuous adherence to the objective ego function assessment tool did not prove to be feasible because of the taciturn nature of the client. An experiential assessment based on Mendel’s phenomenological view of schizophrenia complemented the scientific, objective approach.

The purpose of this paper is to discuss the rationale and the process of adapting the two rather different theoretical concepts which guided therapeutic interventions of the nurse therapist in the interactions with the person leading a schizophrenic existence.

In his discussion of the phenomenological theory of schizophrenia, Mendel states that the interventions, which a human being living a schizophrenic existence engenders in others, frequently have little to do with what is going on in him or with his needs. The response seems to be a combination of the needs of the profession to which the intervener belongs and the views held by the intervener of what it is to be human. He also, rather critically, adds that these interventions will thus have little to do with the needs of the one living this schizophrenic existence. The latter statement might be considered to be rather harsh even though the danger of this possibility has been exemplified all too frequently in many of the helping professions when too strict adherence to theories, principles and intervention strategies prevented innovative and creative approaches. On the other hand, adherence to one or another theoretical framework which can be quantitatively justified can have an advantage in an age of increased emphasis on accountability to the client for the quality of intervention outcomes. For this reason it would seem that the selection of an assessment and treatment modality best suited to the client or the combination of two or more theoretical frameworks which serve as a basis for the intervention would be the mode of choice in therapeutic nursing approaches.

The feasibility of such an approach was tried by the writer in her work with a 25-year-old male client who was hospitalized for the second time within that year because of progressive inactivity and withdrawal from human contacts. He was eventually diagnosed as falling into the diagnostic category of simple schizophrenia even though much of his behavior was characteristic of a borderline schizophrenic affective disorder.

The theoretical frameworks from which the client was viewed and on which interventions were based were those of Leopold Bellak’s concept of the schizophrenic syndrome as manifested by impaired and quantitatively reduced ego functions and the phenomenological theory of schizophrenia as discussed by Werner Mendel who views schizophrenia as a way of life. A combination of these two rather different views was found to be complimentary in the process of therapeutic interactions as will be evident later.

Leopold Bellak formulated the “egopsychological multiple factor psychosomatic theory of schizophrenia” wherein schizophrenia is seen as a syndrome caused by different etiological factors, all of them sharing as the final common manifest paths severe disorders of ego functions. Ego functions are theoretical constructs based on observations and on patient’s reports of their experiences. The ego constructs should be defined in terms of a number of functions that refer to adaptively relevant actions and reactions of the individual person. Bellak quotes Hegel’s concept of “Umschlag von Quantitate zu Qualitate” as justifying his view of quantified ego functions as a measure of a qualitative difference of the client’s behavior. Ego function assessment is particularly useful since it allows for a graphic, quantified presentation of ego strength and weaknesses and therefore the adaptive potential of the client.

Bellak formulated the thought of a diagnostic continuum with mobility in either direction based on the idea of interplay of forces on the continuum which allows one to see the person suffering from the schizophrenic syndrome as one moving on this continuum from a schizophrenic to a depressed or neurotic state. This idea seemed particularly congruent with the behavior of John whose behavior and past history prompted one to view him as moving on
such a continuum even during his hospital stay.
A systematic ego function assessment of John would have been extremely difficult to carry out right following his admission because of the difficulty he had verbally relating his thoughts and feelings and because of his categorical denial of any difficulties. He had at that point withdrawn from all human contact, except his brother, but was able to care well for his own personal needs. He did not work for monetary gain and lived on money from an endowment fund left for him by his father. He spent most of his time “meditating.” Upon hospital admission it soon became evident that the ego functions would have to be evaluated on the basis of behavior manifested to the evaluator rather than the client’s reporting of his behaviors. For this reason the assessment phase was extended over six to eight interviews. During these an attempt was made to systematically evaluate twelve ego functions delineated by Bellak based on the information gathered as the therapist responded to the human being, his frequent nonverbal revelations of pain, joy, and indifference, his distancing and his moving closer through verbal and nonverbal maneuvers.

The twelve ego functions delineated by Bellak are: Reality Testing, Judgment, Sense of Reality, Regulation and Control of Drives, Affects and Impulses, Object Relations, Thought Processes, Adaptive Regression in the Service of Ego, Defensive Functioning, Stimulus Barrier, Autonomous Functioning, Synthetic Functioning, and Mastery Competence. The strength of these functions is quantified and placed on a 1-13 scale. Placement on the scale is indicative of the strength of the adaptive ability of the ego function. The evaluation of John’s ego functions was based on material gathered during the first six to eight interviews, interviews with the psychiatrist, and notations on his chart. On the basis of these the following picture emerged: His weaknesses, the lowest ratings were in the areas of object relations (6), defensive functioning (6), and mastery competence (5). The strengths which emerged were: thought processes (10), reality testing (10), and autonomous functioning (9). See Appendix.

The graphic picture was congruent with what was experienced by those who were in contact with him. He was actively participating only when asked. He never interacted voluntarily with either staff or the patients on the unit yet he never refused to meet with those who saw him for therapeutic reasons. He was rather passive, unable or unwilling to talk about his feelings and masked his aggressive impulses which surfaced only on occasion during competitive games in which he frequently engaged and which he performed very well. He frustrated his opponents during these games by suddenly pulling back and not performing well any longer. As much as all concerned tried to convince him of the opposite, he staunchly refused to “compromise his integrity” and do what he did not see necessary, namely, to actively participate in society by seeking employment and becoming involved in the mainstream of life. He claimed that only one relationship was important to him, his relationship with his family, his brother and mother. The longer one knew him the more evident it became that there was something amiss, that John was on the edge of an abyss and that the strength of his ego functions which were intact were holding him back from the fall.

The construction of the ego function graphic was quite helpful for two reasons: the therapist was not as easily caught up in the world of the schizophrenic existence. The ego function assessment was scientifically tested by Bellak and thus considered by the nurse therapist a reliable assessment tool which gave the assessment process objectivity. Secondly, Bellak’s formulations of therapeutic interventions for the strengthening of the weak ego functions guided the working phase of the relationship. Emphasis was placed on the development of a therapeutic relationship with the nurse. Particular attention was given to any potential difficulties which might arise out of the one-to-one relationship: transference, countertransference, resistance and eventually difficulties around termination.

Group participation was encouraged because in groups object relationships are corrected and new ones developed without the danger of penalties of total rejection. Optimal distance or closeness also can be learned easier in group settings. An improvement in object relations leads to an improvement in other ego functions such as in mastery competence. Mastery competence is enhanced also by the treatment of low self-esteem. This is accomplished through the one-to-one relationship with the therapist and other therapies such as occupational and recreational. The nurse therapist encouraged the client in his endeavor in both of these.

The low rating in defensive functioning was indicative of a defensive attempt to avoid anxiety. This was manifested by the client’s withdrawal in an attempt to control hostile, aggressive impulses. Exploration of the behavior pattern and semantic and constructive stage interpretations of the dynamics of these behaviors to the client were undertaken once the
therapist-client relationship attained the needed stability and ego functions were strengthened. Strong ego functions such as in John’s case, where his thought processes and sense of reality were enhanced through reviews and reconstructions of his present and past life. As more information was gathered, changes from the initial assessment could be noted and recorded thus giving a clearer picture of the highest, lowest and characteristic levels of functioning (See Appendix).

According to phenomenological theory of schizophrenia, there are three primary categories of observed existential difficulties of the schizophrenic lifestyle. These are: the failure of historicity which is considered the basic difficulty; the failure of anxiety management; and the failure of interpersonal relationships.

The failure of historicity underlies all other difficulties and it leaves the person in a vacuum of the present without recourse to the experiences of the past or the hopes of the future. Effective dealing with all other difficulties has to be through dealing with the lack of historicity. All three primary areas of existential difficulties have to be approached through transactions between the schizophrenic existence and the other existences.

The nurse therapist in her interactions with John placed great emphasis on the transactions which occurred between them. During the time that data were gathered for the ego function assessment the nurse therapist attempted to understand the client’s world and to communicate empathy. The client’s difficulty with historicity impeded the therapist’s attempts to involve the client in any type of problem defining and resolving. The therapist concentrated on establishing historicity through the relationship by frequent contacts outside of the scheduled sessions, punctuality during sessions and promises kept. The therapist observed poignant trials of the client to regain some historicity by willingly relating his past and by his difficulties in establishing a link between his past, the present and his future. John’s difficulties with anxiety management were confirmed by the low score on the ego function scale. The excessive use of defensive behavior inhibited John in his interpersonal relationships as these added to his anxiety. His passive expressions of aggression were a good example of over-active defensive functioning.

The prolonged time needed for ego function assessment resulted in repeated contacts with the client. Thus the increased opportunities for observation and empathic responses communicated to the client contributed to the development of therapeutic transactions between the therapist and client. The combined use of the two orientations, namely, the scientific evaluation of ego functions and the experiential assessment of the schizophrenic existence provided an effective framework for the nurse therapist’s interventions in the short-term therapy setting.

The blending of the two approaches based on two different conceptualizations about the client’s difficulties also serves the function of helping the therapist to remain objective, creative and innovative during the long hours of working with a client who lives a schizophrenic lifestyle. The therapist uses the “self” as a therapeutic tool in the client-therapist interactions. This self has to remain alert, and highly receptive to the expressions of the client’s needs. To be therapeutic, the therapist has to convey to the client respect and genuineness, and communicate accurate empathy. This, at times, might prove to be quite difficult for the therapist who is also human. Particularly, when the client possesses the elusive qualities of the schizophrenic lifestyle. Changing back and forth between two divergent, yet complementary, approaches allows flexibility and an opportunity for the therapist to view the same problems from different points of view thus enhancing alertness and creativity during the therapeutic process.

REFERENCES


BIBLIOGRAPHY


(Appendix on next page)
APPENDIX I
EGO FUNCTION PROFILE