A Perspective on the Psychotherapy of Schizophrenia Project

by William T. Carpenter, Jr.

Abstract

Psychotherapy of schizophrenia has engendered widespread interest and controversy. Etiologic theories and ideologic orientation toward psychopathology have unduly influenced clinicians’ therapeutic approach, and only recently has the drug versus psychotherapy polemic given way to scientific study and integration of seemingly distinct treatments. The Psychotherapy of Schizophrenia Project provides an important new perspective on methodology and data analysis. A differential effect between two psychotherapies was hypothesized, but results support the view that supportive psychotherapy is at least as effective as more intensive psychotherapy based on psychoanalytic theory and psychodynamic practice. The more general question of efficacy of psychotherapies is not addressed, but it is a vitally important issue which demands the critical attention of advocates rather than advocacy devoid of efficacy data.

Millions of people suffer from schizophrenia and schizophrenia-like psychotic illnesses, creating a worldwide health problem with enormous social, economic, and personal implications. Even under the most favorable circumstances imaginable, only a small proportion of these patients could be treated with intensive, insight-oriented psychotherapy. Yet, from Emil Kraepelin onward, this topic has received extensive attention and much heated debate.

Psychogenic theories dealing with etiology and vulnerability abound (Chodoff and Carpenter 1975), but causal connections as distinct from meaningful connections (Jaspers 1963) elude confirmation or disproof. Since assumptions concerning etiology influence treatment attitudes even when no causal link has been established (Soskis 1972), it must be stressed that the question of validity of psychodynamic views of the pathogenesis of schizophrenia is quite different from the issue of effectiveness of psychodynamic therapy. Furthermore, confirmation of biologic factors in the etiology of schizophrenia undermines psychogenic theory and psychotherapy practice only to the extent that psychologic and sociologic factors are hypothesized as incompatible with biologic etiology. The biopsychosocial medical model (Engel 1977, 1980) provides a framework for integrating these seemingly diverse attributes in conceptualizing schizophrenia (Strauss and Carpenter 1981; Carpenter 1983). Viewed in this context, the pharmacotherapy versus psychotherapy polemic of the 1960s loses cogency. Current interest addresses the efficacy of treatments drawn from each domain and from various integrations of the two approaches.

In addition to losing the drugs vs. psychotherapy controversy, psychotherapy advocates have had to weather the storm associated with promulgating the concept of the schizophrenogenic mother. There has also been a general loss of prestige and influence associated with psychoanalysis and psychodynamic psychiatry, and the psychodynamically oriented therapy of schizophrenia is decidedly off center stage, even in the northeastern United States. Increasing public and professional attention to cost effectiveness and reliance on controlled studies to establish efficacy now threaten the
existence of intensive psychotherapy.

Alfred Stanton made very significant contributions to psychiatry during his lifetime. He initiated the psychotherapy of schizophrenia project with the 1960s polemic as a backdrop and with the expectation that one specific form of psychotherapy administered to the right patients by seasoned clinicians for a sufficient period of time would prove superior to a less theoretical, less intensive psychotherapeutic approach. If correct, both the efficacy of psychotherapy and the superiority of a psychoanalytically derived approach would be supported.

Gunderson and colleagues are now completing the psychotherapy of schizophrenia project a decade later against a different backdrop. There is abundant evidence that psychotherapies are effective in many conditions, but little evidence that the therapeutic theory or process determines differential efficacy (Meltzoff and Kornreich 1970; Parloff et al. 1980). As reviewed elsewhere (Heinrichs and Carpenter 1981; Stanton et al. 1984), evidence from controlled and comparative studies regarding the efficacy of traditional psychotherapy with schizophrenic patients is scant and noncompelling; but data are now accruing supporting the role of other interpersonal strategies in achieving such practical goals as stress reduction, enhancement of family coping, and reduction in relapse (Gunderson 1975; Goldstein et al. 1978; Mosher and Keith 1979; Falloon et al. 1982; Keith and Matthews 1982).

The main results of the psychotherapy of schizophrenia project are now reported (Gunderson et al. 1984). Before comments are made about results and implications, a few observations concerning the methodology and conduct of the study are relevant. 1. This study was extremely difficult to conduct. No one undertaking such an ambitious investigation could hope to accomplish the task without adopting compromises, encountering thorny problems with missing data, modifying the idealized treatment processes, and facing the high attrition rate that seems innate to the long-term treatment of schizophrenia. Given the demands of the task, this group of investigators has accomplished the study with impressive skill and perseverance.

2. Description of the work is both candid and informative, allowing the reader a clear sense of design, investigator biases, where and how compromises were made, clinical concepts as they relate to design decisions and data analysis, and so forth. The a priori biases not only favor exploratory, insight-oriented (EIO) over reality-adaptive, supportive (RAS) therapy, but also clinical meaningfulness over psychometric neatness, breadth of assessment over narrowness, a clinician's perspective in data analysis, and evenhandedness over doctrinaire interpretation.

3. Because so many departures from the ideal design were necessary (e.g., substantial attrition, imperfect adherence to the specified psychotherapeutic process), considerable experimental error is introduced into the data. Although this error does not appear biased in favor of one treatment over the other, it tends to undermine the demonstration of differences (type II error).

4. Major hypotheses were postulated in advance. The study design accommodated their testing, and the results are articulated clearly and sensibly. Disappointing (to the investigators) results are dealt with in a forthright manner. Such objectivity has often been difficult to achieve when the investigator is intimately involved with a particular theory or therapy. In this instance, it demonstrates both the feasibility and desirability of applying the methods and principles of clinical science within the context of psychodynamic theory and therapy.

5. Due to attrition, comparative treatment results must be addressed in only a small number of subjects. The report offers extensive documentation that the differential attrition rate between the two treatments does not account for the general lack of difference in results, nor is differential attrition creating type I errors. The analyses also take into account the possible effects of skewing with respect to prognostic and other factors in the two groups. The emphasis on effect size minimizes the likelihood that failure to demonstrate superiority of the EIO treatment is based on inadequate power of the design. It is important to note that often the efficacy of psychotherapy of schizophrenia has been argued from clinical experience involving a few cases from a relatively small number of dedicated workers without controls or attention to selection factors. The fact that the most definitive comparisons of the present study are based on approximately 20 subjects per treatment group limits interpretation, but this cannot be considered a trivial sample size from the vantage point of the psychotherapy of schizophrenia literature.

Comments on the results and implications of this project are as follows:

1. The results do not address the question of psychotherapeutic efficacy. All subjects received psychotherapy, and the results indicate equal effectiveness (or lack thereof) for EIO and RAS. This is the inherent limitation of a design
A credible case for the supposition that both forms of psychotherapy compared in this study operated through similar therapeutic mechanisms can be made. If this is the case, and since the RAS therapy is at least as effective as the EIO therapy, practical implications support the use of the RAS approach, which demands less clinical training, clinician time, and patient involvement.

This study deserves the thoughtful attention of all those concerned with the therapeutics of schizophrenia. It should engender debate, and reasonable clinicians and investigators will have divergent views on future directions. There is a growing consensus that efficacy in psychotherapy is not highly dependent on the theoretical stance of the therapist or the specific nature of the treatment process. As noted above, there is abundant evidence that psychotherapy is effective in a wide range of conditions, and some interpersonal treatment techniques are supported by comparative treatment studies of schizophrenic patients. Future work on the psychotherapy of schizophrenia should emphasize tests of the specificity of those treatment techniques most likely to be widely applied if proved meritorious.

I hope that those professionals most dedicated to the intensive psychotherapy of schizophrenia will integrate this new data rather than reject it on ideologic grounds. This study was formulated and conducted by clinicians whose professional identity is tied to psychoanalysis, psychodynamic psychiatry, and the psychotherapy of schizophrenia. The patients, therapists, and time frame were all consistent with prevailing views of psychotherapy-of-schizophrenia advocates. I see little reason to doubt that patients similar to those receiving EIO in this study are routinely given intensive psychotherapy by clinicians accustomed to providing this type of treatment. Thoughtful criticism rather than censure is needed. Intensive psychotherapy of schizophrenia is an endangered species faced with two grave threats. First, is the growing opinion that it is not a valid treatment with an acceptable benefit-risk profile. Second, is the belief that advocates will continue to disparage negative results while abrogating responsibility for subjecting the treatment to scientific scrutiny (Carpenter and Heinrichs 1980).

While neither this project nor the accumulated evidence can disconfirm the hypothesis that a small subgroup of schizophrenic patients may be uniquely responsive to EIO psychotherapy, it must be recognized that the burden of proof is on those who hold this view. It may well be that significant gains accrue if better patients are selected, more frequent sessions are provided, more years are devoted, more sensitive measures of change are employed, and so forth. Hypotheses involving effectiveness with a unique subgroup remain viable for hemodialysis, zinc treatment, and megavitamin therapy. The enormous effort and cost required to eradicat e all doubt with definitive negative studies would not be a wise deployment of scarce research funds. Hence, the burden must shift to the advocate.

Lastly, this project demonstrates the clinical compatibility of psychotherapy (including EIO) with pharmacotherapy. The time is propitious for the empirical study of integrating divergent treatment techniques. The complexity of such endeavors and the clinical sophistication required to develop suitable methodology are heralded in the present report. Treatment studies need not be reduced to the lowest
References


Gunderson, J.G. "Drugs and Psychosocial Treatment of Schizophrenia Revisited: The Effects of Psychosocial Variables on Outcome of Schizophrenia." Presented at the Fifth International Symposium on Psychotherapy, Oslo, Norway, August 13-17, 1975.


Proposed Art Competition

A group of psychologists at Connecticut Valley Hospital have been discussing the possibility of a state and national art competition among the hospitalized mentally ill—similar in some respects to the High School Arts Competition sponsored by the Congressional Arts Caucus. In most considerations, the mentally ill are seen primarily as needy, and rarely do we hear of positive contributions that they may make. Nevertheless, we feel that they have much to offer in the area of artistic creativity that is unique and of interest to others.

Since 1920 the art of the mentally ill has been recognized in Europe as a significant cultural phenomenon. A museum associated with the Heidelberg Psychiatric Clinic houses a collection of art of the mentally ill gathered by Dr. Hanz Prinzhorn. His book *(Artistry of the Mentally Ill*, Springer-Verlag, New York, 1972, originally published in 1922) remains an outstanding source volume. Some of the work from this museum is scheduled to travel to the U.S. in 1984, to be shown at the Krannert Art Museum in Illinois and other places. The Art Brut collection, Chateau de Beaulieu, Lausanne, Switzerland also contains the work of psychiatric patients, as does a collection of the Swiss Psychiatric Society housed in the Waldau Psychiatric Hospital, Bern, Switzerland.

In this country there is a growing interest in "outsider" art—the art of self-taught artists, and of the mentally handicapped who are outside the mainstream of art. We would like to capitalize on this interest and on the pioneering work done in Europe by throwing national attention on the art of our publicly institutionalized psychiatric patients. We believe this would enhance public interest in the welfare of such patients and add a needed positive note to their image.

Our plans are rudimentary as yet, and depend a good deal on response of those who work with the hospitalized mentally ill. In broad outline, we would like to see each state or regional group of states hold an art contest for its publicly hospitalized psychiatric patients, with the best pieces going into a national exhibition in Washington, D.C.

*Schizophrenia Bulletin* has for many years shown the art of psychiatric patients on its front cover, so its readers are aware of this potent source of expression for patients. The undersigned would welcome hearing from those in public psychiatric hospital work across the country who would like to participate in this project. Please write to let us know whether within your hospital and within your state, an "art of the mentally ill" contest would be feasible. We will share our thinking further with you and work toward consensual, practical guidelines to ensure an interesting successful, and repeatable effort.

Julius Laffal, Ph.D.
Director of Research and Psychological Services
Connecticut Valley Hospital
Middletown, CT 06457

William T. Carpenter, Jr., M.D., is
Director, Maryland Psychiatric Research Center, and Professor of Psychiatry, University of Maryland School of Medicine, Baltimore, MD.