Psychotherapy in Schizophrenia: The End of the Pioneers’ Period

by Christian Müller

Abstract

A position in regard to evaluation of the efficacy of psychotherapy with schizophrenia is presented. It is suggested that personal motivation is essential in this type of treatment.

Readers of these important and commendable articles (Stanton et al. 1984; Gunderson et al. 1984) will react in various ways, depending on their respective starting points on the question of schizophrenia and its origins—and on their own therapeutic ideologies.

One reaction will be that of the psychiatrist who is convinced that schizophrenia originates in a metabolic, genetic, or structural condition that will remain the same throughout the life of the patient. He will rejoice as he announces further evidence to show that there is no difference between an analytic approach that could be characterized as “intensive” (exploratory, insight-oriented therapy; EIO) and another approach farther removed from a psychogenetic hypothesis (reality-adaptive, supportive therapy; RAS). It is inherent in this type of study that every reader hopes to find confirmation of what he believes to be the truth.

A second type of reaction may be that of the “neutral” psychiatrist who has a degree of sympathy with psychodynamic theories, but with some reservations. He is likely to say that this study is valid for any kind of mental disorder so far as different psychotherapeutic methods are concerned: that it has not been demonstrated that the psychoanalytic approach, even in modified form, may produce more positive results than behavioral treatment in the treatment of obsessional neurosis, for example.

The third reaction will be that of the psychoanalyst who is enthusiastically committed to the psychoanalytic approach in treating his schizophrenic patient and who will accordingly defend this position by undertaking to criticize the method used and the results obtained by the authors of this study.

Personally, I belong to the third group. For more than 20 years, stimulated by the work of H. S. Sullivan (1935), F. Fromm-Reichmann (1948), and others, I have been a comrade in arms of such European therapists as M. Séchehaye (1954) and G. Benedetti (1966). It would seem understandable that I should react to the impressive material in this remarkably complete work in the same way I reacted earlier to the studies that the authors cite so extensively, in particular that of Grinspoon, Ewalt, and Shader (1968), with a certain degree of disappointment. It would certainly be natural to admit that one’s narcissism would have preferred to discover final proof of the superiority of the psychoanalytic approach in schizophrenics, as compared to other methods. The result of this study is quite clear: It does not provide such proof. What shall we say then of our revolutionary enthusiasm in the 1950s and 1960s, of all the sacrifices we accepted as we linked our own fate to that of our patients, and went through the hell of violent confrontations on occasion? It would be too easy for us to fall back upon the position originally taken by Freud, and his warning that followed us throughout our careers, when he said that we know the psychodynamic mechanisms at work in schizophrenia.

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but do not have strength enough to move the lever.

To begin with, this is a generalization. When we speak in this way, we are not talking about an individual schizophrenic patient but about schizophrenic patients in general; not about an individual therapist but about therapists in general. I should like to consider these generalizations first, quite apart from any criticism of the authors' statistical method. I have no intention at all of criticizing the methodology, which is the very essence of perfection, but which necessarily has its limits.

I have in mind some examples in which prolonged work with patients whose schizophrenia is running a protracted course has produced completely tangible results, not only in the therapist's subjective assessment but also as measured by objectifiable parameters in the patients—such as integration into sociocultural life, work capacity, sense of well-being, and disappearance of symptoms. How can we reconcile these isolated successes in frequently desperate circumstances with the results so clearly demonstrated in the present study?

An important element that must be introduced into the discussion at this point is that of the indication. It seems to me quite clear that the indication for an intense modified psychoanalytic treatment cannot be based on purely logical and rational criteria. The therapist's decision to undertake such a treatment is one that is difficult to define, and it is made in accordance with motivations that embody numerous elements. Let us consider the following situation: that of a psychoanalytically oriented psychiatrist working in an institution, who is in contact in the course of years with hundreds if not thousands of schizophrenic patients.

He obviously cannot choose any one of them at random with whom to engage in a long therapeutic combat. In only a few special cases will he feel drawn to bring the best of his resources to bear and commit himself to major personal sacrifices.

This occurs at crucial moments when, sooner or later, the therapist arrives at the conclusion that he simply cannot treat his schizophrenic patient in the usual manner, by prescribing drugs, invoking the help of rehabilitation services, or consulting the family, but must instead conclude an unwritten contract with the patient, involving a long-term obligation and binding his own destiny, as I noted before, to that of the patient.

I have strong doubts about the idea that these personal motivations, which one might place in the category of countertransference, are measurable, quantifiable, and therefore objectifiable. As Searles has shown, the patient will assume an important place in the private and professional life of the therapist; there will be mutual identification and instead of speaking of a "systematic treatment," it would be better to speak of it as a common adventure, involving a common destiny.

However, in the study we have been discussing here, this element, the subjective, personal motivation of the therapist in undertaking such a treatment, hardly appears at all. Indeed, it could not appear in such a study, for this would make it necessary to penetrate into the deepest layers of the personality of each potential therapist, to know what one patient, as compared to another, really represents, standing in relief against the background of the personal history of the doctor, the psychiatrist, the analyst. It would be necessary, in theory, to take into account all the problems of the narcissistic equilibrium of the therapist, his position and status in the institution, and his subjective attitude toward the study and its purpose. In brief, I think we are dealing with a multitude of conscious and unconscious factors that simply cannot be dealt with by statistical analysis.

For the conclusion of a valid therapeutic contract between an analytical therapist and a schizophrenic patient, there must be a very great freedom of choice. However, in the context of a systematic study, the research design required for statistical analysis prohibits this freedom. For me, therefore, there is a profound incompatibility between the purpose of such a study and the reality of the relationship between a patient and his doctor.

Having stated this, one must still note that this study is much more nuanced and sensitive than those previously published. One might possibly regret that the authors did not create a third control group, which would have concerned itself primarily with a familial approach based on the theories of ecosystems. In my opinion, this is a new field of therapeutic intervention that deserves our full attention and interest.

References


Grinspoon, L.; Ewalt, J.R.; and Shader, R.I. Psychotherapy and


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**Announcement**

Postgraduate Center for Mental Health. A conference co-sponsored by the Postgraduate Center for Mental Health and the Department of Psychiatry, New York University School of Medicine, will be held on February 9-17, 1984, in Puerto Vallarta, Mexico, at the Plaza Vallarta Hotel. The topic is Differential Therapeutics in Clinical Practice: The Art and Science of Treatment Selection, and principal lecturers are Allen Frances, M.D., Associate Professor of Psychiatry, Cornell University Medical College, and John Clarkin, Ph.D., Director of Psychology, New York Hospital-Westchester Division. The Conference, which offers continuing education credit units, will be moderated by Robert Cancro, M.D., Professor and Chairman, Department of Psychiatry, New York University School of Medicine, and Lewis R. Wolberg, M.D., Emeritus Dean of Postgraduate Center for Mental Health. Registration closes December 10, 1984. Tuition/Registration Fee is $330. For further information contact:

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