Ideology and Science in the Individual Psychotherapy of Schizophrenia

by Gerald L. Klerman

Abstract

The efficacy of individual psychotherapy for acute schizophrenics has been the source of controversy for many decades. Discussion of the scientific issues, such as design, methodology, and assessment, has been clouded by strong ideological conflicts. The relative value of drugs and psychotherapy for schizophrenics has been the subject of tension and dispute between various psychiatric schools—psychoanalytic, interpersonal, biological, and behavioral. The Psychotherapy of Schizophrenia Project is discussed in terms of the mixture of scientific and ideological issues.

Historical Background: The Power of Ideology

This pair of articles (Stanton et al. 1984; Gunderson et al. 1984) is best assessed against the historical perspective of American psychiatry since World War II. As Stanton et al. (1984) point out, during this period, the "era of psychodynamic psychiatry, characterized by psychological observation and psychoanalytic theory, was giving way to the era of biological psychiatry" (p. 520).

Individual psychotherapy of schizophrenia was a major concern of American psychiatry in the two decades immediately following World War II. This approach was developed at Chestnut Lodge in Rockville, Maryland, where, in the late 1940s, a group of brilliant psychoanalysts and social scientists were assembled under the leadership of the hospital's director, Dexter Bullard, M.D. Notable among this group were Frieda Fromm-Reichmann and Harry Stack Sullivan. Frieda Fromm-Reichmann had come from Europe to escape the Nazi persecution. Harry Stack Sullivan lectured at Chestnut Lodge. Interpersonal psychiatry, a new paradigm of psychiatry, was developed, and its main clinical application was the psychoanalytically oriented psychotherapy of schizophrenia.

Orthodox Freudian psychoanalytic theory, in the period between the two World Wars, held that psychoanalysis and, by extension, psychotherapy, were impossible with schizophrenic and other psychotic patients, because they fell into the category of "the narcissistic neuroses," and were incapable of developing transference neurosis, considered the essential component of psychoanalytic treatment.

The therapeutic position taken by psychoanalysis was ironic in view of the impact of psychoanalysis on the origin of the concept of schizophrenia. The modern concept of schizophrenia was developed by Eugen Bleuler (1911) at the Burghölzli Hospital in Zurich, Switzerland, in the first decades of this century. It was at the Burghölzli, under Eugen Bleuler's leadership, that another group of brilliant young psychiatrists gathered before World War I. These included C. Jung (1907), from Switzerland, A.A. Brill (1915) from the United States, and K. Abraham (1927) from Germany. They developed some of the most seminal observations of the psychopathology of schizophrenia. Influenced by Freud's ideas, under Bleuler's leadership, they explored the extent to which the mental productions of the schizophrenic patient could be understood by application of the new psychoanalytic

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method. Although Bleuler later repudiated a psychogenic theory of schizophrenia, in the early 1900s he was strongly influenced by Freud's psychoanalytic theory, particularly the theory of association.

Nevertheless, independent of the influence of early psychoanalysis on the Burghölzli group, by the late 1930s, a number of Freudian psycho-analysts, particularly E. Simmel (1929) and P. Federn (1952), challenged this orthodox view. However, it was not until the emergence of the interpersonal paradigm in the Washington/Baltimore area that a systematic approach to the theory and practice of individual psychotherapy of schizophrenia was formulated.

As the authors point out, this new paradigm had a powerful impact on American psychiatry. The dominant teaching through the 1940s and 1950s was that schizophrenia was due to interpersonal factors, particularly within the family of origin, and that the preferred treatment was intensive individual psychotherapy. The techniques developed at Chestnut Lodge were adopted by many influential psychiatric treatment centers, including McLean Hospital in Belmont, Massachusetts, and the Austen Riggs Center in Stockbridge, Massachusetts. Fromm-Reichmann's (1960) writings on psychotherapy were standard in most residency training programs.

At the same time, new biological treatments were developed: insulin coma therapy in 1936, electroconvulsive therapy in 1940, and the new psychotropic drugs in the early 1950s. The resultant ideological controversies were intense. Acrimony and polemic attended any discussion of the treatment of schizophrenia.

Observers characterized these ideological mechanisms in different ways. Hollingshead and Redlich (1958), in describing psychiatric practice in New Haven, divided the practicing community into D-O (Direct-Organic) and A-P (Analytic-Psychological) groups. Later, Strauss et al. (1964) in Chicago, Sharaf and Levinson (1957) at the Massachusetts, Mental Health Center, and Armor and Klerman (1968) offered evidence for a three-way split in American psychiatry: psychodynamic, biological, and social psychiatric.

However, even with the number of alternative paradigms, the psychodynamic view remained the dominant paradigm, and only since the 1970s has its power diminished.

The Randomized Clinical Trial in Evaluating Psychotherapy of Schizophrenia. One factor leading to the weakening of the psychodynamic and interpersonal paradigms has been the demand for evidence of efficacy of all treatments. In the past, differences in opinion as to the efficacy of treatment were handled either by recourse to authority or by arguments and polemic. However, since the late 1950s, evidence from randomized control trials became increasingly accepted as the standard for the evaluation of all treatments, including psychopharmacology and psychotherapy. Eysenck's (1965) article ushered in a period of intense debates about the nature of evidence for efficacy of psychotherapy, and reports of controlled clinical trials evaluating various forms of psychotherapy began to appear.

The results of the small number of randomized trials of individual psychotherapy of schizophrenia have been the source of intense controversy. They include the studies by P. May (1968) at Camarillo State Hospital in California, the Massachusetts Mental Health Study reported by Grinspoon, Ewalt, and Shader (1972), and the trials by the two midwestern groups, led by Karon (Karon and O'Grady 1969; Karon and VandenBos 1970, 1972, 1981) in Michigan and Rogers (Rogers et al. 1967) in Wisconsin. With the exception of the Karon study, these studies have all reported negative findings. The studies have been criticized for insufficient attention to the nature of the treatment, use of inexperienced therapists, too short a duration of treatment, and lack of sufficiently comprehensive assessment methods.

In an attempt to meet these criticisms, the research group organized by Alfred Stanton, in association with Peter Knapp and John Gunderson in Boston, designed a comprehensive study in the early 1970s. Employing advanced methods of research design, standardized diagnostic assessment, and multidimensional modes of outcomes, they painstakingly designed and conducted a difficult, some might say, "near impossible" study.

Research Design and Methodology

Against this historical and conceptual background, let us now look in detail at the research project reported on in this pair of articles. From the point of view of a research design, it is important to specify what this study is not.

First, it is not a study of the efficacy of psychotherapy against a control group. It is a comparison of two forms of psychotherapy that differ in theoretical focus and intensity of contact between the therapist and the patient. This design precludes the comparison of efficacy of psychotherapy against a "placebo" or no psychotherapy control condition. The authors assume, or do not state directly, that the rehabilitative model of psychotherapy has
been established in the studies by Hogarty, Goldberg, and Schooler (Goldberg et al. 1977; Hogarty, Schooler, and Ulrich 1979). Research designs that compare two active treatments without a placebo or treatment control group are fraught with difficulties. It is a common design when two drugs are compared, particularly a new drug against a standard drug. If there is a failure to detect differences, it could be because the research system is unable to pick up differences, and neither treatment alone offers anything beyond a placebo or control condition. Inasmuch as there were a number of differential effects across the two treatments, it is unlikely that this design feature completely prevents any inferences from being drawn.

Second, this is not a comparison of psychotherapy against medication. All the patients in both treatment groups received medication, and this is a study which attempts to assess whether or not psychotherapy offers anything above standard antipsychotic neuroleptic medication. It is of note that this is the design currently being employed in almost all studies of psychosocial interventions in schizophrenia. The extensive set of studies comparing family therapy based on the English research on expressed emotion (EE) also use this design (Vaughn and Leff 1976, 1981). It is an indication of how far the field has moved since the 1950s that is, that drug therapy is now regarded as a standard treatment. Viewed against the ideological conflicts and disputes of the 1950s, the pharmacology of schizophrenia has triumphed; there are very few, if any, practicing psychiatrists who would attempt to undertake a trial of psychotherapy alone, without medication.

These comments about the nature of the research design are not intended as criticism. The authors adopted the conventional standards of the early 1970s, the period when this study was designed. However, it is important to be aware of the nature of the design, lest inferences beyond the design be made. The authors have not done this, and have been modest in the interpretation of their findings.

Another feature of the project that is noteworthy is the extensive selection of a wide range of outcome variables. Treatment studies since the advent of psychopharmacology have been criticized by psychotherapists as relying almost exclusively on symptom reduction. This criticism was corrected by the investigators of this project, and they developed an extensive and comprehensive battery of assessments that evaluated cognitive functioning, ego activity, social adjustment, and interpersonal relations. Having done so, they were confronted with the need for data reduction and have reported to us their painstaking efforts to use factor analysis for data reduction.

In response to criticism of prior studies, the duration of treatment was extended to 2 years, and the study employed experienced therapists in both treatment groups. Nevertheless, they had a very high attrition rate, such that only about one-third of the patients initially allocated to the two treatment groups completed the projected 2 years of treatment.

Outcomes, Interpretations, and Conclusions

The outcome of this carefully designed study with multiple assessments and extensive statistical analysis is, from one point of view, quite meager. As the authors point out, there were very few differences between the two treatments, and most of the differences favored the standard treatment (RAS) rather than the intensive individual psychotherapy (EIO).

What then is the "bottom line"? The authors are quite hesitant to draw any major conclusions, staying
very close to the statistical analyses. However, this reader and commentator was left with the conclusion that the experiment had failed to affirm the convictions of its designers that psychoanalytically oriented and intensive individual psychotherapy of schizophrenia would have a beneficial effect not only on cognitive functioning and interpersonal relations, but on clinically significant outcomes, such as symptom reduction and social adjustment. The rationale for the focus on cognitive processes and other intrapsychic mechanisms is that they are important process variables which must improve before the patient's symptom picture and social functioning can improve. The results of this study do not indicate any support for that theoretical position. In fact, while there were modest or minimal effects on cognitive functioning and a number of other intrapsychic features, they were not translated into clinically meaningful improvement in symptoms or social functioning. In fact, the RAS group did better on those outcome variables.

One must conclude that the interpersonal paradigm failed to establish evidence in support of its claims that individual psychotherapy is the most effective treatment of schizophrenia. Even in the presence of medication, the treatment failed to achieve any of the goals of its proponents, and performed poorly in comparison to the more pragmatic and less expensive RAS.

This failure of individual psychotherapy should be compared with reports of four recent control trials, which indicate the efficacy of family therapy directed at reducing intrafamilial expressed emotion (EE) against individual therapy. These studies have recently been reviewed by Goldstein (in press) and have formed the basis of a large multicentered collaborative trial, being organized by the NIMH Center for Studies of Schizophrenia and the Pharmacologic and Somatic Treatments Research Branch, with Sam Keith and Nina Schooler as the principal investigators. If I were to serve on a possible advisory committee of NIMH to advise the desirability of a multicenter trial to test this form of psychotherapy for schizophrenic patients, I would conclude that the evidence does not justify any further research on the intensive individual psychotherapy of schizophrenia, either in the acute hospitalization phase or in immediate aftercare.

In evaluating the quality of evidence in a given field, decisions need to be made when further studies are not indicated. We have excellent criteria for the evaluation of individual studies, but we lack criteria to evaluate a body of research. Whatever criteria one uses, whether box score, scholarship, or meta-analysis, the evidence from at least half a dozen studies would indicate that no further research on the intensive individual psychotherapy of schizophrenics based on psychodynamic or interpersonal principles is warranted.

The Role of Alfred Stanton.

Particular tribute should be given to Alfred Stanton, who recently died. Stanton was an early leader of the interpersonal school, having been on the staff of Chestnut Lodge during its period of greatest innovation. With M. Schwartz, he authored the insightful volume *The Mental Hospital*, which became the classic study of interpersonal relations and social structure within the hospital (Stanton and Schwartz 1954). Through intensive observation, they described how changes in the interpersonal patterns between patients and staff, staff disputes, and strains within the social structure had a powerful influence on the patients' psychopathology, including fluctuations in violence, incontinence, withdrawal, and forms of psychotic behavior. Along with the writings of Sullivan (1962) on general theory and Fromm-Reichmann (1960) on psychotherapy, the Stanton and Schwartz volume provided the rationale for intensive milieu therapy and restructuring the patient's social environment.

In the 1950s, Stanton became Psychiatrist-in-Chief at McLean Hospital in Belmont, Massachusetts, and incorporated many of these ideas into the clinical organization of the hospital, especially the therapist/administrative split, and the increasing application of long-term intensive individual psychotherapy for psychotic patients.

K. Popper (1960) has enunciated the doctrine that the central principle of modern science is the falsifiability of its propositions. Stanton, in designing this project, made use of the technique of the randomized trial to "test" his cherished beliefs that individual psychodynamically oriented psychotherapy would have a therapeutic effect on the cognitive functioning, psychopathology, and social functioning of schizophrenic patients.

References


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