

Hidden Secret:

The Successful Psychotherapy of Schizophrenia

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Abridged Version

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Acknowledgment

Without Dr. Otto Allen Will's encouragement, this article would never have been written. Dr. Will was that rarest of rare bird psychiatrists, the prototypic therapist for psychotic adults. Over the course of his lifetime, he successfully treated dozens if not hundreds of seriously ill schizophrenic patients, employing psychotherapy alone without medication. He exemplified everything this article conveys. When I mentioned my interest in writing this paper, Dr. Will replied, "Just write it up!" I remember his words clearly, as if he said them yesterday. Now that it's twenty-five years later, finally—I just wrote it up.

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The Question

It was in 1943 that the renown psychoanalyst, Kurt Eissler, first observed that “a tremendous wealth of psychological knowledge related to the schizophrenic disorders had been accumulated,” and yet “man had not been able to make practical application of his research keep pace with his increasing insight.” No doubt—with an estimated 51 million people currently suffering from schizophrenia worldwide, twenty million of whom remain untreated (source: NIMH)—Dr. Eissler’s observations are as relevant today as they were seventy years ago, if not more so.

Eissler eventually concluded that successful therapy required a more intensive focus upon the treatment instrument itself; which is to say, upon the personality of the clinician.

Since Eissler’s time, highly reputable clinicians have independently identified the therapist’s personality as the single most powerful element of successful psychotherapy with schizophrenic patients. In 1975 two high profile psychiatrists, Drs. John Gunderson and Loren Mosher, conducted an impressive, large scale, clinically relevant research endeavor into the psychotherapy of psychotic adults. Their results:

The personality of the therapist is the single most influential determinant of outcome in the intensive psychotherapy of schizophrenic patients.

Whereas it took the likes of a Dr. Gerald Aronson (1975) to straight-out state,

The nature of the therapist as the therapeutic agent puts technique in the shade. Words treat neurotics. People treat schizophrenics.

Yet it was Dr. Eissler who gave us what is perhaps the clearest, most powerful prescription for effective psychotherapy with psychotic patients. His final conclusion: A successful therapeutic outcome is dependent upon the investigation of one question.

What are the conditions in the psychic apparatus of the psychiatrist which would increase the chance of the successful treatment of schizophrenics?

The Answer

Schwing

Gertrud Schwing was arguably the most effective therapist for schizophrenic patients who ever lived. Highly reputed psychoanalytic theoreticians, Drs. Arthur Burton (1969) and Kurt Eissler (1951) among them, employ the word “saint” to describe her impact upon the psychotic patient. Eissler:

Like a mediaeval saint she [Gertrud Schwing] released the schizophrenics from their straitjackets, and patients who had just been howling immediately quieted down when she turned towards them. There is no doubt that some personalities have the distinguished quality of spreading a richly structured background atmosphere... The effect they have on others always goes beyond what they directly say or do. It concerns a non-analytic problem, namely what is it that in a person is responsible for an effect which is close to fascination in others. (1951, p. 156)

Schwing herself (1940/1954) describes an encounter with one patient:

In another room I found a thirty-nine-year-old woman in an acute attack of mania. Her eyes were glowing, her hair ruffled. Screaming and raging, she twisted and turned constantly. The bed linen was wadded into a pile; the mattress, the gown, and the strait-jacket were covered with menstrual blood. The face was smeared and the lips bitten. The patient's body appeared burned-out, as if consumed by some eerie fire. At first the patient stood for a moment, then with tremendous vigor and strength she began to shake the imprisoning lattice of the bed. She soon stopped this display however, in order to lash the bed with her back. During all this she was ranting and raving, and gripping the mattress between her legs.

After having observed this appalling sight for a moment, I walked toward her. I then opened the lattice and asked the patient what it was that she so very much wanted. Startled, the raging patient peered at me. Her face and attitude expressed surprise, amazement and doubt. Two seconds were sufficient in order to bring about a complete change. “The Holy Mary, the Mother of God has come to me!” she exclaimed. She then began to tell me of her feelings during these moments of change. She remained passive as I proceeded to straighten the bed. I asked her if I might comb her disheveled hair, and she began to sob. (pp. 32-33)

Ms. Schwing believed that only those therapists whose personalities were oriented in the “motherly” direction could reach severely regressed patients (1940/1954). The quality of “motherliness” was influential during the acute phase of the illness, subsequent to which the patient would have to be formally analyzed.

While Ms. Schwing didn't describe her contributory personality characteristics in great detail, she did write about the childhood antecedents of her skills. Her childhood identification with the role of rescuer served to master the turmoil she herself experienced at that time in her life (1940/1954).

From early childhood nothing preoccupied me more, was closer to my heart, or influenced me more decisively, than my interest in illness and death. During my early childhood I spent my school free afternoons and many Sundays in a hospital which was used as a last station for the incurables.

When I was with them I forgot both space and time. I was with the dying, the frightened, those who suffered from severe pain and those who could not die. How could I sit and do geometry assignments or French translations while hourly and by the minute people suffered and died? (pp. 12-13)

Will

Otto Allen Will, Jr., MD (1910 – 1993), the maverick Sullivanian analyst, was the quintessential therapist for schizophrenic adults. Known for his consistently successful treatment outcomes, Dr. Will wrote eighty-five articles on the subject, succeeded Frieda From-Reichmann as Clinical Director of Chestnut Lodge (1954 – 1967) and subsequently became Medical Director of the equally renowned institution, Austen Riggs in Stockbridge Massachusetts (1967 – 1978). More impressive than his external achievements, Will possessed a singular therapeutic style characterized by a *fearlessness* rarely seen among psychotherapists.

Midway into his career, Will was approached by a seriously depressed forty-year old man with a mild psychosis and self-destructive pattern in his relationships with women. Exciting at the beginning, this man's romantic relationships would rapidly deteriorate within a matter of months. Over and over again, he begged Dr. Will to accept him as a patient; eventually, Will obliged him.

Several sessions into treatment, the patient walked into Will's consulting office, sat down and said, "Doc, I fell in love. She's the woman of my dreams; she makes me happy. I finally found my soul mate."

Dr. Will's response: "You can either have the relationship with your new female friend or me—but not both. If you want to continue seeing her, I'm not willing to see you in therapy. You'll have to choose." The patient separated from the woman, chose psychotherapy with Dr. Will and they met five times weekly for years. The treatment was an unequivocal success (personal communication, 1988).

Dr. Will relied upon the bare therapeutic relationship devoid of (what Will considered) distractions; and not only temporary romantic relationships but any and all psychiatric medication as well. An interviewer once asked Will,

Were you ever obliged to use any form of medication with the patients you saw in psychotherapy?

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Epilogue To Follow

Epilogue

Mr. S.R., a thirty-two year old single African American male, was tormented by command auditory hallucinations that ordered him to physically assault whomever he happened to be interacting with. Medication didn't impact the voices. He once bit a man's forefinger off at the base of the knuckle and set a house on fire. Typically, Mr. S.R. would emerge from fugue states, find himself in court and while he knew he wasn't guilty of the charges, to the dismay of his family, would plead guilty because the hallucinations ordered him to.

At one point, he entered a course of five-times-weekly psychotherapy and was treated by the same clinician for years. Predictably, the auditory hallucinations ordered Mr. S.R. to perform violent acts upon his therapist.

When he began therapy, he believed, "If I was on a ship that was sinking and my mother was on the ship and I could only save one person, I'd save my mother. That's how much I love her." By the end of therapy, he talked a fair amount about his legitimate feelings of anger and hatred for both mother and others in his family of origin. His childhood was characterized by, among other types of horrific abuse, daily whippings with a switch, on nearly every body part, almost always until he bled and not for punishment but to either show off to the neighbors or as family play.

This writer knows a fair amount about Mr. S.R. I was his therapist.

At the conclusion of treatment, the patient no longer required medication, the violence ceased, he no longer experienced fugue states and was able to engage in healthy relationships; but most importantly, Mr. S.R. was free of auditory hallucinations and all other symptoms of psychosis.

It's no secret that both psychological and economic forces in the culture run counter to intensive psychotherapy with both schizophrenic and seriously troubled adults, generally; and yet, a small group of clinicians relentlessly devote their very lives to this endeavor, this writer included. Simplistically, there are three requirements for treatment: (1) the setting, usually a private practice office unless the patient needs hospitalization; (2) a motivated, seriously ill patient with the requisite intellect and (3) a clinician with the personality characteristics described throughout this work.