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The Psychotherapy of Schizophrenia: A Review of the Evidence for Psychodynamic and Nonpsychodynamic Treatments

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ABSTRACT

Following the discovery of chlorpromazine's effectiveness as a treatment for schizophrenia in the 1950s, a gradual shift away from psychotherapeutic and toward biological methods of investigation has ensued. Nevertheless, psychological approaches to schizophrenia have a long history and continue to represent an important component of schizophrenia treatment. In the past 2 decades, there has been renewed interest in psychotherapy for schizophrenia among some clinicians and researchers. This article examines the current evidence for both psychodynamic and nonpsychodynamic (cognitive-behavioral, cognitive enhancement, and psychoeducational) therapies for schizophrenic illness. There is evidence to support the use of both types of therapies though these orientations generally differ in their views on the role of psychological factors in the etiology of schizophrenia. It is argued that a pluralistic or biopsychosocial model of schizophrenia is necessary to account for the complexity of the disease and to provide the most effective treatment.

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INTRODUCTION

Nearly 70 years after the discovery of the first neuroleptic drugs, schizophrenia continues to cause widespread burden and disability. Even with good pharmacological treatment, many patients continue to suffer and remain symptomatic throughout the duration of their lives. While research in neuroscience has yielded exciting information regarding the physiological aspects of the disease, these findings have not translated to improvements in treatment.[1] Indeed, the most effective medications for schizophrenia today are those discovered over a half-century ago.[2] Given this state of affairs, it seems wise to review the role of psychotherapy, psychiatry's other core treatment, in the management of schizophrenic disease.

The psychotherapy of schizophrenia has a long history that predates the discovery of neuroleptics and electroconvulsive therapy for several decades. Freud believed that the schizophrenic was inaccessible to psychoanalysis but maintained that later modifications to psychoanalytic technique might render the patient treatable in psychotherapy. The psychiatrist Adolf Meyer, the first psychiatrist-in-chief at Johns Hopkins Hospital, developed a psychological theory of schizophrenia in the early 1900s. In the mid-20th century, a number of psychoanalysts, including, most notably, Harry Stack Sullivan, Silvano Arieti, and Harold Searles, studied schizophrenia from the psychodynamic perspective. Perhaps the most comprehensive text on the psychotherapy of schizophrenia *Interpretation of Schizophrenia* was published by Arieti[3] in 1974 and won the U.S. National Book Award in the Science category the following year. More recently, scholars from different psychotherapeutic modalities, such as cognitive behavioral therapy (CBT), have made their own contributions to the literature on schizophrenia, as the psychoanalytic tradition lives on.

This article seeks to provide a brief overview of several psychotherapies for schizophrenia (CBT, cognitive enhancement therapy (CET), psychoeducation, and psychodynamic psychotherapy) and review their evidence base. It is meant to inform the practicing clinician of the various therapeutic modalities to help select and guide treatment for the schizophrenia patient. It is not intended as an exhaustive review of any one of these psychotherapies; for this material, readers are directed to the authors cited in each section of this paper. Compared to other reviews of this topic, this paper seeks to adopt

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a more historically informed perspective, particularly on psychodynamic treatments for schizophrenia.

Nonpsychodynamic Therapies

Cognitive behavioral therapy was pioneered by Beck who in the early 1960s developed his cognitive therapy for the brief treatment of depression. Interestingly, Beck himself considered CBT to be a neo-Freudian therapy in the ego psychology school[4] though few modern CBT practitioners consider it as such. Since that time, CBT has been applied to a variety of psychiatric disorders, and much of Beck's later work examined its role in the treatment of schizophrenia.[5] Early applications of CBT to schizophrenia focused mainly on the negative symptoms and emphasized behavioral strategies to improve social and independent-living skills, improve medication adherence, and provide other tools to solve day-to-day life challenges.[6]

The positive symptoms of schizophrenia were initially not targeted by CBT interventions on the assumption that they are phenomenologically different from ordinary mental experiences and thus not amenable to the cognitive reframing strategies utilized in nonpsychotic illnesses. However, more recent modifications to CBT have opened the door to the use of these techniques for delusions and hallucinations, which are now conceptualized by CBT therapists as either intrusive thoughts—similar to those experienced in obsessive-compulsive disorder—or as misperceptions of reality.[6] This normalization of psychotic symptoms is said to help patients avoid negative thought loops and reframe problematic behaviors (such as social withdrawal) as compulsions based on a misinterpretation of outer threats. In 2021, the Beck Institute in Pennsylvania hosted its first-ever CBT for Schizophrenia workshop.[7] Other adaptations of CBT for schizophrenia have been advanced by researchers in the United Kingdom.[8]

What is the evidence for CBT in schizophrenia? A 2001 meta-analysis of 7 controlled studies of cognitive treatment for chronic schizophrenia found a large mean effect size for the decrease in psychotic symptoms from pre- to posttreatment (0.65).[9] In the subset of 4 studies that followed patients for more than 6 months posttreatment, the mean effect size was even larger (0.93). It should be noted that in this study, cognitive treatments were defined as those targeting belief symptoms rather than information-processing abilities or behavior. A more recent British meta-analysis of 36 randomized controlled studies of cognitive behavioral therapy for psychosis (CBTp) concluded that while CBTp has a small therapeutic effect on functioning at the end-of-trial, it is not significant at follow-up. Furthermore, the authors noted that while CBTp produced a small benefit on distress, this was likely due to publication bias and became nonsignificant when adjusted.[10] Another review of 16 published articles including 12 randomized controlled trials found beneficial effects of CBT for both positive and general symptoms of medication-resistant psychosis, a finding that was also observed at follow-up.[11] A recent review of CBT for psychosis concluded that CBT can prevent the first episode of psychosis in ultra-high-risk patients and is effective in improving depression, self-esteem, and psychological well-being. Its use was associated with positive changes in thinking and mood, and sleep quality leading to improved everyday life.[12] Patients who underwent CBT had fewer hospitalizations with a higher number of voluntary hospitalizations as compared to patients with usual care, who underwent a higher number of involuntary hospitalizations.[12] Still, publication bias may account for some or all of these findings.

Given this mixed evidence for its effectiveness, CBT's broad application for schizophrenia remains questionable. Substantial controversy has developed, particularly in the United Kingdom, surrounding its use.[13] It is noteworthy, however, that roughly 25%-50% of schizophrenia patients suffer from depression,[14,15] and the suicide risk in schizophrenia is high. The evidence for the use of CBT to treat depression is robust[16] and thus CBT may have utility in those schizophrenia patients with comorbid depressive illness. As with any psychotherapy, appropriate patient selection is paramount, and some schizophrenia patients may do quite well in CBT treatment.

In the mid-1990s, Gerard Hogarty, a social worker and professor of psychiatry at the University of Pittsburgh, developed personal therapy (PT) for schizophrenia, which combined psychoeducation with behavior therapy.[17] A few years later, Hogarty and Flesher[18] revised PT and developed a new treatment, CET, which aims to help schizophrenia patients improve subtle cognitive skills required for socialization. Whereas earlier therapies, including PT, utilize rote instruction to help prepare patients for social engagement, CET attempts to promote spontaneity and flexibility through structured but unrehearsed activities.[6] Cognitive enhancement therapy uses both computer-based exercises and group therapies. Computer-based exercises focus on improving cognitive skills, and group exercises seek to improve problem-solving skills and the ability to relate to others. The typical course of CET is 18 months.

MAIN POINTS

- Psychotherapy, often in conjunction with pharmacological therapy, represents an effective treatment for schizophrenia.
- Biological and psychological theories of schizophrenia are complementary, not antagonistic, approaches to the disease.
- There is evidence to support the use of both psychodynamic and nonpsychodynamic therapies for schizophrenia, though nonpsychodynamic treatments may be limited in their ability to address potentially underlying etiological factors.
- A pluralistic or biopsychosocial approach to schizophrenia is necessary to account for the complexity of the disease and to provide most effective treatment.

A recent multisite randomized controlled trial of 102 patients with early schizophrenia found that CET improves both overall cognition and attention/vigilance in these patients, though CET did not outperform the control group, which received enriched supportive psychotherapy (EST), in social adjustment, as both the CET and supportive therapy groups had considerable improvements in this domain.[19] Patients were assessed at both 9 and 18 months, and the benefits of CET appeared to increase with treatment retention. A study of 58 patients with early-course schizophrenia (mean disease duration of about 3 years) comparing CET to EST found differential effects in favor of CET at 2 years in social cognition, cognitive style, and functional indications such as competitive employment, social functioning, global adjustment, and negative symptoms.[20] These effects were broadly maintained at 1-year posttreatment.[21] A 2022 analysis of 86 outpatients with early schizophrenia found that in addition to improving cognition, CET also significantly improves functional capacity as measured by the Brief UCSD Performance-Based Skills Assessment.[22] This suggests that CET's effect on schizophrenia translates to real-world improvements in patients' basic living skills.

Given these findings, CET appears to present a promising form of cognitive remediation for patients in the early stages of schizophrenic illness. Its adoption outside of university settings, however, has been limited. Much of the research on CET is conducted by a relatively small group of researchers at the University of Pittsburgh and a few other universities. As Brus et al[6] point out, most of the studies on CET have included patients with schizoaffective disorder in addition to schizophrenia, and they have excluded patients with comorbid substance use disorders and those who are medication nonadherent. Thus, CET's broader utility in schizophrenia has not been fully studied. Additionally, CET does not target the positive symptoms of schizophrenia, which for certain patients (such as those with paranoid-type schizophrenia) comprise the most disabling feature of the disease.

Psychoeducation reflects another intervention for schizophrenia which has been considered a form of psychotherapy. The term was introduced in 1980 by the American researcher C.M. Anderson, also at the University of Pittsburgh, in the context of the treatment of schizophrenia. Generally, psychoeducation seeks to increase patients' knowledge and understanding of their illness and its treatment. It is also frequently provided to the patient's family members or caregivers. In the course of psychoeducation, schizophrenia patients are taught, for instance, that antipsychotic medication forms an integral part of treatment and can prevent relapse of symptoms. A large review of 5142 participants with schizophrenia (mostly psychiatric inpatients) concluded that psychoeducation significantly reduces relapse, readmission, and length of hospital stay, in addition to promoting medication compliance.[23] Evidence also suggests that participants receiving psychoeducation are more likely to be satisfied with mental health services and have improved quality of life.[23] Another recent study found that psychoeducation resulted in consistent improvement in psychotic symptoms as well as treatment adherence in patients treated pharmacologically with long-acting, second-generation antipsychotics.[24] In this study, patients given psychoeducation also evidenced improvements in several metabolic and physiological measures, indicating that psychoeducation can help reduce severity of medication side effects and provide benefits beyond a reduction in psychiatric symptomatology.

Other nonpsychodynamic therapies for schizophrenia include family therapy, humanistic and existential psychotherapy, vocational rehabilitation, social skills training, metacognitive training, and social cognition therapy, and among others. While this article does not review these forms of treatment, their exclusion here should not necessarily be interpreted as implying a lack of efficacy or the unimportance of these treatments.

Nonpsychodynamic therapies like CBT, CET, and psychoeducation may each play a role in the management of schizophrenia patients, yet they are treatments designed to target only the symptoms of the disorder; there is little evidence to suggest that any of these treatments deal with the psychological factors which serve to engender the disorder from a biopsychosocial perspective. Thus, nonpsychodynamic therapies may be limited in their ability to address underlying etiological factors which play a role in the development of the disease.

Psychodynamic Therapy

The history of psychodynamic treatment of schizophrenia is over 100 years old.[25] Freud was originally pessimistic about the possibility of treating schizophrenia (then called "dementia praecox") with psychoanalysis as he believed the patient was incapable of developing a transference. In time, Freud modified his views and insisted that the schizophrenia patient required a more active and confrontational method than utilized in classical psychoanalysis. Early pioneers in psychoanalytic work with schizophrenia patients include Paul Federn, Karl Abraham, Poul Bjerre, Alfred Alder, Adolf Meyer, and among others. In these first few decades, the psychoanalytic treatment of schizophrenia was met with uncritical acceptance. We must remember, however, that many of the patients treated by these analysts came from well-to-do social classes and were thus able to afford such intensive treatment. They were also likely more ambulatory than the average schizophrenia patient.[25]

The mid-20th century saw great excitement in the possibility of psychoanalysis to prevent and cure schizophrenia. The first director of the U.S. National Institute of Mental Health (NIMH), practicing psychoanalyst Robert Felix,

explicitly forbade government expenditures on biological investigation, insisting that advances in psychoanalysis would soon solve the problem of schizophrenia and, in fact, all mental diseases.[26] Psychoanalytic hospitals, such as Chestnut Lodge and the Menninger Clinic, opened as centers for the psychoanalytic treatment of schizophrenia. Leaders in this area during the 1940s and 1950s included Frieda Fromm-Reichmann, Melanie Klein, and Harry Stack Sullivan. It was perhaps Sullivan who was the most influential of these theorists in the mid-century, his ideas laying the groundwork for much of the later developments in the psychotherapy of schizophrenia and in psychoanalysis more generally (such as the so-called "relational turn"). His 1962 book *Schizophrenia as a Human Process* provided a primarily psychological, as opposed to biological, conception of the root causes of schizophrenia.[27]

In the following few decades, 2 analysts stand out as the preeminent figures in the psychotherapy of schizophrenia: Silvano Arieti and Harold Searles. Searles is noted for his emphasis on countertransference in work with these patients. Arieti, whose clinical approach emphasized emotional warmth and basic trust, provided a psychologically informed, pluralistic approach to the disorder, his work serving as a precursor to the field's later adoption of Engel's biopsychosocial model.[28]

A thorough review of the psychodynamic approach to schizophrenia is outside the scope of this paper, and theories within psychoanalysis are vast and sometimes contradictory when it comes to work with these patients. In fact, there is no single "psychodynamic therapy" for schizophrenia but perhaps dozens or even hundreds. Still, psychodynamic approaches to schizophrenic illness tend to share some common features. These include a focus on the early environment of the patient, in particular, the causative role of anxiety; the meaning and symbolism of psychotic symptoms; an emphasis on the relationship between patient and therapist, including transference and countertranference reactions; the etiological role of the psychological factors (as opposed to the view that psychological dysfunction is merely *caused by* the disorder; see section on the pluralistic approach below); and a long-term (or longer-term) approach to psychotherapy.

Central to the psychodynamic perspective is the belief that in the mental world, as in the physical world, events are determined by the events which precede them; nothing in the psychological realm can be said to happen by chance. This is true even for those mental experiences that seem so foreign to most of us: psychotic symptoms. Despite the often bizarre and illogical nature of these symptoms, a careful psychodynamic investigation can reveal their idiosyncratic meaning and function.

I will share a few brief examples to illustrate a psychodynamic interpretation of schizophrenia.

In paranoid-type schizophrenia, the patient is engrossed in a delusional theme which places them at the center of some dreaded situation or plot. Frequently, the patient experiences auditory hallucinations which align with the delusional ideas; they hear others speaking negatively or critically about them. In these cases, the patient *projects* to the external world his hostile feelings toward himself; no longer does the patient accuse himself, now the accusations come from others.

The patient who experiences olfactory hallucinations of a foul odor emanating from his body has concretized his unconscious belief that he is a bad or rotten person; as unpleasant as it is to smell awful, it is much more tolerable than to believe that one *is* awful.

A man who believes that others are controlling his thoughts experiences a reactivation and concretization of the way he once felt that his parents were controlling or trying to direct his life and way of thinking.

In cases of catatonic schizophrenia, the patient may assume a statuesque position for long periods of time. Overwhelmed by the intense anxiety which accompanies responsibility, the patient becomes "frozen in time," shielded from the potential destructiveness of his own actions.

In each of the above examples, the schizophrenic symptoms are interpreted as defense mechanisms that serve a psychological function for the individual, namely, to alleviate an unbearable anxiety rooted in intense self-criticism. Nevertheless, the symptoms eventually come at a much greater cost to the patient than whatever benefit is had, and it is for this reason that they are pathological.

What is the evidence for the psychodynamic treatment of schizophrenia? The literature is filled with anecdotes and case reports highlighting successful treatment of individual patients. Perhaps the best-known example of such writing is the semi-autobiographical novel of one of Fromm-Reichmann's patients, the 1964 bestseller *I Never Promised You a Rose Garden*.[29] One of my own patients, a young man with paranoid-type schizophrenia whom I have been treating for 5 years, wrote the following about our psychodynamically oriented psychotherapy:

> The work didn't click for me until years in. Every psychotic experience was always preceded by a split second shift in my emotional state. Over time, I was able to feel this window open up … and my experiences slowly dissipated. I still experience psychotic symptoms but at a much less frequent rate. Every session a new layer of what has happened to me is unraveled through therapy. Almost every time a link has been discovered, I subsequently experience less symptoms.

These types of case reports notwithstanding, there exists a dearth of high-quality, modern research on the psychodynamic psychotherapy of schizophrenia. There are

likely several reasons for this, and one does not have to be too cynical to recognize them. Certainly, the advent of the neuroleptic medications ushered in a new era in psychiatry, and the influence of the insurance industry led to a prioritization of manualized, short-term therapies and more symptom-focused approaches to treatment. As the old saying goes, "He who pays the piper picks the tune." Additionally, most psychoanalysts work with schizophrenia patients in private practice settings and do not hold full-time faculty positions at universities where they conduct research on psychotherapy. In fact, as Shedler[30] has repeatedly pointed out, the researchers who study psychotherapy tend to know the least about psychotherapy as a clinical discipline; many of them have not seen a patient in treatment for decades. Yet, psychoanalysis as a discipline shares the blame in all of this too. For decades, psychoanalysis was an insular community that was disinterested in demonstrating the efficacy of its treatments via contemporary research. (Analysis is by its very nature an intensely private endeavor that is ill-suited for modern research designs.) And it is true that the efficacy of psychoanalytic treatments for schizophrenia was likely exaggerated by most mid-century analysts, who refused to consider the influence of biological and genetic factors and the effectiveness of antipsychotic drugs.

The largest study of psychotherapy for schizophrenia to date was the Boston Psychotherapy Study, conducted in the 1980s.[31] Done at a time when the influence of biological therapies was growing, the study compared exploratory, insight-oriented psychotherapy (EIO), which employed psychodynamic techniques, with reality-adaptive supportive psychotherapy (RAS), which focused on here-and-now problem-solving. It was conducted at 3 sites and involved 95 patients and 81 experienced psychotherapists, with a 2-year follow-up, albeit with a significant dropout rate. The main finding was that while patients improved with psychotherapy, there was no difference between therapy groups on most measures. Consistent with the primary focus of each therapy, RAS showed an advantage in reducing hospital readmissions, improving work-role performance, and maintaining household responsibilities, while EIO showed an advantage in improved ego functioning and cognition. A subsequent analysis revealed a significant relationship between the therapist's skillful dynamic exploration and better outcomes. As Garrett writes, "An enormous amount of thought, time, and resources went into this study, an effort not soon to be repeated in the current climate of research funding which favors neuroscience."[32]

So, where does that leave psychodynamic psychotherapy for schizophrenia? After treating hundreds of schizophrenia patients with year-long psychodynamic treatment, it is my view that such therapy is at least as important as biological therapies in the management of the disease and that psychodynamic treatments address certain core psychotic problems that cannot be addressed by either pharmacotherapy or nonpsychodynamic forms of therapy. Undoubtedly, further empirical research is needed to confirm these observations, and some patients are simply not suitable for psychodynamic treatment (such as those who have failed previous psychodynamic treatments and those in the latter stages of the disease). Yet, this belief in the fundamental role of psychodynamic therapies is shared by many analysts and analytic therapists who have worked with schizophrenics in the past half-century. As the expert pharmacologist and ethicist Louis Lasagna noted in 1975, most of our knowledge about the disease and its treatment comes "not from controlled trials, but from natural observations by smart physicians using their past knowledge and experience as control."[33] Certainly the same is true for psychotherapy.

Although psychodynamic therapy for schizophrenia has been an understudied subject, empirical support for many of the concepts central to psychodynamic work with schizophrenia has been established in the past 2 decades. This includes confirmation of the importance of early attachment in the later development of psychotic disorder;[34,35] the meaning of psychotic symptoms and their relationship to adverse environmental experiences;[36,37] and the relationship between biology and psychology in individual susceptibility to schizophrenia.[38] Thus, there exists evidence in addition to clinician and patient experience to support the use of psychodynamic interventions in schizophrenia.

A Pluralistic Approach to Schizophrenia

Since the early 1980s, the predominant theoretical model in academic American psychiatry has been Engel's biopsychosocial model, which considers biological, psychological, and social factors in the etiology of mental disorder. This was predated by Adolf Meyer's *psychobiology* in the early 20th century and, as noted above, Arieti's pluralistic approach in the mid-to-late 20th century. Nevertheless, much of the research and scholarly activity on schizophrenia over the course of the past 40 years has been strictly biological in nature. Modern textbooks on schizophrenia may only include short passages on psychosocial approaches which are usually limited to brief, manualized therapies, and psychosocial rehabilitation. Discussions of the psychological aspects of schizophrenia often consider these problems as consequences rather than as causes of the disease. Thus, much of the modern psychiatric literature on schizophrenia lacks the pluralism that is found in writings from the past century.

For instance, in the second edition of their now-classic textbook *Perspectives of Psychiatry,* McHugh and Slavney[39] write, "Schizophrenic symptoms are psychological events without explanation, and *without* is the operant word" [emphasis in original].[39] They add that these symptoms are "mental phenomena in which no glimmer of psychological cause and effect can be perceived."[39] The authors write

as if they are unaware of the long and enduring history of psychologically informed approaches to schizophrenia though this is a gratuitous assumption. In many circles in the 1990s, schizophrenia was declared a brain disease *by fiat*, not because psychological or psychodynamic theories were proven false.

In his 1956 paper "The Possibility of Psychosomatic Involvement of the Central Nervous System in Schizophrenia," Arieti[40] describes a nuanced biopsychosocial theory of the etiology of the disease:

> The impact of the psychological conflicts is too much to bear for a part of the central nervous system which is already genetically vulnerable. At times it may be too much to bear even if such hereditary predisposition does not exist. On the other hand, the hereditary vulnerability alone, without the psychogenetic factors, would not be enough to engender the disorder.

Here we see the view that the psychological factors are etiological ones and that schizophrenia is caused by a complex interplay between biology and the environment and not solely by neurobiological mechanisms. It is this perspective upon which most psychodynamic therapies for schizophrenia are based, whereas some nonpsychodynamic therapies either reject such etiological theories or remain neutral on the matter of cause.

While it is certainly true that psychotherapy alone cannot cure schizophrenia, it is equally true that for many patients, psychotherapy is the key to finding meaning, reclaiming a sense of personal satisfaction, and improving the patient's general life situation. Writing beautifully in 1974, Arieti[41] describes the goal of psychotherapy for schizophrenia:

> To summarize, with many patients who receive intensive and prolonged psychotherapy we reach levels of integration and self-fulfillment that are far superior to those prevailing before the patient became psychotic. As I have said elsewhere, this does not mean that all the troubles of the patient will be over, even after successful psychotherapy. We must repeat once again the famous words of Frieda Fromm-Reichmann that we cannot promise a rose garden. It would be utopian to believe that the promise of life is a life comparable to a rose garden, utopian for the patient and utopian for us, who want to be his peers. But I think it is not utopian to promise to the patient what we promise to ourselves, his peers, sooner or later in life: to have our own little garden.

As clinicians and researchers, we must remain open to exploring all vistas when it comes to schizophrenia and work toward bridging equally plausible theories from both the biological and psychosocial perspectives. At times this may mean revisiting the work of those theorists who came before us. They were, after all, seeing the same types of patients with the same kinds of illnesses, often in work conditions much better suited for a thorough psychological investigation of the patient's mind and its workings. In the end, no reductionism but rather informed pluralism must prevail in the understanding and treatment of this severe disease.

CONCLUSION

Despite increased interest in the genetic and biological studies of schizophrenia in recent decades, psychotherapy continues to play an important role in the treatment of this major psychosis. Schizophrenia is a complex illness that is best conceptualized utilizing a pluralistic or biopsychosocial framework. In any given case, biological, psychological, and social forces are at interplay and thus a comprehensive approach to treatment is needed to produce the best result. While antipsychotic medications are effective in reducing the positive symptoms of schizophrenia, treatment response is often incomplete and many patients continue to suffer indefinitely. These medications also often carry significant side effects. The psychotherapeutic approach, which is best considered as a complement to pharmacotherapy, has a long history for schizophrenia, beginning with the psychoanalysts in the early 20th century. Since then, advancements in psychoanalytic thinking as well as contributions by authors from other theoretical orientations have broadened our understanding of the disorder. There is evidence to support the use of both psychodynamic and nonpsychodynamic therapies in the treatment of schizophrenia, though these approaches generally conflict in their views on the role of psychological factors in the etiology of the disease. While there is a dearth of randomized controlled data on the use of psychodynamic approaches, there exists a world literature spanning many decades supporting their effectiveness in schizophrenia.

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