

Traditionally, double-blind RCTs have been used in testing the efficacy of drugs, and in this situation they are clearly the most adequate. Also in other cases, where the treatment in question can be reduced to a circumscribed and well-defined action (e.g. the cognitive-behavioural therapy with 10 sessions in a major depressive episode), the RCT is a feasible design to test the efficacy. The problem is, however, that the treatment of schizophrenia in everyday practice cannot be pressed into a circumscribed and well-defined package.

An alternative approach to assess psychotherapeutically orientated treatment of patients with schizophrenic psychoses can be brought, for example, from the more than 30-year action research, conducted in the Department of Psychiatry of the University of Turku, Finland by Prof Yrjö O. Alanen and his co-workers [4]. The result of this research is the so-called Finnish Integrated Model for Early Treatment of Schizophrenia and Related Psychoses [3]. The overall goal of this model has been to develop a treatment for new schizophrenic patients that is predominantly psychotherapeutic, family centred and comprehensive, with a psychodynamic and systemic basic orientation. One of the central premises of the model has been the fact that schizophrenia is a very heterogeneous entity. This also leads to a diversity of therapeutic challenges. They should be met flexibly and individually in each case, on the basis of both an individual and interactional interpretation of the situation, and of the consequent definition of the therapeutic needs. This need-specific or need-adapted treatment approach has been described intensively elsewhere [4,6].

A different approach has also been chosen in assessing the efficacy of this model. It has been done by several follow-up studies of incidence cohorts of consecutive first-time patients in the schizophrenia group from 1960s up to 1990s in the catchment area of Turku [5]. Because of the priority of the development goals, RCTs were not applied in these prospective follow-up studies. It was felt that the main principle of the model, adaptation of the treatment to the patients' and their network's needs, made use of randomized patient groups impractical. Instead, the strategy chosen allowed comparison of the outcomes in different stages of the development of the model. These comparisons show a continuously increasing improvement of the outcome. For example, in the cohorts from the 1980s and 1990s no psychotic symptoms were present at the 5-year follow-up after admission in more than 60% of the patients. This figure is in clear contrast with the corresponding figure from the 1970s (about 40%), and it is also satisfactory when compared to other first-episode follow-up studies.

My main conclusion is that we should not forget the manifold needs of the schizophrenic patients in seeking for the most effective treatment. Most importantly, psychosocial measures should always be included in the comprehensive treatment regimen of these patients.

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To Integrate the Psychotherapy of Schizophrenia into the Activities of the Multidisciplinary Team, and to Base it on the Principles of Evolutionary Biology

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In their comprehensive and scholarly review of the application of psychotherapy to schizophrenia, Birchwood and Spencer have revealed two outstanding achievements of recent years. First, they show that psychotherapeutic techniques are able to modify the course of a schizophrenic illness, albeit to a moderate extent; and, secondly, they provide detailed evidence that these improvements have been confirmed in well-conducted, randomized controlled trials. In view of the nature of schizophrenia, and of the extreme difficulty in mounting a controlled trial of any psychiatric treatment, these results are a tribute to the ingenuity and perseverance of a generation of clinicians and researchers.

In the brief space allocated to me, I should like to make only two points. The first is that the psychotherapy of schizophrenia should be integrated into the activities of the multidisciplinary team, rather than carried out in a separate psychotherapy department. Much important psychotherapy is carried out in the daily work of psychiatrists, community nurses, social workers, occupational therapists, art therapists and others who regularly come into contact with patients. It is virtually impossible to evaluate the effect of this "everyday psychotherapy", let alone subject it to randomized

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trials; but common sense would suggest that it is responsible for the fact that most schizophrenic patients live reasonable lives and do not end up in prison, or sleeping rough, or committing suicide. If it is possible to have a clinical psychologist in the multidisciplinary team, so much the better, for he or she can act as a catalyst to orientate the team to new approaches; but even lacking such a specialist, the team can profit from some of the literature now available [1].

A current trend in psychotherapy is for integration, both the integration of different theoretical models [2], and the integration of different disciplines within the therapeutic team [3]. In the case of schizophrenia, even more than in other conditions, it is important to avoid the splitting that may be introduced when the main management of the patient is by a multidisciplinary team, but the patient is sent off for "psychotherapy" to a specialized department. All mental health professionals dealing with schizophrenic patients should feel comfortable with family interventions and with cognitive behavioural therapy, and most importantly, they should all regard themselves as psychotherapists.

My second point is that in planning the psychotherapy of schizophrenia, we should be prepared to go back to the drawing board and rethink psychotherapy from basic premises; there is no reason why techniques developed for the treatment of depression, anxiety and personality disorders should be applicable to schizophrenia. We should start by trying to conceptualize the biological function of the schizophrenic diathesis [4, 5].

One can discern in schizophrenia and the schizotypal personality a "dispersal phenotype"; that is, an evolved strategy which in the past has served to disperse the organism around the full range of its potential habitat. In the schizophrenic process, we can discern a vector influencing the individual to leave the natal group (into which he or she has been born and indoctrinated) and to disperse into uncharted terrain. Both attractive and repulsive forces promote this vector. On the one hand, the patient is drawn to some destination which is often conceptualized as a "promised land", and goes there under the influence of Messianic delusion, hopefully with a following of disciples to take care of the more practical aspects of life and performing much the same function as psychiatric nurses. On the other hand, the patient is driven from the natal area by paranoid delusions of persecution, often accompanied by hostile voices. The end result is a new community, with a new world view, incompatible with the natal group. Unfortunately, the process often goes astray, and the patients end up, not in a promised land, but in a shop doorway or a psychiatric ward. Or there may be a more benign outcome, and they may remain in the natal group as shamans, mystics and holy men [6].

In dealing with the schizophrenic patient, we encounter within a social group phenomena which are characteristic of relations between groups: languages do not coincide, and arguments are made from different premises. For this reason, too, it is important that psychotherapy should be the responsibility of the team rather than an individual, both for the sake of the patient, so that the team can decide how, and how much, the patient can be encouraged to rejoin the main stream of society, and for the sake of the therapist, so that professional identity can be firmly based in team membership. We are on the threshold of a psychotherapy which is firmly rooted in the principles of evolutionary biology: a truly biological psychotherapy [7].

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Psychotherapy for Schizophrenia: An Important Addition to Medication Alone?

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Many researchers and clinicians regard the recent introduction of atypical antipsychotics as the most important advance in the treatment of schizophrenia. However, atypical antipsychotics are not appropriate or effective for all people with schizophrenia and, crucially, rates of medication

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