A. CONCLUDING COMMENTS

Joseph Zubin, Ph.D.

Despite vast differences in the geographical origin of our panelists, ranging from London to Zurich, Boston to Rochester and New York, the degree of disagreement is rather meager and the degree of consensus rather remarkable. We all agree on the following:

1. First, schizophrenia today is much less disabling than in the first half of this century.
2. The course of the disorder, even when little or no therapeutic or custodial intervention takes place, is rather varied.
3. The assumption that psychosocial therapeutic approaches are of limited value is no longer tenable.
4. Close relationships with family or important others in itself is not disabling to the schizophrenic, but close involvement with hostile environments is.
5. Social impoverishment leads to clinical impoverishment, whereas social enrichment leads to clinical improvement.
6. The vulnerability concept is regarded as useful by all participants.

There is no consensus on the following: 1) acceptance of the concept of a “natural history” of schizophrenia; 2) the expected proportions of recovered, improved, and chronically ill; 3) the degree of heterogeneity-homogeneity in outcome; and 4) the role of triggering events in onset of an episode.

How did the panel deal with role of type of onset (sudden or insidious) and type of outcome in relation to good versus poor premorbid patients? Is it possible to find some integrating principle that could contain the various consensual agreements that were reached? Without wishing to foist another paper onto the session, I would like to suggest that the concept of vulnerability is a good candidate for integrating the agreements and disagreements. If we assume that the permanent characteristic of the schizophrenic is not the disorder but the vulnerability to the disorder, and that the episodes of the disorder are time limited, we can provide the desired integration. Vulnerability is the proneness to develop an episode when sufficient stress-producing life events (external as well as internal) occur that exceed the stress-tolerance of the person. When the stress level again falls below the threshold, the person returns more or less to his premorbid level and resumes his place in society. If he had a good premorbid level of adaptation, he will be regarded as recovered or improved. If his premorbid adaptation level was poor, he may be mistakenly regarded as continuing in his episode even though the episode is ended and he has returned to his premorbid, albeit poor, level. In the past, many patients failed to recapture their premorbid level because of iatrogenic effects such as hospitalism or other impediments imposed by the sick role. Today, I believe that the role of iatrogenically produced deficits has been reduced though not eliminated.

Consequently, a more optimistic view of schizophrenia has resulted. This optimism has been further aided and abetted by follow-up studies of entire cohorts of patients such as those conducted by Professor Manfred Bleuler. He points out that his father’s rather
pessimistic attitude towards outcome of schizophrenia was based on limited follow-ups of rehospitalized patients, since he never saw again those who were so well-recovered that they never returned to the clinic.

It should be understood, however, that not all the patients returning to or remaining in the hospital are still in their original episode. For some, the episode is over and yet they may continue to be treated as if they were still sick, sometimes maintained continuously on drugs until tardive dyskinesia sets in. This is one of the reasons that monitoring of the beginning and end of episodes is so essential. Part of the variability in outcome probably reflects variability in the degree of premorbid adjustment to which the patients return at the end of the episode, as well as the variability in degree of vulnerability. Hence, variable outcome should not be taken as evidence of the non-applicability of the concept of a natural history of the disorder.

Another important source of variability in onset and in outcome is the fact that, unlike somatic disorders, behavioral disorders are judged on the basis of observed behavior. But this observed behavior includes not only manifestations of the focal disorder but also the premorbid personality and premorbid ecological niche on which the focal disorder is imposed. This, in part, is what Professor Wing refers to as the extrinsic disadvantages, unconnected with the disorder. For this reason it is well to try to separate, if possible, the "illness," which combines the focal disorder and its impact on the premorbid personality, from the focal disorder itself. That is, the observed illness is unique to each individual, depending upon his distinctive premorbid personality, even though theoretically the focal disorder may be conceptualized as independent of the premorbid personality. This may explain why clinical schizophrenia appears so variable. If we had knowledge of the focal disorder of schizophrenia itself, it might prove to be no more variable than somatic disorders. For this reason also, we need not deny the existence of a natural history for schizophrenia.

The relation between prognosis and vulnerability remains unclear. Prognostic indicators tell us what may happen after an individual develops an episode, but they do not predict who will have an episode nor who is more prone to have one. This is why measures of vulnerability must be developed independent of prognosis of outcome so that preventive methods can be utilized for the prevention of episodes in the first place.

The relationships among premorbid personality, onset, and outcome of schizophrenia are very complicated. Elsewhere (1), I have pointed out that premorbid personality may be related to the occurrence of an episode of schizophrenia in one of three ways: 1) the future schizophrenic has a premorbid personality which eventually blooms into the psychosis (a hypothesis probably congenial to psychoanalysis); 2) the premorbid personality is independent of the occurrence of the disorder (a disease model probably congenial to Kraepelin); and 3) the premorbid personality interacts with the disorder (probably a view congenial to Adolf Meyer). The available data do not lend any overwhelming weight to any one of these possibilities. The studies of Essen-Müller (2) and Hagnell (3) utilizing Sjöbring's (4) method of personality assessment, however, lend support to the second hypothesis—that is, independence, and it may be valuable in future work to adopt this null hypothesis in order to test if it is tenable.

Perhaps the most rapid advance made in the fields of onset and outcome during the last decade has been the provision of systematic structured interviews and rating scales for assessing these factors. There has been a virtual explosion of diagnostic techniques which have capitalized on the accumulated observations of 34 centuries of sagacious
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clinicians, and have systematized them. However, the inundation of new techniques one after another, reminiscent of the sorcerer's apprentice dilemma, must now somehow be stopped and a return made to detailed, firsthand observations of patients. Otherwise, our clinical understanding will not deepen.

In summary, this panel has provided a new view of schizophrenia, freeing it from the previous pessimistic view regarding its persistence and deteriorating outcome. The views expressed, especially by Bleuler and Wing, offer a veritable Emancipation Proclamation for schizophrenics. It is possible that if we regard only the vulnerability to schizophrenia as being more or less permanent, but the episode(s) of the disorder as being time-limited and recoverable, much of the apparent confusion and variability can be explained.

Regarding the existence of a natural history for schizophrenia, even the natural course of a river, from which the analogy probably arose, is not preordained for all rivers, since the course depends on the rainfall, nature of terrain, etc. Nevertheless, there are certain generalizations which can be made about the course of rivers based upon geological considerations. In the case of schizophrenia, if we could separate the focal disorder from the broader illness, we may, at least conceptually, find it possible to accept the natural history approach.

Thus, adapting a Newtonian view in which we postulate both that a body once set in motion will continue forever and that friction with surfaces will gradually halt the body, we can by analogy hypothesize that there is an expected course for schizophrenia even though this course can be modified by degree of vulnerability and the ecological niche which the person occupies in life.

REFERENCES


B. DISCUSSION: INTEGRATION AND EDITORIAL COMMENT

Rue I. Cromwell, Ph.D.

The floor discussion that followed the papers on Onset and Course was directed toward three specific themes. While a number of issues in the onset and course of schizophrenia were not mentioned, those that were discussed seemed to reflect the current status of thinking in this field.