SECOND DRAFT

A VULNERABILITY MODEL FOR LONG-TERM SCHIZOPHRENIC STATES

by

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Introduction

Because of the time limitation that affects all of us, I have decided to abbreviate the paper for this occasion, omitting the theoretical discussion, the design of the study, as well as the data, and present only the conclusions. I have several copies of the full paper for those who would like to see it. It is the dessert without the main course and I hope it will be digestible but leave you hungry.

This paper focuses on the interaction between vulnerability and psychosocial factors in the course and outcome of schizophrenic illnesses with a poor long-term prognosis.
We have been studying schizophrenic disorders among long-term outpatients in the Veterans Administration Medical Center in Pittsburgh, Pennsylvania area. It is a prospective study of socioenvironmental factors associated with relapse. The hospital outpatient population is screened for individuals under 56 years of age who meet the Research Diagnostic Criteria for schizophrenia and show no evidence of current alcohol or drug abuse. After a baseline assessment covering mental state and psychiatric history, as well as current social network, continuing difficulties, and selected aspects of premorbid functioning, patients are interviewed every four weeks for two years using a structured clinical instrument. A life event schedule is administered every twelve weeks, while variations in ongoing difficulties and the status of the patients' social networks are assessed annually.

The size of the study series is still small. Data covering the first six monthly follow-ups have been analyzed for only 25 patients. A total of 45 patients are currently being seen on a monthly basis and 85 patients have qualified for the study diagnostically. Our eventual goal is to collect 24 months of data on a series of 100 outpatients.

The outpatients recruited for this study demonstrate considerable psychopathology. After the first six follow-up examinations, forty-eight percent of the outpatient series were classified as continuously psychotic throughout the period. Twenty-eight percent of the patients relapsed during the first
six months of follow-up, while only twenty-four percent of the series remained in a state of remission throughout the period.

SLIDE - GRAPH I

In other words a majority of the outpatients recruited for this study have a rather poor clinical and social outcome. They are roughly comparable to the group of patients who make up the worst third of most longitudinal studies.

Preliminary Findings

Initially, we were interested in identifying the kinds of life event stressors capable of "triggering" the onset of relapse. Past research with schizophrenic patients indicates that stressful life events have their effect during the three week period preceding the appearance of positive psychotic symptoms. Among our group of relapsed patients, about two-thirds reported at least a single life event occurring in the three week period immediately preceding the appearance of positive psychotic symptoms. The following considerations, however, led us to doubt whether these results demonstrated definitively the hypothesized triggering effect in a majority of our relapsed patients. First, many of these events appeared to be illness provoked, second, several of the events preceding the onset of positive psychotic symptoms were of such an insignificant nature that it was difficult to credit them with much influence on the timing of the patient's episode and third, the same patients often reported life events of equivalent stressfulness that failed to be followed by the onset of an episode.
These negative findings sent us back to the data to explore three additional hypotheses. First, we wanted to look at the possibility that the life events which trigger psychotic episodes have some kind of special characteristics or meaning for the patient. Second, we wanted to investigate the possibility that the patients’ episodes may have been provoked by stressful circumstances other than major life events. Third, we wished to find out whether there was reason to conclude that buffering factors such as the supportiveness of the patient’s social network helped to prevent or delay the appearance of positive psychotic symptoms even when sufficient stress occurred.

We discovered few obvious commonalities between the events preceding the onset of relapse beyond their requirement that the patient adapt to undesirable social circumstances. There were various kinds of threats, disappointments, and losses, but similar events also occurred to other patients without the appearance of positive psychotic symptoms. It did appear, however, that some patients suffered a series of minor undesirable events which may have had an additive effect over time on their mental state. Rather than a clearly defined triggering effect, this process suggested a progressive wearing down of the patient’s resistance to psychotic processes. Included here were hostile family members, stressful working conditions, a lack of financial resources, chaotic household situations, and the like.
These kinds of stressors approximate what some investigators have called "daily hassles", the irritating, frustrating, distressing demands and troubled relationships that plague us day in and day out. Some of these hassles are transient, others are repeated even chronic. These hassles should be distinguished from dramatic, change-centered life events. The key problem was that many of these daily hassles seemed to be a product of the patient's chronic illness state. For example, peoples' negative attitudes and reactions often seemed to be conditioned or provoked by the patient's difficult behavior.

On the other hand, evidence was also discovered indicating that active support received from members of the patient's social network could serve to delay — perhaps, indefinitely — the appearance of positive psychotic symptoms. The term "active support" implies more than simply a positive emotional attitude on the part of the network member. Here we are referring to the cases in which a parent, spouse or girlfriend (all of our patients were males) actively intervenes to deal with crises or routine problems that the patient would otherwise have had to handle alone.

Adaptation to Illness

While reviewing these data, we also observed that these patients often develop an adaptive process of social disengagement that permits them to come to terms with their extreme vulnerability. The idea that there might be a gradual
process of adaptation to illness occurred to us because the younger patients in our series appeared to respond to their illness differently than the older patients.

Many of the younger patients in our series appeared to be confronted by a contradiction involving their vulnerability to episodes of psychosis on the one hand, and the goals valued by their family and friends, on the other. These patients value education, work, and independence, even though their background and training is limited. Unfortunately, their efforts to achieve these goals often lead them into the kinds of stressful situations that provoke further episodes of illness. In a number of these patients it was possible to trace what seemed to be a painful and destructive cycle of continued striving, followed by frustration and multiple hospitalizations.

Eventually, important changes begin to occur in the patient’s relationship to his own values and ideals. These changes usually involve a clear reduction in the patient’s striving to achieve his goals and a whole or partial withdrawal from the kinds of social settings previously experienced as overly stressful and demanding. The patient, for example, may drop out of school or may enroll in superficial educational programs that make few real demands on his time and permit him to progress at his own rate. If he is employed, he may begin to reduce the number of hours he works or seek simpler, less demanding jobs. In some cases the patient simply quits work and refuses to find another job. The patient may also begin to
withdraw from complex interpersonal relationships, moving in the direction of fleeting and shallow contacts with others.

The patient's family can react to this process in a number of ways. They may continue to insist that the patient try to meet the goals of a normal member of society, criticizing and rejecting him when he cannot. On the other hand, they may try to be supportive, within reason, finally becoming ever more disillusioned and frustrated with the patient's behavior. In such cases, there is generally a growing sense of alienation between the patient and members of his family as both sides mutually withdraw from the painful experience of living together. Alternatively, some family members, usually parents, allow patients to insulate themselves from stress by permitting the development of highly dependent relationships. Such relationships must not be confused with the phenomena of emotional over-involvement since the relative usually remains affectively neutral towards the patient while caring for all his needs and serving as his representative to the outside world.

An additional factor that seems to be associated with this adaptational process is a growing sense of demoralization on the patient's part. Our monthly interviews often turn up what appear to be secondary depressive reactions focused around hopelessness, negative self evaluations, and pessimistic attitudes about the future. This sense of demoralization seems to disappear in the older patients who have relinquished all initiative and display scorables levels of emotional flattening and apathy.
The end point of this adaptational process may approximate the traditional concept of the clinical poverty syndrome. Over time, the patients may avoid both the exacerbation of positive psychotic symptoms and attendant inpatient hospitalizations by progressively restricting their range of instrumental and emotional functioning.

The evidence presented to this point suggests that the hypothesized vulnerability to schizophrenic symptomatology varies markedly among patients and, probably, plays a fundamental role in determining the eventual course and outcome of their disorder. The relative degree of the patient’s loading for the disorder appears to be the critical or "primary" variable that determines the significance of other "secondary" factors (e.g., social support, coping skills, ecological niche) in determining outcome.

In the case of the highly vulnerable individual, the dynamics of the schizophrenic process no longer approximate occasional crises followed by a return to premorbid levels, as is the case with the less vulnerable.

Instead, psychotic symptoms remain continually present or threaten to return on a permanent basis. Dramatic life events are no longer required to trigger illness episodes since symptoms may be provoked (or maintained) by the stress involved in minor hassles of the kind that make up the routine texture of everyday life. The negative behavior associated with the patient’s acute
sensitivity to stress may progressively exhaust the supportiveness of relatives and friends, eventually leading to further isolation and withdrawal—except, perhaps, in the most extreme cases where the patient is permitted by other family members to assume a totally passive and dependent attitude towards the outside world. As part of this process, we have tried to describe how this morbid sensitivity to stress may lead these patients to undertake an adaptive process of social disengagement in an effort to avoid further painful episodes (or exacerbations) of illness. We have argued that the key feature of this adaptation to illness is a growing poverty of instrumental and emotional functioning that often approximates the traditional psychiatric concept of chronic deficit states.

Whether the adaptation process leading to the poverty syndrome is primarily a response to the disorder, or an indigenous biologically based part of the disorder itself, remains moot until a measure of degree of vulnerability becomes available. Then, we may be able to compare the mildly vulnerable with the severely vulnerable to determine the relationship between the adaptation process and degree of vulnerability.

We have been looking primarily at the negative aspects of the adaptation process in long term patients, but the same adapting process can turn out to be positive in less vulnerable patients under favorable situations, and it seems possible that even very vulnerable people under suitable conditions can recover or improve.
CONCLUSION

The ideas put forward in this paper are admittedly speculative. It is not simply a matter that we have been working with a small sample size. Further evidence collected in the course of the Recidivism and Schizophrenia Project is unlikely to provide definitive proof for this model because we lack independent measures of the patients' underlying vulnerability to illness. Without such independent measures, it is virtually impossible to (i) refine the various elements of our model and (ii) test its predictions against alternative theories of the origin of chronic deficit states in schizophrenia. By way of illustration, we hypothesized above that the patient's underlying vulnerability to illness was the primary factor in determining the course and outcome of the disorder. It may, in fact, be the case that what we have termed secondary factors (e.g., premorbid personality, social network, ecological niche) play a much more influential role that has been suggested here. Without an independent measure of the patient's underlying vulnerability to illness, however, it is practically impossible to formally test such questions. In other words, further progress in this area of psychosocial research appears stymied until additional significant findings are provided by biologically oriented investigators. It seems ironic yet wholly appropriate to conclude this paper with Kendall's (1984) observation that, "The future lies mainly - but not exclusively - in the hands of laboratory scientists."