The Impact of the Negative Symptoms Category on 
Schizophrenia Research and Treatment

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Treating the Negative Symptom of Schizophrenia, held on 
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INTRODUCTION

The Annual Newer Strategies Series, at its Post-Bar Mitzva 
session, like it predecessors in this series, has again 
anticipated a new trend and foreshadowed a revolution in the 
research and treatment of schizophrenia.

Just as the front line soldiers in the trenches never know 
of the revolutions going on behind the lines, so, the average 
clinician is not always aware of the changes brewing around him. 
The purpose of this symposium was to alert the practical 
clinician of the progress under way. If I were to ask for a show 
of hands of those who had heard of negative symptoms a decade 
ago, very few if any would respond. Negative symptoms have burst 
on the horizon like Haley's comet.

Most of the speakers and discussants have written widely 
about their views in such publications as the Schizophrenia 
Bulletin which devoted an entire issue to the problem, but the 
clash between the different points of view presented at the 
symposium clarified the issues. Here, we need only give an 
account of the major issues that arose and this is one man's 
opinion of the impact the meeting made on him and on the 
audience.

The symposium is divisible into two sections - one dealing 
with the current status of treatment through pharmacological 
agents (Goldberg) and institutional approaches (Ferman) and the 
other dealing with relatively newer techniques such as prevention 
by means of environmental manipulation (Beels) family role 
(Terkelsen) and psychosocial rehabilitation (Fields). Keith gave 
an overall overview which presented the background of the 
negative symptom problems.
Goldberg reviewed the status quo of drug treatment pointing out the efficacy of the drugs not so much in curing the disorder as in postponing relapse especially when contrasted with placebo treatment. The question remains why does relapse occur even in the face of ascertained drug intake. Is there a gradual tolerance developing toward the impact of the drugs which eventually overcomes their ameliorative effect, or is there an accumulation of stress induced either by internal neurohumoral secretions or external events? We shall deal with this in the conclusion.

Ferman pointed out the role of the OMH in developing outpatients community outreach to tackle the problem of the released patient by providing suitable agencies for resocialization and rehabilitation. Whether the hospital is a suitable place for dealing with negative symptoms remains an open question, though the depopulation of the hospitals has presumably made them more suitable for therapeutic efforts.

Among the newer techniques reflecting the revolution against the imperialism of drug treatment and routine hospital care is Beel's preventive methods through environmental manipulation. He points out that there is a need for giving the expatient a raison d'être through a group to which he can belong and share its ideology, rather than face alone a hostile unresponsive environment as is often the case.

In similar vein Terkelsen points out the role of the family as an agent in returning expatient to social life or, in a negative way to reverse his progress and produce relapse. It should be pointed out that the discovery of the effect of high emotional expression in families of returned patients on relapse is as great a contribution to patient welfare as the discovery of the tranquilizing effect of neuroleptics. Somehow the Zeitgeist is such that psychosocial discoveries are not regarded on a par with biological discoveries!

Field's inspiring appeal towards having respect for the patient's individuality struck a responsive chord in the audience and his and Terkelsen description of the denigrating influence of labeling the patient as hopeless deserves more attention. While the optimistic view presented by Fields was moving, we must not lose sight of the fact that the problem of the chronic patients is not easily solvable and can not be overcome by enthusiasm alone.

In his masterful review of the problem of negative symptoms Keith struck the high note of the symposium. There is little
left to say after his analysis, except perhaps to raise the question of etiology. While his suggestion that it aint ignorance that causes our trouble but knowing things that aint so, is well taken. science, nevertheless hates a vacuum and despite ignorance of both types, an etiological point of view is necessary to live by.

There was an implicit but unfocused contrast between the biological and enviroetal points of view throughout the symposium. This is, unfortunately, an ongoing difference which splits the field of psychopathology despite lip-service agreement that is is the interaction between the two that we see in our patients. In an attempt to provide a more integrative point of view, I have some time ago proposed that instead of regarding schizophrenia as a persistent chronic disease leading to inevitable deterioration we might regard the individual who develops an episode as a vulnerable person who under sufficient stress will develop an episode. This episode does not last a life time but when the patient recovers he usually returns to his premorbid level. If his premorbid level was good, we regard him as recovered or improved. If his premorbid level was poor he also returns to it, but we cannot tell whether the episode is over, since he still cannot cope with life exigencies even as he could not premorbidly. Many of the so called chronics fall into this category.

Even if a vulnerable individual undergoes a sufficiently stressful life event, he need not develop an episode if he is protected by a good social network, a good ecological niche, and a good premorbid personality. These moderating variables absorb the stress and prevent the episode from developing. Perhaps the 50% of monozygotic cotwins who never develop an episode fall into this category.

The value of the vulnerability hypothesis is that it helps explain some of the contradictory views that were presented during the symposium. Thus, relapse under drug treatment may be explained by either a gradual accumulation of life stressors that finally overwhelm the protective shield offered by the neuroleptics. Similarly, those responding to placebos, perhaps do so by virtue of the protective shield offered by a good social network, ecological niches or premorbid personality. Recognizing that we are dealing with a vulnerable person might explain the need for extreme caution in dealing with the requirements of respect for the individual patient.

Renée Dubos* has pointed out that the biological substrates of behavior are merely the props or underpinnings of the stage on which mankind acts. They are the scenery, stage effects,
lighting and plumbing underneath the stage on which the actors perform. The performance itself, depending though it does on the underpinnings is not fully controlled by them. Man, in addition to obeying the ground rules laid down by biology also has that rare gift of self-direction and free decision making, something which the mental patient sometimes loses as a result of the impact of iatrogenic, ecogenic and nosocomial invasions of his privacy**. It is this self-determination that we must return to the patient, and this can be accomplished only by bringing back his self-respect. This is the message which Fields brought and which closed the meeting on such a high note of optimism.
