Newer Strategies Series Hits Positive Note On
Managing Negative Symptoms of Schizophrenia

By Joseph Zabin, Ph.D.

Just as soldiers in the trenches rarely know of the revolutions flaring behind the front lines, so the average clinician is not always aware of the changes brewing around him. The 14th Annual Newer Strategies Series, sponsored this winter by the New York State Psychiatric Association’s Joint Committee on Schizophrenia, aimed at alerting the practical clinician to the coming revolution in the research and treatment of schizophrenia.

One section of the symposium surveyed the current status of treatment, including pharmacological agents (Solomon C. Goldberg, Ph.D., Director of Psychiatric Research at the Medical College of Virginia) and institutional approaches (Johanna Ferman, M.D., Deputy Commissioner, Division of Clinical Programs, NYS-OMH). The other section focused on relatively newer techniques such as prevention by means of environmental manipulation (Clemens C. Beels, M.D., Director of Fellowship for Public Psychiatry, N.Y.S. Psychiatric Institute), family role (Kenneth Terkel, M.D., Medical Director, Family Institute of Westchester), and psychosocial rehabilitation (Steven Fields, Executive Director of Progress Foundation, San Francisco). Samuel Keith, M.D., Director of the Center for Studies of Schizophrenia at NIMH, described the background of the negative symptom problems in an overview of the area.

Why do relapses occur?

Goldberg pointed out that drugs in current use do not so much cure the disorder as they postpone relapse. Why relapse should occur at all in subjects who continue to take medications as prescribed is still unanswered. Does tolerance to the drug develop and eventually overcome its ameliorative effects? Or is relapse due to an accumulation of stress, induced either by internal neurohumoral secretions or by external events?

Even though depopulation might make hospitals more suitable for therapeutic efforts, Ferman noted that it remains an open question as to how well they deal with the negative symptoms of schizophrenic patients. OMH now sees development of community outreach and outpatient programs as a major challenge, so that the released patient can be guided to appropriate resocialization and rehabilitation services.

Facing a hostile environment

Among the newer techniques reflecting the revolution against the imperialism of drug treatment and routine hospital care is Beel’s method of prevention through environmental manipulation. He underscored the need for providing the former patient with a raison d’être through a group to which he can belong and whose ideology he can share, as opposed to facing a hostile and unresponsive environment completely on

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his own.

In a similar vein, Terkelson described the role of the family as an agent that can either help the expatiant return to social life or reverse his gains and produce relapse. 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 was the discovery of the tranquilizing effect of neuroleptics. Yet the Zeitgeist is such that psychosocial advances are not regarded on a par with biological discoveries.

Labelling has its dangers

Field’s inspiring appeal to respect the patient’s individuality struck a responsive chord in the audience, and his and Terkelson’s descriptions of the denigrating influence of labeling the patient as hopeless deserve more attention. It must be remembered, nonetheless, that the problems of chronic patients will not overcome by enthusiasm alone.

A masterful review of the problem of negative symptoms Keith struck the high note of the symposium. As he noted, “It ain’t ignorances that causes our trouble, but knowing things that ain’t so.” Despite ignorance of both types, the clinician needs an etiological point of view in order to operate. That need may be what engenders conflict between the biological and environmental points of view, a contrast that was implicit but unfocused throughout the symposium.

The “Vulnerability Hypothesis”

In an attempt to provide a more integrative approach, I proposed some time ago that instead of regarding schizophrenia as a persistent chronic disease leading to inevitable deterioration, we might better regard the person who develops an episode as a vulnerable subject who, under sufficient stress, will develop an episode. That episode does not last a lifetime, but when the patient recovers he usually returns to his premorbid level. If the premorbid level was poor he returns to that level, but the clinician cannot tell if the episode is over, since the patient remains unable to cope with life exigencies just as he had been unable to cope before he fell ill. Many so-called chronic fall into the latter category.

Even a vulnerable subject exposed to a stressful life event need not develop an episode if he is protected by a good social network, a good ecological niche, and a good premorbid personality. By absorbing stress, such moderating variables may prevent the episode from developing. The 50 percent of nonvacular co-twins who never develop an episode may belong in this category.

The value of the vulnerability hypothesis is that it helps explain some of the contradictory views presented during the symposium. Relapse under drug treatment, for example, may be due to a gradual accumulation of life stressors that finally overwhelm the protective shield provided by neuroleptics.

Similarly, patients who respond to placebos may do so because they are protected by a good social network, ecological niches, or premorbid personality. Recognizing that we are dealing with a vulnerable person might explain the need to remain particularly sensitive to his need for respect as an individual.

René Dubos regarded the biological substrates of behavior as the props or underpinnings of the stage on which the actors perform. Man must obey the ground rules laid down by biology, but in addition he has the gift of self-direction and free decision-making. That is what the mental patient sometimes loses as a result of the impact of iatrogenic, genic, and nosocomial invasions of his privacy. That self-determination is what we must restore to the patient, and that can be accomplished only by bringing back his self-respect. Such was the message that Fields brought and which closed the meeting on such a note of optimism.

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