Clinicians Pay
More Attention To
Psychosocial Treatments

By Joseph Zubin, Ph.D.

The Newer Strategies series which was initiated by Area II’s Joint Committee on Schizophrenia under the guidance of Dr. Lester Shapiro has now reached its adolescence — its 15th anniversary. The anniversary meeting was devoted to “The Clinician and the Newer Treatment Options for Schizophrenics.”

The program made note of the growing concern regarding the short and long term negative effects of neuroleptics. This resulted in a reexamination of their place in the treatment of schizophrenia. Out of this emerged a number of alternative adjunctive measures whose importance has only recently been recognized and documented. The symposium was geared to bringing these to the attention of the clinician, whether based in clinic, hospital, or private practice.

In the first morning session, Dr. Robert Cancro, Chairman of the Department of Psychiatry at New York University School of Medicine, reviewed the historical development of the application of different treatment regimens, beginning with moral therapy. He described the gradual shift from earlier noninvasive approaches, such as interviewing, phenomenological analysis of the patient’s problems and custodial care, to the modern drug era. He showed that psychiatry followed the path of general medicine by gradually elevating somatic treatment and denigrating psychotherapy.

Thomas McGlashan, M.D. introduced the new trend in individual treatment, which regards patients as vulnerable individuals who need more than mere drug treatment. Encouragement, optimism and kindly attention are needed not only to ameliorate the patient’s immediate pain but also to provide an explanation of what might have brought about the illness and why the treatments being given can help in bringing the patient back to health. The patient thus becomes a local partner in the treatment regimen and not just a passive participant.

The vulnerability theme was reemphasized by Robert Liberman, M.D., who pointed out how the role of psychosocial factors in treatment is needed to bring about the desired improvement in the patient’s life. He dealt particularly with the role of the psychosocial factors in the return of the patient to the community after the acute episode has terminated. Introducing specific learning techniques to guide the patient in social skills, in looking for a job, and in the general attitude he adopts towards himself and the community were the ingredients of Dr. Liberman’s rehabilitation regimen.

Mr. James Howe, past president of the National Alliance for the Mentally Ill (NAMI) and an economist by profession, described the therapeutic scene from the point of view of the family and the patient himself. He noted that some of the current trends in research failed to address the questions that were uppermost in the mind of the family and the patient. The plan he outlined included first a determination of diagnosis and appropriate labelling of the patient, then use of the neuroleptic most suitable for the specific condition, and finally rehabilitation. He apparently side-stepped the need for psychosocial treatment to accompany neuroleptic treatment as well as what approach to use with those patients who either did not need neuroleptics or might even be harmed by them.

Steven Sharfstein, M.D., described how legislation had developed for the care of the mentally ill and the complex specifications for defraying the costs of mental illness.

The ensuing discussion made it clear that the bewildering array of available options for treatment could be confusing and needed some explanation. How could such a wide variety of therapies, ranging from drug treatment to group therapy, bring about recoveries? Was there any common link connecting them? To answer this question, a quick review of the development of modern medical treatment was required.

Modern medicine emerged with the discoveries of Pasteur and Koch, and their impact radically altered the role of the physician. The physician was no longer a mere observer of illnesses that pursued their unrelenting course; now he became an active interventionist.

In the second half of the twentieth century, the relationship between doctor and patient has changed greatly. In the majority of cases, its context has shifted from the home to some institutional setting. The healer is often unknown, or only casually known, to the patient. Even

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the place of drugs in therapeutics has changed — not only in the sense that the efficacy and mode of action of most drugs are better understood, but also in the social ambience that surrounds their use. The patient still maintains faith in the physician's prescription — often, in fact, demanding such a prescription — but the faith is of a different order than it was in the nineteenth century. At that time, drugs (along with other medical rituals) were typically thought of as a means of helping nature restore an optimal balance to the intake and output of the human organism. Natural healing, aided and abetted by the physician's personal warmth, optimistic attitude and encouragement were the effective techniques to maintain the patient's hope while the physician worked for his recovery.

With the further development of modern medicine, more and more faith was put in drugs and surgery to deal with man's ailments, and Hippocrates' injunction to help nature take its course was often laid aside. Less and less attention was paid to the bedside clinical approach in tending to the patient's needs, and much of such care was relegated to the nursing staff since it was not considered the primary factor in recovery.

Current medical practice seems to be giving attention again to the psychosocial needs of the patient, and their role in outcome has been verified by clinical investigation. Psychiatric practice, oddly enough, has not yet fully accepted the recent trend in recognizing psychosocial variables. One reason for the recent meeting was to promote such a reassessment.

There is no doubt that the ecological niche in which man finds himself determines his well-being, that his genetic makeup limits his potential, that his internal environment and neuropsychologic makeup control his behavior. But to describe human behavior solely in those terms is to ignore its most important determinant — man's ability to be a self-starter, to alter development trends, to modify his internal environment as well as his neurophysiologic equipment. Unlike other organisms which are shaped by their environment through eons of gradual evolutionary developments, man can shape his own environment if he chooses to do so. He has developed the know-how to apply changes not only to the exogenous but even to the endogenous environment. It is in these directions that the future of man's normal development, as well as the containment and improvement of abnormal development, lies.

Is this attempt to introduce the concept of natural healing too optimistic? Will it work with chronic patients? What about patients who refuse therapy? All these questions were raised during the discussion periods.

The recently reported NIMH collaborative study of depression suggests an answer to the first question. All the therapies used, psychosocial as well as biological, exceeded placebo results, and no advantage was found for the biological therapies over the psychosocial. Why should such disparate approaches fare equally well? Perhaps each in its own way helps to release the innate capacity for natural healing. Dr. Loren Mosher cited an array of studies indicating that chronicity may be an artifact produced by iatrogenic, ecogenic, or nosocomial factors.

Particularly difficult to deal with is the patient who refuses treatment. Perhaps behavior modification techniques may help, especially the technique for the shaping of behavior. This may be a sufficiently important topic to provide the subject for the next title in the "Newer Strategy Series."

Dr. Zubin is associated with the Veterans Administration Medical Center and with the Department of Psychiatry at the University of Pittsburgh School of Medicine. He was formerly on the staff of the New York State Psychiatric Institute.