Thoughts on the Treatment of Schizophrenia

by William T. Carpenter, Jr.

Abstract

The author contends that the clinical relationship is the foundation for treating the person with schizophrenia. However, the models and scientific data available to the clinician have been limited by prevailing ideologies. Despite important contributions from interpersonal, pharmacologic, and rehabilitation treatment perspectives, each has curtailed the range of clinical observation and the capacity for integration of treatments. Even recent advances in clinical science methodology have contributed to a short fall in treatment knowledge.

The author espouses a broad medical model for defining the range of data and integration of techniques relevant to therapeutics. He views phenomenology as the crucial concept for clinical exploration, and contrasts this approach with the shallowness of purely descriptive approaches on the one hand and the distortion imposed by theoretical presentiments of psychotherapy on the other. Continuity of care and integration of therapies can emerge from phenomenology in the context of the clinical relationship.

Clinical scientists too often find themselves so involved in methods, operations, and data interpretation that they fail to contribute adequately to the public discussion of perspective and clinical meaningfulness of the data they generate and interpret. On the other hand, clinicians often feel they cannot critically assess the scientific methods, technologies, and statistical assessments commonly employed in modern clinical studies, and thus fail to decipher the data from a clinical perspective. The “At Issue” section of the Bulletin provides the opportunity for me to wear both hats and express a personal view on issues relevant to the treatment of schizophrenia. The major premise of this view is that parochialism and scientific shortcomings in such areas as psychodynamically based interpersonal treatment strategies, psycho-pharmacotherapy, rehabilitation, and clinical trials research methodology have undermined the integration of what, in fact, are complementary treatment approaches and have thus sharply limited the informational base from which the therapeutics of schizophrenia ultimately evolve.

Interpersonal Therapeutics

Despite Freud’s dictum that persons with schizophrenia could not form a transference neurosis and, therefore, were not suitable subjects for psychoanalytic inquiry (Freud 1953, 1957), the preeminence of psychodynamic psychiatry in North America at mid-century afforded the circumstances in which psychogenic theories were judged most promising and psychotherapeutic approaches were...
presumed efficacious. Influential theories concerning familial interactions in the etiology of schizophrenia were espoused, and family therapy gained wide acceptance. These were the best of times for psychodynamically oriented clinicians, some of whom contributed substantially to our understanding of the phenomenology of schizophrenia and of the psychotherapeutic process with psychotic patients. For those interested in engaging in empirical work, research funding was readily available. Contributions from this area were embraced by both the academician and the practitioner. These favorable circumstances, however, did not prove to be an impetus to scientific development or to major advances in the clinical care of persons with schizophrenia. There were notable exceptions, of course, but the following principal consequences of this lengthy dominance in American psychiatry discouraged:

- the scientific evaluation of treatment efficacy;
- the development of interpersonal treatment strategies which did not derive from the predominant ideologic and theoretical position;
- the development of interpersonal strategies that could practically be delivered to the vast numbers of patients with schizophrenia;
- the implementation of phenomenologic investigation relatively free of theoretical presentiments;
- the integration of interpersonal therapeutic strategies with the burgeoning field of psychopharmacology; and
- a constructive collaboration between clinicians and families.

During the 1950s and 1960s, psychotherapeutic services for the schizophrenic patient were considered an ethical imperative, though this view contrasted with a reality in which significant psychotherapeutic services were available for only a few schizophrenic patients. In the mid-1980s, however, the majority of professionals seem to view psychotherapeutic intervention as irrelevant. Where an effect is noted, as many argue that it is dangerous and countertherapeutic as are prepared to argue that it is distinctly therapeutic. Even those who, by professional training and personal proclivity, are most prepared to deal intimately with the severely disturbed individual over time are unlikely to pursue such an opportunity or to be encouraged to do so by their colleagues.

This has resulted in a dearth of talented individuals capable of integrating interpersonal treatment strategies with pharmacologic treatment, or of providing the vantage of psychodynamic psychiatry in developing and interpreting clinical data germane to the care and study of persons with schizophrenia (Carpenter and Heinrichs 1980).

Pharmacotherapy

The introduction of antipsychotic drugs to the treatment of psychotic illness in the early 1950s has profoundly altered the theory and therapy of schizophrenia. Clinically effective psychoactive drugs have had an unprecedented impact on the study of brain physiology and have provided the impetus for reestablishing biology as a foundation of American psychiatry. The use of systematic descriptive methods and controlled study designs proved an efficient mechanism for demonstrating that neuroleptic drugs were capable of reducing the relapse rate in recovered or clinically stable patients and were causally associated with reduction in a broad range of psychopathologic manifestations in the acutely ill patient. Unfortunately, such results were greeted derisively in some quarters, with derogatory reference made to the virtual use of chemical lobotomies or straight-jackets, the superficiality of symptom suppression, and the undermining of the patient's motivation to help himself.

Effective pharmacotherapeutics created a political, as well as a scientific, challenge to the psychodynamic leadership in American psychiatry. Unfortunately, the competition between therapies was dominated by oppositional views that were of marginal scientific validity. Given this ambiance, comparative treatment studies consistently found psychopharmacotherapy to be superior to psychotherapy (Schooler 1978; Gunderson 1979; Mosher and Keith 1980; Heinrichs and Carpenter 1981; Stanton et al. 1984). As a result, psychiatry has now become extensively reoriented, with the majority of young clinicians being trained in the use of therapeutically active drugs and espousing their role as crucial in psychiatric therapeutics. Not only has the psychodynamic sphere of influence lost preeminence, but the psychodynamic viewpoint is no longer adequately represented in the scientific academic community. The ill-conceived censure of the pharmacotherapeutics of schizophrenia has not proven valid and is now only of incidental interest. There are, however, new criticisms of a pharmacologic approach that must be addressed. Schizophrenia is manifested with considerable variation from one case to another, yet pharmacotherapeutics are used with remarkable uniformity. Inadequate attention has been given to the identification of neuroleptic-
nonresponsive subgroups, subgroups responsive to alternative drugs, and subgroups with an unfavorable risk-benefit ratio.

The assumption that schizophrenia is a heterogeneous syndrome and that any discrete disease entity within the syndrome may have a multifactorial etiology provides a compelling rationale for seeking multiple treatment strategies and ascertaining their optimal integration. Clinical psychopharmacologists are only now beginning to recognize the necessity for implementing psychosocial approaches as a primary, rather than simply supportive and humanistic, attribute of clinical care (Schooler and Carpenter 1983; Mosher and Meltzer 1984).

The nature of schizophrenia varies within the individual according to the phase of illness. Some patients may demonstrate recovery or extensive stability after an initial episode and others, despite repeated episodes during young adulthood, may become clinically stable at a later period in life. The prevailing view calling for continuous drug treatment in all patients for maintenance and prophylactic purposes is not compatible with the nature of the disease as seen from the vantage of long-term studies (Bleuler 1972; Ciompi 1980). The field must develop methods for more highly individualized pharmacotherapeutic strategies (Davis et al. 1980; Carpenter and Heinrichs 1981; Tamminga and Carpenter 1982).

It is now evident that tardive dyskinesia occurs with alarming frequency with neuroleptic drugs. It is also possible that drugs with such varied effects on brain physiology will prove detrimental in the long term in other areas of functioning. In fact, in primates and in nonpsychotic human subjects, neuroleptic drugs induce behavioral changes which mimic many aspects of the deficit syndrome (Carpenter, Heinrichs, and Alphs 1985). It is, therefore, incumbent upon the field to develop treatment strategies which reduce the exposure of schizophrenic patients to neuroleptic drugs to an extent compatible with effective treatment of psychosis. Furthermore, the long-term effect of these drugs on core features, often referred to as negative or deficit symptoms (Strauss, Carpenter, and Bartko 1974; Andreasen and Olsen 1982; Heinrichs, Hanlon, and Carpenter 1984; Andreasen 1985; Bilder et al. 1985; Carpenter, Heinrichs, and Alphs 1985; Carpenter, Heinrichs, and Wagnar 1985; Cornblatt 1985; Crow 1985; Gibbons et al. 1985; Goldberg 1985; Lewine 1985; Mayer et al. 1985; Pogue-Geile and Harrow 1985; Sommers 1985; Strauss 1985; Zubin 1985) (e.g., amotivation, anhedonia, restricted ideation, and affect), must be ascertained to determine whether there is a negative or beneficial interaction between neuroleptic drugs and personality integrity over extended periods of time.

Rehabilitation

In the long-term treatment of individuals with schizophrenia, psychiatry has relied too extensively on hospital care and asylum. We were ill-prepared for deinstitutionalization and have not provided effective leadership in the comprehensive clinical care of noninstitutionalized chronic patients (Bachrach 1983).

The void is being partly filled by social rehabilitation workers who have developed a number of models for providing work, shelter, and life support for the chronically ill (Anthony, Cohen, and Cohen 1983). While these contributions are to be applauded, they are too often associated with rejection of the medical model and a failure to solicit, or even permit, integration of medical management with psychosocial care. No doubt, this is partly the result of rarely finding the medical community available, responsive, or informed in these matters, but it is nourished by an unfortunate suspiciousness, competition for funds and influence, and rejection of the tenets of the medical model.

Research Methodology

Psychiatry has experienced an extensive development of clinical research methods over the past two decades. These methods have enhanced our ability to communicate concerning diagnosis, to distinguish between association and cause, and to obtain empirical evidence to support and refute theories rather than rely on prevailing views and personal authority. Research developments have also enabled psychiatry to contribute substantially to the study of the brain and to the integration of biologic data with clinical observation. However, there have been some unfavorable undertones.

The hypothesis-testing demand of isolating and manipulating a variable to demonstrate the existence of functional relationships often results in designs that reduce observed phenomena so extensively that clinical reality is no longer represented. The exigencies of research prompt attention to treatments that can be highly specified, delivered in short time, and easily measured with respect to outcome. The field thus shifted away from the study of complex and subtle psychopathology and toward psychopathologic attributes that can be assessed with minimal clinical involvement. Core
features of illness are ignored if inconvenient (Carpenter 1980; Carpenter, Heinrichs, and Hanlon 1981), and data analysis and interpretation too often are based on computing capability and the availability of statistical programs, rather than on the utilization of statistical approaches that relate to clinical concepts and meaningfulness (Glantz 1981; Carpenter, Bartko, and St. Claire Evans 1983). As a result, little of this research is germane to the task of integrating seemingly diverse treatments in a manner appropriate to an individual patient’s psychopathology, personality, and circumstances. These criticisms do not belie the impressive progress made in clinical science. Nor are they shortcomings of scientific methods per se, but rather an unnecessary side effect. Such practices persevere, in part, because clinical psychiatry has not been sufficiently critical of its research products (Strauss and Hafez 1981).

The Integration of Treatment Strategies

Integrating treatments in schizophrenia requires a conceptual approach which can define the range of data pertinent to understanding the schizophrenia syndrome and treating the individual. Although the medical model has no competitor capable of dealing with the full range of data already demonstrated to be relevant to schizophrenia, the biomedical version of the model is too narrow. Engel (1977) has pointed out that the biomedical model is preeminent in Western medicine, but its scientific validity is undermined by reductionism (attempting to account for illness and treatment in solely physico-chemical terms) and exclusiveness (considering factors not reducible to physico-chemical explanation as not relevant or trivial). The introduction of general systems theory to the study of biological organisms (Von Bertalanffy 1952, 1967) has clarified the intricate connectedness between the various levels of functioning of the human organism (Grinker 1975; Engel 1977; Marmor 1983). The resulting biopsychosocial medical model (Engel 1977, 1980) provides a model for the hierarchical organization of the individual which is heuristically valuable in the comprehensive study of health and disease. The importance of factors drawn from the biological, psychological, and sociological levels of abstraction is illustrated by the substantial contribution of behavioral variables to mortality (Hamburg 1982) and in the impossibility of accounting for a mere blush without considering social, psychological, and biological factors simultaneously.

A developmental, interactive medical model seems optimal for the study and treatment of persons with schizophrenia (Strauss and Carpenter 1981; Carpenter 1983). In this model, attention is called to etiologic factors and their interaction with environmental factors during development to determine vulnerability. The manifestation of psychotic illness in the vulnerable person may be determined by innate factors and temporal stresses. Once psychosis is manifest, various biological, psychological, and social factors determine the course and eventual outcome of the illness

The causes of schizophrenia(s) remain an enigma, but present data on risk factors suggest contributions to etiology from genetics, gestational and birth complications, and an unknown factor associated with winter birth (Neale and Oltmanns 1980; Pulver, Sawyer, and Childs 1981; Pulver et al. 1983; Boyd, Pulver, and Stewart 1986). The role of developmental factors in shaping the degree of vulnerability in the etiologically predisposed individual has received considerable theoretical attention, but specific processes involved in pathogenesis have not yet been scientifically confirmed.

Some putative factors, such as the schizophrenogenic mother (Fromm- Reichmann 1948), were based solely on ideologically based retrospective study to which little credence can be granted. Other factors, such as parental communication deviance (Wynne and Singer 1963; Wynne et al. 1975), are firmly established in association with some forms of schizophrenia. But, it is not yet clear whether the intrafamilial communication pattern has a causative role, is reflective of the presence of a schizophrenic offspring, or is the result of parent and child sharing some third factor. These are not mutually exclusive possibilities. For example, communication deviancy could be a heritable trait linked with schizophrenia. A parent and the ill offspring may share the genetic trait—and thus the association. Furthermore, communication deviancy in the home may increase vulnerability to psychosis in the etiologically prone offspring. Finally, the presence of an offspring with schizophrenia may increase the communication deviancy of the parent. In any such circumstance, a disease model integrating genetic, cognitive, and social interactive variables over time is required. Those interested in the pathogenesis of schizophrenia and in prevention will surely scrutinize the many interpersonal and biologic factors that influence development (Mednick and McNeil 1968; Baumrind 1975; Reiss and Wyatt 1975; Hirsch 1981). In addition to etiological and developmental considerations,
another set of more proximal variables must be considered. Application of the stress-diathesis model (Rosenthal et al. 1974; Spring and Zubin 1977; Cancro 1980; Zubin 1981; Nuechterlein and Dawson 1984) is appealing for the clinical task faced with schizophrenia, for it is useful to conceptualize vulnerability to an illness where the timing and nature of manifestations are importantly determined by temporal factors described under the rubric of stress. This gives patient and clinician an opportunity to examine meaningful relationships between illness and the person’s experience without postulating etiologic significance and provides a basis for an analysis of interpersonal dynamics which are not implicated with respect to etiology.

When we speak of the manifestation of schizophrenia, we refer to a variety of psychopathologic attributes that are present in varying degrees and mixtures in different patients. We decline to make the diagnosis of schizophrenia in the absence of positive symptom manifestations, which include hallucinations, delusions, and conspicuous disturbances in the content and flow of thought. We also observe a range of deficit or negative symptoms in which the diminution or absence of ordinary functioning is observed (Strauss, Carpenter, and Bartko 1974). These features represent the personality impairment and deterioration so devastating in the long term. It is thus useful to consider the manifestations of illness in a social context since diminished engagement in the social sphere is one of the devastating and disheartening aspects of schizophrenia.

At the turn of the century, Kraepelin (1971) described the manifestations of dementia praecox as indicative of the dissolution of the very essence of the person. Although the nature of this most devastating disease was clearly described so many years ago, our knowledge of cause, prevention, and cure remains rudimentary.

**Personal Experience**

In followup studies of a quasi-representative cohort drawn from various treatment facilities (Carpenter, Strauss, and Bartko 1973; World Health Organization 1974; Strauss and Carpenter 1977; Pulver and Carpenter 1983), I noted the uniformity of treatment with antipsychotic drugs despite tremendous differences in illness manifestations and course. I also noted that the majority of patients had little opportunity for treatment beyond drugs and brief visits with various clinicians. They often did not know their doctors’ names and were uncertain with whom they would talk if they kept their clinic appointments. The patients with most favorable outcomes often seemed to make their adjustment “on their own.” Also, many of the patients with very poor outcome eschewed the advice of doctors, failed to comply with long-term drug treatment, and had no involvement with professionals who might guide, encourage, or otherwise support realistic adjustment.

On an inpatient program at the National Institutes of Health Clinical Center designed for the care and study of schizophrenic patients in the early phases of their illness, I had the opportunity to become intimately familiar with the experiences of acutely psychotic patients during periods off medication (McGlashan, Levy, and Carpenter 1975; Sacks, Carpenter, and Richmond 1975; Wadeson and Carpenter 1976; Carpenter, McGlashan, and Strauss 1977). Therapeutics were based on a number of interpersonal techniques as well as pharmacotherapy in selected cases. I was impressed by the strength and resiliency of patients facing the most vexing and devastating mental alterations. The fact that many patients did well during hospital care and at 1-year followup attests to their favorable prognostic status, and it was always difficult to ascribe change to decisive therapeutic interventions. These patients varied considerably in which elements of treatment they found useful and meaningful. Any therapeutic intervention welcomed and used by some patients was experienced as noxious and counterproductive by others. Two lessons were evident. First, treatment approaches need to consider the qualities of each patient, and sweeping generalizations based on diagnostic class cannot be implemented successfully without this individualized context. Second, many attributes of interpersonal care are found meaningful and helpful by patients having psychotic experiences.

**Treatment Relevant Subgroups.** For patients with a diagnosis of schizophrenia, it is useful to determine their similarity to certain treatment relevant subgroups. Further research findings in this regard will emerge, but we can now identify subgroups with distinguishing features or patterns of illness. Among these are groups associated with neurologic impairment, computed tomography scan evidence of altered brain structure, poor premorbid development, and chronic functional deficits. Such patients may be distinguished from those with neurologically intact, better prognostic, and more episodic types of illness (Crow 1985). For the former subgroups, the therapeutic benefits of neuroleptic drugs may be weaker and the risks
greater than in the latter. Similarly, patients may be categorized according to environmental circumstances (Carpenter and Heinrichs 1981; Leff, Kuipers, and Berkowitz 1983; McFarlane and Beels 1983). Those living in highly challenging, arousing circumstances require entirely different interpersonal strategies than those found in isolated, understimulating, low expectation environments. The administration of prophylactic antipsychotic drugs may be crucial in the former and deleterious in the latter. A manner of defining treatment relevant subgroups on the basis of clinical data alone is described elsewhere (Carpenter and Heinrichs 1981).

The fact that this effect is not robust on psychopathological attributes most likely to serve as a basis for judging treatment efficacy challenges psychiatry to better define the relevance of perspective, understanding, support, and placing the when and how—but not the why—of illness experience in a comprehensible personal framework. The following views on the role of diagnosis, treatment relevant subtypes, the individualization of treatment, pharmacotherapy, and interpersonal intervention are based on personal experience and a general synthesis of the literature.

**Diagnosis.** The introduction of psychoactive drugs with differential effects on various aspects of psychopathology made diagnosis of practical importance to therapeutics. It is not important because psychotherapeutic drugs are disease-class specific, for none are, but because purpose and choice of drug varies with classification. Both the diagnostic class and process are critical to therapeutics. Diagnostic class provides the first approximation of treatment requirements, and diagnostic process should be richly informative concerning illness manifestations, the personal strengths and weaknesses, and the circumstances of illness. A comprehensive diagnostic evaluation that includes a sufficient period of observation to become thoroughly informed as to the inner world of the patient is an indispensable starting point.

In addition to recognition of any definable illness, a careful differential diagnosis of functional psychoses is critical. The diagnosis of schizophrenia is reserved for patients with a psychotic experience which is not due to any known medical condition or to the effects of drug or toxic substance. DSM-III (American Psychiatric Association 1980) provides a number of alternative categories for the schizophrenia-like psychoses. These are not putative disease entities with their own set of therapeutic considerations, but they serve the useful purpose of withholding the designation of schizophrenia, which is associated with presumptions about therapy and course. Errors in the diagnosis of schizophrenia are not likely to be clinically damaging in early stages, since treatment considerations for alternative diagnostic classes may be essentially the same as for the acute phase of schizophrenia. From that point on, the patient with chronic or recurring forms of schizophrenia will provide sufficient clinical manifestations to revise the diagnosis to one of schizophrenia. With currently prevailing attitudes regarding the treatment of schizophrenia, it may be advantageous for early cases of schizophrenia to be treated as though they were an uncertain form of psychosis for which individualized, practical treatment decisions are more likely to be made. It is a more serious mistake to diagnose schizophrenia in cases with affective psychoses and organic psychosyndromes, for which treatment considerations are quite different.

More explicit guidelines for establishing treatment relevant subgroups of schizophrenia will undoubtedly be developed. Assessments of social environment, electrophysiology, psychophysiology, cognitive performance, clinical dimensions, course and drug response, biochemical markers, brain imaging, and personality will be of relevance to tomorrow's treatment planning.

**Individualized Treatment Decisions.** While characteristics of diagnostic and treatment relevant subgroups define the range of therapeutic considerations, the actual selection and implementation of treatment in any given case must depend on the specific evaluations of the individual patient and his or her circumstances. It is not only the nature of psychopathology but also the environmental circumstances and personality strengths and weaknesses of the patient that guide the clinician in selecting treatments. Such individualized decision-making requires a strong and continuous clinical relationship in which the clinician must be intimately informed about the patient's inner world, reactivity to various environmental circumstances, and responsiveness to various therapeutic maneuvers. The patient's ability and willingness to collaborate in the various treatment procedures is influenced by the bond that forms in this relationship.

The doctor-patient relationship affords the opportunity for phenomenologic evaluation (Jaspers 1963; Carpenter and Heinrichs 1980; Carpenter and Hanlon 1986) in which the experiences, perceptions, and behaviors emanating from illness and from adaptive response to the
illness can become known to the clinician. It is crucial to engage in this process relatively free of theoretical presentiment, if the uniqueness of each patient is to be fully appreciated. The resulting longitudinal framework thus yields a data base on which treatment decisions can be validly based, regardless of modality (Carpenter and Heinrichs 1980; Strauss and Carpenter 1981).

**Pharmacotherapy.** It is surprising that the pharmacotherapy of schizophrenic patients is so focused on neuroleptic drugs that a full exploration of the therapeutic potential of other types of drugs is rarely undertaken. In treating such an incapacitating illness, some risk-taking concerning pharmacotherapeutics is warranted to identify those individuals who would be responsive to non-neuroleptic drugs. Also, because of the grave consequences of the long-term use of neuroleptic drugs in many patients, the assumption of some risk in seeking treatment strategies that minimize exposure to these drugs is justified.

No low-risk treatment is presently available for schizophrenia, and clinical experimentation which deviates from the standard practice of administering neuroleptics does not shift from low to high risk, but rather alters the profile of risks and benefits. The treatment of schizophrenia is now freeing itself from the Procrustean bed where uniformity reigned and individual experimentation was curbed by legal, administrative, professional, and consumer pressures.

Although we do not yet have guidelines for selecting schizophrenic patients who will prove responsive to other classes of psychoactive drugs, there is ample descriptive literature and some empirical documentation of responsiveness to lithium and antiseizure medication. Also, dysphoric affect in the schizophrenic patient may at times be alleviated by anxiolytic or antidepressant medication, and hypnotic drugs may be effective for insomnia. This entire range of clinical manifestations is usually treated with antipsychotic drugs alone even when not part of a psychotic episode. Painful anxiety, in the absence of psychotic deterioration, suggests a role for antianxiety drugs. Significant depression, in the absence of florid psychotic symptoms, may be sufficient indication for a trial with antidepressant drugs. Patients with a history of seizure disorder, inexplicable and stereotyped behavioral outbursts, head trauma, pathologic intoxication, and microamnestic episodes may be candidates for a trial with antiseizure medication (Monroe 1970, 1982).

Inasmuch as they are faced with a likely prospect of lifelong illness and reliance on antipsychotic drugs, even patients without clear indication of potential responsivity could be administered other types of drugs and followed on an empirical trial basis. Responsiveness to lithium is a case in point. It would seem evident that the greater the similarity with the affective disorders, the better the indication for a trial with lithium. The clinical trial literature does identify a subgroup of lithium-responsive schizophrenics, but does not confirm the expected delineation of this subgroup. Schizophrenic patients without characteristics similar to the affective disorders appear as likely to be lithium responders as those with affective features. Donaldson, Gelenberg, and Baldessarini (1983) provide an excellent literature review and discussion of non-neuroleptic pharmacotherapy in schizophrenia. The unfortunate fact that most patients with chronic schizophrenia will not be robustly responsive to these drugs is no basis for failing to find the minority who will be responsive.

New strategies with neuroleptic drugs are warranted (Schouler 1983; Mosher and Meltzer 1984) in an effort to reduce the incidence of tardive dyskinesia and minimize other long-term adverse drug effects. Efforts to reduce neuroleptic drug exposure with low dose or noncontinuous treatment are yielding favorable preliminary results in controlled studies (Carpenter and Heinrichs 1983; Donaldson, Gelenberg, and Baldessarini 1983; Falloon and Liberman 1983; Friedhoff 1983; Kane 1983; Schooler and Carpenter 1983).

Investigations concerned with pharmacologic intervention during the prodromal phase of relapse to determine if patients can remain off medication for substantial periods and still gain prophylactic benefits from an early intervention strategy require a clinical program that integrates psychosocial approaches, phenomenology, and psycho-pharmacotherapy. The low-dose continuous drug approach is another neuroleptic drug reduction strategy proving feasible for clinical application. It appears that dosages in the range of 10-20 percent of prevailing levels are almost as effective as these levels at reducing relapse rates, and may be associated with enhanced cognitive function and social adjustment. The psychosocial aspect of therapeutics for both the intermittent and continuous drug administration strategies emphasizes continuity of care, education of patient and relatives, clarification of the prodromal phenomenon, crisis management, environmental support, and other practical considerations. Finally, although transitory negative
symptoms respond to neuroleptic treatment of acute psychoses, almost unexplored is the pharmacotherapy of long-term negative or deficit symptoms (Carpenter, Heinrichs, and Alphs 1985).

Interpersonal Strategies. Evidence to date has not established the therapeutic efficacy of exploratory, insight-oriented psychotherapy in schizophrenia. Comparative studies have failed to demonstrate that this form of treatment is superior to less theoretical, more supportive interpersonal strategies or to pharmacologic treatments (Gunderson 1979; Mosher and Keith 1980; Heinrichs and Carpenter 1981; Stanton et al. 1984), and May's (1968) seminal contribution has withstood challenge despite methodologic problems. Empirical data supporting the efficacy of more practically derived family and individual techniques are encouraging (Paul, Tobias, and Holly 1972; Falloon et al. 1982) and provide a beginning for the examination of the integration of interpersonal and pharmacologic treatment strategies (Stein, Test, and Marx 1975; Heinrichs and Carpenter 1982, 1983; Anderson 1983; Falloon and Liberman 1983).

A well-designed study of the efficacy of intensive psychotherapy in schizophrenia requires enormous effort. The equivalent of a placebo control is difficult to construct. Alternative interpersonal treatments may be usefully compared, but this addresses the secondary question of comparative efficacy rather than the primary question of efficacy per se. The goals of psychoanalytically derived therapy, however, can be clearly articulated and reliably assessed (McGlashan and Miller 1982), and the operations of such treatment for persons with schizophrenia have been recently reviewed (McGlashan 1983).

The recently completed psychotherapy of schizophrenia project (Gunderson et al. 1984; Stanton et al. 1984) illustrates the feasibility of conducting an arduous experiment, and found that exploratory psychotherapy was not superior (as hypothesized) to supportive psychotherapy. However, the primary psychotherapy efficacy issue still remains to be directly assessed (Carpenter 1984).

In clinical practice, it is time to return to a basic empirical approach. The irreducible essence of our interest in schizophrenia is the nature of another person's experience. It is in the subjective and inner world of volition, perception, cognition, and affect that schizophrenia is manifest. Empathy is crucial in discovering the subjective life of another person, and to engage in this process with the psychotic person requires skill, intuition, training, and perseverance. Jaspers recognized that knowledge of this inner world was central to diagnosis, prognosis, and treatment, and he borrowed phenomenology from Husserl's philosophy and introduced it into medicine as a scientific method (Jaspers 1963). Phenomenology defines the goals and methods used by the clinician to generate the observations upon which clinical decisions are based. When this base is weakened by narrowly defining psychopathologic attributes, or by distorted observation with premature inference and theoretically determined assumption, our view is truncated and the science of clinical care is compromised.

The Clinical Relationship

The cornerstone of treatment of the schizophrenic patient is the clinical relationship. This relationship needs personal continuity over time, not simply because this is a more sensitive delivery of care, but because the patient with schizophrenia is so likely to have difficulty establishing relationships, maintaining trust, and taking initiative. The type of relationship envisioned need not be and, for practical matters, cannot always be with a physician. I would stress, however, the importance of the primary clinician being familiar with the full range of potential treatments ranging from psychosocial rehabilitation through family and dyadic treatment strategies to pharmacologic considerations.

The initial task in the clinical relationship is phenomenologic, and does not require a theoretical or therapeutic orientation. A focused psychotherapeutic stance is thus based on observed difficulties and the discernment of potentially attainable goals. Psychotherapeutic work need not be exclusive, nor should it compete with other aspects of treatment. The reworking of personality structure no longer seems a suitable or practical goal in the treatment of most schizophrenic patients. Psychotherapeutic tasks are more promising when based on short term, highly individualistic goals, such as reducing stressful, idiosyncratic reactions to environmental events or developing insight into warning signs of impending relapse.

As part of his work, the clinician has important educational responsibilities to the patient and other household members. The patient and family may be so burdened with misconception and misinformation that an educational effort is reassuring and illuminating. To be optimally effective, such education should be personalized so that it takes on real meaning to patients and their families. Dealt with in
abstraction, the information may prove difficult to incorporate and use. Furthermore, each case has specific considerations which may not be addressed in a more general educational presentation.

Present therapeutic work that involves the family has made an important shift from an etiologically oriented—often experienced as blaming—approach to one that emphasizes collaboration with those most extensively involved in caring for the patient. The importance, for example, of stress reduction and stress coping strategies in general in the management of an individual with a stress-sensitive illness is more readily understood in a benign context where collaboration is established.

Many other issues having a bearing on treatment emerge in this clinical relationship. We can, for example, counsel on the genetics of schizophrenia, but only after developing a view of the particular concerns and assumptions of each patient and family (Tsuang 1978; Kessler 1980). Also, recognition of the role of violent fantasy and primitive impulse can enable the clinician to monitor dangerousness. When the primary clinician requires the involvement of other clinicians to administer specific treatments, the medical model provides a basis for integrating the professional team. It is crucial that the patient deal with new treatments—e.g., change in drug status—with a familiar clinician. There are scores of such crucial components which can only be illuminated and responded to in the context of an ongoing clinical relationship. The establishment of a health care system that interjects a different person and place for each therapeutic shift—e.g., “Go to the emergency room and tell the doctor the voices are coming back,” was designed without regard to the nature of schizophrenic illness.

The clinician’s role is a challenging one. A broad knowledge of psychopathology, interpersonal skills, the medical model, and diverse treatment techniques is required. The work is frustrating, for cause and cure remain elusive. The patients are often fascinating, often fatiguing, but their courage is remarkable and their need compelling. We are presently in a position to move knowledge forward by relying more extensively on what is observable and verifiable, and by integrating clinical observation with the rapid advances in technology and science now occurring in the life sciences. We must resist the temptation of oversimplifying schizophrenia. The presentation of a medical model scientifically valid for the care and study of persons with schizophrenia may also serve as a standard for other fields of medicine where clinical observation is too narrowly defined, where biologic reductionism belies the complexity of human organization, and mindfulness of the human dimension is no longer understood in a benign context where collaboration is established.

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Schwartz, M., and Wiggins, O. Medical science and humanism: A phenomenological view. Perspectives of Biology and Medicine, in press.


Wynne, L.C., and Singer, M. Thought disorder and family


Zubin, J. How to break the logjam in schizophrenia. *Journal of Nervous & Mental Disease*, 169:477-492, 1981.


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**An Invitation to Readers**

Providing a forum for a lively exchange of ideas ranks high among the *Schizophrenia Bulletin*’s objectives. In the section At Issue, readers are asked to comment on specific controversial subjects that merit wide discussion. But remarks need not be confined to the issues we have identified. At Issue is open to any schizophrenia-related topic that needs airing. It is a place for readers to discuss articles that appear in the *Bulletin* or elsewhere in the professional literature, to report informally on experiences in the clinic, laboratory, or community, and to share ideas—including those that might seem to be radical notions. We welcome all comments.—The Editors.

Send your remarks to:

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National Institute of Mental Health
Alcohol, Drug Abuse, and Mental Health Administration
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