Discussion of Neuroleptics and Psychosocial Treatment

by Clarence G. Schulz

Abstract

The author discusses the Neuroleptics and Psychosocial Treatment issue of the Schizophrenia Bulletin from the viewpoint of a practicing clinician. The clinical implications of each of the review articles are assessed in turn, and conclusions derived from the articles are summarized.

My discussion of the collection of articles on neuroleptics and psychosocial treatment published in this issue will be from the standpoint of a clinician who is interested in the practical applications of research findings. Before turning to the specific articles, I would like to comment on what I see as the problems in carrying out research on the treatment of schizophrenia. I would first ask whether the orientations of researcher and therapist are not antithetical. The researcher is required to be open-minded, skeptical, and to achieve results within a short enough period of time to conclude his study and publish it. The clinician must have some conviction and bias about the effectiveness of his approach and requires a longer term application of the treatment. The clinician's treatment plan is usually a comprehensive multidimensional approach based on the assumption that a combination of factors might be more effective than a single modality. By contrast, research studies reduce the variables to fit a research design, and often tend to provide a minimally intensive psychosocial treatment as compared to more adequate use of medication. Sometimes investigators who prefer the neatness of the pharmacological paradigm have a disdain for psychosocial treatments such as milieu, psychotherapy, and activities. Psychosocial treatments are more difficult to define and to quantify. It is a problem to determine how much psychosocial treatment the patient is actually getting—since there are no "blood levels" to measure—and to assess outcome in terms other than rehospitalization—for example, items such as "quality of life" and "insight." Dr. Kubie raised the seemingly simple question, when do you measure outcome? Should it be when one completes the treatment? On the face of it, this would seem logical. But beneficial treatment effects, such as transference resolution, continue to be active for some time after the formal treatment ceases. Again, what does one measure to assess outcome? Gross behavioral change? Rehospitalization? The ability to make choices?

The authors of the articles in this issue have correctly emphasized controlled studies. Nevertheless, one can naively ask: Is it possible to have a truly matched control? Is it possible to alter one variable at a time? Have uncontrolled, impressionistic studies no place in assessing treatment effectiveness?

Most of the problems of the field are mentioned in the review article by Mosher and Keith (1980). Some of these are worth reminding ourselves about here. The heterogeneous composition of the schizophrenias suggests we may be dealing with conditions analogous to fevers or cardiac decompensation. The psychoses represent a final common path to a multiple vector situation, where the malfunctioning of a combination of factors leads to a breakdown in the system. Conversely any improvement in some combination...
of factors might be enough to restore function and bring about improvement. I once heard the analogy of a table with six legs. The table could conceivably still stand with three of its legs removed, but not with four removed. It might be restored to some semblance of stability if one additional essential leg were strengthened, or it might withstand greater stress if several legs were made sturdy depending upon their relation to each other. All of this is by way of reiterating the problems in the field we are trying to study and of maintaining a degree of skepticism about the confusion in our findings. When we include the possibility that a variety of “schizophrenia” can occur in the same person with a variety of “affective disorder,” the picture becomes further complicated.

These articles are especially timely because we need more specific indications for the use of neuroleptic medications, as well as for psychosocial modalities of treatment. Such long-term side effects of neuroleptic drugs as tardive dyskinesia are of increasing practical concern to the clinician. Mosher and Keith (1980) observe that “neuroleptic drugs are now an almost universal element in the treatment of schizophrenia” (p. 11). Some patients do improve without medication, and we need to learn who they are. I would guess that the younger generation of psychiatrists, both residents and researchers, have not had the experience of patients getting well without medication. This in itself calls into question the routine early use of neuroleptic medications solely on the basis of diagnosis. There are other reasons to learn more about psychosocial modalities. We are in an era when it is becoming increasingly frequent for patients to exercise their right to refuse medication. These refusals are part of an increasing popularity of rights’ issues, but also reflect a growing concern about the environment and what goes into our bodies—whether it be carcinogens or medications that can produce side effects. We should be able to determine not only whether psychosocial treatments are effective but what particular modalities are useful for what patients and in what phase of treatment. Psychosocial treatments involve staff time, which is very costly and must be used with efficiency. As some of the articles demonstrate, the psychosocial modalities can enhance the effectiveness of medications (and vice versa) and at times replace medications. Moreover, we need to have effective alternatives to pharmacotherapy if patients refuse medication, if there are contraindications that preclude the use of medication, and if patients prove unresponsive to neuroleptics.

The review by Mosher and Keith (1980) summarizes the problems in assessing the psychosocial treatment of schizophrenia. Although there is relatively little “research evidence” documenting the efficacy of psychosocial treatment, most of us who work in the field are convinced of the importance of human relationships in the treatment of schizophrenia. Mosher and Keith point out the wide variety of ways in which such relationships can be fostered. They rightly take the position that community support systems have powerful effects on outcome and are not merely a background for the “real” treatment (neuroleptics or individual therapy). I would call the reader’s attention to the following important sentence: “For the purpose of this review, we will assume that psychotherapy is not being conducted in a setting in which it is dismissed as a waste of time, and medication is held to be the only effective treatment for schizophrenia” (p. 12). Their assumption needs to be underlined, for I am afraid that all too often medication, by itself, has become the prevailing treatment approach in many short-term inpatient units as well as aftercare clinics.

Mosher and Keith’s list of six requirements for psychotherapeutic research is rather comprehensive and should be kept in mind. They also identify flaws in psychosocial research—for example, the tendency to use rehospitalization as the major measure of outcome. Their review of studies on individual psychotherapy makes clear that all these studies have design problems. Since Mosher and Keith limit themselves to controlled studies, they necessarily ignore earlier uncontrolled accounts of effective psychotherapy. It ought to be clear by now that psychotherapy, by itself, without an appropriate corresponding psychotherapeutic milieu, is about as effective as surgery in a dirty operating room. The authors cite the study by Hogarty et al. (1973, 1974a, 1974b) as an example of exemplary treatment research. From that study it is important for clinicians to know that the patients receiving neuroleptics and “major role therapy” did better than patients treated with neuroleptics alone—and this was not simply because major role therapy increased medication compliance.

Again the Mosher and Keith account of group therapy illustrates all the problems of psychosocial research—what constitutes group therapy, the relatively short periods of treatment (6 weeks), and the problems of outcome measures and who does the ratings. For the practicing clinician, I think one might conclude that group therapy should be considered in the posthospital aftercare
of chronic patients. One can also conclude that a community support system is an essential element in any program for the treatment of severely ill schizophrenics, both for the prevention of hospitalization and for rehabilitation following hospitalization. The community support system includes a wide variety of programs, the essential ingredients of which we do not know for certain but which might be hinted at in the article by Gunderson (1980). Gunderson points to the ingredients of a successful milieu when he focuses on the "high interaction between patients and staff" and "the degree to which patients and staff are involved in decisions and share responsibilities" (p. 67). He writes that "the current studies all underscore the potential role of nonprofessionals within successful milieus and suggest that their motivation and enthusiasm may be as important as the specific treatment model around which the milieu is organized" (p. 68). This is in accord with my own conclusions from observations of Sullivan's interviews with patients 50 years ago and from my ongoing work with patients in treatment. The intensity of the involvement of the therapist with the schizophrenic patient is an important indicator of the likelihood of the psychotherapy's being effective.

Gunderson's article is particularly relevant at a time when insurance companies do not regard the milieu aspect of treatment as reimbursable, since every program "provides a milieu." In the studies reviewed by Gunderson, the intensive psychosocial milieu often makes a difference for nonchronic schizophrenic patients, and may be as effective as drug treatment without an intensive milieu. Another finding not to be overlooked is the conclusion that nonchronic schizophrenic patients did better with 3 to 4 months of intensive milieu therapy than with only 1 month in the same milieu. We can see the importance of length of stay, at least for some patients. This observation should be kept in mind when there is an overzealous push by third party payers to limit hospitalization. What seems to emerge is the rediscovery of the value of the social field (milieu) and its influence on inpatients, together with the importance of good relationships with the family (as pointed out by Young and Meltzer, 1980). The crucial function of the social field was apparent over 25 years ago as a result of work such as that of Stanton and Schwartz (1954). Those findings, together with the development of the open door hospital and early efforts to keep patients in the community, were largely eclipsed by the rapid development of pharmacotherapy. Many programs jettisoned psychosocial dimensions in favor of an exclusive pharmacological approach and are only now rediscovering the importance of the social field.

I am sure that "flaws" will be discovered in the retrospective study of Young and Meltzer (1980) but they made an important effort to characterize patients who are likely to recover without medication. It will be apparent from some of the other articles still to be discussed that efforts should be made to avoid medication if possible, to use the smallest dose needed, and to continue medications for the shortest period of time. In summary, the characteristics of those patients likely to be successfully treated without high dose medication are the following: female, first admission, hospitalization within a week of onset of psychosis, less likely to have prominent excitement, less likely to have specific somatic or auditory hallucinations, and nonparanoid/nonschizoid premorbid personality. I would guess these to be almost identical with the features of good prognosis patients in general. Again, the article by Young and Meltzer presents cogent reasons for attempts to avoid routine high dose medication in newly admitted schizophrenic patients.

The review by Davis et al. (1980) demonstrates that antipsychotic medications are clearly better than placebo in the treatment of acute patients. This conclusion seems contradictory to those of the previously mentioned articles. One should keep in mind that there was no description of an active effective milieu program being given along with the placebo. It is quite likely that medication by itself is more effective than any single modality of anything else (psychotherapy, milieu). But the review also makes clear that some patients improve on placebo, and it is important to try to find out which ones these might be. For the practicing clinician, one can conclude that initial rapid high doses of medication with acute patients are of no greater benefit than moderate doses and only result in an increase in the number of side effects. In chronic patients, doses above a certain range, in general, are of no increased efficacy, but we still have to individualize dosage for the particular patient. There may be some chronic patients who require large doses of medication. Also, as has often been stated in maintenance therapy, medication prevents relapse, but we must remind ourselves of the dilemma between the potentiality of the development of tardive dyskinesia and the possibility of relapse from psychosis. Instead of using statistical probabilities, the clinician would have to try each patient to determine if he or she can be medication free or maintained on the
lowest possible therapeutic dose.

This brings me to the Berger and Rexroth (1980) article on tardive dyskinesia. One finds that it is important to distinguish tardive dyskinesia, which is limited to movements as a consequence of neuroleptic administration, from other similar involuntary movements. The article points out that the latter were described by Kraepelin and Bleuler long before the introduction of neuroleptic drugs. In addition to the fact that prevalence rates vary considerably, there are a number of unanswered questions about tardive dyskinesia: Who is most susceptible? Is it dose related? Do we have any effective treatment? Do drug holidays aggravate the problem? Spontaneous remissions make it difficult to assess the effectiveness of treatment of tardive dyskinesia. It will be important to keep abreast of future research developments which may provide some answers to these questions. The article illustrates the complexity of interpreting neuropharmacological research findings. It is humbling to be reminded that we are still very much in the beginnings of the explanation of neurobiological mechanisms. As mentioned at the outset of this discussion, it is important for us to find alternatives to the present medications and to use additional treatment methods that themselves need to be further studied and refined.

Finally, the article by Wallace et al. (1980) on social skills training points out that “Perhaps the greatest limitation of an exclusive reliance on drug therapy is its inability to impart new instrumental role behaviors and interpersonal skills with consequent improvement in patients’ quality of life” (p. 42). The field of social skills training, an important one in terms of enabling patients to cope with their interpersonal environment, is difficult to assess for the same reasons that milieu and group therapy have been difficult—namely, the variations in definitions, cases being treated, and methods of evaluation. All of these are readily identified by the authors. Wallace et al. indicate that there is evidence of the effectiveness of these procedures, but “that changes do not occur for every patient and, when they do occur, often do not generalize to new situations” (p. 42). Social skills training does not yet result in as clinically meaningful a set of changes as might be desired.

My conclusion from these articles is that we would want to treat the patient in a setting (not necessarily a hospital) that allows one to postpone administering neuroleptics, provides alternative means of responding to intolerably disturbed or regressed behavior, emphasizes responsive, involved staff, and presents expectations of the patient’s highest potential level of functioning. Medications should be available if necessary, used in the smallest amounts needed, and for the shortest period of time. Efforts should be made to restore coping functions, improve family relationships, and provide a community support system. The maintenance of a human relationship is essential to the welfare of the schizophrenic patient.

References


The Author

Clarence G. Schulz, M.D., is Senior Psychiatrist, The Sheppard and Enoch Pratt Hospital, Towson, Md.