

INTERPRETATION OF SCHIZOPHRENIA

The Choice of Treatment

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The Choice of Treatment

In the presence of a schizophrenic disorder the therapist's first duty is to choose the type of treatment. At the present stage of psychiatric development, the methods of treatment are few, and yet the choice may be difficult even among few possibilities. The psychiatrist must be aware that he is generally inclined to select, at times unwisely, the type of treatment that is in agreement with his own theoretical orientation. For instance, an organically oriented therapist may be inclined to recommend physical therapy and discard any other; a hospital psychiatrist may be inclined in the majority of cases to recommend hospitalization. Each therapist must learn to counterbalance his own biases in order to evaluate properly each individual case.

I

Hospitalization versus Ambulatory Treatment

One of the first decisions the psychiatrist has to make is whether to recommend hospitalization or to pursue a type of ambulatory treatment. Until approximately 1955, the presence of a psychotic

disorder, even a mild one, was almost always followed by a recommendation for hospitalization. A long tradition was behind this practice. Kraepelin's concept of dementia praecox developed in a mental hospital setting and the equation "psychosis = hospitalization" was almost automatically made. Different criteria have lately prevailed, as our better understanding of the disorder and our techniques of prompt intervention have opened up new approaches. However, hospitalization is still to be recommended in many cases. The following are the main indications of a need for hospitalization, not listed in order of importance, which varies in each case:

1. To provide treatment that cannot be given on an outpatient basis; or when drug therapy has to be administered at dangerously high doses, or at such frequent intervals that the family cannot properly carry out the program; or when electric shock treatment or insulin is required, and so on.
2. The patient is so disturbed or so acutely ill, or his delusion may be so irrational, that he constitutes a danger to himself or to others.
3. The patient's behavior is so bizarre as to put him into conflicts with society that are of such magnitude as to have an adverse effect on the subsequent course of his

illness.

4. To remove the patient from the usual environment where the conflicts are perpetuated or where a climate of hostility and rejection prevails.
5. To provide relief to the members of the family who can no longer endure the state of tension and turmoil created by the patient. This situation is keenly experienced when children are to be taken care of or when a family member is sick or pregnant.
6. When the patient who in the past had a psychotic episode from which he had a remission shows signs of decompensation or not adjusting again and seems in urgent need of a less demanding environment. We must not wait until the tenuous grasp on social life has been lost.
7. The patient is in need of a therapeutic community. Group therapy and a special type of living and working, are needed more than individual therapy, or are needed *in addition to* individual therapy.
8. The patient feels in a general state of malaise and wants the security of hospitalization. In most of these cases the psychosis is already in action. In some cases the patient feels he is falling apart, or vaguely or even distinctly persecuted, and seeks the refuge and protection of the

hospital. In some of these cases by hospitalizing the patient, the psychiatrist prevents an exacerbation of the disorder.

Contraindications to hospitalization are the following:

1. The symptomatology is not severe. We must remember that the presence of such symptoms as hallucinations, delusions, or ideas of reference, or peculiar behavior is not in itself sufficient indication for hospitalization. These symptoms constitute grounds for hospitalization when they bring about the conditions that we have outlined above.
2. Psychotherapy and/or drug therapy are diminishing the symptomatology to such an extent as to remove the indication for hospitalization.
3. The symptomatology is not expected to worsen because the patient has free social contacts.
4. The patient receiving ambulatory treatment is able to work and provide for his own treatment. Stopping work may be experienced as a defeat and should not be resorted to unless necessary.
5. The patient is able or willing to receive office or clinic treatment.

6. Environmental conditions can be changed. It is possible to make them less demanding, less traumatic, and more accepting.

The listed positive and negative variables can be subsumed under fewer categories or further divided into subclasses. It may be a difficult task for the therapist to evaluate all of them in a relatively short time and to reach a quick decision. In clear-cut cases, such as those of acutely ill patients, or homicidal and violent patients, the indications are evident. Several cases are doubtful, because indications may vary in a short period of time. Other factors at times hamper the decision of the psychiatrist. For instance, in the presence of paranoid persecutory ideation, the danger that the patient constitutes to himself or others may be very remote, and yet the therapist may be reluctant to assume even a little risk. Errors are unavoidable, because each variable can be weighed only in an approximate manner and according to criteria that often are only subjective in nature. Society must learn to accept the inevitability of some errors.

Extreme cautiousness and propensity to hospitalize or to keep patients in hospitals for a very long period of time may avoid some pitfalls but bring about many others. We have learned in Chapter 23

that hospital life promotes so-called hospitalism, a passive life without challenges, where an impersonal or even callous atmosphere and limitation of activities often prevail. Hospitalization *per se* does not *cure* schizophrenia. A form of milieu therapy is often helpful but insufficient.

II

Physical Therapies versus Psychotherapy

Such treatments as insulin coma therapy, electric shock treatment, and especially psychosurgery are no longer used today in a routine way. They are resorted to very sparingly, and only in those cases that have not responded to other types of treatment. They will be studied in Chapters 42 and 43 of this book. The cogent dilemma today is between the use of psychotherapy and drug therapy.

I have already, although indirectly, manifested my bias in favor of psychotherapy. I have tried to demonstrate that although psychodynamic factors may not constitute the total etiology of schizophrenia, they are essential or necessary elements of it and can be altered by psychotherapeutic methods. In other words, although psychotherapy cannot be considered totally specific and attacking all

the etiological elements, it may attack enough of them to make the existence of the disorder impossible. Because genetic factors cannot be changed, psychotherapy seems to me a much more causative and much less symptomatic type of treatment than any other type of therapy I know of. I have obtained my best results with patients treated exclusively or predominantly with psychotherapy.

However, I hasten to state that I use drug therapy as a routine practice with some patients. It is not difficult to explain why my attitude diverges according to the case in question. In spite of the tremendous progress made in the field of psychotherapy, this type of treatment is long and, in some cases, unpredictable. It is fair to admit that some patients have not responded enough to this type of treatment even when such treatment has been given by the best specialists in the field. It is also correct to say that drug therapy is only a symptomatic type of treatment; its main or only function may lie in the reduction of anxiety. This reduction would make the symptoms, which are pathological defenses, unnecessary. On the other hand, drug therapy has the following advantages: in many cases it decreases the intensity or acuteness of the overt symptomatology; in other cases it eliminates the overt symptomatology entirely. In still other cases, even

though the symptoms remain, they cause less disorganization of the personality. The patient is able to maintain a certain distance from his symptoms and becomes capable of being reached by psychotherapy. Many patients who would have to be hospitalized, interrupt work and abandon their families, can be treated outside the hospital and can continue to work and provide financially for their treatment. In a certain number of patients the therapist is able to establish relatedness with the patient only when drug therapy is administered.

The advantages of drug therapy are so many that many readers may wonder why I refrain from a total endorsement. The main reason is that in my experience drug therapy makes the patient less sensitive not only to his own anxiety but also to the treatment. Psychotherapy, although still effective, makes less of an impact on the medicated patient. Thus no instructions can be given that apply to every case. Each patient must be evaluated individually. If what we gain with drug therapy is more than what we lose, we must by all means institute drug therapy, at least for the initial stage of the treatment. If the patient cannot be affected by psychotherapy alone and especially if no relatedness can be established, drug therapy should be initiated. Another variable is constituted by the therapist himself and by the

degree of experience he has with psychotherapy alone.

In many parts of the world psychotherapy is not yet available. In those cases, of course, symptomatic therapy is mandatory.

Most therapists today have solved the dilemma by accepting a mixed treatment, which consists of both psychotherapy and drug therapy. I do not see counterindications for this type of treatment in the majority of cases. As a matter of fact, the reader must be clear on one point—although I am in favor of using drug therapy in some cases, I never rely on drug therapy alone. I believe that concomitant psychotherapy is necessary if we want to obtain more than the removal of the overt symptomatology. The aim of the psychotherapist should be that of changing the patient's inner life rather than simply freeing him from his symptoms.

As already mentioned, a number of hard-core cases do not respond either to psychotherapy or usual drug therapy. Other types of treatment must be resorted to, as described in Chapter 43. Family therapy and the use of the therapeutic assistant will be discussed in Chapter 39.

III

Comparison of Different Results

Studies comparing the different methods of treatment of schizophrenia have debatable value. In most of these studies loss of overt symptoms is confused with recovery. When psychotherapy has been compared with other methods, it has generally been psychotherapy given by residents who had little experience in treating patients with intensive psychotherapy. A valuable type of comparative analysis could be offered only by a therapist who has profound experience with all the types of treatments in a statistically significant number of cases.

May (1968), in a comparative study of five methods (milieu therapy, electroconvulsive therapy, drug therapy, individual psychotherapy, individual psychotherapy plus drugs), found that drug therapy alone and psychotherapy plus drugs were the most effective treatments and also the least costly in time and money. By clinical criteria the advantage between the two was generally with psychotherapy plus drugs. However, the difference between the methods was small, "insubstantial and never impressive." May saw no antagonism between drugs and psychotherapy; on the contrary, when

an effect existed, it was in the direction of potentiation of the positive drug effect. In May's study psychotherapy alone "appeared to have little effect or even a slightly adverse one." Again we must remember that in May's studies psychotherapy was done by inexperienced residents. They had supervision, but they were supervised by analysts experienced in classic Freudian analysis, which is not the most suitable for the treatment of schizophrenia.

IV

Therapies Not Described in This Book

As mentioned in the preface of this book, the very important topics of group psychotherapy, day hospital, milieu therapy, and therapeutic community will not be discussed in this volume. The omission of them should by no means be interpreted as disregard on my part for these types of therapy.

These therapeutic approaches are very important and very useful in many cases. They have to be considered as adjunct therapy. With the exception of a few cases, they cannot replace the others described in Chapters 35 to 43. The reasons why they are not mentioned in this book are several: (1) The author has made no contribution to these

fields; (2) excellent reviews of the literature of these subjects exist; (3) it is not necessary for the therapist who treats the individual patient to know these techniques. On the other hand it is advisable for the therapist who practices them to have a knowledge of the subjects treated in this book.

Psychosurgery is briefly discussed in Chapter 43, not because I recommend it (as a matter of fact, I am opposed to it), but because of its theoretical implications.

For an excellent review of the literature on group psychotherapy of schizophrenics the reader is referred to the work by Schniewind, Day, and Semrad (1969). For works on day hospital the following works are recommended: Kramer (1962), Axel (1959), and Zwerling (1966). For works on milieu therapy the book by Artiss (1962) is suggested. For hospital treatment in general the following books are recommended: Stanton and Schwartz (1954), Linn (1955, 1959, 1961), and Galnick (1969). For the therapeutic community see Jones (1953) and Kraft (1966).

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