The Management of Chronic Schizophrenia

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With the movement of psychiatric patients from chronic mental hospitals to local communities over the past 20 years, family physicians have provided care for increasing numbers of chronic schizophrenia patients. The residual symptoms which these patients demonstrate require special communication skills on the part of the physician if a collaborative patient-physician relationship is to be established. The management of the disease should be founded on an understanding of its psychopathology. In this paper, the authors describe this psychopathology and suggest therapeutic interactions and interventions specific to the disease process.

Within the past two decades, the population of state mental hospitals decreased by two thirds. In large part, this reduction was accomplished through improvement in the control and management of florid psychotic symptoms in patients with chronic schizophrenia. As a result, thousands of chronic patients were able to shift their residence from mental hospitals to local communities.[1,2] As this movement occurred, their general medical and psychiatric care shifted to the health care providers within these communities.

At the present time, the health systems providing this care vary widely from one community to another. For example, many communities have no mental health centers and no psychiatrists. In these communities, the family physician must manage both the general medical and psychiatric needs of these patients. Further, mental health centers differ from one community to another in the services they provide. Many centers have minimal services for patients with chronic schizophrenia and responsibility for their care falls, as in the case above, to the family physician (and psychiatrist if one is available). Even in communities where the mental health centers and psychiatrists provide the full range of psychiatric services for these patients, the family physician must often attend to their general medical problems. The family physician must thus provide (1) general medical care, and (2) psychiatric care where psychiatric services are not available for ambulatory patients with chronic schizophrenia.

Training for the management of these patients varies from one residency or postgraduate program to another, but, in general, there is little emphasis on their specialized needs beyond the prescription of psychotropic drugs. Should interested physicians seek information from the literature, they will encounter similarly limited or impractical references. For example, excellent guidelines for medication management can be found in journal articles,[3,4] texts on psychopharmacology,[5] and texts that address the topic of psychiatry in general medical practice.[6-8] Some of the latter sources review symptomatology and offer cursory guidelines for patient management but fail to relate

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0094-3509/80/090407-07$01.75
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one to the other. Psychiatric texts[9,10] add discussions of individual, group, family, and network therapy, but these are addressed to the practicing psychiatrist or psychoanalyst and are of limited practicality for the family physician. Thus, neither basic training programs nor continuing medical education resources provide comprehensive or practical patient management knowledge and skills.

While a paper of this length cannot redress this lack completely, the authors intend to expand upon certain aspects of the disease process which are underemphasized elsewhere and which are of major importance in the management of chronic schizophrenia. Appropriate interventions and management strategies will be discussed. Since multiple sources of information are available that cover the use of antipsychotic medications, this aspect of patient management will not be addressed in detail.

Difficulties Encountered by the Physician

Following an acute psychotic episode, the residual symptoms exhibited by patients with schizophrenia are particularly trying for the physician to deal with as they involve the basic communication system between physician and patient. The physician is dependent upon this communication system to receive clear and relevant information from the patient upon which to base his medical assessment. He is further dependent upon this system when he transmits information and recommendations to the patient. If the patient cannot receive and interpret these accurately, he will be unable to implement the treatment plan. Yet, it is in this very process of receiving, processing, and transmitting information that the patient with schizophrenia is defective.

To elaborate, first, the patients' ability to accurately perceive incoming sensory stimuli is frequently impaired. What they see, hear, smell, taste, and feel is distorted. These distortions have a tremendous impact on the medical interview. For example, one patient characteristically sat through interviews with his head bowed while staring at the floor. Although he could converse fairly well with the physician while maintaining his downward gaze, whenever he looked up and made eye contact, he would become confused and perplexed and, at times, laugh inappropriately. He was able to explain that when he looked at the physician's face, it became distorted, the eyes bulged, the nose grew, the mouth twisted. He was so distracted by these distortions that he would disregard the ongoing interview. When he laughed, he did so because the physician's face looked so funny. In conversation with a normal individual, eye contact facilitates communication; with this patient, eye contact jeopardized it. Another patient reported an auditory distortion. At the end of the preceding interview, the physician had actually said, "Have a good weekend." The patient said this statement "went right into" her head. It was "like the voice of God commanding" her to enjoy herself. For the entire weekend, she was unable to remember another thing that was said during the interview as she struggled to obey the command. This patient frequently commented on the "power and magic" that some of the physician's words had on her. Since the physician could never determine in advance which words would have such an effect, it was impossible to modulate the interview in a fashion that accurately reflected what the physician intended to convey. Other common perceptual distortions experienced by patients with schizophrenia are auditory hallucinations. For example, during an interview with another patient, the physician noted that periodically the patient seemed to drift off and become preoccupied with something other than the interview. At these times, it was difficult to know whether or not the patient understood what the physician was saying. When he was questioned, the patient revealed that at these times his voices were talking to him. Usually, they were making derogatory comments about the physician and what he was saying. These comments not only distracted the patient but also undermined the patient-physician alliance. As these examples illustrate, the patient's perception of input from any sensory modality may be inaccurate. When it is, the patient's mind will have faulty information to process.

The second problem which the patient with schizophrenia demonstrates is a defect in processing information. He tends to misinterpret and misunderstand incoming stimuli and his logic is often faulty. To illustrate, one young man reported that he was feeling discouraged because he was

unable to hold a job. He had been fired from a series of jobs and he no longer "felt like much of a man." While in this state of mind, he had gone out drinking with a male friend. The friend made some sexual comments about the people in the room around them and the patient became sexually aroused. Since his arousal was in the presence of a male, he became concerned that this might mean that he was homosexual. For him, this indicated that he was even "less of a man." As his concern about his masculine identity increased, he began to search for explanations. One evening as part of his search, he examined his genitalia and found some patches of vitiligo at the base of his scrotum. He concluded that the loss of pigmentation was evidence of old scars. Since he could remember no trauma to his genitalia, he further concluded that his parents had had a sex change operation performed on him at birth and that he really was a girl, which accounted for the fact that he was not "much of a man." His literal interpretation of manliness and his misunderstanding of physiologic and pathologic processes coupled with his loss of self-esteem led to the formation of a delusion which relieved him of responsibility for his egodystonic behavior.

Patients, like normal people, seek explanations for what is happening to them. When their perceptions are contradictory, puzzling, or unusual, they search for understanding. Nowhere does their search lead to more unusual explanations than when they attempt to explain their auditory hallucinations. It must be an unsettling experience for a person to realize that he is hearing voices no one else can hear, and patients tend to explain this phenomenon to themselves in a wide variety of ways; some claim powers of extrasensory perception, some assume their nervous system picks up radio waves, while others believe God and/or the devil speak to them. They choose the most acceptable explanation that their knowledge and experience allows them to choose. They know that for most people auditory hallucinations are symptomatic of psychosis, but the thought that they might be "crazy" is so unacceptable to them that they grasp at almost any other explanation. Their reasoning is understandable but nonetheless illogical.

Finally, the patient with schizophrenia has difficulty making himself understood. His communications tend to be unclear and puzzling to the listener in two ways: first, in what he says, and secondly, in how he appears to feel. One patient, for example, when asked about his occupation, answered, "I impose the positive by projecting it into the negative." Upon further questioning, the man said he made metal castings; the molds were the "negatives" into which he poured or "imposed" the molten metal which "emerged" in a "positive" shape. He appeared to be very angry during this interchange yet denied feeling any anger whatsoever. Not only were his words confusing, but his affect was threatening, although he intended neither to confuse nor to threaten the interviewer. Many patients with schizophrenia show blunted affect when they speak about topics which would evoke a range of emotional responses in normal people. The affective blunting gives them a robot-like quality that reduces empathy in the listener. Indeed, the combination of inappropriate affect and unusual verbal communications tends to make the listener uncomfortable and retards the establishment of rapport. Physicians, being human, may experience the same reluctance to interact with these "strange" patients and may retreat from a collaborative patient-physician relationship. They are less likely to do so if they can appreciate what the patient is demonstrating and if they have some techniques and skills for dealing with these pathologic manifestations.

Guidelines for Interviewing the Patient with Chronic Schizophrenia

Like other patients, schizophrenic patients come to the physician for a variety of reasons. Some come because they are sent—by family, state hospital physicians, social workers, or psychiatrists. Other patients are self-referred, some with physical complaints, others because they sense that something is amiss in their psychological state. Whatever their reasons, the initial task for the physician is to find out why they are there.

Because they have trouble making themselves understood, the physician should help them to express themselves. When their messages become vague, confused, or garbled, he should ask for clarification. He might say, "I do not understand

what you are trying to tell me. Would you use other words (paraphrase) to explain it to me?" This request for clarification may need to be repeated several times before the physician begins to grasp the meaning of the communication. Patience and persistence are necessary on the part of both the physician and the patient. As understanding increases, the physician should reflect back to the patient what he understands, ie, "Let me tell you what I understand you to be saying, and see if I have it straight. Tell me if I am right and correct me if I am wrong." This repeated quest for clarity may seem tedious and condescending, but the physician must resist the impulse to shorten the interview if he is to obtain accurate information.

Puzzling non-verbal messages should also be investigated. If, for example, the affective display is inappropriate, the physician might say, "You have told me several things that might depress a person, yet you do not display any sadness. Could you tell me how you feel?" or "When you answer my questions, you sound very angry. Do the questions offend you?" It is important not to dismiss how the patient says he feels because he *appears* to feel otherwise. Unlike many people, his "true feelings" may be closer to what he describes than what he shows.*

What must be remembered is that the "body language" of the schizophrenic may be just as garbled as the verbal language. The bland affect of many schizophrenics may be particularly misleading when bodily pain is present. The patients do not appear to suffer and their unemotional descriptions may lead the physician to underestimate their pain. If physical pathology is to be assessed accurately, complaints of pain must be given careful consideration.

Hallucinations are an important source of information about the patient. The voices speak the thoughts the patient may not acknowledge as his own. They offer a commentary on his internal conflicts. What the voices say should be taken into account. If they tell him to disregard the physician's advice, the physician should investigate the patient's ambivalence concerning that advice. If they tell him to kill himself, the physician should investigate the patient's suicidal potential. If they tell him the medicine is poison, the physician should investigate the patient's attitudes toward medication. During the interview, the physician should inquire about what "those others" are saying whenever something seems to be distracting the patient. As often as not "they" have valuable input that the physician needs to know.

It is important for the physician to utilize other sources of information about the patient when these are available. A call to the referring psychiatrist or mental health professional is always in order. Even when a patient is self-referred, consultation with those therapists who have treated the patient for his mental and emotional problems clarifies what is known about his condition and what role the family physician should play with him. Similarly, discussions with the family and other associates may be helpful not only in obtaining information but also in facilitating any treatment plan.

Once the physician determines what the patient has come to him for, he must decide upon a treatment plan and share that with the patient. The plan may be relatively simple, eg, "The sensations you describe as the devil eating your intestines are sometimes symptomatic of gall bladder disease. I would like for you to have some x-rays taken of your gall bladder to be certain we aren't overlooking a physical illness that may need attention." Sometimes the plan is more elaborate, eg, "Since you have been referred to me for follow-up care of your schizophrenia by the hospital doctors, I feel I will need to get to know you better than I can in one interview. I suggest that you come in once a week, for one half hour appointments, during which we can review how things are going for you now that you are home and can check your medication levels. After a month or two, we should be able to decrease the frequency and length of appointments, but since yours is a chronic condition, it is important that you see me periodically." Whatever the physician says, the patient needs to understand him correctly. Important instructions should be written also.

Since patients with schizophrenia misperceive and misinterpret incoming sensory messages, the physician should utilize interview techniques that maximize clarity. To do so, he should speak in a clear, concise, and deliberate manner. He should never use cryptic, enigmatic, or metaphorical lan-

*This is contrary to the teaching in many interviewing courses, where non-verbal affective cues are given greater weight than verbal statements because non-schizophrenic individuals tend to deny unacceptable emotions, but convey them nonetheless by "body language."

guage as his meaning may be taken literally or misconstrued. His non-verbal behavior should be consistent with his verbal messages. Complex comments and questions should be avoided as they overload the patient's ability to sort out incoming messages. For the same reasons, non-verbal messages should be simple and clear. The physician should carefully monitor his own emotional display. It is particularly difficult for patients with schizophrenia to assess accurately emotional levels in other people. A voice raised in pitch and intensity to emphasize a point may be heard as anger. A wavering reply may be perceived as fear. The patient should be asked to state what he understands the physician to have said and meant. Misunderstandings can then be caught as they occur, and clarified. Eye contact makes many schizophrenic patients uncomfortable. They report that it feels to them as if their minds are being read or controlled by the interviewer. They sense a penetration of their body boundaries. The physician should keep eye contact to a minimum with patients who complain of this symptom. Similarly, many schizophrenics feel uncomfortable when people come near or get behind them. They require a greater distance from others for comfort and they become apprehensive when they cannot keep others in their field of vision. They should be allowed to sit at a comfortable distance from the physician.

The physician should not be hesitant to contradict the patient's misperceptions and misinterpretations. The patient needs to be "oriented to reality." Fixed misperceptions such as hallucinations and delusions, however, need to be handled with tact. The physician should neither confirm their validity nor demand that the patient deny their validity. Rather, alternate explanations for their presence may be offered when the occasion presents itself. For example, many patients will accept over time the concept that their voices are merely some of their own thoughts made audible by a defect in their central nervous system which is part of the schizophrenic process. To do so, they must accept ego alien thoughts as their own and they must accept the fact that they have a mental disease. The skillful therapist works patiently and persistently at presenting both of these possibilities to the patient in a manner that may eventually allow him to accept them. There is no hurry, and if it never happens, no harm is done. If, however, he can accept his voices as some of his own thoughts, he can then gain a measure of autonomy. He can audit his own internal dialogue and feel less at the mercy of external forces.

Since many of these patients come for help in solving problems in daily life such as organization of tasks, conflict resolution, and the handling of interpersonal interactions, it is important that they receive guidance and advice. They need to sort out their thoughts before they act. The physician can help them to do so by sharing his own thoughts about the material they present. He should think out loud: share his premises, his logic, and his decision making processes. In this way he can demonstrate and teach a pragmatic approach to problem solving which patients may emulate.

Other Factors Affecting the Communication Process

Many things affect one's thinking processes, such as chemicals, fatigue, and sensory overload. These need to be given special consideration in schizophrenia because the thinking processes are already impaired and anything which compromises them further should be avoided.

For example, many substances muddle the mind—alcohol, amphetamines, marijuana, hallucinogens, even the stimulants in "cold remedies." These substances are known to alter the perception and interpretation of incoming stimuli in ordinary people and they do so with even more devastating results in schizophrenia. An evening of marijuana smoking or the ingestion of some "allergy pills" may precipitate a recurrence of hallucinations. All mind altering substances should be avoided.

Conversely, anti-psychotic medications improve the thinking impairments found in schizophrenia. Since the severity of symptoms varies, dosage needs adjustment from time to time. A low (maintenance) dosage will usually suffice during periods of stability. During periods of stress or psychological disorganization, the dosage should be raised. Some patients can do without anti-psychotic medications between periods of disorganization.

Sleep is important. Insomnia is one of the first symptoms of recurrence of the acute psychotic

state. The dosage of anti-psychotic medication should be increased during episodes of sleeplessness and most, if not all, of the drug should be taken two to three hours before bedtime. Sleep induction techniques such as meditation or relaxation may also be utilized.

Emotional arousal leads to confusion. Research indicates that patients returning to families where there is a high degree of emotional intensity and involvement with the patient tend to have more frequent relapses.[11] Other emotionally charged situations are also disorganizing for the patient and should be avoided. If they cannot be avoided, medication levels may be raised temporarily.

An isolated lifestyle also has its hazards. Patients who eschew human contact have no one to correct or validate their perceptions and interpretations. Their need for "reality orientation" is unmet and their view of the world tends to become increasingly distorted. Patients should maintain contact with other people and use them to increase the accuracy of their perceptions and interpretations.

Patient Education

Patients need to be educated about their disease. Without adequate knowledge, they are unable to collaborate effectively in its management. Most chronic patients have learned that their disease is called schizophrenia. What they seldom learn is what schizophrenia means. They need to know this also if they are to understand the rationale behind their therapy. Explanations should be given in terms that the individual patient can understand. For example, a patient with an understanding of electrical circuitry might be told, "You have a disease called schizophrenia. People with this disorder often have difficulty thinking. Something seems to be defective about the circuitry in their minds. The input filter distorts incoming information and the messages get garbled and misunderstood. As a result, people with schizophrenia are often confused about what they see or hear. At times, their output is also garbled so they have trouble making themselves understood."

This type of explanation is a base upon which education about other aspects of the management can be built. It offers an operational introduction to the rationale behind the interviewing techniques and the advice to be given. When the patient is later requested to paraphrase his statements or repeat what was said to him, a related operational explanation can be offered, ie, "I am having trouble understanding what you are telling me at this point. Your message is not coming out clearly. Could you say it some other way?" or "I want to be certain that you understand what I am saying to you—that the input from me to you is clear. Would you tell me what you understand me to have said?" Similar education about the necessity to eschew mind altering substances and to comply with the medication regimen can be given. The justification for avoiding emotional situations may be couched in terms of input overload, or the reason for avoiding isolation may be justified in terms of feedback distortion.

Chronic schizophrenia has a fluctuating course. Acute psychotic episodes occur despite the best management regimen. These episodes are often precipitated by alterations in the social network of the patient. The patient may need hospitalization during periods of decompensation. Neither the physician nor the patient should feel a sense of failure should hospitalization be needed. The patient needs to learn that his disease has a fluctuating course and that hospitalization is a temporary expedient to be used in time of crisis following which he will return to outpatient status. As patients grow older and adapt to their disease, the frequency of acute episodes of decompensation diminishes. The patient should be appraised of the prognosis of his disease so he can anticipate the future and plan his life accordingly.

Hospitalization may be necessary not only for the patients' benefit, but, at times, for the benefit of those people who provide the support system which surrounds the patient. For example, should a supportive family wish to take a vacation of reasonable length without the patient, hospitalization may be an appropriate alternative support system during the family's absence.

Education of Family and Associates

Whenever possible, significant people in the patient's "network," including family, close friends, agency personnel, and landlords, need to

be involved in the treatment plan. These "others," like the patient, will collaborate with the physician more effectively if they can be educated about the disease processes and the related therapeutic rationale. While interviews with relatives and telephone calls to case workers are time consuming for the busy practitioner, the results are worth the effort. Family counseling and/or therapy may be particularly helpful to the patient when it deals with events and interactions within the family to which the patient is sensitive. Integrating the efforts of those who are involved in helping the patient reduces conflicting advice and misunderstandings, and enhances effective management of the disease. As in the management and treatment of other chronic diseases, the wise physician teaches those people who must care for the patient the knowledge and skills necessary to do their tasks effectively, and, in so doing, enhances his own effectiveness as a healer.

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