British Journal of Psychiatry (1994), **164** (suppl. 23), 121–122

Discussion of Sørensen's and Salokangas's Papers

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In their papers, both Sørensen and Salokangas contribute new knowledge and new perspectives to the treatment and care of schizophrenic persons. Sørensen describes an intensive study of a small catchment area, while Salokangas examines a need-adaptive approach with a national perspective. The two papers are in fact complementary. Salokangas puts a main emphasis on the outcome, after the initial need-adaptive approach. Sørensen reports on the 'strategic network model', which is used to curtail the schizophrenic patient's ''network-reducing spiral''. One of Sørensen's observations which bears frequent repetition is that social well-being is not necessarily correlated with a low degree of psychopathology. This means that there is good reason to be cautious in trying to treat persisting psychotic symptoms too vigorously. Both negative and positive symptoms may be acceptable to many patients, if they are helped to live with them and handle them adaptively. Today, there must be a large number of patients who could profit considerably from a gradual reduction of neuroleptics.

In Harding *et al*'s (1987) follow-up study from Vermont, 68% of the chronic schizophrenic patients were found to be leading a ''full life'' 30 years after discharge from hospital. Only 25% of them were taking neuroleptics and most had a functioning social network, which had been activated on their leaving hospital in the late 1950s.

But simultaneously with social rehabilitation, there is a need to develop treatment methods in a more specific sense – especially in the early phases of the illness. All knowledge of preventive work in medicine suggests that an early approach is better than a late one, especially if the interventions are need-adaptive in nature. It is somewhat disappointing to hear from Salokangas that the effects of the nationwide Finnish schizophrenia project, with its intensive humanistic integrative approach, do not seem to have been overwhelming. No reduction in unmet needs was noted after the first five-year period.

Salokangas finds a deficient integration between in-patient and out-patient care, and a heated discussion is currently taking place in Sweden on whether to separate in-patient care administratively, so that the providers of out-patient care can purchase hospital care where it is available at a competitive price.

Salokangas also stresses the need for easily-accessible crisis teams. The inflexibility of the ordinary community mental health centres is well known, but this is unacceptable when dealing with psychotic patients and their network. Therefore, the conclusion seems to be that the need-adaptive approach must develop in the direction of crisis support, including short-stay hostel beds and network support, especially a few years after the onset of the disorder. An ideal could be a combination of the Finnish model and the Lofoten strategic network model. Continuous treatment teams (in the terms of Stein & Test, 1980) will probably always be necessary for this special group of patients. Ten years ago, the Nacka psychiatric sector was subdivided into general out-patient psychiatric services and out-patient psychosis services, and this has been found to be extremely fruitful.

There is a risk of underestimating the degree of disability of many patients, and the need for intensive social support and rehabilitation is somewhat neglected when we expect still better treatment results.

In Salokangas' paper I would have liked a clearer definition of the term 'unmet needs'. Is it the perceived gap between 'normality' and the patients' actual abilities? Or is it really a need which should and could be responded to and satisfied by the public sector, provided the organisation and resources existed? I can see a risk that this might lead to demands that could prove impossible to satisfy in reality. This in turn might evoke burn-out among the staff. However, Bleuler (1974) observed that after a five- or seven-year period, there is often a natural decrease in schizophrenic symptoms and less of a tendency to develop new crisis reactions or psychotic outbreaks. If the follow-up study could also cover the second five-year period, positive effects might be seen which are not discernible at the end of the first one.

I would like to discuss a problem which I consider to be the most pertinent to treatment and outcome studies in schizophrenia. It seems as if *the concept of schizophrenia may be concealing more than it reveals*. There is now striking evidence to support looking at this group of disorders in terms of several aetiological dimensions. Each of these have certain treatment and prognostic implications, which may

sometimes be contrary to each other. One patient may have suffered obstetric complications, be socially withdrawn at an early age in spite of a fairly 'normal' upbringing, show a widened third or lateral ventricle on CT scanning, suffer from chronic auditory hallucinations, and respond poorly to neuroleptic drugs. This patient is in a rather different situation from one with the same diagnosis who has been living in a very difficult family situation, has a close relative with a psychotic disorder, and becomes well between the schizophrenic episodes; he/she may appear promising in ability during his/her early years, but suddenly begins to withdraw, exhibiting psychotic symptoms.

Why are these two disorders labelled with the same name? They should certainly be treated differently. The need for family-systems-orientated treatment and for individual psychotherapy is overwhelming in the second case. In the first, such treatment might seem inappropriate, although there may be a need for family education, individual support, and rehabilitative training. In fact, intensive dynamic psychotherapy might make the illness even worse in such a case, and the family might easily feel insulted – sometimes with good reason. I have encountered both these reactions. Thus, when undertaking follow-up studies and comparing treatment and rehabilitative approaches, we may unknowingly put together subgroups which need quite different treatment. For this reason, the results of one group may extinguish those of others in follow-up studies. The Finnish need-adaptive approach seems to be a suitable way of dealing with these subgroup difficulties. There is a pressing need to find methods of facilitating an early and reliable diagnosis as to the prognostic and aetiological subgroup to which the patient might belong. Sørensen's network-building ideas are, however, of great value irrespective of the patient's diagnosis. That is the "intricacy of the ordinary".

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