Treating schizophrenia without drugs? There's good evidence for it.

Tim Calton April 24, 2009

Award-winning researcher and psychiatrist examines studies demonstrating how psychosis can be managed without medication. He argues that such non-drug approaches should no longer be ignored.

Over two hundred years ago medical psychiatry planted its standard within the realm of the human experience of 'madness', quickly becoming the dominant paradigm. Other ways of understanding and tending to mental distress were suffocated or retreated to the margins. Psychiatry's success in creating and disseminating knowledge about those forms of life which get described as 'madness', 'psychosis', or 'schizophrenia', quickly becomes apparent when surveying the first National Institute for Clinical Excellence (NICE) guidelines for the treatment of people diagnosed with schizophrenia.

This document, a synopsis of so-called 'best practice' in the clinical treatment of 'schizophrenia' within the NHS, clearly states that antipsychotic drugs are necessary in the treatment of an acute episode (National Institute for Clinical Excellence, 2002), a mandate not extended to psychosocial interventions.

Last month we had the updated quidelines (National Institute for Clinical Excellence, 2009). They do appear somewhat more balanced (stating that cognitive-behavioural psychotherapy should be offered alongside medication), although important semantic emphases remain (such as the fact that clinicians need only 'discuss' alternative therapies, not necessarily offer them). The importance granted medication, at the expense of other ways of understanding and helping with mental distress, reflects the tendency for medical psychiatry to see aspects of the vast and complex realm of human experience as mere disease.

Although the NICE guidelines carry a powerful political imprimatur they reflect the deep but extremely narrow tradition of biomedical research into madness; research which would have us believe that the only way to 'get better' and 'stay well' are to take antipsychotic medication, for life if necessary.

The question remains, however, as to whether it is possible to help people experiencing 'psychosis' without recourse to antipsychotic medication? Such a question might provoke a range of immediate and urgent responses depending on your sociopolitical context, life history and experience. One way of mediating this array of responses would be to scrutinise 'the evidence' supporting the use of no or minimal medication approaches to the treatment of 'psychosis'/'schizophrenia'.

There is certainly a wealth of historical evidence supporting a non-medical approach to madness ranging from Geel, the city in Belgium where the 'mad' lived with local families, receiving support and care that allowed them to function in the 'normal' social world despite the emotional distress some experienced (Goldstein, 2003), to the so-called Moral Treatment developed at the York Retreat by William Tuke towards the end of the eighteenth century (Digby, 1985), which advocated peace, respect, and dignity in all relationships, and emphasised the importance of maintaining usual social activities, work and exercise. These approaches, predicated as they were on a gentle and humane engagement with the vagaries of human experience at the limits, and invoking respect, dignity, collective responsibility, and an emphasis on interpersonal relationships as guiding principles, have much to tell contemporary biomedical psychiatry.

In the modern era, non-medical attempts to understand and tend to 'psychosis' have coalesced into a tradition counterposed to the biomedical orthodoxy. The richest seam of evidence within this tradition is that relating to Soteria House , the project developed by Loren Mosherand colleagues in San Francisco during the early 1970s. Here, people diagnosed with schizophrenia could live in a suburban house staffed with non-professionals who would spend time 'being' with them in an attempt to try and secure shared meanings and understandings of their subjective experience.

Antipsychotic medication was marginalised, being considered a barrier to the project of understanding the other, and was only ever taken from a position of informed and voluntary choice. Arguably the most radical aspect of the Soteria project was the emphasis given to building a case across many different rhetorical levels, including the scientific/evidential Subjected to a randomised controlled trial in comparison to 'treatment as usual' (TAU - hospitalisation and medication), with follow-up assessments at six weeks and two years it proved at least as effective as TAU with some specific advantages in terms of significantly greater improvements in global psychopathology and composite outcome, significantly more participants living independently, and significantly fewer readmissions (Bola, 2003). A Swiss iteration of Soteria reported similar results and suggested these could be achieved at no greater fiscal cost than TAU (Clompi, 1992), whilst a recent systematic review of all the evidence pertaininq to Soteria confirmed both claims (Calton, 2008).

More evidence supporting the use of non-medical approaches to helping people diagnosed with 'psychosis' / 'schizophrenia' has emerged from Scandinavia and the USA (Calton, 2009) In the former, so-called 'Need Adapted' treatment, an approach which places great emphasis on interpersonal relationships and striving after meaning, whilst decentring medication treating it as merely one of a plurality of interventions, is associated with people spending less time in hospital experiencing fewer 'psychotic' symptoms, being more likely to hold down a job, and taking much ' less antipsychotic medication. In the latter, evidence from an innovative series of research projects conducted in the 1970s suggests not only that people diagnosed with 'schizophrenia- can recover without the use of antipsychotic medication when exposed to a nurturing and tolerant therapeutic environment, but also that antipsychotic medication may not be the treatment of choice, at least for certain people, if the goal is long-term improvement.

To conclude then, it seems appropriate, given the evidence, to claim that the human experience of 'psychosis' can be helped without recourse to the use of antipsychotic medication. The research cited above does not appear to have been considered in the current NICE guidelines (presumably because of the small number of studies undertaken using minimal or no medication approaches), though may well be incorporated into the next iteration. This should happen because the lack of any meaningful idea of choice with regard to treatment for people diagnosed with 'psychosis' / 'schizophrenia' in the. UK is abundantly apparent; a state of affairs that may not be sustainable given recent pronouncements on patient choice (DoH, 2008).

We must remember, honour and reiterate these alternative traditions of thought and practice if we are to overcome the extant biomedical hegemony.

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