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Revision of the Rationale of Long-term Drug Treatment in Psychiatry

The medical model which appeals to the majority of contemporary psychiatrist should not be analogous to orthopedic manipulation of fractures (break down), but should also be comparable to the management of cardiac arryhthmias. Any psychiatric practice depends on how man is conceptualized by the practicing psychiatrist. This is true if the psychiatrist knows it, and is more so if he does not. If man is taken as a machine that just needs repair every now and then, we have to expect that isolated physical therapy could be considered rational. But if man is taken both biologically and existentially as a pulsating growing organism, then drug therapy alone could never be accepted as satisfactory.

This concept i.e. man as a pulsating ever-growing organism stems from Erikson's eight ages crises (Erikson,, 1972) as well as growth oriented humanistic psychologists (Maslow, 1969, Sutich 1969), but it extends beyond these concepts to include the pulsating nature of vital matter as a cardinal feature for understanding man in his personal evolutionary movement. as stated elsewhere by the author:' The march of growth takes a pulsating, spiral and dialectic synthetic pattern. The wakefulness-sleep alterations, the REM-NREM alterations and the incubation-activity alterations are but aspects of this systolic (unfolding) and diastolic (assimilating) growth pulsations (Rakhawy,1979). Thus psychiatric disorders are to be considered as temporary or permanent hazards of human pulsation along either the individual's evolution (growth). Modern schizoid life, particularly the western model, seems to favour neurotic (psychotic equivalent) steady linear existence for taking man as a continually pulsating biological existence. In psychiatric practice, the rapid decline of the incidence of periodical manic-depressive illness (Pugatch and Solomon,1974, Cohen,1976) and other periodical disorders is another warning. Can we correlate the latter observation to the world wide use of tranquilizers, particularly phenothiazines? Such chemical restraint was originally used as a temporary control, but later it has found its place as part and parcel of our permanent biological structure of our patients. This is the actual outcome of the so called long-term (regrettably to say, rather permanent) inhibitory therapeutic policy. The new lithium era, in the last decade, has been participating in eliminating human pulsations manifesting occasionally as periodical mental disorders.

Now, I shall try to raise, rather than answer, certain questions concerning long-term drug treatment in psychiatry.

1-What is the rationale of long-term (drug) treatment in current psychiatric practice ?

2-What are the qualitative changes in human existence that accompany the disappearance of symptoms with this long-term drug treatment in psychiatry.

3-Is there any other alternative based on a different theoretical orientation?

A regards the first question we can say without any innovation that the main, or rather the only, indication of long-term treatment is either recurrence or persistence of disabling symptoms. But, if we take psychiatric illness as a meaningful reaction as well as an action, as a language and as a goal-seeking form of behavior, then recurrence or persistence of the 'same' symptoms should be taken as a failure of the already offered solution. In other words, it is a refusal of a given dish, preferring starvation, if no other is available. The psychiatrist insisting to overuse long-term drug treatment answers this protest on the part of the patient by pushing more and more of the same unwholesome remedy, claiming that it was not hefty enough, or was not given long enough. This rationalization should be taken at most as only partly true.

As to the second question, assessment of the outcome of the claimed success of long-term (drug) treatment is considering only, or at most predominantly, the symptom-free dimension. Such a psychiatrist usually overlooks investigating the direction of the post crisis shift and the effect of his medication on variables like emotional resonance, responsive awareness, active relatedness or creative existence and production. The emerging concept of post psychotic personality disorders (Lion, 1975) declaring malorganization, signifies that ego-syntonic pathology has replaced the ego-alien one, the detection of the former is more difficult as it is out of focus to the active drug therapist.

Now, coming to the third question, whether there is an alternative or a complementary procedure or not, one has to reconsider the evolutionary value of psychotherapy. No doubt, the result of individual psychotherapy have always been beyond the tolerance of those who are interested in the welfare of masses. In its analytic version it is getting to be restricted to research purposes or to be considered as a luxurious pastime .Group therapy is taking more and more its place all over the world. In Egypt, after many trials to introduce such a technique, the author has established his own so called evolutionary technique, participating in this healthy movement (Rakhawy, 1978). It is an intensive procedure, concentrating on the here and now, depending in its initial stages on the activity and personality of the therapist and later, on the intrinsic growth of the group.

A research trial applying this technique to resistant personality disorder, (including post psychotic residue) and recurring psychoses (Hamdi,1978) has emphasized the need for other measures to evaluate the results of long-term treatments in general.

It is fair to conclude that unless the basic structure of the personality is altered to reorganize on a higher level, neither recurrence in a mutilated form, nor stagnant conforming pseudo-unfolding can be avoided. The suggested approach aims to reactivate pulsating unfolding to enhance dialectic growth in a better medium in order to achieve such a prophylactic level of reorganization. Though optimistic and satisfactory, such results could not be over-evaluated or generalized. Follow up is indispensable, and has already been going on for the last two years after termination of this group. So humble as they are, the available results are apt to stimulate revision of hypotheses related to psychiatric management especially in relation to long-term drug therapy. The chemical and synaptic hypotheses are not enough to explain either the pathogenesis or the therapeutic response of psychiatric illness. They could not be excluded at all but they are never satisfactory alone. We are in need of a more holistic biological orientation integrating the harmony between hierarchical evolutionary levels of the brain with macro-molecular intracellular coding along with the interpersonal and trans-personal adaptation with its chemical and psychological accompaniments.

Coming back to the original hypothesis offered in this paper, we suggest conceptualizing the human brain as a pulsating, (or at least phasic) organ undergoing everlasting dialectic growth. If, then, psychiatric disorders are considered as complications or hazards of imperfect growth in the form of abnormal pulsations or hazards or a disharmonious malorganization, one has to revise the rationale of many therapeutic procedures taken for granted. Electroshock, an ultra short term therapy, is to be taken then as a very useful defibrillator technique if properly timed, prepared for and followed up by appropriate rehabilitation. This looks more natural and harmonious with the concept of human pulsations. Psychotherapy is to be considered as a form of reparatory life model that liberates natural growth in the form of dialectic pulsations. Chemotherapy could be visualized selective control contradicting biological levels of the brain as they fail to be synthesized in the new whole during unfolding. Proper chemical aid may favour temporarily one level over the other. Long-term drug therapy may be accepted as a temporary chemical plaster jacket, but never as a permanent intracranial nail.

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