HOW NON-DIAGNOSTIC LISTENING LED TO A RAPID "RECOVERY" FROM PARANOID SCHIZOPHRENIA: WHAT IS WRONG WITH PSYCHIATRY?

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Summary

An experimental interview with a young woman diagnosed with paranoid schizophrenia led to her rapid recovery. This incident and questions raised about psychiatric practices suggest that something is seriously wrong with psychiatry. It lacks insight into its own behavior, invalidates constructive criticism, avoids the kind of self-examination it urges on "patients," shows little interest in accounts of successes with "schizophrenic" individuals, erroneously lumps all the schizophrenias (plural) together in research studies, feels helpless and hopeless about schizophrenia, dismisses evidence that contradicts its inaccurate beliefs, and misrepresents what is known about "schizophrenia" to the public and to patients. The argument is put forward that research should begin to focus on the mind of the beholder. It is time for researchers to examine the cognitive processes, personality traits, and motives of "mental health"

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professionals who perceive schizophrenia in others and insist that schizophrenia is an incurable brain disease.

When I was a staff psychologist at a neuropsychiatric institute in 1965, I conducted an experimental interview with an 18-year-old woman diagnosed as "acute paranoid schizophrenic." I'd been influenced by the writings of Carl Jung, Thomas Szasz, and Ayn Rand and was puzzled about methods for training psychiatric residents that are unreported in the literature. I prepared for the interview by asking myself questions. I wondered what would happen if I listened to the woman as a friend, avoided letting my mind diagnose her, and questioned her to see if there was a link between events in her life and her feelings of self-esteem. My interview with her was followed by her quick remission.

This account raises important questions about (a) the powerful influence of the interviewer's mindset and way of relating to patients perceived as "schizophrenic," (b) aspects of psychiatric training and practices that have never been researched, (c) why psychiatrists misrepresent what is scientifically known about "schizophrenia," and (d) why the psychiatric literature is silent about the personality characteristics of people who fully recover from their so-called "schizophrenia" and the processes by which they recover.

My duties as a staff psychologist at the Neuropsychiatric Institute at the University of Michigan Hospital in 1965 included attending morning "rounds." The staff gathered in a small conference room at 7:30 a.m. to hear various announcements and reports about patient admissions and discharges.

One morning, the head nurse of the locked ward reported the admission of an 18-year-old woman. The psychiatric resident who admitted her the previous evening said, "Molly's[1] parents brought her in. They told us Molly claims God talked to her. My provisional diagnosis is that she is a paranoid schizophrenic. She is very withdrawn. She won't talk to me or the nurses."

For several weeks, the morning reports about Molly were the same. She would not participate in any ward activities. She would not talk to the nurses, her caseworker, or her doctor. The nurses couldn't get her to comb her hair or put on makeup.

Because of her withdrawal and lack of response to staff efforts, the supervising psychiatrist, David Bostian, told the resident in charge of Molly to begin plans to commit her to Ypsilanti State

Hospital. Bostian said the university hospital was a teaching facility, not one that could hold patients who need long-term treatment. The staff consensus was that she was so severely paranoid schizophrenic she would probably spend the rest of her life in the back ward.

I decided that because she was headed for the "snake pit," this was an opportunity to interview a psychiatric patient in a way very different from how I had been trained in my clinical psychology program. I asked Molly's doctor, a third-year resident, for permission to administer some psychological tests and interview her before she was transferred to the state hospital. The resident said I could try, although she expected nothing to come of my efforts.

I contacted the head nurse and arranged to meet with Molly the next morning in the ward dining room. At home that evening, I prepared myself for the interview with Molly by reflecting on a cluster of the following four issues and concerns:

1. After reading *The Myth of Mental Illness* by Thomas Szasz (1961), I began to notice that the only time I saw "mental illness" in anyone was when I was at the hospital wearing my long white coat, working as a psychologist. When I was outside the hospital, I never thought of anything people said as "sick," no matter how outrageous their words or actions. I found it interesting that my perception of "mental illness" in people was so situationally influenced.
2. I had been puzzled about an unresearched, unreported aspect of the way psychiatric residents talked to newly admitted mental patients. At our institute, each psychiatric resident was required to convince his or her patients that they were "mentally ill." I was present in the office of a resident, for example, during a shouting match with a patient, Tony, who refused to believe that he was "mentally ill." Tony was a 20-year-old unemployed factory worker. He was in our facility for a court-ordered examination because he had beaten up his father in a fistfight. Also present in the room were his wife, a social worker, and a large male aide.

   The psychiatric resident said, "Tony, your behavior is sick. We can treat you here as an outpatient, but you must understand you are mentally ill before we can make any progress."

   Tony shouted, "No, I'm not! You doctors are crazy if you think I'm mentally ill!"

   The resident, with his voice raised, responded, "We've argued about this before. You must believe you are mentally ill or we can't help you!"

   Tony's face got red. His nostrils flared. His breathing quickened. He yelled, "I'm not mentally ill!"

   Tony's wife reached over and put her hand on his arm.

   The resident yelled, "Yes, you are!"

Tony yelled, "No, I'm not!"
The resident responded, "Yes, you are!"
And so it went.
Finally, the resident shook his head and said to the aide, "Take him back."

Such arguments between psychiatric residents and patients were common. I searched through the psychiatric literature, but could not find any research about why it is essential in the early stages of psychiatric treatment to convince patients that they are mentally ill. *How to Live with Schizophrenia*, by psychiatrists Abram Hoffer and Humphry Osmond (1966), contains a written statement typical of what patients were commonly told:

> As a patient, you have a grave responsibility to yourself and to your family to get well. You will have no problem if you are convinced that you are ill. But no matter what you think, you must do all you can to accept the statement of your doctor that you are ill. (p. 153)

The psychiatric literature contains a few articles and discussions about "lack of insight" in patients (McEvoy et al. 1989b), but there is no research exploring the validity or therapeutic rationale of efforts to convince people they are ill.

Such efforts, routine at our institute, created some weird situations. For example, we heard at staff rounds about a man admitted to our service with a diagnosis of "acute paranoid state." His main complaint was that people were trying to force thoughts into his mind. I was curious about his point of view of his experience. I obtained permission from his psychiatric resident to interview him. An aide brought the man, whom I will call Ron, to my office. He was 25 years old, about 6 feet tall, clean-shaven, in good physical shape, and nicely dressed in slacks and a clean shirt. He shook hands with me and moved with confidence.

After he sat down, I asked him, "Why are you here in the hospital?"

Ron: My wife and family say I don't think right. (clenches jaw) They say I talk crazy. They pressured me into this place.
A.S. (Al Siebert): You're a voluntary admission, aren't you?
Ron: Yes. It won't do any good though; they're the ones who need a psychiatrist.
A.S.: Why do you say that?
Ron: I work in sales in a big company. Everyone there is out for themselves. I don't like it. I don't like to pressure people or trick them into buying to put bucks in my pocket. The others seem to go for it . . . self-

ish, clawing to get ahead. I tried to talk to my boss, but he says I have the wrong attitude. He rides me all the time.

A.S.: So what is the problem with your family?

Ron: I've talked about quitting and going to veterinarian school. I like animals. I'd like that work. My wife says I'm not thinking right. She wants me to stay with the company and work up into management. She went to my parents and got them on her side.

We talked for a while about how his wife and parents wanted him to live up to their dreams for him. I said, "I still don't see the reason for your being here."

Ron: They're upset because I started yelling at them how selfish they are. My wife wants a husband who earns big money, owns a fancy home, and drives an expensive car. She doesn't want to be the wife of a veterinarian. They can't see how selfish they are in trying to make me fit into a slot so they can be happy. Everyone is telling me what I should think and what should make me happy.

A.S.: So you told them how selfish they are?

Ron: Yes. They couldn't take it because they believe they are only interested in my welfare. (He sagged in his chair and held his face in his hands.)

A.S.: Did you tell the admitting physician about them trying to make you think right?

Ron: Yes. Everyone is trying to brainwash me. My wife, my parents, the sales manager. Everyone is trying to push their thinking into my head.

A.S.: How do you feel about all this?

Ron: I feel angry. They say they have done this to help me, but they don't care about me. They're all selfish. Afraid I'll upset their tight little worlds. I shouldn't be here.

I saw that Ron's doctor was obediently acting as trained when he diagnosed Ron as paranoid. The consequence, however, was a "crazy-making" double-bind for Ron. His doctor was saying to him, in essence, "Because you believe that people are trying to force thoughts into your mind, you must accept into your mind the thought that you are mentally ill."

Two days later, Ron signed out. It was rumored that he took off for California.

These incidents helped me see how hard psychiatrists try to force their words and thoughts into patients' minds without insight into what they are doing. When a patient disagrees, this is diagnosed as "resistance" or "lack of insight" and viewed as another sign of "mental illness."

3. During admissions meetings, I had observed that when a patient was reported as talking in bizarre ways, the staff would reflexively declare the person "schizophrenic." Diagnosis seemed more important than understanding. No one seemed influenced by Carl Jung (1961), who said in his autobiography,

   > Through my work with the patients I realized that paranoid ideas and hallucinations contain a germ of meaning . . . . The fault is ours if we do not understand them . . . . It was always astounding to me that psychiatry should have taken so long to look into the content of the psychoses. (p. 127)

4. I had just finished Ayn Rand's book *Atlas Shrugged* (1957). I was impressed with her portrayal of how the need for self-esteem influences what people do, say, think, and feel. I'd been noticing, for example, that when someone made a statement of extremely high self-esteem, most people reacted negatively and tried to tear the person down. I wondered what was wrong with thinking highly of oneself.

MY QUESTIONS

As I prepared myself for my interview with Molly the next day, I developed four questions for myself:

What would happen if I just listened to her and did not allow my mind to put any psychiatric labels on her?
What would happen if I talked to her believing that she could turn out to be my best friend?
What would happen if I accepted everything she reports about herself as being the truth?
What would happen if I questioned her to find out if there is a link between her self-esteem, the workings of her mind, and the way that others have been treating her?

THE INTERVIEW WITH MOLLY

The next morning, I took my Wechsler Adult Intelligence Scale testing kit and Bender-Gestalt cards with me to the ward. I laid out the materials on a table in the dining room and waited until the nurse brought Molly in.

Molly was about average height and looked slightly overweight. Her shoulders slumped forward. She was a plain-looking young woman wearing no makeup. Her straight, light brown, shoulder-

length hair needed washing. She wore a loose, faded, cotton dress. *Dowdy* was the word that came to mind.

When the nurse introduced us, Molly glanced quickly at me. She did not say anything, even though I could feel her attention on me. She seemed frightened and lonely.

I seated her at the end of a table and I sat at the side. Instead of trying to talk with her, I put her to work copying Bender-Gestalt designs onto sheets of paper. She cooperated and did what I asked.

I was not especially interested in how well she could draw; I just wanted her to become comfortable with me. I sat, relaxed and quiet. When she finished a drawing, I would say, "Good," "That's fine," or "Okay, here's the next one."

When she finished the drawings, I started her on the Wechsler block design test. She followed instructions accurately and worked at a good speed. I could see that she was not depressed and had no obvious neurological problems.

She gradually warmed up to me, and she relaxed as we proceeded. After about 15 minutes, she peeked out from under her hair and looked cautiously into my eyes.

At the first moment of good eye contact, I smiled and said "Hello."

She blushed and ducked her head.

I felt a rapport with her and felt that I could start a conversation. It went like this:

A.S. (Al Siebert): Molly? (She looks up at me.) I am curious about something. Why are you here in a psychiatric hospital?
Molly: God spoke to me and said I was going to give birth to the second Savior.
A.S.: That may be, but why are you here in this hospital?
Molly: (startled, puzzled) Well, that's crazy talk.
A.S.: According to whom?
Molly: What?
A.S.: Did you decide when God spoke to you that you were crazy?
Molly: Oh. No. They told me I was crazy.
A.S.: Do you believe you are crazy?
Molly: No. But I am, aren't I? (dejected)
A.S.: If you will put that in the form of a question, I'll answer you.
Molly: (slightly puzzled, pauses to think) Do you think I am crazy?
A.S.: No.
Molly: But that couldn't have happened, could it?
A.S.: As far as I am concerned, you are the only person who knows what happens in your mind. Did it seem real at the time?
Molly: Oh yes!

A.S.: Tell me what you did after God spoke to you.
Molly: What do you mean?
A.S.: Did you start knitting booties and sweaters and things?
Molly: (laughs) No, but I did pack my clothes and wait by the door several times.
A.S.: Why?
Molly: I felt like I would be taken someplace.
A.S.: It wasn't where you expected, was it?
Molly: (laughing) No!
A.S.: One thing I'm curious about.
Molly: What?
A.S.: Why is it that of all women in the world, God chose you to be the mother of the second Savior?
Molly: (breaks into a big grin) You know, I've been trying to figure that out myself!
A.S.: I'm curious. What things happened in your life before God spoke to you?

It took about 30 minutes to draw out her story. Molly was an only child who had tried unsuccessfully to earn love and praise from her parents. They only gave her a little love once in a while, just enough to give her hope she could get more. She voluntarily did many things around the house, such as cooking and cleaning. Her father had been a musician so she joined the school orchestra. She thought this would please him. She practiced hard, and the day she was promoted to first chair in the clarinet section, she ran home from school to tell her father. She expected him to be very proud of her, but his reaction was to smash her clarinet across the kitchen table and tell her, "You'll never amount to anything."

After graduation from high school, Molly entered nursing school. She chose nursing because she believed that in the hospital, the patients would appreciate the nice things she would do for them. She was eager and excited about her first clinical assignment, but it turned into a shattering experience. The two women patients she was assigned to criticized her. She could not do anything right for them. She felt "like the world fell in." She ran away from school and took a bus to the town where her high school boyfriend was in college. She went to see him, but he told her to go home and write to him. He said they could still be friends, but he wanted to date other girls.

A.S.: How did you feel after that?
Molly: Awful lonely.

A.S.: So your dad and mom didn't love you, the patients were critical and didn't like you, and your boyfriend just wanted to be friends. That made you feel very sad and lonely.
Molly: (head down, dejected) Yes, there didn't seem to be anyone in the whole world who cared for me at all.
A.S.: And then God spoke to you.
Molly: Yes. (quietly)
A.S.: How did you feel after God gave you the good news?
Molly: (looks up, smiles warmly at me) I felt like the most special person in the whole world.
A.S.: That's a nice feeling, isn't it?
Molly: Yes, it is.

(The kitchen crew came into the dining room to set up for lunch.)

A.S.: I must go now.
Molly: Please don't tell them what we've been talking about. No one seems to understand.
A.S.: I know what you mean. I promise not to tell if you won't.
Molly: I promise.

Two days later, I was walking through the locked ward to see another patient. When Molly saw me, she walked over and stopped me by putting her hand on my arm. "I've been thinking about what we talked about," she said. "I've been wondering. Do you think I imagined God's voice to make myself feel better?"

She surprised me. I did not intend to do therapy, but she seemed to see the connection. I paused. I thought to myself, "Maybe so. But if there is an old-fashioned God who does things like this, then He is watching! I don't care what the other doctors and nurses do, I am not going to give her a rough time. I am going to be her friend!" I shrugged my shoulders. I said "perhaps" and smiled at her. She smiled back with good eye contact, then turned and walked away.

At staff rounds, the head nurse reported a dramatic improvement in Molly. She was now a cheerful, talkative teenager. She spoke easily with her doctor, the nurses, and other patients. She started participating in patient activities. She brushed and combed her hair, put on makeup, and asked for nicer looking dresses.

At rounds a week later, Dr. Bostian described her amazing recovery as "a case of spontaneous remission." The plans to commit her were dropped. A few days later, she was transferred to the open ward and she did so well that the doctors and nurses expected her to be discharged soon. I left the hospital soon after, so I was not able to follow up. What would have happened to her if I had not taken

time to listen to her with an open mind and affirm her reality? The psychiatric staff's prediction that she would spend many years in the back ward of the state hospital would most likely have been validated.

DISCUSSION

One expects mental health professionals to be exemplary models of mental health. This would include being open-minded about new and better ways to be effective and receptive to constructive feedback. But, just as the writings of Thomas Szasz have been rejected and dismissed by mainstream psychiatry for over three decades (Leifer, 1997), my efforts to have this account of my interview with "Molly" published in a professional journal were, until now, unsuccessful for more than 30 years. The one time the interview was published in a newspaper article, the psychiatric community reacted very negatively.

About 20 years ago, a patients' rights advocate with the Mental Health Association of Oregon asked me to write one of five articles commissioned for a series critical of psychiatric practices. The series was preapproved by the editors of *The Oregonian*, our local newspaper. My article asserting that mental illness is a faulty paradigm included Molly's story (Siebert, 1976). It was selected to run first. The morning it was published, a group of prominent local psychiatrists demanded and were given an immediate meeting with the publisher. At that meeting, they persuaded the publisher to cancel the series and not publish the other four articles. Their main argument, I was told, was that it is harmful for psychiatric patients to have doubts about the competence of their therapists.

The publication of "label dissolving" interventions by Aaron Kramer and Lucien Buck (1997) and now this article are signs that the time may have arrived for the research lens to turn around and focus on the cognitive processes, motives, and actions of those who perceive others as schizophrenic. Until now, all published research about "schizophrenia" has focused only on persons declared to have it. No professional journals have published research examining the mental processes of those who perceive "schizophrenia" in other humans.

There is ample evidence that something is wrong with psychiatry. It is predictable, for example, that current experts on "schizo-

phrenia" will declare that the psychiatric staff at the University of Michigan Hospital made an incorrect diagnosis of Molly, that she was not really "schizophrenic," and that she is not representative of "schizophrenic" patients who end up in mental hospitals. The key to significant progress with "schizophrenia" may be to stop looking at what "mental health" practitioners think about their patients and to look at how the practitioners themselves think. Important research questions would include the following:

Why is the psychiatric literature silent about why psychiatric residents must try to make patients believe they are mentally ill?

The requirement that psychiatric residents work to convince patients they are "mentally ill" appears to be a real-life demonstration of research about reduction of cognitive dissonance (Festinger, 1957). A person who asserts a certain belief gradually comes to believe what he or she is saying. Would psychiatry be populated by practitioners who can see signs of mental illness in almost every human (Caplan, 1995) if this practice were changed?

A related issue is lack of insight that psychiatrists have about incongruent "mixed messages" in their actions and words. A psychiatrist will, in effect, say to a person diagnosed as delusional, "Because you believe that people are trying to force thoughts into your mind, you must accept into your mind the thought that you are mentally ill." The psychiatrist is unaware that he or she is doing the very thing he or she is declaring is not happening. This is a "crazy-making" experience for psychiatric patients.

When someone diagnosed as schizophrenic disagrees that he or she is ill, why does the psychiatric profession insist that the person "lacks insight"?

McEvoy et al. (1989b) conducted a study to explore "failure of insight in schizophrenic patients." They concluded that "many schizophrenic patients . . . deny that they are ill, are unwilling to enter or remain in the hospital during exacerbations of their illness, and discontinue prescribed medications after discharge" (p. 46). Furthermore, McEvoy et al. (1989a) found that "lack of insight operates independently from levels of psychopathology at admission and decrease of symptoms during treatment" (p. 50).

The point here is that when people diagnosed as having "schizophrenia" disagree that they are mentally ill, many psychiatrists believe their own perceptions are "reality" and that the patients "lack insight." No consideration is given to the possibility that the so-called "schizophrenic" person's view that he or she is not "ill" is valid.

The situation is especially disturbing in light of an observation made by psychiatrist Werner Mendel (1976):

> In the post–World War II literature, there are many examples of patients who went to state hospitals incorrectly diagnosed either as schizophrenic or mentally retarded and who stayed for thirty or forty years only to be discovered, during the renaissance of psychiatry after World War II, not to be ill at all. These patients show a psychological condition based entirely on having been in the hospital for thirty or forty years without any initial mental illness or mental retardation. (p. 123)

What has changed since the 1940s? What if many people diagnosed as "schizophrenic" today are as right in their protests about not being "mentally ill" as were patients in the past (Farber, 1993)?

What are the cognitive processes in the mind of a person perceiving "schizophrenia" in someone else?

Why does the thought, "That's schizophrenic," get triggered in the minds of clinicians when they hear a person reveal certain thoughts and feelings? Why is a disturbing person perceived as "disturbed"? Is the perception of "schizophrenia," in part, a stress reaction in the mind of the beholder?

Why does the psychiatric profession feel compelled to "treat" people diagnosed as having "schizophrenia" when, after 100 years of clinical experience and research, there is still no proof in the psychiatric literature that what is called "schizophrenia" is a medical disease with demonstrable neurophysiological dysfunction?

Emil Kraeplin presented his concept of "dementia praecox" at the University Psychiatric Clinic in Heidelberg on November 27, 1898 (E. Bleuler, 1950; Strömgen & Wing, 1973). A few years later,

in 1911, Eugen Bleuler (1950) wrote in the German edition of his classic textbook on schizophrenia, "We do not know what the schizophrenic process actually is" (p. 466). During the 100 years since the phenomena called "schizophrenia" were first observed, research has established the following:

- Schizophrenia remains a diagnostic enigma (Carpenter, 1983; Gottesman & Shields, 1982; Menninger, 1970). Even though more than 100,000 books and articles have been published on schizophrenia (M. Bleuler, 1979a), contemporary psychiatrists confess that they still do not know what "schizophrenia" is. Cancro (1974) admits that when he was asked, "What is schizophrenia?" by a psychiatric resident, his first thought was, "God only knows" (p. 1). Rifkin (1984) says, "The plain fact is that we just don't know what schizophrenia is" (p. 84). Herbert Pardes (1989), while president of the American Psychiatric Association, wrote in one of his monthly columns, "I do not know what this disease is yet; I do not know how many diseases it may entail" (p. 3). The diagnosis remains now, as 100 years ago, a subjective conclusion based on being familiar with the current diagnostic indicators.
- Most cases of "schizophrenia" occur in physically healthy young adults (ages 16 to 25) who often have a life history of being bright and capable. "Schizophrenia" rarely first occurs in anyone over 40, no matter how extreme the emotional and biological stressors (American Psychiatric Association, 1994; Arieti, 1979; M. Bleuler, 1979b; Hoffer & Osmond, 1966; Ponyat, 1992; Smith, 1982).
- "Schizophrenia" occurs spontaneously with no identifiable cause (M. Bleuler, 1979a; Smith, 1982). Who will get "schizophrenia" is unpredictable, and there is no immunity to it.
- The diagnosis or nondiagnosis of "schizophrenia" can be more strongly influenced by the mindset and expectations of the clinicians than by the mental and emotional condition of the person diagnosed (Rosenhan, 1973; Strauss & Gift, 1977; Szasz, 1976).
- People diagnosed as "schizophrenic" often have to be talked into thinking they are sick and, in many cases, are forced to submit involuntarily to treatment (Appelbaum, Mirkin, & Bateman, 1981).
- The long-term outcome for any individual diagnosed with "schizophrenia" is unpredictable (American Psychiatric Association, 1994; E. Bleuler, 1950; Marengo, 1994; Möller & von Zerren, 1988). Some people fully recover; roughly one half stabilize in socially acceptable ways; and the others continue to have difficulties (Warner, 1985). It is not a condition of slow, life-long, progressive deterioration (Ponyat, 1992). It does not generally progress more than 5 years

from onset; rather, it improves (M. Bleuler, 1979b; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Mendel, 1989).

- There is no known cure for "schizophrenia." Medication makes some people with "schizophrenia" worse (Buckley, 1982; Cohen, 1994; Rappaport, Hopkins, & Hall, 1978), and hospitalization makes some people worse (Kiesler, 1982).

Why do psychiatrists who specialize in schizophrenia misrepresent what is known about schizophrenia to the public?

Prominent schizophrenia psychiatrists such as Nancy Andreasen, editor-in-chief of the *American Journal of Psychiatry*, David Pickar, chief of the experimental therapeutics branch of the National Institutes of Mental Health, and E. Fuller Torrey have stated in national broadcast interviews that schizophrenia is a brain disease like Alzheimer's, Parkinson's, or multiple sclerosis (Farnsworth, 1998; Torrey, 1983, 1988, 1997a; Yolken & Torrey, 1995). These statements are inconsistent, however, with research facts and scientific evidence.

- Neurologists cannot independently confirm the presence or absence of schizophrenia with laboratory tests as they can with Alzheimer's disease, multiple sclerosis, and Parkinson's disease. Postmortem studies of deceased "schizophrenic" patients find no Alzheimer-like neuropathology (Baldessarini, Hegarty, Bird, & Benes, 1997). The majority of people diagnosed as having schizophrenia show no neuropathological or biochemical abnormalities, and a few people without any symptoms of schizophrenia have the same biophysiological abnormalities as do a few people with "schizophrenia" (Siebert, 1999).
- No one can catch a schizophrenia from someone else. During the entire history of psychiatry, no psychiatrist, psychologist, nurse, social worker, aide, or family member has ever caught or developed a schizophrenia from contact with so-called "schizophrenic" persons (Bernheim & Lewine, 1979; Gottesman, 1991).
- No one dies from schizophrenia, even when it is untreated (Mendel, 1989), although the suicide rate is above average in persons treated for "schizophrenia" by the mental health system (Caldwell & Gottesman, 1992; Roy, 1982).
- Contrary to the assertion that schizophrenia is a devastating, dementing illness of progressive deterioration of cognitive processes (Lindenmeyer & Kay, 1992; Maddox, 1988; McGlashen, 1988), re-

search shows no decline in IQ from childhood to adult years (Russell, Munro, Jones, Hemsley, & Murray, 1997). Richard Warner (1994) reviewed all published "long-term follow-up studies of schizophrenics" and found that "complete recovery occurs in roughly 20-25 percent of schizophrenics and social recovery in another 40-45 percent" (p. 79). Longitudinal studies of thousands of ex-patients in many countries show that one half to two thirds of the individuals diagnosed as schizophrenic are found, many years later, to have achieved full recovery or made significant improvement (Harding et al., 1987; Siebert, 1999).

- No one with Alzheimer's, Parkinson's, or multiple sclerosis has recovered from his or her condition with psychotherapy, but many people have achieved full recovery from schizophrenia as a result of psychotherapy and/or milieu therapy, often without using medications (Artiss, 1962; Colbert, 1996; Jung, 1961; Karon, 1998; Laing, 1967; Perry, 1974; Sechehaye, 1951; Sullivan, 1962).
- Individuals diagnosed as "schizophrenic" may be unusually perceptive and insightful; they may enjoy rich inner lives and achieve successful professional careers (Arieti, 1979; M. Bleuler, 1979b; Buck & Kramer, 1977; Grant, 1975; Rokeach, 1981; Smith, 1982). Psychologist Fred Frese is an outstanding example (Buie, 1989).
- A few people diagnosed with "schizophrenia" have recovered on their own with no treatment of any kind (Brody, 1952; French & Kasonin, 1941; Hoffman, 1985; Nasar, 1998; Rubins, 1969).

Why is the psychiatric literature silent about the personality characteristics of people who fully recovered from schizophrenia?

Malcom Bowers, Jr. (1979) reports that "Some psychotic patients recover and go on to progress psychologically and socially; that is, continue to grow" (p. 151). Karl Menninger (1963) stated,

> Not infrequently we observe that a patient . . . gets as well as he was, and then continues to improve still further. He becomes, one might say, "weller than well." . . . there are thousands of unknown examples who have not been discovered or who have not yet written about their experiences. (p. 406)

What are people like who were made better by their so-called "schizophrenic" experience (E. Bleuler, 1950; Pickering, 1976, Sannella, 1981)? What is the frequency of "spontaneous remission" from schizophrenia? Why does psychiatry demonstrate no interest in people who fully recover from schizophrenia?

Why is psychiatry indifferent to pioneering breakthroughs that demonstrate effectiveness with people diagnosed as "schizophrenic"?

Many reports of psychotherapeutic successes with people diagnosed as schizophrenic have been published (Artiss, 1962; Colbert, 1996; Hoffer, 1997; Jung, 1961; Karon, 1998; Karon & Vandenbos, 1981; Laing, 1967; Mosher, 1978, 1999; Perry, 1974, 1999; Sullivan, 1954), but the psychiatric profession shows little interest in learning from these successes. Why is psychiatry different from other medical specialties when better ways of being successful (other than prescribing the latest neuroleptic drug) are discovered?

When Warner (1985) compared recovery rates from schizophrenia decade by decade, he found that "recovery rates from schizophrenia are not significantly better now than they were the first two decades of the century" (p. 79). Why has psychiatry lagged so far behind, in light of solid breakthroughs achieved by other medical specialties in the past 100 years?

Why do psychiatrists react to reports of successful treatment of schizophrenia by rejecting the original diagnosis? Has psychiatry developed a closed belief system?

Carl Jung (1961), after describing some of his early successes with schizophrenic patients between 1905 and 1909, wrote the following:

> While I was still at the clinic, I had to be most circumspect about treating my schizophrenic patients, or I would have been accused of woolgathering. Schizophrenia was considered incurable. If one did achieve some improvement with a case of schizophrenia, the answer was that it had not been real schizophrenia. (p. 128)

Kenneth Artiss (1962) reports the same reaction from a group of psychiatrists who heard him explain how, by using milieu therapy, he had achieved a 64% recovery rate from a group of 42 patients all diagnosed as schizophrenic by qualified psychiatrists. Some psychiatrists in his audience wrote to him afterward, saying, "We are amazed and incredulous concerning your reports about the speed with which symptoms disappear. We wonder if the cases treated are really schizophrenic at all" (p. 136).

When faced with evidence that many people once diagnosed as "schizophrenic" have fully recovered, psychiatrists appear to have developed a closed belief system when they declare that the diagnosis was wrong instead of questioning what they believe about "schizophrenia" (Sarbin, 1990).

Why is psychiatry not able to understand the difference between psychotic breakdowns and transformational breakthroughs?

- Some people not only fully recover from a "schizophrenic" episode but the experience has beneficial effects, leading to favorable changes in personality and improvements in psychological strengths (Arieti, 1979; Bernheim & Lewine, 1979; E. Bleuler, 1950; Cancro, 1974; French & Kasonin, 1941; Jung, 1961; Rubins, 1969; Silverman, 1970; Sullivan, 1962; Warner, 1985).
- Elements of transcendent experiences and the highest states of consciousness are typically confused with symptoms of "schizophrenia" by psychiatrists (Fischer, 1971; Huxley, 1972; Maslow, 1971; Prince & Savage, 1966; Siebert, 1986, 1993, 1996; Wapnick, 1969).

Why do research reports about schizophrenia refer to all patients as having the same unitary illness? Why does psychiatry's lack of critical thinking and scientific inaccuracy go unchallenged?

The *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition) (American Psychiatric Association, 1994) states that "no single symptom is pathognomic of schizophrenia" (p. 274). There is no simple, objective, diagnostic criterion for schizophrenia—no defining symptom, no psychological test result, no brain image, no blood test. All basic psychiatric references, starting with Emil Kraeplin (1902), say that the symptoms of "schizophrenia" vary widely between people and within individuals, and that the "schizophrenias" (plural) are best understood as a heterogeneous group of conditions (Andreasen, 1985; E. Bleuler, 1950; Kraeplin, 1902; O'Donnell & Grace, 1998).

Despite what the basic references say, however, all published schizophrenia studies refer to subjects as being "schizophrenic" (singular). The authors of research reports about schizophrenia speak as though all the subjects in their research had identical symptomatology.

Why do editors and publishers of psychiatric publications tolerate this glaring lack of critical thinking and scientific inaccuracy in schizophrenia researchers? Do they even notice?

Is the erroneous belief that "schizophrenia" is a brain disease with no known cure a symptom of a profession that feels helpless and hopeless?

E. Fuller Torrey (1983) and the National Alliance for the Mentally Ill have unequivocably stated for many years that schizophrenia is a brain disease without a cure (Johnson, 1989). Many psychiatrists who specialize in schizophrenia have themselves so convinced that it is an incurable brain disease (Andreasen, 1995, 1997; Torrey, 1988, 1995; Weikert & Weinberger, 1998; Zigun & Weinberger, 1992) that they make discouraging statements to their "patients." Gotkin and Gotkin (1992) report that as Janet Gotkin was being discharged from a psychiatric hospital, a staff nurse said to her,

> Of course you feel good now, but there's one thing you must remember. Wherever you go, whatever you do, however you feel, you will always have to take care. You will never be like the rest of us, you will always be schizophrenic. (p. 380)

Michael Allen (1999) says,

> After 5 years of therapy and Thorazine, I knew the psychiatric community was not healing me. If I would have stayed in my doctors' care, I'd still be in the mental health system surviving day to day only with the aid of "chemical straight-jackets" (psychotropics). I had the courage, the strength and the wisdom to know when and how to go off the Thorazine. When I told the psychiatrist I was off the medicine, he told me that there was a 90% chance that I would end up in the hospital again. So I told him that meant there was a 10% chance that I wouldn't. He disagreed and said not exactly. I've been out of the community mental health system and off medications for 7 years now. I am so happy I had the strength and confidence to stop taking the Thorazine the psychiatrist demanded that I could never stop taking. (pp. 1-2)

Are schizophrenia psychiatrists projecting feelings of helplessness and hopelessness onto their patients? To what extent do their

gloomy prognosis and subsequent actions turn this pessimistic prediction into a self-fulfilling prophecy?

What cognitive processes had mental health professionals calling their patients "schizophrenics" for so many decades?

Sarbin and Mancuso (1980) argue that the perception that someone is "a schizophrenic" is more of a moral verdict than a medical diagnosis. What are the cognitive processes that have influenced mental health professionals to engage in diagnostic labeling that is prejudicial and lacking in objectivity (Goffman, 1961; Menninger, 1970; Scheff, 1975; Szasz, 1961, 1976)? Why has using a pejorative noun (Menninger, 1970) in referring to patients as "schizophrenics" been such a widespread practice in psychiatry?

Why does the psychiatric profession react so defensively to feedback that it makes mistakes and could be more effective?

Mentally healthy people and competent professionals in most fields welcome constructive criticism and feedback about how they could be more effective. The psychiatric profession is not a good role model, however, for its patients (Torrey, 1997b). For example, Rosenhan (1973) published a study in *Science*, reporting that when he sent pseudopatients to psychiatric facilities, all except one were diagnosed as "schizophrenic" on admission, and all were said to be "in remission" when discharged. After the study was published, every letter to the editor from a psychiatrist condemned and attacked the study as invalid, flawed, and without merit. No psychiatrist wrote a letter saying, "Thank you for bringing this matter to our attention; we need to reexamine our practices."

CONCLUSION

Something is seriously wrong with the way the psychiatric profession thinks and acts toward people perceived as "schizophrenic." After a century of research, psychiatrists who specialize in schizophrenia admit they still do not know what it is, what causes it, or how to cure it. Even E. Fuller Torrey (1983) admits that "it is likely that the twentieth century psychiatrists as a group have done more harm than good to schizophrenics" (p. 157).

Despite all this, psychiatrists remain adamant in their insistence that even though "schizophrenia" is an incurable "disease," it must be "treated."

Questions raised in this article indicate that the psychiatric profession lacks insight into its own behavior, invalidates constructive criticism, avoids the kind of self-examination it urges on its "patients," shows little interest in breakthrough accounts of successes with so-called "schizophrenic" individuals, erroneously lumps all the schizophrenias (plural) together in research projects, dismisses evidence that contradicts its inaccurate beliefs, and misrepresents what is known about "schizophrenia" to the public and to patients.

In addition, the psychiatric profession sustains stigmatization of people said to have "schizophrenia" (Menninger, 1970) by not challenging, disclaiming, or censuring practitioners who incorrectly describe "schizophrenia" to the public as a chronic, disabling, devastating mental illness (Lindenmeyer & Kay, 1992; Maddox, 1988).

The questions raised here are not at odds with clinical evidence that some people diagnosed as "schizophrenic" benefit from medications, brief hospitalization, and therapeutic support. That is not the issue, nor is this an "antipsychiatry" article. The point is simply to assert that there will be no significant improvement in treatment outcomes with "schizophrenia" until research explores the cognitive processes, personality traits, and motives of "mental health" professionals who perceive "schizophrenia" in others and insist on treating "schizophrenia" as a brain disease.

NOTE

1. All patients' names in this article are pseudonyms.

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