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DEBATE

The Rational Organization of Care for Disabling Psychosis: "If I Were Commissioner"

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Care of the mentally disabled could be immensely improved by shifting the focus of their treatment to competent, present-oriented counseling/psychotherapy provided by the same psychiatrist who cares for the patient both in and after hospital—a system based on continuity of care—and away from medication where it lies today. While such continuity is easy to set up in the private sector, its establishment in the public sector would require significant attitudinal and organizational changes.

Individuals diagnosed as suffering from schizophrenia and other serious mental disorders will continue to be harmed by fragmented, drug-focused "care" until such care is organized properly. For public sector patients, organizing and administering that care is the task of a state mental health commissioner operating under laws passed by the state legislature. Fifty-seven years of psychiatric experience, much of it in state hospitals, and 3 months of voluntary hospitalization in 1963 for paranoid schizophrenia are the basis for this discussion of how that care should be organized.

What is "schizophrenia," the most serious mental illness? Jenkins' (1952) explanation may be the simplest and the best: an unmysterious state of neuropsychological disorganization followed by reorganization of various kinds. The disorders we call acute schizophrenia are characterized by acute disorganization; those we label as chronic involve warped, psychotic reorganization. Operating under this concept, psychiatrists should therefore tell patients that they are suffering from a reversible disorder, a "nervous breakdown" from which they can, and do, often recover, rather than from any mysterious, permanent "brain disease." Such a statement would be consonant with the little-known findings of long-term follow-up studies: "a 50-50 or better chance of significant improvement and perhaps recovery" (Harding, 1995). This approach also offers the possibility, which does occur in real life, that a patient reorganizes after his breakdown at an even higher level than before it, and that attaining such a higher level can actually be a treatment goal.

THE PSYCHIATRIST-PATIENT RELATIONSHIP: THE HEART OF EFFECTIVE CARE

A strong doctor-patient relationship—a patient's trust in his physician—stands at the heart of any effective medical treatment. That relationship is probably responsible for approximately half the therapeutic impact of *any* medical intervention (White, 1991, p. 158). In psychiatry, which lacks specific therapeutic agents, the relationship's impact is likely to be even greater. The positive effect of the therapeutic relationship in psychiatry is maximized when the same doctor treats the patient from the beginning to the end of his illness—both in and after hospital, if hospitalization has been necessary. The absence of therapeutic trust impedes recovery, while the loss of that trust after it has been established aggravates disorder. This is one important cause of current treatment's harmful effects, such as the loss of effective behavior patterns (habits), the lowering of personal goals, and the abandonment of hope for a full, useful, and satisfying life.

American psychiatry's redefining medication as the core of treatment, and consequently neglecting *both* the doctor-patient relationship and psychiatry's central task—psychotherapy/counseling—are largely responsible for the specialty's worsening treatment results and mounting harm to patients (Hegarty, Baldessarini, Tohen, & Waternaux, 1994). While medications can help, especially in low dosages during short periods of acute disorganization, they all produce brain damage. This can be serious when continued for years on end. That damage is manifested by widespread tardive dyskinesia and akathisia, two of the many iatrogenic/drug-induced disorders afflicting psychiatric patients.

WHAT ABOUT NON-MEDICAL THERAPISTS?

Psychiatry has relegated the task of psychotherapy/counseling, and therefore the creation of meaningful treatment relationships, to non-medical professionals of lower status—psychologists, social workers, nurses, and even "case managers." Today's psychiatrists see patients primarily in terms of diagnostic labels, which supposedly determine which drug they should prescribe. Their interactions with patients are therefore largely limited to questions about medication. But even though psychiatrists hardly know their patients, they retain ultimate authority for their care. This splitting of responsibility between non-medical professionals who know the patients and psychiatrists holding final treatment authority over them can be called "schizotherapy."

Does this psychiatric abandonment to non-medical professionals of the responsibility for knowing patients as human beings, and therefore really being able to help them, warrant giving the non-medicals the formal responsibility also? While such a shift may sometimes be desirable, especially today, it would not, in general, be a good idea. This problem would be much better resolved by psychiatrists' returning to the physician's traditional counseling role rather than continuing to limit their therapeutic role to the control of medication.

A medical degree is necessary for treating hospitalized mental patients for several reasons. Physicians have a long-standing social aura of responsibility and reliability. Everyone has been to doctors and has usually been helped. The initial trust in doctors *qua* doctors, more than in other professions, is an important therapeutic tool which can and should be used to foster recovery. (The extent of that trust's abuse within psychiatry cannot, of course, be denied.)

Psychiatric hospitalization often involves tense, dangerous, emergency situations, which physicians are uniquely trained to handle. Medical schools teach the ability to take responsibility in crisis situations, as well as courage and knowledge, all of which are needed in such circumstances. The possibility of associated medical problems in the acutely disturbed is another reason for keeping ultimate responsibility on physicians' shoulders. The claim that responsibility should be limited to physicians because they are the only ones trained to use drugs, and drugs are so important in psychiatric treatment, does not, however, seem valid. Psychiatry's over-reliance on drugs has long been a national scandal.

The fierce anti-medical biases existing in some non-medical mental health professions also deserve mention here. Aside from the important but little-mentioned issue of interprofessional economic turf warfare, that bias is largely based on the false idea that permanent conflict exists between psychiatrists and their patients, with the latter therefore needing protection against their doctors, which attorneys and/or social workers then supply. That logic would call for an attorney or social worker in all situations in which a patient cannot protect himself against his doctor, such as general anesthesia.

MY OWN EXPERIENCES

Some personal experiences are relevant to discussing how care should be organized. In 1951-1953, when barbiturates and bromides were the only drugs available, I was psychiatrist-in-charge of the female reception service at a large state hospital. Each afternoon, I met every newly admitted patient to introduce myself and to tell her that we were there to help her calm down so she could then return home. Our social environment was both compassionate and structured—I had a superb head nurse—so most patients did calm down and leave. Few were readmitted.

In 1963-1964, I was voluntarily hospitalized for three months at Mt. Sinai Hospital in New York City. Difficult as the hospitalization itself was for me, my picture of myself would have suffered even more had I been hospitalized involuntarily. Although sometimes necessary—and, if so, only for a brief period—involuntary hospitalization contradicts the voluntary nature which psychiatric treatment should always have. My diagnosis was paranoid schizophrenia—the consequence of four years of skillful political harassment. The most important reasons for my recovery were a stable environment, which protected me from further harassment, and my engaging, on my own, in useful and satisfying activities. My psychiatrists, preoccupied with my childhood and refusing to examine my recent past, were essentially irrelevant to my eventual improvement. Fortunately, however, they discontinued my medications after two weeks; I had been tonguing half of it anyway because of its very severe side-effects. My recovery was due to my running a mile a day in the gym, starting again to play my violin, and beginning a research project in the history of psychiatry at the nearby New York Academy of Medicine (Lehrman, 1966).

In 1978, after I retired after five-and-a-half years as Clinical Director at Kingsboro Psychiatric Center, I saw an effective care system based on the seamless integration of hospital and aftercare services (Lehrman, 1985) in Cambridge, England. Its core concept was having the same trusted, competent psychiatrist caring for a patient both during and after hospitalization, that is in both ward and clinic. Drugs were used but at much lower dosages and for shorter periods than here in America. Patients, families, and doctors were all deeply satisfied with the care, and the number of staff needed per 100,000 population,

and therefore the comparative per capita costs, were far less than those of the New York State system then (Lehrman, 1983). Since that time, the New York system's costs have risen and its effectiveness has fallen.

After my return, I took a part-time position at another state facility aftercare clinic where I had excellent results treating the chronic patients I inherited by insisting on the reversibility of their psychotic thinking and behavior patterns and by working psychotherapeutically with them and their families to help them change. I encouraged their involvement in "useful and satisfying" activities—like my own at Mt. Sinai—and reduced and often eliminated their drugs (Lehrman, 1982). At the same time, I continued a part-time private practice, helped by an attending staff appointment at a nearby community hospital in which I could admit patients to its psychiatric ward. Even though the hospital culture forced me to medicate my newly admitted patients much more heavily than I wanted to, I was nevertheless able to reduce their dosages rapidly so that they were receiving little or none when I discharged them. I then followed them in the office. Since admission could be arranged immediately if necessary, the hospital's availability allowed me to begin treating patients in their homes who might become too disturbed to continue there. In all these cases, I worked closely with both patient and family, and when I did prescribe medication it was usually for small amounts and brief periods.

ORGANIZING INPATIENT CARE

The Hospital: A Structured Asylum Where Continuity of Competent Care Begins

The first treatment need of disturbed mental patients, especially those called schizophrenic, is a structured social environment within which they can calm down. Mosher (1999) has described one type of such environment. But *all* psychiatric inpatient facilities should serve as they did in mid-19th century America (Bockhoven, 1963), as did the hospital I worked at in 1951-1953, and as Mt. Sinai did for me 10 years later, as asylums within which patients can settle down, with or without medication. If a hospital leadership respects patients and their dignity, its staff can be trained relatively easily to treat patients similarly.

A patient's relationship with his psychiatrist or other therapist, the heart of successful treatment, should begin immediately upon admission, as they formulate his history by examining together the experiences preceding his breakdown/illness. History-taking should then evolve into present-focused counseling/psychotherapy, designed to help the patient learn better ways to deal with the problems which threw him. To accomplish this, meetings with the family and/or others close to the patient will be necessary.

Ward Organization and Activities

Hospital wards should be organized into small social groups, 8 to 12 patients and a few staff members. Such groups can increase the hospital's effectiveness in calming patients, and all can benefit if patients longer in hospital assist the frightened, newly admitted. Idleness is a major cause of hospitals' harming patients. While exhausted patients should be permitted to rest, others should be encouraged to engage in "useful and satisfying" activities, such as physical activity in gymnasia and exercise rooms and mental stimulation in libraries. The endlessly running television sets often found on psychiatric wards create a mood of apathy and undercut patients' efforts to regain stability and effectiveness; they should therefore be turned on only for specific programs.

The Role of Medication

Sleep disturbances are common among newly admitted patients, who may therefore need sedative medication for at least their first night in hospital. Medication to calm agitation is also often useful to patients, and to staff. From the moment of admission, all medication decisions—whether for sedative, tranquilizer or energizer—should actively involve the patient as much as possible. The psychiatrist should explain what he is prescribing and why, how it may help, and what its side effects might be. If the patient refuses—which should occur rarely if he is approached respectfully—that refusal should usually be accepted. Subsequent medication orders should also be joint decisions as much as possible. Ongoing feedback to the doctor from both patient and family about the medication and its effects is beneficial in itself and because it strengthens ties among them all.

Whitaker (2002) recently showed the dubious value of current drugs for treating psychoses. He also pointed out that much better treatment results with schizophrenia are obtained in third-world countries, in which the drugs we use are too expensive for routine use, than in our heavily drug-prescribing "developed" nations. Overmedication of patients upon release from hospital is often a serious problem. While medication reduces the possibility of patients' exploding in the short term, it blunts their feelings and thinking, thus impairing their ability to participate in social living and gainful employment. Careful monitoring, while dosages are reduced as quickly as is safe, is therefore vital.

Length of Hospitalization

Since hospitalization can produce infantilization (Lehrman, 1961), it should be as short as is clinically safe, but it must be long enough for the patient to gain maximum benefit of hospitalization by calming him sufficiently. When he has become composed, has had successful home visits, and the necessary post-release fiscal, treatment, and living arrangements have been made, he can be discharged, to be cared for afterward by the same doctor/therapist in office or clinic: true continuity of care.

Post-Hospital Care: Continuity of Competent Aftercare

Aftercare is more difficult and more important than in-hospital care. Unfortunately, however, its lower reimbursement rate encourages its neglect. A disorganized patient can become reorganized more easily in hospital than at home because he is separated from the social environment in which his breakdown occurred. A major purpose of aftercare, when the patient has returned to his earlier social environment, is to help him (and those around him) learn more effective ways of dealing with each other.

The relative importance of in-care and aftercare services was demonstrated at Kingsboro in the late 1970s, when a chief of service, responsible for both ward and clinic services to his catchment area, found that his most effective division of staff involved assigning two-thirds to the clinic and the rest to the ward. The clinic kept the patients functioning in the community, and few readmissions were necessary; the ward therefore remained unfilled and beds were always available.

The post-hospital counseling/psychotherapy, which schizophrenia patients should receive (of which cognitive psychotherapy is the best known type) should focus primarily on today's significant issues. These include:

1. the patient's relationships with his family and friends, and at work or at school;

2. identifying and helping him correct his inappropriate modes of behaving, relating or thinking, which may include setting limits on a patient's inappropriate behavior, such as his using his "illnesses" to justify his wrongful conduct (Lehrman, 1991); and
3. examining and helping him implement his current and future goals, both work and personal.

If the counseling/psychotherapy focuses on specific problem areas in which change is being sought rather than on free-associational rambling, I found that, after establishing initial contact (and without current emergencies), 15 minutes every week or two is sufficient to keep patients improving (Lehrman, 1982).

Conflicts often arise between patients and families when patients return home. One of the major, and most difficult, therapeutic tasks is to prevent explosive situations there by teaching the patient and his family how to amicably resolve the differences which inevitably arise. A critical point in the life history of the formerly hospitalized mental patient often occurs after his first or second admission, when the question arises of whether he can remain in his previous residence—usually with his family—or needs placement in a mental health facility in the community. Too often, mental health professionals' response to such conflicts is permanent removal of the patient, even though the family, despite the quarrels, should remain a major source of strength and support. If therapists worked more effectively in the early stages of breakdown, with the patient still in hospital, to strengthen family units, fewer former patients would now be living isolated lives, and there would be much less need for expensive, special long-term housing for chronic patients.

Those with primary therapeutic responsibility for these patients must therefore be trained in both present-oriented individual counseling, such as cognitive psychotherapy, and family-oriented joint interview methods (Lehrman, 1962). To help with difficult situations, experienced consultants should be available. The availability of such consultation can also directly benefit the patient. Should he be unhappy with his therapy or therapist, an expert consultant can help solve the problems in the therapy or recommend transfer to another therapist.

Chronic Patients and Their Medications

Chronic patients may come into a psychiatrist's care already receiving large dosages of medication. As a matter of medical principle, these dosages should be reduced as much as possible. Methods for doing this stepwise and gradually have been described elsewhere (Lehrman, 1982). The task is difficult and requires considerable clinical skill as well as a close relationship among the psychiatrist/therapist, the patient, and the patient's significant other(s).

CARE TODAY, AND THE HARM IT CAUSES

Mental health care for public sector patients had long differed considerably from the ideal just presented. Today, a frightened, disorganized person is brought into the hospital (often against his will), told he is seriously ill with a "brain disease" for which medication is the definitive treatment, and is then given a large, typically disabling, dose. If admitted to a "receiving hospital" a few days later, just when he is beginning to understand his initial surroundings and relate to them, he may be transferred to another facility. In the new hospital, he must relate to entirely new people and circumstances. In each facility, a social

worker, psychologist, or nurse will take his history; his contacts with the psychiatrist responsible for his care will only concern medication. Whatever personal, therapeutic relationships he forms will therefore be with non-medical personnel who lack ultimate authority over his care. When he is discharged, all his therapeutic relationships will end, although his medications will usually be continued.

Should he then reach an aftercare clinic or office (without "falling between the cracks"), he will have to tell his story to, and relate to, yet another non-medical professional whose personal or team's approach may differ from what the patient has already experienced. His new psychiatrist's approach may also differ, perhaps involving medication change—but with drugs still the only subject they discuss. If the patient needs readmission, as frequently occurs, another unfamiliar treatment team will take his history and provide his counseling and medication. Each subsequent discharge and readmission will involve retelling his story and forming still another set of treatment relationships. As a whole, this process seems almost deliberately designed to produce insanity.

Two prominent real-life cases illustrate this observation. Almost 20 years ago, Susan Sheehan's (1982) book, *Is There No Place on Earth for Me*, described the true experiences of "Sylvia Frumkin." Over the previous 18 years, this patient had been treated in 45 different settings at an estimated cost of $636,000 (Moran, Friedman, & Sharfstein, 1984). Fragmentation of care and neglect of human relationships also characterized the treatment of Andrew Goldstein (Winerip, 1999), a once brilliant graduate of Bronx High School of Science. On January 3, 1999, after 11 years of medication-focused, depersonalized psychiatric care in a host of different settings (he had 13 hospitalizations in 1997 and 1998 alone) and repeated unsuccesful efforts to get readmitted, he pushed Kendra Webdale to her death beneath a subway train.

TREATMENT ATTITUDES REQUIRING CHANGE

Obviously, profound changes in various professional attitudes are necessary for successful treatment of those diagnosed with schizophrenia or other serious mental illness.

Restoring Hope by Abandoning the Myth of Incurability

Although the central role of hope in treating the sick has always been a medical maxim, today's treatment of serious mental illness has essentially abandoned hope. The optimism of mid-19th century American mental hospitals, and their successful results, was followed by the pessimism evoked by increasingly overcrowded facilities and poorer outcomes (Bockhoven, 1963). While studies of patients long retained in hospitals found poor prognoses, recent follow-ups of *all* once-hospitalized schizophrenia patients revealed the better outcome mentioned earlier: that over half of them now function normally (Harding, cited in Karon, 1999). Therapeutic hopelessness has been massively increased by the National Institute of Mental Health's central operative concept that mental illness is really a form of brain disease and therefore essentially irreversible until the proper drug is found. The question of therapeutic hopelessness has strong personal relevance since, when I was hospitalized, the professionals told my family that I would never be the same again.

Integrating Care by Correcting Its Fragmentation

A patient's trust in his doctor/therapist and treatment team should be a major, positive element in his treatment beginning from the moment of admission. The yo-yo-ing of fragmented care—the repeated evocation of trust followed by its destruction—reduces that hope. Several such readmissions and discharges destroy trust altogether, and hope with it, leaving the patient more demoralized than when he started treatment. The fragmentation of care can be further aggravated by the existence of a host of private and public agencies, each responsible for only a part of the patient's needs, and all competing for funding.

Returning Medication to Its Secondary Role in Treatment

Above and beyond the toxic effects of psychotropic drugs on the brain, other harmful consequences stem from making these substances the sole or primary treatment of serious mental illness. Overattention to medication has stood on its head the relationship between patient and the professionals treating him—transformed it from cooperative to adversary—thus seriously impeding recovery. The professionals are taught to continue medications indefinitely while patients object to the drugs' interference with their thinking and behavior. The patients' resultant catch-22 situation is almost certain to produce antagonism between them and their caretakers. If they continue taking the drugs, their ability to function will remain impaired, and their chance of returning to responsible citizenship will be reduced. But should they stop medications—which almost all former schizophrenics now functioning at normal levels did (see Karon, 1999)—they lose the emotional support of the clinic and risk explosion from too-rapid dosage reduction, including involuntary rehospitalization in states with active programs of "assertive community treatment."

Therapeutic overattention to medication justifies neglect of the patient's real-life problems and denial of his responsibility to deal with them. This phenomenon was demonstrated by the hospitalized patient who told his psychiatrist, "I am upset today because of my brain chemistry; would you please adjust my medication?" and by the mother of another schizophrenic patient who said, "We just hope that some day you doctors will find a way to fix his brain chemistry" (Pinheiro, 1989). Over-reliance on, and over-prescription of, these drugs easily create dependency/addiction to them—not only of patients but also of prescribers and other professionals.

Changing Psychiatrists' Approach to Treatment and Making It Effective

Psychiatrists, like most human beings, want to do their jobs well. Replacing their belief in drugs as the heart of treatment by the interpersonal psychotherapeutic/counseling approach described earlier will require retraining them. This can be done through supervision by psychiatrists proficient with the counseling approach—a group which is unfortunately dying off rapidly. These consultants could hold regular teaching case conferences at the various wards and clinics to present and discuss problem cases, and then return regularly to evaluate with the staffs the results of the treatment changes they recommended.

Organizational Changes Required for Continuity of Public Care

In the private sector, continuity of care can be set up easily by having privately practicing psychiatrists with admitting privileges caring for their patients both in and after hospital. In the public sector, however, major organizational changes are necessary for continuity of care to be established. Responsibility for the patient both in and after hos-

pital must rest on one psychiatrist/therapist, and therefore on one agency, rather than on the host of agencies currently providing specialized services at different stages of the patient's illness.

In the Cambridge system I saw in 1978, each patient from a given catchment area was hospitalized in one ward and treated afterward at a closely affiliated clinic, both parts of the same agency. Since the same psychiatrist treated him at both locations, the doctor spent part of his work week at each. Such a structure could have been established easily in New York State when aftercare was still the responsibility of the state psychiatric centers. In 1984, however, aftercare was transferred to state-funded non-profit and private agencies (Lehrman, 1995). Establishing continuity of public care today would therefore necessitate withdrawal of state funds from many of these agencies, although any agency capable of providing *both* in-care and aftercare services to a specified population might thrive.

Opposition to Efforts to Establish Good Care

Opposition to establishing continuity of competent psychiatric care in the public sector can be expected from several directions:

1. the drug companies, which profit enormously from patients remaining confused and therefore heavily medicated
2. the psychiatric research establishment—the research tail which wags the treatment dog by virtue of its control over psychiatric training programs

   (Psychiatry department chairmanships are determined increasingly by grantsmanship, and therefore by research—almost all of which is biological—rather than by competence in treating patients or in organizing their care. The research is, in turn, largely controlled by the drug companies and by the National Institute of Mental Health, which has been actively publicizing the brain-disease model of mental illness)
3. the American Psychiatric Association (APA) itself, also influenced increasingly by the drug companies

   (In 1980, the APA significantly aggravated the fragmentation of public psychiatric care by redefining "continuity of care" as making sure patient records do not get lost as the patient is shuffled from one agency to another [Lehrman, 1995])
4. the political administrators now running state mental health programs as patronage pork barrels, with few standards for jobs within many state facilities
5. the host of politically connected, heavily publicly funded private and supposedly non-profit social and treatment agencies, which, as in New York State with over 2,000 such agencies, profit heavily from the fragmentation of care they created in 1984 (Lehrman, 1995)
6. some non-medical mental health professionals who, correctly condemning psychiatry and its practitioners for the harm they inflict on patients, claim it has forfeited any right to care fot its patients.

   (In attacking psychiatry, they may also attack the professionalism needed for care of the mentally ill, claiming even that peer-treatment by other ex-patients can be equally helpful.)

WHAT CAN BE DONE?

Mosher (personal communication, May 2000) believes that substitutes for mental hospitals, such as the effective Soterias he has created and described, are necessary for the successful treatment of "schizophrenia," something that he thinks existing institutions will never be able to do. I disagree. I believe the task can be done better and more easily by operating already-existing facilities properly. The changes needed can be started on a small scale by privately practicing psychiatrists with admitting privileges in community hospitals. They can provide continuity of care by following their patients afterward in their offices. Correcting the system as a whole, however, requires state commissioners with sufficient knowledge and power to reorganize their facilities so that they too provide continuity of competent psychiatric care.

This would be a difficult task, and a political one. For it to occur, allies would have to be found. Possible supporters include:

1. the psychiatric survivor/consumer movement, if it focused on the proper organization of mental health care rather than on psychiatry-bashing or "peer-support" programs—getting co-opted by obtaining pieces of the treatment action;
2. the psychiatrists and other professionals who are becoming increasingly disgusted with psychiatric care's increasing harmfulness;
3. medical schools or large social agencies willing to take responsibility for all inpatient and outpatient care for a particular catchment area; and
4. health maintenance organizations (HMOs), which would first have to be convinced how much cheaper and better care would be when organized in this way.

Making the mental health system helpful rather than harmful will not, however, be an easy task.

REFERENCES

Bockoven, J. S. (1963). *Moral treatment in American psychiatry*. New York: Springer Publishing.

Harding, C. M. (1995). The interaction of biopsychosocial factors, time and the course of schizophrenia. In C. L. Shriqui & H. A. Nasrallah (Eds.), *Contemporary issues in the treatment of schizophrenia* (pp. 653-681). Washington, DC: American Psychiatric Press.

Hegarty, J. D., Baldessarini, R. J., Tohen, M., Waternaux, C., & Oepen, G. (1994). One hundred years of schizophrenia: A meta-analysis of the outcome literature. *American Journal of Psychiatry, 151*, 1409-1416.

Jenkins, R. L. (1952). The schizophrenic sequence: Withdrawal, disorganization, psychotic reorganization. *American Journal of Orthopsychiatry, 22*, 738-742.

Karon, B. P. (1999). The tragedy of schizophrenia: Its myth of incurability. *The General Psychologist, 35*, 1-12.

Lehrman, N. S. (1961). Follow-up of brief and prolonged psychiatric hospitalization [original title: The uselessness of prolonged hospitalization]. *Comprehensive Psychiatry, 2*, 227-240.

Lehrman, N. S. (1962). The joint interview: A method of resolving family and psychotherapeutic impasse. *American Journal of Psychotherapy, 17*, 83-93.

Lehrman, N. S. (1966). *Psychiatry vs. history: American psychiatry's misevaluation of the medieval witchcraft epidemic*. Paper presented at the Annual Meeting of American Psychiatric Association.

Lehrman, N. S. (1982). Effective psychotherapy of chronic schizophrenia. *American Journal of Psychoanalysis, 42*, 121-132.

Lehrman, N. S. (1983, January). Public mental health services in New York State. *Newsletter of the Nassau (N.Y.) Psychiatric Society*, p. 3.
Lehrman, N. S. (1985, November 1). Case continuity. *Psychiatric News*, p. 5.
Lehrman, N. S. (1991). Chronic patients' power games and the proper setting of limits. *Psychiatric Quarterly, 62*, 67-74.
Lehrman, N. S. (1995). The bureaucratic destruction of patients' faith in their doctors: Public psychiatry's negative lessons for general medicine. *Bulletin of the New York Academy of Medicine, 71*, 194-217.
Moran A. E., Freedman, R. I., & Sharfstein, S. S. (1984). The journey of Sylvia Frumkin: A case study for policymakers. *Hospital & Community Psychiatry, 35*, 887-893.
Mosher, L. R. (1999). Soteria and other alternatives to acute psychiatric hospitalization: A personal and professional review. *Journal of Nervous and Mental Diseases, 187*, 142-149.
Pinheiro, M. V. (1989). Viewpoint: U.S.A., 13 years later. *Psychiatry, 52*, 469-474.
Sheehan, S. (1982). *Is there no place on Earth for me?* Boston: Houghton Mifflin.
Whitaker, R. (2002). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*. Cambridge, MA: Perseus Books.
White, K. L. (1991). *Healing the schism: Epidemiology, medicine and the public's health*. New York: Springer-Verlag.
Winerip, M. (1999, May 23). Bedlam on the streets. *New York Times Magazine*, 42f.

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