

Schizophrenia: an alternate view

Written 23 years ago, this paper remains completely valid. Its then ongoing Creedmoor research was presented at the American Psychiatric Association's 1980 Annual Meeting in San Francisco (where it was placed to get minimal attention as compared to papers on drug treatment) and was published in 1982 in the *American Journal of Psychoanalysis* as "Effective Psychotherapy in Chronic Schizophrenia." - NSL

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Dr. Lehrman is deputy director, clinical (retired) at Kingsboro Psychiatric Center, Brooklyn. The following article was submitted in response to an interview on schizophrenia which appeared in the July 1979 issue of This Month in mental health. We welcome the receipt of divergent viewpoints from our readers.

This Month in mental health's informative interview with Drs. Kline and Sachar presented the usual concept of schizophrenia: a mysterious condition, which can be helped but not cured, with medication its most important treatment modality, and with important biological and genetic causes which we are on the threshold of understanding definitively — a threshold upon which psychiatry has been poised for at least 50 years. Commonly accepted concepts are not necessarily true, however; for millenia, it was commonly accepted that the earth was flat and that some people were tainted with a mysterious mark of the soul, visible only to trained witch hunters.

I would like to offer a minority view, based on over 30 years of direct, continuous patient care responsibilities, during the last nine months of which, since I retired, I have had the direct responsibility, half-time at a Creedmoor after-care clinic, for examining, reviewing and treating chronic patients: the sickest patients there are.

Dr. Karl Menninger is the father of the view presented here: the unitary concept of mental illness. Unlike the common concept, it does not see individuals called schizophrenic as basically different biologically, and from the viewpoint of health, as inferior, to the rest of us. The work at Creedmoor has, however, produced some new elaborations of his ideas, particularly from the viewpoint of treatment, which will be outlined here.

Menninger's view is, very simply, that schizophrenia is nothing but panicky disorganization. Functional impairment, such as brain damage or even retardation, makes an individual more vulnerable to such disorganization; hence the higher statistical incidence of such conditions in schizophrenia.

All of us have had the experience of suddenly becoming so frightened we were unable to think or even of having crazy ideas under such circumstances. Many of us have been unable to think about particular subjects or events for decades because of the intense pain or fear attached to them. Schizophrenics can be seen as people whose fears, particularly of other people,

have become so fixed that their imaginations tend to run wild when difficulties occur, especially with other people. Because they have so much difficulty with others, they often tend to withdraw — and the more they withdraw, the more their idle minds latch onto crazy notions, which can first scare them, and, from their resultant behavior, scare those around them.

According to this approach, medication, used judiciously and for very limited periods, can be valuable by reducing the wild, panicky oscillations of thinking and behavior which would otherwise occur — and which are major causes of hospitalization and rehospitalization. Its therapeutic effects are only accomplished, however, at the expense of dulling *all* the patient's emotional responses, pleasurable as well as painful. While he does not cry and yell so much, he does not laugh so much either. Medicated too long, he often becomes a zombie.

At Creedmoor, we have been working increasingly with the "significant other" in the patient's life: his spouse, child, parent, foster-parent, boarding home proprietor, residential counselor or whoever. Indeed, we do not believe in discharging patients from the hospital unless there is such a "significant other" since no man, to paraphrase John Donne, can long stand an island unto himself. Working conjointly with the patient and the "other" — accentuating the positive and eliminating the negative, as the old song used to say — and helping patients solve their own day to day problems, we have found that such relationships can be helped to become increasingly supportive and stabilizing. As this occurs, patients get stronger, and more capable of tackling tasks on higher levels. As the relationships strengthen, the need for medication falls, and gradual dosage reduction becomes possible. Using these individual and conjoint psychotherapeutic techniques, together with supportive facilities like day centers, transitional residences and sheltered workshops, we find that our patients gradually become human again, able once more to love and to laugh — and even to cry — without fearing immediate rehospitalization.

Cure does not occur overnight, but progress does occur in stepwise fashion. Each step forward evokes more anxiety in the patient. Competent professionals — psychiatrists, first of all, but also social workers, psychologists and nurses — help the patient to keep moving forward, but not to bite off more than he can chew. After the anxiety accompanying a new

step forward has subsided, another step forward is taken, also followed by a pause, to enable the new advance to be assimilated also. Like good parents, we learn when to warn and when to urge; when to set limits and when to let go; when to treat and, most important, when to let the patient do it himself.

A key element in this program must be the concept of continuity of care. Without it, one has a situation where new sets of professionals are taking new stabs at old patients — and such new stabs from ever-new directions hardly help patients. When patients and staff, doctors particularly, know each other well, and are both pointed toward the same goal of stepwise improvement, the inevitable setbacks become far less threatening and demoralizing to the patient. If, on the other hand, the patient must get acquainted with new staff every time something changes in his life, the possibility of good results is seriously undermined.

Emphasizing the central importance of continuity of care in the prevention of chronicity, Dr. Ernest H. Gruenberg, professor of psychiatry in public health at Johns Hopkins, pointed out over 10 years ago how "destructive patterns from the past persist too frequently in affluent private services, many university services and other prestigious places. Perhaps 'high standards' and high staff ratios produce excessively rigid divisions of staff and agency functions," he suggested.

Given the "closed staff" administrative organizations of so many such esteemed facilities, we can easily see how these "destructive patterns" operate. In a facility where each treatment element has its own staff, with which a patient must connect as he moves from one setting to another, it would not be unusual for a patient to have at least four new doctors, and staffs, to get acquainted with, and supposedly to place his trust in, during the relatively brief — perhaps four month — period when he is at his sickest.

The psychiatrist treating him in clinic or office would be the first. Next would be the psychiatrist treating him in the inpatient unit, admission to which would have been necessitated by his worsening condition on the outside. Unless still another inpatient psychiatrist assumed responsibility when the patient moved to a different inpatient ward or level during his, say, two months inpatient stay, or unless a rotation of doctors occurred (which the patient would have a one in three chance of experiencing if rotations occurred semi-annually), his third psychiatrist might be at the Day Hospital, to which he might be sent for a month for a smoother transition between in- and out-patient status. Fourth would be the psychiatrist (who might occasionally be the first) treating him in clinic or private office after release from hospital.

Irrespective of how crazy the patient was upon admission — and a certain level is necessary — a system requiring him to establish a trusting relationship, so necessary when he is sick, with

so many different individuals (while simultaneously terminating with the predecessor), might easily aggravate rather than reduce his initial craziness. That aggravation might well be intensified by the fact that each new relationship must be established precisely when his vulnerability is increased by a change of level or status in relationship to the hospital, one aspect of which is loss of the previous therapist.

The fundamental importance of the doctor-patient bond, recognized since the time of Hippocrates, cannot help but be diluted and trivialized by such "longitudinal schizotherapy," which divides the patient sequentially in time among so many doctors. "Simultaneous schizotherapy" is also often seen, with a psychiatrist and relatively independent psychologist, group therapist or other therapist each taking responsibility for a separate aspect of the patient's mind — which is expected thereby to become reintegrated.

Gruenberg also pointed out "how sensitive the manifestations (of psychosis) are to the way in which people with psychotic disorders are cared for," and how we "may require a theory as to why these manifestations are so sensitive to the organization of psychiatric care." One aspect of such a theory may be the fact that the emotional uncertainty to which we subject patients by making them change doctors so often may be harmful to their mental health.

Almost 20 years ago, I asked, "Do Our Hospitals Help Make Acute Schizophrenia Chronic?" and described several ways in which they do. I omitted administrative arrangements preventing continuity of care. If we are really looking for the causes of continuing schizophrenia in our chronic hospital populations, however, we might find that our psychiatric administrative arrangements, whose existence we recognize easily but whose significance we consistently ignore (as we relegate them to "administrators," many of whom have never had responsibility for patient care), may be far more responsible than all the biological factors so long on the verge of being defined.

This issue may be more important than is usually realized, inasmuch as the very process of studying patients on short term units necessarily interrupts their continuity of care.

It is noteworthy that the key demonstrations in this country of the central importance of continuity of care in the prevention of chronicity were made in this department, by the same Ernest Gruenberg, working at Hudson River State Hospital.

Perhaps a little more attention to the human needs of our patients, with administrative structure being determined by treatment needs, rather than the reverse, as sometimes still occurs, and maybe a little less focus on the endless quest for the ideal drug will help us treat our patients more successfully. It might also enable each of us to return home at night feeling that he had done a humane day's work with human beings.