Notes on Orthomolecular Psychiatry and Psychotherapy

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It sometimes appears from discussions in the literature, excerpts from articles and press reports, that psychotherapy and Orthomolecular psychiatry are ineradicably opposed, especially as regards schizophrenia. Orthomolecular psychiatrists, and many others, are agreed that psychotherapy is neither the only nor the best treatment for schizophrenia, but this does not mean that it has no place at all in that illness and we know of no Orthomolecular psychiatrist who has suggested this. Nevertheless, misunderstandings have arisen which suggests that the relationship of Orthomolecular psychiatry to psychotherapy, particularly in schizophrenia, should be discussed, for in so doing we may acquire a better understanding of the nature of psychotherapy itself.

Psychotherapy is a vague inclusive term which has been used at one time or another to cover everything from those courtesies, considerations, and explanations which a good doctor gives all patients, and which is sometimes called, derogatorily, the bedside manner, to mind-expanding inspirations which engender a change of life in the well or ill. Between the ends of this vast spectrum of diverse activities will be found Freudian psychoanalysis, encounter groups, primal screaming, Berne's game playing, Classer's reality therapy, and innumerable permutations on an enormous theme. The purveyors of any particular psychotherapy, however modestly they begin, tend, usually with growing momentum, to become convinced that their particular method or interpretation is not only better than anyone else's, but also has universal applications to the human condition. Some people have even suggested that any or every conversation occurring in hospitals of all kinds is either therapeutic or antitherapeutic.

Meaningless expansion of this already vague term has led some doctors to state that everyone in a psychiatric hospital is or ought to be a psychotherapist. This seems to be about as sensible as stating that everyone in a

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general hospital should be a physician or a surgeon, for while it is true that, as in any other organization, every staff member in a hospital or clinic contributes to its atmosphere or ambiance, it is pointless to say that all are psychotherapists. This expansion and vulgarization of the word psychotherapy has added to our confusion while benefitting no one.

In a book now being prepared for publication (Osmond and Siegler, in press), we have suggested that there are at least three kinds of psychotherapy which must be distinguished from each other. All three derive their initial impetus from medicine, for the formal development of this activity owed much to Freud and his associates; Janet; Coue, the father of auto suggestion; and to many other physicians who worked during the last century or so. The very name, psychotherapy, implies some kind of medical activity aimed at treating the mind or soul. This has introduced a certain ambiguity for medicine is not, in principle, concerned with the salvation or philosophy of its patients but with the response of their minds and bodies to illness and to bettering their condition. We have called this activity **Psychotherapy I** or medical psychotherapy, and have defined it as a form of treatment for ill people who are in the sick role which can only be given by a physician or someone supervised by a physician with the intention of alleviating or curing illness. Although this kind of activity has only been recently formalized as psychotherapy, it has been part of medicine for millennia. It is not confined to psychiatry and never has been.

Within these medical goals of **Psychotherapy I** there are two main components. The first of these applies to any and every illness and is concerned with the proper and effective use of the physician's authority for the benefit of a particular patient. This is the appropriate employment of what Paterson has called Aesculapian authority (Paterson, 1957). Its fulcrum is the right of the physician to give the sick role to those whom he considers require it, and once this role has been accorded and accepted, the patient then receives the rights and must undertake the duties of that role, however onerous, unpleasant, or dangerous these may be. The sick role is very old, highly cross cultural, and is learned during the first year or two of life. It appears that those who have not learned how to request or how to accept it are probably in grave danger.

It is easier to accept the sick role in some illnesses than in others. It is seldom difficult to persuade those who are in grave pain and believe themselves to be in peril of their lives that they are ill. Nevertheless, even in such extreme cases, people are not always accorded and do not always accept the sick role. There is a record of a doctor who had a coronary, refused the help offered by his colleagues, and died at his desk in spite of their protests. Physicians receive little or no instruction regarding this fundamental skill, which suggests that they pick it up fairly easily as medical students and that the expectations of the public are so well attuned to these matters that it is easy for them to do this. Nevertheless, some doctors are far more adept in this fundamental medical art than others, and it is probably they who become famous for that frequently underestimated skill called the bedside manner.

In all illnesses, both serious and trivial, the patients' faith in the physician is likely to determine whether they follow his advice or not and for this reason alone will have a considerable bearing upon the outcome of illness. In recent years, psychiatrists have tended not to use their Aesculapian authority directly and explicitly, and have sometimes justified this by the notion that indirection is of more value than direction. Whatever the virtue of this may be in the neuroses, in such serious illnesses as schizophrenia and the affective diseases it is unlikely that polite indirection will suffice to persuade very ill patients that their doctor is seriously concerned about them. This penchant for indirection is often ascribed unfairly to the

founders of psychoanalysis, but as Paul Federn (1955) points out, the early psychoanalysts did not believe that their treatment was suitable for those suffering from psychosis and they often made strenuous efforts to avoid treating such patients. Federn himself was one of the few early pioneers who did treat them. He stated that:

"With neurosis, the psychoanalyst endeavors to make unconscious, repressed material conscious. In psychosis, he has to deal with too much unconscious material already brought to consciousness. Thus, the therapeutic aim here is not the release of repression but re-repression. In antithesis to Freud's well known motto: 'Where there is Id, let there be Ego,' we must say with regard to psychosis: What has become the Ego's territory should be returned to the Id.'"

Even for those who find psychoanalytic jargon tiresome, chapters six to 10 of Federn's book showed him to be an extraordinarily acute and intelligent observer with a deep understanding of schizophrenia.

The doctor-patient relationship is often said to resemble the transference in which the psychoanalysands perceive the analyst in terms of some earlier figure in their lives, usually a parent. This may, perhaps, be so, but common observation of small children suggests that they are able to differentiate the doctor from their parents very early in life. Children play fathers and mothers without supposing that they are playing doctor and nurse. I know of no study showing which of these games are usually learned first. Freud developed his theory of transference to account for the observation that patients in psychoanalysis, then a medical treatment, became unusually attached to their doctors. The doctor-patient relationship then can be seen as an aspect of medical psychotherapy not specific to psychiatry. In addition to this many psychiatric patients clearly require a great variety of different kinds of psychological intervention to speed their recovery and once they have recovered, to help them to make the best use of their newly regained health and to maintain it without relapse.

This then is the second aspect of Psychotherapy I, whose goal is to speed recovery from illness, to repair damage done by illness, and to prevent its recurrence. This is a medically directed enterprise even though the physician may do no more than prescribe the particular activity or activities which will then be given to some other specialist. An exact analogy can be found here with physiotherapy. Most physicians who prescribe physiotherapy are far less competent at doing it than those physiotherapists who give the treatments. Nevertheless, physiotherapists accept general medical direction which speeds' recovery, repairs damage, and often prevents further misfortune. It might seem that all psychotherapy is or ought to be medically directed, but in our opinion this is not so. Medical psychotherapy is a limited activity connected with the treatment of illnesses whose nature can be specified by psychiatrists, the physicians concerned with these illnesses. There is much more to psychotherapy than this.

Psychotherapy II probably emerged from Psychotherapy I during those years in which training analysis was slowly developing in psychoanalysis. It appears that Jung and others discussed this matter from about 1908 onwards. There are various claimants for the honor of initiating it, but these details are less important than the fact that by the 1920s Freud and his colleagues were psychoanalyzing people who were *not patients* and did not fit into the sick role, except perhaps in the sense that all of us are subjected to a universal neurosis — a concept of much the same order as original sin. Those early analysands who were no longer patients, for they did not occupy the sick role, were of two kinds. Some were psychoanalysts in training, whether medically qualified or not, and others were creative people who wished to undertake

psychoanalysis to increase their insights into life, to acquire greater self understanding, and to increase their well-being. Since the analysand role seems to be clumsy and is seldom used today, we suggest that this be called the "psych" role, for the person concerned is not a patient and, therefore, illness and recovery cannot be the issue.

Psychotherapy II is a form of educational psychotherapy, aimed at promoting social and psychological skills in people who are not ill and do not occupy the sick role. Its goal is to help a person to develop his assets and reduce his liabilities. This kind of therapy includes some forms of psychoanalysis, various kinds of counselling, guidance, behavior therapy, and teaching desirable skills which have not yet been acquired. It might also include Dale Carnegie courses, Arthur Murray dance courses, public speaking courses, language courses, and other 20th century versions of the schools of deportment. It seems unlikely to us that a medical education is a prerequisite for undertaking this sort of teaching activity.

As Freud became more and more preoccupied with the "psych" role, which is a special aspect of Psychotherapy II confined to psychoanalysis, he became less interested in the medical concern with treating patients. Towards the end of his life he devoted much time and energy in an attempt to separate psychoanalysis from medicine and to establish it as a discipline in its own right (Federn, 1967). This caused much disagreement within psychoanalysis itself. During the last 40 years a great variety of these educational psychotherapeutic endeavors have developed from which the curious, energetic, adventurous, and dissatisfied may make their choice. There is now a plethora of psychotherapies ranging from classical psychoanalysis, which still continues even though it has become steadily longer with the years, to a great variety of encounter groups whose sizes range from seven or eight to as many as 100, whose members undertake their exertions decorously or with abandonment, sometimes completely clothed and at others entirely nude. Psychiatrists, generally speaking, have been unenthused about these activities, some perceiving them as forms of treatment, which may or may not have their approval, while others look upon them as if they were dangerous sports which, like other dangerous sports, may be harmful to some people.

Like other physicians, psychiatrists have different opinions regarding the propriety of their patients or potential patients engaging in dangerous sports. Some orthopedic surgeons use a disproportionate amount of their surgical skill upon victims of skiing accidents, bobsledding, sky diving, and grand prix driving. They have done much to encourage the development of safer equipment, protective clothing, etc. but so far as we know they have not attempted to discourage these sports and some surgeons have, themselves, become distinguished participants.

Few psychiatrists have been able to recognize Psychotherapy II as some kind of recreation or sport and usually discuss it, often heatedly, as if it were a clandestine treatment. It can only be considered a treatment if the term treatment itself is expanded beyond all usefulness. Physicians can hardly object to people improving their social, sexual, psychological, and managerial manners and this is clearly the intention of many of those who participate in Psychotherapy II. If the distinction between these varieties of psychotherapy was made explicit, it would then be possible to place an obligation upon ethical psychotherapists practicing these educational skills to avoid including among their pupils those who were evidently ill or who had come to them in the mistaken belief that they would receive psychiatric treatment.

There are many sports in which skilled instructors require from their pupils some kind of medical examination before they present themselves for training which may be rigorous and dangerous. In some sports, the

illness of a participating member may endanger not only the well-being but sometimes even the lives of others. Mountain climbing, some forms of deep sea diving and flying are examples of this. However, the fact that medical advice is sought by some participants in these activities does not link them to medicine or suggest that physicians should be teaching people these agreeable pastimes.

In some medical schools courses of sex education are being given to the students on the assumption that physicians will play a large part in this clearly important activity. In a recent film, it was suggested that every other married couple had problems of this kind, which indicates that somewhere between 50 and 100 million people might require this kind of education. If this is true, it is very unlikely that counselling available from physicians would be of much benefit to many of those distressed by sexual uncertainties. While no one denies that it is valuable and probably necessary for physicians to understand the extent of problems of this kind, could so great and widespread a need possibly be met by medicine?

We must expect to see educational psychotherapy expand steadily in many directions, and as it does so, there will certainly be casualties associated with it. We should not condemn this kind of psychotherapy simply because it produces casualties, but see it in the light of a more or less perilous sport or enterprise which people choose to undertake. Our responsibility as physicians is surely to suggest that some thought be given to the qualifications of those who teach others how to comport themselves in those many situations which occur in a complex and changing society.

Our studies of psychotherapy suggested that bettering illnesses and improving oneself in regards to psychosocial skills did not exhaust the goals of psychotherapy. A small number of psychotherapists were concerned with neither of these activities; their goal appears to be enlightenment and their hope is to recruit disciples who will become enlightened. We. therefore, called this **Psychotherapy III,** enlightenment psychotherapy. Those who are enlightened transcend natural limitations and so the candidates, as a general rule, are thought not to be in need of Psychotherapy I or **II.** People become enlightened by finding a suitable master or guru who is enlightened, becoming a disciple and abiding by the rule of the enlightened person until it "takes"; when, in some way still obscure, one is recognized as being a member of the elect.

Dr. Laing and some others seem to believe that people who, to use his terminology, have been labeled "schizophrenic" are particularly good candidates for enlightenment under his guidance, but not all of those who are engaged in the enlightening of others consider that schizophrenia is a valuable first step towards this desired end.

We do not understand why these three very different entities have become more or less inextricably muddled during the last 20 or 30 years, yet this has happened and whether we like it or not we are faced with the bewildering consequences of this failure to be explicit about matters in which ambiguity must reduce understanding, decrease the chances of benefit, and increase the likelihood of harm. This is not an academic matter; treatment for illness, receiving further education, being guided towards enlightenment are all worthy enterprises, but those engaged in any of them have a right to know which one they are undertaking, whether they are agreeable to it, and whether it will best meet their needs.

Of what importance is this to Orthomolecular psychiatry or, indeed, to psychiatry generally in the treatment of schizophrenia in particular? We believe that medical psychotherapy has two distinct phases. The first is concerned with patients whose perceptions, affect, or thinking are much impaired. What is required here is the strongest reassurance possible about the naturalness of the phenomena being experienced by the patient, a rapid induction of the most explicit kind into the sick role, a

repeated emphasis that people get better in spite of present discomforts. This must be combined with the use of the E.W.I. or the H.O.D. to pinpoint the many and various perceptual and affective disturbances which afflict the patient, and so allow further reassurance based upon widely used tests of a technical kind which reduces tension and anxiety while encouraging cooperation with treatment.

This is not a new technique, for it was used by John Conolly (Conolly, 1849) in the 1840's, who encouraged patients to describe their perceptual disturbances to him when he would then indicate to them that their supposed delusions were well-known symptoms of illness for which he could now give a better explanation backed by his Aesculapian (medical) authority. For instance, one patient told him that she was being poisoned. He then inquired carefully from her about the taste of this poison and, discovering that it was metallic, he told her that this was a frequent symptom of her illness. He agreed that it was quite rational to suppose that foul-tasting food is poisonous, but emphasized that many people do not realize that one's taste and smell perception can be altered by illness even though the common cold demonstrates this frequently to many of us. In this way, Conolly reduced strongly held delusions to mild differences of opinion between him and the patient, thus strengthening the relationship between them while discouraging the patient from extending delusional thinking.

Our colleague, Abram Hoffer, and we have used this same approach to patients distressed by perceptual anomalies for many years. It is simple and straightforward. Once one knows what misperceptions are occurring and has heard what the patient is doing about them, it is usually possible to commend them for their courageous behavior, but to emphasize that with the new knowledge which they now have they will be able to behave no less courageously but a good deal more sensibly. A simple example such as color blindness is used to show patients that those who do not know that they are red-green color blind can, and have, become victims of their misperceptions, which is inconvenient and even dangerous for them and for everyone else.

We are not suggesting that all complex delusions based upon misperceptions will be quickly exorcised in this manner, but we have seen some dissipated quite quickly, while with others the injection of doubt by means of firm but gentle Aesculapian authority increases trust and confidence in the physician's knowledge. What one does not do is to deny the experience; quite the contrary, one can and should discuss it with interest and concern. Using materials from such books as Carney Landis' splendid *Varieties of Psychopathological Experience,* Thomas Hen-nell's *The Witnesses,* or *I Never Promised You A Rose Garden,* and the many others available (Sommer and Osmond, 1960), the patient's experience can then be related to that of other mentally ill people, particularly those who have recovered, in a manner which is not unflattering to them. These activities not only reduce the patients' fear of unusual and often frightening events, but they increase their hope that the physician has knowledge denied to most others, a most important aspect of medicine, a reasonable expectation for patients, and a way of gaining their trust and confidence. It helps to recall a similar symptom in some other patient who is now recovered, and so allows the current patient to know that someone else not only shared his appalling disturbances but is now quite well. In other branches of medicine this is simply good practice, yet in recent years this simple but valuable technique has seldom been undertaken in psychiatry, probably because of a preoccupation with the passivity shown by psychoanalysts in the later phases of that treatment, for in its early days psychoanalysis was nothing like as passive as its proponents now believe.

This is not new. We are simply returning to an older tradition in psychiatry and the usual customs of medicine. Dr. Samuel B. Wood-

ward was employing similar tactics at the Worcester State Hospital over 130 years ago. It was written of him by a contemporary:

"His intercourse with the sick was so gentle, cheerful and winning, that he soon gained their confidence and love. He nourished their hopes of recovery by holding up the bright side of their cases. They anticipated his visits with pleasure, as their physician and their friend. He recognized the influence of the mind over the physical functions and by his relation of agreeable stories and successful cases of a similar kind of theirs, he animated their hopes."

Animation of hope is something which medicine must never forget, but which some psychiatrists have neglected and even totally disregarded. Bizarrely enough, one of the criticisms of Orthomolecular psychiatry arises from the fact that it does animate hope.

Once the patients' perceptions have been stabilized, as measured by the H.O.D. and E.W.I. test and, of course, by the patients' descriptions of their experience, and once mood has been normalized, then the psychiatrist has to decide whether or not psychotherapeutic intervention is required and, if so, of what kind. If it is required, then he must also decide whether he, himself, will undertake it or suggest a suitable therapist. There are some doctors who are excellent at dealing with biochemical disorders but whose temperament is unsuited for at least some aspects of psychotherapy.

However, whether psychotherapy is needed or not, we believe that psychiatry greatly requires an innovation developed in the Joslin Clinic in Boston, one of the finest centers for the treatment of diabetes in the world. For many years this famous clinic has been using a form of special education for patients of all ages who are taught about their illness, how to give themselves their medication, how to maintain their diet adequately, and how to recognize when they are well and when they are becoming ill again. This teaching is systematic, employs at least one classroom equipped appropriately, among other things, with cooking facilities so that the patient-students can learn in the best possible circumstances. The students range from the very young to the old, all of whom receive a good practical course about their illness and at the end even have some kind of test or examination.

The Joslin Clinic is giving the sick role in a most explicit manner but, in addition to this, its patients are considered to be responsible human beings who are not to be kept in the dark by unnecessary medical secrecy or mumbo-jumbo and are shown, by the behavior of their physicians and others treating them, that they are expected to be much more than the passive recipients of treatment. The whole nature of the course emphasizes that they are responsible participants, indeed, the key members of a team effort aimed at maintaining their own health and preventing relapse. There is no reason whatever why this same technique should not be applied in Orthomolecular psychiatry, indeed, Dr. David Hawkins on Long Island is already doing just this (Hawkins, 1973). Such an approach is well-received by patients and their relatives who are relieved to know that there is much which they themselves can do to further health and guard against relapse.

In many cases the restoration of stabilized perception with a sense of well-being that goes with it, combined with the kind of information and approach which we have described earlier, is sufficient for patients and their families to reknit their relationships with remarkably little help; but this is not always so. Schizophrenic illnesses, especially those which have lasted for many years, leave deep psychological scars, not only within the sick person but within other family members even when they are, themselves, completely well and sometimes not all of them are. The penchant for accusatorial and denunciatory psychotherapy, which has been so marked in the last decade or two, has not reduced this scarring. When schizophrenia occurs during adolescence, normal maturation at this age,

which is often stormy, is frequently greatly exacerbated by the illness. Many patients either lose or fail to acquire those skills which are essential for their survival as social, sexual, or economic human beings. The longer illness has endured and the earlier it has begun, the more likely it is that psychotherapy of one kind or another is not merely desirable but absolutely essential if the fullest recovery is to take place as quickly as possible.

We learned much about this from an intelligent young lady who made an excellent recovery from an illness of four years' duration which had started when she was about 14. At the age of 20, when she was now perceptually stable and feeling very well, she told us that she was now going to start growing up because she felt as if she was only a teenager. Two years later, asked how old she felt, she said, "\ now feel about 21", her actual age then being about 22. She had spent much of those two years deliberately learning how to act her age. She sometimes found this complicated, difficult, puzzling and even annoying. We hope that one day we shall persuade her to give an account of this delayed growing up.

There is still much work to be done in increasing our understanding of the consequences of developing schizophrenia at particular times in one's life. It appears to us that some social skills are lost, some are never acquired, while others are acquired but in an unusual or eccentric way. These skills run the whole gamut from such apparently simple matters as table and telephone manners to the complexities of dating and courting and the capacity to recognize those social and sexual signals which differentiate behavior likely to be interpreted as attempted rape from that which might be welcomed as seduction. Distressing problems arise from parents who, after recovery, tend to see the recovered members of the family as if they were either still ill or still much younger than they really are. With energy and good will many of these problems are dissipated spontaneously far more easily than one might expect, yet there remain a residuum of people who, even though they are now perceptually and affectively stable, have neuroses requiring psychotherapy, and there are families who may require much skilled counselling and direction.

Schizophrenics who have recovered from their illnesses and are perceptually stable tend to be more tolerant of their parents and relatives than one might have expected from hearing them talk about them when they were ill. At least some of their irritability and intolerance with their families, which simply adds to everyone's misfortune, derives from some of those notions, fashionable today, that patients have been driven mad by the thoughtlessness or viciousness of their relatives. This is an unwelcomed and unnecessary iatrogenic exacerbation of an already serious illness which has hindered the recovery of many patients and caused them and their family avoidable suffering. The spread of greater knowledge about schizophrenia combined with the appropriate and determined use of the medical model allows us to avoid these orgies of blame which do so little good and often impede recovery.

Psychotherapy for perceptually stabilized schizophrenics would be much enhanced if we had some simple quantitative instrument resembling the H.O.D. or the E.W.I. which would give us an understanding of the psychosocial skills the patient has relative to actual age. It seems likely that in the plethora of psychological tests that exists already something very suitable may be found, though we have still to come across it. If it is not already there we are certain that our psychologist colleagues can construct a suitable and useful instrument, once we make clear to them the need for it.

As regards Psychotherapy II (educational psychotherapy), we find it hard to believe that patients with disorders of sense perception, mood, or thinking are likely to be benefitted by these exertions, particularly if their psychotherapists either do not know that they are ill or do not recognize that there

is such a category as illness. Some of those who have become unwell following encounter groups and similar activities are schizophrenic patients with misperceptions who have been overwhelmed by the complicated and sometimes distressing social arrangements in which they have found themselves. However, after recovery when their perceptions are stable, schizophrenic patients, like anyone else, may wish to improve their psychosocial skills or develop new ones. Once we are sure that they are not ill we encourage them to do this and advise them to guard against extreme fatigue, overstimulation, and being pressed beyond their capacities. It seems wise for them to avoid activities which place great emphasis on catharsis and to beware of therapists who are believers in traumatizing their clients. We know of no evidence that psychotherapists who pursue a gentle course are any less successful than those who believe in subjecting those whom they treat to as much anguish and distress as possible.

Sometimes, as a result of the unusual experiences which they have had during their illnesses, schizophrenic patients become interested in the pursuit of enlightenment. It is not part of the physician's task to set limits to those interests which patients may wish to develop. It is, however, prudent and, indeed, his duty to recognize that there are strategies of various kinds which some gurus and teachers employ that may be medically unwise. Most religions have been able to make dispensations for illness, and those which fail to do this raise the serious question as to whether they are really concerned with the well-being of the particular human being who is in search of enlightenment. So long as the schizophrenic patient is perceptually stable, he or she should be encouraged to continue a suitable regimen both of diet, exercise, and megavitamins. It is imprudent to oppose or denigrate the goal so good, or so universal, as the search for enlightenment. However, it is sometimes necessary to remind patients not to be unduly anxious about these matters or to attempt to force the pace. Enlightenment comes in its own good time.

When enlightenment is pursued by using psychedelic substances, we discourage such adventures for they carry with them the risk of relapse and we do not believe that it is true that a guide or guru, however skillful, will necessarily succeed in terminating a bad trip before grave damage has been done. No physician should assume that patients, however amiable or intelligent, will necessarily abide by even the best advice. We, therefore, urge them that should a relapse of this kind begin, immediate treatment is likely to benefit them and it is, therefore, most important to report quickly and get help. We have known a number of patients, particularly young people, who have one fling of this sort, realize that it has done them harm, and avoid such dangers conscientiously in the future.

Like any delicate, useful, and expensive tool, psychotherapy must be employed with discrimination, and to obtain the best from it its limitations must be understood. When this is done it will be found to be as useful and important in Orthomolecular psychiatry as in any other branch of our specialty. We hope that others will record their views about this matter and so add to our knowledge which can then be made available to our patients.

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