To the Editor:

I am with Lorraine Bouthilet all the way on her recent editorial ("A Place in the Country," Schizophrenia Bulletin, No. 6:5, Fall 1972). Now, what practical steps are being taken—or can be taken—to move the function and image of the public mental hospital along the lines you suggest. You can count on me for support within the limits of my capabilities.

Jack Elinson, Ph.D.
Professor,
Columbia University School of Public Health and Administrative Medicine
New York, N.Y.

To the Editor:

"A Place in the Country" left me a bit puzzled. Before a movement is started to renovate psychiatric hospitals into "watering places," "dude ranches," "Cannes," etc., it would seem appropriate to comment on Dr. Bouthilet's assertion that, "No one these days could argue against the many virtues of treating mental illness out in the open in the local community." A recent review article, "Efficacy of Psychiatric Rehabilitation," by Anthony et al. (Psychological Bulletin, 78:447, 1972) contests this assertion by concluding that transitional facilities reduce recidivism only as long as the patients remain members of the facility; that is, they permit the patient to "transfer" his dependency from one facility (the hospital) to another (the community mental health center).

Dr. Bouthilet advocates lovely, sumptuous dwellings for schizophrenics, but I am not convinced that this would alleviate or preclude schizophrenia. My own research seems to demonstrate that the schizophrenic, even in clinical remission, is still quite ill according to my physiological criteria. It follows that psychiatric hospitals and transitional facilities are not adequate because we still don't know the etiology or the effective therapy. In conclusion, I humbly suggest that funds would be better spent on research than on "watering places."

Leonard S. Rubin, Ph.D.
Head, Psychobiology
Eastern Pennsylvania Psychiatric Institute

Dr. Bouthilet replies:

Many thanks to Drs. Elinson and Rubin for their comments. I agree with Dr. Rubin entirely that research should receive the highest priority in mental health funding and, until we know more about the etiology of schizophrenia and more about how to treat it, most of what is being done is stopgap and purely palliative. However, my main point was that, until we do know more about etiology and effective treatment, we can perhaps provide a more humane atmosphere in our service organizations.

Lorraine Bouthilet, Ph.D.
Editor, Mental Health Digest
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chronic schizophrenia—readers' opinions

To the Editor:

After residency training in 1957, I was appointed Chief of Service for a 700-bed "continued treatment" unit for chronic schizophrenics. My first decision was to eliminate deadwood in the person of a senior physician and accept the challenge of running the entire service with only two psychiatric residents. We felt that not only is chronic schizophrenia iatrogenic—the question raised in AT ISSUE (Schizophrenia Bulletin, No. 6:4, Fall 1972)—but that hospital staff may be equally chronic. Because we had only one social worker, one occupational therapist, and a half-time psychologist, we had to depend on patients to help us. And our main contribution as experts was the sensitive deployment of nursing staff. To my delight, the lubricant which kept the few wheels running smoothly was primitive lust (described as loving concern for each other) between the medical and the nursing staff. The usefulness of the libido in promoting harmony is still unexplored but not unexperienced. I also discovered that apathy among patients is not schizophrenic but suitably adaptive. It is as natural as hibernation and as physiological as the action of servicemen on a 6-month tour of military duty on the Aleutian Islands. It is also rapidly responsive to rising social expectations. Social stimuli which mobilize large muscle groups cannot be denied. Merely rearranging the furniture changed habitual caloric expenditure and awakened dormant muscles and their manager, the brain.

Results in our unit support the contention that chronicity in schizophrenia is more a function of dynamic expectation on the part of staff than of number of staff. To speak of staff-patient ratios reallocates patients to the passive status of helpless recipients instead of allowing them to be participants in an active treatment experience. The result is self-defeating, and the motive may even be unconsciously hostile. Thus, the iatrogenicity of chronic schizophrenia may be in terms of rationalization of neglect by projection of blame onto budgets and bureaucrats by the chronically apathetic staff.

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