teaching about schizophrenia

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In response to the editor's request for descriptions of training programs related to schizophrenia, this is a short report about a course on schizophrenia that I teach. Although I assume that there are lectures or courses given about schizophrenia in most psychiatry residencies and graduate programs in psychology, I am not aware of any written descriptions of them. It would be interesting to know who is teaching what to whom about schizophrenia across the country, and it seems that the Schizophrenia Bulletin would be an appropriate place to exchange that information.

My own course is offered as part of "The Graduate Program at NIH," an evening school on the grounds of the National Institutes of Health. The school offers graduate credits for those in the Washington, D.C., area, but it is not itself a degree-granting institution, and it is not affiliated with any university. The students include graduate students at other institutions, researchers on all levels at NIH, and college graduates throughout the area. Courses are offered, following the wish of the instructor, with or without a limited enrollment or prerequisites. I decided to offer a course open to anyone (i.e., requiring only a bachelor of arts degree), in part to discover the extent and range of people interested in such a course.

In the course catalog, the announcement read as follows:

The aim of this course will be to review what is known and what has been said about schizophrenia from many different viewpoints. Topics will be chosen from the following: symptomatology, subjective experience, diagnosis, genetic research, biochemical research, family interaction research, pharmacological therapy, and psychotherapy. Readings, mostly journal articles, will be assigned and discussed.

The resulting interest was even greater than expected. Twenty-five people registered for the course by the end of the registration period, making it one of the largest classes at the school. I stopped further enrollment, fearing that too large a group would inhibit discussion. The group included eight researchers in various fields (physiology, psychology, hematology), four graduate students, three nurses from nearby Chestnut Lodge Hospital, and people with a range of other occupations, including two housewives and one drug salesman. When I asked each member why he was taking the course and what he hoped to learn, there were many different replies, usually related to the research, nursing, or other work or study in which the student was involved. However, there was another theme that came through repeatedly—they were interested in schizophrenia, but knew very little about it and knew of no place or way to learn about the subject. What they had learned—even the researchers—was mostly at the level of popular myth. Those who had consulted textbooks had found them practically unintelligible, presuming knowledge or presenting terminology and theories that the students were honest enough to admit they did not understand and/or believe.

I had a similar difficulty—to find teaching materials and to design a course that would neither require any extensive knowledge nor presume the correctness of any one viewpoint. Instead of "explaining" schizophrenia on the basis of psychoanalytic or biochemical theories, I wanted to teach in a more critical way, helping the students to differentiate what is known about schizophrenia from what are speculations about it. Unfortunately, most books on the subject do not clearly distinguish between theory and fact—a flaw that mars much of the psychoanalytic literature, the genetic literature, the family-study literature, the orthomolecular treatment literature, and so on. For this reason I decided to reject many of the classical theoretical writings such as Freud’s description of the Schreber case.

Major Areas of Study

I divided the course into four major areas: phenomenology, subjective experience, research, and therapy. The week-by-week topics and readings were as follows:

- September 19. Introduction.
  Film: Breakdown. Canadian Department of National Health and Welfare.
- September 26. Dementia Praecox.
  Films: 1) Hebephrenia; 2) Catatonia; and 3) Paranoid States. National Film Board of Canada.
  Readings: Kraepelin, E. Description of hebephrenia, catatonia, and paranoid forms of dementia praecox from his Textbook of Psychiatry. 7th ed. (1902) Translated by Diefendorf.
- October 3. Schizophrenic Symptoms I.
  Readings: Kraepelin, E. Descriptions of hebephrenia, catatonia, and paranoid forms of dementia praecox from his Textbook of Psychiatry. 7th ed. (1902) Translated by Diefendorf.
- October 3. Schizophrenic Symptoms I.
  Readings: Bleuler, E. Description of altered associations from Dementia Praecox, or the Group of Schizophrenias. (1911, pp. 14-40) Translated by J. Zinker.
In the beginning of the course, the assigned readings (see entries for September 26 through October 17) contained a heavy dose of Kraepelin and Bleuler, which would not seem to be in accordance with the nontheoretical approach mentioned above. In reviewing these readings with the class, however, I concentrated on these authors’ observations of patients rather than on their theories of etiology and pathogenesis. Diefendorf’s translation of Kraepelin (which is appropriately abridged) gives excellent descriptions of the classic symptom groupings called hebephrenia, catatonia, and paranoid types. Similarly, Bleuler gives some excellent examples of disordered speech and behavior. It was my intent to use these descriptions to communicate a picture of the more characteristic and severe symptoms of schizophrenic patients without accepting Kraepelin’s theory of a uniformly deteriorating course nor Bleuler’s dictum that a thought disorder is pathognomonic for schizophrenia. Similarly, Hoch and Polatin’s article (assigned for the October 17 session) was used to illustrate the possibility of finding a mixture of neurotic and psychotic symptoms, but not as proof that patients with multiple neurotic symptoms should be classified in the same group with patients having predominantly psychotic symptoms.

Films

Essentially, my aim in the first part of the course was to illustrate, not define, schizophrenia. Here, it would have been very helpful to have had good films (the ones I used are listed above). The film Breakdown was chosen because it shows the development of symptoms over a period of weeks in a single patient, a girl in whom social withdrawal is followed by bizarre behavior and hallucinations. The later part of the film portrays, in a rather idealized and sentimental way, her treatment in a mental hospital in the 1950’s, and this concluding segment lessens the film’s usefulness. The other films shown, depicting hebephrenic, catatonic, paranoid, and simple schizophrenia, are excellent even though old. Their major drawback is that, in selecting typical cases at a certain point in time, the films give the impression that the majority of patients diagnosed as schizophrenic have a clear-cut, unchanging set of symptoms.

Diagnosis

In discussing diagnosis, I emphasized the arbitrary nature of the process, and the various conflicting
Mental Disorders

October 31 and November 7). The two reports differ

alternative, we read two self-reports by recovered

ask this of any patient or former patient As an

had recovered from an episode of psychosis. However,

directly with patients, the students came to realize the

was much appreciated by the students, especially those

who were researchers and had not had much direct

contact with living patients. In this exercise, as in dealing

with patients (Pfeifer and Green, see assigned readings for

October 31 and November 7). The two reports differ

greatly in form and content, and this was useful in
dispelling ideas that the experience of a schizophrenic

psychosis was a uniformly similar experience—an idea I

have encountered frequently among laymen who have read only Green's I Never Promised You a Rose Garden.
The task assigned the students was to attempt, while

reading these accounts, to determine at various points in

the narrative how the patient would have appeared to the

outside observer (i.e., what "symptom" he or she

was demonstrating) and to correlate this with the

author's description of his or her own thoughts, feelings,

and aims at that moment. As an example, Green
described herself as emitting such incomprehensible

statements as "Out at the eyeholes, maybe..." (p.

102), which must have, to an outside observer, clearly

evidenced a Bleulerian defect of associations. However,

Green also gives us in her account some idea of the

communicative aim of the statement, as well as the

mixture of misery and relief that prompted it.

The final paper in the section on subjective experi-
bence, by Bowers (assigned reading for November 14),
makes some generalizations, but does so mainly in an

attempt to define the sequence of subjective states in a

developing psychosis. Always staying close to the col-

lected case material, Bowers does not define a theoreti-
cal set of "unconscious emotions" or promote a theory

of emotional causation of symptoms. As such, the paper

was well received and, I believe, well understood by the

class.

Research and Pharmacological Therapy

The next two sections of the course, on research and

pharmacological therapy, require less comment, for

tese involve more the teaching of statistics and facts

than the definitions and concepts discussed in the

previous sections. The need here is for review articles

that are complete, comprehensive, and not too lengthy.

Rosenthal's article on genetics (the assigned reading for

December 5) best fit this ideal. Boulton's article on

biochemistry (see November 28) was also good; it was

difficult reading for those without a scientific back-
ground, but its conclusions were clear, and the more

technical details could be discussed during class. There

was a similar situation with psychopharmacology: the
chapter from Klein and Davis' book was selected because

it reviews their conclusions regarding drug therapy in a

comparatively straightforward manner. More technical
details and studies on psychopharmacological drugs are

contained elsewhere in the book, and I presented these

in class rather than in assigned reading. In the field of

family studies, the review by Mishler and Waxler (1965)
best covers the topic, but it was not assigned because of its length. Its conclusions were also described in class, and Wynne's paper (see November 21 entry) was substituted as an example of such research.

There is an obvious gap in the readings on psychotherapy, milieu therapy, and behavioral therapy approaches to schizophrenia. My exclusion of them was not so much based on bias as on not knowing appropriate sources that could be used to teach these topics. Not only is the literature on how to do psychotherapy with schizophrenics difficult and conflicting, but also concise literature on the results of such therapy is, to my knowledge, unavailable except for the negative results reported by May (1968) and by Grinspoon, Ewalt, and Shader (1968). The alternative I chose was to invite someone experienced in these matters to discuss with the class in a more anecdotal way his experience with psychotherapy, family therapy, and Laing's type of milieu therapy.

Final Examination

Since grades were expected to be given in this course, I was faced with the problem of designing a final examination. I decided that this would be an appropriate time to present the students with some theoretical generalizations about schizophrenia and to see how well they would be able to evaluate them, after having learned some of the basic phenomenology, subjective experience, and research. I presented them with four statements, all of which were taken from a recent book on schizophrenia edited by Cancro (1970):

1) Discuss: The word schizophrenia should be abandoned, for several reasons:
   - It has no historical priority. It is clear that Bleuler added nothing of value to the concept formulated previously.
   - It misleadingly implies an understanding of a supposed basic disorder. There is absolutely no evidence that the basic disorder is dissociation, and the word schizophrenia is therefore misleading. Moreover, it connotes a purely psychologic etiology and pathogenesis, a concept which is clinically invalid.
   - It is difficult to use in clinical practice. [Adapted from Altschule 1970, p. 22]

2) Discuss with reference to the two autobiographical accounts of schizophrenic illness:

Delusion, like fever, is to be looked upon as part of nature's attempt at cure, an endeavor to neutralize some disturbing factor, to compensate for some handicap, to reconstruct a working contact with the group, which will still satisfy special needs. [From Campbell 1927, quoted by Burnham 1970, p. 199]

3) Discuss ways of homogeneously subdividing schizophrenia—whether this would benefit research and, if so, how:

The most fundamental problem in research in the schizophrenic syndrome remains the development of more homogeneous diagnostic categories. [Cancro 1970, p. 190]

4) Discuss the genetic studies of schizophrenia, and what use can and should be made of this knowledge in genetic counseling:

The knowledge that schizophrenic disorders have a genetic basis... provides a sound basis for genetic counseling, so that schizophrenics and close relatives of schizophrenics can be advised about the likelihood of having a schizophrenic child. [Rosenthal 1970, p. 255]

Conclusion

This report is written to describe my own way of teaching about schizophrenia, not to promote this syllabus as the right or the best way. There are no conclusions to be drawn other than to report that the students stated that they liked the format and most of the readings, with the exception of Bleuler. I would be interested in the comments of teachers or students about this syllabus or about other approaches to this topic that they have found useful.

References


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1 Since the preparation of this syllabus, excellent reviews on these topics have been published in Schizophrenia Bulletin No. 6, Fall 1972.

Campbell, C. M. *Delusion and Belief*. Cambridge, Mass: Harvard University Press, 1927.


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the role of the paraprofessional

To the Editor:

An unresolved issue in treatment today is the role of the paraprofessional in mental health. In too many ways, hospitals and clinics are remaining locked into a system which sees the professional alone delivering services to the client population. I would suggest that this is a very ineffective system for delivering services. The fears often expressed by the institution are, although legitimate concerns, unacceptable excuses for withholding information as vital to the line staff as to the therapist.

It appears that the paraprofessionals working in hospitals, clinics, and other day and residential settings are experiencing a type of institutional schizophrenia, in which the institution withholds pertinent information about the patient from the paraprofessional staff, while at the same time expecting them to help in the treatment process. Within this system, the paraprofessional becomes, in fact, a child submissive to the institution and the therapists in charge. One wonders whether it is because he shares the same living space and spends all of his working day with the clients of the institution that the paraprofessional in some ways is a patient in the institution's eyes, needing to be closely observed for some aberrant behavior that will reveal his true colors.

Whether the roots of this sickness are in the insecurity of the professional staff and their fear of failure or in the caste system existing in the mental health field, there needs to be a change. I strongly advocate a total team involvement in which ideas and treatment strategy are shared without respect to status or position. My own experience with such an approach has been extremely successful. The availability of knowledge about a case or a treatment decision should not be reserved to the therapist alone but shared with all whose contact with the patient is significant.

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