on the nature of schizophrenia: changes in the observer as well as the observed (1932-77)*

John Romano

Introduction

What could be more applicable to the clinical phenomenology of the schizophrenic patient than the lesson learned from the poem, “The Blind Men and the Elephant,” written a century ago by John Godfrey Saxe (1859), the Vermont poet and lecturer? Some of you may remember the first stanza:

It was six men of Indostan
To learning much inclined,
Who went to see the Elephant
(Though all of them were blind),
That each by observation
Might satisfy his mind.

And after the blind men, for reasons sufficient to each, likened the elephant to a wall, a spear, a snake, a tree, a fan, and a rope, the author concluded:

And so these men of Indostan
Disputed loud and long,
Each in his own opinion
Exceeding stiff and strong
Though each was partly in the right
And all were in the wrong!

With schizophrenia there may be more than six blind men.1 Obviously, whatever blindness we have stems from our beliefs and practices—in short, from the limits of our experience. Brown (1976) reminded us that Berkson updated the lesson taught us by poet Saxe and his memorable elephant, and cautioned us that false conclusions can come from clinical surveys of patient samples unless the relationship of the selected patients to the source population is carefully controlled. Consider the plight of attempting to make intelligent comparisons of schizophrenic patient populations when one group is from back ward patients who have been hospitalized for long periods and are of low social class origin with negligible social competence at the onset of their illness, and little acquired since, while another patient population is middle class, married with intact family, children and parental responsibilities, and hospitalized for short periods in a psychiatric unit in a general hospital.

While the characteristic hallucinations, the occasional incomprehensibility, the disorders of thought, the experiences of passivity, and their delusional interpretations—all occurring in a state of wakeful consciousness—constitute a mosaic or a cluster of signs and symptoms that have demarcated this type of madness from others, nevertheless there are important differences among patients with these characteristics. It has proved difficult to provide a clear line between this behavior and other types of madness. Perceptive, seasoned clinicians, beginning with Thomas Willis in the 17th century and others in the 18th and 19th centuries, did their best to differentiate what today we call schizophrenia from melancholia, from mania due to fever and that due to wine, from the enfeeblement of the aged, and from those who suffered brain damage in war. Long before that, through the mists of antiquity, the notion of paranoia emerged, and before it acquired its modern denotative persecutory meaning, it meant more simply “beyond understanding.” Although schizophrenia had many names—stupidity, foolishness, vesania, idiocy, monomania, paranoia, and others—the early clinicians described the characteristics of family origin, endogenous cause, early onset, remitting or progressive course, bizarre ideas,
dissociation of thought and emotion, and social withdrawal. These descriptions were written long before the more precise contributions of Morel, Hecker, Kahlbaum, Kraepelin, and Bleuler, and the subsequent designations of dementia praecox and schizophrenia. Then, as now, other types of madness, like melancholia and mania, seemed more capable of empathic understanding, more consonant with human psychological experience. Then, as now, there was a lack of clarity and consistency in diagnosis (Romano 1976).

What one sees and hears is dependent, in some part, on expectations, and these are determined by one's a priori ideas of the nature of the distress. Consequently, diagnosis, classification, and treatment approaches to the schizophrenic patient and his family can be influenced by the following factors:

1. The range of clinical experience
   - Opportunity to study and treat patients at the onset of their distress; in response to emergency needs; during short-term as well as prolonged inpatient hospitalization; and during continuing outpatient care and office visits.
   - Patient populations studied: patients who are young and old, rich and poor, black and white; those subtly as well as flagrantly psychotic; and those reflecting various cultural and ethnic backgrounds.
   - Methods of study and treatment: engagement with the patient alone; with the patient and his immediate family in group therapy; engagement with families of origin, and with relevant others; emphasis, for example, on pharmacotherapy, hospital milieu, and behavior therapy.

2. The influence of professional education on practice and personal beliefs
   - Exposure to one or more etiologic models (e.g., genetic, biochemical, psychodynamic, psycho-social, existential; influence of major teachers and supervisors in defense of or challenge to the etiologic paradigms of conflict or of deficit.
   - Influence of the psychiatrist's personal emotional reaction to social implications of the diagnosis of schizophrenia.
   - Procedures of inquiry and examination: genetic history; interviews with family; psychological tests; physical, neurologic, and laboratory examinations; developmental, social, and medical history; capacity for informed differential diagnosis: e.g., mania, depression, temporal lobe seizures, alcohol, brain tumor, and personality disorder.
   - Study of relevant scientific literature, past and present.

3. Factors external to the patient and to the examiner
   - Dependence on and allegiance to standard uniform nomenclatures, initiated in Standard Nomenclature of Disease (Logie 1933) and later by the American Psychiatric Association DSM-I Diagnostic and Statistical Manual of Mental Disorders (1952) and DSM-II Diagnostic and Statistical Manual of Mental Disorders (1968). In these one finds very interesting changes in description and subtype category, and many more changes are anticipated in DSM-III, which is expected to be published in 1978 (Spitzer, Endicott, and Robins 1975).
   - Attitudes of society toward the schizophrenic patient; tolerance of deviance and strangeness; labeling; hospital detention; acceptance into the community; employment policies.
   - Fads in choosing diagnostic subtypes of schizophrenia; tendency to resort to chronic undifferentiated schizophrenic subtype as expedient.

**Dementia Praecox**

Personal experiences may provide illustrations of the evolution of my current understanding of the schizophrenic patient and his family. My initial intensive experience took place when I was a medical student and was assigned with a classmate to serve as a student extern at the Milwaukee County Asylum for Chronic Mental Diseases. The patient population was exclusively that of chronically ill persons. There was a medical superintendent whom I saw rarely and another full-time psychiatrist whom I saw occasionally. There were no registered nurses, only attendants, and my classmate and I had to assume many nursing as well as medical duties. In addition, due to the unpredictability of the pharmacist, we not only prescribed but dispensed drugs (bromides, barbiturates, chloral hydrate, hyoscyamine, paraldehyde, paregoric, digitalis, potassium iodide, arsenicals, cathartics, laxatives, insulin, iodine, salves, lotions, ointments, and vitamins). We served there full time during the summer months, and after 5 p.m. through the night during the succeeding school year (1932-33).
We were poorly prepared in psychiatry for the assignment. As third-year students, we had had two brief visits to the County Mental Hospital, a sister institution. During one of the visits I had the sobering experience of being assigned to a patient who had been a classmate of mine in high school many years before. He had been ill continuously for a period of 7 years and was considered a chronic schizophrenic (Romano 1972). I had a sickening sense of human inertia and aloneness in seeing so many patients just sitting and staring into space, but what disturbed me most of all was the presence of my former classmate. Someone whom I knew had become mad and remained socially incompetent and disabled all those years. It was my introduction to chronic as well as to mental illness.

During our third year in medical school we also had been required to attend a series of psychiatry lectures, read sonorously by a local practicing psychiatrist, who worked in a large sanatorium spa and served as the part-time chairman of the Department of Psychiatry in the Medical School. The book from which he read was the 12th edition of William Alanson White's *Outlines of Psychiatry* (1929). The psychiatrist's reading of it, without any comment based on his personal experience, was dull and uninspiring. I remember little of what he read, but later I read directly and learned from this excellent text. During the summer of our extern assignment, my classmate and I also read from Brill's translation of Eugen Bleuler's *Textbook of Psychiatry* (1924) but had to wait almost 20 years to read the English translation of Bleuler's monograph *Dementia Praecox or the Group of Schizophrenias*, translated by Zinkin (1950).

Many of the patients for whom we cared in the several buildings of the chronic hospital were diagnosed as having dementia praecox. I don't remember that the term "schizophrenia" was used very frequently. Most patients appeared to be in their forties or fifties or older, and I recall walking on hospital floors where one would find row after row of patients sitting on chairs placed against the walls of large rooms, sometimes rocking, nodding, or performing certain peculiar mannerisms of hand-to-hand, hand-to-face, hand-to-body rubbing, frequently masturbatory. Several had edematous cyanotic feet and legs, called blue piano legs, from having sat still for hours each day. Others would be standing immobile or would shuffle or walk, at times with peculiar or bizarre gaits. Most were silent or would mumble, and occasionally there would be explosive verbal outbursts on the part of one or more patients, at times followed by physical injury to themselves or to those about them.

My impression is that most of the patients were of lower socioeconomic status, that most had had limited social competence at the long-ago onset of their illness, and that many were poorly educated. I don't remember seeing members of the patients' families visiting them, nor do I remember interviewing or meeting with family members.

Most of these persons did not seem to change except, I thought, for the worse, when they became excited or assaultive. Few were discharged and even fewer ran away. In this setting, my classmate Leander J. VanHecke and I took part in a somewhat amateurish experiment. Together with two young occupational therapy students at Milwaukee Downer College, and with the able supervision of Mrs. Arvilla Merrill, who was in charge of the hospital's recently established occupational therapy unit, we chose to convene 10 men who not only had been hospitalized for what to us seemed an eternity, but who we were told had not uttered any articulate sound for almost 20 years. We called them our Van Winkle group. Rather naively, we wondered whether we could get them to relate to us, perhaps even talk with us, or at least change in some way if we paid particular and sustained attention to them. We daily spent many hours with this group of men, who besides not speaking also averted gazes and kept at some physical distance from each other. At times we thought one or more were hallucinated. Initially, we brought them together to sing. Mrs. Merrill played the piano and the four of us young enthusiasts sang some of the old chestnuts like "Gently Sweet Afton." Many songs were sung and many days passed before we heard the first almost inaudible hum from one of our patients, followed by louder hums and then an occasional word appropriate to the song. After several weeks, three patients would sometimes sing a bit but still would not talk to us or to each other.

About the same time, we began to play baseball. Initially, when the ball was thrown, the patients would make no effort to catch the ball, but would allow it to hit their unprotected face or body. Again, after much repetition they reached out for the ball and began to catch it. Later several men caught the ball and threw it back to us. In addition to the singing group and the baseball game, we would spend at least 2 to 3 hours...
each day with individuals or with the group, at times sitting silently with them and at other times walking with them, sharing coffee and doughnuts, and listening intently to whatever they said. You can imagine how excited we were with the minor victories of our patients’ responses.

We learned then that patients in the chronic back ward, while at times mute, seemingly inattentive, and almost dehumanized, can still respond to overtures of interest and kindness. When my classmate and I could no longer spend the greater part of the day with our patients because of the start of our fourth school year and our occupational therapy student colleagues also returned to their school, those patients who had responded to our efforts returned to their earlier regressive levels of mutism and withdrawal.

Some years later I listened with interest to Abraham Myerson’s (1939) description of the “total push” method in the treatment of chronic hospitalized schizophrenic patients. His method included vigorous physiotherapy, walks, outdoor activity, formal gymnastic exercises, increased and more liberal diet, and more pleasant surroundings for dining. In addition, small doses of insulin were used to awaken appetite, and vitamins were also used to some extent. Patients were dressed in more attractive clothing, men were shaved regularly, nails were cared for, and women’s hair was dressed. With all of this, Myerson concluded that the deterioration of the chronic schizophrenic—by which he meant an individual who had been mentally sick from 6 to 20 years, had never exhibited remission or improvement, and had gradually deteriorated—is not altogether a natural or a necessary product of the disease, and that deterioration can be eliminated, at least in part, through restoring the patient to more human and active appearance.

I cannot remember the specific subtype diagnoses of our patients, other than that they were considered to be chronic praecox patients, nor do I remember having access to case histories. If they did exist, I don’t believe they would have been very helpful because of the absence of any developmental data and social or medical histories. As I look back, I suppose the men with whom we worked were either catatonic patients with chronic course and without remission, or were severely regressed hebephrenics with extreme social withdrawal. In the hospital there were quite a few patients who exhibited extreme grandiose or persecutory delusions. They would become angry and argumentative and, at times, violent. Many of these patients, whom I understood were paranoid, were capable of working in the hospital and in the hospital gardens and farms. Because it was a chronic hospital to which patients were sent from other hospitals and acute receiving units, the principal populations of the hospital other than chronic praecox patients were many epileptic patients with psychosis, occasional patients with chronic irreversible depressions, a few with chronic manic excitement, and many with organic brain disease, principally senile dementia and residual general paresis. I was not aware of any psychotic patient with pellagra.

That early adventure remains an impressive experience in my life. The patients seemed almost impervious in terms of any human encounter, and yet I learned, as did Myerson, that what seemed impenetrable was not so. Perhaps our naivete, our youthful enthusiasm, our insistence on sustained and scheduled participant activity, permitted us to touch their lives and in some way evoke their responses, minimal and fragile as they were.

While there seemed to be little question of the diagnosis of the patients’ dementia praecox, both my classmate and I could not help wondering whether the pervasive apathy and withdrawal we observed could be attributed exclusively to their disease, or to what degree it might have emerged from having lived long lives of social impoverishment in an institution. Myerson later claimed that the usual hospital care given to schizophrenic patients produced a “prison stupor” which interacted with the social regressive aspects of their illness. But it was not until 1959 that my colleague Russell Barton presented in a systematic form the devastating mental changes that may result from institutional life.

Initially, I must have formed an extraordinarily narrow concept of dementia praecox. I looked upon it as an illness that devastated the person in his thinking, feeling, general behavior, and relations with others. The patients I recognized as dementia praecox had delusions and hallucinations and signs and symptoms called catatonic. At that time I had no experience with persons at the onset of their illness. The patients I saw were those who had been ill many years, resulting in global deterioration of their humanness.
Schizophrenia

My concept of schizophrenia was broadened in the year of my graduate assignment in psychiatry at Yale (1934–35). In the first place, dementia praecox had become schizophrenia. From our professor, Eugen Kahn, who had been a colleague of Kraepelin, I learned not only of Kraepelin, but of the contributions of other continental psychiatrists. Particular emphasis was placed on the contribution of Kretschmer's body build notions (1925). However, I was not too impressed with the reliability of the interobserver judgments at patient conferences when independent decisions were made of the patient's habitus (leptosomic, pyknic, athletic, and dysplastic). From Kahn, I learned of the attempt of Rüdin (1916) to study schizophrenia according to Mendelian principles and later learned, as did others, of the difficulties encountered in describing the mental disorders other than schizophrenia observed among proband relatives. From my readings I became familiar with the several etiological models—genetic, biological, and psychosocial—and tried to learn how each could help in understanding my patients' behavior.

During the year at Yale, 100 patients were assigned to my immediate care and study and about one-fourth were diagnosed as schizophrenic. Not only was I able to observe patients at the onset of their distress, but I was able to study them carefully and listen to them attentively. It was here, too, that I met with members of the patient's family and with relevant others concerned with the patient.

It appeared to me that there was a higher incidence of mental illness in the families of the patients whom I saw, as compared with medical patients I had cared for earlier. At times I was impressed with the strangeness of certain parents of my schizophrenic patients, but I could not be sure then, nor am I now, of any consistent pattern different from the parents of my other psychiatric patients.

Although I was often struck with the incomprehensible patients' language, I learned that the longer I stayed with a patient, and the more intently I listened, the more understandable did most of what I heard become.

I was impressed, too, with the short-lived episodes of a number of young and middle-aged housewives of Italian ancestry, who would exhibit florid psychotic symptomatology, with hallucinations, delusions, and extraordinary excitement, from which they would recover and return home without symptoms in a fortnight. Quite often the "mal occhio" was evident as was shame, guilt, fear, and hate related to sexual and family relations. We called this the acute Mediterranean psychosis and wondered how or why the patients recovered so quickly. (In the future, with a new classification, such patients may be designated as suffering from brief reactive psychosis.) There were other patients who were perplexed, upset, at times excited, and with depersonalization, and many of these, too, improved in a short time.

I remember particularly the response of two young patients with whom I worked intimately for several months. One was a bright young graduate student whose more or less abrupt change from a high level of creative scientific competence to a condition of confusion, perplexity, and excitement, with ideas of reference, brought him to the attention of his department chairman and eventually, through the student health clinic, to our service. In what undoubtedly was an innocent and naive but perhaps effective means of establishing a state of trust between us, I helped him to modify some of his ideas. We met daily and took long walks, during which he would talk about his scientific work, his feeling of inadequacy, and would express certain ideas of reference relating to his peers and his professor. I was able to clarify some of his notions, arranged for meetings with the patient and his professor, and helped the student realize his quite significant achievement to date.

I learned then that the onset of his illness was precipitated by certain competitive rivalrous situations with others in his work, in which his esteem and self-confidence were seriously diminished. There appeared to be little question that his psychosis emerged under conditions of psychological stress, but in working with him further, I realized that a major part of his anxiety was a residual of unfinished emotional business earlier in his life. At that time I had not read Kasanin's (1933) study of patients whom he described as acute schizoaffective psychoses, and I don't remember the term being used, but I was aware of the common depression variously exhibited and experienced by the schizophrenic patient.

The second patient, who was perhaps erroneously considered schizophrenic, taught me the need for humility in predicting outcome. The patient was a 16-year-old adolescent who was brought by her parents to our clinic in 1934. On admission, she said, "If I had to say this in a few words, which I would like to do, I
would say that I am trying to feel natural. Things don't seem the same. It seems I don't belong anywhere. I feel rather strange, but that's only a part of it, I guess.”

The oldest of three children, she was born in Tibet of American missionary parents. She was said to have had a normal infancy and childhood, and when she was 9, because of agitation among the Chinese banditry, she and her parents returned to America. During this trip it is said that she suffered a severe bout of malaria. She was said to have been an excellent student and had many friends. Two months before the hospital admission, a friend had noted that she was not feeling so well as she had been.

After complaining of dizzy spells and headaches, she withdrew from campus activities and appeared to take little interest in school work or in relations with others. This behavior was followed by periods of starvation, 3 or 4 days at a time, with only a cup of coffee or a piece of bread. Upon being urged to eat, she would say, “It's no use, don't waste your time on me. I'm not worth it.” Before she came to the hospital, she wrote notes and in one of them included her last will and testament. When examined, she appeared apathetic, with grimacing of an irregular pattern. On one occasion she said, “It seems as if I don't belong anywhere, and sometimes things aren't real to me. I have always felt rather strange, perhaps because I was born in China—things aren't the same.” Again, she said, “I keep trying to fight off not being natural. I was able to hold the upper hand until just lately. The first year I didn't have any trouble, but I felt this way somewhat. The second year I felt it a little bit more. I wanted to fight it off. Perhaps it's inferiority. Perhaps I'm not as good as I should be and I try to be much better.”

The staff conference consensus was that the patient's prognosis was most grave, with a course of continuing disability being predicted. This unfavorable prognosis was based on the insidious onset, symptoms of headache, dizzy spells, periods of starvation, and feelings of not being natural. It was also thought that she showed depersonalization, perplexity, and blocking. There was no family history of mental illness, the patient was intelligent, the premorbid history was that of a healthy, active, successful person, and the patient had no delusions or hallucinations. Thus, the gravity and severity of my colleagues' prognostic statements surprised and shocked me.

My own prediction of her prognosis was more favorable, perhaps because of my serious involvement with her and with my great wish that she become well. I saw her a few times in the outpatient department after her discharge. Her condition seemed improved, although she was somewhat lethargic. Occasionally she slept late in the morning and appeared irritable and cross. She had a pleasant summer and spent a great deal of time with a girlfriend. She returned to her school in September 1935 and the school was advised to plan a 2-year curriculum for her so that she could finish her third and fourth years in a more leisurely manner.

Thirty years later (1964), I was asked to see her in consultation by a neurologist colleague. She was then 46 and was said to have experienced a peculiar seizure and on two occasions had momentary lapses of attention lasting a few seconds. Neurological and laboratory examinations revealed no significant abnormalities. She remembered me and wished to see me. Married for many years and the mother of three children in their early teens, she had lived a compatible life with her husband. After finishing secondary school, she had gone on to receive a master's degree in clinical psychology and had worked in a clinic until her marriage. She had never been rehospitalized, and her memory of her adolescent episode was that she had lost her mind, had not been able to sleep, could not relate to others, and had neglected her personal care. While she was understandably confused and somewhat depressed about the unexplained seizure, I saw no evidence of schizophrenic illness.

Experiences in Colorado

In Colorado I had the opportunity of spending 4 months at the Colorado State Hospital in Pueblo, where some of my patients from the Colorado Psychopathic Hospital in Denver were transferred for long-term care. Table 1 illustrates clearly the high percentage of patients diagnosed as schizophrenic who were transferred from the Colorado Psychopathic Hospital in Denver to Colorado State Hospital in Pueblo for the 2-year period, 1936–38, the last 2 years of my Commonwealth Fund Fellowship appointment at the University of Colorado.
Table 1. Colorado Psychopathic Hospital—Admission and transfer statistics,
July 1, 1936 to June 30, 1938

1. Total admissions .................................................. 1,502
   Number of schizophrenics ...................................... 299
   Number of paranoia and paranoid conditions ............. 13
   20.8% of total admissions

2. Total readmissions ................................................ 205
   Number of schizophrenics ...................................... 57
   Number of paranoia and paranoid conditions ............. 2
   28.8% of total readmissions

3. Total first admissions and readmissions .................... 1,707
   Transfers to Colorado State Hospital ....................... 359
   Of those transferred number of schizophrenics,
   paranoia, and paranoid conditions ......................... 130
   7.6% of total and 36.2% of those transferred

From Ebaugh (1938).

It may be interesting to compare admission and discharge statistics for that time in Colorado, more than 40 years ago, with statistics for Rochester, N.Y., in the past 15 years (H. Babigian, personal communication, 1976). In the calendar years 1960-64, an average of 9.7 percent of admissions to the psychiatric unit of the University of Rochester teaching hospital were transferred directly to the Rochester Psychiatric Center, a New York State Hospital. In the second 5-year period, 1965-69, 5.9 percent of all patients were transferred, and in the third 5-year period, 1970-74, 4.0 percent were transferred. While the functions and operations of the Colorado Psychopathic Hospital were not the same as those of Rochester’s teaching hospital psychiatric unit, I believe the differences noted reflect the changes in the number of transfers to a state hospital for continuing care. Several factors undoubtedly have brought about this reduction, including the work of the psychiatric unit in the general hospital, the use of psychotropic drugs, and increased public tolerance of deviant behavior.

In my third year at Colorado (1937-38), I undertook a catamnestic study of 600 patients diagnosed schizophrenia, paranoid condition, and paranoia, who had been admitted to the Colorado Psychopathic Hospital in the period January 1, 1933 through December 31, 1936. In the published preliminary report of these findings (Romano and Ebaugh 1938), 345 patients or 57.5 percent of the total number were reported to have been examined. Of the 345 patients seen, 247 were hospitalized. Tables 2 and 3 indicate the location and status of the patients at the time of the study.

The study had many deficiencies, but I was struck by the number of persons who were lost, the small number of persons who refused to be examined, and the high mortality. Of the patients examined, three-fourths showed no improvement or appeared to be worse; one-fourth showed improvement or marked improvement. It was my impression that many of the patients who were lost to us may have shown improvement, marked improvement, or even recovery, and therefore the pessimistic statistics may have understated the potential for improvement or recovery.

I was also impressed with the limited usefulness of questionnaire information as compared with the direct examination. In 61 instances, it was possible to compare the questionnaire, as filled in by the family, with a personal examination of the patient. There was a significant error in 31, or 50.8 percent of this series. It demonstrated to me the limits both of the questionnaire study itself and of depending too heavily upon the family’s judgment of social adjustment as a criterion of recovery or improvement. However, my meetings with the family taught me many things. I was impressed with the fact that many signs and symptoms of a psychotic patient are much less upsetting to the family than they are to the psychiatrist, that many families found some of the most disturbing aspects of caring for psychotic relatives to be their inertia and apathy together with
Table 2. Location of 600 patients at time of followup (1938), Colorado Psychopathic Hospital

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<thead>
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<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
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<td><strong>Hospital:</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Colorado hospitals</td>
<td>115</td>
<td>119</td>
<td>234</td>
</tr>
<tr>
<td>Out-of-state hospitals</td>
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<td>6</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>122</td>
<td>125</td>
<td>247</td>
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| **Examined in community:**                    |      |        |       |
| Denver                                         | 23   | 37     | 60    |
| Colorado other than Denver                     | 15   | 23     | 38    |
| **Total**                                      | 38   | 60     | 98    |

| **Information obtained about patient not examined:** |      |        |       |
| Colorado                                             | 15   | 17     | 32    |
| Out of Colorado                                      | 26   | 21     | 47    |
| Out of country (Puerto Rico)                        | 1    | 0      | 1     |
| **Total**                                            | 42   | 38     | 80    |

| **Examination refused:**                          |      |        |       |
| Refused by relative or by patient although         |      |        |       |
| information given by a relative                    | 13   | 11     | 24    |
| Refused by relative and no information given       | 0    | 3      | 3     |
| Refused by patient and no information given        | 1    | 1      | 2     |
| **Total**                                          | 14   | 15     | 29    |

| **Lost:**                                          |      |        |       |
| Colorado                                           | 40   | 21     | 61    |
| Out of Colorado                                    | 21   | 17     | 38    |
| Out of country (China)                             | 1    | 0      | 1     |
| **Total**                                          | 62   | 38     | 100   |

| **Dead:**                                          |      |        |       |
| Natural causes                                     | 19   | 19     | 38    |
| Suicide                                           | 4    | 4      | 8     |
| **Total**                                          | 23   | 23     | 46    |

| **Grand total**                                    | 301  | 299    | 600   |
Table 3. Status of 345 patients when examined at followup (1938), Colorado Psychopathic Hospital

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<thead>
<tr>
<th></th>
<th>Number</th>
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<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
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<tr>
<td>Remission</td>
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<td>1</td>
</tr>
<tr>
<td>Marked improvement</td>
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<td>13</td>
</tr>
<tr>
<td>Improvement</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>No improvement</td>
<td>82</td>
<td>110</td>
</tr>
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<td>Worse</td>
<td>39</td>
<td>34</td>
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<tr>
<td><strong>Total</strong></td>
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<td>185</td>
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<th></th>
<th>Number</th>
<th>Percent</th>
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<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Remission</td>
<td>0.00</td>
<td>0.54</td>
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<tr>
<td>Marked improvement</td>
<td>7.50</td>
<td>7.03</td>
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<tr>
<td>Improvement</td>
<td>16.87</td>
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<td>No improvement</td>
<td>51.25</td>
<td>59.46</td>
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<tr>
<td>Worse</td>
<td>24.38</td>
<td>18.38</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<td>100.00</td>
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disorders in eating, sleeping, and personal grooming, rather than their hearing voices. I found also that many families felt quite lonely and abandoned in being entrusted with the care of the patient and would have appreciated assistance from others with similar experience, and perhaps some help in trying to understand the patient's behavior.

As I look back on the patients I examined in the hospitals, many were what I considered to be catatonic, hebephrenic, or socially disabled paranoids. For the most part, those I examined in the community were probably schizoaffective, but occasionally a family would harbor a severely deteriorated, withdrawn, hebephrenic patient.

Both at Yale and Colorado we seem to have had an endless number of acutely disturbed patients, and we would respond to their emergent needs, together with our nurses and attendants, with the gusto of seasoned firehorses. We used wet packs and tubs and chloral and bromides, paraldehyde and barbiturates, as wisely as we knew how, and at the end of the Colorado period we were involved with dauerschlaf and insulin. Metrazol was begun and ECT and lobotomies were on the horizon. A young schizophrenic patient, experiencing continuous and enervating excitement, was given dauerschlaf treatment. Although prolonged sleep as a treatment for mental symptoms had been used in the past, the more systematic use was introduced by Klaesi (1922). We followed his method, as modified by Cloetta, and kept the patient in a barbiturate narcosis for a 10-day period. I was not impressed with the effectiveness of the treatment with this patient nor with others who followed her. The first patient experienced seizures following the sudden withdrawal of the barbiturate drugs.

Although I found schizophrenic patients in all social classes in the populations with which I was engaged, a followup evaluation of patients diagnosed schizophrenic (Romano and Ebaugh 1938) revealed that most who were not in institutions were living in deteriorated social areas of the community. This was before the publication of the work of Faris and Dunham (1939). Later I became aware of the notion of downward social drift.

I never was quite sure of how reliable or valid was the diagnosis of simple schizophrenia, and later on was even more dubious of the concept of latent schizophrenia and its sister subtypes, pseudoneurotic and pseudopsychopathic. On reflection, I have the impression that I saw more patients who were diagnosed catatonic and hebephrenic schizophrenia than I observed later on.

I was immensely impressed with the dramatically sudden change that occurred during my examination of a young college student who had been admitted in a catatonic state 2 hours before I saw him. It was said that there had been no preceding abnormal behavior of any type, and while serving dinner to his fellow fraternity members, he had "a funny spell," after which he became mute and fixed. When I saw him, he was mute, had a vacuous, staring facial expression, an awkward and constrained posture, and maintained for several minutes induced positions of his arms and legs. Suddenly, in the midst of my examination, he assumed a more relaxed position, stroked his chin, shook his head, blinked his eyes, and said, "Hi! Who are you? Where am I? What am I doing here?" His face remained expressionless, and while his speech was not spontaneous, he answered my questions coherently.

It was at Colorado, principally through Henry Brosin, that I learned more about the contributions of Adolf
Meyer. Meyer stressed the need for a longitudinal study of the patient’s life, as he believed that schizophrenia was the result of an accumulation of faulty habit disorders and inadequate responses (Meyer 1928). I have vivid memories of filling out for each of my patients what we somewhat irreverently called “the Meyerian torpedo.” This was a diagram of a life chart, which briefly described the family in terms of possible hereditary factors, and then, over the life span of the patient, significant physical, psychologic, and social events, as well as educational and work records. The chart taught us something of the healthy as well as the sick aspects of the patient’s life. It indicated the stresses he had been subject to and his success or failure in adapting to them. What it didn’t do was to differentiate between the various faulty life habits, as in some instances where the accumulation of such habits led not to psychosis but to neurosis.

John Benjamin, freshly arrived from Zurich and his association with the Bleulers and with Emil Oberholzer, shared with us his knowledge of psychoanalysis and the Rorschach. He also drew our attention to the European studies of cognitive disturbances and other thought disorders of schizophrenic patients. In the absence of formal seminars, literature reviews, or case supervision, we learned most from our patients and from our own informal discussions. I remember vividly and with sincere appreciation the discussions held with my colleagues, Henry Brosin, Jack Ewalt, John Benjamin, John Evans, and others.

Personal Impressions—1938

If I were to try to summarize my impressions at that time, I would include the following:

• I was reasonably convinced that a mental illness called schizophrenia did exist and that it manifested itself in a number of forms.
• There were differences in the behavior of persons eventually diagnosed catatonic or hebephrenic from that of those called paranoid.
• The illness remained enigmatic. No single or specific cause had been discovered.
• The disorder at times seemed to be ushered in by physical illnesses, more often by psychological stresses. I was impressed with those stressors that diminished the patient’s esteem and confidence.
• I was not convinced that there was any specific pre-illness pattern of behavior, and I never found useful the concept of the schizoid personality as being the exclusive preface to the illness.

• It seemed to me that there were always signs of mental health, even in the most abject and deteriorated patients, and I felt obliged to find these signs and to try to build upon them.
• At times it was difficult to understand all that the patient was saying, but this seemed to be a function of how attentive and psychologically minded I was and how much time I spent with the patient. Schizophrenic behavior always seemed quite human to me, and I was fascinated by the remarkable repertory of delusions, hallucinations, and cognitive dissonances in thinking.
• I have never been impressed with what has been called “flat affect.” I did find it difficult to understand the schizophrenic affect, but sensed the exquisite and at times poignant intensity of the feelings of those with whom I worked.
• I believed that genetic factors were significant but neither exclusive nor sufficient. While at times members of the patient’s family appeared somewhat strange and different from members of other families, I was not convinced of any specific pattern but wondered if there were more subtle differences.
• At times, the illness appeared suddenly, without forewarning, even in persons considered healthy. With others, the onset was insidious, the course mostly chronic and progressive, but occasionally brief or with recurrent episodes.
• I was impressed, and still am, with the often silent and private courage of many psychotic patients, harrassed and distressed for years by hallucinated voices.

The Shock Treatments

I have often wondered what the effect was on our understanding of the nature of the schizophrenic patient and his family of the more or less simultaneous emergence in the middle 1930’s, coincidental with my early professional life, of a number of physical measures pursued with considerable therapeutic vigor and enthusiasm. Earlier in the century, Wagner von Jauregg (1918) had introduced malaria treatment in general paresis, and Klaesi had used prolonged narcosis treatment as early as 1922. But it was a decade later that the major thrust of physical treatment took place, initiated by Sakel (1936) with hypoglycemic coma treatment, and by von Meduna
(1938) with pharmacological convulsive therapy. Electroshock therapy was first demonstrated by Cerletti and Bini (1938). Almost at the same time, Moniz (1936), in cooperation with Lima, reported on a surgical approach to the treatment of psychosis. In a parallel instance Elvehjam et al. (1938) showed that nicotinic acid could cure black tongue in a pellagra-like disease in dogs. Shortly thereafter, nicotinic acid proved effective in the therapy of clinical pellagra.

I remember vividly the excitement and promise that attended these ventures, and later it occurred to me that our expectations may have been similar to those of clinicians who worked with psychotic patients following the demonstration by Noguchi and Moore (1913) of Treponema pallidum in the brains of paretic patients, namely, substantiating a physical base for madness and subsequently introducing the fever treatment.

At long last there appeared to be a physical basis for mental disease and there were many who believed that the shock treatments supported the idea of a physical basis for the enigma of schizophrenia. Nebulous neurophysiologic notions emerged from these empiric approaches and were considered the theoretical basis for action—but none was convincing. It taught me that therapeutics has always had its own imperatives, at times more conservative, at times more audacious than those of scientific inquiry. Written records that long antedate written medical records are replete with therapeutic ventures that have been rational and irrational, enlightened and unenlightened, effective and ineffective, safe and harmful.

However, there were serendipitous effects of these measures. One was in the improved care of patients and in the overall conduct and organization of the hospital. A second was in the more precise approach to diagnosis, including differentiation of types and subtypes of the schizophrenic condition. A third was the growth of more systematic studies of neurochemistry and neurophysiology. What remains most vivid in my mind was the careful, vigilant, enthusiastic, and compassionate care of the patients chosen to receive insulin therapy when we began to do this some time in 1937 in Denver. As I look back, I believe that the patients we chose for insulin treatment were intelligent, attractive, most often with a sudden onset of illness that occurred in a setting of significant, even dramatic, psychological stresses. In short, I think most of the improvements we saw took place in what we would call reactive rather than process schizophrenics, and probably would have taken place without insulin treatment. The close, intense motherly care given during the treatments also struck me as a possible reason for recovery.

This was less true in 1946 when I observed insulin treatment given to many patients in the Canandaigua Veterans' Administration Hospital. It was there, too, that I examined a considerable number of patients preparatory to lobotomy. These were those long-hospitalized patients who had not changed materially after extended courses of insulin and electric shock treatment. Most were excited, aggressive, and assaultive; others were withdrawn. I saw them again following surgery that had been done elsewhere, and was not impressed with any significant change in their mental status or overall behavior.

I am not sure when I became aware of the distinction made between reactive and process schizophrenia. My own observations had led me to differentiate between acute and chronic and between paranoid and nonparanoid patients, and to consider another type of schizophrenic patient whose behavior was most difficult to differentiate from the affective disorders. I believe it was John Benjamin with whom I worked in Denver (1935–38) who introduced me to the notions of reactive-process. Together, we examined a number of schizophrenic patients, using the Rorschach, a series of problems and phrases, simple logical problems, geometrical figures for classification, orally presented stories for discerning and reporting the moral, and problems requiring ingenuity to solve. This work is unpublished, although referred to briefly in a short paper by Benjamin (1944). In this paper the major point was that formal thinking disorder was indicative of process schizophrenia, and its presence could be elicited through the Rorschach test. From Benjamin I learned something of the evolution of the hypothesis of process and reactive schizophrenia, which dated back not only to Jaspers (1910) but to antiquity. The hypothesis has appeared in some fashion or other since Bleuler, later by Kretschmer, Langfeldt, and many others (Kantor, Wallner, and Winder 1953).

The Duke studies in schizophrenia of Eliot Rodnick and Norman Garmezy were summarized in their report entitled “An Experimental Approach to the Study of Motivation in Schizophrenia” (1957). I believe their interest in the process-reactive concept had been stimulated by Rodnick’s earlier work with David Shakow and Leslie Phillips, the latter of whom was interested in premorbid adjustment. Phillips (1953) was interested in identifying premorbid factors that would predict which patients would and would not profit from ECT.
More recently detailed reviews of the hypothesis by Higgins (1969) and by Garmezy (1968) have pointed to the major issues concerned. Garmezy summarized these as follows:

(1) Are process and reactive schizophrenia two separate and distinct disorders, or do both stem from a common disease entity? (2) Is the process-reactive distinction best viewed as a dichotomous typology or as a continuum? (3) Can process schizophrenia be equated with an organic etiology and reactive schizophrenia with psychological origins? [p. 457]

From a practical clinical point of view, I have not been able to convince myself that there is any basic difference in the treatment programs presented to patients, whether they be identified as process or reactive. I believe this applies to the various modes of psychotherapy, hospital milieu treatment, and medication.

Psychotherapy

With the exception of the remarkable benefits obtained through the use of ECT with depressed patients, the physical treatment methods did not fulfill their promise, eventually were used less and less, and finally were abandoned by most. Quite predictably, with this disillusionment the pendulum swung from physical causality toward reconsidering schizophrenia as a psychosocial disorder. Undoubtedly, many factors led to this change. After World War II there was a surge of interest in all aspects of psychotherapy, with a considerable increase in the number of psychiatrists seeking further training in psychoanalytic techniques. Consequently, there were attempts on the part of a number of psychoanalysts to extend their psychotherapeutic efforts toward the psychotic patient.

In our country there were the earlier influences of William Alanson White and Adolf Meyer. Edward J. Kempf, as early as 1919, had recorded in detail the psychoanalytic treatment of a patient. However, the major influence was undoubtedly the work of Harry Stack Sullivan (1962). He helped us rediscover the human family as well as the human community and influenced considerably the members of the Washington-Baltimore groups associated with the Sheppard and Enoch Pratt Hospital and the Chestnut Lodge Sanitarium, who vigorously pursued intensive psychoanalytic study and treatment of the chronic schizophrenic patient. The group included Burnham, Fromm-Reichmann, Hill, Kafka, Pao, Schulz, Searles, Stanton, Will, and others.²

Some years later I learned of the pioneering efforts made at the beginning of the century to treat the schizophrenic patient with psychoanalytic therapeutic methods. Müller (1958) informed us that many of the notions and methods used by Fromm-Reichmann, Rosen, and others had been introduced earlier in the century by several European psychoanalysts, both in Vienna and Zurich. Recently, Chodoff and Carpenter (1975) reviewed the debate between proponents of the conflict and deficit theories of schizophrenia. They pointed out that both theories, as well as the attempts to synthesize them, are derived from psychoanalytic observation and inference and are concerned primarily with the nature and quality of a child’s early object relationship. The evolution of these ideas and the ensuing family approaches stem principally from the psychoanalytic study and treatment of the schizophrenic patient. Chodoff and Carpenter drew our attention to the fact that many of the initial psychoanalytic investigations were undertaken with chronic hospitalized patients, while family theorists have included among their subjects younger patients, including outpatients. They state that “The family findings, unlike those resulting from earlier psychoanalytic studies, are based on both reactive and process schizophrenic patients, although this characterization of the patients under study is not generally stated” (p. 59).

This is the matter alluded to earlier, namely, the ever-present source of error in attempting to compare findings from heterogeneous samples. There has been a significant decline in the current psychiatric literature dealing with the psychotherapy of schizophrenics. The limited documented evidence for the efficacy of psychotherapy and the prodigious cost, time, and special skill required make it impractical for most patients. But there is little question in my mind that the psychotherapeutic approaches have helped us estimably to understand better the schizophrenic patient and his family. In reviewing the several decades of investigation into psychogenetic and psychodynamic factors,

²In the early 1950's a generous research grant was made to the group at the Chestnut Lodge Sanitarium for clinical investigation into the field of schizophrenic illness. The grant was made by the Behavioral Sciences Division of the Ford Foundation, whose executive chairman was Bernard Berelson. The members of the advisory group who recommended the grant included John Eberhardt, Merton Gill, Ernst Hilgard, Seymour Kety, David Shakow, and myself.
Chodoff and Carpenter state that a consensus has been achieved about the following propositions:

(1) Schizophrenia, or at least chronic schizophrenia, develops in a family milieu which is seriously disturbed. This disturbance may be gross and overt, but it also may be subtle in character and not immediately obvious to superficial observation. (2) Faulty and idiosyncratic communicative processes within the family are central to the family disturbance. (3) The early object relations of the future schizophrenic do not proceed in a healthy development, but are blighted in a way which has serious consequences for later adaptation. (4) The schizophrenic patient suffers an agonizing ambivalence in his attitude towards interpersonal closeness. [p. 73]

Rue Cromwell (personal communication, Feb. 1977) takes issue with the first proposition, indicating that one must consider the process-reactive dimension before making such generalizations. He cites the studies of Mishler and Waxler (1968), who found no significant evidence of family disturbance in process schizophrenics.

**Diagnosis and Classification**

Factors that led to renewed interest in biologic factors and in physical causality were the resurgence of genetic studies, using new and sophisticated methods, and the introduction of the psychoactive drugs by Delay and Deniker (1952). The effectiveness of these drugs in bringing about changes in the lives of the schizophrenic patient and his family has been truly remarkable. There was also the rediscovery of the moral treatment of the insane; that is, the community mental health movement, intent upon resocializing patients. These factors undoubtedly have influenced concept, diagnosis, and treatment procedures.

In the past two decades I have noticed a certain looseness, if not slovenliness, in clinical diagnosis, with downgrading of diagnostic precision, greater emphasis on the state of the emotional relationship between patient and psychiatrist, and less regard for signs, symptoms, and the social competence of the patient. Observers have appeared more interested in what patients felt than what they thought or did. Happily there appears to be a renaissance of interest in diagnosis and classification. Several factors may have contributed to this change. First was the lack of reliability of standard national and international classification systems, with the subsequent limited value for purposes of assignment of treatment, prediction of course, and basic understanding of the condition. Second was the response of the psychiatric profession to the accusation of “labeling,” which emerged from a sociological perspective on psychopathology as well as from challenges to the validity of the “medical model” from nondirectivists, behavior modifiers, and others. From a practical clinical point of view, it has become necessary to discriminate carefully among schizophrenia, mania, the several types of depression, and other psychotic behavior in order to prescribe the appropriate medication.

Beyond this, as Blashfield and Draguns (1976) have noted, is the recognition of the problems shared by classification in psychiatry with those in more basic scientific disciplines, notably biology, and the development of new statistical methods for generating classifications. The recent international diagnostic studies (Kendell et al. 1971 and Carpenter and Strauss 1974) attest to this greater interest and concern in proposing new classification systems. Several studies have been undertaken to introduce specified criteria aimed at increasing the reliability of diagnostic judgments. Spitzer and his colleagues suggest that such criteria should be included in the forthcoming *DSM-III* of the American Psychiatric Association (Spitzer, Endicott, and Robins 1975). Strauss (1975) and Robins (1976) discuss at some length the advantages and disadvantages of typological and dimensional diagnostic systems. What is common in this renewed interest in diagnosis is the insistence on greater specificity and explicitness of rules. While this is to be applauded, I wonder if in our search for reliability we may lose something of validity.

Personal experiences also confirm the international concern with diagnosis and classification. In 1959-60 and again in 1970, I had the opportunity to visit and study in a number of clinics and hospitals in the British Isles, the European continent, Scandinavia, the Soviet Union, Lebanon, and Israel. In 1970, with several other Americans, I took part in an international symposium on schizophrenia, which took place in Leningrad under the auspices of the World Psychiatric Association, the Academy of Medical Sciences of the U.S.S.R., and the Academy of Medical Sciences of the Georgian S.S.R. I presented a paper, under the joint authorship of my colleagues, Haroutun Babigian and Charles L. Odoroff (1971), on our clinical epidemiological studies of schizophrenia. We concluded:

These studies reflect the gradual evolution of increasing interest in the members of our faculty with the generally prevalent view that schizophrenia is multiply determined, that a significant determinant is
I learned then of the almost exclusive concern of the Academy of Medical Sciences of the U.S.S.R. with the problem of schizophrenia and later, through the excellent review by Holland and Shakhmatova-Pavlava (1977), about the classification of schizophrenia in the Soviet Union. The authors report, and I agree, that while there is no single school of psychiatric thought in the Soviet Union, the impact of the Moscow School, under Professor Snezhnevsky, has been significant over the past decade, and the classification developed by him (1968) is in wide use by Soviet psychiatrists. His classification recognizes three forms based on clinical course: continuous, shift-like, and periodic. Furthermore, the eventual diagnosis is the final step following the accumulation of data about family history of mental illness, life history of the patient, premorbid personality, psychological signs during illness, level of adjustment during remission, and the nature and rate of progression of the clinical course. It is believed that these subclassifications are of prognostic value since the future clinical course of the patient can be predicted. The three forms support broad limits for the definition of schizophrenia, including patients with predominantly pseudoneurotic symptoms on the neu- rotic side, and exclusive only of patients with purely affective symptoms on the border with manic-depressive psychosis. The continuous form will probably be that which most closely resembles the criteria to be outlined in DSM III (Spitzer, Endicott, and Robins 1975). The shift-like form is probably transitional between the narrow diagnosis of schizophrenia, as outlined in DSM III, and the broader definition, as recognized in DSM II (American Psychiatric Association 1968). The periodic form with the best prognosis is probably closest to our concept of the schizoaffective type of schizophrenia.

I read with interest and appreciation the monograph Schizophrenia by Fish (1962). In presenting the work of German psychiatrists largely unfamiliar to English-speaking psychiatrists (e.g., Karl Kleist, Karl Leonhard, Karl Jaspers, Kurt Schneider, and Klaus Conrad), Fish added immeasurably to our understanding of the schizophrenic patient. I believe his monograph has had some influence in the movement toward greater precision in the diagnosis of schizophrenia that is being contemplated in the formulation of DSM III, which includes greater attention to the presence of delusions, hallucinations, and thought disorders. Fish’s review has helped me to put Schneider’s emphasis on pathognomonic symptoms and cluster of symptoms, Kraepelin’s concepts of prognostic course, and Bleuler’s concept of basic psychological deficit into perspective with the cumulative faulty habit concept of Meyer, the notion based upon the nature and quality of a child’s object relationships, and the subsequent studies of communication deviance in the family of the schizophrenic patient.

Incidence and Prevalence

Our interest in matters of diagnosis and classification, and more broadly, in the course of patients’ illnesses, led us to establish the Monroe County (New York) Psychiatric Case Register, beginning January 1, 1960 (Gardner et al. 1963). I had been aware for many years of the speciousness of basing judgments about patients and their families mainly on observations made at the time of hospitalization. When I was able to follow patients and their families for longer periods of time and see them at various intervals throughout their lives, I learned something of the natural course of the illness, its impact on the families, and the families’ support or lack of support for the patients. I also learned something about the effectiveness or noneffectiveness of my efforts to help. The experience was revealing and informative, but also humbling, since it required constant reexamination of my understanding of the patients’ problems. Probably most important, I learned the healthy aspects of my patients’ lives and how I could help them use these strengths to return to better health and to social competence.

Initially, the goal of the register was to provide clinical, epidemiological, and service evaluation data; however, its use in research soon became apparent. Demographic and geographic factors added to the attractiveness of the county area as a site for epidemiologic research and the creation of the patient register. High quality local services and the long distances from comparable services reduced the tendency for patients to seek help outside the county. Since the hospital was the only university medical center in the area, most of the practicing psychiatrists in the county were associated with the Department of Psychiatry and were pleased to partici-
pate in the register. Furthermore, the hospital worked closely with its sister institution, the Rochester Psychiatric Center. The support of their staff and of the Albany Office of the New York State Department of Mental Health was most helpful. My colleague, Haroutun M. Babigian (1975) has summarized the epidemiologic data that have emerged from the register.

As I indicated earlier, a certain looseness in clinical diagnosis prevailed for some years, which resulted in a downgrading of diagnostic precision and a tendency to overdiagnose schizophrenia. In the past 15 years, however, I have noticed a trend toward more precision in the diagnosis of schizophrenia. To ascertain any facts reflecting this apparent change, data were obtained from the register on the number of patients admitted to county psychiatric facilities during three successive 5-year periods, beginning in January 1961. Figure 1 shows the decline in the percentage of first admission patients diagnosed as schizophrenic over the 15-year period.

It is interesting to compare this change with data reported by Morrison (1974) at the Iowa State Psychopathic Hospital, where the 5-year average never rose above 18 percent.

Further evidence of diagnostic looseness has been gathered from the University of Rochester Child and Family Study. Under the leadership of Lyman Wynne, the study attempts: (1) to identify children who genetically have a high or low risk for schizophrenia; (2) to examine these groups through three classes of predictor variables: (a) diagnostic assessment of the biological parents to determine whether there were different genetic loadings for high risk children of schizophrenic parents as opposed to low risk children of parents who had other kinds of psychiatric disorders, (b) different patterns of psychosocial competence, adaptation, and biological functioning of the children, themselves, and (c) factors in family and school environments that could differentiate high risk from low risk children; and (3) to follow these families to determine whether or not the initial differences were maintained in developmental trends. Since the start of the study, 115 families have been seen. In the first 91 families, 44 patient parents have been diagnosed as schizophrenic during the inpatient hospital period of the study (Romano 1976). Using information from a review of hospital records together with current diagnostic interviews with former patients and spouses, researchers disagreed with the initial hospital diagnosis of schizophrenia in 23 of 44 patients or 52 percent. Forty-seven patients were not diagnosed as schizophrenic, but here diagnoses were in agreement with those of the hospitals in 96 percent of the cases. Criteria for our diagnoses were basically those outlined in the proposed DSM III (see table 4).

Changes in Diagnosis of Schizophrenia

Of special interest are the studies of diagnostic changes in psychiatric syndromes. In the past 15 years studies by Beck (1962), Schorer (1968), and Babigian et al. (1965) have examined consistency of clinical judgments and ratings. Babigian et al. found that 70 percent of all patients first diagnosed as schizophrenic received the same diagnosis on subsequent contacts. The range of agreement for patients with different numbers of contacts was 63 to 72 percent. The study found greater consistency in the diagnosis of schizophrenia than for affective psychosis; the highest rate of overall agreement (92 percent) was found for chronic brain syndrome. Brill and Glass (1965) drew attention to the limited number of studies of diagnosis and classification and concluded that hebephrenia is actually a severely regressed state, usually part of a later stage in the chronic schizophrenic process, but that it may occasionally be present early in the development of the illness. Most of the hebephrenic patients whom I have diagnosed have been persons with chronic illness, although some exhibited hebephrenic behavior from the very onset of their illnesses.
Table 4. The University of Rochester Child and Family Study diagnostic breakdown of 91 families

<table>
<thead>
<tr>
<th>REDIAGNOSIS</th>
<th>HOSPITAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>+</strong></td>
<td>+</td>
</tr>
<tr>
<td>21 Patients</td>
<td>23 Patients</td>
</tr>
<tr>
<td>0 Spouses</td>
<td>1 Spouse</td>
</tr>
<tr>
<td><strong>-</strong></td>
<td>-</td>
</tr>
<tr>
<td>3 Patients</td>
<td>45 Patients</td>
</tr>
<tr>
<td>0 Spouses</td>
<td>3 Spouses</td>
</tr>
</tbody>
</table>

++ = Hospital diagnosis schizophrenic; we agree
+- = Hospital diagnosis schizophrenic; we disagree
-+ = Hospital diagnosis not schizophrenic; we disagree
-- = Hospital diagnosis not schizophrenic; we agree

Morrison (1974), in his review of admissions to the Iowa State Psychopathic Hospital over a 47-year period, reported the diagnosis of catatonic and hebephrenic schizophrenia decreased markedly; paranoid schizophrenia, with some variations, remained nearly constant, chronic undifferentiated schizophrenia greatly increased. He ascribed his findings to changes in definitions and in hospital admission practices, to the more effective use of therapy, to degrees and types of drug abuse, and to the waning interest of psychiatrists in clinical diagnosis.

Particularly impressive were observations made at the Second Rochester International Conference on Schizophrenia by two experienced clinical psychiatrists who shared their views of the changes in the nature of schizophrenia.

Roy Grinker, Sr. (1976) said the difficulties in diagnosing schizophrenic patients were: (1) the frequent occurrence of elevated excited moods resembling mania and depressed suicidal behavior that leads to use of the subtype "schizoaffective" (which he considers hedging); (2) the dubious tendency of distinguishing acute schizophrenia, with one or several psychotic breakdowns, from slowly progressive schizophrenia; (3) the changing manifestations over time of all psychiatric disorders, both neurotic and psychotic, and the general tendency toward more restricted and constricted characters; and (4) the variability in life histories of schizophrenic patients in which there may be subtype shifts and alternations of acute and chronic courses.

Manfred Bleuler (1976) briefly described his unique long-term study of 208 schizophrenics of the Burghölzli Clinic admitted after he became its director in 1942. Bleuler treated all of the patients studied and followed them until death or for at least 22 years. He also had the opportunity to observe patients' parents, siblings, spouses, and children. Bleuler said he believed that the average course in schizophrenic psychoses has changed over the years, noting that "The most severe psychotic conditions are milder than before; the chronicity of schizophrenic psychoses (in particular, chronic hospitalization in schizophrenics) has become less frequent, while phasic course (hospital discharges and readmissions) has become more frequent." He believes so-called catastrophic schizophrenia, characterized by the very acute onset of a most severe psychosis early in life and followed without any interruption by a severe life-long chronic psychosis, was frequent at the beginning of this century, but has practically disappeared within the last decades. He
added, however, that this improvement does not hold good for every aspect of schizophrenia.

The truly remarkable aspect of Bleuler's experience is the extensive depth and breadth of his knowledge about each patient and his family. With the exception of the quite rare single case histories, most studies of schizophrenic patients have been one-time observations at some point in the patient's life, usually at a time of crisis or decompensation. Bleuler's knowledge of patients over a considerable period of their lives has permitted him to learn of the healthy, as well as sick, aspects of their experiences and of the broad repertory of psychological and social adaptive devices used by them and their families.

Earlier I pointed to decreases in the percentage of first admission patients diagnosed schizophrenic, and admitted to the psychiatric hospitals of Monroe County for three 5-year periods. With this same population, the percentage of schizophrenic diagnoses by subclass was also determined (see figure 2). There are negligible percentages of patients diagnosed hebephrenic and simple, and the percentage diagnosed catatonic decreases. The slight increase of those diagnosed latent may be a function of this category's introduction as a subtype in DSM II (American Psychiatric Association 1968). The decrease in the schizoaffective diagnoses in the third 5-year period may reflect the increased diagnosis of manic-depressive illness following the greater use of lithium carbonate. However, the most striking changes are the increase of acute and chronic undifferentiated schizophrenia diagnoses and the decrease in the paranoid diagnosis.

These findings are very similar to those reported by Morrison (1974) and probably can be explained by the factors he noted. I am aware of only one study in which an increase in the diagnosis of hebephrenic schizophrenia was noted. It found a sudden sharp increase in the diagnosis of hebephrenia in 1971 and 1972 (Remar and Hagopian 1973). Research data were gathered from questionnaires mailed to 268 mental hospital administrators in the United States and Canada. Of 130 questionnaires returned, 112 gave appropriate information. Among the findings noted was a decrease in the diagnosis of catatonic schizophrenia for first admissions.

Table 5 (Guggenheim and Babigian 1974a) and figure 3 (Guggenheim and Babigian 1974b) illustrate clearly the differences between the diagnoses of first admission schizophrenia (1960–66) at three hospital facilities in Monroe County—the state hospital at the Rochester Psychiatric Center, the university hospital (Wing R of Strong Memorial Hospital, University of Rochester), and the community hospital at Monroe County Hospital. The greatest number of catatonic and hebephrenic patients were seen in the state hospital population, because most of the first admissions diagnosed catatonic and hebephrenic had been there for 20 years. The first admissions to the two other hospital units included no patients chronically ill and continuously hospitalized for long term periods of time.
Changes in the Observer

Interest in how clinicians reach diagnostic decisions led David Soskis (1972) to undertake a study aimed at determining: (1) How clinicians form a theory of the nature or cause of schizophrenia from the several competing and complementary perspectives. (2) Which areas of function and psychological signs are seen as most helpful in arriving at the diagnosis of schizophrenia. (3) What therapy or therapies current practicing clinicians find most useful in treating schizophrenia. (4) What
Table 5. Percentage of diagnoses of schizophrenic types on first, second, and third hospitalizations: 1960–66

<table>
<thead>
<tr>
<th>Cases</th>
<th>State hospital</th>
<th>University hospital</th>
<th>Community hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First admission (n = 873)</td>
<td>Second admission (n = 359)</td>
<td>Third admission (n = 253)</td>
</tr>
<tr>
<td>Catatonic</td>
<td>13.1</td>
<td>13.4</td>
<td>14.2</td>
</tr>
<tr>
<td>Hebephrenic</td>
<td>22.2</td>
<td>2.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Paranoid</td>
<td>49.3</td>
<td>44.7</td>
<td>45.8</td>
</tr>
<tr>
<td>Schizoaffective</td>
<td>3.1</td>
<td>16.7</td>
<td>16.2</td>
</tr>
<tr>
<td>Acute undifferentiated</td>
<td>0.1</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Chronic undifferentiated</td>
<td>6.2</td>
<td>18.1</td>
<td>16.6</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.0</td>
<td>3.8</td>
<td>4.7</td>
</tr>
<tr>
<td>Simple</td>
<td>3.0</td>
<td>1.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
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</tbody>
</table>

Clinicians’ beliefs are concerning the current course of untreated and treated schizophrenia.

A structured questionnaire was used to sample opinions among 132 Rochester area psychiatrists. Genetic, psychodynamic, and family learning perspectives were favored in that order by the respondents in assessing the nature of schizophrenia. Characteristic psychological signs were seen as the most important factor in diagnosing schizophrenia. Social problems and family history of schizophrenia were the other most frequently cited factors. Among 11 psychological signs stressed were associational difficulties, affective disturbance, autism, delusions, hallucinations, and paranoid thought. Antipsychotic drugs were rated as the most useful treatment. Untreated schizophrenia was viewed as having a serious and declining course which changed with appropriate treatment to episodic illness with stable, yet lowered, baseline.

Carlos Frias (1974) administered Soskis’s questionnaire to two groups of psychiatrists in Buenos Aires, Argentina, and found it to be a useful tool for the transcultural evaluation of attitudes and opinions of psychiatric clinicians with respect to the etiology, diagnosis, treatment, and prognosis of schizophrenia. In Buenos Aires, as in Soskis’s Rochester study, regardless of the psychiatrist’s theoretical position, antipsychotic drugs were favored. Frias also commented on the trend in Argentina to give greater diagnostic importance to hallucinations, delusions, ideas of influence, and paranoid ideation.

**Chronic Illness**

Over the years I have had experience in caring for and learning from chronically ill and acutely ill patients. For 26 years (1946–72) I conducted weekly teaching rounds at the Veterans’ Administration Hospital in Canandaigua, N.Y. Impressive to me were the major changes in the hospital patient population that occurred in that period. Let me quote from an earlier report (Romano 1973):

In 1946, 166 patients were admitted; in 1972, there were 1,813 patients admitted; in 1946, 163 patients were discharged; and in 1972, 1,909 patients were discharged. The earliest year in which the average length of stay was recorded was 1953, and in that year the average length of stay was 1,577 days; in 1972, it was 546 days. [p. 7]

A sobering note illustrating past patient hospital practice in caring for chronically ill patients is the following:

On February 6, 1973... the volunteers of the hospital arranged a special party for 22 male patients who had come to the hospital initially on February 6, 1933 and had remained in the hospital since then, that is, for a period of 40 years. The average mean age of the men is 78.5 years; the mode is 82 years;
the median is 79.5 years. The diagnosis of 20 of the 22 patients is that of schizophrenia. One patient was diagnosed central nervous system syphilis, and one 80-year-old man was, and still is, diagnosed as antisocial reaction! [Romano 1973, p. 7]

I learned that one of the main concerns of a hospital like the one in Canandaigua was the continuing care of a number of patients hospitalized for long periods. I always believed that there was much to be learned from this residual intramural population.

I asked myself, Who are they? What kind of men are they? Are their illnesses a different clinical type than the illnesses of patients who left the hospital? Were there differences in symptomatology or in psychopathology? Are there gross differences in communication, in terms of intelligible speech? What is their prespsychotic history? What levels of social competence had they attained before becoming sick? How old were they when they were admitted? Are there differences in genetic loading? Were there differences in their acceptance or rejection of the hospital, in the hospital's treatment modalities, or its personnel? Why had they been unable to leave? Was there no place for them to go? Was there a family into which they could be reintroduced? How did they expect the external world to identify them? Would they be labeled? Could they sense anything in the external world as satisfying as the hospital setting in which they were?

Most of the residential population at the Rochester Psychiatric Center also are long term, but today's policy is to discharge newly admitted patients as soon as possible after initial study and care, and to provide for necessary readmission.

Center Director, Dr. Russell Barton, provided me with the data shown in table 6 which illustrates changes over the years perhaps even more striking than those cited from the Veterans' Administration Hospital in Canandaigua:

In 1976, of the average daily resident population, about 1,200 of the 1,543 patients were long term, most likely more than 10 years. Of the 2,158 admissions, including transfers, 1,834 were short term and were hospitalized an average of 22 days. Two thousand of the 2,158 admissions were discharged during the year.

Admission and readmission practices are clearly illustrated in a sample month of April 1976, during which there were 173 admissions. Sixty-nine patients were readmissions who had been out for 60 days or longer; 37 patients were readmitted after being out less than 60 days; the remaining 67 patients were admitted for the first time, although most had been hospitalized elsewhere before admission.

However, in the past 6 years at the Center, as well as in the University General Hospital Psychiatric Unit, there has been a vigorous and consistent attempt to identify carefully the nature of the newly admitted patient's distress, that is, to become more precise in diagnosis; to engage the family as soon and as much as possible in the therapeutic program; to facilitate the patient's resocialization; to prescribe medication appropriate to the patient's needs; to try to understand the precipitating, provoking, or modifying life experiences that may have stressed the patient at the onset or recurrence of illness; and to avoid unnecessary lengthening of hospitalization.

I have noticed a considerable number of persons, other than psychiatrists, who assume responsibility for the daily care of the patient. These include psychologists, social workers, nurses, nurse-clinicians, and para-professionals, such as nursing assistants, mental health counselors, patient advocates, and others. Many assume

<table>
<thead>
<tr>
<th>Years</th>
<th>Daily average resident population</th>
<th>Admissions (transfers, etc.)</th>
<th>Discharges (including transfers, deaths, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1946</td>
<td>3,461</td>
<td>711</td>
<td>714</td>
</tr>
<tr>
<td>1956</td>
<td>3,712</td>
<td>1,446</td>
<td>1,517</td>
</tr>
<tr>
<td>1966</td>
<td>3,200</td>
<td>1,686</td>
<td>1,664</td>
</tr>
<tr>
<td>1976</td>
<td>1,543</td>
<td>2,158</td>
<td>2,578</td>
</tr>
</tbody>
</table>
In the chronic hospitals I have found that most of the elderly patients hospitalized for long periods of time are not those with senile dementia or other organic psychoses, but are schizophrenic patients who have lived longer than their predecessors and now have become quite old. This must be due to the reduction of the previous high mortality due to the several diarrheas, pneumonia, urinary infections, and tuberculosis.

In other ways, chronic hospitals are quite different from those I knew in the past. Then, many patients were occupied throughout the day in various work programs, all associated with the functions of the hospital. I remember being with patients in Milwaukee many years ago while they were working in hospital jobs and on the grounds. I have a vivid memory of the pride of Dr. Hans Hansen, manager of the Veterans' Hospital in Canandaigua (1946), and the work programs he had established for his patients. Each day, much like a men's work camp, patients would come or would be brought to their several assignments in hospital services, landscaping, flower and vegetable gardens, chicken and pig farms, etc.

I spent considerable time with Dr. Hansen and his patients while they were at work and was impressed with their feelings of satisfaction and dignity in being engaged in the work of the world of reality. Most of the men were long-term chronic schizophrenic patients. Today, because of the legal requirement to pay patients minimum hourly wages, which most hospitals cannot do because of insufficient funds, patients must remain idle and cannot occupy themselves in meaningful, purposeful, and necessary work.

The point was made clearly and eloquently by a 62-year-old white single woman whom I saw recently on one of my weekly teaching rounds. She had been hospitalized continuously for over 35 years, since she was 27. There was significant mental illness in the family. She had completed eight grades of school and had worked as a clerk in a store and in a factory before entering a convent at age 21. She was dismissed from the convent after 10 months and returned to live with her mother, whom she helped to keep house. During the succeeding 5 years she became increasingly psychotic, was hallucinated, became ever more suspicious and delusional, and had many ideas of influence. After a dramatic display of her deviant behavior, she was brought to the hospital where she has remained ever since. From time to time serious attempts were made to return her to her family, but the mother insisted her daughter was too much for her, and the patient preferred to return to the hospital. From the beginning she took part in hospital work, choosing the dining room, where she became a regular and responsible attendant. The patient resisted other attempts to interest her in vocational or recreational assignments and insisted on remaining in the dining room. Her mother died in 1973, and the patient attended the burial ceremony without incident. She is alone, and there are no others who are interested in her or who visit her. The hospital, especially the unit in which she lived, and most particularly the dining room in that unit, was her world. She spoke to me with tears and with indignation about having lost her job and how much she missed it. The hospital had insufficient funds to pay her the minimum hourly wage.

For the most part, in Rochester we have attempted to shield patients from the indignities suffered when they are discharged prematurely or without adequate community aftercare facilities. There is always the specter of the New York City "jungle" (Reich 1972) and other large urban areas, where long-institutionalized, chronic, psychotic patients, with either absent or negligible social skills, have been catapulted into the community without adequate means for their care. However, in spite of the fact that much of this has been avoided in Rochester, in numerous instances I have listened to patients—principally elderly, long hospitalized patients with no viable family support—pleading with me and their doctors and nurses not to discharge them from the hospital. A number have spent short periods in nursing homes from which they have been returned to the hospital because they were "too much trouble." The patients resist, believing the nursing homes and halfway houses are inadequate to care for them, but they miss most the presence of those who have cared for them for so many years. To many, the hospital has not only become their house, but quite literally their whole life. Their greatest fear is not death but abandonment.

I have learned more from the families into which the
patient has returned and realized at times how limited is our help to them in their care of the patient. Often, we have overemphasized the significance of the patient's medication to the neglect of the importance of emotional support and practical advice to the family.

There is little question that the person experiencing an acute psychotic episode today is in a much more advantageous position than he was 40 years ago. Even though an understanding of the basic causes and mechanisms of mental illness has not been achieved, progress has been made. Psychotic patients are better understood and society has become less distant and frightened. There are more competent psychiatrists in the private and public sectors intent on careful diagnosis. Psychiatric units in general hospitals are available now for emergency, first aid, and increasingly for more protracted study and outpatient care as well as inpatient care. In spite of the problems alluded to above, many patients live good lives outside of hospitals because of the intelligent and appropriate use of the psychoactive drugs and the early involvement of the family in supporting re-socialization.

One of the truly great changes has been the increased tolerance of both families and society in caring for and living with patients who are manifestly psychotic. It has enabled more patients to leave the hospital and to be free in the home and the community. But what price does one pay for the freedom of the patient? What of the freedom of the family now entrusted with the care of the psychotic patient in the home? Even when the family receives help from medical, judicial, legal, and social agencies, there are times when the burden is not only great, but fearful.

Freedom for Whom?

The following brief excerpt from a case history of a patient seen recently illustrates the point. The patient—a 33-year-old, white, unemployed husband and father of six living children—dates the onset of his distress to early 1973. His maternal grandmother had broken her leg, and his mother had died of cancer. After the birth of a sixth child, his wife had her gallbladder as well as her remaining ovarian tube removed. After he had signed the form giving consent for his wife's sterilization procedure, he became quite upset at the prospect of having no more children as he felt this had destroyed him. He thought that because he had signed the sterilization consent form, he too had been sterilized. Since the operation, he felt his wife had less vaginal lubrication, which made it difficult for them to have intercourse. He felt the doctors had put a tube in his wife's vagina and the tube, in turn, had been introduced into his penis, which had made him impotent. Eventually, he began to smell odors, the nature of which was impossible for him to describe. But the smells would be persuasive and would in fact drive him toward or away from that which he was to do, almost as if there was an invisible wall of smell he could not penetrate. At times the messages from the smell would be similar to the impressions he would get from his boss to hurry up at work. Some of the smells were unpleasant; some were vaginal smells. Smells had powers over him.

In some way the town banker was involved with the smells, and he told the banker to "quit it" because he had heard voices telling him that the banker had drugs in the bank. Later he heard voices—including the voice of the man who had sold him his house—telling him to "Change your sewer system," which he proceeded to do. He had peculiar tactile sensations. He felt houseflies in an envelope, and the vibrations told him not to throw it away. Upon picking up the mail, he could tell through smell and touch whether or not to open it. He was aware of other smells on his children's school papers. He heard voices saying, "We don't care," and he thought this meant that he should kill himself. He almost did this with his shotgun but stopped after he thought about leaving his wife and children alone. There was evidence of thought broadcasting, thought insertion, and somatic hallucinations, including the feeling of a hammer hitting him on his tailbone, rump, scrotum, and penis. He said he had trouble maintaining an erection and ejaculated quickly. He said there were wires in his nose and head with repetitive banging, almost like a heartbeat.

At his wife's urging, he was hospitalized on two occasions in a general hospital near his home in November 1973 and again in April 1974, each time for about a 10-day period. After treatment with Stelazine, he improved to some degree but about December 1974 stopped taking his medication. In April 1975 he was seen in the medical clinic of the university hospital, where he was treated for a minor skin rash. As his behavior was manifestly psychotic, he was admitted for the first time to the university hospital psychiatric service for a 3-week period. (This was his third hospital admission.) On my teaching rounds I saw him shortly after his admission, at which time I also interviewed his wife. He
responded favorably quite quickly to Haldol and to hospital milieu treatment, and his delusions diminished but did not disappear. To deal with some of their marital conflicts, he and his wife began couple psychotherapy, but this could not be continued because they lived far from the hospital. He was referred to a psychiatrist in his community but failed to follow through. In July 1975 on a return outpatient visit, he looked intent, shook one leg throughout much of the session, remained fixed in his delusion about the smells, and still believed that there was a tube in his penis. His wife corroborated the fact that he continued to act quite odd and at times had a fixed smile on his face. The patient, his wife, and usually the three youngest children were seen at 2-week intervals. Medication was changed to Navane, which he tolerated better. When the smells came back, the patient became quite suspicious of his wife, accused her of extramarital sexual activity, and when driving his car, looked back constantly, believing someone was following him. As he became more disturbed, his wife reluctantly agreed to have him return to the hospital. This was his fourth admission. He remained with us for another 3 weeks, and during this time he felt he had had a brain operation that had removed all of his senses, each of which was replaced intact except for his sense of smell.

In December 1975, on his outpatient visit return, he reported that he had been taking his medicine regularly, said he was no longer troubled by smells, but was worried because he had fewer erections. However, he no longer believed that something from within his wife was put inside him. He blamed his wife for his lack of potency. Because he felt less like a man, he wondered if he should divorce her; yet he felt that he would miss her and the children. He was pursuing plans for a job through reha-

2-week period, was the first on an involuntary basis. He was given to his wife through the county welfare social worker and through the psychiatrist who saw the patient. He was further concerned about the unpredictability of the family as an autocracy ruled by its sickest member. He became progressively less withdrawn and delusional after resuming his medication, and with improvement, he was discharged, with arrangements made again to introduce him into a vocational rehabilitation program. In December 1976 the patient started a job in automotive training 24 miles from his home. At that time, he was better and the children were doing well. Early in February 1977 the wife called again to say that the patient was becoming depressed and was not taking his medicine. She explained that he worried about his maternal grandfather's health and felt he was making both his grandparents worse.

The patient has had five hospital admissions since November 1973, each for a period of less than 30 days. Although he lives some distance from the hospital, he returns, albeit reluctantly, with his wife and three youngest children for periodic visits. At the urging of his wife and the psychiatrist, he does take the medication, but at times suddenly stops taking it.

He remains unemployed, although efforts are repeti-
tively made to engage him in a rehabilitation program leading to a semi-skilled job. He, his wife, and six children are supported totally by county welfare funds. The oldest son, age 10, because of past temper tantrums, was seen by a school psychologist. The family is visited regularly by a county welfare office social worker, who communicates with us about the state of the family. The social worker and those of us in the hospital are continuously concerned about the unpredictability of the patient and the possibility of his injuring himself, his wife, or his children. The wife is hesitant to initiate movement toward hospitalization because of his threats to kill her if she persists in hospitalizing him.

The wife is clearly tyrannized by the patient's threats to harm her and the children should she arrange for emergency hospitalization without his consent. She is aware that she can call the police, who would respond to her call and make a decision whether they believe the patient is sufficiently sick or disturbed to be brought to the nearest county mental health facility. Up to the present time the wife has been reluctant to do this. She has also refused to initiate any involuntary hospitalization through court order of the Town Justice. She has a good relationship with the county welfare social worker and through her could also take legal measures to arrange for involuntary detention of her husband.

One can readily appreciate the wisdom of the remark made so many years ago by C. Macfie Campbell, defining the family as an autocracy ruled by its sickest member.
Conclusion

Ten years ago, on the occasion of the First Rochester International Conference on Schizophrenia, I said, "The magnitude of the prevalence of schizophrenia, the lack of agreement about its diagnosis and course, the multiple conjectures about its origins, all attest to the fact that it constitutes modern psychiatry's greatest challenge" (Romano 1967, p. 1). At the Second Rochester International Conference on Schizophrenia, I said, "We are encouraged to learn that in the past decade there appears to be an increased world-wide interest in and support of the investigation of the schizophrenic patient and his family. This is shown by the number of published scientific papers and monographs, the international studies of diagnosis and course, the development of new methods of biologic research, and the frequent convening of interested groups in assemblies and conferences" (Romano 1976).

Let me compare my impressions and beliefs today with those I held earlier at the end of my resident period in 1938:

• I am more convinced than ever that the mental illness we call schizophrenia exists, that it is not a myth, and that it manifests itself in different ways.

• I believe that schizophrenic illnesses today are milder and that one rarely sees patients experiencing an acute unremitting catastrophic course. Hebephrenic and catatonic subtypes occur less often, but some of this behavior may be included in the designated subtypes of acute and chronic undifferentiated schizophrenia. One sees more patients with phasic psychotic episodes with greater affective components. These vary in duration, with improvement in many instances to good social competence.

• No single or specific cause of schizophrenia has been ascertained. More workers in the field support the multifactorial view that genetic, biologic, familial, social, psychologic, and cultural factors contribute to cause in varying degrees and in varying instances. We find fewer persons who support the exclusive polar extremities of the biophobe and psychophobe.

• At times the illness may be ushered in by physical illness and/or by psychological stresses, particularly those that diminish the esteem and confidence of the person. At other times the illness may appear suddenly, without notice, even in persons considered healthy. I am not certain of any firm identifiable prepsychotic personality or character type.

• I have not been impressed with any consistent evidence of neurological or endocrine disabilities in the patients whom I have studied.

• I believe now that genetic factors are necessary but neither exclusive nor sufficient to cause schizophrenia; similarly I believe that environmental factors are necessary but neither exclusive nor sufficient.

• I am more impressed with the evidence of health as well as of sickness in the patients for whom I have cared over the years.

• Rarely do I find the messages of my patients incomprehensible.

• The use of the psychoactive drugs has brought about a remarkable change in the behavior, signs, symptoms, and course of the patient. At times the drugs are used unwisely, in dosages which are either too small or too large, by many psychiatrists with limited knowledge of pharmacology.

• Today, for several reasons—including greater tolerance of social deviance, the use of psychoactive drugs, and the movement toward resocialization of patients—there are more schizophrenic patients outside the hospital participating, with varying degrees of social competence, in community life.

• I have not found social class and occupational criteria to be significant determinants of cause, as in most instances these can be attributed to downward social drift.

• I believe the earlier psychoanalytic studies of chronic patients have led to more sophisticated and systematic studies of adverse emotional influences in the family, with particular reference to confused, contradictory communications within the family, richly explored by my colleague Lyman Wynne (1971).

• Thanks to the psychological investigation of schizophrenic patients and their families, the patients have become more understandable, more human, and we in turn have become less frightened and more able to relate to them and to their families in a helping manner.

• I agree that if we wish to achieve reliability in grouping homogeneous populations for study the diagnosis of schizophrenia must include evidence of at least one of the following: delusions, hallucinations, or formal thought disorder at some time during the illness of the patient. I would add that the dimensional diagnostic
model has provided data of individual differences between psychotic patients.

- I have thought that the "labeling" theory is not only mistaken, but a bit absurd, and believe that Jane Murphy’s (1976) recent report of her studies of the Eskimo and Yoruba groups supports my view.

- With the use of hospital treatment during periods of acute distress, the judicious use of the psychoactive drugs, and the increasing psychological sophistication of those who care for schizophrenic patients and their families, it is gratifying to learn how many more can live lives outside of institutions. However, at times we are insensitive to the needs of those who care for patients in the community—the family and other caretakers—and we have not helped them as they deserve.

- For years I have held in high regard the sustained high-level research of Zubin (1975) and Shakow (1962) in their experimental laboratory studies of schizophrenic patients. However, when one examines the current scene, one realizes how little these laboratory studies have influenced or modified the daily practice of the treatment of the schizophrenic patient and his family. Cromwell (1975) summarized the results of these experimental laboratory studies and listed the schizophrenia-related deficits to be those concerning reaction time, size estimation, illusion, galvanic skin response, heart rate, and language. It may be that one day the results of these studies will become more important and useful in helping us identify the differences between groups of schizophrenic patients, so that, as a result, we can devise either drugs or psychotherapeutic means to correct whatever deficiencies the patients may exhibit, whether they be those relating to attention, thinking, or socialization. Perhaps most of the current notions which support biochemical theories of schizophrenia will be less useful in the future. As Matthesse and Lipinski (1975) have indicated, most of the theories have not proven to be very good, with the possible exception of the dopamine hypothesis, from which more appropriate medication could be derived. I believe the factors which have been most significant in influencing the present-day practices of psychiatrists who treat schizophrenic patients and their families have been derived principally from clinical observation and study. These would include studies of the society—e.g., the social structure of the hospital; the confirmation of the effectiveness of the neuroleptic drugs; improved psychological understanding of the patient and his family; and social and political measures to promote resocialization of the hospitalized patient.

- For several reasons I would predict that in this last quarter of the century we shall be increasingly concerned with psychosis rather than neurosis, which occupied our major attention in the middle third of the century. This will lead to expanding research into the biologic as well as the psychologic and social aspects of the psychotic patient and his family; it will influence considerably the nature of the professional preparation of tomorrow’s psychiatrists and will emphasize and reinforce the major function of the psychiatrist, and one unique to him, which is to serve as a crucial bridge between genetics, biology, and clinical medicine, on the one hand, and behavioral sciences on the other (Romano, in press).

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