The Future of Psychiatry

A. Hoffer, M.D., Ph.D.

Recently, in an orthodox medical journal, the question was discussed whether psychiatrists were still going to be needed. Basically, modern psychiatrists have two main treatment functions: they prescribe drugs - tranquilizers or antidepressants; and they may also do psychotherapy or counselling. It was suggested that general practitioners are just as capable of prescribing drugs, and that psychologists and counsellors are perhaps even more capable of doing psychotherapy and counselling. In other words, the family physicians could initiate the medical regimen, and the psychologists could take over the counselling function.

This was not a very radical idea as it has been happening for many decades. Psychiatrists themselves have started deserting the really seriously ill–the schizophrenics, the senile states, the personality disorders–and have devoted themselves more and more to the more benign forms of disease such as depression and mild anxiety conditions. And general practitioners have become more and more skillful at treating seriously ill psychiatric diseases. I know many physicians (MDs, osteopaths, naturopaths, chiropractors) who practice orthomolecular medicine, and who have a much higher cure rate when treating schizophrenics than do the psychiatrists in their area who work only with drugs. In Saskatchewan many years ago, a family physician was so effective local psychiatrists complained about him. Later he lost his license to practise medicine.

Over the past 100 years, psychiatric conditions that were treated almost exclusively in mental hospitals have disappeared from psychiatry because they were treated successfully by general practitioners. In a book on psychiatry written about 1900, the four differential diagnoses for psychosis were pellagra, scurvy, general paresis of the insane and dementia praecox. The treatment for pellagra was dietary until niacin was recognized to be vitamin B_3 in about 1935. Pellagra has disappeared; at one time it made up as much as one-third of all admissions to mental hospitals in the southern U.S.A. It became the province of the early pellagrologists. But they were no longer needed when synthetic vitamin B3 became available and was added to white flour in the U.S.A. and Canada. Most psychiatrists today would not recognize it if a patient with pellagra walked into their office. Scurvy severe enough to cause psychosis is no longer present. Syphilis responded to the physician and the needle, and is rarely found in mental hospitals.

But dementia praecox, the disease, did not disappear. It was simply renamed schizophrenia, and has remained the major problem for psychiatry. Freud recognized that psychoanalysis would have a short career, only until the physicians with their syringe (drugs) came along. Freud knew nothing about nutrition and nutrients when he practised.

The process of breaking the broad group of the schizophrenias into unitary syndromes still goes on. Arising from our work in Saskatchewan in 1960, Carl C. Pfeiffer was able to divide schizophrenias into three broad groups: those excreting krytopyrrole, the high histamine group, and the low histamine group. Each group requires a different treatment plan, and when they are followed the results are very good. He recognized a fourth large group, the cerebral allergies. But orthodox psychiatry is not aware of this useful subdivision and looks upon each schizophrenic as a member of the same class,–a

class for which the only treatment is to be tranquilized.

If modern psychiatry did its job effectively, there would be no need to consider replacing them with their more biochemically oriented colleagues. The results of modern drug treatment are not very good compared to what was obtained before the tranquilizers were introduced. Thus, at a symposium held in Vancouver in the fall of 1995 sponsored by the Canadian Psychiatric Association, Dr. Alan Brier, Chief, Unit of Pathophysiology and Treatment, Experimental Therapeutics Branch, National Institute of Mental Health, Bethesda, Maryland, is quoted as saying, "Eighty-five percent of all people with schizophrenia who are treated with neuroleptic drugs are deriving suboptimal benefits. So it is clear that new and better drugs are needed". He should have said, more appropriately, that we need better treatment. Orthomolecular treatment is not new, but it is an awful lot better than merely allowing patients to vegetate on tranquilizers.

A fifty percent response rate is pretty good if there are no other treatments which yield a better outcome. In fact, in 1850, Dr. J. Conolly in England reported that fifty percent of his insane patients were discharged well. The early mental hospitals in the northeastern U.S.A. reported similarly good results. What did they use? Good food, shelter, sympathetic care, and respect. This fifty percent is probably the natural recovery rate if our schizophrenic patients were treated with the same sympathetic care, good nutritious food and decent shelter (not the city streets).

Modern psychiatry, with the huge expenditure of money for drugs, has in 150 years gone down to a 15% recovery rate. Yet its practitioners seem to be content with this very dismal response rate while they wait for the miracle,–the drugs which will cure their patients. Each year we hear the announcement of new, ever more expensive drugs, with little evidence they have any major impact on the problem as a whole. I don't see reports that the schizophrenic homeless are no longer homeless, or that the suicide rate among young schizophrenic patients has gone down.

Recently, on Canada's news channel, Pamela Wallin discussed schizophrenia. For the first fifteen minutes a couple spoke about their schizophrenic son, still ill. For the next fifteen minutes the Honorable Michael Wilson, formerly Minister of Finance, described his son's illness culminating in his suicide. The first half hour, then, was devoted to demonstrating the failure of modern psychiatry. The third fifteen minute section was given to a modern psychiatrist who seemed quite cheerful with the present treatment of schizophrenia. He gave a good account of the nature of the illness, but was pleased with the tranquilizers and was cheerfully hoping for that ever new, better tranquilizer. It appeared to me that he had not seen the first half hour of this program. The last fifteen minutes was given to a schizophrenic patient who appeared well, and who created and edits a journal for schizophrenics. It is a good journal to which I have made several contributions which have been accepted, indicating a degree of broad-mindedness which does not exist in standard psychiatric journals. This TV production typifies the state of schizophrenia treatment today: tranquilize, be content, wait for the new, ever-better tranquilizer.

But how long can patients wait? A year in the life of a schizophrenic can be like an eternity. Patients and their families do not have the luxury of waiting for the day when psychiatry will at last start treating their patients properly. It does not provide much solace to the Wilsons and other parents who have lost their children to suicide. (The suicide rate for

schizophrenia is about 25 times that of the general population).

In sharp contrast, at the 25th anniversary conference of the Canadian Schizophrenia Foundation, held in Vancouver in May 1996, two chronic schizophrenic patients, who met and married after they had recovered, described their own illness and their recovery on the orthomolecular program. They had both failed to respond to previous modern psychiatric treatment.

Modern psychiatry has not been very good at treating schizophrenia. One need only glance over at the homeless people who live in the our city centers for the evidence. Is there any other disease, other than addictions, where so many sufferers are forced to wind up in the streets for lack of proper medical attention? Think what would happen if half the homeless suffered from tuberculosis. Tuberculosis is contagious, but in a social sense so is schizophrenia. In my opinion, many patients today are no better off than they would have been in 1950 when they were incarcerated in hopelessly overcrowded dungeons called hospitals. Perhaps they would have been better off then, for at least they had a few nurses and doctors to look after them.

Today patients are released early, after a short stay in hospital in order to start them on tranquilizers. They are discharged as soon as their major symptoms are partially suppressed, but long before they have regained enough health to permit them to live on their own, or with their families. Or, and this is becoming more frequent, their diagnosis is changed from schizophrenia to personality disorder, and they are discharged with the unhelpful advice that personality disorders can not be treated.

The reason why modern psychiatry has failed is that it has such a narrow vision of what to do. All psychiatry knows is to use tranquilizers, waiting for that distant day when they will have a drug, the Holy Grail, which will cure schizophrenia. I do not know of a single xenobiotic chemical that has ever cured anything, even though some of them are useful in ameliorating the discomfort of the disease. The answer to schizophrenia will come from recognizing more clearly its causes and biochemistry and dealing with them, as is done in orthomolecular psychiatry.

Modern tranquilizer psychiatry has been struggling for the past forty years with the tranquilizer dilemma, which they are aware of but have not clearly faced. Very simply it is this: when one uses a tranquilizer, one converts one psychosis, schizophrenia, into another, the tranquilizer psychosis. I believe it was Dr. Mayer-Gross who first suggested, in about 1955, that tranquilizers converted one psychosis into another.

Tranquilizers alleviate many of the symptoms of schizophrenia, and make life more comfortable for the patient and for their families, as well as for the hospital and its staff. As the patient begins to recover, s/he becomes more normal. However, tranquilizers also make normal people psychotic–a fact proven by the Soviet practice of committing dissidents to mental hospitals and giving them tranquilizers. Therefore, we can assume that as treatment continues the patient becomes less and less schizophrenic, and more and more psychotic from the drugs.

The tranquilizer psychosis is characterized by the following features: fewer and less intense hallucinations, fewer and less intense delusions, difficulty in concentration, memory disturbances, indifference, increased self interest, moderation of moods and less agitation, social and behavioral deterioration, and physical side effects such as impotence, tardive dyskinesia, apathy, sluggishness, obesity, deterioration of teeth from lack of saliva. And perhaps most important of all, the inability to engage in productive

labor, i.e. to pay income tax. That is why the average schizophrenic patient will cost the community $2 million over a forty year life span of disease, unless they are treated properly and become well.

Patients prefer to be normal, i.e. they do not prefer the tranquilizer psychosis over the schizophrenic psychosis, but they have no choice and have to accept elements of the tranquilizer psychosis in order to be freed of elements of their original psychosis. The modern solution is to keep them swinging between the extremes of schizophrenia and the tranquilizer psychosis. As they become more and more tranquilized, the dose of drug is decreased to try and halt this process, or the drug will be discontinued. In most cases the original schizophrenia returns. They are suspended in this uncertain world swinging between the two psychoses. They can not escape, and the only choice for these unhappy patients is to take to the streets where they can avoid taking the drugs.

But with orthomolecular treatment patients are offered a real choice, the choice of becoming and remaining well. The large doses of nutrients and the diet will maintain the patient in good health. One can combine the rapid effect of the drugs with the slow curative effect of the nutrients. As the patient begins to recover one slowly reduces the dose of the drugs, and this time instead of become psychotic from the drug they remain well as the nutrients take over.

There is no other answer to this tranquilizer dilemma. This is why acute patients treated for at least one year will reach a 90% recovery rate. By recovery I mean that they are free of signs and symptoms, they are getting along reasonably well with their family and with the community and they pay income tax. They are working, or they are graduating and getting ready to work.

I know of 17 young men and women who became schizophrenic in their teens, were treated properly, recovered, went to college, became doctors and psychiatrists and are practising. A few years ago the father of one of them, a physician, was concerned about his son. His son had been offered an appointment as Chair of a large department in a medical school. His father wanted to know if I thought it might be too stressful for him.

Patients pay income tax because they are well enough to work. I challenge orthodox psychiatric to show me any cohort of patients who have been treated with tranquilizers alone of whom even ten percent are gainfully employed in responsible jobs.

Since modern psychiatry has failed its essential task of curing schizophrenics (in the same sense that insulin and diet cures diabetes mellitus), since modern general practitioners can give tranquilizers as skillfully as psychiatrists, and since counselling and psychotherapy can be given even more effectively by psychologists and social workers and nurses, does it not make sense to replace psychiatry with more efficient health workers? Psychiatry should be allowed to practice only if it is prepared to use the most advanced treatments, and can show that it can do a better job than could other physicians.