PSYCHOPHARMACOLOGY AT CHESTNUT LODGE:AN HISTORICAL PERSPECTIVE

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Chestnut Lodge celebrated its eighty-first birthday this year. It is an institution with a complex and interesting history, a piece of which I would like to explore today. I begin with the words of Frederick Bram, a psychiatrist who worked at the Lodge in the early and mid sixties. At a conference in 1965[1] he said the following:

"I'm not at all sure that fifty years from now the Lodge will exist. I'm not certain that we, who will be the ancestors of that time, will even be able to recognize what it will have become if it does exist. But I can envision that at that time an historian of world psychiatry might try to evaluate [the Lodge's] significance within the larger scope of things. Of necessity he would wonder about the justification of so many devoted to the treatment of but a few in a time when mental instability was a major national problem and the beds in the hospitals were mainly filled with the emotionally disturbed--especially when our statistical claims are, after all, very modest. Perhaps he would see us as a grand beau geste, a gesture to mankind during an era when there was but scant attention to the tolling of the bells and, if he did so, the ghost of me, at least, would not snicker. However, our historian, with the sophistication I attribute to him, would not let us be simply palmed off on history as more humanitarian than the rest. I think he would see us as professionals trying to do a professional job that might best be viewed as an experiment."

Well here we sit, about halfway into Dr. Bram's fifty years. Our presence here today is indisputable evidence that the Lodge still exists. It remains an institution where many are devoted to the intensive treatment of relatively few, and mental illness, as it was in 1965, is still a major national problem. What has changed? It seems to me that any historian of psychiatry would identify the so-called "biological revolution" as having had the most profound influence on the field during the last quarter century. For better or worse this has been the era of the brain in psychiatry, and while we are far from any cures, it is indisputably true that in a relatively brief period of time we have witnessed an enormous surge in activity and progress in the neurosciences as they relate to our understanding of the etiology and pathophysiology of mental illnesses. The watershed event that catalyzed the subsequent developments was the introduction of the psychotropic medications in the mid fifties. Chestnut Lodge, like the rest of the world, had to find a comfortable way to assimilate these medications into its treatment armamentarium. There are few if any subjects that have been as fiercely debated at the Lodge as the place that the psychotropics may or may not have in the treatment of mental illness. And with the publicity surrounding the Osheroff case in recent years the Lodge has somewhat unwittingly found itself thrust into the center of a national debate on this issue. The latest critics of the Lodge in regard to the Osheroff case cannot claim the distinction of originality in their condemnatory attacks. The Lodge has long endured the charge from at least a segment of the psychiatric community that the hospital has too stubbornly clung to its cherished psychoanalytic notions while refusing to admit new and important discoveries in the field, especially the biological discoveries just mentioned. I'll never forget when I told one of the professors in my residency program that I was leaving Georgetown to continue my training at the Lodge. She wished me luck but then quipped

that what I would learn there would be about as valuable as learning how to ride dinosaurs. Fortunately I ignored her. Whatever combination of truth and distorted mythology it is that motivates such comments, I do think it is safe to say that the Lodge accomplished the process of assimilating the psychotropic medications with a greater struggle than did many other institutions. What I want to do in my presentation today is to take a closer look at this struggle, as it unfolded over the course of the history of the Lodge. I will restrict my discussion of this issue as it relates to the treatment of schizophrenia, first because historically the Lodge saw as its mission the study and treatment of this disorder, and secondly , as will become clear, the greatest medication controversies arose vis a vis the schizophrenic patients. My sources of information in this study were many. First of all, I studied a portion of the Chestnut Lodge archives, which contain enormous amounts of rich material dating back to the opening of the hospital. I also spoke with several Lodge staff members whose experience here is much more extensive than my own. Specifically, I am grateful to Bob Cohen, Bob Gruber, Tom McGlashan, David Feinsilver and the late John Fort, all of whom were kind enough to share their personal reminiscences and impressions with me. And of course I trust that my own four and a half years at the Lodge left me with some measure of wisdom about the heart and soul of the work that is done on a daily basis with patients here. Finally, I hope that I can meet Dr. Bram's challenge at least in part. That is, after reviewing this aspect of the hospital's history I will move from this one institution to some more general comments that might place the Lodge into the larger scope of things.

Chestnut Lodge was founded by Ernest Bullard in 1910 as a rest cure asylum for the mentally ill. It wasn't until the 1930's when Ernest's son Dexter, Sr. took over the medical directorship that the hospital began an experiment, that is the attempt to apply the relatively new discoveries of psychoanalysis to the treatment of psychotic illnesses. To be sure, this experiment would not have gotten much support from the founder of psychoanalysis, since Freud was convinced that the psychoses were inaccessible to analytic treatment. "We understand them well enough," he said, "to know the point at which the levers should be applied, but they would not be able to move the weight." In an oft-quoted passage which is quite relevant to our topic today, he went on to say: "It is here indeed that hope for the future lies: the possibility that our knowledge of the operation of the hormones may give us the means of combating the quantitative factors of the illnesses. But we are far from that today." Clearly, Freud was predicting the development of biological psychiatry. Freud's pessimism notwithstanding, the early pioneers at the Lodge forged ahead. Dexter Bullard, Sr. had a remarkable knack for selecting a bright and varied group of psychiatrists to work at his hospital and for creating a stimulating and tolerant intellectual milieu in which these individuals could exchange and develop their ideas. About 175 psychiatrists and psychologists have spent varying periods of their professional lives at the Lodge. Some achieved national or international recognition for the work they did here, such as Frieda Fromm-Reichmann, Otto Will, Harold Searles, Ping-Nie Pao and others. Harry Stack Sullivan, who never actually worked at the Lodge, held weekly conferences here between 1942 and 1946. Sullivan's theories rested on a basic premise-his so called one genus hypothesis. At once obvious and elegantly profound this hypothesis states: "We shall assume that everyone is much more simply human than otherwise." That is, no matter how foreign or bizarre the schizophrenic patient may appear to us, it is taken as a given that that person <u>can and must</u> be understood in the same terms in which we understand ourselves.

Chestnut Lodge had established its niche in American psychiatry by the 1940's and 50's. It was beginning to be regarded as a place of last resort for those most severely disturbed patients who did not respond to the prevailing treatments of the time, such as electroconvulsive therapy, insulin coma, sedation or simple asylum. The Lodge was a hospital among several others, such as Sheppard Pratt and Menningers which offered a different kind of treatment for such patients---intensive psychoanalytically oriented psychotherapy. In 1955, the introduction of the antipsychotic medications, beginning with Thorazine, was greeted with hope and enthusiasm throughout the world. While it soon became clear that these medications did not represent a cure, they certainly did produce significant improvements in some of the more florid psychotic symptoms of many schizophrenic patients.

As might have been expected, an institution like the Lodge, which saw as its mission the elucidation of the psychodynamic complexities of the schizophrenic illness, greeted the introduction of the phenothiazines with a mixture of apprehension and skepticism. Bob Cohen has remarked : "The employment of a new therapeutic modality widely hailed as the remedy for a biological disease was bound to cause serious problems at [the Lodge]." "When I arrived at the Lodge," said one psychiatrist at a conference in 1961, "I was as much against ataractic drugs as I was against sin!" He was somewhat chagrined to admit, however, that his reaction to the drugs was, as he put it, "uncontaminated by clinical experience!" and was a product instead of what he had heard from others about them. Some psychiatrists didn't want to believe the medications had anything to offer, and chose to see them as one more in a series of psychiatric fads, like the "shock craze" of the thirties and early forties, when the dramatic claims of the efficacy of ECT turned out to be wildy exaggerated. But the effects on the positive symptoms of schizophrenia could not long be denied by even the most cynical observers. What, then, were the Lodge therapists to do with these new substances that in a single stroke eliminated some of the bizarre psychotic symptoms, which they were sure were the result of interpersonal difficulties and intrapsychic conflict? How was the hospital to retain its sense of purpose? My impression is that early on there was a sense that to acknowledge that the psychotropics had a genuine salutary effect on schizophrenic symptomatology would be tantamount to abandoning the core philosophy by which the hospital operated. One psychiatrist boldly proposed a kind of "credo" by which he felt the hospital should abide: "We believe that psychosis, psychotic symptoms and mental illness are a product of past relations with people, that they are understandable in terms of the past relations, and that they are available to change in terms of future relations." Many of the early Lodge therapists, I think, were too rigid and dogmatic in their insistence that such a credo represented a complete etiological explanation of mental illness as well as a clear prescription for its treatment and that this rigidity resulted in their stubborn refusal to admit medications into the treatment regimen of their patients. However, as I read through the archival material, what also came through was that at least for a subset of the medical staff, the initial revulsion to the medications gave way to a commitment to learn something about them, but with the important condition that they be examined within the hospital's own context and area of expertise, --the interpersonal, psychoanalytic framework. A group of six or seven psychiatrists did in fact meet for a series of seminars in the early sixties with the task of examining the treatment of a number of patients at the Lodge, with specific attention to the way in which the pharmacological treatment they were receiving effected various aspects of the psychotherapeutic relationship. The discussions were informal and free-wheeling and while there was a call for the

group to pull together a more systematic formulation of their findings, as far as I know this was never done. It appears that the seminar gradually disbanded as the members began to feel the pressure of clinical and personal responsibilities.

The sixties and seventies were a time of very active debate about medications, in formal and informal settings. Mostly the discussions occurred in case conferences. David Feinsilver, who has been at the Lodge for some twenty years, has characterized the typical kind of controversy as follows : "The question of using medication usually arose in a case conference, [and usually involved] a regressed schizophrenic patient. The issue would ... be introduced by someone peripherally related to the treatment of the patient, [but] never by the therapist. The discussion around this would quickly polarize into extreme opposing [camps] , each claiming, often in irrational, chaotic terms [that their way was] vitally necessary as the only... right way to treat the patient, each side usually basing its argument on proper moral and ethical considerations. [This would] often lead to each party threatening to resign from the treatment unless his way was followed." While this description is probably somewhat caricatured, it certainly captures the degree of heat that was generated by the medication question.

But why all the heat? What was fueling the fire? There are many ways of interpreting the data, but I detected three major themes that ran through the records. The first theme of controversy was the issue of competition and/or envy aroused in the therapists by the use of medications. In other words, sometimes therapists were concerned that the drugs were doing more for the patients than they, the therapists, were doing. It must be recalled that the patient population at the Lodge, especially in those years was quite chronic and profoundly disturbed. If psychotherapeutic efforts were going to be effective then it would certainly take a long time and there would likely be periods during which therapists would experience feelings of discouragement and hopelessness. But this very hopelessness was considered an important part of the therapy , a reflection of some issue in the transference/countertransference axis which had to be worked through. The suggestion that there was a chemical substance that would in some way provide a "short-cut" in the working through process, or that would make such a process unnecessary was alien and threatening to the theoretical principles of intensive psychotherapy.

The second theme of controversy was this: in those cases where drugs were to be used, who would prescribe them and who would be in charge of the changes and adjustments in dosage and type of medication? In order to understand this aspect of the medication question it must be recalled that the Lodge has for years used the model of the therapist-administrator split in the management of patients. In other words, at the time of admission each patient is assigned two psychiatrists. One of them, the administrator or ward director, is responsible for managing the day to day details of the patients' treatment, such as privileges, activities, and medications. This leaves the therapist free to work on psychological issues in therapy. While it has always been the administrator who writes the orders for medications, there has been a gradual shift over the past thirty years in the staff's attitudes and expectations about who is really in the "pharmacological driver's seat." In other words, in the 1960's it would have been almost inconceivable for a patient to be placed on medication without the therapist being consulted and usually giving his or her blessing to the undertaking. Probably by the mid to late seventies and certainly into the eighties, the administrators began to act more independently and assertively when they believed that a

medication trial or adjustment was indicated. While the ideal may still be that all members of the treatment team be involved in any change in a patient's treatment, in practice the therapist is not always informed or consulted when pharmacological decisions are made. There are many reasons for this, many having to do with the exigencies of modern psychiatric practice, which too often seem to be imposed on us by legal and financial pressures.

Finally there is the question of the so called therapeutic regression. That is, is there a value to some period of unmedicated regression in the long-term treatment of some schizophrenic patients? Gunderson has said of this question: "Perhaps more than any other topic in the area of psychotherapy of schizophrenia, `regression' has come to be charged with affect and disagreement. Signals of the extent of these feelings can be seen in the rhetoric used by the opposing camps to describe each other's treatment. Treatment that takes active measures to oppose regression is described as `manipulative' and `inhuman.'... Treatment that is permissive of regression is described by its enemies as `infantalizing' and `outdated.'" The controversy around this issue at the Lodge had all the qualities that Gunderson describes. For many years the standard Lodge procedure was to withdraw newly admitted schizophrenic patients from all medications for a period ranging from a few weeks to a year or more. Often a psychotic regression would ensue and therapists would attempt to work psychotherapeutically with patients during such regressions. Many therapists felt that this intensive period was invaluable in the overall course of the therapy, as it allowed a special kind of primitive relatedness to develop which enriched the subsequent work after medication was reinstituted. Feinsilver and Yates, for example, in a retrospective study of the treatment of 36 patients at Chestnut Lodge cautiously suggested that some chronic, treatment resistant schizophrenic patients may show new signs of improvement when they are remedicated after a prolonged unmedicated regressive phase. They hypothesized that this improvement correlates with the patient's progression in a "primitive psychotherapeutic relatedness" during the unmedicated phase. The value of their conclusions may never be fully clarified. Nowadays, rarely if ever do schizophrenic patients get withdrawn from all medications at the Lodge or anywhere else for that matter. At least that is true in this country--Interestingly, when I discussed this issue with an Italian psychiatrist who visited the Lodge last year, he told me that the practice of working psychotherapeutically with unmedicated schizophrenics is still alive and well in his clinic in Italy. He was surprised to learn that this was not standard practice at the Lodge now. John Fort, who had extensive experience with both unmedicated and medicated schizophrenics, remained mixed in his opinion about the matter until the end of his life. He said "In 1976 I wrote cautiously of the possible value of a period of regression in the treatment of newly admitted patients who had had many years of treatment with antipsychotic medications with poor results. A period off medication seemed to promote a `clearing' of the system and a realignment of forces in the patient's inner psychological structure...This theoretical position still has its appeal, but so much was lost and the journey back to reality was so fraught with peril that we are less inclined today to allow this to happen with most patients. There are some, however, who cry out for an approach in which, at least for a prescribed period of time, medication is not used."

In 1984, a "drug committee" was established at the Lodge. This committee was composed of several senior staff members and was created "to delineate [the staff's] prevailing views concerning the compatibility of psychotropic medication with intensive

psychoanalytically oriented psychotherapy, [and] to suggest studies which might settle [unresolved issues]...concerning the specific effects of drugs on the psychotherapeutic process." All members of the medical staff were interviewed, and their experiences with well over one hundred patients were discussed. The interviews were informal and there were no statistics compiled regarding the results of the interviews. Every psychiatrist believed that almost all patients should have some drug-free period, but it was also generally felt that the optimal timing and duration of such a period was not clear. There was little disagreement that the psychotropic medications usually contributed to improvement in chronic schizophrenia, although there was less general agreement on the effect medications had on the psychotherapeutic process. One group of therapists felt that medications were compatible with and in fact enhanced the psychotherapy. Another group had some reservations. This group expressed the conviction that recovery without psychotropic medications was in some way superior to recovery with medication. The tenor of the discussions regarding the issue of regression was much the same as and included many of the arguments which I have already described.

I don't know what a 1991 survey of Lodge staff would reveal regarding attitudes about psychotropic medications in schizophrenia. I can only make educated guesses. The facts about current drug utilization at Chestnut Lodge are clear. The hospital probably uses as much and as varied a selection of medications today as any other modern hospital, and the psychopharmacology is state of the art. The Lodge, for example, was one of several institutions in this area that participated in the clinical trials of Clozapine before it became generally available. The rumors that still seem prevalent in some segments of the community that allege that the hospital does not use psychotropics are at this point pure mythology. A survey today would probably show that all members of the current staff believe that medications are appropriate in the vast majority of schizophrenic patients. However, I think there would still be considerable diversity of opinion regarding the effect these medications have on the psychotherapeutic process. I think some would like more flexibility to try selected patients off medications for some period of time during their treatment, but this is rarely if ever done these days.

That brings us to the present. I have presented an outline of the history of psychopharmacology at Chestnut Lodge, which by necessity is a condensation of an enormous amount of material and which illustrates the issues in very broad strokes. Nevertheless, I hope I have portrayed some sense of the character of and the forces that contributed to this history. But any historical study is of limited value unless some attempt is made to place the subject of the study into a larger context, in this case the history and present state of psychiatry as a whole.

Today, we in the mental health field are faced with the reality of less time and fewer resources with which to treat the sickest patients. Until relatively recently, the Lodge had the luxury of time as it pursued its goal of reaching the person suffering from the disease. Trends these days are in the direction of shorter and shorter lengths of stay--even at Chestnut Lodge. Managed care is a fact of life for us all. Whenever we admit a patient to the hospital now, we can be sure to receive a call from our friendly managed care representative, asking for a discharge date practically before the admission note is in the chart. I recently had the experience of treating a young man at Suburban Hospital who was going through a first psychotic

breakdown. After ten days of hospitalization, his HMO told me that if he was not yet ready for discharge then he was obviously not amenable to short-term treatment. Translation: we don't want to pay anymore, and if you think he's still sick you better find a cheaper way to treat him--now! Their pronouncement had nothing at all to do with clinical realities. We all have our own stories. But whenever I get enraged at an insurance company I have to stop and assign the blame where it belongs. Managed care did not rise up from some dark netherworld to torment us. Not at all. We as a society and a profession are the creators of our own monster. We have produced the current model of "patch 'em up and get 'em out psychiatry" that seems to be the accepted (or at least the financially supported) model these days. Don't get me wrong: I am not so naive as to be unaware of the fact that health care costs are out of control and that we must cut back somewhere. But when I read about the hundreds of thousands of dollars spent for a single patient to receive an artificial heart or another organ transplant, while most HMO's will relegate their chronic schizophrenic patients to a woefully understaffed and inadequately funded public mental health system after such patients have used their allotted twenty visits a year, I do wonder about our societal values and priorities. These patients are supposed to represent one percent of our population after all.

Sullivan insisted that we see schizophrenic patients as being "much more simply human than otherwise." Our refusal to accept this premise lies at the root of our failure to provide adequate and dignified care for a large number of schizophrenic individuals. Harold Searles has said: "The estimated 47 percent of all mental hospital patients who suffer from schizophrenia are there...not only because they have written off their fellow human beings as not kin to them, but also because their fellow human beings have come to accept this as functionally true." We haven't really come as far as we'd like to believe in reducing the stigma of mental illness. The attitude seems to be that if we just don't pay for their treatment, maybe all those chronic schizophrenics will just go away.

What was most striking to me as I examined some of the raw historical data of Chestnut Lodge's day to day functioning, (in the form of the verbatim transcripts of conferences and case reviews), was the deeply held conviction of those who worked here that the schizophrenic patients were in fact kin and that there was enormous value in pursuing the sometimes painful task of identifying the elements of this kinship through human relationships. If Dr. Bram and his colleagues from 1965 recognized little else about the Lodge during a return visit in 1991, I think they would be pleased to find that this belief continues to guide the daily work with patients here. The psychopharmacological boom, beginning with the appearance of neuroleptics on the scene, collided head-on with the more exclusively interpersonal and psychoanalytic approach of Chestnut Lodge. As I have tried to show, the Lodge at first battled with and eventually assimilated these modern trends in the treatment of the mentally ill. From my perspective, both sides in this collision exemplified a kind of thinking in our field that has a tendency to be counterproductive in the long run. Tom McGlashan has characterized this as "...the all-or-nothing cry for a single, clear and definitive answer to the maddening and persistent enigma labeled schizophrenia." The Lodge's early reaction to the medications was influenced by this mode of thinking. That is, I think that the early pioneers at the Lodge felt that psychoanalytic theory, which offers us such a profound and compelling vision of the passions of the human psyche, was the only tool one needed to tackle the enigma of schizophrenia. Clearly,

as we have found out, it is not. Similarly, neither does neuroscience offer us the definitive answer. And despite the claims of some that we can look forward to the day when all mental illness will be quantifiable and treatable in terms of chemicals and genes, I don't think it ever will.

In my opinion, our old friend the pendulum has swung too far again. I worry that psychiatry today is losing its mind in search of its brain. I worry that we are missing the person in pursuit of his disease. James Baldwin once said: "I have always felt that a human being could only be saved by another human being. I am aware that we do not save each other very often. But I am also aware that we save each other some of the time." If Chestnut Lodge never contributes anything else to psychiatry it will have handed down a legacy which heartily affirms this axiom.

As is always the case, our patients are our best teachers. I conclude with the words of a schizophrenic patient who issued this plea in 1986 in the American Journal of Psychiatry:

"Some accounts that I have read suggest or state that by definition the schizophrenic patient is unable to care about or to fully relate to other people because of an overwhelming fear which drives him inside himself. I know I have the capacity to care but overcoming what seems to be an inborn terror often seems as difficult as scaling a granite wall without ropes....The question of whether the fragile ego of the schizophrenic patient can withstand the rigors of intensive therapy seems to me an unfortunate hindrance to the willingness of some psychiatrists to attempt psychotherapy with schizophrenic individuals. A fragile ego left alone remains fragile....Medication or superficial support alone is not a substitute for the feeling that one is understood by another human being...I know I have a long road ahead of me , but I can honestly say that I am no longer without hope."

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