Dr. Osmond's Memos

DESCRIPTION OF HALLUCINATIONS, A MATTER OF MODELS.

SOMETHING SCHIZOPHRENIC PATIENTS SHOULD CONSIDER.

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The New York Times, February 16, 1975, contained a news story claiming that "some deaf persons report hearing music and they fear they're going crazy. They are not, according to a new study which indicates they are experiencing instead auditory hallucinations made possible by their memories."

The two cases referred to were studied by five Boston doctors who found that the symptoms were physiological rather than psychiatric in nature. The patients, a 75-year-old man who had been deaf for 10 years and an 83-year-old woman who had been deaf for 25 years, lost their anxieties when they were assured they weren't losing their minds. The man said he heard a voice singing hymns he had once sung in a church choir. The woman heard a continuous medley of Irish jigs and Christmas carols.

The purpose of the doctors' report, which was published in The journal of the American \ Medical Association, was to alert other physicians to hallucinations so that more attention could be paid to the condition. According to the newspaper, "only five substantiated cases of auditory hallucinations have been reported previously in English-language medical journals. . .The Boston doctors said many deaf persons may be reluctant to mention the symptoms for fear that it would suggest a psychiatric disorder." Dr. Osmond comments on this story.

This is really very odd indeed and suggests (1) the remarkably crude thinking on the part of the doctors involved, (2) the exceptionally reassuring nature of the medical model even when it is used fairly ineptly.

I must try and discover by exactly what kind of magic the doctors found that "the symptoms apparently were not psychiatric in nature but physiological." This implies that "psychiatric" auditory imagery and therefore hallucinations are cerebro-psychic events occurring without any demonstrable brain activity, which is self-evident nonsense. However, good clinical medicine does not require any sound logical and physiological basis, because we learn "The patients lost their anxieties when they were assured that they weren't going out of their minds."

That, apparently, was the modest extent of the reassurance given, apart

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from a really splendid piece of mumbo jumbo and gobbledygook. This reads: "On the basis of their studies, the Boston doctors suggested there may be other explanations in the two cases, and that many physiological mechanisms were involved, but they could not be more specific."

It is hard to beat this for vaguely evasive generalizations, but that is not the point which I want to make. The point is that, shabby and imprecise as this explanation was, "the patients lost their anxieties." With all their imperfections, the doctors' explanations served to remove the old lady and the old gentleman from the psyche role and placed them firmly in the sick role, which immediately, it seems, assured them that they weren't losing their minds.

It is indeed curious that there are said to be only five "substantiated" (whatever that may mean) cases of auditory hallucinations reported in English-language medical journals. This must presumably mean in deaf people. Jack Ashley, an English Member of Parliament, who went totally deaf, wrote an admirable account of his ordeal called **Journey Into Silence.** I reviewed this book at some length in the **Journal of Orthomolecular Psychiatry,** Volume 3, Number 3, Third Quarter 1974, pp. 156-161.

Ashley describes his experience early in the development of his total deafness. "Soon after entering the hospital, I heard the Liverpool trams clanking and roaring outside, but —remarkably enough —their screeching and groaning sounds did not vary with the changes recorded on the technician's equipment. The first time I was allowed out of bed, I went to the window and looked out into the street. To my astonishment there were no trams or tramlines. The clanking and roaring I could 'hear' were noises within my head, known in the medical world as tinnitus. Head noises are a profoundly distressing byproduct of some forms of deafness and they are incurable; my experience was the first dose of daily suffering which any victim endures throughout his life. Doctors and consultants are helpless so I was faced with the prospect of living in the worst of both worlds. Deprived of any meaningful sound, yet denied the tranquility which others imagine to be one of the tiny consolations of total deafness."

Presumably tinnitus does not count as substantiated auditory hallucinations for it is hardly conceivable that there are only five such cases in the literature. What I wonder is, what would have happened if Jack Ashley had been told that those screeching and groaning and clanking and roaring trams were "psychiatric in nature"? So far as I know, nobody has much idea just how or why that "screeching and groaning etc." is generated, but doctors sensibly ascribe them to physiological mechanisms of an unknown nonspecific kind. Ashley was not happy to learn that he might expect to endure this "daily suffering" for the rest of his life. He learned this at the very beginning of his illness and "heard" the bad news with the full weight of Aesculapian Authority.

How was this done? Ashley and the two unnamed deaf patients all knew that they had a severe perceptual disturbance—deafness. The peculiar noises were "heard" in the context of total deafness, while the better organized "sounds" may have been something of a consolation as well as a source of distress. I wonder how many schizophrenics ever receive information about this kind of experience in the way that Ashley and the Boston doctors describe. This kind of technique has probably not been employed, with a rare group of exceptions, since the days of John Conolly over a century ago.

The usual reason for not doing this, put forward today, is that we don't know the physiological mechanisms involved. This squeamishness is clearly not shared by the Boston doctors or by Jack Ashley's English doctors; they are quite ready to postulate and reassure their patients with wholly hypothetical physiological mechanisms.

The great difference was that Ashley

and the two patients described by the five doctors were certainly in the sick role; indeed they may have been explicitly removed from the psyche role by means of Aesculapian Authority Exactly the opposite occurs with most cases of schizophrenia who are often explicitly forced into the psyche role by means of Aesculapian Authority. In the same **Journal of Orthomolecular Psychiatry,** Volume 3, Number 3, 1974, Leslie N. Louis describes how she removed herself from the psyche role after years of illness and placed herself in the sick role in spite of all kinds of difficulties. Perhaps patients would appreciate an opportunity to be in the sick role from the very beginning of their illnesses.

Leslie N. Louis had been ill for eight years and had spent most of that time in some variation of the psyche role before she placed herself in the sick role. Once she had done this she became increasingly responsible as her paper and later her thesis shows (she is an anthropologist by profession). She is an intelligent, adaptable lady whose personality is such that she does not encourage herself in paranoid constructions even when they might be easy and convenient. Like the two deaf people, she was able to switch from the psyche role to the sick role with no particular difficulty. I don't suppose that all schizophrenic patients will be equally obliging, but the very fact that some are should make us keen to encourage all to acquire this highly functional role.

When I was in London recently discussing our "Models and Megavitamins" at the British Schizophrenia Association meeting, Dr. Michael Bott of Headingly Hospital told me and a large audience that with some trepidation he began to discuss patients' illnesses with them about a year ago. His results had been far better than he had expected. Most patients knew already, but all were pleased, relieved, and sometimes flattered that their doctor had taken them into his confidence. Consequently the doctor-patient relationship was much improved. Dr. Bott was greatly interested to learn that when Abram Hoffer and I began doing this about 15 years ago, we had exactly the same kind of apprehension that he himself experienced; however, as with him, this proved to be quite unnecessary. He was also intrigued to discover that the technique seems to have developed in the beginning of the 19th century among physicians. The earliest reference that I can find is to Matthew Bailley, John Hunter's nephew c. 1820. It had been adopted by psychiatrists in the 1840's and is described by John Conolly and others.

Using the medical model well and appropriately in psychiatry is probably the quickest, easiest, most feasible, and cheapest change that we could make. It would require no expenditure, only a certain amount of effort and planning, and very little anguish for anybody. Compared with the extraordinary and usually fruitless efforts required for a therapeutic community or patient self-government, the exertion needed would be very little. Patients who have experienced induction into the sick role explicitly are nearly always pleased and frequently become strongly identified with its proper use. Like Leslie Louis, they find themselves participating in the battle against their illness and do this so determinedly and surprisingly that it is sometimes difficult to realize that they are suffering from schizophrenia, an illness notoriously disruptive of social relations and so making insight hard to achieve.

Insight is sometimes looked upon as an intellectual matter and that is one aspect of it, but only one. Insight in medicine shows that doctor and patient are in agreement; that the patient has been accorded and has accepted the sick role and is willing to participate as a responsible patient. Since schizophrenia, due to its many perceptual anomalies, is so damaging to social relationships, insight would naturally be harder to achieve. We do not yet know just how much more difficult this is in schizophrenia than in other psychiatric illnesses and in other medical and surgical

illnesses because few comparative studies have been made. In recent years due to the confusion between psyche and sick roles, it has been impossible to guess just how resistant to insight in terms of the medical model schizophrenics are. The experience of Samuel Woodward, John Conolly in the mid-19th century, and our own experiences in the mid-20th century suggest that provided the sick role is accorded explicity and determinedly,* most patients will achieve insight and the heightened cooperative participation (methexis) which goes with it. Woodward and Conolly by using, whether they knew it or not, Baillie's method were very successful in achieving methexis, insight, and appropriate induction into the sick role.

The psyche role, that of analysand, with its lack of direction and lack of proper use of Aesculapian Authority is quite unsuitable for those whose capacity to make and sustain social relationships is badly damaged by illness. Paul Federn emphasized this about 50 years ago when he strongly advised against using psychoanalytic techniques in schizophrenia. His reasons for doing so were obscured by psychoanalytic jargon, and at that time neither the sick role nor our models of madness were available. He was, however, an able doctor who treated schizophrenics successfully and was frank enough to say that his use of psychoanalysis in such cases consisted in knowing not to use it.

Whatever virtues the Rogersian technique may have for those in the psyche role, it has no place at all in the sick role. It is likely to damage and confuse patients. This account of three deaf and one schizophrenic persons suggests that much may be done when we have limited resources by intelligent, explicit use of the medical model. The rules involved can be formulated easily, and once this has been done it is far easier to obtain a consensus between patient, doctor, nurse, social worker, psychologist, aide, family, community, and government than by any other means. This is not idle rhetoric. We know the sick role and its environs very well. It is probably built into our genes.

Such a development would, so far as I know, place Alabama well ahead of any State in the Union or province in the Dominion. It is there for the asking.

* Although it should not be necessary to emphasize this, it is sometimes not recognized that many surgical and medical patients achieve only a modest degree of insight combined with methexis. This can be highly detrimental to their treatment and may cost them their lives.