



TWO ARTICLES
PUBLISHED IN
THE BALTIMORE SUN

SCHIZOPHRENIA

A four part series by
Scott Shane

AND

THE MAKING OF A PSYCHIATRIST

A two part series by
Alice Steinbach



CONTENTS

SCHIZOPHRENIA

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Photography

Algerina Perna

Irving H. Phillips Jr.

Gene Sweeney Jr.

Perry Thorsvik

PART 1

Catastrophe of the Mind

Page 3

PART 2

A Biological Reality

Page 10

PART 3

The Families' Burden

Page 16

PART 4

'No Place to Go'

Page 21

THE MAKING OF A PSYCHIATRIST

Written by

Alice Steinbach

Photography

David Harp

PART 1

The making of a Psychiatrist

Page 26

PART 2

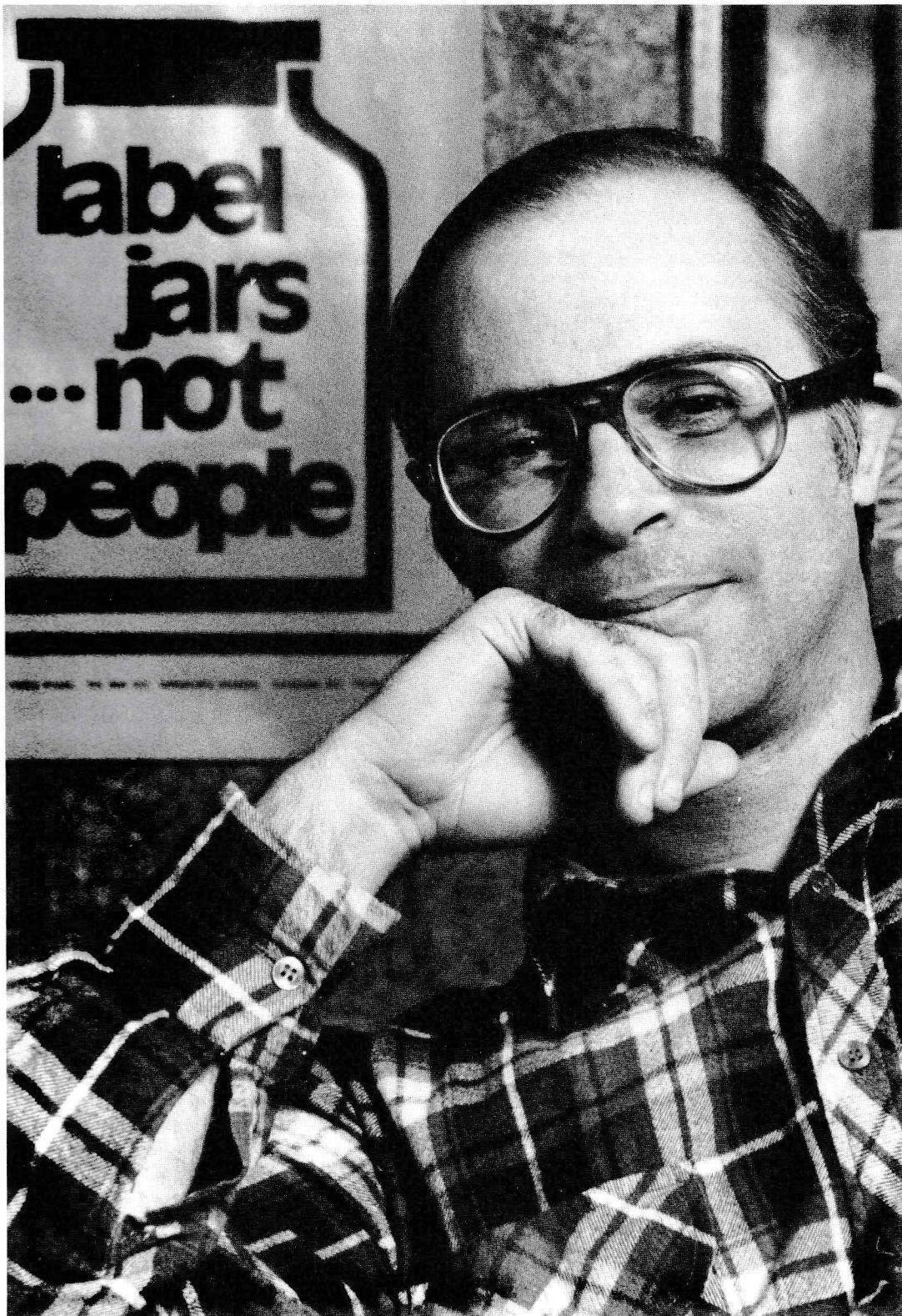
Dr. Lee on call

Page 34

Cover:

A futuristic drawing by 36 year-old man with schizophrenia, was a release of frustration for him while a patient at the Spring Grove Hospital Center.

1 Catastrophe of the Mind



Philip A. Kumin,
34, president of
On Our Own sup-
port group for
former mental
patients.

REPRINTED FROM A SERIES PUBLISHED IN THE BALTIMORE SUN JULY, 26-29, 1987

THE BALTIMORE SUN

At age 10, she won a watercolor competition with a painting of her Ohio elementary school. At 12, she auditioned successfully for a singing part in a musical staged by a local college. At 14, she played classical works on the violin with extraordinary skill.

Then, at 16, Elizabeth Kerr began hearing voices no one else could hear. She grew frightened and withdrawn. Gradually, her personality was submerged beneath bizarre beliefs, illogical fears and erratic behavior.

Finally she was hospitalized, and the psychiatrists gave it all one terrifying name: schizophrenia.

Today, Elizabeth Kerr, 38, lives on a locked ward at Springfield Hospital Center in rural Carroll County. She favors long dresses and knitted shawls that give her an elegant, 19th century look. She often smiles an enigmatic smile, as if she knows things no one else knows.

Sometimes she is Queen Elizabeth or Queen Victoria. Sometimes she is the wife of the Ayatollah Khomeini or another public figure. Sometimes she talks inscrutably about "bombing communism" or about "the Germans," who are apparently out to get her, about books she has written or weddings or funerals she plans to attend. She avoids the pizza at a nearby eatery, convinced that the mushrooms are poisonous.

She talks about these delusions with casual conviction, in the same tone in which she talks about the weather or the hospital food, her attempts to quit smoking or the restaurant her sister took her to last Sunday. Her conversation mixes the apocalyptic randomly with the mundane.

She is unpredictably generous, bestowing a coveted pack of cigarettes on an astonished fellow patient or presenting each visitor with a plastic pack of tissues "to remember me by." Most of the time, she is good-humored and scrupulously polite. But, for now, the phantoms in her mind make it impossible for her to function outside the hospital's protective walls.

One night, through some miracle of persistence, she managed to telephone the White House from the pay phone on the ward, talking incoherently about Henry Kissinger. This prompted a visit from some Secret Service agents, who soon were convinced she was harmless.

Last March, she wandered off the grounds and made her way to Baltimore, where she ordered a meal in a chic Charles Street restaurant. When she told the waiter to charge the meal to Ronald Reagan, she was arrested and spent a night in City Jail before she was identified and returned to the hospital.

Springfield has been her home off and on since 1980, and constantly since 1983. Before that, her sister, Barbara Larcom, 41, looked after Elizabeth, renting a Baltimore apartment for

her and arranging daytime activities. Ms. Larcom had taken over her sister's care from their parents in 1979, when they decided they could no longer manage with her very demanding care at home in Ohio.

But after settling in Baltimore, Elizabeth began knocking on neighbors' doors at 2 or 3 in the morning and asking for cigarettes. One evening at rush hour, Ms. Larcom found her directing traffic in the middle of Charles Street. Her illness spun out of control, and Springfield's green and wooded Carroll County campus offered the only asylum available.

Like numerous parents and siblings of schizophrenics, Barbara Larcom found her sister's plight so dominated her life that eventually she took the cause of the mentally ill as her work. Today, she is the executive director of the Alliance for the Mentally Ill of Maryland, spending her days working to improve the prospects for housing, treatment and public understanding of people with mental illnesses.

"When I first got Elizabeth off the plane in 1979, I really thought I could handle her illness," Ms. Larcom said. "When I found I couldn't cope with her outside the hospital, I felt a lot of anger and frustration. I've learned to cope better, but every time I interact with Elizabeth, every week, it's all brought home to me."

"This disease," she said, "is baffling."

Misconceptions and misery

Something has gone drastically awry in the brain of Elizabeth Kerr. But, though scientists today have some tantalizing leads, no one can say precisely what has gone wrong. The cause of schizophrenia, its biological mechanism, prevention and cure — all remain an enigma.

What is abundantly clear is the tragedy wreaked on patients and families by schizophrenia.

In Baltimore, a 27-year-old schizophrenic woman has drifted into prostitution and drug abuse, exploited by strangers who do not understand her handicap.

A 75-year-old woman lives above a bar with her 55-year-old schizophrenic son, trying despite her own frail health to keep his bizarre behavior from getting him into trouble.

A 31-year-old schizophrenic man lives with his parents in Lansdowne, rarely leaving home and unable to work despite an engineering degree and extensive experience with computers, acquired before he grew ill.

"There's a thinking disorder in schizophrenia, but there's also incredible demoralization," said Dr. John A. Talbott, chairman of psychiatry at the University of Maryland School of Medicine and a former president of the American Psychiatric Association. "Young people see their

friends going off to college, and they can't even get out of bed in the morning."

"My home was in a state of mourning for about 10 years after Steve got sick," said Janet Edelman, a Baltimore woman whose brother, now 33, developed schizophrenia at age 16. "One of the hardest things for my family is looking at family movies. You can see his personality, and that's something the illness took away. His disposition is very flat now. He can't understand humor."

The enormous personal cost of schizophrenia is compounded by the widespread public misunderstanding of this most devastating of mental illnesses, the scarcity of money for research on its causes and treatment, and the shortage of programs to care for its victims.

"Schizophrenia is a problem of massive proportions," said Dr. William T. Carpenter Jr., director of the University of Maryland's Psychiatric Research Center in Catonsville and a prominent schizophrenia researcher.

"There's nothing close to the minimum acceptable resources available either for the care of patients or for the acquisition of knowledge. . . . It's a poverty-ridden health-care sector."

Dr. E. Fuller Torrey, a psychiatrist at St. Elizabeths Hospital in Washington and author of several books on schizophrenia, is even more outspoken. "Why, in the late 20th century, when we are such an affluent country, do we do such a terrible job of caring for people with this illness?" he asked. "I think it's the social and medical scandal of our time."

The disease is far from rare. About one in every 100 people develops schizophrenia during their lives, and 100,000 new cases are diagnosed every year in the United States — nearly as many as there are new cases of breast cancer.

If there were 1,000 students in your high school, chances are that about 10 will have developed schizophrenia within 15 years of graduation. Of those 10, odds are that three will recover completely, three will never recover and will require constant care, and the rest will have cycles of disease and remission for the rest of their lives.

But you may never hear about them. Schizophrenia is a disease kept under wraps by families and by patients themselves, who are wary of the irrational fears and hardy myths that surround its public image.

"People are learning a lot about schizophrenia, but most of what they're learning is wrong," said Otto F. Wahl, a psychologist at George Mason University who has studied public misconceptions about the disease.

Much of the public thinks schizophrenia is "split personality" and trace its origins to emotional trauma, stress or weakness of character, Dr. Wahl's surveys found. In fact, multiple per-

sonality is a different and far rarer disorder, and most scientists think schizophrenia is a brain disease related to genes and biology rather than stress or character.

Another damaging misconception about schizophrenia links it with violence. A 1982 television survey by Dr. Wahl showed that nearly half of people portrayed on television as being mentally ill were portrayed as dangerous, a distortion that had not changed since the 1950s.

In fact, a small fraction of schizophrenics do commit crimes — John Hinckley, who shot President Reagan, has schizophrenia — but they are far more likely to be shy and withdrawn than to be violent.

The truth about schizophrenia is sufficiently discouraging without the lurid exaggeration of television. It first strikes people in their teens or 20s, from the most impoverished ghetto to the wealthiest suburbs. Its symptoms are a separation from reality, a loss of the ability to think coherently or logically, a shattering of the personality.

People with schizophrenia often have delusions — false but unshakeable beliefs, groundless convictions that others are watching or listening to them or intend to do them some harm. Often, they hear inner voices that comment on their activities or tell them what to do. Sometimes they are tormented by bizarre physical sensations or have emotions utterly out of sync with their situations.

Sometimes the patient speaks in gibberish or in sentences connected more by sound than meaning. One Anne Arundel County mother of a 25-year-old schizophrenic son described him repeating apparently meaningless coined words, such as "rebrew," or, when she suggested that he "go outside and get some sunshine," repeating "sunshine," then "son of a son of a sunshine," then finally growing angry and transforming the phrase to "son of a bitch."

Sometimes even more disabling than these "positive" symptoms of schizophrenia, as doctors call them, are the "negative" symptoms: profound apathy, lack of motivation, absence of emotions, inability to take pleasure in anything. Medicines often control the positive symptoms, but they cannot touch the negative symptoms.

Schizophrenia has gotten relatively little attention from the enormous private mental health system that has developed in recent decades in the United States.

"Private psychiatrists have had almost no role in schizophrenia," said Dr. Torrey, who thinks his profession has devoted itself to the lucrative counseling of the "worried well" while ignoring the seriously mentally ill. "Patients with schizophrenia are not 'good' patients. They pace in the waiting room. They scare the other patients. They scare the secretary."

Dr. Henry T. Harbin, director of the Maryland

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"People are learning a lot about schizophrenia, but most of what they're learning is wrong."

- Otto F. Wahl
psychologist,
George Mason
University

"We still don't fund schizophrenia [treatment and research] the way we fund cancer and other diseases, but we are getting better."

**Dr. John A. Talbott,
University of Maryland**

Mental Hygiene Administration, agreed that schizophrenia "has been on the back burner in the psychiatric profession." The illness is not often susceptible to dramatic cures, he noted, and as a psychiatrist, "you don't want to own up to your own impotence."

Private mental hospitals do treat patients with schizophrenia. But, because insurance coverage for mental illness is far skimpier than coverage for medical illness, many patients swiftly exhaust their policies and end up in state hospitals.

"You can't talk about schizophrenia without talking about the public mental health system," Dr. Harbin said. "The state hospitals and the state mental health clinics basically take care of this illness."

Indeed, a few decades ago, in Maryland and elsewhere, most schizophrenics languished for most of their lives in the grim, overcrowded wards of state hospitals. Then the discovery of anti-psychotic drugs, along with a shift in mental health philosophy, led to a movement to get patients out of the hospitals.

Most mental health advocates think "deinstitutionalization," as the movement is known, was a good idea. But it, too, has been beset by problems.

Public money never followed the patients back to the community. People with schizophrenia come home to families ill-equipped financially, emotionally and practically to care for them. Others, even today, are given "Greyhound therapy" — a bus ticket to the nearest city, where they end up homeless.

Today, schizophrenics wander the streets of Baltimore and every other American city, talking to themselves or to non-existent companions, sleeping outdoors or in shelters.

Often without medication or other therapy to help them cope with their symptoms, they often live chaotic, miserable lives. Sometimes they die on the streets — like Corona Baker, 61, a homeless woman with a history of mental illness who died of a cerebral hemorrhage behind a downtown Baltimore building during freezing weather in January.

Beyond its horrifying human toll, the economic cost of schizophrenia is enormous: \$48 billion a year in the United States, according to one 1983 estimate by the National Institute of Mental Health.

The illness usually attacks about the time a person otherwise would be ready to begin earning money, and it is so disabling that many patients require hospital care or close community supervision for the rest of their lives. Roughly 10 percent of all the nation's hospital beds, medical as well as psychiatric, are occupied by people with schizophrenia.

The nation's investment in research on

schizophrenia has been paltry by comparison with the money spent on other diseases. The annual federal research budget for schizophrenia amounts to about \$20 a patient this year, compared with \$300 to \$500 a patient for such diseases as cancer, multiple sclerosis and muscular dystrophy.

Yet there are signs of change. Driven by an increasingly vocal movement of families of schizophrenics, the federal government is gradually boosting spending for schizophrenia research. Scientists are beginning to penetrate the mysterious biology of the disease.

Maryland, like many other states, is beginning to put more money into community programs for the chronic mentally ill. In Baltimore, a major grant from the Robert Wood Johnson Foundation is to be used to explore ways of keeping schizophrenics and other people with mental illness off the streets and in safe, productive environments.

"We're gathering steam, but we still have a long way to go," said Dr. Talbott of the University of Maryland. "We still don't fund schizophrenia [treatment and research] the way we fund cancer and other diseases, but we're getting better."

How schizophrenia feels

People who have descended into the abyss of schizophrenia often describe it as a baffling, frightening experience, a discovery that those around them do not share the same reality that seems obvious and palpable to them.

"It started at night," said a 33-year-old woman who lives near Memorial Stadium and had her first symptoms of schizophrenia in 1979. "I could hear voices from outside the house, like people were watching me and saying what I was doing: 'She's going in the kitchen to cook. She's going to the bathroom.' "

The voices began to haunt her more and more frequently, disrupting her sleep and finally becoming a 24-hour presence. She described one night in harrowing terms:

"I was lying in bed, and it was like evil spirits were pulling my body apart. It's like when you go to the dentist and he numbs your gum and when he pulls the tooth you can feel the pressure but you can't feel the pain."

"They were pulling my body apart. I started saying the 23rd Psalm, and they were saying, 'Shut up! Shut up!' I heard my mother [who was not in the house] saying 'Hush, hush.' I said, 'God,' and my body went back together."

She arose from bed, ignoring the shouting, taunting voices. Then she began to hear the sound of Jesus being nailed to the cross. "I could hear the banging of the nails," the woman recalled. "Then I heard a crash, and I thought

someone had broken my window, so I called the police."

She was stunned when the police officer who responded said he could not hear the voices.

Today, her delusions well-controlled by medication, she lives a fairly normal life. Even when the voices occasionally return, she usually is able to distinguish them from reality and ignore them.

Robert Downs, a bearded, outgoing man of 35 who lives in downtown Baltimore, has similarly learned to tolerate the phantasms schizophrenia still sometimes sends to haunt him.

"Now if I hallucinate [hear voices], I can cope with it," he said. "If I'm watching TV, and I think they're talking to me, I can just tune it out. I turn up the TV a little louder and pay a little more attention."

Such equilibrium is a momentous accomplishment for Mr. Downs, who, like many schizophrenics, survives on a Social Security disability check.

His illness began in 1970, as he emerged from a sleeping hut in Phu Bai, Vietnam, where he was serving in the Army. He looked up at the pitch-black midnight sky and suddenly realized "that the Viet Cong were controlling the weather." For the next decade, he battled paranoid delusions about the Vietnamese, the Chinese, Satan and World War III that put him repeatedly in mental hospitals.

He suggested that people trying to understand the experience of schizophrenia consider their own dreams, in which bizarre and illogical events and feelings are created by the mind and seem perfectly real.

"That's exactly what it's like," he said. "Your mind can trick you to see a vision or hear a voice that's not there."

Though it often eases the most blatant symptoms, medication is far from a cure for schizophrenia. For many patients, drugs keep the illness barely at bay, with relapse constantly threatening.

"There's a general uneasiness," said a 33-year-old Glen Burnie man who has been hospitalized for schizophrenia four times but now shares an apartment with another ex-patient.

"Your thoughts can get personified. They get intense. There are days when I don't like to be in crowds, or too far from home. I feel nervous, nauseous, agitated. . . . You don't know how far into the sick feelings you're going to go. You think, 'Hey, am I going to lose it?'"

Other schizophrenics, even with therapy, never give up their delusions — even if they learn to keep the bizarre thoughts to themselves.

A case in point is a 36-year-old Baltimore man who graduated with honors from Morgan State University and completed law school at

the University of Maryland before developing the symptoms of schizophrenia. For several years, he has managed to work at a responsible paralegal job, careful to remain silent about his illness.

But ask him about his delusions and he can talk for hours, describing the elaborate system of thoughts he has created and recorded in 23 volumes of diaries.

Unlike the random beliefs of many schizophrenics, his delusions are a tapestry of paranoid politics, woven from the central thesis that "the American ruling class" secretly controls everything.

"Joy," he explains matter-of-factly, is "the northern branch of the ruling class," and "road" is the southern branch of the ruling class. They are a sort of cabal made up of prominent, wealthy people known as "Khans," he explained.

He said he writes letters of advice to Joy in care of a major U.S. newspaper (which he asked not to be identified for fear that his parents would intercept the letters). "I told them not to attack Nicaragua," he said. "I told them to feed the people in Ethiopia."

His problems started in 1979, he said, when Leonid Brezhnev "put me on the hit list. I was black and I was intellectual, and he was neither," he said. "Road" has frequently hunted him or attacked him with "applicators," a kind of laser gun designed by the U.S. Department of Energy, but "Joy" protects him.

During an interview, the man displayed an encyclopedic memory for facts and figures about world affairs, which he mixed grotesquely with bizarre beliefs. He claimed that his decision to go to the Jewish Community Center on Park Heights Avenue "to apply for an exchange program with [Israeli] Prime Minister Begin" had "broken the ice" and led to the Camp David peace accords between Israel and Egypt.

Likewise, he said he had caused the overthrow of the shah of Iran, because "Joy" had broadcast his thoughts about "Marxism and humanism" around the globe, inspiring the Iranian people to revolt.

An articulate man with a deep voice, he admitted that his beliefs "sound crazy" and "fit the pattern" for schizophrenic delusions. "It's frustrating — put it that way," he said. "I believe in all these things I can't prove. I'm not being recognized and respected for it."

His father, a retired educator and social worker, said his son's inability to give up his delusions, and his family's unwillingness to discuss them, had left them estranged.

"The hardest part is that he comes home, maybe gets something to eat, and then goes upstairs to bed. There's no conversation. That's not family," the father said, with deep sadness in his voice.

—
"Your thoughts can get personified. They get intense. There are days when I don't like to be in crowds or too far from home. I feel nervous, nauseous, agitated..."

-Robert Downs,
patient

"I made up my mind that I was going to get better."
- Phillip A. Kumin, patient

Some can bounce back

In a Northeast Baltimore basement formerly occupied by a tattoo parlor, a dozen people gather on a Thursday night to chat and drink coffee. On a wall, a poster reads: "Label Jars, Not People."

They are male and female, old and young, black and white, single and married. They have in common only that they have spent time in what one of them calls, bitterly, "the Gulag" — the state's public and private mental hospitals. Many have been diagnosed as having schizophrenia.

"On Our Own," says the tiny sign on the door, beneath a lawyer's office and next to a chocolate shop. The 6-year-old organization is linked with several dozen similar groups into a nascent national movement of former mental patients — the "consumer movement," as it is called by its members, the "consumers" of mental health care.

"It's traumatizing and alienating to be in a mental hospital," said one 36-year-old woman who regularly visits the Belair Road drop-in center of On Our Own. "To be in a group of people who've all had the experience is really helpful. It's a place where you can get angry. It's a place where you can talk openly about your experiences."

At On Our Own, members compare notes about doctors, hospitals, programs and medications, building a bank of shared knowledge for the use of other "consumers."

They plan lobbying efforts to boost the financing for research and programs for the mentally ill or to expand the rights of hospitalized patients. Many of its members can attest to the healing power of the friendship and advice they have gotten from other members.

One is a 34-year-old man with schizophrenia named Phillip A. Kumin, who is president of On Our Own. Today, he impresses an interviewer as an intelligent, articulate, outgoing person with a keen sense of humor. But the story he tells of his own life under the sentence of mental illness is horrifying.

Mr. Kumin was born into a well-to-do Northwest Baltimore family, had what he remembers as a normal and happy childhood and had his first symptoms of mental illness while attending boarding school in Massachusetts.

Looking back on it now, he thinks he was "terribly depressed, terribly lonely and terribly insecure" during his last two years at the Stockbridge School. But it was only in 1971, after he graduated and entered Elmira College in New York that he fully broke down, landing in the first of four mental hospitals where he has been treated.

Mr. Kumin never heard voices. His only hallucination was a recurring physical sensation

— particularly as he went to sleep — that his feet were somehow protruding from his chest or neck. He had paranoid delusions about people at the school or at the hospital who he thought intended to harm him. His most disabling symptom, however, was a tendency to become silent and immobile when under stress — what doctors call catatonia.

Off and on from 1971 to 1976, the nadir of his illness, Mr. Kumin drifted, living in Boston, New York and Washington. He was homeless for weeks at a time, sometimes sleeping in cardboard boxes, office building lobbies, apartment laundry rooms or college dorms.

Despite a monthly income from a family trust fund that would have been sufficient to pay a modest rent, he was so disabled by anxiety and paranoia that he simply could not manage to arrange housing.

Like many of the homeless mentally ill, he blundered into brushes with the law. He was arrested at various times for trespassing or disorderly conduct. Once he was charged with arson, when someone burned a T-shirt on a stairwell of the run-down hotel where he was renting a room; police learned of his history of mental illness and assumed they had the culprit, Mr. Kumin said. He spent 4½ weeks in City Jail before prosecutors dropped the charges for lack of evidence.

"It was the most desperate time in my life," Mr. Kumin recalled. "I was confused, stranded. I could not commit myself to stay in one place and stop drifting. I didn't know what the devil was wrong with me." At times, he would stand in one spot on the street for two or three hours, unable to motivate himself to move on.

But at some point in that period, Mr. Kumin said, "I made up my mind that I was going to get better." Though his physical situation did not improve, he was less desperate, less frequently catatonic, and on more than one occasion he actually sought treatment — an enormous step forward.

In October 1976, under pressure from his family, he entered the Sheppard and Enoch Pratt Hospital in Towson, where he spent the next 20 months — until his father's insurance coverage was exhausted.

He has deeply mixed feelings about his experience at the hospital, which he calls "an elitist, exclusive country club" not oriented to restoring patients to independence.

But during that hospitalization, Mr. Kumin gradually fought his way out of the grip of schizophrenia. He ran through a laundry list of anti-psychotic drugs, finally hitting upon the right drug and the right dose to control his symptoms without leaving him overly sedated.

Through an uncle, he found a job in the shipping department of a film company that he managed to keep for more than four years.

Most important, in 1984, he discovered On

Our Own. "This was the turnaround for me," he said. Sharing pent-up feelings about his illness and the trial-and-error therapy he had been given for it was cathartic. The support of fellow "consumers" gave him the knowledge and courage to change therapists and generally to take control of his own life, he said.

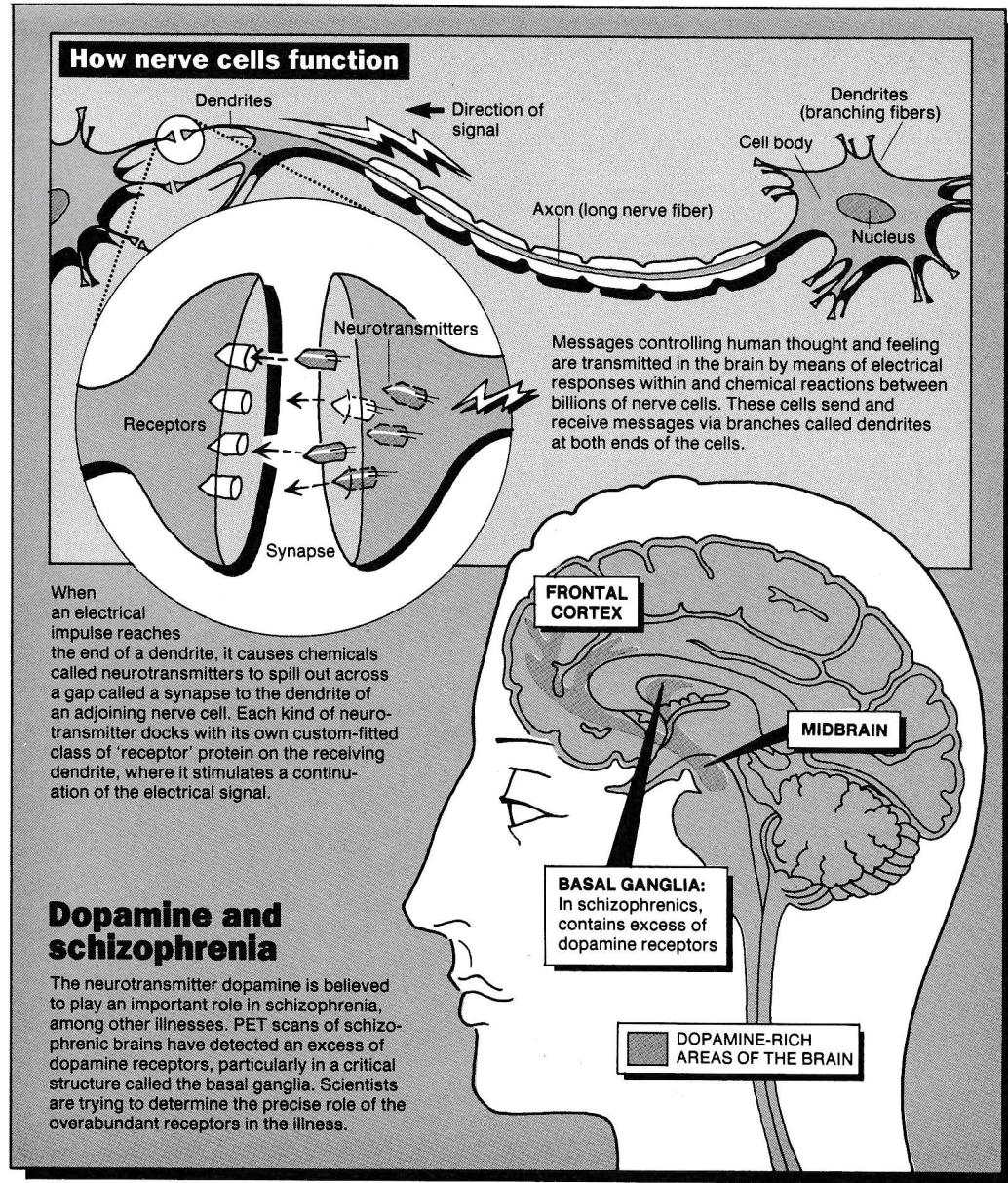
"Thank God I live in a part of the country where there's an ex-patient program," Mr. Kumin said. "On Our Own empowered me."

None of his progress has come easily. Mr. Kumin said he is still troubled by "paranoid pre-

occupations" and by anger and discouragement over his illness. In recent months, he has held a series of low-paying jobs, none of which has proven fully satisfactory.

"I still get depressed that I'm schizophrenic; that society doesn't deal well with that; that I may live alone the rest of my life, and I don't want to," he said. "My life is still very difficult, and it's always going to be difficult."

"But I'm tremendously proud of what I've accomplished. I'm dealing with reality now. That may be depressing, but it's not going to kill me."

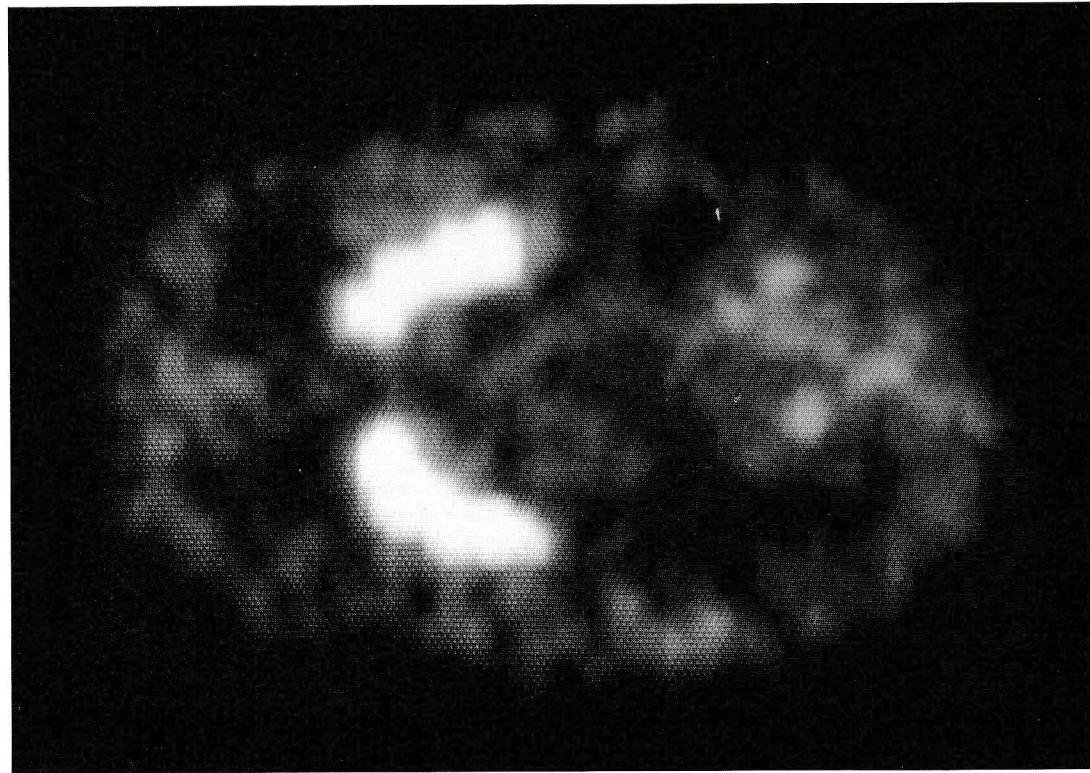
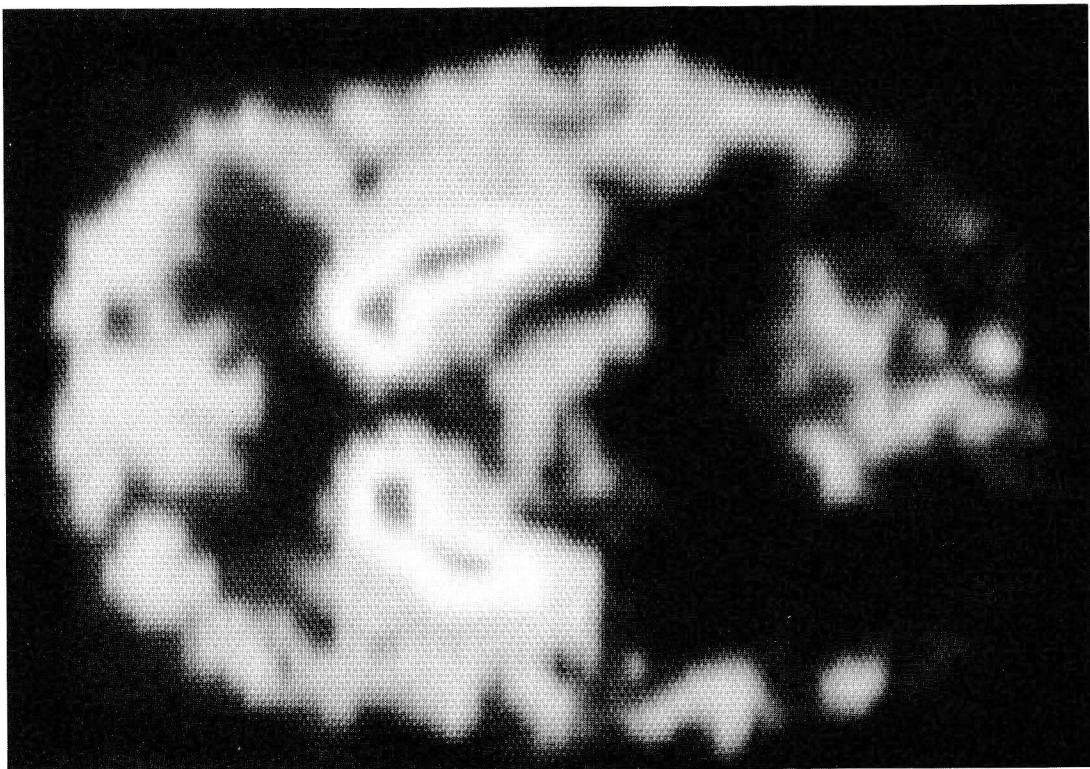


THE BALTIMORE SUN — KATHY CORDES

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2 A Biological Reality



The brain of a schizophrenic, top, shows excessive activity of the chemical dopamine. The bottom photo shows an absence of dopamine in a patient's brain because of the presence of an anti-psychotic drug.

REPRINTED FROM A SERIES PUBLISHED IN THE BALTIMORE SUN JULY, 26-29, 1987

One day in the summer of 1985, in the basement brain-scanning unit at Johns Hopkins Hospital, Ken found himself staring at a video image of the illness that had derailed his life.

Until 1977, Ken had been distinguished only by his intellect and talent for science. He excelled in high school and in his engineering courses at Northwestern University, in Evanston, Ill. Then, the summer before his senior year, he began to withdraw from his friends and family.

"I started sleeping a lot of the time. I started to become suspicious of people," Ken recalled recently, sitting in the living room of his parents' Lansdowne town house. "It was very vague, and it came on very gradually."

His condition deteriorated steadily. He burned his clothes. He began to think "bizarre thoughts, that people in my family were descended from kings and queens and had special powers," he said.

An uncle who lived near Northwestern found Ken so disturbed that he immediately put him on a plane home. He arrived in Baltimore mute and immobile, unable even to undress himself.

Doctors at Hopkins diagnosed the problem as schizophrenia and prescribed anti-psychotic medication. Despite his struggles with paranoid delusions, he managed to finish his electrical engineering degree, working part time at Honeywell Corp. He went on to enter medical school at the University of Maryland, finishing three years of courses and working summers in the pediatric surgery laboratory until 1983, when the voices and delusions produced by his illness made it impossible to go on.

Ken retreated to his parents' home. He has since tried a number of increasingly undemanding jobs, including packaging garbage bags in a sheltered workshop and volunteering at St. Agnes Hospital, but the anxieties of his illness have proven too debilitating. Today, he contents himself with writing simple computer programs and rarely leaves the house.

Two years ago, however, when his doctors at Hopkins asked him to undergo a series of PET scans — positron emission tomography, high-tech X-rays that display the internal biochemistry of the brain — he agreed.

After the scan was finished, Ken watched the brilliant colors of his PET scan on a video screen. His medical school courses on brain structure permitted him to understand what he was seeing: "After taking neuroanatomy," he said, "it was just another picture."

But last December, when the team of Baltimore scientists published their study of Ken's scans and those of 14 other patients in the journal *Science*, their findings riveted the attention of schizophrenia researchers.

They were studying the way the brains of people with schizophrenia handle chemicals

called neurotransmitters, which permit the transmission of nerve impulses that produce ideas and feelings. With the aid of the scanner, they were looking at proteins called "receptors" that are custom designed to bind chemically with specific neurotransmitters. In effect, the molecules of the neurotransmitters spill out of one brain cell into the receptors on the next brain cell, like a baseball landing in a catcher's mitt.

Their dramatic finding: The schizophrenic brains showed an abnormally high density of receptors for a key neurotransmitter called dopamine, which researchers had long suspected might play a central role in the illness. When the subjects were given a standard anti-psychotic drug, the scans showed the dopamine activity being blocked.

The symbolic significance of the research was striking: On the PET scanner's glowing video screen, doctors could actually see a mental illness.

Schizophrenia, the PET scans showed, was not some vague, subjective, debatable concept. It was a physical, biological reality, as palpable as a fractured bone or a malignant tumor.

The scan study exemplifies the new direction of schizophrenia research. This most disabling of mental illnesses is looking more and more like a biological phenomenon, far more comparable to cancer or heart disease than scientists even a decade ago believed. Genes clearly play a role in schizophrenia, and viruses may even be part of the cause; life experiences and family relationships may influence the severity of the illness, but they appear less and less likely to be part of its cause.

Yet the scientific inquiry into the biology of schizophrenia is only in its earliest stages.

Tens of billions of exquisitely sensitive nerve cells are linked into an incomparably complex network in the brain's three pounds of flesh.

They make possible the immense potential of a human being for intelligence, emotion and communication, but they also create an infinite number of ways things can go wrong. Scientists are beginning to understand how a brain works when it works right. They only have hints of what mental illness does to disrupt it.

"What you're seeing is psychiatry entering a whole new age, you're coming in on Day 1," said Dr. Larry E. Tune, a Hopkins psychiatrist who selected patients for the PET study. "The good news is we can study the brain in a living person. The bad news is we've just begun. There are over 200 neurotransmitters, and we've reported on just one."

The scientific quest for clues to schizophrenia is complex, since most researchers believe the illness is probably not a single entity, but a collection of related diseases. One patient may begin hearing voices at the age of 13 and never

"What you are seeing is psychiatry entering a whole new age, you're coming in on Day 1."

**- Dr. Larry E. Tune,
psychiatrist,
John Hopkins
Hospital**

"If a patient with schizophrenia walks into my office, I'm not optimistic about my ability to do something dramatic and awesome for him right now."

**Dr. John A. Talbott,
University of Maryland**

recover. Another may be normal until the age of 30, develop paranoia and delusions but never hear voices, then recover fully after one year. But both patients would be diagnosed with schizophrenia.

Such dramatic variation points to more than one biological mechanism. Dr. Douglas Heinrichs, chief of outpatient programs at the Maryland Psychiatric Research Center, suggests an analogy with cancer — another blanket term for a number of related diseases. Leukemia, skin cancer and lung cancer, for instance, have different causes, different treatments and only a minimal resemblance to one another.

"I think the way schizophrenia research is going to advance is through the identification of subgroups," Dr. Heinrichs said. If researchers can find patterns of symptoms that define one subtype of schizophrenia, they may be better able to tailor-make treatments, he said.

Historically, the slow progress in schizophrenia research has discouraged talented young scientists from specializing in it — which, in turn, has reduced the prospects for scientific advances, said Dr. David Shore, a psychiatrist at the National Institute of Mental Health. "For a person who has to publish 15 papers in two or three years, schizophrenia can look very daunting," he said.

By definition, there can be no animal model for schizophrenia; animals get heart disease and cancer, but they don't hear voices and suffer delusions. And since most schizophrenic patients must take powerful anti-psychotic medication, researchers often have trouble untangling characteristics of illness from effects of drugs.

Perhaps because of the difficulty of studying schizophrenia, the illness has been peculiarly susceptible to theories and treatments hailed as breakthroughs, only to be exposed later as worthless or even harmful. "A lot of simple answers have been proposed, but they've all turned out to be wrong," Dr. Shore said.

But after decades of relative neglect by researchers, schizophrenia is now attracting renewed scientific interest. The change is partly a result of new technology and basic medical discoveries that have opened fertile routes of inquiry, and partly a response to growing political pressure from families of people with schizophrenia. Several nationally significant research projects are under way in Baltimore, in the Hopkins imaging work and particularly at the University of Maryland's Psychiatric Research Center in Catonsville, which has a \$1.3 million federal grant to study schizophrenia.

The National Institute of Mental Health last year identified schizophrenia as "its highest priority," said psychologist Nina R. Schooler, deputy chief of the institute's 2-year-old Schizophrenia Research Branch. Panels of independent sci-

entists are now devising a national plan for research on the disease, to be completed by this fall, she said.

"We're ready to explore a range of theories without saying, 'If I'm right, you're wrong,'" Dr. Schooler said. Meanwhile, the federal schizophrenia research budget has risen from \$18 million two years ago to \$30 million this year — a two-thirds increase in a time of shrinking overall budgets, though it is still only 12 percent of NIMH's total spending on research.

"If a patient with schizophrenia walks into my office, I'm not optimistic about my ability to do something dramatic and awesome for him right now," said Dr. John A. Talbott, chairman of the psychiatry department at the University of Maryland. "But given the tools we've got, all the way from epidemiology to brain imaging, I'm very enthusiastic about our chances for real progress in the next few years."

A history of theories

"There is not a sight in nature so mortifying," the English essayist Joseph Addison wrote in 1712, "as that of a distracted person, when his imagination is troubled, and his whole soul disordered and confused. Babylon in ruins is not so melancholy a spectacle."

As late as Addison's time, insanity was generally seen as a symptom of demonic possession or witchcraft and often "treated" by execution, imprisonment or restraint under the most primitive conditions. In London's infamous Bethlehem Hospital, the mentally ill were on display for "penny tours" by the curious; its chaotic conditions are suggested by the fact that the word "bedlam" is derived from the old pronunciation of the hospital's name.

Only in the 19th century, did madness begin to be widely viewed as an illness. The ingenious "cures" imposed on patients were ineffective and often dangerous. One school held that congestion of blood in the brain was at fault and devised whirling chairs, beds and barrels to try to spin the victim back to rationality. Another recommended trap-door tumbles into ice water, on the theory that the shock might snap the patient out of his illness.

Until the late 1800s, all diseases that could produce bizarre thoughts, talk or behavior were lumped together as insanity. They included everything from syphilis to pellagra, a simple deficiency in vitamin B, both of which can produce mental illness.

Only in 1898 did a German neurologist, Emil Kraepelin, distinguish the disease now called schizophrenia from mental problems with other causes. He called it dementia praecox — "preco-
cious insanity," a mental deterioration afflicting the young. Kraepelin's follower, a Swiss psychiatrist named Eugen Bleuler, coined the term

schizophrenia in 1911.

Bleuler did not mean "split personality," as the word is inevitably misunderstood, but a shattered personality, an inability to harmonize thought and emotion. His discussion of schizophrenia, replete with case descriptions, has never really been superseded — which says much not only about his insight but also about the slow progress of schizophrenia research.

Throughout the 76 years since Bleuler's publication, new theories have led to new therapies — usually more sophisticated than the 19th century efforts, but often equally ineffective.

One sought to remove a presumed toxin by kidney dialysis; others attempted to correct a supposed dietary imbalance by huge vitamin doses or special foods.

More dramatically, some doctors tried electroshock therapy (still used today to treat depression and unusual cases of schizophrenia), insulin-produced comas, or prefrontal lobotomy — surgical separation of part of the brain. But as with other therapies that enjoyed brief vogue as miracle cures, experience soon wilted early hopes.

As these medically oriented treatments waxed and waned in popularity, Freudian psychoanalytic theory came to dominate academic thinking about schizophrenia during the 1940s and later. Ironically, Freud himself, a neurologist by training, had believed schizophrenia to have a biological basis and not to be susceptible to psychotherapy.

But his followers, particularly in the United States, developed elaborate theories tracing the origin of the illness to problems in family life. During the 1940s and '50s, at the Sheppard and Enoch Pratt Hospital in Towson, among other places, psychiatrists used "talk therapy" on schizophrenic patients.

Their theories often centered on the schizophrenic's mother — the schizophrenogenic mother, a tongue twister coined by one Maryland therapist — who was said to be cold and unloving, or to send contradictory messages with her speech and her behavior. Some medical centers actually hospitalized the parents along with the patient in order to study the allegedly destructive family interactions.

The beginning of the end of the psychoanalytic approach to schizophrenia came in 1950, when a Paris surgeon named Henri Laborit, searching for drugs that might help with anesthesia, stumbled on an antihistamine that seemed to have a powerful calming effect on patients. He finally talked a psychiatrist into trying the drug, chlorpromazine or Thorazine, on psychotic patients — with dramatic results.

Within a few years, Thorazine and related anti-psychotic drugs were revolutionizing the treatment of schizophrenia, relieving the most flagrant symptoms of thousands of hospitalized

patients — and undermining the psychoanalytic theories. If a chemical could so drastically improve some schizophrenics' thinking, people asked, what was the likelihood that parents had really "caused" the illness? And what was the need for hours on a psychoanalyst's couch?

Over the past 30 years, such thinking created what is often referred to as a "biological revolution" in the mental health field. The anti-psychotic medications remain the only consistently effective treatment for schizophrenia. The psychoanalysts have been gradually replaced by scientists who looked to brain microbiology, rather than family relationships, for the key to schizophrenia.

The anti-psychotic medications remain the only consistently effective treatment for schizophrenia.

The beginning of understanding

Ask the father of a 25-year-old schizophrenic from Glen Burnie whether there is any history of mental illness in his family, and he immediately mentions "an uncle who's dead now who wasn't right in the head."

"He'd been a prize fighter when he was young," the father says, "and the family always blamed it on that."

Such tales are common, though often they are cloaked in euphemism or guarded like a shameful family secret. Schizophrenia unquestionably runs in some families.

Twenty years ago, when psychoanalytic theories of schizophrenia held sway, such families were considered to be so emotionally unhealthy that they somehow caused the illness. But it took awkward contortions of logic to explain why, for instance, an uncle and a nephew living in different cities could somehow be subject to the same family stress.

Today, scientists are virtually unanimous that families with more than one schizophrenic member are evidence of the genetic component of schizophrenia — examples of how the DNA that carries the code for the color of our eyes and our aptitude for music also can place a person at high risk for schizophrenia.

The genetic risk is dramatic: The average person has a 1 percent chance of developing schizophrenia. But the person with one schizophrenic parent has 10 times that risk — a 10 percent chance. And the son or daughter of two schizophrenic parents has a 40-fold increased risk, or a 40 percent chance of developing the disease.

To nail down the idea that this increased risk is related to genes and not to the emotional hazards of being raised by a mentally ill parent, Danish researchers tracked the children of schizophrenic parents who were adopted at birth and raised by normal parents. They found that the children still had an increased risk of the illness, proving the genetic link.

"There's general agreement that genes are

"Strange as it sounds, it may be that if you're vulnerable, and your mother gets an infection during pregnancy, that may trigger schizophrenia in you 20 years later."

**-Dr. David Shore
of the NIMH**

involved in schizophrenia," said Ann E. Pulver, an epidemiologist at the Maryland Psychiatric Research Center. "But no one knows which ones they are, where they are or how many there are."

Several research teams are searching for the genes involved, and one group at the University of British Columbia announced in May the discovery that a man and his nephew, both schizophrenic, had an extra copy of chromosome 5, one of 23 pairs of chromosomes that carry hereditary information in humans — potentially a vital clue to the identification of a schizophrenia gene.

Still, genes don't tell the whole story. Identical twins have identical genes. Yet only in about half of cases where one identical twin develops schizophrenia does the other develop the disease, too.

So what is the next step in the story? Evidence is accumulating that in at least some cases of schizophrenia, unlikely as it may appear, the culprit may be a virus.

The strongest clue to a viral connection is the puzzling finding, now confirmed by about 20 separate studies, that schizophrenics are more likely than other people to have been born in winter or early spring. Viruses tend to be seasonal, with many peaking in fall and winter, so some researchers have concluded that schizophrenia may be associated with a viral infection of the mother during pregnancy.

The notion that a mental illness could be produced by a germ seems almost preposterous, and some psychiatrists are still inclined to scoff. But the viral theory is gaining credence because of growing scientific knowledge of so-called "slow viruses," which can invade the body, hide inside its cells and do their damage years later.

The viral theory is not necessarily in conflict with evidence of genetic vulnerability. Scientists know people can inherit a vulnerability to a virus, just as they can inherit a vulnerability to certain cancers or to heart disease.

"Strange as it sounds, it may be that if you're vulnerable, and your mother gets an infection during pregnancy, that may trigger schizophrenia in you 20 years later," said Dr. Shore of the NIMH.

Another variation on the viral theory suggests that the viral infection of the fetus does not do all the damage. It simply makes changes in the brain that confuse the body's immune system, whose job is to attack foreign bodies and protect against disease.

Later, according to this theory, the immune system fails to recognize the changed brain cells as its own and attacks them, producing brain damage that results in schizophrenia. A number of other illnesses, including multiple sclerosis and the kind of diabetes that strikes in youth, are suspected to be such "autoimmune" dis-

eases.

Dr. Rohan Ganguli, a psychiatrist at the University of Pittsburgh, has identified different kinds of antibodies in schizophrenic brains than exist in normal brains, particularly in an area called the hippocampus. Antibodies are the tiny proteins created by the immune system to attack and neutralize invading infections, so they are possible evidence of an autoimmune process in schizophrenia.

"We've discovered a remarkable similarity to autoimmune-caused diabetes," said Dr. Ganguli. "But instead of the pancreas being the target [of the misguided immune response], the brain would be the target."

Whatever the underlying causes of schizophrenia, the disease apparently produces an overactive dopamine system in the brains of its victims — a long-held belief now confirmed by the Baltimore PET research.

Of the several dozen drugs now used to treat schizophrenia, all appear to work by blocking the action of dopamine. Significantly, one long-term side effect of such drugs can be an involuntary twitching of the face and tongue called tardive dyskinesia. Parkinson's disease, which also produces muscle tremors and rigidity, is known to be caused by a loss of dopamine-producing cells in the brain.

But like so much about schizophrenia, even the evidence on dopamine is not definitive. Though dopamine-blocking drugs can control the illness, dopamine still may not play a role in its cause.

Dr. Solomon H. Snyder, a pioneering brain scientist at Hopkins, offers an analogy with aspirin: If a person with a high fever from strep throat takes aspirin, he will feel better. But the chemical make-up of aspirin has nothing to do with the cause of strep throat — which is a strain of bacteria.

"I'd be very hesitant to conclude at this point that dopamine is the key to schizophrenia," Dr. Snyder said. "But the dopamine story is the most promising thing we have."

Because understanding of a cause, let alone a cure, for schizophrenia, appears to be many years away, many researchers are concentrating on the practicalities of improving the lives of schizophrenics.

A team of doctors at the Maryland Psychiatric Research Center, for instance, is studying the effects of taking patients off their medication periodically to reduce the risk of tardive dyskinesia. The contortions of face, tongue and body produced by years of anti-psychotic drugs can be socially crippling for schizophrenics even if their illness is under control, and fear of such side effects is one reason some patients stop taking their medication.

Others researchers are studying the impact of training families to cope with a schizophrenic

relative in a way that reduces conflict and tension. While most doctors now believe family problems have little or nothing to do with who gets schizophrenia, there is strong evidence that families who understand and work to accommodate the schizophrenic can significantly reduce the risk of relapse. Not surprisingly, doctors say, arguing with or criticizing a person with schizophrenia can deepen his paranoia and withdrawal, while a calm, positive, friendly approach can be reassuring and therapeutic.

"There's been rather good evidence that the nature of family interaction can influence the number of psychotic episodes," said Dr. William T. Carpenter Jr., director of the Maryland Psychiatric Research Center. "It is a stress-responsive illness."

The accumulation of biological evidence on schizophrenia over the last few years has led to some outspoken predictions of imminent progress.

Last October, for instance, Dr. Henry Wagner, who headed the Johns Hopkins PET-scanning team studying schizophrenia, told a seminar that if the dopamine receptor findings are confirmed, "it will move schizophrenia from being considered a mental disease to being considered a medical disease." He noted that pellagra, syphilis and thyroid disease all were considered mental illnesses before their underlying biochemistry was discovered.

But the back issues of medical journals are littered with schizophrenia "breakthroughs" that drew wide interest, then sank without a trace, so scientists are reasonably skeptical in the absence of proof.

Indeed, some veteran schizophrenia researchers are uneasy with suggestions that schizophrenia has a simple biological explanation. While acknowledging the fundamental correctness of the biological revolution in schizophrenia research, some scientists fear it has gone too far.

"Biological reductionism is not going to be any more helpful than psychological reductionism in explaining this disease," said Dr. Carpenter. "Too few investigators are looking at psychosocial influences on schizophrenia — maybe because that's so much harder. It's so much easier to do a clinical trial of a new drug."

"Ironically," said Dr. Talbott, "I think we [psychiatrists] are more biologically inclined now than the cardiologists and pediatricians, who are saying, 'Hey, let's look at psychological factors.'"



Drs. Dean F.
Wong, Helen S.
Mayberg perform
PET scan at
Johns Hopkins
Hospital.

3 The Families' Burden



Hyman Rosenfeld
chats with his
wife, Doris, who
has schizophre-
nia.

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THE BALTIMORE SUN

Without support, relatives may find task crippling

One day in 1959, Hyman Rosenfeld's wife, Doris, suddenly began wearing a raincoat, indoors and out, rain or shine. She said she needed it to shield her from "the radiation."

A few years later, Irwin, the elder of the Rosenfelds' two sons, began to perform erratically in school, getting 100 on his Friday math test one week and 0 the next week. He became withdrawn, suspicious, hostile. At 16, he dropped out of school and ran away from home.

So began the education of Mr. Rosenfeld, a 66-year-old carpenter who retired last year from the Edgewood Arsenal, in the frustration, pain and loneliness of living with schizophrenic family members.

Except for one three-month hospitalization in the early 1960s, his wife has always lived at home. She has never had relief from the delusions and voices her illness produces. His son, too, has lived at home for most of the time since he fell ill. Last spring, after nearly a year in Spring Grove Hospital Center, Irwin managed to find a place in a supervised program for the mentally ill, and he now shares an apartment with two other ex-patients.

One recent morning, Doris Rosenfeld, 62, sat at the small dining table in the couple's cluttered Aberdeen home and talked, her words a tangle of delusion and reality.

For 23 years, she said, she has communicated with others by means of "the acoustics, the airwaves." At times, she pauses in conversation, listening to the inner voices, moving her lips to the words she hears.

"If I see a phone, I can talk on it without picking it up, immediately, anywhere in the world," she said. "But I don't abuse it. I'm authorized by AT&T, in the Yukon. And RCA."

Mr. Rosenfeld asked her to explain the "state order," a recurring subject in her delusions. "That's the products that have to be used," she said. "I've given it 23 years. It's sugar, flour, salt, 'twixt thee and me. All sorts of things — furniture, appliances. People say what they need and people at the factories hear it and provide the things, via the acoustics."

Asked about her mentally ill son, she replied, "Irwin is 20 different people. I think I have about 6. The rest I can't take back. The rest are older."

"He'd be a good clergyman. He could take the pulpit in a minute, Christian or Jew. We're very religious."

"I just want to do a little farming. My Irwin has done spring onions. I want to get a tractor, but he [gesturing toward her husband] won't let me. Isn't that ridiculous?"

Mr. Rosenfeld, exasperated but patiently declining to argue with his wife, whispered to a visitor, "See? There's a thread of rationality there, but just a thread. What do I do?"

For nearly three decades, Mrs. Rosenfeld's deranged conversation has been the back-

ground noise of her husband's home life. Since the couple's normal younger son, Roy, moved to Knoxville a decade ago to take a mechanical engineering job with the Tennessee Valley Authority, Hyman Rosenfeld has coped alone with his wife's and son's illness, an apparent tragedy of genetics.

During the years Irwin lived at home, his erratic behavior led to conflicts with his father, some of which ended with physical tussles. Eventually, in 1985, Hyman Rosenfeld decided his son really needed to be in the hospital.

"My problem was how to get him psychiatric treatment," Mr. Rosenfeld said. "Every time we had a disturbance, I'd call the police. They'd come and say, 'We didn't see any law broken.' Unless a law was broken, they said they couldn't take him to a hospital or anywhere else."

Finally, early last year, a fight between father and son ended with Mr. Rosenfeld's glasses broken. The police agreed to charge Irwin with assault and battery and to lock him in jail, and Mr. Rosenfeld, desperate to force his son into treatment, went along.

When Mr. Rosenfeld was summoned to court, he said, "The prosecutor started talking about [criminal] violations. I said, 'That's not the point. The point is mental health. I want to get him treatment.'" At last, Irwin was sent to Spring Grove.

A year later, Irwin Rosenfeld is stabilized on medication and living in an apartment rented by Homecoming Inc., a program for ex-patients. "The medication he's taking completely turned him around. He's a different person," said his father.

But Doris Rosenfeld continues to refuse to try anti-psychotic medication. Because she is not a danger to herself or to others, she cannot legally be hospitalized or forced to take medication — even medication that, paradoxically, might relieve her symptoms and persuade her to continue treatment voluntarily.

"Under a democracy," said Mr. Rosenfeld, "you have a right to be ill."

His tone is one of frustration, not bitterness. "For years, I thought I could lick the illness or circumvent it somehow, in both of them, by giving them security," he said. "I'll say now I was wrong about that."

"It's like the vineyard: The guy wants the vine to grow a certain way, and not its natural, erratic way. He has to prune it constantly. So he becomes a slave to the illness. That's what I have had to do."

"It's like the vineyard: The guy wants the vine to grow a certain way, and not its natural, erratic way. He has to prune it constantly."

Hyman Rosenfeld

Families do hospitals' work

The family of a person stricken by cancer or a paralyzing injury can battle with the patient against the illness. But schizophrenia, by defini-

"Families, not hospitals, now shoulder most of the burden of care for schizophrenics."

- Dr. William T. Carpenter Jr., Maryland Psychiatric Research Center

tion, is inextricably tangled with the patient's personality and identity.

The patient and the disease are far harder to separate, and relatives often find it hard not to blame the patient for his symptoms, particularly in the early stages, before there is a definite diagnosis. No parent ever criticized his child for growing a tumor; but many parents of young schizophrenics may berate a child for the erratic behavior or illogical statements the disease brings on.

So a family's fight against the illness may virtually become a fight against the patient, driving the family apart rather than pulling it together.

Schizophrenia is especially costly to family life because it most often makes its appearance in late adolescence or early adulthood — just when parents are expecting a child to take a job or go to college, or when a person has recently married. The reversal of the parents' or spouse's expectations can be devastating.

The illness forces on families terrible choices: caring for the victim at home, which can be a draining, demoralizing, 24-hour-a-day job, or trying to commit him, against his will, to a hospital where the care may be indifferent or worse.

Moreover, since the 1950s, a revolution has occurred in the way Western society treats people with chronic mental illness. Previously, the majority of schizophrenics spent much of their lives in state mental hospitals. Today, the vast majority live with their families.

This dramatic social change was driven by the advent of anti-psychotic drugs, a philosophy favoring community care over hospital care, and a renewed emphasis on patients' rights. But it has placed a tremendous, sometimes crippling obligation on the patients' families, who become round-the-clock psychiatrist, nurse and social worker, often without much support.

"Families, not hospitals, now shoulder most of the burden of care for schizophrenics," said Dr. William T. Carpenter Jr., director of the Maryland Psychiatric Research Center in Catonsville. "Society must ask if it's a fair shift of burden. They're doing what hospitals with 24-hour nursing staffs have done."

One Govans couple in their 60s recalled how their son, a precocious child with an IQ of 127, had gradually become surly and resentful at age 13. The pediatrician said it was just adolescence. In fact, it was schizophrenia.

Today, their son is 40. He still lives at home. His parents cannot leave him alone for more than a few hours, so they never take vacations or visit relatives.

"You survive day to day," said the father. "You don't live your own life — 75 percent you live his life. It's like having an infant at home."

The practical and financial demands on the

family of a schizophrenic come atop the anguish and guilt the illness brings to parents and siblings.

For most of this century, many American psychiatrists traced the origins of schizophrenia to flawed child rearing by the parents, essentially blaming them for the illness. In the past decade, as evidence has accumulated that schizophrenia has a biological and genetic basis, this theory has been all but routed. But in the absence of scientific certainty about the cause of the disease, many parents inevitably feel they are somehow responsible for their child's schizophrenia.

"You wonder why it happened to you," said the father of the 40-year-old schizophrenic man. "Sometimes you wonder what you did, or didn't do, when he was a child. You lose faith in God sometimes."

The man's mother said, "At the height of his illness, I used to cry myself to sleep. I'd even wake up crying."

In theory, this couple would like to find a group home for their son — partly because they worry about his future when they can no longer care for him. In practice, few such places are available, and they fear that even mentioning the possibility to their son would upset his delicate balance and send him deeply into psychosis.

"I like to be there to shore him up and reassure him that things he believes aren't true," the mother said. When the rock musician Boy George was charged with drug possession, "he was convinced the police were going to kill Boy George and then come for him."

"When he's having a thought like that, and you reassure him, the world is lifted from his shoulders. One thing I have earned is his trust," his mother said.

The commitment dilemma

Over the past decade, bolstered by the growing evidence of a biological basis for schizophrenia, relatives of schizophrenics and other victims of severe mental illness have banded together in an increasingly militant movement seeking mutual support, public education, better care and more money for research. The National Alliance for the Mentally Ill now has chapters in every state, including a fast-growing Maryland group.

"The growth of the family movement is one of the most exciting things to happen in mental health," said Dr. Henry T. Harbin, who as director of the state Mental Hygiene Administration feels the pressure of the movement. If the mental health system is to make progress, he said, "We need the advocates and the families holding our feet to the fire."

Last year, the Alliance for the Mentally Ill of Maryland targeted the state's commitment laws for change, seeking to make it easier to hospitalize a mentally ill person. Instead of having to prove that a person poses an "imminent danger" to himself or others, as existing law requires, AMI would change the standard to "gravely disabled." The group also is seeking an "outpatient commitment" statute that could legally require a patient to take medication, for instance, to stay out of the hospital.

The group argues that the current law effectively denies needed hospital care to desperately ill people and creates a "revolving door" of brief hospitalization, relapse and return to the hospital that is hard on both patients and their families. Some patients have a pattern of stopping their anti-psychotic medication after their release from the hospital and swiftly slipping into psychosis, requiring a return to the hospital — to begin the cycle again.

One Glen Burnie couple has fought hard for new laws on the basis of their experience with their son, who is now 25 and has suffered from schizophrenia for the last 10 years.

Like a small but significant minority of schizophrenics, he is subject to precipitous mood swings that have led him on several occasions to threaten and even physically attack his parents and police. "See that patch on the plaster?" his father said during an interview in the kitchen of the family home, explaining that his son had smashed a hole in the wall. "I've got a lot of those in this house."

Since his first hospitalization in 1979 — when a psychiatrist told his parents that schizophrenia resulted from "emotional deprivation" — he has bounced in and out of hospitals. While at home, he sometimes stayed in his bedroom for hours, holding lengthy conversations with himself in three or four different voices; for a time, he slept in the woods near the house. Drinking and drug abuse complicated his fragile mental state, and he has become explosive, his mother said.

Last summer, in a violent rage, the 6-foot, 200-pound man beat up his mother with a 2-by-4. On another occasion, when his frightened parents locked him out of the house, he tore the garage door off its hinges and emerged with a bucket of gasoline and an ax, threatening them and the police officer who responded to their call. Another time, he provoked a police officer who had no knowledge of his mental illness to draw a gun on him.

Yet at other times, particularly when he has been taking anti-psychotic medication regularly, he can be "warm, calm and loving," said his father, a crane operator. His volatile changes of mood have frequently led his parents to seek to have him hospitalized, only to have doctors and nurses conclude that he is not sufficiently ill to

need inpatient care. So he has been discharged within hours or a few days — only to become threatening or violent again shortly after his release.

Once, when hospital emergency room doctors said they saw no reason to hold him, his father suggested that they ask him about "the White House lawn" — a phrase from a Rolling Stones song that his son believed had been stolen by "mind projection" from his brain. They did so, the father said, and when he called back a few minutes later, the doctors already had signed the commitment papers.

Today, in ironic counterpoint to the parents' inability to get long-term hospital care for their son, he is serving a four-year term in a Hagerstown prison for violating the terms of his probation on an earlier breaking-and-entering case. How did he violate his probation? By failing to take his anti-psychotic medication.

"There's no way I feel he should be on the street because of what he did to me and to her [his wife] and the possibility that he might do it again," the father said. "But he certainly doesn't belong in a penal institution. We're between a rock and a hard place."

When the mother told her story to a recent AMI meeting and someone asked who in the audience of about 75 people had had "similar experiences" with the difficulty of getting relatives hospitalized, about 30 hands were raised. Such experiences have created strong political pressure for changed laws.

But ex-patients and their advocates oppose with equal vehemence any legal changes that would make it easier to put people in the hospital and keep them there. AMI's unsuccessful push for changed commitment laws in this year's General Assembly session was opposed not only by On Our Own, an ex-patient organization, but also by the Mental Health Association. Both groups that are usually AMI's ally in lobbying for more community programs for the mentally ill.

Unrelieved strain

When a person with schizophrenia is hospitalized for a long time, the family's round-the-clock responsibility for care may be gone. But the strain on the family is rarely relieved. For many families, visiting the patient and taking him out, monitoring the quality of hospital care and searching for a community placement, if the patient improves, can become a constant burden.

Janice Becker of Sykesville knows all about that burden.

One day in 1985, Mrs. Becker walked into Springfield Hospital Center and was shocked to see her schizophrenic daughter, Gail, tied to a chair. The nurses told her Gail had kicked a

—
"There's no way I feel he should be on the street because of what he did to me ... But he certainly doesn't belong in a penal institution."

- father of a man with schizophrenia

"The truly sad thing is the more in touch with reality she is, the more depressed she becomes."

**- Janice Becker,
mother of a
woman with
schizophrenia**

trash can across the ward. Isolation in the tiny seclusion room was no longer an effective punishment, they said, so she had been bound with towels by the arms, legs and trunk.

Only five years earlier, Gail — the third of four children — had always been the helpful one, offering to set the table, washing her own clothes, doing a lot of cooking. She had graduated with honors from South Carroll High School and entered the Carroll County branch of Catonsville Community College, hoping to become a chemist or lab technician.

But after one semester, she stunned her parents by telling them she wasn't returning to college. "I don't think I can handle it," Gail told them.

"A week or so later, I had been reading, and she came in and started talking very bizarrely," Mrs. Becker recalled. "She had been reading the Bible, and she thought she was damned, that she was going to burn in hell, that the devil was part of her."

Mrs. Becker stayed up with Gail until 3 or 4 in the morning, trying to calm her and reassure her, with little success. "She was very upset and agitated. She just paced the room the whole time," her mother said. "In retrospect, I think she did not understand what was happening to her and was frightened and looking for help."

The next day, she took Gail to the county mental health center in Westminster, where a psychiatrist examined her, advised that she needed "something to keep her busy" and set up regular appointments with a social worker.

But in the coming months, she became steadily more disturbed, pacing, playing her stereo at high volume and talking about what she called "abstract thoughts" — the disembodied voices of schizophrenia.

Sometimes, after listening to the voices, she'd set out barefoot, in cold weather, to walk the six miles to Westminster. She had a car accident, became frightened and ran away and was charged with leaving the scene. In conversation, "she'd be very specific — and completely illogical," her mother said.

She was placed on an anti-psychotic medication and had a severe allergic reaction, her muscles growing stiff and painful, and had to be rushed to the emergency room. Then she refused to return to the mental health center and finally was hospitalized at the Sheppard and Enoch Pratt Hospital in Towson.

Over the next 22 months, despite their relatively comprehensive insurance, the Beckers spent about \$40,000 out of pocket on Gail's care. The doctors tried their entire pharmacopoeia of drugs, without dramatic improvement.

They suggested family therapy, so Carl and Janice and the four other children drove to Sheppard-Pratt for regular sessions, again without apparent progress. And all along, the doc-

tors declined to give a diagnosis, saying they didn't like to label patients.

Finally, from her own reading, Mrs. Becker became convinced that her daughter had schizophrenia. "Toward the end, I said to one psychiatrist, 'Why don't you just say she's paranoid schizophrenic.' He said, 'Well, we don't think she's paranoid.' That was as close as I came to getting a diagnosis."

By 1982, Mrs. Becker had discovered the Alliance for the Mentally Ill and begun to educate herself about the illness. The Beckers had Gail transferred from Sheppard-Pratt to Lutheran Hospital, then drove her to Princeton, N.J., for evaluation by a doctor who believed schizophrenia might be caused by a vitamin deficiency.

Nothing seemed to work. She came home from Lutheran in August 1982, talking about possibly returning to school or finding work.

"Each day, she did less and stayed in her room longer and stayed up later at night," Mrs. Becker said. "My whole life was geared around her cycle. If she stayed up till 3 in the morning, I stayed up, too. Sometimes I'd go to bed and try to listen for her. But I got calls from three different neighbors who saw her wandering outside at night."

Mrs. Becker would leave the house and return to find a glass shattered on the floor or other evidence of anger or disturbance. But Gail avoided the family, skipping meals and turning the stereo up in an attempt to drown out the voices.

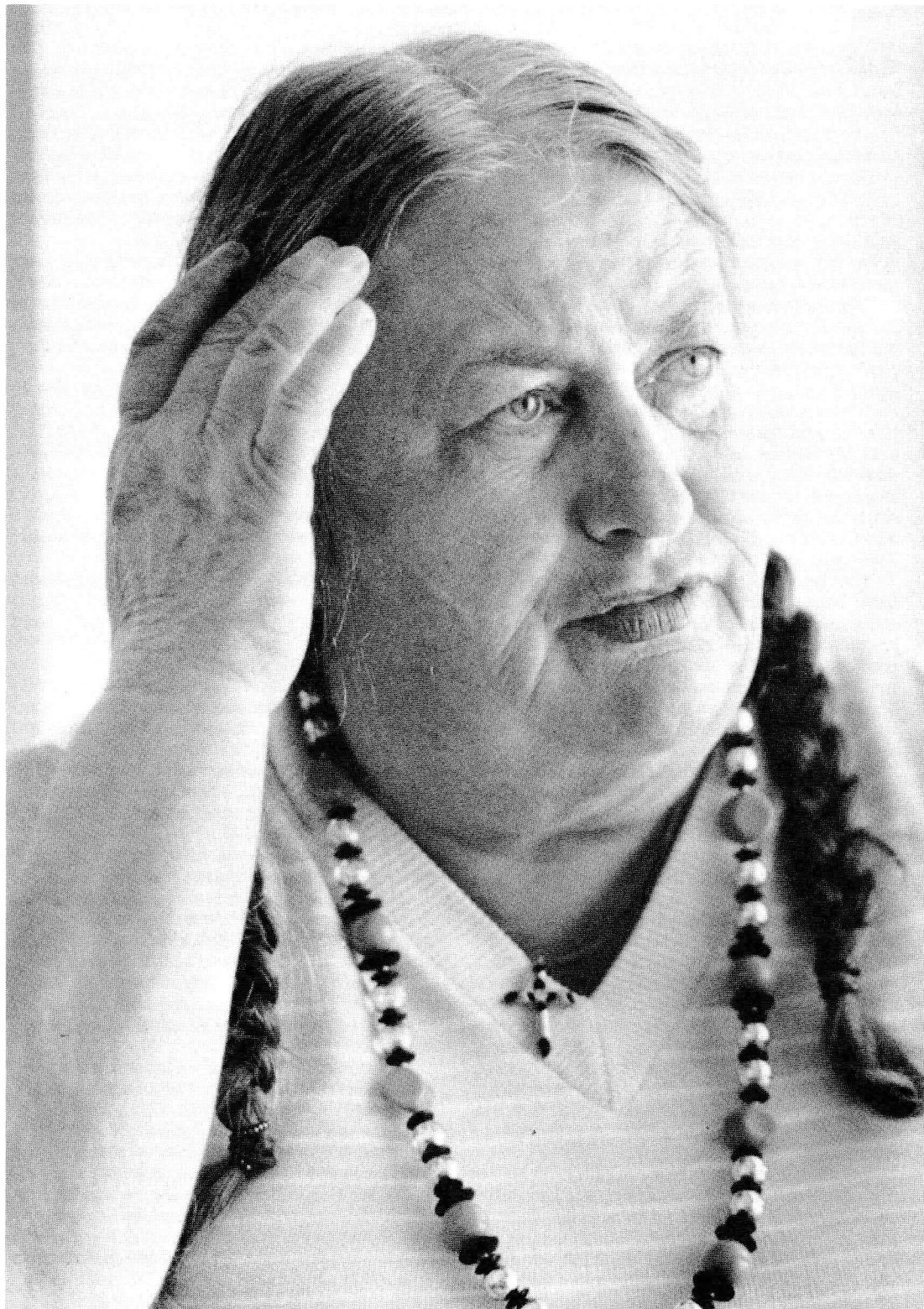
Finally, the day before Thanksgiving 1982, Gail suddenly decided she had to have an injection of vitamin B-12 and began to try to insert the needle into her leg through her jeans. Her brother grabbed for the syringe, they struggled, and the needle broke off in his chest. He got five stitches, and she went to Springfield. She remained there until this summer, when she was transferred to a research unit at a second state hospital, Spring Grove.

Her mother has dealt with her own anguish by throwing herself into mental health advocacy, serving on seven different local and state boards of mental health groups, including the advisory board at Springfield, where she is trying to open a coffeehouse for patients. But her obsession remains her daughter's future.

"I've seen my daughter turn from being sharing, industrious, caring, observant, intelligent and helpful to being absorbed by the illness," Janice Becker said. "The intelligence turned to manipulation, the industriousness to pacing.

"It's devastating to her, as well as to us. She says, 'I wish my head was as it used to be.' Or, 'I wish I could concentrate and read.' She tends to compare herself to her siblings and come up lacking. The truly sad thing is, the more in touch with reality she is, the more depressed she becomes."

4 'No Place to Go'



Mary L. Thomas,
56, has schizo-
phrenia and
has stayed in several
hospitals and two
Baltimore parks.

Sometimes they come by taxi, fare paid in advance, from psychiatric wards as far away as Springfield, a state mental hospital in rural Carroll County. Sometimes they're sent over from another Baltimore shelter that has no empty beds. Sometimes they wander in alone, seeking asylum from the hostile streets.

But the severely mentally ill show up nearly every day at an aging row house on the corner of North Avenue and Calvert Street that Project PLASE (People Lacking Ample Shelter and Employment) workers struggle on a shoestring to make into a home.

"The state has really failed these people," said Bonnie Rohr, a counselor at the shelter, which the Baltimore Department of Social Services and other agencies frequently depend on for emergency housing for the mentally ill.

"There's just no place for people with schizophrenia and other chronic mental illness to go," said Ms. Rohr. "We all run into a wall with mentally ill people. We try to show them some love and compassion, but in the long run, we're shuffling them around from one place to another. That's all we're doing, and we know it. There just aren't enough programs."

The temporary tenants at Project PLASE have been discharged from hospitals without other housing, or kicked out by families who no longer will tolerate their demands and disruptions, or driven by their mental demons from the last seedy rooming house where a harried social worker managed to place them. They include the most difficult of the mentally ill — those who refuse treatment, who are also alcoholic, addicted to drugs, anti-social or violent.

Some become familiar figures on downtown Baltimore streets. Among them is Mary L. Thomas, 56, who has had schizophrenia since her early 20s, when growing feelings of paranoia and anxiety forced her to quit her job as a keypunch operator for the Social Security Administration. Her blond-brown hair in neat braids, she told her story in the Project PLASE shelter where she stayed for two weeks in May.

From 1955 to 1969, she said, she was hospitalized at Spring Grove Hospital Center in Catonsville. She was given 25 electric shock treatments, which she blames for destroying her memory of keypunch skills. During the last 18 years, she has been in and out of various hospitals, mainly Springfield, but has spent much of the time homeless, including one three-year stretch.

Usually, she slept in a park on St. Paul Street, across from the state Department of Licensing and Regulation, or in another park in front of St. Vincent de Paul Church east of the Fallsway — the two places, she said, homeless women considered safest. But even there, Ms. Thomas said, hoodlums "would steal your shoes,

or put their hands up your dress or try to rape you."

A couple of years ago, she and a schizophrenic man who had become her constant companion combined their disability checks and found a cheap apartment on St. Paul Street. But last March, Ms. Thomas and her friend were jailed on separate charges. She was sentenced to 30 days for failing to stay in touch with her probation officer following a 1984 conviction for littering, resisting arrest and battery.

Her friend died of a heart attack in City Jail in early April. When she was released a few days later, she discovered that the landlord had re-rented their apartment, and thrown their clothing and other possessions in the trash bins behind the building.

She went to the YWCA shelter on West Franklin Street, where she stayed until mid-May, when she moved to Project PLASE. At the time of the May interview, she was on anti-psychotic medication provided by a psychiatrist who works with the homeless, feeling well and hopeful about finding an apartment she could afford on her Supplemental Security Income check.

For the mental health system in Maryland and the nation, Mary Thomas and the thousands like her are a badge of failure, testimony to the holes in the net of community care for mental patients discharged from hospitals.

"They go from the shelter to the hospital and after three weeks the doctors say, 'They're on medication. They're ready for release. They're fine,'" said Sister Patricia Rogucki, who has worked with the homeless in Baltimore for 11 years. "They're not fine. The medication doesn't get them housing. The medication doesn't take care of their other needs."

Maryland's homeless schizophrenics occupy a netherworld that is almost, but never quite, out of the view of the rest of society. Too disabled by their disease to care for themselves, they are not sufficiently dangerous or suicidal to be hospitalized. They need subsidized, supervised housing; regular, supportive visits with doctors who understand anti-psychotic medications; and accommodating jobs or daytime activities.

All those services exist — but current programs meet only a small fraction of the need.

Maryland has about 1,500 community beds for the mentally ill in foster homes, group homes and other supervised programs — a sharp increase from the 200 available in 1980, but far short of the 6,500 beds that state mental health officials themselves estimate are needed. More than 30 years after the state hospital population peaked, Maryland spends about 67 percent of its mental health budget on hospital care and 30 percent on community programs.

Bonnie Rohr, who, like the other Project PLASE counselors, earns \$5.32 an hour, estimates that on average more than three-fourths of the men and women who fill the shelter's 13 beds suffer from serious mental illness.

Workers at other shelters report lower proportions of the mentally ill, but every Baltimore shelter regularly houses people whose bizarre talk or behavior, hospital history or medication identifies them as mentally ill. A study of homelessness in Maryland published last year estimated that more than one-fourth of the homeless are mentally ill, and 20 percent of Baltimore's homeless are without shelter because of their discharge from mental hospitals.

"We'll get a call from Springfield, Spring Grove or one of the city hospitals," said Jeff Singer, a veteran social worker with the Department of Social Services unit that helps the homeless. "A patient is ready to be discharged and they have no home and no resources, so we take them to a shelter. It happens at least a couple of times a week."

Most such people qualify only for general public assistance, an adult welfare check of \$156 a month, Mr. Singer said. Some get Supplemental Security Income, federal support for the disabled, at \$340 a month. But even the most modest room-and-board houses charge \$300 and up per month, so the private housing market for the mentally ill is virtually nonexistent. People like Mary Thomas shuttle between the shelters, the hospitals and the streets, rarely settling anywhere for long.

After about two weeks at Project PLASE in May, Ms. Thomas departed without warning, according to the shelter staff. She returned to the streets for a time, then was hospitalized for a month at Johns Hopkins Hospital. In mid-July, she found a bed in the night program of My Sister's Place, a downtown program for homeless women.

During an interview this week, she seemed pleased with her new home. "I don't break any rules," she said. "I'm so quiet. I'm just real pleased to have a room of my own."

Inside the hospitals

A good starting place in understanding the plight of Mary Thomas and people like her is a 1949 series in *The Sunday Sun* and *The Evening Sun* entitled "Maryland's Shame."

"Maryland's overcrowded state mental hospitals are breeding chronic insanity faster than they can cure it," the series began. "The five tax-supported mental institutions were built to house 6,000, but already, nearly 9,000 are packed into their gloomy, frequently foul-smelling rooms.

"Inside the walls of these Maryland 'snake

pits,' men, women and children are living like animals," the first story declared. For the skeptical reader, the series' outspoken prose was accompanied by horrific photographs, including some of patients chained naked to the floor.

The Maryland asylums had been built in the late 19th century in peaceful, rural locations, where the mentally ill could rest, do farm work and recover their senses, in accordance with the psychiatric theories of the day.

But this well-intentioned rest therapy could not cure schizophrenia and other severe mental illnesses, and the hospitals' rural locations made them out-of-sight dumping grounds for people whose mental problems made them inconvenient for families or for society. The state hospital populations grew until they gradually overwhelmed the facilities.

Within a few decades, the hospitals had become hellish parodies of what they were designed to be, ripe for exposés, such as "Maryland's Shame." The resulting hospital scandals made the Maryland and national officials eager for a way to reduce the overcrowding — so the discovery in the early 1950s of anti-psychotic drugs appeared to be just what was needed.

Indeed, after rising steadily from the turn of the century, the population of Maryland's mental hospitals peaked in 1956 at 9,530. As the hospitals' population declined, the feelings of mental health professionals about deinstitutionalization, as the movement out of the hospitals was dubbed, remained upbeat.

When Congress passed the Community Mental Health Centers Act in 1963 to create a network of clinics to care for those leaving the hospital, "prominent psychiatrists were saying that the anti-psychotic drugs would wipe out schizophrenia," said Dr. John A. Talbott, chairman of the Department of Psychiatry at the University of Maryland. "There was a naive belief in the '60s that if you got rid of mental hospitals, you got rid of mental illness."

In fact, the new drugs eased the illness for many patients, but did not cure it. Patients who did not like the nagging side-effects of the medications would stop taking them shortly after their discharge, swiftly becoming psychotic and returning to the hospital.

In the decade after 1956, as the hospital population fell from 9,530 to 8,076, the number of admissions per year rose from 3,785 to 8,551. The back wards where patients had vegetated were gradually being emptied, but many patients seemed caught in a revolving hospital door, unable to survive for long in the community.

More important, the community mental health centers proved ill-equipped to treat psychotic patients. "For most of the '60s and '70s, all we had

"There was a naive belief in the 60's that if you got rid of mental hospitals, you got rid of mental illness."

Dr. John A. Talbott,
University
of Maryland

"The gentrification of Baltimore City has eliminated that marginal housing where a lot of these people went when they were discharged from the hospital."

Stelios S. Spiliadis, heads Project Home

was 9-to-5 clinics that could provide medication and individual psychotherapy," said Dr. Henry T. Harbin, director of the state Mental Hygiene Administration. Schizophrenics needed housing and supervision, "and when they didn't get it, they often dropped out."

The centers, meanwhile, found a new clientele.

As people with schizophrenia and other chronic mental illnesses dropped out, the mental health centers found a different niche — helping people with marital problems, the stresses of adolescence, anxiety and depression, said Stelios S. Spiliadis, who worked in a South Baltimore mental health center in the 1960s and now heads Project Home, a state foster care program for mental patients.

"Resources that theoretically were to be directed to the chronically mentally ill were instead diverted to the mental health needs of the general population," he said.

But meanwhile, deinstitutionalization had become a popular buzzword, and a series of patient-rights lawsuits had made it harder to keep people in the hospital against their will. Maryland mirrored a national trend that saw state mental hospitals' census fall from 550,000 in 1955 to about 120,000 today.

The incidence of mental illness was remaining the same, so more and more victims of severe mental illness were living outside the hospitals. Most were living at home, often imposing extraordinary strain on their families. Others — like Mary Thomas — were landing on the streets, victims not only of the delusions and hallucinations of their illness, but of muggers, robbers, rapists and rain, snow and freezing cold.

Through the 1960s and most of the 1970s, Baltimore had a supply of rooming houses and cheap hotels that were often substandard but kept many of the mentally ill off the streets. Urban renaissance has largely done away with that market.

"The gentrification of Baltimore City has eliminated that marginal housing where a lot of these people went when they were discharged from the hospital," said Mr. Spiliadis. He said he regularly visited clients in cheap rooming houses on Montgomery Street in South Baltimore in the 1960s; now the street is lined with costly renovated homes.

In 1973, downtown Baltimore had 18 "single-room occupancy" hotels, most of them affordable on a monthly disability check, according to one city study. Today, none remain that are cheap enough to serve the mentally ill.

"I'm not saying that's what we need," Mr. Spiliadis said of the cheap housing that has disappeared. "But that's why you didn't see them sleeping on a bench across from City Hall."

Maryland at a crossroads

Last July, a team of federal inspectors spent five days at Springfield State Hospital. Their 25-page report of conditions at the state's largest mental hospital was a depressing tale of decaying facilities, an overwhelmed staff and unattended patients.

Some showers had no hot water, while others were coated with mildew. Plumbing was leaking and wiring exposed. Flies, ants and mice infested dining areas.

Beds in some units were less than three feet apart. The hospital had so few housekeepers that nurses were doing the cleaning, and so few nurses that the beleaguered staff frequently had to rely on tying patients in chairs or locking them in seclusion rooms.

The inspectors found there had been 1,692 assaults by patients in 1985, a 50 percent increase over 1984. In just the month of May, the team found that patients were locked in seclusion for a total of 1,623 hours and restrained in chairs for 735 hours.

With the support of top state health officials, the hospital's new superintendent, Dr. Bruce Hershfield, set about to turn the situation around and avoid the threatened loss of federal Medicare funds, which totaled several million dollars a year.

With the help of a \$2.5 million emergency appropriation and round-the-clock work by staff, Springfield hired additional nurses and psychologists and made numerous physical improvements. When the federal auditors returned last October, they were stunned to find the "horrendous problems" of July virtually solved, according to minutes of the October meeting. Use of restraint was down by two-thirds, and use of seclusion cut in half.

But the improvements took money sorely needed by community programs for the mentally ill. Ironically, a significant number of Springfield's 900 patients are sufficiently recovered to leave the hospital — but there are not enough community programs to accommodate them.

Even with the improvements, the hospital is spending about \$150 per patient per day, less than half the average cost per patient at the state's private psychiatric hospitals. Springfield has approximately the same number of psychiatrists and psychologists as the private Sheppard and Enoch Pratt Hospital — for three times as many patients.

Even the staffing numbers don't tell the whole story. "We have a much smaller staff, but we get the patients the other [private] hospitals don't want because they're dangerous, disruptive and treatment-resistant," said Dr. David Waltos, who left Sheppard-Pratt last year to become clinical director at Springfield. "Sheppard-

Pratt can turn people away. Springfield can't."

Despite the strapped budget, many ex-patients and their families give the state hospitals relatively high marks for providing pragmatic therapy and reasonable care under difficult circumstances. Some patients actually prefer the state hospitals to costly private institutions that emphasize psychoanalysis. But the century-old buildings and chronic staff shortages set limits to the quality of treatment at the state hospitals.

"The state hospital system is at a real crossroads right now," said Dr. Harbin, who has headed Maryland's mental health system for about 18 months. "We face the dilemma every state faces — of trying to build up our community programs while also trying to enhance the quality of care in the hospitals."

The promise of change

This month, a long-awaited consultant's report plotted a bold alternative for Maryland's mental health system.

The state, the report said, could close the hospitals and dramatically expedite the process of moving patients to community facilities — nursing homes for the elderly, local hospital psychiatric units for the severely disturbed and well-supervised community programs for the rest. In fact, this Utopian model would cost the state \$15 million less each year than the current system, the report calculated.

A commission studying the future of the state hospitals said the report would become a centerpiece of its deliberations. The commission is to hold its only public hearings at 1 p.m. and 7 p.m. tomorrow at the State House in Annapolis.

Meanwhile, less dramatic changes are slowly improving care for the mentally ill.

On a small scale, nurses and doctors are taking psychiatric care to the homeless and homebound instead of waiting for them to become so ill that they require hospitalization. Under the Johns Hopkins Hospital Community Psychiatry Program, a mobile mental health team visits patients at their homes, bringing medication and therapy to them. The state plans to create several more such units in the coming year.

Another Hopkins program, funded by the Robert Wood Johnson Foundation and called Health Care for the Homeless, sends nurses and psychiatrists into Baltimore shelters to treat the mentally ill. A separate, major grant from the same foundation, awarded to the city of Baltimore last October and expected to total \$3 million to \$4 million over the next five years, will be used to design a coordinated system of care for the mentally ill to reduce homelessness and help more patients lead productive lives.

And though they are far too few to meet the need, successful community programs for the mentally ill do exist.

One is People Encouraging People, or PEP, opened in 1981 with a combination of public money and donations from Northwest Baltimore businesses. With a \$1.5 million annual budget, PEP is now Maryland's largest community support program for the mentally ill, serving about 180 people at a time, 80 percent of them schizophrenics and most former patients of the state hospitals.

About 80 people each day come to the Bernard Schapiro Rehabilitation Center, where they learn simple clerical, carpentry and cooking skills, produce a PEP newsletter or learn basic social skills and personal hygiene. Another 20 at a time work at the PEP Bargain Outlet Store, selling clothing and household items in the Northwest Plaza shopping center.

In addition, PEP offers 41 beds in two supervised apartment complexes.

"We see even the most regressed folks move forward," said Stephen T. Baron, PEP's executive director. "For some, it may be that their task attention goes from three minutes to 15 minutes. For others, it may mean they get a real job."

The variety of jobs in the PEP store accommodates the episodic nature of an illness like schizophrenia. "If you start to hallucinate, maybe you can't work the cash register, but maybe you can sort merchandise," Mr. Baron said.

Dr. John B. Imboden, chief of psychiatry at Sinai Hospital, which works closely with PEP, said the program sometimes proves effective treatment for the "negative" symptoms of schizophrenia — apathy and lack of motivation — which anti-psychotic drugs cannot reach.

"Some of our patients who go to work in the store and have to pay attention to their dress, to combing their hair, they really seem to respond," Dr. Imboden said. "If you put someone in a group situation where a lot of interest is taken in him, it can really help with his morale."

A case in point might be Agnes C. Griebel, 66, who has schizophrenia and came to PEP in 1982 after 12 years at Springfield. She has been hospitalized briefly a few times since 1982, but on each occasion she was discharged not to a shelter or the streets, like Mary Thomas, but to a foster home and to the day program at PEP. Recently she moved to a new foster home in East Baltimore and began to attend a different program, called Crossroads.

At PEP, she worked mainly in the kitchen. "I clean up mostly," she said during an interview. "I might help to prepare simple things. I set the table. I wipe the table after lunch."

Despite the simplicity of the tasks, her participation had transformed her feelings about herself, Ms. Griebel said.

"You have to feel useful, you know?" she said. "I've come out of my shell. We laugh, and that makes me feel good."

—
"You have to feel useful, you know? I've come out of my shell. We laugh and that makes me feel good."

- Agnes C. Griebel, patient

The Making of a Psychiatrist

By Alice Steinbach



**Dr. Shayna Lee
began her six
training on Ward
3-F with some
apprehension.**

The names of the patients in this series, as well as certain details of their illnesses, have been changed to protect their privacy.

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THE BALTIMORE SUN

The day had barely begun on Ward 3F, one of four adult psychiatric units at University Hospital, but already the 15 patients on the unit were in disarray. It was 9 a.m. on a cold Monday morning in late March and group therapy had just started in the solarium at the back of the ward but, within minutes, anger surfaced as the theme of the meeting: Anger at the psychiatrists, anger at the nurses, anger at each other and, more subtly, anger at the distressing and puzzling illnesses that had brought each patient to this place.

The agitation, interruptions and shouting in the group escalated until some of the patients, frightened at the out-of-control behavior they were witnessing, withdrew into silence. Two of the patients stormed out of the meeting. One of them, Ellen Hopper, a short, compact woman with a pale, expressionless face and a history of manic depression, delivered a parting shot to Dr. Shayna Lee, the psychiatric resident who was leading the group that day:

"You think you know everything, but you don't. Everybody's at each other's throats, and I can't stand it," shouted Miss Hopper defiantly as she left the solarium.

Dr. Lee, who seemed unfazed by the outburst, responded by trying to bring the remaining patients into the discussion. Instead, a verbal fight broke out between two female patients who were sharing a room, with each accusing the other of annoying habits and sloppy hygiene. Threats of violence followed.

Dr. Lee quickly stepped in: "There is no place for violence on this ward. That's it," she said firmly. The two women backed off.

But the meeting was permanently off track, and at 9:40, the usual closing time, Dr. Lee ended it and the sullen, angry patients filed out of the solarium.

"Well, that was a toughie," said Dr. Lee to the staff who remained behind to discuss the patients' reactions. "But things were already boiling when the meeting started."

"This group is like a meat grinder," responded Dr. Gerard Hunt, a staff sociologist who has the chief responsibility for supervising the group meetings. "If you put your hand in today, you got it ground up. The healthy people are staying quiet. But I was thinking if I were here as a patient, I'd stay quiet too. It's just too expensive to get involved in the crazy, psychological behavior that's going on here." Then, turning to Dr. Lee, he said, "I thought you did a very good job in keeping order in a tough situation. It's hard work."

"Thanks," replied Dr. Lee. "I needed to hear that."

An hour later, Dr. Lee stopped in to see Ellen Hopper, who had been placed in seclusion in Ward 3F's "quiet room" for being "threatening" and "disruptive" out in the day room. Most psy-

chiatric units have a quiet room where patients who need to be removed from painful stimuli can be placed until they are able to regain control and deal with the ward environment. Technically, the room is called the quiet room when the patient can open or close the door at will. The same room is called "seclusion" when the door is kept closed (locked) whether the patient wants it or not.

Miss Hopper, 29, was no stranger to the seclusion room. Suffering from manic-depression — a mood disorder that is characterized by dramatic swings from profound depression to manic elation — Miss Hopper was a classic case of the "revolving door" patient. In and out of institutions for half of her life, she was able to function only when taking lithium, a potentially toxic drug that is the medication of choice for the treatment of mania. But, like many psychiatric patients on medication, Miss Hopper often forgot or refused to take her medicine. She also was one of those patients who needed to get to an almost toxic level of lithium before it calmed her down.

Inside the seclusion room, which is a bare room about 10 feet by 10 feet with a mattress on the floor and a window in the south wall, Dr. Lee was joined by Dr. William Hicks, the unit chief and attending psychiatrist of Ward 3F. On 3F — which is officially called the Affective Disorders Unit — Bill Hicks is the boss.

Together they approached Miss Hopper who, after an hour of howling and banging on the locked door, had seated herself on the bare floor next to the mattress and was rocking back and forth in a curled-up position. There was a strong odor of urine in the small room. Both Dr. Hicks and Dr. Lee assumed a squatting position and talked quietly to Miss Hopper who seemed to be responsive to their presence.

Then, suddenly, Miss Hopper jumped to an upright position. "Did you know that someone tried to murder me five times?" she asked, her voice rising. Dr. Hicks and Dr. Lee listened to her attentively and tried to question her, but she ignored them and grew more confrontational and angry. As they turned to leave, Miss Hopper lashed out at the two doctors: "Now that you've got what you want, you just leave."

"Miss Hopper, we're going to bring your lunch in here," said Dr. Hicks, "and then we'll come back later to talk to you."

By 1 p.m., Miss Hopper was out on the ward again. Her mood seemed to have soared. In the day room, where patients gather when not attending meetings or activities, she sang "Three Blind Mice" and performed an odd, little dance over and over again. But despite the seeming energy, her face betrayed no emotion. Except for the eyes. In Miss Hopper's darting, blinking eyes, there was more than a hint of desperation and fear.



The keys, for opening locked doors and the journal, for unlocking patient's problems.

Many psychiatrists look back on this aspect of their training as the hardest six months of their four-year residency. Her salary as a second-year resident was \$22,600.

None of the other patients sitting in the hot, smoky room paid any attention to her. Nor did they pay any attention to the flickering picture on the TV screen or the melodramatic voice accompanying it.

"Like sands through the hourglass," intoned the voice to a roomful of non-listeners and one dancer, "so are the days of our lives."

AT THE TIME OF THE INCIDENT WITH ELLEN HOPPER, Shayna Lee, then 28, had been a psychiatric resident on 3F at University Hospital's Institute of Psychiatry and Human Behavior for almost three months. She was one of 14 residents — half of them women — who were in their second year of psychiatric training at the institute, a center which offers a 4-year program designed to meet the requirements for the American Board of Psychiatry and Neurology.

Dr. Lee had spent her first year in the program — from July 1, 1985, to June 30, 1986 — doing six months of medicine and six months of psychiatry. The first six months of her second year — July to December 1986 — had been spent at Springfield, a large state hospital in Carroll County which, at any given time, may treat about 1,200 patients on more than 40 wards. On Jan. 2 of this year, she and five of her fellow residents — who had also been training outside of University Hospital at state facilities — rotated into the institute for a six-month stint working with acutely ill patients. Many psychiatrists look back on this aspect of their training as the hardest six months of their four-year residency. Her salary as a second-year resident was \$22,600.

At the end of June, the second-year residents would move on to their third year of training, a year devoted largely to work in the Division of Adult Outpatient Psychiatry. They would also continue treating discharged patients with whom they worked in their second year, as well as devoting time to child psychiatry. During the fourth and last year of training, Dr. Lee and the other residents would continue their supervised psychotherapy with outpatients and pursue elective work in areas of special interest to them.

Dr. Lee, a native of Houston, had done her undergraduate work at the University of Texas in Austin and then completed medical school at the University of Texas in San Antonio. She had applied to several prestigious post-graduate programs in psychiatry and received positive replies from places such as the Yale University Medical Center, the Johns Hopkins Hospital and University Hospital. She chose to train at University Hospital's Institute of Psychiatry and Human Behavior because she found it "larger, more diverse and eclectic than the others and because it is a good mixture of both aspects of psychiatry — the biological and the psychodynamic."

A confident, strikingly attractive woman with a healthy degree of competitiveness, Dr. Lee had begun her six months of training on Ward 3F with some apprehension. At Springfield, there was a much less rapid turnover of patients plus an internist who was available to take care of the patients' medical problems. On Ward 3F, where the average stay is about 18 days (although some patients may stay as little as 3 days and some as long as two months), the constantly changing patient population meant faster diagnosis, shorter treatment time and mountains of paperwork. The two residents assigned to the ward are also responsible for the medical as well as psychiatric care of the patients.

And there was one other factor which concerned both Dr. Lee and Dr. Joanna Brandt — the other second-year resident assigned to 3F — as they reported for work on Friday, Jan. 2: What would it be like working for unit chief Dr. William Hicks? His reputation had preceded him; the word was out among the residents that he was a bit obsessive and it took some time to get used to the way he did things. He was also known as someone who worked extremely hard, but sometimes kept odd hours. In addition to supervising the residents on a day-to-day basis, each attending psychiatrist, to a large degree, sets the tone of the ward for both staff and patients. The question was: Would there be harmony or dissonance on Ward 3F?

SHAYNA LEE'S FIRST DAY ON THE JOB — a gray, snowy day filled with post-holiday let-down among both patients and staff — began at 8 a.m. with "rounds" in the staff room. Rounds on 3F, which consist of the nurses' report on the behavioral and medical status of the patients on the ward, took place each day and were usually attended by Dr. Hicks, the two ward residents (Dr. Lee and Dr. Brandt) and Joanne Mahabal, the nursing supervisor. On this day, staff sociologist and consultant Dr. Gerard Hunt was also present.

The staff room, where the meeting took place, is a small, cluttered, airless room located just next to the quiet room. It is furnished with two rather worn sofas, several molded plastic chairs, a coat rack hung with wire hangers, a number of lockers used to house the staff's personal belongings and a small coffee maker.

After Ms. Mahabal briefed the group on the actions of the patients over the previous 24 hours, Dr. Hicks took over. He presented a brief history of the 11 patients who were on the ward and, in a businesslike manner, assigned five patients to Dr. Lee and six patients to Dr. Brandt. About 925 patients are admitted to the hospital's psychiatric wards in a given year, and over the course of the next six months about 75 of them would become Dr. Lee's responsibility.

(In the 1970s, a resident in Dr. Lee's position would have been responsible for about 20 patients over a six-month period; the increase in the number of patients passing through the ward is partly due to the emphasis now on short-term care for the acutely ill and partly to insurance coverage limitations.)

Although 3F is designated as the Affective Disorders Unit (a term used to categorize a group of mood disorders including depression and manic depression), only one of the patients assigned to Dr. Lee — a suicidal young man suffering from major depression — carried a diagnosis of an affective disorder. Because of the lack of space in other wards, there was a surplus of patients on 3F with schizophrenic symptoms of delusions and disorganization, as well as at least three patients diagnosed as having "borderline personalities," a puzzling, difficult-to-manage condition characterized by self-destructive, manipulative and impulsive behavior.

Joanne Mahabal, an experienced nursing supervisor, was candid with the two new residents about the state of affairs on 3F: "It's a war out there, and it's hard to change that with borderlines up against schizophrenics. What happened to the manic depressive ward? What happened to the manics? Where are they now that we need them?"

"That's a very good question," responded Dr. Hicks. "I laughingly told a colleague as I walked in this morning, 'We don't have one intact ego on the ward.' But let's not forget — they are patients who need to be in a hospital."

Later that morning, Dr. Hicks met privately with his two new residents to lay out his philosophy of how he ran 3F and what they could expect from him. An energetic, boyish-looking man of 30, Bill Hicks appeared to be an unusual combination of a take-charge attitude coupled with an unstudied gentleness, the latter quality being most evident when he dealt with patients. With residents, he was warm but sometimes, at least in the beginning, oddly formal.

"I'm an obsessive type," he began, confirming immediately the stories heard by Dr. Lee and Dr. Brandt. "And I'm very critical. But I wouldn't be doing you any favor by not being critical. You're here to learn. These are my patients and your patients, but in the push and shove of things I'm responsible for them legally and medically." He paused. "But as long as you do things the way I would do them, it's OK with me." It was a playful remark delivered with a smile and it coaxed laughs from the two residents.

"With a patient who is here for 16 days, you can only do so much," continued Dr. Hicks. "You have to set goals. By the time you leave here I want you to be able to make an accurate diagnosis — or to know that you don't have the data to make an accurate diagnosis. I want you to get

comfortable with deciding when and how to use a wide variety of psychotropic [mind-altering] medication. And I want you to develop a strategy for managing patients with complicated and acute and severe mental problems — often accompanied by severe physical problems. You will find that the patient's diagnosis is loosely related to the treatment. And the treatment? Well, the treatment is whatever works."

Then Bill Hicks added a few cautionary words of advice to Dr. Lee and Dr. Brandt: "People in medicine generally — and residents in particular — are often perfectionists. And they struggle to do things well. And you'll do that too. But sometimes — even if you had forever to work with a patient here — their illness will resist your best knowledge and those patients will stay sick."

After the meeting was over, Dr. Lee and Dr. Brandt walked to their offices — two small, sparsely furnished rooms adjacent to the staff room — and agreed in their assessments of Dr. Hicks. "I think there might be some minor clashes, but no major ones," said Dr. Lee.

Just outside the door to her office, Dr. Lee made the first contact of the day with one of her patients — a 41-year-old man named Joseph Biggs whose diagnosis was "schizophrenia, paranoid type." Schizophrenia has been described as an "enigmatic" illness, and one textbook defines it as "a group of disorders manifested by characteristic disturbances of thinking, mood and behavior." People with schizophrenia often suffer from delusions and auditory or visual hallucinations, symptoms which, because of their bizarre nature, are easily observable and have come to represent society's image of the "crazy" person. Mr. Biggs, a new admission, heard voices that told him he could fly; the voices then encouraged him to jump off the roof of the World Trade Center to prove his flying abilities. He also had an unshakeable delusion that he was the adopted son of Bob Hope.

"This is a good hospital," he told Dr. Lee, stepping in front of her and blocking the door to her office. "You just got to know what the deal is and get them to give you the right medications. If you don't get the right medications, you might end up hitting one of those doctors right in the head."

Before Dr. Lee could respond, Mr. Biggs, who was refusing all medications, turned and walked away. Later that day, after threatening several patients, Mr. Biggs had to be restrained and kept in seclusion for three hours. (Patients in seclusion are checked by a nurse every 15 minutes and after six hours of seclusion, a new order must be written by a physician for another six-hour period.)

Weeks later, Dr. Lee admitted that she was "very afraid" of Mr. Biggs initially and that days



Dr. Hicks on the left and Dr. Lee on the right of a patient.

"We don't have one intact ego on the ward. But let's not forget — they are patients who need to be in a hospital."

-Dr. Hicks



"Have you ever taken an antipsychotic?" Dr. Lee was asked. "No, but I've been thinking about it. All the patients say it's awful..."

passed before she felt comfortable seeing him alone in her office for psychotherapy.

ABOUT 97 PERCENT OF THE PATIENTS on 3F were prescribed one form or another of medication. Still, non-compliance (refusing to take medication while on the ward or discontinuing it once out of the hospital) was a constant problem faced by Dr. Lee and the other psychiatrists. There are a number of reasons for non-compliance, but the two most prevalent are the belief held by many acutely ill patients that they are not ill, and the frightening and debilitating side effects which often accompanied the medications.

Among the most common side effects caused by antipsychotic drugs such as Haldol and Thorazine (drugs that are often quite effective in reducing or controlling certain schizophrenic symptoms but not curing the illness) are drowsiness, dry mouth, blurring of vision and constipation. Often such symptoms disappear as the patient adjusts to the medication. More frightening to the patient, however, are the symptoms involving posture and movement: uncontrollable and bizarre movements of the face, neck, tongue and eyes (known as a dystonic reaction) or a diminished spontaneity of physical movements and speech (akinesia).

Such side effects can often be dealt with by lowering the dosage of the medication or switching to another medication. In addition, there are drugs such as Cogentin or Artane, which may block the side effects. Unfortunately, these drugs also may produce their own side effects.

One of the most serious possible side effects, appearing usually when a patient has been on an antipsychotic drug for more than one to two years, is tardive dyskinesia. It is a disfiguring condition, sometimes an irreversible one, characterized by jerking movements of the body, arms and legs and involuntary facial grimacing, lip smacking and darting, snakelike tongue movements.

For a psychiatrist like Dr. Lee, prescribing such drugs becomes as much an art as a science: Changing medication, adjusting dosages, combining a number of medications involves keeping both safety and sensitivity in balance. It also requires a certain empathy for what the patient is experiencing, coupled with an ability to convince those desperately in need of medication that the benefits of a carefully monitored drug therapy outweigh the possible side effects. Usually, Dr. Lee was able to convince her patients — often in the psychotherapy sessions she held with them in the afternoons — to comply with the medications.

One afternoon in late March, however, when Dr. Lee and Dr. Hicks were interviewing Cheryl Larsen, a very articulate 35-year-old woman who was refusing all medication, they were con-

fronted with an interesting question from their patient. Miss Larsen — a woman who was diagnosed as having a borderline personality disorder and had been brought to 3F, handcuffed to a stretcher, by the police — was telling the two psychiatrists that all the medications made her physically ill. Dr. Hicks responded by trying to come up with a drug that would not upset her physically.

Suddenly Miss Larsen lashed out at Dr. Hicks: "How would you know what drug upsets me physically? How would you know how it feels? Have you ever taken one of those drugs?"

"That's a good question, Miss Larsen," replied Dr. Hicks evenly. "No, I haven't." The interview continued for several more moments but there was no resolution to the problem and the patient left still refusing medication.

"She's still very psychotic," commented Dr. Lee. "Yes, she really is," responded Dr. Hicks. "And if she doesn't agree to take the drugs in a few days, we'll convene a clinical review panel. In an emergency situation I can authorize medication against her will."

Oddly enough, about three weeks before Miss Larsen asked Dr. Hicks if he had ever taken an anti-psychotic medication, Dr. Lee had been asked the same question, but not by a patient. Residents training on the inpatient wards at the hospital are supervised by two experienced psychiatrists who each come into the hospital once a week to discuss specific patients under the residents' care, and the question to Dr. Lee was posed by Dr. Sunday June Pickens, one of her supervisors. The two women were discussing the issue of non-compliance with medication when Dr. Pickens suddenly asked: "Have you ever taken an antipsychotic?"

"No," Dr. Lee answered, shaking her head. "But I've been thinking about it. All the patients say it's awful. That it slows your thinking and makes you zombie-like. I can relate to that part of it." She laughed. "After being on call for 36 hours, my thinking is slowed. What I can't relate to is the frightening aspect of it."

"It is awful," said Dr. Pickens. "I tried it when I was a resident — and I have never done it since. I took Haldol and Mellaril [drugs commonly used to treat schizophrenic symptoms] and it was a frightening experience. It's like waking up in a swimming pool full of water and trying to struggle to the top."

"How long did the effect last?" Dr. Lee asked.

"Well, there's a different effect when you don't have a psychotic experience. But you experience all the main effects. You have an abnormally keen sense of hearing, often with pain in the ears. You drop a pencil and it sounds like an explosion. And you have a sense of foreboding, a feeling that something is wrong, and you can't even turn around to cope with it because you

feel like you've got all these nets and sinkers hanging from you. It seemed to last a long time and it certainly made me a believer in paying attention to patients' complaints about medication."

"Knowing all that," Dr. Lee asked, "how do you reconcile encouraging patients to take it?"

"I think the patients respond to your awareness that it is an unpleasant and uncomfortable experience — but that it's better for them to do it. Non-compliance is one of the major causes of relapse and patient education about drugs is a very important aspect of treatment. And after you have been on the medication for a few months, many of the side effects start to wear off."

"Yes, I've seen that with Joseph Biggs," said Dr. Lee. "He came into this hospital very paranoid — very hostile and very aggressive and non-compliant with medication. For the first 10 days he was very threatening. But after a week or so on high doses of Haldol, he was much, much better. It's amazing. I was so afraid of him when he first came in. A couple of times he actually cornered me in the day area . . . But that's disappeared and he doesn't even remember it. Now he's pleasant and able to talk to other people, although he still has some persistent paranoid [ideas] . . . But the striking thing about this patient — and I haven't seen it with other patients — is that now he is able to verbalize his feelings about the paranoia, the illness."

"That's good," responded Dr. Pickens in an encouraging voice. "A patient's ability to talk about his illness is probably where you're going to learn the most about any disease process. The more information you get from a patient about their comparison between now and then — and their awareness of the differences — the more you're in a position to help them understand their illness." It was a useful piece of information that Dr. Lee was to use over and over again in the interviews she conducted from that point on.

The discussion turned to Anne Jarvis, another of Dr. Lee's patients. Miss Jarvis, a clinically depressed 45-year-old woman who had been in and out of therapy for a period of 20 years with very little change in her condition, spent a good bit of her time complaining to Dr. Lee that not only was she not being helped, she was actually growing worse each day. Her accusation troubled Dr. Lee and evoked feelings in her that she was not doing a good job with this patient.

Dr. Pickens listened attentively to the doubts expressed by the young doctor who sat opposite her. Then she answered: "You know, you're particularly vulnerable in your residency as far as being able to feel like you're doing a good job. To some extent you'll probably always feel vulnera-

ble. Most of us do when patients say, 'You're not helping me.' But it is much more of an issue now because you're less secure about your ability."

It had been a helpful and productive hour for Dr. Lee who admitted, as Dr. Pickens rose to leave, that she was feeling more than a little "overwhelmed" and "stressed out" as she drew near the end of her second month on the ward.

Out in the hallway, the two women talked about Dr. Pickens' dogs. "Hey," asked Dr. Lee, "can I borrow one of the dogs for the weekend? I feel so lonely. It would be nice to have someone around."

Sunday June Pickens, named in honor of her birthdate, is a warm, attractive and extremely bright psychiatrist who seemed to have forged an especially close relationship with her younger colleague. In addition to their professional interests, they had at least two other shared experiences: Both are black and female which make them something of a rarity in the field of psychiatry. Of the approximately 35,000 practicing psychiatrists in this country, about 6,000 are women. And of the approximately 900 black practicing psychiatrists, roughly 265 are women.

Dr. Pickens expressed high hopes for Dr. Lee's future: "She has good instincts and a level of confidence that allows her to try things," she said one day after a supervisory session with Dr. Lee. "She's sensitive, she reads a lot and she's very receptive to supervision. I think she's going to be an excellent psychiatrist."

Dr. Pickens and Dr. Lee both belong to the Baltimore chapter of the Black Psychiatrists of America and saw one another at meetings as well as socially. It was part of the support system Dr. Lee, who is one of the two unmarried residents in her group, had built up during her first year in the program. But the demands of the job left little time for a social or personal life. Dr. Lee, who rose at 6, officially began her day at 8 a.m. and often worked until 8 or 9 in the evening. Then she usually headed home to the downtown apartment she shares with a female attorney to read professional papers until midnight. Lunch and dinner — when she took time to eat a meal — often consisted of a sandwich eaten during a meeting or a quick pass at the patient's buffet table in the day room.

Residents on the inpatient wards were also required to be on call every sixth night. Beginning at 4 p.m. and continuing until 9 a.m. the next morning, the on-call resident was responsible for covering the acute needs of all the psychiatric wards and for providing emergency consultation to the general hospital wherever a psychiatric problem arose.

In addition, the on-call resident was responsible for rendering psychiatric evaluation of pa-

"Non-compliance is one of the major causes of relapse and patient education about drugs is a very important aspect of treatment," says Dr. Sunday June Pickens, one of Dr. Lee's supervisors.

Dragging a plastic trash bag filled with her belongings, Miss Hopper then turned to Dr. Lee:

"I'm really going to miss you. You've been good to me. I need to grow up, don't I?"

tients referred by the emergency room. Emergency room consultations during a resident's on-call night were considered one of the most difficult aspects of the job, partly because of the emergency nature of the situation and partly because the resident was called upon to make crucial decisions (often after being awake for more than 25 hours) as to whether a patient should be admitted to a hospital or released. With suicidal patients, this could be a life-and-death decision. There were weeks when Dr. Lee and her fellow residents were scheduled to be on call twice in a period of 7 days.

Although Dr. Lee — a woman with a slim, well-toned body and a natural elegance that suited perfectly her stylish way of dressing — never looked or acted tired in meetings or with patients in the ward, the grueling schedule was taking its toll. "I'm just dragging," she said sitting in her office one morning after an on-call night. "My energy level is way down. It's only March and already I feel burned out. I had one and a half hours sleep last night and I'm going downward. I saw one patient in the emergency room last night who was a homeless drug addict — and I didn't want to admit him. We're not a drug treatment program. But what am I going to do? He's saying, 'I'm going to leave here and kill myself if you don't admit me. But first I'm going to tell the whole world I saw you and you wouldn't help me.'"

Dr. Lee admitted him.

Earlier that day Ellen Hopper's insurance ran out (to be admitted to University Hospital, a patient's approximately \$400-a-day stay must be covered by some form of insurance) and she had been transferred to a state hospital. Disruptive up to the last minute, Miss Hopper was able to emerge from the quiet room about 10 minutes before the ambulance and attendants arrived to transport her. For several moments she worried out loud about the safety of the move: "Are you sure they won't hurt me over at that hospital?" she asked in an uncharacteristically timid way. "How do you know those ambulance drivers won't take me into the woods and dump me? Do you know them personally?"

Dragging a plastic trash bag filled with her belongings, Miss Hopper then turned to Dr. Lee: "I'm really going to miss you. You've been good to me. I need to grow up, don't I?" she asked. "You need to take your medication [lithium]," Dr. Lee responded, putting an arm around the frightened woman's shoulder and walking with her to the exit.

DR. LEE WAS NOT THE ONLY RESIDENT who was reacting to the long hours, the fast turnover of patients and the grueling paperwork. Often the six residents on the inpatient wards met for lunch — usually a sandwich or salad hastily eaten during a meeting to discuss

how they were doing — and inevitably the talk turned to the amount of stress each was feeling. One day — about four weeks into her residency — Dr. Lee took time out to lunch in the cafeteria and compare notes with Dr. Joanna Brandt, her fellow resident on Ward 3F.

"I wish I were back at Springfield," said Dr. Brandt, referring to the six months she and Dr. Lee had spent training at the state hospital.

"I don't think I can take this for six months," Dr. Lee responded. "There are too many patients and they're here for too short a time. What we're doing on Day 1 here is what we'd be doing on Day 16 at Springfield." She paused and shook her head. "Diagnosis and disposition [planning for the release of the patient] on the same day."

"I didn't know I'd have so little time in the office with patients," said Dr. Brandt. "I guess I expected it, but it's still disappointing."

On the positive side, however, both residents agreed that working with Bill Hicks had turned out to be — so far — a good experience. "I think Bill is good at what he does. He's smart and has a lot to impart," said Dr. Lee. Joanna Brandt nodded in agreement. "He does take the time to know the patients on the ward, and he can talk about any of them with you. I like that part of him."

In fact, Bill Hicks — whose teaching style was anecdotal and literate and often peppered with quotes and ideas from Mark Twain, William Faulkner and Greek myths — was turning out to be a supportive and insightful supervisor. He was also a hands-on kind of supervisor, one who preferred not to keep his distance from the patients.

The pressures on 3F, however, continued to build and by the middle of March, Dr. Lee seemed to hit her lowest point.

The patients were unusually disruptive and some tension had developed between the nursing staff and the doctors about approaches to patient care and what constituted an appropriate admission. It was a predictable development in a situation where the residents might come and go but the nurses remained, the true foot soldiers in the day-to-day battle against the patients' illnesses.

"I'm feeling cranky and irritable," Dr. Lee said after a particularly bad on-call night at the end of the second week of March. "I just want to leave the nursing area to come to my office for solace. I have the urge to throw things, and I'm feeling depressed and not sleeping well. And I'm being overly compulsive here. Even though I hate this place right now, I'm staying here till 11 at night — punishing myself. I feel I can't do anything right."

It was not an unusual reaction to the rigors of working with acutely ill patients who were quite capable of using their manipulative skills to sep-

arate the staff into smaller, fractious groups. At a deeper level, each resident had to struggle with the daily exposure to the psychopathology exhibited by 3F's patients — and their personal reaction to it. Often such interaction with the patients caused the residents' own conflicts to surface, and gaining insight into these feelings was an important part of their training. At least three of the residents were already in psychotherapy and Dr. Lee was thinking about it.

"There's a lot of stress in doing this that I never realized would have to be dealt with. And that's why I think being in therapy would be helpful. I didn't realize how difficult it would be to do therapy with patients — getting into their personal problems and remaining objective. A lot of things patients say may stir up some unresolved issue of my own and I want to be able to process that."

"And I think I am being harder on myself than I need to be. I always feel I should know more and do better. And I have to ask, 'Why am I doing this to myself?'" She laughed. "People ask me if I feel any special pressure to prove myself because I'm black. Well, I always felt there's a special pressure to prove myself because I'm me. I'm competitive."

By the beginning of April, however, Dr. Lee was feeling more confident about her duties on Ward 3F. Two of the patients she had discharged a month earlier continued to do well on the outside and she laughingly referred to them as her "success stories." She was also doing out-

patient therapy with two other patients and found it very challenging. The paperwork, while still voluminous, had become more routine and she was able to schedule more time for individual psychotherapy with patients on the ward.

"I feel better about things," she said one morning toward the middle of her fourth month on 3F. Then she laughed. "Maybe it's just that I've lengthened my day and I'm spending more time here. I may be here until 10 at night. So now instead of going home and collapsing at 7, I go home and collapse at 10. Or maybe it's just that I feel more competent than before."

Dr. Lee's competence would soon be tested by a particularly challenging patient. On the following Monday morning Dr. Hicks approached her after rounds. "We admitted a new patient over the weekend," he told Dr. Lee, "and she's going to be your patient. But she's got a lot of problems and I'd like to talk to you about her."

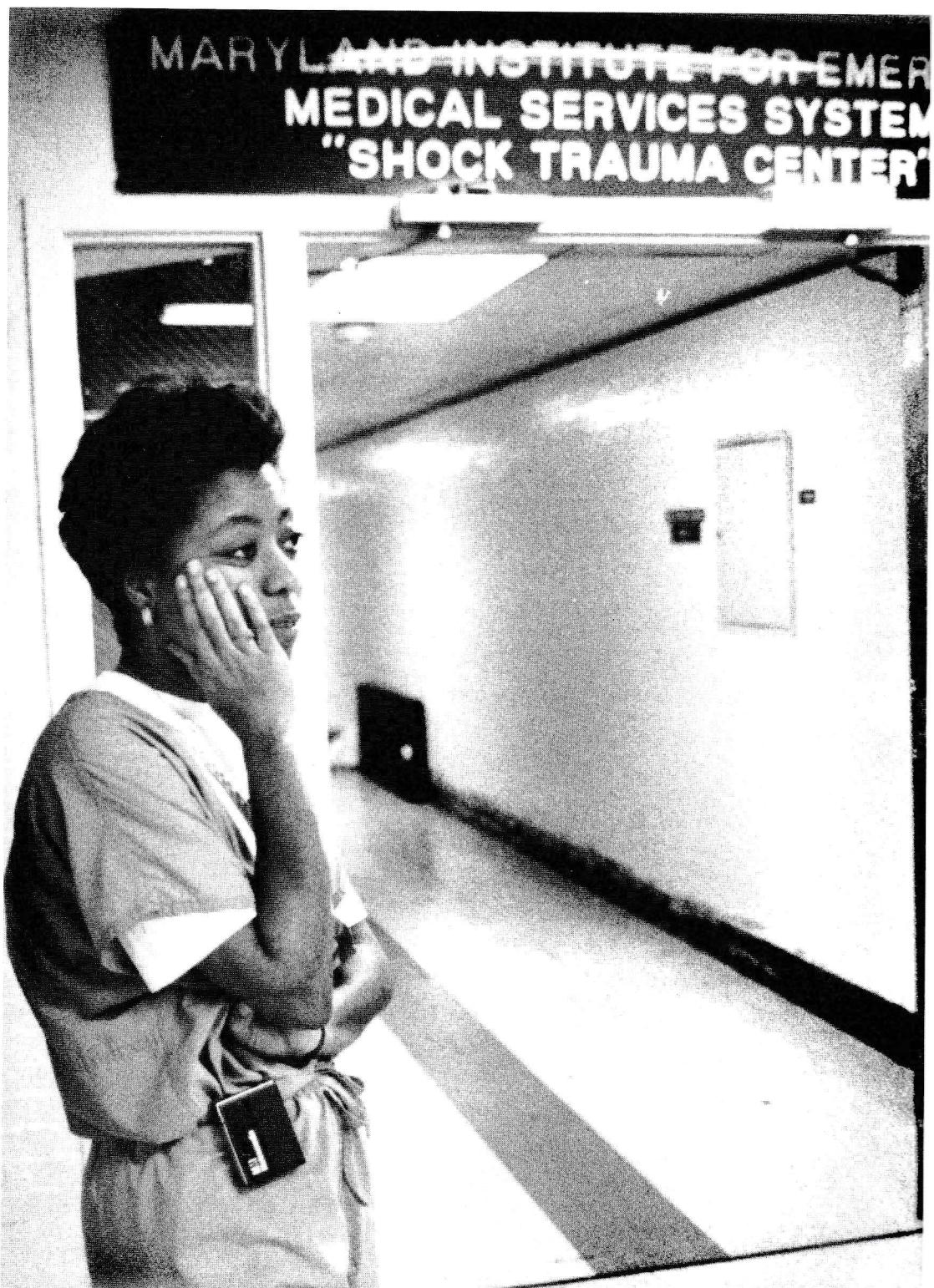
"What's her name?" asked Dr. Lee.

Bill Hicks handed her a blue binder filled with notes. "Her name is Patricia Wells and she's an attorney — a very bright, verbal woman. With a patient like this you have to be very careful not to treat her like a VIP. There's a tendency to identify with this kind of patient. She's pretty sick, though. I think she has a borderline personality. Somebody like this is going to set you up for rejection. The other thing she'll do is set you up to put limits on her and then get really angry at you for doing it. So be real careful," he warned.

"A lot of things patients say may stir up some unresolved issue of my own and I want to be able to process that," said Dr. Lee.



Dr. Lee on call Part two



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THE BALTIMORE SUN

At 8 a.m. on a rainy April morning, the phone rang in Dr. Shayna Lee's office, waking her up from a 30-minute nap. "It's going to be a crazy Monday," predicted Dr. Lee, a psychiatric resident on Ward 3F at University Hospital, as she roused herself from the couch in the small office she occupied.

Although the 15 patients on 3F, one of four adult-inpatient wards at the hospital's Institute of Psychiatry and Human Behavior, were just beginning their day, Dr. Lee was about to start her 24th hour on the job. She had been the on-call psychiatric resident for the entire hospital the night before and, not surprisingly, her energy level was way down. She realized that getting through the day — particularly a Monday — would require summoning up all her reserves of stamina and patience.

Dr. Lee's three months on the job had taught her, among other things, that Monday mornings on 3F were, as one patient put it, "the pits." Partly the Monday morning mood on the ward could be attributed to the usual beginning-of-the-week blues; partly it was due to the frustration felt by many of the patients who were returning from a leave of absence on one or both of the weekend days.

Going home was often a difficult experience for the patients confined to Ward 3F, a ward officially designated as the Affective Disorders Unit. Suffering from such illnesses as major depression, manic depression and schizophrenia, 3F's patients were in the hospital, in part, because they needed to be temporarily sequestered from the outside world. And often even a brief return to family and friends stirred up troubled feelings — which then were acted out on the ward.

But as Dr. Lee washed her face and brushed her teeth in the small lavatory attached to her office, she sensed that this Monday had the potential to be far worse than usual.

It had already been a crazy night for the 28-year-old resident. Her on-call work had kept her in the emergency room much of the night admitting acutely ill patients — one of them a depressed, 11-year-old girl who had attempted suicide by setting herself on fire — or trying to find beds at other facilities for those who had to be turned away. On top of that, at about 11 p.m., a fight had broken out on 3F between two particularly disruptive patients.

One of them — a loud, aggressive 30-year-old woman named Helen Grant, who carried a diagnosis of manic depression — had provoked a verbal confrontation with Susan Robinson, 28, a hallucinating, schizophrenic patient. But despite Miss Grant's surplus of hostile, manic energy, she proved to be no match for the much larger and stronger Miss Robinson, who grew more and more out of control. As the angry

confrontation escalated and physical threats erupted, other patients on 3F jumped into the fracas. It was midnight before Dr. Lee and the nursing staff were able to get the situation under control.

Four of the patients involved in the fight, including Miss Grant and Miss Robinson, had to be placed in small, locked "seclusion" rooms throughout the hospital. According to the nursing staff on 3F, this had never happened before — so many patients in seclusion at one time — and it cast a particularly troubled shadow over the ward.

As Dr. Lee prepared to face the day, she reflected on the incident that had occurred on her watch and the way it was affecting the mood on the ward: "This morning the nurses complained to me, 'This is the worst it's ever been — all the seclusion rooms in the psychiatric wards are filled with our patients.' I feel like it's all my fault." She paused and turned to stare out the window.

"But this is exactly the kind of thing you worry about when you're on call and have to make quick decisions. I was concerned there would be physical blows, and I wanted to avoid that. Susan looked like she was going to kill Helen. So I said, 'Separate the women and put them in quiet rooms.' And, as a result, there were no blows. In my opinion, I made the right judgment call."

In fact, despite the momentary confusion on the ward, Dr. Lee was feeling much more confident and competent in her work as she approached the last two months of her second year as a psychiatric resident. When she first arrived on Ward 3F on Jan. 2, she had felt frustrated by the constant staff meetings she was required to attend, the overwhelming paperwork attached to each patient and the limited stay (18 days on average) of 3F's charges. Over and over again during those early months, Dr. Lee questioned whether it was possible under such conditions to make a difference in any of her patients' lives.

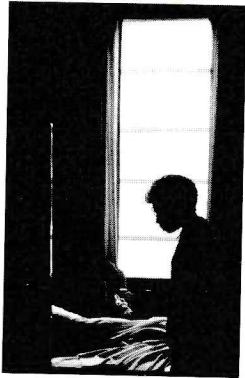
But in subtle ways, the months of training under the supervision of several experienced psychiatrists, social workers and psychologists, as well as the hours spent each Thursday in classes and seminars, had started to kick in. Not only was Dr. Lee feeling confident enough to take in stride an incident such as the one between Miss Grant and Miss Robinson, she had also been able to reach a more realistic view of what she could offer a patient on 3F.

"My task here is to learn to do good inpatient work," said Dr. Lee as she continued to review the previous night's incident. "And, certainly, crisis intervention is part of that."

Later that day, Dr. Lee was visited by Miss Robinson's mother. She wanted an accounting from Dr. Lee of the way her daughter had been



There is an overwhelming amount of paperwork attached to each patient.



"A patient like this has a strong investment in being the way they are - any time you try to bring them over to your way of thinking, there's going to be resistance," Dr. Hicks told his young resident.

handled the night before. "I know Susan's sick, but why was she put in seclusion and given medication after she had calmed down and gone back to her room?" asked Miss Robinson's mother in a challenging manner.

"We had to put her in the quiet room because she lost control of the situation," responded Dr. Lee in a sympathetic, soothing tone of voice. "And we gave her medication because she was very loud, kicking and unable to calm down."

Miss Robinson's mother listened without comment and Dr. Lee continued: "Susan is going through a very difficult time right now. She is under a tremendous amount of stress and what we did was to prevent her from hurting Miss Grant — or hurting herself. You realize that your daughter was on suicide precautions when she first came in." Dr. Lee paused. "How does she look to you today?"

"She looks awfully angry," replied the patient's mother. But the challenging tone had disappeared, and she seemed to accept Dr. Lee's assessment of the situation.

While Dr. Lee was talking to Miss Robinson's mother, a commotion had been going on out in the hallway. When Dr. Lee stepped out of her office she saw seven staff members — five men and two women — gathered around the doorway to 3F's quiet room. Inside the quiet room was Hannah Rogers, one of the most combative patients on the ward. An extremely manic, angry woman who heard voices that told her to stab someone, Miss Rogers, in prior hospitalizations, had been treated with a long list of drugs including Prolixin, Navane, Mellaril, Thorazine, Stelazine (all antipsychotics) and lithium (a drug used to treat mania).

Now — completely out of control and refusing medication — Miss Rogers was being confronted by the staff in what is called a "show of force." (The philosophy behind a show of force is that a patient with no inner controls will respond to signs of outer controls and calm down.)

"She is one of the most abusive patients I've ever seen," said Dr. Sharon Bisco, a psychiatric resident from another ward who was participating in the show of force. "Everyone on the ward is frightened of her. Lithium might help her, but she won't take medication. Months could pass before she gets better without it. In the old days — before lithium — that's exactly what would happen to a patient like this."

Kneeling beside Miss Rogers in the quiet room was Dr. William Hicks, the young, energetic psychiatrist in charge of Ward 3F. He was having no success in his attempt to persuade her to take the medication she needed. Finally, without her consent (patients who present a danger to themselves or others may be medicated against their will), she was given an injection of Prolixin, an antipsychotic drug.

For the next week, Miss Rogers continued to act in a wild, threatening manner. All attempts to move her out of seclusion and back onto the ward ended in failure. The staff could only hope that the forced injections would take effect so the doctors could convince her to be treated with lithium.

ABOUT HALFWAY THROUGH HER RESIDENCY, Dr. Lee received her first evaluation from Dr. Walter Weintraub, the institute's director of graduate education. "It was a very favorable evaluation," she said one afternoon in early March. "But I need to work more on getting an in-depth history about the patient, formulating character structure and ego functioning — taking a more psychoanalytic view. I'm very weak in that. You really need to do outpatient work over a long period of time to begin to feel comfortable with that."

"Right now, I'm concentrating on the acute process, and I often overlook the underlying psychological structure — because I'm trying to get patients out of the hospital. And I guess at this point, I don't feel comfortable working with neurotic patients because my level of expertise is so bad."

But about a month after this candid appraisal of her skill, or lack of it, in dealing with the complexities of insight-oriented, or psychoanalytic, therapy, Dr. Hicks asked Dr. Lee to take on a 35-year-old woman who would require just this sort of approach.

"Her name is Patricia Wells, and she's an attorney," said Dr. Hicks. "A very bright, verbal woman — the kind of person it's easy to identify with. But she's pretty sick. She's got a history of anorexia (an eating disorder), depression and suicidal thoughts. I think she has a borderline personality. And there's no magic bullet for a character disorder like this — no Haldol [an antipsychotic drug] you can give her to bring back her self-esteem."

"A patient like this has a strong investment in being the way they are — and any time you try to bring them over to your way of thinking, there's going to be resistance. There are only two things you can do with this kind of disorder: One is to keep them from killing themselves, and the second is to do your level best to see when they leave the hospital, they go into some therapeutic setting."

Over the next few weeks, it was clear that Dr. Lee was struggling in her work with Miss Wells. In her weekly sessions with supervising psychiatrist Dr. Sunday June Pickens, Miss Wells was usually the first case Dr. Lee wanted to discuss.

"I feel so insecure about her," she told Dr. Pickens one morning. "I need to get to know her better, and so I'm trying to see her every day for 30 minutes. There's a lot of identification going on — I look at her and see a lot of myself in her

— the ambition, the dedication to doing well in your work. She has accomplished that in the past.

"But there's also a lot of subtle power plays going on. She'll tell me: 'Doctor, I really feel good talking with you. I feel comfortable, I feel relaxed.' I have this sense she's thinking, 'If I butter you up, you'll give me what I want.' And although parts of the relationship have been positive, I think that in a long-term therapy situation it could become negative. I see conflicts coming up because she's not going to get what she wants. Right now, it's almost like we're both trying to please each other." Dr. Lee paused. "I'm having trouble deciding what I should focus on in this stage of the treatment."

"Have you talked to her openly about the issue of not giving her what she wants?" responded Dr. Pickens.

"No, I haven't," replied Dr. Lee. "But I see myself getting to that point."

"It is probably important to confront that issue now. You're getting the feeling that Miss Wells is asking you to do something that will be detrimental for her — that she's negotiating with you. That's the way she operates, the way she's gotten things done. Let her know how she's negotiating with you. Get her to recognize that just because you won't do things her way doesn't mean you're not aware of how she feels."

Dr. Pickens paused and then, in a reassuring voice, added, "Right now you're not feeling very secure about your ability. You want to help the patient but you're at a stage in your residency where you're feeling very vulnerable. Particularly with a patient like this . . . What you need to do now is find the common thread among all her symptoms and connect them together. And that's going to help her see herself as a whole."

Then she cautioned Dr. Lee: "She could become a suicide risk as discharge time comes closer. And, if she has the insurance, I would probably lean in the direction of giving her a little more time. She is the type of person who is at high risk."

Over the next few weeks, Miss Wells was moved from the hall (she was on suicide precautions and slept near the nurses' station) into a semiprivate room. At first she spent most of her time sitting at a table in the day area, crying. Gradually, though, she began to talk to the other patients. Her eating problem, however, continued. She refused to eat the specially prepared meals and burst into tears at even the slightest suggestion by the staff that she try to eat more. "You're just trying to control me," she would shout. "Don't you think I know when to eat?"

One afternoon Dr. Lee discussed Miss Wells' treatment with Dr. Hicks. "I've never treated anyone with an eating disorder before," Dr. Lee

said. "And a patient with an eating disorder and a borderline personality . . ." Her voice trailed off. "All I did this weekend was read on eating disorders. Miss Wells has become a great challenge."

Dr. Hicks agreed. "A patient like this is very difficult to treat. It takes lots of effort. You're talking long-term therapy — with lots of ups and downs. It has been my experience with this type of anorexic patient that they stay sick a long time. Sometimes they die. But sometimes over a long course of therapy, the cumulative treatment begins to take effect. And sometimes it is pretty dramatic."

"I guess I'm feeling very guilty that she's not doing better now," Dr. Lee said. "I guess that's the part of me that wants to heal all quickly. But I have to recognize that here's a lady who will need long-term psychotherapy, and that there is no quick cure for her."

"She will try to manipulate you," warned Dr. Hicks. "People with personality disorders like Miss Wells are constantly trying to manipulate you, because they have such an unreliable sense of self-esteem. But it's important to remember they manipulate from the standpoint of protecting themselves."

Over the next few weeks, Miss Wells began eating, and her mood on the ward was definitely brighter. The sessions with Dr. Lee seemed to be helping Miss Wells in the sense that she was able to contemplate seeking long-term treatment upon her discharge from 3F. Miss Wells brought up the subject one day with Dr. Lee: "I'm thinking about who my outpatient therapist is going to be. And I'm wondering if you could continue to see me."

Dr. Lee hesitated before answering. "I think we both have to think about that and talk about it some more," she replied.

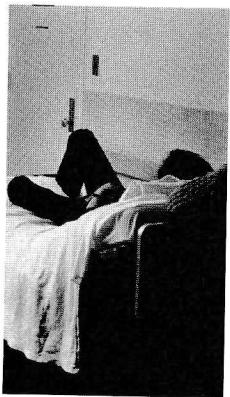
AT 4 P.M. ON A THURSDAY AFTERNOON in May, Shayna Lee clipped on a beeper and prepared for the long night ahead of her. Psychiatric residents at the hospital were required to be on call every sixth night and, in many ways, it was the most demanding part of the job. Not only were they required to work straight through the night (after putting in a regular 9-hour day), they were also responsible for covering the acute needs of all the inpatient psychiatric wards and providing emergency consultation to the general hospital.

It was an awesome responsibility, one which required making crucial decisions about acutely ill people, often in a crisis situation. And even though there was a backup system — a resident could call a senior psychiatrist for consultation — Dr. Lee and her fellow residents approached their on-call duties with some apprehension.

On this particular night, there were four beds available for new admissions on the inpatient



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"Why are you here?" "I took an overdose," he replied in a flat voice. "Why did you do that?" "I don't know. I guess for attention."

wards — two of them on 3F. Once these beds were filled, Dr. Lee would have to locate beds at other facilities for patients needing hospitalization.

At 4:30 Dr. Lee checked her beeper. "I just want to make sure it's working," she said. "Usually by this time, something's going on."

In fact, as 8 p.m. approached, it looked as though it might be a quiet night. The patients on 3F were preparing to attend a dance in another part of the building, and the ward had taken on an odd, festive air — almost reminiscent of high school students getting ready for a prom. Patients talked together in small groups as they waited for aides to accompany them to the dance, and it was obvious most had taken some pains with their appearance. Even Miss Rogers, so wildly agitated just a few weeks before but now responding to medication, had combed her hair and put on lipstick.

But the star of the evening was Helen Grant, the instigator of the fight that had broken out on 3F a few weeks earlier. The last to emerge from her room, she sailed into the day area like an exotic parrot. Wearing striped purple, red and green harem pants, a shimmering metallic blouse, high-heeled green pumps, a feathered hat and pixie sunglasses, she exuded a peculiar sort of high style. Like an avant-garde artist who pushes the boundaries of ordinary beauty beyond the public's ability to understand it, Miss Grant managed to convey a sense of aesthetic symmetry that was dazzlingly original. ("It is a trait that is often true of maniacs," said Dr. Lee of Miss Grant's unconventional artistry.)

As the patients trooped out of the ward to the dance, Dr. Lee's beeper went off. It was the admitting office. An 11-year-old boy had just been brought in by his mother after he had attempted suicide. Would Dr. Lee come down to talk to him?

When she arrived in the admitting office, Dr. Lee introduced herself to Billy Andrews, a sixth-grader who had taken an overdose of his mother's medication. Drawing the confused-looking boy aside, she gently questioned him. "Why are you here?"

"I took an overdose," he replied in a flat voice.

"Why did you do that?"

"I don't know. I guess for attention."

"Are you still feeling like you might hurt yourself?"

"No," he answered softly.

After talking to the young boy for 30 minutes, Dr. Lee decided to admit him to Ward 4G, the children's unit.

It was a little after 9 p.m. and, by now, Dr. Lee's beeper was going off regularly. Two patients were waiting to see her in the admitting area but, as she started toward them, her beeper went off again. She picked up a phone to answer

her call and was told there was an emergency on the 10th floor of the hospital. A patient recovering from serious surgery was threatening to leave against the medical staff's advice. "So what you're saying," Dr. Lee replied, making sure she understood the situation, "is that this is a life-threatening situation, and if he walks out the door he could die." That was the case, she was told.

It took Dr. Lee about four minutes to get from the admitting office to the 10th floor. When she arrived on the scene, the patient was dressed and standing next to the elevator. Three security guards were standing off to one side and a number of nurses and residents were trying to reason with him. "I am leaving tonight," he screamed as Dr. Lee approached him. "Leave me alone. I'm not talking to you." the man's fury was evident and, for a few tense moments, the situation had the potential for violence.

Dr. Lee continued to talk to the man, holding her ground a few feet in front of him. After about 10 minutes, he reluctantly returned to his room. After consulting by phone with a senior psychiatrist, Dr. Lee decided to draw up certification papers for the man, a procedure which would allow the staff to use restraints if the patient tried to leave again. It was 10:30 p.m. when Dr. Lee left the 10th floor.

Over the next four hours, she admitted two patients, saw a third in the emergency room and released him, and spent an hour in Ward 4G with Billy. It was 2:30 a.m. when Dr. Lee returned to 3F to plop herself down on the sofa in front of the television set. The patients were asleep and the ward was quiet, almost eerily so. She ate some saltine crackers and watched television with the two night staff members for a few minutes and then headed into her office to dictate some discharge summaries.

After about 20 minutes of dictation, Dr. Lee realized she hadn't turned on her tape recorder. "I'm too sleepy," she said, disgusted at the time she had wasted. "I'm going to bed." On her way up to the fifth-floor on-call room where residents can nap, her beeper went off again. It was the emergency room; they needed a confirmation on the medicine she prescribed for a patient.

At 3:30 a.m., after wearily changing into some cotton surgical pants and a red T-shirt, Dr. Lee left a wake-up call for 6 a.m. and crawled into bed. She was due back on 3F at 8.

ON A HOT SPRING DAY DR. HICKS SAT down in Dr. Lee's office to review a new patient with her. Despite the high temperatures and stale, sticky air, Bill Hicks was wearing a navy blazer, white shirt with striped silk tie, and khaki pants. In his attire, it seemed there was no middle ground; the boyish-looking, 30-year-old psychiatrist either dressed formally or tended to show up in jeans and a white shirt open at the

neck.

It reflected exactly his relationship with the staff: A curious, but extremely successful, combination of formality and relaxed congeniality. With his patients, however, Dr. Hicks was consistently respectful, gentle and skillful; even the most difficult patients on the ward seemed willing, at least, to listen to him.

Dr. Lee, while less experienced, displayed many of the same qualities of concern and sensitivity in her contact with the patients. There was also about her an air of personal calmness that was remarkable in its soothing effect on the patients. Although, in private, she sometimes expressed feelings of weariness, frustration and self-doubt, it was never visible on the job. What was visible was a clear determination to excel at her work.

Now, reading from the chart he held in his hands, Dr. Hicks briefed his resident on the new admission: "Robert Barnes — a 35-year-old, divorced, white, Catholic gentleman. Born in New York, lives in Catonsville. Admitted on Saturday around 7 p.m. with suicidal ideation [ideas]. Has been depressed at least once before. Generally very anxious, performs repetitive, ritualistic behavior, depressed with thoughts of being ill with cancer. Unable to eat or sleep and is unable to make decisions. Gets distracted with obsessional thoughts."

Bill Hicks looked up from the chart to make a comment to Dr. Lee: "Many people weather a major depression by becoming obsessional. Did you know that? The problem is, it can get to nearly psychotic proportions."

Since being admitted, Mr. Barnes had been on "suicide watch." This meant he was required to stay in sight of the nursing staff at all times. He slept in the hallway and was accompanied to the bathroom by a staff member. Every 15 minutes, contact was made with the patient by an aide or nurse.

"As long as he's watched," Dr. Hicks told Dr. Lee, "he feels connected. But the minute a patient like this feels unwatched, they're at very high risk for suicide. The rule of thumb with someone like Mr. Barnes is you get very paternalistic. You give them a chance to make a decision but if they don't bite right away, you just make them do it. Otherwise, it's cruel."

"We could cure him quickly — with ECT [electroconvulsive therapy] — but he won't let us. It's impossible for people who are very depressed like this — with all the ambivalence and indecisiveness — to make a decision like having ECT, unless they've had it in the past."

Known to the public as "electroshock," ECT today bears little relationship to the crippling procedure depicted in Ken Kesey's "One Flew Over the Cuckoo's Nest." Today the method has been modified (among other things, a muscle

relaxant is given to prevent fractures from the seizure induced by ECT) and is generally acknowledged as having a high success rate for severe depression. Although there may be a short-term memory loss as a result of ECT, a National Institute of Mental Health study estimated that less than one-half of 1 percent of ECT patients suffer severe memory loss.

Still, many patients fear it and refuse, as one patient put it, "to have that electric head stuff."

Mr. Barnes had refused to see Dr. Lee in her office, so Dr. Hicks suggested they go to him. They approached him in the hallway outside of his room. "I can't talk," Mr. Barnes said in an agitated manner when the two doctors gently tried to prod him into a conversation.

"You have to," responded Dr. Hicks. "That's what you're in the hospital for. We want to help you. We can talk right here. Let's talk about how suicidal you are. Are you hearing voices? Do you feel people are out to get you?"

Then Bill Hicks brought up the matter of ECT. "It would resolve your problem," he told the agitated and trembling patient. Mr. Barnes, who had reached out to touch Dr. Lee's arm, abruptly turned and walked away.

"What's your diagnosis?" Dr. Hicks asked his resident after returning to her office.

Dr. Lee thought for a moment. "Major depression, with or without psychotic features," she replied. "But one thing I noticed is that he doesn't mind us being close to him. He'd reach out and touch your arm."

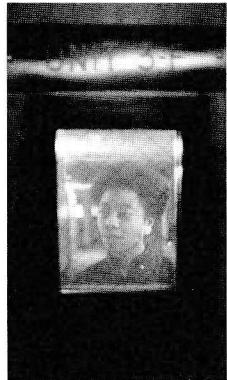
"He wants the contact," agreed Dr. Hicks. "But what are we going to do with him? I don't think he'll agree to ECT, and if it increases his anxiety I wouldn't pursue it."

For several minutes, the two doctors discussed the possibilities of ECT and antipsychotics for their patient. They both agreed that he was very unpredictable and needed close observation. Then Dr. Hicks offered a word of caution: "This is a man that you can talk to in the hall one minute and then five minutes later, you walk into the bathroom and he's strung up," he told Dr. Lee.

"I agree," she said soberly, her voice reflecting the gravity of her patient's illness. "I am just afraid this man might have made some decisions to hurt himself. There is no way of knowing for sure."

Bill Hicks stood up to leave. "There never is," he said, a wistful note creeping into his voice.

AT 9 A.M. ON MONDAYS, WEDNESDAYS and Fridays, the patients on 3F were required to attend group therapy. The two residents on the ward — Dr. Lee and Dr. Joanna Brandt — alternated in leading the meetings under the supervision of Dr. Gerard Hunt, a staff sociologist experienced in group therapy, and Dr. Hicks. Also present at the meetings were



"As long as he's watched," Dr. Hicks told Dr. Lee, "he feels connected. But the minute a patient like this feels unwatched, they're at very high risk for suicide."

"You have to take control of your life like it's a steering wheel. And drive it. Not the other way around."

Joanne Mahabal, the nursing supervisor, several nurses, the two third-year medical students rotating through the ward, and various social workers and staff therapists.

On a Friday morning in April — about halfway through her six-month stint on the ward — Dr. Lee walked down the hall toward the solarium where the group meeting was about to begin. It was her turn to lead it. At the doorway, a patient greeted her: "So. Who are you putting on the hot seat today?" he asked sarcastically.

"Is that how you felt when you first came in?" replied Dr. Lee.

"Yeah," he said, looking down at the floor, "that's exactly how I felt."

It was not an inaccurate assessment on the patient's part. New patients attending group therapy for the first time often seemed to feel uncomfortable when the spotlight is turned on them. But, as a rule, there was more than enough hostility to go around and, on this particular morning, things had gotten off to an unusually bad start.

Someone on the ward had not been properly flushing the toilets, and the issue became a lightning rod for all the unrelated frustration and anger felt by the patients. There were angry accusations and threats of a confrontation. Suddenly, the patient on the receiving end of the group's hostility, visibly upset, stood up and strode out of the room — in violation of the ward rules.

At that point, the group — whose makeup was about evenly divided between men and women, blacks and whites — began focusing on racial and sexual issues. Then, in a further breakdown of anything resembling a therapeutic group, the older patients began subtly confronting the younger patients. Finally, through the intervention of Dr. Lee, Dr. Hunt and Dr. Hicks, the group settled down.

What happened next was totally unexpected. Tommy Jackson, an appealing 17-year-old suffering from schizophrenia, was being transferred to a state hospital — a facility where many of the patients had been hospitalized at one time or another. And, as the patients said their goodbyes to him, there emerged a poignant glimpse of something approaching tenderness toward the young man, who was clearly frightened at the prospect of a new and unknown situation.

"Oh, God," one woman told him, "you'll love it. It's beautiful out there."

"I practically grew up there," offered one of the middle-aged male patients. "I'd go back if I could."

Then, the usually combative and hostile Miss Grant spoke up: "What are your plans, Tommy?" she asked.

"To let life take me," he replied.

"You can't do that," Miss Grant told him, her voice supportive. And then, in a rare moment of insight, this woman whose own life was out of control more often than not, gave him a piece of advice: "You have to take control of your life like it's a steering wheel. And drive it. Not the other way around."

Later, after the patients had left, the staff discussed the meeting. Dr. Lee expressed some disappointment in the way she had handled the confrontational feelings among the patients. "I felt I was in the middle and that I divided the room up. That I was unable to get the people on this side of the room to connect with the people on the other side. And I didn't know how to handle that."

"But the group gave Tommy some good feedback," said Dr. Hunt encouragingly. "When they were talking about going to the state hospital, it began to sound like someone going to the Virgin Islands." The remark drew laughs from the staff and seemed to defuse, somewhat, the tension.

Then Dr. Hicks spoke up. "Why do we have group therapy?" he asked. "What function, if any, does it serve? What's the value of having three or four patients talking about hearing voices?"

One of the medical students answered. "So you don't believe you're alone in hearing voices," he said.

"And what's the value of that?" continued Dr. Hicks. Then he went on to answer his own question. "One of the fundamental goals of group therapy is to reduce the patient's experience of being disconnected. Being connected is important somehow. They feel better, they function better. Being connected is as fundamental as breathing, food, water. And one of the basic therapeutic goals of group therapy is that there is a relieving value in recognizing other people have been through what you're going through. Why? That's not clear, but we do know that commiseration is valuable."

ONE MORNING IN JUNE, AS THE END OF her residency on ward 3F drew closer, Dr. Lee sat in her office and tried to sum up her feelings about the previous six months. Several weeks earlier she had taken a week's vacation and gone home to Houston to celebrate her 29th birthday with her family. She'd been homesick and had really looked forward to the vacation, so it came as a surprise to her that she found herself thinking about her patients and actually missing some of them.

When she returned, several of her patients had been transferred or discharged, and she admitted to feelings of guilt about taking the time off. Miss Wells was scheduled to be transferred to a state hospital while Dr. Lee was on vacation; the two had said their goodbyes the week before Dr. Lee left. "It was hard for both of

us. Miss Wells was tearful all week, saying how much she was going to miss me," said Dr. Lee. "We talked a lot about why I thought it would not be a good idea for me to be her outpatient therapist — for one thing, I'll be leaving in two years — and she seemed to accept that. But I kept thinking about her, and wondering how she was doing, all during my trip home."

Gone, too, were Miss Grant and Miss Rogers — also transferred to state hospitals.

But Dr. Lee was finding her job on the ward more enjoyable. "I've gotten into a real good schedule of seeing patients," she said. "And I've finally gotten to the point where I can say, 'These are the things I'm going to let upset me — and these are the things I'm not going to let upset me.'

"But I still think that working on an inpatient ward is probably the hardest six months of a psychiatric residency. I try to imagine what it would be like if I had to come in here, day in and day out, like Bill Hicks does. Like the nursing staff does. I admire them for doing it. I admire anybody who does this day after day. I feel terribly burned out after only six months."

Two more years of training lie ahead of her and then she hopes to return to Texas to practice psychiatry — a practice she hopes will include white patients as well as black.

"I think being black has made a difference in the way patients view me — and will continue to make a difference. I have had patients here who told me they didn't want to work with me because I'm black. But in the end, they were the ones who came and told me 'I'm glad you were my doctor.'

"I think cultural differences definitely play a part in analyzing a person. They're very important in forming a psychodynamic picture of the patient — and if you don't understand them, you can be totally off. I think it's even more so when you have a white psychiatrist with a black patient. When I hang up my shingle, I don't expect whites to beat a path to my door — but as my reputation grows, I think that will happen."

Dr. Lee stood up. It was time for group therapy to begin. "I see psychiatry as such a young field — and I have this hope that I will make a difference in my patients' lives," she said, pausing at the door. "I have no regrets about what I've chosen to do. I think I found the right field — and the field has found the right person."

On her way to the solarium, Dr. Lee briefed Dr. Hicks on two new admissions: "Donald Morris came in last night. He was very agitated, delusional, paranoid. Had to be strait-jacketed and put in seclusion. Jane Martin is in a very confused, manic state — complaining of auditory hallucinations. She says she's hearing a loud, booming voice and it's threatening her. We had to keep reassuring her this morning that she's not going to be killed. She's quite frightened."

As they were about to enter the room for group meeting, a nurse rushed up: "One of the aides has had a scuffle with a patient," she told the two doctors. "And the panic button didn't go off. Could you come to the nurses' station right away?"

Dr. Lee looked at Dr. Hicks. "Well," she said evenly, "it looks like it's going to be another crazy day."

"I admire anybody who does this day after day. I feel terribly burned out after only six months," said Dr. Lee.





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