

By Invitation

Schizophrenia – moving from horror to hope

Medical science has made strides in treating this complex mental disorder, which once involved infecting patients with malaria and blamed inconsistent mothers for the condition. Today, underscoring the message of hope in this year's Schizophrenia Awareness Week, much can be done and there are lessons, too, in learning to keep faith with the patient.



Chong Siow Ann

For *The Straits Times*

Schizophrenia – that most severe of mental disorders – exists in every race, every culture and every level of society, and is probably as old as humankind, though known perhaps under different names depending on the culture.

The term “schizophrenia” only came into existence in the early 20th century when it was coined by Eugen Bleuler, a Swiss-German psychiatrist. A contemporary of Sigmund Freud, Bleuler took charge of a mental asylum near Zurich and spent his years there observing and talking to his patients, and kept copious records of them.

Many of his patients, who he found – in his own words – to be “stranger than the birds in my garden”, had some sort of malady where their thoughts were fragmented and the “connections between associations are lost”, he wrote in his classic psychiatric text that was published in 1911. “Thus, the result of the thought process is rendered unusual, and often logically incorrect.”

He called this disorder “schizophrenia”, which he derived from its Greek roots schizo (“split”) and phrene (“mind”) to denote the “loosening of associations”.

This notion of a “split mind” has unfortunately led to the embrace of “schizophrenic” into popular culture and its vernacular as a

shorthand description of anything that is nonsensical, unpredictable, confusing and contradictory.

And it may even be tempting to apply this much misused adjective to describe the history of schizophrenia and the quest to uncover its cause and origin, as well as of the desperate attempts at finding a treatment.

It is not a chronicle of steady and orderly progress; instead it is littered with touted inroads that turned out to be dead ends; of treatments that had seemed revolutionary then but barbaric in retrospect; and its leitmotifs of hubris, paternalism, misperception and hype.

DESPERATE MEASURES

When earlier efforts to look for the biological origins of schizophrenia – by examining any gross and microscopic abnormalities in the brain – did not bear fruit, it caused a split in the field, with some turning away from peering into the microscope to delving into the nebulous human psyche and the forces that shape it.

For a while, mothers were thought to be the culprits. In the 1930s, Frieda Fromm-Reichmann, a psychoanalyst, proposed that the condition was caused by a toxic combination of “severe early smothering and rejection” that a person with schizophrenia had received during infancy and childhood from what she called a “schizophrenogenic mother”.

Other psychoanalysts and psychiatrists also blamed the mother – who could be bad in any number of ways: some said she was rejecting, others called her rigid, yet others thought she was domineering, or too anxious.

In the wry words of a noted feminist of the day, “the mother could be blamed for almost



everything. In every case history of a troubled child... could be found a mother”.

In 1970, a group of female psychotherapists distributed pamphlets to their colleagues in the American Psychiatric Association that chastened the psychiatric community: “Mother is not public enemy No. 1. Start looking for the real enemy.”

Neither did therapies championed by these mother-blaming psychoanalysts prove to be effective. The seemingly implacable and debilitating course of schizophrenia led to a sense of desperation among psychiatrists, patients and families. With that came a reckless willingness to try any measure, no matter how bizarre, that held out any hope.

The first half of the last century saw the introduction of a series of “shock” treatments for schizophrenia: patients were deliberately infected with malaria in the hope that recurrent fevers would drive the “madness” from their mind; insulin or camphor was also administered to “shock” the patients by inducing comas.

Perhaps the most grotesque manifestation of the early biological approach to psychiatry was lobotomy, an incision through the prefrontal lobes of the brain, a procedure invented in the 1930s by Antonio Egas Moniz, a Portuguese neurologist who was subsequently awarded the Nobel

Prize in Medicine in 1949.

The treatment was popularised across the United States by Walter Freeman, a neurologist who traversed the country in his station wagon on what he frivolously called “Operation Icepick” (he used an icepick-like instrument to carry out his lobotomy). He promoted the technique in various state mental hospitals and performed it on thousands of patients from the 1930s to the 1960s. He ended up destroying their personality, and taking away their agency and drive.

By the mid-1960s, both mother-blaming and lobotomy were waning – partly due to the accidental and serendipitous discovery of the first effective anti-psychotic medication. This led to illuminating insights into the biochemical mechanism of psychosis, which galvanised the pharmaceutical companies into developing an array of psychotropic medications.

GLIMMERS OF LIGHT

What we know at present about the pathogenesis of schizophrenia are glimmers of light amid its shroud of darkness. That there is a biological disposition to schizophrenia is no longer in doubt. What the research of the past decades has shown is that biology and environment work powerfully together on the brain and the mind; and where foetal

infection, birth trauma, earlier life experiences as well as pressures of the environment and society could play a part. Genetics is important. My colleagues and I were part of an international consortium which carried out genomic surveys of schizophrenia. These surveys involved tens of thousands of patients and the latest analysis, which was recently published in the journal *Nature*, found more than a hundred independent segments of the genome to be associated with schizophrenia. This probably means that each gene has but a modest effect on causing schizophrenia. There is still a long way to go towards understanding how most of these genes work and interact with each other and the external environment.

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wherewithal and expertise to help a patient with a complex disorder like schizophrenia, with all the complicated life issues that come with the illness, and where family members also often need support.

For all that, I depend on my other fellow healthcare professionals and their different skills – case managers, social workers, psychologists, occupational therapists and peer support specialists.

I have learnt something else from looking after those with schizophrenia – the importance of keeping faith and sticking by your patient. In treating a person with schizophrenia, one can never be certain of the eventual outcome.

Responses to treatment are extremely varied: some show little or virtually no response and often have cycles of hospitalisations of increasing duration, culminating in life-long institutionalisation. But there are others who would respond remarkably well and recover without sequelae. In between these two extremes are the majority of patients who might be vulnerable to relapses but, with careful and continuing treatment, could still experience life as much as anyone could.

For more than a decade now, I have treated a young woman who first became my patient when she was in her early adolescence. Over a few months, she had shown increasing irritability and anxiety and low mood, and her academic performance dropped off dramatically. As her condition worsened, she started experiencing florid auditory and visual hallucinations, paranoid delusions and episodes of catatonia where she would be immobile and mute – all classic features of schizophrenia.

The prognosis seemed bleak: an early onset of illness, multiple members of her family similarly afflicted with schizophrenia, and a very severe illness that was not responding well to the first-line anti-psychotic medications.

The initial years of her illness were tumultuous, with many periods of hospitalisation (she was particularly distressed by noises in her surroundings flooding her at full, overwhelming volume). She had courses of electroconvulsive therapy and different trials of psychotropic medications until, rather fortuitously, we hit on the right combination of drugs.

When she emerged from the shadow of what could have been an obliterating illness, seeing her at my clinic was always a pleasure – she was engaging, articulate, funny, insightful and kept to her medications. She resumed and triumphed over her studies. She graduated from university, found a job, dated and married.

On that Saturday morning of her wedding, she sang a solo on stage. As I sat in the middle pew of that crowded church, I was moved by her voice: it was confident and lush, crystalline and pure.

stopinion@sph.com.sg

• Professor Chong Siow Ann is a senior consultant psychiatrist at the Institute of Mental Health.