Outlines for lecture

Dificultades y posibilidades en el tratamiento de los primeros episodios psicóticos

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This honouring invitation

Pat McGorry – a dear friend and a source of inspiration. Melbourne 1996

Instead of presenting research I today wish to be somewhat personal about "my universities" (Gorkij).

Dec 12th over 60 years ago… my brother E was 25 y o student of art at the Royal Sw Ac of Art. I was 22 and a medical student of my 3rd year not knowing anything about psychiatry. E told me about conversing with Mozart and Picasso…

University mental hospital of Stockholm

4 year's period of cruel hospital care. Very psychotic, anxiety driven. Not allowed to paint, secretly beaten.

New medication: Chlorpromazin, Nozinan, also Rauwolfia drugs. No pos effects

180 full insulin comas, strengthened by 128 ECT:s – according to the records.

Finally my parents demanded E's discharge – Yes, on our own risk!

Not only schizophrenic but also with an organic confusion, double his ordinary weight, never more wanting to see a hospital or a doctor voluntarily.

After another 5 years in diff asylums and on massive doses of long-term neuroleptics allowed to paint in a "treatment home". In the 80ies I overtook prescribing his medication – reducing the dose to very small. At the end of 1970ties E was given an apartment of his own with a work-room.

E has never been out of schizophrenia since his first admission. In spite of that he has an impressive personality – but very deranged socially – what was the disorder and what was caused by destructive treatment? Several women have tried to cure him with their love – ending in catastrophy. Hallucinating voices, always oil painting on the clothes and furniture and his hair. Today living in his own home with massive help from social agencies. Otherwise, after a few days the whole apartment is a mess. Parkinson´s dis. is a serious side effect

His first exhibition was in Sthlm during the seventies. Separate exhib at Sw MoMA and Royal Ac of Art the last years

4 pictures: E around 19, E around 45, E 75. Self-portrait 1955

What have I learned during these over 50 years? Both from the very special situation (E a gifted, well-known artist) and general as a patient (pervading illness).

What did it mean to my parents, sister and brothers, to myself?

After 20 years ready for psychosis specialization – psychoanalysis, guilt.

My night-mare

Essential: Psychiatry often: just seeing an illness to treat, very violently and aggressively. Alternatively seeing the person, trying to get a cooperation, listening as long as possible, working with the net-work. Of course not without coercion when absolutely needed.

Medication extremely high doses – 10 times. Side-effects a heavy nuisance. Exaggerating negative symptoms.

Risperidone / Haloperidole 2-4 mg /day. Over that only side-effects and no more anti-psychotic effects.

A “cured” person with schizophrenia, how does he/she look like? What is our goal.

PPT 5 Bleuler’s words

Two contradictive tendencies in chronic schizophrenia: 1: towards shutting off ext world, towards chaos, inner death, stereotypia, fractal life. Simulating dementia.
2: towards slowly healing, communicating, humour and tenderness. Grieving of lost years. Voices and delusions may exist but do not interact with others very much.

Courtney Hardings research from 1988.

Our goal must **not** be: A “normal” person according to WHO. Then we will be unsuccessful.
But a person with a reasonable good quality of life and self-confidence, abilities to make his/her own choices, where hallucinations and delusions need not dominate and medication is only given with the consent of the person.

He/she may not be characterized as ill, but an unusual person. This person may need social assistance like other people with some disability. We can pay our respect, interest and perhaps admiration.

Some first rank prerequisites for achieving recovery

- Human relations from the first moment of care. Being met as a guest in the psychiatric team, with the respect, interest and openness to hear the person’s needs and preferences. At least “team continuity”
- Room of one’s own and private living as soon as possible. Later perhaps supported but still private living.
- Meaningful occupation preferably with a group

More prerequisites

- Doctor as the patient's consultant. Antipsychotic medication with lowest effective dose. Much negotiations and reconsideration of effects. The patient may be the winner.
- Psycho-dynamic conversations for better understanding of personal history. Classic long-term psa pst waste of time.
- KBT for better dealing with long-standing symptoms (depression, delusions, hallucinations) and for better taking control over external world.
- Family support

This means an organisation

- with easy accessibility for at least 5 years
- small crisis homes (Soteria homes, asylums)
- The staff contains long-term hope for a progress. More in attitudes than in words
- Such was also the philosophy which I met when I visited Pat McGorry's EPPIC project in Melbourne!

Thank you Pat