The Ex-patient:
A New Perspective!

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The growing tendency for releasing mental patients to the community is not a recent development. It was evident even before the chemical treatment era (Zubin & Burdock, 1965). The factors behind this trend are too numerous to detail, but those most prominently discussed are economic and social gains brought about by early discharge. The cost of housing patients in hospitals when the same patients could fend for themselves under minimum supervision at a fraction of the cost is a major factor in the trend. The rehabilitative aspects of phasing back the patient into community living is another and the self-help and mutual-help of ex-patients banding together to help each other is a third. Humanitarian gain in returning the patient to the community as well as the economic gain through employment and reduction of hospital expenses are strong arguments in favor of the trend.

Good as these arguments are, and though they have succeeded in persuading the hospital authorities to release patients, they have failed in many instances to provide the support and supervision for these former patients in the community, and abacklash is setting in because of the now "Toms O'Bedlam" that are crowding the run-down areas of our cities. It is to be hoped that this error is planning will be corrected and the good intentions implemented to the full.

But even if we would succeed in good after-care, there remains a problem which has not been faced squarely—the appellation of 'ex-patient.' As long as we continue to label him as such, we are bound to limit his opportunities, by continuing the prejudicial status that he has acquired. In order to alter this status a new view of mental disorders has to be inculcated which would free the former patient from his bondage. This is a view which has been championed by many socially minded mental health professionals and more recently by Mrs. Rosalyn Carter.

Several attempts have been made in the past for dealing with this problem. Denial of former patient status is one option which works for those who can "pass" but is certainly not a universally acceptable option, for it means going back "into the closet." Declaring mental disorders as a myth perpetrated by the psychiatric establishment for the purpose of controlling behavior is another option which flaunts the face of reality. Accepting the former patient status is another option and responding to the way some ex-alcoholics do, by proclaiming their victory over their illness, is another option which may work for some. But all of these options are based on a fundamental fallacy that mental disorders are a more or less permanent characteristic of the person from which he cannot extricate himself except by heroic efforts. Once a patient, always a patient seems to be a dictum which still lies at the bottom of society's view of mental disorders and this despite the facts that according to the best estimates, only 10% of the most severely ill schizophrenics in Switzerland (Bleuler, 1972) remain more or less permanently ill, while 50% are returned to the community permanently, and 40% suffer one or more brief relapses but spend the majority of their life in the community. If we take into consideration not only the hospitalized mentally ill, but also those seeking help in out-patient clinics and community mental health centers, the proportion of permanently disabled reduces to a trickle. The reason why the malignant attitude towards schizophrenia has developed is attributed by Manfred Bleuler to the fact that the earlier generation of psychiatrists saw only the patients who returned to the clinic after discharge and never laid eyes on those who recovered successfully without relapsing so that they did not require a return to the clinic.

Is there any way in which this curse of ex-patienthood can be removed? Can we eliminate this leperous label which attaches itself to the ex-patient and prevents his full acceptance in society?

We do not refer to individuals who have recovered from TB as ex-tuberculosis patients; why insist on the label for mental patients? To be sure, when TB was feared as the White Plague, the few that recovered were called ex-tuberculars, but with the conquest of TB, the label has disappeared. Do we have to wait until the cause of schizophrenia is discovered before eliminating the label?

I would like to propose a new view of schizophrenia and of the other mental disorders which breaks with the past's view of the permanency of the disorder and thus frees the patient from his bondage. This new view postulates that the person who has suffered an episode of mental disorder is not a permanently disabled person with a chronic persistent illness, but is instead a vulnerable individual who, when subjected to sufficient stress may develop an episode of mental disorder. Once the stressful situation is resolved, he returns to his premorbid level of adjustment and resumes his place in society, free from the episode of mental disorder which he underwent. From this point of view, mental disorders are similar to allergic states. When the pollen is in the air, the
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the occurrence of mental disorders (Zubin, 1972) it became clear that, at the present time, there is no one explanation possible. Because of our abysmal ignorance of the causes, each school has provided "as if" causes, or models, if you will, of the causes, which can provide starting points for investigation. The spectrum of causes ranges from field theories (ecological model) at one end to atomic or molecular theories (genetic model) on the other end. Thus, the ecological model postulates that the field forces which impinge on the ecological niche which a person occupies are the sources of both his ill-being and well-being. Among the ecosystem parameters which have been studied are social-economic factors, social organization-disorganization factors, living arrangements, minority status, etc. The developmental model postulates that in the transition between the various stages of development from fertilized ovum to old age, certain supplies and supports and nourishments are required, and failing these, episodes of disorder will develop. The learning model stipulates that habit formation and reinforcement schedules are the bases for health or illness. The genetic model stipulates that the primary basis for the disorders is to be sought in the genotype while the internal environment model stipulates that the biochemistry of the body including the brain is the spawning ground for the mental disorders. The neurophysiological model stipulates that the manner in which the brain processes incoming information is the system to be studied for the causes of mental disorder. But not one of these causes is a sufficient cause though it may be a necessary cause. Thus, even the most accepted and advanced form of the genetic model can be supported only partially on its own account, since only 40% of pairs of monozygotic twins are concordant for schizophrenia. In 60% of the pairs, there must be some discrepancy in the environment (defined in the broadest way to include even the environment provided by other genes) between the members of a discordant pair. Thus, each of the models requires the interaction with the other models for the development of both illness and health. This fact has led to the conclusion that if we were to squeeze all the models into a gobbet and examine the common elixir that would emerge, it would be a vulnerability factor.

This vulnerability factor is distributed in such fashion that those of low vulnerability require a tremendous stress-producing factor to trigger an episode while those of high vulnerability would succumb to an episode even when the stressor is quite mild. But even those who succumb experience a time-limited episode from which they recover after a longer or shorter period. The so-called chronic patient is becoming much less frequent than formerly because of improved treatments and some so-called chronic patients have learned their chronic habits by adjusting to hospital expectancies. There may also be a small proportion of patients who remain chronically ill because of persistent disturbance in their neurochemical balance. Still others may appear chronic because even their permanent status was not an adaptive status, and when the episode ends and they return to their permanent status, it is difficult to tell whether the episode is ended or not.

If our hypothesis is correct, we must search for markers of vulnerability to distinguish those who are susceptible to mental disorders and try to intervene preventively to ward off new episodes. Some suggestions for markers have already been explored (Zubin & Spring, 1977). By screening the population with the markers, the vulnerable individuals can be detected and preventive strategies developed.

Summary

It has been pointed out that our best efforts in rehabilitation are doomed to failure unless we get rid of the label of "ex-patient" for those who have recovered from an episode of illness. If we could change the attitude of our general population from regarding mental disorders as permanent characteristics to regarding them as time-limited episodes in the same way that we regard tuberculosis today, we would eliminate the unfortunate labelling fallacy with all its attendant difficulties. One avenue for bringing about this change is to regard the individual who is having or has had an episode of illness, as a vulnerable individual who, when subjected to sufficient stress-producing events, will develop an episode. But this episode is not permanent, though his vulnerability to future episodes may persist. The problem of preventive therapy then becomes that of preventing new episodes from developing in the vulnerable by determining the contingencies in which his vulnerability is elicited. We then have two basic problems to solve: (1) to determine by means of special markers, who are the vulnerable; (2) to determine which exigencies elicit their vulnerability. A program for carrying out such research has been proposed.