"Suddenly he now finds someone who is on his side -- his psychiatrist, who seems to encourage free expression of the patient's anger. Indeed he may demand violent verbal expressions of hate and distrust. The patient gladly gives the psychiatrist what he asks for. But, unfortunately, this unburdening does not lighten his heart. It only nurtures his hostility against his parents until it boils over into the home.

"Instead of the patient being treated for a disease having a physical origin, we now witness a home divided into enemy camps. The parents are frightened and sometimes angry with the doctor. They are even more angry with the patient who has been causing them such a great deal of trouble. Worse still, the patient is increasingly resentful and angry, and cannot respond to treatment. For example:

"Brenda was 17 years old when she first came to us as a patient. She had become a victim of an insidious form of schizophrenia beginning about four years before. During that time, her behavior was such that the parents could only describe her as being immoral, difficult, unreasonable and many other things besides. It took them several years to realize that she was not simply ill-behaved, but was in fact seriously ill. They then placed her under psychiatric care.

"Her psychiatrist was well-known to us as one dedicated to the concept that all schizophrenics are ill because their mothers or fathers had brought them up the wrong way; an idea still widely popular among many of our colleagues, even though the hard evidence for this is apparently non-existent.

"So Brenda received psychotherapy, a 'talking-out treatment' for many months. She was encouraged to speak freely against her parents and to talk about any problem she could bring to mind. Placed in a hospital, she was still treated with this permissive type psychotherapy. Instead of getting better, she got worse. Her behavior which previously was merely bad, now became intolerable.

"She was then transferred to our care as a last resort before committing her. In our first interview, we informed her that she was ill; that she had schizophrenia and that she would be treated with nicotinic acid plus ECT. When she still spoke very angrily about her parents whom she blamed for all her difficulties, we told her that they were in no way responsible for her illness.

"She was treated for some months in this different way, and began making great improvements. When later discharged, her relations with her parents had already become good. She no longer voiced her delusional hostility against them. She has now remained well for nearly six years without requiring any further treatment. She still gets along very well with her parents.

"We have witnessed this sequence of events, time after time."

A.A. physicians will readily observe the parallels between this approach and the one we A.A.'s make to alcoholics. We tell the newcomer what alcoholism is, and encourage him to face the fact. He is told that alcoholism, at least in part, is a physical malady. We then suggest that he quit blaming himself, his parents and other circumstances that may have done him emotional damage in the past. We also

urge his relatives and parents to quit blaming themselves for the alcoholic's condition. To a considerable degree, our A.A. approach corresponds with those of Hoffer and Osmond.

It should be remembered, too, that both Hoffer and Osmond are themselves psychiatrists. Hence their changed views respecting psychiatric treatment for schizos are in no way based on professional ignorance of the prevalent psychiatric theories respecting the malady.

Since schizophrenia evidently is far more a physical illness than alcoholism, these attitudes of Hoffer and Osmond would seem to be all the more justified. The very considerable results already obtained by these Saskatchewan researchers appear to strongly support their present views.

PHYSICAL TREATMENT FOR SCHIZOPHRENICS AT UNIVERSITY HOSPITAL, SASKATOON, SASKATCHEWAN

Below is a relevant directive given by Dr. Hoffer to his staff:

Diagnosis:

(a) Mental - in the usual way including HOD or psychological E. W.I. tests as indicated.

(b) Physical - check for all abnormalities and correct. The presence of any defect reduces the patient's chance for recovery.

Classification of Patients

Type I consists of all out-patients, i.e. patients with schizophrenia who are still able to function in the community, and who can cooperate effectively in the treatment. (I suggest that all patients with the "mauve factor" (slight toxicity) should also belong in this class and I myself will hereafter so regard my own patients.)

Treatment, Type I: nicotinamide or nicotinic acid 3-6 grams per day by mouth for at least a month. If patient is excessively agitated, may add barbiturates or tranquilizers. If given these adjuncts, assess clinical conditions at least once per week and adjust doses of barbiturates and tranquilizers downward as quickly as possible. Librium is a good adjunct to nicotinic acid for extremely anxious patients -- 25-75 mg. per day. Patients will also receive ascorbic acid -- 3 grams per day throughout their treatment in hospital.

If patient responds (as shown by clinical state, subjective account and "HOD") keep on medication with vitamin for at least one year. At the end of the year, the patient may discontinue medication, but should be watched very carefully. At the first indication of relapse he should be started on the vitamin again.

Type II

(a) All schizophrenic patients who have not responded to Type I treatment.

(b) All schizophrenics who are admitted to hospital, excluding those who have formerly been housed in a mental hospital more than five years.

Treatment, Type II:

(a) ECT, unmodified and without atropine, unless there are specific indications why it should be modified, e.g. old age, osteoporosis, etc. Mean series 8-10.

(b) Nicotinic acid or amide 3-6 grams per day.

(c) Sedatives or tranquilizers as needed as adjuncts, but under continuous control as in Type I.

Patient may be discharged one week after last ECT if he is well enough. Preparations for discharge should be halted if HOD or E.W.I. scores have not shown a major decrease. We will conference all patients intended for discharge if they have high scores. All patients should have HOD or E.W.I. as soon as discharge seems imminent. After discharge keep on vitamin at least one year, as in Type I.

Type III

(a) All schizophrenics who have not responded to Type II treatment.

Treatment, Type III:

(a) ECT as with Type II, but about 3-5 per patient.

(b) Nicotinic acid 3-6 grams per day. (Note: nicotinamide not to be used here.)

(c) Penicillamine 2 grams per day concurrent with ECT.

Continue penicillamine 10 days unless (1) temperature elevates to 103 F., (2) patient develops a rash or other allergic manifestations. Patient will lose most of these allergic changes in 24 hours.

After discharge continue as for Type II.

Type IV

All schizophrenics who have not responded to treatments I, II and III.

Treatment, Type IV:

There are several ways of dealing with failures of Type III treatment, in order of preference.

(a) Out-patient ECT beginning with one each week for four weeks and then gradually expanding the interval between treatments. Maintain on nicotinic acid or amide.

(b) Maintain on heavy doses of tranquilizer plus vitamin. This will help some, keep others out of hospital.

(c) Or certify to mental hospital

(d) Or make special research investigations.

Treatment, non-specific:

(a) Psychotherapy - supportive - analytic therapy has no proven value and often serves to fixate the patient on false causes. Psychotherapy should be similar to kind given all people who are ill in this hospital. Explain specific perceptual disorders to patient, if present.

(b) Nutrition - ensure this is adequate in protein, calories, minerals and vitamins. Aim for a weight increase. Weigh once per week.

(c) Education - if required. How to dress, apply make-up, cook, relate to other people, etc.

(d) Ot and RT

(e) Correct any physical defects:

1. Pre-menstrual tension
2. Infections
3. Hormone deficiencies
4. Others

(f) Contra indications:

1. Sympathomimetic amines
2. Antidepressants -- these often give an apparent improvement because patient is activated, but this may be spurious. Depression in schizophrenia is usually a symptom of, and not a cause.

Conclusion:

Schizophrenic treatment for serious cases requires a sense of dedication from the physician. This illness should be given the same enduring care as is given to a patient with diabetes.

If this treatment program is followed one may expect:

(a) A marked increase in the number of recoveries

(b) A marked decrease in the number of relapses.

APPENDIX II

BIBLIOGRAPHY

Hoffer (often collaborating with Osmond) has produced four books, and some 30 papers covering the whole range of the schizophrenia illness -- its research, its cause, its treatment, and the results attained. These books contain extensive references to medical papers -- their own and others.

1. Hoffer and Osmond, Chemical Basis of Clinical Psychiatry, Charles Thomas, Springfield, Illinois, 1960.

2. A. Hoffer, Niacin Therapy in Psychiatry, Charles Thomas, Springfield, Illinois, 1962. (Specially recommended. This work also discusses general uses of B-3.)

3. A. Hoffer, Nicotinic Acid and/or Nicotinamide for Treating Schizophrenia, University Hospital, Saskatoon, Sask. (Contains much research information; also follow-up reports on very difficult chronic cases.)

4. Hoffer and Osmond, How to Live with Schizophrenia. To be published in January 1966 by University Books, New Hyde Park, New York. (A most comprehensive and up to date work, specially recommended.)

* * *

References to Mark Altschule, the Harvard researcher who has independently confirmed the organic and toxic nature of schizophrenia:

1. Altschule, M.D. (1960), J. Neuropsychiatry 2, 71

2. Altschule (1962), American Psychiatric Association Annual Meeting, Toronto, Canada.

3. Altschule, Dis. Nerv. Syst. 23, 592

4. Altschule, NATO Conference on Molecular Mechanisms of Mental Disease. Norway, 1965. (See "Problems in the Measurement of Adrenochrome.")

Next follows a book by a layman, Gregary Stefan (not his real name), entitled "In Search of Sanity," University Books, 1601 Jericho Turnpike, New Hyde Park, New York. The author, a former patient of Hoffer and Osmond (and now some years recovered), presents a graphic picture of acute schizophrenia as he experienced the illness.

A pamphlet, What you Should know About Schizophrenia (.25¢) can be purchased from the American Schizophrenia Foundation, 204 Nickels Arcade, Ann Arbor, Michigan.

APPENDIX III

NIACIN AND NICOTINAMIDE WHOLESALERS

1. Canada

Jules R. Gilbert, Ltd., 3701 Dundas Street West, Toronto 9.

2. U.S.A. - West Coast

Kirkman Laboratories, Inc., N.E. 25th Avenue, Portland, Oregon 97208

3. U.S.A. - East Coast

Bell-Craig Pharmaceuticals, Inc., 41-14 27th Street, Long Island City, New York