Snakepit in Eden

The Darkside of Sunnyside

Summary: Problems in the operation of a hospital unit operating in the context of an integrated community treatment program in New Zealand are identified and discussed by a locum tenans psychiatrist. The excessive use of high dose neuroleptics, loss of therapeutic focus, and profoundly disturbed flow of information emerge as signal elements in a disturbed and disturbing counter-therapeutic milieu.

"The two dreams are isomorphic: the first expressing in a very positive way the strict, militant, dogmatic medicalization of society, by way of a quasi-religious conversion, and the establishment of a therapeutic clergy, the second expressing the same medicalization, but in a triumphant, negative way, that is to say, the volatilization of disease in a corrected, organized, and ceaselessly supervised environment, in which medicine itself would finally disappear, together with its object and raison d'etre."

Foucault, The Birth of the Clinic (1)

Introduction:

I arrived at Sunnyside Hospital in Christchurch NZ in Feb. 1994 as 3 month locum tenans (temporary) psychiatrist. I was assigned to a team that served a specific geographic catchment area and shared physical space and staff with another team. The unit was already identified as problematic and recruitment for a permanent replacement psychiatrist was underway.

Initially, fundamental areas of unit malfunction were identified and discussed with hospital and unit administration, the centralized pharmacy, and unit staff. Despite considerable verbal support for operational change, even modest alterations to minimal standards were resisted. For example, drug histories were not available even in the case of patients known to the institution for many years. The lack of longitudinal pharmacological monitoring seriously compromised judgments and subjected patients to iterative previously failed drug regimens. My initial impression and subsequent serious recommendation that the unit be closed because of danger to staff and to patients was rejected. The major manifestations of difficulty were as follows:

1. Danger to patients and staff
2. Multiple readmission and rapid recycling of problem patients
3. Excess and compulsory administration of psychotropic medication.
4. De facto Unit management by nursing and junior medical staff
5. Chaotic ward-secretary managed communications system

The extent of disordered process became increasingly evident over my three month stay. Despite some corrective efforts the institution was resistant to significant process change. Like a masked virus embedded at the ganglionic level, periodic flare-ups with pain and anguish, recurred at vulnerable surface loci and were attributed to relational and/or staff morale issues, thus confounding cause and effect.

Cases:

1. LW is a 38 year old male. He jumps up and down biting his sheets, flopping back onto the bed, legs pushing and pulling, eyes rolling back in his head, teeth gnashing at the bedclothes. He is covered with sweat. There is no relief from IM chlorpromazine, IM clonazepam, or IM cogentin (among the multiplicity of drugs applied). The attacks have become more frequent in the last year and may persist up to 8 hours. He describes marked premonitory anxiety, during which he will down "any drug I can get my hand onto." Marihuana is useful. Despite an apparent connection with past-alcohol DT's this syndrome has presented itself on the unit after several weeks in the absence of alcohol intake, and was first seen in his early 20's after the use of massive neuroleptic doses, to control street drug/alcohol aggression and "schizophrenia." He is not schizophrenic. LW has no thought disorder. His sensorium is clear. But he will not stop using alcohol and MJ. He believes the latter is especially useful to abort the onset of his "anxiety." Withdrawal from daily neuroleptics and bimonthly depot injections is initiated. No psychosis appears. But the "attacks" become more frequent and of longer duration. Tardive dystonia is diagnosed. Treatment is not successful.

2. CF is now 44. He opens doors. Rapidly interjects questions. Then ducks out. His speech is characterized by multiple repetitions, stuttering, and intermittent angry, demanding, expletives, directed at any human within his purview, sometimes accompanied by property destruction and a chanting, abusive stream of invective against every one who has been involved in his treatment. These sessions can last hours. During them he demands cigarettes persistently. He is also creative and caring, and after a drug-induced (Clozaril and valproic acid) fever, his behavior improved to remission, he became self-positive, yet his "stuttering" got significantly worse. Shortly thereafter he manifests his ugly behavioral "attack" and is placed back on chlorpromazine. At first I diagnose Tourette syndrome. But early evidence for it is not documented. Although institutionalized at an early age, his records are sparse or non-existent. Fall back diagnosis: tardive dystonia/explosive disorder. Psychiatrists at Sunnyside have called him "retarded" due to the stuttering. He is not. He is a remarkably caring, intelligent, and guilt-driven person, despite years of psychiatric abuse.

3. MB is a 34 year old male. He is also a creative, not quite gifted artist, with a passion for extraterrestrial subjects. He frequently paints spaceships blasting through hyperspace, with fanciful renditions of cathodes, quarks and quasars. Everything is grist for his racing mind. Everything is a portent, a symbol, an interpretative interactive subjective world. When he is bad he is in everyone's hair trying hard to direct the management/treatment of his lover, TB. He is also big. He issues veiled and indirect threats about what he will do (kill) anyone who "comes on to her." He is very alert, the first one in the morning to make a request from the first staff through the door. If he doesn't get his way he may assume the he did. He periodically leaves the hospital without authorization. He may or may not return until the police retrieve him. Recently he was located at the airport where he claimed he was meeting Yasar Arafet to "resolve the Mideast Crisis." He pesters travelers.

MB consumes mental health services with a voracious appetite. He has several doctors and multiple agencies working on his requests. He does not respond consistently to low or high potency/dose neuroleptics. And he persistently complains of a multiplicity of troubling side effects including heart pain and eyes which roll back in his head. He has been accused of abusing cogentin, an anticholinergic used to treat the eye-rolling problem and muscle spasms (dystonias). He has also been accused of "manipulating" the system, a euphemism for his milieu-motivated control of symptoms for personal gain. He is a known user of alcohol, which leaves him highly susceptible for aggressive interference with others, and marihuana, which appears to decrease his pressure for action, but interferes with his judgment.

I was initially concerned that Unit staff allocated more time discussing his problems than those of his partner (TB) who was at that time a unit patient. MB was busily attempting to direct her management. He and TB filed an abuse complaint with the hospital director. She was discharged, basically unchanged from her ambivalent and tormenting depression, due primarily to his efforts. In brief, he consumes mental health services like a rocket consumes fuel. He is demanding, paranoid, and difficult. Although threatening and abusive at times, he can be sweet and cooperative for significant periods. He is diagnosed paranoid schizophrenic, with a strong manic element.

4. RW is angry and disagreeable. At 24 he is also isolative and rejecting of authority, uses significant amounts of marihuana and alcohol, and has dealer "friends." He is "managed" with depot and daily neuroleptics and has demonstrated significant periods of remission both when on and off psychotropics, since his first diagnosis of paranoid schizophrenia at the age of 18. I spent many hours with RW. He is very intelligent. He prefers "being angry" to being "drugged" (by prescription neuroleptics). He plays chess with a high level of anticipation and good concentration. He answers question in a direct and blunt fashion. After alcohol he becomes more aggressive. He postures and behaves "strangely," especially after use of street drugs. He has no use for the staff, but makes friends with several patients.

His father believes he is very dangerous, especially as the result of marihuana. The nursing staff ignores medical orders and the treatment plan, and provokes the patient into a fight by refusing him access to his clothing. They release information to the patient's father in disregard of his privacy and confidentiality rights. He then initiates an investigation when RW is converted from involuntary to voluntary status in accord with provisions of the NZ Mental Health Act. On the day of his planned discharge RW leaves without notice, and is not available for followup. The investigation raises important issues regarding his management and refers them to the hospital authorities. However, it neglects to include provisions for interview and examination of the patient in the investigative process.

5. VT has been on neuroleptics and antidepressant medications for almost two decades. She is very suicidal, very changeable in mood, and her behavior rapidly shifts in accord with her mood of the moment. She is quite incapable of maintaining her traditional helpfulness on the family farm. She gets little relief from any intervention. While on

the unit she tries to hang herself from the ceiling. When I speak with her she calms to a certain extent. Several critical nursing staff identify her suicide attempts as willful and manipulative. They believe she "can control her behavior." She makes little progress on the medication I prescribe. She is discharged only slightly improved.

Comment

Sunnyside hospital was established as the outgrowth of the Littleton Jail by Edward William Seager, experienced as a jail administrator. (2) With the strong support of his wife as Matron, he developed a "therapeutic community" with a "work ethos." He was displaced due to lack of "professional training" in the late 1800's by a medical doctor. The institution began a long downhill course. However, by the mid 1980's its fortunes had been reversed and Sunnyside was a model psychiatric institution with a multiplicity of service, noted for its training programs both for nurses and physicians, and its leading role in the provision of community services.

By 1994 a different story is apparent. Fractured by the de-emphasis on treatment and the hypertrophied role of community management, Sunnyside has become the repository of the recidivist patient, the filtrate, an exemplar of *the failure* of management strategies, primary prevention, compulsory community treatment, and the revolving door the most serious and persistent disturbance. (3)

The patient is caught in the squeeze. Antiquated information systems depend on the Ward Secretary. No computer facilitation of clinical tasks has reached this outpost. Details on drugs, psychiatric history, treatment failures, are consigned to illegible records, often lost in hyper-administrative space. Uncertain future employment, declining bed space, increased staffing, and failures in training and supervision, have result in low morale. Inadequate psychiatric supervision is especially noteworthy, and the units are organized around "house surgeon" (intern)/registrar (resident) to psychiatrist-consultant clinical authority chains. Lack of treatment planning, failure to identify specific treatment goals, ineffectual mandatory treatment, and dangerous on-the-ward conditions eventuate in the de facto management of patients by the nursing staff with the passive collusion of psychiatrists in the administration of excessive and involuntary medication. The excess use of benzodiazepines and the manipulation of cigarettes as reward and punishment is particularly noteworthy.

Drugs

While the use of neuroleptics at high doses in treatment resistant patients in an acute case may be justifiable, a pattern of continued high dose treatment in chronic psychiatric disturbance displaying marked adverse effects is scarcely tenable where treatment failure is persistent and obvious. (4) Furthermore, persistent abuse of non-prescription drugs, even during hospitalization, represents a real but unrecognized problem regarding pharmacokinetics, drug interactions, and toxicity. Finally, the use of excessive medication, both in dosage and polypharmacy, may be a serious index of generalized treatment failure, low staff morale, and administrative as distinct from therapeutic intervention.

Sedation

When I first came on the unit, one evening nurse blandly informed me, that the entire strategy of evening and night shifts was to "keep them sedated." This is reflected in the excessive use of chlorpromazine and clonazepam for sedation, regardless of diagnosis. One predictable side effect of such use is "rebound chaos" on the day shift. Also predictably, such misbehavior is routinely assigned to the patients' characterologic defect or "personality disorder.[H] This tendency was facilitated by prior psychiatric mislabeling or compound diagnosis emphasizing this category of disorders, in part due to the confounding influence of widespread alcohol and drug abuse.

Cognitive effects and State Dependent Learning

Besides rebound disturbance, other medication effects are clearly at work. One is cognitive interference. When I examined one patient at morning meeting, the nocturnal use of the sedating drug clonazepam had resulted in slurred speech, sedation, and incoordinate and slowed responses on interview. This effect was roundly denied by nursing staff. The next evening, a medication shift to an antihistamine (Polaramine) for sedation provided the proof. The second adverse effect is a problem in the transfer of learning referred to as "dissociation," "state-dependent" or "drug-discrimination" learning (5) In this circumstance, memory retrieval depends upon reinstatement of the drug condition that prevailed during memorization. That is, what is learned while taking a drug, is forgotten or absent when the patient is no longer medicated. This non-transfer of learned behavior is the result of certain medication among which anesthetics (e.g., alcohol, barbiturates, phencyclidines), the benzodiazepines (e.g., diazepam, flurazepam), nicotine, and anticholinergics (e.g., artane, cogentin, scopolamine) have been most clearly implicated. Such effects hinder the withdrawal process by leading to worsened behavior on withdrawal. Perhaps more ominous, this phenomenon confounds the therapeutic project itself by creating a significant endemic reservoir of drug-dependent learning-impaired individuals.

Movement and Behavior Disorders

Other side effects of medication, including acute and chronic akathisia (restlessness), dystonias, dyskinesias are regularly ignored. Special pleadings by the patient on their own account are labeled "manipulative" and "drug-seeking." The review of these pleadings is superficial, sometimes spurious. "Non-compliance" which is the failure to take prescribed medication, tilts with "medication drug-abuse" as diagnoses of derogation, rationalizing treatment failure. These "explanations" replace older categories of psychopath and sociopath. On my unit, characterologic and personality disorder diagnoses supplanted psychotic disturbance categorization, despite clear evidence to the contrary. These diagnoses are then used to deny treatment, to withhold adequate treatment, and to justify extraordinary involuntary containment management strategies.

Nicotine

Nicotine administration remains controversial in therapeutic settings, due to high rates of staff smoking, and its usefulness to junior and nursing staff as an informal technique of control. On this unit further patterns of disruption were occasional by dispensing "smokes" in the nursing station, permitting patients frequent and disruptive access to this area of crucial regulation and information exchange. Secondary smoke also became an inevitable part of important and dysregulating factor both in the secure unit and in the general meeting room. Attention to this important "uncontrolled" drug in terms of self-medication, state-dependent learning, psychotropic-nicotine interactions, and behavioral interventions requires therapeutic attention,(6) but the consequences of ignoring its deleterious effects have been known since its introduction to Western culture over 200 years past and to psychiatry for at least the past two decades.(7) I designated the brown nicotine stained finger-tips/nails "Seth's Sign" as an indicator of akathisia in patients on neuroleptic medication, a correlation supported by independent research. (8,9)

Disordered Patient-Staff Interactions

The failure to include patients in their own treatment appears as a byproduct of the overall management strategy which has displaced treatment and put the hospital in the role of a detention center to provide immediate "community relief." An examination of the authority structure of the institution places the managerial authority at the highest level, with the clinical realm often out of the line of patient management control. This can result in serious maltreatment. In one instance, despite my insistence on the priority of "treatment," a patient was transferred to another unit because the nursing staff felt "endangered" by his behavior in the light of non-documented anecdotal recall of his "destructive" history. In another instance, a patient for whom I had direct supervisory responsibility, and in whose management I had been actively engaged, committed suicide after two prior nights of same-method attempts. I was not consulted regarding the level of supervision or restrictive environment needed in view of his clear and immanent risk, and was not notified of his successful attempt until the following morning.

Inclusion of the Patient

A treatment bias against active patient participation may reflect an apparent result of ill-considered compulsory pharmacological intervention which disregards the actual failure treatment in favor of a myth of "usefulness." One patient of mine, on review for a long term compulsory outpatient treatment order was caught in a multiple bind, with no way to gain relief from potential duly-authorized medication abuse. He had a penchant for taking a lead [Pb]-based remedy for peripheral muscular weakness; and a history of periodic relapse into disturbed, self-referential (paranoid) behavior within his family. He also took care of an aging mother. Despite the failure of the prescribed neuroleptic to alter either his "delusions of grandiosity" (he was in fact a

loose follower of Theosophist Madame Blatavsky) or his self-prescription of lead salts, there was no was in which he could prove therapeutic "improvement" such that would justify taking him off his neuroleptic depot injections. Yet together we worked out just such a program, which involved his leaving the family and maintaining a period of stability in his own apartment as a criterion of improvement. As I departed the consultant service, this "plan" was apparently being countermanded by strong family pressure to "continue treatment." In a similar but less ambiguous case, a patient's "treatment" with depot neuroleptics had clearly failed to reduce relapse, but "non-compliance" established the "necessity of continued treatment."

Abuse of Patients by Staff

Patients are also subject to specific forms of ritual abuse and harassment by poorly trained staff, including the use of seclusion, limitations of privileges, with-holding of personal clothing, etc. Absent a therapeutic rationale other than containment, their use is demonstrably punitive. When several patients complained, the complaints were turned upon staff that refuse to participate in the ritual abuse. On several occasions the apparent anger and hostility of "acting-out" patients was simply resolved by my taking them out of seclusion and off the ward itself, away from the mass interaction and threatening display behavior of staff. (10) For this action, I was rebuked for not getting "nursing permission" to enter the seclusion room, because a) it was too dangerous; b) the patients were just being "manipulative."

Information Dyscontrol

Such cases illustrate the elements involved in the failure of a hospital unit to meet its clinical responsibilities. While the issues that confront the therapeutic task are complex, they are subject to inspection and analysis of the potent sources of clinical confusion. First the disturbed behavior is identified. Then diagnosed. Then treated with appropriate review and evaluation of the consequences of treatment, beneficial and adverse. Each of these steps requires current and unimpeded information. But the flow of information is currently severely compromised. Nothing less than an overhaul of this system is required. An adequate clinical computer resource is a first imperative. (11) These are rare and challenging cases that defy standard treatment. On site world-wide literature search process needs to be a standard part of any persistent treatment failure. The skill and training of the psychiatric consultant must be appropriate to this task, and the substantial therapeutic resources of unit personnel effectively utilized. Medication is but one element in treatment. Yet its use must be mastered, and subject to a coherent system of guidance and control. Alternative therapies must be considered where prior interventions have failed. But most importantly, the patient must be acknowledged as the active agent in the treatment project and given an opportunity for drug-free learning. Without this crucial acknowledgement, therapy and management are indistinguishable, and the patient residual fodder for competing agencies in the therapeutic state. (12)

Notes

1 Foucault M. The Birth of the Clinic: An Archaelology of Medical Perception. (New York: Vintage, 1975 [1963]) 32.

[2] Madeleine Seager. Edward William Seager. (Waikanae, NZ: Heritage Press, 1987).

3 Raphael B. Primary prevention: fact or fiction. Australian & New Zealand Journal of Psychiatry Sept. 1980; 14(3): 163-74.

4 Hirsch SR and Barnes TRE. Clinical use of high-dose neuroleptics. British Journal of Psychiatry 1994; 164:94-96.

5 Overton DA. Drug state-dependent learning. In Psychopharmacology in the Practice of Medicine ed. Jarvik ME (New York:Appleton-Century-Crofts, 1977) 73-79.

[6] Romans SE, McNoe BM, Herbison GP, Walton VA, Mullen PE. Cigarette smoking and psychiatric morbidity in women. Australian and New Zealand Journal of Psychiatry 1993; (27):399-404.

7 Boston Collaborative Drug Surveillance Program. Clinical depression of the CNS due to diazepam and chlordiazepoxide in relation to cigarette smoking and age. New England Journal of Medicine 1973; 288:277-280.

8 Goff DC, Henderson DC, Amico E. Cigarette smoking in schizophrenia: Relationship to psychopathology and medication side effects" Am J Psychiatry Sept. 1992; 149:1189-94.

9 Menza M, Grossman N, Van Horn M, Cody R, et al.,. Smoking and movement disorders in psychiatric patients. Biological Psychiatry July 1991; 30(2): 109-115.

10 Hammill K, McEvoy JP, Koral H, Schneider N. Hospitalized schizophrenic patient views about seclusion. J Clincal Psychiatry 1989; 50:174-7.

H J-esage J. Clinical application of data processing in psychiatry. Canadian Journal of Psychiatry 1985; 30(7):513-20.

12 Szasz T. The Therapeutic State: Psychiatry in the Mirror of Current Events (Buffalo NY: Prometheus, 1984).