Spontaneous Relapses Myth or Reality

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To the scientific mind an effect without a cause is absurd. An effect without an apparent cause is another matter. This only means that the cause cannot be detected or measured by our present existing instruments or clinical acumen. Yet in the field of mental illness there is a pervasive impression given to patients and their families that no matter what is done in the interest of recovery the disease will somehow reassert itself spontaneously or without any major causative factors.

We have studied psychotic illnesses exhaustively as to cause. We know we can induce psychosis by chemical ingestions (LSD, Cortisol, PCP), vitamin deprivation (B3), sleep or sensory deprivation. Also implicated in the genesis of psychosis are psychological and spiritual factors, brain trauma, environmental stress, and an inherited biochemical predisposition may be a substrate prerequisite. We know we can remit psychosis by chemical ingestion (psychotropic drugs), diet and supplements, rest, supportive milieu, ECT, or a combination of several of these.

An orthomolecular eclectic program of recovery incorporates all the factors known or reasonably hypothesized to be involved in the illness into a holistic treatment plan.
The patient is familiarized with his individual recovery program and reinforced in applying this until it becomes part of a new health/management lifestyle.

If a patient then fully incorporates such an eclectic health regimen into his daily life, can he expect to remain relapse free? 1 believe it is clinically appropriate to assure patients on that point.

Patients cannot be exactly given a guarantee because there are unforeseen factors that can arise. No reasonable person expects such guarantees. I have reviewed a number of clinical relapses in patients whose psychosis was brought into remission by an orthomolecular eclectic program in an attempt to establish if any cause and effect sequence can be demonstrated. The following five case histories exemplify our findings. Case #1 — R.N.

W/F/28 discharged from the hospital 7/12/82 in full remission of symptoms. She was readmitted on 8/5/83 in a state of full

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relapse with delusions, malnutrition and unable to function.

In retracing the course of the relapse, we found the patient had lost her job through layoff (no fault of patient) three months prior. She had gradually gone off nutrition program and put herself on a bizarre diet including fasting and spiritual exercises. She hid this program from her counselor. The patient also failed to show up for medical management aftercare sessions. Psychotropic medication had been gradually discontinued over the first six months of patient's aftercare.

The patient failed to recognize the danger signals and was unable to draw on the information she had learned regarding relapse prevention. The patient refused to go back on the medical nutrition program; she continued to deteriorate and required involuntary emergency admission. In this case, a major unpredictable stress (losing job) occurred. The patient totally disregarded program instructions as to how to handle such an event. She went off nutrition program and induced a state of malnutrition. She rejected the intervention of the program staff. The relapse gained momentum and the biochemical and psychosocial imbalance became complete. The patient quickly responded to reintroduction of the previous treatment plan and was discharged again in full remission on 9/2/83.

Case #2 — K.C.

W/F/32 discharged on 9/9/81 on an orthomolecular eclectic aftercare program. She was readmitted 12/26/81 in full relapse of psychosis with somatic delusions; paranoid outbursts and bouts of depression alternating with hypomatic episodes.

In reconstructing the relapse, we discovered from the family the patient (1) had gone off her nutrition program (2) drank coffee all day (3) cooked evening meal late at night (4) began socializing in bars and consuming heavy amounts of alcohol. The patient gradually became isolated from healthier social activities. This behavior caused increasing altercations with the family with whom she was living. Her family endured this behavior until it became too disruptive to their household.

The patient had been unreliable in taking her prescribed medication. Under the above circumstances, with several major violations of recovery or health principles, it is readily understandable that a state of biochemical and psychosocial homeostasis could not be maintained.

Despite repeated attempts to educate this patient, she refuses to take responsibility for her recovery, refuses to give up alcohol, and looks to romantic relationships with men to rescue her from her life predicament.

Case #3 — E.C.

W/F/23 was discharged to her own apartment 11/12/82 continuing with the orthomolecular treatment on a day-student basis. On 1/10/83 she was readmitted as her condition had gradually deteriorated. (1) She did not attend her day program regularly. (2) Her compliance with medication was poor. (3) Her lithium levels were below therapeutic range. (4) She maintained late hours, frequented night spots, and socialized with drug-using peer group. (5) It is probable that this patient abused alcohol or drugs although she tended to deny this. She was sleeping late in the morning and did not get a job.

This patient responded well to active treatment and medication and was discharged to the transition facility on 2/4/83 where she remained until her final discharge to independent living on 10/21/83

Case #4 — K.U.

W/M/33 discharged 2/16/79 in full remission of symptoms of paranoid schizophrenia on the orthomolecular holistic program. The patient relapsed and was admitted to the hospital on 7/16/81.

In analyzing the relapse, it was found (1) Major problems had erupted in the marriage which were not being dealt with in any kind of counseling or therapy. (2) The patient began abusing alcohol and cocaine, and had gradually gone off his diet. The patient had not discontinued his maintenance of psychotropic medications as far as determined.

The patient was withdrawn from alcohol and drugs, given marriage counseling and re-established on his orthomolecular program. His condition quickly restabilized. He was discharged from the day-student program 9/8/81 to aftercare counseling and has maintained good remission since with strict adherence to his program.

Case #5 — Q.T.

W/F/38 discharged in full remission of psychosis 4/15/82. The patient was fully aware of the holistic program necessary for prevention of relapse. She was readmitted on 12/15/82 in full blown psychotic condition.

In reviewing the relapse, it was noted (1) Patient had become lax in attending her aftercare counseling sessions and had gotten into the habit of calling into the office for renewal of medication, missing her medical management sessions. (Patient was on lithium maintenance). The patient finally dropped out of contact with the office completely. (2) The patient, without our knowledge, scheduled herself for and received a hysterectomy. She received no therapy or counseling regarding this major event. (3) The patient was only partially compliant with diet, tended to abuse alcohol, and kept late hours, frequently visiting night spots.

In this relapse, there were major violations of her recovery program. She had completely disregarded advice regarding handling new major stresses (hysterectomy). Starting with complacency, she had gradually left herself without any aftercare program. She readily responded to the reinstitution of her treatment program and was discharged 1/7/83 in full remission of psychosis.

The above five cases are typical of the relapse records in our files over the past three years. Numerous other cases are available which lead to similar conclusions. I was unable to find any case of relapse in our records without such major neglect of health principles involved.

The above review was undertaken for the purpose of examining some basic aspects of recovery from major mental illnesses and the phenomenon of relapses. The life history of these diseases has been widely described as including a gradual downward drift over time regardless of type or regularity of the treatments applied. The pervasive impression given to patients and their families and to students of psychiatry has been that relapses are inevitable and to a large degree of unknown origin or spontaneous. In our review, however, as stated, I could not find any case of relapse that fit this category. Each case demonstrated that one or several violations of major recovery principles took place and were continued over a considerable period of time prior to the emergence of the relapse.

These violations included going off the orthomolecular diet, abuse of alcohol and drugs, going off psychotropic medication without medical supervision, failure to attend aftercare sessions and failure to make any allowance or get any help for major traumatic events.

It was also noteworthy that the psychoses were readily brought back into remission with the reintroduction of the orthomolecular eclectic program where the patient cooperated with the treatment.

The salient point in the recovery and maintenance of the recovery seemed to be the consistent application and continuation of the treatment program. This involved the patients learning to take responsibility for the process. To the degree that a patient can do this, it would seem that relapse could be prevented. Thus, mental wellness or mental illness in a patient who has been psychotic could be better viewed as an organic process or continuum that can be influenced in either direction by the presence of factors that are disease or repair promoting.