YOU CAN SEE A LOT BY JUST LOOKING BUT HOW AND WHERE? MY EXPERIENCES IN PSYCHIATRY

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Thank you very much for your introduction Kai. I take your comments about my interest in the breadth of psychiatry as a very great compliment, since the kind of breadth you were talking about is an extremely important value for me. About two years ago I was giving a talk at a psychiatry department in a Paris hospital. It was a talk about psychiatric disorder, its social aspects and the objective and subjective ways of understanding a person with a psychiatric problem. The talk was broad ranging – some people would consider it too broad – but a couple of the psychiatry residents came up to me afterwards and said something that was very touching to me but also sad. They said we didn't know psychiatry could be that way. I think that breadth is how psychiatry has to be.

There's certainly a need for specific inquiry into various areas, but I think a major issue is how to have a broader conception as well, one that takes into consideration psychological, biological, and social aspects, and also pays attention to objective and subjective sources of knowledge. But I want to start out first by saying that this series on intellectual trajectories is an exciting idea. It has been wonderful to hear about these various trajectories. I think you'll see as I continue why I feel so strongly about it.

Actually, my thoughts related to presenting a trajectory here started about a year ago when Natalie Radding suggested to me that I try to do one of them, and I thought that was a fantastic idea. So I started thinking about what I would say or how I would even think about it. What I did next was something I do fairly often when trying to figure out a big question. I started talking with friends about it. This time my question was about the intellectual trajectory series, and every time I would talk with somebody – well, if you talk with people about their intellectual trajectory, you'll learn something about them that you never knew before. Even people you know very well come right out of the woodwork, which is incredible. For instance, I started talking about the series with a friend of mine who is about 83 years old, French, and living in Paris. She thought for a moment and said, "Well, my intellectual trajectory started around 1850." She is a very bright woman, and fortunately I knew enough to shut up as she continued talking.

My friend told me she had a great, great, grandfather who was a copper artisan in France at the point when Napoleon III was involved with the Suez Canal in Egypt. They needed somebody there who was skilled in copper work, maybe to develop ways to store wine or something, so they got him to go to Egypt. Subsequent members of her family continued their contacts with Egypt, and my friend's father, in his turn,

became an Egyptologist. After the Second World War, he was able to resume his archeological work in Egypt and prepared to return there. My friend, then a teen age girl who disliked school and was not much of a student, loved drawing, but she had been told to do her schoolwork and forget art. It could never lead to anything. Before her father left for Egypt, he was having trouble finding a person who could draw the artifacts he would be digging up so he asked my friend, his own teenage daughter, if she would go with him to do that work. She did, and she's been an artist ever since. As she said, her intellectual trajectory began during the reign of Napoleon III, well over 100 years before she was telling me about it.

Her story really took me off-guard because I had assumed, naively – and I should have known better – that an intellectual trajectory starts, at the earliest, with one's own life. And of course that really is naive. Another instance in which the sheer act of raising the idea of an intellectual trajectory opens up new possibilities was with a friend of mine here in New Haven. I was telling him about the series, and he said, "Well, I have two intellectual trajectories. One is in art, the other is in medicine." Having two trajectories was another possibility I hadn't thought of. Then, as another example, I was reading an article in a French journal, and the authors were discussing intellectual itineraries rather than trajectories, which of course is another way of thinking since it focuses more on the steps rather than on the linearity or the pathway.

Then last week, trying to make myself look at least a little respectable for this presentation, I got a haircut from the woman who has done that for about 24 years. I was telling her about this program, and she stopped for a minute and said, "Well I don't have an intellectual trajectory, I'm just busy all the time." That, of course, is another way of seeing things. That's her trajectory. So in preparing for this occasion I just keep learning about people and about this question.

When Kai invited me to give this talk a couple of months ago I focused down on it more and tried to figure out what my own intellectual trajectory was. I found that my life had been quite fascinating. I was feeling guilty for being such an egotist, but was reassured by my friend Elena Pelus, a graduate student in Spanish Literature who told me not to worry about that because Una Muno, the Spanish author, said that everybody thinks that his life is fascinating.

As I started to consider my own trajectory, my first thought was that it was entirely chance. A lot of other people who have reported in this series have said the same thing. My impression was that I was like an electron in a cloud chamber revealing Brownian movement. You go one way and you hit something and then you go another way and then you hit something else and you go still another way. It's just as though that kind of chance were the only determinant.

Then I began to think, well, no it couldn't be just that. There must be some sort of continuity or some sort of themes. So then I thought of several possible themes and I will discuss two of them here.

One involves methodology. That theme is really best summarized by a saying of Yogi Berra, the former catcher and then manager of the New York Yankees, who is of course known for his very witty sayings that sound silly but in fact are very profound. One thing Yogi Berra said (paraphrased) – it has been the major methodological theme of my work – was, "You can see a lot by just looking." So that's my methodology theme. For me it suggests that what you see and what you don't see depend on how and where you look. I'll say more about that as we proceed.

The second theme deals with content. A friend, Ashley Clayton, and I were having breakfast at Atticus and she asked, "Well, what have you been doing?" I told her that a couple of days earlier I had given a conference to second year residents in psychiatry. She asked, reasonably enough, what it was about. I thought for a minute and said, "I don't really know. It seemed to have gone well but I'm not sure what it was about." She's very kind and patient and she waited for a bit. Then I said, "I think what it was about is that people are not billiard balls." So that's my content theme: people aren't billiard balls.

Rather arbitrarily, I'll start with when I was in college at Swarthmore and majored in psychology and in the humanities. In case I wanted to go to medical school, I took pre-medical courses on the side. The Swarthmore psychology department at the time was unlike psychology in other places in the '50s. At Harvard, for instance, Skinner had been studying pigeons pecking at bars to get food. At Yale, Neil Miller and others were studying rats in mazes elaborating rules for the relationships between stimuli and responses. At Swarthmore, we had several German refugees in the psychology department and they were interested in gestalt psychology. Wolfgang Koehler was the professor who taught learning. Rather than being interested in pigeons or rats, Koehler had studied his favorite chimpanzee, Sultan. Sultan had figured out that to get a banana that was hanging out of his reach, he could pile one box on top of another and then climb on top of them and get the banana. Clearly that was a much more complex view of cognition and of learning than interested the pigeon and rat people. Another kind of problem that the gestalt psychologists were interested in was the Umweg or detour problem where for example there is a fence, and a dog is on one side and some meat is on the other. According to a lot of American psychologists at the time, the dog should have just more or less broken his head on the fence trying to get the meat. But although some dogs did just that and without success, other dogs actually ran along the fence, found the end of it, and then came back on the other side to get the meat. The question generated by the dog experience as with the chimpanzee experience in contrast to the pigeon and rat research was how should one think about and study thinking. There seemed to be a reason to view cognition at a much more complex level than is suggested by observing only pigeons or rats. The answer suggested by the gestalt people was to use a structuralist model of thought. It seems to me that such models always involve problems with their hypotheses and demonstrations, but they also provide interesting approaches to understanding complex processes of mental life.

I graduated from Swarthmore and came to Yale Medical School. I loved Yale because they treated you like an adult, which most medical schools did not at that time. At Yale there were no exams and you needed to write a thesis. The thesis was wonderful because you could do Nobel Prize level work or you could do practically nothing at all; it was really up to you what you wanted. After about a year and a half of the preclinical courses, I had had enough of pure biology for a time, although studying the human body and its processes was fascinating.

To take a break from the medical curriculum I arranged to take a year off and go to work towards my medical school thesis with Jean Piaget in Geneva and Paris. That was quite an experience. I took every course of the three that Piaget gave that year. One of them was a small seminar with about six people so that we could really learn how Piaget thought about understanding human mental processes.

Two things that I learned from Piaget were particularly important for me, although I didn't realize it until about 30 years later. One was that he used what he called the clinical method to do his research. In that method he would give a standardized test situation. This was always with children because he was studying human cognitive development. The child would do whatever he or she was going to do to deal with the problem posed. That was the standardized quantitative part of the clinical method. After that the investigator could ask any questions or change the situation in any way that he wanted to try to get an idea why the child said what he said. As simple and obvious as it may sound, this was the only approach that I'd seen that provided for a combination of quantitative and qualitative research. As I say, it took me about 30 years to figure out how creative and how important such a methodology was. With the approach of Piaget you could see not merely if the child succeeded or failed at a test but you could also clarify why that happened. I think that was my earliest introduction to the idea that what you see depends on how and where you look.

The other thing about Piaget that was so impressive was that when he would present a question about developmental cognition to a class he would give an example of the problem and then ask the class what the child would do. For example when the child saw you pouring water from a narrow glass into a wide glass and noticed that the level of the water was lower in the second glass, what would he or she say about that change? The students would suggest various possibilities and Piaget would say, well, actually you can't tell what the child would say because in order to understand what's going on in the child's mind you have to see how children respond across various ages. Thus the other incredibly important principle from Piaget that I learned besides the combined use of quantitative and qualitative methods was this longitudinal principle. I realized later that it has also been historically crucial in medicine which I'll discuss later, but stated more generally, if you want to understand process, you have to do some kind of longitudinal investigation.

I graduated from medical school and went to McLean Hospital in Boston to do my psychiatric residency. The program had a very psychodynamic, heavily Freudian

orientation and I learned a lot about psychodynamic approaches to people with severe mental illness, including people with schizophrenia. The only thing that troubled me was the approach to the nature of proof. The nature of proof seemed to be that the person highest up in the psychoanalytic hierarchy knew the truth. People farther down didn't know the truth unless you couldn't get to the highest one, in which case the lower person did. That seemed bizarre to me as a way of deciding truth.

After my residency I went to the National Institute of Mental Health in Washington and after about a year there got involved in a study called the International Pilot Study of Schizophrenia. That project was a nine country study, involving India, Czechoslovakia, Denmark, UK, Colombia, Taiwan the US, the Soviet Union, and Nigeria, to see whether it was possible to develop a system usable in the nine different countries to identify people who could be considered as having schizophrenia. Psychiatry, because of its mixed focus on human psychological experience and physical illness, has struggled to meet all the requirements of other sciences. Even at the most basic level it has been difficult to define reliably and usefully basic diagnostic categories. Several years ago it was common that psychiatrists from different parts of the world or even from the same city used the diagnosis schizophrenia, for example, to mean entirely different things. So in the International Pilot Study by using structured interviews to interview patients in the nine different countries we were trying to set up operational criteria for diagnosis that people could agree on.

I had taken a course in statistics in college years earlier but my knowledge was just abstract and I didn't really learn to use statistics. But in the International Pilot Study I had to learn their application because our Washington center became the base for analyzing issues of validity and agreement about judgments. There, with Will Carpenter and John Bartko, who was our biostatistician, I really learned the value of measurement and statistics in order to identify and check hypotheses. As part of the International Pilot Study, we were also doing a two year follow-up of study patients, and in the Washington Center, where I was the head by this point, we developed an outcome scale, to asses two-year outcome.

We carried out two-year follow-up interviews on the patients in the study most of whom had schizophrenia, and found that about 30% actually improved. Since we had reliable criteria to show that, it disrupted the field of psychiatry a bit. The founder of modern psychiatry, Emil Kraepelin, had posed as a basic belief that you could put together different syndromes, that is groups of symptoms, as defining a disorder if they all had the same course. That is the same idea as the Piagetian idea of defining process by longitudinal changes. Kraepelin named these diverse groups of symptoms as the disorder "dementia praecox," since he believed they always had a deteriorating course. Dementia Praecox later became known as schizophrenia. There we were showing that, no, not everybody with these symptom groups did actually get worse.

Thinking for a moment about the methodologic theme, I was beginning to get a clearer idea of the importance of the Yogi Berra saying, "You can see a lot by just look-

ing." During my residency we focused particularly on mostly open-ended listening and interpreting in working with patients. In the International Pilot Study we used highly structured and reliable interviews, attention to sampling issues, and extensive work with statistics. In my residency it would have been anathema to have an interview form in front of you and be making check marks as you talked with a patient. In the International Pilot Study we never would have gotten the data we did if we had limited ourselves to open ended questions and interpretations. When Yogi Berra watched a baseball game, he was able to see things that I will never be able to notice or decipher. In psychiatry, different methods of inquiry give vastly different ideas of what the problems are and how to understand them. It began to seem to me that limiting oneself to one approach would essentially preclude your seeing the whole phenomenon, the old story of the blind men and the elephant.

And now back to the content theme that people aren't billiard balls.

The idea of a longitudinally defined process is not only true for Piaget and Kraepelin but has a long history in medicine. Sydenham in the 17th century and Hippocrates in ancient times founded their important ideas of what defined a disease entity in the same way. The basic idea again was that if you want to understand something, such as a disease process, you had to look at it over time. So, we continued doing follow-up studies and I went on with the chairman of our branch at NIMH to the University of Rochester and then came to Yale, all the while continuing to carry out longitudinal studies. Having used these approaches, we had been able to suggest the multiaxial structure (considering several areas of function in parallel) for the radical new standard psychiatric diagnostic system (DSM III), suggest various prognostic dimensions, and describe the important longitudinal processes in schizophrenia which, borrowing from the work of Hughlings Jackson, a British neurologist, we called positive and negative symptoms

In my research group we began to wonder: why just do outcome studies? We were really interested in the process of what happens over time, so why not see people periodically instead of just after two years? We began to conduct follow-up interviews with patients every three or four months over a period of four years in order identify ups and downs they might have, and then ask what might account for those ups and downs. We inquired into the role of medications and psychotherapy, the person's living situation, social relations, and their work.

What happens when you conduct repeated interviews with a person, though, which we should have anticipated but didn't, is that relationships develop. The people who were doing the research interviews had dual backgrounds as clinicians and researchers, and we decided that if we were going to see the study patients repeatedly over time, we should have the same investigator see the same patient at each of the series of interviews. We were using structured interview schedules with specified questions such as "do you hear voices?" and "do you have ideas that other people might think were bizarre?" But what happens when you see people repeatedly, of course, is

that after a while you get to know each other and when you get to know each other, the people (if you're reasonably nice, which most us were,) start to ask you questions that you never thought to ask or you never even thought about. So the Yogi Berra precept comes back, how you look relates to what you see.

Our research subjects started to tell us things that we hadn't thought to ask about. The biggest shock, though I don't think I realized it fully at the time, was when one of the people, a young woman with schizophrenia, during the third or fourth follow-along interview I was conducting said, "you're asking me about my work and my medication and everything else, but you're not asking me what I do to help myself." That question changed my whole research career.

What she was doing was raising this billiard ball question. In other words, people with severe psychiatric problems are not just passively affected by their treatments, living situation, etc. People are not billiard balls. She was suggesting that our view of psychiatry and actually somewhat of medicine in general is that people are more or less passive recipients of treatment. She was saying in a way, "No, no, that's not the only story, people are people and take an active role in trying to help themselves and do well."

So we started perseverating a little bit. We kept doing the same things, asking the same kinds of questions, but we added some that we considered to be quite radical. We started asking patients in the research whether there were things they could do to help themselves. Alan Breier, who was a resident here at the time, and I then wrote a paper about what people with severe psychiatric disorders do to help themselves.

One of the interesting things that often happens when you ask somebody with a severe psychiatric disorder, "Is there something you can do to help yourself?" is that they look at you strangely because nobody has ever asked them that before. You can use that question not only for research but clinically as well. I was gradually getting sensitized to this whole subjectivity thing, that people are not billiard balls, that they have the courage and will power to try things out. I know that realization sounds a bit naive if not downright stupid, but I started noticing other things, too. There was one patient, a young man with schizophrenia, who told me, "I was on the psychiatric in-patient ward and I looked around and I looked at all these people and I said to myself, I can do better than this. So I decided to pull myself together." And apparently he did, or at least his resolve appeared to be an important contribution to his improvement.

One of my favorite examples of the "people are not billiard balls" idea was a woman in her late 30s, also with schizophrenia, at about her fourth or fifth interview. She was a woman who heard voices, but she also had trouble organizing her thoughts, which is another major problem for some people who have schizophrenia. She was telling me that she worked in a large office where people were coming and going and saying, "Shirley, would you do this," and " Shirley, don't forget that, take care of this, and, oh, the phone is ringing." I asked her how, with her problem of organizing her thoughts, she was able to work in that kind of a setting. And she smiled kind of benignly at me and said, "Dr. Strauss, I told you this before" (and she had at earlier

interviews but it hadn't registered with me): "You know, when I'm in that kind of a setting, I *have* to organize my thinking." So, again, the non-billiard ball principle. People with severe psychiatric disorders work, sometimes effectively, to help themselves do better.

One thing led to another and I started trying to get more of a grasp on this question that people with severe psychiatric problems may have important subjective processes that are active and helpful and not only bizarre and harmful. Around that time a friend of mine in Toronto had developed some audiotapes that sounded like auditory hallucinations. The tapes had been made with some friends, and then they had been shared with psychiatric patients who heard voices and had auditory hallucinations, and they helped my friend fix the tapes so they sounded more like real hallucinations (I know that's a strange concept, "real hallucinations"). So, my friend asked if I wanted to put on the earphones and listen to this tape, and of course I said "sure". By that time in my career I had already seen at least a few hundred people who heard voices. The tape was on a Walkman, so I knew it was just a tape, but I found that these "voices" almost take over your being in a way that I had never suspected. I had not even had a clue how overpowering they were. My friend and I were going to go out to a movie that night so she handed me a movie guide to the movies in Toronto, and asked "why don't you pick out a movie for us to go to." I couldn't even find the movies in the movie guide, and that was all there was in it. Not only that, but when my friend tried talking to me every once in a while I was really angry because I wanted to listen to my voices that waxed and waned, were sometimes incomprehensible and at other times stopped only to resume a minute or so later.

Experiences like that, giving even a slight idea of what the subjective experience of a "symptom" is, changed my whole attitude when I saw people that had auditory hallucinations subsequently. Fortunately there are a lot of tapes like that available now. After that, more by intuition than by conscious plan, I think I started exploring other ways of putting myself in the place of a person with major psychiatric problems. One approach was by role playing. I'd present a talk at a conference and ahead of time would ask a friend who was a psychiatrist to interview me in front of the audience. I would be a person who came to him or her because I was hearing voices. The role-playing provided for me yet another kind of incredible learning experience. I started writing groups for people working with psychiatric patients, writing creatively about clinical experiences. I run two of these groups now here at Yale and have given similar groups pretty much around the world for people who work with patients. Members of the groups can be professors or undergraduates or nurses or people who have severe psychiatric disorders who work with others. These groups serve to validate and to emphasize the importance of one's own subjective experience as well as to comprehend better the experiences of others.

A couple of years ago I was in Paris. I stay at a little hotel in a room on the sixth floor. They always give me the same room and the people who run the hotel are al-

most like family. I was listening to my radio and there was an interview with a woman named Sandra Meunier who worked as a clown with patients on palliative care units, people who are often elderly and many of whom are on their way to dying. Sandra sounded very impressive so I went downstairs to the reception and found Sandra's website. On it there was a phone number. So I called her and said that I was really interested in what she was doing and could we meet at a cafe which is a favorite of mine and talk further. She said yes, and from that encounter we arranged for me to follow her around on the palliative care ward where she worked.

I arrived at the hospital, talked briefly with the chief of her unit who gave me permission to observe her, and then on the ward I followed about ten yards behind Sandra trying to look like a relative of one of the patients. Sandra was ahead of me, an apparition with braids out perpendicular to her head, a big red nose, big red lips, and a fluffy kind of blouse and skirt, and with an MP3 player playing bird songs at her belt. In the past I have had several administrative roles, and I was thinking if somebody had asked me if I would let this woman on my ward, I would have said no. That would have been a mistake.

Sandra would knock on a patient's door and ask if it was all right to come in. Most were happy to see such a being there, and she would go in and would talk with them. It was fascinating to see the kind of responses this clown had on this ward, a serious ward of adult patients.

Sandra and I talked later. She had written some things about some of the experiences she had with patients. To give an example, she walked into one woman's room and the woman said, "I heard the bells last night." As a patient or as a medical person you don't talk about this kind of thing on a medical ward. In fact if you were part of the medical staff you would probably never know that it existed. I need to note that Sandra is a European type clown, so no juggling, making jokes, not that kind of thing. She's a little more sober than that. Sandra being Sandra, asked the woman, "And what did they say, the bells?" And the woman responded, "Well they asked me if I was coming soon." Sandra said, "And what did you tell them?" And the woman said, "Well, I know I have to come soon, but I'm not quite ready yet."

This level of experience and discourse is really not very acceptable in most medical settings and Sandra was tapping into it. This is another aspect of a patient's subjectivity, of not being a billiard ball.

A few months ago I published an article in *Schizophrenia Bulletin,* a sober, highly valued psychiatric journal. Actually, even though it was an invited article, there was some hesitation on the journal's part to publish it. The main point of the article was that there are two kinds of knowledge needed for psychiatry to be a human science, which it is or should be. One kind of knowledge is discursive knowledge, the regular objective kind of traditional scientific knowledge. The other is experiential or subjective knowledge. And for each of these we need different methodologies. One type of knowledge cannot be subsumed in the other. I got only one response from that article,

and that response was, "It's good you're a humanist." It's nice to receive a compliment but that was really not my goal. I did not and do not understand how our field can fail to see this simple epistemological problem, which to me now seems so obvious. The response and non-responses reminded me of a similar response I got at a large conference when I was just beginning to talk about subjectivity. During the question period after my presentation one person got up and said, "You know, John, when you used to do your quantitative studies of outcome and diagnosis you did such good research."

So, to close: first, you can see a lot by just looking, but the question is how and where you look. These things determine what you see and what you don't see, what you learn and what you don't learn.

Second, people are not billiard balls, not just passive recipients of psychiatric disorder and treatment, but complex active individuals with crucial ways of experiencing their lives, including what we call "symptoms," and the treatments we provide. And people act, often in ways not considered in our conceptualizations, to help themselves and to lead their lives guided by their understandings, needs, desires, and hopes.

Finally, it seems to me to be so hard to get a field to change, to recognize the diversity of methodologies required and the complexity of the processes that we are attempting to understand and influence.