About Dr. T. Robie

A. Hoffer, M.D., Ph.D.[1]

During September, 1957, Ted Robie, then chairman, Section on Private Practice, American Psychiatric Association, asked me to discuss a paper Dr. Linus Pauling had agreed to read—"Biochemical Factors in Mental Illness." Eventually Dr. Pauling was unable to be present. But the association of interest of these two men was perhaps prophetic for Ted Robie became the first U.S.A. psychiatrist to try megadoses of vitamin B3 and Dr. L. Pauling became the first biochemist of first rank to see the theoretical and practical value of mega-vitamin therapy—more recently "Orthomolecular psychiatry."

I knew that Ted was able to corroborate our findings on his patients, but I was very surprised and pleased when I received his letter around Christmas, 1965. This is reproduced here.

Sometime ago, I decided to write you this letter and now the date when I wanted you to receive it is almost upon us. There are three persons to whom I owe a lot for making this, my 65th Christmas, a particularly happy event.

I have been in practice now 40$^{1/2}$ years, the entire period devoted to psychiatry. During the first $3 years of my practice, I found the treatment of schizophrenics particularly difficult. I could often induce a temporary remission with EST during the 19 years [up to 1958) after shock therapy came in, but in general, schizophrenics were not long-time patients because we did not have anything that would keep them reasonably becalmed, except through EST.

When I began the use of the hyper-nicotinic acid regime, which you fathered, I did so with skepticism. However, it was not long after starting the regime that I found that patients who would cooperate became lasting friends so far as I was concerned, and the degree of satisfaction in seeing a relatively high percentage of these patients remain in good or partial remission was the most satisfying of all.

That is the chief point of this letter, namely that we now do have something that we can give to schizophrenics and feel that we are truly doing something for them. The man who originated this (and his copartner in alchemy, Humphry Osmond) contributed to my Christmas in great measure by the satisfaction one derives in seeing the patients who do well on this regime and appreciate the doctor's efforts. I assume that you see five patients to my one. Therefore, your satisfaction must be multiplied by five.

[1] **3A - 2727 Quadra Street, Victoria, B. C. V8T 4E5.**

The above had been dictated before a patient of mine brought me the N. Y. Times clipping which described the formation of the American Schizophrenia Foundation by you and Dr. Osmond and others. It is quite possible that you may hear from this young man, who is anxious to make a contribution to some chemically minded psychiatric foundation. His chief problem is depression, but I assured him that you were just as much interested in depression as you were in schizophrenia and I knew of no more worthwhile cause to which he might contribute. Should you hear from him, his name is
C. W. My best to you and Humphry in your
new venture. If or when new members
are sought, I should like to be included.
One could not be associated with any
more dedicated people than you two.

Best regards **(Sgd.) T. R. Robie**

Ted not only had become an enthusiastic Orthomolecular psychiatrist, but he shared his views freely with his colleagues and fought against the establishment of which he had been a member for so long. When the **APA News** ran a misleading story early in 1967, he sent a letter to the editor which was rejected.

The **APA News** was not then disposed to carry favorable information about a treatment they "knew" was incorrect. I am reproducing Ted's letter.

Mr. Robert L. Robinson, Editor Psychiatric News
1700-Wth St. N. W. Washington, D.C.

Dear Mr. Robinson:

It is most unfortunate that such a schism hasoccurredas the result of assigning to Lee Baihly the job of attempting to smother the American Schizophrenia Foundation.

Let us suppose that some well-meaning group had attempted to smother the Infantile Paralysis Foundation at its inception. Would we have the means of
preventing poliomyelitis that we possess today? Think of the thousands of persons who have already been saved from the fate of incapacitation or handicap in the few years the Salk Vaccine has been known, and of the millions who will be saved from that fate as the years pass. The Public *put over the Infantile Paralysis Foundation!*

In the past 25 years or so, a number (seven or more, I believe) of researchers have been seeking a cure or alleviation of schizophrenia. All have given us helpful insights into this baffling disease, but not one of them has given us a therapy except the Hoffer-Osmond program of mega-vitamin B3. This vitamin therapy has shown us how to attenuate the illness or produce a remission in a sizeable proportion of cases. There is no greater satisfaction a physician or psychiatrist can experience than that of observing a patient or relative of one who has seen the remission that is possible in certain schizophrenics administered hyperniacin therapy (megavitamin B_3).

/ have been practicing psychiatry for 42 years, and in 30 of those years I was unable to find a therapy that truly helped these unfortunate cases. It was 12 years ago that I first heard Dr. Abram Hotter talk at a research meeting in Chicago. At the time I was treating a man who had required two courses of electroshock therapy in a state hospital, where he had been committed because of fixed delusions. He improved for a time, but soon relapsed after each of these courses of EST. I administered a prolonged course of outpatient EST—12 treatments over a four week period (three per week), then maintenance therapy every 10 days or two weeks, later reduced to every third week. This was continued for nearly a year, since it offered the only hope of keeping him in remission. After hearing Dr. Hotter speak, I tried this patient on hyperniacin therapy, with the understanding that he would resume EST again, if his delusions recurred. He has remained free of delusions since that time and is active in civic work. He drives his car wherever he pleases and works hard caring for his beautiful home. He causes no social dis-

turbances whatever, although his delusions involved him in many such difficulties in the five years previous to hyperniacin therapy.

It is not surprising that his wife and other relatives are pleased and astonished over his 11-year remission from, schizophrenia. Many psychiatrists would, I believe, consider this ***a cure*** *if they examined him and studied the history. The word "cure" by the way, is defined in the* Winston Dictionary *as "The act or art of healing . . . to remedy, remove or nullify, as a disease in a sick person, an evil condition in society . . . to cause a return to health." Webster defines "cure" as: "the state of being healed."*

It is possible that some persons have used the term "cure" unwisely concerning schizophrenia, but when one sees a result such as I described above, in a person chronically sick for several years with delusions (i.e. the false belief that his wife was trying to poison him 11 years ago), it would not be surprising for someone to apply the term "cure."

I shall not attempt to describe other cases with similar results. However, they are all annotated in my records.

The Lee Baihly article entitled "Psychiatrists Seek The Public's Support For Drug They Say Cures Schizophrenia" may be misleading. Many of us have considered it wiser to describe the treatment result in these terms: "a remission from illness has been induced and maintained for many years on hyperniacin therapy."

It was most unfortunate for Mr. Baihly to confuse the reader, especially since the new biochemical terms are often long and ponderous. In column 2, an absolute error was made when he stated "public support being wooed for . . . niacin therapy (or nicotinamide adenine dinu-cleotide megavitamin B_3*)." Niacin and NAD or nicotinamide adenine dinucleo-tide are two entirely different chemicals. A far more serious error was made in the 4th column, where it was stated "Dr. Hoffer reported that 13 of 17 schizophrenics treated with niacin recovered within three to five days." I was present at the meeting and know Hoffer made no such statement. Dr. Hoffer whose paper was on NAD (nicotinamide adenine dinucleotide), not niacin, did describe his experiences with that new chemical, which were surprisingly good.*

When errors as serious as this are published in a newsletter that goes to 12,000 psychiatrists monthly, it would seem obvious that biochemical reports should be edited by a biochemically oriented psychiatrist, with his name and background annotated. Certainly a fledgling reporter should not be assigned such a task without any authoritative reviewer.

It should always be remembered that every living psychiatrist hopes he will see the day when a specific cure or alleviator for schizophrenia will be known to all. Niacin has been demonstrated to accomplish this purpose in a certain proportion of cases and is, therefore, the best we know at this time..

I do not know any more dedicated psychiatrists than Hoffer and Osmond, who discovered the efficacy of this megavitamin therapy.

Very truly yours, **(Sgd.) T. R. Robie, M.D.**

When Humphry Osmond and I organized the American Schizophrenia Association, we set up a Committee on Therapy and Ted became one of our valued members. He was one of the group who read a paper at the first meeting of this Committee at the Brunswick Hospital Center in Long Island in 1967, later published in **J. Schizophrenia** 1, 133-139, 1967 (now **j. of Orthomolecular Psychiatry)** under the title "Cyproheptadine: an excellent antidote for niacin-induced hyperthermia." Here he reported that an antihistamine would prevent or reverse the effect of excessive flushing induced in a few people by niacin. Niacin releases histamine which in a few created unpleasant but very rarely serious side effects.

Ted remained an active member of the Committee on Therapy, attending every meeting except when he was not well enough to do so.

Thus March, 1969, he wrote:

Time has slipped along since your letter of March 3rd arrived. After the period of

hospitalization I had hoped to get back rapidly on my feet and re-establish my practice but, unfortunately, in December, a relatively short time after discharge from the hospital, I developed shingles over my left abdomen and back. This has proven to be a very trying experience and which is only now (last few days) beginning to subside and I am having some relief after three months of this plague for which nobody knows the treatment.

Therefore, I am sure you will not be surprised at my decision to make no plans to attend the Spring meeting in Vancouver. This is the city I have long wanted to see and never have visited. However, the prolonged illness and the fact that I am just beginning to get my practice re-established, even though I managed to stay at work throughout the entire shingles attack on a limited basis, makes such a trip seem impossible.

I am thoroughly in favor of the recording of the meeting and do hope I can read the proceedings and possibly would have belated comments even though I had not attended the meeting. Perhaps the next meeting will swing back to the East coast and by that time I will be back to the status I enjoyed when I last saw you and would be able to attend.

My good results with niacin continue. I have certainly found more cases in which the use of Dr. Bella Kowalson's new term for the schizophrenia process (Metabolic Dysperception), that I championed in California, greatly eases discussion of the illness with patients, eliminating much of the psychic trauma which besets any patient when first confronted with the diagnostic term schizophrenia applied to them.

PLEASE, *please, please, if you ever come East again for radio or TV appearances, let me know in advance. At least a dozen of my patients described hearing and seeing you, and I did not know about your being here until the time had passed.*

Thank you for the recent reprint.

Best regards, **(Sgd.) T. R. Robie**

But Ted continued to treat his patients and continued to exchange his ideas with me and with many others.In January, 1970, he sent me the following letter:

"/ *recently had a very pleasant conference with Dr. Osmond at his office in Princeton. He urged me to send the manuscript of the paper I presented in San Mateo, Cal. in September, 1968, back to you as the current Editor of the Journal Schizophrenia. He believed your ideas might differ from the former Editor and might be acceptable for publication as is. I have gone through each of the records from which I culled the case histories presented and was not able to find better additional material than presented originally. I am sure you know that many of us form fixed opinions diagnostically with regard to schizophrenics or metabolic dysperceptives, as I am led to categorize them these days because I feel more at home with the latter term. That is the only explanation I can think of for not having a more detailed explanation of the cases that I was convinced were true schizophrenics and were treated as such.*

It is my rather firm conviction there are many cases in whom apathy is the primary symptom, and they do not always express dysperception or bizarre ideas, but have as the primary symptom the narcissistic apathy.

I have seen one case during recent months that did call attention to the dys-perceptive concept more than the cases following cases #7 *and #2 in the paper which showed up, as did the first two cases, the dysperceptive phenomena. I will be perfectly content for you to substitute this in place of one of the other cases (i.e., #3 through #A2). Unfortunately, this patient did not continue under treatment and so I was unable to get further examples of the emphatically distinctive dysperceptive phenomena he showed in his first interview.*

If you are partial to Dr. Osmond's idea of calling the new term "malperceptions" I would agree with you and Humphry on that point. However, I feel that the layman will better understand the idea of dysperception. I would add here that I have found patients under-

stood me better when I discussed dysper-ception rather than malperception. I have discussed it at length with case #2, a college graduate who was a research worker in N.Y.C., and she strongly prefers the term dysperception, whk:h she applies to herself freely.

One more thought: I presume you have encountered Dr. Lawrence Kubie's statement that he believes a new term for schizophrenia should be propounded. It is possible that his thinking may be in consonance with ours.

I will be happy to hear your reaction to these comments.

Best regards, **(Sgd.) T. R. Robie**

And in October, 1971, another one:

/ am writing you concerning the policy statement you are turning over to your board. I believe it is excellent as a whole, but I think it is inadequate in regard to the elements that I shall discuss in this letter. I believe it important to stress the fact that the hypervitamin therapy carries no threat of harm to the individual such as is faced by the use of phenothiazines. Many doctors who prescribe them as a rule advise unconscionably large doses, particularly in our mental hospitals. Phenothiazines are used today for schizophrenic individuals over prolonged periods which very frequently do produce Parkinsonism. As you know, I designate all my cases of schizophrenia today as Metabolic Dysperception. It is in these cases that Parkinsonism is likely to develop, particularly where the doctor has neglected to insist upon the regular use of an antidote against phenothiazine effects. This may persist throughout the balance of life unless the antidotes are used, and if they are allowed to persist for a few months or longer, they cannot be eliminated. This factor is one of major concern and should never be ignored by the treating physician for there are unquestionably many cases of permanent chemically induced Parkinsonism in our society today.

I am listing four chemicals that are recognized as good antidotes for the adverse Parkinsonian effects produced by phenothiazines. I hasten to proclaim that we must remember that today many doctors are giving Prolixin Enanthate by injection and then promptly forgetting that continuous phenothiazine is being administered. Therefore, the recommendations for the use of the antidotes listed below must be applied when this injection is given.

I now list the antidotes:

Cogentin (Benztropine Mesylate) (Merck). This valuable chemical is recommended for symptomatic treatment of Parkinsonism. Cogentin mesylate relieves manifestations of Parkinsonism that may appear during treatment with phenothiazine derivatives or reserpine. Usually it is helpful in combating tremu-lousness; restlessness; feelings of tension; ptyalism; urinary frequency; "lockjaw"; and acute dystonic reactions such as torticollis, oculogyric crises, and dysphagia.

Akineton {Knoll) reduces akinesia, rigidity and, to a lesser extent, tremor, thus diminishing or eliminating symptoms, such as difficulty of initiating movements, masklike face, and pro-pulsive gait. Partially or completely controls excessive flow of saliva and oily skin. Lessens the frequency and intensity of oculogyric crises. Often elevates the mood.

Kemadrin (Burroughs-Wellcome).

This is another antiparkinson drug which comes in 2 mg and 5 mg. Used for the treatment of symptoms of extrapyramidal dysfunction induced by phenothiazines directly. The dosage is adjusted in accordance with the amount of phenothiazines being administered.

Artane (Lederle). Another antidote for Parkinsonism caused by phenothiazines or reserpine. Akathisia and other Parkinson symptoms {akathisia—extreme restlessness) are prevented when this drug is administered simultaneously. It will also reduce or eliminate these aggravating symptoms which may have been present when this drug was administered.

I am very sure that whatever portion of this material you use, it should be an emphatic part of your policy statement (and I expect you to cut it unmercifully),

since many of your board members will not be cognizant of the great significance of this matter. Very serious damage suits have been brought, and won successfully, on this question across the country.

Yours very truly, **(Sgd.) T. R. Robie**

It is clear that Ted was well aware of the undesirable side effects of the tranquilizers. That year his report "The Rewards of Research—A New Clarification of Schizophrenia by the Term 'Metabolic Dysperception' " appeared in **Schizophrenia** 3,168-176,1971 (now **J. of Orthomolecular Psychiatry),** In this report he urged that the newer term developed by Dr. B. Kowalson was more appropriate scientifically, and more acceptable to patients.

In 1972, **Psychiatric News** did publish his brief letter which follows:

/ am pleased that you have published an article concerning the recent article by Dr. Abram Hoffer, "Megavitamin B_3 *Therapy for Schizophrenia"* (Psychiatric News, *March 1).*

I have espoused this treatment. During the first two-thirds of my period of psychiatric practice of more than 45 years, I tried every known psychotherapeutic approach to schizophrenia without success. In the last one-third (15 years) I have come to realize that niacin was the only treatment approach in conjunction with ECT, and/or phenothiazines, if required, that gave me even hopeful results in the treatment of schizophrenia. There is only one difference in the manner of my administering niacin from that of Dr. Hoffer. I always initiate *treatment with 1 tablet (500 mg) q.i.d.,* gradually increase dosage to avoid the flush, and prescribe periactin for all cases, to antidote the flush if it occurs. I ultimately reach megadosage.*

Since I made that statement several years ago, I have continued to have about the same results and sometimes those results have been striking recoveries or remission maintained through the aid of megavitamin-niacin therapy.

(Sgd.) T. R. Robie

with a corrective letter following:

/ am writing at this time to express both appreciation and to make a suggestion.

First, I appreciate your publishing my comments regarding the niacin therapy.

Unfortunately, however, an error crept into the printed letter to the editor.

My letter actually stated, "I always initiate *treatment with 1/2 tablet (500) q.i.d. and gradually increase ..." Unfortunately, you printed "1 tablet" instead of 1/4 tablet."*

I am devoting particular time to this because it is extremely important. If one starts a person on one tablet four times a day, oftentimes they will get a very unpleasant flush. They will not get flush if only VA tablet is given in the beginning and then the dosage is raised gradually over a period of time as follows: 1/4 1/4 1/4 1/2 of 500 mg; after three days: 1/4 1/2 1/4 1/2 of 500 mg.; after three more days: 1/2 1/2 1/2 1/2; and gradually increase in accordance with the same principles. For those who do get a flush, it will be less frequent and will usually be controlled by the antidote "periactin."

(Sgd.) T. R. Robie

Early in 1976 I invited Ted to contribute to a special edition of the Journal. In this edition pioneers in orthomolecular psychiatry would describe why they first became interested, how they were received by their orthodox colleagues and by their patients. Ted agreed to do so, but he died a few months later and so unfortunately was not given enough time. This presentation is a very poor outline of Ted's contribution, but will have to serve in lieu of his own contribution.

*** This should have read % tablet, and was an error in printing by Psychiatric News.**

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