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TREATMENT

OF MENTAL DISORDER

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OF MENTAL DISORDER

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PREFACE

This book is written for students of medicine and physicians. It will be of special interest for young neuropsychiatrists about to enter their period of training. In these times of increased awareness of the role of the mind and the emotions in disease, the general physician too may well feel an obligation to widen his knowledge of psychiatric theories and techniques. The emphasis in the following pages on practical means of therapy, controlled by tests for indications and by statistical evaluation of results, may be said to bring psychiatric treatment within a framework of thought similar to the therapeutic approaches of general clinical medicine.

The present book is the product of twenty-three years of practice, teaching and research in the field of nervous and mental diseases. When I was a medical student, what little was known and practicable about the treatment of most mental illnesses could be adequately expressed in the small paragraphs tucked away at the ends of lengthy chapters on diagnosis, phenomenology and interpretation in the standard textbooks of psychiatry. In the past twenty years, however, this picture has changed decisively. Highly effective methods have been developed both in the field of physical treatment, which gave therapeutic optimism in the field of the major mental illnesses its great new impetus, as well as in the field of psychotherapy, based on deepening of psychodynamic understanding. There has been an understandable yet deplorable trend for these two major methods to be developed and written about in isolation from each other. Thus most books on therapy available to the student on this problem today deal with the subject from a one-sided point of view and with utilization of only one approach.

Contest in the struggle for truth, of course, plays a stimulating part in all scientific development. The time has not yet come, however, when this particular contest can be decided on purely theoretical grounds. The cause of most mental diseases is yet unknown, although certain fragments of the interlocking chains of causality have become exposed beneath frequently puzzling and deceptive surfaces. We are not yet in a position to offer a treatment program based on clear-cut recognition of a single cause, applicable to the majority of mental disorders. I have therefore regarded it as an essential preliminary to the writing of this book to collect, tabulate and statistically analyze all the material on treatment results in unselected series of cases that were available to me from the literature. The tabulations included in this book comprise more than 38,000 cases of mental disorder, including 29,000 cases of schizophrenia, the most challenging field of psychiatric therapy today. The analysis of these data reveals sufficiently consistent and reproducible effects, both of physical and of psychologic techniques, to justify surveying the entire field of existing knowledge of the treatment of mental illness in one comprehensive volume.

While for purposes of research the psychiatrist is justified at times in using one approach only, for practical purposes he should bring as many proven effective means as possible to bear against the illness in order to give his patient the maximum therapeutic help that he needs, as promptly as possible. I have attempted, therefore, to integrate the physical and the psychotherapeutic approaches to the treatment of mental disorder, and to show how fruitful such integration may be under actual therapeutic conditions.

The chief purpose of this book is to demonstrate as specifically as possible how psychic and physical aids to psychiatric treatment must be used as one instrument of therapy. Precise prescriptions for the various practical proven techniques are presented and illustrated in detail. Means to their effective mutual integration are presented, and emphasis is given to complications in therapy and their prevention and management.

It is hoped that this book will not only provide a guide for the practical utilization of the therapeutic tools available today to physicians interested in the therapy of mental disorders, but also a sextant, as it were, for determining our present position in the quest for effective therapy, that may aid others in charting the future course in the advance of our science and art.

LEO ALEXANDER

Boston, Mass.
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Like every physician since Hippocrates, who incorporated this acknowledgment in his oath, I owe a great deal to my teachers. From Otto Marburg I learned about the intricate structure of the brain and the subtle marks of its pathologic changes. By Paul Schilder, one of my most inspiring instructors in medical school, I was first acquainted with genetic and dynamic psychology and psychiatry. Cécile and Oskar Vogt impressed me with the importance of genetic and constitutional factors. From Maximilian Rose and Eduard Beck, whom I met in the Vogts' Institute, I learned about the rich variability of the cortical cytoarchitecture, and they also instilled me with interest in the older psychotherapeutic techniques, especially Du Bois and Déjérine's persuasive technique and hypnosis. By Karl Kleist I was introduced into the traditions of Wernicke's school, and from him I learned that mental as well as emotional aberrations have physical correlates. From Richard S. Lyman, with whom I was associated in China at Peiping Union Medical College and in North Carolina at Duke University, I learned to appreciate the importance of social factors in eliciting,

evoking, enhancing, or relieving mental disorder. I learned more about the influence of social situational stress and motivation on active Army duty overseas, and later at the War Crimes Trials in Nurnberg. From R. G. Hoskins and his group in Worcester I learned about the significance of the bodily state and its biochemical characteristics in reflecting and influencing the mental state. I owe a great deal to the therapeutic genius of Abraham Myerson, with whom I was closely associated from 1935 until his untimely death in 1948. From him I learned about the efficacy of the multifactorial approach, the treatment of the total personality, mental and physical. From Tracy J. Putnam I acquired respect for the persistence, courage, ingenuity, and optimism required for the treatment of illnesses traditionally considered irremediable.

Among those who helped me with the specific task of writing this book, I wish to express my appreciation to my research secretaries, Mrs. Sara Hayes Arnaud, Mrs. Maxine W. Kumin, Mr. Bruce Herrick, Miss Alene W. Mills and Miss Eleanor Regan, for their valuable help with literature research, record research, taking of dictation, transcription of soundscriber disks and the preparation of the manuscript. I also wish to thank the artists, Mr. Ralph M. Glazier and Mr. William Dean Holt, for preparing the graphic material. I am also indebted to my office nurses, Mrs. Charlotte Doherty de George and Mrs. Helen B. Herrick, as well as Miss Jacqueline T. Turcotte, Superintendent of Nurses at Valleyhead Hospital, for valuable contributions and suggestions for the chapter on the role of the nurse. Special thanks go to Mr. Albert Grass of the Grass Instrument Company for his expert collaboration with the oscillographic study of electrical treatment current patterns, and to Dr. David Landau for his collaboration with the respirographic study of electric coma.

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1

INTRODUCTION: THE MAJOR APPROACHES TO THE TREATMENT OF MENTAL ILLNESS

There has been a great deal of progress in the treatment of mental illness during the past twenty years. Advances have been made in technique and practical results along two major approaches; by means of psychotherapeutic efforts based on increased understanding of, and resulting ability to influence, the psychodynamics of the patient; and by physical means, that is, by bringing about physical changes in the brain or the autonomic nervous system, which in turn influence the mental state profoundly.

Most of the workers utilizing these techniques have tended to limit themselves to one of these major approaches, and there have been comparatively few attempts to coordinate these rather fundamentally different lines of attack. It is understandable that the explorer will of necessity have to travel along one road, frequently a narrow one, but there is no doubt that an approach which utilizes many avenues, like an army converging upon a target, will be more effective from a practical point of view than the strict limitation to one approach, important though it is to research and development to try one approach at a time. I feel, however, that our knowledge of the treatment of mental illness has progressed sufficiently to allow a coordinated and multifactorial approach to treatment. Psychiatric therapy is still a young branch of the science and art of healing, since attempts to treat, rather than censure, mental illness are comparatively new in the history of man. Until quite recently people with mental illnesses were regarded as stigmatized by a substantial inherent weakness rendering them permanently unfit for human company, or, on the other hand, as sinners, spiritual or moral offenders against society whose illness was due to their own immorality or spiritual deficiency and who were somehow responsible for getting themselves into such a situation that society must care for them (if indeed society did). They were consequently subjected to harsh discipline, reviled and ridiculed, turned loose to fend for themselves, or, on the other hand, exorcised or preached to. The places of management or treatment were jails or religious organizations—Bedlam or Gheel.

This old dichotomy of spiritual or moral aberration on the one hand and inherent weakness on the other is still with us, and is reflected in the evolution of psychiatric theory and treatment along two major lines, the psychologic and the physical. The psychologic school, whose chief concern

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is psychologic genesis and causation, first developed its thinking in experiential terms, later in terms of personality dynamics, and has most recently incorporated an increasing emphasis on social-cultural factors.

The other main line of development, that along biologic and medical-physical lines, is of more recent origin than the psychologic and actually received its major impetus from Griesinger's famous statement, "Mental diseases are diseases of the brain."[2] The ensuing rather narrow concern with the medical aspects of mental illness has developed a concept of the psychiatric patient as a sick man whose mental and emotional aberrations arise from and are secondary to his physical state, his disturbed body chemistry.

In the last sixty years a science of psychodynamics has gradually evolved which has for the first time made the basic dynamic psychologic factors in human personality a subject for scientific inquiry and scrutiny and has been able to integrate isolated, seemingly bizarre items into a meaningful, intelligible pattern. The consequent findings concerning the basic dynamic processes in human psychology—phenomena which the psychoanalytic school has been foremost in uncovering, formulating, and systematizing—have served as a fundament upon which further psychodynamic knowledge has been carefully built, much in the way that the basic sciences upon which medicine is founded have been evolving into a systematic body of knowledge which allows reactions to be predicted and to be influenced, alleviated, and controlled along the lines of an intelligible and workable system.

On the other hand, most of the physical means of treatment have until recently remained flashes in the pan, with a few exceptions, devoid of an intelligible causal relationship to mental states and frequently so complicated by the psychologic factors in their practical workings that they did not lend themselves to use as building stones in a science of mental disorders.

Thus stood the situation when suddenly, beginning in 1933, new tools of physical treatment became available which had one striking advantage over the older physical approaches—they worked and were effective with certain mental disorders that responded very slowly if at all to psychologic methods. By that very fact, however, although they were satisfying to the pragmatic therapist, they were vexing and confounding to the inquiring scientist because they did not make scientific sense, did not fit in with newly established theory, and therefore remained inadequate for fashioning a foundation for a new basic science of mental disorder. In other words, they remained for the time being empiric panaceas which had no visible connection with many of the gradually and laboriously developed basic principles of psychiatry.

The reactions to the development of these apparent panaceas (insulin and electric shock) were initially three-fold: first came complete emotional rejections by those more rigid protagonists of the science of psychodynamics who felt threatened to the core of their scientific identity by the inroads made by these incomprehensible panaceas. The second type of reaction, among the more flexible psychiatric scientists, was to use these panaceas as a grudingly granted concession to a practical reality, while still adhering to the primacy of the established psychodynamic viewpoint and principles of treatment. Such men used the new tools without real

interest in them, applying them with eyes averted, as it were, and remained basically uninterested in the unknown principle behind their effectiveness, much like a surgeon who, secretly believing in naturopathy, consequently would be bound to neglect his interest in surgical technique. The third and frequent reaction was based on the practical success and seeming simplicity of the new tools and consisted of accepting them as new wonder methods that superseded all other approaches; this led to overrating the merely physical aspects in the technique, accepting it more or less as a pragmatic miracle, and so neither did these psychiatrists become interested in the further understanding and development of the new methods.

Gradually, however, a fourth group of psychiatric workers is starting to emerge and is approaching the problem from three angles: first, in a concern with the scientific investigation of the basic principles involved in the new methods with an attempt to understand them against the background of neurophysiologic knowledge, correlating them with the established facts and scientific principles of neurophysiology; second, in a study of the actual direct consequences of these methods on the patient in the light of our knowledge of the integration of higher cortical activity—for which I should like to use the term, *psychophysiology;* and third, in attempts to test and investigate the interrelations between these newly discovered psychophysiologic phenomena and the body of psychodynamic knowledge. It is to these attempts that this book will be especially devoted.

Rejection of the physical treatment methods on the grounds of the academic point of view is, of course, bound to remain ineffectual. For a long time medicine was not disturbed by empiric panaceas and could develop under the strict scientific guidance of biophysics, biochemistry, bacteriology, and allied sciences. This happy state of order, however, was recently rudely disrupted by the discovery of ACTH and related endocrine substances that shook up the general principles of medicine along hitherto unpredicted lines. The fact that ACTH threatened the established principles of scientific therapeutics had a wholesome effect in reducing rigid scientific thinking among medical men and biochemists; it reestablished a searching humility.

The fact that the new physical "panaceas" in psychiatric treatment have not yet had this effect on academic psychiatry is obviously due to the fact that the shock treatments have been more difficult to integrate into the scientific principles than were the general principles of action of a new hormone. Such integration will not be possible until the general principles of the new physical therapies in psychiatry are better understood.

The complete flowing apart of the streams of development in the sciences of psychodynamics and psychotherapy on the one hand from that of the biologic or physical developments in psychiatry on the other is in some ways surprising and anachronistic because of the increasing emphasis—alas, too often lip service—given to the unity of mind and body. This divergence has been somewhat counteracted in psychosomatic medicine, where, however, the primacy of the psyche as the big brother and the soma as the little ignorant brother makes their symbiosis more acceptable to the prevailing academic psychodynamic pattern of thinking.

But even assuming the primacy of the psyche, the importance of the somatic changes occurring in mental disease has not been fully recognized

or integrated. This attitude has culminated recently in a purely interpersonal concept of psychiatry (H.S. Sullivan,[3,4] Frieda Fromm-Reichmann[1]) and formulation in purely interpersonal terms of the disturbance of the mental patient, who is viewed not primarily as a sick person, but rather as a person who has problems and difficulties in dealing with people—that is, in his interpersonal relationships—and who unconsciously and consciously defends himself against these difficulties, thus adding new problems. The fact that the nervous system of the mentally ill patient itself functions abnormally is all too often either overlooked by the psychodynamicists or unduly emphasized by the exponents of the physical primacy in mental disease.

There is a growing body of evidence lending itself to the interpretation of mental diseases as true psychosomatic disorders of the nervous system, thus bringing about a possible synthesis of Sullivan's and Griesinger's points of view. Beyond doubt there exists an experiential stress factor in the genesis of mental disorders; there may also be an underlying predisposing somatic sensitivity; there is certainly a concomitant somatic malfunctioning which in severe cases is not remediable by psychologic therapy alone, nor is alleviation by purely physical means a substained one—relapse is inevitable unless the psychological stress has been relieved.

There is a great deal of evidence that mental disease is merely an example of a specific organ choice, namely of the central nervous system, in a psychosomatic illness. This view may be further supported by the well established observation that mental disease may alternate with other psychosomatic illnesses such as ulcerative colitis and asthma. Certain basic personality patterns of psychotic and psychosomatic patients are similar, especially the rigidity of the defenses during the healthy intervals.

It would therefore seem that in the treatment of such disorders one of the cardinal steps which holds the key to the decision as to whether or not physical treatment is to be used, is to determine whether such psychosomatic aberrations of the nervous system have yet actually occurred. If they have, and if they are of sufficient severity, physical means of restitution should be employed, with subsequent or simultaneous psychologic measures undertaken to relieve the psychologic stress and to prevent an otherwise inevitable relapse. In mild cases either approach alone may be effective. Psychologic treatment may relieve mild or incipient psychosomatic alterations; conversely, effective and quick physical relief may be sufficient to relieve psychologic stress, especially if it is recent. Physical treatment will, however, gain its optimal relieving power only if the recovery is made psychologically meaningful to the patient. In severe cases it is necessary to employ both approaches with the utmost skill. In such cases results obtained with physical means alone are too short-lived, too ephemeral; results with psychologic methods alone may be too slowly forthcoming or not obtainable at all. The effective and carefully planned combination of both methods is the basic philosophy of our approach which will be dealt with in greater detail in the following chapters.

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II

THE PSYCHOLOGIC NATURE OF MENTAL DISORDER

In the broadest descriptive sense, we may say mental disorder ensues when a person's perception of the world of social and objective reality becomes highly personalized in comparison to the degree of personalization by most individuals in his group, and when his emotional and intellectual reactions are so distorted by this personalization that his day-to-day functioning and relations to others become poorly adapted to his own interests in living. As the illness becomes more serious, these personalized thoughts, which no longer relate to reality, assume a repetitive autonomy.

The nature and origins of such mental disorders have occupied the best minds in the history of psychiatry; their psychologic aspects have been expressed in many terms, reflecting in general the broad sweep of contemporary thought, philosophic predilections, and often unrecognized assumptions about the nature of reality. We are most concerned, however, with those schools of thought that are still influencing psychiatry today, although, indeed, it is difficult to say if any established school of thought ever really loses all influence on subsequent thought.

THE EARLY FORMALISTIC APPROACH

Beginning, therefore, with the great psychiatric reforms in the late eighteenth and through most of the nineteenth century, we see that the formal theories then current were based on an atomistic approach to knowledge, with growing faith in objectivity through experiment and statistics, and a belief in rigid and specific causality. A great deal of effort was devoted to searching out the specific causal factors in etiology (Cameron[5]), with much reliance on exhaustive, often acute clinical description, a phenomenologic approach resorted to in the hope that resulting classifications would lead to common causes. Yet at the same time, in contrast to the statistics and classifications, there ran concurrently a rising tide of concern with the dignity and worth of the individual.

Following the humanistic trend of the times, tremendous reforms in the institutional treatment of mental patients took place in the late eighteenth century, notably under the aegis of Pinel[27] in France and Tuke[28] in England, and soon spread over most of Europe and America (Zilboorg[30]). The enormous practical demands of the situation did not encourage investment in theory that was not immediately applicable; the psychologic aspects of mental disorder were still regarded chiefly as symptomatic, as secondary

to somatic change. To be sure, the psychologic features were net ignored and in some cases recognition of psychologic determinants existed Esquirol,[7] for instance, felt that emotional states might influence certain mental illnesses, although he attributed such effects more to what are today called precipitating events than to basic underlying affective patterns (Zilboorg). The emphasis, however, was on humanizing treatment, instituting hospital reforms, and on furthering psychiatric research and treatment by attention to the individual, securing case histories and keeping clinical records.

Psychology in the late eighteenth and most of the nineteenth century was still largely under the influence of philosophy. Psychologists thought in terms of faculties, neatly compartmentalized from one another, each with its intrinsic characteristics. They were far more concerned with discovering general laws than with devising theory about the non-general and deviant. When they did turn to the abnormal they did so in terms of disturbances of faculties—such as disturbances in sensation, perception, conation (see, for instance, William James' discussion[17] of hallucinations under disturbances of perception, impulsive behavior under disorders of will, and the like). They tended to regard mental disorders as disturbances of intellectual functioning rather than of emotional, and assumed inherent somatic weakness of the nervous system or organic lesions as the basis.

Similarly, the influential voices in nineteenth century psychiatry spoke in terms of constitutional degeneracy. of as yet undiscovered organic lesions of the central nervous system, or of imbalance of metabolic or endocrine factors (Kraepelin[20]). The psychologic manifestations of mental disorder were most often regarded as secondary to physical changes, and their content was considered meaningless and irrelevant, as due to chance factors. One of the main foci of interest remained in classification of mental disorders, in lumping like symptoms or details with like, in the hope of establishing discrete categories that shared common patterns of onset, course, and outcome.

The great exponent of this approach, *Emil Kraepelin*, succeeded in statistically verifying certain clinical patterns, most of which had been previously described by individual workers. His approach in its dependence on broad statistical trends necessarily neglected individual differences and atypical patterns, and in its dependence on the medical concept of onset-course-outcome it lumped together some disorders that actually had little relation to each other in terms of either etiology or process. While a stupendous work and probably a necessary step, it was unavoidably static, and as Zilboorg[30] points out, was rather fatalistic in that it assumed a relatively fixed course arising from relatively unalterable causes with little consideration of the reciprocal relation between the individual and the forces impinging on him that Cameron[5] delineates so clearly.

Out of this somewhat static background of search for physical causes, there began to emerge the first systematic studies of the psychologic aspects of mental disorders, particularly of hysteria, at the Salpêtriere under Charcot[6] and at Nancy under Bernheim,[2] studies later expanded and supplemented by Janet,[18, 19] Bleuler[3] and the early psychoanalysts; this systematic experimental approach stood in contrast to the previous isolated speculations of individual psychiatrists. In one sense this interest in the psychologic features was forced on these workers by the results of their

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