

The History of Electroconvulsive Therapy in the United States and Its Place in American Psychiatry: A Personal Memoir

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The history of electroconvulsive therapy (ECT) in the United States is traced from its crude beginnings in 1940 to its emergence as a highly sophisticated and effective treatment for many severe psychiatric disorders. The general distrust of all somatic therapies in the 1930s and 1940s expressed by many prominent psychiatrists (both analysts and nonanalysts) contrib-

uted to an ambivalent relationship between ECT and the rest of American psychiatry. The media coverage of ECT is reviewed, and suggestions for dealing with the antipsychiatry movement and anti-ECT prejudice are discussed.

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AMERICAN PSYCHIATRY BEFORE ECT

THE HISTORY OF electroconvulsive therapy (ECT) in the United States cannot be completely understood without knowing something about the history and character of American Psychiatry from its European roots to the evolution of its uniquely American style.

In colonial days and for many years thereafter, the only psychiatry known in the United States was mental hospital psychiatry. We borrowed heavily from the Tukes and the Quaker retreats in England, but in the early 1800s, American psychiatrists developed a system of "moral treatment" that elicited praise and admiration from many including the famous novelist Charles Dickens,¹ who described his visit to the Boston Psychopathic Hospital in 1842 in glowing prose. Shortly thereafter, the flood of immigration to our shores plus the increase in our population overburdened and overwhelmed the state hospital systems and the quality of care deteriorated.

In April 1938, when ECT was first used in Italy, the state hospitals in this country were still overcrowded and grossly understaffed. The only medications available were sedatives, chiefly in the form of barbiturates, bromides, paraldehyde, and chloral hydrate. Theelin injection was occasionally used (with equivocal results) for menopausal depressions. Hydrotherapy with cold packs, continuous tub baths, and Scotch douches were a mainstay of most state hospital treatment. However, the major

approach to treatment was psychological, supportive or custodial. There was general distrust of somatic therapies for the functional disorders.

The chief exception was the Sodium Amytal Interview introduced in the 1920s, which often enabled mute catatonics to speak under its influence. Unfortunately, the long-term results were disappointing. Equally disappointing had been the introduction of "Dauerschlaf" (1922) by the Swiss psychiatrist Klaesi,² which consisted of administering large amounts of barbiturates over a long period, thus placing the patient in a state of mild barbiturate intoxication until such time as he was permitted to awaken and presumably resume his more normal activities. Because of the frequency of pneumonia and the poor success rate, this treatment never gained acceptance and was soon abandoned.

The first of the somatic therapies used to treat a then-major mental disorder was the malarial therapy for general paresis (1918) for which Professor Wagner von Jauregg³ of Vienna was awarded the Nobel Prize in Medicine in 1927. However, the general distrust and dislike of somatic therapies by

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many psychiatrists in the United States extended even to such a clearly organic disorder.

An excellent example of this attitude was given to me by Joseph Wortis of New York (personal communication, July 1984), who (in 1937) invited Professor Adolf Meyer, then Psychiatrist-in-Chief at Johns Hopkins University Hospital and one of the great leaders of American Psychiatry, to participate in a major meeting on insulin shock therapy sponsored by the New York Academy of Medicine. Dr. Meyer finally accepted the invitation but with marked ambivalence, as indicated by the following excerpt from his acceptance letter:

Dear Dr. Wortis:

There are two extremes in the attempts to play the savior role in psychiatry; work at the root—which is evidently not Insulin work—and importations which have next to nothing specific to do with psychiatry but exploit the patient and resources through and for imported interests; and this is the case of Insulin. I am always sorry to see the latter get on top. Whenever it does my interest wanes. I have allowed the paresis problem to pass into the domain of the Lues department because Paresis is a 'dirty' experiment of nature without localizing or any other control being possible. I am willing to leave it to the spirochaetist [sic]. And with Insulin we deal with even more of an importation apt to divert the attention completely from the illness by absorbing the attention in the direction of something pharmaceutical.

Another factor contributing to the bias against somatic therapies (particularly ECT) has been the dominance of psychoanalytic theory in most medical schools and psychiatric training centers. This dominance began at the end of World War II and lasted until the mid 1990s, when it began to wane. Little attention was given to teaching students the indications and contraindications for ECT. Many psychiatrists would take, and pass, specialty board examinations without having witnessed, much less administered, an ECT. The attitude toward ECT displayed by many teaching psychiatrists and psychoanalysts varied from overt antagonism to smug condescension. The psychiatrist who still administered ECT was often viewed with the same gaze that gynecologists used to reserve for their colleagues who performed abortions in the days before legalization. In some centers, a double standard seemed to exist. I have known analysts who condemn ECT in public but who have privately recommended it for individual patients and even for members of their own family. Even after the patient has made a good recovery with ECT, they often manifest a curious lack of interest in the case.

SOMATIC THERAPIES OF THE 1930s

It should be noted that all of the somatic therapies for the major mental disorders had their origins in Europe, mostly in the 1930s, and were rapidly introduced, accepted, and in many cases modified and improved in the United States. It should also be noted that the theoretical underpinnings for these treatments were often erroneous and unsophisticated in light of our present knowledge of brain physiology.

The four major somatic therapies are listed below in chronological order of discovery.

1933: Insulin Shock Therapy

This was introduced by the Austrian, Manfred Sakel,⁴ who (influenced by his observation on withdrawal symptoms in drug addicts) thought that an increased level of adrenaline was responsible for many mental symptoms and that insulin could be used as a biological antagonist to adrenaline. After a wave of enthusiastic acceptance in this country (roughly 1936 to 1946), the treatment fell into disuse largely because it was so cumbersome, costly, and relatively ineffective.

The general distrust of somatic therapies for the so-called "functional" disorders was again clearly apparent when insulin therapy was first introduced in the United States by Joseph Wortis⁵ and Bernard Glueck.⁶

In 1936, Dr. William A. White, then superintendent of St. Elizabeths, showed no enthusiasm for insulin, but by February 1937, he was no longer able to resist the pressure from his staff and he invited Dr. Sakel to give a speech on "Hypoglycemia Therapy." Dr. Wortis accompanied Dr. Sakel on this visit as interpreter and cicerone. Dr. Wortis' comments on what happened are revealing:

At St. Elizabeths I remember how William Alanson White fretted while his staff besieged Sakel with questions. There was a politely hospitable but constrained luncheon, and when White then escorted us to the gate Sakel clicked his heels in Central European style, bowed, put forth his hand and said, in halting English, 'Dr. White, I wish to thank you for your hostility.' (Personal communication, July 1984.)

1934: Metrazol Convulsive Therapy

This was introduced by the Hungarian psychiatrist, Ladislaus von Meduna,⁷ who thought there was a biological antagonism between schizophrenia and epilepsy. Others had observed dramatic improvements in schizophrenics who experienced

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