**Alternative Primary Sources** **The Evolution of the Treatment of Mental Illness**

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| **Document F:** When do meds make the difference?  <https://www.apa.org/monitor/feb08/meds>  As new psychotropic drugs enter the marketplace, and more psychologists gain the ability to prescribe, an inevitable question arises: Are drugs, therapy or a combination the best form of treatment?  Research shows fairly consistent results: For most non-psychotic disorders, behavioral interventions are just as effective as medications, and they hold up better over time.  "When researchers have directly compared empirically supported therapies with drugs in nonpsychotic populations, they hold their own very nicely," says Vanderbilt University depression expert Steven D. Hollon, PhD. Such therapies are also stronger in terms of enduring effects, he says. "People come away from treatment not only having their symptoms relieved, but learning something they can use the next time," he notes.  Meanwhile, research is continuing on combining drugs and therapy in treatment, and there, results are more mixed, says David H. Barlow, PhD, director of Boston University's Center for Anxiety and Related Disorders. In some cases, one treatment may boost the other. In other cases, there is no effect. Other times, combining the two may undermine an effective treatment. In addition, combination studies have been hobbled by theory and design problems, but research is improving and eventually should lead to clearer outcomes, Barlow says.  Research on depression shows that medications and empirically supported therapies such as cognitive behavioral therapy (CBT) and interpersonal therapy are equally effective, with each modality helping about 60 percent of clients, notes Hollon… [and] combining medication and therapy raised treatment effectiveness to as much as 75 percent.  Likewise, large-scale studies on anxiety disorders find that people do equally well with medication or CBT, but that fewer people relapse with CBT than with medication, says Barlow, a lead researcher in the area. Unlike with depression, however, combined treatments don't seem to confer extra benefits, he notes.  The same pattern holds true for social phobia, says Temple University's Richard G. Heimberg, PhD, who has conducted a number of studies in the area. "You might get a bigger short-term burst from medication, but CBT is about as effective, and it's also associated with better protection against relapse," he says.  Transporting such findings into the real world can, of course, be challenging. Unlike the relative purity of the lab, the treatment world is a teeming bazaar of providers-many of whom do not have the credentials or training of psychologists-turf issues, cost concerns and varying patient inclinations and needs, experts say.  …Cost issues can prevent the most effective treatments from being used, those involved say. For instance, therapy may be more expensive up front, though studies show it is often more cost-effective over the long run, Matranga notes.  Insurers are sometimes more willing to pay for medications than for therapy, and some primary-care physicians are more likely to prescribe medications before therapy for a range of psychological conditions, he says, particularly if they don't have easy access to someone trained in these therapies.  Patient variables present a mystery in need of greater understanding as well, says Heimberg: Some people don't believe that "talking" can help, others are too anxious to try medications on one side or therapy on the other, and still others can't tolerate medication side effects, for example.  Likewise, research is beginning to show that clients' preferences make a huge difference in outcome, says Klein. "They're more willing to stick with and invest in something they believe will work," he notes.  Finally, drugs and therapy each carry pros and cons that need to be assessed when finding the right treatment for someone, Hollon says. With therapy, there's a learning curve; with drugs, there are side effects, he says.  Given that we're moving into an era where pharmacological and behavioral strategies will be increasingly used and blended, it's wise to be as informed as possible, Heimberg emphasizes.  "The ultimate positive circumstance," he says, "is to have as many tools as you can." |

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| **Document G:** The Surprising History of the Lobotomy  <https://psychcentral.com/blog/the-surprising-history-of-the-lobotomy/>  Today, the word “lobotomy” is rarely mentioned. If it is, it’s usually the butt of a joke.  But in the 20th century, a lobotomy became a legitimate alternative treatment for serious mental illness, such as schizophrenia and severe [depression](https://psychcentral.com/depression/). Physicians even used it to treat chronic or severe pain and backaches.  In 1935, Portuguese neurologist Antonio Egas Moniz performed a brain operation he called “leucotomy” in a Lisbon hospital. This was the first-ever modern leucotomy to treat mental illness, which involved drilling holes in his patient’s skull to access the brain. For this work, Moniz received the Nobel Prize in medicine in 1949.  The idea that mental health could be improved by psychosurgery originated from Swiss neurologist Gottlieb Burckhardt. He operated on six patients with schizophrenia and reported a 50 percent success rate, meaning the patients appeared to calm down. Interestingly, Burckhardt’s colleagues harshly criticized his work at the time.  In 1936, psychiatrist Walter Freeman and another neurosurgeon performed the first U.S. prefrontal lobotomy on a Kansas housewife. (Freeman renamed it “lobotomy.”)  Freeman believed that an overload of emotions led to mental illness and “that cutting certain nerves in the brain could eliminate excess emotion and stabilize a personality,” according to article. He wanted to find a more efficient way to perform the procedure without drilling into a person’s head like Moniz did. So he created the 10-minute transorbital lobotomy (known as the “ice-pick” lobotomy), which was first performed at his Washington, D.C. office on January 17, 1946.  According to the NPR article, the procedure went as follows:  *“As those who watched the procedure described it, a patient would be rendered unconscious by electroshock. Freeman would then take a sharp ice pick-like instrument, insert it above the patient’s eyeball through the orbit of the eye, into the frontal lobes of the brain, moving the instrument back and forth. Then he would do the same thing on the other side of the face.”*  Freeman’s ice-pick lobotomy became wildly popular. The main reason is that people were desperate for treatments for serious mental illness. This was a time before [antipsychotic](https://psychcentral.com/lib/antipsychotic-medications/) medication, and mental asylums were overcrowded, Dr. Elliot Valenstein, author of Great and Desperate Cures, which recounts the history of lobotomies, told NPR.  “There were some very unpleasant results, very tragic results and some excellent results and a lot in between,” he said.  Lobotomies weren’t just for adults either. One of the youngest patients was a 12-year-old boy! NPR interviewed Howard Dully in 2006 at the age of 56. At the time, he was working as a bus driver.  Dully told NPR:  *“If you saw me you’d never know I’d had a lobotomy,” Dully says. “The only thing you’d notice is that I’m very tall and weigh about 350 pounds. But I’ve always*felt*different — wondered if something’s missing from my soul. I have no memory of the operation, and never had the courage to ask my family about it…”*  The reason for Dully’s lobotomy? His stepmother, Lou, said Dully was defiant, daydreamed and even objected to going to bed. If this sounds like a typical 12-year-old boy, that’s because he was. According to Dully’s father, Lou took her stepson to several doctors, who said there was nothing wrong with Dully, and he was just “a normal boy.”  But Freeman agreed to perform the lobotomy. You can check out the [NPR article](http://www.npr.org/templates/story/story.php?storyId=5014080) for Freeman’s notes on Dully and more from his patients’ families. (There’s also lots more on lobotomies on their website.)  In 1967, Freeman performed his last lobotomy before being banned from operating. Why the ban? After he performed the third lobotomy on a longtime patient of his, she developed a brain hemorrhage and passed away.  The U.S. performed more lobotomies than any other country, according to the [*Wired article*](https://www.wired.com/thisdayintech/2010/11/1112first-lobotomy/). Sources vary on the exact number but it’s between 40,000 and 50,000 (the majority taking place between the late 1940s and early 1950s). Curiously, as early as the 1950s, some nations, including Germany and Japan, had outlawed lobotomies. The Soviet Union prohibited the procedure in 1950, stating that it was “contrary to the principles of humanity.” |

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| **Document H:** A Brief History of Electroconvulsive Therapy  <https://www.psychologytoday.com/us/blog/freud-fluoxetine/201811/brief-history-electroconvulsive-therapy>  Of all treatments in contemporary psychiatry, perhaps none is more commonly misunderstood than [electroconvulsive therapy](https://www.psychologytoday.com/us/therapy-types/brain-stimulation-therapy) (ECT). Its depiction in the popular media and in movies such as One Flew Over the Cuckoo's Nest has contributed to its controversial reputation in the general public.  Yet research indicates that nearly 80 years after its discovery, ECT remains the single most effective [therapy](https://www.psychologytoday.com/us/basics/therapy) for treatment-resistant cases of [depression](https://www.psychologytoday.com/us/basics/depression) and some cases of [bipolar](https://www.psychologytoday.com/us/basics/bipolar-disorder) affective disorder and schizophrenia.  Although its exact mechanism of action is unknown, electroconvulsive therapy works by inducing seizure activity via electricity in the frontal lobes of the brain. The treatment itself lasts only several minutes, and a usual course of ECT involves treatment two or three times a week for a few weeks, followed by maintenance therapy on an outpatient basis.  Like many treatments in psychiatry and medicine more generally, ECT was discovered serendipitously (see Lieberman & Ogas, 2015). Early asylum keepers recognized that the symptoms of [psychotic](https://www.psychologytoday.com/us/basics/psychosis) patients who also suffered from epilepsy seemed to improve after having a seizure. The Portuguese psychiatrist Ladislas Meduna began experimenting with different ways to induce seizures, and in 1934 discovered that Metrazol, a [stimulant](https://www.psychologytoday.com/us/basics/nootropics) drug, produced seizures if given in high enough doses. Amazingly, Meduna noted that his patients' psychotic symptoms did, in fact, diminish after a Metrazol-induced seizure. This novel treatment quickly became known as convulsive therapy.  In 1937, the first international conference on pharmacologic convulsive therapy was organized in Switzerland by the Swiss psychiatrist Max Müller. By this time, however, it was realized that there were a few problems associated with this treatment, most notably, the fact that Metrazol produced violent thrashing convulsions which would commonly result in vertebral fractures. Additionally, the drug would produce a feeling of morbid apprehension before the convulsions began. For these reasons, psychiatrists began searching for alternative ways to induce seizures.  Around the same time, Italian neurologist Ugo Cerletti was experimenting with seizure induction in dogs by delivering electrical shocks directly to their heads. [Psychiatric](https://www.psychologytoday.com/us/basics/psychiatry) legend holds that Cerletti was shopping at a butcher shop one day in Italy and noticed that the butcher would deliver an electrical shock to the heads of pigs before slaughtering them. The electricity caused the animal to enter an anesthetized coma-like state. Cerletti wondered whether electricity applied to the heads of human patients would similarly produce anesthesia before provoking convulsions. Electroconvulsive therapy was born.  In 1938, Cerletti and his psychiatrist colleague Lucio Bini developed the first ECT device and treated their first human patient, a diagnosed schizophrenia with delusions, [hallucinations](https://www.psychologytoday.com/us/conditions/hallucinogen-persisting-perception-disorder), and confusion. The treatment worked just as planned, and the patient's condition improved markedly. Beginning in the 1940s, the electrical technique was adopted by almost every major psychiatric institution around the world as a treatment for serious mental disease…  In the 1950s, a new wave in psychiatry was ushered in with the advent of chlorpromazine, the early [antidepressants](https://www.psychologytoday.com/us/basics/ssris), and the discovery of lithium's effectiveness as a mood stabilizer. Yet, it was ECT that represented the first major breakthrough in biological psychiatry…  In the 1960s, psychiatrist Thomas Szasz spearheaded what came to be known as the "antipsychiatry movement" which attacked psychiatry on multiple fronts, including the practice of ECT, viewed as inhumane and torturous. ECT fell out of favor in the 1960s and 1970s, but it made a resurgence in the 1980s. Today, it is a widely accepted treatment for serious mental disorders and is taught and practiced at hospitals throughout the world. It is estimated that one million people receive ECT annually (Leiknes, Schweder, & Høie, 2012).  ECT's discovery as an effective treatment for severe mental disorder represented the first real hope for patients once considered to be untreatable, and it continues to offer many patients relief from otherwise unrelenting and debilitating psychiatric symptoms. Its story reveals a history that is just as remarkable as its well-established effectiveness. |