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

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| **Document A:** Electroconvulsive Therapy  <https://www.wakehealth.edu/Treatment/e/Electroconvulsive-Therapy>  Electroconvulsive Therapy (ECT) is a treatment option for patients suffering from severe depression who have been unsuccessful with other forms of treatment, such as antidepressant medication and psychotherapy. A thorough psychiatric evaluation must be completed to determine whether or not a patient is a good candidate for ECT.  Prior to the ECT procedure, the patient will be medically evaluated by multiple physicians, namely a psychiatrist and an anesthesiologist.  ECT induces seizure activity by releasing an electrical pulse through a portion of the brain while patient is under general anesthesia. Invented in 1937, ECT has been performed with anesthesia since 1952. In recent years, techniques for providing ECT have improved greatly.  ECT is used for people whose depression is severe or life-threatening or who cannot take antidepressant medication. ECT is often effective in cases where antidepressant medications do not provide sufficient relief of symptoms or in cases where the side effects, caused by antidepressant, are not tolerable.  ECT is done under brief general anesthesia in an operating room setting. After general anesthesia is induced, a muscle relaxant is given before ECT electric stimulus. Two electrodes are placed at precise locations on the head to deliver electrical impulses.  The stimulation causes a brief (about 30 seconds) seizure within the brain. The patient does not consciously experience the electrical stimulus. For full therapeutic benefit, at least six-nine sessions of ECT are typically given at the rate of three per week.  The actual procedure itself lasts only a 2-3 minutes and the patient wakes up from the effects of anesthesia within 5 to 10 minutes. It is a well-controlled and highly successful treatment option.  Side effects may result from anesthesia, ECT treatment or both. Common side effects include temporary short-term memory loss, such as recent events, dates or recent meals.  Other side effects could include confusion, nausea, muscle aches and headache, mostly on the day of the ECT procedure.  Some people may have longer-lasting problems with memory after ECT, but this type of memory loss is rare. In most patients, the memory disturbances go away within a few hours.  ECT is an effective medical treatment option, helping as many as 80-85 percent of patients who receive it. Most patients remain well for many months afterwards. The tendency to relapse after a favorable treatment outcome can often be countered by medication after a series of treatments. |

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| **Document B:** The Pros and Cons of Prescription Drugs  <https://www.focusforhealth.org/depression-and-the-over-use-of-antidepressants-are-we-treating-the-real-problem/>  Depression is classified as a psychiatric disorder. The use of the phrase ‘psychiatric disorder’ should to be clarified. Historically, emotional disturbances were thought to be related to the mind, and the separation of the mental and the physical was the standard way of thinking. As we learn more about the way the human body works, and the infinite factors that affect mood and behavior, scientists are starting to focus on the physical influences responsible for determining our state of mind.  In the late 1980’s, a line of selective serotonin re-uptake inhibitor drugs (SSRIs) were developed and marketed based on the theory that serotonin deficiency was the cause of depression. Prozac is the best known of these drugs, and is still widely prescribed today. The market reach has increased to include consumers struggling with alcoholism, ADD, sleep disorders, headaches, mental illness, post-traumatic stress disorder, premenstrual syndrome and postpartum depression. Unfortunately, medication use based on the theory of serotonin deficiency has, in many cases, produced disappointing results.  Serotonin is only one of many (as many as one hundred) neurotransmitters in the brain. Some new research has shown a connection between chronic inflammation and neurotransmitter dysregulation leading to depression, anxiety, and other mood disorders. While targeting neurotransmitter dysfunction as a cause has merit, moving past treatment as a cover-up, and getting to the root cause of the problem, will inevitably lead to more successful therapies.  Recently, researchers from the University of Virginia’s School of Medicine found that the brain, like every other tissue in the body, is connected to the immune system via a network of lymphatic vessels previously thought not to exist. This was an immensely important discovery, because it demonstrates a definitive brain/immune connection.  Studies have shown that short term antidepressant use can be successful in decreasing systemic inflammation. However, recent data shows that long-term antidepressant use not only exacerbates the inflammatory response, but can be a precursor to secondary pathologies like Type II diabetes, heart problems, cancer, and chronic depression. These medications may be a temporary fix, but clearly, they cannot be used as a longstanding solution.  Recent studies have shown that the balance of microscopic organisms in the gut has an effect on both inflammation and the central nervous system (CNS). Disruptions to the gut microbiome – which have been found to affect vital brain, immune, digestive, and hormone functioning – also affect a person’s mood. Some have suggested that ingesting more fermented foods, decreasing intake of processed foods, and avoiding the over-use of antibiotics in order to restore healthy gut bacteria can have a dramatic effect on systemic inflammation. Restoring the body to a more balanced state of health can have a bigger impact on happiness than we once believed  Scientists say that the human brain does not stop maturing until the age of 25. Because of this, some hypothesize that the adolescent brain may be particularly vulnerable to medications that affect brain chemistry. Teenagers tend to have more dramatic adverse reactions to pharmacological interventions, and for children, the risk is even greater.  Although it is now widely acknowledged that antidepressants used during the time of brain development can cause an increase in self-directed violence, there are also reports of an upsurge of violent behavior directed towards others. In the wake of the increase in horrific acts of violence carried out by teens in recent decades, the connection between aggressive behaviors and antidepressant use in this age group needs to be investigated. |

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| **Document C:** Insulin Coma Therapy in Schizophrenia  <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1297956/pdf/10741319.pdf>  …Deep insulin coma therapy (DICT) was regarded as the only specific treatment for schizophrenia in the late 1930s until it was discredited in the late 1950s. This account focuses in the history of DICT in England and Wales where in general it was given uncritical acceptance for over twenty years. The method had government approval and its exponents were professional leaders.  The therapy was developed by Manfred Sakel at the University Neuropsychiatric Clinic in Vienna. He… worked in a private hospital in that city [Berlin] where he treated morphine addicts and found that small doses of insulin helped withdrawal. When he tried insulin in psychotic patients, like other experimenters, he noted improvement. After animal experiments, allegedly in his own kitchen, he satisfied himself that hypoglycemia could safely be reversed, thus permitted deeper levels of induced coma… In 1933, he felt he was ‘on the road to great discoveries’ and returned to Vienna to work as a volunteer assistant in the University Clinic where he was allowed to practice his technique. His theory was that insulin antagonized the neuronal effects of products of the adrenal system, these being the physiological cause of the patient’s state…  DICT was extremely rigorous. It was administered in a separate unit, the patients staying together with the same doctors and nurses throughout. Comas were induced on five or six morning a week. Typically, the third does of insulin was 10-15 units with a daily increase of 5-10 units until the patient showed severe hypoglycemia. Treatment continued until there was a satisfactory psychiatric response or until 50-60 comas had been induced. Experienced therapists let patients spend up to 15 minutes in a ‘deep coma’… Clinicians noted gross variation between individuals in response to a give does of insulin. Also, in the source of treatment a patient could show day-to-day variation in his reaction. Further, there was an uncertain relationships between clinical signs and the blood glucose level. The hypoglycemia made patients extremely restless and liable to major convulsions. Comas were terminated by administration of glucose via a nasal tube… Patients required continuous nursing supervision for the rest of the day since they were liable to further hypoglycemic ‘aftershocks’ and a doctor had to be immediately available…  DICT was adopted quickly and by 1938 it was established in 31hospitals in England and Wales. The Board of Control monitored it and offered consultation with Dr. Wilson to anyone wishing it use it… Mainland European doctors trained in DICT, especially those fleeing Nazism, were employed to introduce it. The ensuing war years set back DICT in civilian hospitals with severe depletion of staff and serious sugar shortage. The post-war years saw restoration and expansion…  This seemingly professional consensus was publicly disrupted by… ‘The insulin myth’. The young author, Dr. Harold Bourne, had obtained psychiatric experience in the British Army and was at the time a junior doctor in a hospital for learning disabilities. He purported to show that there was no sound basis for the general opinion ‘that insulin therapy counteracts that schizophrenic process’. He cited papers showing that diagnosis earlier in the disease in unreliable. However, the belief that DICT was more effective than earlier it was given led to treatment being started ‘on a suspicion… |

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| **Document D:** The Strange and Curious History of Lobotomy  <https://www.bbc.com/news/magazine-15629160>  Deep in the archives of London's Welcome Collection, that great treasure trove of medical curiosities, is a small white cardboard box.  Inside is a pair of medical devices. They are simple. Each consists of an 8cm steel spike, attached to a wooden handle.  "These two gruesome things are lobotomy instruments. Nothing sophisticated," says senior archivist Lesley Hall…  These spikes once represented the leading edge of psychiatric science. They were the operative tools in lobotomy, also known as leucotomy, an operation which was seen as a miracle cure for a range of mental illnesses.  The Portuguese neurologist, Egas Moniz, believed that patients with obsessive behavior were suffering from fixed circuits in the brain… In 1935, in a Lisbon hospital, he believed he had found a solution. "I decided to sever the connecting fibers of the neurons in activity," he wrote in a monograph titled How I Came to Perform Frontal Leucotomy.  His original technique was adapted by others, but the basic idea remained the same.  Surgeons would drill a pair of holes into the skull, either at the side or top, and push a sharp instrument- a leucotome- into the brain.  The surgeon would sweep this from side to side, to cut the connections between the frontal lobes and the rest of the brain.  Moniz reported dramatic improvements for his first 20 patients. The operation was seized on with enthusiasm by the American neurologist Walter Freeman who became an evangelist for the procedure, performing the first lobotomy in the US in 1936, then spreading it across the globe…  The reason for its popularity was simple- the alternative was worse.  "When I visited mental hospitals… you saw straitjackets, padded cells, and it was patently apparent that some of the patients were, I'm sorry to say, subjected to physical violence," recalls retired neurosurgeon Jason Brice… The chance of a cure through lobotomy seemed preferable to the life sentence of incarceration in an institution.  "We hoped it would offer a way out," says Mr. Brice. "We hoped it would help.”  However, he [Mr. Brice] had increasing doubts about lobotomy, especially for patients with schizophrenia.  Psychiatrist Dr. John Pippard followed up several hundred… patients. He found that around a third benefited, a third were unaffected and a third were worse off afterwards.  Although he himself had authorized lobotomies, he later turned against the practice.  "I got increasingly conservative about it because I don't think any of us were ever really happy about putting in a brain needle and stirring the works," he says. "Not a nice thought."  In 1949, Egas Moniz won the Nobel Prize for inventing lobotomy, and the operation peaked in popularity around the same time.  But from the mid-1950s, it rapidly fell out of favor, partly because of poor results and partly because of the introduction of the first wave of effective psychiatric drugs.  Decades later, when working as a psychiatric nurse in a long-stay institution, Henry Marsh used to see former lobotomy patients.  "They had been lobotomized 30-40 years ago, they were chronic schizophrenics and they were often the ones were some of the most apathetic, slow, knocked-off patients," he says.  Mr. Marsh, who is now one of Britain's most eminent neurosurgeons, says the operation was simply bad science. "It reflected very bad medicine, bad science, because it was clear the patients who were subjected to this procedure were never followed up properly.  "If you saw the patient after the operation they'd seem alright, they'd walk and talk and say thank you doctor," he observes. "The fact they were totally ruined as social human beings probably didn't count. |

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| **Document E:** What is Psychotherapy?  <https://www.psychiatry.org/patients-families/psychotherapy> ****Psychotherapy****, or talk therapy, is a way to help people with a broad variety of mental illnesses and emotional difficulties. Psychotherapy can help eliminate or control troubling symptoms so a person can function better and can increase well-being and healing.Problems helped by psychotherapy include difficulties in coping with daily life; the impact of trauma, medical illness or loss, like the death of a loved one; and specific mental disorders, like depression or anxiety. There are several different types of psychotherapy and some types may work better with certain problems or issues. Psychotherapy may be used in combination with medication or other therapies. Therapy may be conducted in an individual, family, couple, or group setting, and can help both children and adults. Sessions are typically held once a week for about 30 to 50. Both patient and therapist need to be actively involved in psychotherapy. The trust and relationship between a person and his/her therapist is essential to working together effectively and benefiting from psychotherapy.  Psychotherapy can be short-term (a few sessions), dealing with immediate issues, or long-term (months or years), dealing with longstanding and complex issues. The goals of treatment and arrangements for how often and how long to meet are planned jointly by the patient and therapist.  Confidentiality is a basic requirement of psychotherapy. Also, although patients share personal feelings and thoughts, intimate physical contact with a therapist is never appropriate, acceptable, or useful.  Research shows that most people who receive psychotherapy experience symptom relief and are better able to function in their lives. About 75 percent of people who enter psychotherapy show some benefit from it. Psychotherapy has been shown to improve emotions and behaviors and to be linked with positive changes in the brain and body. The benefits also include fewer sick days, less disability, fewer medical problems, and increased work satisfaction.  With the use of brain imaging techniques researchers have been able to see changes in the brain after a person has undergone psychotherapy. Numerous studies have identified brain changes in people with mental illness… as a result of undergoing psychotherapy. In most cases the brain changes resulting from psychotherapy were similar to changes resulting from medication.  Psychiatrists and other mental health professionals use several types of therapy. The choice of therapy type depends on the patient’s particular illness and circumstances and his/her preference:  **Cognitive behavioral therapy (CBT)** helps people identify and change thinking and behavior patterns that are harmful or ineffective, replacing them with more accurate thoughts and functional behaviors. It can help a person focus on current problems and how to solve them. It often involves practicing new skills in the “real world.”  **Interpersonal therapy (IPT)** is a short-term form of treatment. It helps patients understand underlying interpersonal issues that are troublesome, like unresolved grief, changes in social or work roles, conflicts with significant others, and problems relating to others. It can help people learn healthy ways to express emotions and ways to improve communication and how they relate to others.  **Psychodynamic therapy** is based on the idea that behavior and mental well-being are influenced by childhood experiences and inappropriate repetitive thoughts or feelings that are unconscious (outside of the person’s awareness). A person works with the therapist to improve self-awareness and to change old patterns so he/she can more fully take charge of his/her life.  **Supportive therapy** uses guidance and encouragement to help patients develop their own resources. It helps build self-esteem, reduce anxiety, strengthen coping mechanisms, and improve social and community functioning. Supportive psychotherapy helps patients deal with issues related to their mental health conditions which in turn affect the rest of their lives. |