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In My Own Time

Schizophrenia

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When I qualified, a person with schizophrenia (using the term as Bleuler intended it to be used, as a group of similar but by no means identical mental illnesses) admitted to a mental hospital for the first time had only a one in three chance of being discharged within two years, after which the hope of discharge withered with each passing year.

At this time, in the mid-'thirties, psychiatry—or institutional psychiatry, to be precise—was somnolent if not fast asleep, a condition symbolised, and in some measure brought about, by the sedative drugs (paraldehyde and bromide, in particular), which were doled out by the bucketful.

In effect, mental hospitals were then closed institutions. The patients—a high percentage of whom suffered from schizophrenia and were in various stages of disintegration—were uniformly dressed in drab, ill-fitting suits or dresses, matched only by the drabness of their surroundings. Apple green and chocolate brown were the predominant colours in the decor, if such an elegant word is appropriate. The too-too solid furniture was adequate, but obviously designed for durability rather than comfort.

The nursing staff were in uniform; the women in starched dresses, aprons, and caps; the men in sombre dark suits, white shirts, and black ties, and, for outdoors, a military-type peaked cap. White coats, made-to-measure on the premises, were mandatory for all grades of medical staff except for the medical superintendent, who, as befitted an autocrat, could please himself.

The organisation of the mental hospitals was rigid and inflexible. Everything was done by the book of rules, and woe betide anyone who broke the rules. There was work for some of the patients—on the farm, in the immaculately kept gardens, in the laundries and kitchens, or in the various utility shops. But for the most part the insult of enforced idleness was added to the rest of the misfortunes suffered by the patients. This does not mean that there was any deliberate physical ill-treatment. There was not. The damage that was done was

psychological. The attitudes and habits to which patients became accustomed over the years progressively reduced their chances of readapting to the needs of the greater community if and when they were discharged.

A more relaxed regimen

About this time, however, there were some indications of imminent changes. The Mental Treatment Act 1930 was enormously important in that it enabled persons suffering from mental illness to be admitted to mental hospitals on a temporary or voluntary basis, thus avoiding the lifelong stigma of certification. The inclusion of the word "treatment" in the title of the Act was important too. Perhaps psychiatry was inspired by the epoch-making advances in treatment in general medicine, of which the use of the newly discovered drug Prontosil is a splendid example.

I remember working in Leicestershire as a locum in a small well-organised, run-of-the-mill mental hospital. I and a young whimsical Scot—whose Glasgow accent you could slice with a caber—were the only two resident doctors. There was no dispenser on the staff, so any dispensing was done by us. At dinner one evening my colleague suddenly announced, with all the passion of a divine revelation, that what our schizophrenics needed was "not sedation, but stimulation." We there and then made our way to the dispensary and concocted a mixture of tonics in two winchesters, one full-strength and the other half-strength. The first we labelled, in excruciating dog Latin, "Mist omnibus robusta," and the other, "Mist omnibus lenta." We then proceeded to reduce or omit the dose of bromide or paraldehyde prescribed for some of the patients with schizophrenia and to substitute one or other of our stimulating mixtures. The results were far from dramatic, but nevertheless apparent: there was less somnolence, and the stench of paraldehyde was certainly less pungent. My job finished some time later so that there was no follow-up as far as I was concerned—apart, that is, for an urgent request from my research co-worker for the precise ingredients of our mixtures, which, alas, I had forgotten. Our experiment reflected, perhaps, the current zeitgeist. Throughout the civilised world the same stirrings were to be felt, although the means to the same end were infinitely more dramatic and in many ways far less innocuous.

Von Meduna, who was the first of what proved to be a veritable international brigade of workers, made his contribution

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in Budapest in 1934. He based his work on the premise, entirely false as it so happens, that epilepsy and catatonic schizophrenia were incompatible. Hence he argued that if artificial epileptiform convulsions could be induced in patients with schizophrenia the disease process, whatever that might be, would be attacked, or possibly eradicated. To this end, after a series of experiments on animals, convulsions were produced in patients by intramuscular injections of 25% camphor in oil. The results were variable, but the side effects—namely, delirium, prolonged vomiting, and pain at the site of the injection—were so unacceptable that this particular convulsant agent was abandoned. After further experiments, Von Meduna introduced leptazol (Cardiazol) as a safe and reliable agent.

Safe and reliable it may have been, but I can well remember the considerable reluctance of patients—no matter how psychotic they were—to continue treatment, so terror-stricken had they become during the preconvulsive period, a period for which no amnesia resulted. It became a matter in some cases of, “first catch your patient.” Nevertheless, in 1937, Kennedy,¹ in a seminal paper based on the results of over a thousand selected cases so treated, maintained that there was a complete (sic) remission rate of over 70%, not including partial or “social” remissions.

About this time, too, Sakel, following a series of hunches, used insulin hypoglycaemia in the treatment of schizophrenia in the Vienna clinic. The results were so favourable (apparently) that his method spread rapidly throughout Europe and America. Again, extravagant claims were made for its efficacy. Pullar Strecker² in 1938, for example, claimed that, “Taking the spontaneous remission figures, we find that 23.6% of the total cases remitted, whereas practically double that number remitted with insulin treatment.” He went on to say categorically, “. . . Insulin therapy does constitute a decided advance in the treatment of schizophrenia.”

Intense therapeutic activity

My personal experience with deep insulin therapy (DIT) began after the war. I was responsible for setting up a clinic in my own hospital after secondment to established clinics. A team of nurses were trained for the far from simple, and at times, hazardous and occasionally fatal, procedure. Staff morale was inordinately high: we were doing real somatic doctoring and nursing. More than that, we believed absolutely in the worthwhileness of what we were doing despite the fact that some of our patients took on a grotesque appearance as a result of weight they gained.

Italy came into the field in 1937. Cerletti and Bini first introduced electric convulsion therapy (ECT) in 1937 for treating schizophrenia. From about 1940 onwards papers appeared in prestigious journals claiming success rates that varied widely, but which were all decidedly encouraging—In 1943 Kalinowsky and Worthing,³ for example, stated among their conclusions: “The rate of remission (recovered and much improved) is 67.4% for cases of less than six months’ duration, 43.1% between six months and two years’ duration, and 9.2% in those of more than two years’ duration.”

ECT in those early days was given “straight”—that is, without using relaxants and intravenous anaesthesia. A squad of trained nurses attempted to reduce the effect of the violent spasm of powerful muscles at the onset of the fit by applying pressure on the shoulders, hips, and legs. Even so, dislocations and fractures of the long bones and crush fractures of the lower dorsal and lumbar vertebrae were not uncommon. Nevertheless, so convinced were we of the efficacy of the treatment—particularly of the acute phase of schizophrenia and for the “maintenance” of the chronic cases—that ECT clinics were the order of the day. Clinics were held at least biweekly for from 20 to 30 cases.

To my mind the most regrettable innovation in the treatment of schizophrenia was the blind, mutilating operation on the

brain—the so-called prefrontal leucotomy (or lobotomy), introduced by Moniz in Portugal in 1936, and first performed in this country at the Burden Institute, Bristol, in 1940. The protagonists of the operation were loud in its praise—Fleming,⁴ for example, described prefrontal leucotomy as, “one of the most startling of modern therapeutic procedures,” and sharply rebuked those who dared criticise it. “There has been some hostile criticism of the operation by medical men with no experience of it and little experience of psychiatry,” Fleming thundered in the same paper. At the time of writing (May 1943), some 350 leucotomies had been performed in Great Britain and, in an analysis of 184 reported by seven authors, Fleming deduced that 72 were much improved and 44 improved. It is noteworthy that by 1963 the number of operations reported in Great Britain exceeded 15 000.⁵ I confess that I was guilty of recommending the operation for 20 or so of my schizophrenic patients, and, may I add, nothing I have done weighs more heavily on my conscience.

It is as well to remember that at this time of intense therapeutic activity, which replaced the despairing nihilism of the ‘twenties and before, prognostic optimism rode high. This coincided with a radical change in the ethos of the mental hospital. Little could be done about the buildings themselves, but the interiors were transformed by the introduction of attractive decorative schemes, modern furniture, and the like. The creature comforts were vastly improved so that the penurious, workhouse atmosphere was largely eradicated. Locked wards were, in the main, a thing of the past, so that security, if such were needed, became virtually impossible. The gibe, therefore, that doctors and nurses in mental hospitals were gaolers in white coats could no longer be applied. In all, the improved milieu in which schizophrenics were treated—an improvement that was to be later reflected in the community itself—must have had a positive effect on the prognosis, at least in social terms.

Nevertheless, as time went on, the scales of euphoria began to drop from our eyes and we were able to appraise, or re-appraise, the advances in the physical methods of treating schizophrenics more clearly and rationally. As a result, Cardiazol was abandoned completely; the deep insulin therapy clinics were dismantled. ECT persisted, modified by relaxants and intravenous anaesthetics, and was used predominantly in the treatment of depression. The flood of prefrontal leucotomies was reduced to a trickle—those that were performed demanded much more precise techniques, and were carried out largely for conditions other than schizophrenia.

Pros and cons of drugs

Into the vacuum created by the disappointment with, and reduction in, the use of physical methods of treating schizophrenia, stepped the phenothiazines of which Largactil (chlorpromazine) was, and still is, the most important. Largactil was introduced into clinical psychiatry in 1952, since when there has been a constant stream of so-called psychotropic drugs coming off the pharmaceutical production lines.

Despite any reservations one may have, and I have plenty, there cannot be the slightest doubt that the introduction of these powerful drugs heralded the onset of a revolution in the treatment of schizophrenia. From a practical standpoint their main virtue is that they are easy to handle and may be administered by general practitioners in the home, or by psychiatrists in outpatient or psychiatric units attached to general hospitals. If admission to a mental hospital is necessary, the stay there may be measured in weeks rather than months, although shortness of stay may not in itself be a reliable guide to the long-term prognosis. Nevertheless, their usefulness in aborting an acute episode of the illness seems undoubted. Their efficacy, however, in chronic schizophrenia—and it is estimated that one-third of all cases become chronic—is more debatable. It could be that in certain of these intractable cases acute

relapses can be prevented—at a price. The side effects occasioned by these drugs, given orally or by injection, may be pretty intolerable. One percipient and articulate schizophrenic reflected, “I think that the richness of my pre-injection days (of Moditen, a long-acting phenothiazine)—even with brief outbursts of madness—is preferable to the numbed cabbage I have become.”⁶ Another patient remarked with comparable poignancy: “Medication obviously plays a part but somehow I prefer to be a little ‘mad’ than overdosed by major tranquillisers.”⁷

It is when faced with such *cris de coeur* that I hear, somewhere in the inner recesses of my mind, the inspired slogan of my Scots colleague—“Not sedation, but stimulation.” There is a danger, as I see it, that by the injudicious use (or abuse)

of psychotropic, or tranquillising drugs—call them what you will—we may be edging back to something akin to the era of bromides and paraldehyde from which we escaped nearly half a century ago.

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MATERIA NON MEDICA

Icebergs and albatrosses

When we sailed from Cape Town with 32 days at sea ahead I felt homesick for the first time. This comes and goes I was told—comes when you sail and goes when you fly home. By the third week monotony has become a problem, with every day the same; there were no novelties left. I'd learnt how to work the ship's radio, played iceberg spotting with the radar, and been round the engine room. Outside the world changed from day to day—storms one day and calm and bright the next. There were days when it was impossible to go out and everything mobile ended up on the floor.

Then suddenly the weather became bright and sunny again and we could see icebergs everywhere. There were all sorts of fantastic shapes: elephants, canoes, castles, and then one morning a strange one with a green line round it. It seemed to be coming towards us while we were “on station” so the scientific work was stopped and we moved a few hundred yards away and had breakfast. We were eating when this huge lump of ice, which completely filled the view from the porthole, began to roll quickly over. Huge pieces broke off and the sea boiled as it turned. The green line that had been the previous water line rose into the sky as the new centre of gravity established itself. On days such as this we did our “keep fit” on the deck completely dominated by icebergs, rather as Table Mountain overshadows Cape Town. The next day the barometer fell quickly to 959 mb and we were in mountainous seas and a 50-knot wind. Work was impossible and we hove to to try and maintain a steady position. The wind drove the icebergs at us, and the bridge spent the morning dodging them.

The weather improved and we were pushed south. We'd planned to go as far as possible, and at 68° south we ground to a halt with the continent 90 miles away across the ice.

As we turned around and headed back to Cape Town I reflected on our 32 days of isolation and the experiences I wouldn't have missed—the icebergs, whales, and the albatross with its 12-foot wing span.—PETER ROWAN (ship's surgeon, RRS *Discovery*).

Laws and customs

It all started when I unthinkingly entered “Surgical spirit, 2 oz” on the customs declaration form as we approached Bombay. We had been using the spirit for prickly heat, and how was I to know that Bombay was a “dry” state? When we reached the customs shed it was very hot, and we had 16 assorted trunks and boxes to be checked. The officer kindly let my wife take our 1-year-old daughter to a rest house on the other side of town while I sat with the baggage. After two hours my turn came, and all he wanted to see was the bottle of spirit. Where had I packed it? As I rummaged tentatively in the corner of a vast trunk, a picture suddenly flashed into my mind: the picture of my wife leaving the shed with the baby and a basket of baby things and, sticking out from among them, the bottle of spirit.

The customs man looked thoughtful when I told him, and went off to confer with his superiors. Eventually he came back, beaming. They had found a solution. They had entered on the form, “Since consumed on board ship.”

“Just sign here,” he said. But I was young and new and did not like my first act in my adopted country to be the initialling of an

untruth, even one so trivial. So I had to get a taxi several miles across town to the rest house where my wife was keeping a meal ready, recover the spirit, and taxi back to the port, waving it triumphantly in the air.

“We shall have to confiscate this, Sir,” the man said. He could do what he liked with it as far as I was concerned. I was tired and hot and the last passenger to be cleared; and I just had time to collect my wife and daughter and catch the night train for the Punjab—without supper.

Two months later I received an official letter from Bombay.

“Unless you produce an import licence for the spirit within twenty-one days,” it said, “the bottle will be sold by Public Auction.”

I often wonder who bought it, and what he thought of the taste.—T PETER SNELL (general practitioner, Chester-le-Street).

The queue at my birdbath

“Ssh! Keep still.” I cautioned my two little granddaughters as they sidled up to me on the garden bench. “The queue is on.” I had just finished my morning ritual of cleaning the birdbath. Its dapple-grey colour camouflaged it from predators and catapults. The drought was severe and it was the only source of water for the wildlife in my garden. The queue was very orderly and captivating, size determining priority.

A ribald crow, already perched on the eaves, impatiently raised his raucous cries summoning his mate. She arrived with a crust of bread. Together, they settled on the brim and dropped the crust to soften. They then swallowed it piecemeal and flew off. A male magpie, who had just finished serenading his mate from a treetop, descended gracefully. He looked around and gingerly stepped into the bowl, puffing out his breast feathers and white wing coverts. He then quickly ducked his head and noisily ruffled his feathers several times scattering the water. A flock of perhaps 10 babblers came hopping along the lawn, chattering, squeaking, and babbling in endless conversation. The leader joined the magpie. A sudden high-pitched call of a squirrel warned them off. A pair of red-vented bulbuls with jaunty crests and a pair of mynahs, very dapper in appearance, followed on.

An excited bark came from Rover, our terrier, as he raced across the lawn, scattering the birds. He placed his forepaws on the brim and quenched his thirst. A large crowd of house sparrows chirruping loudly then invaded the pool, while a chameleon lay motionless for his turn.

The *pièce de résistance* of the morning show was the arrival of a pair of tiny Loten sunbirds. They were attracted by the spangled water collections on the adjoining foliage, which resembled miniature silver-bottomed pools. They hovered over these for a brief moment, creating a mirage of a million wings, and suddenly dived down with cries of delight. As the leaves swayed they flew up again, and when the leaves regained their original position they scabbled about the wet surfaces until quite bedraggled—their antics displaying an abundance of *joie de vivre*.

The noon-day heat cast a languorous spell. The cicadas drummed frenetically overhead. The bambino yawned. L'autre fille murmured ecstatically, “Every moment was beautiful.” She had the capacity to capture the rapturous frolics of nature—the delights of a dilettante.—K MAHADEVA (Colombo, Sri Lanka).