Papers and Originals

Psychiatric Treatment in General Teaching Hospitals: a Plea for a Mechanistic Approach*

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Brit. med. J., 1966, 2, 257-262

"The physician of today is twice as well equipped in the war with disease as he was when I was a student. And the physician who knows what is wrong with the patient and has an effective remedy in his hands can cut the cackle. He has no need of it."—LORD MORAN, Harveian Dinner, Royal College of Physicians, 1945.

As the first physician in psychological medicine to give the Watson Smith Lecture I want to discuss matters of interest and importance to both general medicine and psychiatry. Fortunately there are plenty of these at the present time, especially in the realm of treatment. Psychiatry, for better or worse, has become by far the largest and probably the most important specialty in the practice of medicine today. And this is because, as I hope to show in this lecture, there are so many thousands of people at any one time suffering from what have now become easily treatable and recoverable psychiatric illnesses.

Psychiatry and general medicine have drifted steadily further and further apart. Relations have obviously deteriorated since 1764, when the Royal College of Physicians elected the last of its only two presidents specializing in psychological medicine. There is now even a threat of a breakaway by psychiatrists to form a college of their own. But, whatever the outcome in the medico-political field, in this lecture I want to re-establish the clinical unity of psychiatry with general medicine, and to do this by discussing the quite fascinating treatment possibilities now opening up, both for general medicine and for psychiatry, by working together again in the general teaching hospital.

Background to General-teaching-hospital Treatment

In earlier times general physicians and healers of the mind were also more often theologians and philosophers, and there was always a considerable overlap in religious, philosophical, and medical treatment methods. Then these healing methods started drifting more and more apart. Psychiatry, understandably in the circumstances, tried to keep a foot in all camps. Large churches were placed in the centre of the old asylums as the means of implementing the then philosophical and religious concepts about the "moral" treatment of the insane. These churches supplemented the frequent mechanistic blisterings, bleedings, and purgings also given.

Both psychiatric feet, however, became dislodged as the gap between healing methods grew wider and wider. And psychological medicine ended up in the Victorian era segregated and safely locked away with its own mad patients in its own asylums and is only just starting to be let out again.

I think some psychiatrists are still inclined to remain confused and uncertain about what their future role should be vis-à-vis general medicine. They still wonder whether it would not be better to remain as a segregated group, even if they do return to general hospitals, and advocate generalized philosophies about the need to treat and heal the "whole man." Many want to hold on strongly, almost as an act of faith, to present Freudian and other metaphysical beliefs. Too few wonder if it would not be much better to enter into a more active working partnership again with general medicine, and to welcome the development of much more mechanistic attitudes to treatment. It must never be forgotten that the *effective* and *practical* treatment advances in medicine only happened after it had severed its connexions with metaphysical and older psycho-therapeutic systems of healing. With all the present talk, even in general medicine, about the need to treat the "whole man," it was, paradoxically, only when general medicine at last stopped bothering about the whole man, his internal humours and external vapours, and insisted on fragmenting him, and specially treating the liver, the heart, the blood-stream, the brain and nervous system, and the like, that the present stupendous treatment progress in general medicine really started.

As time went on medicine also had to start to use completely empirical methods of treatment, such as quinine in malaria. This treatment went against all the metaphysical theories of humours and vapours affecting the whole man, on which treatments such as blood-letting for malaria and so many other medical illnesses had been based for so long. Nobody, for 200 years or more, could hope to know just why quinine worked so very well compared with blood-letting; simply because the microscope had not been invented to provide the answers. Today we face exactly the same problem with our new empirical and mechanistic treatments in psychiatry, as we still have so little idea of how the brain really works. But, as in general medicine, this is no excuse at all for not using them empirically for the next 50 years or more if necessary, provided they really work.

Lack of Student Teaching and its Results on Treatment

The present segregation of psychiatry from medicine, which has occurred with too few protests from psychiatrists themselves, has been in spite of the fact that for many years now a quarter of all patients coming to general teaching hospitals for investigations and help turn out in the end to have simple psychiatric illnesses of one sort or another. Teaching medical students how to treat these, and what will be a third or more of all the patients they will have to treat later in general practice, should be one of the first essential aims of the training of medical students. Unfortunately, the General

* The Watson Smith Lecture given at the Royal College of Physicians of London on 10 January 1966.

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Medical Council, in the criteria laid down by them, has always seemed very little concerned with the training of medical students in general-hospital and general-practice psychiatry. Members of the G.M.C. must really know that it is not just an act of God that is compelling 20,000 to 30,000 distraught patients to try to kill themselves every year in England and Wales. It is mainly due to the sheer inefficiency of the present medical-student training, for so many of these treatable and recoverable patients even attempt or succeed in suicide by using the very medicines prescribed to them by their doctors. The whole tragedy becomes even more tragic when, as I hope to show in this lecture, so many of them can now be helped by simple methods of treatment, provided they have been of reasonably good previous personality. And so many of the nearly 6,000 patients who really do succeed in killing themselves fall into just this particular category.

Professor Mapother's Foresight

The main credit for seeing the urgent need for ending the long segregation of psychiatry from general medicine in recent years must be given to the late Edward Mapother, first professor of psychiatry at the Maudsley Hospital. He insisted that psychiatry would and could never come into its own until it had rejoined general medicine in the general teaching hospitals of this country, rather than isolating itself in the asylums and in postgraduate institutes, such as the Maudsley Hospital. I was privileged to train and work under Mapother at the Maudsley before going to St. Thomas's Hospital. He always insisted that the Maudsley, and all other psychiatric hospitals, would remain without any real influence in general medicine until its best physicians, like those at Queen Square and all other specialized postgraduate institutes in London, not only had beds at the postgraduate institute but also taught medical students from other beds of their own at the London undergraduate teaching hospitals as well. And I, for one, resigned from the Maudsley Hospital after 13 years as a matter of principle and in protest when, after Mapother's death, the medical committee at the end of 1948 passed a resolution which made it virtually impossible for all those of us who had obtained such beds with their commitments at other London teaching hospitals also to continue to have ordinary clinical beds at the Maudsley. But there is every reason to hope that this state of affairs will not continue very much longer.

As long ago as 1934, being himself on the staff of both King's College Hospital and the Maudsley, Mapother was experimenting with a special large psychiatric ward at King's College Hospital, staffed from the Maudsley across the road. This took an important part in the psychiatric teaching of King's College students, and I was fortunate enough to work in it for some time. But because there were so few special treatments for the mentally ill in those days, other than psychotherapy, Pantia Ralli Ward at King's College Hospital was forced to remain a rather grim, locked, and window-barred ward. It therefore became only a "mad" ward to King's students, and lost its influence with them, in contrast with the position which now exists at, say, St. Thomas's. Here, with a unit of only 22 beds in the near-by Royal Waterloo Hospital, we can take in the most acute cases of schizophrenia, the most severe cases of suicidal depression, and all the other cases of recoverable and acute psychiatric illnesses in patients of good previous personalities. These unfortunately are still having to be treated in segregated mental hospitals in most parts of the country. But in a general-hospital ward there is now no need for locked doors or barred windows. This is because of the development of new and more mechanistic treatments, and despite the increasing acuteness and severity of the illnesses in patients admitted.

There have been only two suicides in the past 15 years among patients in this ward, both taking place well away from

the hospital itself. And in both patients essential physical treatments had been delayed for social reasons. The most acute and severely ill patients can now in fact be treated in these general-hospital units, and most of them can be discharged home in a matter of a few weeks rather than the old months or years.

Early Experimental Work at Belmont Hospital

How has this tremendous change come about since the old days of the Pantia Ralli Ward in King's College Hospital under Mapother and as late as 1937? The first opportunity of finding out what could be achieved in the treatment of psychiatric patients came immediately after the outbreak of the second world war in 1939. The Maudsley had to close down and evacuate to two emergency hospitals in the north and south of London. Insulin coma, convulsion therapy, sleep treatment, leucotomy, the short-acting barbiturates by mouth and intravenously, new vitamins and endocrines, and many other physical treatments were all just coming into use. Half of us, and fortunately some of the most actively treatment-minded among the medical staff, went to Belmont Hospital, in Sutton, where we became a joint general and neuropsychiatric hospital within the King's College sector of the emergency medical service. Here, because we are dealing mostly with military cases, such as battle neuroses and other neuropsychiatric casualties, there could be no locked doors, as the patients were not officially considered as mad, and they strongly refused to think of themselves as such. Through the grounds ran an unguarded electrified railway line, emergency water-tanks were available in which patients could drown themselves, lavatories had locked doors, and windows could open easily for precipitation purposes. And yet we soon realized that, with a reasonable selection of cases and a very active physical treatment and general rehabilitation programme, many more patients were able to be treated effectively in such general-hospital conditions than we had ever thought possible before the war.

All this exploratory work was done long before most of the ordinary mental hospitals felt it safe to start opening doors of their own locked wards. I believe it was the early findings of the Maudsley group at Belmont that helped to set the original pattern for the later great advance in the opening up of the wards of so many of the mental hospitals themselves. A year spent on a Rockefeller Fellowship at the Massachusetts General Hospital before the war, and another year as Visiting Professor at Duke University Hospital in 1947, gave me a further opportunity of studying the many ways of using psychiatric beds in general teaching hospitals, although unfortunately the wards in American teaching hospitals still remained locked, providing a striking and obvious contrast to the Belmont experiment.

Treatment and Research at St. Thomas's

Returning to England in 1948 to work at St. Thomas's, I was greatly helped by the rest of the medical staff to set about building up a comprehensive psychiatric unit there, with beds for intensive treatment, teaching, and research. There are now 30 beds available in the St. Thomas's group of hospitals, as well as generally over 20 other beds in the medical and surgical wards, in which the department is helping with detailed psychiatric treatment advice. A very active outpatient physical treatment unit, in addition to the ordinary outpatient diagnostic and psychotherapeutic work, was also developed. This was done to try to prevent as many patients as possible from having to continue to go into mental hospitals for such treatments as E.C.T., drug abreaction, modified insulin treatment, the new antidepressant drugs given in combination, and the like. It was found very easy to learn how to carry out these treatments on an outpatient basis. These, together with other general

outpatient treatment facilities, have enabled us to deal with up to 17,000 new and old outpatient attendances in a year; and it has also provided a quite invaluable source of clinical material for essential treatment, research, and clinical teaching.

Lessons Learned

What have we learnt during the past 15 years in this treatment, teaching, and research unit, providing both in-patient beds and outpatient special physical and psychotherapeutic treatment facilities, so valuable to both general medicine and psychiatry alike? The answer is, a very great deal. And it is important that I should go into our findings during recent years so as to develop my important later theme and conclusions.

Because we have had the advantage of close collaboration of general physicians, neurosurgeons, and research workers on the medical professorial units; and because one cannot help being so constantly reminded in general teaching hospitals how far modern medicine has progressed by disregarding most of the treatment tenets which many psychiatrists still hold so dear, we have been able to develop and improve enormously on the possibilities of simple mechanistic physical treatments of the mentally ill. And, as Mapother truly predicted, this has enabled us to dispense with the need for the enormous amount of psychotherapy which used to be thought so necessary in many of the same patients treated in the past.

Treatment of Depressions

Starting the investigation in 1949 we were, for instance, able to show by 1953 that the long courses of E.C.T. which had been given to so many patients with depressive illness in the past were quite often unnecessary. Because we could treat a large number of these patients early in an outpatient setting in a general hospital, we were able to show that when four, mostly weekly, treatments or fewer were given to outpatients they could often do just as well as if they had been admitted to mental hospitals, or had had a much larger number of outpatient treatments at St. Thomas's before the shorter courses were introduced as a research project. Moreover, a few outpatient E.C.T.s given in the basement of a general teaching hospital are so much pleasanter for the patient than having to spend two to three months in a mental hospital, which was so common at that time, and is still unfortunately happening at some mental hospitals even today (Sargant and Slater, 1954).

In recent years we have also been able to test all the new and effective antidepressant drugs on literally thousands of patients, using the 17,000 new and old outpatient attendances a year already mentioned. And so we have been able to learn their proper use and their real, rather than imaginary, dangers (Sargant, 1963a, 1963b; Gander, 1965), and where they can and cannot replace E.C.T. or may be combined with it.

In 1959, because of the enormous amount of outpatient material available to us of the very varied types of depressions seen in general hospitals, we were, for instance, able to discover and report on the specific action of the new monoamine-oxidase inhibitor drugs in patients suffering from what we then called "atypical" or "hysterical" depressions (West and Dally, 1959; Sargant, 1961); but this was the result of two years of continued intensive clinical investigation. We were by then able to show that these patients with a well-defined group of clinical symptoms responded to those drugs sometimes in a matter of 10 days or more, though they may not have been helped in years by E.C.T. psychotherapy or the tranquillizers. True endogenous depressions, however, still remained much better helped by imipramine hydrochloride (Tofranil) and later by amitriptyline hydrochloride (Tryptizol). The monoamine-oxidase inhibitor group of drugs had initially

been introduced into psychiatry for the treatment of these much more severe states of depression, and an M.R.C. (1965) investigation showed statistically what we had already found clinically to be the case some years before (Sargant and Slater, 1963). Now, with all physical treatments combined if necessary, practically all cases of depression in good previous personalities can be helped and recurrences often prevented or greatly modified. Chronicity should have by now become a very rare occurrence indeed.

Treatment of Phobic Anxiety States

Soon after our repeatedly confirmed finding of the value of the monoamine-oxidase inhibitor drugs in atypical depressions we were able to report the first rapid and successful treatment of phobic and other anxiety states, also in patients of good previous personality, and again by using the same monoamine-oxidase inhibitor groups of drugs, even in some patients whose illnesses had lasted 20 years or more; and many such patients had been ill for at least five years (Sargant and Dally, 1962). Again, this group had proved particularly resistant previously to psychotherapy. One might have had to spend hours trying, often unsuccessfully, to persuade patients that there was nothing wrong with their heart, or trying to decondition their phobias by behaviour-therapy techniques, so as to overcome the cause of their repeated panics. Most of these patients gravitate sooner or later to general hospitals if only to exclude fears of heart disease. Again, all that is needed for the monoamine-oxidase inhibitor drugs to be effective in these phobic anxiety states is a good previous personality, the history of a continued attempt to try to fight the symptoms of the illness, however long it may have lasted, and the absence of a severe underlying depressive illness. Then the use of amitriptyline and E.C.T. or new combined treatments (see below) may also be needed in their total treatment. A modified leucotomy is now rarely necessary for severe chronic phobic anxiety states in good previous personalities, whereas in the past it had to be used as a last resort on such patients, who had remained so badly handicapped for so long and in so many aspects of their ordinary daily life.

Modifying Leucotomy Operations

Though we have always been trying to develop more and more simple methods of treatment so as to avoid modified leucotomies, in the past 15 years we have continued research, started as early as 1942 at Belmont Hospital, to try to find out exactly what sort of leucotomy operation promised relief of symptoms in patients who could not be helped by any other method, and also guaranteed that undesirable general side-effects would not occur, provided the right type of patient was selected for this operation. And I think we have been able to show with the greatest certainty over the past 15 years at St. Thomas's, and with the help of Mr. Harvey Jackson, that it is when the lower medial quadrants of the frontal lobe alone are operated upon that tension and obsessive rumination alone is greatly diminished. It is the outer quadrant which must be avoided at all costs.

Our present certainty, now confirmed by so many other workers, is based on a long follow-up of various types of modified operations and reoperations done since 1942. Working at a general teaching hospital, and also at Belmont with McKissock, has made the carrying out of varied selective leucotomies and many reoperations done by neurosurgeons of the very highest calibre much easier and more fruitful than it would have been otherwise (Sargant and Slater, 1954, 1963). There is still a definite place for modified leucotomy, when all other treatments have failed, in anxiety states, depressions, schizophrenias, and some obsessional neuroses in patients of good previous and obsessive personality.

Treatment of Schizophrenia

After the introduction of chlorpromazine hydrochloride (Largactil) in the early 1950s, and by still combining E.C.T. and modified insulin therapy with it in the treatment of schizophrenia, we were able to show for the first time in two consecutive two-year follow-ups of cases of schizophrenia in good previous personalities that no less than 86% of patients treated in our general hospital unit were at home two years after their discharge, and with an average stay in hospital of only six weeks (Rhode and Sargant, 1961; Kelly and Sargant, 1965). We were able to compare this figure with the 50% of such patients helped when treated in our unit earlier on with insulin coma and E.C.T. before the introduction of chlorpromazine, and contrast both these findings with the 33% of good results in a three-year follow-up in the old days at the Maudsley Hospital (Guttmann, Mayer-Gross, and Slater, 1939). This was when only the best prognostic cases of schizophrenia were admitted to the Maudsley, but all that was then available to help patients was psychotherapy and general methods of rehabilitation.

It is also important to emphasize that no special psychotherapy at all was necessary to achieve this doubly confirmed figure of 86% of cases of schizophrenia, nor generally were any special techniques of rehabilitation.

Treatment of Anorexia Nervosa

In 1958, by following up treatment clues seen during the new drug treatments of schizophrenia, we were also able to develop a new treatment of anorexia nervosa, using very large doses of chlorpromazine, combined if necessary with modified insulin treatment, to speed up remission (Dally and Sargant, 1960). This method is now replacing or supplementing psychotherapy in most psychiatric units in general hospitals, where the latter had to be attempted alone, with so little success, before the discovery of this new and most effective method of breaking up resistance to food intake. It also brings about very rapid and substantial gains in weight in these hitherto most difficult patients to treat. Most anorexia nervosa patients do gravitate in the first place to the general medical wards of hospitals (this new treatment is now being used at St. Thomas's and elsewhere), and are only subsequently transferred to special psychiatric units or mental hospitals in their downhill course. An interesting comparative follow-up study of all such patients treated in recent years at St. Thomas's and Westminster Hospitals is shortly to be published (Dally and Sargant, 1966).

Present Treatment Possibilities

The clinical research carried out over the past 15 years at St. Thomas's, developing the intensive but selective use of a whole variety of physical treatments, together with an even longer follow-up of patients also treated previously at the Maudsley and Belmont Hospitals since 1936, has led to the main claim that I wish to make in this lecture, and explains the provocative quotation at the start. This is that most psychiatric patients with anxiety states, depression, and schizophrenia, and a good previous personality (meaning the presence of drive, a previously good social adjustment, conscientiousness, and only minor obsessive traits) can now quickly be got well or at least very much better again. But one must be prepared to use every *physical* treatment now available to us to do so. An important point to emphasize is that very little or no specialized psychotherapy is needed. And there is no longer need for such patients and their relatives to anticipate a prolonged chronicity of illness, much less a prolonged stay in a mental hospital, as so often used to happen.

Combined Physical Treatment

A fact contributing to the avoidance of modified leucotomy and getting so many patients well again who have a good previous personality, however long the illness has lasted, has been the excellent nursing available in a general hospital unit of this nature. With the advantage of very high nursing standards, and an attitude of mind prepared to take calculated risks to get every patient well, we have even developed a new method of combining continuous narcosis and electric-shock therapy with both groups of antidepressant drugs (mainly iproniazid (Marsilid) with amitriptyline), all often given at the same time. With these new combined methods we have recently been able to save 55 out of 73 patients with states of chronic incapacitating tension, often accompanied by depression, from having to undergo modified leucotomy, though they had mostly been sent to St. Thomas's by other psychiatrists specially for consideration of this operation, everything else having failed to help them (Sargant, Walter, and Wright, 1966). It is also important to emphasize that the average length of illness of the group saved from leucotomy by such combined treatments was no less than *eight years*. All, however, had had good previous personalities.

Again, it might be argued that such cases should surely have needed some sort of intensive psychotherapy, especially after having been neurotically ill for so long and proving so resistant to all other treatments. Yet these great improvements and recoveries in patients who had sometimes been ill for up to 20 years occurred without the need for any real psychotherapy at all, and often despite having had so much of it before. This lack of the need for anything but simple psychological advice was also seen in the phobic anxiety states and in the atypical, hysterical, and reactive depressions helped by the monoamine-oxidase inhibitor drugs. Even the 86% of schizophrenic patients improving so quickly with combined E.C.T., modified insulin, and chlorpromazine rarely needed any special psychotherapy at all. What is, however, *absolutely essential* is that the patient should carry on with the proper drug or combination of drugs in correct dosage for the proper length of time, just as in other illnesses, such as tuberculosis, pernicious anaemia, diabetes, and the like.

Patients Not Helped

Simple physical-treatment methods have been discussed which will help most of the anxiety states, depressions, and schizophrenic illnesses in patients of good previous personality, while many obsessional phobic states are now also coming within the range of simple mechanistic treatments. But obsessive compulsive illness still remains more difficult to treat in many instances. One must, however, stress that at present we have no physical treatments which can help patients with adolescent psychopathy and chronic sexual deviations. Nor can we yet, except very rarely, make the patient of previously chronically inadequate personality into somebody with an adequate one. But neither, unfortunately, has specialized psychotherapy been of any real help in exactly these same despairing groups of patients. All we can really seem to do at the present time in psychiatry is to restore the *status quo*.

Physiological Tests in Treatment

Recently, however, Kelly (1966), using Barcroft's forearm blood-flow test in Barcroft's own physiological laboratory at St. Thomas's, and combining it with a series of psychological tests, has been able to isolate what appears to be a genuine physiologically abnormal group of patients with chronic anxiety who can be resistant to all treatments discussed so far in this lecture, except for the modified leucotomies confined to the lower medial quadrants of the frontal lobe. In these

patients: a resting forearm blood-flow may be found which is twice as high as normal. This blood-flow can only be markedly increased with difficulty, unlike in most other patients, by putting the patients under strong emotional stresses. Their bad response to any of the other treatments discussed, and their frequent improvement with modified leucotomy, make this piece of research a most important break-through in at last linking up physical treatments in psychiatry with clear-cut physiological tests. It has often provided a valuable guide to helping at least one small special group of patients without such a good previous personality as had been required before for operation.

Furthermore, if the resting forearm blood-flow test is high and cannot be much further heightened by stress, one knows from the start that other treatments are less likely to work. If the forearm blood-flow is normal, then the antidepressant drugs, and some of the combined sleep, drugs, and E.C.T. treatments already discussed, should be tried, regardless of whether the presenting psychiatric picture is one of an anxiety state or a depressive illness (Kelly, Walter, and Sargant, 1966). In fact we may, in part, accidentally be on the way to solving a problem which has bedevilled psychiatric treatment for so many years now, and that is whether anxiety states and depressions form one long treatment continuum and can respond to the same treatments, and where exactly the exceptions to such a generalization lie. At present it seems to me that clinically they do appear to form an overlapping treatment continuum, except perhaps for a rare group of almost lifelong anxiety states with a high-resting and relatively unalterable forearm blood-flow among their other abnormalities. It is exciting that the selection of suitable physical treatments may at last sometimes be made on the basis of physiological and psychological test differences, rather than always having to rely on the patient's past history and the differences in the symptoms shown during the illness. We have lacked physiological aids to our physical-treatment decisions ever since their recent development, but they will surely come soon with patience and determination.

Research Possibilities

It is important to stress that all the important practical treatment advances made at St. Thomas's in the past 15 years would never have happened if I had not been working in a general teaching hospital atmosphere, if practically all the registrars working in this department had not obtained the M.R.C.P. before or just after starting work there, and if the neurological registrars, also with the M.R.C.P., had not spent half of their time working in our department, where general nursing facilities of the very highest order are also available. It must be remembered too that all this work was supervised by part-time clinicians intent solely on remaining actively at the treatment bedside itself, and a relatively small staff of full- and part-time registrars, but with no official outside research support whatsoever. Fortunately, valuable help was obtained from the endowment funds of St. Thomas's and from gifts of money from private lay persons. The possibility of such clinical mechanistic treatment research in a general-hospital academic and professorial unit, fully staffed and with the ample research funds which the Medical Research Council and the Nuffield Foundation have showered on much less fruitful types of psychiatric research in academic units, makes one's mind positively boggle.

Of one thing we can be absolutely certain, and that is that we are only at the beginning of the development of the same treatment road in psychiatry which general medicine has had to travel for 100 years or more to achieve its present greatest triumphs. This can still be developed only by the clinician staying watchfully *at the bedside itself*, keeping out of professorial and committee chairs, and by deliberately breaking

away from the philosophical and metaphysical concepts of disease which dominated the general medicine of St. Thomas's for hundreds of years and still dominate the minds of too many administrative professorial psychiatrists directing our policies today.

Failure of Psychotherapy as a Treatment

Yet one can hardly leave things in so unsatisfactory a state as to declare, so dogmatically and without explaining why, that attempts at psychotherapy in most of the neurotic and other psychiatric patients are of little value, and that only the mechanistic and physical treatments hold out real hope of practical treatment progress in the future. Many of us must have benefited from the advice and help of others at certain times in our lives without having had to take phenelzine hydrogen sulphate (Nardil) or chlorpromazine at the same time. How can one reconcile the failure of psychotherapy to help most of the neurotically ill, and certainly most of the more mentally ill, with its very obvious value in the lives of normal persons such as those who are listening to me now?

My working as a clinician in a general hospital makes this so much easier to understand than if I were treating the mentally ill in segregated hospitals where one does not see all the normal people being treated under the same conditions.

During the war we at Belmont Hospital were the first to report on the value of drug abreaction in the treatment of acute battle neuroses seen in previously normal persons after Dunkirk and the London Blitz (Sargant and Slater, 1940, 1944). I have therefore had the unrivalled opportunity to study such psychotherapeutic methods very intensively during all the war years and since, and they became very widely used and reported on by others. For a year before the war I had also deliberately worked, for comparison with the Maudsley, at a psycho-analytically orientated clinic in Boston.

Combined with the use of "front-line" sedation, drug abreaction probably saved millions of pounds in pensions by the avoidance of so much of the terrible chronicity that was seen in very similar previously normal patients after the first world war. The giving of a drug which helped to release intense excitement, anger, or fear about horrifying and sometimes repressed past happenings could sometimes be quite miraculous in its results, and patients might literally change for the better overnight (Grinker and Spiegel, 1943). These dramatic results ceased to happen, however, when we tried to use the same abreactive and psychotherapeutic methods on ordinary peacetime neurotics (Shorvon and Sargant, 1947; Sargant and Slater, 1948), generally with a much stronger obsessive component to the illness. Whereas during the war normal subjects sometimes became so suggestible under abreaction and psychotherapeutic treatments that we were quickly able to break up recent patterns of gross hysterical behaviour and produce an almost blind faith in the powers of the therapist concerned, the ordinary peacetime neurotic proves to be far less easily helped by such methods, just as the psychiatric patient, in contrast with the normal, is generally so unamenable to hypnosis and to suggestion in all its many forms.

Since the war, on many lecture trips abroad, it has also been possible to continue to study, on one excuse or another, the power of abreactive and other faith-creating methods of treatment in groups of people as variable as Stone Age and Nomadic man in Kenya, the transitional Afro-Christian religions of Brazil, in the Voodoo temples in Haiti, and in the religious hill-billy, snake-handling, and other revival groups seen in parts of the U.S.A. The power of these methods to create new beliefs or maintain old beliefs, to make people prepared to follow implanted beliefs to their death, and the power of rhythmic drumming and induction of hysterical trance to sweep even a whole country off its feet, became only too obvious.

Hitler showed this in Germany in one setting, and the Beatles recently did so again in this country in another. But such powerful methods prove of little use in helping the ordinary run of severely neurotic patients.

I am sure the answer lies in the fact that most severe neurotics and most mentally ill patients are not half as suggestible as, say, the ordinary medically ill patient and the ordinary medical student in a teaching hospital. We have made the great mistake, both in medicine and in psychiatry, of thinking that the psychiatrically ill should be more suggestible than the normal, instead of being generally much less so. But one quickly sees this if only the trouble is taken to examine the hypothesis in such a general teaching hospital. Here one sees the ease with which the normal patient, dying with cancer, can be reassured by the medical or surgical consultant that there is nothing very much at all the matter with him. One contrasts this with the difficulty the same consultant has when truthfully trying to make the healthy cardiac neurotic believe that he is going to live out the rest of the day. The anger of general physicians and general practitioners with the neurotic and the mentally ill is so often aroused because they will not swallow the "line of talk" so successful with all the rest of their patients and the medical students as well.

In *Battle for the Mind* (Sargant, 1957) and other papers (Sargant, 1949, 1951) I have tried to summarize all the research that brought me to the conclusion that psychotherapeutic techniques creating faith and increasing suggestibility in the normal can indeed make such people believe that they are even able to move mountains. But the same methods cannot usually make the neurotic phobic patient cross the road without renewed panic. It is this other research interest of mine which enables me to round off realistically what may have seemed at first, to some, to be too one-sided a treatment approach.

Conclusions

It seems that psychiatric patients are usually ill because there are components to their mental state, and an abnormal brain function which stops them, temporarily or permanently, showing the normal degrees of suggestibility essential for the ever-varying adaptation of the whole normal man to his changing environment.

Physical treatments seem able to restore the brain's normal flexibility, and so make it normally suggestible and adaptable again.

The Victorians were probably right when they thought that the main function of doctoring, and even of philosophic and

religious doctoring, was to produce a *mens sana in corpore sano*. This means, however, that the mind must often be made well again so as to be able to benefit from the valuable lessons that can be taught to it by our philosophers and priests. But we have to produce a *mens sana* in the mentally and neurotically ill by treatment of the brain itself. We must stop thinking that the mind of the "whole man" can be made *sana* simply by treating some theoretically disturbed metaphysical humours and vapours, or warring super-egos, egos, and ids; or that the psyche can, so to speak, be made to pull itself up by its own metaphysical bootstraps. This in the past has been the great mistake of doctors, psychiatrists, and even men of God when treating the psychiatrically ill in or out of hospitals of all kinds. They have forgotten what we have had to learn again and again in the past 15 years at St. Thomas's—namely, that brain function can best be brought to normal in exactly the same way that bodily functions have most easily been brought back to normal. And that is by modern empirical, mechanistic, and physiological treatments. Only after this has been done can one set about treating and trying to help the "whole man" with any hope of success. As the great Dr. Samuel Johnson—himself a victim of recurrent melancholia—so aptly put it: "Stay [with me] till I am well, and then you shall tell me how to cure myself."

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Mineral Metabolism, Mania, and Melancholia*

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Brit. med. J., 1966, 2, 262–267

"For the consideration is double, either how, and how farre the humours and affects of the bodie doe alter or work upon the minde; or againe, how and how farre the passions, or apprehensions of the mind doe alter or work upon the bodie."—FRANCIS BACON (1561–1626).

An increasing understanding of the mechanisms underlying mental illness is coming from psychological, psycho-analytical, sociological, biochemical, and other fields of study. Probably some disciplines will contribute more to the comprehension of one illness, and others will add more to another. The affective disorders may be an example of this, as there is strong evidence

that they have a predominantly biochemical basis. This evidence neither devalues nor excludes psychological factors, especially as bereavement and other psychic traumata are major aetiological factors in some patients who develop affective disorders. However, once established, the fact that the affective illnesses respond to physical methods of treatment is in favour of a biochemical hypothesis. In addition, the association of

* Based on an essay awarded the Registrars' Mental Health Research Fund Prize, 1965.

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