

Letter to the Editor

Dear Editor:

The American Psychoanalytic Association is pleased to announce the winners of the 1994 American Psychoanalytic Association Fellowship for psychiatric residents.

They are:

Jodi Brown, M.D.
Jefferson Medical College
Philadelphia, PA

Galina Bunina-Bass, M.D.
Einstein Medical College
New York, NY

Cynthia G. Ellis, M.D.
UCSF Langley
San Francisco, CA

Michael Feldman, M.D.
Massachusetts Memorial
Boston, MA

Kenneth E. Fleishman, M.D.
Emory Medical College
Atlanta, GA

Andrew C. Furman, M.D.
Emory Medical College
Atlanta, GA

Payton Hobson Hurt, M.D.
Walter Reed Medical Center
Washington, DC

Margaret R. Karp, M.D.
California Pacific Medical Center
San Mateo, CA

Ubaldo Leli, M.D.
Cornell Westchester Division
Westchester, NY

Sarah H. Lisanby, M.D.
Duke Medical Center
Durham, NC

Adam F. Lowry, M.D.
Cambridge Hospital
Cambridge, MA

Jonathan M. Metzl, M.D.
Stanford University
Palo Alto, CA

Annette C. Stevens, M.D.
Hinks Center
Toronto, Canada

William Tomlinson, M.D.
Columbia University
New York, NY

The Fellowship is awarded to those residents who have demonstrated interest and expertise in the field of psychodynamic psychiatry. The winners will be sponsored to attend the annual meeting of the American Psychoanalytic Association where they will be active participants. They will also have the opportunity to work for a full year with senior psychoanalysts on a conjoint scholarly project.

For further information on the Fellowship please contact Dr. Elise Snyder (203)624-0029.

Elise W. Snyder, M.D.

Letters to the Editor

To the Editor:

It is good to read of the public excitement which convulsive therapy has aroused for more than 60 years. Steven Jenkusky [*This Journal* 1992; 10:2–11] presents a very readable review of popular views, and the waxing and waning of the controversies over its use. He shows how the press and some physicians sustain a controversy about a treatment that was first hailed as a cure for dementia praecox—a disease which, at the time the treatment was described, was thought to be an untreatable genetic condition with a relentless course ending in dementia. For those who have seen the miracles of ECT—its success in reducing the mutism of catatonia, the agitation of melancholia, the drive to suicide, the uncontrolled excitement of mania, or the delusions and hallucinations of the schizophrenic—the public's antagonism remains a mystery. Dr. Jenkusky suggests that the fault lies in the lay press and in the comments of a few doctors. While these experiences affect the public image, I do not think that these occasional efforts are sufficient to sustain the antagonism. I believe the main determinant of the antipathy lies closer to home—in the ambivalence and hostility of psychiatric leaders who have rarely spoken out in support of the treatment and who, for irrational and economic reasons, foster the belief that convulsive therapy is inherently antithetic to the mainstream of psychiatric thought.

An example of the perverse attitude among professionals is the imbalance in the availability of ECT facilities and the condoning of a two-tier treatment pattern for the severe mentally ill. For more than two decades, ECT facilities and use have been limited to academic psychiatric centers [medical schools, university hospitals, and private hospitals affiliated with medical schools], and a few private-for-profit hospitals. ECT has been almost universally unavailable in state, municipal, or Federal [including V.A.] facilities which care for the majority of the mentally ill of our nation. Patients who are well educated, white, high middle and upper class Americans, can and do get ECT when their condition compels its use; while the less well educated, lower class, non-white citizens find ECT unavailable. This discrepancy is not an 'official' governmental decision, but rather an abdication by the psychiatrists who lead and work in these institutions. Their willingness to provide inadequate care is apparently endorsed by their political masters, who take their cues from the leaders of the psychiatric community.

How did this two-tier system develop when other therapies are apparently equally available? One explanation lies in the changing fashions in our ideas about mental disorders. We began the century believing in the genetic inheritance and immutability of mental diseases; then the flag of childhood trauma and psychodynamic repression was raised; this era was suddenly replaced by the flag of psychopharmacology; and we now pledge allegiance to the neurosciences.

Convulsive therapy, and two other somatic therapies—insulin coma and leucotomy—burst upon psychiatry between 1933 and 1938. It was the same time that the intellectual emigres from Nazi Europe transplanted the seeds of the psychodynamic philosophy of Freud and his followers to America. These different philosophies of the cause and cure of mental disorders were immediately in intellectual conflict.

The conflict was exacerbated by a large influx of trainees into psychiatry. During the Second World War, the U.S. military forces trained hundreds of physicians in psychiatry; their training included the range of philosophies prominent at the time—psychodynamic brief and long-term therapy, ECT, insulin coma, and barbiturate abreaction. Immediately after the war,

many of these veteran novice psychiatrists, encouraged by the post-graduate educational funds provided by the GI Bill, elected training at the newly formed psychoanalytic institutes.

Psychodynamic treatments require hours of interpersonal sessions, dream analysis, hypnosis, a complex theoretic structure, and is often interminable. By contrast, convulsive therapy is time-limited and does not require a complex theoretic structure. These diverse views were in philosophic and economic conflict, competing for public acceptance, for leadership in the new psychiatric departments in medical schools and hospitals, and for funds from the external granting programs of the National Institute of Mental Health. A public that was confused by recurrent [and generally unfulfilled] promises of cures for mental illness was encouraged to believe that ECT was a controversial therapy.

One foray in this conflict between therapies was led by Karl and William Menninger. In 1947, they formed the Group for the Advancement of Psychiatry, a self-selected review panel for psychiatric issues. Their first [and most notorious] report was on *Shock Therapy*, issued from Topeka, Kansas on September 17, 1947 (1). It was clearly a defense of psychodynamic practice. "Your Committee feels that the overemphasis and unjustified use of electroshock therapy short-circuits the training and experience which is essential to modern dynamic psychiatry." In another paragraph, the authors argue "... active research is still indicated in ... combined physiological and psychodynamic studies which would lead to a greater understanding of the [patient's] basic problems."

These men, who were the owners and proprietors of a psychiatric empire in Topeka, Kansas, were also leaders in their communities, in academic and hospital medicine, and in the American Psychiatric Association. In their hospitals they emphasized the psychodynamic virtues and established a training school in psychodynamic psychiatry. In each venue, they set the tone that ECT was less than acceptable, and young psychiatrists with academic and professional aspirations, received the message—as did the writers in public journals. The anti-ECT examples cited by Dr. Jenkusky were, in many instances, inspired by 'dynamic' psychiatrists who saw journalists, authors, publishers, and artists among their analysands and their friends.

Another psychodynamic attack on ECT was led by Thomas Szasz, and his disciple, Peter Breggin. Szasz argued that there are no mental disorders, only different patterns of socialized (and unsocialized) behavior. When psychiatrists opine that patients are 'ill' and support the State in the patient's incarceration and forced treatment, he sees psychiatrists as fascist agents of the State. While Szasz has taken a limited public position with regard to ECT, Breggin has written diatribes against ECT and against the use of psychoactive drugs (2,3). He has appeared before legislative bodies seeking to enjoin these treatments and has been successful in a number of venues [recently the Texas legislature voted to restrict the availability of ECT for adolescents under the age of 16]. Breggin has been an active supporter of legal suits for malpractice against psychiatrists, acting on behalf of plaintiffs supported by the Church of Scientology.

For decades, ECT remained a special interest of a small cadre of physicians, many of whom were also, like the psychoanalysts, trained in Europe. With the discovery of psychoactive drugs, this new flag took over the profession, eclipsing both psychodynamic and the somatic therapies. An unstable equilibrium developed, and leaders of American psychiatry eventually [though reluctantly] acknowledged the importance of ECT. The most important support was enunciated in 1978 with the first APA Task Force report (4) which was soon followed by further endorsements: the 1985 NIH Consensus Conference on ECT (5), the 1989 report of the Royal College of Psychiatrists (6), and the 1990 APA Task Force report (7) are recent examples. As Dr. Jenkusky notes, the change in public perception has encouraged a greater use of ECT.

Professional hostility to ECT is not limited to the U.S. In the past two decades, ECT has not been available for patients in Japan, Germany, Netherlands, or Italy; in each country, psychiatric leaders failed to withstand the braying of the anti-psychiatry movements among their professional colleagues and their fellow citizens.

Nor is professional hostility limited to the modern period; it was also present at the time the treatment was developed. When Ladislav Meduna successfully treated a patient suffering from dementia praecox, he was aware that he had stumbled upon an important medical discovery, but one that put him at some risk. Dementia praecox was considered a fatal, inherited disease, with no conceivable treatment. Anyone claiming such a success was considered a charlatan! Indeed, Meduna's peers in Hungary disbelieved him, and it took decades before his work was acknowledged in that country (8).

Fortunately, professional writing does not respect geographic boundaries. Meduna presented his initial results in January, 1935 and published his case reviews in 1937 (9). By the summer of 1937, an international meeting of the Swiss Psychiatric Association discussed various new treatments of dementia praecox. The proceedings were published in German, but the editors of the *American Journal of Psychiatry* commissioned a translation of the papers and published the whole in a special supplement to the *Journal* (10). This edition put the imprimatur of the Association on this treatment, and encouraged its widespread use in the U.S. for the next decade.

These are a few examples of the professional antipathy to ECT, an antipathy that continues the 'controversy' about ECT. The 'controversy' is mainly philosophical but is also fostered by competitive economic concerns, and by the embarrassment that psychiatrists must feel when they are unacquainted with the many changes in ECT practice—changes in energy, dosing, anesthesia, drug use, electrode placement, seizure duration monitoring, to name a few important technical changes—and embarrassed to seek the training that would qualify them to undertake this successful treatment.

The public's view of ECT as a 'controversial treatment' does not arise from defects inherent in the efficacy or the safety of the treatment, nor in its application, but derives from the economic conflicts that remain at the heart of human endeavors. Psychiatrists, despite their protestations of greater insight into human foibles, are not immune from the unconscious effects of economic competition nor the frailties of ambition, jealousy, and envy.

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Dear Editor:

We read with interest the article entitled "A Resident Initiated Prite Review Course: Trials and Tribulations" published in the Volume II, Number one issue of 1993 of your journal, authored by David W. Metzler, M.S., M.D., Daniel L. Kinsey, M.D., Lesley R. Dickson, M.D. and Mark Hyatt, M.D. The fact that psychiatric residents nationally are giving such attention to appropriate preparation for psychiatric examinations, including PRITE is quite meritorious, and deserves to be supported by the field. Also, the fact that the Editorial Board of *The Jefferson Journal of Psychiatry* selected this article for publication denotes the priority and importance attached to the educational methods and tools described in the article. From a historical perspective, we would like to emphasize that the PRITE exam is under the sponsorship of The American College of Psychiatrists since 1982, and that the main objective of The College in sponsoring such an examination is to provide an appropriate and objective self-assessment tool for residents in psychiatry. Moreover, PRITE provides a reasonably objective criterion for use on a voluntary basis by training programs wishing to scrutinize curriculum content, goals, and effectiveness.

We thank you in advance for the attention paid to our request.

Pedro Ruiz, M.D.
Chair
Ad Hoc Commission on PRITE

Layton McCurdy, M.D.
President