PHYSICAL THERAPY OF MENTAL DISORDER*

BY

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The full title of this talk was "Some Reasons for a Personal Prejudice against the So-called Physical Therapies of Mental Disorder." By representing my ideas in this form I admit that I prejudice the situation. This may be an unscientific approach, but perhaps it is a suitable one in the case of such unscientific methods of treating the disordered mind. My objections are not to the brutality of the methods. Compared with psychiatric illness, even a broken back is not much, and a broken leg nothing. Moreover, with good care these accidents can be so reduced as to be negligible. I of course assume the good faith of those who practise the arts against which I am prejudiced. I know of no case whatever in which I would ascribe the giving of physical therapy to any but the ordinary motives of the practising physician.

Science in Medical Practice

A doctor is consulted because someone suffers. Patients, and especially relatives, demand therapy; but the doctor is trained in the scientific method, and his job is to apply science. The doctor is asked to cure magically, but he applies science. By so doing he disappoints even if he gives relief to his patient. But he serves the community by being part of a bulwark against superstition. It is open to anyone to go to a quack for magical relief, but it is the doctor who is expected to represent science, or objectivity, and to be not afraid to do nothing if science cannot help. Diagnosis is based on scientific knowledge; the basis of therapy should be the same.

Scientific Psychology

A scientific approach to mental phenomena follows on acceptance of the theory that mental disorder is a disorder of emotional development, that the basis of mental health is laid down on what is inborn, from birth, by the course of development of the personality and development of the individual's emotional contacts with external reality. Through Freud's formulations and work, especially his method for objective investigation of unconscious phenomena, there has been a steady development of psychological insight.

The development of scientific psychology could briefly be described in three stages: the first bringing understanding of neurotic ambivalence, the second bringing understanding of depression and hypochondria, and the third bringing understanding of the more primitive mental states which reappear in the insanities.

First came the elucidation of the disturbed relationships between people and the disturbances in people of their instinctual functions as a result of their unconscious conflicts. The work was done from the sorting out of love and hate as it emerged in the transference situation. Following this, as it appears to me, the patient's conscious and unconscious fantasy about himself began to become analysed: his depression and conscious sense of guilt became his sense of something wrong inside himself, and the psychology of hypochondria became the psychology of the results of loving and hating. The incorporation and discharge of objects came into the analytic interpretation. Melanie Klein's work made all this possible, and mania as an alternative to depression was seen to be an extreme example of hypomania as a denial of depression.

The new work on depression naturally linked up with the examination of the integration of the personality itself, and phenomena of integration and reality appreciation, etc., began to be able to be dealt with in the transference developments and to be brought into relation to instincts. These developments have enabled psychology to encroach on the domain of the alienist, the doctor who manages the insanity case.

Convulsion Therapy

Along with this steady progress of psychological science there has been a development of the practice of convulsion therapy.

*Abridgment of a paper read before the British Psychological Society (Medical Section) on Nov. 27, 1946

My main objection to convulsion therapy is that it comes as an escape from the acceptance of the psychology of the unconscious and from the implications of the psychological developments of the past fifty years.

It is well known that there are several techniques, but from my point of view the electric technique is worse than the others because of the ease with which it can be done. Moreover, electricity has special significance for the unconscious, and paranoid and schizoid persons are well known to mix up the idea of electricity with ideas of magical influence. Such considerations do not necessarily make E.C.T. bad, but they certainly put us very much on guard when we interpret results, and when we meet the prejudice in favour of E.C.T. that is common among psychiatrists to-day. Whatever the technique, convulsion therapy is empirical. No one has the slightest idea how it works, when it does work. It is true that empiricism carries no final objection. However, scientists hate empiricism and regard it as a stimulus to research.

Our responsibility is great. What is done here in England tends to be done blindly in many parts of the world, especially where there is no access to libraries or training in psycho-analytic method or free scientific discussion. The sociological ill effect of a therapy has to be considered as well as the immediate effect on individuals.

Theory of Mental Health

The march of psychology, because of psycho-analysis, is towards the completion of the theory of mental disorder as a disturbance of emotional development. The basis of mental health is being laid down in infancy, in the developing relationship between infant and mother, and even in a more primitive way between the infant and his subjective mother, and more primitively still in the infant's self-establishment. The result of this theory is the fruitful one that the prevention of mental disorder is a new task of paediatrics. In contrast, the result of the empirical therapy of mentally ill people by physical methods is a relatively unfruitful one; it is that more and more neurologists must be found who are qualified to give people fits. These are two sociological results that can be compared one with the other.

Many besides myself have deplored the fact that convulsion therapy inevitably leads away from the psychological approach to a biochemical and a neurological one. Convulsion therapy attracts to mental hospitals people with first-rate qualifications for dealing with the complexities of insulin shock and of all the biochemical changes that need study in this kind of work. The physical therapies in general draw to psychiatry physically minded young doctors, and it is always unlikely that men and women who have reached a high degree of postgraduate training on the physical side will be willing or able to start again and to go into psychology at its beginning. Leucotomy in an extreme degree attracts the wrong kind of doctor to psychiatry. To my mind the modern acceptance of leucotomy is the direct result of the acceptance of empirical shock-therapy.

If the sociological results of convulsion therapy are bad the sociological results of leucotomy are deplorable. I think leucotomy is the worst honest error in the history of medical practice. In mental hospitals the result of leucotomy is a new accession of power to the neurosurgeon, an unqualified practitioner from the point of view of the psychologist. Let us not be deceived by his very high degree of skill as a neurosurgeon, this having nothing to do with the case. If one deplores leucotomy and its collaterals one must deplore the convulsion therapies that paved the way for it. The feeling against leucotomy is too great to find expression—the general public and doctors alike are too appalled by this application of empirical method to do anything about it. And they are afraid that if they raise objections the psychiatrists will cease to relieve them of the awful burden of insane relatives and patients.

Let me apply the formula I devised earlier on. Now, instead of private suffering with demand for magical treatment being met by the doctor who applies science, it has become true to say that society's suffering (on account of its mentally ill members) leads to the use of the doctor (because of his being supposed to act according to scientific principles) to cover a panic application of magic. Leucotomy should be a quack remedy, available for those who ask for "cures."

From this subject of leucotomy with its irreversible brain changes I come back to convulsion therapy with a feeling of relief. At least here no damage is done (so we blandly assume). If it should turn out that the effects, good and bad, of E.C.T. are, after all, psychological effects, no one individual has been finally hurt, and the convulsion subject can still employ psychotherapy if it should come his way. He can even recover spontaneously in the course of time, with good management, if he is so disposed.

Objections to Convulsion Therapy

To condense my views so far expressed I would say I would not give convulsion therapy, because (1) I would not have it done to myself; (2) it draws to psychiatry the wrong kind of doctors, skilled in the wrong way; (3) it undermines the public's justification for relying on doctors to keep their scientific heads in face of the demand for magic; (4) this form of therapy done here in England leads to mass treatments by the same methods of treatment all over the world; (5) physical methods of treatment represent a tendency away from scientific psychology. Here I would like to add a new point—which is that the chief indication for E.C.T. seems to be involuntal melancholia and the lesser depressions.

Now, *depression is the illness of valuable people*. At the borderline depression is the breakdown of people who are overburdened with responsibility or loss. On this side of the line is the valuable person, often a good mother, who burdens herself with too much concern. On the other side is the same phenomenon, but less conscious, and this is depression. In depression at least the patient suffers for her own illness. E.C.T. is at present being applied to the valuable people, and if this is recognized it no doubt makes the psychiatrist very concerned indeed as to his own suitability for his task. Few of us are innocent of depression, and if we have escaped it we may have done so by a contra-depressive defence which is more abnormal than the frank depression phase of a patient.

Psychological Effects of Convulsion Therapy

Having thus summarized my prejudice I would like to give my guess as to the future developments in the psychology of convulsion therapy. I think that psycho-analysts and those trained in that sort of way should work at present on the assumption that all the results of E.C.T.—good, bad, and indifferent—are psychological results. The immense field of the psychological effects of the idea of E.C.T. has been seriously neglected. To discuss this it is not necessary to have given E.C.T. to a thousand patients, or indeed to have given any at all. What we need to do is to pool experiences of the feelings and ideas found during analysis of patients who have had convulsion therapy, and of patients who are in touch with fellow patients who have undergone convulsion therapy.

Need for Research

I give two lines of approach. The subject that urgently needs research and discussion is that of the patient's conscious and unconscious reactions to (a) the idea of E.C.T., etc.; (b) the experience of submission to convulsion therapy; and (c) the actual fit. Here are some suggestions.

(a) *Reaction to the Idea of being given a Fit*.—I suppose a normal person hates the idea. It must be for this reason that psychiatrists do not have fits given to themselves whenever they feel a bit depressed. *Anxious* people are likely to be able to become frightened at the idea of the fits, in the same way as they can become frightened at the idea of anything. In contrast they may be especially brave in relation to the actual experience. *Obsessional* patients' difficulties are greatly increased when the idea of convulsion therapy is put before them. The organized defence against spontaneity and uncontrol is liable to be strengthened. Obsessional doubt is liable to find a setting in the problem whether to give or to withhold permission. Guilt will be felt whichever line is taken. In organized *paranoia* the fits are easily felt to be part of the hostile attack that is expected. In one patient, a girl who had a delusion that someone was trying to destroy her brain, this form of therapy was felt to be absolute confirmation of her delusion. In cases with thought-transference delusions and the fantasies that so readily get mixed up with theories of electrical phenomena and malicious influence, it can well be imagined that electrical shock therapy has a special significance.

(b) *Reaction to the Experience of being given Fits*.—In cases with a tendency to *conversion hysteria* a partial knowledge of brain-

functioning is easily used in rationalization of paralyses and paraesthesiae following convulsion therapy. *Depressive people* equate the convulsion with dying, and easily feel absolved by having experienced what it is like to meet death. They hanker after convulsion therapy. In some cases each successive convulsion becomes more dreaded, and the last one is equated with death, and recovery from it gives a new lease of life because of the emotional experience. *Suicidal* impulses can be met by the convulsion. By this seeming experience of death a suicidal patient can use convulsion therapy as an alternative to suicide. This is comparable to the relief that a suicidal patient can get through a genuine suicidal attempt—one from which the patient recovers through successful intervention.

(c) *Reaction to the Fit Itself*.—In what may be called *introversion neurosis* the patient has organized a secret inner world in which relationships are good, and this has been done at the expense of trust in the external world in which are placed the bad relationships. It is probable that in these cases the actual fit is felt as a threat to the artificially good inner world, and in consequence a rearrangement has to take place with less complete secret hoarding of good relationships within.

This approach is tentative and admittedly incomplete, but I give it to indicate the way the results of shock therapy may be examined as psychological phenomena. It is just here that research is most urgently needed. Curiously enough, it is also just here that there is an unwillingness on the part of practitioners of convulsion therapy to investigate. Much of the objection to convulsion therapy would disappear if the mechanism by which results are obtained were understood. The main trouble is that false theories are built around the assumption that the mechanism by which change is brought about is a physical one, and these theories have already paved the way for the wide employment of leucotomy—and who knows what may follow?

Society's Unconscious Reactions to Insanity

I also want to put forward the idea that these physical therapies express society's unconscious reaction to insanity. This is by far the most difficult thing I have to say. I have reason to believe that the good results that can come from these physical therapies depend on this—that by them expression is given in an acceptable (because hidden) form to the unconscious distress society experiences in face of mental illness. By unconscious I really mean unconscious, and I mean repressed and unavailable to consciousness. Massive guilt feelings and fear and consequent hate are roused in people who are concerned with mentally ill persons, and I think this unconscious hate also underlay the cruelty to mental patients that notoriously coloured the management of the insane up to recent times.

Tail-piece

As a last word I would like to say why I have no hope that these arguments will make any sudden difference to the now established practice of psychiatry. Mental disorder can be maddening to nurse. Abolition of shock therapy to-morrow would place on the doctors and nurses of mental hospitals an emotional burden which they could not suddenly take, and there will be those who claim that this alone justifies the method. I see this argument, and respect it. Nevertheless, there seems to be a need for someone to register a strong objection to easy and seductive methods which tend to lead away from the difficult path that must be walked by those who try to understand human nature and to eschew magic.

The Psychoanalytic Clinic for Training and Research of the Department of Psychiatry, College of Physicians and Surgeons, Columbia University, 630 West 168th Street, New York, offers a three-year graduate residency training programme in psycho-analytic medicine to qualified physicians. The programme is based on the student's analysis and on hospital and clinic material for psycho-analytic work, and includes lectures on Freud's work, psychodynamics, psychosomatics, experimental analysis of animal behaviour, technique, growth, and development, comparative analysis of cultures, methodology, and theoretical and practical training in psychiatry. Upon fulfilment of the training requirements students will be awarded a certificate of training in psycho-analytic medicine. Those students who, in addition, undertake satisfactory research and pass a supplementary examination in the related basic sciences may also be awarded the degree of Doctor of Medical Science. Applications for training are accepted throughout the year.