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Comparison of Osteopathic and Allopathic Results in Dementia Praecox*

FRED M. STILL, D.O.
Macon, Mo.

Our time being so short necessitates the limiting of our comparison of osteopathic and allopathic results in the treatment of mental diseases, and because of its importance we have chosen dementia praecox. The statistics used were compiled at the request of John E. Rogers for the A. T. Still Research Institute. The number of cases covered was 1,002. These cases were not selected but constituted all the dementia praecox patients who remained in the Still-Hildreth Osteopathic Sanatorium long enough for diagnosis.

Before taking up the comparison between the allopathic and osteopathic results obtained, I shall quote two authorities who know the prevalence of this disease and what an economic problem it has become. The first, in Stricker & Ebaugh's Clinical Psychiatry we have, "Dementia praecox, the mystery of psychiatry, constitutes a challenge to investigators in every field of medical research. Its etiology is unsettled, its pathology unknown, and its clinical limits in dispute, and yet it is a more serious problem than either tuberculosis or carcinoma. There are twice as many hospital cases of dementia praecox as tuberculosis."

The second quotation is taken from a recent address of Dr. C. G. Hoskins of Boston before the American College of Physicians at Montreal. In his talk on dementia praecox, he had the following to say: "Dementia praecox is the outstanding medical problem of our time; one-fifth of all American hospital beds are filled by dementia praecox patients, while losses resulting from the disease are estimated at one million dollars a day."

From the allopathic viewpoint the question of recovery in dementia praecox is debatable. White says: "The question of recovery is a mooted one, but in general it is conceded that the patients that recover present to careful analysis certain residuals, which may be of any degree in the individual patient."

Zablocka in a series of 513 cases found that 60% proceed to light, 18% to medium, and 22% to severe deterioration. From these two it would

seem that there is always an impairment following dementia praecox and that recovery is not complete in any case.

The Colorado Psychopathic Hospital in a series of 242 dementia praecox patients discharged 3% as well and 30% as improved. In a follow-up of from one to five years the recovery rate was increased to 7.4% and the improved to 40%.

Diefendorf classifies the dementia praecox patients into three different types; the hebephrenic 58% of the total, with 8% recoveries; the catatonic 13% of the total, with 18% recoveries; the paranoid 22% of the total, without any recoveries, or a recovery rate of 7% of the total number of patients.

Our total of 1,002 patients was divided into men 517 or 52%, and women 485 or 48%. There were 351 recoveries, or a recovery rate of 35%. The men recoveries were 202 or 39%, the women recoveries 149 or 31%. This compares very favorably with the 3% discharged as cured by the Colorado Psychopathic Hospital and the 7% that Diefendorf found recovered.

In classifying our patients according to types we found that they were divided into the hebephrenic 594 patients, or 59%; the paranoid 198 or 20%; the catatonic 160 or 16%, and the unclassified 50 or 5%. This followed the percentage of Diefendorf, although differing considerably from other authorities. The recovery rate for the hebephrenic type was 36% in comparison with Diefendorf's 8%. In the catatonic 44% in comparison with 18%, and in the paranoid we had a recovery rate of 26% in comparison with no recoveries in Diefendorf.

In making this comparison we included all patients regardless of whether we received them in the beginning of the disease or whether they had already deteriorated before they came under our care. And six weeks was considered a long enough time to establish a diagnosis.

When patients are given more adequate treatment there is a material improvement in their recovery rate. The following mentioned patients were all treated over a period of more than three

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months and of course all the different types were included.

There were 263 patients brought to us for treatment within the first six months of their illness. Of these 179 recovered, or 68%. There were 163 patients with a duration of illness from six months to a year, with 78 recoveries, or 48%. There were 129 patients with duration of illness from one to two years, with 37 recoveries, or 29%. With duration of illness over two years there were 285 patients, with 57 recoveries, or 20%.

The importance of early treatment is very strikingly shown by results in the patients who are treated early, the recovery rate being more than three times as great in the patients who were placed under treatment within the first six months of their illness as in those who were allowed to become more chronic and were not treated until after their illness had progressed for two years or longer.

In comparing the results from the standpoint of osteopathic and of allopathic treatment, we find that 7% is about the average rate of recovery under the latter treatment. The average rate of recovery of all patients under osteopathic treatment was 35% or 5 times as great. If we take the patients who were placed under osteopathic treatment early in their illness the rate was 68% or almost ten times as great as under allopathic treatment. And this comparison is probably fair, as undoubtedly the cases used for allopathic statistics were early cases.

There are several ways in which error might come into this report. First it is possible that we may have missed the diagnosis in some of our cases, but I do not think this is true in many instances because the average case of dementia praecox is not hard to diagnose. Then, fully half of our patients have been diagnosed by capable allopathic psychiatrists before they ever came to us. Then again, our percentage of dementia praecox patients to the total number of patients received compares very favorably with that found in other institutions.

We may have pronounced some patients cured that were not fully recovered. However, we did not consider them as being well unless they were able to return home and resume their former places in society, and unless their families thought they were normal; and this at least from the economic standpoint differentiates the sick patient from the well person.

The only explanation I have to offer for the radical difference between the osteopathic and allopathic results in the treatment of dementia praecox is the difference in their methods of treatment.

Allopathic practice in the treatment of dementia praecox is very much in keeping with the different theories as to the cause of this disease. Kraepelin, an international authority, is of the opinion that we have to deal with an actual chemical injury to the cortical cells, which is caused by auto-intoxication, arising possibly in connection with processes going on in the sexual organs. He is led to this idea by the close association of the disease to the age of development and undoubtedly his belief has con-

tributed to the development of glandular therapy in the treatment of the disease.

A theory evolved by Jung on the basis of the Freud psychology is that many cases of dementia praecox are of psychogenic origin, that is, they owe their origin to repressed emotional complexes, and, to account for the actual deterioration, he conceived the idea that some toxin is ultimately created by the emotional condition. The treatment which follows this theory is psychoanalysis.

During the past few years the late Dr. Cotton has laid a great deal of stress on focal infections and the part they contribute in this disorder. His treatment is the surgical eradication of any possible harbor of infection.

Another view which has wide acceptance is that each individual is created with a certain force for physical development, and that in some this force is prematurely exhausted, and the intellectual powers give out, dwindle and disappear. With this in mind the treatment becomes custodial rather than active.

Diet, hydrotherapy, occupational therapy and psychology are all used in varying degree in the allopathic treatment of this disease.

The many different beliefs about this condition have led to the various methods of treatment and at present there is no universal or accepted method. The use of drugs or serums is not resorted to except in scattered cases.

The osteopathic treatment is based primarily upon the idea of physical causes. Hydrotherapy, diet and exercise are all used to build up the patient; the influence of focal infections or other organic lesions is not overlooked. Even psychology is used to the extent of wholesome surroundings, kind treatment and encouragement, but to me these are only contributing aids, which are not indispensable.

My theory of dementia praecox is necessarily based upon an osteopathic concept of this disorder. The chemical injury, the glandular, the focal infection and the psychogenic theories may all carry their certain elements of fact but in my opinion the autonomic nervous system is fundamentally involved and the distorted mentality and accompanying physical phenomena are symptoms of this difficulty. The basic regulatory functions of the nervous system, designated as autonomic, with their intimately associated circulatory and endocrine control, when in disorder gradually have their unfavorable effect upon the higher centers and account for the profound biological changes in the absence of constant and definite cerebral pathology. Early in this illness there should always be a hopeful prognosis. Deterioration is usually a slow and irregular process and certain to advance only to the degree in which the autonomic stress is unrelieved.

The very theory of osteopathy is based upon physical causes which have their influence largely through autonomic action. The same fundamental principle which applies to the treatment of other organic disorders applies also to disorders of the intellect. In my opinion no field more truly demonstrates the value of osteopathic care than dementia praecox.

Still-Hildreth Osteopathic Sanatorium.