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ORATION: The Psychiatric Revolution (1792- 1970)

More changes have taken place in psychiatry in the past 20 years than in the preceding 200 years. These current changes are as dramatic today as the removal of the chains from the so-called "lunatics" in 1792 (less than 200 years ago). Psychiatry has progressed from the chained patient kept in a dungeon to the care of the patient within his own community. No longer do we isolate the mentally ill patient from the community.

There have been four major revolutions in psychiatry since 1792. The concept of "moral treatment" initiated the first major change in psychiatry at the end of the 18th century. Up to this time patients (who were then called inmates) were kept shackled to the floors and loaded down with chains. They were at the mercy of cruel attendants who whipped them at will. An unknown practicing physician, Dr. Philippe Pinel, could not tolerate such conditions, and in a historic act struck off the chains from the inmates of a mental hospital at Bicetre, France. He proposed instead a regime of treatment based on sympathy and kindness which originally involved 53 patients at the hospital. The success of this humane treatment spread to other countries, and, consequently, in the nineteenth century we see the development and improvement of caring of the mentally ill patient.

Sigmund Freud marks the beginning of the second revolution in Psychiatry. During his lifetime (1856-1939) he made significant contributions to the study of the ego, mechanisms of defense, the unconscious, hysteria and dreams. All these studies placed emphasis on the individual and his psychological make-up, and eventually led to the psychoanalytical movement in the first half of the twentieth century. This movement led to a concentrated interest in the individual personality, its growth and development. Freud believed that a better understanding of personality and pathologic development would lead to an understanding of and a rationale for the treatment of mental illness. The history of psychiatry suggests that this method has not been a cure-all, but rather one important phase of development in the treatment of mental disease. From Freud's emphasis on the psychological, psychiatry has progressed into its investigation of the biological and social systems.

The third revolution in psychiatry started in 1951 when Dr. H. Laborit stumbled upon the synthesis of chlorpromazine. This marks the beginning of the modern era of psychopharmacology. Originally this drug was intended to be a hypothermic agent in the management of general anesthesia for prolonged surgical cases. However, it was found to have accidental tranquilizing effect without altering consciousness, and so, on an empirical basis, was given to a number of disturbed psychiatric patients with favorable results. Within three years chlorpromazine and reserpine were widely used for the treatment of psychosis. Other new drugs, such as meprobamate, diazepam and chlordiazepoxide proved successful in the treatment of neuroses and stress reactions.

Another significant discovery in psychopharmacology occurred when the anti-depressants and energizers were introduced. These drugs were also accidentally discovered. At that time an anti-tubercular drug called iproniazid was in use, and one of the effects it produced was euphoria. Thus began the second significant change in the treatment of mentally ill patients with drugs. The use of these drugs (iproniazid, imipramine, amytryptiline) which are popularly known as tranquilizers and anti-depressants have kept thousands of mentally ill out of hospitals, emptied

much of the state hospital population, and enabled many thousands of people to have out-patient therapy. In the past 11 years there has been a decrease of 110,000 resident patients in state mental hospitals in this country.

We are now in the midst of the fourth revolution in psychiatry which started in 1963 when the Community Mental Health Centers Act was passed in Congress at the urging of President Kennedy. This legislation recognized the declining use and effectiveness of the state hospital and in its place proposed the community mental health centers program as a gradual replacement for the state hospital system. The law proposed to divide each state geographically as well as by population into regions, each of which would have full resources for psychiatric care. This would include out-patient, in-patient, partial hospital care, child, adult and geriatric psychiatric treatment, all types of psychotherapy, emergency and evaluation services. This law looks upon psychiatric treatment as a right of every individual, not a privilege, just as we look upon general medical care. Thus, we see governmental influence moving from the previously isolated control of state hospitals into the community. The patient will be treated while he is in the community, not as a segregated patient in a state hospital. In addition, this whole movement is concerned as well with the legal, educational, religious, and social problems of the community. Originally it was planned to have these mental health centers adjacent to general hospitals, but it has not always worked out this way.

What effect has this most recent development had on psychiatry in Worcester? The answer to this question lies in an understanding of the psychiatric facilities available in this area. Compared to other areas of the state and country, Worcester is rich in psychiatric facilities. Three state hospitals (Worcester, Grafton and Westboro) are within ten miles of each other. The Worcester State Hospital has been for many years a leader in the field of psychiatric hospital care and research For over 30 years psychiatric consultation has been available in every general hospital in the area for medical, surgical, obstetrical, and pediatric patients. Worcester City Hospital has maintained an active in-patient service for many years. In 1954 a psychiatric section of 50 beds was opened at St. Vincent Hospital. This was part of a nation-wide movement to institute psychiatric inpatient treatment within the framework of a general hospital, thus keeping the patient in the community with an emphasis on speedy and intensive treatment to enable the patient to return to normal function as soon as possible. At the present time the number of annual admissions to this unit at St. Vincent Hospital equals approximately the number of admissions annually to the Worcester State Hospital.

Worcester State Hospital also has an active out-patient psychiatric clinic and day care center, where patients are supervised during the day and return to their homes in the evening. Another well-known facility in Worcester is the Youth Guidance Center which serves as an out-patient treatment center for children, as well as a training center for child psychiatry. Both of these facilities are government sponsored.

There are out-patient psychiatric facilities at The Memorial Hospital, Worcester City Hospital and St. Vincent Hospital. In recent years The Memorial Hospital has also had an active program for treating children. Although Worcester can boast of a good number of psychiatric facilities, we still do not have enough to meet the psychiatric needs of this community.

The number of psychiatrists in Worcester has steadily increased. In 1947 there were three psychiatrists in full time private practice, and in April of that year (when I hung up my shingle) that number was doubled. Since then the number has increased to at least 25 to 30 practicing psychiatrists.

Worcester has innovated some of the programs of the Community Mental Health Centers Act, but there is much more to be done. We have been slow to move in many areas. To mention a few: we do not have a children's in patient care facility, nor do we have adolescent centers, or

half-way houses for alcoholics and drug addicts. We need a program for group therapy, at 'well as a good geriatric program. There is much to be done in the area of poverty, such as furnishing treatment to people who cannot afford it. It is apparent that Worcester psychiatry has not involved itself too deeply with that community, and, therefore, we might say that Worcester seems to be experiencing psychiatric evolution rather revolution.

What will be the final results of the revolution in psychiatry? What can we expect of the future? A recent article in the *Massachusetts Hospital General News*, gives us a glimpse into the future. An angry young man is alone in an examining room of the Massachusetts General Hospital Logan Airport Medical Station. He is talking via television to a staff psychiatrist at the hospital many miles away. They have already given this new method of treatment a name ---Telepsychiatry. There are several centers which have these set-ups for treatment of acute cases that often occur at public places, or where there are no psychiatric facilities within a 50-100 mile range. These first aid stations will be of great help in areas where there are no psychiatrists.

The development of partial hospitalization appears certain to grow. There are many day care centers where patients spend the entire day under supervision and return to their families in the evening. Conversely, in the night care centers the patient uses the facility for residence and returns to the world each day in the community. Since both day and night centers are feasible within the general hospital, we shall see many more of these facilities in the future.

Half-way houses instead of hospitals are now being used for the successful treatment of alcoholics and drug addicts. Eventually the commitment procedure for admission to state hospitals will be replaced by voluntary admission. Group therapy will be widely used by the psychiatrist, since this method can reach a larger group of people and has many advantages that individual therapy does not have. This type of therapy has given us a greater understanding of mental illness.

Because of the shortage of psychiatrists, it seems apparent that para-psychiatric personnel will be used more and more, hopefully under supervision. This includes social workers, psychologists, nurses, and other aides. These workers have already been participating in the team approach to mental illness since World War II.

Community mental health centers will develop and grow in number. They will provide psychiatric care at all levels, especially in communities where there is no care available. Treatment for people of limited means will be more readily available in large part because of the government's role. State Hospitals will continue to have a declining population, and some day when the cure for schizophrenia is found, the need for the present day type of state hospital will be obsolete.

Involvement in sociological problems as causes of mental illness will be the responsibility of the psychiatrist. The mental health center is intended to reach out into the community where these social problems exist and lend a helping hand. The psychiatrist will be involved with all the sociologic problems — the legal, the religious, the educational — more and more, and as he enlists the aid of the other workers, there will be a large increase in the number of lay people in the mental health program.

Most of these trends suggest a lessening of the physician-patient relationship and an increasing emphasis on the physician-group relationship. The psychiatrist of tomorrow may very well face a dilemma. Shall he treat patients individually in his office, or can he give better service by becoming part of the community and treating individuals on a group basis? This will be a difficult choice, but it is a problem which he must face before the problems of the future pass him by.