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Psychiatry at 2000

A bird's-eye view

To cram 2000 years of the history of psychiatry into the space allowed me in this paper is like attempting to transcribe the Lord's Prayer onto the back of a postage stamp. It's well-nigh impossible, but it can be done. Fortunately for me, the task has been made infinitely less difficult by the fact that psychiatry as an organised, independent discipline dates back only as recently as the last decades of the 18th century and its history is, therefore, correspondingly short. So, I'll begin there.

Britain at that time was illuminated by an increasing awareness of the sufferings of the underprivileged: and no better example can be found than they who suffered the double deprivation of poverty and mental disorder, the 'pauper lunatics' as they were opprobriously called. The 'well-heeled lunatics' by comparison were amply cared for in private 'madhouses' which flourished particularly in the first half of the 19th century.

A further important contemporary event was destined to elevate the status of the mentally ill and the 'mad business' as well as those who traded in it. George III, a popular and much loved monarch, fell victim to recurrent episodes of mental derangement. The King's physicians were out of their depth. Reluctantly, they sent for the Reverend Dr Willis, known to be of "peculiar skill and practice in intellectual maladies". From then on, psychiatry, having been found to be "of assistance in the treatment of a great personage" could no longer be ignored and its respectability as a branch of medicine was acknowledged. The King improved, in all probability, quite spontaneously. Dr Willis was given the credit and so it could be claimed that lesser mortals suffering from comparable maladies could be expected to benefit.

For whatever reason, public asylums were built at the end of the 18th century by voluntary public subscription. Examples are those in Manchester (1766) and York (1777), the latter not to be confused with the Retreat at York opened in 1796. This, a Quaker foundation, led the civilised world as an example of 'moral management' which meant in practice the virtual abolition of physical restraint.

However, the distinction for first introducing this humane practice belongs to a Frenchman, Phillipe Pinel (1745–1826), chief physician in turn of the renowned hospitals in Paris, the Bicêtre and the Salpêtrière. In so doing he defied both the French public and the Revolutionary Government by unlocking the chains of his patients and prohibiting other barbaric methods. Instead, he introduced a raft of innovations, all designed to bring a semblance of gentleness and friendliness into their hitherto sordid lives.

The grand design of the reformers in England was sadly frustrated by the eruption of economic and social upheavals, brought about by increasing industrialisation and concomitant urbanisation, both factors aggravated by a dramatic rise in the birthrate. The facilities so far provided for the mentally disordered were swamped. The over-spill drifted into the streets as vagrants, or into workhouses, or into houses of correction, or even more tragically, into gaols. The appalling state of affairs occasioned a public scandal and so great was the outcry, that in 1815, a Parliamentary Select Committee was set up. It found that:

> "If the treatment of those mentally disordered in the middling or in the lower classes of life shut up in hospitals, private madhouses or parish workhouses is looked at, your Committee are persuaded that a case cannot be found where remedy is more urgent".

A condemnation as vehement as this could not be ignored, and in 1815, an Act amending that of 1808 (Wynn's Act) was quickly introduced which provided for counties to borrow for the purpose of building asylums. But the counties dragged their feet, and by 1844, the number of such asylums actually built numbered a mere 15. This was intolerable, and in 1845, the counties were no longer exhorted, but compelled to build asylums. The majority of the county asylums that were subsequently built, incidentally, are (or were) our psychiatric hospitals of today.

The county asylums, it must be emphasised, were conceived in an atmosphere of benevolence and therapeutic optimism. The good faith of the planners shone out like a beacon: they earnestly believed, naively perhaps, that admission to an asylum would *per se* cure insanity.

This far-reaching development spread rapidly, overcoming national frontiers, and new asylums were founded all over the civilised world. For example, Jean Esquirol (1772–1840), a successor of Pinel at the Salpêtrière, and one of his most ardent disciples, was instrumental in the construction of 10 new asylums in France.

But in England the ever-increasing proliferation of asylums and the uncontrollable increase in the number of beds crammed into them proved to be counter-productive. The rosy optimism of the early planners and the medical staff turned into bitter pessimism as they saw their hospitals choke with the chronically insane, a dire situation which prompted the acid comment, ". . . a gigantic asylum is a gigantic evil and figuratively speaking a manufactory of chronic insanity".

During the late 19th and early decades of the 20th centuries, Britain's asylums, like those in Europe and America, languished in the doldrums: custodialism took precedence over treatment. However, between the two World Wars, as I will describe in more detail later, a radical spirit of reform began to creep in akin to the zeal that motivated the early Victorian reformers such as the

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opinion & debate

seventh Earl of Shaftesbury (1801–1885). In essence, it saw the transformation of the previous quasi-prison/workhouse milieu into one characterised by humanity, active treatment and rehabilitation.

Treatment: from nihilism to cautious optimism

This transformation coincided with treatments which, it was fondly hoped, were curative rather than palliative. The principal instigator of these heroic methods, all targeted initially at schizophrenia, were: Ladislav Von Meduna (1896–1964) in Hungary, (artificially induced convulsions leading to electroconvulsive therapy); Manfred Sakel (1900–1957) in Austria (insulin-induced hypoglycaemic coma); and Antonio Moniz (1874–1955) in Portugal (psychosurgery, or pre-frontal leucotomy).

Tragically, the heart-warming optimism which greeted the much-vaunted 'physical methods', as these were called, proved to be illusory, and those who practised them, including myself, regard them in retrospect with more shame than pride.

It was fortunate for our morale, sadly punctured by the false dawn of the physical methods, that a real dawn was at hand which was to prove the most important innovation in the chequered history of psychiatric treatment. I refer to the era of psychopharmacology, introduced in 1952 by the French firm, Rhône–Poulenc who marketed a phenothiazine (chlorpromazine). These drugs have spawned a vast pharmaceutical industry and have revolutionised the theory and practice of psychiatry for all time.

At this juncture a corner must be made for a nearly-forgotten triumph – the conquest of General Paralysis of the Insane (GPI), a late destructive syphilitic effect on the brain and central nervous system.

To put this major success in context: in 1913, of the 103 842 people suffering from mental disorder in 95 public mental hospitals in England, 6380 were diagnosed as suffering from GPI. There was no cure – no hope.

No hope, that is, until in 1917, in Austria, Julius Wagner-Jauregg was able to induce malaria with dramatically successful results. But it was not until 1922, for obvious reasons, that it was considered to be propitious for British scientists to visit Austria and sit at the feet of Wagner-Jauregg. Subsequently, centres were established in Britain both for the use of malaria therapeutically and for purposes of malaria research. Of particular importance was the Horton Malaria Laboratory, Epsom (1925–1975), where 10 000 patients were treated with a 30–35% recovery rate.

By 1950, the advent of penicillin as a potent treatment of syphilis caused a sharp decline in the incidence of its sequealae, including GPI, leading inevitably in 1975 to the demise of the Horton Malaria Laboratory.

Concomitant legislation

In accord with the more sympathetic view of the public towards mental illness, new and more liberal legislation was enacted. Important in this context was the Mental Treatment Act 1930 which allowed for the first time for the admission to mental hospitals on a temporary or voluntary basis, so avoiding the serious stigma of certification. The inclusion of the word 'treatment' in the title of the Act was also an important 'first': the implication here was that mental illness was at least treatable.

Although in 1845 attempts had been made by Acts of Parliament to protect and improve the lot of the mentally disordered, the first fundamental revision of the English Mental Health Law since 1845 came with the Mental Health Act 1959 and its Amending Act in 1983. The main principles, indeed, the ones on which the Acts are based are that as much treatment as possible, both either in-patient or out-patient, should be given on a voluntary and informal basis. Furthermore, offenders with mental disorders should be disposed of through the mental hospital system and not the penal system, or, in other words, that those mentally ill, irrespective of their crime, should be allowed the benefit of treatment and not punishment.

As far as the status of British psychiatry *per se* was concerned, nothing can compare with the benefits accrued from the provisions of the NHS in July 1948. In this, mental hospitals, for too long the Cinderella of the hospital service were given the same status as general hospitals. All psychiatrists of sufficient seniority were designated consultants establishing equality with other specialists and breaking down the primacy of the medical superintendents. Psychiatric out-patient departments in general hospitals within the catchment areas of mental hospitals were established. Thus, for the first time, individual consultants could choose which patients were to be admitted to their wards, and which would continue to be treated after discharge.

Psychiatry in war

Casualties are the inevitable, gruesome consequence of war, but it is only in relatively recent times that it has been acknowledged, grudgingly perhaps, that hurt can be suffered to the mind as well as to the body.

The high incidence in the First World War of 'shell-shocked' combatants and others with hysterical conversion symptoms, together with other varieties of neurotic breakdown, attracted the attention of physicians whose roots were in neurology, internal medicine and general practice. This new dimension coincided with and, indeed, was fuelled by, the upsurge of psychoanalysis and kindred forms of psychotherapy. For example, the sterling work of Craiglockart War Hospital in Scotland, in which Dr William Rivers was the prime mover, was conducted on psychoanalytical lines.

With the advent of the Second World War a skeleton staff of 'regular' service psychiatrists was already in place to be swollen in 1939, at the outbreak of hostilities, by some of the *crème de la crème* of British psychiatrists and neurologists. The RAF (who called us 'neuropsychiatrists') boasted Air-Vice Marshal Sir Charles Symonds as our head; Brigadier Jack Rees was Director of the Army,

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opinion & debate

and the Royal Navy was directed by Surgeon Captain Desmond Curran.

For those selected, including myself, service as a specialist in the armed forces was a privilege. Most of us had been recruited from mental hospitals and had suffered the narrow confines, the damaging inward looking attitudes inherent in closed institutions, as they then were. It was tantamount to an escape: apart from opening chapter after chapter of new clinical experience we had benefited inordinately from working cheek-by-jowl with, and learning from, senior teachers who hitherto had been only hallowed names atop revered textbooks.

Evolution of the Royal College of Psychiatrists

The proliferation of private licensed madhouses and county asylums in the first half of the 19th century meant that more and more medical men were appointed to run them, although it was not obligatory for the proprietors or the managers of madhouses to be medically qualified.

The 'medical gentlemen connected with lunatic asylums', on the initiative of Dr Samuel Hitch, Resident Superintendent of the Gloucestershire General Lunatic Asylum, were circularised with the suggestion that some formal organisation should be founded. A preliminary meeting was held on 27 July 1841, at Hitch's asylum from which the Association of Medical Officers of Asylums and Hospitals for the Insane was born which, under different titles, with varying degree of success, has had a continuous existence for nearly 160 years – the oldest of its kind in the world.

In 1865, the title of the Association was changed to the Medical–Psychological Association, the implication being that any qualified medical practitioner interested in the treatment of insanity was welcome to membership.

The prestige and dignity of the Association was enhanced by the receipt in 1926 of the Royal Charter of Incorporation entitling it to change its name to the Royal Medico-Psychological Association – the RMPA.

In spite of its aggrandisement it is important to stress some of the negative aspects of the RMPA and, indeed, the status of psychiatry in general, at least until the outbreak of war in 1939.

Psychiatrists were still at that time cartoon characters, as witness the plethora of derisory synonyms they invited – nut doctors, shrinks, trick-cyclists, for example. Academically, they were disadvantaged: postgraduate teaching in psychiatry was available only at the Maudsley in London, or in Leeds or Manchester. Furthermore, the existing postgraduate qualification, the DPM, fell far below the status enjoyed by the MRCP or the FRCS. As the result of its low esteem few teaching hospitals had appointed psychiatrists to their consultant staff.

As for the RMPA itself, it had attracted relatively few members. The skimpy secretariat was housed in one rented, woefully inadequate room, albeit located in a magnificent Adam mansion in ultra-fashionable Queen Anne Street, W1E.

Sadly, as a political instrument, the RMPA was limp, and insofar as psychiatric matters were discussed at all in debates of national importance, the Royal College of Physicians took it upon itself to speak for it.

Nevertheless, from 1961 onwards there was a growing pressure from some members of Council and the membership itself for the creation of a Royal College, but that it took 10 years to achieve is due to the intrigue, back-biting and in-fighting that was enacted between members of Council. A brilliant, evocative account has been given by Howells (1991).

In the end wisdom was allowed to guide: on 16 June 1971 the warrant was duly signed, and the Royal College of Psychiatrists proudly came into being: its success has been undoubted (Rollin, 1987).

Impact on psychiatry of Nazism and the Second World War

Psychiatry, at the end of the 19th and beginning of the 20th centuries, was firmly rooted in Europe, particularly in Germany and Austria. At that time those countries boasted many of the founders of modern psychiatry, such as Alois Alzheimer (1864–1915), A. A. Brill (1874–1948), Emil Kraepelin (1856–1926), Hans Creutzfeldt (1885–1964), Ernst Kretschmer (1888–1964), Otto Binswanger (1852–1929), Josef Breuer (1842–1925) and Baron Richard Von Krafft-Ebbing (1840–1902). Of comparable stature in the burgeoning speciality of psychoanalysis there were Sigmund Freud (1856–1939) and his daughter, Anna (1895–1982), Alfred Adler (1870–1937), Melanie Klein (1882–1960) and her daughter, Melissa Schmiderberg.

The effect on psychiatry, psychiatrists and the care of the mentally ill of the Second World War was devastating. Nazism was synonymous with anti-Semitism, but an anti-Semitism of a particularly vile and virulent variety. In Germany, as in Austria, within the ranks of psychiatrists, Jews were substantially over-represented, particularly among the practitioners of psychoanalysis, a subject reviled by the Nazis as "the despised Jewish science". The public burning of the works of Freud in 1933 in the quadrangles of German universities was, except symbolically, the least important of the infamies perpetrated by the Nazis; but it was a warning of the shape of things to come. Those Jews who saw the light in time fled, mainly to the USA, and to a far lesser extent to the UK, as did men of world-class fame such as Alfred Meyer, Willi Mayer-Gross, Erwin Stengel and, in 1938, Sigmund Freud himself. Those who would not, or could not, flee were mercilessly slaughtered or subjected to the unspeakable horrors of the Holocaust. The Aryan psychiatrists left were guilty of condoning the atrocities, or actively promoting them. German psychiatry plunged to its nadir: it was disgraced and discredited.

But Germany and Austria's loss was the gain of whichever country was wise enough to accept the refugees. This was particularly so in America where psychoanalysis, mainly of the Freudian variety, had taken firm root. The advent of additional skilled Jewish analysts

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opinion & debate

added a decided impetus and popularity, to the point that psychoanalysis was elevated to the status of a cult, or, indeed, a religion.

Psychoanalysis aside, America boasted other advantages. It was rich, well-resourced and had *in situ* an enviable number of eminent centres for psychiatric research. Important, too, is that, happily, it had not suffered the physical and economic ravages of the most destructive war in history.

Not surprising, then, that the cream of Europe's war-weary psychiatrists, underpaid and under-resourced, as they were, were tempted to cross the Atlantic in search of a better personal and professional life. And tempted they were. In the 1950s, the 'brain drain' was firmly underway, so much so that instead of speaking German, as it did in the 19th century, world psychiatry today speaks English, but with a distinct American accent.

But there was, and remains, an unsightly wart on the otherwise attractive face of American psychiatry. It is in the shape of the public asylums administered by individual states, counties or cities. These gigantic asylums were chronically over-crowded, under-staffed and under-funded, in sharp contrast to the luxurious private clinics available only to the well-heeled.

In keeping with countries in Europe, particularly in the UK and Italy, certain states in America tried to solve the problem of the gigantic asylums by emptying them and relying on community care to carry the burden of the unfortunate ex-inmates. The result was disastrous in social terms as described by Professor Alan Stone (1984). Nevertheless, the pre-eminence of American psychiatry today is without doubt.

The anti-psychiatry movement

In the 1960s a new movement emerged to trouble the waters of the psychiatric establishment – psychiatry. The movement, left-wing in politics, sported an international membership including, for example, Ronald Laing and David Cooper in England; Thomas Szasz in America and Michel Foucault in France, the only one, incidentally, without psychiatric credentials. The gospel according to this group was that psychiatry was a form of social repression; that treatment was disguised punishment and, above all, that mental hospitals must be closed forthwith to avoid further damage to the patients.

The movement for a time enjoyed widespread popularity; but it died, because, in practice, the results were an unmitigated disaster, as witness David Cooper's venture in England in 1962. "The lunatics have taken over the asylum", was how it was aptly summarised.

Psychiatrists *v.* politicians

Conventional wisdom would have us believe that asylums or mental hospitals were designed for the care of the mentally ill. It follows, then, that the overall control of these sick people should lie with doctors, or more precisely, psychiatrists.

In this instance, conventional wisdom is found lacking. Initially, asylums came to be built because of the determined efforts of powerful philanthropists against the will of the politicians. The grand design of the philanthropists was frustrated by their own naivety plus unforeseen social and demographic events, none of which was under the control of the medical staff. The result was the creation of the gigantic asylums.

And so it remained until the mid-20th century when, particularly in Britain, a spontaneous movement arose within the psychiatric hierarchy itself to improve the lot of the patients in their care. It was tantamount to a crusade led by the likes of T. P. Rees of Warlingham Hospital, Surrey; T. M. Cuthbert of St Luke's, Middlesbrough; Joshua Carse of Graylingwell, Sussex and Maxwell Jones of Belmont, Surrey. The resultant transformation inspired the term 'therapeutic community', or 'the new moral treatment of the insane'.

The fulsome and universal praise for Britain's humane initiative was, not surprisingly, not echoed in totalitarian countries where psychiatrists danced to the tune of their political masters, as in Nazi Germany, and in communist Russia where psychiatric treatment was routinely used, or abused, as an instrument of penal policy.

Nevertheless, it is a bitter irony that at the very time that British mental hospitals basked in their well-deserved fame, plans for their destruction were being laid. Enoch Powell, a brilliant scholar – but a sadly flawed politician, was then Minister of Health. In his contentious speech of 1976, based on dubious statistics, he opined, with more eloquence than accuracy, that mental hospitals rather than being 'good objects' were 'bad objects'.

Mr Powell's Hospital Plan split the psychiatric establishment in two, but in the end he won the day. Mental hospitals were to be destroyed and their patients were to be shared between general hospitals and 'community care' – a most seductive and charismatic slogan, to be sure. Once begun, the rate of destruction and translocation acquired its own momentum, so fast indeed that the number of beds available has dropped from 150 000 in 1960 to 37 000 today.

But the Hospital Plan, like its progenitor, was sadly flawed, a fact that has become increasingly evident as the years have rolled on. Irrespective of political colour, the press, for example, has deplored the deteriorating situation. Prominence has been given to the tragic plight of mental patients tipped out of mental hospitals into scantily available general hospital beds and, not infrequently, community care, which doesn't care. Failing these facilities, the hapless victims of the Plan have swollen the numbers of people and the petty offenders who choke the penal system. Far more tragic are the 1000 who annually commit suicide and the 200 or more who each year commit casual and purposeless murder. Echoes of the same social disorder prompting the outcry leading to the 1815 Parliamentary Select Committee are all too evident.

Public patience and tolerance are fast running out. So intense is the demand for reform that Frank Dobson, the then Secretary of State for Health, was compelled to

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act. In January 1998, in a widespread press statement, he promised far-reaching reforms.

How to end this strange, eventful postage-stamp history and at the same time to epitomise the sorry state of affairs into which our contemporary politicians have landed us? On reflection, there is nothing more apt and more succinct than the trenchant comment of the distinguished sociologist, Professor Kathleen Jones, who has experienced at first hand the current situation both in England and in post-Basaglia Italy.

She writes:

> "Nobody seriously argues for the return of the old mental hospital system; but its abolition has left a chasm between intention and performance. From the 1930s to the 1950s, British mental health policy set a standard for the rest of the world. Only positive action at the highest level can repair the damage of the past three decades." (Jones, 1993)

opinion & debate

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