Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

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William James College

Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated.
For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE FIFTH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Science and Service in Psychiatry in the 1980s

Speaker

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This is a particularly interesting time for us to be focusing on that aspect of Lindemann's work which dealt with social psychiatry. As all of us know, community psychiatry was hailed by its enthusiasts as the third psychiatric revolution. That revolution is now pretty thoroughly in the dog house andis regularly pronounced dead, not only in the professional literature but also by politicians and others who seek to reverse processes that radically changed professional practice and the face not only of psychiatry, but to some extent of our communities. In psychiatry and in the mental health professions in general,we are moving rapidly away from social and humanistic concerns toward an emphasis on the findings of biomedical science, specifically neurobiology. This is especially the case with psychiatry, which has one foot in medicine. The other mental health professions, too, are moving toward more supposedly scientific approaches to their particular aspects of the field. The balance between science and service is currently unstable and is shifting rapidly. My title was chosen, not for its obsessive sibilance, but rather because it seems to me to point to a major characteristic of our field in the 1980s. In stressing its problems at the moment one can also see its potential promise for the future.

History is one of my interests, and I would like to take you back to some of the history of our field. Henry Ford said to a Chicago Tribune reporter in 1916, "History is more or less bunk." Naturally I don't agree with that. It is probably truer, more to the point, that history is always written from a particular standpoint which some historian chooses to coincide with his view or purpose. Perhaps the final word about history belongs to Robert Benchley, who once said that in every news photo of epoch-making events there always seems to be a man in a derby hat looking in the opposite direction from the action. I find myself feeling that way—like the man in the derby hat—about social and community psychiatry. Having been somewhat puzzled at the outset about its revolutionary character, I found myself participating in it without ever being convinced either that I was violating established principles of traditional psychiatry, or breaking much new theoretical ground. Now that it has been declared a failure, along with deinstitutionalization, I feel a bit strange to discover that both community psychiatry and deinstitutionalization are alive and reasonably healthy at the Masachusetts Mental Health Center and in most of the Region VI programs in this city, albeit with the recognition that our situation has certain special characteristics compared to the national scene.

In any case, let me start by reviewing the history, as I see it, of our arrival at this state of affairs between science and service in the '80s. The modern era of psychiatry began with Pinel at the time of the French Revolution. He was best known for striking off the chains of the lunatics at the Salpetriere in Paris. He is usually identified as the founder of the humane approach to patient care. That is correct. But he was not against institutions nor was he against science. In fact he was part of the philosophical school called "The Ideologues," whose point was that medicine and other human endeavors should be based on fact, not on theories. They emphasized induction and observation of phenomena, and refused to speculate about the ultimate nature of disease. Pinel did not make much headway in medicine with the philosophical approach. He was much more influential in his therapeutic recommendations. He rejected purely physical causes of mental illness and found from his own experience that grieving did not help with disordered people. Moral therapy, that is the therapy of the interpe rsonal, and what we would now call the psychological, aspects of illness was what spelled to him the opportunity for making therapeutic gain.

To provide moral treatment, according to Pinel, called for a new environment: understanding, patience, kindness and guidance, as he put it. Striking off the chains at the Salpetriere was not an anti-hospital move, but part of creating the appropriate therapeutic environment. Pinel, interestingly enough, was not above using what he called "the happy effect of intimidation" as one of his therapeutic modes.

Similar ideas were developed at the York Retreat in England. Quite independently and for different reasons, the Retreat was opened in 1795. It came about because Quaker patients were felt by their co-religionists to be influenced adversely by institutions which did not take their religious beliefs into account. Kindness was a major issue for the Quakers, and they expected that kindness would engender self-constraint and self-control. It was only after the York Retreat, based on these principles, had been in existence for ten years that they learned of similar ideas of Pinel.

Both the York Retreat and Pinel's ideas were substantially influential in the New World. In the first twenty-five or thirty years of the nineteenth century they influenced the development of institutions for the care of the insane as an alternative to poor houses and jail. In the United States of America prior to the eighteenth century both the mentally and the physically ill were generally cared for in their homes, often with financial assistance from the Towns, if it was needed. This form of medical care was primarily for upper and middle-class people. It was only low income people who received institutional treatment in alms houses, poor houses and the few work houses that were present. There were no hospitals except for the pest houses which were hastily created during epidemics.

When the Towns reached a certain size, about 20-25,000 in the last few years of the 18th century, then institutions began to develop in response to public concern for the increased number of cases. The Pennsylvania Hospital was founded in Philadelphia in 1762 by Thomas Bond and by Benjamin Rush, who had Pinel's works in his library and who knew of the work of the two families in England who ran the York Retreat. The Pennsylvania Hospital and the New York Hospital, which was started shortly afterward, accepted both physically and mentally ill persons until the Institute of the Pennsylvania Hospital began as a separate institution and moved a few miles away. The first few mentally-ill people at the New York Hospital were treated in the basement, very poorly. It was only when Bloomingdale started off in 1821 that the New York Hospital became substantially and creatively involved in the treatment of the mentally ill. McLean Hospital, developed originally as part of the Massachusetts General Hospital, opened in Charlestown in 1818. Other small institutions emphasizing moral treatment, each a mixture of public and private funds, began in these early years of the nineteenth century: for example, the Friends Hospital in Frankfurt, Pennsylvania and the Hartford Retreat. Note that moral treatment was not community treatment—it was hospital treatment, depending on the creation of a special kind of atmosphere.

Each of these institutions went through a similar kind of evolution. They started off taking every referral, often for religious and humanitarian reasons; but soon the load of chronic patients would fill up the institution and run up the expenses to the point where the so-called treatable patients could not be received, and as a result a move would be made to do something about the longer-term patients.

By the 1830s there began to be moves to develop what we now think of as more truly public institutions. This was a time when many institutions were developing. There were no organized police departments, for instance, in Massachusetts until the 1820s and 30s. In the same period, public education as an organized system rather than isolated schools began; and prisons became a focus of humanitarian interest. Some of you may know that the reason de Toqueville came to the United States was not to study democracy - he came with Beaumont to find out why prisons in this country were so excellent and should be copied by the French.

In any case, the Boston Prison Discipline Society was founded in 1825 by Rev. Louis Dwight, Thomas Mann and Samuel Gridley Howe. Its concern was the rehabilitation of prisoners. It was this group that put in a petition for the development of the Worcester State Hospital, not to start hospitals particularly, but to get lunatics out of prisons so that prisoners could be appropriately rehabilitated as well as mental patients be treated. So mental institutions really developed as part of prison reform and as a development of public policy to takecare of dependent persons; and this was a good twenty years before Dorothea Dix began her reforms.

The first superintendent of Worcester State Hospital was Samuel B. Woodward, who was a Quaker familiar with moral treatment. He therefore stressed that what was required for treating mental illness successfully was a close personal relationship between the patients and the superintendent and his family, who lived on the grounds and often were expected to eat with the patients and be accessible to them. Secondly, hospitals were to be at a distance from cities, not so much as a subtle form of exclusion, but to protect patients from the perils of urbanization, industrialization and the stresses of city life, which, along with biological causes, were felt to cause mental illness. Woodward was a prolific writer, who would put out a 150-page report in batches of three thousand copies and send them all over the world. It was a sort of triumph of the pen, establishing him as an expert on hospital care and the Worcester State Hospital as the most famous hospital in America.

By 1846 this hospital, built for 120 patients according to sound principles of moral treatment, actually had a census of 359 patients. It had been enlarged twice because it was so crowded, and the trustees at one point, around 1845, voted to tear it down and start over because it was a terrible mess. Massachusetts' chief legislative industry then, as now, was investigation: needless to say, a legislative committee was set up to investigate the situation at Worcester. Their report rejected not only destroying Worcester, but also rejected separate facilities for alien races —the Irish and central Europeans—and decided instead to build Taunton and within a few years, Danvers State Hospitals.

How did it come about that a man as high-minded as Samuel B. Woodward, who knew clearly what he wanted, namely 120 patients, could end up thirteen years later with nearly 400 patients? Laws passed in 1797 and 1816 were modified to apply to Worcester State Hospital and required that all dangerous insane persons must be sent there by the courts. They also prohibited the discharge of patients into the community until the original cause of the commitment had ceased to exist. As a result, Woodward had no control over either admissions or discharges. He would have to keep patients even though they were better or quiescent. In effect, Worcester State Hospital was operating as part of the welfare system, dealing with people who had posed a certain kind of danger to the community or to themselves, not people who were defined by virtue of having an illness. The result was to fill up the Hospital with patients for whom no provision had been made.

Note that in all of this there is no evidence that anyone, either the legislature or Woodward himself, had made any estimates of the demand which would be created by the laws which regulated the hospital. It was not until 1854 that Edward Jarvis got money from the state to do the study he had wanted to do for a long time, which was to talk to everybody in Massachusetts who might know the answer and find out how many

mentally ill people there were. He enumerated all the people who had various kinds of mental illness—the first great psychiatric epidemiologic study. He learned a great deal, but this was in 1854, well after the horse was out of the barn.

Where was science in all this? It's clear that science was not in estimating demand for service; and at the outset it wasn't much in therapeutic endeavors, either. The theory of illness which these men operated on was rather complex and rather sophisticated. They acknowledged that there were physical causes of mental illness: that if the sense organs were deranged, then faulty thinking and faulty behavior could result. They also felt very strongly that there were psychological or "moral" causes - that experience could act on the sense organs to derange them and secondarily derange thoughts in the mind. The favorite whipping boy then, as now, was the stress of urban life. It's very interesting to read contemporary accounts of why mental illness was increasing: cities are developing, families are being broken up, things are too hurried, tram cars can go eight miles an hour now and it's clearly too fast for a human being. All of these things cause pressures and stresses that lead to an increase in mental illness.

Furthermore, as an extension of that theory, wrong living, failure to live up to good, sound Christian principles, was also regarded as a cause of insanity. As a result, moral treatment, on the one hand, involved a great deal of reeducation in an atmosphere of respect, to lead people back to ordered and sensible ways of life, and on the other hand, involved many of these early physicians and leaders in state institutions in prescribing to society how society ought to live. I find it very interesting to hear my colleagues talk about how psychiatrists particularly, and other mental health professions have gone off the track: we have fallen away from the true path which is medical, scientific, sticking closely to clinical diagnosis and treatment, that can be verified. We got off on the wrong foot by prescribing to society about day care centers, urban planning, preventive mental health, etc.

This view is a misunderstanding of history. For at least 150 years people have been interested in the mentally ill and concerned about the way in which wrong living, however one defines it—whether it's child abuse or tram cars going eight miles an hour - contributes to disordered behavior. Therefore our profession has always been a bunch of preachers who were saying to society, "On the basis of what we know about individuals you really ought to mend your ways." It's an honorable tradition, and one which we are very busy expunging. Moral treatment did not exclude drugs: morphine was given to quiet patients, and other drugs as indicated; but they were not the main part of therapy.

In the early years of moral treatment in this country there was optimism that mental illness could be short. Inherent in the idea that wrong habits led to mental illness was the belief that training people in right habits would reverse it. There developed what was called "the cult of curability," and with a little statistical befuddlement these early

institutions managed to convince themselves that cure was possible in over eighty percent of the patients. However, they did not count the person who was cured today and came back a week from now. They continued to count him or her as cured. They didn't work in recividism as a factor. So the statistics were somewhat exaggerated, if one looks at it the way we do, as a recurrent illness. This period of optimism waned as changes in society led to increasing numbers of long-term patients filling up the institutions. The number of beds increased to keep pace with population; immigration and racist attitudes toward immigrants, which were at least as pervasive if not more pervasive than now, played a part in emphasizing the welfare function of mental institutions versus their medical function.

By the end of the nineteenth century there was great dissatisfaction again with mental hospitals. Statistics were getting better; it was realized that so-called cures, even if one corrected for the misunderstanding about recividism, were going down. People were staying at hospitals longer. In addition, the mental-hospital-investigating industry got going in the 1850s. The same cast of characters that we see around us now started long ago. Successful books were published by patients like E.P.W. Packard and Elizabeth Stone, who wrote accounts of being railroaded and mistreated in hospitals; lawyers began to sue superintendents and directors of nursing for mistreating patients; legislators began passing laws containing infuriating regulations. One of them was a law passed by the Rhode Island legislature in the 1850s, forbidding superintendent and staff from opening or censoring the patients' mail. Isaac Ray, Superintendent of the Butler Hospital, had to set up a box for patients to put their mail into. Listen to what he wrote:

The legislation these people seek is anomalous, utterly indefensible. You may challenge them to show any malpractice or abuse that should furnish the grounds for it, or any complaint or petition for it. Let them look at the workings of these arrangements - the boxes for letters written by inmates. I suppose it should be under the control of an outside and independent force. Ifso, how can their judgement be better than that of the officers who have an intimate acquaintance with the writers and know all about their friends and connections? The boxes themselves would be a standing proclamation to the patient that the officers were unworthy of their confidence and they must look to the outside force for protection against the superintendents, assistants and trustees who are combined for the purpose of depriving them of their liberty.

One had at that point the last element in this little drama, namely, the harried hospital people trying to do good things, feeling misunderstood and hurt by implications that they don't have their patients' interest at heart.

Gradually, also, in the latter part of the nineteenth century, there was a greatly increased emphasis on anatomical causes in mental illness. Microscopic pathology in Germany and later in England and France began to show some changes in the brain

tissues of certain patients. The cult of curability of fifty years before was attacked and dismissed. Hospitals were deliberately used as warehouses pending the expected scientific discovery of the causes of the disorders. Science in this case, combined with social factors, led to a therapeutic nihilism which, by the turn of the century, was causing increasing distress in the professional and lay community.

By the beginning of the twentieth century there began again to be a move away from therapeutic nihilism. Adolph Meyer, William James, Freud and others created modern psychotherapy —a latter-day version of moral treatment, which said that mental illness, at least in part, had something to do with the habits that people develop in their interactions with society, with their families, etc., and that cure, or at least alleviation, might be possible, even though basic biological matters might continue to be important.

The sequel to this was the enormous expansion of services in which we all have participated. By 1976 over a billion dollars was being spent on 650 service centers in whose areas over ninety-three million people, close to half of the population of the country, live. There was a major shift from state hospitalbeds to community mental health centers; a great expansion of outpatient episodes relative to inpatient episodes. However, the number of inpatient episodes from 1965 to 1975 stayed approximately the same, although they were somewhat shorter episodes.

We find ourselves today at the far end of this era, with community psychiatry being tagged as a major mistake perpetrated by a group of wild-eyed zealots who are trying to solve social problems through inappropriate routes, namely, mental health services. The program of deinstitutionalization is considered a failure, and the current wisdom has it that the whole field should retreat back to science and find its way through neurobiology. This had to do in part, obviously, with the fact that science has made some important new discoveries in our field. Various exciting things are happening in psychopharmacology, for example. So it is not just disappointment over the shortfall between what people had hoped for and what actually happened. And in part, psychiatry is responding to the pervasive influence of third party payments, which create private practice opportunities, not only for psychiatrists but for other mental health professionals: threatened by psychology and social work, psychiatry is being driven back to medicine to profit from its identity and its advantages.

I feel ominous trends are visible; I think one could reasonably argue that we always forget the tendency to overdo a change in direction and go too far. Rarely is it possible to make a move without overstating one's case and proceeding on a course where everybody gets burned and has to go back. Now we hear talk about reinstitutionalization; and all of sudden some of my colleagues forget what life was really like at the Metropolitan State and Boston State Hospital in the old days. They begin to rhapsodize about how wonderful things were in the time of Walter Barton, Elvin Semrad

and James Mann. That was the west side of Morton Street. They forget the east side of Morton Street and the miserable mess in the wards there. People are now eager to rush back into state institutions and pretend that they were much better than they really were.

What I have been trying to sketch for you is that over time there has been an imbalance in one direction or the other between service and science. During the last twenty years, thanks to a humanistically-oriented surge in the elective process, the service component achieved enormous success. Taking Massachusetts as an example, I believe our success is due to the fact that we were successful romantics - I mean that in the sense of the romantic versus the baroque. In our concern for individual patients we used very real tragedies and very real and substantial opportunities to sell to the public and to the legislature programs which had expanded beyond our means to support them. What we did not do—and it is clearer now than it was then—was to pay enough attention to the scientific aspects of what we were doing. I mean scientific in the limited sense of program evaluation based on data collected with objective instruments.

Mental health business is clearly at risk because of our difficulty in demonstrating the terrific things we are doing, owing to lack of the tools that science should have made available to us. For those of us who beat the drum and sold programs, there are several possibilities. Scientific advances of the last twenty years, such as client information systems, management information systems and program evaluation would greatly enlarge our technical base. Without them we are having great difficulty in competing fairly and maintaining our position. Program evaluation is not very vigorously encouraged at the federal level. Although there have been booming attempts to develop information systems on the state level, they have never really come through as a need from the Department of Mental Health or the State Legislature. None have been well thought through and none have been funded. So that's one way that science and service got out of relationship to each other in the last fifteen to twenty years.

Now I think things are moving in the other direction: there's a danger now, certainly at the conceptual level, of science running well ahead of service. In a vindictive mode, we of psychiatry are daily reminded that we ought to give up cultural approaches and go bearing back to diagnosis, neurobiology and neurogenetics. Therapeutic nihilism, I suspect, is around the corner, standing right next to reinstitutionalization as a panacea. The next wisdom will be that we should do nothing at all that can't be absolutely proven. I've been known to fly off in desperate moments myself, wishing somebody would do some research on what doesn't work so that we could stop putting money into it and concentrate on what does work. I feel danger in that approach: that is, to wait until we know absolutely what works may be a disservice to patients in 1982 just as it was in 1882 or 1885.

Looking at the future in practical terms, there is much going on, in spite of our romantic tendency to regret change. We should emphasize data instead of clinical progress: intuition and anecdotes, unfortunately, do not any more substitute for accountability and demonstration of effectiveness. We have a lot of catch-up to do. Need for data about clinical programs is particularly true here in Massachusetts. We also need to be sophisticated about our theory. Psychiatry should recognize that its roots, while they are medical to some extent, are equally strong in the welfare system and in the so-called moral aspects of our field. We should not be ashamed of showing our facade to society, just be better at it, developing better ways to say what we know about the effects of social factors and interpersonal factors on the receiver. The new social psychiatry that Leston Havens has talked about is one aspect of this. Until now, therapeutic psychiatry has been based on understanding people's fantasies about reality. What do we do with terrible reality, for example child abuse? That's a terrible challenge, and one which is clearly not solved.

There is also great promise in developments in psychiatric epidemiology. We may be witnessing a new wave of what Erich Lindemann stood for, which will restore a just proportion between the moral and psychological aspects of our field and the contributions of neurobiology. The long-range prospect is exciting.