Editorial

THE FUTURE OF PSYCHIATRY

Humphry Osmond, M.R.C.P., F.R.C.Psych., and A. Hoffer, M.D., Ph.D.

Every illness involves the two environments, the psychosocial and the biophysical. Every individual responds to these two environments.

The biophysical environment has generally been ignored by psychiatrists who have studied the psychosocial problems only. They have concluded that the patients' psychosocial reaction was the illness, not a result of biophysical disturbances. Nearly every mysterious illness of obscure causation has been considered of psychosocial origin. This includes syphilis, once thought to be due to the over-stimulating effects of the railroads, and more recently Down's syndrome, also considered a good example of a psychologically produced disease. There are very few diseases considered biophysical which have eventually been proven to be of psychosocial origin. As long as biophysical causes remain unknown or disbelieved, the speculations of psychosocial theorists are limited only by their imagination.

A psychosocial disease may be treated by psychosocial methods, i.e., by psychotherapy, behavior modification, biofeedback. But it may also be treated by suppressing or dampening down the psychosocial symptoms by means of psychopharmacologicals. A psychiatrist who only treats symptoms by methods which require continuous symptomatic control is as much a practitioner of psychosocial medicine as is a pure psychotherapist. Toximolecular psychiatrists (psychiatrists who use only tranquilizers or synthetics normally not found in the body) may consider themselves to be biological practitioners, but they are not. Even though tranquilizers can be very helpful, they are little more than superior sedatives. They control psychosocial symptoms, but patients pay a price which may include permanent incarceration in chemical straight jackets, while dangerous side effects begin to accumulate.

Psychiatric journals represent the cohesiveness between these two schools of psychosocial psychiatry. It is doubtful that these journals could survive without the support they receive from drug advertising. This is illustrated in a striking way in the July issue, 1977, of Psychiatric Annals. This issue is devoted to what is called the psychological ecosystem, i.e., to a consideration of psychosocial factors, but excluding the patient and of course any biophysical considerations. This issue runs to 96 pages of which 46 are entire page ads describing various antidepressants, tranquilizers, and other drugs. Nearly half the issue describes the drugs used to control symptoms, while the remaining half is

devoted to psychosocial interests.

No illness can be caused by a deficiency of synthetic substances not normally in the body. Arthritis is not due to a deficiency of aspirin or gold salts. Schizophrenia is not caused by a deficiency of tranquilizers, electroshock, or psychotherapy. The use of these therapies must therefore remain a palliative only, even though they can be palliatives which are helpful and essential.

The development of toximolecular psychiatry, rightly considered a revolution in psychiatry, has not solved the main problems facing this specialty. The flight from the mental hospitals has merely transferred the problem from a concentrated area, the hospital, to a less concentrated one, the community. The whole community has become the mental hospital. It in turn has sought to deal with this development by promptly placing a large number of discharged patients in institutions not legally able to refuse admission, our prisons. As our mental hospital population goes down our prison population goes up. It has been said that one can judge the communities' sympathy toward the mentally ill by the institutions most receptive to them. It now seems prisons are providing asylum (shelter and comfort) which is denied to the mentally ill by many psychiatric hospitals.

The present crisis of modern toximolecular psychiatry was foreseen by Dr. Henry Rollin (1977), an English psychiatrist, about 17 years ago. The British Mental Health Law of 1957 called for a new era in psychiatry, a psychiatry which would see a withering away of the mental hospitals. The new act made two main assumptions: (1) tranquilizers could cure most mentally ill patients, (2) the community was more therapeutic than the mental hospital. A wave of enthusiasm swept the country, and the Minister of Health predicted in 1962 that by 1975 half the mental hospitals would have disappeared. Dr. Rollin had questioned this prediction claiming that what would be changed would be that the open door policy of the hospitals would be changed to the revolving door policy now in existence.
The number of beds has indeed declined, but at what cost to the patients and to the community? The prognosis for schizophrenics remains much the same. Many are readmitted over and over again. Many swell the ranks of the unemployed, chiefly the unemployable. Very few tranquilized schizophrenics pay income tax. Others join the army of vagrants and "elbow each other off the park benches or lengthen the queues outside the doss houses"—many wind up committing petty and serious crimes until they are once more institutionalized in prisons.

In one British study an attempt was made to trace 174 schizophrenics discharged from one hospital. Twelve months later only 94 were found. Of these only 29 had satisfactory accommodation, 33 were unemployed, and 25 were neglecting themselves. The fate of 50 (not found) is unknown. From 1961 to 1974 the number of patients discharged over a period of a year who committed a crime for which they appeared in court increased from 6,366 to 12,530.

The same deplorable situation has occurred wherever community psychiatry (combined with toximolecular psychiatry) became the fad. Most areas have wisely refrained from publishing their statistics, but where they are available they are equally dismal, from California to New York, state, from Massachusetts to Saskatchewan.

This English fad is still spreading to other countries. The **New York Times** (July 17, 1977) reported the "new" and "highly" original views of a Dr. Franco Basaglia, an Italian psychiatrist partly trained in the U.S.A. He believes that society has made psychotics ill and must be made responsible for them. A psychotic, he declaims, has the best chance of cure when he is treated "within his own neighborhood and social surroundings." Following this "revolutionary" view he has discharged 900 patients from San Giovanni Mental Hospital in Trieste, Italy, leaving only 150 in, but waiting for placement. Those still waiting are no longer "patients," they are guests. Apparently the community did not volunteer to become the therapy for Dr. F. Basaglia's guests, and they have started complaining, especially when one patient he released

murdered his parents. Some years ago New York City residents were equally unhappy. A series of stories in New York media did much towards forcing a reduction in the New York State drive to empty its mental hospitals, as well as resulting in the discharge of the psychiatrist most responsible. Perhaps Dr. Miller should have a chat with Dr. Basaglia.

The Ministry of Health and Social Security, England, which has more experience than any other government with community psychiatry, about 17 years, concluded in 1975: "Those who work in the health and social services fields have to recognize that families and relatives and indeed the public at large cannot be expected to tolerate under the name of community care the discharge of chronic patients without adequate arrangements being made for after-care and who perhaps spend their days wandering the streets or become an intolerable burden on the lives of their relatives."

Rollin concludes his hard-hitting report as follows: "But the most important statement of all is that of the then Minister of Health and Social Security, Mrs. Barbara Castle, herself. In the foreword she writes: 'What we have to do is to get to grips with shifting the emphasis to community care'-as good an example as one could wish for, of the futility of closing the stable door 17 years after the horses have left, or more accurately, were driven out."

The situation is no better in Massachusetts. Dr. Robert Okin, the new commissioner of Mental Health, had this to say, " 'Many patients who had been institutionalized for years now find themselves living in low cost rooming houses, rocking in front of TV sets and wandering the streets. Okin noted that some states failed to appreciate the extent to which the institution was, for many, an integrated human services system which provided medical, nutritional, vocational rehabilitation, residential, and economic services, albeit very inadequately. Such services have never been sufficient to serve this population in the community."

Starting with Tooth and Brooks in 1958 psychiatrists managed to whip their often more sober psychologist, social worker, and even sociologist colleagues into a frenzied optimism. Each discipline added its own special bit of foolery, and this folly has congealed around the patients.

We suspect that Aesculapian authority played a harmful part here. Tooth is an able psychiatrist who dabbled in statistics. We do not know what statisticians thought of his 1958 efforts at the time; with the benefit of hindsight some have been quite unkind. One of the few people who showed unmistakable foresight was Dr. Henry R. Rollin in England in 1960. He noted repeatedly that people were being evicted from hospitals administratively and not because of any great medical improvement in their condition. Rollin and Dr. J. D. W. Pearce drew this first to our attention very early in the 1960's. And it was this, as much as anything else, that made us maintain and even expand our work with megavitamins. Had the tranquilizers acted as Tooth and Brooks believed, there would have been little point in continuing to study megavitamins.

What is astonishing is not that Tooth and Brooks made this error, but that their advice was only followed in the U.S.A. a decade later when it was clear to almost everyone that a serious miscalculation had been made. Saskatchewan, California, Pennsylvania, New York, and much later Alabama belatedly and mistakenly followed Britain's lead. There was plenty of time to think again, but it was not thought but rhetoric that filled the psychiatric journals, began to spread to legislators, and also infected our nursing, psychologist, and social work colleagues. The results of those policies have been described as being a failure by Dr. Robert Okin. Dr. Okin, it should be noted, is not suggesting that attempts should be made to develop better treatments, or that we should even examine the outcome of treatments that exist, but that we should "transform community attitudes."

Basaglia has 150 patients left who are now "guests." Weyburn, Saskatchewan (the mental hospital), "disappeared" in 1968 or so. Unluckily the mentally ill in Saskatchewan, as elsewhere, have not vanished. They live on, as described by Dr. Robert

Okin, in a wretched condition usually. No one would guess from this that even at their worst during the 20's, 30's, and 40's the mental hospitals did pretty well in getting 30 percent of schizophrenics and sometimes more back into the community and keeping them there.

The **New York Times,** in keeping with its liberal stance, is often wedded to models such as the social which resolve our difficulties by massive but unspecific reforms. This preoccupation makes it possible for its editors to find news value in something as out-of-date and unoriginal as Dr. Basaglia's study. It is a pity that so notable a paper uses much of its mental health (which usually means mental illness) space on aspects of psychiatry which exemplify the great paper's sociopolitical views. What one might call the accusatorial social model of mental illness does from time to time act as a spur to some changes; apparently it had that effect on Dr. Basaglia some years ago. The trouble is that as with Savanorola, the great reforming monk, a time comes when the public is sated with chiding. Unluckily it will not be Dr. Basaglia who bears the brunt of this accumulated irritation, but his poor patients out in the community.

Fifteen years ago Professor Robert Sommer showed in a paper, 'The Schizophrenic No-Society," just why this should be. It is not malevolent societies which reject or extrude schizophrenic patients. All societies do this because schizophrenia itself erodes the social glue upon which human relationships always depend. We must use well-aimed biological, psychological, and social means to restore that massive and disastrous social loss found in few other human misfortunes.

Dr. Basaglia began his work in 1971. Dr. Duncan MacMillan was doing something very similar in Mapperly, England, before 1942. Our friend, J. M., visiting from Saskatchewan a few weeks ago, gave us a vivid account of the misfortunes of schizophrenics held in the community with prolixin and group activities. Some of them, she felt, were worse off than in Weyburn in 1960.

In our opinion psychosocial psychiatry has failed. Whether it practices symptomatic control by psychosocial techniques or by biochemical suppressive methods, the results are equally dismal. One result of this failure is a resurgence by psychosocial psychiatrists who are now beginning to "prove" that toximolecular psychiatry is no more effective than psychosocial psychiatry. True. Both are not significantly more effective than natural remission rates for recovery.

What is left? What are the alternative therapies? There is only one, Orthomolecular psychiatry. This is the only modern psychiatry which attempts to convert sick into normal people. The symptomatic control does not arise from a suppression of symptoms, but from their removal. When the symptoms are removed, so are most of the psychosocial consequences. Orthomolecular psychiatrists are the only group which incorporate into their program the best elements of psychosocial and toximolecular psychiatry. Psychosocial psychiatry aims at either changing the sick patient's behavior by verbal means or by forcing the community to accept unacceptable behavior. Impossible demands are made either of the patient or of the community. Toximolecular psychiatry makes only one demand of its patients—to take their tranquilizer regularly. But Orthomolecular psychiatry makes the reasonable demand that patients alter their life pattern to one which will optimize their chances for recovery. This is done by adopting optimum nutrition, by using supplements in most effective doses when indicated, by using tranquilizers at home or in hospital as temporary medication much as one uses simple analgesics to cover the rare headaches of some people—and by emphasizing physical fitness. Orthomolecular patients and Orthomolecular doctors work as a team for the betterment of the patient. Perhaps this is why schizophrenics recovered by Orthomolecular means have banded together to force a reluctant profession to be good, to improve their results. We are not aware of any concerted attempt by patients to demand more tranquilizers; on the contrary, many patient groups are actively hostile to the use of tranquilizers. The future of psychiatry is Orthomolecular.