

Cuts in budget series

Six articles from the new book EVERY OTHER BED by Mike Gorman,
prepared for newspaper serialization.

Approximate length, each article: 1500 words

- ✓ #1 - AN EPIDEMIC SWEEPS THE LAND
- ✓ #2 - A PITTANCE FOR THE HUMAN MIND
- ✓ #3 - WHY NOT MORE ORGANIC RESEARCH?
- ✓ #4 - THE NEW FRONTIER IN CHEMOTHERAPY
- ✓ #5 - SHORTAGES OF PSYCHIATRIC PERSONNEL
- ✓ #6 - CITIZEN ACTION AGAINST MENTAL ILLNESS

Second serialization rights available from:
The World Publishing Company
119 West 57th Street
New York 19, New York
Att: Mr. William Targ

#1 - AN EPIDEMIC SWEEPS THE LAND

Dr. Robert H. Felix, Director of the National Institute of Mental Health, was testifying in October, 1953, before a Congressional committee investigating the extent of the major illnesses in this country. He had a seventy-page statement filled with carefully documented statistics on the overwhelming cost of mental illness in terms of human suffering, tax dollars, loss in income and industrial productivity, juvenile delinquency, crime, alcoholism, dope addiction, and so on. The documentation was so far-ranging in its impact that it was almost impossible to digest: It was somewhat like conceiving a clear picture of the holocaust resulting from the dropping of a series of hydrogen bombs upon our major cities.

Sensing the difficulty, Dr. Felix tried to project the impact of mental illness in the simplest way.

"Mr. Chairman," he said, addressing Representative Charles A. Wolverton, "I should like to mention one other figure, and I hesitate because I do not want to discourage you....If the present birth rate remains constant, if the number of mentally ill who are hospitalized remains constant, and if the cost for hospitalizing the mentally ill remains constant, each year's crop of new babies will, because of the percentage of them who will go to mental hospitals, cost the taxpayers - this is just the taxpayer and not any private foundation - \$800,000,000 before they die."

There are close to six hundred hospitals for the mentally ill, and their total bed capacity is in excess of 700,000. This is approximately one-half of all the hospital beds, both public and private, in this country.

Because 97 per cent of these patients are in tax-supported hospitals, it costs the American people more than one billion dollars a year to care for them and to pay pensions to veterans with psychiatric disorders. And the cost is rising at the astronomic rate of \$100,000,000 a year, with no end in sight.

Every three minutes, the gates of a mental hospital open somewhere in the country to admit a victim of mental disease. Each year, there are from twelve to sixteen thousand more patients in our public mental hospitals than there were the year before.

Testifying before a Senate committee in 1954, Dr. Kenneth Appel, then the President of the American Psychiatric Association, had this to say:

"We are on a treadmill, and we are losing 16,000 a year - that is, there is a 16,000 increase over the previous year....And that means in ten years over \$1,200,000,000 for bed construction alone."

Dr. Appel then pointed out that thousands of the mentally ill could not be admitted to mental hospitals because there were no beds available. Senator Edward Thye, incredulous, queried Dr. Appel:

"Where are those mental cases then if there are not facilities and beds available? Where are they? They cannot be at home, if they get too violent."

"Some of them are in jails," said Dr. Appel, "some of them are lying on floors, and some of them are lying in triple-decker beds in state hospitals."

In the period between 1903 and 1950, the percentage of our population in long-term mental hospitals has doubled. Since 1939, the remarkable increase in our population has been outstripped, percentage-wise, by the increase of our mental hospital population.

The state governments, which have assumed the major responsibility for care of the mentally ill since Colonial days, have made heroic efforts these past few years to keep abreast of the increased flood of mental illness. In the past decade, state expenditures for mental health programs have increased more than 300 per cent, amounting to more than \$560,000,000 in 1953. In a number of states, these programs cost more than one-third of the total operating budget. [New York State, for example, spent \$160,000,000 last year for care of its mentally ill.

This was not only by far the largest departmental allocation in the budget, but was actually about 38 per cent of the entire State Purposes Budget of New York.]

Particularly since the close of World War II, state after state has floated bond issues to construct hospital beds to meet the mounting tide of admissions. Since 1945, an average of \$200,000,000 a year has been appropriated by state legislatures for this purpose. [A few years ago, New York appropriated \$200,000,000 to provide sixteen thousand new beds in forty buildings. But the epidemic of mental illness mounts, and in November, 1954, New York voters approved a bond issue for an additional \$350,000,000 of badly needed mental hospital construction. Will this bond issue be the last one? Not one mental health official I talked to in New York believed so.]

Late in 1953, the Council of State Governments summarized the building situation this way:

"Overcrowding runs as high as 50 per cent in many states and estimates indicate an immediate national shortage of approximately 300,000 beds, which computed at the rate of \$10,000 per bed, would call for immediate expenditure of three billion dollars for buildings alone.

"However, the problem does not cease even with expenditures of this magnitude. The number of people entering mental hospitals increases each year and one estimate for 1960 indicates a total mental hospital population of around 750,000. This figure would call for additional expenditures of \$250,000,000,000 for buildings, or a total of \$5,500,000,000. To this sum must be added the replacement of obsolescent structures."

If the future is dark at the state level, it is equally if not more dark at the Federal level. Back in 1945, when the Veterans' Administration launched its modern psychiatric program, the cost of caring for mentally ill veterans was about \$44,000,000. In the fiscal year 1954 it had gone up 500 per cent - to more than \$200,000,000 a year. In fiscal 1955, with pension and compensation costs included,

the psychiatrically disabled veteran cost the Federal taxpayer approximately \$632,000,000. [And this is exclusive of construction costs; the Veterans' Administration has spent several hundred million dollars for construction of new beds since the end of World War II.

Depressing? As the average age of the veteran increases, more and more hospital beds will be needed. Authorities estimate that the hospital and compensation bill for psychiatrically disabled veterans will exceed one billion dollars within a few years.]

Why are these figures so astronomical? Is it because we are pampering the mental patient, lavishing excess medical and social attention upon him?

In the Year of Our Lord 1955, in this democracy which is the apogee of civilized man, we were still spending less than \$3.00 a day to feed, clothe, and give "medical care" to our mentally ill. In 1953, in one of the great states of the Midwest, patients were being fed on a budget of 17 cents a day. By contrast, we spend more than \$20 a day for those suffering from physical ailments and bedded down in our general hospitals.

[In the year 1953, the sovereign Empire State of New York spent less per capita to care for its mentally ill than it did to feed and maintain criminals confined to its prisons.]

If we are spending only a few dollars a day to care for these unfortunates, how come total costs are in the billions? Because, penny wise and pound foolish, we spent a pittance and sow the ugly harvest - thousands upon thousands of suffering human beings wasting their lives away in custodial institutions. According to figures compiled by the National Institute of Mental Health, the average length of stay of a mental patient in a state institution is eight years. Figured at an approximate annual per capita cost of \$1,000, the more than 700,000 patients comprising the average daily mental hospital census in 1955 will cost the nation

more than \$5,500,000,000 (five and a half billion dollars) before they either die or are returned to society. If the maladies of these people could have been prevented or cured before the need for hospitalization, these people could have earned more than sixteen billions over the eight-year hospital span, and they would have paid Federal income taxes totaling several hundred million dollars on these earnings.

#2 - A PITTANCE FOR THE HUMAN MIND

The corrected figure for fiscal 1955 is \$10,786,253 spent by Federal, State, and national voluntary agencies for research on mental illness. This munificent sum is the approximate cost of a single B-52 designed to drop a hydrogen bomb. [The new program of the Department of Defense contemplates the construction of a fleet of these B-52's at a total cost in excess of \$4,000,000,000. There is always money for more B-52's, but when those of us who testify for more psychiatric research ask the Congress for an additional million or two, the screams of "economy" and "Where will we get the money?" can be heard over in Virginia.]

For a number of years, the psychiatric profession was anything but outspoken in attacking the inadequate sums spent on psychiatric research. In hearings which I have observed and reported on, both at the national and state level, psychiatrists invariably assumed the role of mendicants; they held their hands out in supplication and were appropriately rewarded with some splinters from the bottom of the barrel. However, they have recently taken courage from the example of a few outspoken laymen who come before the Congress each session and give their representatives a real working-over. Typical of these is a wealthy Alabama lumberman, Ben May, who comes up to Washington several times a year and gives luncheons for key congressmen. After the congressmen have consumed the thick steaks, Ben [gets off his haunches, and in a high-pitched voice lubricated] with deep conviction, takes them to task for the way they are spending his and the other taxpayers' money.

"If the Du Ponts were running this country," Ben told a group of Senators at one luncheon, "we would be spending ten times as much on research as we are spending now. Why? Because they learned that research pays off, that new discoveries create new wealth. Each year, the Du Ponts spend many times more on industrial research than we are spending on our most precious commodity - the human mind."

[At a luncheon in June of last year, Ben got really worked up. After pointing out that the American people spend as much on goldfish as Federal, state, and

private sources spend on psychiatric research, his voice hit a high, indignant contralto and his index finger waved accusingly as he chastised them.

"It is not a case of whether or not our country can afford to spend money for research into the mental diseases," he pointed out. "The proposition is better stated as follows: We are not rich enough, and we are not strong enough, to heedlessly accept this ever-continuing hemorrhage of lost manpower, lost military power, and lost money occasioned by mental illness, when research can show us how to stop a considerable part of the hemorrhage." □

Despite the eloquent pleas of Ben May and other dedicated laymen, psychiatric research is still getting the splinters at the bottom of the barrel. Last year, this country spent more than \$4,000,000,000 in both governmental and nongovernmental research. Industry alone spent more than \$1,000,000,000 searching for new products, and a number of industrial companies spent individually much more for research activities than the country spent collectively for psychiatric research.

Of late, much has been made of the fact that the Federal government is spending for scientific research and development twenty times what it spent before the outbreak of World War II. On the surface, a jump in research from \$100,000,000 in 1940 to \$2,000,000,000 in 1954 looks tremendously heartening. However, a breakdown of the over-all figure is a quick disillusioner. More than 85 per cent of the \$2,000,000,000 (about \$1,700,000,000) is allocated for military research - how to build better and more potent weapons of destruction. Way down near the bottom of the list is psychiatric research, which is allocated its "proper" share of our national government's expenditures - less than one four-hundredth of the total!

Dr. Lawrence S. Kubie, distinguished psychoanalyst and Clinical Professor of Psychiatry at Yale University School of Medicine, has done some extensive studying of the financing of psychiatric research.

On the basis of these laboriously accumulated findings, Kubie concludes:

"Psychiatric research in this country is indeed being starved to death, starved for lack of funds, starved for lack of space, and starved for lack of personnel adequate either in numbers or in maturity....Evidently, in spite of the enormous amount of talk about psychiatry in this country, there is an even greater failure on the part of the country to meet the challenge of its psychiatric needs. America is still only talking about mental hygiene. It is not acting....When we look at our figures, we need no longer feel surprise that, in spite of all the popular talk about psychiatry, not one of the psychiatric discoveries of the past fifty years was made in this country."

The 1954 session of the United States Congress provided an illuminating contrast in the kinds of support given various programs.

During the week of April 12, the House of Representatives opened debate on appropriations for the Department of Agriculture for 1955. The House Appropriations Subcommittee had allocated \$82,059,453 solely for agricultural research, \$3,324,730 more than the year before, but \$4,206,255 under what the Administration had asked for.

From the opening bell of the debate on the bill, the screams about the cut in agricultural research reverberated with a mighty fury from the well of the House. Dire predictions were made of the holocaust which would follow if the cut were allowed to stand. [Mr. Matthews of Florida cried out in a voice charged with emotion: "I believe historians will agree that one of the chief reasons for the decline of any civilization has been the ruin of the soil. Certainly Rome is a great example of what will happen when people turn away from the land and permit it to fall into ruin."]

For three days, the debate raged. Each speaker in turn pointed up the perils if research were to be reduced on the Citron black fly, the Mexican fruit fly, Hall's scale eradication (affecting two counties in California), grasshopper and mormon cricket control, cattle ticks, scabies, the Hessian fly, rust-resistant

grains, the golden nematode, commercial fertilizer, the corn borer, swine feeding, and so on.

[Mr. Horan of Washington delivered himself of a massive oration on the value of agricultural research:

"To produce enough for the 1975 population, our present flocks would have to average 241 eggs per hen. It is virtually impossible on the basis of present knowledge. The 241 average exceeds the best average records obtained in such an example of advanced application of available knowledge about breeding, feeding and care of poultry as the Connecticut egg-laying contest....Since a ceiling on the frontiers of knowledge about egg production has persisted, obviously the backlog of unused information that farmers can adopt has been considerably reduced."]

About a month later, hearings were held before a Senate Appropriations Subcommittee on the fiscal 1955 budget proposed for the National Institute of Mental Health. The Eisenhower Administration requested \$12,460,000 for all the activities of the Institute - research, training, clinical and community services, and the operation of intramural psychiatric research at the Institute's Clinical Center. The National Mental Health Committee appeared at the hearings to protest the grave inadequacy of the Administration sum. In its prepared testimony, it pointed out that the Administration did not allow one cent for construction of badly needed psychiatric research-laboratories, although there were carefully screened and validated requests totaling more than \$22,000,000 from hard-pressed medical schools, private hospitals, and research centers in all parts of the country.

Two months after the hearings, the National Mental Health Committee got the bad news. The House of Representatives had tacked an extra million on to the Administration request, and the Senate had added to this only \$687,500. The final figure - \$14,147,500 - was more than \$15,000,000 short of the minimum budget asked by the National Mental Health Committee. And not one cent for construction of research laboratories.

This \$14,147,500 was not all for research; only about \$6,000,000 went for that. Contrast this, if you will, with the action of the House of Representatives in adding more than \$14,000,000 for agricultural research, raising the total sum for that activity to more than \$92,000,000!

One important qualification is required at this point. While it is true that the United States Congress is far from lavish in its support of psychiatric research, its interest and support are exemplary when contrasted with the actions of most of the state legislatures. Until a couple of years ago, it was practically impossible to get a state legislative committee to hold a hearing on psychiatric research, much less appropriate any significant sums for it. As one state Senator remarked to me just a few years ago when I asked him to take an interest in psychiatric research:

"What kind of research can you do on a bunch of nuts? If they're crazy, what can you learn from them? The only thing they need is food and a place to sleep."

But research on hens? Yes, a thousand times yes! Our whole way of life depends on the highly productive hen!

#3 - WHY NOT MORE ORGANIC RESEARCH?

In no field of medicine are the resistances to basic physiological research more pronounced or more violent than in the relatively new specialty of psychiatry.

"The observation and classifications of mental disorders have been so exclusively psychological that we have not sincerely realized the fact that they illustrate the same pathological principles as other diseases, are produced in the same way, and must be investigated in the same spirit of positive research. Until this be done, I see no hope of improvement in our knowledge of them, and no use in multiplying books about them."

Dr. Henry Maudsley penned the above statement in 1870. Some of us who follow the literature can attest wearily to the fact that Dr. Maudsley's stricture has had little effect during the past eighty-five years in stemming the flow of psychiatric books running the gamut from outright metaphysics to downright mumbo jumbo. [The past decade has seen a cascade of volumes whose average length is inversely proportional to the amount of solid, scientific knowledge contained therein. On schizophrenia alone there have been hundreds of books and magazine articles, each of them invariably touting a "new" definition of schizophrenia - followed by a single case history which, of course, gives scientific validity to the definition.]

Fortunately, a number of the leaders of American psychiatry have, in recent years, initiated a manful effort to clamp down on the proliferating palaver and swing psychiatry back to its rightful niche in the discipline of medicine. At the 105th annual meeting of the American Psychiatry Association in 1949, Dr. William S. Terhune, one of the nation's leading psychiatrists, delivered a magnificent lecture entitled "Physiological Psychiatry."

"Although psychiatry now emphasizes the psychological interpretations of mental disease, we doctors know that these psychological phenomena occur only as a result of physical processes and basic bio-chemical reactions in the nervous system," Dr. Terhune told his colleagues. "Fifty years ago medicine had no explanation to offer as to the nature of these reactions, and medical research

contributed little to solve the mystery. Factually, there was no outstanding and practically no approach to the treatment of mental illness. In this situation, psychiatry accepted Freud's original and dynamic concepts of mental disease, together with his related methods of psychotherapy, as the foundation of modern psychiatry. But it would seem that the situation is changing and we have reached a point where we must attempt to correlate the findings of organic medicine with those of psychodynamics, psychopathology, and psychotherapy, and that if we wish to continue to dwell in the house of medical science we must study the organics of psychodynamics and study them in accordance with the principles of scientific medicine....Not until psychiatry can correlate the physiological and biochemical reactions of the nervous system with the apparent psychological results will psychiatry and psychodynamics stand on a firm scientific foundation, and only in this way can the true pathogenesis of mental disorders be understood."

The short history of psychiatry is replete with examples of stubborn refusals to recognize the physiological bases underlying many mental diseases. As Albert Q. Maisel has pointed out on a number of occasions, for generations paresis was dealt with in the medical and psychiatric literature as an insanity of purely psychological origin. Dr. Richard von Krafft-Ebing, one of psychiatry's greatest pioneers, wrote a study of paresis in 1877 in which he listed, as some of the possible causes of the disease, dissipation in alcohol, the smoking of too many Virginia cigars, excessive love-making, the rigors of making a living, and fright. As Maisel pointed out in a magazine article, "Is Mental Disease Mental?" Krafft-Ebing "never so much as mentioned the spirochete of syphilis as a possible cause."

For many years, despite increasing evidence that paresis was a physically induced infection, the resistance to a physiological explanation for it was fierce.

["Even as late as 1898," Maisel writes, "the famed German physician, Virchow, heatedly denied even the possibility of paresis' having a syphilitic origin."]

Pretty much the same story can be written of resistances in other mental diseases now amenable to physical treatment. The invention of the electroencephalograph and the development of many effective new drugs disclosed the essential neurological nature of epilepsy, putting an end to centuries of quasi-religious, metaphysical speculations about its causation. [More recently, the discovery of niacin as a specific cure for pellagra brought to a roaring halt scores of tedious tomes and brochures attributing the disease to everything from the unusually warm springtimes in the South to the general malaise which followed upon the rigors of the Civil War and the Reconstruction Era.]

This predisposition toward psychological and cultural explanations for the major mental maladies also flies in the face of impressive anthropological evidence to the contrary. In a series of lectures in 1953 to the New York Academy of Medicine, Dr. Ralph Linton, Sterling Professor of Anthropology at Yale, pointed out that neuroses, psychoses, and hysterias are common to all people and all cultures. The fact that these mental diseases are prevalent in every culture known to anthropology is a strong argument for a biochemical basis for these diseases.

[If upbringing were an important factor, Dr. Linton argued, some societies should be free of mental disease, since their free-and-easy ways of acculturating the young meet all the approved canons of modern psychiatry. In other societies, all the young go through rigid, striated periods of disciplined development, with no deviation from the tribal patterns. Yet these societies also produce their percentages of neurotics and psychotics. In sum, whatever the patterns, whatever the differences in psychological and cultural upbringing of the young, there is still a roughly comparable incidence of mental illness.]

Concurrent with the growth of this new understanding of the importance of physiology in mental illness there has developed a powerful clinical and philosophical concept of physical and mental illness which many believe to be the most important and far-reaching since the pioneer work of Sigmund Freud.

This is the concept of stress. The development of the stress theory is largely the work of the German-trained Dr. Hans Selye, who for the past twelve years has headed the Institute of Experimental Medicine and Surgery at the University of Montreal.

Selye's theory of disease holds that the body, under excessive external pressures of one sort or another, reacts chemically. The key roles in this chemical reaction are played by the pituitary and the adrenal glands. They provide the hormones which enable the body to fight off the disease. In his massive work, Stress, published in 1950, Dr. Selye describes this over-all marshaling of chemical fighters as the General Adaptation Syndrome (G-A-S). In a more recent treatment of the subject, in the January, 1954, issue of The Practitioner, Selye breaks this general adaptation down into three stages: (1) the alarm reaction, in which the body is alerted to the threat of disease or attack; (2) the stage of resistance, in which the glands produce excess hormones to ward off the attack; and (3) the stage of exhaustion, in which the defense mechanism breaks down, and stress produces any number and kind of diseases - hypertension, arthritis, ulcer, and so on.

The concept of stress is gaining increasing acceptance in the field of psychiatry. Each year, additional psychiatric researchers are producing detailed evidence indicating the basic physiological impairments underlying many mental illnesses. Furthermore, significant comparative studies on the handling of stress are being suggested. For example, A and B are both business executives with fairly comparable psychological stresses. Both use alcohol as a means of relieving strain. However, A cannot handle alcohol, and his life and that of his family have been smashed by it. His counterpart, B, consumes an equal amount of alcohol, but his functions are little impaired. Why the differences? From this fairly simple point of departure, research must extend into more complex areas. C and D have

seemingly comparable psychological loads, and both receive treatment for severe neuroses. C responds and is functioning again. D fails to respond and for the last six years has been in a mental hospital. Why the differences?

#4 - THE NEW FRONTIER IN CHEMOTHERAPY

In the entire history of the physiological attack upon mental illness, no development has been more significant than the recent introduction of new drugs in the treatment of a wide variety of mental illnesses.

The surface story of the remarkable achievements of these new drugs has been told in scores of technical and popular articles. Yet, beneath the surface, there is a deeper story which illustrates in a graphic manner the thesis of this entire book - that physiological treatments must still fight an uphill battle for recognition among the High Priests of Psychiatry. This writer has witnessed, during the past several years, a set of resistances to the new drugs running the scale from downright ignorance and bureaucratic apathy to vicious, bitter attacks upon every researcher reporting success in using them. And this resistance was not, and is not, confined to the psychoanalysts, many of whom were rushing to second-hand dealers with their sagging couches. In its initial phases, it included a number of tax-supported Federal and state mental health officials whose bounden duty it is to support any treatment which holds promise of alleviating the miseries of the mentally ill.

Rauwolfia serpentina, a snakeroot plant, has been used in India for centuries for a wide variety of illnesses - epilepsy, insomnia, diarrhea, headaches, fevers, mental illness, etc. In Bihar province, the powdered roots of the plant were used as a sleeping potion for infants. [(At the 1955 New York Academy of Sciences Symposium on Rauwolfia, a Texas pediatrician reported that the drug was the most effective agent known in the treatment of hyperactive and irritable infants with bizarre sleeping patterns.)]

Although known to European scientists as far back as the seventeenth century, it was relegated to an undeserved obscurity until a few decades ago. In 1931, two Indian chemists, Drs. Salimuzzaman Siddiqui and Rafat Hussain Siddiqui, obtained Rauwolfia roots from the bazaar at Patna and from them isolated five crystalline

alkaloids. They reported in the Journal of the Indian Chemical Society that the purified substances extracted from the root were particularly effective in disturbed types of mental illness complicated by acute insomnia.

In the same year, two Indian physicians, Drs. Gananath Sen and Kartrick Chandra Bose, published an account of their clinical work with two of the new alkaloids.

This report, written twenty-five years ago, could be given at any scientific gathering in 1956, and it would be hailed as an amazingly precise delineation of the treatment potential of the Rauwolfia alkaloids.

Yet Drs. Sen and Bose perceived that the defenders of the familiar and the timeworn would look askance at anything new, even though it offered great hope in the fight against the world-wide scourge of mental illness. They concluded their report with a plea that "medical men all over the world would work out the effect of this remedy both pharmacologically and clinically as it promises to be a valuable addition to the armamentarium of the physician." But their plea was in vain. Those medical men who read their report discovered it had something new to say, so they retreated to the safe confines of existing knowledge.

One young psychiatric researcher finally broke the ice. Dr. Nathan S. Kline, thirty-seven-year-old Director of Research at New York's massive Rockland State Hospital, got interested, he said later, because of "the tremendous paucity of pharmacological methods of treating mental disease."

Dr. Kline reported the results of his experiment in February, 1954, at a New York Academy of Sciences symposium devoted mainly to reports of the successes of Rauwolfia in physical illnesses. His paper was an extremely cautious one. [He reported that the drug had a generally calming effect on the ward; incidents of violence were reduced by a third, and much less restraint and seclusion were employed. But he leaned over backward in summarizing the results.]

"A great deal more investigation is needed to insure that the improvement noted was not the result of 'psychological' factors," he warned. ^I "Those cases reported on showed improvement, and the time elapsed has been too brief to know if there is not a rapid relapse unless other treatment is maintained. There is little doubt that in most people Rauwolfia brings about a change of psychic state. This in itself may be the 'effective' factor in conjunction with psychotherapy."]

What could be more cautious? Impressed with Dr. Kline's paper, and deeply convinced he had opened the door to a vast new chemical attack upon mental illness, I circulated his paper among some of my psychiatric and medical-writer friends. With a few notable exceptions, the responses were astonishing. I was solemnly warned that I had succumbed to "sensationalism," that Dr. Kline had plunged far beyond the pale of "responsible scientific behavior," that it was "barbaric" to suggest that a mere drug could alleviate anxieties, and so on. A number of the psychiatrists got up on their moral high horses and cried out that we were arousing "false hopes" in the mentally ill and their families, and that psychiatry had been through this business before with a lot of other therapies. As politely as possible, I replied that all we wanted was a fair trial for the new drug. [Why didn't they try it before burning Kline at the stake?] Furthermore, what was wrong with giving the mentally ill some hope, in whatever degree? What hope did the current state of knowledge in psychiatry offer them? To those in the high income brackets, five years of psychoanalysis at a cost of \$10,000 or more, so they could learn to live with their symptoms. To those of average income, years of misery and neglect in a public mental institution. [What the hell is so wrong, I asked, with trying anything that offers some hope of breaking through the gloom, doom, and despair in which American psychiatry is wallowing? In my angrier moments, I suggested that the psychiatrists themselves take the drug to calm their ever-present anxieties and insecurities about anything which was a little off the beaten, weary track.]

While Reserpine was daily demonstrating - even to the most die-hard skeptics - its right to a pre-eminent place in the armamentarium of both the hospital and the private psychiatrist, an even more remarkable drug was having trouble gaining entry into this country.

Chlorpromazine was first discovered by basic scientists in the Rhone-Poulenc Laboratories in France early in 1951. They were actually hunting for a new kind of antihistamine which wouldn't induce so much drowsiness in patients. One day they mixed up a chemical compound - R.P. 4560 - which acted strangely on a group of test animals. Given the new compound in large amounts, the animals quickly went to sleep. But the drug differed from the ordinary run of sedatives in that it did not "slug" the dogs - they could be easily aroused for feeding or other purposes.

In May, 1953, there came to my desk a translation of an article by Drs. J. Sigwald and D. Bouttier which had appeared in a recent issue of the French Annals of Medicine. It was a superb description of French experience with the drug since 1951. [In addition to a summary of the literature, the authors detailed, with Gallic meticulousness, the case histories of sixty-six patients on whom the drugs had been used. They reported the successes and they reported the failures.

The French authors concluded their twenty-nine-page paper with a critique of the metabolic action of the drug which has not been excelled in any of the papers that have appeared in America and Canada since then, even though such brilliant investigators as Drs. Heinz Lehmann, Harold Himwich, Frank Ayd, Jr., Vernon Kinross-Wright, and others had the advantage of much subsequent experience before publishing their findings on the possible mode of action of the drug.]

As in the instance of Dr. Nathan Kline's pioneer paper on Reserpine, I called the Sigwald-Bouttier paper to the attention of a number of prominent psychiatrists, including two state mental health commissioners and a few state hospital superintendents. They patted me kindly in the area of the midbrain, generally regarded as the seat of the emotions, and warned me about French scientists - "so sensational,

so dramatic." I guess they were right. After all, Louis Pasteur was so "sensational" he shocked the French Academy of Sciences. And, of course, there were the Curies.

However, there were a number of adventurous spirits still alive and kicking in this great land of ours. Like Dr. Kline, they were pretty fed up with the feeble armamentarium of the latter-day psychiatrist. When the Smith, Kline, and French Laboratories imported a shipment of Chlorpromazine, they jumped at the opportunity of testing it in clinical trials.

The new era wasn't ushered in without a scrap. On the second night of the 1955 convention of the American Psychiatric Association, a panel discussion was held on the new drugs. It opened with the reports of top Canadian and American researchers on their clinical experiences with the drugs. One was struck with the youthfulness of the scientists on the panel and with both the precision and enthusiasm of their papers. [The Canadians - Drs. Heinz Lehmann and Gorman Hanrahan - were wondrously meticulous in their descriptions of both the clinical and metabolic effects of the drugs, and their American confreres - Drs. Vernon Kinross-Wright, Nathan Kline, Veronica Pennington, Harold Himwich, et al. - were equal to the technical pace set.]

Then the meeting was thrown open for questions, and the jam-packed room seethed with excitement. After about fifteen minutes of polite sparring, the lines were sharply drawn. The Elder Statesmen began peppering the Young Turks with "questions" - usually in the form of statements raising doubts about the efficacy of the new drugs.

The first line of attack pictured the drugs as "merely palliative." This one didn't get very far. Dr. Lehmann agreed that the drugs were largely palliative, but what drugs weren't? Was insulin not palliative? Was digitalis not palliative? Was cortisone not palliative? [Dr. Lehmann then challenged his critics to name any medical procedure, other than the excision of a diseased organ, which was not, in

essence, palliative. How could one speak in terms of "absolute cure" of a mental illness? Conversely, what was wrong with palliation or alleviation of anxieties which were crippling thousands of patients?

The Old Guard then fell back upon a line of attack similar to that used by the Russian tourist who, having all the usual criticisms of American democracy cut out from under him, cried out: "But what about the lynchings in the South?" So now the Elder Statesmen cried out: "But what about the side-effects?"

The panelists answered this one with a wealth of documentation. They pointed out that the drugs were remarkably low in toxicity. Furthermore, the major side-effects were easily manageable. In the small percentage of cases where the side-effects were severe, cessation of administration of the drugs cleared the condition. They cited an elaborate study of the side-effects of Chlorpromazine done over a fourteen-month period upon twelve hundred patients at the University of Texas Medical Branch at Galveston. Dr. Irvin M. Cohen, who headed the study, reported that Chlorpromazine is a remarkably safe drug and that even the most severe complications occurring in a small percentage of patients cleared completely when the drug was withdrawn. Several state hospital superintendents joined the fray at this point. They agreed that both drugs had some bothersome side-effects; however, they admitted that the complications worried the doctors more than the patients. The patients realized the enormous benefits they were gaining from the drugs, so their attitude was: "Damn the side-effects - Full Speed Ahead!"

As the drug panel staggered on toward midnight, the metabolic malfunctionings of the Elder Statesmen took their toll in an increasing verbal irascibility. At one point, the revered superintendent of a New England hospital got to his feet and, with the typical Yankee aversion to the new and challenging, cried out in warning: "You had better use these new drugs while they work." This was a fairly ungracious remark, and he got his comeuppance from a number of indignant state hospital men who documented the transformation the drugs had brought to their hospitals.

The revolution could not be stemmed, and it was in evidence everywhere at the 1955 convention. For the first time since I had started covering national psychiatric conventions a decade ago, I felt that I was at an honest-to-goodness medical meeting. [There were a number of excellent physiological exhibits. The drug houses had their medical men and their detail men out in full force. The scientific sessions were liberally sprinkled with neurologists, chemists, anatomists, physiologists, and even a couple of very brainy mathematicians.]

#5 - SHORTAGES OF PSYCHIATRIC PERSONNEL

On March 10, 1955, Dr. Daniel Blain, Medical Director of the American Psychiatric Association, and I testified before the House Interstate Commerce Committee in favor of a Congressional resolution for a three-year nationwide study and re-evaluation of the human and economic problems of mental illness. In the preamble to the resolution, buried deep among all the "whereases," there was this strong statement which provoked an hour-long battery of Congressional questions:

"Whereas, there seems to be a discouraging lag between the discovery of new knowledge and skills in treating mental illness and their widespread application, as is evidenced by the fact that only about one-third of newly admitted mental patients are on the average discharged from State hospitals in the course of the year, whereas in a few outstanding institutions the recovery rate is 75 per centum or more."

What was common and somewhat bitter knowledge to Dr. Blain and myself seemed astounding to the congressmen. Here we were talking about the remarkable new drugs, Chlorpromazine and Reserpine, and yet we were forced to admit that their application was being severely limited because of shortages of psychiatric personnel in the state hospital systems.

Over the past several decades, the American Psychiatric Association has established and published a set of minimum standards on the number of personnel needed to care for mental patients. For example, it recommends one physician for every 30 patients who are acutely ill, and one physician for every 150 patients on the "continued treatment services," a euphemism for the chronics who are relegated to the back wards. Applying these standards on a national basis, the 1953 study by the Council of State Governments found that the average ratio of physicians to patients in state mental hospitals was one to 228. However, as the Council study pointed out, many of these physicians had no formal psychiatric training. In fact, the actual ratio of psychiatrists to patients in state mental hospitals was one to 311. [In documenting its figures, the Council report states:

"In 1951, there were slightly over 7,000 psychiatrists in the entire United States, of whom about one-fifth held full-time positions in state mental hospitals. The number of psychiatrists - 1,578 - and other physicians - 578 - in state hospital service obviously is extremely small considering the almost half-million patients now dependent upon their services....

"In 1951, only ten state mental hospitals in the country were able to report a complement of physicians adequate to provide the standards of care recommended by the American Psychiatric Association. Most of these ten were special psychiatric institutes, involved primarily in research. Their combined patient population does not number more than a few hundred....Although the average ratio of patients to psychiatrists in state institutions was 311 to one, about one-fourth of all state hospitals still had fewer than one psychiatrist for every 500 patients. Such a spread permits a psychiatrist - even if he neglected all other duties - to provide only fifteen minutes of treatment a month to each patient in his care."

In analyzing the major causes underlying the inability of the state mental hospital system to attract psychiatrists to its ranks, the Council report ripped through to the nub of the issue in these words:

"Through the country, not more than 450 psychiatrists complete the three-year residency annually. With the current need for psychiatrists estimated at between 10,000 and 20,000, it is evident that the states must seek ways of competing with private practice for the services of existing psychiatrists, and at the same time seek other means of providing for improved patient treatment."

[The situation is no better with relation to auxiliary psychiatric workers. Although these professionals - psychologists, psychiatric social workers, nurses - are in far greater supply than psychiatrists, only a relatively small percentage work in state mental hospitals.]

In a lead editorial in the March 5, 1955, issue of The Journal of The American Medical Association, Dr. Winfred Overholser, Superintendent of St. Elizabeths

Hospital in Washington, D.C., and a former President of the American Psychiatric Association, took off the gloves and told some plain truths. He pointed out that of 2,482 psychiatric residencies offered by state, Federal, and private hospitals in 1954, only 1,632, or 70 per cent, were filled. He expressed particular concern at the high number of vacancies among first-year appointments; while 649 first-year appointments were made, there were 336 for which there were no takers.

Deploring the drift of the psychiatric profession away from the state mental hospital, Dr. Overholser cited his own St. Elizabeths as an example of a large public mental hospital - it houses 7,000 patients - where this isolation had not occurred.

"Formerly, the public mental hospital was practically the only place in which psychiatrists were trained, or at least in which they learned basic psychiatry. Indeed, it is the opinion of many that even today it is in the state hospital that basic psychiatry is to be learned."

Dr. Overholser concluded by pointing a knowing finger at the medical profession for its ostrich-in-the-sand attitude toward state mental hospitals.

"Physicians - psychiatrists and non-psychiatrists alike - have an obligation to the profession and their fellow citizens to aid such public mental hospitals as may be found in their vicinity, to supplement the efforts of the staffs of those hospitals in developing their training facilities. If the state hospitals are found wanting in the fulfillment of their professional training function, the medical profession - of which the members of the staff of the state hospitals are a part - should rightfully share in some measure the responsibility for that delinquency."

Private psychiatry has been very slow to assume that responsibility, and its diffidence has had some mighty unhappy consequences. In the past few years, the people have become aroused about the need for better state mental hospitals. Since the end of World War II, they have supported bond issues aggregating close to two

billion dollars for the improvement of physical facilities. Even more important, they have supported a number of successful efforts to take the mental hospitals out of politics and place them in separate departments administered by medical men.

Heeding the insistent cry of the people, a number of Governors have shaken off the shackles of the past and sought out top psychiatrists to head up their state programs. In only a few cases have they succeeded. For the most part, the leading psychiatrists have turned down challenging opportunities to spearhead revolutionary state mental health programs. I know, and bitterly, whereof I speak. With the election of a new group of Governors in November, 1954, the National Mental Health Committee was asked to lend its effort in obtaining top psychiatrists to head programs in several of the key states in the country.

The procedure was a disheartening one. We would comb through the same handful of people we thought might be interested. Even though the salaries offered were high - in a number of cases \$20,000 to \$25,000, usually far more than the Governor's salary - we were invariably turned down.

The Governors were deeply disturbed and puzzled by this reluctance. In a private conversation, a Governor of one of the large Eastern states expressed his deep disappointment in these words:

"The people of my state have given more than their share of sweat, blood and tears to pressure the state legislature into setting up a new, adequately financed mental health program. But when I turn to the psychiatric profession to find just one person to head up this revolution, I am met with one excuse after another. There are several hundred psychiatrists in private practice in this state. Is it really true that not one of them is willing to answer this great challenge? To me, this is a betrayal of the wishes of the electorate."

This is no exaggeration. In state after state, dynamic new programs are still in the blueprint stage because of the wall between private psychiatry and the state mental hospital system. Many of the very psychiatrists who are the most caustic

and condescending in their public discussions of the deficiencies of public psychiatry are the ones who cannot spare even one hour of their busy week for teaching in a state mental hospital.]

This reluctance has sown a tragic harvest. Because so few psychiatrists are available for public work, bidding for them is all out of proportion to their worth. One state bids \$5,000 more a year and pirates a psychiatrist from another state. Everyone is quite surprised, because they know the psychiatrist in question didn't exactly set the world on fire in his native state. But he fulfills the prime requisites - he breathes fairly regularly, he is available, and the Governor has grown weary of interviewing psychiatrists who, unlike Jenny, can't say "yes."

I am weary of attending psychiatric conventions which have become recruiting depots for mental health officials offering fantastic prices for proven mediocrities. The whole procedure is unhealthy, and it is building up powerful additional resentments against psychiatry. [Another Governor expressed it to me this way:

"My state mental health commissioner makes far more than I do, and far more than any other cabinet officer. In addition, he is paid for some teaching he does, and I understand he handles a couple of patients. He is not a very popular person in the cabinet. In fact, my state health officer, a competent physician with years of experience, is champing at the bit. I am afraid I am going to lose him."

In many of these situations, the day of reckoning is close at hand. The Governors and the people can't wait forever.]

#6 - CITIZEN ACTION AGAINST MENTAL ILLNESS

Citizen action in the field of mental health has a proud early tradition to live up to. One magnificent citizen, Dorothea Lynde Dix, was responsible for the establishment or expansion of more than thirty mental hospitals in the United States and abroad during the middle decades of the nineteenth century. However, in the later years of her life, Miss Dix saw many of "her" institutions sink to the level of snake pits because of medical Toryism and public apathy. As Albert Deutsch has noted, it was beyond the capacity of any individual at that time to create a national citizens' organization to enforce better care for the mentally ill.

In the first decade of the twentieth century, Clifford Beers, a former mental patient, wrote A Mind That Found Itself. In the book, Beers outlined his plans for the creation of a strong national citizens' organization to work for better care and treatment of the mentally ill. On February 19, 1909, the National Committee for Mental Hygiene was born at a meeting in New York City.

Serving as its secretary for three decades, Beers proved an indispensable spark plug. Under him and under two excellent medical directors - Dr. Thomas W. Salmon, who served from 1915 to 1922, and Dr. Frankwood E. Williams, who succeeded Dr. Salmon and served until 1932 - the old NCMH sponsored numerous state and local surveys of mental hospital conditions, played a vital role in the birth of the new profession of psychiatric social work, pioneered in fostering public understanding of the need for psychiatric classification and treatment of prisoners, and made its greatest contribution in leading the fight for more preventive services, particularly child guidance clinics.

Beers died in 1943, and the history of the citizens' mental health movement since then has been a pretty sorry one. World War II brought an enormously heightened interest in psychiatry, and in state after state major reform movements blazed into action. All across the land citizens were begging for technical help in building state mental health societies, but the reply of the National Committee was a feeble and inept one.

Sensing that the inactivity of the National Committee was creating a series of vacuums which had to be filled if we were to go forward, a group of conscientious objectors who had done magnificent work in state mental hospitals formed the National Mental Health Foundation in the immediate postwar years. Abandoning the ostrichlike tactics of the National Committee, they published a series of harrowing eye-witness reports on conditions in state mental institutions.

The American Psychiatric Association also moved in to fill the breach. At its 1946 annual convention, it adopted a courageous report by its Committee on Psychiatric Standards and Policies urging the entire Association membership, "including state mental hospital superintendents, to call forcefully to the attention of the public and their legislators all of the shortcomings and deficiencies in state hospitals, and to demand the assistance and backing necessary to maintain mental hospitals in fact as well as in name." In furtherance of these and other aims, leaders of the APA formed the American Psychiatric Foundation to raise funds for the inspection of mental hospitals and the promotion of research.

In 1950, the three organizations amalgamated into the present National Association for Mental Health. However, the dreary bureaucrats of the old National Committee for Mental Hygiene continued to hold the balance of power. The young firebrands of the National Mental Health Foundation, many of whom had taken staff positions with the new organization, soon found themselves gasping for air amid the encircling smog of the hayloft at 1790 Broadway. Most of them left for greener and more lively pastures.

Paradoxically, the amalgamated organization is more conservative and much more timid than the Old National Committee for Mental Hygiene. Although the old committee lacked the foresight and imagination to build a strong national citizens' movement, it did play a key role in the Congressional testimony which led to passage of the National Mental Health Act of 1946. Major credit for this move must go to Dr. George S. Stevenson, then medical director of the committee.

It is really most difficult to portray the negativism of the "new" National Association for Mental Health. The name implies that it takes a stand for mental health. As to mental illness, it has never taken a clear-cut position one way or the other. Like Calvin Coolidge's minister, who was against him, I believe the NAMH is against both sin and mental illness, but I have little evidence to go on.

At the important Federal level, the Association has constantly refused to face up to its responsibilities. It seems terrified that the Congress will bite it. The annual battle for increased appropriations for the National Institute for Mental Health is a fierce one, and even a small effort by the NAMH over the past few years would have undoubtedly resulted in an expansion of desperately needed funds for research, training, and clinical work.

Its leaders hold to the view that visible efforts for increased federal moneys might be construed as "lobbying." Well, what's wrong with some good, well-placed lobbying? More than a century ago, Dorothea Lynde Dix spent six years lobbying the Federal Congress for a land-grant program to aid mental patients whom she described as "wards of the nation." Sixty years later, Clifford Beers described one of the major purposes of the newly formed National Committee for Mental Hygiene in these words: "To enlist the aid of the Federal Government so far as may seem desirable."

At the state level, it's the same sad story. Although most of the state mental health associations are now affiliated with the National Association, they get little NAMH support at the legislative level. I have pounded scores of state legislative corridors these past few years, and I have yet to bump into a representative of the NAMH. The major traffic hazard on these jaunts is Dr. Dan Blain of the American Psychiatric Association, who holds the track record for whizzing down Capitol corridors.

Many of these state societies are a refreshing contrast to the NAMH. They have clear-cut eight- and ten-point programs, and they know how to work a state capitol from stem to stern. If the national leaders really want to learn how to convert

citizen heat into legislative light, they might start by visiting Ohio, Pennsylvania and Florida. In each of these states, state and local mental health societies have blueprinted dynamic new programs and then stormed the state capitols to get them enacted.

It is shameful that these state and local societies are not tightly welded into a national movement with a unified, forward-looking program. Sam Whitman, who has done a magnificent job over a decade as Executive Director of the Cleveland Mental Hygiene Association, put it beautifully in a recent conversation. "We are isolated pockets of influence," he told me. "When are we going to tie the spur tracks together and run the big railroad right?"

However, the time of decision is near at hand. In my recent travels around the country, I sensed a growing restiveness among state and local mental health people. Unless the national organization pulls itself up by the boot straps and moves strongly into the public arena in the next year or two, it will sink out of sight.

For a decade now, many of us in the mental health field have spent many a long evening discussing the possibility of a new national mental health organization. We have gotten to the edge of the water on several occasions, but we have always been dissuaded by those who have asked "more time" for the present organization to assert itself. Next year will be better, they argue, but next year never is. When we bring this home, they serve up their trump card: How would it look to have two national organizations competing for public support?

I cannot understand this line of reasoning. Isn't our fundamental concern the welfare of the millions of mentally ill in this country? How long must they wait, when every waiting day is a sickly, dragging one? What do we say to the families of the mentally sick - that we refuse to do what we know to be right because we are afraid of the mincing displeasure of a few bureaucrats and a few professionals? Isn't it our main job to create a powerful citizens' mental health movement, existing organization or no? When we battled at the state level for a new day for the

mentally ill, we tore down many a time-honored citadel and chopped off scores of bureaucratic heads. And many a state mental health society was born out of the needs of the time, replacing older societies which were fiddling with pamphlets while the citizenry burned with indignation. If the present national organization is unable to do the job for which it was created, then in all honesty it should dissolve itself. If it refuses to do so, then those of us who want action have an inescapable duty to create a new democratic vehicle through which the good citizens of this great land can give expression to their deep and burning interest in this problem.

All arguments pale in the light of a major necessity - we must create a powerful national voice for those who are unable to speak for themselves. We have temporized long enough, and we have forgiveness enough to ask of our brothers who are tormented in mind. And if we falter anywhere along the way, we have only to look to the life of little, frail Miss Dix for guidance, she who during her forty-five-year battle for the mentally ill bowed to no one, not even the President of the United States.