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Then and Now

By FELIX POST

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Dear Editor,

You kindly asked me to write a short autobiographical paper 'Then and Now' summarizing at the time of my retirement the passing psychiatric scene as I had experienced it for almost forty years. Let me explain why I am unable to write such a paper.

You will recall that your suggestion was made after one of the weekly meetings on current topics organized by the junior medical staff of our hospital. At that particular meeting one of the registrars gave an excellent survey of the literature concerning the pros and cons of ECT. I was asked to contribute to the discussion, but felt moved to precede my remarks with a personal confession to the effect that without ECT I would not have lasted out in psychiatry, as I would not have been able to tolerate the sadness and hopelessness of most mental illnesses before the introduction of convulsive therapy. The impact made on me by the mentally ill and their treatment has continued to be highly emotionally coloured, and though I have tried to cultivate a scientific outlook I would find it difficult to compile a cool and detached paper, in which the effect on my work of the development of psychiatry over the last forty years would be adequately documented.

My very first impressions of psychiatry in 1938 were emotionally disturbing. After some perfunctory lectures at 'Bart's', those of us who found the time and energy to venture out that far attended case demonstrations in one of the Bethlem wards, where patients were paraded like animals in the circus. As a schoolboy I had read some psychological literature and especially Kretschmer's *Bodybuild and Character*, but these experiences as a medical student almost succeeded in extinguishing this spark of interest. It was rekindled when as a house physician at the Hammersmith Hospital it was one of my duties to look after a Dr A. J. Lewis, accompanying him during his ward consultations. I thus received demonstrations of psychiatric interviews from a master. Much of what was offered, including the master's illegible scribble, was incomprehensible to me, but later emerged a crisp typewritten psychiatric report of great clarity and practical value. Here was a challenge to emulate the intellectual feat of creating order from chaos!

When a year or so later I found myself at a loose end I applied to Dr A. J. Lewis and obtained a house physician's post in the wartime Mill Hill branch of the Maudsley Hospital. Here I experienced the fascinations of the hypnotic sessions and of pentothal interviews with service neurotics, and witnessed the first beginnings of Maxwell Jones' approach to neurotic problems, which were initially group-didactic rather than group-psychotherapeutic. I also met my first depressives. Indeed, my very first experience at Mill Hill was having to assist with the setting of a humerus fractured during a cardiazol fit. The far less distressing electro-convulsive therapy, which was demonstrated to us a few months later at Bexley Hospital, was only a shade less unpleasant to witness and to administer; but it did work.

Soon I found myself transferred to the Royal Edinburgh Hospital (for Nervous and Mental Disorders, to give it its full name); and working at first in the department for ladies and gentle-

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men of unsound mind rather than for rate-aided patients, I became increasingly upset with the dehumanization wrought through chronic mental illness in these people. There were whole wards filled with posturing schizophrenics, and one floor at least, called the Refractory Ward, where one only did one's daily round covered by a posse of male attendants even though some patients were in strong suits or restrained in their beds. Even more distressing were the chronic melancholics. I finally persuaded Professor D. K. Henderson to allow me to use the newly acquired ECT machine. He was very reluctant at first because, like me, he disliked deliberately producing epileptic fits. However, once again, after a few treatments, the miracle happened, especially impressive in patients who for years had had to be tube-fed twice daily. Unfortunately there was also the old colonel who became persistently hypomanic, exchanging his sober civvy suit for a kilt and marching up and down playing his bagpipes. But by then I had fled from the chronic psychotics to the more hopeful precincts of the hospital at Jordanburn. Here, and in the Army, I remained largely protected from severe and persistent mental illness.

To a similar extent I was afforded this shielding after my appointment at the Maudsley and later at the Bethlem Royal Hospital. Only voluntary patients were admitted. Schizophrenics who had suffered recent breakdowns were treated with insulin comas. Those who did not respond, chronic depressives and dements, were banished speedily to the outer darkness of the area mental hospital. Some did surprisingly well there, but many seen in relation to follow-up research confirmed one's sense of failure. Occasionally leucotomy prevented transfer to a long-stay hospital, but it was only after the introduction of major tranquillizing and anti-depressant drugs that such transfers on account of complete treatment failure became rare.

I am well aware that there are scientifically validated studies which show that improvements in the outcome of severe mental disorders had become more striking and more frequent long before the introduction of modern somatic treatments. But in terms of my personal experience of tremendous relief and increasing hopefulness, the turning point occurred with the introduction of ECT, and even more so following the arrival of anti-psychotic drugs.

Sometime before that stage had been reached I entered a clinical field which was widely regarded as particularly distressing and depressing: the psychiatry of late life. Back in Edinburgh Professor Henderson had said to me at the end of a ward round: 'Post, look at all these old people here, why don't you write 'em up?'—and so that's what I have been doing ever since!

The Edinburgh study 'inspired' in this way had produced a pretty dismal picture. Dementing patients mostly died soon after admission, and it seemed likely that beds would be blocked to an increasing extent by what we then regarded as involutional and senile melancholics. These were even then clearly recognized as being very different from dements, but likely to live longer without making good remissions. Later on, of course, it turned out that the newly introduced physical and drug treatments were particularly effective in the affective illness of the old and ageing. While requiring continuous psychiatric attention over many years, they ceased to need long-term in-patient care. Paranoid illnesses of old people were shown to respond to major tranquillizing drugs even better than the schizophrenic conditions of younger subjects.

In the case of patients of all ages this change to a general sense of optimism was equally marked in relation to less ill psychiatric out-patients. There is in retrospect a strong impression that their numbers had increased over the years and that one began to see many more atypical and less severely ill patients, who more often might have asked their family doctors for referral to psychiatrists. Many could be shown to be suffering from masked or mild affective disorders. In the past one had to carry psychiatric out-patients over many months or years with bromides and very wearying supportive interviews: 'I.S.Q.' was the usual last or only entry in the progress notes. Now most of these patients could be significantly improved and much benefited by psycho-pharmacological preparations, whose therapeutic level can now be monitored. In the case of illnesses related to

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more long-standing emotional problems there was no longer (at any rate in the out-patient department of my hospital) the need to struggle on one's own: facilities for expert planned and supervised group as well as individual psychotherapy had begun to become available to an increasing extent. However, many patients with well-established phobic or obsessional symptoms, in whose case anti-depressant and simple behavioural approaches had failed, continued to prove an intractable problem. In adult psychiatry, psychologists used to be backroom workers, who were asked occasionally to produce some cognitive or projective test results, and to whom an occasional hopelessly complicated patient would be turned over for 'psychological treatment'. Over the last twenty years increasing numbers of clinical psychologists have emerged as professional colleagues, investigating patients in general, devising management, and treating those with phobic and obsessional illnesses with increasingly impressive results.

The first psychiatric social workers I met were formidable middle-aged dames who had taken some part-time training, and who often worked as voluntary ladies-bountiful. The professionally trained worker appeared after the war, and apart from assistance in the resettlement of patients the new psychiatric social worker developed expertise in assessing and guiding patients' situations within the family during treatment and following discharge from hospital. With the introduction of modern treatments it became relatively easy to remove symptoms, and thus interest shifted to the assessment of long-term outcome and adjustment, both by clinicians and by social workers. Once the outcome in response to treatment of the major psychiatric disorders had been described, the research interest of psychiatrists moved to international and transcultural follow-up studies, and that of social workers to the influence on outcome of family relationships. It is not surprising that the experiences gained have led many social workers to claim much more strongly a therapeutic role.

It would be tedious to enumerate in detail all the other paramedical workers like nurses and occupational therapists whose increasingly sophisticated standards of working have transformed psychiatric work. Instead, I would like to reminisce on the changing teaching ward round. Senior doctor, junior doctor and senior nurse used to move through dormitories and day rooms from patient to patient. It was important to have seen everybody and to have spoken to everybody; often there was also a *sotto voce* case discussion a few steps away from the patient. In my earliest professional lifetime this changed into a more secluded affair: patient, senior doctor and junior doctor in an interview room, occasionally and briefly joined by a senior nurse. Obviously the rounds of the more important consultants and teachers attracted more junior doctors, but the transformation of teaching round into ward conference has occurred only gradually over the last one third of my professional life. There is really no need nowadays to ask the patient's permission to appear at a ward conference. He can be truthfully told that with the exception of an occasional visitor all the people present have been or are likely to be involved in the management of his problems. Everyone present may speak to the patient and take part in the discussion after the patient has left. In this way the patient is evaluated along many different dimensions and all decisions are agreed. When there is conflict of methods of approach the sequence in which opposing treatment policies are to be applied is agreed. Foolish or potentially dangerous plans can always be shown up as such during discussion, and I cannot recall a single occasion when I have had to use the consultant's veto. Time rarely allows an identical approach in the out-patient department, but fewer people are involved with the patient and mutual consultation can occur seriatim.

My personal experience of psychiatry has thus changed profoundly. I started as a lone doctor, bewildered and frightened by the multitude of apparently hopelessly ill and deteriorating patients. I end as member of a professional team and with the certainty of being able to help to an important extent almost all my patients, not just through my own efforts, but by enlisting on their behalf other workers. Obviously, and especially in my own geriatric specialty, there are still hopeless

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dements and a few equally distressing persistently ill depressives. Frequently things go wrong, at least initially, on account of one's own or one's fellow workers' shortcomings. The community care of persistent schizophrenics is deficient, but one no longer sees posturing or refractory patients in ward after ward.

Justified criticisms can be made of most innovations in psychiatric practice. We do not know scientifically that ECT works, there have not been any double-blind trials. We do not know how it works. Even worse, psychosurgery has not been scientifically investigated at all. There is no proof that psychopharmacological preparations have affected the long-term outcome of mental illness. The efficacy of psychotherapy has never been demonstrated. It is often pointed out that social workers spend too much time talking at meetings and have unrealistic ideas, and that nobody makes a clear decision any longer. There is no 'real' leadership. We are concerned over the consultant's responsibility. It must be agreed that the psychiatric world is far from the best of all possible worlds, but in the last forty years at any rate it has been moving rapidly in the right direction.

Yours sincerely,

Felix Post

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