THE THIRD PSYCHIATRIC REVOLUTION — REALLY?
A Consideration of Principles and Practices in Community Psychiatry

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Current developments in mental health theory and practice are being billed as “the third psychiatric revolution” — community psychiatry. In such a climate of high expectations, it is important to critically re-examine concepts, definitions, and practices; and to avoid self-deluding convictions of newness and omnipotence. Community psychiatry has evolved out of three major research and theoretical sources — biological, psychodynamic, and social — and is characterized by only new combinations of antecedent styles of practice. Differences in emphasis and in deployment of professional resources, rather than radical departures in practices or marked expansion in knowledge or skills, characterize recent trends.

The first sentence on the first page of the most recent book on community psychiatry states, “Community psychiatry might well be considered a third major revolution in the history of psychiatry.” (Bellak, 1964).

The late President of the United States, John F. Kennedy, on February 5, 1963, informed the Congress of the United States:

I propose a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill. This approach relies primarily upon the new knowledge and the new drugs acquired and developed in recent years which make it possible for most of the mentally ill to be successfully and quickly treated in their communities and returned to a useful place in society.

These breakthroughs have rendered obsolete the traditional methods of treatment which imposed upon the mentally ill a social quarantine, a prolonged or permanent confinement in huge, unhappy mental hospitals where they are out of sight and forgotten. . . . We need a new type of health facility, one which will return mental health care to the mainstream of American medicine, and at the same time upgrade mental health services. (Kennedy, 1963, pp 3-4).

In commenting upon the President’s message, the author of another recent book on community and preventive psychiatry stated:

The promise contained in the President’s message and in the legislation to secure its implementation is that, for the first time, an organized program is being prepared that will seek to reduce the problem radically at the community level; and that this nationwide program will be directed, controlled, and partly funded by the Federal government and implemented by state and local government and private organizations. This should provide a framework within which psychiatrists and their colleagues will have the possibility of meaningfully introducing a community and preventive focus into their work. They will in fact be called on to do so by the leaders of our nation. (Caplan, 1964).

In the same vein, Bellak (1964) has proclaimed, “Community psychiatry is designed to guarantee and safeguard, to a degree previously undreamed of, a basic human right — the privilege of mental health.”

In this climate of exalted hope, excitement, and hunger for innovation, community psychiatry has stepped to the center of our professional stage. The spotlight is on it, the audience is knowledgeable and critical, and the curtain has gone up. As the preceding quotes demonstrate, the score and lyrics have already been written, rehearsal time has been brief, and the star player is relatively inexperienced. Will the play be a success?

WHAT IS COMMUNITY PSYCHIATRY?

Ironically, there is doubt as to whether all the major proponents and practitioners of community psychiatry agree upon a definition. One that has been proposed is: “Community psychiatry can best be defined as a resolve to view the individual’s psychiatric problems within the frame of reference of the community, and vice versa.” (Bellak, 1964).

Melvin Sabshin, Professor of Psychiatry at the University of Illinois College of Medicine, suggested at a recent seminar on community psychiatry at the University of Wisconsin a definition — the approximation of which follows — :

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Community psychiatry is subsumed under the generic heading of social psychiatry. Social psychiatry may be defined as an emergent theoretical and research field in which social and psychiatric variables are used to study, and eventually to remedy, situations related to mental illness. Community psychiatry, as a species of social psychiatry, is concerned more with application; but should not be strictly pragmatic or service-oriented if high quality personnel are to be attracted and retained. Community psychiatry involves the utilization of techniques, methods, and theories of social psychiatry and the other behavioral sciences in meeting the needs of a defined population over a significant time span, and in turn feeding knowledge back and affecting the development of social psychiatric theory.

Gerald Caplan (1964) has written

"... the term "preventive psychiatry" refers to the body of professional knowledge both theoretical and practical, which may be utilized to plan and carry out programs for reducing (1) the incidence of mental disorders of all types in a community ("primary prevention"), (2) the duration of a significant number of those disorders which do occur ("secondary prevention") and (3) the impairment which may result from those disorders ("tertiary prevention").

Preventive psychiatry, social psychiatry, community psychiatry, community mental health — are they only different words describing the same field of theory and practice, or do they refer to different aspects of theory and practice? There does seem to be general agreement that we are in a transitional stage in the development of psychiatric science and art, and reasonable agreement exists concerning the antecedent phases and events that led up to it. Most authors indicate that the end of the 18th century marked the beginning of developments to improve the lot of the mentally ill. The work of Pinel, Joly, and Tuke is representative of this phase. Most authors cite Freud as signaling the beginning of a second phase in the development of psychiatric science and art, and reasonable agreement exists concerning the antecedent phases and events that led up to it. Most authors indicate that the end of the 18th century marked the beginning of developments to improve the lot of the mentally ill. The work of Pinel, Joly, and Tuke is representative of this phase. Most authors cite Freud as signaling the beginning of a second phase in the development of psychiatry, one which emphasized the elaboration of psychogenetic theories and practices.

And most authors agree that something is happening again to redirect energies and reshape American psychiatry today. Both the heritages of humane concern for the welfare of the patient, and the psychoanalytic emphasis upon intra-psychic life, genetic past, and psychodynamic causation contribute heavily to the current scene. The influence of behavioral scientists — other than psychiatrists, clinical psychologists, and psychiatric social workers — such as Hollingshead and Redlich (1958), and Stanton and Schwartz (1954) is also of major importance. Likewise, attempts to extend public health theory and practice to include mental and emotional illness are relevant. The work of Lemkau (1955) is typical.

As John F. Kennedy’s message indicated, the advances in psychopharmacology deserve equal credit for some of the developments in psychiatry today. It is paradoxical that this branch of our science, which has turned away from interpersonal and intrapersonal explanations of disorder to look for physical causes and cures, should be primarily responsible for triggering a reorganization of psychiatric practice — a reorganization which includes an increased emphasis on interpersonal and social factors in the cause and treatment of emotional illness.

Increased public awareness, through the activities of the National Association for Mental Health and such individual psychiatric leaders as Karl and Will Menninger, also has given impetus to the current realignment in psychiatric practice. Our experiences in World War II served to alert not only the public but also key opinion-setters and decision-makers about the prevalence and seriousness of mental disorder in the United States. It also introduced segments of the psychiatric community to concepts of immediate, brief, battlefield psychiatry.

OTHER FACTORS

There may, however, be other factors at work which have not been mentioned so often, and perhaps should be touched upon here.

For example, the accelerating increase in absolute numbers of mental health practitioners cannot help but affect the locus and style of psychiatric practice. While the numbers of persons recognizing the need for and desiring individual psychiatric treatment has undoubtedly grown as rapidly or more rapidly than the number of practitioners able to supply this treatment, the number of individuals able to afford such treatment, and residing in major urban centers of popu-