behavior is not infrequent and the drugs are largely illicit. Such cases have relatively little contact with medical practice except when they are brought for treatment of their dependence and its complications.

When I entered medicine in 1932, bromide over-use accounted for many admissions to psychiatric hospitals and barbiturate complications were already a common place in medical practice. Medical attitudes toward all drugs therapy was one of profound skepticism and the few drugs which had some influence in mental and emotional conditions were seen as relatively harmless, but ineffective if used in small doses and dangerously toxic in larger amounts. Then came an era of spectacular advance in pharmacology and with the appearance of the miracle drugs skepticism gave way to an unbounded optimism which in retrospect is easy to understand. I saw the new tranquilizers initiate a revolutionary advance in our own hospitals and in mental hospitals all over the world. A long-term relentless increase of population was suddenly halted and reversed, the atmosphere in the wards became quiet and relaxed, restraints disappeared, and the open mental hospital ward finally became a reality for all psychiatric institutions. Some 60% or more of mental hospital cases were soon on drug therapy and this is the situation currently. In the meantime, penicillin had made paresis a thing of the past; the anticonvulsants phenobarbtial and diphenylhydantoin were preventing the psychiatric complications of epilepsy so well that special hospitals for this condition began to disappear while other new drugs lightened the burden of mental patients by spectacular control of many infections including tuberculosis which in our patients had produced a mortality 19 times as high as it did in the general population. Under such conditions the general public and the medical profession was ready to believe almost any claim made for a new drug and correspondingly the demand for relief of symptoms was increased.

Additional drugs appeared for the treatment of major mental disorder and such substances came to be classed as major tranquilizers. Later a special group of anti-depressants were added and neither these nor the major tranquilizers created problems of abuse by patients although they caused many other types of adverse reactions.

Very early in this period a new class of drugs later known as minor tranquilizers was introduced particularly for out-patient work. From the very start it was obvious that the spectacular results of mental hospital practice were not to be repeated with these new drugs in out-patients with less serious forms of disorder. It was also clear that these drugs belonged to the general class of barbiturate-like drugs although their effect on anxiety was more pronounced in relation to the degree of somnolence produced. They also shared another characteristic of the barbiturates; if used in high doses for prolonged periods they were capable of creating an addiction. While not as attractive to "street addicts" or non-medical drug abusers they still posed a problem in medical drug dependence and together with the stimulant drugs which are also used in out-patient practices they have become a matter of serious concern, although other forms of toxicity are relatively mild in most cases.

As early as 1957, many questions were being raised about the effects of all the new psychiatric drugs; but their use continued to increase rapidly. Accounts in the public press and promotion to the medical profession undoubtedly played a large role in the rapidity with which the minor tranquilizers were widely accepted, but it would be a serious mistake to assume that this was solely and simply an interest induced in an otherwise healthy population. The effects of these drugs fell short of expectations and there was much concern as to how well they met the needs of the patients but there could be no doubt about the existence of a vast need. This was only too apparent in simple clinical experience and repeated scientific surveys showed that between 15% and 25% of the total adult population suffer from a disabling degree of psychiatric disorder at any given time although such disability is only partial in most cases. The situation was further complicated by the fact that in ordinary medical practice major physical illness is regularly accompanied by anxieties and tensions which must be controlled if they are not to prolong the condition or even threaten life itself.

As a result the use of all these drugs was not limited to well defined indications but came to be applied in the widest variety of conditions often combined with other drugs and the treatment of many emotional disorders resolved itself into nothing more than a long term self-administration of these drugs. That this represents inadequate medical practice is beyond argument and it has been opposed by organized medicine and academic groups everywhere, but it was not