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Admissions in Dromokaition Psychiatric Hospital of Athens: 1901–1985

D. Ploumpidis,¹ S. Gatzonis,² G. Akontidis,³ K. Politis³

¹1st Department of Psychiatry, Medical School, ²Department of Neurosurgery, Medical School, University of Athens, Athens, ³Department of Statistics & Insurance Science, University of Piraeus, Piraeus, Greece

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Established in 1887, Dromokaition is the first psychiatric hospital in Athens. Information available for the profile of patients admitted to psychiatric hospitals in Greece, especially for the first half of the 20th century, is very scarce. The aim of the study is to point out the characteristics of patients admitted and the influence of European dominant views on mental diseases in Greek psychiatry. Data for 3014 patients (20% of total number) for the period 1901-1985 were obtained via systematic sampling. The data available were: entry date, gender, age, occupation, brief medical history. The 56 diagnoses have been classified into 9 groups. We have used descriptive statistical methods, two-way associations, odds ratios and cluster analysis, permitting to point out the main characteristics of admitted patients. The preponderance of male admissions in the first decades of the 20th century has been progressively balanced out. About a half of total admissions were schizophrenia-related. The percentage of male patients was significantly higher in personality disorders; for major affective disorders and neuroses the opposite occurs. Progressive paralysis of the insane, a frequent diagnosis in the first decades of the 20th century becomes rare thereafter. In conclusion social changes, major historical events and the evolution of views on psychiatric care have left their traces in the profile of patients admitted.

Key words: Dromokaition Psychiatric Hospital of Athens, schizophrenia, progressive paralysis of the insane, gender, occupation

Introduction

The modern Greek state was established in 1828, following the Greek war of independence from the Ottoman empire. It is obvious that pressing practical needs as well as clinical, epidemiological and public health problems had to be tackled.¹

The practice of committing patients to psychiatric institutions appeared in the island of Corfu in 1838, when the *Mental Asylum of Corfu* was established by the British Governor of Ionian islands. Internment became gradually the main strategy for patients with severe and “noisy” symptoms, but a full century

elapsed before this trend was sufficiently generalized, following the creation of a network of public and private institutions. Only in the 1970's this practice became a controversial issue.

Dromokaition psychiatric hospital opened its doors in 1887. It was the sole psychiatric institution for the capital until 1904. The French psychiatrist L. Lunier² contributed to the conception and realization of the hospital, focusing on the care of patients in separate wards following hospital fees, diagnosis and clinical course.³ It has been, over time, one of the main gates of entry for therapeutic and organizational methods of modern psychiatry into Greece.

We expect that the study of admissions in a large psychiatric hospital for 85 years will reveal both the profile of patients admitted and the influence of European psychiatry in our country, since only a small number of studies is available.⁴

Material and method

The data used were obtained via systematic sampling from the total hospital admissions between 1901 and 1985. In particular, we selected patients

with a last digit 2 or 7 in their admission serial number. 1901 was chosen as the start date due to a more systematic keeping of admission records. The end year of the study was determined by the introduction of the National Health Service in Greece and the emergence of new developments in psychiatry.⁵

For hospital entrants, the following data were available: date of entry, gender, age, occupation, brief medical history (usually simply the diagnosis at entry), while in some cases doctors included treatment methods, or even writings from the patients themselves. Information about the follow-up patient status is very sparse and sporadic.

Criteria for grouping diagnoses

The 56 different diagnoses found in the hospital records are shown in table 1. These were classified into 9 categories (disease groups, including a group of unclassified, table 2). For the grouping, we have used mainly the criteria by WHO (1975)⁶ concerning the period under investigation and ICD 10, (table 2, column 4), cross-examined by relevant psychiatric manuals and published studies.⁷⁻¹⁰

Table 1. Main diagnoses/gender.

Diagnosis	Number			(%)	
	M	F	Total	M	F
1. Primitive/precocious dementia	98	42	140	70	30
3. Paranoid psychosis	205	104	309	66.3	33.7
4. Schizophrenia	562	353	915	61.4	38.6
23. Progressive paralysis of the insane	166	13	179	92.7	7.3
13. Manic-depressive disorder	42	67	109	38.5	61.5
39. Toxic mania	57	3	60	95	5
25. Elderly psychosis	14	40	54	25.9	74.1
5. Psychosis due to degeneration	42	11	53	79.2	20.8
26. Alcoholic psychosis	71	6	77	92.2	7.8
35. Neuroses	30	38	68	44.1	55.9
29. Organic encephalopathy	25	19	44	56.8	43.2
6. Periodic psychosis	56	27	83	67.5	32.5
45. Psychosis on a ground of mental retardation	35	24	59	59.3	40.7
15. Melancholy of involution	19	36	55	34.5	65.5
16. Melancholy	59	70	129	45.7	54.3
8. Intermittent psychosis	25	32	57	43.9	56.1
47. Paranoia	24	19	43	55.8	44.2
49. Psychoneurosis	20	17	37	54.1	45.9
52. Psychomotor agitation	23	10	33	69.7	30.3
53. Mental confusion	27	15	42	64.3	35.7
55&56. Unclear or no diagnosis	49	36	85	57.6	42.4

Table 2. Table of initial diagnoses/groups of diseases.

<i>Code Nr</i>	<i>Initial registration of diagnoses</i>	<i>Number of patients and (%)</i>	<i>Groups of diseases</i>	<i>Number of patients and (%)</i>
1.	Primitive dementia	140 (4.1)	1. Schizophrenia and related diseases F20, F20.0, F20.2, F20.3, F22, F23.0, F22.9, F23.0, F23.1, F25	1531 (50.8%)
2.	Paranoid psychosis	309 (10.5)		
3.	Acute schizophrenic syndrome	10 (0.3)		
4.	Schizophrenia	915 (30.4)		
5.	Psychosis due to degeneration	53 (1.8)		
6.	Periodic psychosis	83 (2.8)		
7.	Psychomotor agitation	5 (0.2)		
8.	Intermittent psychosis	57 (1.9)		
9.	Catatonic agitation	3 (0.1)		
10.	Schizoaffective psychosis	15 (0.5)		
11.	Schizophreniform reaction	2 (0.1)		
12.	Melancholic psychosis	31 (1.0)	2. Major affective disorders F30, F30.0, F31, F32.2, F32.3, F33, F39, F06.32	352 (11.7%)
13.	Manic depressive disorder	109 (3.6)		
14.	Maniac agitation	23 (0.8)		
15.	Involution melancholy	55 (1.8)		
16.	Melancholy	129 (4.3)		
17.	Hypomanic syndrome	4 (0.1)		
18.	Manic syndrome	1 (0.0)		
19.	Neurologic syndrome	23 (0.8)	3. Neurologic diseases G30–G32	24 (0.8%)
20.	Manic depressive disorder	1 (0.0)		
21.	Secondary dementia	24 (0.8)	4. Organic syndromes F00–F05 and F07–F09, F10, F19	471 (15.6%)
22.	Involution dementia	23 (0.8)		
23.	Progressive paralysis of the insane	179 (5.9)		
24.	Psychosis due to toxics	15 (0.4)		
25.	Senile psychosis	54 (1.8)		
26.	Alcoholic insanity	77 (2.6)		
27.	Acute infections of the brain	5 (0.2)		
28.	Early senile psychosis	24 (0.8)		
29.	Organic encephalopathy	44 (1.5)		
30.	Post infectious psychosis	2 (0.1)		
31.	Epileptic psychosis	39 (1.3)		
32.	Psychomotor epilepsy	1 (0.0)		
33.	Post partum psychosis	3 (0.1)		
34.	Epilepsia with psychotic symptoms	3 (0.1)		
35.	Neuroses	68 (2.3)	5. Neuroses F44–F48	73 (2.4%)
36.	Hystero epileptiforme attack	2 (0.1)		
37.	Hysteria	3 (0.1)		
38.	Neurasthenia (1 man, 1941)	1 (0.0)		
39.	Toxic mania	60 (2.0)	6. Personality disorders F10–F19, F60.9	97 (3.2%)
40.	Alcoholism	15 (0.5)		
41.	Cerebral-spinal alcoholic infection	1 (0.0)		
42.	Psychopathic personality	19 (0.6)		
43.	Psychopathic state	2 (0.1)		
44.	Idiotism	7 (0.2)	7. Mental retardation F70–79	94 (3.1%)
45.	Psychosis on the ground of idiotism	59 (2.0)		
46.	Mental retardation	27 (0.9)		
47.	Paranoia	43 (1.4)	8. Psychotic syndromes of not origin F22, F28, F29	193 (6.4%)
48.	Selective insanity	1 (0.0)		
49.	Psychoneurosis	37 (1.2)		
50.	Hysterical psychosis	2 (0.1)		
51.	Psychosis (not specified)	35 (1.2)		
52.	Psychomotor agitation	33 (1.1)		
53.	Mental confusion	42 (1.4)		
54.	Simulation of disease	4 (0.1)	9. Not classified diseases or states F09, F59, F89	179 (5.9%)
55.	Mental disease not classified	31 (1.0)		
56.	No diagnosis	54 (1.8)		

Insanity due to degeneration, primitive or precocious dementia and schizophrenia have been grouped in the group of schizophrenia. In the group of diseases of organic origin we have included the progressive paralysis of the insane – frequent in early 20th century, toxic psychosis, epileptic psychosis, senile psychosis and also post partum psychosis (only three admissions till 1973). Mental confusion has been grouped in psychotic syndromes of non organic origin (42 admissions, 1.2%), as clinical pictures referred to primitive dementia, schizophrenia, or Chaslin's primitive mental confusion (1895). Among them, a significant number of housewives and military, especially in times of war, 1920–1922, 1940–1941, 1946–1947 and ages from 20 to 30 years.

Periodic psychosis and intermittent psychosis have been grouped in schizophrenia. Clinical pictures did not refer to affective disorders. Also the timing of these diagnoses, till 1953, refers to discussions on primitive dementia and schizophrenia.¹¹ For a small number of patients, less than 10% of the total (approx. 300), the diagnosis was unclear and based on the overall clinical picture, following necessarily current nosological criteria, for example 41 out of 915 diagnoses of schizophrenia registered before 1920.

Results

The sample represents approximately 20% (3014 patients) of the total number of admissions to the hospital, both for the total duration of the study and for each year separately. The sample consisted of 1847 (61.3%) males and 1145 (38%) females; no gender was recorded for 22 patients.

The total number of entrants through time

Figure 1 presents the time series plot for the number of entries to the hospital for each year in our period of study.

For the analysis, we have divided the sample into three sub-periods:

A. 1901–1920: Between 1887 and 1904, Dromokaition was the only psychiatric establishment in Athens. We note the high incidence of progressive paralysis of the insane, indicative of the syphilis epidemic in that period. A large number of diagnoses refers to the theories on the insanity due to degeneration of the 19th century.¹² The high incidence of primitive/precocious dementia refers both to German and French nosography admitted in Greece.

B. 1921–1953: The large population increase of Athens and the settlement of a large number of refugees from Asia Minor, following the Greek-Turkish war of 1922^{13–15} resulted in a substantial rise both in admissions but also in the total number of hospitalized and chronically treated patients. In this period, we also find the catastrophic consequences of World War II.

C. 1954–1985: Further increase in the population of Athens. Introduction of modern psychopharmacology and social psychiatry and consequent attempts to reform the hospital.

Most medical expenses in period C were paid by the state, instead of patients paying hospital fees themselves in periods A and B.

Two prominent changes observed when one moves from one period to the next are:

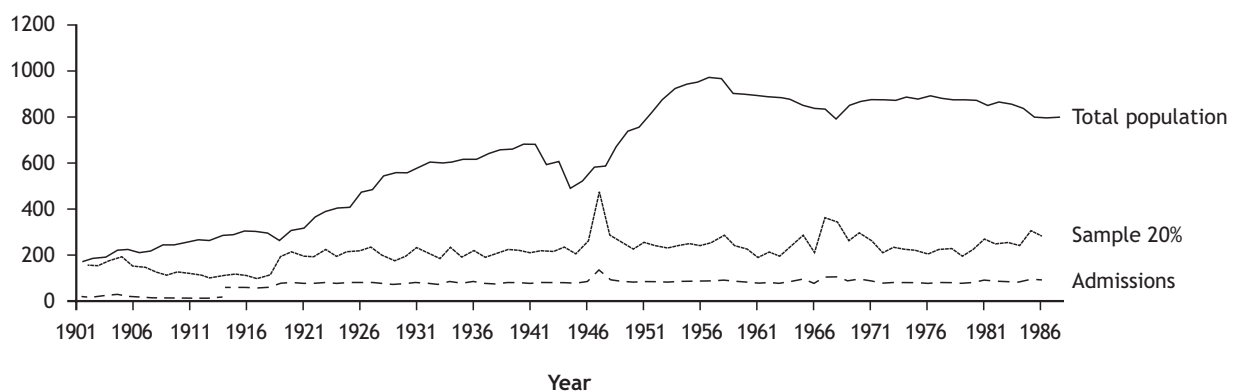


Figure 1. Count data: Total population and admissions (total number and the sample of 20%).

- i. The progressive increase of the female percentage of entrants. Women represent 21.7% of the new entries at the hospital between 1901–1920, 34.5% between 1921–1953 and they reach almost half of the total entries in the last period (1954–1985).
- ii. The emergence of schizophrenia as the predominant diagnosis for entrants to the hospital. While schizophrenia-related diseases (Disease group I) represent around a half of new entries through the period of study, the incidence of schizophrenia increases rapidly in period B and represents more than 50% after 1953 (table 2). In contrast, primitive/precocious dementia is the second most frequent type of diagnosis (following progressive paralysis of the insane) in the first 20 years of the 20th century, and is totally absent after 1953.

Other variables – descriptive analysis

Figure 2 presents the age distribution of the hospital entrants, both for each gender separately and in total; here age has been grouped in 5-year intervals. It is apparent that women tend to enter the hospital at an older age, although the difference is not statistically significant.ⁱ

ⁱ Using the exact age for each entrant in our sample, the descriptive statistics we obtained are:

- For men: mean=35.58, median=33, standard deviation= 12.73
- For women: mean=40.14, median=38, standard deviation= 14.96.

However, the Kolmogorov-Smirnov two-sample test (using the exact age for each person) showed no evidence of difference between the two genders, in terms of their age distribution (p -value<10⁻³).

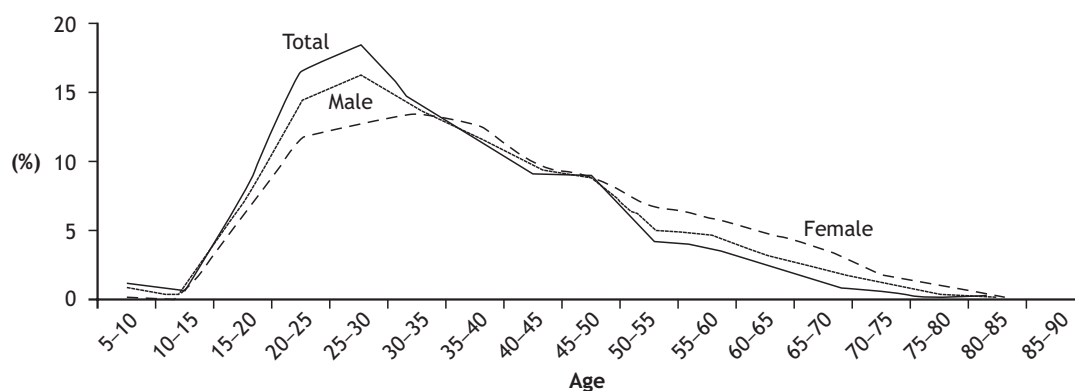


Figure 2. Age distribution of new entrants.

For the remainder of the study, age was divided into 7 groups: *Age unknown*: 22 (0.7%), 0–20 (years): 229 (7.6%), 21–30: 928 (30.8%), 31–40: 768 (25.5%), 41–50: 553 (18.3%), 51–60: 296 (9.8%), 61+: 218 (7.2%). The age distribution of the entrants in period A and B is very similar, the main remarkable feature seems to be the increased proportion of older entrants (age 51+) during the period C, 12.5% and 10.4%, for the ages 51–60 and 61+.

The *occupations* of the entrants have been coded into 12 groups: 01: Self employed (3.6%), 02: Employees (6.5%), 03: Merchants (6.0%), 04: Workers in manufactures/services, (5.4%), 05: Workers of primary sector of economy (agriculture etc) (11.2%), 06: Individual trades and small businesses (5.3%), 07: Unqualified workers (8.2%), 08: Students (5.2%), 09: Housekeeping (31.7%), 10: Military (4.0%), 11: Unemployed (9.3%), 12: Other (3.1%). Apart from housekeeping (82%), women represent more than 10% only in Groups 01, 04, 11 and 12.

Table 1 shows the absolute and relative frequencies, per gender, for the main diseases diagnosed in the period under examination. As expected, gender seems to be very strongly associated with the occupation of hospital entrants. While the profile of occupations by the men seems to cover the full spectrum of occupations for the period under investigation, 82% of women declared themselves as housewives. This means that the effect of gender on the type of disease diagnosed, discussed above, and could be confounded with the association between occupation and disease. Moreover, the high percentage of women with affective disorders and neuroses is anticipated.¹⁶

Statistical analysis

Table 2 shows the set of 56 diagnoses at entry and the 9 disease groups we formed (columns 2 and 4 respectively). The third and fifth column of the table present the counts and percentages for each disease group. The absolute and relative frequencies for the main diagnoses are given in table 3.

Two-way associations and odds ratios

We have looked at two-way associations between diagnosis and each of the three other categorical variables in our sample (gender, age group and occupation). All three two-way associations were highly significant.ⁱⁱ We have constructed a table of odds

ⁱⁱ In the disease group – gender association, the observed value of Pearson’s chi-square was 110.14 on 8 df, while in the disease group – age group association, the value of the chi-square statistic was 513.99 on 40 df. On both occasions, this gave a p-value less than 10⁻⁸, thus providing overwhelming evidence for lack of independence. In the disease group-occupation cross-tabulation, due to the large number of categories in each variable, we had several zero counts and a few very small ones.

ratios, in order to investigate further the association between the main initial diagnoses and the gender of the patient (table 4).ⁱⁱⁱ

Since no merging of classes seemed legitimate, we used Monte-Carlo simulation to obtain the p-value of the test for independence. The observed p-value was less than 10⁻⁵.

ⁱⁱⁱ The values in the table present the odds for a patient to belong to one of two disease groups, as opposed to the other, if the patient is a male, divided by the same odds for a female. Thus, for instance we see that the odds for a male to be diagnosed with a personality disorder, rather than emotional psychosis, or neurosis, is about 7 times higher than the corresponding odds for a female. A value "x" in the table indicates a non-significant departure from 1 at the 5% significance level. The main reason that Disease group 6 (personality disorders) is male-dominated seems to be the effect of the common diagnosis of "toxic mania" in the 1930's. In particular, among the 97 entrants in our sample falling in the Disease Group 6, 60 were diagnosed as "toxic maniac" (Disease Code 39), 60% of which entered the hospital between 1929–1939 – admissions related to the use of substances accelerated by the Greek-Turkish war of 1922 and the settlement in Greece of more than a million refugees coming from Asia Minor.

Table 3. Absolute and relative frequencies of main diagnoses per entry period.

Diagnosis	Frequency			Rel. frequency (%)		
	1901–1920	1921–1953	1954–1985	1901–1920	1921–1953	1954–1985
1. Primitive dementia	47	93	0	11.5	7.4	0.0
2. Paranoid psychosis	25	117	167	6.1	9.3	12.4
4. Schizophrenia	41	345	529	10.1	27.5	39.2
8. Progressive paralysis of the insane	66	103	10	16.2	8.2	0.7
9. Manic-depressive disorder	2	57	50	0.5	4.5	3.7
31. Melancholia	33	41	55	8.1	3.3	4.1

Table 4. Odds ratios of disease groups per gender.

Disease → group	Women								
	1	2	3	4	5	6	7	8	9
Men ↓									
1	–	2.2	x	0.6	2.2	0.3	x	x	x
2	0.4	–	x	0.3	x	0.1	0.4	0.6	0.3
3	x	x	–	0.4	x	0.1	x	x	x
4	1.5	3.4	2.6	–	3.3	0.4	x	2.1	x
5	0.4	x	x	0.3	–	0.1	0.4	x	0.3
6	3.2	7.2	5.5	2.1	6.9	–	3.1	4.3	2.5
7	x	2.3	x	x	2.2	0.3	–	x	x
8	x	1.6	x	0.4	x	0.2	x	–	x
9	x	2.8	x	x	2.8	0.4	x	x	–

* The "x" means that the value does not differ significantly from 1% at 5% significance level

Cluster A	Cluster B	Cluster C
<ul style="list-style-type: none"> • Entered during period A (1901–1920) • All disease groups except schizophrenia • Age groups 0–20 and 41–50 • All occupations except housewives 	<ul style="list-style-type: none"> • Entered during period C (1954–1985) • Female entrants • Housewives • Age groups 51–60 and 60+ 	<ul style="list-style-type: none"> • Entered during period B (1921–1953) • Male entrants • Disease group schizophrenia • Age groups 21–30 and 31–40

Cluster analysis

We have also performed cluster analysis, in order to look at similarities both between items (subjects) and between variables. In the former case, we classify the observations into groups (clusters) using an appropriate similarity measure and trying to form clusters that are as homogeneous (with respect to that measure) as possible. In the latter, we form the clusters looking at similarities between the different levels of our categorical variables.

The cluster analysis among items classified the entrants into two groups. Gender seems to be the overriding issue in the two-step analysis. The two clusters had 1839 and 1136 observations respectively; the first cluster consists of males only, while in the second we find all 1088 females and 48 males. There seems also to be a clear-cut discrimination for the occupation groups, but this seems to be a consequence of the strong occupation – gender association mentioned earlier. Age groups and disease groups, on the other, do not seem to be well discriminated between clusters, as each of the two clusters possesses a fair proportion of the above groups at each level. One notable exception is Disease group 6: 87% of entrants that were diagnosed in that group fell into the cluster dominated by the male entrants, which confirms the evidence from the odds ratios table.

The second type of clustering we conducted is between variables. A hierarchical approach gave three clusters, and each of three time periods fell into a separate cluster. The profile of entrants into each of the three clusters is given diagrammatically below.^{iv}

^{iv} Looking at the forming of clusters at a higher level, we find that the first of these three groups (the one on the left in the table above), which is the largest group and contains a fair mix of entrants of both sexes, can be further sub-divided into five sub-clusters as follows:

Discussion

The recording of patient diagnoses refers clearly to clinical syndromes that have been proposed by the French and German psychiatry during the period under consideration. The influence of British and American psychiatry emerged only after the Second World War and culminated in the 1970's.

Around World War II we note: a relatively constant rate of admissions from 1941 to 1945, a large increase in 1946 (450 admissions) and then a relatively small fluctuation in admission numbers. The number of hospitalized patients shows a significant reduction in 1942–1943 and then increases steadily. These figures may obscure a large number of deaths from hunger in cities between 1941 and 1944,¹⁷ and in psychiatric institutions of Athens.^{18,19}

The fact that in Dromokaiteio, except for the years 1942–1943, there is no major reduction in the total number of patients on care, suggests that those who died from hunger were replaced by new entries. The liberation of Athens in October 1944, was followed by great social upheaval (battles in December 1944), while the whole country was

- Disease groups 3 (neurological syndromes), 5 (neurosis), 6 (personality disorders), 7 (mental retardation), and 9 (unclassified); this sub-group contains persons whose occupation code is mostly 1 (self employed) or 10 (military).
- Disease group 8 (other non-organic causes). Occupation codes 02, 03, 04, 06 and 08. Age groups 0–20 and 60+.
- A small sub-group which contains almost exclusively people with occupation code 07 (unqualified workers).
- This sub-group consists mostly of patients in Disease group 2 (major affective disorders), with age group 51–60 and occupation code 05 (workers of the primary sector of economy).
- Patients in this sub-group were mostly in Disease group 4 (organic psycho-syndromes), nearly all of them entered the hospital during the first period (1901–1920) and the typical age group in this class is 41–50.

sliding towards a civil war (1946–1949). These social events rendered the presence of mentally ill in families problematic. In addition two new wings in Dromokaition, opened in 1946, contributed to the increase in admissions.³

The statistical analysis of the main parameters of admissions during World War II (age, sex, diagnosis) did not show statistical differences from the entire second period (1921–1953).

We note that after 1985, following our period of study, the reduction in the number of admissions was accelerated as a result of the application of a reform in public psychiatric services.²⁰

Regarding the age of the entrants, the preponderance of the socially active groups of ages is expected. A special comment is needed for the younger entrants, aged until 20. Until 1958 there was no child psychiatric hospital in Greece. In this age group we find a child aged 7 (idiotism) and a 10-year old child (psychosis due to degeneration) in 1918. For ages 10–15 years, we have 12 cases – of schizophrenia and epileptic psychosis, while in the main subgroup of 15–20 years of age we have 229 cases; the principal diagnoses are: schizophrenia: 35%, primitive/precocious dementia: 9% and epileptic psychosis 6.1%.

The large majority of female entrants are housewives, and although women tend to enter the hospital at an older age compared with men, the difference is not statistically significant. The main disease groups dominated by women are Groups 2 (major affective disorders) and 5 (neuroses). The gradual rise in the proportion of female admissions is likely to be linked with the increasing abandonment of the traditional characteristics of the Greek society, before we observe a substantial increase in the active employment of women.^v

Significant changes observed:

- The increase in admissions of women observed in the 1930's, continued steadily thereafter

^v Official statistics show that women in employment represent 12.7% of the active population in 1907, 16.7% in 1928 and 21.7% in 1951, the percentage increasing steadily.²¹ The very large number of women who declared housewives (82% in our sample) does not represent the total female population and probably reflects the presence of individual and family weaknesses or a disease that did not allow them to be engaged in employment.

- The gradual domination of schizophrenia as the most common diagnosis
- In the first 20 years of the 20th century, primitive/precocious dementia is the second most common diagnosis, following the progressive paralysis of the insane. It is interesting to note that in the long history of the institution, the disappearance of some older diagnostic categories followed a slow process, probably related to the presence of older physicians or cases “fitting” better these classic descriptions
- In the “organic syndromes” we observe a relatively low average age of the total sample, 46.4 years. This is due to the presence of many young patients with diagnoses: progressive paralysis of the insane, epileptic psychosis and toxic psychosis. The admission of patients with senile organic syndromes increased significantly only in period C (1954–1985), following the social changes in urban population of Athens
- The main reason that Group 6 (personality disorders) is male-dominated in the 1930's seems to be the addiction to toxic substances as it was the case in the public psychiatric hospital of Athens.²²

Conclusions

The recording of a long series of admissions in Dromokaition psychiatric hospital shows:

The expected dominance of diagnoses classified in the group of schizophrenia. Due to the epidemic of syphilis in the early 20th century, progressive paralysis of the insane has been the leading cause of admissions from 1901 until 1920. The gradual increase of women in the population of the institution seems to reflect the changes in the traditional organization of greek society. The large number of admissions in the years 1941–1946 obscures a large number of deaths from hunger and indicates how major social events can affect the existence of the mentally ill. The increase in admissions of organic syndromes for older patients, after 1954, followed the growth of urban population and the disorganization of traditional greek society. The changes in diagnoses reflect, with a relative time-lag, changes in the prevailing conceptions of European psychiatry, mainly French and German for most of the period we have studied.

Εισαγωγές ασθενών στο Δρομοκαΐτειο Ψυχιατρικό Νοσοκομείο: 1901–1985

Δ. Πλουμπίδης,¹ Σ. Γκατζώνης,² Γ. Ακοντίδης,³ Κ. Πολίτης³

¹Α΄ Ψυχιατρική Κλινική, Ιατρική Σχολή, ²Νευροχειρουργική Κλινική, Ιατρική Σχολή,
Εθνικό και Καποδιστριακό Πανεπιστήμιο Αθηνών, Αθήνα,

³Τμήμα Στατιστικής και Ασφαλιστικής Επιστήμης, Πανεπιστήμιο Πειραιά, Πειραιάς

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Το Δρομοκαΐτειο ιδρύθηκε το 1887 και είναι το πρώτο ψυχιατρικό νοσοκομείο στην Αθήνα. Οι διαθέσιμες πληροφορίες για τα χαρακτηριστικά των ασθενών που εισάγονταν σε ψυχιατρικά νοσοκομεία στην Ελλάδα, ειδικά για το πρώτο μισό του 20ού αιώνα, είναι σπάνιες. Ο σκοπός της μελέτης είναι να επισημάνει τα χαρακτηριστικά των ασθενών που εισήχθησαν στο νοσοκομείο, αλλά και την επιρροή των ευρωπαϊκών κυρίαρχων απόψεων σχετικά με ψυχικές ασθένειες στην ελληνική ψυχιατρική. Τα δεδομένα των εισαγωγών για δείγμα 3014 ασθενών (20% του συνολικού αριθμού) για την περίοδο 1901–1985 ελήφθησαν μέσω συστηματικής δειγματοληψίας. Τα διαθέσιμα δεδομένα ήταν: ημερομηνία έναρξης, το φύλο, η ηλικία, το επάγγελμα και σύντομο ιατρικό ιστορικό. Οι 56 καταγεγραμμένες διαγνώσεις έχουν ταξινομηθεί σε 9 ομάδες. Στη στατιστική ανάλυση χρησιμοποιήθηκαν περιγραφικές στατιστικές μέθοδοι, συσχετίσεις διπλής κατεύθυνσης, πηλίκιο λόγων (σχετικού κινδύνου) και ανάλυση συστάδων, που επέτρεψαν την ανάδειξη των κύριων χαρακτηριστικών των ασθενών. Η υπεροχή των εισαγωγών ανδρών κατά τις πρώτες δεκαετίες του 20ού αιώνα εξισορροπήθηκε σταδιακά. Περίπου το ήμισυ του συνόλου των εισαγωγών σχετίζονται με τη διάγνωση της σχιζοφρένειας. Το ποσοστό των αρρένων ασθενών ήταν σημαντικά υψηλότερο στις διαταραχές προσωπικότητας, ενώ το αντίθετο συνέβη για τις μείζονες συναισθηματικές διαταραχές και τις νευρώσεις. Η διάγνωση της προϊούσας γενικής παράλυσης, συχνή τις πρώτες δεκαετίες του 20ου αιώνα, μειώθηκε σταδιακά και εξαλείφθηκε μετά το 1950. Τα χρόνια του Β΄ Παγκοσμίου Πολέμου αποτελούν μια ιδιαίτερη περίοδο για το ίδρυμα. Οι κοινωνικές αλλαγές, τα κυριότερα ιστορικά γεγονότα και η εξέλιξη των απόψεων για ψυχιατρική περίθαλψη έχουν αφήσει τα ίχνη τους στην φυσιογνωμία των εισαγομένων ασθενών.

Λέξεις ευρετηρίου: Δρομοκαΐτειο Ψυχιατρικό Νοσοκομείο Αθηνών, σχιζοφρένεια, προϊούσα γενική παράλυση, φύλο, επάγγελμα

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Corresponding author: D. Ploumpidis, Assoc. Professor of Psychiatry Medical School, University of Athens, 14 Delou street, GR-161 21 Kesariani, Athens, Greece
Tel: (+30) 6944 189 393
e-mail: nattedim@otenet.gr