



The Struggle for Identity

Issues and Debates in the Emerging Specialty of American Psychiatry from the Late 19th Century to Post-WWII

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Abstract: The story of the emergence of psychiatry is one of a struggle for professional and theoretical identity. Psychiatrists struggled to define themselves, their beliefs, and their specialty in the face of one of the most confounding phenomena of humankind, the derangement of the mind itself. The nature of mental illness has confounded humans from time immemorial, yet it is tempting to believe that from where we sit today, our current beliefs have finally arrived at a viable and rational solution to the problem. By looking backwards, however, and as the story of psychiatry can attest, beliefs about the nature and etiology of mental illness, and therefore the best way to deal with it, are inextricably linked with the climate of the times. The emergence of psychiatry as a profession occurred during a time in our history where an unprecedented faith was put in science and technology. It is not surprising, then, that an overwhelmingly organic view of mental illness has dominated psychiatry for most of its existence. However, it was also a time when the push for social reforms facilitated a greater examination of the role social and environmental forces play in human behavior, and this too was forced into the equation. In addition, psychiatry continued to struggle with the debate over mind and body—are they one in the same, or do they exist apart? And which deserves primacy? With these theoretical questions as a backdrop, psychiatry was also fighting for its legitimacy as a profession; and for its exclusive jurisdiction over the treatment of the mentally ill. To accomplish this, they were forced to suppress the natural ambiguities inherent in a profession built on a foundation of speculation, and put forward the foot of self-proclaimed expertise, even if this expertise was questionable. They put their faith in the bedrock of medicine, a field highly respected by professionals and laypersons alike and perfectly suited for acceptability in an age of science. But to maintain their tenuous hold, they circled the wagons in tight, to the ultimate exclusion and subordination of other lines of research into the question of mental disorder. But this is the danger inherent in standing behind and fiercely defending theoretical positions—the complexity and subtle nuances of the problem get lost, and the tendency is to throw all one's eggs in one basket. The danger in this, of course, is in putting too much faith in specific treatments that reinforce the theory one is defending, and this is where the patient, who should be the primary concern yet tends to get lost in the midst of professional posturing, potentially loses. This is a valuable lesson we can learn from the history of psychiatry, which is painfully illustrated in the treatments that came and went.

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Rigid self-inspection is the surest method of keeping sound, whether in theology or in medicine, and it can but be to our advantage to overhaul ourselves now and then to find out what we really are, what our motives and our purposes are, and what we are doing to attain the things we stand for.

—A “distinguished Southern surgeon”¹

INTRODUCTION

When someone seeks help for a mental health problem today, the options are many. Psychiatrists, psychologists, social workers, mental health counselors, religious leaders—all may be consulted when a person is faced with a mental health crisis. But at the top of this professional heap, in the consciousness of most Americans, sits the psychiatrist. In fact, the U.S. Department of Labor’s “Occupational Outlook Handbook” describes psychiatrists as “the primary caregivers in the area of mental health,” an official endorsement of their status at the top of the mental health field. Unlike any other mental health profession, to become a psychiatrist one must first become a medical doctor, completing four years of medical school and a one-year internship before spending three years specializing in psychiatry. Today, psychiatry is recognized as a distinct medical specialty, and psychiatrists are seen as uniquely qualified to treat those suffering from mental disorders.

Behind all of this lies an inherent and important assumption: mental disorders are organic, biological diseases that are best treated by medically trained professionals. But here is the paradox—the specific organic nature and causes of mental disorders have yet to be found. Even more confounding, non-medical, psychological treatments have been found to be as effective in treat-

ing mental disorders as biological interventions in many instances, and occasionally may be even *more* effective. So how did psychiatry become the medical specialty it now is, and where did our conception of mental disorders as biological diseases come from?

The truth is, the exact nature and causes of mental disorders remain elusive, and although more and more correlations are being drawn between certain disorders and specific patterns of brain function and anatomy, we no more hold the key to mental disorders now than we did 100 years ago. Although the American Psychiatric Association (APA) claims boldly on its website that mental illnesses are “real illnesses—as real as heart disease and cancer,”² the truth is we don’t know this for a fact. Ironically, the APA itself recommends in its practice guidelines a combination of medication and psychotherapy as the best treatment protocol for such illnesses as major depression and bipolar disorder,³ a recommendation that could be viewed as contradictory to a strict disease model of mental illness (in no other medical specialty is a non-organic treatment officially recommended for the direct treatment of a purely organic disease). But despite this, psychiatry officially puts forth the foot that mental disorders are organic brain disorders best treated medically.

Perception is a powerful thing, and if psychiatry is believed to be at the forefront of the mental health professions, and psychiatry as a profession promotes itself to be a science rooted in biology and mental disorder to be a medical disease just like any other, this is the message the public picks up, and this begins to color how we as a society see mental disorders. And in an age where insurance companies are dictating

¹ As cited in William Francis Drewry, “The Scope of the Activities of an Alienist,” *American Journal of Insanity* 67 (1910), 2.

² American Psychiatric Association, “What is Mental Illness?”; available from http://www.psych.org/public_info/mental_illness/what_is_mi.cfm

³ Lurhman, T.M., *Of Two Minds* (New York: Vintage Books, 2000), 204.

what constitutes appropriate treatment, pushing medications and abandoning psychotherapy, what we as a society are willing to believe about mental disorders, and therefore willing to accept as appropriate treatment, becomes critical.

The question is: how did we arrive at the point we are today, with a belief in a medical model of mental disorder and psychiatry as the profession most qualified to treat it? Did psychiatry's biological stance influence the way we as a society view mental disorder, or did society's faith in biology drive the profession of psychiatry to adapt its own views? How have we reached the conclusion that a medical approach to mental disorder is the best and most viable one? And if we are to accept psychiatry as sitting at the top of all mental health professions, "the primary caregivers in the area of mental health," what do we know about how it got there?

As the wise "Southern surgeon" said in the opening quote, "it can but be to our advantage to overhaul ourselves now and then to find out what we really are, what our motives and our purposes are, and what we are doing to attain the things we stand for."⁴ In an effort to do just that, this article will examine the evolution of psychiatry as a profession, retracing psychiatry's steps during its most critical nascent period from the end of the 19th century through post-WWII, examining the issues and debates that confronted psychiatry as it struggled for its own professional identity. Through this "rigid self-inspection," it is hoped we might gain a better understanding of our current conceptions of mental disorder and the best methods of treating it, by shedding some light on why we believe what we believe today. Along the way, we will discover that our beliefs do not evolve in a vacuum, that we are pushed and pulled by the philosophies and beliefs of our times, that what appears definitive today becomes

transient with time. At the heart of the story of psychiatry is the story of a changing world, a world turning from its faith in God towards a new faith in science and progress. It is a story of the ancient debate, still unresolved, over mind and body—are they distinct, or are they one and the same? Most importantly, it is the story of a profession struggling to define itself around the stubbornly indefinable—mental illness itself.

MORAL TREATMENT AND THE BIRTH OF A PROFESSION

The story of American psychiatry begins with an important shift in attitude towards the mentally ill; a shift not originating in America, but in France and England.

In the old system, the insane were sequestered away in prisons and hospital basements, banished from society and left to languish in oftentimes horrific conditions. The primary "treatment" goal of these storehouses of the insane was to keep the mad subdued, whether by chains, beatings, bleedings or purges.⁵ In places like the infamous Bethlem hospital in London, the insane were gawked at as a form of amusement for the rich, as if they were caged beasts. In the 1790s and early 1800s, Philippe Pinel, head of the asylum at Bicêtre prison and later at La Salpêtrière, and Samuel Tuke of the York Retreat in England, dramatically changed this view of the mentally ill.⁶

Pinel advocated a new, humane approach to the treatment of the mentally ill, one in which the shackles were thrown off, the chains removed, and the insane were re-

⁵ William Logie Russell, *The New York Hospital: A History of the Psychiatric Service 1771-1936* (New York: Columbia University Press, 1945), 52.

⁶ Andrew Scull, "The Discovery of the Asylum Revisited: Lunacy Reform in the New American Republic" in *Madhouses, Mad-Doctors, and Madmen*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 146-148.

⁴ Drewry, 2.

leased from their dungeons into the open air. The insane would be treated non-violently and non-medically, would be engaged individually, and would be carefully observed for the purpose of empirical study. Around the same time in England, Samuel Tuke was advocating for similar humane treatment of the mentally ill, using his family's York Retreat as an example.⁷ And thus, "moral treatment" was born.

The concept of moral treatment hinged upon the belief that humane treatment of the mentally ill would result in their recovery.⁸ By allowing them fresh air, exercise, and social engagement (all of course under the watchful supervision of the superintendent and staff), and treating them with such things as hydrotherapy, milk baths, massages, and proper diets, the mentally ill would be restored to a point that would enable them to possibly even rejoin society.⁹ Rather than being housed in asylums, the mentally disordered would be housed in "retreats," built not for the purpose of confinement and segregation but for the possibility of recovery. In America, Eli Todd brought the concept home with the founding of the Hartford Retreat in Connecticut in 1824, advocating a "law of kindness" towards the mentally ill.¹⁰ By the mid-1800s, several similar institutions were up and running in the U.S.

Through moral treatment, the key figure in the care of the mentally ill changed from the layperson, whose primary duty was to maintain order in the asylum, to the medical man, instilled with the necessary "expertise" in treating mental illness. These

early psychiatrists served as the medical superintendents of the asylum, and were the single pivotal figures overseeing not only all patients but all asylum operations as well. Although many were physicians trained at medical schools, their "expertise" in treating the mentally ill didn't come so much from a medical background as a religious one. While only a little more than half of asylum physicians prior to 1860 were medically trained, most all of them had strong religious convictions, primarily coming from the Protestant Christian faith.¹¹ It was this faith, much more than science or medicine, that drove these early psychiatrists, finding it their duty to serve those less fortunate and to elevate those gone astray to a higher standard of morality. Further, for those early psychiatrists that did hold a medical degree, what it meant to be a medical physician in the mid-1800s was quite different than what we conceive of today. Medicine in the mid 1800s was still an emerging profession, with no clear established standards for medical degrees or practice and no clear lines separating allopathic physicians from homeopathic or botanical practitioners.¹² Religion stood side by side with medicine and science, and the early psychiatrists' views of the nature and cause of mental illness reflected this blend.

The problem of determining the causation of insanity rested, then as now, upon the philosophical dilemma of the relationship between mind and body. For the early psychiatrists, any conception of the causation of insanity had to comply with their deeply held religious beliefs; and in the Christian and Protestant faith, the mind, as the seat of the soul, was immortal. Therefore, any concept of mental illness that pointed to a diseased mind was unacceptable, as anything that could be diseased could not be immortal. As the early psychi-

⁷ Ibid.

⁸ Michel Foucault, *Madness and Civilization* (New York: Mentor Books, 1965), 241

⁹ Henry Maudsley, *The Pathology of Mind: A Study of its Distempers, Deformities, and Disorders* 1865 Rev. ed. (New York: St. Martin's Press, 1979), 545-563; Russell, 369.

¹⁰ Lawrence B. Goodheart, *Mad Yankees: The Hartford Retreat for the Insane and Nineteenth-Century Psychiatry* (Amherst, MA: University of Massachusetts Press, 2003).

¹¹ Gerald Grob, *The Mad Among Us* (New York: The Free Press, 1994), 56.

¹² Ibid.

trist Amariah Brigham of New York's Utica State Lunatic Asylum argued, "If the mind could be deranged independently of any bodily disease, such a possibility would tend to destroy the hope of immortality, which we gain from reason: for that which is capable of disease and decay must die."¹³ Therefore, mental illness was not a problem with the mind; instead, mental illness was caused by an interaction between the mind and a diseased brain. However, attributing mental illness to a disease of the brain necessitated an "act of faith" on the part of psychiatrists, because the actual physical lesion or abnormality was not able to be identified. Rather, mental illness was identified on the basis of observable behavioral symptoms, and the underlying disease entity was simply assumed. As the historian Gerald Grob describes, "Psychiatrists accepted disease as a given; the inability of patients to function, combined with severe behavioral symptoms, was sufficient evidence of the presence of pathology."¹⁴

But while mental illness was a product of a diseased brain and not the mind, it nevertheless manifested itself in a disordered mind. To reconcile this, a complicated relationship was established between deviant, immoral behaviors and the diseased brain. Disease was conceptualized as an imbalance resulting from deviations from divine laws of nature governing human behavior; in other words, behaviors that fell outside the accepted conventions of the Protestant or Christian religion. Therefore, the disease of insanity resulted when a diseased brain conveyed false impressions to the mind, which in turn caused the mind to stray and indulge in deviant or immoral behavior. Brigham described it this way:

It is true that moral and mental causes may produce insanity, but

they produce it by first occasioning either functional or organic disease of the brain...Such a diseased state of the organ of the mind, of the very instrument of thought, or of some part of it, deranges the intellectual faculties just as a diseased state of the stomach deranges digestion. The material mind is, in itself, surely incapable of disease, of decay, of derangement; but being allied to a material organ, upon which it is entirely dependent for its manifestations on earth, these manifestations are suspended or disordered when this organ is diseased.¹⁵

Therefore, a diseased brain distorts the mind, causing the individual to engage in immoral behavioral patterns, which in turn drive the individual to a state of insanity. Thus, the major causal factors of insanity listed by early psychiatrists included such things as masturbation, intemperance, overwork, religious fanaticism, domestic strife, excessive ambitions, disappointment, and pride.¹⁶ The early psychiatrists tended to emphasize these moral causes over the physical, primarily because the actual physical causes remained elusive and abstract, while deviations in moral behavior could be addressed and therefore cured or prevented.

The primary role of the psychiatrist, therefore, was to correct immoral behavior through exposure to a more appropriate and morally superior environment; to remove the patient from their home into the safe confines of the asylum where they might correct their immoral behavior through occupational therapy, hydrotherapy, recreation, and religious exercises.¹⁷ The psychiatrist's authority and legitimacy rest-

¹³ As cited in John P. Gray "Thoughts on the Causation of Insanity," *AJ* 29 (1872), 270.

¹⁴ Grob, *The Mad Among Us*, 59.

¹⁵ As cited in Gray, 270.

¹⁶ Grob, *The Mad Among Us*, 60.

¹⁷ *Ibid.*, 65.

ed upon his high moral character, which more than anything granted him his position as medical superintendent of the asylum. The importance of the asylum itself was also asserted by the belief that the mentally ill must be removed from their home environment as, "the same causes which produced his disorder continue to operate with their original force, and oppose every exertion which is made to mitigate its symptoms or arrest its progress."¹⁸ Therefore, upon the doctrine of moral treatment, these early asylum psychiatrists justified not only their position as the best qualified to care for the mentally ill, but also the importance of the asylum setting in which the treatment occurred. As Grob states, the asylum was "not merely the place where the mentally disordered were confined and treated; it was the embodiment of a moral ideal of a caring profession...It's very existence was intended to inspire public faith in the state and to reinforce the institutional and professional legitimacy of psychiatry."¹⁹

In 1844, a significant step towards legitimizing the profession of psychiatry was taken as medical superintendents organized themselves into the first-ever medical society, the Association of Medical Superintendents of American Institutions for the Insane (AMSAII). The Association had its own journal, the *American Journal of Insanity (AJI)*, founded and published by Brigham. The main topics of discussion both in the early meetings of the Association and in the pages of the *AJI* are revealing of the focus of the budding specialty of psychiatry: discussions centered not around mental disorder itself but rather around issues of asylum construction and management.²⁰ Moral

treatment meant that care was not only therapeutic but also custodial, therefore issues centering around the ideal architectural design and layout of the asylum and its smooth administrative operation were of utmost importance.

The growth and activities of the AMSAII served to further strengthen the perception in the public's mind that mental illness required the care of professionals with special knowledge of issues of insanity, operating within the confines of institutions. As Grob states, "Mid-nineteenth century Americans believed in the redemptive ability of institutions to alter and shape human behavior in socially and ethically desirable ways."²¹ But it was this faith, coupled with the growing support for state-funded institutions, that would dramatically change the character of asylums, threatening both moral treatment and the legitimacy of psychiatry itself.

THE LURE OF SCIENCE AND PROGRESS

The beginning of psychiatry as a profession was built upon the foundations of moral treatment. Moral treatment hinged upon the idea of individualized care; therefore, to work, the patient population had to remain small. Indeed, one of the first organized actions of the AMSAII was to draft guidelines for the ideal institution, which included the stipulation that the patient population should not rise above 250 patients.²² This was possible in the early, private institutions that most psychiatrists worked in and which catered largely to a paying, middle and upper class clientele. In an atmosphere of individualized care, these institutions boasted of high success rates, with patient recoveries reported as high as 80%.²³ This purported success contributed

¹⁸ Scull, 9. Citing Friends' Asylum, *Annual Report*, 1836.

¹⁹ Grob, *The Mad Among Us*, p. 71.

²⁰ Albert Deutsch, *The Mentally Ill in America: History of Their Care and Treatment From Colonial Times* (New York: Columbia University Press, 1949), 274.

²¹ Grob, *The Mad Among Us*, 71.

²² Grob, *The Mad Among Us*, 72.

²³ *Ibid.*, 99.

to the growing public support of the institutional model in the treatment of the mentally ill, support that would lead to the emergence of new, public institutions, funded by the states.

The public acceptance of the idea of constructing state-funded institutions was due in part, ironically, to the fundraising efforts of private institutions. In an effort to raise public awareness of the necessity of the institution, private institutions went to great lengths to promote the dual message that with proper medical treatment insanity was largely curable, and that to leave a "madman" at large in society was both a danger to the community and to the madman himself. In response to this message, by the mid-1800s, state funded institutions began to open their doors, such as the Utica Asylum in New York and the Worcester State Hospital in Massachusetts. Unlike their privately funded counterparts, however, these state-funded institutions were increasingly called upon to take in not only the mentally ill, but the poor and aged as well.

The improved public opinion towards institution as places of humane care and cure encouraged many families to turn over their elderly, infirm, or just plain difficult family members to state institutions, turning to institutions to provide the care to family members they did not have the time or resources themselves to provide. This drastic change in the character and atmosphere of institutions was further exacerbated by the new spirit of Progressivism in the nation. Within this reform movement, care of the poor, infirm, and mentally ill increasingly was viewed as the responsibility of the state rather than the local community. The New York State Care Act of 1890, for example, officially ended county care and mandated the transfer of county inmates to state institutions. Subsequently, state asylum populations began to swell dramatically, and in turn recovery rates fell. For example, the population of the Utica Asylum in

New York nearly doubled between 1886 and 1899, and the recovery rate fell from near 20 percent to between 7 and 9 percent during those same years.²⁴

Under the growing burden of overcrowding, the medical superintendents' attention was forced increasingly away from treatment and towards administrative matters. As one superintendent stated, "I cannot know the daily changes in the symptoms of 450 patients—the operations on the farms and in the workshops—the domestic operations—direct the moral treatment—conduct the correspondence with friends—wait upon such visitors as demand my personal attention and various other things..."²⁵ In addition, new studies brought earlier claims of high recovery rates into question, and highly publicized scandals regarding involuntary commitments and poor treatment of patients began to tarnish the image of institutions in the public's mind. The position of psychiatrists as the best suited for the care of the mentally ill, as well as the notion of institutions as the best place for the treatment of the mentally ill, was beginning to be seriously questioned.

The most vocal challenge to the legitimacy and jurisdiction of psychiatry came from the new field of neurology. Neurology had found its beginning as a profession as a result of the bloody conflict of the Civil War. Here, surgeons had the unprecedented opportunity to study the effects of injury on the nervous system, and therefore the nervous system itself. After the war, neurology quickly established itself as a medical profession with great influence, organizing as the American Neurological Association and creating the *Journal of Nervous and Mental Disease* in the mid-1870s. Neurologists noted that many cerebral and spinal diseases,

²⁴ Ian Robert Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* (Ithaca, New York: Cornell University Press, 1997), 40.

²⁵ Grob, *The Mad Among Us*, 92.

such as meningitis, epilepsy, or locomotor ataxia, resulted in mental symptoms resembling insanity, such as delirium, hallucinations, or amnesia.²⁶ As a result, neurologists became interested in “mental medicine,” and drifted towards the treatment of patients suffering from minor mental illnesses in private practice, primarily nervous disorders.²⁷ Neurologists began treating patients with nervous disorders in private practice, using such treatments as hydrotherapy, massage, or the neurologist S. Weir Mitchell’s famous “rest-cure,” (consisting of an enforced period of rest prohibiting any outside stimulation, including visits from family members or reading or writing, under the supervision of the neurologist).²⁸

As a result of its foray into mental medicine, neurologists began turning a critical eye towards their professional counterparts in asylums, and a bitter rivalry ensued. Medical superintendents firmly believed the study and treatment of mental disorders was inextricably bound to the asylums they managed. Neurologists, however, saw it differently. They objected to the medical superintendents’ self-declared monopoly over the study and treatment of insanity and claims to the profession of psychiatry, particularly as they viewed medical superintendents to be decidedly unscientific and backward in their approach and understanding of mental pathology. To the neurologists, this monopoly was not only unfair to other professions, but also completely unwarranted. As Albert Deutsch describes, “They heaped ridicule upon the medical superintendents as persons who were at best merely efficient business executives, without either scientific knowledge or interest, and berated them roundly

for their apparent indifference to scientific research.”²⁹ As the neurologist William A. Hammond noted, there was “nothing surprisingly difficult, obscure, or mysterious about diseases of the brain which can only be learned within the walls of an asylum.”³⁰ If anything, neurologists declared, psychiatry should be a subsidiary of neurology—the seat of insanity was the brain, and while medical superintendents’ knowledge of the brain was limited at best, neurologists were experts in the entire nervous system of which the brain is only one part.³¹ Further, insanity was a by-product of many diseases of the nervous system, therefore all forms of insanity should fall under the jurisdiction of nervous system disorders, to be dealt with by those specializing in the nervous system. As New York neurologist Edward C. Spitzka noted, “many of the symptoms of insanity occur separately or combined in many diseases not classed under the head of insanity; and any attempt to consider the amnesia or delirium following and apoplexy, as something intrinsically distinct from the amnesia and delirium found respectively in dementia and maniacal excitement, is inadmissible.”³² This was a decidedly different view of mental illness than the medical superintendents had espoused—rather than viewing insanity as a result of immoral behavior, this was a purely organic point of view.

In 1878, Spitzka published an article in the *Journal of Nervous and Mental Disease*, castigating the medical superintendents for their scientific inadequacy. “If asylum superintendents stand so high in scientific *morale* as to be able to determine themselves to be the only psychiatrists in America,” he objected, “surely they should have such results to show in proof of this, as would jus-

²⁶ Edward C. Spitzka, “Reform in the Scientific Study of Psychiatry,” *The Journal of Nervous and Mental Disease* 5 (1878), 203.

²⁷ Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: Wiley & Sons, 1997), 129-130.

²⁸ *Ibid.*, 131-133.

²⁹ Deutsch, 277.

³⁰ Gerald N. Grob, *Mental Illness and American Society, 1875-1940* (New Jersey: Princeton University Press, 1983), 53.

³¹ Spitzka, 204.

³² *Ibid.*, 203.

tify their self-implied omnipotence.”³³ Instead, Spitzka claimed, medical superintendents were embarrassingly negligent in scientific studies, squandering ample opportunities for pathological research, particularly the many opportunities to conduct autopsies on mental patients (“There is no grander field for research than that of human comparative cerebral anatomy”³⁴). Their asylums lacked any equipment necessary for scientific investigation, with not a microscope or even a scale for weighing brains in sight. Further, even if the proper equipment for scientific research was to be found in the asylums, it was doubtful the medical superintendents would know how to use it. The claim by medical superintendents that only those who worked in asylums should be allowed to engage in discussions concerning insanity, and the exclusion of all non-asylum physicians from the AMSAII, was particularly objectionable to Spitzka, for the claim that asylum experience granted superior knowledge of the subject of insanity carried absolutely no weight in the mind of the neurologist. Having superior knowledge of the management and operations of an institution, Spitzka reasoned sarcastically, did not grant insight into the pathology of insanity. In fact, he charged, medical superintendents were embarrassingly behind in their concepts of the nature and etiology of mental diseases, with articles on the subject in the AJI centering around historical accounts of insanity and “tracing the development of humanitarian sentiments to the present day.”³⁵ In summary, Spitzka argued, “Judging by the average asylum reports, we are inclined to believe that certain superintendents are experts in gardening and farming..., tin roofing..., drain-pipe laying..., engineering..., history..., in short, experts at everything except the diagnosis,

pathology and treatment of insanity.”³⁶

Sixteen years later, in 1894, the neurologist S. Weir Mitchell brought the message home to the medical superintendents when he was asked to deliver the address at the 50th annual meeting of the AMSAII (renamed the American Medico-Psychological Association, or AMPA). Having been invited to deliver the anniversary address, Mitchell used the opportunity to lay bare all of psychiatry’s inadequacies and delinquencies. Psychiatry, he charged, was too far isolated from other medical specialties; too far removed from the challenges and criticisms that naturally propel professions to remain on the cutting edge of scientific advances and research. “You were the first of the specialists and you have never come back into line,” he asserted, “You soon began to live apart, and you still do so. Your hospitals are not our hospitals; your ways are not our ways. You live out of range of critical shot...”³⁷ This isolationism, he went on, had done untold damage both to the study of insanity and to the patients. “I am strongly of the opinion that the influences which for years led the general profession to the belief that no one could, or should, treat the insane except the special practitioner, have done us and you and many of our patients lasting wrong.”³⁸

The close proximity to thousands of cases of insanity was a golden opportunity to study mental illness that, to neurologists, was being ignorantly squandered by the medical superintendents. “Frankly speaking,” Mitchell asserted in his address, “we do not believe you are so working these hospitals as to keep treatment or scientific product on the front line of medical advance....You have immense opportunities, and, seriously, we ask you experts, what

³³ *Ibid.*, 205.

³⁴ *Ibid.*, 206.

³⁵ *Ibid.*, 208.

³⁶ *Ibid.*, 209.

³⁷ S. Weir Mitchell, “Address Before the Fiftieth Annual Meeting of the American Medico-Psychological Association,” *The Journal of Nervous and Mental Diseases* 21(1894), 414.

³⁸ *Ibid.*

have you taught us of these 91,000 insane whom you see or treat?"³⁹ In the field of neurology, by contrast (and for that matter in European psychiatry), new lines of research were investigating what seemed like promising scientific leads into the possible causation of insanity, including the localization of function in brain anatomy and the hereditary nature of diseases, yet American psychiatry remained amazingly mute, contributing nothing to these scientific advances. In fact, to neurologists, the medical superintendents seemed shockingly negligent in considering *any* of the physiological or biological aspects of insanity. As Mitchell declared, "...we are too often surprised at the amazing lack of complete physical study of the insane, at the failure to see obvious lesions, at the want of thorough day by day study of the secretions...of blood counts, temperatures, reflexes...all the minute examination with which we are so unrestingly busy."⁴⁰

Finally, Mitchell rounded out his verbal attack by criticizing the medical superintendents for clinging to the belief in the curative power of institutions, and therefore their distinct jurisdiction over mental illness. As another prominent neurologist William A. Hammond had declared, "the medical profession is, as a body, fully as capable of treating cases of insanity as cases of any other disease, and that in many instances sequestration is not only unnecessary but positively injurious." Clearly, neurology was oriented away from institutions, and now viewed asylums as purely a last resort after all other treatment measures had failed. This was in sharp contrast to the ideas of the early psychiatrists, whose very existence hinged upon the idea that nowhere else but the asylum was the proper place to treat insanity.

Mitchell's address did not fall on deaf ears, nor was it particularly shocking to

many psychiatrists. While some took a deep offense to Mitchell's words, calling them "unjustly severe,"⁴¹ for many psychiatrists, much of what was said echoed their own complaints about the specialty. In fact, Mitchell's address in many ways served to vocalize what was becoming a growing split within psychiatry, between the "old guard" asylum psychiatrists on the one hand, and their younger counterparts eager to break free of asylums on the other.

The first psychiatrists had placed their faith in moral treatments and the curative ability of asylums. By contrast, the younger breed of psychiatrists increasingly saw the custodial nature of their predecessors as lagging behind the scientific progress being made in all other medical specialties. To them, asylums with their overflowing populations of chronic patients represented a "scientific and medical backwater."⁴² They looked to the growing faith in science and the medical laboratory, and saw progress outside the asylum. As Grob states, "To younger physicians trained in the precepts of scientific medicine, their asylum brethren appeared a vestigial remnant of the past. Whereas the former were exploring the biological roots of disease, the latter remained preoccupied with administrative and managerial functions associated with the care of large numbers of dependent chronic mentally ill persons."⁴³

Rather than emphasizing the custodial function of psychiatry, burdened with the care and maintenance of chronic patients for whom nothing could be done, the new breed of psychiatrists hoped to build a profession based upon laboratory studies investigating the causes and treatment of acute, and therefore potentially curable, mental diseases. A career in an asylum rep-

⁴¹ Livingston S. Hinckley, "Difficulties Which Prevent the Realization of Dr. Mitchell's Ideal Hospital for the Insane," *The Journal of Mental and Nervous Diseases* 21 (1894), 600.

⁴² Grob, *The Mad Among Us*, 115.

⁴³ *Ibid.*, 130.

³⁹ *Ibid.*, 422, 424

⁴⁰ *Ibid.*, 424.

resented a dead end, whereas opportunities outside the asylum seemed full of promise. Following in the example of neurology, there's was a vision in which the treatment of mental illness was unified with general medicine, with the inclusion of special mental wards in general hospitals, and where the treatment of mental diseases occurred side by side with the treatment of other diseases. Like the neurologists, the new psychiatrists viewed asylums purely as a last resort, to be used when treatment in hospitals and outpatient facilities failed. Nevertheless, asylums should not be without a laboratory for the purpose of pathological research, should be staffed by a qualified and knowledgeable pathologist, and psychiatrists themselves should be knowledgeable of the latest advances in scientific medicine.⁴⁴

In the mid-1880s, the push for change within psychiatry began to manifest itself in a movement to expand and rename the AMSAII. Younger, more scientifically minded psychiatrists pushed for membership to be opened to assistant physicians, not simply to medical superintendents as had been the case since its inception. This suggestion, however, threatened to profoundly change the character and orientation of the Society's membership, and therefore was met with resistance from older members. Traditionally, membership had been limited to medical superintendents concerned primarily with the management and operation of asylums. Assistant physicians tended to be better educated in the medical sciences than superintendents, and tended to greatly outnumber superintendents as well. Therefore, to include them as members was to allow a shift in emphasis to the scientific aspects of mental disease. Accompanying the push to widen membership was the suggestion to rename the Society. Psychiatrist Pliny Earle suggested the Society should be known as a

"medico-psychological society" to reflect the concerns of the society rather than the professional title of its members. This was a significant difference, as the new name would shift the focus from asserting the members' professional jurisdiction over mental illness to their scientific purpose in the study of mental illness.⁴⁵

In 1892, the Society adopted both changes, and the AMSAII was renamed the American Medico-Psychological Association (AMPA). Assistant physicians were allowed partial membership, and could become full members after five years of asylum service (a compromise that retained a modicum of the traditional belief in the importance of asylum experience for claiming expertise in dealing with mental illness). A new constitution claimed the Association's goal was "the study of all subjects pertaining to mental disease, including the care, treatment, and promotion of the best interests of the insane."⁴⁶ The focus of subsequent papers presented at AMPA meetings and printed in the *AJI* reflected a "new concern with pathology, physiology, and pharmacology, as well as a receptivity toward experimentation with surgical and endocrinological treatments."⁴⁷ A committee formed to review the original propositions of the ASMAII gave the new recommendation that, to be qualified, superintendents ought to be "thoroughly educated in the sciences, and experimentally successful practitioners of medicine."⁴⁸ This was a new face of psychiatry, one that was moving away from the traditional emphasis on moral treatment and custodial care and towards a more scientific, physiological model of mental illness. In his 1895 presidential address to the AMPA, the psychiatrist Edward J. Cowles, superintendent of McLean hospital and one of the earliest

⁴⁵ *Ibid.*, 67.

⁴⁶ *Ibid.*, 139.

⁴⁷ *Ibid.*, 140.

⁴⁸ As cited in Grob, *Mental Illness and American Society*, 68.

⁴⁴ Grob, *Mental Illness and American Society*, 69.

voices urging the inclusion of pathological laboratories and qualified medical researchers in asylums, described the new psychiatry this way:

The alienist [psychiatrist], as a psychologist, is a general physician who is a student of neurology, and uses its anatomy and physiology; but he does a great deal more, for he must include all the bodily organs...He is being aided by the more promising contributions from organic chemistry, and bacteriology...Thus it is that psychiatry is shown, more than ever before, to be dependent upon general medicine.⁴⁹

It is useful to pause for a moment here in our story, in order to take note of an important ideological shift occurring in America during this time. The eagerness with which the new generation of psychiatrists embraced scientific ideas was not unique to psychiatry, or even to medicine. Rather, it was a reflection of a growing faith in science and progress that permeated much of America at the end of the 19th century and the beginning of the 20th. Equally important, concepts of the relationship between mind and body were drifting increasingly towards a materialistic view, wherein the physical reigned supreme, influencing the way in which psychiatrists viewed the nature and treatment of mental illness.

The 19th century saw the supreme place religion had held in ordering people's lives slowly replaced by a new faith in science and progress. This new "scientism" proceeded from Enlightenment ideals, which placed reason and logic above beliefs and superstitions. The principles of the Enlightenment held that, contrary to a belief in the supernatural or metaphysical, the universe was rational, orderly, and comprehen-

sible, and subsequently, knowledge ought to be organized rationally. Within the doctrines of Enlightenment thought were the beliefs that,

reason is the most significant and positive capacity of the human...; reason enables one to break free from primitive, dogmatic, and superstitious beliefs holding one in the bonds of irrationality and ignorance...; through philosophical and scientific progress, reason can lead humanity as a whole to a state of earthly perfection...; beliefs of any sort should be accepted only on the basis of reason, and not on traditional or priestly authority.⁵⁰

Evolving out of these Enlightenment ideals, scientism has been described as "a scientific worldview that encompasses natural explanations for all phenomena, eschews supernatural and paranormal speculations, and embraces empiricism and reason as the twin pillars of a philosophy of life appropriate for an Age of Science."⁵¹ Scientism sees science alone as the key to the truth about the world and reality. Further, "Scientism sees it necessary to do away with most, if not all, metaphysical, philosophical, and religious claims, as the truths they proclaim cannot be apprehended by the scientific method. In essence, scientism sees science as the absolute and only justifiable access to the truth."⁵²

This was the outlook of the neurologists and the new generation of psychiatrists, whose identification with the newly emerging scientific medicine stood in stark contrast to the early psychiatrists' religiosity and "pietistic Protestantism."⁵³ Rather than

⁵⁰ Counterbalance Foundation, "Glossary" from *Faith and Reason* <http://www.pbs.org/faithandreason/>

⁵¹ Michael Shermer, "The Shamans of Scientism," *Scientific American* June 2002, 35.

⁵² Counterbalance Foundation

⁴⁹ *Ibid.*, 69.

equating mental illness with religious morals, the new scientism demanded approaches to the study and treatment of mental illness built upon the principles of the scientific method, which in turn demanded empirical proof for all claims. Rather than assuming a physical lesion existed and relying on signs and symptoms, the new emphasis on science demanded systematic research into anatomy and physiology through the use of laboratories, microscopes, and autopsies, in order to uncover the true organic nature behind mental illness that was assumed to exist. Indeed, advances in other areas of medicine held forth the promise that the discovery and eradication of disease was possible through the use of science. As Deutsch describes, "The epochal discoveries of Pasteur, Koch, and the other pioneer microbe hunters had, in a remarkably short period, made possible the prevention of diseases that had hitherto taken huge annual tolls in human life. Man was at last beginning to master his unseen enemies in the microscopic world. One after another, disease-bearing germs were being discovered and destroyed."⁵⁴ The promise held out by science that man could master nature had a profound impact upon the way people thought. As a steady stream of scientific discoveries and technological marvels captured the public's attention and held out the promise of a better life, science was quickly becoming the new religion. As Leland V. Bell states, "These tangible achievements not only enhanced the prestige of medicine but also helped to confirm science as the new panacea for solving human problems."⁵⁵

Alongside this growing faith in rational, methodical, empirical science was a growing belief in materialism. Materialism holds that the only thing that truly "exists"

is matter.⁵⁶ Therefore, in contrast to Cartesian dualism, in which the mind exists as a separate entity from the body, in materialism mind and body are one and the same, the mind simply being an extension or product of the observable, physical brain. The mind not only did not exist apart from the brain, but also was dependent upon the physical properties of the brain. Therefore, the emotions and behaviors that characterized symptoms of mental illness were no more than products of abnormalities in the structure or function of the physical brain. This view, of course, negated free will, much to the objection of psychiatrists like John P. Gray, and subjugated desires, passions, even reason to the consequences of the physical inner workings of brain matter. Indeed, the "science" of phrenology rested on the belief that behaviors, thoughts, and emotions were localized in different regions of the brain and could be mapped out anatomically (although phrenology was later rejected due to lack of empirical evidence).⁵⁷ With the rise of materialism, the focus of mental illness shifted away from moral causes and towards physiological ones. As Deutsch describes, "The causes of mental disorder were no longer being sought in divine dispensations or metaphysical mysteries, but in the anatomy and physiology of the brain."⁵⁸ More to the point, mental illness no longer had to do with the individual; instead, mental illness was the result of general pathology of the brain, the universal cause of which it was hoped would be discovered through the promise of scientific investigation.

It was in this spirit, therefore, that the new generation of psychiatrists looked to liberate themselves from the backwater of asylum medicine and expand their specialty elsewhere. The lure of science and

⁵³ Grob *The Mad Among Us*, 132.

⁵⁴ Deutsch, 301.

⁵⁵ Leland V. Bell, *Treating the Mentally Ill: From Colonial Times to the Present* (New York: Praeger, 1980), 74.

⁵⁶ <http://www.pbs.org/faithandreason/>

⁵⁷ Robert J. Waldinger, "Sleep of Reason: John P. Gray and the Challenge of Moral Insanity," *Journal of the History of Medicine* 34, 167-170.

⁵⁸ Deutsch, 284.

progress breathed new life into a profession crushed under the weight of seemingly endless streams of hopeless chronic cases. Instead, they would elevate the profession of psychiatry and bring it in line with other medical specialties, focusing on “real” science and biological research. The psychiatrist Edward Cowles spoke of the promising future directions of psychiatry, which included the exploration of the “toxic causation of disease” and the employment of “new methods of investigating the anatomy and physiology of the nervous system.”⁵⁹ The new scientific—and biologically-oriented psychiatrists looked upon this era as the dawning of a new “golden age of discovery,” in which methodical, scientific research would ultimately uncover the true etiology, pathology, and subsequent successful treatment of mental illness. “The past of psychiatry,” proclaimed the neurologist Bernard Sachs, “has been full of discouragement; the present is involved in a maze of uncertainty; but the future is full of hope.”⁶⁰

The new generation of psychiatrists looked outside asylum walls and pushed for changes that would bring psychiatry closer in line with medicine. This included the opening of pathological institutes dedicated to the study of mental illness; the opening of psychopathic wards attached to general hospitals and free-standing psychopathic hospitals modeled after the general hospitals; as well as the opening of outpatient facilities geared towards early treatment of mental illness with the hopes of preventing the need for institutionalization.

As a first step, the Pathological Institute of New York opened its doors in 1895, funded as part of the New York State hospital system. The lofty goals of the institute, as stated by the director Ira Van Gieson, a neu-

ropathologist, was to “carry on studies on abnormal mental life and their neural concomitants, based on psychology, psychopathology, experimental physiology and pathology, cellular biology, pathological anatomy, comparative neurology, physiological chemistry, anthropology, and bacteriology.”⁶¹ Van Gieson’s vision was never realized, however. He believed progress in the study of mental illness could be made only after undergoing a thorough study of normal functions and tissues of the brain. Asylum superintendents, who as leaders within the state hospital system essentially oversaw the Institute, rejected this approach and wanted Van Gieson to maintain a close relationship with clinical work, but Van Gieson viewed the focus on clinical work as unscientific. Unable to gain the support of asylum superintendents, Van Gieson was soon replaced by the famous psychiatrist Adolf Meyer. Meyer’s research did not fair much better. He took a more clinical approach, to the satisfaction of the asylum superintendents, and compiled detailed case histories of individual patients, hoping to reconcile physiological findings with the clinical picture presented by live patients. However, these copious notes did not actually add up to anything of substance. As C.P. Oberndorf, a colleague at the Institute, later recalled, “where Meyer’s grasp seemed wanting was in the correlation of a wealth of laboriously ascertained facts with the meaning of the clinical picture that the patient presented. Facts without theory, just as theory without facts, are not enough.”⁶²

Although none of the research at the New York Pathological Institute bore fruit, a major discovery made by the bacteriologists Hideyo Noguchi and J.W. Moore in 1913 added fuel to the fire of psychiatrists whose faith was in the scientific, biological

⁵⁹ As cited in Grob *Mental Illness and American Society*, 108.

⁶⁰ *Ibid.*, 112.

⁶¹ Deutsch, 285.

⁶² As cited in Grob, *Mental Illness and American Society*, 130.

model. Noguchi and Moore isolated the germ responsible for syphilis within the brain of paretics. Paresis, it turned out, was the final stage of the disease syphilis. A vast majority of the chronic patients within state asylums had suffered from general paresis, and here was found a direct bacterial cause. This was proof that an organic, biological cause for mental illness could be found.

Inspired by this discovery, other institutes were opened in states such as Massachusetts, Illinois, and Wisconsin, and psychiatrists eagerly threw themselves into scientific, laboratory research. In Massachusetts, E.E. Southard, pathologist for the Massachusetts State Board of Insanity, and later head of the Boston Psychopathic Hospital, undertook a massive effort comparing the anatomy of brains from normal and demented individuals, hoping to find a link between brain structure and mental disease. The Illinois State Psychopathic Institute conducted tests on metabolism and examined brain specimens. The Psychiatric Institute in Wisconsin undertook biochemical and metabolic studies hoping to find the causes of schizophrenia. But in spite of these efforts, nothing of substance came from any of these studies, and the revolutionary findings of Noguchi and Moore were never matched. In the end, the institutes never lived up to their promise to advance through science our understanding of mental illness. The psychiatrist John Whitehorn wrote in 1944: "In retrospect, it may seem that these research aims were somewhat too sharply defined in certain instances, with too complacent an assumption that the clinical field had been adequately and accurately surveyed, and that what remained to be done was merely the application of laboratory methods to the elucidation of causes, from which would flow naturally the rational modes of prevention and therapy."⁶³ Instead, the search for clues to insanity under the microscope was proving to be a futile effort. Indeed, Simon Flexner of the Rockefeller Institute for

Medical Research cast his doubts as to whether psychiatric research was worth pursuing at all, claiming, "there were no problems in a fit state for work."⁶⁴ The quest for science and progress within psychiatry had hit a dead end.

The challenge put forth by neurology at the end of the 19th century had sent psychiatry on a quest for scientific and medical legitimacy. Yet the complex nature of mental illness meant this legitimacy would not be easily won. Neurology's push for psychiatry to become more scientific—and therefore more legitimate—in their approach to mental illness had not yielded the "golden promise" either neurology or psychiatry had hoped for; for mental illness stubbornly refused to yield to mere theories about its nature. In the end, the result of the challenge by neurology had simply hastened a split within psychiatry's ranks, with asylum psychiatrists on the one hand and a new generation of psychiatrists seeking opportunities outside the asylums on the other, leaving both sides vulnerable to attacks on their legitimacy as a profession and in their jurisdiction over the treatment of mental illness. While psychiatrists were no closer to solving the problem of mental disorder, they managed to fan themselves out in a multitude of directions in their search to solve this problem. This would serve to further confuse the issue of mental illness, and leave psychiatry struggling for a professional identity. Nowhere was this more apparent than in the varied conceptions of the nature and appropriate treatment of mental illness.

⁶³ John C. Whitehorn, "A Century of Psychiatric Research in America," in *One Hundred Years of American Psychiatry, 1844-1944*, eds. J.K. Hall, Gregory Zilborg, and Henry Alden Bunker, 3rd ed. (New York: Columbia University Press, 1944.), 170.

⁶⁴ As cited in Grob *Mental Illness and American Society*, 134.

THE NATURE AND TREATMENT OF INSANITY: MIND, BODY, OR ENVIRONMENT?

By the early 20th century, the vision of psychiatry as a scientifically and biologically based medical specialty, with buzzing laboratories uncovering the pathology of mental illness and mental patients being treated, side by side, with patients suffering other somatic diseases within general hospitals, was proving to be more elusive than had been hoped. Yet, the seeds for a new direction in psychiatry had been sown, and a return to asylum life was not only unappealing, but would also be an admittance of defeat. To concede that psychiatric research was a dead end was to “surrender the vision of a truly scientific psychiatry at a time when the prestige of scientific medicine was clearly on the rise.”⁶⁵ For many psychiatrists, assuming a purely caring and custodial function was no longer an option, as “their vision of a new psychiatry which eradicated an age-old malady proved irresistible.”⁶⁶ Instead, many psychiatrists sought to expand their jurisdiction outside asylums, and pursued other possible avenues in the treatment of the mentally ill. Others, however, remained firmly entrenched in the asylum. As a result, psychiatrists were no longer unified in their approach to and understanding of mental illness—a patchwork of theoretical perspectives competed for legitimacy, and each promoted their own agenda in the care and treatment of the mentally ill. As Grob states, “some explored the somatic roots of mental diseases in laboratories; some developed a psychogenic psychiatry that incorporated Freudian insights; some attempted to unify psychological and physiological phenomena in hope of illuminating disordered thinking; some experimented with novel therapies...”⁶⁷ Each of these approaches had

their own ideas about the nature of and appropriate treatment for mental illness. Ironically, in the many efforts to define psychiatry, the needs of mentally ill patients were considered less and less.

The beginning of the 20th century saw some psychiatrists swept up in the social reform movement of the Progressive era. These psychiatrists sought to expand psychiatry’s reach into the community, joining their colleagues in general medicine in heralding the message that prevention was the best cure, in what was to be called the mental hygiene movement. What began, from the vision of an ex-mental patient, Clifford Beers, as a movement to improve the conditions of mental institutions and their patients, transformed into a campaign to cut mental illness off at its roots and propel society towards optimum mental health and “happier and more efficient living.”⁶⁸ The mental hygiene movement saw psychiatry as playing a leading role in the redemption of society from social ills, providing their expert guidance on human behavior issues of education, criminality, and social policy. Chronic patients in asylums were no longer part of the picture, as they were already beyond saving. Instead, the focus was on preventing future chronic cases from developing.

Many of these socially active psychiatrists modeled their beliefs about the nature and etiology of mental illness after the leader of the mental hygiene movement, the psychiatrist Adolf Meyer. Meyer rejected a strictly biological model of mental illness. Instead, he promoted a holistic, pluralistic concept that integrated mind and body, psychology and biology. Termed “psychobiology,” this concept “centered on the individual’s reacting and adjusting to concrete environmental settings...and viewed the individual as a physical and social being, the product of a unique environment and

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Grob *The Mad Among Us*, 141.

⁶⁸ Bell, 100.

life experience."⁶⁹ The focus of the psychobiological approach was prevention, and the preferred setting was in the community where "things have their beginnings," and it was here the mental hygienists hoped to affect the greatest change. Their prevention efforts eventually concentrated on children, believing if one could effect the environment and the development of behaviors and habits early on in life, the development of mental illness could be curtailed. Through child guidance centers and education reform, they hoped stem the tide of mental illness, for "a concerted preventative attack on mental disorders in childhood, largely through the schools, would dramatically diminish the numbers of mentally ill persons and improve the health of the nation."⁷⁰

The mental hygiene movement provided psychiatrists with an appealing alternative to the isolated backwaters of asylum life, as here psychiatry played an important role in society at large. Psychiatry's influence and expertise would be needed not only in schools but in courtrooms, police stations, factories and labor disputes, even in politics and social policy decisions. Thomas W. Salmon declared, "the part of the psychiatrist must be that of leadership not only in research but in the formulation and to a certain extent in the execution of policies. No other science provides so direct an approach to the problems which must be solved before these movements can succeed."⁷¹ In an even loftier assessment of psychiatry's new important role in society at large, the psychiatrist G. Brock Chisholm, in a lecture entitled "The Psychiatry of Enduring Peace and Social Progress," proclaimed: "psychiatry must now decide what is to be the immediate future of the human race. No one else can. And this is the

prime responsibility of psychiatry."⁷²

But social redemption and a utopia built by the hands of psychiatry was not to be the legacy of this era. The mental hygiene movement was based on a model of the prevention of mental illness, but how to prevent something whose etiology and nature is not understood proved a difficult task. Its larger aims were "obscure and impossible to attain...The concept of mental hygiene lacked precision. Much was said about what mental hygiene could do, but little about what it actually was."⁷³ Instead, what was to define this era in the story of psychiatry, from the beginning of the 20th century through the period just after WWII, was the emergence of two distinct theoretical camps—the psychoanalytically oriented psychiatrists and the somatically-oriented psychiatrists—each developing their own distinct views of mental illness and its appropriate treatment, and each eventually fighting for legitimacy both within the profession and without.

The story of psychoanalytically oriented psychiatry began with a shift in focus from the body to the mind; from the biological to the psychological. As the somatic approach to mental disorder, stressing biological foundations of mental disease, appeared to be coming up empty handed, some psychiatrists began to consider other approaches to mental illness. One of these was a growing interest in psychological perspectives. The introduction into psychiatry of the principles of psychology in relation to mental illness can be attributed primarily to two prominent psychologists: William James and G. Stanley Hall.

James, considered the "dean of American psychology," introduced psychological concepts such as the "stream of consciousness," in which he posited that humans experience their world as an unbroken continuum of constant and ever-changing

⁶⁹ Ibid., 84.

⁷⁰ Ibid., 99.

⁷¹ Thomas W. Salmon, "Some New Fields in Neurology and Psychiatry," *Journal of Mental Disease* 46 (1917), 98.

⁷² As quoted in Deutsch, 516.

⁷³ Bell, 99.

experience, over which we exercise a selective influence. In this way, the mind is an "active and adaptive instrument." James rejected materialism, and instead emphasized the power of free will to transform the environment.⁷⁴ His interest in mental pathology stemmed from his own personal struggle with depression, which he claimed to have pulled himself out of through an act of will, and it was this experience that served to inform his subsequent theories about mental illness. Hall was the recipient of the first American doctorate in psychology from Harvard University, president of Clark University, and founder of the American Psychological Association. He conducted psychological research into such issues as disorders of speech, illusions, and "the psychological aspects of insanity."⁷⁵ Hall was a supporter of psychotherapy, a treatment approach which had been in use by neurologists in private practice since the end of the 19th century, and single-handedly introduced Freud to America when he invited the Viennese neurologist and his disciples Carl Jung and Sandor Ferenczi to speak at Clark University's twentieth anniversary celebration. Both Hall and James brought psychology directly to psychiatry through instructional visits with psychology students to asylums like the Worcester State Hospital in Massachusetts and the Bay View Asylum in Baltimore. Alongside other psychologists, they "encouraged physicians to analyze mental disorders from a psychological viewpoint."⁷⁶

In the wake of the disappointing results of the somatic view of mental illness, psychological theories of the nature and cause of mental illness offered an interesting alternative. As Leland Bell points out, critics of the organic approach believed that "Continually to connect insanity to some anatomical lesion without concrete supporting evi-

dence...represented a fruitless exercise. Until a firm somatic foundation was built, they called for an exploration of the potentials of psychological observation and treatment."⁷⁷ In 1905, Hall proclaimed to a meeting of the American Psychological Association that psychiatry was "coming our way," that its "subservience to neurology" was giving abating, and that now was an "unprecedented opportunity" for "psychology to influence psychiatry."⁷⁸

Psychological theories of mental illness stressed a dynamic interaction between the individual and their environment. In contrast to a somatic view of mental illness, in which symptoms of mental illness are caused by a physical lesion in the brain, and which the individual was powerless to influence on their own, psychological theories saw symptoms of mental illness as the result of unique, reflexive responses to the individual's environment, and saw these responses as modifiable within the individual. Treatment would therefore entail a focus on the individual and would address maladjustments in the personality as a result of maladaptive responses to the environment. In contrast to the somatic approach, which sought a disease entity that could be generalized across all patients on the basis of similar symptoms, the psychological point of view held that each individual case, and each individual symptom, must be approached as a unique problem. For, as the psychiatrist Lawrence S. Kubie noted, "It is not possible to generalize about the applicability of psychic determination to the disorders taken as a group..."⁷⁹

The best method of addressing psychological maladjustments was through psychotherapy. The goal of psychotherapy as a treatment was to overcome the environ-

⁷⁷ Ibid., 80.

⁷⁸ Ibid.

⁷⁹ Lawrence S. Kubie, "The Psychoanalyst's Point of View" *The Problem of Mental Disorder* eds. Madison Bentley and E.V. Cowdry. (New York: McGraw-Hill, 1934), 71.

⁷⁴ Bell, 78.

⁷⁵ Ibid., 79.

⁷⁶ Ibid.

mental factors contributing to mental illness, by “psychologically readjusting the patient to those conditions or removing the patient from the pathological milieu.”⁸⁰ As the psychiatrist William Malamud described, “A number of methods evolved, differing in some aspects but based on the same broad foundation of treating personality disturbances through the medium of analysis of the patient’s life problems, his historical background, his social and psychological needs, supplemented by readjustment of his environmental settings and a practical system of re-education.”⁸¹ Psychotherapy was seen to fall into two types: the first utilized techniques of suggestion and the second utilized mental analysis. As the psychiatrist George H. Kirby described:

In the first group are found such procedures as suggestion in hypnotic or waking states, persuasion, reeducation, progressive relaxation, discipline, isolation, rest, etc. In the second group fall (1) the method of personality analysis and psychiatric interview as developed by Adolf Meyer; (2) the psychoanalytic technique of Freud; (3) other methods which are variants of modifications of the psychoanalytic.⁸²

Neurologists had been practicing the first variation of psychotherapy since the late 1800s, as in the use of Mitchell’s rest cure; however, psychotherapy became popularized both in the medical community and the public at large in the early years of the 20th century. Medical journals and psychiatric journals alike carried articles on the new therapy, and progressive journalists introduced the promising new treatment to

laypersons. Prominent psychiatrists and neurologists put their support behind the treatment and lent it credibility and respectability, such as Morton Prince of Tufts Medical School, Smith Ely Jelliffe, owner of the *Journal of Nervous and Mental Disease*, and William Alanson White, superintendent of St. Elizabeth’s Hospital for the Insane in Washington, D.C.

More than the push by prominent figures and the popular press, however, the effect of the experience of WWI and WWII served to solidify the validity of psychological theories of mental illness and of psychotherapy as an effective treatment approach. Ordinary servicemen with no prior history of psychiatric disorder were suffering severe nervous breakdowns on the battlefield. “Shell shock,” as the condition became known, appeared to be the result of the extreme environmental stress experienced by soldiers on the front lines, and not from some unknown physical disease entity. It appeared that normal, healthy men could just as easily fall victim to mental illness as anyone. As Grob states, “Wartime psychiatric studies suggested that fatigue and the stress of prolonged combat did more to explain psychological malfunctioning than did predisposition; even the healthiest of individuals could break down under the influence of environmental stress.”⁸³

The lessons from the war experience were important and profound. First, they served to lend support and solidify a new model of mental disease, as had been promoted by Freud, Meyer, and White. Rather than the assumption that a sharp distinction existed between disease on the one hand and health on the other, in which an individual was either healthy or ill, the new model posited that disease proceeded along a continuum, in which an individual went

⁸⁰ Ibid., 90.

⁸¹ William Malamud, “The History of Psychiatric Therapies” in *One Hundred Years of American Psychiatry*, 310-311.

⁸² Deutsch, 445.

⁸³ Gerald N. Grob, *From Asylum to Community* (Princeton, N.J.: Princeton University Press, 1991), 12.

from normal to abnormal by varying degrees. The crucial implication of this new model was that early intervention could help stem the tide of approaching mental illness. This was demonstrated in the successful interventions employed during wartime, in which addressing stress and fatigue early through rotation schedules, periods of rest, and early psychotherapeutic interventions served to repair shattered nerves and stem the tide of shell shock. Second, the validity of psychological and environmental interventions over somatic interventions was fortified, as a combination of psychotherapy and rest, sleep, and food provided virtually instantaneous results in overcoming combat fatigue and shell shock. As the psychiatrist John C. Whitehorn noted:

Successful treatment seemed to depend less on scientific procedures or specific drugs than upon general principles—promptness in providing rest and firm emotional support in a setting in which the bonds of comradeship with one's outfit were not wholly disrupted and in which competent psychiatric reassurance was fortified, symbolically and physiologically, by hot food and clean clothes...⁸⁴

The validity of a psychological model of mental illness, solidified by both public and professional support and by the war experiences gave psychiatrists a viable alternative to the organic, somatic model of mental disorder. However, there was nothing inherent within psychological theories that justified allowing psychiatry distinct jurisdiction over psychotherapy as a method of treating the mentally ill. Psychotherapy was practiced by laymen, religious figures, and "quacks" alike. It was Freudian

psychoanalysis which furnished psychiatry with a specialized technique over which they could claim their unique expertise.

After his lecture at Clark University in 1909, Freud's theories were quickly disseminated through medical and psychiatric journals, and included in medical textbooks. In 1911, two societies were founded for the purpose of organizing and promoting the new discipline: the New York Psychoanalytic Society and the American Psychoanalytic Association. Freud's theory had evolved out of listening to his patients while a practicing neurologist. Its essence was that mental illness was caused by "unconscious conflicts over the desires, wishes, and ambitions rooted in early-childhood psychosexual experiences. A healthy maturation process channeled conflict into constructive outlets; an unsuccessful sublimation produced mental illness."⁸⁵

The technique of psychoanalysis included such methods as free association and concepts of wish fulfillment and repression. Through discourse between the doctor and patient, the patient gained insight into their unconsciously motivated difficulties and desires and worked out their own solution to the problem.⁸⁶ Appearing at the height of the psychotherapy movement, psychoanalysis was initially absorbed as another form of psychotherapy. But by the end of WWII, gradually increasing support for the discipline was boosted by an influx of Viennese Jewish immigrants fleeing the war, who brought with them a fervent belief in the Freudian doctrines. Psychoanalysis was quickly claimed by psychiatrists, and fast became a defining branch of psychiatry.

Enthusiasm for psychoanalysis, however, was not shared by all. Somaticly oriented psychiatrists, which made up the majority of asylum psychiatrists by the early 20th century, rejected psychoanalysis as "the unscientific moonshine of madmen."⁸⁷

⁸⁴ As cited in Grob, *From Asylum to Community*, 16.

⁸⁵ Bell, 89.

⁸⁶ *Ibid.*, 91.

To them, psychoanalysis was a psychiatric theory based upon metaphysical speculation rather than scientific, biological fact. Many saw it as a passing fad, and looked forward to its eventual demise. As the psychiatrist Theodore H. Kellogg declared in 1916 in the *Reference Handbook of Medical Sciences*: "Psychoanalysis, as now known, will not become of general use in mental disorders and a decennium hence will probably only be referred to as an interesting phase in experimental psychiatry."⁸⁷ More importantly, the somatically oriented psychiatrists pointed out, psychoanalysts treated mild, acute psychoneuroses outside asylums, whereas somatically oriented psychiatrists were primarily treating chronic psychoses within asylums. Psychoanalysis offered little to psychiatrists burdened by overcrowded asylums filled with hundreds of chronic patients. Even Jelliffe, a staunch supporter of psychoanalysis conceded that psychoanalysis practiced in asylums was "practically useless. One has not the time, nor are the patients in the main of the type for whom it can be used."⁸⁸ Even to those somatically oriented psychiatrists who did not wholly reject psychoanalysis, the point was it was irrelevant, as it had no therapeutic value to the patients they saw. Instead, somatically oriented psychiatrists held fast to the belief that mental illnesses were biological illnesses whose nature would be discovered through the application of science, and who would be amenable only to physical, not psychological, treatments.

Unlike their psychoanalytically-minded counterparts, whose focus was on the inner mental life of the individual, somatically-minded psychiatrists viewed mental illness as a physical disease whose entity had yet to be discovered. A patient's mental illness was to be understood based upon the diagnosed disease, as was the case in in-

ternal medicine. But lacking a clear etiological understanding based upon which mental illnesses could be grouped, classified, and diagnosed, they overwhelmingly adopted the classification system devised by Emil Kraepelin. Kraepelin's system was based primarily upon disease course and outcome, rather than on etiology. As Kraepelin stated, "Judging from experience in internal medicine, the safest foundation for a classification of this kind is that offered by pathological anatomy. Unfortunately, however, mental diseases thus far present but very few lesions that have positively distinctive characteristics, and furthermore there is the extreme difficulty of correlating physical and mental morbid processes."⁹⁰ Therefore, he declared his system to be the most rational due to the difficulty inherent in classifying diseases with no known etiological basis or clear, distinct symptoms. Under this system, a diagnosis of manic-depression implied the possibility of cure, while a diagnosis of schizophrenia implied a chronic, incurable condition. The majority of patients in asylums were classified as one or the other, with a large portion receiving the less promising diagnosis of schizophrenia.

Believing mental illnesses to be the result of physical causes, somatically oriented psychiatrists looked hopefully to the day when mental illnesses could be treated much in the same way as other physical diseases, and when mental medicine would come to resemble general medicine. The recent discoveries of the etiology of paresis and pellegra (a form of insanity linked to poor nutrition) added a tangible basis to this hope. As the psychiatrist *Abraham* Meyerson stated:

The point of view of the medical psychiatrist is that, whether or not

⁸⁷ *Ibid.*, 91.

⁸⁸ As quoted in Deutsch, 490.

⁸⁹ Grob, *Mental Illness and American Society*, 121.

⁹⁰ Emil Kraepelin, *Clinical Psychiatry: A Textbook For Students and Physicians*, trans. A. Ross Diefendorf. (London: MacMillan Co., 1907.), 116.

our present understanding of the major mental diseases qualifies us to speak of them as pathological units, our working hypothesis will be more fruitful if we postulate that they are such units, provided that we realize that our classification is a mere scaffolding, to be discarded without emotion or egoism when a more solid structure appears.⁹¹

Without a clear understanding of the etiology of the diseases they were treating, upon which effective treatments could have been based, for much of the early part of the 20th century, somatically oriented psychiatrists had to content themselves with a handful of therapies primarily aimed at maintaining peace and stability within overcrowded asylums, which were swelling with an ever-increasing load of chronic patients. Asylum treatments had not evolved much since the days of moral treatment, and included such things as hydrotherapy to calm agitated nerves; colonics to relieve the gastric distress thought to accompany many disorders; and occupational therapy to provide distraction. Attempts to develop new types of therapy yielded “tent treatments,” in which small numbers of patients were removed from the cramped, stuffy wards to tents on the grounds and allowed sunshine, fresh air, reading materials, and “amusements;” “musical therapy” which consisted of musical performances by patient orchestras; even an obscure treatment called “photochromatic treatment of insanity,” which “required a patient to absorb sunlight filtered through stained glass windows.”⁹² “Therapy” also involved reward systems for good behavior, and “normal living” models wherein life in the asylum was made to resemble the outside world as much as possi-

ble in the hopes patients would eventually re-adjust themselves to a normal life.⁹³ While these therapies were applied in the hopes to alleviate some degree of suffering and maintain some modicum of calm and control in the asylums, none of them were considered efficacious in directly targeting the underlying pathology of mental illness.

Faced with seemingly insurmountable numbers of chronic patients, many psychiatrists began to experiment with somatic therapies based upon mere theories about the organic roots of mental illness, in the hopes of finding some intervention that would work. Illustrative of this was the infamous work of the psychiatrist Henry A. Cotton, superintendent of the New Jersey State Hospital. Convinced of the theory that focal infections were responsible for psychosis, Cotton began extracting patients’ teeth, performing tonsillectomies and appendectomies, and irrigating patients’ sinuses and intestinal tracts. These “treatments” were based upon his belief that these were the routes by which infection spread throughout the body, which in turn lead to psychosis.⁹⁴ In another infamous example, a few psychiatrists, convinced that mental illness in women was due to their reproductive organs, performed ovariectomies on female patients.⁹⁵ In yet another infamous turn, some psychiatrists, most notably in the state of California, found themselves swept up in the wave of degeneracy theories and the mandates of eugenics, and advocated a policy of forced involuntary sterilization for mental patients. This was based upon the belief that mental illness was hereditary and incurable, and the only true treatment was to prevent the afflicted from passing their defective genes on to a new generation of mentally ill. As the psychiatrist William Frances Drewry

⁹¹ Abraham Myerson, “Medical Psychiatry” in *The Problem of Mental Disorder*, 28.

⁹² Bell, 75-76.

⁹³ Bell, 75.

⁹⁴ Grob, *Mental Illness and American Society*, 124.; Deutsch, 496-497.

⁹⁵ Grob, *Mental Illness and American Society*, 123.

proclaimed in his 1910 Presidential Address to the AMPA, "it is especially incumbent upon psychiatrists to give most careful study, without prejudice, to every proposed rational means that gives any promise of improvement of the race by lessening the number of mental wrecks and degenerates that come into the world."⁹⁶ The push by psychiatrists and eugenicists for sterilization of "defects" resulted in state legislated mandatory sterilization of over 18,000 mental patients between 1907 and 1940.⁹⁷ (In a fateful turn, Adolf Hitler drew his inspiration for his sterilization and later euthanization program from the sterilization policies of the U.S., the tragic result of which swiftly put an end to support of forced sterilization in America).

While these instances were extreme and were not widely supported by psychiatry in general, they are illustrative of the extreme lengths to which some were willing to go to find a cure for mental disease. Faced with such limited treatment options as the extension of moral treatments and the adoption of extreme measures, a therapeutic pessimism descended upon somatically-oriented psychiatrists for much of the early 20th century. However, the promising new interventions of fever cure and shock therapies transformed this pessimism into a renewed faith in psychiatry's ability to heal the mentally ill, and lent support for both the biological model of mental illness and the hope of uncovering the biological basis of mental diseases.

In the late 1800s, Viennese psychiatrist Julius Wagner-Jauregg began speculating that fever might alleviate psychosis after a female psychotic patient suffering a streptococcal infection went into remission. In 1917, he injected a neurosyphilitic patient suffering general paresis with the blood of a soldier infected with malaria. The patient's psychosis gradually abated, and within six

months he was discharged as fully recovered. Thus the malarial fever cure was born, for which Wagner-Jauregg received the Nobel Prize in 1927. The fever cure was tried on every other type of mental illness, but did not yield the same promising results. Nevertheless, as Edward Shorter describes, "Wagner-Jauregg's fever cure was a beginning, touching off other efforts to discover cures for psychosis. For decades to come, the search for physical therapies for the "functional" psychoses, meaning those in which no obvious lesion was present, was the main narrative strand in the history of major psychiatric illness."⁹⁸

The search was on for promising somatic interventions for mental illness, and in the 1930s, a stream of radical new somatic therapies imported from Europe, collectively known as "shock treatments," arrived on America's shores and transformed institutional psychiatry. The first to arrive was Manfred Sakel's insulin shock treatment. Sakel's treatment evolved out of his work with morphine addicts. Addicts were given injections of insulin to help manage withdrawal symptoms, but from time to time an overdose of insulin caused the addict to go into a hypoglycemic coma. Once revived, the addict had lost their craving for morphine entirely. Curious about these results, Sakel began experimenting with the use of insulin on his schizophrenic patients. In his results he claimed a high percentage of his patients experienced a full remission while a smaller percentage experienced a "social remission," allowing them to return to the community.⁹⁹

Insulin shock treatment involved injecting the patient with insulin sufficient to send the patient into a hypoglycemic coma (the result of abnormally low blood sugar). After a period of time ranging from twenty minutes to one or two hours, the patient was returned to consciousness by adminis-

⁹⁶ Drewry, 12.

⁹⁷ Grob, *The Mad Among Us*, 161.

⁹⁸ Shorter, 193-194.

⁹⁹ Shorter, 210; Bell, 135.

tering a carbohydrate solution, thus returning blood sugar to normal levels.¹⁰⁰ The treatment, used primarily to treat schizophrenia, was given on average five times a week until 50 or 60 treatments had been applied. The reported effect on the patient was the gradual loss of hallucinations and delusions, the transformation from violent outbursts to a calm, lucid state, and the gradual return of a “normal” consciousness.¹⁰¹ Psychiatrists proclaimed the treatment the “best available therapy.” The treatment, however, was not without serious risks, which included “fatalities, cardiovascular and respiratory disturbances, vertebral fractures, and the occurrence of prolonged coma.”¹⁰² But despite these risks, psychiatrists embraced the new treatment eagerly, as here was finally, in Sakel’s own words, “an instrument with which they can break through the barrier and attack the psychosis.”¹⁰³

Insulin comas were quickly joined by another promising new shock treatment: Metrazol convulsive therapy. Metrazol convulsive therapy was developed by Budapest psychiatrist Ladislav von Meduna. Meduna was intrigued by studies which had reported that epileptics who had developed schizophrenia experienced a lessening of their epileptic symptoms. He wondered if the relationship might go the other way as well, believing there may be a “biological antagonism between the two diseases.”¹⁰⁴ He experimented by inducing convulsions in patients, first using camphor, and eventually settling on the more reliable Metrazol. After a few weeks of convulsive therapy, patients were said to “improve dramatically.”¹⁰⁵

Metrazol convulsive therapy was easier to administer and took less hospital staff to

administer as compared to insulin shock therapy, and it quickly gained popularity in American asylums. But Metrazol convulsions had one major drawback—they were extremely violent, unpredictable, and terrifying for the patient. Patients suffered injuries as a result of the convulsions, including “dislocation of the shoulders or the jaw, loosening and breaking of the teeth, and fractures of the humerus, the femur, the spine, and the vertebrae.”¹⁰⁶ The treatment didn’t always produce convulsions, and the convulsions themselves were difficult to terminate if necessary. Most disturbing, however, was the patients’ intense fear of the treatment, which “stemmed from experiences during the brief period between injection and convulsion, when sensations of impending death, of sudden annihilation, of being overpowered and killed were felt,” an experience evident through the patients’ expressions of horror and terror.¹⁰⁷

Metrazol was soon replaced by a less violent convulsive therapy—electroconvulsive therapy (ECT). ECT grew out of the Italian psychiatrist Ugo Cerletti’s experiments inducing epilepsy in dogs with the use of electric currents. Inspired by Meduna’s work, he wondered if electric currents could be used on humans to induce convulsions as an alternative to Metrazol. A trial on a patient in 1938 yielded promising results—after 11 applications, his psychosis apparently abated. The use of ECT quickly spread throughout asylums and, due to its ease of use, to private practices and outpatient clinics as well.

ECT worked by rendering the patient unconscious, followed by generalized convulsions replicating an epileptic seizure, after which the patient fell into a deep sleep lasting four or five minutes. Within 15 to 20 minutes the patient was able to walk around. Initially, ECT had some of the same violent side effects as Metrazol, such as frac-

¹⁰⁰ Shorter, 212.

¹⁰¹ Bell, 136.

¹⁰² *Ibid.*, 137.

¹⁰³ *Ibid.*, 136.

¹⁰⁴ Meduna, as cited in Shorter, 215.

¹⁰⁵ Shorter, 216.

¹⁰⁶ Bell, 138.

¹⁰⁷ *Ibid.*

tures, dislocations, respiratory problems, even fatalities. But the addition of a muscle relaxant solved this problem, and soon the greatest negative consequence was brief, sometimes prolonged amnesia experienced by the patient. Although initially intended to treat chronic patients, proponents claimed the “borderline’ neurotic patient showed the most positive and striking response to the treatment.”¹⁰⁸ Before long, the somatically oriented psychiatrists were shouting its praises, claiming the results were “unparalleled in the history of psychiatry.” Through the use of ECT, they claimed, “the depressed patient became euphoric, the extremely agitated became calm, hallucinating paranoids lost their false perceptions and beliefs.”¹⁰⁹

Others were not quite so convinced. Critics of ECT, and for that matter of all the shock treatments, pointed to inflated claims of efficacy and questionable parameters for what was considered “recovered,” “much improved,” “improved,” or “unimproved.” For the most part, the evaluation of the outcome of therapies was made by the same psychiatrist responsible for administering the treatment, which naturally calls into question the reliability of the results. The neuropsychiatrist Stanley Cobb charged that “the diagnoses of the diseases treated were vague; the course of the diseases were not reliably predictable; there were inadequate controls; and animal experimentation was deficient.” Further, evaluation of the treatment was based upon “clinical impression,” reflecting above all the opinion of the attending psychiatrist rather than indisputable fact. The actual experience of the patient was not considered, beyond the effect of the treatments on the specific symptoms thought to make up the patient’s disorder. White, himself psychoanalytically inclined, mused to a colleague, “I have a suspicion that some of these schizophrenic patients

get well with insulin shock treatment and other similar methods that are exceedingly painful and disagreeable in order to get out of the sanitarium where they use such methods or at least to escape their repetition.”¹¹⁰

The fact was, there was no solid theoretical basis for why shock treatments worked, and their efficacy was purely empirical conjecture. Still, faced with thousands of seemingly hopeless cases, psychiatrists were faced with a dilemma—should they withhold a promising treatment that held out the hope of providing some relief to patients simply because they did not fully understand the mechanism by which it worked? For many, some form of treatment was far superior to no treatment. The psychiatrist Oskar Diethelm, however, warned his colleagues against unquestioning acceptance of the new somatic therapies, stating “It is important in medicine to recognize fully the responsibility with regard to those who follow voluntarily, that is physicians; those who follow blindly, that is laypeople; and those who are forced to follow, that is patients.”¹¹¹ The psychiatrist Louis Casamajor opined in 1943, “One may question whether shock treatments do any good to the patients, but there can be no doubt that they have done an enormous amount of good to psychiatry.”

Shock treatments officially ended a long period of “therapeutic nihilism” that had permeated somatically oriented psychiatry. It ushered in a new “golden era” of hope for the possibility of real progress towards the treatment of mental illness. In addition, somatic therapies brought psychiatry closer in line with medicine, something somatically oriented psychiatrists had been trying to do for decades, by offering treatments that more closely resembled treatments in other branches of medicine. What

¹⁰⁸ Bell, 139.

¹⁰⁹ Ibid.

¹¹⁰ Grob *The Mad Among Us*, 181.

¹¹¹ Grob, *Mental Illness and American Society*, 295.

was conspicuously absent from this picture is the actual effect on the patients. As asylums opened wards for shock treatments, shock therapies became “maintenance therapies,” employed liberally and thus simultaneously simplifying the control of difficult or violent patients and boosting the moral of asylum staff. As Bell notes, “there was an almost reckless commitment, indeed capitulation, to an indiscriminate application of shock therapy to every patient on the chronic wards. Practitioners of maintenance treatment believed that all schizophrenics needed some form of shock, contending that it avoided reliance on such disagreeable measures as force-feeding and the use of restraining devices.”¹¹² But patients receiving multiple shock treatments were at a higher risk of brain damage due to hemorrhages, and often wound up with a markedly altered personality characterized by a dull, flattened affect and lack of motivation or intuition.¹¹³ Although psychiatrists may have seen these personality changes as favorable outcomes, one wonders the true subjective effect on the patients themselves.

Nowhere was the personality of the patient altered more severely than through the last and most extreme of the somatic therapies to appear during this time—prefrontal lobotomy. The inspiration for lobotomy came from the studies of two professors at Yale University, Drs. Carlyle Jacobsen and John Fulton. After performing a “frontal operation” on a chimp who characteristically flew into a rage whenever she made a mistake on a task, the chimp subsequently became lucid and gentle. Similar behavior changes were found in humans who had experienced frontal brain damage. Dr. Egas Moniz, a professor of neurology from Lisbon University, hoped to apply the same procedure to humans to alleviate psychosis. He hoped that by severing “certain cell-

counting structures in the brain, certain symptomatic complexes of a psychic nature” would disappear.¹¹⁴ He performed the first ever lobotomy on a woman suffering “involutional melancholia,” and declared her cured two months later. Lobotomy was subsequently popularized in America through the efforts of Walter Freeman and James Watts of George Washington University. Freeman alone performed over 3,500 lobotomies by the mid-1950s.

Lobotomies were intended as a last resort to be used on patients who had no hope of otherwise recovering. Although lobotomies were thought to be most efficacious in treating manic-depression, schizophrenics soon represented the largest group receiving lobotomies.¹¹⁵ The operation involved severing the fibers connecting the frontal lobes with the thalamus. Although the theoretical basis for this was fuzzy, Freeman and Watts claimed severing the connection between the centers for insight and foresight (the frontal lobes) and the centers of emotion (thalamus) would allow the patient to be free from the intense emotional involvement with his or her psychosis.¹¹⁶ But lobotomies did more than this. As Bell describes, “the psychological changes were most obvious, more permanent, and often disheartening. The lobotomized patient lost something: soul, or spirit, or driving force, or sparkle; clearly some flavor of the personality was gone.”¹¹⁷ Proponents for lobotomy argued, however, that this blunted, “intellectually and emotionally flat” demeanor was better than the “immaturity and brief outbursts” they exhibited in their psychotic state. Further, lobotomies were a way to control violent and destructive patients within asylums, and asylum psychiatrists often chose candidates for lobotomies

¹¹² Bell, 140.

¹¹³ *Ibid.*, 142.

¹¹⁴ As cited in Bell, 144.

¹¹⁵ Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (New York: Cambridge University Press, 1998), 160-161.

¹¹⁶ Bell, 145.

¹¹⁷ *Ibid.*

based upon aggressive or violent behavior. Other asylum psychiatrists viewed lobotomy as “a reasonable and ethical alternative for the patient trapped by unbearable obsessions and doomed to a grim lifetime in the back ward of a mental hospital.”¹¹⁸

As was the case with shock treatments, somatically oriented psychiatrists supported the treatment as a promising intervention that brought them closer to their medical colleagues. The prospect of conducting surgical brain operations in asylums meant more than ever asylums could be viewed as being just like general hospitals, and psychiatrists as medical doctors just like any other medical specialist. The New York Times printed an editorial in which it was proclaimed, “surgeons now think no more of operations on the brain than they do of removing an appendix...it is just a big organ...no more sacred than the liver.”¹¹⁹ The use of lobotomy symbolically validated the somatically oriented psychiatrist’s assertion that mental illnesses were physical in origin and therefore ought to be treated like any other physical disease of the body. As Pressman states, “The demonstrated success of lobotomy also was seen as effective in undermining the dualistic model of mind and body, the widespread belief that mental functions could not be understood in physiological terms—a philosophy that many professionals thought was a hindrance to further progress.”¹²⁰

To psychoanalytically oriented psychiatrists, shock treatments and lobotomy represented extreme, possibly even barbaric treatments. They protested against what they believed to be a gross misuse and overreaching application of the new treatments and, echoing the somatically oriented psychiatrists’ complaint against psychoanalysis, argued their efficacy and usefulness was based on purely empirical, and there-

fore subjective, evidence. There were some who attempted to apply psychoanalytic theories to why the somatic therapies might work, such as the possibility that shock treatments broke down defense mechanisms which stood as barriers to achieving insight. But for many, the somatic therapies represented a method of control and did not address the underlying factors causing mental illness. As White noted in a criticism of lobotomy, “something that is worthwhile in this situation may have escaped me, but you naturally know my disinclination to consider the destruction of the organ in which the difficulty lies as legitimate therapy.”¹²¹

Thus, by the end of WWII, two distinct camps existed in psychiatric thought—one promoting a psychological concept of mental illness, the other a biological one. Both had a vested interest in promoting their own agenda and saving the future of psychiatry from the other. And both had a vested interest in securing psychiatry’s authority and legitimacy as a profession, both in the eyes of the public and in defense against the growing encroachment of alternative mental health professions. What is interesting to note, however, is despite this professional angling and the diffusion of psychiatry beyond asylum walls, the profession of psychiatry had still not come far from their predecessors in narrowing the nature and cause of mental illness. In fact, in an ironic twist of fate, those who had left asylums behind in the quest to follow neurology’s materialism and scientism by and large eventually flip-flopped, rejecting materialism while adopting a psychological, or at the very least a psychobiological, model of mental illness. At the same time, those who remained in asylums became the staunchest supporters of the materialistic, biological view.

Throughout both camps in psychiatry,

¹¹⁸ Ibid., 137.

¹¹⁹ As cited in Pressman, 185.

¹²⁰ Ibid.

¹²¹ As cited in Grob, *Mental Illness and American Society*, 305.

there existed an illusion of progress, and indeed the profession had come a long way from the medical superintendents who had come under attack by neurologists. But underneath psychiatry's new clothes the underlying riddle remained to be solved. As Dr. I.S. Wechsler noted in 1930, "Sad as it is to make the confession, the fact remains that, despite accumulation of knowledge, the ultimate cause or causes of nervous and mental diseases is unknown. There are a great many theories but few facts. Their very profusion not only is in inverse ratio to our knowledge but is an actual confession of ignorance or merely a verbal cloak."¹²² Expanding the reach of psychiatry beyond asylums and bringing psychiatry closer in line with science and medicine still had not unlocked the mystery of mental illness. Thus, by the 1940s psychiatry as a specialty remained as vulnerable as it had been fifty years prior, and the need to define psychiatry both within the profession and without became more crucial than ever.

THE STRUGGLE FOR IDENTITY: INTERNAL FRACTURES AND EXTERNAL PRESSURES

Over the first few decades of the 20th century, psychiatrists began to align themselves with one theoretical position or another. While there were middle-of-the-road psychiatrists who embraced an eclectic view of mental illness, a large number of psychiatrists declared themselves either on the side of psychoanalysis and psychopathology or on the side of biology and organicism. It was only a matter of time before these two positions would clash in a struggle to define psychiatry. The pressure to define itself was not unfounded, as the legitimacy of the profession itself was once again being questioned.

¹²² As cited in Grob, *Mental Illness and American Society*, 179.

The conflict within psychiatry began when members of the APA endorsed a petition criticizing the AJI for its narrow and outdated focus. It called for the organization of a special committee, the Committee on Psychiatric Standards and Policies, for the purpose of "suggesting changes to the journal 'for the betterment of society' and to publicize its value 'to the entire medical profession in order to disseminate psychiatric knowledge'."¹²³ The Committee came back with the recommendation that the time had come to reorganize and modernize the structure of the APA. The main representative body of psychiatry, the APA, seemed to exist "mainly to hold annual meetings where friends could meet," had no centralized location or an adequate full time staff, had a less than secure financial base, and overall was relatively inactive as an organization. In late 1944, a Special Committee on Reorganization was formed, chaired by Karl A. Menninger, a high profile psychiatrist sympathetic to psychodynamic psychiatry and psychoanalysis. The purpose of the Special Committee on Reorganization was to study the APA's organizational structure and to appoint a salaried Medical Director. The Committee charged that the APA's mission was vague, its structure was inadequate to the size of its membership, and that before anything could be done, its purposes and goals needed to be defined. Rumors soon began to circulate that a small clique of psychiatrists sympathetic to psychoanalysis and pushing an agenda of social activism were attempting to take over the APA. The psychiatrist Clarence B. Farrar believed the suggestion of an appointment of a Medical Director to be an effort to impose a dictatorship and create "a potential bureaucracy in our democratic organization," the goal of which was "domination by this radical sectarian group."¹²⁴ A

¹²³ Gerald N. Grob, "Psychiatry and Social Activism: The Politics of a Specialty in Postwar America," *Bulletin of the History of Medicine* 60 (1986), 480.

subsequent series of events only served to validate their fears.

The Committee itself pulled back its efforts at reorganization after sensing the growing dissention and finding an intense apathy amongst APA members to the issues of restructuring and raising dues (a questionnaire circulated by the Committee only received an 8% response rate), and instead proposed a "down-to-earth discussion of the practical problems our members meet in their daily work," to be held during the 1946 national APA meeting. However, a new organization, formed by members closely tied to the reorganization effort the day before the 1946 meeting, appeared to confirm the belief that psychoanalytically oriented psychiatrists were attempting to take over the APA. The new group was to be called the Group for the Advancement of Psychiatry (GAP), and was led by William C. Menninger, a leading force behind the popularization of psychoanalysis and the brother of the Committee's chair. Menninger had become the first psychiatrist to hold the title as General Officer of the army during WWII, and was profoundly affected by the war experience. He brought home from the war the message that environmental influences greatly determined behavior, and believed that the reach of psychiatry should extend beyond care and treatment of the mentally ill and into the resolution of social and cultural questions that worked towards a better world, such as "Can the culture of a race, the Germans for instance, be changed?" The primary question considered at the first meeting of the GAP was whether the focus of the APA could be changed to include a more socially active and dynamically oriented agenda, or "whether its diversity and unwieldy constitution precluded 'decisive action' and thus mandated the formation of 'a new militant body'."¹²⁵ At the APA meeting the next day,

members of the GAP nominated three of its members as alternative candidates for the APA Council, and all three were elected. As Grob states, "Those who harbored suspicions of reorganization and were opposed to GAP viewed the election results as confirmation of their belief in the existence of a plot by a minority group to seize control of the Association."¹²⁶

Soon after the founding of the GAP, an opposition group led by Farrar formed its own group, called sarcastically "The Group of Unknowns in Psychiatry" (GUP). They declared themselves a "very select outfit," and demanded that members "should be required to grow long beards and wear dark green spectacles; and...at meetings...wear their coats and vests buttoned up behind." In an obvious allusion to the belief that the GAP did not represent medicine, the proposed slogan of GUP was to be "Back to Hippocrates." A requirement for membership would be to write a thesis on topics such as "Group Psychotherapy during Passage in the Ark which Permitted all Passengers to Land with Sound Minds" or "The Malign Influence of Grandpopism." The GUP officers would include a "Grand Bazooka, three Grand Trombones, a Great Dictaphone who shall keep records, and as many Grand Trumpets as there are members."¹²⁷ Clearly, somatically oriented psychiatrists not only viewed the encroachment of psychoanalytically oriented psychiatrists as threatening, but also considered the positions and opinions of their "rivals" as trivial, unscientific, and ridiculous.

The next action to perpetuate the formation of a schism within psychiatry was the commencement by the GAP to publish reports by individual GAP committees, formed to study the status quo in psychiatry. The first report was released in late

¹²⁴ Grob, "Psychiatry and Social Activism," 481.

¹²⁵ *Ibid.*, 484.

¹²⁶ *Ibid.*, 485.

¹²⁷ *Ibid.*, 486.

1947, and was a scathing review of electroshock therapy. The report was highly critical of what the committee considered the "indiscriminate use of the technique," especially to the exclusion of psychotherapy. The next report targeted lobotomy, and not only criticized the therapy but also the lack of scientific controls in studies on its efficacy. The implication of these reports was clear to the opponents of the GAP: here were out and out attacks on the use of somatic therapies, intended to discredit somatic approaches and further promote a psychoanalytical agenda. Particularly objectionable was the impression that GAP reports represented the official opinions of the APA, an impression that was the result of the tremendous overlap between GAP members and APA officers.

The conflict within psychiatry escalated further with the elections held during the annual meetings of 1947 and 1948. In 1947, William Menninger won the presidency after a narrow victory, officially turning over control of the APA for that year to a psychoanalytically oriented psychiatrist (Menninger was also President of the American Psychoanalytic Association). Farrar believed Menninger's victory was due only to the fact that two candidates ran against him, not one. Had only one been considered, Menninger surely would have lost (indeed, the count was Menninger 41%, Nolan D.C. Lewis 35%, and Arthur P. Noyes 24%).¹²⁸ The following year, however, tensions officially erupted.

Shortly after Menninger's election, opponents began lobbying for his successor. They settled on C. C. Burlingame of the Institute for Living (formerly the Hartford Retreat). Burlingame was a staunch supporter of lobotomy and envisioned turning the Institute into a center for the surgery. One psychiatrist wrote that the APA "needs at this time a forceful president who will not be dominated by a minority group and who

will uphold the traditions of the Association as a scientific medical group and not one that is trying to tell everyone else what to do and how to live."¹²⁹ In 1948, the Nominating Committee offered Burlingame as the sole candidate for President. The GAP as a group was hesitant to nominate someone from the floor; but knew something had to be done to save the APA from the radical leadership of Burlingame, who as a proponent of lobotomy surely would take the APA down the wrong path. They persuaded Dexter Bullard, a psychoanalyst not associated with GAP, to nominate George S. Stevenson, a proponent for social activism and head of the National Committee for Mental Hygiene. Bullard not only nominated Stevenson from the floor, he used the opportunity to blast Burlingame for his beliefs, holding up Burlingame as a candidate whose current views leaned towards psychosurgery and lobotomy, whereas Stevenson stood for preventative aspects. The psychiatrist Karl Bowman quickly chided Bullard for openly attacking a colleague in public. The vote yielded a 389 to 342 victory to Stevenson, a tight race highly indicative of the division within psychiatry.

Later that year, a counter-organization to the GAP was formed. Called the Committee for the Preservation of Medical Standards in Psychiatry (CPMSP), it invited all APA members to defeat the reorganization plan widely believed to be geared towards the self-interest of the GAP. It called for a greater emphasis on "biological investigation and study, and less emphasis on teaching a patchwork of philosophical theories that the public has already rejected as bearing the imprint of neither science nor sense."¹³⁰ The CPMSP newsletter charged that the GAP was "conceived on the emotional level of high school days and is remi-

¹²⁹ Clarence O. Cheney, as cited in Grob (1986), 490.

¹³⁰ CPMSP *Newsletter*, No.1 (Jan 1949), as cited in Grob, "Psychiatry and Social Activism," 495.

¹²⁸ *Ibid.*, 489.

niscient of the gappa gappa clubs,” and that it was “a devious political group established to obtain control” of the APA. The CPMSP even went so far as to threaten legal action against the APA for reimbursement of the monies spent on the appointed Medical Director. The harsh language and charges brought forth by the CPMSP sent shockwaves through the APA, and it became apparent that the schism had reached such a height it now threatened to disintegrate the organization and undermine psychiatry’s legitimacy altogether. As Grob describes, “The airing of intraorganizational differences in the open threatened to undermine public respect and confidence and thus destroy the very legitimacy essential to the well being of any professional group.”¹³¹

Recognizing this danger, both sides eventually did back down, and psychiatry settled into a compromised pluralism in which each side tolerated the other. But what is striking about this episode in psychiatry’s history is that while on the surface this was a fight for control, underneath it was two sides arguing for their closest approximation of what the nature of mental illness truly is. In fact, neither side held the key—the nature and etiology of mental illness remained unknown. As Grob points out, “Admittedly, it might have been possible for psychiatrists to concede their inability to explain complex physiological and mental processes. Such a concession, however, would have threatened the legitimacy of the specialty and perhaps opened the door to those claiming to possess answers.”¹³² Instead, both sides acted from a position of assumed authority, and were not only threatened by each other but were also unyielding to one another. Each side’s rejection of the other was, in many respects, indicative of their vulnerability; as each side could not definitively say they held the key

to mental illness, each side had to vigorously defend their intuited solution. What is equally striking, as Grob points out, is even though mental illness was still not understood in the same way other physical diseases in medicine were, psychiatrists still spoke as if they were. As Grob states, “the language of psychiatric debate was couched in traditional medical and scientific terms. This was true even though the issues—the sources of behavior and human nature—were not, at least at the time, susceptible to conventional scientific analysis...so firm was the faith in science and medicine that virtually none of the protagonists recognized that their respective claims rested on shaky foundations.”¹³³

Ever since the days when neurology attacked it for its isolation, psychiatry had been aligning itself with medicine to assert its legitimacy. It was through scientific claims, not philosophical claims, that psychiatry could defend its rightful authority over the treatment of the mentally ill. Subsequently, it modeled itself as a profession after other medical specialties. In an era when faith in science was strong, only through the assertion that psychiatry itself was a real medical specialty, taking its logical place within the sphere of general medicine, could psychiatry gain public and professional support. As Bowman said in his 1946 address, “Mental illness is a form of disease. Psychiatry is a branch of medicine. We must keep this relationship constantly before the public.”¹³⁴ But this posed a considerable challenge, as the realm of mental disease never quite conformed to science in the same way other physical diseases did. Therefore, psychiatry’s legitimacy was based upon a tenuous claim, and was always precariously close to being discredited by its medical colleagues and other emerging professions that began to deal with the mentally ill.

¹³¹ *Ibid.*, 495.

¹³² *Ibid.*, 499.

¹³³ *Ibid.*, 500.

¹³⁴ As quoted in Pressman, 183.

The push to be accepted as a legitimate branch of medicine motivated much of the directions psychiatry took in the early 20th century. It colored the way psychiatrists approached the study and treatment of mental illness, and influenced the way in which psychiatrists envisioned themselves functioning as professionals. The push early on in the century for the inclusion of mental wards in general hospitals and the opening of free standing psychopathic hospitals was motivated by the hope to “blur the distinctions between institutions—general hospitals and mental hospitals.”¹³⁵ As J.K. Hall mused to a colleague, “I wonder how long it may be before the medical profession is able to think of a state hospital as a general hospital in which mental disease is also treated?”¹³⁶ The dominance of the organic approach to understanding mental illness, and the hope for somatic therapies, was influenced by the advances in the study of diseases, bacteriology, and anatomy enjoyed by other areas of medicine. Even psychoanalysis to a certain extent was sold as an extension of medicine, as a growing interest by the medical community in the phenomenon of psychosomatic illness demonstrated the connection between the psyche and physiology and was used to defend psychoanalytical theories. In short, medicine in the early 20th century was increasingly held in high prestige, and anything coming out of the field of medicine, or for that matter science, was considered legitimate in the public’s mind. An organic approach was the essence of medicine, medicine represented science, and in the 20th century, science represented progress.

Securing a position within medicine, given the obscure nature of mental illness, was not particularly easy, however. As Salmon opined, psychiatry was for many years the “Cinderella of Medicine.” As

¹³⁵ Grob, *Mental Illness and American Society*, 234.

¹³⁶ As cited in Grob, *Mental Illness and American Society*, 234.

Deutsch noted, “So long had the public at large, as well as the general practitioners of medicine, thought of healers of mental disorders in terms of priests, mystics, and wonder-workers, that only with the greatest difficulty did it achieve recognition as a scientific specialty.”¹³⁷ Many of psychiatry’s “medical brethren” held them in low esteem, doubting psychiatry was a real science. As the internist Arlie W. Bock stated, psychiatrists had “managed so successfully to shroud their art in mystic terminology that we have often regarded them in the light of mesmerists...Just what goes on behind their closed office doors has seemed so evanescent to most practitioners as to border on the ludicrous.”¹³⁸ Echoing the sentiments of Mitchell forty years earlier, the neurologist T.N. Weisenberg commented, “If psychiatry is to be judged by its scientific output, it has certainly made a very poor showing in the last few years.”¹³⁹

Psychiatry had to defend its position not only to the rest of the medical profession but to a growing number of fields outside medicine as well, who had begun to work with the mentally ill. One of the drawbacks of expanding the jurisdiction of psychiatry into the community was that it lost its exclusive claim to the treatment of mental illness, a claim that had been maintained in the past by the promotion of the idea of the necessity of the asylum in treating mental illness, the domain of which belonged entirely to psychiatrists. Now psychiatrists were coming into contact with social workers, occupational therapists, sociologists, anthropologists, and perhaps most threatening, psychologists. As the goals of psychiatry expanded to include mental health and prevention as part of a larger Progressive movement, and as the social and environmental role in the etiology of mental illness

¹³⁷ Deutsch, 272.

¹³⁸ As cited in Grob, *Mental Illness and American Society*, 266.

¹³⁹ As cited in Grob, *Mental Illness and American Society*, 279.

began to be considered, these other professions became part of an essential "team" in the fight against mental illness. However, as these professions became increasingly organized in their own right, their assumed subservience to psychiatry began to be questioned. The inroads made by these professions was particularly disturbing, as "first because they have threatened to alienate a certain part of the regular medical practice and secondly because they have challenged the term 'disease' as the final and fundamental concept underlying the disorders."¹⁴⁰ For example, clinical psychologists began to question the assumed unique jurisdiction claimed by psychiatrists in dealing with all forms of mental illness. As the psychologist Shepherd Ivory Franz commented, "some of the abnormalities of which psychiatrists talk as fields for the psychiatric expert, such as criminality, prostitution, vagabondage, etc.," rightly belonged to the field of psychology, and further, "How many psychiatrists are really able to deal with questions 'involving the whole mental and physical life of the individual?'" Why, he continued, was knowledge of physiology looked upon as necessary for the physician but psychology not regarded as a required subject for the psychiatrist?

Aware of the increasing activities of clinical psychologists, psychiatrists grew increasingly suspicious, and in 1916 the New York Psychiatric Society appointed a committee to investigate the activities of psychologists. The committee subsequently made the following recommendations, revealing of a growing need for psychiatrists to assert themselves:

1. We recommend that the New York Psychiatric Society affirm the general principle that the sick,

whether in mind or body, should be cared for only by those with medical training who are authorized by the state to assume the responsibility for diagnosis and treatment.

2. We recommend that the Society express its disapproval and urge upon thoughtful psychologists and the medical profession in general an expression of disapproval of the application of psychology to responsible clinical work except when made by or under the direct supervision of physicians qualified to deal with abnormal mental conditions.

3. We recommend that the Society disapprove of psychologists...undertaking to pass judgement upon the mental condition of sick, defective or otherwise abnormal persons when such findings involve questions of diagnosis, or affect the future care and career of such persons.¹⁴¹

Five years later, a conference was held, sponsored by the National Research Council, on the relationship between psychology and psychiatry. The aim of the conference was to address such questions as "If psychologists dealt with the control of behavior, how could they be distinguished from physicians?" "Should psychologists be permitted to practice for fees, and should they be certified and licensed?" and "Should the term 'clinical' be dropped from the language of psychology because it implied a medical problem?" The psychologist Robert S. Wood described the growing rivalry between psychology and psychiatry this

¹⁴⁰ Madison Bentley and E.V. Cowdry, "The Character of the Problem" in *The Problem of Mental Disorder*, 2-3.

¹⁴¹ Thomas Verner Moore, "A Century of Psychology in its Relationship to American Psychiatry" in *One Hundred Years of American Psychiatry*, 472.

way: "The offensive behavior of which psychologists are guilty consists in a crowding in upon the field of the psychiatrist, in aping the medical profession, and treading on the sensitive medical toes. The offense of the psychiatrist consists in staking out, on paper, an exclusive claim to a large unoccupied domain, and insisting that the psychologist shall only work there in subordination to himself."¹⁴²

Psychiatry responded to the doubts to its legitimacy and threat of encroaching professions by shoring up its foundation as a medical specialty. In a symbolic gesture to assert its professional identity, psychiatry's professional organization changed its name a second time in 1921 from the American Medico-Psychological Association to the American Psychiatric Association. In the 1920s and 1930s, a great effort was launched to improve psychiatry's presence in medical school curriculums and to establish board certification for psychiatrists. In this way, psychiatry hoped not only to improve psychiatry's place within the medical community but also to ensure the exclusion of other professions not qualified to practice mental medicine. The emergence of shock therapies, representing successful somatic treatments easily recognizable by the medical community and requiring a specific "expertise" to administer, served to bolster these efforts. Despite the fact that the medical specialty of psychiatry still rested on a purely theoretical foundation, psychiatrists clearly were sold on their own identity as medical experts, as is evident in the comment by the psychiatrist C.M. Hincks. Responding to a Methodist minister inquiring about the type of training he would need to handle the mental problems of his parishioners, Hincks replied, "The practice of psychiatry is so rooted in medical science that it could not possibly be entrusted to the hands of a layman, no matter how wide his

readings on the subject has been. Many mental ailments have their causes in physical conditions and only the trained psychiatrist is qualified to examine the patient and diagnose his case."¹⁴³ The idea of psychiatry as a medical specialty and mental illnesses as organic in nature had become so firmly entrenched that it was now taken as a resolute fact.

What is significant about this struggle for the identity of psychiatry, both internally and externally, is that it had little to do with finding the best way to help patients, either by trying to understand mental illness from multiple angles or by finding the best possible treatments. Much of the debates centered upon establishing and maintaining professional legitimacy and jurisdiction and promoting specific professional agendas. As a result, many psychiatrists did not look beyond their own theoretical orientation for ways to improve or expand their ability to treat mental illness, and instead fiercely defended their chosen positions. This is not to say this was the case for all of psychiatry. In fact, some influential figures within psychiatry, such as Adolf Meyer, William Alanson White, and Thomas W. Salmon, promoted a vision of psychiatry unified with both the medical profession and the social sciences, working together and informing each other in order to understand the whole person in relation to mental illness. But despite these voices, the predominant theme in the story of psychiatry was not one of unity but rather one of opposing camps, and a profession clinging to its identification with science and medicine to the exclusion of any possibly alternative perspectives. This professional stance has had far reaching implications, and influences the profession to this day, as is evident in the staunch biological position of the present day APA.

The theoretical stance one chooses to take in regard to the nature of mental illness

¹⁴² As cited in Grob, *Mental Illness and American Society*, 262.

¹⁴³ *Ibid.*, 306.

is inextricably linked to the methods of treatment one chooses to pursue and support, and treatment became an important weapon in defining one's theoretical stance and defending one's theoretical position. The story of psychiatry is riddled with instances where treatments that show any promising results are assumed to confirm a particular theory about the etiology of mental illness, despite the lack of any data to support the claim, or the potential long-term damage the treatment may inflict on the patient. As Bell states, "The difficult, obscure nature of mental illness, coupled with the many, frequently fruitless methods of treating it, led psychiatrists to grasp any new therapy that promised good, perhaps even spectacular, results."¹⁴⁴ The danger in this approach, however, is to assume that one has arrived at a solution, and that therefore alternative solutions no longer need to be considered. As the psychiatrist Lawrence S. Kubie wisely stated in 1934, "Certainly no one who reasons clearly would dare to use either the success or the nonsuccess of a therapeutical method as evidence for the truth or untruth of the theory behind the method."¹⁴⁵ One wonders if history may in fact be repeating itself today in the liberal use of drug treatments; will this period be looked back upon in the same way we regard the liberal use of shock treatments or the broad application of Freudian theories, as perhaps being overzealous when something appears to be working?

Thomas W. Salmon, in an address given at the opening session of the College of Physicians and Surgeons at Columbia University in 1923, gave this eloquent description of the difficulty in taking a narrow approach to a problem that is infinitely more complex:

A patient comes to us with a mor-

¹⁴⁴ Bell, 140.

¹⁴⁵ Lawrence S. Kubie, "The Psychoanalyst's Point of View" in *The Problem With Mental Disorder*, 82.

bid fear. That fear, for all practical purposes, is the most important thing in his life. It profoundly affects all his relations—physiological, family and social. It may result in his death—from suicide perhaps—as surely as carcinoma could. Psychiatry regards that fear as a medical fact, although we are utterly unable, in the present state of knowledge, to correlate it with any structural change in organ or system of organs and cannot explain its existence or its significance in anatomical, physiological or biochemical terms. Another science, however, psychology, or, to be more precise, a branch of psychology—psychopathology—very largely developed in the study by physicians of mental phenomena in abnormal states, throws light upon the origin of that fear and the part that it plays in the patient's life as a whole. It also provides means for its management so that the fear itself or the dangers that accompany it can be effectively and permanently removed. This would seem to be a creditable medical achievement, but, notwithstanding the fact that the patient came to a physician for aid, scientific medicine today stands coldly aloof from everything connected with it...The anatomical and physiological part of these reactions will some day be clearly understood and then, doubtless, a better method of practical management will be found than that based upon its psychological nature. But, in the meantime, should we be inhibited from even attempting to interpret the psychological phenomena connected with our patient's fear or from using psychological measures in dealing with it, unless we

are willing to see patient, earnest work regarded as “unscientific” and, in some intangible way, “non-medical?”¹⁴⁶

The implication of Salmon’s hypothetical case is clear—was psychiatry, by rigidly aligning itself with one theoretical camp or another, or putting all of its faith in mainstream medicine, really doing the best possible thing for the patient? We might ask ourselves the same question today.

CONCLUSION

The story of the emergence of psychiatry is one of a struggle for professional and theoretical identity. Psychiatrists struggled to define themselves, their beliefs, and their specialty in the face of one of the most confounding phenomena of humankind, the derangement of the mind itself. The nature of mental illness has confounded humans from time immemorial, yet it is tempting to believe that from where we sit today, our current beliefs have finally arrived at a viable and rational solution to the problem. By looking backwards, however, and as the story of psychiatry can attest, beliefs about the nature and etiology of mental illness, and therefore the best way to deal with it, are inextricably linked with the climate of the times.

The emergence of psychiatry as a profession occurred during a time in our history where an unprecedented faith was put in science and technology. It is not surprising, then, that an overwhelmingly organic view of mental illness has dominated psychiatry for most of its existence. However, it was also a time when the push for social reforms facilitated a greater examination of the role social and environmental forces play in human behavior, and this too was forced into

the equation. In addition, psychiatry continued to struggle with the debate over mind and body—are they one in the same, or do they exist apart? And which deserves primacy? With these theoretical questions as a backdrop, psychiatry was also fighting for its legitimacy as a profession; and for its exclusive jurisdiction over the treatment of the mentally ill. To accomplish this, they were forced to suppress the natural ambiguities inherent in a profession built on a foundation of speculation, and put forward the foot of self-proclaimed expertise, even if this expertise was questionable. They put their faith in the bedrock of medicine, a field highly respected by professionals and laypersons alike and perfectly suited for acceptability in an age of science. But to maintain their tenuous hold, they circled the wagons in tight, to the ultimate exclusion and subordination of other lines of research into the question of mental disorder.

Psychiatry today continues to uphold a biological model of mental illness. Although psychoanalysis dominated the field through most of the 50s and 60s, the advent of drug therapies swung the pendulum back in the direction towards an organic conception of mental illness. And even though, unofficially, a more pluralistic view of mental illness has evolved over the last half of the 20th century, lines continue to be drawn between somatic approaches to mental illness and psychological approaches. As the anthropologist T.M. Luhmann discovered in her four years entrenched with budding young psychiatrists in medical school, allegiances are made early, and each side holds a certain amount of disdain for the other. There is a sense that these two approaches primarily tolerate each other. The lines that were drawn in the days of the GAP and GUP have proven difficult to blur.

A comment in Edward Shorter’s *A History of Psychiatry* is revealing of this enduring division. Shorter remarks, “when it comes to treating individual patients, the perspectives themselves really are polar op-

¹⁴⁶ Thomas W. Salmon, *Mind and Medicine* (New York: Columbia University Press, 1924), 19-22.

posites, in that both cannot be true at the same time. Either one's depression is due to a biologically influenced imbalance in one's neurotransmitters, *perhaps activated by stress*, or it stems from some psychodynamic process in one's unconscious mind. It is thus of great importance which vision has the upper hand within psychiatry at any given moment [emphasis added].¹⁴⁷

What Shorter fails to see in his own comment, however, is that the "stress" he attributes the imbalance of neurotransmitters to may be the result itself of a psychodynamic process—therefore one may influence the other, and therefore both *can* be true at the same time. But this is the danger inherent in standing behind and fiercely defending theoretical positions—the complexity and subtle nuances of the problem get lost, and the tendency is to throw all one's eggs in one basket. The danger in this, of course, is in putting too much faith in specific treatments that reinforce the theory one is defending, and this is where the patient, who should be the primary concern yet tends to get lost in the midst of professional posturing, potentially loses. This is a valuable lesson we can learn from the history of psychiatry, which is painfully illustrated in the treatments that came and went. As Adolf Meyer stated in 1917, "Our people are brought up in dogma and they are rarely satisfied without some dogma and many are tempted to bow. Why not swear allegiance to the rich harvest of fact and the dictations of its conclusions?"¹⁴⁸

There are other lessons to be learned from the voices of the history of psychiatry. Not all psychiatrists were compelled to defend psychiatry's territory by throwing all their weight behind a single theory. There were other voices that saw the value in a wealth of ideas shared between disciplines, in a joint effort to tackle the problem of

mental illness. In 1934, the National Research Council, with the support of the Carnegie Foundation, convened a group of experts from all relevant fields in the study of mental illness. The topic was "The Problem of Mental Disorder," and the delegates included experts in neurology, psychobiology, psychoanalysis, physiological psychiatry, clinical psychiatry, genetics, clinical psychology, anthropology, neurocytology, and education. In the introduction to its subsequent published study, the editors noted that when it came to mental disorder,

It is...widely agreed and commonly admitted that present knowledge and existing agencies are quite inadequate for the problem in hand. We may reasonably assume, therefore, that most persons who are actively and responsibly concerned with the disorders and the disordered would agree that new knowledge and new instruments of research brought together from the wide field of the sciences are just now urgently needed to supply new facts, to correct orientation, and to free the subject from the domination of speculative creeds.¹⁴⁹

As we consider psychiatry, and as we consider its place among the other mental health professions, it might do good to heed these historic words. And as we think about mental illness, and evaluate the best approach to its study and treatment, it might serve us well to try to remain aware of the forces that are driving our conceptions, being ever open to question our motives and beliefs, in the hopes of one day getting closer to uncovering the mystery of mental illness.

¹⁴⁷ Shorter, 26.

¹⁴⁸ As cited in Grob, *Mental Illness and American Society*, 116.

¹⁴⁹ Bentley and Cowdry, "The Character of the Problem," in *The Problem of Mental Disorder*, 3.

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