Psychiatry’s Complex History

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SHRINKS: THE UNTOLD STORY OF PSYCHIATRY
By Jeffrey A. Lieberman
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Psychiatry has had a unique history compared to other medical specialties. Unlike other specialties, where private practice was the norm, psychiatry originated within an institutional system designed to care for people with severe and disabling mental disorders. Indeed, to be a psychiatrist in nineteenth-century America was synonymous with employment in an asylum. The prevailing consensus was that institutional care for mental disorders represented the appropriate and professional policy choice. By the mid-1950s the daily census at public mental hospitals exceeded half a million people. Not until after 1945 did psychiatrists begin to abandon their institutional origins and move into private practice.

In Shrinks, Jeffrey A. Lieberman—a distinguished psychiatrist and former president of the American Psychiatric Association (APA)—has attempted to present the history of his specialty. His narrative embodies a familiar theme—namely, the evolution from ignorance to enlightenment. “I wrote this book,” he notes, “to provide an honest chronicle of psychiatry with all its rogues and charlatans, its queasy treatments and ludicrous theories.” Psychiatry’s narrative was marked by false starts and extended periods of stagnation. Scorned by physicians and patients alike for much of their history, however, modern psychiatrists have created the tools to lead people “out of a maze of mental chaos into a place of clarity, care, and recovery.” Lieberman’s glowing account of modern psychiatry, as we shall see, is seriously flawed and demonstrates a lack of knowledge of recent historiography.

Leiberman begins his narrative by noting that the discovery of some mental health disorders, such as paresis (which leads to partial paralysis and mental illness in its tertiary stage), had a recognizable biological basis, while others, such as schizophrenia, dealt with invisible disorders with no (or unknown) biological origins. The result was two distinct disciplines. Neurology dealt with disorders with an observable neural stamp; psychiatry dealt with the invisible disorders of the mind. The failure to find a biological basis for most mental disorders, ironically, led to the estrangement of psychiatry from the rest of medicine, which by the late nineteenth century had been transformed by the germ theory of disease and the establishment of general hospitals with a commitment to medical technology (such as x-rays).

The founding of state hospitals in the early nineteenth century—most of which were located in rural areas far removed from the medical mainstream—were under the jurisdiction of alienists (those who dealt with alienated individuals and later renamed psychiatrists). The role of those who worked in these hospitals, according to Lieberman, was that of a “compassionate caretaker rather than a true doctor.” Their choice of therapies—purges, cold packs, and restraints—only reinforced the separation of psychiatry from medicine. Mental hospitals became simply custodial institutions caring for patients without any hope of recovery.

Into this peculiar mix appeared Sigmund Freud, a figure who, Lieberman writes, was “simultaneously psychiatry’s greatest hero and its most calamitous rogue.” Mental illnesses, according to Freud, were the result of conflicts between unconscious mechanisms that could be identified, analyzed, and even eliminated. His ideas were disseminated by a small group of colleagues, some of whom were eventually ostracized because of their alleged deviations from orthodox psychoanalytic theory.

The migration of these devotees to the United States during the 1930s and the experiences of servicemen traumatized by combat during World War II transformed American psychiatry after 1945. In the ensuing three decades, psychoanalytic and psychodynamic psychiatrists dominated the specialty by training younger figures entering the specialty and chairing most departments of psychiatry within medical schools. These psychiatrists were influenced by the “dogmatic and faith-based approach” of psychoanalysis and hostility toward the inquiry and experimentation of Freud, argues Lieberman, and became “a plague upon American medicine.” The result was a shift in psychiatry’s attention from those with serious mental illnesses to those currently known as the worried well. The publication of the APA’s Diagnostic and Statistical Manual of Mental Disorders in 1952 (commonly known as DSM-I) symbolized the triumph of psychoanalytic and psychodynamic psychiatry, despite the fact that none of its diagnostic categories were based on scientific evidence and empirical research.

By the mid-1970s psychiatry was under siege. The antipsychiatry movement (associated with such figures as Thomas Szasz, Erving Goffman, and R. D. Laing) and the rise of competing specialties (such as clinical psychology) had seemingly undermined the legitimacy of psychiatry. The absence of a reliable nosology for diagnosing mental illnesses only
exacerbated the crisis.

All, however, was not lost. A series of fortuitous developments laid the foundation for a fundamental shift. By the early 1970s gay activists had launched a crusade against the psychiatric claim that homosexuality was a mental disorder. Robert L. Spitzer, a young psychiatrist who had served on the DSM-II task force, was impressed with the energy and activism of gay activists and ultimately concluded that there was no credible data indicating that homosexuality was the result of a pathological process.

The elimination of the diagnosis in 1973 by the APA’s Board of Trustees and confirmation of the elimination by a vote of the membership in 1974, however, raised a troubling issue: Were psychiatric diagnoses a matter of personal preference?

Cognizant of the dilemma, Spitzer found an ally in a group of Washington University psychiatrists who believed that it was possible to develop a diagnostic system based on a set of symptoms and the temporal course of those symptoms for each disorder. Psychiatrists could then diagnose illnesses in the same way regardless of theoretical orientation, thus ensuring consistency and reliability. Spitzer ultimately was appointed chair of the committee that led to the publication of DSM-III in 1980—a book that revolutionized psychiatric diagnosis by eschewing etiology and sounding the end of psychoanalytic and psychodynamic dominance. Although changes were introduced in subsequent editions (DSM-IV in 1994 and DSM-5 in 2013), the basic structure remained intact.

In the second part of his book, Lieberman charts the course of psychiatric therapies, beginning with treatments used in the 1920s to the 1940s that included induced fever and coma, lobotomy, and electroconvulsive treatments. The introduction of antipsychotic drugs, such as chlorpromazine and tranquilizers, beginning in the 1950s provided more effective treatments and thus contributed toward integrating psychiatry back into the broader field of medicine. At the same time, the hitherto subordinated and largely ignored group of biological psychiatrists began to focus on the brain and explain mental illnesses in physiological and somatic terms, a development made possible by the introduction of new imaging technologies. At the beginning of the twenty-first century, psychiatry had been reborn. Brain imaging technology and a large and effective psychopharmacological armamentarium placed the specialty squarely within the medical domain.

Lieberman’s book recalls the famous American historian Carl Becker’s comment on Algie Simons’ Social Forces in American History (1911), which, Becker observed, appeared to have been written “without fear and without research.” Since the 1960s the literature on the history of psychiatry has undergone a dramatic if controversial expansion. Books and articles have proliferated and shed new light on psychiatry’s past. With but a few exceptions, Lieberman either lacks knowledge of or ignores these contributions. As such, the presentation of psychiatry as the story of progress from ignorance to enlightenment feels obsolete.

Lieberman’s history also lacks context, such as in his one-sided treatment of mental hospitals. From the early nineteenth to the mid-twentieth centuries, these institutions—whatever their shortcomings—played an important role in providing care for a population with severe disabilities at a time when there were few alternatives. Moreover, any care is a form of treatment, a phenomenon long recognized within medicine itself. Indeed, lengths-of-stay in nineteenth-century hospitals averaged between three and nine months; the long-stay patient was the exception instead of the rule. To be sure, commitments were common. But a late-nineteenth-century follow-up study (published in the Worcester State Hospital Annual Reports between 1881 and 1893) examining nearly 1,000 patients over more than a decade found that 57 percent of those discharged as “recovered” were never again hospitalized. Another analysis, by Morton Kramer (the first head of the National Institute of Mental Health’s biometrics division) and colleagues, of 15,472 patients followed between 1916 and 1950 at Warren State Hospital in Pennsylvania, found that release rates (the point in time in which the staff agreed that the patient was ready to return to the community) increased from 42 percent to 62 percent between 1926–35 and 1946–50.

It is true that twentieth-century mental hospitals had a large population destined never to return to the community. But who were these patients? Between 1900 and 1960 the elderly constituted by far the single largest group. As late as 1958 nearly a third of all state hospital resident patients were older than age sixty-five. The passage of Medicaid in 1965 led states to send these individuals to chronic care facilities, thus absolving the state of a financial burden by transferring fiscal responsibility to the federal government. Similarly, the availability of such federal entitlement programs as Supplemental Security Income, Social Security Disability Income, Section 8 housing, and Medicaid led to the discharge of huge numbers of patients back to local communities, even though most lacked an integrated system capable of providing care and treatment. Community mental health centers, created by federal legislation in 1963, had long since lost interest in treating such patients and were focused on other populations. Lieberman’s dismissal of the social and political context of psychiatry and other mental health professions hardly supports his optimistic view of psychiatry.

Lieberman’s comments on the efficacy of contemporary psychiatric therapies are also overly optimistic. Basic psychiatric care leaves much to be desired, especially for those with severe and disabling disorders. Individuals with such disorders who are served by the public mental health systems die, on average, twenty-five years earlier than the general population as a result of treatable medical conditions. Too many people with mental illnesses are incarcerated rather than in treatment; care remains fragmented and uncoordinated; and people with these disabilities develop secondary problems that are preventable. Translation of much of what we have learned in psychiatry into clinical practice has been exceedingly slow. There is an unwillingness to recognize how little we really know, and too many claims and treatments cannot be sustained by any reliable evidence. The power of pharmaceutical companies and their corruptions remains pervasive, and many psychiatric researchers have compromised ties with the indus-
try. Lieberman’s account does not mention such grave issues.

Lieberman’s enthusiasm for DSM-III and its successors also ignores certain elements. It is true that their diagnostic categories are reliable: There is a high degree of agreement in how different clinicians might diagnose the same patient. But it is also true that these diagnostic categories lack validity and do not necessarily measure what they are supposed to measure. Nor are Lieberman’s claims about the efficacy of psychiatric therapies—especially drugs—supported by available data. There have not been any significant breakthroughs in pharmaceutical innovation in recent decades, and newer drugs are not more effective than earlier ones. Lastly, Lieberman’s glowing comments about neuroscience research are hardly persuasive; they represent a sort of “on the threshold” mentality in which promise of future progress is conflated with contemporary developments. Unfortunately, this book, while ambitious, does not offer a framework to illuminate the complex history of psychiatry.

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