

The many faces of mental illness through time

Hans Pols explains how changes in psychiatry's "fashion-of-the-day" have shaped treatments for mental illness.

Throughout history, mental illness has caused great suffering and anguish to afflicted individuals. People suffering mental illness have inspired concern, puzzlement and frustration from their friends and family members. Mental illness constitutes one of the most difficult challenges for medicine. Because it has biological, psychological, social and cultural components, it does not fit easily into conventional categories. As a result it requires a comprehensive bio-psychosocial approach. Psychiatric explanations for mental illness have often emphasised one of these elements to the exclusion of all others and changes in emphasis have frequently occurred.

Today, psychiatry is considered one of the least prestigious medical specialties. Although our insights into the nature of mental illness have increased, the condition is still poorly understood. While the emotional, social and economic costs of mental illness to individuals, families and society are high, funding for mental health care services has always been modest and is currently declining in the Western world.

During the 1960s, psychiatry was criticised by a number of social commentators. These critics pointed out that most physicians treated patients who sought their assistance voluntarily. Psychiatrists, on the contrary, treated individuals referred to them by the police, the courts, officials responsible for the poor and destitute, and exasperated family members (Szaz, 1995). Unlike other medical specialists, most psychiatrists were not free to choose their own patients and had to provide treatment to individuals who did not ask for it.

Other critics of psychiatry have argued that mental illness is a label for behaviour that does not meet social expectations (which are defined

by individuals in position of power). Psychiatric intervention transforms unconventional and rebellious behaviour into individual pathology (Scheff, 1966). According to these critics, mental illness is not really a disease at all; it is only by pretence that psychiatrists present themselves as doctors (Szaz, 1961). Seen this way, psychiatrists protect the status quo by medicalising, pathologising and

“...the demands of modern life were seen as too much for oversensitive minds”

marginalising those individuals who do not fit in (in this context the treatment of political dissidents in the former Soviet Union is always cited as an example) (Foucault, 1988).

Other critics have argued that mental hospitals make even the healthiest individuals insane by their degrading and dehumanising conditions (Goffman, 1961; Rosenhan, 1973). The critics of psychiatry have overstated their case in many respects, yet their ideas point out vulnerabilities and challenges psychiatrists are facing on a daily basis.

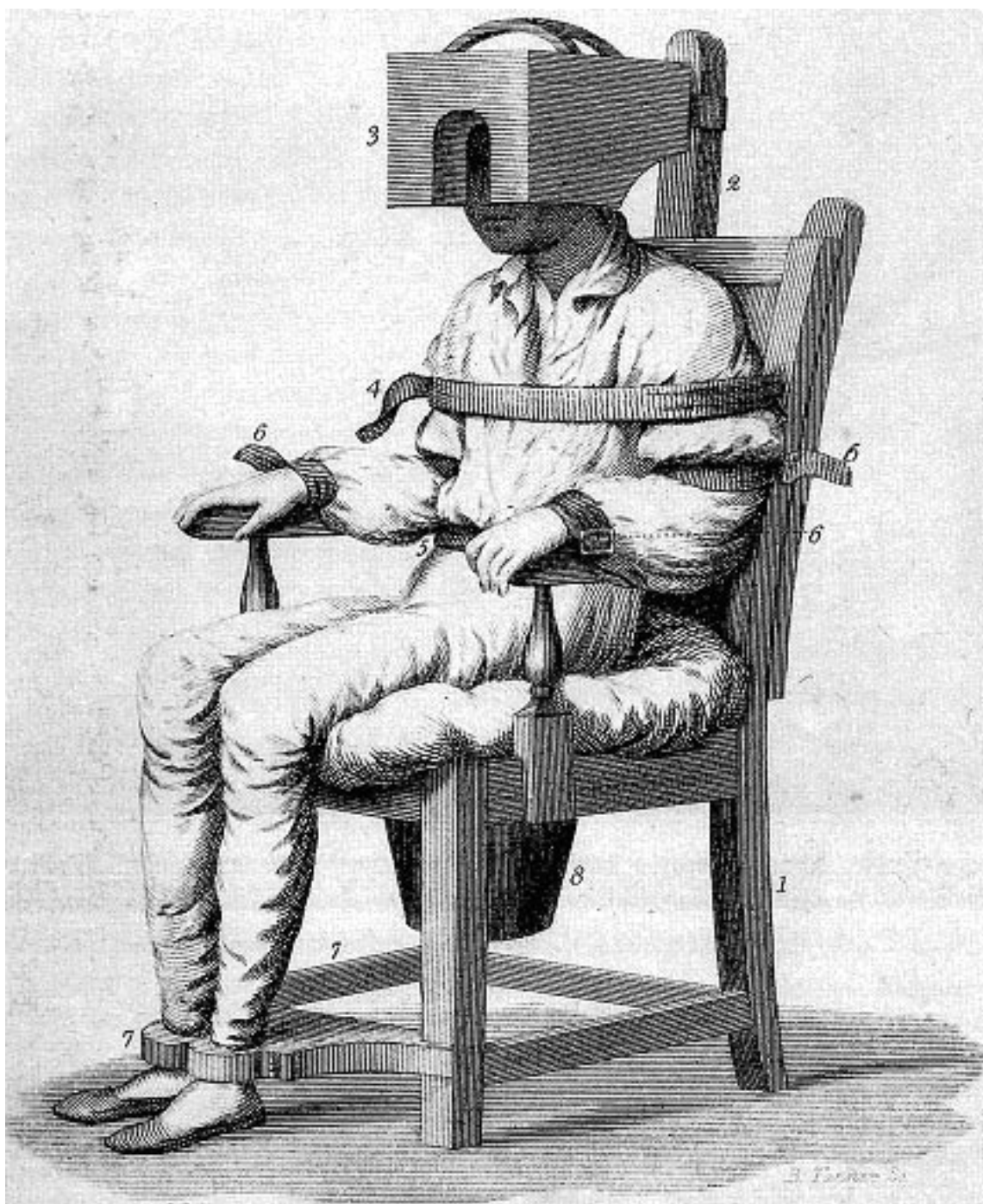
Mental Hospitals and Psychiatry

Treatment of mental illness began in institutions run by the church in which

the poor and destitute could find shelter during periods of need. The famous Bethlehem Hospital in London (popularly named Bedlam) was founded in 1247 by the Order of St. Mary of Bethlehem before it became a Royal and later a City Hospital.

From the 16th century on, a small number of physicians operated institutions where wealthy individuals were treated without the stigma of insanity or where individuals could be placed when their families no longer wished to care for them. Insanity was viewed as a disturbance of reason. Due to their lack of rationality, the mad were considered nothing more than beasts and treated accordingly. Medical intervention followed the heroic treatments common at the time, such as bloodletting, scarring, and leeching (treatments provided by the American physician Benjamin Rush are a well known example) (Rush, 1962). In addition, physicians developed methods to force the mad to conform to the demands of reason by providing severe punishment for the transgression of arbitrary rules.

In the early nineteenth century, Philippe Pinel (in Paris) and William Hack Tuke (in Britain) developed the principles of moral treatment. Both men advocated the view of the mentally ill as confused children who needed a gentle but firm guiding hand. The causes of mental illness were seen as environmental in nature: the demands of modern civilization were seen as too much for oversensitive minds. Tuke convinced his fellow Quakers to raise funds for an institution for individuals suffering from mental illness according to the principles of moral treatment. He abolished the use of restraint and physical punishment by instituting a strict regime in which conforming behaviour was rewarded



***Above: Tranquilising Chair
designed by Benjamin Rush
(1745-1813)***

by approval, special privileges and placement in better wards.

Mental hospitals were housed in beautiful buildings with exquisite gardens. They were staffed by idealistic physicians and guards who were infused by an almost religious zeal to provide treatment (Tomes, 1994). The results were highly favourable. An era of therapeutic optimism commenced. During the second part of the nineteenth century, large mental hospitals were built by the state in several western countries as a result. Psychiatry as a discipline found its origin in these mental hospitals.

This optimism did not last. At the end of the nineteenth century,

mental hospitals became increasingly overcrowded. Many inmates suffered severe and persistent forms of illness and only left in coffins. Large institutions often cared for thousands of patients. Individualised attention was virtually impossible; most patients suffered from conditions which were barely amenable to treatment. As a consequence, an era of therapeutic pessimism commenced. Psychiatrists believed that degeneration

and faulty heredity were the prime causes of mental illness. They did not develop new treatment methods; most individuals with mental illness suffered by neglect.

The Twentieth Century

This was the situation around the turn of the twentieth century. At that time, Sigmund Freud published his *Interpretation of Dreams*. Freud advocated his theory of psychoanalysis and his talking cure as a treatment for mental conditions. According to Freud, mental disorder was caused by



FIG. 71.—THE MANIAC.

Above: Image of a dangerous madman (1806). (Sir Charles Bell, Essays on the Anatomy of Expression in Painting (Longman))

psychological factors; treatment needed to address psychological conflicts and traumatic memories. Freud was part of a group of physicians and lay healers who emphasised mental factors over biological causes (Caplan, 1998). They developed a variety of psychotherapeutic methods to address mental problems. This constituted a significant innovation in the history of psychiatry.

Psychotherapists generally addressed the neuroses or the life problems of individuals who were, in most instances, able to live independently but who suffered mental anguish. As a consequence, they reached a new group of individuals who had not received medical attention for their problems previously. They also treated these patients on an out-patient basis, which was in most cases much more appropriate. Unfortunately, a number of psychiatrists interested in psychotherapy

“..mental illness is a label for behaviour that does not meet social expectations..”

lost their interest in mental illness, which was much less amenable to treatment.

While psychoanalysts and psychotherapists opened private practices in large cities, the medical profession was developing new biological treatment methods for mental illness (Shorter, 1997; Braslow, 1997.) In 1917, the Viennese physician Julius von Wagner-Jauregg experimented on patients with insanity and paralysis resulting from neurosyphilis. He injected them with malaria to induce a high fever and observed that their symptoms subsided.

The German physician Manfred Sakel experimented in the early 1930s with inducing a coma and, sometimes, convulsions in patients suffering from schizophrenia, by injecting them with insulin. At the same time, the Hungarian physician Ladislav J. von Meduna injected schizophrenic patients with metrazol in order to produce convulsions, which he believed were antagonistic to this condition. A few years later, the Italian physician Ugo Cerletti administered electric shocks to a variety of patients claiming it relieved their symptoms.

After their discovery, malaria fever therapy, insulin coma therapy, metrazol shock therapy, and electroconvulsive therapy (ECT) were widely used all over the world. At the end of the 1930s, the Portuguese psychiatrist Egas Moniz developed an even more radical treatment for mental illness: lobotomy, in which parts of the frontal lobes of patients were deliberately destroyed. Lobotomy was widely used in the 1950s and was heralded as a miracle cure (Pressman, 1998; Valenstein, 1986).

All these therapies were received optimistically because they promised to cure mental illness and enabled individuals to leave mental hospitals, which were widely acknowledged to be dismal places. Unfortunately, optimism about these therapies was mostly misplaced. The long-term effects were often disappointing, the side-effects were very serious, and mortality was high. Only ECT, in a modified form, is still used for severe depression which has not responded to other forms of treatment.

In 1954 Thorazine (chlorpromazine) was released. It was a medication which had beneficial effects for individuals suffering from schizophrenia. After World War II, the pharmaceutical industry distributed various chemical compounds to physicians to test on their patients; Thorazine was mostly a chance discovery. The effects for psychiatry were tremendous. The medical model which viewed mental illness as a condition for which a biomedical cause could be found gained momentum as a consequence.

This view on the nature of mental illness was codified in the third edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, which was published in 1980 (Kirk and Hutchins, 1992; Kutchins and Kirk, 1997; Horwitz, 2002; Spiegel, 2005). It defined the different diagnostic categories of psychiatry by symptoms into neatly

defined and separate disorders. The DSM became the diagnostic Bible of psychiatry and is currently used for research into the nature of mental illness around the world.

Current Developments

After 1945, psychoanalysis was dominant in American psychiatry. Australian psychiatrists were never particularly impressed with psychoanalysis and remained strongly adherent to biological models (Damousi, 2005). The discovery of lithium as a treatment for bipolar disorder by the Australian John Cade in Melbourne fit this tradition. After the discovery of Thorazine and lithium, biological psychiatry became dominant world-wide.

The 1990s have been called the decade of the brain and most research funding in psychiatry went to research in biological psychiatry (Andreasen, 2001). In 1992 Prozac hit the market, followed by a number of similar drugs (the selective serotonin-reuptake inhibitors). Initially, Prozac and the other antidepressants were heralded as miracle drugs (Kramer, 1993). The antidepressants became an enormous financial success for the pharmaceutical industry, which made billions. Just like previous episodes in the history of psychiatry, a number of physicians and psychiatrists followed the fashion of the day and came to adhere to

one-sided views on the nature of mental disorder.

Currently, there are a number of concerns about antidepressants. It appears that the data that have been supplied to the [American] Food and Drug Administration were not complete. Complications with the use of these drugs have not always been revealed to the relevant authorities (Healy, 2004). For example, most antidepressants are not suitable for children, who may experience an increased risk of suicide when taking them.

The pharmaceutical industry has attempted to create new diagnostic categories for which their medications could be marketed (social phobia, for which Aropax was marketed, can serve as an example) (Moynihan et.al., 2002; Starcevic, 2002). Antidepressants are currently over-prescribed and, in many

cases, they are the only treatment offered. There is extensive evidence which demonstrates that a combination of medication and psychotherapy provides the best and the most stable long-term outcomes. The treatment of mental disorders requires more than medication alone. Individuals with severe and persistent forms of mental illness generally benefit from taking medications when they are provided in combination with a balanced program of supervised living, guidance and, at times, psychotherapy.

A second challenge to a balanced mental health care policy is the emergence of post-traumatic stress disorder. During World War I, shell shock was generally recognised as a cause of disability in the Army. During World War II, there was a similar recognition of battle fatigue and combat exhaustion (Pols, 1999; Pols, 2004). After the Vietnam War the psychological effects of warfare were generally acknowledged, but only after intense lobbying by veterans groups and the psychiatrists associated with them (Scott, 1990). With the diagnostic category of post-traumatic stress disorder, it was recognised that warfare, violence, and rape can be severely traumatic and cause a variety of psychological problems. This diagnosis has become increasingly popular in modern society and several critics have argued that it is overused today (Furedi,

*“...mental
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insane”*

*Right: Scene
of Bethlam
Hospital
(Bedlam) from
Hogarth's
A Rake's
Progress*





“people often end up homeless or in prisons..”

2004). A sole emphasis on trauma and psychological factors ignores the many facets of mental illness and leads to one-sided treatment approaches.

Conclusion

Contemplating the history of psychiatry and mental illness does not always induce optimistic feelings. Despite the enormous financial cost of mental illness to individuals, families, and society, funding for mental health care in the Western world is declining. In Australia, federal and state funding for mental health care is significantly less than other Western countries.

Australian psychiatrists continuously report that it is impossible to find beds for individuals who need them or to conduct psychotherapy in a meaningful

way (Zwi et.al., 2003). After the closing of mental hospitals, individuals suffering from severe and persistent forms of mental illness often end up as homeless individuals or in prisons.

Social prejudice against mental illness appears to be as strong as ever - having been prescribed antidepressants can still lead to higher premiums on life insurance policies, for example. The case of Cornelia Rau reminds us how poorly the general public (and immigration officers) understand mental illness.

Psychiatry is one of the most challenging medical disciplines dealing with one of the most difficult medical conditions. Mental illness has biological, psychological, social and cultural aspects and requires a comprehensive, bio-psychosocial approach. What is needed, first of all, is a public recognition of the enormous cost of mental illness and a willingness to fund mental health care services accordingly. Secondly, mental health care providers need to be aware of the enigmatic and multi-faceted nature of mental illness, which generally defies quick and easy solutions. In many cases, severe and persistent forms of mental illness are chronic conditions which

require life-long support. This is costly and not necessarily glamorous. We have an obligation to our fellow human beings to provide the support they need through a balanced program of psychiatric treatment and care.

Acknowledgements:

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2. Image of a Dangerous Madman used by kind permission of J. Howe, Boston College.

3. Scene of Bethlam: http://en.wikipedia.org/wiki/Insane_assylum

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"..it is impossible to find beds for those in need"

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