

20th Century History of the Treatment of Mental Illness: A Review

By Ann Palmer

At the close of the 20th century, it seems fitting to review the past 100 years of the treatment of mental illness. A retrospective may reveal how far we have come. Some advances are obvious: from asylum care to community mental health centers, from the use of physical restraints to the current use of medications, from silence to open discussion. This article acknowledges the development and advances in psychiatry (in particular, psychotropic medication) from the mid-century on. Psychiatry, a science once stigmatized itself, has grown into a legitimate discipline that specializes in diseases of the brain and mind.

Mental illness was once considered a disease of personal failing or a spiritual disease (the mentally ill patient was often considered possessed by evil spirits, thought to be under the spell of witchcraft, or influenced by the moon, from the origin of the term "lunacy"). The insane were seen as incurable, subhuman creatures doomed to a life in shackles and chains at an almshouse (poorhouse) or in jail cells for the mad.

The cause of mental illness is now considered an aberration of the brain, a chemical imbalance. Professionals, we trust, are duty-bound to consider mental illness in a less judgmental, more scientific way. In the best of cases, we hope that individuals with mental illness are treated with respect and compassion. Mental illness should be treated with research, medicine and legislation rather than moralizing. The intent of this article is to reveal the contributions to mental health care throughout the last century of the millennium.

Asylums were created in the hope that by removing "lunatics" from the community, they could be restored to health in a therapeutic environment. The aim was to promote recovery with the hope that individuals could return to their communities. In addition to the use of wrist and ankle restraints and straitjackets, asylum physicians used bromides and other drugs to induce a more tranquil state in agitated patients. Another intervention was sterilization of patients, if their mental condition was deemed incurable. Custodial concerns soon overwhelmed therapeutic goals; lack of beds was a major problem (Grob, p. 104). Often, the problems of wrongful confinement led to exposes of the conditions of the "madhouses."

The 1890 State Care Act (Grob, p. 121) led to state responsibility for the mentally ill. It was hoped that state control would focus responsibility, enhance accountability, and ensure higher standards of care of the mentally ill. One consequence of this was that the mental hospital took on the almshouse's (home for the poor) function of caring for those who were deemed chronically insane. Mental hospitals often took on the function of old age homes by caring for the elderly population, often patients with Alzheimer's disease or senile dementia. Also, care was provided for individuals suffering from the insanity (and paralysis - syphilitic paresis) resulting from venereal disease. By inoculating (injecting) the patient with malaria, doctors found that the progression of paresis could be halted. The patient was then given quinine to combat the malaria (Grob, p. 124; Shorter, 1997, p. 193). This treatment offered one of the first hopes that biology could help persons with severe mental illness. It was also used on patients with a variety of other mental illnesses, with no success.

With the rise of scientific medicine (Grob, p. 130), a shift occurred from custodial care to an exploration of the biological bases of mental illness. The goals were to identify causes and develop appropriate interventions for those suffering from acute illnesses.

Early 20th century psychiatry advanced the concept of mental hygiene - the belief that it was easier to prevent rather than treat mental disorders (Grob, p. 151). Laboratory science allowed scientists to examine the brain to reveal the mysteries of mental illness. Neurologists and microbiologists concluded that mental illness was a disorder of the nervous system. Psychiatric diseases were now being viewed as medical problems requiring medical solutions. In 1920, the American Medico-Psychological Association became the American Psychiatric Association (Grob, p. 162).

Also at the turn-of-the century, psychoanalysis, developed by Sigmund Freud, was gaining popularity. Psychoanalysis peered into the inner lives of patients, viewing their symptoms as personal stresses or social dysfunction stemming from the negative influences of childhood events. Group psychotherapy was introduced in 1934. Patients expressed relief at hearing they were not alone with their difficulties (Shorter, 1997, p. 237). The attempt to merge the medical and psychoanalytic treatment approaches would take years.

In many cases, doctors used drugs that not adequately tested, as well as electroconvulsive therapy (which was first called electroshock therapy), insulin shock therapy (which induced comas in patients by the injection of insulin), Metrazol (induced seizures), hydrotherapy (the wet sheet pack, the continuous bath), fever therapy and lobotomy (Grob, p. 178). Professionals held out hope on the remote chance that these largely experimental treatments would help the mentally ill patient. Lobotomies, in particular, achieved rapid acceptance due to widespread publicity in the media (Grob, p. 183). They were commonly believed to assist in controlling psychotic behavior. The procedure of the lobotomy, introduced in 1946, was often performed with an ice pick on the frontal lobes of the brain. While it did serve to tranquilize some agitated patients, it more or less deprived them of their social skills and judgment. Nonetheless, the director of this procedure won the Nobel Prize in Physiology and Medicine (Shorter, 1997, p. 227). This therapeutic technique would fall by the wayside with the introduction of antipsychotic drugs in the 1950s.

During the war years, there was an alarming shortage of personnel in the existing mental hospitals. Also, limited time was devoted to teaching mental diseases in medical school. After 1945, there was an effort to shift the care and treatment of the mentally ill from the asylum to the community (Grob, p. 191). For well over a century, the asylum had been the primary model of care for the mentally ill. Public outrage ensued when asylum conditions were brought to light. The term "snakepit" emerged around this time to describe the horrifying conditions of the asylum.

The Group for the Advancement of Psychiatry (GAP) considered itself a vehicle for change. They sought to develop mental health policy, create a political agenda, and highlight the severe problems in the nation's mental hospitals. [This call for reform exposed the deplorable, overcrowded conditions and chronic understaffing and brought a renewed determination to change asylum conditions (Grob, p. 200).

The 1946 Mental Health Act awarded grants to establish mental health clinics and treatment centers (Grob, p. 205). This helped create an organized mental health lobby which led to better policy making. Also established were the National Institutes for Mental Health (NIMH) programs and research foundations to initiate change. The acceptance of psychiatry as a legitimate and vital discipline, the information gathered on mental symptoms of soldiers who fought in WWII, the publicized standards of care in mental institutions, and the introduction of the federal government into the mental health system (Grob, p. 223) all served to shed a much-needed light on the care and treatment of the nation's mentally ill.

In 1949, lithium was discovered to treat and reduce symptoms in manic patients. After a long delay, the FDA approved the drug in 1970 (Shorter, 1997, p. 256). Lithium was a significant scientific accomplishment in the treatment of mania and depression.

In 1952, chlorpromazine (Thorazine) was discovered by Henri Laborit. The condition of patients with psychosis and delusion who were given the drug improved markedly. Considered a wonder drug, Thorazine alleviated symptoms of hallucinations, delusions, agitation and thought disorders (Shorter, 1997, p. 252). Yet this miracle drug had its drawbacks: a cluster of involuntary and reportedly embarrassing movements. This condition is called *tardive dyskinesia*. The patient exhibits extrapyramidal symptoms (involuntary grimacing and embarrassing, uncontrollable body movements). Improved patients could be discharged, yet when they experienced symptoms of tardive dyskinesia in the community, they would often stop taking their medication (Shorter, 1997, p. 253). Regardless, the success of Thorazine paved the way for increased research in the field of psychopharmacology. For many patients, Thorazine so lessened psychotic symptoms that many could lead relatively normal lives. With the introduction of Thorazine, the age of psychopharmacology had begun (Shorter, 1997, p. 255). Here were sown the seeds of deinstitutionalization. Viewed as virtually cured, mental patients could be released back to their families and communities. Many ex-patients were unable to organize their lives, find housing or work and many became homeless (Shorter, 1997, p. 280). The states, for the most part, never created the outpatient services that were supposed to replace those of the state hospitals. This phenomenon grew over the next few decades before measures to alleviate the problems were implemented.

The development of promising psychotropic drugs, and the growing use of psychotherapy and other treatments, increased the likelihood of improved care of the mentally ill. The mental hospital was soon seen as a therapeutic community where insights were gained and limitations were revealed. There was a shift from the institutional to a community practice of psychiatry, coupled with the expanding field of psychiatric social work and nursing. Unfortunately, these advances were of limited benefit to the severely and persistently mentally ill individuals.

In 1953, the National Mental Health Association, in the hope of banishing forever the former deplorable treatment of individuals with mental illness, sought to create a symbol of hope and freedom in the casting of a bell made from hundreds of metal restraints formerly used in mental hospitals across the nation. The inscription on the bell reads: "Cast from shackles which bound them, this bell shall ring out hope for the mentally ill and victory over mental illness."

Meprobamate (Miltown, Equanil) achieved enormous popularity and the name *Miltown* became part of the popular culture. Tranquilizers had hit the market on a mass scale starting in 1955 (Shorter, 1997, p. 316).

The first antidepressant drug *imipramine* (Tofranil) was developed in the 1950's. By 1980, there would be dozens of brands and types to choose from. The availability of this and other drugs began to transform the practice of psychiatry. A new branch called biological psychiatry (or biopsychiatry) began gaining popularity. Also, there was a growing use of the term *community psychiatry*, which included prevention, care, treatment, and rehabilitation programs (Grob, p. 250).

In the late 1950's, the Joint Commission on Mental Illness and Health (JCMIH) submitted a report entitled *Action for Mental Health*. There was a call for increased research, financial support, educational and research activities outlined for NIMH, and federal support for research centers. Also, recommendations were outlined regarding increased and better trained staff, new services for the mentally ill, and methods to increase public awareness about mental illness (Grob, p. 247). After this report was released in 1960, there was a greater public awareness of the outdated nature of institutions for the mentally ill. The goal was to develop a new system of care and treatment and to rebuild the state hospital system.

In 1960, R.D. Laing put forth the idea that the mentally ill were displaying a 'sane' response to a mad society (Shorter, 1997, p. 276). Institutional psychiatry had come under attack. While there had been numerous exposes on the poor conditions of asylums, these new critiques focused on the dehumanizing aspects of institutions. Moreover, a new sociological theory called "labeling theory" asserted that an individual, once diagnosed with a mental illness, was subject to stigmatization and actually produced behavior that psychiatry labels "disturbing." In this light, sociologists contended the field of psychiatry encouraged self-fulfilling prophecies (Grob, p. 272).

In the 1960s and 1970s, the antipsychiatry movement gained momentum. It was a resurgence of critical thought and expression regarding psychiatric illness. Proponents contended mental illness is not medical, but has its roots in social, political and legal areas. Researchers, writers and protestors firmly believed that psychiatric illness is purely a social construct (Shorter, 1997, p. 274). Here, sociologists (and others) offered their critiques and demanded the deconstruction of psychiatric illness with the intent of liberating individuals from the stigma of being labeled pathological. *The Myth of Mental Illness* by Thomas Szasz was widely popular.

Shaping the idea that mental health community care was better than confinement in remote, custodial-care mental hospitals, the Community Mental Health Centers Act (signed into law by John F. Kennedy on October 31, 1963) demanded a national system of care to meet the needs of severely and persistently mentally ill (SPMI) individuals and allow for a range of services outside the hospital (Grob, p. 279). Yet, the Act did not serve the needs of psychotic patients, but mainly offered psychotherapy for non-chronic patients (Shorter, 1997, p. 238).

The implementation of the CMHC Act of 1963 was stalled by the Vietnam War. However, there was yet an increase in the number of community mental health centers and a decrease in the number of patients on the inpatient wards of mental hospitals. This was decidedly a success in the care and treatment of mentally ill persons. Critics thought otherwise. CMHCs were charged with providing only counseling and crisis intervention for problems in daily living, becoming therapeutic offices for the 'walking well.' The needs of the SPMI population were overshadowed yet again by the treatment of individuals with substance abuse histories.

In the 1960's and 1970's, there was a push away from traditional psychoanalysis, and a return to approaching psychiatry as a neuroscience: a disorder of the brain. Study of brain chemistry increased. Medications developed as a result of psychopharmacology. Antidepressants and anti-anxiety drugs (Librium and Valium chief among them) were developed and mass-marketed. They were later found out to be addictive.

In the 1970's, a new cluster of symptoms of Vietnam veterans was given a name, however cumbersome: posttraumatic stress disorder (PTSD).

Another development in the 1970s was the discharge of a greater number of the severely and persistently mentally ill (SPMI) from mental hospitals. Media coverage brought to light the individual and social costs of mental illness, as well as the inadequacies of mental health care and treatment. The supports available through federal entitlement programs also facilitated the discharge of many institutionalized patients. Yet, there was still a core group of patients who required long-term institutional care.

Deinstitutionalization, as a whole, allowed a large part of the SPMI population to receive a number of services that would allow them to live independently in the community. Support networks, outpatient clinics,

job search assistance and halfway houses were a few of the newer programs for released patients.

Also in the 1970s, a new group of mental patients was evolving. In what could be described as revolving door patients, these chronically ill people were released, often went off their medications, refused to participate in their treatment plans, and were generally noncompliant. Many had a dual diagnosis of mental illness and substance abuse, making their cases harder to treat at the outset.

Congress passed a law in 1975, mandating that CMHCs provide a number of services allowing for comprehensive community mental health care (Grob, p. 283).

Also in 1975, the release of the movie *One Flew Over the Cuckoo's Nest* (a 1962 bestseller) gave the public an awareness of the horrors of electroconvulsive therapy (ECT). It seemed to persuade this generation that ECT was on par with lobotomy so that it took over a decade to reintroduce the procedure (now proven to assist those individuals in recovery from depression). Some critics maintained the movie's message was that psychiatric patients are not ill, they're deviant. Thus psychiatry was an illegitimate means of social control against the deviance some individuals manifest (Shorter, 1997, p. 275).

In 1977, President Jimmy Carter assisted in the creation of the President's Commission on Mental Health, which would hold meetings, review needs, and make recommendations. The Commission found that many people released from mental hospitals were at high risk of rehospitalization, partly due to lack of adequate food, clothing, shelter and community supports.

In 1980, the Mental Health Systems Act was signed into law. It outlined the basics of a national system for mental health community care and treatment. Newly sworn in as president, Ronald Reagan nullified this policy almost immediately, stressing that federal funds must be cut (Grob, p. 301).

Selective serotonin re-uptake inhibitor (SSRI) drugs came out in the early 1980's. By a mechanism not fully understood, this class of drugs tends to reduce depression. They are now being used to treat other syndromes and disorders such as bulimia, obsessive-compulsive behavior and panic disorder.

There was a trend to view distress in psychological, rather than medical or social terms. For example, what was once youthful exuberance became ADHD. Once commonly known as frightful experiences became PTSD. Depression's serious symptoms (bleak mood, anhedonia, suicidal thoughts) widened to include a more common form of unhappiness, clinically known as dysphoria (Shorter, 1997, p. 290). The widespread diagnosis of depression from its mild to more severe forms contributed to making Prozac the most successful psychiatric drug in history. Prozac treated depression and anxiety on such a common basis; it was a pill that offered the promise of helping individuals cope with life's stresses in the absence of psychiatric illness, as it has usually been defined. Nevertheless, the success of the drug gave social legitimacy to mental disorders, depression especially and made the public aware that mental illness can be treated. Individuals were seen less and less as having failings of moral character. Stigma, we can surmise, was reduced.

Naming diseases (the term *nosology* was used) began in the earlier part of the 20th century and books proliferated over the years until, in 1949, the APA oversaw a project to begin a single, national method of classification: the Diagnostic and Statistical Manual of Mental Disorders (the DSM-I).

In an attempt to standardize mental health diagnoses, the DSM-II was published in 1968. The DSM-III updated the old version in 1980, with more precise diagnoses that were based on symptoms rather than theoretical bases (which was much more open to interpretation). The DSM-III-R (revised edition, 1987) was

of historical import in that it eliminated the listing of homosexuality entirely. In 1994, the DSM-IV listed 297 disorders. This figure was up from 180 disorders in the DSM-II (Shorter, 1997, pp. 298-305).

Even though a cure for mental illness is still beyond the reach of mental health professionals, it is still an ongoing struggle. Mental health services, entitlements (SSI, SSDI, Medicare, Medicaid, and others), housing and social supports can open the door to a better way of life. Most recently, there has been a growing movement in what is abbreviated as the C/S/X (Consumers/Survivors/Ex-patients) group. Consumers of mental health services have become involved in issues involving their care and treatment, lobbying for their rights, and representing themselves on community service and advisory boards.

Society's beliefs about causes and science's treatment of mental illness has certainly advanced in the last one hundred years. Not too long ago, public perception of the mentally ill was one of moral or personal failings. The treatment of mental illness has since evolved scientifically, politically, and publicly. Psychiatric professionals, legislators and advocates have come forth to offer more assistance to those with mental illness. No longer hidden in the back wards, people with mental illness have received adequate and sometimes miraculous treatment that gives them the independence and freedom each of us deserves.

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