HISTORY OF MEDICINE

A Scandalously Short Introduction

SECOND EDITION

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Wrestling with Demons: History of Psychiatry*

No one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast, and seeks to wrestle with them, can expect to come through the struggle unscathed.


Mental illnesses are unique because they continue to be defined by assessment of the patient’s symptoms or behaviours, rather than by physical, chemical, or anatomical tests. Many themes presented earlier come into play in this chapter. They include the long-standing importance of a life force in explaining the functions of living beings (see chapter 3) and the tension between two pairs of rival disease concepts: first, disease from the outside versus disease from within; and second, disease of the individual versus disease of the group (see chapter 4).

The mind has often been equated with a vital spirit. Just as Galen’s concept of a life force resonated for Christian theologians who saw it as the soul, vitalism has had explanatory power in psychological theories of illness. Vitalism makes a comeback in psychosomatic theories that link physical ailment to prior emotional suffering. As a result, mental illness relates to physiological or holistic concepts when it is diagnosed by observation of the disturbed relationship between a body and its environment.

*Learning objectives for this chapter are found on pp. 455–6.
But mental illness also relates to ontological concepts when its cause implicates discrete changes inside the body provoked by external agents, be they demons or chemical derangements. Much recent research builds on a commitment to this latter view by analyzing external triggers and why or how various drugs accomplish their helpful effects.

The word ‘psychiatry,’ derived from two Greek words meaning ‘soul’ (or ‘mind’) and ‘healer,’ is relatively new: it was coined by the German physician Johann Christian Reil, and used in English less than two centuries ago. The word ‘psychiatry’ implies that these conditions are of the psyche, not the soma. By definition, then, psychiatric disease is disorder of mind, not body, with respect to its cause and manifestations. Mental illnesses may display alterations in the body, but they are not identified by them. Rather, they are distinguished by changes in behaviour, perception, thought, or affect. Yet in contrast and throughout history, mental diseases were usually considered to be the product of unseen physical causes, such as diet, poisonings, occult infections, or structural and biochemical change.

Prior to the integration of anatomy with bedside medicine, the classification of all diseases, or nosology, was based on the study of patients’ symptoms (see chapter 4). As physical pathology grew, some diseases once thought to be of the mind were reclassified as diseases of the brain, the nerves, or the metabolism: epilepsy, tertiary syphilis, tetanus, congenital mental deficiency, cretinism, and deafness. They now appear in the psychiatric literature only because of associated symptoms, such as depression and anxiety. Psychiatric disorders are ailments that are ‘left over,’ they cannot yet be sorted into an anatomical or physiological realm.

Classification of disease in modern psychiatry remains in a state of subjective symptomatology akin to eighteenth-century nosology. Notwithstanding the exciting discoveries of many scientists, no blood tests, biopsies, ultrasounds, scans, or electrodynamic studies can objectively confirm a psychiatric diagnosis.

**Themes in the History of Psychiatry**

First, the tension between the physical and psychological causes of mental disease has been apparent throughout the history of mental illness. Until recently, neurology, as the study of brain and nerves, was indistinguishable from psychiatry. Disorders of the mind were assumed to be of the brain; premortem detection of specific lesions was beyond the capacity of doctors. Indeed well into the twentieth century, practitioners often specialized in both neurology and psychiatry. Only with the advent of anatomical definitions, and especially imaging, did the neurosciences begin their distinct rise (see chapter 3). The dichotomy between physical and psychological causes of mental illness has increased, and a debate over their relative importance pervades psychiatry today.

Second, ‘normal’ behaviour is socially and culturally determined; therefore, behaviours that are labelled ‘abnormal,’ ‘mad,’ or ‘insane’ can also be socially determined. Actions considered normal in one culture may be unacceptable in another; examples include incest, cannibalism, killing, genital mutilation, predicting the future, and political dissent. As a result, the mental state that leads an individual to socially unacceptable actions can be viewed variously as criminal, sinful, or sick. Psychiatric diagnoses can and have been socially constructed; as a result, psychiatry is vulnerable to abuse as an instrument of social control. The judiciary exploits the subjective nature of psychiatric diagnosis when expert witnesses are selected to contradict each other in court over questions of sanity. Additionally, the recognition and the experience of mental illness varies from culture to culture; our concern in this chapter, as elsewhere in this book, is psychiatric history in the West. (For histories of other medicines, see online resources at http://histmed.ca).

Finally, mental illness has carried a stigma, deriving from the patient’s apparent unreliability, unpredictability, tendency to violence, and perceived responsibility for the illness. Unlike most bodily ailments, mental disorders can sometimes be feigned. Homer’s Odysseus, the biblical King David, and other ancient heroes pretended to be mad to achieve specific ends. This common knowledge tends to imply that all persons who behave unacceptably may have consciously chosen behaviours that they could or should be able to control or prevent.

**Historical Overview**

Madness has been recognized since the earliest times, but it was not
always a problem for doctors. In antiquity, it was identified by wide-ranging symptoms, including convulsions, crying, laughing, screaming, violence, emotional pain, and the inability to learn or remember. In Hellenic and Judeo-Christian traditions, people so afflicted were sometimes taken for prophets; examples include the Trojan princess Cassandra and the Christian saint John the Baptist. A few ancient writers cited psychological or emotional causes to explain the behaviour, but most found physical explanations residing in naturalistic and material theories of the humours. For example, in Hippocratic writings, epilepsy was the result of phlegm obstructed in the brain; depression was due to an accumulation of black bile — hence the term ‘melancholia’ (from Greek, melanos [black], khole [bile]); Afflictions of women, both physical and mental, were attributed to a wandering womb (hystera) — the origin of the term ‘hysteria,’ invented at a much later time (see chapter 11). ‘Hypochondria,’ now restricted to excessive worry about illness, originally referred to any symptom, usually pain, situated under (hypo) the ribs (chondros [cartilage]), that is, in the upper abdomen; the term was indifferent to the perceived cause, be it physical or mental.

In the second century A.D., Aretæus of Cappadocia, who vividly described diabetes and other physical ailments, defined ‘mania’ as delirium without fever, distinguishing it from ‘phrenitis,’ which was delirium with fever. He also recognized that periods of mania, or fury, could alternate with periods of depression (Chronic Diseases I, v, vi). Emphasizing the perceived physical causes for these conditions, treatments were also physical, including diets, baths, ointments, drugs, and rest. Greek and Roman societies created laws to protect families from dangers posed by the insane, who were feared, shunned, prayed over, and mostly left alone.

The first institutions for the care of the insane were the ninth- and tenth-century mauristans in the Islamic cities of Baghdad, Cairo, Fez, and Damascus. Muslim societies believed that the insane were divinely inspired rather than demonically possessed; words to describe them were majnoon (veiled) or ma’ajin (pulled, by the grace of God). Because mad people were holy, emphasis was placed on providing comfortable accommodation rather than treatment or confinement. Mauristans are said to have been luxurious, but restraints were used to control violent outbursts.

The first European mental institutions appeared in places that had felt Islamic influence, especially fourteenth-century Spain at Granada, Valencia, Zaragoza, Seville, Barcelona, and Toledo. A Spanish shepherd-turned-merchant, who had suffered a psychotic episode, founded an order of hospitaliers, later named after him as the Order of St John of God; he was buried in Granada and canonized in 1690. Like their Middle Eastern predecessors, these widespread institutions functioned as hospices for decent care, not cure, of people suffering from all ailments, physical and mental (see chapter 9).

Citing literary sources, some scholars have suggested that medieval doctors conceived of emotional causes for mental disturbances and consequently sought emotional cures (Alexander and Selesnick, 52). In the late Middle Ages and Renaissance, social control of deviance became a major preoccupation. Persons given to unusual behaviour were thought to have let down their moral guard and been possessed by demons. ‘Treatments’ resembled persecutions and included beating, whipping, expulsion, and execution. Care of the mentally disturbed was the responsibility of each community, and patients were lucky if they were simply neglected. Some communities in northern Europe are said to have hired sailors to remove the unruly — hence the origin of ‘ship of fools,’ a metaphor for the human condition in sixteenth-century Germany. Over a period of three centuries, unknown numbers of unconventional women were burned as witches by perpetrators who feared epidemics of madness — perpetrators who themselves have been portrayed, more recently, as victims of mass hysteria. Those whose distress did not threaten their survival or that of others managed alone, doubting that help could come from medicine.

Mind and Medicine

What physic, what chirurgery, what wealth, favour, authority can relieve, bear out, assuage or expel a troubled conscience? A quiet mind cures all.

— Robert Burton, Anatomy of Melancholy (1651), pt 5, 4.2.4
Hospitals founded to provide humane care gradually became horrifying places of incarceration. The Charité de Senlis, in France, run by the order of St John of God, forbade restraints and punitive therapies, but such leniency was the exception. Ostensibly to protect society, criminals, beggars, prostitutes, the poor, the chronically ill, and some mad people were held indefinitely in squalid, rat-infested places and subjected to punitive ‘treatments,’ designed to shock or humble them into behaving ‘rationally.’ The administrators of these so-called hospitals in France, Germany, and Britain enjoyed absolute power over the occupants and immunity from the courts and police.

By the eighteenth century, St Mary of Bethlehem Hospital in London, built in 1247, had become the fearful ‘Bedlam.’ In his series of engravings, The Rake’s Progress, William Hogarth depicted Bedlam as the miserable and deserving end of a wanton bon vivant. Custodial rather than medical, these institutions employed few doctors and ignored physical health. Their seemingly less-than-human occupants became objects of paid entertainment; however, the oft-repeated claim that 96,000 annual spectators paid a penny apiece to stroll the wards of Bedlam is probably a gross exaggeration (Patricia Allderidge, in Bynum, Porter, and Shepherd, vol. 2). At Bethlehem hospital, four generations of the Monro family occupied the post of director; John Monro’s 1766 case book has recently been published by J. Andrews and A. Scull, shedding some light on the matter. Scholars now try to discern how much (or little) superintendents focused on diagnosis and care of patients.

Asylum reform spread over the Western world at the end of the eighteenth century. ‘Asylum’ implies a safe place for seclusion, care, and restoration. The movement was fostered by Benjamin Rush in Philadelphia, William Tuke in England (who was a Quaker and not a physician), and Christian Reil in Germany. In France after the revolution, Philippe Pinel was appointed director of two Paris hospitals – the Bicêtre for men and the Salpêtrière for women, where he implemented a figurative ‘un chaining’ of the insane (see figure 12.1). Influenced by English writers, he argued that many patients were sick from emotional or ‘moral’ causes, and their treatment should be based on emotional or ‘moral’ principles. Unchaining is an appropriate metaphor for Pinel’s work, and it has been portrayed many times in medical art, although the precise moment probably
never took place in the literal sense. Controls were not abandoned.
Patients continued to be confined, and their violence was subdued
by modified straitjackets and other forms of coercion, such as hydro-
therapy (baths). However, tending to diminish the gothic horrors
ascribed to this past is R.J. Esther's analysis of the use of restraints in
a late nineteenth-century American state hospital: they were applied
about 10 per cent of the time, at a rate similar to that of Esther's time
of writing (1997).

Asylums gathered many people with like symptoms and gave phy-
sicians an opportunity to observe patterns of mental illness. Their
goals were to protect and to 'console and classify.' In conjunction
with the scientific zeitgeist, classification of insanity (also called alien-
ation, or vesania) became the cutting edge of research into mental
disturbances. William Cullen of Edinburgh created a category called
neurosis - a Latinization of the word for nervousness. He reasoned
that functional conditions resulted from a highly sensitive reaction
to outside stimuli mediated by the nerves. Within this physiological
category of neurosis, he situated the older concepts of melancho-
lia, hysteria, hypochondria, and sexual deviation. In France, Pinel
and his student Jean-Étienne-Dominique Esquirol also devised clas-
sifications; they distinguished between mental retardation, cretinism,
senility, melancholia, and a category called monomania, in which the
descriptions of neuroses used today could be grouped (see figure
12.2). These doctors were known as 'alienists' - specialists in diseases
that alienated patients from reality.

As explained in chapters 4 and 9, all disease concepts became
increasingly anatomical during the nineteenth century. In conjunc-
tion with the asylum movement, scientists were forging links between
physical changes in the nervous system and certain behavioural dis-
orders. Gradually, organic correlatives were found for conditions that
could no longer be thought of as diseases of the mind: epilepsy, ter-
tiary syphilis, vasculitis, allergy, and stroke. Rigorous anatomical local-
ization of specific changes in the nervous system led to the growth
of the related but separate discipline of neurology. The anatomo-
physiological explanations that had characterized Cullen's approach
gave way to purely functional explanations. The category of neurosis
persisted, but lack of physical findings led to its 'denervation.' 'Psy-
chosis' became the mid-nineteenth-century term for serious alienation or complete disorientation. 'Neurosis,' or 'monomania,' was reserved for alienation in only one dimension.

Psychiatry dealt with what was 'left over' when the neurological disorders were removed. Reil's new word 'psychiatry' (like pediatrics and podiatry) referred to 'healing' of the soul, unlike most other medical designations, which end with the suffix 'ology' (= words or theory about). The etymological choice is telling: the newborn psychiatry of the early nineteenth century was confidently optimistic that it would not only care but cure.

Asylum architecture was designed to demonstrate the imposing stature, power, and authority of the promising new profession. Historians have used architectural designs as a vital source for the aspirations of various societies. Unlike the ancient hospitals in Europe, which slid more or less into becoming warehouses for the insane, asylums in North America were purpose-built through the well-intentioned principles of the asylum movement.

In the United States several institutions were founded on the basis of dignified care: the Maclean Hospital in Massachusetts (1811), the Hartford Retreat in Connecticut (1822), Brattleboro Retreat in Vermont (1834), and the Pennsylvania Hospital for the Insane (1841). They were deeply influenced by Quaker ideals and the European concepts of moral therapy; William Tuke's York Retreat served as a model. Reformer Dorothea Dix, who had herself suffered a 'nervous breakdown,' and physician Thomas Kirkbride of Philadelphia worked to implement these plans on a broad scale.

In Canada, the first dedicated-use asylum was completed in 1850 at 999 Queen Street West, Toronto (see figure 12.3). It was quickly filled to capacity with over 500 patients brought from other hospitals, attics, basements, barns, and shelters. In Hamilton the 1875 asylum, built to house 200 patients, accommodated more than 1,300 by late 1914; during the same period, the London asylum grew from 120 beds to 1,130. The superintendents, Joseph Workman at Toronto and Richard Maurice Bucke at London, became known for their practice based, like those of asylum keepers elsewhere, on the principles of moral restraint.

The word 'asylum,' which still conjures up notions of safety and shelter in a political sense, gradually took on the stigma of mental illness, and various other terms were used to describe the institution (see table 12.1). Strangely, rather than abolishing the negative stereotype, the stigma would eventually attach itself to the new name and another would be chosen. For the Toronto asylum, the address itself also became synonymous with madness and was changed, in the 1970s, to 1001 Queen Street West in an attempt to obliterate its negative associations. Typifying the experience in many places, other Ontario institutions experienced rapid expansion.

As these institutions kept careful records, recent study of their practices and their directors has launched a veritable boom in historical writing because they reveal so much about society as well as medicine (see Suggestions for Further Reading). Some take the life and works of an individual asylum keeper as a window on practices in a time and place: Kirkbride, Monro, Workman, Bucke, Cotton, and many others have been examined in this way. More recently scholars, such as Kerry Davies, Ellen Dwyer, and Geoffrey Reaume, have used remarkable sources produced by patients to uncover personal experiences and the nature of life inside.
Table 12.1
Successive name changes in various Ontario hospitals for mental illness, 1850–2000

<table>
<thead>
<tr>
<th>Lunatic Hospital</th>
<th>Lunatic Asylum</th>
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<tr>
<td>Asylum for the Insane</td>
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<tr>
<td>Insane Asylum</td>
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<tr>
<td>Sanatorium</td>
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<tr>
<td>Ontario Hospital</td>
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<td>Mental Health Centre</td>
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<td>Psychiatric Hospital</td>
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<td>Regional Centre</td>
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<td>Retreat</td>
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<td>Developmental Centre</td>
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<td>Continuing Care Centre</td>
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Historians are divided over whether or not the asylum keepers were heroes or villains. In the more traditional histories, they are portrayed as heroes because they attempted to improve conditions, sought better understanding of psychiatric disturbances, adopted the ideals of moral cause and moral treatment, and tried to find cures. Despite the medical, verbal, and architectural trappings, however, asylums continued to be places of confinement, where diagnoses often incorporated prejudicial notions of class, gender, and race. Some new therapies were worse than useless; they were eventually shown to be harmful. Yet these therapies were not designed to hurt patients deliberately. Why did they once seem to be rational, justifiable, and effective? The answer lies in the generally accepted concepts of mental disease in the nineteenth and twentieth centuries, and possibly also in the frequency of spontaneous remissions, now estimated to be 30 per cent. Natural remissions of illness would suggest effectiveness of treatment through the logical fallacy of post hoc ergo propter hoc (one thing occurring before another makes it seem to be the cause).

By the late nineteenth century, psychiatry was losing professional credibility. Anesthesia, antisepsis, germ theory, and public health had fostered effective interventions for other human problems and had generated great optimism for surgeons, internists, obstetricians, and their patients. Psychiatrists, on the other hand, had yet to make equivalent discoveries – discoveries that could explain, predict, cure, or prevent. One Canadian scholar (Dowbiggin) cited this borderline professional despair as a reason why psychiatrists clung passionately and stubbornly to etiological theories of heredity, degeneracy, and self-abuse – hypotheses that tended to blame patients, rather than medicine, for their incurability – hypotheses that latter fed the eugenics movement.

Notwithstanding the moral cause and moral treatment hypothesis, psychiatric disorders were increasingly perceived to be disorders of the brain, not of the ‘soul.’ If mental processes resided in the brain, then physical and physiological treatments seemed to be justified. Johannes B. Friedreich took a strongly somatist approach to mental disorders; Wilhelm Griesinger combined physical and emotional therapies. Jean-Martin Charcot, a French neurologist, studied hysteria and its modification through hypnotism, but some contemporaries and historians have demonstrated that his desire to find hysteria prompted his patients to reproduce it for him.

Sophisticated observation of the mentally ill continued with the longitudinal study of case histories and autopsies; modifications to the classification schemes were made. In 1899 Emil Kraepelin defined the two major psychoses as manic depression and dementia praecox, subdividing the latter into hebephrenia, catatonia, and paranoia. Two years later, dementia praecox was named ‘schizophrenia’ by Paul Eugen Bleuler. With considerable modification, these categories are still in use.

Twentieth-Century Psychiatry

At the beginning of this century, psychiatric research expanded in three different directions, all of which continue: psychoanalysis, psychosomatics, and psychobiology.

Psychoanalysis

Psychoanalysis had precursors but did not receive medical approbation until the work of Sigmund Freud. A Viennese Jew, Freud began his career as a physician interested in physical and neurological disturbances. During 1885–6, he spent a few months in Paris with Charcot and Pierre Janet, where his interests turned from neuropathology
to psychopathology. But as Freud himself later claimed, it was through the ‘teachings’ of his own patients, most of whom were wealthy and neurotic, that he was led to his theories of the unconscious.

The ideas expressed in Freud’s extensive publications have become cultural icons: the interpretation of dreams, the unconscious, the ego and the id, the importance of childhood experience, sexual conflict, the hydraulic theory of neurotic defence mechanisms, repression, fixations (anal, oral, and genital), fantasy, wish fulfilment, symbols (phallic and otherwise), catharsis, free association, analysis, and complexes—named for mythic figures of antiquity. Critics claim that Freud’s work applied only to himself or to upper-middle-class males in turn-of-the-century Europe, and that its ethnocentric and androcentric concepts, such as penis envy, made it irrelevant to others. Yet whether Freud is lauded or deplored, medicine, psychiatry, and Western culture in general were irreversibly altered. The rapid dissemination of his thought testified to a perceived need for the articulation of non-physical etiologies.

Freud first began publishing in the 1890s. His ideas met with some opposition, but he and his collaborators, Carl Jung and Alfred Adler, found supporters almost immediately. His influential book *The Interpretation of Dreams* was published in 1900; the first international congress on psychoanalysis was held in Salzburg in 1908; and by 1911 the American Psychoanalytic Association had been founded.

An important boost to psychoanalytic theories of disease came during both world wars, when psychiatrists interpreted the debility of soldiers exposed to the stress of war: ‘healthy’ soldiers accepted the constant threat of killing and being killed without incapacitating distress or fear. Unlike other specialties and possibly due to the influence of Jung, psychoanalysis sometimes welcomed the leadership of women: for example, Karen Horney, Anna Freud (daughter of Sigmund), Melanie Klein, and the Canadian Grace Baker.

The ideas of Freud and Kraepelin came to the United States through the Swiss-born Adolf Meyer of Johns Hopkins University; he insisted on careful record keeping and influenced two generations of psychiatrists as his trainees and in his role with national associations. Two of the eight founders of the American Psychoanalytic Association were from Toronto: Welsh-born Ernest Jones and Canadian-born John T. MacCurdy. Jones first learned of Freud in 1903. He brought analysis to Toronto in 1908, when he began working for the dean and first professor of psychiatry, Charles Kirk Clarke; the prestigious psychiatric institute bears his name. Jones was charged with sexual misconduct several times, but he was never convicted. Perhaps the accusations were an occupational hazard of zealous application of the new psychoanalytic theory in a disbelieving society. Jones was one of Freud’s many biographers, and his personal acquaintance with the master lent an authority to his opinions that has only recently been questioned by new historians free of filial devotion. Because Canadian analysts participated in the American organizations, the Canadian Psychoanalytic Society was not formed until 1952.

Theoretical rifts in psychoanalysis developed. But Freud’s ideas have been an important prototype, if not the basis of all psychotherapy – which is treatment by talking, without drugs or other physical modalities. Reflecting the biases of its creators, psychotherapy is generally thought to help the educated, middle- or upper-class neurotic and to be of little benefit to the uneducated, the poor, or the psychotic. Rifts among analysts are reflected in the medico-historical study of Freud, in which his life, his patients, and the evolution of his theories are debated with passion. Restrictions on access to his papers have led to media scandals (see Malcolm 1985; Gelfand and Kerr 1992).

In the last two decades Freud has virtually disappeared from medical school curricula, although his ideas are visible elsewhere. Some medical historians, like Edward Shorter, find this to be a just turn of events away from a brief aberrant moment, when emotional rather than physical causes came to the fore, when deluded doctors invested time in the ramblings of patients rather than probing their brains with scalpels, electrodes, and drugs.

**Resolving Conflicts**

Fortunately, analysis is not the only way to resolve inner conflicts. Life itself still remains a very effective therapist.

— Karen Horney, *Our Inner Conflicts* (New York: Norton, 1945), 249