The History of Psychiatry as a Clinical Science

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Over the years, historians of medicine with Ph.Ds in History have understood the history of medicine largely as an exercise in intellectual or cultural history. But for historians of psychiatry, another orientation is possible: using the vast record of psychiatry's past as a creek in gold country to be sifted until precious nuggets are found that may be of relevance to the care of patients and the advancement of science today. This is presentism with a vengeance, approaching the past not to justify the present, but to aid it. Yet clinical medicine is all about helping patients and furthering science. Why should the history of medicine not also be about correcting current concepts of diagnosis and therapy by recurring to the wisdom of past times? Much was done in the past in psychiatry that was unwise, such as ovariectomies for hysteria or the treatment of chronic psychosis with lobotomy. Yet in many ways psychiatry today is the poorer for having largely lost contact with its own past, because many of the diagnoses of yore (and some of the treatments) cut nature more closely to the joints than do diagnosis and treatment today.[1]

Why psychiatric historians have shied away from the study of disease

Previous historians have taken diagnosis largely as an exercise in intellectual history. They have studied the filiation of ideas as the diagnoses were handed down over the years.[2] They have mocked ironically diagnoses that are somehow out of step with contemporary culture.[3] They have tried to understand the social sources – as opposed to the biological urgings – that gave rise to some diagnoses, such as hysteria.[4] With the exception of the

[1] For background see: C.M. Swartz and E. Shorter, *Psychotic Depression* (New York 2007); E. Shorter, *Before Prozac: The Troubled History of Mood Disorders in Psychiatry* (New York 2009); E. Shorter, *How Everyone Became Depressed: The Rise and Fall of the Nervous Breakdown* (New York 2013).

[2] P. Kury, *Der überforderte Mensch: Eine Wissensgeschichte vom Stress zum Burnout* (Frankfurt 2012).

[3] G. Minois, *Histoire du mal de vivre: De la mélancolie à la depression* (Paris 2003).

[4] E. Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (New York 1985).

great work of German Berrios, a psychiatrist, on the history of mental symptoms[5], most historians of psychiatry never really get much beyond hysteria. Mood disorders, psychosis, delirious mania: much of the rest of the field has been left fallow.

In this volume Matthew Smith reconstructs the 'ontology' of Attention Deficit Hyperactivity Disorder (ADHD), focusing on the finances of psychiatrists, the profits of pharmaceutical companies, and the pathologisation of ADHD itself. While it is true that the diagnosis has become vastly overblown beyond its natural limits, in some children nature does take a hand: ADHD may correspond to an organic brain condition that is not a product of social construction; this is among the earliest findings in the study of hyperactivity. Many such children have an abnormal electroencephalographic (EEG) examination and such EEG findings date from 1938; one would expect historians of ADHD to be aware of this.[6]

But what if the diagnoses are real, as opposed to being social labels? What if they correspond to what people actually had? What if the diagnoses of the past in fact represent real disease entities? If the diagnoses change, then either the diseases themselves have changed – witness the debate over the apparent increase in the frequency of schizophrenia[7] – or the worldview of the diagnosticians themselves has changed. It was not because of advances in diagnostic science that the diagnosis 'neurasthenia' was replaced with 'depressive neurosis'. It was because psychoanalysis, as a social and cultural movement, eclipsed biological thinking in psychiatry in the 1920s.[8] In other words, society won out over biology.

In this volume Jaap Bos, of the University of Utrecht, examines the decline of psychoanalysis, asking whether it has been marginalized because science overtook it, or because of a 'self-marginalizing discourse that made itself superfluous'.

In my essay, the question is: Why have historians of psychiatry tended to shy away from histories of psychiatric disease?

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[5] G.E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century* (Cambridge 1996).

[6] H.H. Jasper et al., 'Electroencephalographic Analyses of Behavior Problem Children', *American Journal of Psychiatry*, 95 (1938) 641-658.

[7] On this debate see: E. Shorter, *A History of Psychiatry* (New York 1997) 62-63.

[8] For background, see: S. Wessely, 'Old wine in new bottles: neurasthenia and 'ME'', *Psychological Medicine*, 20 (1990) 35-53.

One big reason is that psychiatric historians were infected about thirty years ago with a highly virulent strain of the antipsychiatry virus. Many writers are reflexly sympathetic to the patients and hostile to the physicians. The general stance seems to be that if you had those problems, you'd be depressed too. In a sense, the field has never gotten over Michel Foucault. Antipsychiatric themes dominated the numerous histories of asylums that were churned out then.[9] Knowing references to 'schizophrenia' peppered the texts. There was a collective sense of disbelief that inhabited the field: These patients aren't suffering from disease, they're suffering from labeling![10] (These antimedical attitudes were not confined to historians of psychiatry. I remember arriving at a meeting in those years on the history of childbirth. I had with me a bag of old-fashioned obstetrical instruments, and I recall the gasps of horror as the audience realized that I wanted to talk about the history of the actual conduct of childbirth rather than the oppression of women.) Thus, given the skepticism about the reality of psychiatric disease, given the tardive echoes of the 1960s in the field, and the attachment to ideas that portray psychiatrists as agents of capitalism rather than as healers, it is unsurprising that few historians chose to research the history of the diagnosis and treatment of actual illnesses. (Historian Markus Schär's work *Seelennöte der Untertanen* on the history of melancholic depression in Zurich is a brilliant exception to this[11]).

Secondly, writing the history of disease, either within psychiatry or any other medical specialty, requires some technical knowledge. Historians unable to differentiate catatonia from mania may feel somewhat cast adrift when confronted by case records or the literature of the day. Someone doesn't need to be a clinician to make basin-level assessments (getting the patient into the correct general illness basin); after a period of study of clinical psychiatry, the main points should swim readily into view. However it is helpful, in writing the history of disease, to have some knowledge of psychopathology. I cannot think of a single PhD historian who has attended psychiatry rotations, observed in a clinic, or accompanied staff on hospital rounds – in order to get a hands-on sense of what disease feels like in psychiatry. I did all of these things, and I was regarded as a bit of an odd-

[9] R. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley 1978).
[10] See: the section 'Antipsychiatry Movement' in: E. Shorter, *A Historical Dictionary of Psychiatry* (New York 2005) 22-26.
[11] M. Schär, *Seelennöte der Untertanen. Selbstmord, Melancholie und Religion im Alten Zürich, 1500-1800* (Zürich 1985).

ball by my colleagues. So not all historians of medicine go in for this kind of hands-on training. But it is very useful in writing the history of disease, whether in nephrology or psychiatry.

Finally, many historians have a residual attachment to seeing the history of medicine as the study of ideas. What interests them is how ideas about disease have changed over the years, and the interaction between society and medicine – how women were supposed to be hysterical, et cetera. In psychiatry there is no better illustration of how social ideas influence treatment than the stigmatization of electroconvulsive therapy (ECT) that took place during the 1960s and 1970s. So strong was the stigma that the practice of ECT – psychiatry's most powerful treatment – was almost abandoned.[12]

To be sure, much of medicine can be understood as a study in the filiation of ideas: in psychiatry how the depression diagnosis replaced hysteria is an example; this happened not because of new data but because ideas about both hysteria and depression changed. Hysteria was thrown out as a diagnosis in the third edition of the Diagnostic and Statistical Manual of the American Psychiatric Association in 1980, and depression shifted from melancholia to a kind of featureless dysphoria called 'major depression', as common as the common cold.

Physicians versus historians in writing the history of psychiatry

Psychiatric history is genuinely interdisciplinary, in that it probably takes training as a historian to recognize the primacy of primary sources and to put medical events in some kind of cultural context. If the subject is the history of diagnosis and treatment in psychiatry, as opposed to 'psychiatry and culture', some kind of medical training is an advantage because these subjects can be quite technical. I am not arguing that historians should stay away from writing about diagnosis and treatment, for these are matters that may be studied and assimilated, just as historians of mathematics are not themselves required to be mathematicians. I am also not suggesting that physician-historians shy from the hot iron of 'culture', even though their training has not equipped them to confront some of the complexities of society. Rather, I am arguing that some 'hands-on' knowledge of medicine

[12] See: E. Shorter and D. Healy, *Shock Therapy: A History of Electroconvulsive Treatment in Mental Illness* (New Brunswick 2007).

will permit historians to come to grips with the central issues of clinical science, namely the history of diagnosis and treatment.

The historian as clinical scientist

This brings us to psychiatric history as clinical science. Both historians and physicians are theoretically capable of contributing to clinical medicine today, yet only physicians seem keen on doing so. Let us contrast the best efforts by psychiatrists to write their own history with efforts by historians to write psychiatrists' history for them. Which up to now has been clinically more useful?

Werner Janzarik, professor of Psychiatry in Heidelberg in the 1970s and 1980s, was a deeply learned individual intent upon carrying on the Heidelberg tradition of the study of psychopathology. Eric Engstrom, a historian by trade and currently teaching medical history in Berlin, is not less learned, but in letters not in science. Yet a comparison of their work leaves the reader uncertain if they are describing the same discipline. Janzarik, who appears not to have had a great grasp of cultural history, is obliged to move at the technical level of diagnosis, yet does so with an expertise that subsequent generations of clinicians will find illuminating; Engstrom, who seems to care little for the clinical practice of psychiatry, ends up placing psychiatry in an especially unfavorable social light that will strike many as antipsychiatric in content – certainly as antipsychiatric for its querulousness of tone.

In 1978 Janzarik led a team of physician-historians commemorating the centennial of the founding of the Heidelberg University Psychiatric Hospital. Heidelberg, under Emil Kraepelin and his followers Franz Nissl and Karl Wilmanns, became the premier world centre for the study of psychopathology, and the essays in Janzarik's volume ventilate this theme in various ways. Janzarik's own contribution, for example, reviews the psychiatric literature of the 1870s, and in this light examines the case histories of a hundred patients admitted to that *Klinik* in 1878-1879.[13] We are in the presence of a commanding figure in understanding the intricacies of psychiatric diagnosis in past times.

[13] W. Janzarik, 'Die klinische Psychopathologie zwischen Griesinger und Kraepelin im Querschnitt des Jahres 1878' in: W. Janzarik ed., *Psychopathologie als Grundlagenwissenschaft* (Stuttgart 1979) 51-61.

In 2003 Engstrom published a no less commanding work on the history of psychiatry in Imperial Germany, touching at length on such technical issues as the importance of clinical course, yet reserving his major firepower for the relationship between psychiatry and society, Engstrom writes:

> This assessment of the vicissitudes of German society emphasizes that the construction of university clinics as urban asylums needs to be seen as representing part of a larger socio-political commitment and claim on the part of academic psychiatrists to do battle with madness and other 'diseases of civilization' in an urban setting.

Engstrom continues with the point that academic psychiatry was the 'psychiatric side of Virchow's medical reforms.' Urban asylums, he says, 'were the flagships of a new scientifically based, social psychiatry'.[14] This strikes me as completely correct and of great use in coming to grips with the larger history of the discipline.

As stated, the viewpoint that Engstrom takes in the book is militantly antipsychiatric. I should be surprised if practicing psychiatrists found much there of clinical relevance, though Engstrom certainly offers lessons to be learned. By contrast, the essays in the Janzarik volume are full of reflection about such diagnoses as 'paranoia' and 'catatonia'; pondering these deliberations might have been of great use to the drafters of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, currently in its fifth edition.[15] Dr Janzarik was indubitably a clinical scientist. Yet I am confident that few members of the DSM Task Force had ever heard of him, and that fewer still had read his book, written as it was in German. The efforts of a psychiatrist-historian probably had little impact, at least on the hegemonic American scene. As for Dr Engstrom's work, I have not discussed this personally with him, yet I find it unlikely that he might describe himself as a 'clinical scientist'.

[14] E.J. Engstrom, *Clinical Psychiatry in Imperial Germany: A History of Psychiatric Practice* (Ithaca 2003) 86.

[15] American Psychiatric Association, *DSM-5: Diagnostic and Statistical Manual of Mental l Disorders*, 5 (Washington DC 2013).

Some examples

Other historians have pursued the double role of functioning simultaneously as humanist and clinical scientist. The first PhD historian explicitly to step into these clinical shoes was Howard Kushner at Emory University; it would be fair to say that Kushner has 'pioneered' it. Kushner has broken new clinical ground in the study of two diseases: Tourette Syndrome, a motor disorder resembling catatonia, and Kawasaki Syndrome (KS), an autoimmune disorder involving inflammation of blood vessels throughout the body. In Kushner's Tourette's project, historical sources confirmed that some cases resulted from exacerbations following infection by rheumatic streptococcus, based on the model of Sydenham's chorea.[16] The Kawasaki Syndrome team at the University of California at San Diego and Emory University used history to revise the then-current diagnostic criteria of KS, alerting clinicians to be sensitive to atypical presentations.[17] Kushner observes:

> Both of these investigations illustrate how historical interrogations of syndrome construction can elicit useful issues for the development of research hypotheses and novel approaches to medical conundrums.[18]

Kushner was the first trained PhD historian, of whom I am aware, to lay out a historian's agenda for contributing to clinical medicine.[19]

In my own work, I have tried to contribute to clinical science in several ways. Family history led me to curiosity about women and the history of their health care, given that women's ill-health[20] – in the form, for example, of infected abortion – has played such a capital role in their lives historically. This greatly interested me in the history of medicine, but I soon became aware that I knew nothing about medicine or the basic medical

[16] H.I. Kushner, *A Cursing Brain? The Histories of Tourette Syndrome* (Cambridge 1999).
[17] H.I. Kushner, 'From Gilles de la Tourette's disease to Tourette syndrome: a history', *CNS Spectrums*, 4 (1999) 24-35; H.I. Kushner et al., 'Rethinking the boundaries of Kawasaki Disease: Toward the next case definition', *Perspectives in Biology and Medicine*, 46 (2003) 216-233.
[18] H. Kushner to E. Shorter, personal communication, 4 Feb 2014.
[19] H.I. Kushner, 'History as a medical tool', *Lancet*, 371 (2008) 552-553.
[20] E. Shorter, *A History of Women's Bodies* (New York 1982).

sciences, and that it was impossible to read the scientific literature without some kind of medical or scientific background.

I therefore went to medical school and by 1982 had completed the basic science courses of a rigorous medical program. With such subjects as Anatomy, Histology, and Pathology under my belt I now had the same basic science preparation as a clinician. I did not continue in medical school, but in order to gain some exposure to clinical realities, I observed at clinical rounds and Grand Rounds in departments of psychiatry and neurology in various of Toronto's teaching hospitals. (The highpoint of my 'medical' career was being able to diagnose a patient with Progressive Supranuclear Palsy (PSP), an obscure but deadly neurological affliction, before the diagnosis occurred to any of the clinicians in the room). With this background, I returned to research in the history of medicine.

One area in which I have tried to contribute to clinical science is understanding what was once called psychosomatic illness, currently 'somatoform disorders' and 'somatization', basically, breakdowns in the mind-body relationship. My 1992 book *From Paralysis to Fatigue* introduced the concept of a 'symptom pool' from which patients are able subconsciously to select the symptoms they wish to present, as supposedly 'organic', to their medical consultants. Items selected from the pool have changed over the years.[21] Yet some items present in the symptom pools of other cultures, such as *koro* (the delusional belief that one's penis is shrinking and is about to retreat inside one's abdomen, leading to death), is not found in the western symptom pool.[22] Nor are such symptoms of voluntary self-starvation as anorexia nervosa, amply abundant in the western symptom-pool since the late nineteenth century, found in many non-western cultures.[23] It would be tedious to trace the impact on medicine and psychiatry of this concept of the symptom pool.

I have collaborated with clinicians in the study of pediatric autism and intellectual disability. Lee Wachtel, director of the Neurobehavioral Unit at the Kennedy Krieger Institute in Baltimore and associate professor of psychiatry at Johns Hopkins Medical Institutions, made several

[21] E. Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York 1992).
[22] See: H.B.M. Murphy, *Comparative Psychiatry: The International and Intercultural Distribution of Mental Illness* (Berlin 1982) 273-276.
[23] E. Shorter, *From the Mind into the Body: The Cultural Origins of Psychosomatic Symptoms* (New York 1994) 149-193.

fundamental discoveries in this area, reporting that a devastating symptom called self-injurious behavior (SIB), found sometimes in children with autism and intellectual disabilities, was catatonic in nature, and that it responded readily to such anticatatonic treatments as benzodiazepines and convulsive therapy.[24] Yet was there further evidence of the catatonic nature of SIB? Working with Dr Wachtel, I searched the pediatric literature of the past, and found around eight cases of SIB where the clinical course was reported in detail. In all of these, other symptoms of catatonia accompanied the SIB, providing highly suggestive evidence – in addition to the current-day data on responsiveness – of the catatonic nature of SIB.[25] (This is important because, as I pointed out above, catatonia can be readily treated.)

Our autism research also raised the question, what is autism? A single syndrome that can be arrayed on a spectrum of severity called Autism Spectrum Disorder? Or a group of distinct illnesses that have been somehow lumped together in an autism basin? It was clear to Lee Wachtel and myself that some autistic children are also psychotic, others not. Some had catatonia, others didn't. Autism, catatonia and psychosis often occurred together. In 2012 Wachtel and I proposed the concept of the 'iron triangle', a possible subset of autism, involving psychosis and catatonia.[26] I provided historical examples, she current ones. Is the iron triangle differentially responsive to treatment? We don't know yet.

The last example of a clinical contribution I shall mention here concerns the classification of psychiatric illness, which is called 'nosology'. It is clear on the basis of historical data that the chief international classification today, the Diagnostic and Statistical Manual of the American Psychiatric Association, falls wide of the mark in terms of identifying distinctive psychiatric disease entities as they exist in nature. The Manual is, in other words, full of artifacts.

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[24] L.E. Wachtel et al., 'ECT for self-injury in an autistic boy', *European Child & Adolescent Psychiatry*, 18 (2009), 458-463; L.E. Wachtel and D.M. Dhossche, 'Self-injury in autism as an alternate sign of catatonia: implications for electroconvulsive therapy', *Medical Hypotheses*, 75 (2010) 111-114.

[25] L.E. Wachtel and E. Shorter, 'Self-injurious behavior in children: A treatable catatonic syndrome', *Australia and New Zealand Journal of Psychiatry*, 47 (2013) 1113-1115.

[26] E. Shorter and L.E. Wachtel, 'Childhood catatonia, autism and psychosis past and present: Is there an 'iron triangle'?', *Acta Psychiatrica Scandinavica*, 128 (2013) 21-33.

One artifact is the diagnosis of 'major depression', which currently counts as the chief form of depressive illness. Yet psychiatry historically has always recognized at least two distinct forms of depression, melancholia and other forms of depressive illness that are not melancholic in nature. In 1996 Sydney psychiatrist Gordon Parker labeled these 'melancholia' and 'non-melancholia'.[27] In 2006 U.S. psychiatrists Michael Alan Taylor and Max Fink, leading figures among international students of psychopathology, further positioned melancholia on the radar of the field with a clinicians' guide to its diagnosis and treatment.[28]

Because Dr Fink and I had been working together, with David Healy, on a history of electroconvulsive therapy, I was up to date on the melancholia discussion, and in 2006 Tom Bolwig, professor of psychiatry in Copenhagen, and I organized an international conference on melancholia, the proceedings of which were published the following year.[29] In 2013 my own book on the history of depressive illness, which prominently featured melancholia, appeared.[30] These combined efforts have helped contribute to elevating the prominence of melancholia in the eyes of the profession, from a 'specifier' of major depression to, in the eyes of some, an independent illness of its own.

Another artifact plaguing the current nosology is 'schizophrenia', artifactual not because chronic psychosis does not exist, but because it exists in multiple forms; there is no single, distinct disease called 'schizophrenia', even though the term seems to have a choke-hold upon the field. Breaking schizophrenia into its component parts is one of my current research aims.[31]

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[27] G. Parker et al., *Melancholia: A Disorder of Movement and Mood* (Cambridge 1996).

[28] M.A. Taylor and M. Fink, *Melancholia: The Diagnosis, Pathophysiology, and Treatment of Depressive Illness* (New York 2006).

[29] T.G. Bolwig and E. Shorter ed., 'Melancholia: Beyond DSM, beyond neurotransmitters', *Acta Psychiatrica Scandinavica*, 115 (2007) 1-183.

[30] E. Shorter, *How Everyone Became Depressed* (New York 2013).

[31] M.A. Taylor, E. Shorter, N. Atre-Vaidya, and M. Fink, 'The failure of the schizophrenia concept and the argument for its replacement by hebephrenia: applying the medical model for disease recognition', *Acta Psychiatrica Scandinavica*, 122 (2010) 173-183.

The general conclusion is that historians of psychiatry are able to contribute to clinical science, once they appreciate which current problems may be illuminated with historical understanding. Yet achieving this very appreciation may involve additional preparation going beyond the traditional history curriculum. The whole trail of knowledge that stretches from organic chemistry, across psychopharmacology and psychopathology, and into clinical psychiatry, may pass through unfamiliar terrain. Yet the journey is worth commencing.

I have said a few words about **Matthew Smith** of the University of Strathclyde and **Jaap Bos** of the University of Utrecht. Let me introduce now the remaining authors in this volume: **Sander L Gilman**, at Emory University, a well-known historian of Freud and psychoanalysis, writes about popular stereotypes of mental illness as reflected in the claims that it constitutes a form of disability; **Dorothy Porter**, in the Health Sciences Faculty of the University of California San Francisco, discusses how new insights into the genetics and biochemistry of Parkinson's Disease have shifted the psychological profile of the patients from the classical turn-of-the-century 'Parkinsonian personality' to a more creative profile. This is in line with the discovery that brain diseases may have liberating functions; **Joost Vijselaar**, of the University of Utrecht, engages with the role of the passions and imagination in treating the mentally ill in the eighteenth-century Netherlands, a concept that influenced the development of Dutch psychiatry in the nineteenth century; **Leo van Bergen** looks at the historical development of the concept of 'shell shock', in the context of writing on the larger issue of the neuroses and their classification; **Herman Westerink** analyzes changes in psychiatric understanding of demonic possession. There were similarities, especially in the work of Charcot and Freud, in seeing possession as a form of hysteria. The article examines differences between Charcot and Freud on this important subject. **Léjon Saarloos**, of Leiden University, examines the rise and fall of the career of Dutch psychiatrist Gerbrandus Jelgersma, a career that ended in the infamous Papendrechtse Strafzaak (Papendrecht trial) of 1907-1910, in which all the witnesses for the defense were declared to be insane. The case had unfortunate consequences for forensic psychiatry.