CHAPTER 16

The history of psychiatry

The history of psychiatry is surprisingly lengthy and this reflects the long time that humankind has suffered with symptoms of mental illness.

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INTRODUCTION

The position of psychiatry as a medical discipline has been largely affected by tensions between various beliefs about mental illness held by the prevailing culture.

1 Madness could be perceived as an internal bodily illness or it could be projected externally on supernatural causes. In the past people with mental illness have been seen as prophets, shamans, to suffer from a 'sacred disease' or to be witches. The attribution of mental illness to a medical model has been relatively recent and could be seen by some to be jeopardised by the introduction of community mental health teams rather than hospital-based care.
2 A second tension is the contribution of personality to the illness. At one extreme of the spectrum the personality could be seen as affected by illness, at the other end of the spectrum the illness itself can be seen as a manifestation of personal sin or even a degenerative family process.
3 A third tension is the culture and whether it thinks scientifically, i.e. whether society as a whole regards things in a rational light and takes a logical view of cause and effect. The views of people of learning in the Enlightenment, for instance, could be contrasted with the lack of logical thinking by people in the Dark Ages with their emphasis on magical constructs.
4 The final tension on the position of psychiatry in society is a conflict between a community model of looking at mental health and an idea of containment. Should patients be special people with special staff treating them in a special place outside society? In this model doctors and nurses dealing with the mentally ill are very much 'alienists' possibly seen as protecting society. The alternative could be a community model where people with psychological problems are seen as members of a community and that all members of society have an active input into their welfare and well-being.

The current model could be expressed as seeing insanity as an illness rather than resulting from a supernatural cause; that personality factors have a place in the form of mental illness and how patients can be engaged in therapy but that they are not personally totally responsible for their illness. Society adopts a logical approach to mental illness rather than approaching it from the point of view of magical thinking. At present our society has moved away from a hospital model towards a community care model and there is a demedicalisation of mental illness. Whether this matters will be considered further in this chapter by referring to historical eras where madness was not seen as a medical entity.

MENTAL ILLNESS IN ANCIENT TIMES

The early great cultures of Egypt and Mesopotamia viewed mental illness very differently from how we view it today, often ascribing a supernatural rather than a natural aetiology. The patients with mental illness were then sometimes seen as oracles or as divine conduits from the gods, rather similar to the position of a shaman in North American Indian tribes.

The views of Greek physicians progressed beyond external projection. Hippocrates himself certainly recognised the simple phobia as an example of mental illness and had experience in treating depression. With regard to epilepsy, Hippocrates (460–377 BC) wrote, 'The position regarding the so-called sacred disease is as follows: It seems to be no more divine and no more sacred than other diseases, but like other affections it springs from natural causes . . . those who first connected this illness with demons and described it as sacred seem to be no more different from the conjurers, purificators, mountebanks and charlatans of our day, who pretend to great piety and superior knowledge. But such person are merely concealing . . . their perplexity and inability to afford any assistance.'

Galen (AD 129–216), a Greek physician who treated five Roman Emperors, wrote about

melancholia, which he said was due to a localisation of vapours or humours in the brain, blood or gut.

Soranus of Ephesus (AD 100) described a condition called 'phrenitis' in which thinking was predominantly affected. He distinguished it from mania and melancholia. Other features of phrenitis that he described, beyond affected thinking, were acute fever, foolish gesticulations and a small, full pulse. It may be that he was perhaps describing an acute confusional state or condition similar to lethal catatonia. Soranus was also interesting in terms of his philosophy in that he thought that the process of thinking was localised to the head where others favoured the heart. He also described delusions in mania, that people saw themselves as perhaps sparrows, cockerels, gods, orators, actors or the centre of the universe. He also wrote about a form of cognitive therapy and with manic patients he would adopt a 'serious demeanour' and with depressives he would adopt a 'cheerful demeanour' to try to alter their mood. He would also try to 'strengthen their reasoning powers by asking them questions or getting them to read and criticise text which contained false statements'.

The concept of hysteria was recognised by the Greek physician Aretaeus of Cappadocia, who ascribed hysteria to a wandering uterus but recognised that the same clinical picture could occur in men, which perhaps defies logical thinking. As regards his philosophy of mental illness, Aretaeus stressed the frequency of relapses that he saw in cases of mental illness, the incurability of mental illness and also asserted the right of the physician not to treat incurables.

Some Roman archives suggest that the mentally ill were essentially warehoused in prisons but that they were able to receive medical care. The use of chains is documented in Roman literature. A pious Roman lady, Fabiola, went so far as to found a dedicated institution for the care of the mentally ill in the 4th century AD. The Emperor Constantine, a Christian, started many hospitals but no specific mental asylums. The 4th century also saw the first record of a specific house for lunatics in Byzantium and another in Jerusalem in AD 491.

AD 560 TO THE MIDDLE AGES

Some monasteries specialised in the care of the mentally ill, e.g. in Cologne in AD 560. There are records of Islamic asylums from the 7th century, for instance at Fez, and an early Caliph founded an asylum in Cairo where the inmates were daily entertained by music. There are some records of private charitable asylums in England in AD 700 but by and large care of the mentally ill and their cure was ignored and relegated to a supernatural realm.

There are progressively more records of establishments as time goes on and one notable one is of an asylum in Baghdad called the House of Grace in 1173 where the insane were brought from all over Persia to receive medical care. Patients were essentially detained until they were well but it is of note that every month the asylum was visited by a magistrate who examined the patients and discharged those who had recovered. There was also a community care system in that patients who had returned home received medical attention for a few months in order to prevent relapse. There is also a reference to music and storytelling as therapies.

In England in 1369 a hospital was founded by Robert Denton, Chaplain, for poor patients and other men and women that were 'sick of the phrenzie to remain there until whole or restored to good memorie'.

In 1377 the Bethlem Hospital (Bedlam) started to receive lunatics – it had been founded earlier in 1247, but had a general medical remit. The therapeutic armamentarium of the Bethlem Hospital at that stage included the manacles, stocks and padded rooms.

A Royal Commission looked into the running of the hospital in 1403 and criticised the Janitor, Peter Tavener, for purloining the patients' goods and for running a bawdy house at the gate of the hospital where his wife sold beer. The Commission further commented

that the nuns who ran the hospital were 'looking through the windows a little too earnestly at the world' and that the prioress was commanded to 'sleep in her own bedroom'.

Elsewhere in Europe there were other asylums such as one in Spain in 1409 which was established 'because the maniacs were hooted by the crowds and otherwise persecuted by the people'. At Granada in the 15th century the Hospital De Los Locos was completed under the command of Charles VI. This specifically admitted the insane, but specifically excluded cases of senile dementia.

MIDDLE AGES AND THE RENAISSANCE

Medieval medicine saw a fragmentation into various specialities. Barber surgeons and their assistants looked after surgical cases, childbirth was looked after by midwives and the mentally ill were looked after by exorcising priests, the church and, most unfortunately, witch finders. The Middle Ages period was also infamous for the resurgence of the idea that mentally ill were possessed; that their hallucinations were apparitions and the work of the devils. There are numerous accounts of patients who were hallucinating being put to death as they were consorting with the devil. In 1486 a handbook for witch hunters called the *Malleus Maleficarum* was put together by the Dominicans Kraemer and Sprenger, who were also Inquisitors. This book includes quite clear descriptions of psychopathology which were misconstrued by society and used as a basis for executions and the stake in a period running from the 15th to 17th centuries. In one paragraph the monks Kraemer and Sprenger brush aside the whole mass of such psychiatric knowledge as had been collected and preserved over the previous thousand years or so by medical investigation and say, 'The devil has extraordinary powers over the minds of those who have given themselves up to him so what they do in imagination is they believe they have actually and really done it in the body.' Even illusions acknowledged as such do not excuse a woman from the crime of being a witch. Kraemer and Sprenger believed that the soul afflicted by mental illness in terms of hallucinations and illusions could be set free again if the body was destroyed, and to the men of those days the destruction of the witch was therefore an act of mercy salvaging a soul from corruption. The possessed were collected together and condemned in groups of 10, 15, or even as large as 150. Examples of those destroyed by fire included a 60-year-old priest who for 30 years had heard the voice of a woman lusting for him and acting as a succubus to him. This sounds very much like a possible combination of auditory and somatic hallucinations. Another example was an old woman 'of such ugliness and deformity as must be a witch'. A further example is an old priest who in great sadness admitted that he had sucked the blood of many babies. This sounds very much like a delusion of guilt and a depressive psychosis. A further example is a young girl who while playing at her father's tomb saw a 'black man' who admitted that he was Satan and wanted to violate her. He suggested to her that she scream or jump into a well or strangle herself. This sounds like an unfortunate case of second person auditory hallucinations and a visual hallucination possibly in somebody with a depressive psychosis.

In the reign of Francis I it is possible that 100 000 people lost their lives through such inquisitions and misconceived beliefs about mental illness. The culture was such that in medieval times physicians had to be particularly careful what they termed or treated as a disease. It could be a distinctly political exercise. In considering the aetiology of syphilis a physician called Von Mellerstadt in 1496 had to be very careful in his phrasing with regard to balancing his view that syphilis was a disease and the church's view that it was the manifestation of sin. Despite this the hold of the Church on the mentally ill was slipping. Psychiatric wings were developed in most of the general hospitals in Europe including Paris, Lyon, London, Zurich and Basle.

Sin and mental illness became equated in men's minds. Inspired by Kraemer and Sprenger's *Malleus Maleficarum* and the *Codex Theodisianus*, witch hunts began after a Papal Bull was issued in 1484: 'in some parts of Northern Germany and other dioceses . . . many people have abandoned themselves to devils, incubi and succubae . . . have slain infants yet in the mother's womb . . . have blasted their harvest . . . hinder women from conceiving . . . committing and perpetrating the foulest abominations and filthiest excesses to the deadly peril of their own souls'.

The Pope appointed Inquisitors to purge the land, punishing as they thought fit. The *Malleus Maleficarum* began to be applied throughout Europe with great zeal. In the first part of the *Malleus Maleficarum* the authors prove the existence of witches and in the second part they give clinical reports on how to identify a witch. In the third part they describe how to examine and then sentence a witch. The punishment was usually death. Doctors who spoke out against the *Malleus Maleficarum* were labelled as heretics and received due punishment. At the beginning of the Renaissance increasing numbers began to speak out, for instance see Reginald Scott's book *The Discoverie of Witchcraft* dated 1584. Paracelsus in 1567 was writing of 'diseases which lead to a loss of reason' and stated quite clearly that mental illnesses were not caused by spirits but by natural causes. He was able to differentiate cases of epilepsy, mania, 'true insanity' and melancholia. He thought epilepsy rose from either the brain, heart, liver or intestines or limbs and that it began very early in life, possibly from intrauterine causes. He also thought epilepsy was a phenomenon in animals and also plants! In terms of treating mental illness he asked apothecaries to make up specific prescriptions incorporating camphor, skull shavings, unicorn and herbs.

In 1624 Robert Burton wrote the *Anatomy of Melancholy* which considers the nature of depression. Felix Plater (1536–1614) was a Swiss physician who produced a classification of psychiatric diseases, distinguishing mental impairment from mental illness and was also the first to describe an intracranial tumour (a meningioma). He also described alcoholism (the distilling process itself was invented in the Middle Ages).

In France in the mid-17th century society's answer was to incarcerate all mentally ill in special insane wings where they were chained. In Britain there was a developing system of 'houses of correction' and early workhouses.

Thomas Sydenham, born in 1624, was a Puritan and a sometime officer in Cromwell's army. He qualified as a physician aged 39 in 1663, escaped the plague in 1665 and died in 1689. He recognised the condition of hysteria which he thought was primarily a female disease and he also thought that men who tended to lead a sedentary life could also succumb to it. He did mention problems with the condition and was also aware of the difficulties that could be caused by diagnostic errors. He said that people with neurotic illnesses such as hysteria often held their reason but were often depressed as well. In terms of treatment he recorded using phlebotomy, iron preparations, milk diets and horse riding.

Thomas Willis (1621–75) (of Circle of Willis fame and co-founder of the Royal Society) saw the brain, not the womb, as the site of hysteria. He advocated strenuous treatment for chronic mania, and changes including changes of scene and work on the land. He also made observations of cases of mental deficiency, epilepsy and a schizophrenia-like illness. He also described patients with clear manic-depressive mood swings. Besides describing the arterial supply of the brain he also described cranial nerves, the autonomic nervous system and originated the concept of the reflex. He was also aware of cerebral localisation as a phenomenon and was responsible for the description of the condition myasthenia gravis.

Napier, the English physician, working around 1660, thought that purges were extremely useful for the mentally ill and

advocated laxatives and emetics. He had a thriving private practice nevertheless.

In 1761 Morgagini distinguished himself by particularly looking at the pathology of the brains of deceased mentally ill patients. Nevertheless treatments were often of a rather desperate quality predicated by the apparent incurability of mental illness despite therapeutic endeavour. Examples include the grandfather of Charles Darwin (Erasmus Darwin) and his infamous spinning chair in which the insane were rotated until blood oozed from their mouths, ears and noses. It had, apparently, anecdotal success. Other dramatic interventions included castration, starvation, and the use of camphor to induce fits.

A series of textbooks began to be published at the end of the 18th century, for instance William Battie's *Treatise on Madness*, dated 1758; Benjamin Rush produced the first American book on mental illness, but also invented the restraining chair of great fame.

The conditions that the mentally ill were warehoused in continued to be of concern to a certain number of individuals. Haslam, the apothecary to Bedlam until 1861, was dismissed because of appalling conditions that prevailed there. Philip Pinel struggled with the tension in the system which threatened to see the mentally ill as people who should merely be locked up. He published the *Philosophy of Medicine for Mental Alienation*. This noted physician, born in 1745 in the south of France, developed an interest in psychiatry only when he was aged 40. Pinel tried to bring order into the chaos of the plethora of unpleasant and often ineffective treatments. In terms of his observations on the causation of mental illness he thought heredity was the primary cause but that secondly harmful social factors, for instance poor education, were of distinct importance. His other important causative areas were thirdly an irregular way of life, fourthly spasmodic passions (for instance rage and fright), fifthly inactivity and, sixthly, a melancholic constitution. Pinel taught eminent psychiatrists including Esquirol, who later went on to develop a system of classification.

There were advances made towards the end of the 18th century particularly in terms of an approach towards the mentally ill. Key players included aforementioned Philip Pinel of Paris, William Tuke the Quaker of York and Langerman in Bayreuth. Their philosophy of mental illness was that it was precisely that, an illness, and that it should not be treated in workhouses or prisons and that the use of chains was unethical. They worked to produce a system of care, which did not rely on physical restraint but created humane asylums. Pinel saw the hospital itself as the main therapeutic tool and was very keen on the organisation of mental hospitals, which he thought should apply a vigorous, hopeful and liberal attitude to the treatment of mental illness.

Before the modern 'medical model' of mental illness, the place of the lunatic was dire indeed. Esquirol wrote to the Minister in Paris describing their plight in 1818: 'I saw patients naked, with rags or nothing more than straw to protect them against the cold, damp weather. I saw how in their wretched state they were deprived of fresh air to breathe, of water to quench their thirst, and of the basic necessities of life. I saw them turned over for safekeeping to brutal jailers. I saw them chained in damp, cramped holes without light or air; people would be ashamed to keep in such places the wild animals which are cared for at great expense in our large cities. That is what I observed almost everywhere in France, and that is how the mentally ill are treated almost everywhere in Europe.'

Pinel thought that the institution should be large enough so that different types of patient could be segregated from one another. For instance, Salpêtrière hospital had separate departments for idiots and thieves, dements, senile dements, incurable agitation and curable agitation. He rejected using chains in treatment but did advocate the use of straitjackets for short periods. He also advocated the use of cold baths but straitjackets and

cold baths were only to be used on the orders of the doctor (to prevent abuse). He recommended a constant routine in the asylum and that this should fit the patient's personality. He thought that there should be a physical exercise and mechanical work programme and he advocated a separation of patients from their families since the family (a) could not look after the patient properly and (b) was often a source of unnecessary strain. Therefore he advocated reduced contact with the outside world as a 'therapeutic measure', thinking that too early a resumption of contact might lead to a dangerous relapse. In cases of food refusal, Pinel introduced tube feeding.

He warned against suicide as an ever present danger both for staff and for patients. He also began to record the results of statistical investigations into various conditions and observed that mania tended to occur predominantly between puberty and 45, that melancholia began between the ages of 20 and 40 often after setbacks in love or property and that it was often linked to amenorrhagia and to puerperium in females. He said that he had a 'cure rate' of 51% for mania, 62% for melancholia, 19% in dementia and 0% in idiocy.

It is important to note that in his early dementia category he would also have been coping with undifferentiated alcoholic dementia, thyroid disease, and other currently reversible causes of dementia.

The average length of treatment he required for melancholia was six and a half months and for mania five and a half months.

Esquirol was Pinel's pupil. He was the son of a doctor and in 1811 joined the staff of the Salpêtrière. His basic attitudes were very similar to his mentor Pinel's but he was a great gifted teacher and responsible for the then pre-eminence of the French school of psychiatry in the first half of the 19th century. He was a better statistician than his mentor and he gave clearer descriptions of progressive paresis and epilepsy. He threw away Pinel's idea that mania was sited in the abdomen and adopted Gall's theory of cerebral localisation. He differentiated between hallucinations and illusions in psychopathology and helped design the French legal code of 1838 to administer the mentally ill. This was used subsequently as the model for legislation in Switzerland, England (1842) and Norway. He designed various asylums in France.

Not all of the reform of the treatment of mental illness was by doctors. The layman Quaker William Tuke and subsequent generations of his family were angered by conditions in which the English mentally ill lived and died, and spent their lives reforming their care. Tuke founded the York Retreat, which was then used as a model for several American hospitals. He inspired his family for generations to come with the same aim of helping the mentally ill. His son, Henry, and his grandson, Samuel, and finally his great-grandson, Daniel Hack Tuke (psychiatrist) were all involved in the treatment of the mentally ill. Daniel Hack Tuke developed a new classificatory system based upon the idea of the presenting complaint. He worked as a medical student at Barts and the Royal College of Surgeons, received a doctorate from Heidelberg and visited institutions in France, Germany and Holland to pick up their best practices. He went on to edit the *Journal of Mental Science*. He was interested, for a while, in Braidism. James Braid was a Manchester doctor who was interested in hypnotism and operated on patients under its influence. Eventually, Daniel Hack Tuke became the Professor of Psychiatry at Charing Cross.

Unhappily coinciding with Darwinian Theory was the Degeneration Theory in the 19th century. This emphasised the family history of mental illness and proposed that certain families became progressively more degenerate as the years went on; for instance, there might be a neurotic grandfather, producing a depressed mother who might then produce insane offspring; i.e. the theory was that the mental illness became more severe with each successive generation. A main proponent of this theory was Benedict Morel

(1809–73), who wrote the treatise 'Traité des dégénérescences physiques, intellectuelles et morales de l'espèce humaine et des causes qui produisent ces variétés maladives'. He said that 'degenerations are deviations from the normal human type which are transmissible by heredity and which deteriorate progressively towards extinction'. The causes of this degeneration could be very much the 'sins of the fathers' in terms of intoxication, the social milieu, moral sickness within the family, inborn or acquired damage or heredity. He found numerous followers in Germany, for instance Baron Richard von Krafft-Ebing, a psychiatrist who went on to describe various sexual perversions (in the book *Psychopathia Sexualis*). He thought homosexuality and criminality were caused by degeneration. Cesare Lomborso (1836–1909) saw criminals as an evolutionary leftover of a primitive race. Some psychiatrists, including Kraepelin, expressed reservations about the degeneration theory but the idea caught on and became popular. The seed would grow into the Nazi mental health policy in the 1930s that would see a similar number of mentally ill (100 000) killed to that killed by the medieval inquisitions.

In the second half of the 19th century German psychiatry very much took the lead academically. Psychiatrists like Emil Kraepelin published textbooks and assiduously audited their care of patients, but despite their clinical research some doctors persisted in believing that illness was secondary to sin and a disease of the soul or inherited as some kind of genetic leftover of a primitive race. Nevertheless there was some good research by physicians such as Meynert (Professor of Brain Psychiatry at Vienna) who believed that external stimuli set up cerebral cortical excitation at specific points. He thought that various psychological states had anatomical correlates within the brain. Professor Wernicke was famous for his studies on aphasia and also described Wernicke's psychosis. In 1857 the physicians Esmarch and Jessen in Germany proposed a link between general paresis of the insane (GPI) and syphilis. This view was not generally accepted.

Alzheimer found that 30% of the mental hospital population had a demonstrable disease of the brain on post mortem, emphasising the medical aspect of mental illness.

Eugene Bleuler (1857–1939) demonstrated that dementia praecox did not always end in a dementing state and preferred the term schizophrenia.

The undifferentiated nature of some of the psychosis proved problematic but people were beginning to get a handle on the organic causes. Conditions such as general paresis of the insane (GPI) and *tabes dorsalis* still were not recognised as being caused by a single microorganism. A heated debate went back and forth. Pinel in 1858 had talked of an illness with tremor of the tongue, difficulty in articulating speech and abnormal gait with poor balance, which he differentiated out from the morass of other mental illness. Neuropathologists noted a 'softening of the brain' associated with GPI but postulated that this was due to 'cerebral congestion causing inadequate nutrition to the brain'; i.e. they had a circulatory hypothesis for GPI rather than an infective one.

In vain doctors were looking for a cause. Bayle thought that GPI and *tabes dorsalis* had a multi-factorial model with moral and physical causes. He thought that the association of the condition with the male sex was 'easily explained because males were more subjected to mental shocks, excessive drinking, suppression of the haemorrhoidal flow and injuries to the head'. He also noted that the condition was most common between the ages of 30 and 60 but thought that personality might be important and that those who suffered were previously of a sanguine temperament or choleric and passionate. He noted that 50% of cases had a family history and that in terms of an occupational association, soldiers were often seen because of 'privation and excessive drinking associated with Napoleonic wars'. He thought that a half of the cases followed

disappointment, violent love, profound jealousy, or excessive intellectual endeavour. He did note that a fifth of the patients had had venereal excesses but these excesses are 'common anyway' and so he thought there was no role in the aetiology.

Lumbar puncture had been developed in 1890 by Quirke and in studies Babcock showed (in 1896) that there was an increased protein level in the cerebral spinal fluid of patients with GPI. In 1906 the German, August von Wasserman, developed a test for blood serum and CSF which was proved to be 90% positive in people with GPI. In 1912 Lange found that the abnormal protein in the CSF precipitated the colloidal gold from a solution and this represented a further test for GPI.

Although people now began to see that there might be an infective cause of general paresis and *tabes dorsalis*, i.e. syphilis, caused by *Spirochaetes*, there was no specific treatment. Mercury and potassium iodide were used. In 1910 Paul Ehrlich advised the use of salvarsan (arsphenamine) given intravenously; it was an organic arsenical compound. Later on the drug was given into the subdural space via trephine and subsequently even into the lateral ventricles themselves. None of these desperate measures worked particularly well. Some people advocated malarial therapy. Only later during the 20th century did proper antibiotic treatment produce dramatic effects.

20TH CENTURY

The final recognition that syphilis was caused by a specific micro-organism and that there was a specific treatment allowed the decanting of almost 10–20% of patients from asylums.

Around the same time there was increased interest in neurotic illness and adherents of psychoanalytic theory, led by Sigmund Freud (Austrian physician, 1856–1939), were spreading their theories around the Western world. Sigmund Freud had started as a neurologist (he made observations about the potential use of cocaine as a topical anaesthetic). Freud then went to Paris and saw Charcot (the noted French physician – Charcot's joint and Charcot's triad) demonstrating patients with hysteria.

Freud became interested in this illness and moved away from neurology into the field of psychiatry and built up a private practice of patients with hysteria. Initially he used hypnosis to treat them but found the sometimes alarming effects (positive transference in patients) unsettling and resorted to using pure talking treatments (psychoanalysis). In psychoanalysis patients were allowed to talk at length for a considerable time until their 'resistance' was broken. He used dream therapy and regarded dreams as the 'royal road to the unconscious'. Freud's contributions to psychological theory include the id, the ego and the superego and the ideas regarding the unconscious. His daughter Anna developed various concepts including psychological defence mechanisms. His many followers, including Jung, took his ideas further. Jung contributed concepts such as word association, extroversion and introversion, and rebelled against Freud's theories that the primary drives of human beings included *eros* and *thanatos*. Freud often employed a notion of spirituality in his therapy and regarded one of the life aims of people as being to 'individuate' and develop spiritually in life. Jung was also responsible for the ideas of archetypes and symbol and worked very much in terms of symbols in dreams.

Germans made such a contribution to psychiatry in the late 19th and early 20th centuries, but the advent of the Nazis launched a tidal wave of destruction as far as German psychiatrists and German psychiatric patients were concerned.

The National Socialist Party in 1933 passed the Law of 'Erb-Gesundheitsgesetz' to 'protect the race' by introducing the forced sterilisation of the incurably mentally ill and handicapped. Psychiatric doctors and institutions were required to make card registers of all psychiatric patients. Dissenting doctors (e.g. 61 psychiatry professors), were removed from office and from then on only 'reliable members' of the Nazi Party were allowed to be

appointed. The editorships of medical journals and the presidencies of medical associations were manipulated by the Nazi Government. Between 1936 and 1939 psychiatrists who were employed were involved in administrating 'Racial Hygiene Policies' rather than necessarily treating illness. The youngest reported victim of psychiatric sterilisation was a two-year-old girl. In 1939 there was a change in policy, but not for the better; from then on only 'life worthy of life' was allowed to continue and 'life unworthy of life' ('Lebensunwertes Leben') was eliminated. Both fiction and non-fiction cinema were used to put over the doctrine of euthanasia for the mentally ill as a 'kindness'.

There are echoes here again of the 'kindness' meted out to the socially inadequate and ill in the Middle Ages by putting witches to death and thereby saving their souls.

A board of psychiatrists and pharmacologists was put together in Nazi Germany and consulted on the most 'humane' way of killing the mentally ill and carbon monoxide was decided upon as the killing agent of choice, but to their questionable credit doctors refused to have anything further to do with the policy.

In November 1939 the heads of all the German asylums were required to notify which patients were curable and which patients were incurably ill. 'Special treatment centres' were set up and incurable patients were sent there. The majority of psychiatrists unfortunately did nothing to stop this process. Some did, but they were arrested, interrogated and executed by guillotine. Other psychiatrists protested to the Church which denounced the murders in turn. Nevertheless the policy continued in secret. In 1941 some medical students from the University of Munich and a philosophy professor formed an opposition group called 'The White Rose'. They wrote pamphlets denouncing Hitler's regime and his policy of exterminating the vulnerable. As a result of this resistance campaign, the core students and their professor were beheaded in 1943. Some 100 000 mentally ill or disabled patients were murdered and only a fifth of all psychiatric inpatients survived the Nazi regime.

ENGLISH PSYCHIATRY IN THE 20TH CENTURY

A 20th-century English psychiatrist, Dr William Sargent, was a pioneering doctor with a belief that physical treatments would relieve much of the suffering of mental illness:

> In the early 1930s, when I took up this speciality, the usual medical approach to the treatment of the mentally ill was almost a wholly negative one. In Great Britain most patients were obliged to enter a 'lunatic asylum' as they were still often called, the majority of them were compulsorily certified as insane and many of them were detained for very long periods under the old Poor Law and Lunacy Acts. Discharges were much rarer than today. At the famed Maudsley Hospital, even where all entries were voluntary, and the best available treatments were tried out on cases specially chosen for having a good prognosis, only a third, for instance, of our patients suffering from schizophrenia were back home and reasonably well three years after admission. Roughly two-thirds of all the other half-million schizophrenics were either kept locked up in mental hospitals, or stayed at home more or less incapacitated from work. The suffering involved was fearful. Few patients, however, died of this mental disease; most of them lingered on, imprisoned with their often agonizing delusions and hallucinations under jail-like conditions for as long as forty years or more.
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> Sufferers from anxiety states and depression fared little better; the more depressed patients often died earlier than schizophrenics because of their continued distress of mind, extreme agitation, loss of weight and final refusal to eat. Tens of thousands of such patients tried to commit suicide, thousands succeeded before they could be brought to hospital. Even today, depression

accounts for nearly one-third of all patients with psychological illnesses who apply for treatment from their general practitioners. Depression accounts for nearly a quarter of all those who go to general hospitals for medical investigation and physical check-ups (and who are too often informed after medical examinations that 'nothing wrong is found').

At one British mental hospital before World War II, the average duration of a severely depressed patient's stay – unless he quickly died of agitation or managed somehow to kill himself – was 381 days, in addition to all the time off work before going into hospital and after being discharged. A severe attack of depression or anxiety – to which some hundreds of thousands in Britain are still liable today – could last anything from two to twenty years. Minor depressions and anxiety states, though almost too numerous to assess, can involve weeks or months of incapacity and suffering. After World War II, Paul Wood suggested that of those patients who had 'anxious hearts' or suffered from a purely functional heart disorder named 'effort syndrome', no more than one-third ever really recovered; the rest were either liable to frequent attacks or remained permanently ill. 'Creaking doors hang long': a relative of my own, though otherwise well and married to a professor interested in psychology, confirmed Paul Wood's findings. She was incapacitated by a functional heart disorder from going out by herself from the age of twenty-five right up to her death at ninety-three. The incidence of mental illness, mental defect, psychopathic personality, and of all minor and major neuroses, is as cruel now as it ever was, but treatments are at last being discovered that relieve, even if they do not always cure, some of these many varied disorders.

Freudian techniques of psychotherapy and its derivatives were tried out in World War I and came into increasing use in the 20s. These techniques with those of Adler and Jung were the sole special forms of psychotherapeutic treatment then available to British psychiatrists. If they had proved efficacious at a time when they constituted a practical monopoly of the specialized treatment of mental ills, everybody would very soon have recognized it.

The Unquiet Mind, William Sargent, 1967

LEARNING POINTS: HISTORY OF PSYCHIATRY

- Madness has existed since ancient times.
- The view that madness was mental illness delivered the mentally ill from the hands of the witchfinders, the superstitious and those who would imprison them in prisons.
- The asylums were intended as a therapeutic environment.
- Scientific data collection and classification of mental illness allowed doctors to separate out causes of mental illness, e.g. neurosyphilis.
- Political systems have used mental health legislation to distort the public perception of and treatment of the mentally ill and have led to abuses in various countries including Germany, America and the USSR.
- In the 20th century more specific and more effective treatments began to be developed.
- Specific treatments enabled the decanting of thousands of mentally ill from the asylums and prepared the ground for community treatment.
- There are cycles in the history of psychiatry that tend to repeat.
- Cheap and inadequate community care and the demedicalisation of mental illness contain intrinsic threats for the mentally ill, allowing them to perhaps be portrayed in the future as other than 'ill' – maybe as dangerous, or responsible for all their actions, or even as immoral.

Table 16.1 NHS admissions for schizophrenia – all ICD-10 types

	Years			
Admissions	2002–03	2003–04	2004–05	2005–06
Male total	14 391	13 968	14 677	13 558
Female total	7262	7169	7434	6776

Source: HESONLINE Statistics.

EXPLORATIONS

Use the resources and further reading suggestions for help with the following.

The government invested hundreds of millions of pounds in creating teams for treating severe mental illness in the community in the early years of this millennium. One of the promises made for such teams was that they would prevent hospital admissions. Using the figures in Table 16.1 of the admissions for schizophrenia, describe any trend you observe. Next use search engines to find up to date admission statistics and continue the table for 2006–07, etc. What trend do you find?

Find out the figures for total NHS mental illness beds for the years above. Express the admission figures in terms of percentages of the total NHS mental illness beds available. What trend do you find?

FURTHER READING AND REFERENCES

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RESOURCES

Case histories from psychiatry
http://bms.brown.edu/HistoryofPsychiatry/hop.html

Hospital Episode Statistics (NHS) – HES Online
www.hesonline.nhs.uk/

'Life Unworthy of Life' and other Medical Killing Programmes – Dr Stuart D. Stein
www.ess.uwe.ac.uk/genocide/mord.htm