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The Problem
of Mental Disorder

Mental disorder affects the lives and well-being of millions of people through-out the world. The exact number of persons who suffer from some form of it is not known. Many afflicted people do not come to the attention of reporting agencies and community investigators face a multitude of problems in obtain-ing fully reliable data on the extent of mental disorders in noninstitutional-ized populations. But enough data are available in advanced societies to make relatively accurate assessments, and it is clear that mental disorder is a major social problem. Perhaps almost one out of every five Americans is affected by some type of mental disorder annually. This estimate comes from two major surveys: the Epidemiologic Catchment Area (ECA) study of the early 1980s and the National Comorbidity Survey (NCS) of the early 1990s. These surveys estimated that during a one-year period, approximately 22 percent of the U.S. adult population between the ages of 18–54 years—about 44 million people—has diagnosable mental disorders. However, in 2002, William Narrow and his colleagues (Narrow et al. 2002) reexamined the data and revised the estimate to the lower but still substantial figure of 18.5 percent of all adults 18–54 years of age.

The extent of mental disorder and the high social and economic costs associated with it are considerable. But what is truly the most damaging aspect of mental illness is its shattering effect on its victims and their families. Suicide, divorce, alcoholism and drug abuse, unemployment, child abuse, damaged social relationships, and wasted lives, not to mention the incalcula-ble pain and mental anguish suffered by those involved, are among the conse-quences of mental illness. In these respects, mental disorder can be regarded as a terrible affliction for many people in the United States and elsewhere in the world.

With increasing numbers of studies uncovering a significant relationship between social factors and many psychiatric conditions, the study of mentally

disturbed behavior has become an important area of research in sociology. A substantial body of evidence has accumulated over the past several decades supporting the conclusion that the social environment has important consequences for mental health (Aneshensel and Phelan 1999; Busfield 2001; Horwitz and Scheid 1999; Schwartz 2002; Wheaton 2001). Unlike psychiatrists and clinical psychologists, who usually focus on individual cases of mental disorder, sociologists approach the subject of mental abnormality from the standpoint of its collective nature; that is, they typically analyze mental disorder in terms of group and larger societal processes and conditions that affect people and their mental state. What sociologists primarily do is investigate the consequences of social structures and relationships on mental health with the goal of identifying those aspects of society and social life that cause harm (Schwartz 2002). As Leonard Pearlin (1999a:410) puts it: "Sociological interest in mental health and disorder is rooted in its mission to identify elements of social life that have dysfunctional consequences."

In a social context, mental disorder is seen as a significant deviation from standards of behavior generally regarded as normal by the majority of people in a society. The relevance of this perspective for our understanding of mental disorder is that, even though a pathological mental condition is something that exists within the mind of an individual, the basis for determining whether a person is mentally ill often involves criteria that are also sociological. A psychiatric finding of generalized impairment in social functioning involves an understanding of such sociological concepts as norms, roles, and social status that establish and define appropriate behavior in particular social situations and settings. It is the disruption or disregard of the taken-for-granted understandings of how people should conduct themselves socially that causes a person's state of mind to be questioned. Consequently, it is the overt expression of a person's disordered thinking and activity as social behavior that ultimately determines the need for psychiatric treatment in most cases.

This situation has attracted sociologists to the study of mental disorder and has led to its development as a specialized area of sociological research. The sociology of mental disorder is generally viewed as a subfield of medical sociology. In fact, it was the funding and encouragement of the National Institute of Mental Health during the late 1940s that stimulated the development and rapid expansion of medical sociology in the United States. Therefore, from its most important beginnings, the sociology of mental disorder has been linked to medical sociology. Yet despite its status as a subfield within medical sociology, the sociology of mental disorder has acquired an extensive literature containing significant theoretical concepts and applied knowledge of the human condition. The purpose of this book is to provide an overview of that knowledge for students, sociologists, health practitioners, and others interested in and concerned with the social aspects of mental disorder.

DEFINING MENTAL DISORDER

Before proceeding, we should first define mental disorder. This is no easy task, as numerous definitions, many of them insufficient, have been offered over the years. In an effort to resolve this situation and formulate a precise concept for the American Psychiatric Association, Robert Spitzer and Paul Wilson (1975) began by asking (1) whether certain mental conditions should be regarded as undesirable; (2) how undesirable these mental conditions should be to warrant being classified as mental disorders; and (3) even if undesirable, whether the conditions in question should be treated within the domain of psychiatry or by some other discipline.

Some psychiatrists define mental disorder very broadly as practically any significant deviation from some ideal standard of positive mental health. This view, as pointed out by Thomas Szasz (1974, 1987), a psychiatrist and critic of his profession, would regard any kind of human experience or behavior (e.g., divorce, bachelorhood, childlessness) as mental illness if mental suffering or malfunction could be detected. Other psychiatrists, in contrast, subscribe to a narrower definition of mental disorder, which views the condition as being *only* those behaviors that are clearly highly undesirable. Behaviors that are merely unpleasant would not be considered mental illness. This narrower definition would encompass those mental abnormalities such as schizophrenia, mood or anxiety disorders, or an antisocial personality, which Spitzer and Wilson (1975:827) describe as "manifestations which no one wants to experience—either those persons with the conditions or those without them." This latter approach appears more realistic.

The problem of defining mental disorder is further complicated by the fact that concepts of mental disorder often change and are even changing now. For example, homosexuality was considered a mental disorder by American psychiatrists until the early 1970s but is not considered such today. Terms such as melancholia (depression), amentia (mental retardation), hysteria (conversion disorder), and moral insanity (for people who were not truly insane but were thought to be perverted, such as nymphomaniacs) are no longer used. Yet they were major classifications of mental disorders at one time or another during periods ranging from ancient Greece to the twentieth century. A recent example is neurosis, which used to be a major behavioral disorder characterized by chronic anxiety, but now has its various subtypes classified under mood, anxiety, somatoform, or dissociative disorders.

Surprisingly, neither standard textbooks in psychiatry nor the first and second editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) generally defined mental disorder. Spitzer, a research psychiatrist who headed the American Psychiatric Association's Task Force on Nomenclature and Statistics charged with developing *DSM-III*, addressed this problem. According to Spitzer (Spitzer and Wilson 1975:829), mental disorder can be defined as follows: (1) It is a condition that is primarily psychological and that

alters behavior, including changes in physiological functioning if such changes can be explained by psychological concepts, such as personality, motivation, or conflict. (2) It is a condition that in its "full-blown" state is regularly and intrinsically associated with subjective stress, generalized impairment in social functioning, or behavior that one would like to stop voluntarily because it is associated with threats to physical health. (3) It is a condition that is distinct from other conditions and that responds to treatment.

Of the three criteria just described, the first separates psychiatric from nonpsychiatric conditions. The second specifies that the disorder may be recognizable only in a later stage of its development (full-blown) and that its identification depends upon consistent symptomatology (regularly associated with). Spitzer also says that the disorder must arise from an inherent condition and that the impairment in functioning must not be limited to a single situation, but should include an inability to function in several social contexts (generalized impairment in social functioning). The second criterion also includes "behavior that one would like to stop voluntarily," for instance, compulsive eating or smoking. The third criterion places the definition within a medical perspective by limiting it to distinct treatable conditions. This definition continues to be followed in the current manual, *DSM-IV-TR* (APA 2000), and it is not known at this time if it will change in the forthcoming *DSM-V*.

MADNESS THROUGH THE AGES

Throughout history, people have attempted to cope with the problem of behavior that was irrational, purposeless, and unintelligible. Ideas about the nature of mental illness have been intrinsic to ideas about the nature of human beings and their mode of civilization. What people have thought about mental illness has revealed what they have thought about themselves and the world they lived in. To better understand contemporary approaches to the problem of mental disorder, it is useful to review the evolution of those approaches from humankind's preliterate past up to the present. Current measures on the part of human societies to cope with mental disorder as a social problem are grounded in the experiences of the past.

Witch Doctors

Primitive attempts to explain both physical and mental disorders were based largely upon intuition. Sometimes, early humans noted a cause-and-effect relationship between taking a certain action and alleviating a certain symptom or curing a wound. Primitive people could certainly understand the effect caused by striking someone with a spear or a large rock. The effect could be injury or death. Most often, an illness, however, especially if its cause could not be directly observed, was ascribed to supernatural powers. In essence, primitive medical practice was primitive psychiatry, as humans applied

subjective notions about their environment to ailments whose origin and prognosis were beyond their comprehension.

In most preliterate cultures, an illness would be defined as a problem brought on because those who were sick (1) had lost a vital substance (such as their soul) from their body, (2) had a foreign substance (such as an evil spirit) introduced into their body, (3) had violated a taboo and were being punished, or (4) were victims of witchcraft. All of these explanations of disease causation are clearly bound up in ideas about magic and the supernatural. Because there was so much mystery about the world around them and the functioning of their own bodies, primitive humans attempted to explain the unexplainable by applying human motivations to the unknown. Yet, as Ari Kiev (1972) observes, these etiological concepts were not random ideas, but were derived from linking particular symptoms to particular beliefs and customs prevalent within a society. Widely held taboos among primitive groups, for example, are murder and incest. Violations of these taboos are thought to have deleterious effects on the mind of the perpetrator. Thus, in this situation, insanity is believed to be a form of punishment by God, or whatever deities are common to that society, for misdeeds that violate collective morals.

Another example is found in Haiti, where the belief still prevails among some superstitious persons that a sorcerer can force the soul from a victim's head through the use of magic and replace it with the soul of an animal or an insane person who had died. This act is thought to be responsible for the victim's subsequent disordered behavior. There is also a belief that a curse can cause death. Here one is dealing with a cultural belief that a curse is "real." The result can be a state of extreme anxiety on the part of the person cursed, who eventually dies from shock induced by prolonged, intense emotion associated with believing in the reality of the curse. This reaction is reinforced by the response of others who seek to avoid contact with the cursed person. Such an event demonstrates the possible psychological leverage that a group can have over an individual in certain circumstances and the significance of the role assigned to that person. According to local customs, being cursed might result in interaction that could hasten a person's death. Of course, this depends on the belief of all concerned, especially the victim, that the curse is fatal.

If evil spirits and *black* magic are believed to cause death and illness, then it is perfectly permissible to employ *white* magic to counter the work of the evil person or supernatural entity causing the suffering. This belief created the need for healers, known as witch doctors or shamans, who work at producing a cure by applying magical arts grounded in folk medicine and prevailing religious beliefs. The most commonly held image of a shaman is that of a medicine man who is susceptible to possession by spirits and through whom the spirits are able to communicate. Shamans can be either men or women, although men are apparently more likely to be extraordinarily successful. This is probably because men can "act" more violently during rituals and thereby appear more powerful. Advanced age, high intellect, and sometimes sexual

deviance, such as transvestitism and homosexuality, are characteristics of shamans. Also, being an orphan, being physically disabled, or even being mentally ill is not uncommon.

The most important equipment for a shaman is a strong imagination, for the shaman theoretically gains his or her strength by mentally drawing upon power that he or she believes exists outside himself or herself in nature or the cosmos. Shamans try to accomplish this through deep concentration while engaging in a mind-set stimulated by chants, prayers, drugs, drinking, ritual dancing, or, perhaps, sex. Shamans work themselves into a frenzy until they sense they have become the very force they seek; when this happens, they project their supposedly powerful thoughts out of their mind toward the intended target. The extent of their influence depends upon the belief that other people have in their ability to conjure up and control supernatural forces for either good or evil.

Although witch doctors have often had considerable power and prestige among the group they serve, they by no means have always occupied a desirable role in society. They may be viewed as deviant and odd, a condition perhaps reinforced by the need to work with undesirable people and matter (e.g., snakes, insects, human organs, excretion). Kiev (1972:99) notes that primitive shamans were often recruited from the ranks of the mentally disturbed. Skill in performance is apparently the most significant criterion in shamanism, rather than heredity or special experience, although the latter can be particularly important. In this occupation, a degree of craziness can be an advantage for the performer.

Typically, the shaman's performance reflects certain principles of magic, such as similarity or "sympathetic magic" and solidarity or "contagious magic." *Sympathetic magic* is based upon the idea that two things at a distance can produce an effect upon each other through a secret relationship. In other words, two things that look alike affect each other through their similarity because the shared likeness places them in "sympathy" with each other. Thus, "like" is believed to produce "like." A well-known example of this notion comes from voodoo and is the sticking of pins into a doll made in the image of a certain person to inflict pain on that individual. In healing, a shaman might act out a sick person's symptoms and recovery, supposedly to "orient" the illness toward recovery. An example of sympathetic magic in relatively recent times comes from the Shona tribe living in southern Zimbabwe in Africa. Here, a common practice of witch doctors is to administer the shell of a tortoise in some form to a patient to promote a general feeling of strength and security; or a portion of bone removed from a python's back may be used to try to restore strength in a patient's back by having the patient eat the bone fragments.

Contagious magic is based on the idea that things that have once been in contact continue to be related to each other. Hence, a shaman might use a fingernail, tooth, or hair as the object of a magical act to affect the source of that part in some way. Among the Shona, all shamans practice contagion. A member of the Shona group might, for example, obtain some article of clothing that

an enemy has worn close to his or her body, take it to a shaman who can produce a spell on it, and supposedly cause the enemy to become ill.

Other measures used by witch doctors include the prescription of drugs made from parts of people, animals, or plants and prepared secretly according to a prescribed ritual. Sometimes, an evil spirit might be forced to leave a body by inducing vomiting, through bloodletting, or as bodily waste. Regardless of the technique, the witch doctor's principal contribution to therapy appears to be that of anxiety reduction, which draws upon the cultural background of the patient. The connection of treatment with the dominant values and beliefs in the community both inculcates and reinforces the patient's faith in the shaman's procedures. Many primitive people have little opportunity to develop reality-testing skills, being exposed from infancy to a system of beliefs that supports the shaman's authority and mode of treatment. Consequently, shamans are able to foster the hope and the expectation of relief by emphasizing faith in themselves, their methods, and spiritual orientation—all grounded in local community norms and customs.

Witch Doctors and Psychiatrists: Points of Similarity

In many ways, the shaman or witch doctor is not unlike the modern-day psychiatrist. E. Fuller Torrey (1973) found many similarities in these two types of healers. These similarities consist of both witch doctors and psychiatrists (1) providing a shared worldview to the patient that makes possible the naming of pathological factors in terms understood within his or her respective culture, (2) having a *personal* relationship with the patient that makes the therapist's personality characteristics significant to the healing process (despite the attempt by some psychiatrists to keep their personality removed from therapy), (3) engendering hope in the patient and raising the expectation of being cured through the therapist's reputation and the atmosphere of the therapeutic setting, and (4) sharing techniques of psychotherapy. In regard to the latter, witch doctors, like psychiatrists, use drug therapy, shock therapy (e.g., cold water, electric eels, drug-induced convulsions), confession, suggestion, hypnosis, dream interpretation, conditioning, and group and milieu therapies.[1] In their own cultures,

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[1]An incident that serves as a comparison of the similarities between witch doctors and psychiatrists is reported by psychiatrist Alexander Leighton during a stay in Nigeria:

> On one occasion a healer said to me, through an interpreter: "This man came here three months ago full of delusions and hallucinations; now he is free of them." I said, "What do these words 'hallucination' and 'delusion' mean? I don't understand." I asked this question thinking, of course, of the problems of cultural relativity in a culture where practices such as witchcraft, which in the West would be considered delusional, are accepted. The native healer scratched his head and looked a bit puzzled at this question and then he said: "Well, when this man came here he was standing right where you see him now and thought he was in Abeokuta" (which is about thirty miles away), "he thought I was his uncle and he thought God was speaking to him from the clouds. Now I don't know what you call that in the United States, but here we consider that these are hallucinations and delusions!" (CIBA Foundation Symposium 1965:23)

Torrey points out that witch doctors have been known to obtain sometimes striking success. "If prostitution is the oldest profession," states Torrey (1973:202), "then psychotherapy must be the second oldest."

Mental Disorder and Modern-Day Bewitchment

The belief that spirits and witchcraft are responsible for mentally disturbed behavior is still prevalent in Africa. Paul Linde (2001), an American psychiatrist working in Zimbabwe, observed that mental illness cuts across all cultures. Acute psychotic patients in Zimbabwe appeared very similar to those he formerly treated in San Francisco. One major difference, however, was the content of symptoms. Instead of hearing Jesus Christ speaking to them or being paranoid about the FBI, Zimbabweans hear voices of their ancestor spirits and are paranoid about witches and sorcerers. Linde noticed that members of the Shona tribe, including medical students, avoided mental patients. The mentally ill are severely stigmatized because they are believed to be victims of witchcraft, and diseases caused by spirits are thought to be contagious. Only rarely did a Shona medical student specialize in psychiatry. Even though these students believed the Western perspective that mental illnesses are caused by biological, psychological, and social factors, they also believed the traditional view that mental disorders are caused by witchcraft or ancestor bewitchment. "Guess which perspective held sway?" asks Linde (2001:57).

These medical students had grown up in households in which spiritual models of illness were not only accepted, but regarded as the most plausible explanation. The influence of the Spirit World was part of their everyday existence, and they believed its powers could be used for evil. "Because the Shona frequently attributed their symptoms of mental illness to bewitchment," states Linde (2001:58), "a psychiatrist in that culture would have to expose himself to the ample dangers of the Spirit World on a daily basis." Consequently, the practice of psychiatry was avoided. It was considered too close to witchcraft and regarded as an area of medicine better managed by traditional healers and the clergy.

Greeks and Romans

Like many other attributes of Western civilization and intellectual development, modern concepts of mental illness originated with the ancient Greeks and Romans. The Greeks, in particular, are noted for formulating a rational approach toward understanding the dynamics of nature and society. They replaced concepts of the supernatural with a secular orientation that viewed natural phenomena as explainable through natural cause-and-effect relationships. One of the most influential Greeks in this regard was Hippocrates, who provided many of the principles underlying modern medical practice. Whether there actually was a Hippocrates, who is thought to have lived around 400 B.C., is not known. Nevertheless, the Hippocratic method, which demands

a rational, systematic mode of treating patients, is credited to him. This method, based upon thorough observation of symptoms and a logical plan of treatment according to proven procedures, is central to contemporary medical practice.

As for mental illness, Hippocrates is believed to have introduced a radical change in the concept of madness by insisting that diseases of the mind were no different from other diseases. In other words, mental illness was not the result of divine, sacred, or supernatural influences. Instead, mental illness was due to *natural causes* that affected the mind and produced delusions, melancholia, and so forth. Although Hippocrates was ahead of his time, he was clearly mistaken in attributing the cause of abnormal behavior to an imbalance in the interaction of the four so-called *humors*—blood, phlegm, black bile, and yellow bile—within the body. An excess of black bile was consistently mentioned by Hippocrates as the cause of mental illness; the recommended treatment was the administration of a purgative (black hellebore) to induce elimination of the disorder through the bowels. Also, vapors, baths, and a change in diet were sometimes prescribed.

The greatest of the Roman physicians was Galen, who lived from A.D. 130 to 200. Galen was greatly influenced by Hippocrates' notion of the four humors, and he reinforced the Hippocratic view by holding that the health of the soul was dependent upon the proper equilibrium among its rational, irrational, and lustful parts. Furthermore, he argued that sexual orgasms were necessary if mental harmony was to exist and tension was to be avoided. Galen was a strong advocate of active sexuality for the promotion of mental health.

Soranus, another leading Roman physician whose life overlapped the first and second centuries after the death of Christ, maintained that the personal relationship between the physician and the patient was of paramount importance in curing mental illness. He argued strongly that physicians needed to be supportive in helping mentally ill persons work out their insanity. Soranus is particularly known for his humanitarian treatment of the mentally ill. He insisted that caretakers of the mentally deranged be sympathetic; mental patients be housed in peaceful surroundings; and, whenever possible, mental patients should read, discuss what they read, and even participate in dramatic plays to offset depression. But probably very few people in ancient Rome could afford the treatment recommended by Soranus. Most treatment was limited to drugs, spells, and religious pilgrimages.

Roman law also redefined insanity as a condition that could decrease an individual's responsibility for having committed a criminal act. The defendant's state of mind, however, was determined by a judge, not a physician. Those persons presumed to be mentally ill were typically remanded to the custody of their relatives or a guardian who was charged with the responsibility for their control, safety, and well-being. Other laws were introduced that defined the ability of the mentally ill to marry, be divorced, testify in court, and make wills concerning the disposition of their property.

The Middle Ages, Renaissance, and Post-Renaissance

The progressive ideas of the Greeks and Romans were stifled with the fall of Rome in A.D. 476. The next five hundred years were particularly chaotic, as wars, plagues, and famines disrupted the social order. At that time, the Roman Catholic Church became the center for learning and preserving intellectual knowledge as Western Europe became dominated by the military power of various barbarian tribes, mostly of Germanic origin. The uncertainty of the period generated great insecurity as many people merged primitive beliefs with Christian theology to explain human suffering.

There was a return to the notion that supernatural forces, namely, the Devil and witches, were responsible for afflictions of the mind. Many psychotics had delusions and hallucinations containing religious content, which reinforced this view. Exorcism was frequently practiced by the Catholic clergy, who followed the example of Christ in the New Testament driving evil spirits out of the bodies of those suffering from bizarre and irrational thinking. Beliefs linking the Devil with mental disorder became so entrenched in the Christian world that they persisted through the Middle Ages, the Renaissance in the fifteenth century, and even the sixteenth and seventeenth centuries. It was not until the eighteenth century that scientific thought and logic prevailed and demonology was rejected as the cause of mental illness.

True, the Renaissance marked the beginning of a European enlightenment that provided an intellectual orientation based upon empirical knowledge and demonstrated scientific validity to which pagan beliefs would eventually succumb. But two other conditions helped to continue the idea that the Devil was behind abnormal behavior. First, the more often science was able to answer some questions, the more often other questions were raised that perpetuated the uncertainty. That is, the more people learned, the more they realized how little they knew about their world and the universe beyond; intellectual discoveries stimulated the demand for more intellectual inquiry. Because so much remained unknown, the ancient beliefs that had been acceptable explanations in the past continued to support people against the anxieties of the present. Centuries of superstition were very difficult to overcome. Second, there was a tacit agreement between the church and medical science that allowed the church jurisdiction over the investigation of the human mind. The church made little or no objection to medicine's interest in the human body as a weak and imperfect vessel intended to convey the soul in its earthly existence, but the study of the mind was another matter, since human reason was defined within the province of religion, not medicine. Thus, physicians largely devoted themselves to research on the physical functions of the body, leaving considerations of mental processes to theologians.

Western witchcraft.   The church defined those persons who did the Devil's work on earth as witches. Szasz (1970) notes that it was easy to blame misfortune on witchcraft. Persons identified as witches were usually relatively powerless and readily available as scapegoats. And who were these witches? Generally, they were women and included heretics, nonbelievers, eccentrics, the mentally ill, and those who in some way were regarded as different or odd by other people. Some of these women may have simply been strong willed. Most were probably innocent victims.

Persons suspected of being witches were often arrested or were simply rounded up, tried by a court, and punished. The punishment was usually death. The so-called witch trials began in earnest in 1245 in France and reached their zenith between 1450 and 1670. A papal bull published in 1486 became the basic how-to-do-it manual for witch hunters. Written by a pair of Dominican monks named Henry Kramer and James Sprenger, the *Malleus Maleficarum,* or *The Hammer of Witches,* was the bible of the Inquisition. Some twenty-nine editions of this document were published up until 1669. Kramer and Sprenger insisted that there were such things as witches and that to question the existence of witches was itself a sign of being a witch. By these means, they rather adroitly overcame any criticism of their theories.

The authors of the *Malleus Maleficarum* argued that it was women who were chiefly addicted to evil superstition. The reason for this assertion was that they believed that all witchcraft was derived from carnal lust, which, they maintained, was insatiable in women. Men, on the other hand, were generally protected from witchcraft because Jesus Christ was a man, and by his being born and suffering for humankind, males were saved from becoming witches. As Szasz (1970:8) comments, "In short, the *Malleus* is, among other things, a kind of religious-scientific theory of male superiority, justifying—indeed, demanding—the persecution of women as members of an inferior, sinful, and dangerous class of individuals." Historically, it has been very convenient for men to support the belief that women are inferior and need to be subjugated and cared for. The dictates of the *Malleus* matched the ideas of many males.

To aid in suppressing witchcraft, the *Malleus* required physicians to verify its presence. An illness was considered to be either natural or demonic in origin; if the physician could find no illness, he was expected to find evidence of witchcraft. Obviously, this gave physicians a convenient means by which to explain away illnesses they could not understand. Witchcraft was, therefore, thought to be behind those illnesses whose onset was sudden, which could not be identified, or both.

The number of people who lost their lives through persecution for witchcraft during the witchcraft mania is not known. One estimate claims that at least two hundred thousand people were put to death in Germany and France; considerably fewer were killed in Spain, because of nationalistic and independent attitudes, and in England, where the pagan Anglo-Saxon

law insisted that a person was innocent until proven guilty (Mora 1985). The persecution of witches spread even to the New World, where one of the final outbursts occurred among Protestants in Salem, Massachusetts, in 1692. In Salem, a group of young girls, demonstrating manifestly silly behavior, was labeled "bewitched" after a physician, failing to find any illness, claimed that the source of the problem was beyond medicine. The resulting witch trials, in a community where tension was rising between local farmers and merchants over town politics and the distribution of wealth, saw some nineteen alleged witches executed out of the twenty-five brought before the court.[2]

Those who lost their lives were mostly community outcasts or others with little social standing. However, as more and more persons of increasingly higher social status began to be accused and as the quality of the evidence correspondingly decreased, the trials came to an end. The final blow was the withdrawal of the support of Puritan clergymen like Cotton Mather, a noted demonologist of the day, who came to express serious doubts about the affair, after having been very influential in initially stimulating community reaction to witches.

The processes that ended witch trials in Salem were similar to those that ended them elsewhere: Eventually, the public became appalled at the excesses committed by the witch hunters. As people of higher and higher social station were called out as witches, both the Catholic and Protestant churches and local governments withdrew their support. Accusations had reached the point at which they were contrary to reason and unsupported by emerging scientific views.

Treatment of the mentally ill.   Not all mentally deranged people were killed or persecuted as witches. Some mentally ill individuals during the Middle Ages and the Renaissance were simply regarded as "fools" and "village idiots." They were tolerated by their communities for purposes of amusement, sadism, or charity, or because they were harmless. Others were kept at home by their families, sometimes in chains; and still others were driven out of their homes and forced to wander over the countryside attempting to survive as best they could.

Some mentally ill people were supposedly placed in boats or ships, the so-called ships of fools, whose boatmen or sailors were bribed to put them ashore at a distant place. According to French social theorist Michel Foucault (1965), these ships of fools sparked the imagination of certain early Renaissance literary figures and artists, notably the writer Sebastian Brant and the painter

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[2]Mary Warren, one of the original group of "afflicted" girls in Salem, attempted to reverse her testimony and discredit that of the other girls during one of the trials. The judges refused to believe her denials, and she herself was eventually accused of witchcraft.

Hieronymus Bosch, both of whom created highly symbolic works depicting cargoes of mad people adrift in search of their reason. Foucault (1965:11) says:

> Confined on the ship, from which there is no escape, the madman is delivered to the river with its thousand arms, the sea with its thousand roads, to that great uncertainty external to everything. He is a prisoner in the midst of what is the freest, the openest of routes: bound fast at the infinite crossroads. He is the Passenger *par excellence:* that is, the prisoner of the passage. And the land he will come to is unknown—as is, once he disembarks, the land from which he comes. He has his truth and his homeland only in that fruitless expanse between two countries that cannot belong to him.

This theme also produced in the European literature of that period the symbol of the soul as a skiff or small boat, abandoned on the sea amid unreason, yet surrounded by mirages of knowledge—"a craft at the mercy of the sea's great madness, unless it throws out a solid anchor, faith, and raises its spiritual sails so that the breath of God may bring it to port" (Foucault 1965:12).

The deliberate shipment of the mentally ill out of communities signified much more than the idea of the mad being put adrift to find normality; rather, it marked the beginning of the strict separation of the insane from the company of the sane. Madness was to be controlled and the next step was confinement.

Beginning in the late Middle Ages, many mental patients were institutionalized in custodial centers to remove them from the general population. Efforts were made to cure them through prayer or physical means such as bloodletting, emetics, and cathartics. It was generally believed that the only way to cure mental derangement was by the divine intercession of saints; therefore, religious practices were emphasized. Finally, in 1409 in Valencia, Spain, the first mental hospital was founded by a Catholic priest, Father Gilabert Jofré (1350–1417). The impetus behind Father Jofré's action was his reaction to witnessing a brutal street scene in which mentally ill persons were tormented and teased. Shortly thereafter, Spanish missionaries founded other mental hospitals in Spain and later, in 1567, in Mexico City.

The relatively tolerant attitude in Spain toward the mentally ill was most likely influenced by its proximity and cultural ties to the Arab world. The Arab countries of North Africa and the Middle East had taken a much more humane view of mental illness. The basis of this approach was the Muslim view that the insane are loved by God and are especially chosen to tell the truth. According to George Mora (1985), as early as the twelfth century, travelers returning to Europe reported a high standard of humanitarian treatment for the insane at various Arab mental asylums. One description tells of fountains, gardens, and a relaxed atmosphere in which patients were treated with special diets, drugs, baths, and perfumes. Note is also made of concerts in which the musical instruments were tuned so as not to jar the patients' sensitivities. Rich and poor were apparently given access to the same facilities.

There were some humane trends discernible in Western Europe other than the work of the Catholic Church in supporting institutions to protect and care for the mentally ill. Johann Weyer (1515–1588), a Dutchman known as the first psychiatrist, strongly rejected the idea of witchcraft and the policies of those clergy who supported witch hunts. He insisted that patients should be treated with kindness and understanding. Therapy was to be derived only from the scientific investigation of a patient's complaints. Another significant physician was Paracelsus (1493–1541), a Swiss who argued that the insane were neither sinners nor criminals but sick people who needed medical help. The first conceptualization of unconscious motivation promoting anxiety is found in his writings. In Spain, Juan Luis Vives (1492–1540), who became the father of modern psychology, likewise spoke out against beliefs in demonology and claimed that mental patients should be treated peacefully if reason and sanity were to be returned. He believed, in opposition to theologians, that the mind should be studied and posited that emotions and instincts are central influences upon behavior. The work of individuals such as Weyer, Paracelsus, Vives, and Cornelius Agrippa (1486–1535), a German scholar who defended women's rights and risked his life to save a woman accused of witchcraft, eventually led to the separation of psychology and psychiatry from theology. But their ideas had little immediate impact, and in some cases, especially that of Weyer, they were viewed as radicals and deliberately ignored by their contemporaries.

Divine healing.   The early Christian explanation of mental disorder, which implicated the Devil and sin, persists among some religious groups. In a study conducted several years ago by Gillian Allen and Roy Wallis (1976) of members of a small congregation of a Pentecostal church, the Assemblies of God, in a city in Scotland, it was found that "possession by evil spirits" is used to explain not only mental illness but also certain other problems, such as dumbness, blindness, and epilepsy. These people believe that demons can be transferred from one person to another by touch and that exorcism by prayer can remove them. Although most church members agree that disease in general can be caused by the Devil, mental illness appears especially demonic in origin.

Accepting the Bible as the literal truth, the Assemblies of God officially support the belief in *divine healing*. This belief is derived from biblical passages indicating that (1) some people have the power to transmit the healing forces of the Holy Spirit or to exorcise demons, and (2) healing can be obtained through faith in the same way as can salvation from sin. The healing procedure is described as follows:

> Prayer for healing in the Assembly of God occurs at the end of normal services when those who need healing or help and advice, are asked "to come out to the front." There the pastor and the elders perform the laying on of hands and sprinkling with holy oil and pray simultaneously: "Oh Lord, heal this woman!

Yes, Lord. We know You can heal her." The occasional case of demon possession is dealt with in a similar way when the pastor or evangelist addresses the demon along these lines: "Get out, foul demon! In the name of Jesus, leave her!" (Allen and Wallis 1976:121)

Although the Pentecostal church fosters divine healing as central to church dogma, it does not prohibit members from seeking professional medical care. Use of divine healing is preferred, however, because it offers the advantage of providing both spiritual and physical healing; it is also believed to work in many cases in which orthodox medical practice has failed. There are many stories among the members attesting to spectacular cures either through the specific effect of the emotional healing services or through the power of prayer in general. Yet because church members also believe that "God's methods are sometimes through humans" and that "God put doctors in the world and gave them their skills," it is permissible to seek a physician's assistance. For serious illnesses in particular, divine healing is used in conjunction with professional medicine. Hence, church members simultaneously hold both religious and scientific beliefs about the causation and treatment of illness, without any apparent conflict. "In serious illnesses," state Allen and Wallis (1976:134–35), "members were not faced with the choice between breaking their religious principles by fetching the doctor and refusing medical treatment altogether." Unlike some faith healers who utilize emotionally charged healing rituals, or believers in the unemotional approach of Christian Science, where the focus is exclusively upon faith and prayer, Pentecostalists are usually able to avoid the dilemma of whether to use *either* a religious *or* a medical curing process.

The Eighteenth Century: The Great Confinement and Reform

The Great Confinement.   The eighteenth century marked the age of the *Great Confinement,* for it was during this century that numerous institutions, many of them called "hospitals," spread across Europe, intended to house and control persons considered to be social problems. Actually, this process began in the middle of the seventeenth century with the founding of the *Hôpital Général* in Paris in 1656, but it reached its zenith in the eighteenth century when an entire network of such institutions was built across Western Europe. Economic recession, unemployment, higher prices, and losses of land had created a serious problem of vagrancy throughout Europe. Many vagrants, turning to begging on the streets of Europe's cities, became a great public nuisance. In recognition of this problem and in accordance with a new definition of social welfare as a community rather than a church responsibility, municipal and national authorities began to extend public assistance to the poor by offering them food and shelter. This policy was also in line with the new

notion of enlightened absolutism in which the monarchs of Europe assumed responsibility for the safety and well-being of their subjects in return for obedience to their absolute authority. Thus, for the first time, purely negative measures of exclusion (e.g., the ships of fools) were replaced by the measure of confinement. The unemployed were no longer driven away or punished. Instead, they were cared for at the expense of the nation, but also at the cost of their liberty.

Consequently, an implicit system of obligation was set into motion between the poor and society at large. The poor had the right to be taken care of, but only by accepting confinement in society's "social warehouses" where they—including the sick, invalids, the aged, orphans, and the insane— were removed from mainstream society. A legacy of this, existing even today in the United States, is that people with chronic health problems requiring long-term hospitalization—the insane, the incurable, and persons afflicted with highly infectious diseases—tend to be sent to public institutions, whereas private hospitals generally accept patients needing to be hospitalized for relatively shorter periods of time. Custodial care thus remains largely within the purview of the state. For the seriously mentally ill, of course, this means commitment to a state or county mental hospital.

Another legacy from this period is the emergence of the Protestant Ethic, grounded in Puritanism, which had an important impact upon the thinking of many Europeans and Americans in the seventeenth and eighteenth centuries and still lingers today. The Protestant Ethic equates productive labor with goodness and morality; idleness and unemployment are viewed as sinful and immoral. The able-bodied poor who were confined to poorhouses and hospitals were required to work to contribute to their support, thereby becoming a source of cheap labor. The insane, however, as described by Foucault (1965), were distinguished by their inability to work and follow the patterns of community life. Hence, madness was defined as a vice as well as an unfortunate circumstance. It joined idleness as a sin. Foucault suggests that the effect of confinement upon the mentally ill was a decisive event in that insanity was now ranked among the problems of the city, similar to poverty, unemployment, and a failure to commit one's self to the collective interest. The ethical value of labor, the obligation to work, and the meaning of poverty all combined to determine the fate of the insane.

For the mentally ill, the era of the Great Confinement was a time of hardship and brutality. Foucault notes that the insane were regarded as being little more than animals and that their animalness was considered protection from hunger, heat, cold, and pain. "It was common knowledge," says Foucault (1965:74), "until the end of the 18th century that the insane could support the miseries of existence indefinitely. There was no need to protect them; they had no need to be covered or warm." The insane were crowded into rooms or cells with little or no warmth even on the coldest days; most were chained to walls or beds. Some had no beds and slept on straw pallets in cells that were

damp and perhaps rat infested. Some went naked. Those who were violent were subjected to brutal punishment because discipline was thought to be a sound method of promoting the return of reason.

Although the insane were locked away from society, they were still the objects of bizarre curiosity. On weekends, it was not uncommon for the mad to be displayed to visitors who would pay an admission price to view the human oddities. For example, it was reported in the House of Commons in London in 1815 that the Bethlehem Hospital for the insane took in about four hundred English pounds in admission fees. At a penny a visitor, this suggests that over ninety thousand people visited the hospital that year during its Sunday open houses. Not only did the general public get a chance to peer at the insane, but sometimes the insane were made to perform dances and acrobatics. "The only extenuation to be found at the end of the 18th century," Foucault (1965:69) states, "was that the mad were allowed to exhibit the mad, as if it were the responsibility of madness to testify to its own nature."

Reform: Chiarugi, Tuke, and Pinel.   Toward the end of the eighteenth century, public outrage grew as the abuses suffered by the mentally ill received widespread attention. An illustration of this reaction is reflected in the comments made by Daniel Defoe, an English journalist and author (*Robinson Crusoe*), and his colleagues, who castigated unworthy husbands who attempted to shed their allegedly normal wives after becoming tired of them by placing them in mental institutions. Defoe and his associates (1973:8) complained:

> If they are not mad when they go into these cursed Houses, they are soon made so by the barbarous Usage they there suffer, and any Woman of spirit who has the least Love for her Husband, or Concern for her family, cannot sit down tamely under a Confinement and Separation the most unaccountable and unreasonable. Is it not enough to make any one mad to be suddenly clap'd up, stripp'd, whipp'd, ill fed, and worse us'd? To have no Reason assign'd for such Treatment, no Crime alleg'd, or accusers to confront? And what is worse, no Soul to appeal to but merciless Creatures, who answer but in Laughter, Surliness, Contradiction, and too often Stripes? All conveniences for Writing are denied, no Messenger to be had to carry a Letter to any Relation or Friend; and if this tyrannical Inquisition, join'd with the reasonable Reflections, a woman of any common Understanding must necessarily make, be not sufficient to drive any Soul stark staring mad, though before they were never so much in their right Senses, I have no more to say.

Reform, however, was on the way, particularly because of three individuals—Vincenzo Chiarugi, William Tuke, and especially Philippe Pinel. Chiarugi (1759–1820), a physician in Florence, argued that medical personnel had a moral duty to treat the mentally ill as individuals and to treat them tactfully and humanely. Chiarugi put his ideas into operation while directing a large mental hospital, and he also wrote a three-volume work on insanity. Unfortunately, his ideas were obscured by the turmoil, revolts, and wars taking

place in and between the various Italian city-states at the time. William Tuke (1732–1819), a Quaker tea merchant living in England, was exceedingly more influential and established a mental asylum at York in 1792. Tuke's approach was strikingly radical for the day because he advocated that mental patients be treated as guests, with kindness and respect. He organized a friendly, sympathetic environment on an estate called "the Retreat" where he housed about thirty patients. There were no chains, physical punishment, or direct physician influence. Work in the form of moderate physical exercise was thought to be therapeutic. Observers from throughout Europe and the United States came to view Tuke's methods, and he achieved much humanitarian reform in England.

Slowly, small pockets of humane care for the mentally ill appeared in the Western world, but it remained for Philippe Pinel (1745–1826) to induce widespread change in the treatment of mental patients. Pinel, a shy, retiring French physician, had impressed his superiors while still a medical student by formulating a program of "moral treatment" for the insane. Pinel believed that mental health was dependent upon emotional stability, what he called a "balance of passions." He argued that mental patients would respond to kindness and sympathy under the firm guidance of the therapist as a father figure. If possible, patients should be allowed to work and participate in recreational activities (concerts, lectures, games) rather than be confined to cells or held in restraint by mechanical devices. The main causes of mental disorder were thought to be psychological (e.g., passions, lust, excessive masturbation) or environmental (e.g., too much freedom, economic uncertainty). As it evolved, moral treatment was essentially a program of reeducation in which mental patients were to be taught how to behave normally within the context of sympathetic living conditions.

In August 1793, in the midst of the French Revolution, Pinel received his wish and was appointed as a physician to the insane asylum of Bicêtre for male patients. Persuading the warden to allow him to unchain the inmates, Pinel walked through the asylums, going from cell to cell freeing the patients. The first man unchained had not walked in forty years but somehow managed to hobble out of his cell to view the sky in a state of amazement.

> The second to be released was a drunkard who had been discharged from the French Guards, Chevigné by name. For ten years he had been in chains. His mind disordered, assaultive, and surly, he was considered incurable. Pinel went to him, took off the iron anklets and handcuffs. Behold a revelation! The vicious sot stood up, and with a courtly flourish bowed to Pinel. He became a model of good conduct and in time was released. (Bromberg 1975:96)

Pinel ordered beatings and other forms of physical abuse halted; food was improved, and the patients were treated with a new drug: kindness. And apparently in many individual cases, there was great improvement. "Dazed lunatics, rubbing their eyes at their good fortune, talked for the first time in

years, and became almost human again" (Bromberg 1975:97). Pinel's program thus called attention to the need for and possible benefits of reform in the care of the mentally ill. It was also an act of great personal courage on his part because it came when the French Revolution had turned on a course of terror. Citizens suspected of royalist rather than republican sympathies or whose actions could be judged as supporting the old regime were sent to be beheaded on the guillotine. Pinel's ideas, however, turned out to be extremely successful. His book, *Treatise on Insanity,* published in 1801, was likewise very popular, and his concept of moral treatment became the basis for French laws pertaining to mental health. He was appointed to a top medical school faculty position and honored by election to the membership of the Institute of France. For about twenty years, he enjoyed success and fame, but eventually he was affected by politics. Suspected of being a royalist for allegedly allowing certain priests and refugees wanted by the government to stay at the Bicêtre asylum, Pinel lost his teaching post and spent the remainder of his life living in poverty.

The Nineteenth Century: Emergence of the Medical Model

The decline of moral treatment.   The nineteenth century began with the influence of Pinel's moral treatment in full bloom. Also influential, especially in England and in the United States because of their close cultural ties, were Tuke's methods as practiced at the York Retreat. In response, several mental asylums were founded in the United States between the turn of the century and the American Civil War. The most noted of these, initially, was the Worcester State Hospital in Worcester, Massachusetts. Here the philosophy of moral treatment was held as an example for the rest of the country, but the reader should not get the impression that all or even most mental patients received moral treatment. Generally, moral treatment was provided by private hospitals or by only the most progressive public asylums. In the United States, moral treatment was most prevalent in New England, and the patients were usually from upper- and middle-class families. Mentally ill persons who were violent, poor, or nonwhite often found themselves in jails or workhouses.

The goal of moral treatment for all the insane was not to be realized, for within a few decades its influence declined significantly. Five factors were largely responsible for this outcome. First, there was no truly cohesive program detailing a systematic approach to moral treatment. Thus, it was difficult to train others in its methods and implement any type of standardization or coordination. This also impeded public recognition of its value. Second, some critics viewed moral treatment as simply a method for enforcing patient conformity—which essentially it was because of its system of rewards for good behavior and punishment (separation) for bad behavior (Scull 1991). Third, mental asylums were overcrowded with people who not only were insane, but

also had related problems of criminality, alcoholism, vagrancy, and poverty. Most mental patients were not misguided souls from affluent families. Instead, most were from the lower class and thus were held in low social esteem. This circumstance was common in the United States, where the inmates of mental institutions came to be considered unworthy tax burdens by many citizens. Resentment was bred by the notions of moral treatment, with its emphasis upon pleasant surroundings and recreation for socially objectionable people who had outraged the morals of the community.

A fourth factor was the increasing popularity of the theory that madness was incurable, a theory that was due principally to ideas about heredity. This influence, largely European in origin but embraced in the United States, encouraged a pessimistic outlook that little or nothing could be done to return mental patients to society in any normal capacity. Social Darwinism, with its advocacy of the survival of the fittest, further contributed to doubts about helping the insane. With a view primarily toward reducing costs, there was a great expansion of *large,* essentially custodial, mental hospitals.

Ironically, this process was helped by Dorothea Dix (1802–1887), a New England schoolteacher who devoted her life to reforming conditions for the mentally ill. During a visit to a Massachusetts jail in 1841, she was outraged by the sight of the mentally ill being housed with criminals, and so she visited every jail and poorhouse in Massachusetts over the following two years. Her next step was to send a report to the Massachusetts legislature describing the plight of the insane. This report caused a sensation, not only in Massachusetts, but nationwide. She subsequently devoted her life to traveling throughout the country inspecting mental institutions and demanding increased financial support from state governments. She personally founded or enlarged some thirty-two mental hospitals and saw to it that physicians were added to the staffs of many of those institutions. In addition, she got the mentally ill out of jails and poorhouses and into asylums.

One of those hospitals helped by Dix was the Worcester State Hospital, formerly a model of moral treatment. What had happened at Worcester was typical of many other places. The low status and bizarre behavior of the inmates promoted contemptuous attitudes toward them by the staff and the community. The overwhelming number of patients, the limited amount of funds available to run the hospital, and the low social value of the inmates influenced the administration in not maintaining an environment for moral treatment. Instead, they adopted custodial procedures that were more cost effective. Hence, Worcester adopted a custodial orientation, as did other institutions. The use of mental hospitals to house the aged poor in particular remained common in state and county mental hospitals until well into the twentieth century.

Finally, there was a fifth factor, the powerful influence of psychiatrists who viewed mental disorder as primarily a disease brought on by organic causes. Benjamin Rush (1745–1813), the father of American psychiatry,

maintained, for example, that abnormal behavior was derived from brain disease that had its locus in the brain's blood vessels. At the Worcester State Hospital, staff psychiatrists emphasized similar ideas as part of their claim to professional legitimacy in medicine. They saw themselves as "scientists" working in the same manner as other medical doctors. Although moral treatment recognized both organic and psychological causes of mental disorder, psychiatric ideology tended to negate measures such as moral treatment because they featured the therapeutic value of the environment. Instead, purely medical techniques were to be used in treating mental patients.

The overall result was the demise of moral treatment, which may not have been the most effective approach for some patients, but had brought improvement to others; more importantly, its philosophy had meant humane care for all.

The medical model.   Nineteenth-century physicians were not the first to argue that abnormal mental behavior was the result of mental disease, not the manifestation of witchcraft and sin. Such arguments had been growing since the sixteenth century, but the 1800s saw the emergence of a scientific framework supporting the concept as it never had before. This was a period of tremendous advancement for medicine, as research discoveries led to highly significant improvements in medical knowledge, procedures, and technology. Louis Pasteur, Robert Koch, and others engaged in bacteriological research leading to the conceptualization of the germ theory of disease, establishing the premise that every disease had a specific pathogenic cause whose treatment could best be accomplished within a biomedical mode. This approach, as is well known, was highly successful in producing cures for acute communicable diseases. In view of this success, it was perhaps inevitable that physicians as psychiatrists would come to view mental disorder in a similar fashion, as an extension of the germ theory. Consequently, organic dysfunctions of the brain were credited as the primary etiology of mental disorder. The most influential textbook of this period, for instance, was written by a leading German psychiatrist, Wilhelm Griesinger (1817–1868), and was titled *Pathology and Theory of Mental Diseases*. The title clearly indicates the approach of its author, for Griesinger claimed that mental illness was brought on by biochemical changes in the nervous system caused by disease. By the mid-1850s, almost all American psychiatrists had come to believe that psychological problems had physiological causes (Mora 1985). This viewpoint also became accepted by the American public.

Postmortem examinations were now primary methods of attempting to discover the origins of mental disorder. Research moved away from living patients to morgues and clinical laboratories as the emphasis turned to brain dissection. Neurology became an important ally of psychiatry as diseases of the nervous system gained acceptance as causes of insanity. Psychiatry, however, struggled with organic definitions of mental disorders, since it was

unable to produce scientific verification of the disease approach. Syphilis was one disease under investigation that produced a psychosis that could be verified as having an organic pathology, and that was treatable by biomedical means. Except for a few other mental disorders related to such conditions as cerebral atherosclerosis, chronic intoxication, vitamin deficiency, and outright physical injury to the brain, there was a lack of direct evidence to sustain the medical model. Nevertheless, bolstered by success in treating *physical* diseases of the body, the medical model remained the most widely accepted explanation of mental disorder.

The Twentieth Century: The Age of Therapies

The twentieth century was unlike any other century preceding it in the variety of concepts of mental illness. Some ideas of the past remained, such as beliefs based upon superstition or notions of the role of the Devil. Other ideas, however, competed for attention and money. Those ideas ranged from sophisticated biochemical research to psychoanalysis, behavior modification, and community psychiatry, to self-help procedures embodied in techniques such as biofeedback and transcendental meditation. All in all, there are at least two hundred therapies and numerous pseudotherapies available in contemporary Western society, all intended to counteract psychological stress and behavioral abnormality. Professionals, paraprofessionals, and laypeople are involved in treating mental problems. The most influential developments in mental health during the twentieth century were the work of Sigmund Freud, the extensive use of psychoactive drugs, and the community mental health movement.

Sigmund Freud.   Freud (1856–1939), an Austrian physician who began practice as a neurologist, established a theoretical basis for much of modern psychiatry. He emphasized psychological concepts of learning, motivation, and personality over purely organic approaches. Most important, he directed attention to the role of instincts and the unconscious in shaping behavior. Freud was a controversial figure, and even some of his supporters and students disagreed with him and broke away to form their own approaches. Yet he was extremely influential—particularly in the United States, where many psychiatrists were receptive to new ideas. At that time, psychiatry had become a relatively static branch of clinical medicine mired in the search for organic causes of mental disorders. Freud had the effect of breathing new life back into psychiatry with the formulation of the psychoanalytic approach, which was highly popular with white middle- and upper-class Americans in the 1940s and 1950s. In psychoanalysis, patients reconstructed their childhood experiences and life events over a period of time. This process was directed toward resolving present conflicts by uncovering the source of mental discomfort in the formative years of the patient's life. Behind this technique was Freud's belief that human behavior was determined by unconscious influences

shaping conscious thoughts and actions. Freud, accordingly, developed an elaborate theory of instincts, personality structure, stages of psychosexual development, and ego defense mechanisms, as well as delving into dreams, group psychology, religion, and other matters.

   Psychoactive drugs: The new medical model.   By the 1960s, however, the optimism that had been generated by Freud had begun to run its course. Psychoanalysis was time-consuming, expensive, and not particularly effective with seriously deranged patients such as schizophrenics and others lacking ego strength and an adequate sense of reality. Its greatest gains had been with patients suffering from anxiety. But as psychiatry was again becoming stalled, it was rescued by the second twentieth-century revolution in mental health, the discovery and use of psychoactive drugs to treat the mentally ill. Although the attempt to justify the medical model through theories of organic brain disease had failed, success came through the biochemical approaches.

   Research in France in 1952 had shown that chlorpromazine was effective in treating psychotic patients. Chlorpromazine was first used in the United States in 1954, and by 1977 other phenothiazines had been developed for treating schizophrenia and manic states; drugs such as iproniazid and, later, imipramine were used for depression. The results were astounding, and the number of resident patients in mental hospitals decreased significantly from 1956 onward.

   To recognize what has happened, we need to briefly review the situation in most mental hospitals since the mid-1800s. Following the reforms of Dorothea Dix, mental hospitals in the United States had grown progressively larger and were generally constructed away from large population centers in order to remove the insane from society. Overcrowding continued to foster trends toward custodial care as hospital staffs became increasingly limited in their capabilities to contend with large numbers of patients. Beginning in 1860, there was a decline in discharges for mental hospitals as patients began to remain hospitalized for longer periods. Discharge rates and lengths of hospitalization stabilized somewhat in the 1920s, but from 1945 to 1955 there was an average annual increase of some thirteen thousand patients. Philip Berger, Beatrix Hamburg, and David Hamburg (1977:263–64) describe the situation in the 1950s before the introduction of drug therapies:

   Pessimism toward severe mental illness was common because each year the number of patients admitted to hospitals increased, while very few were ever discharged. The patients' living areas were crowded and poorly furnished; schizophrenic patients with paranoid delusions crouched in corners in constant fear; catatonic patients were allowed to maintain the same rigid posture to the point of developing swollen legs and pressure sores; hallucinating patients paced the floor talking to their "voices" and unaware of what was going on around them. People sat year after year on benches or on the floor doing nothing, while their physical health deteriorated as well. Violent patients attacked staff members or other

patients for reasons known only to themselves. Manic patients laughed, joked, and moved constantly for days at a time until they collapsed, exhausted. Combative patients were kept in rooms without furniture or strapped to beds that were bolted to the floor to prevent injury to themselves and others. Agitated patients were often placed in warm baths or tied in wet sheets in an effort to calm their frenzy.

The psychiatrists charged with the care and treatment of these patients were baffled by these disorders. Both cause and therapy were quite unknown and untaught in medical schools. Before World War II patients were in the care of physicians trained mainly in neurology, but by the postwar period, many had studied psychoanalytic psychotherapy as well; but neither neurological diagnosis nor psychoanalytic psychotherapy had any substantial effect in the treatment of chronic schizophrenia or severe mania. Regardless of their training, psychiatrists functioned mainly as administrators and custodians.

In 1950 there were 512,501 patients housed in state and county mental hospitals, a figure that had risen to 558,922 by 1955. In 1956, the first year of the widespread use of psychopharmaceuticals in state and local mental hospitals, the number of resident patients dropped to 551,390. This drop has continued, and in 1997 the number of resident mental patients had fallen to 54,015. Moreover, there has been a decline in the average length of stay. In 1955, the average time of hospitalization for mental patients was six months; by 1997, it had dropped to less than fifteen days. Unfortunately, more recent data from the National Institute of Mental Health have not been forthcoming, and current figures on state and county mental hospital resident patients are not available, although it is clear that the inpatient population of mental hospitals is considerably smaller than ever before.

Although not all the credit for the reduction in numbers of mental hospital resident patients is due to psychopharmaceuticals, certainly the use of psychoactive drugs has played a central role. Additionally, the use of drugs helped to promote feelings of optimism and innovation among hospital staff members and encouraged other new forms of therapy, such as family therapy, crisis intervention, and brief psychotherapy. Yet the use of psychoactive drugs does not result in a miracle cure for mental disorder, and enthusiasm for them should be tempered. These drugs do not cure; they relieve symptoms and make social life possible when it was not before. Unpleasant side effects, such as interference with thinking, nausea, and addiction, accompany the use of certain drugs. Hence, the use of psychoactive chemical compounds has both positive and negative results.

Community mental health.   The third mental health revolution in the twentieth century in the United States was the community mental health movement. With the release of large numbers of mental hospital patients back into the community, many of whom were not cured but merely sustained by drugs, some new measure was needed to assist these patients in maintaining themselves outside the hospital. In 1955, Congress authorized and funded

the Joint Commission on Mental Illness and Health. The commission's final report, *Action for Mental Health,* published in 1961, described institutional mental health care as hopelessly custodial and recommended the establishment of local community mental health centers. In the United States, the 1960s were a time of social protest and demand for reform. Particular issues were civil rights and, later, American involvement in the Vietnam War, yet reform in the area of mental health, was also included in those issues that attracted community support. Congress passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act in 1963 to support the establishment of easily accessible and locally controlled mental health centers. This law reflected the philosophy that the objective of modern treatment should be to support mental patients in their own communities as much as possible, so that such persons could lead relatively normal lives.

Community mental health programs have four basic goals. First is the idea that the mental patient's entire social environment be viewed as a "therapeutic community" with treatment resources for mental health professionals. The second goal, clearly related to the first, is that some means must be found to use the patient's relationships with family and friends to improve therapy and prevent recurrence of the mental disorder. The third goal is to develop and organize local community control over these centers so that center policies are community based and oriented. Fourth is the goal of reducing patient populations at state and local mental hospitals by providing prompt response and twenty-four-hour service.

The establishment of community mental health centers has also meant the emergence of a new kind of mental health worker—a layperson, living in the community, who can fill the gap between the mental health center client and the professional worker. The community mental health worker is supposed to be someone who can understand and work with people living in lower-class environments more effectively than middle-class professionals can. This broadening of community participation in mental health has recognized that many client problems are social rather than medical. These problems include unemployment, poverty, poor housing, lack of food and clothing, racial discrimination, law violations, child support, and other characteristics of low-income living.

The movement to extend mental health services into community settings was not just the result of new psychoactive drugs and the negative effects of housing people in mental institutions for extensive periods. A host of other influences were important as well. These included growing public support for a more enlightened, humane approach to treating mental patients; the extension of civil rights as a means to solve social problems to mental patients, thereby making it difficult to administer psychiatric care to people without their consent; and strong lobby efforts on the part of community psychiatry interest groups aimed at obtaining greater government funding and resources for community care. Criticism also emerged in psychiatry, particularly the work

of R. D. Laing (1969) and Thomas Szasz (1970, 1974, 1987), who depicted mental illness as either a different type of reality or a myth, and mental hospitalization as a form of oppression.

By the 1980s, there were 691 community mental health centers in the United States treating noninstitutionalized patients. The number has since declined. Although these clinics had some success in working with patients who could be helped best in the community and in providing prompt crisis intervention services, they have been handicapped by low levels of funding and overburdened by patients. Furthermore, a comprehensive system of facilities and services to support the work of the mental health clinics, to include halfway houses and support networks for patients, never fully materialized in many communities. Consequently, the community mental health movement has not shown widespread success and, in fact, has contributed to a new problem, which is the presence of mental patients living in the community who are ill equipped to deal with life outside an institution. Many of these patients do not live with their families for various reasons and tend to congregate in ghettos of the mentally ill where some live lonely, disorganized, frustrated lives in slum environments. Mental disorder remains a major social problem in the United States.

The Twenty-First Century: The New Genetics?

The twenty-first century is too recent to forecast its precise contributions to the care and treatment of mental disorders. Research on new and improved psychoactive drugs will undoubtedly continue along with advances in understanding brain chemistry. However, a recent and particularly promising development is in the field of genetics. The mapping of the human genome system was completed in the late 1990s and ranks as a major scientific breakthrough for mental health practitioners. It is an established fact that mental disorders are genetically transmitted from one generation to the next—causing them to be more prevalent in some families than others. Gene therapy involving alteration or changes in a person's genetic code may be able to prevent an inherited mental disorder. Furthermore, genetic information may be able to help produce "designer" drugs tailored to match an individual's DNA and be more effective in treating the mental problems of people who need this type of treatment. These promising therapeutic procedures await development, but may revolutionize the treatment of mental disorder sometime this century.

But there are also social implications attached to the geneticization of deviant behavior. As Jo Phelan (2005:307) points out, a consequence of the genetics revolution is an increased tendency to understand human behavior in genetic terms. She found in a nationwide study that attributing mental problems to genetic causes could result in greater stigma for the afflicted person and his or her family, including children and other relatives. That is, people with a genetically caused mental illness were widely perceived by the respondents in her study as fundamentally "different" from other persons,

carried mental illness in their genes, and their family members were viewed with suspicion for sharing the same aberrant gene or genes. A major outcome was the view that such persons were to be kept at a social distance (socially rejected). Jason Schnittker (2008) likewise finds that attributing mental disorder to a genetic cause does not result in greater tolerance for the mentally disturbed. Social rejection was still the norm.

SUMMARY

This chapter has defined mental disorder and traced the changing concepts of madness through the ages. We have seen how ideas about the causes of mental illness have changed from those of evil spirits in preliterate times to contemporary views based largely upon medical perspectives. In the twentieth century, there were three revolutions in the United States that initiated highly influential patterns of treatment for the mentally ill: (1) psychoanalysis and the theories of Sigmund Freud, (2) the widespread use of psychoactive drugs to treat mental patients, and (3) the establishment of community mental health centers. To date, the twenty-first century has yet to make its contribution to the treatment of mental disorders simply because it is too early. But new measures are likely to be forthcoming, especially in the area of brain chemistry and genetics now that the human genetic code has been mapped.