The History of Psychiatry

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Introduction

"I'm not afraid of werewolves or vampires or haunted hotels, I'm afraid of what real human beings do to other real human beings."

-Walter Jon Williams, American author

In order to appreciate the medical specialty of psychiatry and the modern treatment of mental illness, it is pertinent to review and understand the history of the treatment of the mentally ill and of psychiatry, even prior to when it was understood to be a medical specialty. The word ‘psychiatry’ was first used in 1808, by Johann Christian Reil, a German physician, meaning the ‘medical treatment of the soul’.¹¹ It originated from the Greek terms of psych- “soul” and -iatry “medical treatment” or “to heal” and has come to be defined as:

\[
\text{psy\-chi\-a\-try} \\
/\text{sī\'kiatrē, só\'kiatrē}/
\]

A branch of medicine that deals with the science and practice of treating mental, emotional, or behavioral disorders especially as originating in endogenous causes or resulting from faulty interpersonal relationships.⁵³
There is much that transpired in history with regards to psychiatry and the treatment of the mentally ill. Throughout time there have many scientific advancements and medical breakthroughs, but unfortunately, most of the history is grave and disastrous at best.

Ancient civilizations, though unsure of the root of mental illness, generally treated patients humanely. The dawn of the Church in the Middle Ages led to beliefs of witchcraft and sorcery, lending to the locking up and condemning of the mentally ill. Throughout the Witch Hunts, they were prosecuted as witches and burned at the stake.

For centuries those suffering from mental illness were shamed, isolated, tortured endlessly, and left to die. Institutions and mental hospitals throughout time have fluctuated between places of healing and nurturing, to places of maltreatment and despair. The mentally ill were freed of the chains of such institutions, only to end up on our streets and in our prisons.

Much has changed regarding our treatment and knowledge surrounding the mentally ill. Although the specialty of psychiatry is still evolving, we are still not where we could be. We must not neglect the history of psychiatry, as painful as our past mistakes may be. Continuous improvement is vital as our current treatment of the mentally ill is still incomprehensibly flawed. We must not forget that we too shall someday be on the timeline that coming generations will study in the history of psychiatry.

The History of Psychiatry
Humanity

If we don’t feel with our hearts, we don’t belong
If we don’t see as one, the world is wrong
Beyond the wars and the hate and the insanity
We are all connected as humanity
We are the child with cancer who still wears a smile
We are the kid from the projects facing trial
We are the pregnant teen feeling lost and used
We are the elderly man in a home abused
We are the young couple, marriage on the rocks
We are the homeless one in a cardboard box
We are the cold and hungry, sad and depressed
We are the lonely child who never felt blessed
We are the woman whose life was filled with pain
We are the man standing alone in the pouring rain
We are the child who struggles day to day
We are the teenage girl who ran away
We are the soldier killed in an unjust war
We are the young man who can dream no more
We are the inmate locked away for life
We are the old man who has lost his wife
We would be better off without our vanity
And have a sense of belonging to humanity.

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https://www.poetrysoup.com/poem/humanity_265546

The History of Psychiatry
Ancient Psychiatry

The Stone Age
In the Stone Age, it is speculated that popular belief surrounded the idea that mental illness resulted from the possession of the afflicted by evil spirits. The management of mental illness at this time in Europe and in the Americas involved a procedure called trepanation. Trepanation is the act of drilling or scraping holes into the skull, which was first performed 4,000-5,000 years ago with sharpened rocks. It is speculated that this procedure was done with hopes of releasing the evil spirits from the possessed human.\textsuperscript{27}

Trepanation is one of the oldest surgical procedures with supporting archeological evidence.\textsuperscript{56} Trephined skulls represent 5-10\% of all the recovered skulls from the Neolithic period and over 1,500 trephined skulls have been found worldwide thus far.\textsuperscript{29} The discovery of this procedure stemmed from recovery of skulls that
showed careful, intentional removal of cranial fragments versus evidence supporting a violent origin such as a skull fracture. Paleolithic parietal art (cave painting) from this time suggest that trepanation was performed not only for those with mental illness, but also for those who suffered from seizures, migraines, and head trauma.¹⁴

Although trephined skulls of children and women have been unearthed, the recovered post-trepanation skulls from this time period are predominantly of adult males. Many of the recovered skulls with evidence of this procedure show evidence of structural healing of the skull, suggesting that patients would often survive this procedure.⁸⁸ Placement of the cranial fragments in or near the remains suggests that post-procedure the patients would carry the fragment or wear it as a sort of charm or amulet. It has also been suggested that those who survived the procedure were to have supernatural properties and their families were thought to enjoy luck and good fortune after the evil spirit was freed.¹⁹
Ancient Egypt

Ancient Egyptians had a differing belief, and viewed all illness, mental and physical, as one entity. Illness of every variety was believed to result from evil spirits, demons, and the wrath of the gods. Physical illness was treated no differently than mental illness, and treatments were physical and/or involved psychotherapy. The psychotherapy of this time took place in temples and was performed by physicians, magicians, and priests. Ancient Egyptians identified several mental illnesses, including hysteria and depression.

Hysteria was described in Papyrus Kahun in 1900 BC, as resulting from a starved or a superiorly displaced uterus, leading to the overcrowding of the other internal organs. Treatment for hysteria was physical, unlike most ancient Egyptian ailments and was focused around returning the uterus to its proper anatomical position. Often the genitals were covered with sweet smelling materials, believed to entice the uterus to move back into its normal location. If unsuccessful, four substances were inhaled or ingested in order to upset and force the uterus inferiorly.68
Ancient Egyptians believed the mind and the heart co-existed and the two were indistinguishable in text, as they were described and transcribed using the same term. Because of this, ancient Egyptians believed that depression stemmed from cardiac illness. Other issues thought to be of cardiac origin included over-excitement, cognitive delay, and disturbances in mood or thought. Specifically, ancient Egyptians believed that depression was linked to vascular problems (or in some cases, instability in the patient’s fecal matter). The treatment for depression was psycho-religious therapy.

Suicide was not deemed sinful as ancient Egyptians believed in life after death. If someone took their own life, the principle focus became the preservation of their remains with embalming and mummification, in order to keep their soul alive. This allowed the deceased to transform and continue into the afterlife.
Ancient Greece

Although suffering from psychiatric disease is/was tragic regardless of when
and where one existed, in ancient Greece, suffering from mental illness was particularly
shameful. The ancient Greeks were
known to shun and humiliate those with
mental disease. Many Greeks shared the
belief that mental illness occurred in those
that were sinful, and treatment involved
the inducing sleep by priests to interpret
their dreams, purification of the person
from evil by a priest, or the individual
was locked away and sometimes
sentenced to death. Instead, some of the
more fortunate were cared for by their
family.82

Eventually the belief that mental illness stemmed from sin dissipated and the
idea that they should instead look to scientific and physical principles in order to
understand and cure mental disorders began to predominate.55 Many influential
Greeks were responsible for this crucial shift in thinking about the origins of psychiatric
disease including: Thales, Pythagoras, Hippocrates, and Aristotle.
Thales rejected the belief that the gods were involved in mental illness. He believed that disease of the mind originated in the patients themselves and that a scientific, rather than a religious approach, was necessary in treating these patients.\textsuperscript{55}

Pythagoras was the first to acknowledge that consciousness and thought occurred in the brain and therefore postulated that the brain must be affected in mental disorders. He believed that the source of mental illness was due to an imbalance in harmonies (good versus bad, love versus hate, etc.)\textsuperscript{55}

Hippocrates, the father of Western medicine, was among the first to associate mental illness with physiological illness. He also created the first psychological model, which would construct the foundation from which psychiatry would be understood in the following centuries. Hippocrates also refused to accept the common belief of the time that mental disturbances resulted from demonic possession or that they were a form of punishment from gods.\textsuperscript{55}
Hippocrates recognized that the brain was the organ responsible for thought, emotion, intelligence, perception, and all cognitive activity, and that the brain was disturbed in mental illness. He was also able to characterize and differentiate between melancholia, mania, and dementia.69

In his psychological model, Hippocrates explained that the body contained four critical fluids, which he referred to as ‘humors’:

1. Sanguineous or blood
2. Phlegmaticus or phlegm
3. Cholericus or yellow bile
4. Melancholicus or black bile.69

Hippocrates believed that it was an imbalance of the above biological humors that led to mental disorders, and that correcting this imbalance could cure the mentally ill. This theory would remain the overwhelming understanding and the basis of treatment for over 2,000 years.69

The proposed manner of the repositioning of the humors was bloodletting, also known as bleeding or in modern terms, phlebotomy. Bloodletting is thought to have originated in ancient Egypt as a first-line treatment for almost every physical ailment.
Bloodletting was also being performed as an umbrella treatment for most physical disease in ancient Greece.\textsuperscript{16}

\textbf{Ancient Rome}

The overwhelming belief in ancient Rome was that mental illness resulted from excessive tightening of the pores in the brain as opposed to divine punishment or evil forces. Treatments included bloodletting and keeping the person in complete darkness.\textsuperscript{55} Several ancient Romans provided valuable insight into mental disorders, and influential persons included: Asclepiades, Soranus, Galen, and Aurelianus.

Asclepiades believed that environment was responsible for the development of mental disease and therefore recommended relaxing treatments. Additionally, he was the first to differentiate between hallucinations and delusions.\textsuperscript{55}

Soranus was also opposed to the harsh treatments of the mentally ill that were utilized at the time and suggested the use of cognitive exercise, as well as discussions with philosophers, to assist patients in dismissing their anxiety and grief.\textsuperscript{55}
Galen believed that symptoms of mental illness were evidence of faulty neurological structures or pathophysiology. He also wrote of distinct subtypes of depression.\textsuperscript{55}

Aurelianus opposed the belief that mental disturbances were a consequence of humoral imbalance and thought that psychiatric symptoms resulted from conditions that involved physical structures.\textsuperscript{55}

**Ancient India**

Beliefs about mental illness in ancient India were far more in line with the modern understanding of psychiatric disease. They believed in the unity of the mind and the soul. Although they understood that mental illness was a disease of the mind, they also recognized that certain diseases had specific physical signs. Diagnosis of disease relied on the cause, premonitory indications, symptoms, therapeutic tests, and natural history of the development of the disease.\textsuperscript{10}

In ancient India, the first accurate descriptions of differing psychiatric illnesses were described, and were remarkably similar to what we now know to be schizophrenia and bipolar disorder. They also characterized depression,
delirium, paranoid behavior, erotomanic delusions (delusions of love), and understood that medical illness could be the cause of mental illness. Treatment was largely psychosomatic, and in the fourth century BC, ancient Indians provided us with the first record of psychotherapy and counseling. Despite these understandings, ancient Indians too believed that psychiatric illness could be a result of a curse from a divine being.

Medieval Times

The Influence of Christianity and the Church

During the middle ages, religious beliefs and institutions, specifically Christianity and the church, became the overriding influence in most components of an individual’s daily life. This domineering religious ideality was demonstrated by the supposed causes of mental disturbances, as well as how mental illness was handled at this time. An accepted viewpoint during the medieval period was interactionism, or ‘mind-body dualism’. Interactionism was a philosophy that argued that the mind and body are distinct, but have causal interaction.
and may cause effects in one another.\textsuperscript{15}

If someone acted in a way that was positive and agreed with the church, they were deemed to be a god-faring member of society. However, if one acted in a negative or deleterious way that did not agreed with the church, they were thought to have a damaged soul at the hand of the devil. The consequence was the belief, once again, that it was evil itself was responsible for mental illness.\textsuperscript{15}

The spread of Christianity and the intensifying power of the church ensured that the scientific developments and advancements in psychiatry of the ancient populations would be overlooked and abandoned. Mental illness was often regarded as a consequential punishment for sin, a complete lack of morals, or to occur after making a deal with the devil. Additionally, mental illness was also thought to be a result of witchcraft and sorcery.\textsuperscript{15}

Nicholas Cresme, an influential philosopher in 14\textsuperscript{th} century Europe, argued that depression could be a potential cause of psychotic behavior. He also believed that the
observable signs and symptoms of mental illness were the aftermath of the torture that
the devil, demons, and/or witches had inflicted on the patient.  

**Exorcism and treatment**

*When possession by a demon was believed to have ensued, the first-line
treatment for eradicating the demon was to
try to lure it out of the possessed person.
If this failed, the next treatment would be to
yell and offend the demon out of the
afflicted. If insulting the demon was also
unsuccessful, the final step would be to make
the possessed person’s body so unbearable
that the demon would no longer desire to
remain in their body. In order to achieve an
inhospitable environment for a demon, the
patient would endure unthinkable torture,
such as immersion in hot water or sulfur
fumes. Other treatments involved the carving of a cross in the skin on the patient’s
head, forced purging, emetics, starvation, and the continued use of our old friends:
bloodletting and trephination. All of the above treatments were performed in
conjunction with confession and prayer.*  

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The Witch Hunt

Malleus Maleficarum

'MALLEUS MALEFICARUM, Maleficas, & earum haeresim, ut phranea potentissima contersons' (translated from Latin: 'The Hammer of Witches which destroyeth Witches and their heresy as with a two-edged sword'), written by Heinrich Kramer, a clergyman for the Catholic Church, in 1487, described witches as women who showed psychotic or hysterical symptoms and sexual delusions.

*Malleus Maleficarum* endorsed the hunting and then the torture of suspected witches, in order to obtain a confession. This was often followed by death by fire, burning alive at the stake (believed to be the only way to defeat the sorcery and evils of witchcraft).

*Malleus* also gives accounts of witches committing cannibalism, infanticide, the casting of spells to injure their enemies, and the ability to steal a man's penis.

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Sorcery was characterized by the conviction that witches engage in the following six activities:

"1. A pact entered into with the Devil
   (And concomitant apostasy from Christianity)

2. Sexual relations with the Devil

3. Aerial flight for the purpose of attending

4. An assembly presided over by Satan himself
   (At which initiates entered into the pact, and incest and promiscuous sex were engaged in by the attendees)

5. The practice of maleficent magic

6. The slaughter of babies" \(^{50}\)

Both the Roman Catholic and Protestant churches used *Malleus Maleficarum* as a source of evidence concerning Satanism for prosecution in court and as a guide to protection against acts of Satan.\(^{38}\) *Malleus Maleficarum* rapidly spread around Europe and was second only to the Bible in terms of sales for almost 200 years.\(^{36}\)
The Witch Trials

*Malleus Maleficarum* does not only discuss theories regarding theology, but discusses the legal practices to be used in courts and how to meaningfully torture witches to obtain their confession efficiently. Even if the suspected witch confessed, the confession had to be satisfactory to the liking of the court, and then to also to be confirmed, to verify authenticity of their confession. If these terms were not met, the torture would continue.57

Confirmation was obtained in two ways: by the ‘Devil’s Mark’ or by the results after a bound victim was thrown into cold water. If the accused were to sink, they were presumed innocent and rescued from the water. If they floated, they were deemed guilty and executed. To search for the Devil’s Mark, the accused were stripped, shaven, and every inch of their body was searched for skin lesions (including nevi, birthmarks, warts, etc.) in public. They would then prick each lesion, and if the lesion did not bleed or cause pain it was confirmed to be a mark of Satan himself, and they were therefore proven guilty.59
Salem

The witch trials in Salem, Massachusetts, took place between 1692 and 1963, three centuries after they began in Europe. With widespread hysteria already taking place in Europe, it is no surprise that talk of witchcraft began to surface in colonial American. The victims of interrogations and execution in America were alike those in Europe, as they were mostly women and some children, the youngest being a four year old girl.\textsuperscript{12}

Some of the suspects were mentally or cognitively disabled, although many other biological theories exist for others accused, including eating bread from grains infected by the fungus Claviceps purpurea (from which LSD is derived), an epidemic of bird-borne encephalitis lethargica, and sleep paralysis. Sadly, others were likely victims due to spite or jealousy of others, being politically deviant (women who stood up for themselves), or were targeted by past lovers or due to family feuds.\textsuperscript{12}

The state has since apologized for the hangings of these innocent people and in November 2001, the court exonerated all of the accused.\textsuperscript{12}
The Culmination of the Hunt

The hunt and execution of suspected witches for continued for centuries in Europe until physicians began to discover that seizures could be linked to medical conditions, not sorcery, in the 17th century. By the 18th century, the hunt was over, unfortunately by that time thousands were burned at the stake and millions were victims of torture.62

The Renaissance Period

In the Renaissance period, many differing treatments were divvied out to those who were presumed to suffer from mental illness, most often due to their economic and societal class. Treatment also differed in this time in Europe and America, likely due to their differing population densities.20 Common treatments at this time included: confinement, special diets, laxatives, emetics, physical harm as punishment, unreasonable physical exhaustion, immobilizing devices and tranquilizer chairs (see above image), the use of silencing masks on the face, electrical shocks to the body, the use of narcotics for sedation, and horrendous torture such as rubbing abrasive materials on the body.

The Tranquilizer Chair: A cruel device used to restrain a patient by chaining down their limbs and placing a hood over their head.
Source: NIH U.S. National Library of Medicine
surrounded the mentally ill population became as problematic as in Europe. The newly developing society that had previously relied on families and small rural communities to care for those with mental disorders was not prepared to care for the mentally ill on a larger scale. It wasn’t long before this responsibility and the associated financial burden was shifted to the state. Within the next 40 years, every single state had opened a cost-free public mental institution and by the time the Civil War began, many states had multiple. 33, 34

Mental Illness in the Wealthy of England

If one was mentally ill during the Renaissance period in England, wealth proved to be one’s greatest asset and one’s best shot at escaping the brutality of the asylums. Affluent members of society were able to hire a physician to either come daily to watch the mental ill family member, to make house calls when deemed necessary, or to provide specific instruction for the family, so that they felt that felt confident caring for their loved one or their own. Since the majority of physicians at this time had little to no understanding of psychiatric illness or efficacious treatments, the physician most often acted merely as a guardian. 25

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As the predominant theory about mental illness upheld by physicians at this time continued to revolve around the idea of the biological humoral fluid equilibrium, when deemed appropriate, physicians would commonly perform bloodletting and administer emetics in the home. Unlike the poor, who had the misfortune of bleeding by means of incisions, bloodletting in the wealthy often utilized leeches. In contrast to bloodletting, if too little sangious fluid was postulated to be the root of their imbalance, the physicians of the wealthy would sometimes give them transfusions using the blood of animals.25

If the family of the mentally ill decided that they no longer desired to have their family member at home, their wealth enabled them to send them to a private residence to be cared for, rather than admitting them to a mental institution. While the wealthy residing in these private accommodations were provided with a considerably more hospitable and comfortable environment, they still did not receive meaningful treatment for their mentally illness, as efficacious psychiatric therapies had not yet to gained popularity.25
The Unfortunate with Mental Illness in England

In Renaissance England, if one sadly had the misfortune of being both mentally ill and poor, they were now more commonly known as ‘lunatics’, ‘idiots’, and ‘the furiously mad’. Many of the less fortunate, mentally disordered individuals found themselves in prisons, hospitals, or ‘madhouses’ (establishments specifically for the mentally ill), as they weren’t privilege to the same opportunities as the wealthy.  

Poor families during this time period had only two options of where to send their family members who were mentally disturbed: Bedlam or out onto the streets to live as vagrants. Although they knew they were unable to care for their sick loved ones, families were often resistant to shipping them off to overloaded madhouses. The community therefore adopted the mentally ill individuals and treated them under the Poor Law, which they applied to vagrants. Many of the mentally ill were accepted as members of the community and were supported and supervised by extended family, neighbors, or other community members. The few who were deemed too dangerous to be allowed on the streets were usually cared for by churches, hospitals, or were placed in jail, usually for life.
The 'Vagrancy Act of 1714' legalized imprisonment for the reason of lunacy (mental illness). The Vagrancy act sanctioned the public to lock up or chain down the mentally ill, if deemed necessary to control them by two Justices of the Peace. This would vastly change the treatment of the mentally ill and lead to the eventual overcrowding of the mental asylums.²⁵

Hospital of Saint Mary of Bethlehem, Bethlehem Royal Hospital, Bedlam

Bethlehem, originally a religious order, opened as London's first psychiatric hospital in 1403.¹⁷ Although first operating humanely, it has since become famous due to it's atrocious conditions and role in reform for the care of the mentally ill. In fact, the word 'bedlam' became a word of everyday speech synonymous with madness. Today, it is defined in the English language as:

"Bedlam \ 'bed-ləm\ 1. (noun): madman, lunatic
2. (adjective): a place, scene, or state of uproar and confusion."⁵³
In its first 200 years of operation, Bedlam was a small hospital, where patients could enjoy strolls around the grounds freely and visit with family. Though some patients required restraints, all patients appeared to be treated with respect. After the Great Fire of London, officials witnessed the overcrowding taking place inside of the hospital and it moved north of London to Moorfields. The new facility was gorgeous in appearance and allowed for up to 100 patients (the original facility had grown from 6 to 27+ patients). Sadly, its residents would never have the opportunity to learn of its outside appearance and surely weren’t subject to the same conditions on the inside of the hospital.

Families of patients were required to bring clothing, food, and other necessities for their loved ones for the duration of their stay, but these were not the only visitors the patients of Bedlam would see. The general public was allowed to visit Bedlam as well, and it quickly became a tourist destination for those visiting London. Patrons were usually wealthy and visitation was not centered around education, but entertainment or to make a spectacle out of the ‘freak show’. Public visitation was justified by raising the hospital’s income to take care of the needy, but unfortunately it is suspected that the
majority of this money did not go to patients or taking care of the institution. Bedlam closed its doors to visitors in 1770.\footnote{6} When Bedlam’s practices of were out of the public eye, the conditions went from bad to worse. The conditions continued to worsen unimaginably under the control of the notorious and cruel Monro family for four generations.\footnote{61}

Now the patients were stripped of their clothing and their food was often taken from them.\footnote{5} The building itself began to deteriorate. Without a real floor, patients slept on the dirt foundation on which the buildings lie. The roofs were leaking and the cells were not insulated, even in the cold English winter. Patients were often chained to the wall, and as emetics and laxatives were still being utilized to indirectly sedate patients, they were often covered with their own vomitus and feces.\footnote{6}

Population inside the institution rose, as now patients included not only those who were mentally ill, but often included women who were victims of romantic rivals, as sanity was linked to relationship status. Many other ‘conditions’ required admission (see image on page 29). Without much structural expansion, the population of the institution rose to almost 2,000. At this time fleas and lice were rampant, and there are
reports of gangrene and other infections developing among the shackled.\textsuperscript{6} Beatings, bloodletting, blistering, ice water baths, starvation, isolation, torture, and rotational spin treatment, remained common in Bedlam’s patients, even after other institutions utilized scientific advancements.\textsuperscript{5}

The Monro’s fancied the spinning treatment, where a chair was attached to the ceiling or a rope was tied to the leg of the patient, and ropes were used to spin the chair. The patient was rotated around countless times, and intolerable speeds until the patient was compliant with the physician’s commands. Patients often developed nausea, vomiting, vertigo, and bowel movements at this time. Even after patient compliance was achieved, the torture would continue to ensure future adherence. This method was strenuous and patients would often sleep for many hours afterwards.\textsuperscript{18}

The Monro’s instructed that their barbaric and outdated physical treatments were sensible and necessary.\textsuperscript{58} Accounts of such abuse were documented and published by discharged patients and the enraged public demanded change. Finally, the Monro regime fell and a new and more humane physician, Dr. Hyslop, took charge and became the manager of the hospital in 1888.\textsuperscript{86}
### Reasons for Admission
1864 to 1889

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<td>Greediness</td>
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<td>Fever and Loss of Law Suit</td>
<td>Grief</td>
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<td>Fits and Desertion of Husband</td>
<td>Gunshot Wound</td>
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<td>Asthma</td>
<td>Hard Study</td>
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<td>Bad Company</td>
<td>Rumor of Husband Murder</td>
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<td>Bad Habits &amp; Political Excitement</td>
<td>Salvation Army</td>
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<td>Bad Whiskey</td>
<td>Scarlatina</td>
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<td>Bloody Flux</td>
<td>Seduction &amp; Disappointment</td>
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<td>Brain Fever</td>
<td>Self Abuse</td>
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<td>Business Nerves</td>
<td>Sexual Abuse &amp; Stimulants</td>
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<tr>
<td>Carbonic Acid Gas</td>
<td>Sexual Derangement</td>
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<tr>
<td>Congestion of Brain</td>
<td>False Confinement</td>
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<tr>
<td>Death of Sons in War</td>
<td>Feebleness of Intellect</td>
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<tr>
<td>Decoyed into the Army</td>
<td>Fell from Horse in War</td>
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<tr>
<td>Deranged Masturbation</td>
<td>Female Disease</td>
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<tr>
<td>Desertion by Husband</td>
<td>Dissipation of Nerves</td>
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List of admission criteria of the Trans-Allegheny Lunatic Asylum in West Virginia
Likely very similar or even more reasonable than criteria used to admit individuals to Bedlam

*Source: The Trans-Allegheny Lunatic Asylum*
The Age of Enlightenment and Compassionate Reform

Philippe Pinel (1745-1826)

Known by many as the ‘Father of Psychiatry’, Dr. Philippe Pinel understood that those who suffered from mental illness deserved to be treated kindly and began a movement towards ‘moral treatment’. Pinel was the first to take meaningful action towards education of the public in these matters and the development of humane care for the mentally disordered.\textsuperscript{40}

Pinel not only felt that physical abuse was completely unwarranted, but also explained that those who suffer from mental health disorders deserved to be treated with the same respect and dignity as the rest of society. He promoted the socialization of institutionalized psychiatric patients and the providing of relaxing living quarters, appetizing food, temperate attendants, paid occupational therapy, outdoor recreational activities, and various educational opportunities.\textsuperscript{54}
The York Retreat

The York Retreat was established in 1796 by Quakers in England, as a place where psychiatric patients could live instead of to prisons or asylums. In contrast to most asylums and hospitals of the time, such as Bedlam, the York Retreat found physical restraints and brutal treatment cruel and ineffective and opted for moral therapy.¹³

For the first time in centuries, those with mental illness were treated exceedingly well. They were fed four respectable meals everyday, dressed up in normal clothing, and were allowed to play games, read, garden, sew, and engage in other outdoor activities in their spacious and picturesque yard.⁹²

Records show that in the first fifteen years that the York Retreat was open, 70% of those who had been mentally ill for less than a year had recovered and 25% of those who were previously viewed as incurable (mentally ill for at least a year) had recovered.⁹²
Dorothea Dix (1802-1887)

Unlike Pinel, Dix was not a psychiatrist nor a physician, but an American nurse and activist on behalf of the poverty-stricken mentally ill. Shocked after seeing how mentally ill individuals were treated in jail, she set out on a crusade that changed the way America dealt with psychiatric patients. Dix visited every jail in Massachusetts between 1841 and 1842 and documented the abuse of prisoners with psychiatric disease. In 1843, when women were far less accepted by men as equal, especially in the dealings of politics, she presented her findings to the Massachusetts state legislature and demanded change.

"Men of Massachusetts, I beg, I implore, I demand... Raise up the fallen; succor the desolate; restore the outcast; defend the helpless." - Dorothea Dix

By 1847, Dorothea Dix had traveled to over 300 jails and 18 prisons whilst continuing to lobby state legislatures and eventually the United States Congress. Her determination led to the construction of state mental hospitals nationwide. Her efforts were monumental and led to the creation of the first generation of American mental asylums where patients who were mentally ill were treated as patients versus criminals.
From Madhouse to Mental Hospital

After the success of the York Retreat, reformed mental hospitals began opening in the United States as well. Quakers again paved the road, by opening an asylum in Philadelphia in 1817 and the first public asylum was established in Worcester, Massachusetts in 1833. By the early 1840s, there were 16 private and public asylums in the United States.³²

New rules were developed for the growing industry of asylums (as it was now the time of Dorothea Dix). It was a requirement that the asylum be located in the country and that it had no more than 250 patients. The institutions had to be pleasantly appearing and have gardens or outdoor areas that the patients were allowed to roam. The manager and staff had to be kind and respectful, and the patients must be allowed to complete tasks (similar to the York Retreat) and have opportunities for education.³⁴

With new regulations in place, 30-80% of all of the patients that were released within a year were deemed 'cured'.³² The general public marveled at this success and it
became the opinion of many psychiatrists that the majority of the mentally ill would recover if they were institutionalized as soon as possible after developing their psychiatric symptoms.34

Institutionalization

The Age of Asylums
By the end of the 19th century, the integration of both public and private asylums in order to treat psychiatric patients had expanded in both the United States and in Europe. Asylums had proved extremely advantageous to the community and society, but only when they were run appropriately.

In the 19th century the definition of insanity was extended to include the elderly, the cognitively disabled, those with neurologic disorders and those who drained their family of resources. There was a large influx of people into institutions who had no true psychiatric diagnosis. Owing to the new definition of insanity, mental hospitals soon went over capacity.25

Patients wrapped in wet sheets and blankets
St. Elizabeth's Hospital in 19th-20th century
Source: National Archives
With the admittance of all the newly defined 'psychiatric patients' asylums were becoming overloaded and transforming from places of healing and happiness back to places of suffering and brutality. Once overcrowding began, the treatment of patients began to deteriorate. The mental hospitals no longer exemplified the principles their founders valued, nor did they remain places for recovery.92

Eugenics

The eugenics movement in the United States began in the late 1800s after Charles Darwin introduced the concept of natural selection. America was reaping the benefits of selective breeding of crops and farm animals, and Darwin's cousin, Francis Galton, suggested that it could be just as successful at improving the genetic quality of the human race. Between 1907 and 1927, 8,000 people in America had been sterilized forcibly.92

In 1927, the Supreme Court upheld their decision that sterilization of the mentally ill was what was for the best of the country. Shortly afterwards, sterilization became the law in 33 states. Patients in psychiatric institutions were sterilized without their consent, and sometimes without their knowledge.23 These 33 states collectively reported having forcibly sterilized 60,000 people over 50 years.92 Eugenics was seen
negatively after Hitler and Nazi Germany, but some states continued forced sterilization regularly until the 1970s, with the last forced sterilization occurring in Oregon in 1981.\(^\text{80}\)

Sterilization is still legal today in the cognitively disabled or mentally ill if they give informed consent or if unable to give consent, the court finds evidence that the patient is or is likely to engage sexual activity, there is no other contraceptive that is reasonably available, and that they are permanently unable to care for a offspring, making it a "situation of necessity".\(^\text{92}\)

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UNFIT HUMAN TRAITS
SUCH AS Feeblemindedness
Epilepsy; Criminality,
Insanity; Alcoholism,
Pauperism ... MANY OTHERS,
RUN IN FAMILIES AND ARE
INHERITED IN EXACTLY THE
SAME WAY AS COLOR IN
GUINEAPIGS. IF ALL
MARRIAGES WERE EUGENIC
WE COULD BLEED OUT
MOST OF THIS UNFITNESS
IN THREE GENERATIONS.

THE TRIANGLE OF LIFE

1. Pure + Pure = Normal
2. Pure + Admixed = Normal
3. Admixed + Admixed = Admixed
4. Tainted + Tainted = Tainted
5. Tainted + Pure = Tainted
6. Tainted + Normal = Tainted

HOW LONG
ARE WE AMERICANS TO
BE SO CAREFUL FOR THE
PEDIGREE OF OUR PIGS
AND CHICKENS AND
CATTLE, — AND THEN
LEAVE THE ANCESTRY
OF OUR CHILDREN
TO CHANCE, OR TO
"BLIND" SENTIMENT?

Pro-eugenics propaganda posters found in Kansas in 1920, Source: American Philosophical Society

Shock Therapies
Two main types of shock therapy came into popularity around this time, electric shock therapy and insulin shock therapy. Both shock therapies were regarded as a huge success at the time and led to public regarding psychiatry as a real medical specialty that was able to treat disease.
Insulin shock therapy was accidentally 'discovered' in 1927, by Polish neurophysiologist, Manfred J. Sakel, when he observed convulsions after an insulin overdose. He believed that this was an effective treatment for schizophrenia, and reported a 70-90% cure rate in his patients, which prompted adoption of this therapy at the majority of mental hospitals in the 1940s.72

Although there were no guidelines for treatment, patients undergoing therapy would typically receive daily injections of 100-150 units of insulin (sometimes up to 450 units) for 2 months/60 treatments (sometimes for 1-2 years). This therapy fell out of favor when new treatments surfaced due to lack of efficacy and the mounting fatalities.72

Electric shock therapy, currently known as Electroconvulsive therapy (ECT), was invented in 1937, by Ugo Cerletti, an Italian neurologist. He was convinced that metrazol-induced seizures were beneficial for schizophrenia, but knew that they were
too hazardous in application. The notion to use ECT in human beings came to him by watching pigs being anesthetized with electroshock before they were butchered. Early ECT did not use paralytics or anesthesia. Significant improvements have been implemented with regards to ECT, and will be discussed in a following section.

Prefrontal Leucotomy or Frontal Lobotomy
The invention and rapid implementation the frontal lobotomy prior to appropriate scientific testing was quite arguably one of the largest catastrophes in the history of psychiatry. Although gruesome and unfortunate, it is understandable how patients desperate for relief could be coerced into such a procedure, especially as psychopharmacology was not yet developed and the only alternative was a mental asylum.

"I'd rather have a bottle in front of me than a frontal lobotomy." -Unknown

In 1935, after learning of an experiment in which removal of the frontal lobes in two chimpanzees led to more docile behavior, Egas Moniz, a Portuguese physician, postulated that a similar surgical intervention might prove useful in human mental illness. Shortly thereafter, he 'tested his theory' in 11 female asylum patients, who
similarly became cocile post-procedure, and he concluded that his new method was successful. Four weeks after his first lobotomy, he presented his preliminary results, and several weeks later his work was published. Although his research was very preliminary, incredibly inaccurate, and his procedure notably lacked anatomical precision, psychiatrists nationwide quickly and blindly adopted the procedure.

In two years, the frequency of lobotomy procedures had increased from 150 cases to 2,000 cases. After Dr. Egas Moniz was awarded the Nobel Prize in Medicine, "for his discovery of the therapeutic value of leucotomy in certain psychoses" in 1949, the number of surgeries performed reached 18,000.

Dr. Walter Freeman soon gained recognition for his particularly barbaric manner of performing lobotomies and also for his mobile approach. Instead of performing lobotomies under anesthesia with drills in sterile conditions, he opted to hammer an ice pick through the eye sockets of his patients (victims) and forcibly destroyed the frontal lobe by hacking and mixing the tissue once the pick was inserted.
anesthesia, he chose to use an
electroconvulsive shock box to induce a
seizure immediately prior to ice pick
penetration.\textsuperscript{28}

His colleagues were disturbed by
his approach, and when scrutinized, he
took the road in his ‘Lobotomobile’,
unfortunately reaching over 3500
people before losing his surgical privileges.\textsuperscript{28} With the robust evidence of the horrific
chronic effects of lobotomy and the emergence of psychopharmacology, the procedure
fell out of favor.\textsuperscript{2}

Deinstitutionalization

Shell Shock

When American soldiers returned from World War II, there was a high incidence
of those severely affected by the war and showing signs of a psychiatric disorder, Shell
Shock, now known as Post-Traumatic Stress Disorder (intrusive thoughts, nightmares
and/or flashbacks of past distressing events, averting of reminders of trauma,
hypervigilance, and sleep disturbance, all of which lead to substantial societal,
occupational, and interpersonal dysfunction).\textsuperscript{39} This led the American public and
psychiatrists to a new understanding. If the traumatic experience of war elicited these
affects in these citizens who were originally strong, healthy, level-minded individuals, perhaps mental illness was not a defect in the individuals themselves, but occurs as a result of stressors.43

With the understanding that stress can lead to mental disease came the notion that the most appropriate setting for treating the mentally ill was in the community at outpatient clinics versus the stressful hospital atmosphere.

Post-World War II
After World War II, American citizens realized the consequences of Hitler’s Germany and what had been done in the name of eugenics and began to disapprove of the eugenics procedures the United States was utilizing. At this point Americans had also seen the consequences of the frontal lobotomy and journalists had uncovered the truth regarding the torture and horror taking place inside of once humane mental hospitals. Advancements had been made in psychopharmacology and the media boasted of ‘miracle drugs’ that promised to cure mental illness. In addition, several court cases ruled in favor of promoting the rights of the mentally ill and their release from mental hospitals, only strengthening citizen’s conviction for social justice for those
who had been disregarded for so long. The United States government responded to all of the above by initiating deinstitutionalization.\textsuperscript{47,92}

The goal of deinstitutionalization was to empty state mental hospitals and to care for psychiatric patients in federally run community clinics. The intention was to both improve the quality of life of those suffering from mental illness, and to also reduce government spending with regards to the mentally ill. The government took initiatives to increase Medicare and Medicaid funding for treatment in outpatient clinics and the Social Security Act allowed many to leave the hospitals and move to private facilities. As funding shifted, many were released from hospitals to their families, skilled nursing facilities, or shelters.\textsuperscript{47,71,92}

Geriatric patients and those with neurological disease were often moved out of the state hospital and into skilled nursing facilities or private care homes, as they commonly required less intensive care than other patients. On the other side of the spectrum, extremely sick or aggressive patients that had the means were often were moved into private mental hospitals.\textsuperscript{30}
Hospitalization

The state hospital was still utilized for those who could not afford other options or for those whose families wished to keep their loved ones diagnosis secret, as to not lose their social standing. Since the individual could have been admitted to a state hospital for a variety of reasons, it was the preferred alternative to private institutions, which were solely developed for psychiatric patients. The use of state hospitals for this reason helped to protect the mentally disturbed and their families from feeling the stigma surrounding psychiatric disease in society.\(^{30}\)

For the first time it was recommended that psychiatric patients were treated on their own floor, unit, or wing inside of a medical hospital. This unit was to be operated by nurses and staff that had specific training in mental illness.\(^{30}\)

Yet again the pendulum swung, and hospitalization had its benefits for those with psychiatric illness compared to those being cared for in the outpatient setting. Hospitalized patients now had a team of medical professionals looking after them, including doctors and nurses trained to care for psychiatric patients. The team was now utilizing a medical approach when treating patients. As they were located in a

*The Abandoned Buffalo State Hospital in New York*
*Photo by Jeremy Harris in 2008*

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medical hospital, they had access to laboratory testing and other medical professionals when necessary, unlike in the outpatient setting. Major treatments could be utilized (insulin coma and electroshock therapies) with the assistance of trained staff and with additional medical professionals standing-by. Additionally, psychiatrists could visit their patients daily and individuals were also able to receive psychotherapy everyday.\textsuperscript{30}

**Outpatient Clinics and Homelessness**

Deinstitutionalization was intended to give those with psychiatric disorders a more autonomous means of living. Although the measures implemented were of good intentions, the planning was inadequate and the movement was not without many negative consequences for both the patient and society.

Deinstitutionalization assumed that the departing residents of mental hospitals had support systems at home and that transitioning patients back into their families and communities would be an easy process. Unfortunately, many of the mentally ill had no family to go home to. Others returned to families that were unable or unwilling to care for them. Those who’s families did not wish to be responsible for their family member or burdened by their mentally illness, were
often forced into community care or jail, and many ended up living on the street.34,71

Regardless of disposition, almost half of deinstitutionalized patients responded poorly to psychopharmacology and outpatient treatment, and many individuals worsened after they left the hospital. Despite this information, the use of outpatient psychiatric clinics were popular through the 1950s and the 1960s.34

Although it was monumental that provisions to protect the legal rights of the mentally ill were finally implemented, the measures taken to ensure that some individuals weren’t unnecessarily forced into institutions made it extremely difficult to provide the crucial treatments that other individuals needed. As a result of the new laws, individuals that required intensive treatment could no longer be institutionalized against their will.47 These severely mentally ill individuals no longer had the support, supervision, nor treatment they had become accustomed to throughout their lives. They often became homeless or were placed in prison, affecting society as a whole.

Sources: NASMHPD, The Wall Street Journal (left); B.E. Harcourt, "An Institutionalization Effect" (right)

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Modern Psychiatry

Advances in Psychopharmacology

Psychopharmacology became, and still is, the primary method of treatment for psychiatric illnesses. Early psychopharmacology focused on sedation of admitted patients by using opiates. In the 1950s, chlorpromazine use began for management of schizophrenia and psychotic behavior and lithium use was established to treat mania and bipolar disorder.71

The development of improved research practices, (for example, the use of blind studies and control groups) and the establishing of techniques to analyze drug levels in the blood, refined our ability to discover meaningful results of studies and implement appropriate and efficacious treatments in patients. Also in the 1950s, monoamine oxidase inhibitors (MAO-I), tricyclic antidepressants (TCAs), and benzodiazepines came into use.32 Other antipsychotics and antidepressants followed shortly after.

Advertisement for Thorazine (chlorpromazine) from 1962
Source: Unknown

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Prozac (fluoxetine) was discovered in 1987, followed by many other Serotonin Selective Reuptake Inhibitors (SSRIs). Older antidepressants, (TCAs and MAOIs) fell out over favor as they required more monitoring and because unlike previous antidepressants, SSRIs were safe in overdose and far better tolerated.

“Zoloft and Paxil and Buspar and Xanax, Depakote, Klonopin, Ambien, Prozac, Ativan calms me when I see the bills. These are a few of my favorite pills.”

—Next To Normal, American rock musical

Problems surfaced with first generation (classical or typical) antipsychotics including: dystonia, akathisia, parkinsonism, bradykinesia, tremor, and tardive dyskinesia, and the search for effective antipsychotic drugs with a better side effect profile was underway. In the 1990s, second generation (atypical) antipsychotics with reduced extrapyramidal side effects were first implemented.

Today’s Procedure Rooted in Historical Psychiatry: ECT

Electroconvulsive therapy uses an electric current to produce a generalized seizure under general anesthesia and is still indicated today for severe unipolar depression, bipolar disorder, schizophrenia, schizoaffective disorder, catatonia, and neuroleptic malignant syndrome.
The efficacy of Electroconvulsive therapy is well established and it is consistently more effective than any other treatment used to manage severe major depression, mania, or bipolar disorder.\textsuperscript{49}

Electroconvulsive therapy is particularly advantageous in pregnant psychiatric patients, as many of the psychopharmacological options are contraindicated or relatively avoided in pregnancy. There is little to no evidence that exposure to ECT negatively affects intrauterine growth, or that it causes neonatal toxicity or adverse developmental effects.\textsuperscript{93}

In contrast to the early procedures, electroconvulsive therapy is one of the safest procedures that is performed under general anesthesia, with a low mortality rate of 2-4 deaths for every 100,000 ECT treatments.\textsuperscript{3,46} The mortality associated with ECT often results as a complication of pre-existing cardiopulmonary disease (seizures increase oxygen demand therefore increasing the workload of the heart), which is why all individuals over 40 years old (and often younger patients) undergo a cardiopulmonary-focused physical exam prior to treatment.
After the procedure, the majority of patients experience acute and short-lived confusion and anterograde and/or retrograde amnesia. More serious post-procedural effects have been reported, but are rare and include: headache, fractures, aspiration pneumonia, and dental or oral injuries.

Electroconvulsive therapy regimens last for approximately 6-12 treatments, and are generally given at a frequency of three times per week. When indicated, patients may partake in continuation therapy (a single ECT procedure every 1-8 weeks for six months following the completion of their focused ECT regimen) or maintenance therapy (prophylactic ECT periodically administered to prevent relapse of psychiatric symptoms). After the completion of therapy, patients often return for additional rounds of ECT upon the return of their psychiatric symptoms.

Inpatient Psychiatry and Court Ordered Treatment
Although very different from early asylums, inpatient psychiatric institutions are still prevalent, either as stand-alone facilities or as a unit within a medical hospital. Involuntary treatment and commitment are still common in psychiatry as well, but are
strictly regulated and very distinct from early institutionalization. Today, patients are committed involuntarily only under the following circumstances and the proceedings take place in a courtroom with a judge, a prosecutor, a public defender, the witnesses, and often the psychiatrist.

"In Arizona, any adult who is reasonably deemed to be one of the following as a result of psychiatric illness:

1. A danger to self or a danger to others
2. Persistently and acutely disabled
3. Gravely disabled

AND refuses to participate voluntarily may be ordered by the mental health court judge to comply with psychiatric treatment." \(^{52}\)

The patient may be court-ordered to inpatient psychiatric treatment unit, to outpatient treatment in a community-based clinic, or combination or sequence of both inpatient and outpatient treatment. Patients are also court-ordered to comply with their prescription psychiatric medications. \(^{52}\)

Any responsible individual may propose an application for involuntary evaluation of someone who is they allege is aligned with the above criteria. The individual submitting the application is frequently a police officer, a family member, or the patient’s case manager, but the application may be submitted by anyone in the community who can present facts supporting the concerns and allegations. A screening agency assesses the allegations in the application, collects any pertinent information,
and interviews the individual in question. The agency then determines if there is reasonable cause to believe that the individual meets the above criteria, at which point a petition is filed, subjecting the recommended patient to a mandatory 72-hour mental health evaluation.52

During the 72-hour court ordered evaluation, two psychiatrists interview the patient and individually and come to an understanding of their current mental state, the situation leading up to their admission to the mental hospital, and their past psychiatric history. If the patient is found to meet the criteria and to require treatment, they are first asked to comply with treatment voluntarily, prior to the initiation of involuntary treatment.52

Modern struggles in Mental Health

Although psychiatry and the treatment of the mentally ill have come a long way, there are still many struggles facing those suffering from mental illness, and much improvement to be made. Some of the principle issues include the stigma attached to mental illness and the lack of mental health resources and access to care.

Access to Care and Funding
State and local level policies have the largest influence on access to mental health care. States that approved laws supporting application of mental health parity laws and the ‘Affordable Care Act’ showed improvements in access to insurance rates from 2011 to 2014. Additionally, states that had assertive policy modifications, for example the enactment of ‘The Mental Health Services Act’ in California, also resulted in significant increases in access to care from 2011-2014.1

In 2015, an estimated 18% American adults (43 million people) had a mental, behavioral, or emotional disorder that significantly impeded on their ability to live and 4% of all American adults (10 million people) had a serious mental illness. The cost of mental illnesses was at least $467 billion in the America in 2012. The ‘Fiscal Year 2018 President's Budget’ provides $912 million for mental health activities, $252 million below the ‘FY 2017 Continuing Resolution’.75

“A 2011 study estimated that societal costs of mental disorders exceeded the costs of diabetes, respiratory disorders, and cancer combined.”

-U.S. Department of Health & Human Services75

Additionally, the ‘FY 2018 President's Budget’ provides $3.9 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), a reduction
of $399 million below the ‘FY 2017 Continuing Resolution’. The ‘FY 2018 President's Budget’ focuses on addressing America’s opioid crisis, developing suicide prevention efforts, and tackling serious mental illness.\textsuperscript{75}

Mental Health and Stigma

One of the reasons numerous individuals do not pursue or continue in participation of mental health services is the stigma that surrounds psychiatric illness. Individuals don’t want to be labeled as "mentally ill" and unfortunately the stigmatization of mental health contributes to the relationship between mental illness and the shame those who suffer from psychiatric illness bear.

Stigmatizing attitudes not only reduce an individual’s self-esteem, but also frequently deprive them of social opportunities. Individuals who suffer from mental illness consistently experience discrimination in healthcare and employment. Their rights are frequently violated and often they have reduced social support and access to services than those dealing with physical ailments.

Similarly, stigmatization contributes to the lack of uniformity between the treatment of mental and physical disease. This becomes clear with the realization that
mental health services and insurance coverage available for psychiatric disorders lags far behind that of physical illness.

Since mental health stigma influences the health and well-being of the mentally ill, it has been debated that the social determinants of mental health (social conditions that affect mental health, for example, education level, social standing, access to services, income, etc.) should also include stigmatization. There is sizeable evidence that psychiatric disorders play an enormous role in an individual’s health and welfare, and that addressing mental illness can assist in preventing the onset and relapse of psychiatric disorders, lessen healthcare inequalities, and reduce the total cost of healthcare nationwide.

Stigmatizing attitudes do not just affect the health and wellbeing of those affected by mental illness; it is also a matter of social justice. It is the responsibility of our society to begin to talk about mental illness more openly, like is done concerning physical disease. We need to take a stand and start to combat the stigma these individuals face on an everyday basis. Those who suffer from mental illness do not deserve the discrimination they face nor to live in social isolation. We must take it upon ourselves to advocate for the mentally ill and to ensure that the societal treatment of the mentally ill vastly improves during our blip on the timeline of the history of psychiatry.
Bibliography


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Cell wall in Jerome, Arizona; Unknown photographer

Abandoned Connector Hallway, Trenton State Hospital, New Jersey; Photo by Jeremy Harris in 2015