3 Madness and mental health
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Introduction

In this chapter, our focus is on the mental health field. Looking back from the twenty-first century, one is struck by the enormous quantitative growth of the mental health domain - institutions, professionals and clients. In the 1890s, only a very small number of individuals could reasonably have been called psychotherapists. By 1990, a minimum of one third of the U.S. population had used psychotherapy at some point in their lives as an appropriate means for treating a broad array of physical, psychological, and behavioral problems and disorders. By even the most stringent criteria, a minimum of 100,000 fully qualified, highly trained psychotherapists are available to serve the mental health needs of the US today. Using a broader definition, there may be as many as 250,000 psychotherapists and counselors available.1

Secondly, the mental health field has expanded in a qualitative way as well: the array of treatment possibilities has broadened from custodial care and moral treatment in the nineteenth century to a wide variety of psychological and pharmacological approaches in recent decades. Correspondingly, the number of disciplines involved has expanded as well, often in a vehement struggle for supremacy. Nowadays, the mental health field includes not only psychiatrists and psychoanalysts but also clinical psychologists of various persuasions, social workers, and pastoral counselors, to which is added most recently a new wave of physicians who adhere to a neurological and physiological stance.

This expansion of the mental health field is related in a rather complicated way to cultural and social issues, as well as developments within psychiatry and psychology. On the one hand, it is a reflection of broader cultural developments, such as we encountered in earlier chapters, specifically: individualisation, the rise of social management and ‘psychologization’. On the other hand, mental health practices also contributed to individualization by developing therapies specially aimed at treating individual disorders. As we will see, mental health professionals have from the start been active on the social level, as is demonstrated by the mental health movement, the community mental health centers and more generally the involvement of psychiatrists and psychologists in social management practices.

In this chapter, chronology is combined with shifting thematic emphasis. Section 1 focusses on the nineteenth century asylums, moral treatment and the early development of psychiatry. Section 2 shows how the treatment of ‘nervousness’ and other Victorian illnesses in the late nineteenth century gave birth to psychoanalysis and ambulant mental health care. Sections 3 and 4 portray the expansion of the mental health services in the mid-twentieth century, highlighting the crucial importance of World War I and II: the prevention on a mass scale of mental disorders required new, psychological forms of social management. In the process, psychoanalysis was transformed into a dynamic psychology of adjustment, which was complemented by new forms of treatment that fitted both policy and community demands. With the advent of the counter-culture during the 1960s (section 5),
adjustment as a principle was replaced by self-realization, while at the same time anti-psychiatry heavily criticized the pretentions and practices of psychiatry. This paved the way for a massive proliferation of psychotherapy. Section 6 sketches the most recent developments: the rationalization of both the mental health system and the processes of diagnosis and treatment, the return of biological psychiatry, and the demise of psychoanalysis as a therapeutic framework.

1 Early history: Asylums (c. 1800-1900)

The deviant kinds of behaviour we nowadays associate with mental disorders have been reported since antiquity, as is witnessed by, for instance, the way melancholia was described by Aristotle. However, it was only from the late eighteenth century onwards that insanity became a medical issue.

1.1 Alienation

In pre-modern times no sophisticated system of treatment of deviant behaviour existed. During the Middle Ages, people considered 'insane' were usually not confined to special institutions, but were cared for by the family and the community. Only in cases where lunatics were considered dangerous because of their wild and aggressive behaviour, were they temporarily locked up in separate houses, like the famous 'dolhuysjes' in the Netherlands. The first known asylum for more permanent care was founded in Valencia in 1409, followed by a dozen institutions in Spain and many more in other European countries. These asylums, mostly run by the Catholic church, had purely custodial functions.

From the seventeenth century onwards, many farmers in European countries drifted to the big cities to find work. City councils had a hard time maintaining social order. Large institutions were developed, like the Hôpital Général (General Hospital) (Paris, 1656), to confine jobless people who weren't able or willing to conform to standards of rationality and productivity. The creed was that normal people act reasonably, respect the social order and accept the productive economic ideal. Those who did not fit this régime, were considered 'alienated'. In the Hôpital Général, treatment consisted of a tight day schedule, with forced labour and religious exercises. The goal of this all was re-education: the régime forced the 'immoral' poor to internalize the dominant moral norms.

1.2 Moral treatment

In the course of the eighteenth century doctors in various European countries, influenced by Enlightenment ideas, became convinced that madness was a disease and also that it could be cured. In England, William Battie published his Treatise on Madness (1758), which announced the beginning of psychiatry both as a science and a therapeutic practice. A few decades later, physicians like William Tuke in England, Philippe Pinel in France, Johann Reil in Germany and Vincenzio Chiarugi in Italy, developed theories about the possible organic causes of madness. In the same vein, the American physician Benjamin Rush wrote in 1812: 'The cause of madness is seated primarily in the blood-vessels of the brain, and it depends upon the same kind of morbid and irregular actions that continues other arterial diseases'.

These biological ideas about the causes of madness had hardly any practical
value for treatment purposes. It is therefore no surprise that the first therapeutical endeavours were based on social or psychological principles rather than medical ones. The cure that was developed consisted of an intensive and detailed disciplinary system aiming at re-installing morality in the mental life of the patients. To this end, the mentally ill were confined to separate institutions in the country, specializing in 'moral treatment'. The first of these was the Retreat in York, founded in 1796 by William Tuke. In France, Philippe Pinel in his *Traité médico-philosophique sur l’aliénation mentale ou manie* (Medical-philosophical treatise on mental alienation or mania) (1801) emphasized the psychological kernel of moral treatment: patients were to be subjected to the imposing authority of a single man, 'who, by his physical and moral qualities, is apt to exercise on him an irresistible empire and to change the vicious chain of ideas'. In other words, moral treatment consisted of a deliberate system of persuasion and influencing, centered around the moral authority of the doctor, and located in a well organized institution.

The moral treatment régime was popularized most eloquently by Pinel's pupil J.E.D. Esquirol. In 1816, he wrote: 'The patient with mania, restrained by the harmony, order and rules of the house, will get his impulsiveness better in hand and yield less to eccentric acts. (...) The calm that the psychiatric patients enjoy, far from the tumult and the noise, and the mental rest conferred by removal from their business and domestic problems, is very favorable to their recovery. Subject to an orderly life, to discipline, to a well calibrated regimen, they are obliged to reflect upon the change in their life.'

The United States followed the European example. The first American Retreat was founded by Eli Todd in 1824. While the Retreats in the U.S.A. mainly served financially strong citizens, the mentally ill and retarded from the lower social classes were usually housed together with criminals in prisons and almshouses (although there were a few State Hospitals for the insane established from the late 1820s onward). Alarmed by the pitiful condition of lunatics in prisons and almshouses, the philanthropist teacher Dorothy Dix started a crusade in the 1840s, campaigning for confinement of the mentally ill in separate institutions and improvement of the quality of the State Hospitals.

By the middle of the nineteenth century, moral treatment was employed at a number of mental hospitals amid enthusiastic reports of high discharge and discovery rates. Because of the non-medical nature of moral treatment, medical supremacy in the field was challenged by other professionals. Philosophers, jurists, and clergymen claimed to be at least as good as physicians in the practice of moral treatment. Moreover, moral treatment did not appear in the long run to be as effective as was first thought, and was largely abandoned as a therapy in the 1880s.

### 1.3 Psychiatry

Besides the practical work with mental patients in the asylums, there was much speculation about the causes of mental illness. From the beginning of psychiatry as a medical discipline, explanations alternated between psychogenic and organic perspectives on mental illness. During the first half of the nineteenth century, psychological interpretations dominated, especially in Germany. After 1850 however, the *Psychiker* (as they were called) had to give way to researchers with a more organic view on mental illness, the *Somatiker*. Their leading author was the Berlin psychiatrist Wilhelm Griesinger. In his 1845 textbook *Die Pathologie und Therapie der psychischen Krankheite für Aerzte und Studierende* [Pathology and therapy of mental illness]...
illnesses for doctors and students], he passionately defended a reductionist view on mental illness: ‘Geisteskrankheiten sind Gehirnkrankheiten’ (Mental illnesses are diseases of the brain). After the microbe was discovered that produced syphilis, a disease which in many cases led to early dementia, Griesinger became convinced that organic causes would be discovered for other kinds of mental illness as well. In France, the biological perspective was developed by Morel (who coined the term *dementia praecox* in 1860) and others, and in England by Maudsley. However, German researchers were much more sophisticated than the French and the English, in that they from an early stage focussed on systematic microscopic research into the brain. By 1911, in Germany there were 16 university clinics, and 1400 psychiatrists in training.

No matter how enthusiastically the positive results in brain research were reported, for example in Griesinger's journal ‘Archiv für Psychiatrie und Nervenkrankheiten’ [Archive for psychiatry and nervous diseases], the organic view had little to offer in regard to therapy. By the end of the nineteenth century, both the psychological and the biological position were in a crisis: there still was no acceptable theory about the origins of insanity. A way out was offered by the German psychiatrist Emil Kraepelin (1856-1926), who in successive editions of his textbook on *dementia praecox* presented an elaborate diagnostic system of various types of mental illnesses, based on decades of observations of patients in mental hospitals. Kraepelin's classification exerted a tremendous influence on subsequent psychiatric nosologies and on therapeutic attitudes.

### 1.4 Conclusion

During the 'cult of curability' in the nineteenth century, asylums for the insane in Western countries were transformed into therapeutic institutions, housing a steadily increasing number of patients. In the Netherlands, for instance, the number of inmates rose from 39 out of 100.000 citizens in 1849 to 264 in 1928.6 England's asylum population rose from 160 per 100.000 in 1859 to 370 in 1909.7 This dramatic increase was partly constituted by the growing number of people diagnosed as suffering from neurosyphilis, alcohol misuse and schizophrenia. Behind this, a major redistribution of illness (and care) was taking place, that must be ascribed to the new form of social management that asylums offered. For instance, new patients in United States for the most part were European immigrants, 14 million of which arrived between 1860 and 1900.8

Asylum treatment, however, did not correspond with developments in psychiatric theory. While the former largely remained psychological and social, the latter became increasingly biological. Still, the common ground of both treatment and theory was the tradition of the Enlightenment. Theoretically, the focus was on a rational, scientific explanation of insanity; there was strong optimism that the real causes of mental illness (as opposed to mythical or metaphysical beliefs) could be uncovered. On the practical level, progress was deemed possible by the development of new forms of individual treatment within the asylums.

Towards the end of the nineteenth century, the golden age of psychiatry had ended in disillusionment. On the therapeutic level, moral treatment had proved a clear failure. Hardly ever did patients leave the asylum cured, and if they were released they often returned soon - revolving door patients are no recent phenomenon. On the theoretical level, progress had also been minimal: the repeated clash between biological and psychological explanations of insanity had not resulted
in a winning position for either. It is tempting to hail Kraepelin, the third party, as the winner, but his diagnostic system was descriptive rather than explanatory.

Although psychiatry in the early 20th century was expanding rapidly, psychiatrists found their basic work - curing the insane - almost impossible to accomplish. Moreover, in many countries, psychiatrists had gained a bad public reputation, because of the widely reported abuses within the institutions. Psychiatrists responded to their therapeutic failure by invading an adjacent area of pathology: nervous disorders.

2  Nerves (c. 1870-1920)

Alongside the development of institutions, therapies and theories concerned with insanity proper, the late nineteenth century brought another type of mental illness to the fore: milder forms of mental disturbances, incidental rather than chronic, and characterized by such symptoms and complaints as fatigue, general weakness, mental instability and collapse. Next to madness, nervous disorders were introduced as a new category of mental problems. This marked not only an expansion of the field nowadays called mental health, but also the appearance of a new group of professionals: the neurologists.

2.1  Victorian illnesses

Symptoms of fatigue and weakness without any detectable physical origin were already reported in well-to-do circles in the seventeenth and eighteenth century. At the time, these illnesses were treated by a variety of therapies, such as Mesmerism or 'animal magnetism'.

If various forms of emotional instability and strange behaviour had a long history, they became much more prominent from the 1870's onward. This prominence was configured (and enhanced) by the introduction of a new disease-concept: neurasthenia ('weakness of the nerves'), exemplified in a book by the American physician George M. Beard, called American Nervousness (1881). Neurasthenia was a useful concept because it carried the suggestion of a medical disease entity, while simultaneously avoiding the stigma of madness. Apart from identifying a new group of patients, it served as a vehicle for a new category of medical specialists: the neurologists. From the mid-1800s onward, neurology had developed as a new medical specialization, claiming to offer valid results not just for nervous disorders, but for mental disorders in general. Neurologists denied the asylum system any therapeutic value. Instead they advocated treatment in private settings or in university clinics, using methods such as hypnosis or suggestion.

Like the psychiatrists half a century earlier, neurologists found it hard to make a solid connection between theory and therapy. For combatting 'Victorian illnesses', a host of common sense prescriptions was offered, such as travel, rest, and moral exhortation. As America's first neurologist S. Weir Mitchell put it: 'Let us bring in Dr. Diet and Dr. Quiet'. Sanatoria and spas in Europe were ruled by the same philosophy. Private sanatoria for nervous patients both in Europe and in the United States had their heyday in the period 1880-1920. The general theory behind these practices was that nervous disorders could be cured by some form of physical treatment. In the words of Mitchell: 'You cure the body, and somehow find that the mind is also cured'.

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A rival set of ideas concerning the causes of neurasthenia and hysteria, dating back to the eighteenth century, focused not on the nervous system but on mental functioning. In Europe, the roots of these illnesses were thought to be located in the private unconscious, in the form of uncontrollable uncivilized impulses; lifting repression through hypnosis or free association was considered the appropriate course of action. Hypnosis was especially used and developed by the famous French neurologist Jean Martin Charcot. Physicians flocked from all over Europe to see "the Master" in action at the Salpêtrière hospital. A few decades later, the new methods gained an audience in the United States as well, via the *Journal of medical hypnosis*, *Suggestive Therapy* and the popular *Suggestions*. When Charcot's successor at the Salpêtrière, Pierre Janet, visited the United States in 1905, he found a favourable climate for psychological treatment of neuroses.

Regardless of the theoretical perspective, both neurologists and 'mental healers' when dealing with patients implicitly counted on the same principle as used by asylum doctors in moral treatment: the beneficial psychological influence of the authority of the physician. In the United States, the adoption of a psychological perspective was furthered by progressive groups within the Protestant Church. 'Positive thinkers' like Mary Baker Eddy had argued that minor physical problems as well as a host of other personal problems would yield to the disciplined and liberated mind. The individual was to be architect of his or her fate, so it was said.

Of decisive importance was the *Emmanuel movement*, led by the reverend Elwood Worcester in the first decade of the twentieth century. Although accepting medical diagnoses, Worcester advocated using 'the Christian religion as a healing power', aiming at the 'alleviation and arrest of certain disorders of the nervous system which are now generally regarded as involving some weakness or defect of character'. The list of potential clients included 'nervous sufferers, victims of alcohol and other drugs, the unhappy, the sorrowful, would-be suicides, and other children of melancholy.' Religious enlightenment was the context in which psychotherapy in the United States evolved, most aptly illustrated by the bestseller, first published in 1908 and selling over 200,000 copies, *Religion and Medicine: The Moral Control of Nervous Disorders* by Worcester, McComb and Coriat.

In their practical work, clerics drew upon psychological ideas and methods, thereby creating an early form of pastoral-psychological work. In 1906, a collaboration between doctors and clerics was initiated with the founding of the Emmanuel Clinic for physical, mental and spiritual help. Also, training courses (Worcester's 'psychotherapy class') and conferences were devoted to 'psychotherapy', thereby paving the way for a veritable psychotherapy movement that would last until the end of World War I. As a result of this movement, neurologists, after decades of desperately searching for a physical basis of hysteria and taking an explicit anti-psychological stance, increasingly saw themselves forced to recognize the importance of psychic causality.

2.2 Prevention

The introduction of neurasthenia had brought an apparently clear division between two types of mental disorders ('madness' and 'nervousness'), reflected in a corresponding professional division between psychiatrists on the one hand, and neurologists and various other mental healers on the other. Psychiatrists, however, actively sought to bridge this divide, eager to surpass their unfortunate asylum experiences. To this end, they introduced a concept that would radically change the
mental health field: prevention. Assuming that untreated neurosis would degenerate into psychosis, psychiatrists reasoned that moral treatment had failed because insanity would reach a chronic state before psychiatrists saw it. Hence, in the name of prevention, they claimed jurisdiction over the diagnosis and treatment of neuroses.

Of course, these assertions implied an attack on the neurologists' jurisdiction. And although the neurologists had a higher status within medicine than psychiatrists, they could not avoid some form of cooperation with the former asylum doctors. Consequently, the boundaries between the two professional domains gradually became blurred. Eventually, psychiatrists and neurologists increasingly put aside rivalry and competition and combined forces as 'specialists in nervous and mental disease'.

The exodus of psychiatrists out of the asylum also helped to create the new profession of psychiatric social work. The initiator was Adolf Meyer, who was born and medically trained in Switzerland and had emigrated to the United States in 1892. Meyer held the view that psychiatric disturbances in individuals were an expression of unhealthy living, of ineffective adaptions to the environment. While in charge of the New York Psychiatric Institute (1902-1910), he developed a new assessment method: the psychiatric interview, which aimed at a description of personality development, and which was complemented by home visits of social workers to patients' families, so that a more complete life history could be obtained and relatives could be involved in the treatment. Apart from individual therapy, social control was an issue here: sexual perversion, rape and violent criminal behaviour were seen as threats to the social order, and amenable to prophylactic measures within the mental health domain.

The cause of prevention was greatly furthered by the establishment of the National Committee for Mental Hygiene in 1909. The initiative came from a former patient, Clifford Wittingham Beers, who had suffered a mental breakdown at the age of 24, and attempted suicide unsuccessfully. For a year he languished in depression, then was committed to the Hartford Retreat. In 1902 his depression lifted and, apparently in a manic phase, he decided that he would launch a crusade for reform of the mental hospital, prompted by the abuses and cruelties he and his fellow patients had experienced. He ended up in a strait-jacket in a padded cell, and afterwards was transferred to Connecticut State Hospital. Upon his release in 1903, he decided 'to write a book about his experiences and to organize a movement that would help do away with existing evils in the care of the mentally ill and, whenever possible, to prevent mental illness itself'.

Contacting various authorities in the field of psychology and psychiatry, such as William James and Adolf Meyer, Beers managed to get support for his plans and in 1908, he founded the first mental hygiene society, in Connecticut, followed, in 1909, by the National Committee for Mental Hygiene. This Committee stated as its official goal: 'To work for the protection of the mental health of the public; to help raise the standard of care for those in danger of developing mental disorder or actually insane; to promote the study of mental disorders in all their forms and relations, and to disseminate knowledge concerning their causes, treatment, and prevention.'

The Committee initiated a publicity campaign, in which medical and philanthropical principles were combined to reach the goal of preventing mental illness and delinquency. Parents, teachers, social workers and policemen should be
educated into 'mental hygiene observants', and with their activities support the work of professionals in the field, for instance within the Child Guidance Clinics (see Chapter 2).

The changes within the mental hospitals and the activities of neurologists and psychiatrists in the ambulant field, took place in a broader context of social concern and intervention, which in the US was fueled by the Progressive Movement (see Chapter 1). Various types of intervention were regrouped under the banner of 'mental hygiene'. The principle of prevention expanded the mental health domain to include not just mentally ill and neurotic patients, but all individuals at risk: 'Mental hygiene as a philosophy of prevention is an ideal and a guiding principle working wherever possible with the assets of life before the differentiation into the "normal" and the "pathological"", wrote Adolf Meyer in 1930.13

From here, it was but a small step to the medicalization of deviance altogether. Especially in the United States, psychiatry during the first decades was transformed from a discipline concerned primarily with insanity to one equally concerned with normality. Psychiatry and social and pastoral work joined forces to promote the common goal of adjustment and assistance of all those who suffered from psychological malfunctioning.

2.3. Psychoanalysis

Meanwhile in Vienna, Sigmund Freud (1856-1939) had started his own brand of psychological therapy, which would change the course of psychiatry and mental health care in general. Educated as a neurologist, Freud had initially worked as a laboratory researcher, but financial reasons made him start a private practice for patients with 'nervous complaints'. Inspired by the work of Charcot and Janet, Freud started to experiment with hypnosis during the 1890s, in order to discover the causes of the otherwise unexplicable physical symptoms of his patients (mostly upper class women from the city of Vienna).

Gradually, he realised that these symptoms were signs of psychosomatic rather than pure somatic disorders. He also became convinced that these neurotic symptoms had mental causes. This was the starting point for a whole new way of theorizing about mental illnesses: they stemmed from repressed thoughts, memories, and impulses, hidden in the unconscious. According to Freud, traumatic events from childhood were repressed, i.e. transferred to the unconscious part of the psyche. They did not totally disappear, however, but manifested themselves in dreams and neurotic symptoms.

In his treatment practice, Freud invited his patients to lie down and associate freely on what came into their minds, hoping in this way to gain access to the patients' unconscious. In essence, therefore, psychoanalysis was a 'talking cure' (a term one of his patients, Anna O., had invented); not physical interventions but the analysis of individual discourses (in which the analysis of dreams had a prominent position) should do the job.

Hand in hand with his treatment practice, Freud further developed his theory. The most fundamental trauma was supposed to be the child's awareness that it could not take the place of the same-sex parent. This universal desire and the impossibility of its fulfilment became known as the Oedipus complex. By acting as a substitute parent, the doctor would induce the process of 'transference', by which the patient subjected himself emotionally to the psychoanalyst, a procedure which bore reminiscences of the way asylum and sanatorium doctors tried to exert moral
authority over their patients, but much more sophisticated.

By 1908 there were enough people sufficiently interested in psychoanalysis to warrant convening an international meeting in Salzburg. Forty-two people attended, among whom the Swiss psychiatrists Eugen Bleuler and Carl Gustav Jung. In the US, the psychologist G. Stanley Hall had learned about Freud's theory and in 1908, started to give courses on psychoanalysis. In 1909, Hall invited Freud, Jung, and Ferenczi to visit Clark University. In the same period, the United States also saw a beginning of analytic practice, articles on psychoanalysis and translations of the papers of Freud and Breuer on hysteria. This reception was stimulated by the favourable climate engendered by the psychotherapy movement.

2.4 Conclusion

The last decades of the nineteenth century paved the way for the 'second psychiatric revolution' (the first being the establishment of the therapeutic asylum by Tuke and Pinel). The misfortunes of both moral treatment and biological psychiatry forced psychiatrists to explore new avenues, all of which would contribute to the intensification and expansion of the mental health domain. First of all, psychiatrists ventured out of the asylum and into the treatment of a different kind of pathology: the nervous disorders. Second, both in Europe and the United States forms of psychological treatment - psychotherapy and psychoanalysis - were developed that would change the face of psychiatry permanently. In combination, both developments contributed to the establishment of the Mental Hygiene Movement in the early 1900s.

3 Mental hygiene (c. 1914-1940)

Both clinical zeal and a desire for more effective social management led to a considerable expansion of the field of mental hygiene in the Interwar period. This transformation was stimulated in a decisive way by the experiences of World War I. For the first time psychiatrists became directly involved in army activities. They were joined by the clinical psychologists, who had designed a new instrument to make psychodiagnosis more rational and objective: the psychological test. But in the eyes of the public during the 1920s and 1930s the real 'new psychology' became psychoanalysis. At the same time, policy makers in the social field regarded psychoanalysis and its competitor at the time, behaviourism, as important pillars for their efforts to regulate both normal and deviant behaviour.

3.1 Shell shock

From its beginning in 1914, World War I exploited new technologies for destroying the enemy.\textsuperscript{14} The mass slaughter resulting from these technologies not only caused physical injuries but also led to victims suffering from mental disorders, such as hysterical blindness, paralytic seizures, tremors, exhaustion, and total disorientation. In 1916, the British psychiatrist Myers introduced the concept of 'shell shock' for these - often persistent - symptoms. The symptoms were initially attributed to the explosions of shells, producing minute cortical lesions which in turn caused the disorder. But since shell shock was found frequently in troops who had not been exposed to shelling, it was concluded that the disorders did not have physical causes
but were to be seen as neurotic responses of individuals to traumatic situations.

At first, military psychiatrists stuck to traditional methods of countering the consequences of shell shock, derived partly from older military discipline (‘biting the bullet’) and partly from no less repressive psychiatric methods. Shell shock victims thus were subjected to military drill and exercise, electric shocks, isolation, cold showers, phantom operations and ‘suffocation therapy’.

After a few years, the general frame of reference towards psychological problems in war gradually shifted from a disciplinarian to a psychiatric approach. This is witnessed by the work of the Committee of Enquiry into Shell Shock in the UK, which concluded that a more careful selection of soldiers and officers for emotional stability was necessary to prevent future problems in army personnel. The existing forms of care by army chaplains were also backed up by psychiatric and psychological expertise, and expanded to the post-war private life of soldiers. Shell shock victims, when reunited with their families, were psychologically supported in the adaptation to normal life. Neuropsychiatric units were set up to take care of psychiatric problems at the front and to help demobilized soldiers to readjust to life at home. War neuroses also provided new material for observation and pointed to the relationship between psychic disorders and everyday living conditions.

3.2 Clinical psychology

The war also brought a new player into the mental health field: the (clinical) psychologist. In the first decade of the 20th century, psychological intelligence tests had been developed, and these were much in use during World War I. These tests introduced psychologists into the field of psychodiagnostics and clinical work in general, and contributed to public awareness of the uses of psychology.

At about the time that Freud developed psychoanalysis, Lightner Witmer, a psychologist at the University of Pennsylvania, had initiated a training program in a new field that he called ‘clinical psychology’ (see also chapters 1 and 2). In 1896, Witmer founded the first psychological clinic, and ten years later he started a professional journal, The psychological clinic (1907). Witmer's clinical method consisted of gathering instructors, students, and those needing help for the purpose of studying, doing research into, and treating mental disabilities and defects. In this decade only a few psychologists worked outside of universities, and none of them engaged in actual treatment.

The number of university-related psychological clinics in the United States increased to a total of 19 in 1914. Naturally, the expansion of the new profession was anxiously watched by their competitors, the neurologists and psychiatrists. In the 1920s, opposition by psychiatrists to the diagnostic function of clinical psychologists continued. There was also reluctance within psychology: in 1921, the APA reaffirmed that its sole objective was the advancement of psychology as a science, and not psychology as a profession. Nevertheless, a steadily increasing minority of clinicians was attempting to gain recognition within the organization. However, it would take a second World War for them to have their specialty accepted.

3.3 Public interest

From the 1920s onwards, psychological interpretations of human behaviour attracted the interest of the lay public. Within elite circles in the United States, there reigned a 'cult of the self', a permanent search for hidden motives, which of course made Jazz

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Age Americans eagerly devour popular psychological literature, most of it in the psychoanalytical tradition. Especially influential was A.G. Tansley’s *The New Psychology and Its Relation to life* (1920). This book was followed by a host of publications that enabled the public to learn about Freud’s psychological theory: the unconscious, repression, the sexual drives, and the psychological mechanisms and symbols by which drives were indirectly expressed in thought and behaviour. Gradually, psychoanalysis was assimilated into popular thinking which, much to the dismay of professional psychoanalysts, was accompanied by all kinds of distortions and dilutions, and moreover was freely combined with glandular and behaviourist conceptions.

The acceptance of the New Psychology went hand in hand with the promotion of Mental Hygiene. *The National Committee for Mental Hygiene* had been actively involved in the war effort, and this brought psychiatrists, social workers and clinical psychologists into the limelight as professionals whose joint efforts contributed to public and individual mental health. The Child Guidance Clinics (see chapter 2), apart from their practical value in parental advice, were a highly visible symbol of mental health as a public issue. And it was Freudian psychology that forged the link between the various groups of professionals, as well as between professionals and the public.

Developments within American psychiatry were also significant: after World War I the psychological causes of war neuroses seemed undeniable, and psychoanalysis became an irresistible force. Supported by local psychoanalytic societies, private psychoanalytic clinics were established during the 1910s, such as Chestnut Lodge (1910), Austen Riggs (1919), and the Menninger Clinic (1919). These clinics would set an example for fashionable treatment of the ‘neuroses of the rich’. One of the leading psychiatrists in the United States, Morton Prince, commented in 1929: ‘Freudian psychology has flooded the field like a full rising tide, and the rest of us were submerged like clams buried at low water’. During the late 1930s, when a whole generation of European psychoanalysts migrated to the United States, psychoanalysis became the leading theoretical orientation within psychiatry. The popularity of the so-called (psycho)dynamic approach within psychiatry would last virtually unchallenged until the mid-sixties.

Among the European and American public, psychoanalysis popularized the importance of sexual desires and drives: sexual factors were supposed to be present in a variety of non-sexual phenomena. In his book *The psychopathology of everyday life* (1901), Freud had analyzed the dreams, slips of the tongue etc. of normal people, demonstrating how unconscious processes influence the actions of us all, and not just the deviant feelings and behaviour of neurotic patients. Although Freud’s views were controversial, especially his idea that children should be seen as sexual beings, in their diluted form they had a profound influence on mental health policy and culture in general, such as the notion that emotional relationships between parents and children have profound consequences for the quality of emotional life in adulthood. East Coast intellectuals in the United States used psychoanalysis in their cultural struggle against New England puritanism, while on the other hand moral conservatives sought support in Freud to conquer the ‘internal wilderness’ of mankind. As a result, psychoanalysis was Americanized: its aim would no longer be to transform misery into common everyday unhappiness; it would be the pursuit of happiness itself.

The New Psychology, including both psychoanalysis and behaviorism, also
had great potential for applied psychology as a means of social control: it suggested new ways in which instincts, drives and wants of human beings might be regulated. Book titles from the mid-twenties, such as *Means of Social Control* and *Man the Puppet: The Art of Controlling Minds*, illustrated the confidence that knowledge of human motivation would be of considerable use to social policy makers. The implication of new developments within psychiatry and the Mental Hygiene Movement was that this could be most effectively done by a program of individual treatment of large numbers of people. Psychoanalytic and behaviouristic tenets, implying a certain plasticity of human nature, created the possibility of non-residential treatment, which in turn enhanced therapeutic optimism. As a result of all this, psychiatric medicine was freed of its dependence on disease and fired with a new ambition to intervene in the lives of the healthy. As early as 1932 W.A. White declared that (mental) health should be regarded as a positive, not a negative concept (i.e. the absence of disease).

3.4 Conclusion

After World War I, problems of adjustment, deviance and illness on both sides of the Atlantic were increasingly subsumed under the banner of mental hygiene. In 1930 a first International Congress for Mental Hygiene was held in Washington, including many participants from European countries. Although no one really knew what mental hygiene exactly meant, its value as a leading concept was beyond doubt: it signified optimism within psychiatry, the belief that all forms of disorder, ranging from alcoholism, prostitution, juvenile delinquency, child abuse, to psychiatric illness, could be cured or managed by scientifically supported therapeutic interventions.

The psychoanalytic notion that adult problems had their origins in childhood psychological conflicts or trauma supported this optimism within the mental health field and provided a common language for professionals from various backgrounds, including social workers and forensic experts. As the founder of the Dutch Child Guidance Movement, Eugenia Lekkerkerker, stated: 'Psychoanalysis had laid the foundation for an enormous expansion of the domain of mental health care, far beyond the original goal of taking care of the insane. In particular it gave the rationale for preventive activities, which are now also directed towards the "normal" person, who does not or not yet suffer from a pathological disorder.'

As they learned more and more about the endless variety of possible abnormalities on the psychological level, both policy makers, professionals and the public became increasingly concerned about managing abnormality. Their concern fitted in well with the new grid that typified the mental health field: the continuum ranging from the normal to the pathological. It was also supported by new practices: psychological tests offered the opportunity to measure each individual's position on the normal-pathological dimension, and a whole range of private and public institutions offered services for the prevention and cure of mental pathology. From this, a new psychology of adjustment emanated.

4 Adjustment (c. 1930-1960)

World War II marked the onset of a range of new developments in the mental health domain. The war precipitated the growth of the number of professionals involved in diagnosis and therapy. To the general public, psychotherapy was still a little-known
clinical activity in 1940, and in the US only 3 or 4% of the population had used mental health services, which rapidly climbed to 14% in 1957.\(^\text{18}\) This expansion went hand in hand with a social reorientation of psychiatry, both in theoretical perspectives and in practical interventions, leading to institutions of community mental health care. The war also enabled clinical psychologists to gain considerable ground within the field. Finally, the increased status of the United States as a military, political and economical power was paralleled by a rising international prestige in mental health affairs, resulting in a leading position in this domain as well.

4.1 World War II

World War II included more than political and military activities. Having learned from World War I, military and civil authorities in both the German and allied forces were well aware of the strains that war activities would put on service men and women. Therefore, in the recruitment of personnel attention was paid to the physical and mental health of soldiers and officers, and during the war activities a range of mental health services was provided to military personnel. For instance, the United States decided to take psychiatrists on board from the moment America joined the allied forces. The number of psychiatrists available being far from sufficient, a crash course in mental medicine was given to 2400 medical officers, a number equalling the total membership of the American Psychiatric Association in 1940.

Likewise, psychologists were called in to compensate for the shortage of psychiatrists in the services, which apart from necessity should be ascribed to the broadmindedness of progressive psychiatrists, such as William Menninger. As a result, the number of psychologists involved in army activities increased dramatically, reaching up to 1700 at the end of World War II, a significant number of them in clinical capacities.\(^\text{19}\) Apart from actual psychiatric and psychological treatment, much energy was devoted to the dissemination of psychological concepts and techniques among military personnel. Self-help books on emotional self-management, such as *Psychology for the Fighting Man* (1943), were distributed in hundreds of thousands of copies.

The war also accelerated theoretical reorientation. Since psychological selection was part of recruitment procedures, mental breakdown could hardly be attributed to genetic or biological weakness. Consequently, when otherwise healthy officers and soldiers developed neurotic symptoms as a result of their involvement in the war efforts, this was seen as a normal response to an abnormal environment. The 'environmental' interpretation of wartime breakdown pushed the general orientation of clinical professionals in decidedly social directions. Rather than inherent qualities of individuals, mental health and illness became to be considered as conditions enhanced or decreased by social experiences, which required continuous adjustment to changing circumstances. This was a challenge to a new generation of psychiatrists: 'The field of medicine must be recognized as inseparably linked to the social sciences and concerned with healthy adjustment of men, both individually and in groups'.\(^\text{20}\)

Adjustment, as an effective way of dealing with unhealthy circumstances, became the new target for clinical professionals. For instance, Carl Rogers, who was to become the most influential clinical psychologist of post-war America, defined clinical psychology as 'the technique and art of applying psychological principles to problems of the individual person for purposes of bringing about a more satisfactory adjustment'.\(^\text{21}\) Behind the humane goal of individual well-being, social management
issues were at stake: normal neuroses could and should be treated before reaching a point that threatened social stability.

As a consequence, it was felt that the popularisation of mental health techniques should be included in social management strategies, which fundamentally changed the face of psychotherapy. Before the war, psychotherapy had been associated largely with the élite practice of psychoanalysis or psychiatric techniques practiced in the institutional context of state hospitals. Now psychotherapists accepted that non-professionals could benefit from applying psychological knowledge and techniques on themselves, in order to prevent maladjustment, to assist in coping with problems, or to help in presenting more serious disorders adequately to a professional.

4.2 Community treatment

Considering the psychiatric endeavours during the war, it was only natural that measures were taken to provide adequate care for returned servicemen after the war. In the United States, the legal foundation for financial and immaterial support was guaranteed by the Servicemen's Readjustment Act (also known as the GI Bill). The Veterans Administration (VA) was instrumental in the actual organization of facilities. The number of psychiatric cases in the VA hospitals almost doubled between 1940 and 1948. In April 1946, around 60% of all VA patients were diagnosed as suffering from neuropsychiatric disorders of one kind or another.22

The GI Bill was followed by the National Mental Health Act of 1946, that in turn laid the foundation for the National Institute for Mental Health (NIMH). Here the shift in federal policy from mental illness to mental health, and a decidedly preventive and community-directed orientation were materialized and promoted. Also in 1946, a pressure group of 'young Turks' with a background in military psychiatry, was formed within the American Psychiatric Association. Led by William Menninger, this Group for the Advancement of Psychiatry (GAP) set out to push psychiatry in a social direction, as is witnessed by their 1950 manifesto 'The social responsibility of psychiatry'.

Between 1955 and 1960 the federally funded Joint Commission on Mental Illness and Health carried out an extensive survey into mental health and illness in the US, and in its final report (Action for Mental Health, 1960) strongly advised that community mental health centers should be established throughout the country, in the interest of social stability. This was legally enforced by the Kennedy administration in 1963. The reformist zeal of the postwar decades contributed to the increase of psychiatrists in the US, from 3000 during World War II to 17.000 in 1964.23 During the same period, psychiatric focus shifted from the institutions to private practice, a majority of psychiatrists working on an outpatient basis in 1964.

This went in hand with a rising public interest. From 1945 onward, citizens sought therapeutic attention more insistently than ever before, and by 1960 mental illness had become a subject of great interest to the general public, to judge by the number of publications, investigations, debates, and newspaper articles devoted to it, and the popularity of the 'pop psychology' TV-show of Joyce Brothers. As a result, the idea of 'psychotherapy for the normal' became widely accepted. The explicitly non-medical method of psychological counseling, developed in the 1940s by Carl Rogers, fitted in nicely with the new public demands.

Although the mental health industry in Europe did not expand as early and as rapidly as it did in the United States, by 1960 psychiatry and clinical psychology
were well on their way to become established professions. In many West-European countries too a variety of out-patient services was established, importing both theories and techniques from the United States.

4.3 Psychologists on the march

Although clinical psychology had received increasing professional recognition by the late thirties (mainly on the basis of testing expertise), it still retained a distinctly subordinate position in the status hierarchy, both within psychology and in its relation to psychiatry. Their enrolment in military mental health services had enhanced psychologists’ status to the degree that in the postwar era they could both claim and have their share in diagnosis and even psychotherapy.

Being non-medical professionals, even clinically trained psychologists had been and still were excluded from psychoanalytical psychotherapy proper (which before and after World War II had led to vigorous debates, to which even Freud himself had contributed in *The question of lay analysis* (1926)). It took a new kind of psychotherapy for psychologists (with social workers, teachers, clergy, and other professionals in their trail) to enter therapeutic practice. Central in its development was the work of Carl Rogers, a former minister who, after turning to psychology, had made his career in the pre-war years in the domain of child guidance. His ground-breaking book *Counseling and psychotherapy* (1942) not only expressed great confidence in the therapeutic capacities of non-medical professionals, but also put trust in the self-healing powers of the client (not: the patient!), the effective therapist being no more than a facilitator of psychological change in the individual. In the same vein, Rogers’ method brought about a decisive shift of emphasis, from an exclusive concern with the pathological to a focus on ordinary unhappiness and alienation.

Rogers’ ‘client-centered’ approach partly was inspired by philosophical theories from the European existentialist tradition, but on the other hand it had gained respect by the adoption of empirical research methods, used to analyze the process of psychotherapy. The combination of professional innovation and scientific interest provided him with enough prestige to become (in 1946) the first clinical psychologist to be elected as president of the APA. A few years later, Rogers was involved in the exploration of new ideas in clinical training at the Boulder Conference in 1949, the most important achievement of which was the introduction of the ‘scientist-practitioner’-model.

At the same time that Rogerian counseling made its way through the mental health institutions of the 1950s, the foundations were laid for *behaviour therapy*. Presupposing that all behaviour was learned through reinforced stimulus-response associations, behaviourists claimed that the behaviour associated with mental illness also was learned, and that it could be unlearned as well, if only the appropriate methods were used. The first clinician to practice form of behaviour therapy, was J. Wolpe, who was trained in South Africa as a medical doctor and psychoanalyst. Dissatisfied with the meagre results of his treatment practice, he ventured in the late 1940s into experimental psychology, searching for means to create a more effective therapeutic method. After having moved to the United States in the mid-fifties, he wrote the book that would become a milestone in the development of behaviour therapy: *Therapy by reciprocal inhibition* (1958).

In roughly the same period, a team at the psychiatry clinic of Maudsley Hospital in London, led by psychologist H.J. Eysenck, had been studying the
effectiveness of psychotherapy. They concluded 'that the therapeutic effects of psychotherapy are small or non-existent, and do not in any demonstrable way add to the non-specific effects of routine medical treatment, or to such events as occur in the patients' everyday experience'. Inspired by Wolpe and by B.F. Skinner who, in 1954, had coined the term 'behaviour therapy', Eysenck and his team set out to expand and promote the new approach, opposing psychoanalysis with all the methods at their disposal. Apart from claiming a higher effectiveness for behaviour therapy, the bottomline for Eysenck was always the scientific superiority of behaviourism: '...[W]e are concerned with the application of laboratory based scientific findings in the field of learning and conditioning, rather than with the use of Freudian principles.'

The rise of clinical psychology as a force within the therapeutic domain contributed to a growing acceptance within psychology as well. During the period 1957-1960, of the almost 3,100 PhDs awarded in U.S. psychology, one-third were in clinical psychology. The Clinical Division of the APA, largest in the association, had 2,700 members, more than three times as much as the Experimental Division.

4.4 The struggle of psychiatry

While psychotherapists of all varieties enlarged their territory within the domain of ambulant mental health care, psychiatrists in the mental hospitals were still trying to come to grips with patients who were a threat to themselves or their environment, the most difficult category being the schizophrenics. Compared to the asylum days they had not made much progress in curing this kind of patient; what they had to offer was mainly custodial care, which for a large part meant some form of physical restraint.

In the course of the 1930s, when most institutional psychiatrists still favoured a biological approach, attempts at curing schizophrenic patients had focussed on physical treatment. Inspired by the belief that the grand-mal convulsions of epilepsy were biologically antagonistic to schizophrenia, psychiatrists tried to induce these convulsions in schizophrenic patients by injecting insuline or administering electric shocks. Apart from having considerable negative side-effects, these shock therapies appeared to cure some of the symptoms.

In the same period, a more extreme and irreversible form of medical intervention was introduced: prefrontal lobotomy. This method of surgically severing portions of the brain was developed in 1935 by the Portuguese neurosurgeon Egas Moniz, who in 1949 won the Nobel Prize for his invention. In the United States, the neurologist Walter Freedman developed a simplified procedure, which enabled surgeons to operate on patients in a few minutes, using only local anaesthetics. Since the effects on patients seemed beneficial, psychosurgery became a widely used method.

During the 1950s, shock treatment and psychosurgery were complemented with psychotropic drugs, after the first effective antipsychotic drug, chlorpromazine was discovered in 1952. Again, this innovation was a product of trial and error: there was no evidence-based biological theory that had led to the development of psychoactive drugs, nor did neurologists or biological psychiatrists at the time have a solid explanation for their effects. Not surprisingly, this produced dissatisfaction and curiosity in medical researchers. Stimulated by the pharmacological industry, which had an obvious interest in more precise knowledge about the new psychiatric drugs, neurologists and biochemists set out to probe more deeply into the workings of the brain and the endocrine glands.
New advances were also made with respect to diagnosis and classification, especially inspired by the earlier mentioned Group for the Advancement of Psychiatry (GAP). Prompted by the massive number and variety of war neuroses during and after World War II, the GAP set out to create a descriptive system that was to include both psychotic and neurotic illnesses. The first edition of this *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was published in 1952, listing 60 disorders, and, not surprisingly, heavily loaded with psychoanalytic concepts.28

4.5 Conclusion

Generally, the notion that Americans lived in a psychological society took hold rapidly in the 1950s and had become commonplace by the 1960s. The dividing line between serious theory and the simplifications of pop psychology became increasingly blurred. The rapid expansion of psychological services during this period resulted from two converging developments: the massive promotion of the concept of adjustment by politicians and clinicians on the one hand, and cultural changes resulting in an increasing preoccupation with the self on the other.

Although psychoanalysis (or rather psychodynamic psychiatry), especially in the US, had its heyday during this period, alternatives were on their way. Psychodynamic therapy was simply too time-consuming and complicated for mass treatment of normal people with adjustment problems, and therefore ill-suited for the clinical work in the Community Mental Health Centers. The gap was filled by Rogers' client-centered approach which, together with other post-psychoanalytic therapies like behavioural therapy, would eventually contribute to the decline of psychoanalysis in its classic form. Nevertheless, the proponents of these new therapies agreed with the psychoanalytic view that mental problems have psychological causes rather than biological ones, that they can be solved within the context of verbal, ambulant treatment, and finally that psychotherapy should be based on science, not morality. In other words, these alternatives used psychoanalysis as a stepping stone for their own invasion of the field of psychotherapy.

At the same time, the field of mental illness was expanded to include psychological problems of normal people, such as sexual problems, difficulties in interpersonal relationships, and dissatisfaction with oneself. At the other end of the spectrum, psychiatrists in the institutions were struggling hard to find ways to relieve the symptoms of severe mental disorders. Their recourse to physical treatment methods, such as ECT and lobotomy, regardless of their effectiveness, contributed to the public aversion to asylums, especially since these physical therapies were frequently used as horror themes in books and movies.

5 Radicalism (c. 1960-1980)

The 1960s and 1970s were a period of turmoil, both for society as a whole and for the domain of mental health. On the one hand, Western societies saw a continuous acceptance and growth of mental health care, and even the onset of a veritable 'personal growth' movement. On the other hand, radical groups contested fundamental assumptions of mainstream psychology and psychiatry. Institutional psychiatry, in particular, came under attack; mental hospitals were accused of being
repressive institutions, which stigmatized the victims of social injustice. In the same
vein, mental illness was designated as a myth that masked the reality of socially
induced deviance and falsely justified the repressive power of the asylums.
Alternative interpretations of mental illness, such as anti-psychiatry, joined forces
with the anti-establishment battle of the counter-culture, leading to a protest
movement in almost all Western countries, aiming at the abolishment of mental
institutions.

5.1 Counter-culture

In many western countries, the sixties were a period of youthful dissent. Since the
advent of rock and roll, parents and social authorities had worried about the advent
of a serious 'generation gap' that would threaten cultural continuity and the
maintenance of moral standards. From the mid-sixties onwards, post-adolescents
engaged in left-wing political critique of various issues (racial segregation, university
politics and most vehemently the Vietnam War).

But the counter-culture was not just about political consciousness:
consciousness in general was explored, and psychiatry offered some of the means to
do this. During the late 1950s, psychoactive drugs became to be used as a tool for the
exploration of human consciousness. Harvard psychologist Timothy Leary, once an
established director of psychological research, started to experiment with LSD,
proclaiming that LSD was as essential to psychology as the microscope was to
biology. In founding the 'League for Spiritual Discovery' in 1966, Leary crossed over
to the counter-culture and provided the hippie movement with perhaps its most
famous slogan 'turn on, tune in, and drop out'.

Authorities both within and outside psychiatry were quite ambivalent about
the use of drugs. On the one hand, there was a legitimized prescription of drugs
within psychiatric treatment; within the counter culture, on the other hand, there was
a voluntary and illegal use of drugs that was not only subject to legal punishment but
also, as drug addiction, to psychiatric treatment.

While drug-induced consciousness-raising remained rather peripheral and
temporary, other aspects of the counter-culture would have a more profound and
lasting effect, both within and outside the mental health domain. In the early 1970s,
the critique of traditional forms of authority and hierarchy spread from the domain
of politics to a variety of cultural and professional institutions, including psychiatric
hospitals. At the same time, the principle of self-realization became a widely
accepted cultural norm, gradually replacing the earlier and more modest striving for
‘adjustment’.

5.2 Anti-psychiatry

Seen in its historical context, the critical movement designated as 'anti-psychiatry'
seems a paradox. While ambulant psychiatric and psychological treatment
blossomed, and new drugs were introduced that enabled psychiatric hospitals to
leave behind crude ways of restraining psychiatric patients, the psychiatric hospital
regime and the 'medical model' of dealing with mental illness came under attack. In
1960 the psychiatrist Thomas Szasz published The myth of mental illness. He argued
that most psychiatric disorders are expressive of problems in living, and are not due
to diseases or chemical imbalances in the brain. Physical, surgical, or drug treatment
was a fraud and concealed the real problem from both the practitioner and the
While Szasz opposed asylum psychiatry head-on, other professionals, both in the United States and the United Kingdom, were developing alternative treatments for psychotic and neurotic patients, such as group therapy and family therapy. Often it was found that individuals who were considered to be cured developed symptoms of mental illness after returning to their families, or, alternatively, another family member showed up for treatment. This revolving door problem inspired some therapists to invite the whole family for therapy sessions, focusing on the distorted communication patterns within the family. Or, as Jackson put it: Family therapists ‘are much more concerned with influence, interaction, and interrelation between people, immediately observable in the present, than with individual, internal, imaginary, and infantile matters.’

In the UK, Ronald Laing, who during the 1950s had been experimenting with group and family therapy for schizophrenic patients, concluded that the medical approach to mental disturbances was a failure and instead designated society (and especially the family) as their cause. Laing saw a positive side to schizophrenia, which fitted in well with the counter-cultural imperative of ‘exploring the frontiers of the mind’: it should be seen as a natural enlightened mental state that enabled ways of seeing that normal individuals could only reach by using psychedelic drugs.

Fueled by countercultural ideas and sociological analyses of mental institutions, labeling and deviance, the critiques voiced by professionals like Szasz and Laing evolved into a movement directed against the repressive practices within ‘total institutions’ (Goffman) and the unjustified authority of the psychiatrist. In 1967, the British/South African psychiatrist David Cooper coined the term ‘anti-psychiatry’, in his book *Psychiatry and Antipsychiatry*. Critical publications in the same vein appeared in non-Anglosaxon countries, for instance *Bürger und Irre* [Citizens and madness] (Dörner) in Germany, and *Wie is van hout* [Who is made of wood] (Foudraine) in the Netherlands (selling over 200,000 copies). *Histoire de la folie* [Madness and civilization] (1961) by Michel Foucault, an early constructionist reinterpretation of the history of psychiatry, was heralded in retrospect as a predecessor of anti-psychiatry.

The anti-psychiatric sentiments were widely amplified in the media. As early as the 1940s, horrifying conditions within the psychiatric hospitals had been shown to the public in books and movies such as Mary Jane Ward’s *The Snake Pit* (1946/1948). Ken Kesey’s novel *One flew over the cuckoo’s nest* (1962) subsequently had pictured patients as defenseless victims of psychiatric power. When the novel was put on the screen, in 1975, it was heralded as an anti-psychiatric statement. As historian John Reisman put it: ‘The patient was portrayed as the victim of a system, a lunatic society that drove its more sensitive members to rebellion and then cast them into mental hospitals, where vindictive psychiatrists and nurses lay in wait.’ Anti-psychiatry thus turned the traditional rhetoric of the helping professions, based on benevolence and scholarship, upside down. Instead of leaders in the cause of humanitarian progress, psychiatrists were portrayed as servants of power who assisted in eliminating citizens displaying socially and politically deviant behaviour.

The 1970s also saw vehement opposition to mainstream psychiatry and psychotherapy from the feminist movement. Women had been a favourite target of psychiatry and psychoanalysis all along. They were considered as the weaker sex, more neurotic or hysteric and prone to mental illness in general. Taken at face value, figures about hospitalisation and mental health consumption appeared to confirm
this interpretation: over the ages and between countries, they consistently showed an overrepresentation of women among the clientele of mental health provisions. Also, as mothers, women were seen as the cause of mental problems (even schizophrenia) in their children. As early as the 1920s, Karen Horney had criticized Freud from within the psychoanalytic movement for the male bias in his theory. In the 1960s the feminist critique asserted that psychiatry should not label women as neurotic: ‘neurotic symptoms’ in women are merely normal defenses against the oppression to which they are subject. Again, the critique was largely directed against psychoanalysis, probably because it was the dominant theoretical frame of reference. Neo-Freudians like Erikson were attacked in Kate Millett’s *Sexual Politics* (1969). In general, feminist critique borrowed many tenets from antipsychiatry, such as the abuse of power by medical professionals, the depoliticization of mental problems, the bias in professional concepts and theories, the conformism to the establishment, and the neglect of peoples’ subjective experience. Feminist psychologists like Phyllis Chesler (*Women and Madness*, 1972) criticized standard therapies, professionalism and traditional concepts of mental health.

However, although both anti-psychiatry and feminism were critical of mainstream psychiatry and psychology, neither movement opposed psychology per se. In their search for an alternative approach to the interrelation between social and mental problems, both feminism and anti-psychiatry substantially contributed to an enlargement of the psychological domain, by providing it with a variety of new interpretations and therapies. This was exemplified in feminist theories that linked personal experience to social and political issues: ‘the personal is political’, as the credo went. On the practical level, this credo gave rise to a host of self-help therapies: consciousness-raising groups helped women to see that their problems were not unique and should not be seen as a form of illness. Therapy thus became part of a process of growing political awareness, directed toward effective political action. While designed as a means to politicize personal experience, this strategy at the same time led to a psychologization of social issues.

### 5.3 A new psychological awareness

During the 1960s and 1970s, Western societies saw a normalization of mental health care: the taboo on seeking help for mental problems largely disappeared, as can be seen from the rapidly growing number of patients, especially in ambulant mental health care. Between 1957 and 1976, the percentage of citizens in the US applying for mental help rose from 14% to 26%. The interest among the public in psychological issues, is evidenced by the success of the monthly magazine *Psychology Today*: within a few years after its start in 1967, circulation totaled over one million copies. Especially among the younger intelligentsia, therapy almost became a way of life.

Generally, the public interest in psychology was welcomed by professionals. At the 1969 Meeting of the APA on *Psychology and the Problems of Society*, G.A. Miller, in his presidential address depicted psychology as a means of promoting welfare. Because the demand for psychological services seemed practically limitless, Miller encouraged people to become their own psychologists. Selfhelp thus was not just a radical issue, it was part of the protoprofessionalization process in citizens. As Herman put it: ‘Psychological help was defined so broadly that everyone needed it. Neurotic emotional disturbance was gradually accepted as fact and product of modern existence rather than as the shameful secret it had been just a few decades earlier’. Traditional authority, based on fixed norms and standards of conduct, was
gradually replaced by a culture of growth and authenticity, and of democratic interpersonal relationships.

The dissemination of psychology, rather than being 'more of the same', implied the introduction of new theories and therapies, fitting in with the changes in cultural values. The humanistic movement in psychology, headed by Carl Rogers and Abraham Maslow, sought ways to incorporate experiential knowledge into psychological science. They privileged the uniqueness of the individual and sought ways to enhance psychological health, emphasizing personal growth, self-actualization, and the realization of one's potential.

In particular, Rogers' client-centered therapy was welcomed by the culture-critics of the 1960s as a venue leading to a more democratic relationship between professional and client. Apart from client-centered therapy, a host of alternative therapies became fashionable for young middle-class progressives: Gestalt therapy, Transactional therapy, Primal Scream, and various group approaches, such as 'encounter' and psychodrama. The therapeutic center Esalen in California became the merger of self-actualizing therapy and counterculture, in the more general quest for 'authentic interpersonal relationships'.

The 'friends of the new psychotherapies' were to be found within the middle classes, not just the 'drop-outs', but also social science and psychology students, social workers, psychiatric nurses, pastoral counselors and of course psychotherapists of a younger generation. In the quest for authenticity, talking about personal feelings and emotions became almost obligatory; in this respect, the humanistic rhetoric coincided with the basic principles of psychotherapy itself.

5.4 Conclusion

In this period, the social aspirations of the mental health profession were continued and radicalized. Humanistic brands of psychotherapy blossomed and were embraced by members of the hippie movement and protest movements such as women's liberation. Self-realization rather than adjustment became the new target in cultural and mental health politics. At the same time, psychiatry had to cope with both vehement opposition from the anti-psychiatry movement and deinstitutionalization policies within many Western countries, favouring ambulant treatment over the expensive hospital treatment. All in all, the 1960s and 1970s saw a significant enlargement and growing acceptance of mental health activities.

6 Rationalization (c. 1980 - present)

The era of the humanistic psychotherapies and the antipsychiatry movement had stretched the psychosocial aspects of mental health care and psychotherapy to their limits. This went hand in hand with a growing demand of the public for ambulant mental health services, a demand that included advice and help concerning life problems. 'Therapy for the normal' thus became part and parcel of mental health care. This obviously created problems on the financial level. In many Western countries psychotherapy had become part of publicly funded services during the 1970s, and the rising demand forced service providers to find ways to control costs. This called for a rationalization of both the mental health system and the psychotherapy process itself.

From the 1980s onward in most countries scattered public mental health
services were reorganized into larger community centers, where intakes were
centralized and therapies distributed among mental health workers according to the
nature and gravity of the problems. The increasing complexity of the organizations
was met by the introduction of managers, who were entrusted with guaranteeing
both the cost-effectiveness and the quality of mental health care, and who more
generally were supposed to negotiate government policies for the mental health
domain. This found its most manifest expression in the introduction of the system of
‘managed care’ in the United States’, but various European countries witnessed
similar developments.33

The urge to create an effective system of 'managed care' converged with
developments on the diagnostic and therapeutic level. First of all, during the 1980s
the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III,
1980) was disseminated worldwide as the standard frame of reference for psychiatric
diagnosis.34 Psychoanalytic concepts, which had dominated the two previous
editions, were replaced by a more neutral terminology. The list of disorders was also
enlarged from 145 to 230, in order to include the many life problems that mental
health professionals were increasingly confronted with since the early 1970s. Thus,
DSM III was able to categorize such everyday problems as shyness (‘avoidance (?)
disorder’), stubbornness (‘oppositional disorder’), tobacco smoking (‘substance use
disorder’), and significant deficiency in reading or arithmetic (‘specific development
disorder’).

Although DSM-III, and its revised edition in 1987, helped to improve the
reliability of psychiatric classification, it still reflected ignorance about the etiology of
most disorders (especially schizophrenia and depression). In order to gain progress
on this level, psychiatry sought the help of biology and neurology. The identification
of neural mechanisms involved in psychopathology, had constituted a major leap
forward in biological psychiatry. The discovery of the working of neurotransmitters
and the visualisation of differences between patients and 'normal' people in brain
activity, led researchers to believe that psychological disfunctions not only
 corresponded with impaired brain functions, but also were caused by them.
Schizophrenia, for instance, was seen as the result of a disorder in the development
of the brain. Brain-imaging techniques, such as 'magnetic resonance imaging' (MRI)
and 'positron emission tomography' (PET), produced visible evidence of
abnormalities in the brain that corresponded with specific mental disorders.
Likewise, the new interdisciplinary science of psychoneuroimmunology was able to
detect physiological correlates for mental states such as psychological stress.
Although physiological researchers, well aware of the strains of modern social life,
were wary of claiming a simple cause-effect-relationship from biological to
psychological phenomena, their efforts contributed to the rehabilitation of biology as
a cornerstone of psychiatry and clinical psychology.

This rehabilitation was furthered by developments in pharmacology. Since the
1950s, several new generations of increasingly sophisticated drugs for the treatment
of mental disorders had been produced and prescribed. During the 1990s, the public
had proved as eager as policy makers and managers to adopt quick and easy
solutions for psychological malfunctioning, and drug prescription and consumption
expanded rapidly. Instead of engaging in time and energy consuming 'talking cures'
for symptoms of depression, patients welcomed new drugs such as Prozac as easy
cures for their ills.

Although drug therapy proved a much welcomed aid in both the combat of
the discontents of civilization and the social management of deviant behaviour, it was by no means the only new development in therapy. Out of the array of post-psychoanalytic therapies, behaviour therapy, after a period of steadily growing recognition during the 1970s, succeeded in becoming the most widely practiced approach in ambulant settings. The 'token economy’ technique derived from it also has become the second favourite approach in institutional settings, next to drug treatment.

One undeniable advantage of behaviour therapy is its wide range of applicability, both within and outside the clinical field. Moreover, it is not, like psychodynamic therapies, limited to verbally gifted, introspective, intelligent and educated members of western societies. Behaviour therapy is rather straightforward and directive, and places high value on routinized and experimentally evaluated procedures, which is obviously an asset in a period of increasing demand for mental health care. The adoption of concepts and techniques from cognitive psychology, cognitions cleverly being translated as ‘coverants’ (= covert operants), further contributed to the success of behaviour therapy.

Both drug therapy and behaviour therapy boosted the new impetus towards rationalization within mental health care. On the one hand, they facilitated efficiency and cost-effectiveness by stimulating a standardized approach of mental problems, which was subsequently formalized by mental health managers in the form of protocols for diagnosis and treatment. On the other hand, they fitted in well with the demand of both researchers and policy makers for evidence-based therapies. Scientific respectability was further enhanced by the fourth edition of DSM, issued in 1994. Since the last revised edition, DSM had been thoroughly redesigned to include the most recent developments in biological psychiatry, and to maximize both reliability and validity of the classification system.

Unwittingly, the subjectivism and radicalism of the 1960s and 1970s seem to have reinforced in the following decades rationalistic and objectivistic approaches to mental illness in both psychology and psychiatry, as is witnessed by the success stories of behaviour therapy, biological psychiatry, diagnostic classification systems and last but not least, more cost-effective and standardized approaches to treatment. Although most of these approaches date back to at least the 1950s, they had their bloom only from the 1980s onward. Together they succeeded not only in countering the psychosocial trend, but also in defeating the most powerful approach in the mental health domain: Freudian psychodynamic psychiatry.

This is not to say that the 'rationalist' approaches concurred in all aspects. For instance, in its rise to prominence, behaviour therapy permanently defied the medical model of both psychodynamic and biological psychiatry. Psychiatric patients weren't ill, they just suffered from 'maladaptive' or 'socially deviant' behaviour. Feelings of unhappiness, depression or nervousness were the results of this maladaptation, not their cause.

7 Conclusion

In less than a century, the mental health perspective has come to pervade almost every aspect of Western culture and modern life. Originally restricted to the problems of the seriously mental deranged, psychiatry has enlarged its jurisdiction to include virtually all aspects of individual behaviour, as well as a whole range of
social and cultural phenomena. In the process, they got company from a whole range
of other ‘mental health’ professionals, prominent among them psychotherapists and
clinical psychologists. And the end of this process seems nowhere in sight: year by
year, the list of mental problems and disorders seems to become longer, and
epidemiological studies suggest that present use of mental health facilities is just a
fraction of the ‘hidden demand’ of all those suffering from problems.35

How to account for this growing prominence of the mental health
perspective? Undoubtedly, large-scale social and cultural developments such as
individualisation and secularisation have been important factors. With social
structures loosening, social mobility increasing, and traditional moral guidesmen
loosing much of their authority, we have lost many of the traditional reference points
to which to orient our lives. Consequently, we are increasingly faced with the task of
‘turning inward’, finding new points of reference and new guidelines through
introspection, guided by the conceptual tools provided to us by the mental health
paradigm, seeking help from professionals when necessary.

However, these grand explanatory schemes should not blind us to some of the
more specific backgrounds of the mental health ‘revolution’. One of these is
undoubtedly the theoretical framework which guided the mental health movement
for much of the twentieth century: psychoanalysis. Freud’s creation first enlarged the
domain and jurisdiction of psychiatry, in fact saving it from eternal confinement to
the asylum. Second, it provided the public with the means for a new self-
understanding: ‘the unconscious’, ‘trauma’ and many other psychoanalytic concepts
became household words in the first half of the twentieth century. Whereas
psychiatry, as a branch of medicine, for the most part remained esoteric, treatment
being the privilege of trained professionals, psychoanalysis and most post-Freudian
therapies took pride in informing and educating the public about the interpretation
and treatment of mental illness. In the process, the dichotomy between mental health
and illness lost its ‘all-or-nothing’-character: health and illness became two poles of a
continuum, with an infinite number of gradations in between.

Perhaps the most significant and pervasive aspect of the mental health
perspective is the replacement of moral and ethical categories by psychological ones.
In this respect, there is a striking continuity between the first psychiatric revolution
and developments in the century that lies behind us. If Pinel introduced a new
perspective on ‘madness’ as being an illness rather than a sign of moral derangement
and a curse of God, so psychoanalysis and other mental health paradigms have in the
twentieth century ‘secularised’ and psychologised our view on a host of other
phenomena formerly considered primarily from a moral point of view: from varieties
of sexual behaviour to delinquency, and from marital problems to juvenile
unruliness.

Psychological tests, diagnostic catalogues such as the DSM, standardised
forms of treatment and, lately, the reappearance of biological interpretations of
mental disorders have served to canonise, standardise and objectify this new,
psychological perspective. Together, they tend to create the impression that mental
health problems are discrete disease entities, with a universal validity, residing
within the individual and objectively diagnosable. In the process, they have
solidified the position of psychologists, psychiatrists and other ‘psy-experts’, lending
them an authority over virtually every aspect of our lives. However, this
scientification and objectivation of mental problems should not blind us for their
historical and cultural specificity. Historically, the expansion of the mental domain
does not only reflect scientific progress and better understanding of mental phenomena, but at least as much the increased strains and problems of modern Western society. And from a transcultural perspective, the alleged objectivity of mental health nomenclature tends to blind us to/from the culturally specific nature, expression and interpretation of many of the phenomena we consider as ‘mental disorders’.

**Principal sources and further reading**


For the vicissitudes of female patients in both early and recent psychiatry and psychotherapy, see E. Showalter (1985), *The female malady. Women, madness and English culture, 1830-1980* (New York: Pantheon).
References

1 See G. Vandenbos, N. N. Cummings, and P. H. Deleon (1992), A century of psychotherapy. Economic and environmental influences, in Freedheim, History of psychotherapy, pp. 65-102. (p. 97)

2 Shorter, A history, p. 15.

3 P. Vandermeersch (1994), "Les mythes d'origine" in the history of psychiatry, in Micale and Porter, Discovering, pp. 219-31. (p. 222)

4 Shorter, A history, p. 19

5 See Vandermeersch, “Les mythes...


7 Shorter, A history, pp. 46-47

8 Castel, The psychiatric society, pp. 15-16, 48-49.


10 Abbott, The system, p. 301.

11 Reisman, A history, p. 48

12 Castel, The psychiatric society, p. 325.

13 Castel, The psychiatric society, p. 36.


18 Vandenbos, A century, p.74-5.


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Castel, *The psychiatric society*, p. 60.


Herman, *Romance*, p. 262.

Herman, *Romance*, p. 311.

