1 Introduction

THE TRAVAILS OF PSYCHIATRY

I must be a masochist. Almost a half century ago, I embarked on a study of lunacy reform in Victorian England. I have remained obsessed with madness ever since—as unsavory as many find the subject, and as stigmatized and marginalized as those who suffer from mental disturbances almost universally seem to be. Or perhaps I am simply one of Isaiah Berlin's hedgehogs, fascinated by one big thing.[1] If so, it is a thing that haunts all of our imaginations, one that all our efforts at repression cannot succeed in entirely dismissing from consciousness. Madness reminds us of how tenuous our own hold over reality may prove to be. It challenges our very sense of what it means to be human. Madness continues to tease and bewilder us, to frighten and fascinate, to challenge us to probe its ambiguities and depredations. Reason and unreason coexist uneasily in our everyday lives, their boundaries fraught and contested. And, like every society before it, twenty-first-century America finds its efforts to confront and solve the problems posed by serious forms of mental disturbance largely unavailing and frequently counterproductive.

This volume is a collection of some reflections on various aspects of the psychiatric enterprise that I have written over the past decade or so, many of which I revised extensively as I set about bringing them together for this

publication. The essays reflect a lifetime of thinking and writing about mental illness and about those who have made it their professional business to attempt to understand and perhaps ameliorate the sufferings that flow from disturbances of this sort. It is not a history, I'm afraid, of very much in the way of progress, but nor is it one that revels in that sad situation or claims that no advances have been made over the past two centuries.

Madness remains, in my judgment, an enigma. The etiology of the various disturbances psychiatrists have claimed jurisdiction over remains obscure, and the best the profession has been able to offer are palliative measures. For some patients, those interventions have mitigated suffering, and that is something we should not lose sight of and ought to be grateful for. But for many, the weapons at psychiatry's disposal remain ineffective, and sometimes harmful. At times, exceedingly harmful. So, mine is a critical and skeptical view of the psychiatric enterprise. But it is not one that minimizes or denies the reality of mental disturbance and the immense suffering it often brings in its train—not just for its victims but also for those around them. Serious forms of mental illness remain, as they have always been, the most solitary of afflictions and the most social of maladies.

I have made my career in sociology departments, save for a year spent in Princeton's excellent history department, and in an odd way, that has served me well. Historians tend to be hired to plough down a narrower furrow than I would ever be comfortable with, sticking to a particular period and a particular national historiography. The sociology departments I have been fortunate to work in, however, were willing to tolerate someone who spent a good deal of his time working on the distant past and imposed no limits on my scholarship—the University of Pennsylvania, to be sure, because its senior faculty paid little mind to the junior faculty so long as they carried the teaching load; and the University of California at San Diego because its founding figures deliberately distanced themselves from the disciplinary mainstream, and during my time on the faculty, the department has continued to take seriously the idea that sociology can be a historical and comparative discipline.

My first book, as it happens, dealt with the pressing contemporary issue of deinstitutionalization.[2] Its genesis was my experience during my first time on the job market, seeking to persuade North American sociologists that they should hire someone with a bizarre interest in social reform in

Victorian England. I did so in a handful of departments by persuading them that I had something original to say about the origins of the total institutions Goffman had written about just a few years before[3] and by drawing attention to the medicalization of madness that had taken place in the nineteenth century.

Wherever I spoke, however, in those peculiar hiring rituals scholars undergo where they present a canned version of their research, my audience wanted to know what I thought about contemporary developments, and more specifically the abandonment of the asylum. It seemed an odd development to one aware of how much capital, physical and intellectual, Western societies had invested in the institutional solution to mental illness. But it also seemed well worth investigating and trying to understand. So I gave it a shot.

"Community care" was the slogan of the moment, and the consensus appeared to be that abandoning the asylum was a grand reform that would usher the mad back into our welcoming midst, or so the ideologues of the movement would have it. The drugs made it all possible, so the psychiatrists assured us, on the basis of no more than temporal coincidence and their own overweening confidence in chemical cures. It was in part the product of the critical "anti-psychiatry" of people like Goffman and Szasz, claimed their followers. My book rejected or was sharply critical of all these claims, pointing to the limits of antipsychotics and to their many adverse effects, the nonexistence of community care, and the hostility and neglect that were the fate of discharged patients. It argued that deinstitutionalization was driven in great measure by fiscal concerns, and in the United States by the ability to transfer costs between levels of government. And it suggested that the rhetoric of reform masked what was an emerging policy of malign neglect. I think those criticisms have held up rather well, though some of my attempts to link all this to the then-fashionable arguments about the fiscal crisis of the state now strike me as jejune.

Dividing most of my time between two cities in California, I am reminded daily of the consequences of deinstitutionalization as I walk their streets. Visits to New York or London demonstrate that the challenge of the sidewalk psychotic is not uniquely a problem of La-La Land. Though not solely the product of our abandonment of the mentally ill to

their fate, the homelessness crisis is most assuredly exacerbated by that decision, made by our political masters. And it is only one dimension of a problem that extends, of course, to the reinstitutionalization of those who would once have been confined in asylums in our massively overcrowded prisons and jails—the very policy asylums were supposed to supplant.

It didn't take much to justify that line of research to my sociological colleagues, which was fortunate for me in my untenured state, but I swiftly returned to my doctoral researches on lunacy reform and spent much of the next two decades on nineteenth-century matters (though I worked on American as well as European themes).[4] Unlike many who claim to produce historical sociology, I do not shy away from the archives—indeed, I love playing historical detective and am continually seduced by the pleasures of encountering the raw materials that any historical analysis and narrative worth its salt must depend on.

Tenure gave me the freedom to follow my intellectual interests wherever I chose to take them, and I have subsequently ranged across an ever-wider historical canvass. I extended my researches on the emergence of psychiatry as a profession.[5] I worked on the mad trade in eighteenth-century England and on the complex relations between doctors, patients, and families in eighteenth-century London.[6] In the mid-1980s, I was one of the first scholars to engage with the history of psychiatric therapeutics,[7] and that led in turn to a detailed examination of experimentation on vulnerable mental patients in twentieth-century America.[8] Then Oxford University Press invited me to write a book on the protean disorder of hysteria, forcing me to pay attention to the *longue durée*.[9]

On finishing this project on the history of hysteria, I decided that before I declined into my dotage I might indulge in a larger fit of scholarly chutzpah. So, I wrote a book I had long fantasized about producing: an extended examination of madness in civilization that started by ranging from ancient Greece and Palestine to China and the Islamic world before focusing on the history of madness in the West from what we used to call the Dark Ages to what purports to be the enlightened present. What is more, I sought to attack this subject as broadly as possible, moving beyond the relations of madness and medicine and madness and confinement to examine insanity's place in religion and in popular and high culture: in music, in the plastic arts, in literature, on the stage, and even in movies.[10]

Over the course of my career, American psychiatry has undergone a transformation as dramatic and fundamental as can readily be imagined. When I began to explore its past, psychiatry, at least in its American guise, was dominated by psychoanalysis. The Freudian movement had first risen to prominence during World War II with the treatment of "war neurosis." Through the 1960s, its hold over the profession and the public imagination steadily grew. With scarcely an exception, the departments of psychiatry at the major medical schools were headed by psychoanalysts or psychoanalytic fellow travelers. The "refrigerator mother" was blamed for the seeming epidemic of schizophrenia. Although Freud himself had questioned the relevance of psychoanalysis in the treatment of psychosis, his more optimistic American epigones were undeterred. Those who reluctantly began to use the first generation of antipsychotic drugs saw them merely as useful therapeutic adjuncts to calm down florid symptomatology so that the "real" work of psychotherapy could proceed. Hollywood dramatized the miracles of the talk cure in movies like *Suddenly, Last Summer* (1959) and *I Never Promised You a Rose Garden* (1977). Anxious American parents turned to Dr. Benjamin Spock for enlightenment and were rewarded with a bowdlerized version of Freud's theory of child development. Bestseller lists saw the appearance of potboilers such as Robert Lindner's *The Fifty-Minute Hour* (1955), titillating the masses with tales of the secrets of the couch. Psychoanalysis ruled the roost.

And then it didn't. More swiftly and silently than the Cheshire cat, psychoanalytic hegemony vanished, leaving behind not a smile but a fractious group of Freudians and neo-Freudians who squabbled among themselves. Professors of literature and anthropology tried feverishly to fend off the notion that Freud had turned into an intellectual corpse, but cruel realities suggested otherwise. Psychoanalysts were rapidly defenestrated, lost their hold over academic departments of psychiatry, and were replaced by laboratory-based neuroscientists and psychopharmacologists. Psychoanalytic institutes found themselves bereft of recruits and forced to abandon their policy of admitting only the medically qualified. The very term "neurosis" was expunged from the official nomenclature of mental disorder, along with the hypothetical Freudian etiologies for various mental disorders. The "surface" manifestations of mental diseases that psychoanalysts had long dismissed as merely symptoms of underlying psychodynamic

disorders of the personality became instead scientific markers, the very elements that defined different forms of mental disorder. And the control of such symptoms, preferably by chemical means, became the new Holy Grail of the profession. For a historian of psychiatry, living through such revolutionary times has been remarkable indeed.

This rapidly shifting landscape was the context within which my own scholarship has been conducted, and a number of the essays in the third and fourth parts of this book reflect my efforts to grapple with and come to terms with these emergent realities. But our contemporary travails form part of a much larger history that also deserves our attention, and it is those earlier aspects of our encounter with madness on which the first chapters in this book are focused. As a now infamous social theorist once remarked, "The tradition of all dead generations weighs like a nightmare on the brains of the living."[11] We may be experiencing our own nightmares to add to the ones our cultural inheritance brings in its train. But interpreting the dreams of earlier generations may help us to cope with and comprehend a bit better the novel ones we have since conjured up. Or so the historian must hope.

Much of my work on the history of psychiatry has appeared in book form, including the various studies I have mentioned here. But I have also written many essays, which have appeared in a wide range of journals and periodicals. Academically speaking, these span a great number of disciplines, from law to literature, and from a variety of subfields in history (social history, cultural history, and medical history) to general medical and psychiatric and neurological journals. I have also been invited on a number of occasions to review the contributions of other scholars working on psychiatry (which increasingly extends to the territory of the neurosciences), and to do so for a broad audience of general readers.

The chapters that follow constitute my attempt to grapple with the psychiatric enterprise from a variety of perspectives, and in the remainder of this introduction, I suggest that this kaleidoscopic line of attack can provide a valuable portrait of the complexities and contradictions that mark the Western encounter with madness. That portrait is, of course, refracted through a single sensibility, and I hope this gives some semblance of unity to what is otherwise a deliberately fragmentary approach to the protean history of madness.

I have chosen to divide this book into four separate sections that largely follow chronological lines. However, this has proved possible only to a degree, for some of the issues I have sought to address refuse to confine themselves neatly to a single historical epoch, demanding instead a less chronologically constrained approach. Still, the basic principle applies and informs my organization of the chapters that follow.

Part 1 thus deals from a variety of perspectives with the rise of the asylum era, which was essentially a nineteenth-century phenomenon. Those who have grown up in the past four decades can have little notion of the immense sway the idea of confining the mentally ill once enjoyed. In this opening section, I look at where this idea came from and discuss how we are to understand the near-universal embrace of a segregative response to madness in the Western world two centuries ago. It was on these nineteenth-century museums of madness (and their immediate antecedents) that social historians of psychiatry first concentrated their attention when they sought to provide a more critical and nuanced history of psychiatry than superannuated psychiatrists had previously offered in their own reconstructions of their past.

The mentally ill were not always willingly shut up, in the many senses of that term. Protests about their confinement, accusations that alienists (and family members) had corrupt motives for confining them and that asylums were a form of imprisonment or even a kind of living death—all these objections emerged very quickly once madhouses appeared on the scene. The culture of complaint (which allows us a glimpse of mental illness from the perspective of some of those defined and confined as such) is virtually coextensive with the asylum era. It thus forms a vital part of any sustained attempt to come to terms with the meaning and impact of the Victorian asylum. Likewise, as the utopian expectations that accompanied the discovery of the asylum foundered on the recalcitrant realities of unreason, so too some sufferers looked beyond the newly consolidating psychiatric profession for solutions to the problems posed by mental troubles.

Part 2 looks in turn at how this nineteenth-century legacy played out in the first half of the twentieth century. Freud and psychoanalysis provided a challenge to the understandings and practices of institutional psychiatry and helped to broaden the territory within which the profession of psychiatry began to move. Despite Freud's disdain (to put it mildly) for the

United States, his ideas would later enjoy greater resonance there than anywhere else besides Buenos Aires. But that popularity has now waned, save in some humanities departments in academia. For more than a quarter of a century, these lingering traces of psychoanalysis have provoked wrath among a group of critics, who have launched a war on Freud's ideas and reputation. Paradoxically, I suggest, the very vehemence of Freud's detractors has had the perverse effect of keeping his ideas alive. And perhaps that is not entirely a bad thing.

If psychoanalysis formed the basis for one type of extra-institutional psychiatry, university-based psychiatry was another development that altered the professional landscape. How did an academic psychiatry emerge, and how, more broadly, were careers built and mental illness understood and approached once this extra-institutional psychiatry emerged on the scene? What was it like for a woman to try to build a career in what had hitherto been an all-male profession? And as there began to be some experimentation with forms of noninstitutional practice and psychologically based theories and interventions, what became of therapies within the walls of the asylum? These are issues I examine in part 2.

Part 3 provides a systematic examination of the second half of the twentieth century and the impact of World War II and its aftermath on the fate of psychiatry, most especially in the United States. This was the era that saw a variety of attempts by scholars to place contemporary developments in a larger and longer historical context, and so in this section of the book I tend to range more frequently beyond the temporal boundaries of the postwar era. But I also seek to highlight the growing complexity of the psychiatric landscape and to flag what I take to be some major transformations that mark the period between the outbreak of total war and the end of the twentieth century.

In the last quarter of that century, as we will see, mainstream psychiatry embraced a turn back to biology, and much of academic psychiatry embarked on a romance with neuroscience as a unique source of insight into madness. For many, the very idea of *mental* illnesses came to seem like a category mistake. Schizophrenia, bipolar disorder, and a host of other forms of mental disturbance were surely brain diseases. Their visible manifestations in cognitive, behavioral, and emotional disturbances were epiphenomena, and the real essence of mental illness was to be explained

by biology. Psychiatrists, therefore, believed the mentally ill were to be treated with an array of treatments aimed at the body, principally those delivered by the modern pharmaceutical industry. The profession was convinced that the way forward lay in innovations and discoveries made in the laboratory, not those vouchsafed on the couch.

Part 4 contains a series of my essays that confront and critique these developments, and it concludes with my assessment of where psychiatry stands at the end of the second decade of the new millennium. Our ancestors wrestled in various ways with the suffering and turmoil that mental illness brings in its wake. Where has our embrace of contemporary psychiatry as the solution to these troubles left us?

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The title of my most recent book, *Madness in Civilization,* deliberately evoked the English title of perhaps the most famous (or in some quarters infamous) book on the history of psychiatry to appear since 1960. That was no accident. Michel Foucault's work on madness was one of the first serious works on the subject that I encountered in the late 1960s, originally in the abbreviated English translation that appeared under the title *Madness and Civilization* and then in the much longer French original. It was not, I think, at least in Anglophone countries, a famous book when I first read it—as a shoddily produced little paperback on cheap paper published by Mentor Books—but within a decade, the cult of Foucault was in full swing, and his influence across a huge range of scholarly disciplines was undeniable. It is fair to say that Foucault's book helped to persuade me (as it did others) that here was a subject worthy of serious historical attention. However, my reading of the French original had already caused me to be very skeptical of the evidentiary foundation of many of Foucault's claims, and as my own researches in the field proceeded, those doubts only grew. Chapter 2 of this book reflects on Foucault's magnum opus.

From the outset, I welcomed the provocation *Madness and Civilization* provided, and I shared (and still share) some of Foucault's skepticism about the vision of psychiatry as an unambiguously liberating enterprise. But I share only *some* of his stance. Foucault was fundamentally a foe of the Enlightenment and its values. I am fundamentally one of its disciples

and defenders. As I have already indicated, I have written extensively about the complexities of psychiatry's past and the uncertainties of its present. If not quite an emperor with no clothes, it is certainly one in a state of advanced *déshabillé*. There is much in its past and present deserving of critical attention. But that is very different from dismissing the whole enterprise *tout court*. Likewise, Foucault seems to me to ignore or misrepresent the disruptions and the suffering madness brings in its train, and more seriously still, to misconstrue many of the complexities that mark the tortured relationship between madness and civilization.

Some may object to that last criticism (or indeed all of the criticisms I have advanced of Foucault's work in this field) because he did not set out to write a history of madness and civilization. Foucault's own encapsulation of what he was about is *Folie et deraison: Histoire de la folie à l'âge classique* (Madness and unreason: The history of madness in the age of reason). That his work was presented to English-speaking audiences as *Madness and Civilization* was not Foucault's idea or even that of his original translator, Richard Howard. Rather, it was a brilliant marketing concept dreamed up by someone at his English-language publisher in charge of publicizing the book. As a marketing ploy, it was an extraordinary success. And as long as Anglophone readers had access only to a highly abridged version of Foucault's text, the grounding of the grand generalizations that marked the book had to be taken on trust.

Eventually, though, and despite copyright disputes that seemed to drag on endlessly, a complete English translation of the original did finally appear. Some greeted it with hosannas: a masterpiece had finally been revealed in its full glory to a linguistically handicapped Anglo-American audience. As chapter 2 of this book will quickly reveal to the reader, I had a decidedly less sanguine reaction.

Psychiatry was born of the asylum, of the decision, embraced across Western Europe and North America in the first half of the nineteenth century, to lock up the seriously mad in what purported to be a therapeutic isolation. Utopian expectations (which, like all Utopian ideologies, were doomed to end in disappointment), accompanied the mass confinement of the insane, and it was within this vast network of reformed madhouses that a collective consciousness formed among those charged with administering them—a collective consciousness that pronounced madness a

uniquely medical problem and rapidly created professional organizations, journals, and monographs that gave seeming substance to alienists' self-proclaimed expertise in its identification, management, and cure. These nineteenth-century museums of madness were built on earlier foundations, though these antecedents were small and scattered madhouses, scarcely the Great Confinement conjured up by Michel Foucault.

Within less than a century, some alienists and medical psychologists (or, as they increasingly called themselves, psychiatrists) were seeking to escape the confines of asylum life and to embrace new sites within which to practice their art. Relabeling asylums "mental hospitals" fooled no one, least of all psychiatrists, and though the bulk of the profession remained trapped inside the walls of these places as surely as their patients, the more ambitious and entrepreneurial had already begun to embrace the alternatives of the clinic and the consulting room. Yet it was only after World War II that the profession's center of gravity shifted decisively away from the asylum (a phenomenon I examine in more depth in chapters 10, 11, and 12), and only from the 1960s onward that the Victorian bins began to vanish from the scene (something I analyze further in chapter 3).

The legitimacy of the psychiatric enterprise has been almost perpetually under siege, as Charles Rosenberg once sagely remarked.[12] Mainstream medicine may have its critics, and even in the twenty-first century, some stubborn souls still resist its blandishments, sometimes opting for the snake oil salesmen who peddle alternative medicines. But the troubles of physicians on this front, justified as some of them may be, are as nothing when set alongside those of their psychiatric brethren, if brethren they be. The fierce criticisms of psychiatry sometimes (and perhaps most painfully) emerge from within its own ranks, but more often from some of those whose welfare it claims to be advancing. Psychiatry's claims to expertise and its protestations that its interventions are benevolent and beneficent are mocked and excoriated by the very people it proclaims itself in business to help. The profession exists, and has almost continually existed, as chapter 4 makes plain, within a culture of complaint.

At times, dissatisfaction with the medical remedies on offer has prompted some to seek alternative pathways to resolve their mental troubles. In the United States, where religiosity, if not religion, has retained a hold over the popular mind that is unparalleled elsewhere in an increasingly secularized

West, these alternatives have sometimes involved an embrace of religiously based accounts of the origins of mental turmoil and even theologically based attempts at therapy. Given Americans' willingness to accept variants of the forms of Christian belief that originated in the Old World, some of these alternative therapies have tied themselves closely to novel kinds of Christianity, like Seventh Day Adventism and Christian Science. More recently, those have been joined by what I regard as an even more bizarre cult, Scientology, which has made psychiatry its sworn enemy, set up a museum in Tinseltown devoted to exposing the field's horrors and depredations, and denounced the whole psychiatric enterprise as an "Industry of Death." With its vast financial resources and ruthlessness, and its Hollywood connections, Scientology's critique of psychiatry has drawn as much attention and publicity as the teachings of Mary Baker Eddy, the founder of Christian Science, once did. Chapter 5 examines this uniquely American phenomenon.

Part 2 brings together four essays that bear on the question of where a psychiatry hitherto largely confined to institutional settings and isolated from the rest of medicine might move its base of operations (and in the process create a new geography of madness). The flirtation many Americans engaged in with a religiously based psychotherapy, whether embodied in the doctrines of Christian Science or in the more "respectable," upmarket guise of the Emmanuel Movement, led by the Reverend Elwood Worcester in Boston, prompted some disenchanted psychiatrists and neurologists to claim psychotherapy for medicine. There were indigenous moves along these lines, as Eric Caplan has documented.[13] But, beginning in the early twentieth century, there were also flirtations with various forms of psychotherapy being developed in Europe.

The French psychologist Pierre Janet, who had trained under Jean-Martin Charcot in Paris, visited the United States in 1904 and in 1906, and on the latter occasion he delivered a course of lectures on dissociation, fixed ideas, and the subconscious at Harvard. Janet had attracted the New England neurologist Morton Prince, among others, to his theories. Paul Dubois, the Swiss psychologist, had his book *The Psychic Treatment of Nervous Disorder* translated by William Alanson White and Smith Ely Jelliffe in 1904,[14] and his "persuasive therapy" enjoyed a brief vogue in some circles. But in the long run, it was another European physician, who

visited the United States only once, in 1909, who had the greatest impact on American psychiatry. Indeed, for a quarter-century after World War II, his doctrines dominated the commanding heights, such as they were, of American psychiatry and had an enormous impact on American culture, both popular and highbrow. That man, of course, was Freud, and the spread and influence of psychoanalysis is something I will have occasion to recur to several times in the chapters that follow. The irony that psychoanalysis enjoyed its greatest influence in the New World, not the Old, is magnified by Freud's visceral hatred of America and Americans.

Freud has been a long time a-dying. *Time* magazine may have announced his demise in 1993, but like a figure from the world of the undead, he displays an uncanny ability to resurrect himself. Or rather, neither his lingering band of disciples nor his severest critics have been able to leave him alone, instead repeatedly disinterring his life and his work and parsing every exquisite detail. The Freud Wars, as they have come to be called, have now lasted as long as the Thirty Years' War, which devastated seventeenth-century Europe, and alas no resolution is in sight. One of the doughtiest warriors on the death-to-Freud side is the former Freudian Frederick Crews, and his latest salvo prompted me to write my own assessment of the state of hostilities and of whether anything Freudian survives or deserves to do so. It is the first essay in part 2.

Phyllis Greenacre, one of the three central figures in chapter 7, became arguably the most prominent American-born psychoanalyst in the 1940s and 1950s. She was a powerful figure at the New York Psychoanalytic Institute, who, as the psychoanalyst's analyst, knew more than most about the profession's dirty laundry but was a model of discretion. Before her move from Baltimore to New York, however, Greenacre had served as Adolf Meyer's assistant at Johns Hopkins University in its newly established department of psychiatry.

It was Meyer and Meyerian psychiatry, not Freud and psychoanalysis, that dominated American psychiatry in the first four decades of the twentieth century, in substantial measure because, as the first professor of psychiatry at Johns Hopkins, then America's preeminent medical school, he occupied the most powerful institutional position in the country and trained many of those who moved into academic chairs once other medical schools began to find room for the subspecialty that they had hitherto

scorned. Meyer was an eclectic who hid the barrenness of his doctrines behind a fog of verbal obscurantism that he summed up as "psychobiology." The man who became Greenacre's husband, Curt Richter, was, it could be argued, the person who gave the most seeming substance to this nebulous concept, not least by discovering the circadian rhythm, something that quite possibly should have won him a Nobel Prize.[15]

The intersecting and overlapping careers of Greenacre, Meyer, and Richter allow us to witness the appeal and the limits of Meyer's approach to the management of mental illness and the interplay between biological, social, and psychological approaches to mental illness. Simultaneously, the involvement of Meyer and Greenacre in one of the earliest examples of the radical experimentation that was visited on the bodies of mental patients in the first half of the twentieth century helps us to grasp the extraordinary vulnerability of the institutionalized insane. In the face of unambiguous evidence that focal sepsis and "surgical bacteriology"—the removal of teeth, tonsils, spleens, stomachs, uteruses, and colons—were not only therapeutically useless but also killing and maiming patients, Meyer's actions and inaction provide a vivid example and reminder of the recurrent failures of professions to police themselves. Simultaneously, the episode throws into stark relief the choices that confront a potential whistle-blower and how these were exacerbated in this case by Greenacre's gendered vulnerability. Meyer's suppression of her work foreshadowed the failures of the profession to rein in the extraordinary wave of damaging somatic treatments that characterized the 1930s and 1940s.

The most reviled of these in the contemporary world is the lobotomy, which is now almost universally excoriated and viewed as the most signal example of psychiatry run amok. Yet Egas Moniz's decision to excise portions of the frontal lobes of a handful of Portuguese mental patients and the subsequent "refinement" and popularization of psychosurgery by the Washington, DC, neurologist Walter Freeman and his neurosurgical partner James Watts, was hailed in many quarters as an extraordinary breakthrough—"surgery for sick souls," as the *New York Times* science reporter William Laurence informed his readers.[16] Nearly a decade and a half after the first operation, the innovation won Moniz the 1949 Nobel Prize in Medicine.

In 1946, at the height of the procedure's popularity, a version of it was performed on a once-anonymous patient who we now know was an unfortunate man named Henry Molaison. H.M., as he was referred to in the scientific literature for decades, was the pet subject of a whole host of psychologists. The operation destroyed his ability to remember, and he became a prize specimen for those who would build a science of memory. Chapter 8 explores this remarkable story and again raises disturbing questions about professional ethics.

Psychiatry had long occupied the status of the stepchild of medicine. Even as the fortunes of general medicine soared with the advent of the bacteriological revolution and the reforms of medical education that constrained the oversupply of doctors that had characterized the nineteenth century, psychiatry's marginalization seemed to worsen. Adolf Meyer's appointment to a chair at Johns Hopkins gave some small semblance of academic respectability to an isolated, ill-paid, and despised group that seemed increasingly distant from the rest of the medical profession. But so long as most psychiatrists were recruited to the profession by apprenticing in one of the vast bins, where hopelessness and routine were the order of the day, their physical and intellectual isolation was self-perpetuating, and the profession's prospects correspondingly dim.

The Rockefeller Foundation had played a major role in the transformation of American medical schools and medical education during the first three decades of the twentieth century. Its influence was felt everywhere. Its largesse and its prompting underwrote the growing links between the basic sciences and clinical medicine, and between the laboratory and the bedside. It also helped to eliminate the proprietary and second-tier medical schools and thus, intentionally or not, diminished the problem of the oversupply of MDs.

The foundation's decision, at the very outset of the Great Depression, to switch its focus elsewhere and to place the primary emphasis of its medical division on the support and development of psychiatry was thus a momentous one. Chapter 9 explores the factors that led to this paradoxical decision and the way its foundation officers then proceeded. Whole academic departments were created ex nihilo, and the token psychiatric course or two on other faculties were reworked to create some semblance

of a place for psychiatry in the university. And alongside this institution building came some eclectic investments in psychiatric research. One consequence of all this money and activity was the creation of a new psychiatry, one that was for the first time distant from the asylum and even, for the most part, from routine clinical encounters with patients, save as research subjects. Although the postwar period saw the foundation souring on the initiative and beginning to doubt its payoffs, the academic psychiatry it had brought into being now had a new and even more powerful paymaster, the federal government in Washington. Divided between the Old Guard, who ministered to the more than half million inmates in traditional asylums; the academic psychiatrists, who were trying to cement their place in the emerging knowledge factories that universities were fast becoming; and a growing cadre of psychiatrists who had found a way to make a living from office-based practices, American psychiatry was in the process of becoming a very different sort of animal.

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Part 3 of this book consists of a series of interrogations of the transformations that overtook the profession of psychiatry in the second half of the twentieth century. The essays attempt to assess what prompted these changes and what they tell us about the current state of the profession. Psychiatrists have their own versions of these developments, and I begin by critiquing two recent examples of the genre.

Over the years, psychiatrists seem to have been more disposed than most of their fellow medics to dabble in history. Often, but not always, they emulate politicians who try to use their memoirs to establish their favorite version of events before historians cast a critical eye over the scene. That is far from universally the case, and indeed one of the more welcome developments in the history of psychiatry over the past quarter-century or so has been the emergence of clinician-historians who take the history side of the equation seriously and who bring a uniquely valuable perspective to the topics they choose to address. Regrettably, the synoptic in-house versions of portions of the history of psychiatry that I examine in chapters 10 and 11 are not written by authors who belong in their company.

The most wide-ranging of the two accounts I look at in those two chapters was a book written by the chair of the Columbia University Department of Psychiatry, Jeffrey Lieberman, shortly after he stepped down as president of the American Psychiatric Association. Lieberman claims that the history of his specialty has hitherto been ignored, and he announces that his goal is to set the record straight. It is an entirely false claim, matched only by the falsity of the history of heroes and villains he then proceeds to invent for his readers. For him, history is a morality tale, a movement from darkness to enlightenment: a history whose most distinguishing features are how lately psychiatry was riddled with superstition and error and how fortunate mental patients are to now live in a world where we finally understand mental illness is brain disease and minister to it with a range of extraordinarily effective therapies. The only thing standing in the way of psychiatric nirvana, it would appear, is the public's ignorance of just how much progress has been made—and hence its reluctance to volunteer for treatment.

Lieberman peddles one sort of fairy tale. His British colleague Michael Trimble offers another. During the last third of the nineteenth century, a new medical specialty appeared and laid claim to jurisdiction over nervous and mental disorders. Neurology (which in the American case was born out of the slaughter and carnage of the Civil War) defined itself as the curator of diseases of the brain and the nervous system. Its primary initial targets were those with organic lesions of the brain, the spinal cord, and the peripheral nervous system, and the American branch initially treated those with traumatic war-related injuries. But neurologists everywhere soon found their waiting rooms flooded with another kind of patient, those with "functional" nervous illness—disorders whose etiological roots were mysterious and obscure.

Some of these "nervous" patients were suffering from a controversial condition with an ancient pedigree that some were disposed to dismiss as a form of malingering: hysteria. Others, the neurologists decided, were victims of an alternative pathology they dubbed "neurasthenia," or weakness of the nerves. Either way, neurologists found themselves ministering to cases of mental disease. In their eyes, this was not inappropriate, since their shared assumption was that insanity was a brain disease, and who better to treat and understand these patients than the people who made the scientific study of the brain their calling?

The stage was set for a savage jurisdictional fight with the alienists, who ran the asylums and had long claimed mental illness as their exclusive fiefdom. For a quarter-century, the argument raged, until a truce was called. Each specialty retreated to its own heartland, but there were always a few souls who lingered in the borderlands and a portion of the neurological fraternity who began to entertain the heretical idea that functional mental illnesses might have psychological roots. Freud, who had trained as a conventional neurologist first in Vienna and then in Paris under Jean-Martin Charcot, was one of their number, though many associate him only with the talking cure.

Mainstream neurologists have fared only a little better than their psychiatric counterparts when it comes to curing the awful maladies with which they are often confronted. Where they have become more accomplished is in tracing the pathological roots of many of the disorders they have identified, separating them into different syndromes, and providing a prognosis for those unfortunate enough to be stricken with them. If psychiatry was seen for much of history as suffering from a deadly mixture of etiological ignorance and therapeutic impotence, the perception of neurology was that it was only afflicted with the latter. The ability to reliably name and predict the course of its disorders, offer some form of palliative care in certain cases, and demonstrate postmortem findings to support its diagnoses somehow made neurology a high-status specialty and not the medical pariah psychiatry has often seemed to be.

As I will discuss in subsequent chapters, one of the more notable features of the dominant strand of psychiatry in the last quarter-century and more has been its determined embrace of what one leading psychiatrist, Steven Sharfstein, has called a bio-bio-bio model of mental illness. The (re)embrace of the brain (and in some quarters, the genome) has prompted an alliance, in academic psychiatry at least, with neuroscience and to some degree with neurology. Hence the attraction in some circles of relabeling the psychiatric enterprise "neuropsychiatry." And hence the temptation to construct a historical genealogy for a subspecialty with that name, however artificial and unconvincing the result.

Professions traffic in ideas as well as in attempting to connect those ideas to the realm of practice. Abstraction, as the Chicago sociologist Andrew Abbott has argued, plays a vital role in the life of a profession and

its ability to sustain its social legitimacy.[17] Chapter 12 examines the sets of ideas that have prevailed in psychiatry (and to a lesser extent psychology) since the birth of the profession in the mid-nineteenth century. While no ideology is ever completely dominant, I suggest that it makes sense to regard the ruling ideas in the psy-complex (as some have called it) as marked by three major periods and patterns: the dominance of ideas rooted in and justifying asylumdom, the institutional complex that gave birth to the profession; the partial eclipse of that institutionally based ideology by psychoanalysis in the quarter-century following World War II, a period that also saw the rise of a different set of ideas and practices linked to the laboratory and to the rival academic discipline of psychology; and the marginalization of psychoanalytic perspectives that has taken place since 1980 and the concomitant triumph of the notion that mental illnesses are nothing more and nothing less than diseases of the brain.

Ideas do not develop and perpetuate themselves in a vacuum. World War II, the Cold War, and the associated growth of the federal government brought about striking changes in American society. Science and medicine were transformed by massive infusions of federal funding, and the American system of higher education saw an extraordinary expansion. The changes wrought by the Rockefeller Foundation's two decades of support for academic psychiatry were soon eclipsed by the impact of Washington. The prohibition against the involvement of the federal government in the direct provision of psychiatric services that had existed since President Franklin Pierce vetoed legislation to provide such support in 1854 remained firmly in place, but the influx of ever-larger sums of money to underwrite new programs of research and training, and the growing affluence of the postwar era, expanded the number of psychiatrists to an unprecedented extent.

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Part 4 looks at a world where mainstream psychiatry has eviscerated madness of meaning. Murdered memories, according to Freud, refuse to remain buried, and the troubles they foment in the unconscious create all manner of mischief. The traumas of war—specifically the shell shock of the Great War and the combat neurosis that afflicted the greatest

generation—did not conform precisely to the sexual etiology Freud had constructed to explain neurosis, but these epidemics of mental breakdown struck many as rooted in another kind of trauma and were considered to be prima facie evidence of the psychogenesis of at least some forms of mental disorder. Mental illness, on this account, was deeply connected to questions of meaning and repression.

That industrialized warfare and the maintenance of sanity are often at odds with one another is a painful lesson that apparently needs to be relearned periodically. The Vietnam War—when the military forces of the most powerful nation on the planet were defeated by Third World peasants, and when the lies and obfuscations of American politicians exacerbated the fallout from drafting young men to fight a deeply unpopular war—was no exception to the rule. Though initially denied by the military brass, the incidence of long-term psychiatric casualties eventually became a major issue. Angry veterans allied themselves with sympathetic psychiatrists, and the upshot, after much political maneuvering, was the creation of a new diagnostic category that was entered into the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*): post-traumatic stress disorder, or PTSD. But when Robert Spitzer, the editor of the *DSM,* was persuaded to include this stress-related disorder, he did so by widening the diagnosis to include other forms of traumatic breakdown, not just those incurred in the course of military hostilities. The seemingly endless series of wars the United States has waged has nonetheless ensured an ongoing parade of psychiatric casualties among the troops, a phenomenon I consider in chapter 13.

Psychiatry's embrace of neuroscience and the associated claim that mental illness could be reduced to disorders of the brain has had major consequences both within and outside the profession. Internally, it has decisively changed the focus of much psychiatric research. But in bowdlerized form, it has also had a profound impact on many people's view of mental disorders. Helped along by marketing copy produced by Big Pharma to increase the sales of its magic potions, the public has been encouraged to view depression, bipolar disorder, and schizophrenia as problems of biochemical imbalances and malfunctioning brains. Perhaps the Holy Grail of uniting diagnosis and underlying pathology can finally be realized with the help of another remarkable tool of modern medicine,

developed during the same decades? Can modern imaging technology, with its CAT and PET scans and MRIs, at last give us the means to view the inner workings of the brain and allow us to visualize the physical pathologies psychiatrists assure us lie behind the social and psychological manifestations of mental illness?

The Cambridge University professor of developmental psychopathology Simon Baron-Cohen heads the school's Autism Research Centre and has been at the forefront of making such claims. His series of books aimed at a general audience has spread these claims widely and attracted a considerable following among politicians and the chattering classes.[18] He has been particularly aggressive in promoting the idea that functional MRIs can provide a reliable window into our consciousness. He claims to be able to use fMRIs to distinguish male from female brains and to identify the physiological differences that explain autism and lack of empathy.[19] Such assertions have prompted lay disciples to write popular science treatises that embrace these ideas and attempt to disseminate them to a still broader audience, pronouncing them to be the latest findings of esoteric brain science. All this is, I suggest, nothing more than pseudoscience, a modern version of phrenology, but the sense that it is rooted in the unquestionable authority of the laboratory, and the seductive qualities of the carefully constructed color images of the brain that are mobilized in its support, have given it an undeserved authority. Chapter 14 gives some of the reasons why we should resist its charms.

Empathy and autism are not the only fronts on which the neuroscientists have been advancing their claims. As early as the nineteenth century, some psychiatrists have demonstrated a fascination with the intersection of crime and mental illness. Symbolically, the question of how to distinguish between madness and badness rapidly acquired enormous significance for the fledging profession as it sought—often unsuccessfully—to be recognized as the arbiter of the dividing line between the two.[20] In the mid-twentieth century, some psychoanalysts sought to erase the distinction entirely, asserting that criminality was simply an expression of underlying mental illness and that it thus required treatment, not punishment.[21] Not many bought these Freudian arguments. Indeed, many dismissed them as a classic instance of psychiatric overreach. But armed with their images of the brain, neuroscientists have now entered the fray. They argue,

like their psychoanalytic predecessors, that their science can supersede the messy "commonsense" on which the legal system rests and finally deliver an unchallengeable basis for distinguishing the sheep from the goats, determining with scientific certainty guilt and innocence, and much else besides. A legal system based on weighing testimony and relying on the intuitions of lay jurors can at last give way to the certainties of the laboratory. Or perhaps not, as chapter 15 argues.

The human brain is a simply remarkable object. That its structure and functioning might have some relevance to our behavior, our social selves, and the ways in which we construct and respond to the cultures that surround us is surely a truism. But to move beyond crude generalizations and recognize when we are being sold a bill of goods under the guise of science are difficult tasks. Humans, like other mammals, possess double brains—brains that are composed of two hemispheres. Many other organs are also duplicated, of course: eyes, lungs, kidneys, testicles, and ovaries immediately come to mind. But the duality of the brain seems a particularly fascinating aspect of our physical nature, and where once it was thought that the two halves of the divided brain were identical and simply replicated each other, we have for a long time known that this is not so. It is not just the obvious fact of contralaterality, made manifest when a left hemispheric stroke paralyzes activity on the right-hand side of the body, and vice versa; there seem to be broad functional differences between the two hemispheres, and the question is what to make of these differences and their implications. Chapter 16 examines the ambitious attempts of one highly unusual psychiatrist and neuroscientist, who began his professional life as an English don at Oxford, to connect the wiring of the two halves of the brain to central characteristics of the historical evolution of Western culture. The ambition is far-reaching, the erudition remarkable, and the conclusions largely speculative—and the claimed alternation in the dominance of one hemisphere or the other in different historical eras is asserted but not explained.

Contemporary psychiatry often seems bent on robbing mental illness of its meanings. If Freud and his followers once sought to explain mental illness on the level of meaning, to probe its roots by searching for hidden meanings, and to substitute consciousness for the tangles that lay hidden in the depths of the unconscious, modern biological psychiatry has no time for such fairy tales. Madness, orthodox psychiatry asserts, has no meaning.

It represents the epiphenomenal manifestations of an underlying, purely physical pathology and is worthy of no more attention than is merited by its status as the trigger that brings mental pathology to our attention.

This crude biological reductionism is a viewpoint that came to dominate American psychiatry in the 1980s, and it persists as the orthodox psychiatric viewpoint to this day. That epistemology, and the practices that flow from it, can be traced quite precisely to the publication of the third edition of the *DSM* in 1980.

It is true that this document was not American psychiatry's last word on the subject. There have been four revisions since, the most recent materializing—after years of delay and controversy—in May 2013. But all of these versions have hewed to the same basic approach to mental illness: establishing a classificatory system that relies on a mechanized method of diagnosis. It is a line of attack that quite deliberately ignores problems of validity (that is, whether the various labels correspond in any defensible way to differences in underlying pathology). As was true of all of medicine in the eighteenth century (but is no longer the case in other medical specialties), psychiatry continues to rely solely on symptoms and behaviors to render its judgments. Supposedly, the conditions it diagnoses will ultimately be grounded in biology, for the assertion that mental illnesses are brain diseases has become dogma. But that remains a speculation largely ungrounded in evidence, save in the cases of organic conditions like Alzheimer's and Huntington's disease.

Any portrait of twenty-first-century American psychiatry must, of necessity, come to grips with the *DSM* phenomenon. My concluding chapter attempts precisely that task and asks what we are to make of a profession whose identity and legitimacy are closely tied to what increasingly is seen, sometimes even at the very highest levels of the profession, as an approach on the brink of collapse.