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Psychiatric Developments (1939-1974)

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Introduction: General and Methodological Issues

A succinct presentation of the development of psychiatry in the last three decades is not an easy task, especially in view of the great deal of progress made in this field since the end of World War II, of the difficulties involved in carrying on meaningful research in this area, and of the lack of adequate historical perspective to evaluate properly the events related to this progress.

The fact remains, however, that in the period under consideration psychiatry has gained acceptance in the overall realm of medicine and, even more, in the American culture by and large. Psychiatry has now reached the point of being able to look comfortably at its present situation and to draw from the past inspiration for the future.

In this country, following Albert Deutsch's *The Mentally III in America* and Gregory Zilboorg's A *History of Medical Psychology*, a number of general histories of psychiatry, biographical studies (mainly the thorough, yet biased,

study on Freud by E. Jones), histories of diseases, of institutional care, and of basic concepts and trends related to psychiatry (such as the important volume on the development of the unconscious by H. Ellenberger) have appeared.

Moreover, the emphasis on newly published primary sources—for example, Freud's correspondence with pupils and admirers—and on the historical dimension of sociological attitudes toward the mentally ill has become significant. Even the American Psychiatric Association, which has taken many initiatives through its Committee on History, recognized the importance of its own development by republishing the presidential addresses of the last quarter-century on the occasion of the 125th anniversary of its foundation in 1969. In the introduction to this publication, as well as elsewhere, I myself have discussed many important points related to the history of psychiatry, to which the interested reader is referred.

The historical dimension, when presented from a broad cultural perspective, can help to predict future developments and to introduce optimism into the study of certain phenomena—such as apparent manifestations of collective psychopathology and widespread use of "drugs of the mind"—that find antecedents in similar episodes in the past.

Because of space limitations only topics relevant to the main areas of

psychiatry have been considered here. Events related to special and collateral fields of psychiatry, included in the first edition of this *Handbook,* have been omitted. Also, in discussing specific points, full source information has not been provided in the text or in the bibliography, as this will be done in the following chapters of this work.

National Recognition of Psychiatry

Shortly after the first edition of this *Handbook* was published in 1959, *Action for Mental Health,* a milestone in American psychiatry, appeared. The main psychiatric events that took place in the 25 years from the end of World War II to then can be seen as progressively leading to the realization of such an important document.

American psychiatry had originated from the British and continental impetus toward moral treatment in the first part of the nineteenth century, followed by the emphasis on institutionalization of a large number of mentally ill in isolated settings in the second part of the century. The emphasis on the organic etiology of mental disorders has been slowly superseded by Meyer's psychobiology, a convergence of the new European psychodynamic theories and the optimistic American view of environmental forces.

In the late thirties early attempts were made to improve the treatment

of hospitalized patients through the development of aftercare programs in the community, better administrative policies in state institutions, and better training of personnel at every level. The introduction of shock therapies around that time helped to focus attention once again on psychotic patients and on organic psychopathology and research in general; in the two previous decades, at the beginning of the child guidance movement, attention had shifted to neurotic and antisocial patients.

The child guidance movement, originating from the desire to prevent juvenile delinquency, had eventually based its platform on a combination of individual psychodynamics and environmental behaviorism. By the third decade of this century research on new ideas—child psychiatry, criminology, alcoholism— advanced and new clinical techniques, such as projective tests, were introduced. Under the influence of the many psychoanalysts who emigrated from Europe to this country as at the beginning of the forties to escape the Nazi persecution of the Jews, new impetus was given to individual psychotherapy in its various modalities and, to a lesser extent, to research in the new areas of psychosomatic medicine and experimental neuroses.

By that time World War II had revealed the magnitude of psychiatric problems: syndromes of acute breakdown in relation to combat, a large number of inductees rejected for psychiatric reasons, and rehabilitation of many veterans suffering from psychiatric disorders. In a short time the

problem of mental illness came to be recognized at a national level. Especially urgent was the need to train a great number of professionals and nonprofessionals, far above the few psychiatrists hitherto trained with the assistance of some private organizations, such as the Rockefeller Foundation and the Commonwealth Fund.

The Vocational Rehabilitation Act (1942), the National Mental Health Act (1946) leading to the creation of the National Institute of Mental Health (1949)—for research, training, and assistance in developing mental health programs—the National Governors' Conference on Mental Health, the establishment of separate departments of mental hygiene on mental health in many states, these and many other developments can be seen as steps along a continuum of increasing national concern about mental illness.

In 1955 the Mental Health Study Act was passed, providing for the creation of the Joint Commission on Mental Illness and Health. This commission, composed of outstanding leaders from many organizations, in five years of intensive work produced the above- mentioned *Action for Mental Health,* essentially geared to shift the emphasis from institutional to community care of the mentally ill. Eventually in 1963 under President Kennedy the Community Mental Health Act was passed, providing for the creation of a network of community mental health centers able to offer a comprehensive program of prevention, treatment, and rehabilitation

throughout the entire nation. Finally in 1965 funds for staffing these centers were allocated through an amendment to the act.

Regardless of the effectiveness of these legislative actions, they point unequivocally to the recognition of the problem of mental illness at a national level and to a concerted effort to deal with it.

Research and Methodology

In this country research was first carried on systematically at the Pathological Institute (now New York Psychiatric Institute) founded in 1896, and at the Henry Phipps Psychiatric Clinic of Johns Hopkins University inaugurated in 1919 by Adolf Meyer. Early research projects tended to focus on histopathology, genetics, endocrinology, and neurophysiology; later on the themes of juvenile delinquency, psychosomatic disorders, and emotional deprivations became prominent.

Research in psychiatry is vitiated by certain methodological drawbacks related to the difficulties in measuring psychological phenomena, in reaching agreement on symptoms and diagnoses, in producing animal experimentation meaningful for human beings, especially by interdisciplinary teams composed of scientists having different ideas and biases. Moreover, most of the research tends to be supported by the federal government, which relies on a relatively small number of experts, who are inclined to favor certain projects and

themes. Efforts by the government to encourage young psychiatrists to carry on research through mental health careers, investigation careers, and career development awards have met with limited success.

In addition, psychiatrists arrive at the end of their training in their thirties, when the process of creativity is already in decline; in the course of their training they do not receive adequate preparation in research methodology. Consequently research designs tend to be carried on by psychologists, more interested in proper methodology than in creativity, and often in themes peripheral to the mainstream of psychiatry. It is a fact that most of the "discoveries" in psychiatry—from psychoanalysis to shock treatment, psychopharmacology, and community innovations—have been made mostly in Europe by individual psychiatrists often working in poorly equipped settings. The typical pattern has been for American research teams to thoroughly investigate and critically assess discoveries achieved somewhere else through a variety of methodology including double-blind designs, use of placebo, selection of cohorts of patients for comparative purposes, follow-up of patients, "research alliance" between researcher and patient, and so forth.

Twenty years ago Lawrence Kubie, an outstanding American psychiatrist, wrote that "research in psychiatry is starving to death." Since then a considerable amount of research has been carried on. Recently,

however, the issue of research has become more complex than ever as the result of the upsurge of community psychiatry, which requires a difficult type of multidisciplinary research, involving clinical, statistical, and sociological dimensions and not immune from ethical and political pressures. The fear of losing the uniqueness of the doctor-patient relationship, so close to the core of psychiatry, has been voiced by some.

Classification: Normality and Mental Disorders, Epidemiology Statistics

Pathology is meaningful only vis-a-vis normality. Yet normality has not been the focus of psychiatric research up until the last decade or so; possibly the new attention on normality is a response to the need of assessing large groups of people in the context of the new community mental health movement. Among the recent pertinent publications mention should be made of *Current Concepts of Positive Mental Health* (edited by M. Jahova), which emphasizes individual self- actualization; *Normality and Pathology in Childhood* (by A. Freud), which is based on the psychoanalytic developmental perspective; and *Normality: Theoretical Concepts of Mental Health* (by D. Offer and M. Sabshin), which is based on the four dimensions of health, utopia, average, and process. In very recent years the pseudoissue of a "supernormality," that is, "expansion of consciousness" achieved with the help of certain drugs, has been brought forward. Although most psychiatrists reject this notion as absurd, it has a relationship with centuries-old

techniques of mastering the body through the mind—from Yoga to Zen—used in the Far Eastern cultures.

Regardless of all this, in psychiatry, like medicine, the urge to classify reflects the fundamental antithesis of looking for what is different while, at the same time, trying to find what is common. Some years ago H. Ellenberger pointed to the biases of psychiatric nosology in terms of the nature and kind of classifications, the concept of nature, the projection of intellectual schemata, and the unconscious position of the researcher. Yet the history of psychiatry coincides with the history of psychiatric classifications. Since the beginning of our century Kraepelin's notion of the rigid pattern of mental diseases has been superseded by Freud's developmental views and, in this country, by A. Meyer's emphasis on mental diseases as "reaction types"—a position that was accepted in the 1952 official classification of the American Psychiatric Association.

Since then many psychiatrists have stressed the increasingly "dull" aspects of psychiatric symptoms, up to the point of simple boredom or "alienation"; others have emphasized the trend from a cross-sectional to a longitudinal dimension and from "outer" behavior to "inner" feeling; the poorly differentiated "borderline syndrome" (thoroughly described by R. Grinker) and "social breakdown syndrome" (E. Gruenberg) have been described; and finally mental illness has been considered as a "myth"

supported by the psychiatric establishment (T. Szasz).

In the light of all this the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II) published by the American Psychiatric Association in 1968 seems a rather conservative document, attempting to fit into the general scheme of the eighth edition of the International Classification of Diseases (ICD-8), published by the World Health Organization in 1966. At this point it is uncertain what future awaits bold new attempts (such as *New Approaches to Personality Classification,* edited by A. Mahrer) to base classification systems on new parameters (for example, having the patient himself participate in his own evaluation).

Rather, in the light of the community mental health movement, the importance of carrying on research on epidemiology has become evident. Following the methodological clarification of the notions of "incidence rate," "prevalence rate," and "system analysis," epidemiological studies have focused on the incidence of mental disorders in a certain area in toto (Hollingshead and Redlich in New Haven, Rennie, Srole, and collaborators in Manhattan, the Leighton's group in Stirling County, Dohrenwend, in the Washington Heights district of New York City), or in regard to hospitalized mental patients (Malz- berg in New York, Dayton in Massachusetts), to particular ethnic groups (Eaton and Weil on the Hutterite), to samples of brain damaged and retarded children (Pasamanick, *et al.,* in Baltimore).

The impetus toward epidemiological research—in this country by E. Gruenberg and others under the sponsorship of the Milbank Foundation—has resulted in the establishment of psychiatric registers (for example, in Rochester, N.Y., by the Tri-County in Raleigh, N.C., and by the National Clearing House of the NIMH in Bethesda, Md.). Computers, first introduced at the Institute of Living in Hartford, Conn., in 1962, have later been used in other places (New York State Department of Mental Hygiene, New York State Psychiatric Institute, Department of Computer Science of the Stanford University Medical Center in Palo Alto, Calif., Missouri Institute of Psychiatry in St. Louis, the Beiss- Davis Child Study Center in Los Angeles, and a few others). The statistical refinement brought about by the use of computers is outweighed in the minds of some by their dehumanizing aspect, which runs counter to the very essencc of psychiatry. As a senior psychiatrist, Carl Binger, has put it, if the computer takes over, the psychiatric role may be "reduced to machine-processed data of being pushed around like pawns on a chessboard of science.

Psychopathology

Biological Research

America's original contribution to psychiatry can be traced back to Cannon's concepts of homeostasis and of the autonomous reactions of the

organism under stress in the midtwenties, influenced by the dynamic theory of personality and by behaviorism. Such a typical expression of American melioristic philosophy of life was challenged by the great depression in the thirties and by the spread of psychoanalytic ideas in the forties.

The biological trend in psychiatry, which had been prominent in the late nineteenth century, gained momentum again at the end of World War II, for example, the founding of the Society of Biological Psychiatry. Among the main research themes were: stress reactions in Air Force servicemen (R. Grinker and J. Spiegel), theory of emotions (J. Papez), visceral brain (P. MacLean), reticular system (G. Moruzzi and H. Magoun), theory of cell assembly (D. Hebb), stimulation of cerebral cortex (W. Penfield), functions of the frontal lobes (J. Fulton), "stress syndrome" and "general adaptation syndrome" (H. Selye), theory of bodily defensive reaction (H. G. Wolff), experimental neuroses (J. Masserman), and psychosomatic conditions (F. Alexander and collaborators at the Chicago Psychoanalytic Institute).

The tendency of psychiatric research in the forties, under the influence of the psychoanalytic movement, to rely more on personal intuition than on scientific methodology, was superseded by the discoveries in psychopharmacology in the fifties, which represented a return to the philosophy of biological psychiatry. Of the many topics mention should be made here at least of: the genetic role of the DNA molecule and the

transmission of coded messages through the RNA; conditioning responses leading to behavior forms of therapy; clinical recognition of positive spike phenomena in EEG and of REM signs in sleep and dreaming; clinical aspects of sensory deprivation of psychominetic agents, of drug tolerance and abuse; functions of lymbic and reticular systems, of the temporal lobe, and of the neurotransmitters in psychiatric syndromes and in relation to chemotherapy; finally inborn errors of metabolism, enzymatic defects, and chromosexual abnormalities (Down's, Turner's, and Klinefelter's syndromes), leading to new investigating techniques (sex chromation determination, amniocentesis, cytogenetic study of criminal individuals) and to concern for family planning based on genetic counseling.

Such research, mainly carried on by teams of experts from the fields of neuroanatomy, neurochemistry, electrophysiology, and heredity, is largely supported by the National Institute of Mental Health, the National Institute of Child and Human Development, and the National Science Foundation. Even if one disregards Freud's prediction that the ultimate cause of mental disorders will be found one day in biological processes, the fact remains that nowadays a comprehensive view of the personality has to take into consideration the importance of biological research. The collaborative volume *Psychiatry as a Behavioral Science* (published under the auspices of the Committee on Science and Public Policy of the National Academy of Science and the Problems and Policy Committee of the Social Science Research Council) represents an

excellent survey of this field.

Anxiety and Related States

Anxiety is intrinsically related to the human condition of longing for eternity but having to accept death: a theme that can be traced from St. Augustine and Pascal to Kierkegaard and the contemporary existentialists.

In psychiatry the role of anxiety became paramount in Freud's various formulations; his final conceptualization of anxiety as a signal of danger from within (1926) led to the notions of defense mechanisms and of ego psychology. In addition to the semantic difficulty of differentiating between the philosophical and the psychopathologieal meaning of the term, anxiety has been seen as both "positive" (that is, facilitating purposeful behavior) and "negative" (that is, interfering with such behavior) from time to time.

In this country from the forties on, many studies have been devoted to "separation anxiety"; Hans Selye has described the above- mentioned "stress syndrome" and "general adaptation syndrome" as a global reaction of the organism resulting from the interplay of two opposite endocrinological constellations; S. Wolf and H. Wolff have differentiated fear from anxiety on the basis of experimental studies on gastric secretion; others (D. Funkenstein) have differentiated unexpressed anger (anger-in) from expressed anger (anger- out) on the basis of the mechanism of action of epinephrine and

norepinephrine; still others have studied anxiety in experimentally induced neuroses.

These studies have been criticized on various grounds, such as the difficulty of translating animal into human behavior. From a more clinical perspective Sandor Rado has attempted to explain the notion of emergency behavior as related to the level of organization of emotional and unemotional thought; and cultural anthropologists, followed by the neo- Freudians, have insisted on the importance of societal factors in the causation of anxiety, which from a defense may turn into a symptom (K. Horney). Finally the advent of psychopharmacology in the mid-fifties has brought the focus back on the symptomatic factors of anxiety regardless of the total personality. No matter what perspective one adheres to, anxiety remains a highly complex subject, as shown in the two monographs recently published by S. Lesse and by W. Fischer.

Unconscious, Dreams, Sexuality

The existence and main characteristics of the unconscious appeared to be established beyond doubt when the first edition of this *Handbook* was published a decade ago. Freud's overwhelming emphasis on the unconscious, based on solid data on hypnosis, dreams, and countertransference, and its acceptance in psychiatric circles signified the final outcome of a long tradition

beginning with the Greeks, running through the Romantics in the early nineteenth century, and leading to study of hypnosis by the French schools in the latter part of that century.

Although from the forties on the importance of the unconscious came to be reduced, with the emphasis on defense mechanisms and ego psychology, 110 one questioned its existence. As a matter of fact, fresh research on dreams, sensory deprivation, and posthypnotic phenomena seemed to add new evidence to the classical notion of the unconscious.

Yet in the last decade or so the advocates of the unconscious have found themselves on the defensive. Supporters of the new "behavior therapy" and of other related approaches question, not the validity of the notion of the unconscious, but its relevanec for psychiatric treatment, which they view as solely based on learning theory and on conditioning. Whether such a threat to the notion of the unconscious represents a temporary fad or will signify a persistent trend remains to be seen.

It is well known that dreams, like the unconscious, have a centuries-old tradition that can be traced back to ancient Middle East cultures, the Greeks, and the Middle Ages. Such a tradition was given scientific form for the first time in Freud's *Interpretation of Dreams* (1899), which, by introducing a new methodology in psychiatry, initiated the "royal road" to psychoanalysis.

For several decades the importance of dreams was not questioned, although different emphases were placed on their interpretation at variance with Freud's insistence on their sexual and aggressive aspccts: compensation for social inferiority feelings (Adler); manifestation of collective unconscious and archetypal images (Jung); expression of ego's thrust for synthesis (Hartman and Kris); attempt to unify past and future in the light of ego identity and of a life plan (Erikson); struggle to achieve personal self-awareness and responsibility (neo-Freudians); finally a mode of personal existence (existentialists).

In recent years a revolutionary event has taken place: a new methodology based on the discovery of regular periods of eye motility during sleep (E. Aserinsky and N. Kleitman) and their relation to EEG patterns and content of dreams (C. Fisher, W. Dement, M. Ullman, F. Snyder, and others). An imposing amount of data has been gathered on the relation between rapid eye movements (REMPs) and nonrapid eye movements (N- REM), instinctual versus teleological role of sleep, clinical importance of "dream deprivation," interplay of neocortex and basal centers, new meaning of enuresis, somnambulism, nightmares, and so forth.

Interestingly enough this experimental research proves the erroneousness of some of Freud's basic tenets (such as dreams as protecting sleep and the connection between dreaming and psychotic states), while at

the same time it points to the important role of interpersonal relationships, cultural aspects, and historically bound factors in the understanding of dreams. As a result, dreams are seen today from the threefold perspective of their neurobiological substratum, of their psychotherapeutic value, and of their relation to the preconscious level of artistic creativity. The recently established Association for the Psychophysiological Study of Sleep (APSS) is especially concerned with the first of these three aspects. Many interesting points are discussed in the literature of the last two decades, such as Fromm's *Forgotten Language,* Boss's *The Analysis of Dreams,* Tauber and Green's *Pre-logical Experience,* Bonime's *The Clinical Use of Dreams*, French and Fromm's *Dream Interpretation,* and Hall and Van de Castle's *The Content Analysis of Dreams.*

Expressions of sexuality easily can be traced back to every culture, from the early times on, in the literary as well as in the figurative fields. This is true even during periods of severe sexual repression, such as in the Middle Ages, when sex aberrations were expressed in the context of the witchcraft mania.

Early in our century Freud and his disciples faced the manyfold psychological aspects of sexuality in a candid way through the use of a new verbal technique. Thus for the first time the centuries-old intuitions concerning the relationship of sexuality to psychopathology were given systematic form in terms of individual development. Freud's rather rigid

model of the progression from the oral to the anal to the genital stage has remained valid to our day, though modified by some: for example, Alexander has attributed the sexual urge of adults to the surplus of energy after growth is completed at adolescence, while the neo-Freudians have stressed the cultural components of the sexual instinct.

Under the influence of the Freudian school the development of sexuality came to be studied directly in children, rather than in retrospect in adults, from the comprehensive perspective of anatomy, heredity, endocrinology, ethology, and sociology, and research was conducted also in non-Western cultures to test the universality of the psychoanalytic postulates. Eventually even the validity of a notion as basic as that of the oedipal complex came to be questioned.

Undoubtedly a more liberal view of sexual expressions has become noticeable concomitantly to the increasing acceptance of psychiatry. Without dealing with the issue of cause-and-effeet relationship between these two phenomena, mention should be made here of: the two Kinsey reports on the sexual behavior of the male (1949) and of the female indicating a wide range of sexual activity in the American culture; the bold methodological approach introduced by R. Masters and V. Johnson in the psychiatric treatment of sexual disorders; the slowly gaining view of considering homosexuality from the psychological rather than from the moral perspective; finally the rapid

reassessment of the role of the female vis-a-vis that of the male in this country as well as in other Western nations.

Formal or Structural Mechanisms, Cognitive Functions, the Intrapsychic Self

The various concepts listed in the heading of this section have come to acquire significance as the result of revisions of traditional Freudian notions and of the new fruitful integration of data acquired from psychoanalysis, developmental psychology, and other fields. It is the special merit of Silvano Arieti to have focused on the neglected area of the cognitive aspects of the personality in a series of publications that span more than two decades. According to Arieti, this new orientation has the following background: the pioneering eighteenth-century writings on prelogical thinking by the Italian philosopher Giambattista Vico; the differentiation between "abstract attitude" and "concrete attitude" in brain-damaged and schizophrenic patients (K. Goldstein); the essence of identity in paleological thinking being based on identical predicates rather than on identical subjects as in mature reasoning (Von Domarus); and finally the various models of the genetic development of the mind presented by H. Werner in *Comparative Psychology of Mental Development* and by J. Piaget in his many monographs.

In the past some attempts had been made to establish a relationship between psychotic symptoms and formal mechanisms of dreams, languages,

and other human expressions (for example, by the Swiss A. Storch). However, traditionally the emphasis has been on the study of the content rather than the form of psychopathology. As Arieti put it: "The study of formal mechanisms reveals *how* we think and feel. The study of dynamics of psychoanalytic mechanisms reveals *what* we think and feel and the motivation of our thinking and feeling. Both the formal and the dynamic approaches are necessary if we want to understand psychological phenomena fully."

In his early writings, mainly in his *Interpretation of Schizophrenia* Arieti has described in detail the mechanisms of dreams, verbal associations, and infantile and paleological thinking. Later on he has tried to overcome the shortcomings of Freud's positivistic model of the mind and the culturalistic model of the neo-Freudians by asserting the role of the intellect: a position that, historically, represents the grafting of contemporary concepts on the Western intellectual tradition. In his *The Intrapsychic Self: Feeling, Cognition and Creativity in Health and Mental Illness,™* he has described the fundamental stages of human development as a succession of the three categories of primary symbolic cognition (phantasmic stage of inner reality followed by the endocept of the preverbal level and the preconceptual level of thinking), secondary conceptual thinking, and tertiary thinking or creativity. Slowly Arieti has arrived at a phenomenological view of the human personality that has considerable relevance for future developments.

Schizophrenia

Schizophrenia has remained to the present the most studied, yet the most baffling, of the various psychiatric syndromes, whether it is considered as a "disease" according to the European tradition (Kraepelin, 1896, Bleuler, 1911) or as a "reaction" according to Adolf Meyer's philosophy; that is, whether the emphasis is put on its difference from neurosis or, conversely, on a continuum of the neurotic process. Some genetic studies, especially those on twins carried on at the New York Psychiatric Institute by F. Kallman and then by J. Rainer, have thrown some light on this issue, at least in terms of a premorbid personality due to genic factors developing into a schizophrenic process under the influence of environmental factors.

In the late thirties the empirical approach of shock therapies was emphasized, followed shortly thereafter by the psychosurgical procedures (in this country especially by W. Freeman and J. Watts). This overshadowed the therapeutic method of "total push," geared at a massive utilization of all the patient's resources in the context of the hospital setting, as well as the biological research carried on in a few places, notably at the Worcester State Hospital by R. Hoskins and associates. Such a trend was resumed in the midfifties, following the introduction of chemotherapy, resulting in a variety of studies and hypotheses (disturbance of the catecholamines, faulty epinephrine metabolism, serotonine blockade, pathological transmethylation,

taraxein or blood protein factor, presence of the plasma protein alpha-2 globulin, finally urinary discharge of dimethoxyphenylethamine [DMPEA]).

On the psychological side the American contribution has focused on the notions of ego integration, "pseudoneurotic schizophrenia" (A. Hoch and P. Polatin) or "ambulatory schizophrenia" (G. Zilboorg), "early infantile autism" (L. Kanner), "symbiotic psychosis" (M. Mahler), other child schizophrenic syndromes (L. Render, L. Despert, B. Rank, W. Goldfarb, L. Eisenberg, and others). In the above-mentioned *Interpretation of Schizophrenia,* S. Arieti—on the basis of some fundamental notions on paleological thinking enunciated by E. Von Domarus—has indicated that the schizophrenic way of thinking is based on "primary classes" (that is, Freud's primary process) instead of "secondary classes" (that is, the secondary process of the Aristotelian logic). Examples of such primary thinking are the spontaneous productions of patients (as in the famous Schreber's "Memoirs"), which are increasingly assessed today from the intrinsic perspective of the psycho- pathological process rather than from their difference from the normal process of thinking.

In recent years many studies in this country have focused on the issue of the faulty ego development of the patient in relation to his family, already anticipated years ago by the notions of "pseudocommunity" (N. Cameron) and loss of "consensual validation" (H. Sullivan) in paranoid patients. From 1956

on the so-called Palo Alto group (G. Bateson, D. Jackson, J. Haley, and J. Weaklan) has concentrated on the "double-bind" theory of schizophrenia, based on the ambiguous message that the schizophrenic receives from his family members, and on the concept of "pseudomentality," that is, the similarities between the disturbed logic of the schizophrenic and the disturbed interpersonal patterns of his family. Along similar lines T. Lidz and associates at Yale have found evidence of deficiencies of ego nurturing in schizophrenic patients.

The literature of the last decade—for example, *The Origins of Schizophrenia* by J. Romano, *Family Process and Schizophrenia* by Mischler Waxier, *The Meaning of Madness* by C. Rosenbaum and co-workers, and *The Schizophrenic Reactions* by R. Cancro,—has been influenced by the above-mentioned concepts. The various books of the British psychiatrist R. D. Laing have had considerable resonance in this country (so to justify their mention here). Laing's interests have shifted from the phenomenological discussion of the inner process of schizophrenia *(The Divided Self,* 1960), to the dynamics of the communication patterns (*The Self and Others,* 1961; *Sanity, Madness and the Family,* 1964), and recently to a metapsychological position calling for major social and political reforms to make possible the reinsertion of the schizophrenic into society *(The Politics of Experience,* 1967; *The Politics of the Family,* 1969).

Depression

Like schizophrenia, depression has been considered either as a disease (Kraepelin) or as a progressive worsening of a neurotic condition up to a "reaction type" of personality (Meyer's school). No matter what concept psychiatrists adhered to, they came to be increasingly influenced by Freud's famous paper on "Mourning and Melancholia" (1917), until in the forties the attention shifted to the treatment of depression by means of shock therapies.

The emphasis of the British psychoanalytic school (M. Klein) on a normal depressive position in the earlier stages of life never had too much following in this country. American contributions, instead, centered on "anaclitic depression" (R. Spitz) resulting from severe emotional deprivation in infancy and on "bereavement" (E. Lindemann) as a critical condition conducive to maladjustment. Since the introduction of chemotherapy in the midfifties, a great deal of research has focused on the biochemical aspect of depression, such as the antidepressant activity of the inhibitors of monamine oxidase (IMAE), the "catecholamine hypothesis" related to deficiency of noradrenaline, and the effectiveness of lithium carbonate in the treatment of the manic phase of the depressive condition.

All this should not overshadow the advances made in the psychodynamic understanding of depression. In particular, Arieti, aside from the common form of self-blaming depression, has described the "claiming

type" of depression, in which there is a loss of the "dominant other," that is, of the idealized parental figure toward whom the patient is dependent. Moreover, these types of patients present a "fear of autonomous gratification"—that is, independent of external approval—and their severe ego defect neurosis makes them unable to transform the interpersonal into the intrapsychic; thus they remain quite vulnerable to the loss of sources of self-esteem.

Worth mentioning are the monographs published on manic-depressive psychosis by L. Beliak, on depression by R. Grinker and associates, and on pharmacotherapy of depression by A. Hordern, J. Cole, and J. Wittenbom. From the perspective of epidemiology and public health—which has recently received a great deal of attention along with the biochemical and the dynamic orientations— measures to deal with acute depressions (0.5 to 2 percent of the general population) include 24-hour emergency assistance in many American cities and a variety of recommendations by the Center for the Study of Suicidology, established at the National Institute of Mental Health in Bethesda, Md.

Psychosomatic Medicine

In the thirties a number of psychoanalysts "rediscovered" the centuries-old belief in the influence of the mind upon the body in the wake of Freud's

original concept of somatic compliance in the mechanism of hysteria. Certain diseases—peptic ulcer, asthma, rheumatoid arthritis, colitis, dermatitis, hypertension, and hyperthyroidism—were considered as mainly psychosomatic (the ample monograph by F. Dunbar in 1943 is typical).

Under the overall influence of Freud's theory of anxiety (1926), F. Alexander and pupils from 1932 carried on a great deal of research on psychosomatic conditions, which led to the concept of "specificity," that is, of a definite correlation between each one of these conditions and a particular emotional conflict (for example, repressed hostility in hypertension). No matter how meaningful the study of psychological factors has been (such as the correlation between dreams and the biological phases of the menstrual cycle by T. Benedek), the presence of a particular preexisting organ vulnerability (constitutional factor "X") under conditions of stress has been assumed by practically everyone (for example, by J. Mirsky and associates in cases of duodenal ulcer by measuring the secretion of serum pepsinogen).

Other researchers in the field of psychosomatic medicine have made use of Cannon's emergency theory, of Selye's stress theory, of Schur's resomatization concept, of the metapsychological postulates of Hartmann and of Rapaport, of hypnosis, of projective techniques, of verbal behavior in particularly structured interviews (Deutsch's "associative anamnesis," open-end medical interview of the Rochester group), or simply of casual

happenings (such as the famous case of a gastric fistula illustrated by G. Engel and associates). All this research has brought up a number of issues: mechanism of expression of the "body language," interplay of voluntary and involuntary innervated systems, alternation of psychosomatic and psychotic conditions, and so forth.

Among the important publications in this field are F. Alexander's *Psychosomatic Medicine,* T. Benedek's *Psychosexual Functions in Women,* F. Deutsch's *On the Mysterious Leap from the Mind to the Body,* A. Garma's *Peptic Ulcer and Psychoanalysis,* and G. Engel's *Comprehensive Psychological Development in Health and Disease.* From the historical perspective two factors stand out: (1) the methodological approach has shifted from the exclusive psychoanalytic to an interdisciplinary one, inclusive of biochemists, internists, and behavioral scientists; and (2) the various theoretical models of psychosomatic disorders based on a closed system appeared to be superseded by models based on an open system, as that presented by the general system theory.

The Psychoanalytic School

The study of the life and work of Freud has continued to be the subject of a number of studies in the last two decades, typically the three-volume monograph by E. Jones completed in 1957. Such a monograph typified the

mythical representation of Freud's message to which he himself unconsciously gave a prophetic character. Since then, with the help of newly published material—such as Freud's correspondence with some pupils and friends and the minutes of the early Vienna Psychoanalytic Society—important historical studies have appeared by various authors. Controversies have arisen concerning Freud's academic career and his involvement in the suicide of V. Tausk, author of the classical paper on the "influencing machine" in schizophrenia (1919).

All these studies have been overshadowed by the monographs by E. Erikson on Luther (1958) and on Gandhi (1970), which presented an entire historical period from the perspective of the development of one person, thus opening the new field of psychohistory. This has signified a new advance in the application of psychoanalytic insight to literature and the figurative arts, which has had a long tradition in Europe as well as in this country.

Clinical Developments

The most important event in the history of psychoanalysis has been the shift of emphasis from the unconscious to the ego (mainly A. Freud's *The Ego and the Mechanisms of Defense* and H. Hartmann's *Ego Psychology and the Problem of Adaptation),* which occurred in the late thirties, shortly before the exodus of a large number of psychoanalysts from central Europe to this

country. Freud's anticipation at the occasion of his lectures at Clark University in 1909 that psychoanalysis would receive such a great acceptance in the United States to the point of losing its identity appeared to be confirmed.

Actually the bulk of the psychoanalytic movement remained faithful to Freud's traditional teaching based on the integration of empirical therapeutic procedures and theoretical notions of the structural, economic, genetic, and topographical aspects of the mind, as in Fenichel's classical *Psychoanalytic Theory of Neurosis* (1945). The above-mentioned studies on ego psychology, as well as the research on psychosomatic medicine carried on at the Chicago Psychoanalytic Institute under F. Alexander and the new perspectives presented by the neo-Freudians (C. Thompson, Fromm, H. Sullivan), did not have a significant impact until the fifties.

Here mention at least should be made of the outstanding American representatives of the psychoanalytic movement and their particular area of interest: Helene Deutsch for psychology of women; Theresa Benedek for psychosexual disorders of women; Franz Alexander, Carl Binger, Flanders Dumbar, Thomas French, and Roy Grinker for psychosomatic medicine; Felix Deutsch and Maurice Levine for integration of medicine and psychoanalysis; Jules Masserman for experimental neuroses; Spurgeon English, David Levy, Gerald Pearson, and Emmy Sylvester for emotional disturbances in childhood; Erich Lindemann and Nathan Ackerman for family dynamics; Frieda Fromm

Reichmann and Gustav Bychowski for psychotherapy of psychosis; Kurt Eissler for psychotherapy of delinquents; Abram Kardiner, Kenneth Appel, Greta Bibring, Phyllis Greenacre, Ives Hendrick, Robert Knight, Lawrence Kubie, Bertrand Lewin, Sandor Lorand, Karl and William Menninger, Herman Nunberg, Clara Thompson, Gregory Zilboorg, and many others for various clinical matters.

In particular, a few words should be said regarding the work of Franz Alexander, which spanned three decades of uninterrupted creativity. Particularly important are *Psychoanalytic Therapy* (1946), *Studies in Psychosomatic Medicine* (1948) for its many innovating techniques, and *Our Age of Unreason and Western Mind in Transition,* dealing with broad cultural issues; his various papers collected under *The Scope of Psychoanalysis* (1961) focus especially on the three dynamic principles of homeostasis, economy, and surplus energy. Among the other important American contributors, Thomas French has attempted to represent psychoanalysis as a process of progressive adaptation to achieve integration.

Theoretical Developments: Ego Psychology, Life Cycle

The emphasis on the ego that became prominent in the forties left unsolved the issue of its genesis. In the fifties H. Hartmann, E. Kris, and R. Loewenstein tried to explain the development of the ego from an

undifferentiated state of id-ego under the influence of (1) congenital ego characteristics, (2) primary instinctual drive, and (3) external realities conducive to ego development.

The main advance related to the concept of adaptation, which was anticipated by H. Nunberg and thoroughly investigated by D. Rapaport, who defined it as the balance of ego autonomy from the id and ego autonomy from the environment. The adaptive point of view was integrated with the genetic one in Hartmann's definition of the ego as the matrix of the personality, mastering the apparatus of internal and external motility and the perception, contact with reality, and inhibition of primary instinctual drives.

Other theoretical developments deal with the role of the somatic ego related to the body image, the concepts of "ego strength," of "area of the ego free of conflicts," and of "neutralized energy" (that is, desexualized and aggression-free energy), and the role of introjection and identification in the formation of the ego. All this has come to signify historically a rapprochement between psychoanalysis and genetic psychology, this latter represented mainly by H. Werner and J. Piaget. In fact, Piaget's books became significant for American psychiatry in the last two decades coincidentally with the advent of ego psychology, leading to attempts to compare psychoanalysis with the school of Geneva (P. Wolff, J. Anthony, and others).

Aside from this the main innovation consists of the concepts developed in this country by the Danish-born and Viennese-trained E. Erikson, a highly creative personality imbued with literary gifts. Erikson views the personality from the perspective of a comprehensive life cycle, in which the "normal" or "normative" rather than the pathological acquires preeminence. Erikson's two most celebrated books, *Young Man Luther* (1956) and *Gandhi's Truth* (1969), represent the best example of an entire historical period viewed in the light of the individual dynamics of an important figure. In other publications *(Identity and Life Cycle,* 1959; *Insight and Responsibility,* 1964; *Identity: Youth and Crisis,* 1969), all stemming from his basic *Childhood and Society* (1950), he has brought to the fore the identity crisis of adolescence in American society and the basic stages of the life cycle. These latter (in succession "hope," "will," "purpose," "skill," "fidelity," "love," "care," "wisdom"), which he has called "basic virtues," can be easily connected with the fundamental "virtues" of the Judeo-Christian tradition. His views on adolescence have come to be very relevant in light of the growing impact of youngsters in the American cultural scene. Erikson's work has influenced many others (as typically represented by the important volume *The Person* by T. Lidz) and transcends the field of psychoanalysis proper, so one may justifiably question whether Erikson belongs to this school.

New Psychoanalytic Trends

The difficulty of separating theoretical from practical issues has been a constant one in the psychoanalytic school. By and large, however, most American psychoanalysts have remained faithful to the basic principles established by Freud.

As the early generation of European-born psychoanalysts is slowly disappearing, the relevance for psychoanalysis of the biological sciences, on the one hand, and of the social sciences, on the other hand, is being recognized. The American Academy of Psychoanalysis, established about 15 years ago, has represented this new trend, as evidenced by the proceedings of the meetings edited by J. Masserman under the title *Science and Psychoanalysis.* In the collaborative volume *Modern Psychoanalysis: Neiv Directions and Perspectives* edited by J. Marmor, the views of the main exponents (R. Grinker, J. Ruesch, etc.) of the integration of psychoanalysis—conceived of as an open system —with biological and social sciences are clearly stated: use of findings from the fields of communication theory, electrical engineering, cybernetics, information theory, automation, and computing; consideration of adaptional aspects derived from information, self-regulatory, and transactional systems and consideration of the fields of forces in which the therapeutic relationship takes place; in general, replacement of a "closed system" based on the death instinct, the narcissistic drives of the ego, and the isolation of the psychotherapeutic relationship with an "open system" (von Bertalanffy, 1962) as a "reciprocal and reverberating

process," a "transaction, rather than self-action or interaction, which is the effect of one system on another, is the relationship of two or more systems within a specific environment which includes both, not as specific entities, but only as they are in relation to each other within a specific space-time field" (Grinker, 1968).

It is to be hoped that the introduction of biological and social dimensions in the reformulation of psychoanalytic principles will result in a much needed clarification of concepts, elimination of tautologies, and improvement of the communication between psychoanalysts and scientists from other fields. As an example of this, the analysis of the symbolic-linguistic system, which is basic in the psychotherapeutic relationship, is being investigated with the help of a new methodology.

Research

As mentioned above, the American contribution to psychoanalysis has mainly consisted in the clarification and, if possible, the measurement of some of the classical findings by the early psychoanalysts. Among the first examples of this trend, quite often represented by psychologists, is the survey of psychoanalytic data published by R. Sears in 1945. The difficulties inherent to research in psychoanalysis—especially impressionistic bias by the observers, the problem of experimenting with human subjects, and the

question of confidentiality—have not been overcome even in the last two decades, when advances were made in the methodological approach to psychiatric research.

From the developmental perspective, in the last 25 years three main areas have become prominent in psychoanalytic research: assessment of psychoanalytic tenets in various experimental situations, observation of child development in terms of psychoanalytic theory, and measurement of the results of psychoanalytic therapy. In the first area, the research on experimental neurosis—originally introduced by J. Masserman and then by J. Dollard and N. Miller in their classical *Frustration and Aggression*—has been extended more recently to the areas of sleep, hypnosis, sensory deprivation, and mother-child relationship by a number of scientists (H. Middell, H. Harlow, and others), resulting in a rapprochement between psychoanalysis and conditioning. In the second area, a number of centers on child development and treatment have undertaken research projects; perhaps the most important one (following the early studies in the forties by D. Levy and by R. Spitz) is that carried on by A. Freud and coworkers at the Hampstead Child Therapy Clinic in London. In the third area falls the Menninger Psychotherapy Research Project, initiated in 1954 and still in progress; it is hoped that this will result in findings more meaningful than those presented in the Report of the Ad Hoc Committee on Central Fact Gathering of the American Psychoanalytic Association.

Present State of the Psychoanalytic School

When the first edition of this *Handbook* was published in 1959, this historical chapter was presented from a perspective in which psychoanalysis occupied a prominent position. Today this is no longer the case, as it has become clear that psychoanalysis is going through a progressive decline following the high peak it reached in the mid-fifties. This is reflected in the expectation of some segments of the population, in the acceptance of psychoanalytic modes of treatment, and ultimately in the change of self-image of the young psychiatrist, who does not identify any longer with the typical sophisticated, reserved, and well-to-do psychoanalyst.

This is not to say that the psychoanalytic tenets based on the development of the personality from the unconscious matrix in the context of family relationships have been replaced by other more relevant systems. Rather, the attitude of many toward these tenets, especially when not sufficiently proven, has become increasingly critical, and attempts are made to view them from a broader interdisciplinary perspective. Even before the advent of community psychiatry, criticism of the official position of the psychoanalytic association controlled by Freud and his disciples was very vehement, resulting in a number of secessions: in this country, for instance, the founding of K. Horney's American Institute for Psychoanalysis, of W. A. White's Institute, and of T. Reik's Society for Psychoanalytic Psychology. The

other two major issues of the integration of psychoanalysis into medical schools (for example, at Columbia University, the New York Medical College, and the Downstate Medical Center in Brooklyn) and of the exclusion of lay analysts from official recognition (with the exception of very few, such as E. Kris, B. Bornstein, B. Bank, and especially E. Erikson) were particularly debated by the American Psychoanalytic Association, which, founded in 1911, acquired autonomy from the International Psychoanalytic Association in 1938, at the time of the immigration of a large number of analysts from Europe.

While for many years, as it will be shown in the next section of this chapter, the question centered around the acceptance, or rejection, of the official position of the psychoanalytic group, today the main issue concerns the very relevance of psychoanalysis in view of the spread of the community psychiatry movement, which has received massive political and financial support. The reaction of psychoanalysis to this movement has been far from consistent and uniform; it has been punctuated by criticism of community psychiatry for disregarding the basic dyad patient-doctor relationship and training in long-term psychotherapy in order to follow ill-defined methods of treatment and community approaches. All this does not mean that psychoanalysis is dying, as some sensational journalistic reports seem to indicate, but rather that it is increasingly seen as a specific technique instead of a general philosophy of treatment.

Other Schools and Trends of Psychoanalytic Derivation: Jung, Rank, Adler, Reik, Reich, Klein

Aside from some basic notions presented early in his career and absorbed into the mainstream of the psychoanalytic school (mainly introversion and extroversion, complex and collective unconscious), the work of the Swiss Carl Gustav Jung (1875-1961) has received very little notice here. One reason is that his pupils, being of non-Jewish extraction, did not have to emigrate to this country. Particularly ignored is his late production, which has been exceedingly influenced by mystical, esoteric, and religious concepts not very palatable to the pragmatic American mind. Despite the availability of his main writings in this country for many years (and the current publication of his complete works by the Bollingen Foundation), Jung's ideas have found followers mainly in Switzerland and in England (especially M. Fordham, F. Fordham, Y. Jacobi, and A. Jaffe) and in artistic rather than in psychiatric circles.

In contrast to Jung, Otto Rank (1884-1939) brilliant and favored pupil of Freud, has had a considerable following in this country. His influence, however, results not so much from his original concepts—birth trauma, birth of the hero, Doppelgang, and other literary and artistic themes (presented in the journal *Imago,* which he directed)—but from the so-called functional school of social work that he established at the University of Pennsylvania and that was continued by his pupils V. Robinson and J. Taft.

In regard to Alfred Adler (1870-1937), his basic notions of inferiority feelings and of organ inferiority have become universally accepted, in spite of his bitter separation from Freud's school in 1911, followed by the founding of the Society for Individual Psychology. In this country, aside from a few pupils (A. Ansbacher, R. Dreikurs, and others), important aspects of his work—notably his application of psychoanalysis to education, resulting in the child guidance movement—have been almost entirely forgotten, probably because of his rather unassuming personality, unconcerned with academic recognition, and because of the poorly organized style of his writings, directed to the general public rather than to professionals.

Other well-known analysts who worked in this country for many years following their arrival from Europe include Theodore Reik (1888-1969), whose books on various clinical aspects of psychoanalysis have met with success, and Wilhelm Reich (1897-1957), who early in his career introduced the innovating notion of "character analysis" (which anticipated ego psychology), then attempted an integration of psychoanalysis and Marxism (very recently brought to the fore again), and eventually became involved in the controversial "discovery" of "orgone" energy as the basis of life.

Finally the "English" school of the German-born Melanie Klein (1882-1960) has had very little impact in this country. Her main views on the development of the superego in infancy (anticipated by her teacher, K.

Abraham), on the crucial role of the introjection of "good" and "bad" objects, and on a normal "depressive position" early in life have been considered too overdetermined by the American mentality concerned with environmental influences. M. Klein's main contribution lies in her pioneering use of play therapy in the twenties and in some anticipations of the psychoanalytic therapy of psychotic children.

Original American Contributions. Neo-Freudians, Cultural, and Interpersonal Schools: Rado, Horney, Sullivan, Fromm

Rado, Horney, Sullivan, and Fromm typify the original American contribution to the psychoanalytic movement. Although all of them, with the exception of Sullivan, were European-born, their work has taken place almost exclusively in this country. They have all been influenced by the Swiss-born Adolf Meyer (1866-1950), the founder of the school of psychobiology, which had considerable impact on American psychiatry—probably because of its optimistic view of human nature in contrast to Freud's pessimism—and which was represented by a large number of pupils who eventually acquired leading academic positions in this country as well as abroad. Aside from its eclectic orientation and broad acceptance, psychobiology is generally considered to have facilitated the introduction of the psychoanalytic movement in this country.

The "adaptational psychodynamics" of Sandor Rado (1890-1972),

based, like Meyer's philosophy, on an eclectic methodology and on an evolutionary biological orientation, aims at describing the hierarchical levels of central integration and control of the organism's motivation and behavior.

The German-born Karen Horney (1885-1952), an early pupil of Franz Alexander in Chicago, became widely known for her many books directed to the general public, in which she stressed the importance of environmental influences at variance with the rigid aspect of Freud's doctrine of the instincts and of family dynamics (for example, the dominant male role). Her explanation of neurosis as "moving toward," "moving away," and "moving against" and of defenses as "self-effacement," "expansiveness," and "resignation" can be viewed as an anticipation of today's clinical pictures of alienation and lack of emotional involvement.

Harry Stack Sullivan (1892-1949) is unquestionably the most original and significant representative of neo-Freudianism. Under the influence of social scientists (R. Benedict, M. Mead, E. Sapir, H. Lasswell, and others) he departed from Freud's rigid notions of the individual development of the personality (that is, stages of libido, oedipus complex) and elaborated notions based on various modalities of experiencing interpersonal relationship ("prototaxic," "parataxic," and "syntaxic") and on the central role of anxiety as experienced disapproval from others, leading to the appearance of substitutive neurotic and disintegrative psychotic symptoms. Today Sullivan

is especially remembered in American psychiatry for his pioneering attempt to view psychotherapy as a mutual learning experience between patient and doctor and to consider even psychoses as treatable through a correction of distorted processes of communication.

Also geared to the general public are the many volumes of the German-born Erich Fromm (b. 1900), in the past associated with the William Alanson White Institute in New York City. His presentation of personality types ("receptive," "exploitative," "hoarding," "marketing," and "productive") reflects his dramatic view of man in conflict between individual aspirations and dehumanizing collective forms of life. Fromm's writings, in which he has paid tribute to both Freud and Marx, have an appealing and engaging style, but are rather peripheral to the central theme of psychiatry proper. The same can be said of the philosopher Herbert Marcuse (b. 1898), whose humanistic defenses of man from the Marxist perspective have been taken as a symbol by the New Left.

It is too early to pass judgment on the historical significance of Fromm, Marcuse, and others. For the neo-Freudians, instead, the comprehensive works by R. Munroe, C. Thompson, and others are available.

Existentialist Schools

Since the existentialist movement pertains essentially to philosophy and

developed mainly in Europe, it is important to state that, like the rest of this chapter, this presentation deals exclusively with the *American* developments of existentialism in relation to psychiatry and presupposes a basic knowledge of its main tenets. The matter is complicated by the vagueness of the core and boundaries of existential psychiatry, which inherently defies any attempt at categorization into a definite school with clearly established teaching.

Rather, it is generally accepted that existentialism, a fundamental theme of human existence from the Greeks on, tends to become significant at times of general insecurity and weakening of social institutions, leading to a defense of the uniqueness of the individual person. The sources of the existential movement (mainly Kierkegaard, Dilthey, Husserl, Buber, and Heidegger in Europe and W. James in this country) have been well established and presented in comprehensive form, especially in the monograph by H. Spiegelberg. Also it has been said that the essence of the psychotherapeutic relationship includes an existential motive.

The fact remains that in this country, probably in relation to the awareness of new social dimensions (poverty, alienation, racial conflicts, and so forth), existential psychiatry came to the fore in the mid-fifties. Various works by European exponents of existential psychiatry (K. Jaspers, L. Binswanger, M. Boss, and others) became available in translation; a comprehensive volume on this field (*Existence: A New Dimension in Psychiatry*

and Psychology, edited by R. May, E. Angel, and H. Ellenberger, 1958) was published; three journals were founded with the support of G. Allport, C. Rogers, E. Weigert, C. Biihler, H. Murray, and others. The original American contributions worth mentioning are R. May's *The Meaning of Anxiety* (1950), P. Tillich's *The Courage to Be* (1953), and A. Maslow's *Toward a Psychology of Being* (1962); Maslow is a representative of a "third force" in psychology, between behaviorism, on the one hand, and psychoanalysis, on the other hand.

Today, a decade later, it safely can be said that the original impetus of the existential movement has subsided. Even the publications of Erwin Strauss, a distinguished European-born existentialist who has been active in Lexington, Ky., for more than two decades, have received very little notice. It appears that the reaction of many disenchanted with the traditional American style of life has taken the form of "irrational" group expressions (such as the acceptance of Marxism, the spread of collective movements from the hippies to encounter sessions, the refuge into all kinds of beliefs from occultism to Far Eastern practices), rather than of an individual response like in Europe.

New Trends: Ethology, General System Theory, Ecology, Structuralism

These various trends, though apparently heterogeneous, have in common two main aspects: (1) their appearance in the last two decades or so,

in response to dissatisfaction with current concepts of human behavior as not relevant to the new needs of man's changing role under the pressure of collective systems; (2) their interdisciplinary approach, from comparative neuroanatomy to anthropology, sociology, electrical engineering, and environmental planning, aimed at facing today's overwhelming problems of population explosion, environmental contamination, and rise of underdeveloped nations by defending the humanistic core of the individual without escaping from the world, to the point of constituting a sort of "new utopia" (W. Boguslaw). Also two of them, ethology and structuralism, are of European origin and based on innate and congenital postulates; the other two, general system theory and ecology, are of American origin and based on environmental and behavioristic postulates.

Their relevance to psychiatry can be summarized in a few points. Ethology, initiated by Lorenz, Tinbergen, and others, is mainly related to the findings of developmental psychology (R. Spitz, P. Wolff) and comparative development (H. Harlow). General systems theory (L. Bertalanffy) based on the notions of homeostasis, transactional relationship, and communication and information processes, has resulted in works by R. Grinker (*Toward a Unified Theory of Human Behavior),* by K. Menninger *(The Vital Balance,* a new classification of mental disorders based on this theory), by S. Arieti (who has stressed that mental dysfunction is a system disturbance rather than a loss of single functions, especially in schizophrenia), and by others (J. Ruesch's

concern with the human aspects of systems, J. Spiegel's notion of foci in a transactional field, L. Frank's views on organized complexity, J. Miller's behavioral theory as having relevance for community mental health), all presented in the recent volume *General Systems Theory and Psycluatry,* edited by W. Gray, F. Duhl, and N. Rizzo. Ecology, rapidly seen as important for psychology (for example, in *Environmental Psychology: Man and His Physical Setting,* edited by H. Proshansky, W. Ittelson, and L. Rivlin) has resulted in the new ecological model of mental illness and treatment based on the interplay between the individual and his environment (E. Auerswald). Finally structuralism (mainly founded on the writings of the French anthropologist C. Levi-Strauss) is still too new for its relevance for psychiatry to be seen, but it has definite connections with psycholinguistics, communication theory, and transcultural psychiatry, as well as psychology (for this latter, mainly in the book recently published on structuralism by J. Piaget).

Overall Development of Psychiatric Treatment: From Hospital to Community

The expression "community psychiatry" has become increasingly popular in the last ten years. From the historical perspective of this chapter, two points are important in relation to this issue: the developments that led to the preeminence of community psychiatry and the definition of its core and boundaries vis-a-vis other collateral fields.

In regard to the first point, throughout history the mentally ill have been seen in different ways, from being possessed by devils to being emissaries of gods, and consequently worshiped, tortured, or simply neglected. Recent historical studies (mainly by E. Ackerknecht, G. Rosen, I. Galdston, M. Foucault, and others) have attempted to investigate the social and cultural dimensions underlying these various attitudes. In this country a progression can be followed from the emphasis on institutionalization during the late nineteenth century to the recognition of the value of treating the patient in his own environment, to the awareness of prevention of mental disorders, and finally to the ambitious plan of making psychiatry available to everyone at the community level. Some historical presentations of community psychiatry (by J. Ewalt and P. Ewait, J. Brand, W. Barton, A. Freedman, W. Ryan, I. Galdston and A. Rossi) are available.

In regard to the second point, community psychiatry has to be differentiated from social psychiatry. This latter, first defined in this country by T. Rennie in 1956 as concerned with individual and collective forces in relation to adaptation and psychopathology, has been from time to time especially interested in environmental (F.Redlich and M. Pepper). sociocultural (A. Leighton), transcultural (E. Wittkower), ecological (J. Ruesch) and interdisciplinary (N. Bell and J. Spiegel) aspects. In general, the focus of social psychiatry is on theory and research in relation to sociological theories and ecological models.

Instead, the focus of community psychiatry —concretely represented through the concept of "catchment area" as an area of 50,000-75,000 people identifiable for common ethnic, social, and cultural dimensions—is on treatment and on prevention. Treatment is carried on in a variety of ways—also due to the different ethnic, cultural, and religious backgrounds of various groups in this country—justifying the criticism of being "a movement without a philosophy." Prevention relies heavily on the fields of epidemiology and public health and has achieved recognition especially through the many studies published by G. Caplan, who is responsible for the subdivisions of primary, secondary, and tertiary prevention. It is likely that the various schools of community psychiatry now operating in this country (especially important are those at Harvard, Columbia, and the University of California) will contribute in time to the clarification of this new field.

The Movement toward Community Psychiatry: "Action for Mental Health"

The movement of community psychiatry, which was officially initiated in 1961 with the publication of *Action for Mental Health*, represented the culmination of a long period of incubation and the convergence of various trends that can be followed for a considerable period.

Prior to World War II some developments anticipated themes central to community psychiatry: opening of outpatient clinics for adults and then for

children, organization of psychiatric social work, A. Meyer's pioneering views of today's concept of "catchment area," interdisciplinary input by sociology and anthropology, lay involvement in the mental hygiene movement, and new therapeutic optimism derived from collective forms of treatment.

It is well known that World War II emphasized the magnitude of psychiatric disorders and the need for a national program to adequately face this issue. In succession a series of steps were taken: establishment of vast facilities for treatment and training by the Veterans' Administration; passing of the Hill-Burton Act for federal assistance to allocate psychiatric beds in general hospitals (which now number more than 30,000); foundation of the National Institute of Mental Health in 1949, which, under the long leadership of R. Felix, developed a Community Services Branch; participation in research on community aspects of mental health by some foundations. notably the Milbank Memorial Fund.

Meanwhile, in the psychiatric field the social structure of the mental hospital was first described by A. Stanton and M. Schwartz in their pioneering study *The Mental Hospital* (1954), carried out at Chesnut Lodge in Rockville, Md.; this received ample recognition and was followed by others (for example, *From Custodial to Therapeutic* and *The Patient and the Mental Hospital,* both edited by M. Greenblatt, *et al.).* Also the important research on the sociological aspects of psychiatric treatment by A. Hollingshead and F.

Redlich and the "Mid-Town Study" on psychiatric epidemiology in Manhattan by L. Srole, *et al.,* were published.

All this, as well as other developments, eventually had an impact on the political scene. Community Mental Health Acts to assist local community programs were approved (first in New York State in 1954), and the annual Governors' Conference on Mental Health offered the impetus for passing adequate legislation. As a result of the Mental Health Study Act of 1955, the Joint Commission on Mental Illness and Health was established under the leadership of K. Appel and L. Bartcmeier to make an assessment of the system of treatment and care of the mentally ill, identify needs, and propose recommendations.

At the end of five years of work the Commission's Chairman J. Ewalt and collaborators found that the 13,000 psychiatrists then available were largely insufficient to take care of the large number of people in need of assistance; the 1,250 state institutions, where the great majority of the 700,000 mental patients were, tended to be overcrowded and understaffed; moreover, less than one million people were treated as outpatients, although statistics showed that 10 per cent of the general population were affected by nervous and mental illness.

The Commission's recommendations centered around three points: (1)

improvement in the utilization of manpower by gearing psychiatrists toward community mental health and relying on the help of other professionals and nonprofcssionals; (2) opening of many new facilities, such as clinics, psychiatric wards in general hospitals, and centers for rehabilitation; (3) provision of adequate funds at local, state, and federal levels.

Aside from the widely distributed and comprehensive volume, *Action for Mental Health,* nine other books were published on the following topics: concepts and public images of mental health, economics, manpower, community resources, epidemiology, role of schools and churches in mental health, new perspectives on mental patient care, and research resources in mental health. A basic suggestion for the implementation of this new approach was to convert large state hospitals into units of no more than 1,000 patients and to provide a mental health clinic for each 50,000 people.

With the support of many professionals and laymen (such as Mary Lasker and Mike Gorman, executive director of the National Committee against Mental Illness), as well as legislators (mainly Senator L. Hill, Congressmen J. Priest, O. Harris, and J. Fogarty, and A. Ribicoff, then Secretary of Health, Education, and Welfare), proposals to implement the recommendations of the Commission were introduced in Congress. Significant impetus toward the success of this endeavor was provided by the late President Kennedy; on February 5, 1963, in his memorable message to

the 88th Congress on mental illness and retardation, he indicated that what was needed was "a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill—which will return mental health to the mainstream of American medicine, and at the same time upgrade mental health services."

Eventually this political action (described in detail in *Politics of Mental Health,* edited by R. Connery) resulted in the passing of the Community Mental Health Act in 1963, which provided for the establishment of a community mental health center for each "catchment area" of about 75,000 people. Any center had to offer five types of services: inpatient, outpatient, partial hospitalization, emergency and consultation, and education. Other services, such as diagnostic, vocational, training, and research were also recommended, but not mandated. In addition to the $150 million over a three-year period to finance these centers, an amendment to the Act was signed by President Johnson in 1965 to provide federal funds also for staffing. By 1970 more than 400 centers were in operation: some received construction grants, others staffing grants or both. The NIMH budget for that year was $348 million, while moneys allocated by the states reached $2*Vi* billion.

Developments in the Pattern of Delivery of Services: Mental Hospitals, Outpatient Clinics, Community Mental Health Centers

Historically services for the mentally ill have developed according to the order followed in the above heading. Mental hospitals first appeared at the end of the eighteenth century in the process of differentiating the mentally ill from all other outcasts of society; the philosophy of "moral treatment" based on the paternalistic approach of the superintendent was carried on successfully in the small, homogeneous private mental hospitals in the early nineteenth century; later on, with the arrival of many immigrants and the expansion of the frontier, the mentally ill were increasingly institutionalized in large state institutions (many built under the impetus of D. Dix's crusade) where treatment became more impersonal and custodial.

Around the second decade of our century, under the influence of several currents (progressivism, psychoanalysis, behaviorism, and others) outpatient treatment for many people affected with emotional disturbances gained momentum. However, the practice persisted of keeping the mentally ill anonymously in large institutions away from the community. At times it reached the point of neglect and despair, as portrayed in *The Shame of the States* by A. Deutsch and in *The Snake Pit* by M. Ward.

Only in the mid-fifties two concomitant developments, the introduction of chemotherapy on a large scale and a more accepting attitude toward mental illness on the part of many, resulted in a substantial improvement in the delivery of services to mental patients. The first important step in this

direction was the “therapeutic community” described by M. Jones in England in 1953. As a result of clarification of structures, roles, and role relationship reached in mental hospitals through T groups, sensitivity training, crisis situations, and face-to-face confrontations, there was an improvement in staff-patient interaction and increased participation by patients in the therapeutic program (on such issues as confidentiality, authority, decision making, and limit setting.)

In time other modalities of treatment were introduced, first in Europe and then in this country: “day hospitals” for patients not needing full hospitalization; family care and aftercare services; ex-patient clubs; use of volunteers; assignment of patients from the same geographical area to a “unit” in the state hospital to facilitate contacts with their community. All these pioneering endeavors came to be named the “open-door policy” (M. Jones), that is, a shift from a custodial to a therapeutic setting and from a closed to an open system. “Therapeutic community” has also become a very commonly used expression, not only in terms of the mental hospitals, but also in terms of the community at large. As one would expect, these developments have resulted in a progressive decrease—for the first time in the last 150 years—in the number of hospitalized patients from about 559,000 in 1953 to less than 425,000 fifteen years later.

Recently the notion of “revolving door” has been introduced to signify

the flexible approach both of the hospital and of the community, as quite often the problems of the mentally ill cannot be properly met simply by transferring the responsibility for the patient from the institution to his family. Worth mentioning also is the significant role that private mental hospitals (about 170 caring for almost 17,000 patients and involved in the National Association of Private Psychiatric Hospitals) have played in the above-mentioned developments.

The literature on all these events is quite extensive. Among the most valuable works are *The Therapeutic Community* by M. Jones, *The Psychiatric Hospital as a Small Society* by W. Caudill, *Day Hospital* by B. Kramer, *The Prevention of Hospitalization* by M. Greenblatt, *Partial Hospitalization for the Mentally Ill* by Glasscote, et al, *The Day Treatment Center* by Meltzoff and Blumenthal, *The Treatment of Family in Crisis* by Langsley and Kaplan, *Community as Do*ctor by R. Rapaport, *Social Psychiatry in Action: A Therapeutic Community* by H. Wiener, and *The Psychiatric Hospital as a Therapeutic Community* by A. Gralnick.

Outpatient clinics have an important tradition in this country, which can be traced back to the convergence of various movements of social work, voluntary agency, welfare programs, settlement houses, and others early in this century. The original philosophy of these clinics was eclectic and depended largely on community resources. A number of clinics (281 out of a

total of 373 in 1935) served patients discharged from mental hospitals, and most of them were located in the five states of New York, Massachusetts, Pennsylvania, New Jersey, and Michigan.

In the forties and fifties, under the influence of the psychoanalytic school, clinics came to be geared toward long-term treatment of intrapsychic problems by members of various disciplines (mainly psychology and social work) that identified with the psychotherapeutic role of the physicians. Increasingly the philosophy of treatment tended to favor young, intelligent, and sophisticated patients whose values were similar to that of the staff, while the contact with community agencies and schools became negligible.

Around the mid-fifties the country suddenly became aware of the conditions of poverty, neglect, and rejection of a considerable segment of the population (M. Harrington, F. Riessman, M. Deutsch, and others). The fact that middle-class people tended to be treated in clinics while low-class people ended in mental hospitals was well documented by A. Hollingshead and F. Redlich. Slowly many sicker patients, no longer in need of institutional care because of the success of psychopharmacological treatment and the above-mentioned open-door policy of mental hospitals, came to be treated by outpatient clinics with the help of new techniques, such as family and group therapy.

However, the controversies concerning the role of the approximately 2,000 clinics now existing (organized under POCA, Psychiatric Outpatient Centers of America) are far from over. One of the sharpest critics, G. Albee, has written that "the psychiatric clinics in the United States are treating the wrong people; they are using the wrong methods; they are located in the wrong places; they are improperly staffed and administered; and they require vast and widespread overhaul if they are to continue to exist as a viable institution."'

In the context of the community mental health movement, the philosophy of the clinics tends to be influenced by social factors: new therapeutic modalities aimed at treating low- income and culturally disadvantaged groups, as well as patients in critical need of treatment (adolescents, alcoholics, drug addicts, etc.), are developed; efforts are made to open clinics in rural areas and in Midwestern and Southern states with the substantial help of public moneys and, to a less extent, of insurance coverage.

The main issue remains the identity of the outpatient clinic vis-a-vis the community mental health movement. This is colored by considerable ambivalence: on the one hand, the nostalgic feeling toward the traditional small clinic whose staff was quite involved with the patients; on the other hand, the commitment to serve as many people from all backgrounds as possible, in the context of the network of medical, social, educational, and

rehabilitation services in the community.

Community mental health centers, being only less than a decade old, are difficult to assess from the historical perspective. The complexity of any one of such centers, composed of various agencies staffed by an heterogeneous group and located in areas culturally different, contributes greatly to such difficulty.

Yet ten years from *Action for Mental Health,* some trends concerning the development of community mental health have emerged. It is unquestionable that the great expectations raised initially that this movement would constitute a "third" (N. Hobbs) or a "fourth" (L. Linn) psychiatric revolution are not accepted by many. At best it is accepted that this movement helped considerably to create a climate of more favorable acceptance toward emotional disorders and a more optimistic outlook toward their treatment.

However, it is increasingly recognized that the mental health movement is not a panacea for gigantic social problems, from the Vietnam War to drug addiction to changes in the traditional values of this country (J. Seeley). Too often existing services, no matter how labeled, have remained unchanged and therapeutic modalities have remained unaffected by this movement; the role of the so-called paraprofessionals or "activators," tom between their commitment to treating the underprivileged and their identification with the

professionals, has become controversial.

From an overall perspective the dilemma of the psychiatrist toward the patient, or toward the community forces tending to control the patient, has been brought forward, notably in a dramatic form by T. Szasz. Moreover, criticism has been expressed in leftist quarters, mainly in nonpsychiatric literature, toward the "psychiatrization" of social conflicts" (for instance, turning delinquency and youth unrest into an illness); on the opposite side conservative groups have seen the mental health movement as a plot against patriotism by government infringement on the mental health of the citizens.

Among the professionals it is commonly accepted that this movement, while making good use of principles of epidemiology and of public health, lacks a conceptual foundation, to the point of being called "a movement in search of a theory" (J. Newbrough) or "the newest therapeutic bandwagon" (H. Dunham). From the psychoanalytic viewpoint the approach stressed by this movement has been characterized as "a retreat from the patient" (L. Kubie), and a strong defense of the "medical" (that is, "dyadic") model of the doctor-patient relationship over the "social" model has been voiced by some (R. Kaufman, L. Kolb).

All this should not deter anyone from recognizing the moral implications of a movement that, in line with the American democratic

tradition, attempts to bring help to the largest possible number of people in need. Unquestionably some positive results have been achieved: a more flexible use of professionals reached through a slow reorientation of goals and functions; the integration of many nonprofessionals in the work of each community mental health center; the new pattern of cooperation with social agencies, schools, institutions, and other facilities in the community; the increasing integration of health and mental health services; the progressive acceptance of responsibility toward the emotionally disturbed on the part of local, state, and federal agencies; and last but not least, the more accepting attitude toward mental illness by many segments of the population.

These points, and others, have been brought forward in a number of publications, such as the *Handbook of Community Psychiatry* (edited by L. Beliak), *Perspectives in Community Mental Health* (edited by A. Bindman, R. Williams, and L. Ozarin), *Progress in Com- munity Mental Health* (edited by L. Beliak and H. Barten), as well as in special journals (mainly the *Community Mental Health Journal* and *Hospital and Community Psychiatry).*

Thus far most of the impetus toward community psychiatry has taken place in the states of the East Coast, in California, and in some Midwestern states. The realignment of national priorities related to the slight economic recession and other social problems of this country indicates that local communities will have to assume most of the responsibilities for the

community mental health movement. How this will affect the success of this movement in the long run remains to be seen.

Therapy

Any attempt at modifying the mental functioning of a person has to be viewed from the perspective of the theory of mind and body prevailing in each culture at a particular period. In the Western tradition the centuries- old Aristotelian notion of a body-mind unity was replaced by Descartes' splitting of body and mind in the seventeenth century. Consequently mental disorders, which were traditionally considered in the light of that unity, came to be "discovered" from that time on.

In regard to therapy, the decades between the end of the eighteenth century and the beginning of the nineteenth century saw the rise of mesmerism for neurotic patients and of moral treatment for psychotic patients; later on for several decades therapy was influenced by the organogenic notion of the ascendancy of the body over the mind; psychoanalysis reversed this situation by emphasizing the characteristics of mental functions and the treatment of neurotic disorders. The psychodynamic trend has persisted to our days, although organic theories of the mind became prominent again in the thirties in connection with the introduction of shock therapies and in the fifties with the discovery of

chemotherapy.

While all this justifiably has aroused in many the urge to reach a new unitary concept of body and mind, the orientation of most psychiatrists with the psychogenic or organogenic tradition makes this goal unattainable at present. The need to replace today's hybrid eclectism with a comprehensive formulation of body and mind—perhaps based on the new ecological framework of the general systems theory—may very well constitute the challenge of the seventies.

Organic Therapies

Shock Therapies

The notion that sudden and unexpected events (such as a loud noise, an unpredictable shower, or a fall into the water) may alter the mental status of a person is very old; it was used empirically by some German psychiatrists in the early nineteenth century.

In the late thirties shock therapies were introduced in a matter of a few years, first in Europe and then in the United States. M. Sakel (1900-1957) initiated insulin coma in Berlin and Vienna; J. Meduna (1896-1964) eardiazol shock in Budapest; V. Cerletti (1877-1963) and L. Bini (1908-1964) electric convulsions in Rome. The first two moved to this country shortly thereafter,

so that their therapies became an intrinsic part of American psychiatry, while electric shock was imported here by a few European psychiatrists (mainly L. Kalinowski, R. Almansi, and D. Impastato).

From the historical perspective the significance of shock therapies has been to bring new optimism to the treatment of psychiatric conditions, which had been largely missing in the psychodynamic schools, both in the patients and in the professionals. After the wave of enthusiasm shock therapies came to be limited mainly to electric shock, because of its easy use and safety, and to the treatment of forms of depression. The efforts of many to find the explanation of the intrinsic mechanism of action of shock therapies (based on biochemical abnormalities or on other notions) have been unsatisfactory. Also limited have been the technical improvements, such as use of anesthesia and various substances to achieve relaxation. Worth mentioning also are the psychological implications of shock therapies, that is, the patient's regression and dependence on the staff coupled with symbolic death and rebirth. In the last two decades, in connection with the rise of psychopharmacology, the literature on shock treatment has decreased considerably. The classic book on the subject is *Shock Treatment, Psijchosurgerij and Other Somatic Procedures in Psychiatry* by L. Kalinowski and P. Hoch, continually brought up-to-date.

Psychosurgery

Archaeological remnants of past civilizations bring evidence that skull trepanation for the purpose of liberating epileptic as well as mental patients from the alleged possession by evil spirits was extensively practiced. Surgical interventions on the brain are recorded in Roman, Byzantine, and Arabian medicine, while, later on, caution prevailed in connection with the discoveries of the delicate functions of the central nervous system.

By the thirties some knowledge had been gathered on the relationship between cortical and subcortical functions on the basis of data obtained from ablation of frontal lobes in monkeys (J. Fulton, C. Jacobsen), from electroencephalography, and from stimulation and inhibition of cortical areas. The Portuguese Nobel Prize winner Egas Moniz (1874-1955) was the first to perform a successful lobotomy in 1936. His technique was imported to this country and widely used for a number of psychiatric conditions in the forties, mainly by W. Freemann and Y. Watts in Washington, D.C., and elsewhere.

Regardless of the new surgical techniques—topectomy, thalathomy, cingulectomy, and others—the opposition to psychosurgery has mounted in professional quarters in regard to the indications for selection of patients and the postoperative impairment of intellectual functioning and will. Lay and religious groups, from the Catholic Church to Soviet Russia, have condemned psychosurgery on moral grounds. The controversies about psychosurgery have decreased considerably because of its decline and the corresponding

rise of psychopharmacology, which can result in a sort of "functional" lobotomy without producing personality changes and moral conflicts. Very recently some of these issues have been raised again in connection with the research by J. Delgado at Yale University on modification of psychotic behavior through electrodes implanted in various areas of the brain.

Psychopharmacology

The field of psychopharmacology, less than two decades old, has become one of the most important in psychiatry. Today's extensive use of "drugs of the mind" has brought forward many similarities between them and a variety of drugs employed in magic-religious ceremonies of healing in preliterate cultures. Comparative research has been carried on by some, often working in interdisciplinary teams of pharmacologists, psychiatrists, anthropologists, and others.

In the history of Western medicine, aside from hellebore in Greek times, the list of the "drugs of the mind" includes antimony, belladonna, hyoscyamus, cannabis indica, quinina, followed in the nineteenth century and later on by opium, bromides, chloral hydrate, paraldehyde, and finally barbiturates. Mescaline was isolated in 1896 by the German L. Levvin (who published a famous book on the drugs of the mind) " and later synthetized, and its hallucinogenic effects were described in the German literature in this

century.

Later on the therapeutic importance of diphenylhydantoin for some forms of epilepsy was proved by the neurologist T. Putnam. In 1938 lysergic acid diethylamide (LSD 25) was discovered by the Swiss chemist A. Hoffmann, and in the forties amphetamines (benzedrine and dexedrine) were studied by G. Alles, while serotonin was isolated by I. H. Page in 1945. By that time extensive use had been made during World War II of sodium amytal and similar compounds in narcocatharsis, narcoanalysis, and narcosynthesis for the intensive treatment of acute breakdowns. On a more theoretical basis research on hormonal substances was carried on in some centers, notably at the Worcester Foundation by H. Hoagland and associates.

The credit for first having used chlorpromazine in psychotic and agitated patients is attributed to the French P. Deniker, H. Leborit, and J. Delay early in the fifties. This opened the way to a great step forward in psychiatry, that is, to a more optimistic view of mental illness on the part of professionals and patients and ultimately of the community. In rapid succession a number of other important drugs were discovered and used: meprobamates by F. Berger and B. Ludwig (1950); LSD 25 for clinical purposes by J. Elkes; reserpine by the Swiss H. Bein (1956); the antidepressing imipramine by the Swiss R. Kuhn (1957); butyrophenone by the Belgian P. Janssen (1958); chlorprothixene (Taractan) by the Danish R. Ravn (1959); benzodiazepines

(Librium) by I. Cohen at the University of Texas (1960); finally the antimanic effects of lithium by the New Zealander J. Cade in the sixties.

Regardless of national boundaries, great rapidity has characterized the use of these new drugs, be these "tranquilizers" (a term first used by F. Yonkman) or "psychic energizers" (a term coined by N. Kline) or "neuroleptic drugs," which is the term commonly used in Europe (originally introduced by Delay and Deniker). Impetus toward research and practical application of psychopharmacology has resulted from the establishment of research centers (mainly the Psychopharmacological Service of the NIMH and the one at St. Elizabeths Hospital in Washington), from the sponsoring of a number of international symposia with the help of private organizations (such as the Macy Foundation), from the foundation of the Collegium Internationale Neuropsychopharmacologicum in 1957, and from the publications of important serial volumes (such as *Recent Advances in Biological Psychiatry,* edited by J. Wortis). Also worth mentioning from the historical perspective is the monograph containing the proceedings held at Taylor Manor Hospital in Raltimore in 1970 by the discoverers of psychopharmacology. From the lively account of the participants one learns about the creative process of discovery, the interplay of pure research and the interests of supporting drug companies, legal aspects in various nations, and the continuity of the tradition of "drugs of the mind" from preliterate cultures to our civilization.

No matter to what psychiatric school one adheres, he cannot dispute the value of psychopharmacology in alleviating many emotional conditions—especially some that previously required hospitalization. On the other hand, exaggerated expectations about the uncritical use of "psychomimetics" (mainly LSD 25) in the treatment of mental disorders and especially about the power of some drugs to enlarge the field of consciousness and provide new philosophical and religious insights are unrealistic. Concretely many use chemotherapy in conjunction with psychotherapy, regardless of the psychodynamic aspects of the administration of drugs, mainly the orally dependent and the suggestive effects (as proved by some research on placebo). From a broader perspective psychopharmacology has resulted in a much more enlightened attitude toward mental illness on the part of many general practitioners and other physicians and especially the general population at large.

Psychological Therapies

Since the first edition of this book was published, psychological therapies have also undergone a considerable process of reassessment from the historical perspective. Their importance was unquestionably brought forward by Freud's basic concept of the one-to-one relationship. Following the widespread acceptance of Freud's ideas, for a number of years such psychoanalysts as G. Rohcim investigated healing practices for mental

disorders carried on in past or present preliterate cultures.

The innovation that has taken place recently consists in the new methodological approach toward such healing practices by researchers well versed in psychiatry and anthropology (for example, G. Devereux, C. Kluckhohn, A. Leighton, J. Frank, M. Opler). Considerable light has been thrown on the causes of mental disorders in preliterate cultures, be these nonphysical events (that is, power of devils or ancestors and action of words and deeds) or events attributed to the person himself (that is, disregard for certain taboos). Also in the last decade or so, methods of psychological healing stemming from the Greek tradition and their relation to present methods have been made the subject of thorough studies by W. Riese, P. Lain Entralgo, H. Ellenberger, and others.

Psychotherapy has unquestionably become more accepted in this country in recent years, as evidenced by the foundation of the American Academy of Psychotherapy in 1959 and by the annual publication *Progress in Psychotherapy,* edited by J. Masserman since 1956. However, a critical view of the psychotherapeutic process has been advanced by some: for example, J. Ehrenwald's notion of "doctrinal compliance" to explain the tendency of the therapist to fit everything into his own system. Moreover, the boundaries of psychological therapies have been loosened considerably, not only by the success of nondy- adic modalities, such as family and group therapy, but by

the spread of new approaches, from brief therapy and crisis intervention to encounter groups, and by the inclusion of nonprofessionals among the therapists.

Underlying many of these developments appears to be a basic conflict between the traditional Freudian approach based on the doctor-patient relationship in a stable cultural context and the new collective approaches resulting from the urge toward action brought forward by the pressing social problems of this country.

Individual Psychotherapy: Psychoanalytic Psychotherapy and Psychoanalytically Oriented Psychotherapy

For the historian it is intriguing to investigate the causes of a major shift in regard to psychoanalytic therapy that has taken place in the last dozen years. In 1959, when this book first appeared, this chapter was written from the perspective of the preeminence of the psychoanalytic doctrine in the overall field of psychiatry, in terms of expectations from the sophisticated self-image of the psychiatrists, methods of psychiatric training, and doctrinal adherence of most of the psychiatrists in teaching positions.

As a result of many currents, such as the well-documented study by A. Hollingshead and F. Redlich showing that psychotherapy was available only to middle- and upper-class patients while lower-class patients tended to

receive somatic therapies in institutions, *Action for Mental Health* (1961) offered a nationwide guideline for delivery of psychiatric services to all the citizens of the nation. Increasingly the traditional psychoanalytic methods have become diluted by emphasizing symptoms at the expense of the basic personality and healthy potential rather than pathology, to the point of fully justifying Freud's prediction that psychoanalysis would become so accepted in this country that it would lose its identity.

This is paralleled by the trend among professionals, either well-trained psychoanalysts or psychiatrists, to make wide use of psychoanalytically oriented psychotherapy and to restrict classical psychoanalysis to few patients in need of such procedure, which, in addition, is costly and available only in some urban areas. Moreover, the tendency toward integration of psychoanalysis in the training curriculum of some medical centers has been the subject of bitter controversies between those inclined to a dogmatic defense of Freud's message and those open to a dialogue with adherents of other schools.

In the attempt to introduce clarity and specificity in psychoanalytic therapy, many new nomenclatures have been presented in the literature. Aside from the loose distinction of deep versus superficial, insight versus supportive, verbal versus active therapy, descriptions have been offered of listening, clarification, confrontation, interpretation, suggestion, prohibition,

and manipulation, and therapeutic techniques have been listed as suggestive, abreactive, clarifying, interpretative, suppressive, expressive, supportive, exploratory, educational, up to paternal and maternal. To the classic "correctional emotional experience" of Alexander and French have been added the intensive psychotherapy of psychosis (Fromm- Reichmann), the "sector therapy" (F. Deutsch), the "anaclitic therapy" (Margolin and Lindemann), the "diatrophic relationship" (Gitelson), the "working alliance" (Greenson), and the "therapeutic alliance" (Zetzel).

Essentially what these esoteric denominations have in common are: the emphasis on ego psychology and analysis of defenses (A. Freud, Hartmann, Rapaport, Erikson, Lowen- stein, Kris) and on current developmental crises rather than exploration of the unconscious; a more modest view of the healing role of the psychoanalyst; and, historically, a return to some themes brought forward in the early psychoanalytic literature and then forgotten.

Even so, dissatisfaction toward the psychoanalytic movement in toto is mounting, and a "generation gap" is emerging between classical psychoanalysts and young therapists open to eclectic and unorthodox approaches and more attuned to present social realities. While the basic clinical postulates of psychoanalysis will remain valid in the future, it is difficult to predict the outcome of the theoretical foundations of this movement. At the moment the attempts to graft them on a broader and more

relevant context, such as Grinker's "transactional" views, seem the most promising and fruitful.

Hypnosis

Hypnosis, scientifically practiced in the late nineteenth century by the Salpetriere School (Charcot) and by the Nancy School (Liebeault and Bernheim), is at the root of the early psychotherapeutic treatment of neuroses practiced by Freud and Breuer in cases of hysteria in 1893 and 1895. As the psychodynamic school gained momentum, the historical roots of hypnosis, traceable to Mesmer and, further back, to the Greeks and preliterate cultures, were illustrated by some.

It is well known that Freud rejected hypnosis after a few years and that its use for anesthetic and surgical purposes, introduced in the mid-nineteenth century, was soon forgotten, also as a result of the theatrical use of hypnosis. Only in the forties, following some pioneer work by C. Hull *(Hypnosis and Suggestibility,* 1933) was hypnosis scientifically investigated by M. Erickson, L. Mecron, J. Schneck, L. Wolberg, and others. Ry that time considerable experience had been gathered in hypnotherapy and narcoanalysis during World War II. Eventually the Society for Clinical and Experimental Hypnosis (1949) and later the American Society of Clinical Hypnosis, which publishes *The American Journal of Clinical Hypnosis,* were founded.

In recent years the theories of play acting to please the hypnotist (M. Orne) and of archaic oral-dependent relationship between subject and therapist (M. Gill and M. Brennan) have been postulated. Also the connection between hypnosis and depth and extension of the field of consciousness achieved through the use of particular drugs (LSD 25, mescaline, and others) and the relationship of hypnosis to behavior modifications have been investigated. Despite these developments the future of hypnosis remains vague at this point, although its value in conjunction with psychotherapy is well established.

Client-Centered Therapy

Among the various schools of psychotherapy the only one with a fully American origin was developed by the psychologist Carl Rogers (b. 1902) first in Ohio (1940-1945) and then in Illinois (1945-1950). This school focuses on the genuine, understanding, involved, yet supposedly neutral attitude of the therapist, who continually reflects his feelings toward his client. Historically the lay analyst Otto Rank early in the century advocated the analysis of the therapist's feelings and respect for the patient.

Client-centered therapy appears to have elicited an ambivalent reaction from American psychiatry: on the one hand, psychologists, counselors, and other members of nonmedical groups have mainly used this form of

treatment for young and sophisticated clients suffering from problems rather than definite clinical entities (thus nonpatients in the medical sense); on the other hand, Rogers and his pupils have done important research on psychotherapy with the help of purposely designed inventories and tests. In essence this school represents a combination of the humanistic defense of the person and the scientific approach to psychotherapy.

Group Psychotherapy

Group psychotherapy results from the confluence of many trends originally independent from psychiatry. The American inclination toward collective gatherings of different types (intellectual, political, religious) historically appears to be an attempt to overcome the feelings of isolation resulting from the loss of the support provided by each society from which the immigrant groups came. Moreover, in the European societies centuries-old cultural and religious ceremonies contributed to the release of emotions.

In this country great release of feelings was achieved by some religious sects—notably the Christian Science movement in the nineteenth century. With the progress of civilization and concomitant urbanization, as well as decline of the sources of support provided by traditional values, today's man tends to feel alienated, or "other-directed" in the sense of Ries- man (*The Lonely Crowd,* 1950), and influenced by "groupism" in the sense of Whyte

(The Organization Man, 1956).

As a result of this situation groups of patients of different kinds were formed by some: "classes" of tuberculous patients by J. Pratt in Roston (1905), lecture classes for mental patients by E. Lazell at St. Elizabeths Hospital in Washington, D.C. (1919) and by T. Burrows and by L. Marsh in the New York City area, the "impromptu theater" by J. Moreno also in New York (already practiced in Vienna early in our century). While these various groups were composed for different reasons and the emotional outlet was only coincidental, later on psychoanalytic concepts tended to prevail in groups formed for psychiatric purposes: mainly, analytic group therapy introduced by L. Wender and P. Schilder, activity groups for disturbed children practiced by S. Slavson at the Jewish Roard of Guardians, and, to a less extent, "psychodrama," which makes use of particular techniques (auxiliary ego, mirror, double, and role reversal), practiced by J. Moreno, all in the New York City area.

Moreno was the first one to attempt to conceptualize his methods by founding the journal *Sociometry: A Journal of Interpersonal Relations* in 1937. However, aside from psychoanalytic notions, only with the advent of K. Lewin's "field theory" in the thirties (first at Harvard University and then at the University of Michigan in Ann Arbor) were the theoretical foundations of group dynamics able to offer a much needed scientific basis to the field of

group psychotherapy. Since then this field has acquired a more stable image with the help of professional meetings and journals, especially *Group Psychotherapy* (1947) and *International Journal of Group Psychotherapy* (1951), founded by the homonymous associations.

As a result of all this, progress has been made in identifying goals, in selecting proper patients, and in structuring the role of the leader in the formation of groups. '' However, some basic issues, such as the conceptual definition of group psychotherapy and the modalities of training for leaders, are still clouded by uncertainty. In recent years the rise of all kinds of new groups (from Alcoholic Anonymous to encounter groups, sensitivity training, and others) has put the professional movement of group psychotherapy on the defensive. Proper historical perspective may be found in the surveys by J. Klapman, R. Dreikurs and R. Corsini, G. Bach and J. Illing, and others.

Family Therapy

Family therapy, scarcely mentioned in the first edition of this work, has become prominent in the last dozen years, to the point of being considered as the treatment of choice by some. For the historian the reason for this rapid success, over and above the field of psychiatry, has to be found in family therapy's attempt to strengthen an institution that traditionally has contributed a great deal to the prevention and treatment of mental disorders

and that is now affected by some basic problems: decrease of family ties, virtual loss of the extended family, and rise of the divorce rate.

As in group psychotherapy, various trends stemming from psychoanalysis and from group dynamics have contributed to the development of family therapy. No one has been more instrumental in fostering the field of family therapy than N. Ackerman (1908-1971), through his many writings (especially *The Psychodynamics of Family Life,* 1958), lectures, courses, and, eventually, formal training at the Family Institute in New York City founded by him in 1960.

In time the early themes of family therapy based on psychoanalytic notions (family secrets, emergence of a scapegoat, and so forth) have been replaced by notions acquired through study of the group dynamics of the family process either at the research level (J. Spiegel, J. Bell, and others) or from the practical perspective (G. Bateson, D. Jackson, and V. Satir of the so-called Palo Alto Group, which has published *Family Process* since 1962; T. Lidz and A. Cornelison of the Yale Group; Boszormenyi-Nagy, J. Minuchin, C. Sager, as well as R. D. Laing in England, and others).

Essentially the emphasis is on the threefold perspective of the patient's dynamics and role, the sociological approach, and the cultural dimension; this is clinically manifested through identification of areas of health and

pathology, focus on communicating and sharing, and movement toward the ecological model of community psychiatry (E. Auerswald). All this constitutes a considerable departure from the classic dyadic relationship of orthodox psychoanalysis, in which the family was taken for granted as a solid institution. This image of the family is so altered today in American society to be a cause of concern for many. The historical consideration that the family has remained a landmark in all cultures at all times may help overcome this pessimistic view. Within the limits of psychiatry proper, there is no question that the field of family psychiatry will continue to develop, at the expense not only of individual psychotherapy but also of child and adolescent psychotherapy.

Behavior Therapy

Behavior therapy is so recent that it was not even mentioned in the first edition of this work. In a matter of a few years this school has gained a great deal of interest, if not of acceptance, partially as a result of the caustic criticism of psychoanalytic therapy by some, notably H. Eysenck at the Maudsley Hospital in London.

The foundations of behavior therapy have to be related to the two schools of conditioning (or conditional) learning theory and of reinforcement theory, respectively. The first school is identified with the Russian I. Pavlov

(1849-1936), who derived some of his concepts from his fellow countryman I. Sechenov (1829-1905). To a less extent, even the research on "reflexology" by V. Bekhterev (1857-1927) in Leningrad, resulting in the so-called rational therapy—a mixture of medical and environmental regime—is pertinent. Pavlov's notions of conditioning were used in this country first by behaviorists in the twenties, then by animal researchers, and finally by clinicians, notably W. Gantt (b. 1893), who studied under him in Russia and who founded the Pavlovian Laboratory at Johns Hopkins University in 1930 and, more recently, the Pavlovian Society and the *Conditional Reflex and Soviet Psychiatry Journal.* A basic criticism of this movement is the difficulty of translating animal into human behavior, that is, to make the higher nervous activity relevant to clinical issues. The other school of reinforcement theory based on learning, anticipated by E. Thorndike's instrumentalism and by Hull's stimulus-response theory, led to some clinical studies (notably on frustration and aggression by J. Dollard and N. Miller) and to the controversial operant conditioning by the Harvard psychologist B. Skinner.

Behavior therapy, so named by R. Lazarus and H. Eysenck in the late fifties, is especially identified with the work of the psychiatrist J. Wolpe (b. 1915), first at the University of Witwatersrand in South Africa and then at Temple University in this country. His main tenets, presented in detail in Chapter 43 of this volume, are based on desensitization and reciprocal inhibition, positive and negative reinforcement, aversive conditioning,

extinction, and other techniques.

Some reasons for the success of behavior therapy are the dissatisfaction with psychodynamic therapies, its apparent measurability consonant with the English empirical tradition, and, perhaps, the increased status of the psychologist functioning as a therapist. Within the movement of behavior therapy there are considerable internal contrasts between those inclined to emphasize the theoretical assumptions (J. Wolpe) and those inclined to emphasize the empirical applications (R. Lazarus), as well as between the researchers and the practitioners in the psychological profession.

The attitude of most psychiatrists toward this movement is ambiguous: the therapeutic successes are often considered only symptomatic, superficial, and transient; nevertheless, this approach may be useful in treating large numbers of unsophisticated patients, especially in the context of the community mental health movement. In the light of all this, it is difficult to pass judgment on the long- range importance of this school. It is likely, however, that common points—mainly relevance of symptoms, role of the therapist, and the doctor-patient relationship—between the behavioral and psychodynamic schools, rather than areas of disagreement, will be stressed in the future.

New Areas of Psychotherapy

Psychotherapy of Schizophrenia. Even from the scanty reports of treatment of very disturbed patients carried on during the period of "moral treatment" in the nineteenth century, as well as by other systems at other times, it is clear that psychotherapy of psychoses was at times successful. For a number of years after the advent of psychoanalysis, psychotherapy of psychoses was rejected almost universally (K. Abraham was perhaps the only exception) on the basis that the patient was unable to develop a transference neurosis.

In the forties H. Sullivan illustrated concrete cases of psychotherapy of schizophrenia carried out by him at the Sheppard Pratt Hospital in Towson, Md., on the basis of his interpersonal theory of behavior. While his empirical efforts influenced many in this country and in Europe, his theoretical formulations never gained popularity. Much more accepted was F. Fromm-Reichmann's *Principles of Intensive Psychotherapy* (1950), in which the concept of the "schizophrenogenic mother" was stressed. Ry that time considerable controversy had been elicited by the technique of direct analysis introduced by J. Rosen, first in New York City and then at the Institute for Direct Analysis (founded in 1956 at Temple University in Philadelphia); direct analysis is similar to the so-called symbolic realization described by M. Sechehaye in Switzerland.

In recent years sound attempts have been made by some—notably S.

Arieti—to correlate each technique of treatment of schizophrenia with a particular stage of individual development: for example, lack of maturational development in early childhood (H. Sullivan, J. Rosen, L. Hill) or, conversely, compensatory defenses of the second stage in terms of reestablishing disturbed communications between the patient and his family (G. Bateson, D. Jackson, T. Lidz, L. Wynne).

Historically, similar to the neuroses, the emphasis appears to have shifted from individual treatment to the treatment of the patient in the context of his family and community. Thus far, psychotherapy of psychoses has tended to be carried on by a few therapists endowed with strong personality and keen intuition. The need in the future is for methodologically sound research.

Brief Psychotherapy. The expression "brief psychotherapy" has appeared in the literature in recent years, probably as a result of the need to offer treatment to the large number of patients brought forward by the community mental health movement (P. Castelnuovo-Tedesco, 1962). While the focus on this approach is new, its use in some cases goes back to Freud himself (particularly in the famous treatment of the conductor Bruno Walter) and to some of the early psychoanalysts. Alfred Adler practiced short-term therapy for many low-income patients in whom he had considerable interest; S. Ferenczi and O. Rank advocated a limited number of sessions to avoid

unnecessary dependency and regression in the patient in their volume *The Development of Psychoanalysis* (1923); during World War II brief psychotherapy for the treatment of combat neuroses was widely used, as reported by R. Grinker and A. Kardiner; finally shortening of psychotherapy was advocated by F. Alexander and T. French in *Psychoanalytic Therapy* (1946) on the basis of their research at the Chicago Institute for Psychoanalysis.

In spite of all this, psychoanalytic therapy has tended to be taught and practiced from the perspective of long-term treatment. What is new is the emphasis by many today on considering brief psychotherapy as the treatment of choice on the basis of diagnostic considerations and practical aspects (cost, waiting list, availability of staff, community attitudes, and so forth). Clearly, brief psychotherapy focuses on crises, traumata, emergencies, and, in general, acute decompensations, rather than on personality disturbances, and its success is partly related to the patient's and the therapist's expectations.

The main criticism of brief psychotherapy centers on its lack of a theoretical dimension, as it is the result of the amalgamation of all kinds of practices derived from systems as diverse as psychoanalysis and behavior therapy (as illustrated in the recent book by L. Small, *The Briefer Psychotherapies).* This is certainly a considerable weakness, though certainly not unique in the field of psychotherapy, in the light of the unproven

assumptions of longterm psychoanalytic therapy. Nevertheless, in the context of the community mental health movement, brief psychotherapy will foreseeably acquire importance, necessitating proper theoretical formulations and methods of teaching.

Psychotherapy according to Interpersonal Theory, Cognitive and Volitional School, Communication Theory, and Transactional Analysis. Common to all these various trends—most of them already mentioned somewhere in this chapter—are their American origin (though not devoid of indirect European influences) under the impact of the melioristic approach of sociology in this country, their defense of the individual against dehumanizing forces, and their modest view of the role of the therapist as a mediator or interpreter in contrast to the omnipotent image of the psychoanalytic tradition. Moreover, their tenets have been illustrated by their various originators in a rather unsystematic way without the support of rigid organizations, justifying calling them trends rather than schools.

The *interpersonal theory* of behavior is mainly represented by K. Horney, H. Sullivan, and E. Fromm, Horney, influenced by character analysis (H. Schulz-Henke and W. Reich) and the American concept of the "self" (G. Mead), in a number of popular books illustrated the clinical implications of self, self-image and relationship of the self to others on the basis of the experience gathered at the Psychoanalytic Institute in Chicago and then at her

own American Institute of Psychoanalysis in New York City. While these notions have been relevant to American psychiatry, especially in the treatment of asymptomatic eharacterological patterns, her attempt to replace didactic analysis with self-analysis has been rejected.

Sullivan's lasting contribution to therapy, originated with the above-mentioned treatment of schizophrenic patients, lays in his emphasis on the role of the patient as "participant-observer" and the patient-staff interaction in the mental hospital, while his nomenclature of psychiatric conditions is now almost completely forgotten.

Fromm's numerous volumes, primarily addressed to the intellectual and progressive elite, stem from an attempt to combine Marx's notions (mainly the pathos of the "alienated" man in today's collective society) with psychoanalytic insight. Though very appealing, their relevance for psychiatry is quite limited.

The main thrust of the *cognitive and volitional school,* a new trend represented by psychiatrists and psychologists (A. Beck, J. Barnett, J. Bemporad, and others), has been clearly stated by S. Arieti, its originator, in Chapter 40C of this volume: "A stress on cognition and volition docs not imply that affects are not major agents in human conflicts and in conscious and unconscious motivation. It implies, however, that at a human level all feelings

except the most primitive are consequent to meaning or choice. In their turn they generate new meanings and choice." In essence primary consideration is given here to the cognitive dimension in its relation both to conflict and creativity in the light of its unique importance for the human condition.

The *communication theory* of behavior, influenced by philosophical analysis of language, linguistics, and notions of physical field and psychological field theory, has focused attention on the process of verbal communication through which psychotherapy occurs. General systems theory, mainly through the efforts of R. Grinker, has been particularly interested in the transactional perspective.

Finally Eric Berne (1910-1970) has described, in his popular and successful book *Games People Play,* his system of *transactional analysis* in which exteropsychic, neopsychic, and archaeopsychic ego states (colloquially called parent, adult, and child) are combined in the different forms of basic human interactions.

Psychotherapeutic Borderlines: Sensitivity Training, Encounter, and Marathon Groups

The various movements listed in this section are quite recent and all of American origin. Their rapid success in some quarters, mainly outside the realm of psychiatry proper, appears to derive from the increasing isolation

and alienation felt by many; paradoxically these feelings are reinforced by the close and impervious atmosphere of the individual psychotherapeutic relationship.

Historically the psychological aspects of the behavior of crowds were studied by French sociologists at the beginning of our century, followed by the development of social psychology and, in the forties, by forms of collective therapy. The founding of sensitivity training is attributed to the importance given to group self-evaluation during sessions for training of community leaders dealing with racial problems by three educational and social psychologists, L. Bradford, B. Lippitt, and K. Berne in 1946. Out of this initial effort, supported by the Gould Academy in Bethel, Maine, resulted the work of the National Training Laboratories. Eventually in the fifties the emphasis shifted toward individual self-actualization and in the sixties toward antiintellectual and nonconforming techniques.

A variety of issues have risen in connection with this movement: the transitional nature of their methods based on the "here and now"; their appeal mainly to sophisticated people (not "patients") of the East and West Coast; the call for "honesty" on the part of every participant and leader (and the consequent ambiguous role of the leader, perceived as a peer but different); the possibility of bringing underlying psychopathology to the surface through these sessions; and consequently the ethical aspect of the

leader's responsibility.

Similar issues have been raised in regard to nonverbal techniques emphasizing the unity of body and mind and grouped under the term of Gestalt therapy. Common to all of them (initiated by the neo-Reiehian A. Lowen with his bioenergetie group therapy) is the postulate that release of tension, which expresses itself through emotional disturbances or peculiarities of muscular posture, can be achieved just as successfully through physical activities as through verbal psychotherapy. The techniques developed at the Esalen Institute in California since 1964 by F. Peris, B. Schutz, and B. Gunther center around the manifestations of body language in a variety of ways.

For the historian it is too early to pass judgment on the significance of this movement, since it is not clear at this point whether it constitutes a momentary fad or the beginning of a new orientation in psychotherapy. It is a fact that systems of healing of classical Greece and of Eastern civilizations took into consideration the body as well as the mind, as pointed out in some publications (such as *Asian Psychology,* edited by G. Murphy and L. Murphy; *Psychotherapy East and West,* by A. Watts; and a number of monographs on Zen Buddhism). Those therapeutic methods, however, represented an expression of their own culture, while the methods described in this section appear to be isolated attempts to counteract the dehumanizing trends of our

civilization.

Research in Psychotherapy

Reference to research in regard to therapy, including psychotherapy, has already been made in some scattered passages in this chapter. However, the matter deserves more consideration in view of the importance of psychotherapy.

Two points stand out, in some way related to each other. In the first place psychiatrists appear to have been unconcerned traditionally with the careful assessment of the results and follow-up of psychotherapy. This attitude may have been due to a number of reasons: the discouraging number of variables intervening in the psychotherapeutic process; the lack of adequate training in research methodology for medical students; the exclusion of psychologists and other research-oriented nonmedical professionals from psychoanalytic associations; the adherence of each therapist to a particular school, which interferes with the objectivity necessary for research; the empirical attitude of the American mentality, coupled with a humanistic defense of the individual obviously opposed to the quantifying orientation of research; and finally an exaggerated concern about the confidentiality of psychotherapeutic scenes.

In the second place, partly as a result of this situation, partly as an

attempt to show their vital role in the field of psychotherapy, psychologists have taken most of the initiatives in regard to research on psychotherapy. This is substantiated by a perusal of the most important publications in this field such as *Methods and Research in Psychotherapy* edited by L. Gottschalk and H. Auerbach, *Research in Psychotherapy* by J. Meltzoff and M. Kornreich, preceded by the monographs *Research in Psychotherapy* (1959, 1962) published by the American Psychological Association.

Since most psychiatrists appear to disregard psychological literature, the introductory statement to a thorough review of the entire field of research in psychotherapy by H. Strupp and A. Bergin seems justified: "Thus far, research in psychotherapy has failed to make a deep impact on practice and technique." The few issues dedicated to this topic by the *American Journal of Psychotherapy*, the small monograph *Psychotherapy and the Dual Research Tradition* (1969) by the Group for the Advancement of Psychiatry, and the above-mentioned *Psychiatry as a Behavioral Science* edited by D. Hamburg do not essentially alter this statement.

This state of things, which accurately portrays the present situation, may, however, change in the future in connection with some developments: the decrease of the omnipotent image of the therapist and of the charismatic role of therapy; the influence of behavior models of psychotherapy conducive to measurement; and the overall political and social situation, which calls for

a more thorough justification of the use of public funds in the field of mental health, even in psychotherapy.

Milieu Therapy

The influence of the environment in the care and treatment of the mentally ill in any institutional setting may have been overlooked, but it has certainly been present from early times on. Evidence of the importance of environmental factors can be easily found in the early psychiatric literature at the beginning of the nineteenth century and then in the period of moral treatment. Eventually, with the prevalence of large mental hospitals in the latter part of the century, the environment became more custodial and impersonal.

The advent of the psychodynamic approach did not alter this situation as the focus came to be on neurotic, nonhospitalized patients. The same situation persisted with the introduction of shock therapies in the late thirties. Even the interpersonal theories of behavior that developed in this country, while reducing the omnipotent role of the therapist to more modest proportions, did not modify the essentially obscure role of the environment.

A substantial change, in the sense of the environment itself becoming the focus of attention, took place only in the mid-fifties in connection with some important studies: notably, *The Therapeutic Community* (1953) by M.

Jones in England and *The Mental Hospital* (1954) by Stanton and Schwartz, based on their experience at Chesnut Lodge, under the influence of F. Fromm-Reichmann, H. Sullivan, W. Menninger, and others.

Since then many studies carried on in mental hospitals have attempted to define the characteristics of the physical setting, roles and role relationships, authority and control, communication and culture in general. Much effort has been made to prove the underlying assumption that a stable environment, in which the operating forces are known, contributes to the reinforcement of the ego of the patient.

This has resulted in attempts at defining such forces in terms of conflict-free areas of the ego and adaptation (H. Hartmann), in terms of clarification and learning of roles (T. Parsons, G. Mead), on the basis of the notion of the field of forces (K. Lewin's "lifespace"), and from the overall perspective of Western democratic society. Up until now the best attempt to conceptualize the therapeutic areas of the environment remains *Ego and Milieu Therapy* by J. Cumming and E. Cumming. It is likely that in the future the therapeutic milieu will increasingly be considered as an open system from the viewpoint of the general systems theory and will be concretely affected by the movement of community psychiatry.

Psychiatric Education

From the broad perspective of systems of healing and attitudes toward the mentally ill in preliterate societies, it is clear that methods of apprenticeship for medicine men have been in use from earliest times (for instance, in the training of shamans in many cultures). Among their common characteristics were the "call" of the candidate through dreams, a period of isolation under the close guidance of an experienced healer, and finally the return to the community, which had definite expectations of supernatural powers in the new medicine man, to be manifested through rigidly established rituals. All this, of course, bears resemblance to the training of today's psychotherapists.

However, the awareness of these similarities is only recent. Traditionally psychiatric education has been traced back to the early nineteenth century, when young physicians underwent a highly personalized, yet unstructured, system of apprenticeship around moral treatment in the early mental hospitals in the Western countries. The decline of such a philosophy of treatment late in the century coincided with the rise of "scientific" psychiatry, mainly in German universities, based on the belief in the ultimate neuropathological etiology of mental disorders.

In this country, instead, psychiatric training (as well as research) continued to take place very empirically in mental hospitals, thus justifying the famous critical address given by the neurologist W. S. Mitchell in 1894 at

the occasion of the fiftieth anniversary of the American Psychiatric Association. Eventually a new spirit conducive to better training was introduced at the beginning of this century at the Worcester State Hospital by A. Meyer (who first developed there his “life chart” of the individual development of the patient). Later on the Henry Phipps Clinic at Johns Hopkins University also opened under Meyer’s leadership, following the model of the Kaiser Wilhelm Institute for Psychiatry in Munich, the so-called Kraepelin Institute.

Since then much has happened in the field of psychiatric training in this country. The American Board of Psychiatry was established in 1934 to set up standards of training and certify physicians in the specialty of psychiatry." Around the same period teaching in psychiatry came to be organized, both at the undergraduate and at the postgraduate levels, in a number of hospitals and outpatient facilities with the help of private foundations (especially the Commonwealth Fund and the Rockefeller Foundation) and a few interested professionals (such as A. Gregg, F. Ebaugh, and C. Rymer, authors of *Psychiatry in Medical Education*, and H. Witmer, who published *Teaching Psychotherapeutic Medicine).*

World War II, by emphasizing the great need for psychiatry, led to a vast program of psychiatric training by the Veterans’ Administration. From the early fifties on, such a program has been undertaken almost exclusively by

the National Institute of Mental Health through its division of training and manpower. By the time the First Conference on Psychiatric Education was held at Cornell University in 1951, the report on medical education sponsored by the Group for the Advancement of Psychiatry (1948) had identified the main areas of training as personality development, unconscious motivations, and dynamic comprehension of the individual case; a program of "comprehensive medicine" inclusive of psychological development and case work principles was developed in some medical schools (Western Reserve, Colorado, Pennsylvania, Tennessee, and Harvard); and departments of "behavioral sciences" and courses in "human ecology" were offered by others (Syracuse and North Carolina, respectively).

In the fifties, with the rise of psychoanalysis, the issue of psychoanalytic training as an essential aspect of the training of the psychiatrist, to be carried on independently in psychoanalytic institutes or in the framework of medical schools, became outstanding (for example, in the 1954 symposium in the *International Journal of Psychoanalysis* and in F. Alexander's *Psychoanalysis and Psychotherapy).* Despite the many controversies, this issue is still unsettled today, but it has been essentially bypassed by the events related to the decline of the psychoanalytic movement and the parallel rise of the community mental health movement. Instead, what has remained of the psychoanalytic influence has been the system of supervision, defined in its threefold aspect of patient-centered, process-centered, and trainee-centered,

especially in the well- known study by R. Ekstein and R. Wallerstein.

In the last two decades most of psychiatric training has taken place with the support of the federal government: the original program of NIMH began with a little more than 200 grants annually and now is in the realm of 10,000. This has had, on the one hand, the advantage of fostering a certain degree of homogeneity and of maintaining high standards; on the other hand, it has tended to favor large and well-known centers located in urban areas, thus interfering with the aim of making psychiatry available even in less populated areas of the country.

Serious efforts have been made toward offering a comprehensive type of training, including experience in state institutions, outpatient clinics, special facilities (for example, for children or for delinquents), and presenting a manifold philosophical orientation (genetic, organicistic, psychodynamic, and epidemiological) and various therapeutic approaches (chemotherapy, individual as well as group and family therapy, and others). In view of the vastness of each new field of psychiatry, such an ambitious program can be realistically carried on in very few places.

Likewise, limited success has characterized the various efforts to influence practicing physicians to take a more progressive attitude toward psychiatry and emotional disturbances in general, either at the

undergraduate level or at the postgraduate level, with the help of federally supported seminars. In spite of the widespread belief of the pervasive influence of mental on physical pathology in many patients (as represented in the appealing volume *Man, Mind and Medicine,* edited by the distinguished surgeon, Oliver Cope), only slow gains toward the acceptance of psychiatry have been made thus far among the already established professionals. The young physicians recently graduated from medical schools seem to be more open-minded toward psychiatry, even in regard to some new controversial therapeutic group approaches.

Recent developments in the field of psychiatric education include the tendency toward specialization in psychiatry during training in medical school and toward training in a subspecialty of psychiatry during the residency period (initiated at Yale); the concern for providing adequate training in community psychiatry, especially in regard to urban problems; the controversies related to discontinuing the internship before the psychiatric residency (as a result of the Mill's Citizen's Commission on Graduate Medical Education in 1966); finally the programs for continuing education for psychiatrists (mainly under the leadership of the late W. Earley) and the self-assessment project sponsored by the American Psychiatric Association

The future of psychiatric manpower remains far from bright although between 10 to 20 percent of medical students decide now to embrace

psychiatry, which has become the third largest specialty. Also a cause of concern is the shortage of psychiatrists actively involved in research, in spite of the efforts made by the National Institute of Mental Health.

In recent years it has become apparent that many young psychiatrists are interested in humanistic medicine, that is, in the comprehensive approach to patients of any social class and their families and communities. Unfortunately the training of the physician and, subsequently, of the psychiatrist is so long as to discourage a number of young men from entering this field. This has given further impetus to the proposal—advanced by L. Kubie years ago—to establish a doctorate in medical psychology. In view of the traditional determination of professional psychiatric and psychoanalytic organizations to limit training in psychotherapy to physicians, this has remained a very debatable issue up until now. But efforts in this direction continue to be made, as evidenced by the recently published book *New Horizons for Psychotherapy, Autonomy as a Profession,* edited by R. Holt.

The future of psychiatric education, though promising in terms of innovations and increased flexibility, has recently been clouded by the financial restrictions applied to the budget of the National Institute of Mental Health. This may result in a broader support of training at the state and local levels, whose impact in psychiatry is difficult to assess at the present moment.

American Psychiatry in the Context of Psychiatry in Other Countries

Within the limits of this chapter it is possible only to present some general trends concerning the interplay of psychiatry in the United States and in other countries, the reciprocal influence of models of the mind and therapeutic methods, and the foreseeable developments in the future. Since no comprehensive publication on psychiatry throughout the world exists at the moment, the following remarks are the result of a broad perusal of pertinent literature scattered in many publications. The lack of a comprehensive view on this subject here is partially compensated for by the various references to theoretical and practical aspects of psychiatry in other countries made in other sections of this chapter.

From the overall historical perspective the relevance of discussing psychiatry abroad for a better comprehension of American psychiatry is unquestionable, at least on three grounds: (1) the manyfold cultural traditions from Europe, Africa, and, to a less extent, other continents that are the basis of American society; (2) the persistent interest that this country has had in supporting scientific and humanitarian projects abroad, especially in Western countries damaged by World War II, some countries of Latin America, and newly developing Afro-Asian areas; (3) the convergence of practical methods of healing carried on in underdeveloped countries and approaches to community mental health recently introduced in this country.

Even a succinct discussion of the above points calls, however, for some preliminary considerations. The methodological perspective in the comprehension of other countries has undergone a tremendous change in the course of the century and a half of development of modern psychiatry. During a good part of the nineteenth century American psychiatry tended to follow European psychiatry, first in regard to the practical aspects of moral treatment, then in regard to the clinical orientation of the French school and the theoretical research on neuropathology of German universities. The acceptance of the Freudian message, prepared for by the emphasis on environmental factors in the etiology of emotional disturbances brought forward by various trends (progressivism, behaviorism, Meyer's psychobiology), led to the tendency to assess mental pathology and attitudes toward the mentally ill in our country from the almost exclusive perspective of psychoanalysis up until recently. Finally, parallel to the spread of the community mental health movement and to the progress in communication systems (easy transportation, international meetings, speedy translations), approaches to mental illness and its treatment carried on in other countries are becoming more known even in the United States.

Concomitant with this has been a better definition of the three growing fields of: (1) *trans*cultural psychiatry, in which scientific observation is extended to non-Westem practices; (2) *cross*-cultural psychiatry, which focuses on comparative and contrasting dimensions of psychiatry in various

countries; (3) *international* psychiatry, which emphasizes teaching, training, and, in general, organizational aspects in the different political entities of the world. These three fields overlap to a certain extent, and, furthermore, a thorough discussion of the first two will be offered in other sections of this handbook. Consequently here the presentation will be limited mainly to the developmental aspects of international psychiatry, which is not covered elsewhere.

In spite of the tendency toward the spread of Western practices all over the world, resulting in the transformation of "pure" cultures into cultures at different levels of acculturation, for didactic purposes the following discussion is divided into: (1) countries of the Western tradition, that is, mainly Europe (including Russia), Canada, Australia, South Africa, Israel, Latin America; (2) countries of the Far Eastern tradition, that is, India, Japan, China, and some others; and (3) international psychiatry. The developments of psychiatry in these various countries will be presented essentially in their relevance to American psychiatry.

Psychiatry in Countries of the Western Tradition

On the one hand, in view of the different ethnic, cultural, economic, and political aspects of the many countries of the Western tradition, it is impossible to present the developments of psychiatry in a compact and

unitary form. On the other hand, the interchange of ideas and people among these countries has been so great that it is impossible to conceive of the developments of psychiatry in each one of them independently from the others. Yet some general characteristics have emerged in most of these countries, and the discussion will center around them.

To begin with, a few main aspects stand out clearly on the basis of some important publications by G. Allport, H. Ellenberger, L. Beliak, and a few others. There are many similarities between British and American trends, at variance with continental trends: the empirical tradition (derived from Locke), which emphasizes environmental forces, social interaction, and optimistic expectations; a positivistic approach to the formulation of "brain models"; the study of traits, attitudes, and motivation rather than the total personality; the tendency to consider mental disturbances as "reactions" rather than symptoms; the inclination toward pragmatic use of therapeutic methods developed somewhere else regardless of theoretical speculations; finally the interest in experimentally testing the above methods by interdisciplinary teams of scientists. The main difference between Great Britain and the United States consists, of course, in the uniformity of the ethnic and cultural scene of the former vis-a-vis the racial and social pluralism of the latter, with definite repercussions on psychiatry. This is reflected in the mobility of professionals in psychiatry and collateral fields, leading to rapid spread of ideas, homogeneity in clinical practices, and eclectic

approaches.

In contrast, Continental Europe, with the notable exception of Russia and, to a less extent, of other communist countries, has been characterized by the rational tradition (derived from Leibnitz and Kant), which has resulted in a more philosophical view of mental life; the persistent concern with the "whole man," which stems from the Greek tradition and which is somehow responsible for a humanistic (and humanitarian) orientation; a pessimistic orientation toward life in general, probably influenced by the long-term experience of wars, migrations, famines, exterminations, and other horrible events, as evidenced by Freud's preoccupation with death and by the dramatic aspects of the existentialist movement; a concern with the individual rather than with the social dimensions of the personality; a preoccupation with symptomatology and diagnostic categories at the expense of therapeutic efforts; a succession of brilliant "discoveries," from psychoanalysis to shock treatment, psychopharmacology, and community psychiatry, by isolated scientists; finally a tendency toward fragmentation of psychiatric theory and practices into definite "schools," each one led by an academician and followed by his pupils (and represented by special journals and publications), quite often bitterly opposed to each other.

In general, it is very difficult to follow the developments connected with the interrelationship of American and European psychiatry. Regardless of

differences due to language barriers, personality patterns, and social customs, the traditional influence of European on American psychiatry underwent a significant change after World War II; such an influence persisted in regard to discoveries and introduction of new therapeutic systems (for example, in community psychiatry), but was paralleled by an opposite influence of American on European psychiatry, especially in the fields of psychoanalysis, child psychiatry, research, and training.

Historically it would appear that certain periods have been characterized by a common psychiatric approach in Europe and the United States: (i) moral treatment in the early nineteenth century; (2) organicistic philosophy in the late nineteenth century; (3) psychoanalytic influence in the early twentieth century, followed by an interest in shock treatment later on; (4) psychopharmaeologi- cal approach and methods of community psychiatry in the last two decades. For the purpose of this chapter the discussion will be necessarily limited to this last point, as advances in chemotherapy have already been discussed above, also from the international perspective.

Interest in community psychiatry began to be noticeable in this country in the mid-fifties, following the important publications in England on the "open-door policy" in mental hospitals, on day hospitals (J. Bierer), and on the therapeutic community (M. Jones), as well as the successful program of public mental health introduced in Amsterdam by A. Que- rido.

Shortly thereafter, the volume *Impressions of European Psychiatry* (edited by W. Barton, *et al.)* appeared in 1959 under the sponsorship of the American Psychiatric Association. It then became evident what the main positive aspects of European psychiatry consisted of: a better reciprocal respect between patients and staff in institutions, probably because of the humanitarian tradition, systems of education, and division into rigid class systems; a more supportive role by physicians (paternal), by nurses, at times religious (maternal), and by community resources of all types (this latter related to the social stability of the population), resulting in better systems of communication, involvement with families, partial hospitalization, and follow-up; a flexible therapeutic approach, based on chemotherapy and short-term psychotherapy, and carried on by a dedicated staff more interested in their professional vocation than in financial rewards. On the negative side were the uneven and loose systems of training, the lack of systematic support for research even to dedicated scientists, the resistance of professionals to work in interdisciplinary teams (especially in areas such as child psychiatry where this approach is most valid), the dependence of psychiatry on neurology in some Latin countries, the tendency to centralize the decision-making process in psychiatry (be this service, training, or research) on a few people.

Interesting enough from the historical perspective is the fact that European psychiatry, which appeared to be backward when seen from the

American psychoanalytic viewpoint of the fifties, was seen as advanced from the viewpoint of community psychiatry of the sixties. Somewhat related to a more tolerant attitude toward the mentally ill on the part of society, which is basic to community psychiatry, is the pervasive European belief that mental illness is *occurring to* an individual rather than being *synonymous with* him (that is, a patient "has" a schizophrenic illness, but he is not "a schizophrenic").

In *Great Britain* the brilliant psychiatric tradition, initiated with the "moral treatment" and the movement of "no restraint" in the early nineteenth century, was later influenced by the evolutionary concepts of C. Darwin, T. Huxley, and H. Jackson. At the beginning of this century, under the impact of Meyer's psychobiology and Freud's notions, psychoanalysis received great impetus there, mainly through the work of E. Jones. Eventually a good number of psychoanalysts preferred to accept the concepts advanced by M. Klein and even to follow ideas put forward by C. Jung. The trend of organicistie psychiatry has remained very strong, however, in line with the excellent neurological tradition. Training and research are mainly carried on at the Tavistock Institute of Human Relations and at the University of London Institute of Psychiatry, linked to Bethlem Royal Hospital and Maudsley Hospital, while the most important periodical is the *British Journal of Psychiatry* (which superseded the *Journal of Mental Science).* Many of the 3,350 practicing psychiatrists hold the Diploma in Psychological Medicine and

gather around the Royal Medico-Psychological Association, founded in 1841. Among the most prominent psychiatrists are (or have been) D. Henderson, D. Hill, J. Bowlby, E. Miller, A. Lewis, D. Winnicott, W. Fairbain, W. Sargant, D. Leigh, J. Howells, and G. Carstairs. Since 1930, when the Mental Health Act was passed, the social dimension has continually gained importance in psychiatry: in 1948 the National Mental Health Service Act placed the care and treatment of the mentally ill under the Ministry of Health on a regional basis; the Mental Health Act of 1959 removed any legal distinction between patients in psychiatric and in general hospitals. The great majority of psychiatrists work in the context of social medicine and private practice is very limited.

In *France* the pioneering work of Pinel was followed by his favored pupil Esquirol and by many others mainly interested in the clarification of clinical symptoms, in the connection with neurology and in legal- psychiatric matters in the mid-nineteenth century. Later on the advances made in neurophysiology (C. Bernard), psychopathology (T. Ribot), experimental psychology (A. Binet), and social psychology (E. Durkheim and others) were overshadowed by the clinical application of hypnosis to neurotic disorders by the school of Salpetriere in Paris (J. M. Charcot) and by the rival school of Nancy (H. Bernheim and A. Liebeault), both of which influenced Freud directly as well as P. Janet (1859-1947). Through Janet and some of his early disciples the psychoanalytic movement developed on a limited scale, also

with the support (in contrast to the belief of many) of some progressive Catholic quarters. Aside from some psychotherapeutic innovations (such as the technique of "directed daydream" by R. Desoille) the most important event has been the secession from the Psychoanalytic Society of Paris by the French Psychoanalytic Society, led by D. Lagache and J. Lacan; the latter is the author of a famous paper (1953) in which he identified the structure of the unconscious with the structure of the language. Another important group of psychiatrists has centered around the journal *Evolution Psychiatrique,* mainly dominated by F. Minkowsky, a pioneer in the field of phenomenology (represented by M. Merleau-Ponty) and not immune from existentialist influences (J.-P. Sartre). In recent years the two psychiatrists J. Delay and H. Ey, both authors of many publications aiming at the integration of organic and dynamic concepts, have acquired prominence. Recognition has also been given to projects in community psychiatry (especially in the thirteenth arrondissement in Paris). The new trend of structuralism—mainly represented by the anthropologist C. Levi-Strauss and the philosopher M. Foucault (the latter is the author of an important historical study of psychiatry in the age of the Enlightenment)—may also influence psychiatry considerably. Finally mention should be made of the traditional international role played by France, which has contributed to the communication of ideas; in Paris were held both the First International Congress of Child Psychiatry (1937) and the First World Congress of Psychiatry (1950).

Belgium, the country where family care of the mentally ill was continued uninterruptedly at Gheel from the thirteenth century to the present, has essentially followed the French tradition. At the Catholic University of Louvain, where psychology was initiated by Cardinal Mercier, efforts to combine psychoanalysis with a spiritualistic conception of man were made by A. Michotte and J. Nuttin. The *Netherlands,* where J. Wier, the sixteenth-century pioneer of modern psychiatry was born, has lately become known for the important school of phenomenology (J. Buytendijk, H. Van den Berg, H. Rümke, and others) and for advancements in community psychiatry (A. Querido).

In *Germany* psychiatry appears divided into many schools, historically explainable on the basis of the political and academic independence of each region. The controversy between the "mentalists" and the "somatists" in the early nineteenth century resulted in the predominance of the latter, represented by W. Griesinger and later by the school of anatomopathology and histopathology (C. Wernicke, T. Meynert, O. Vogt, and others). Early in this century, preceded by the clinical contributions of E. Hecker and K. Kahlbaum, E. Kraepelin established the fundamental dicot- omy of manic-depressive psychosis versus dementia praecox, which influenced nosology everywhere. It was followed by the constitutional school of personality of E. Kretschmer and by the important trend of genetic psychiatry, mainly represented by E. Rudin and his pupil, F. Kallmann; the latter was active for

many years at the New York Psychiatric Institute. It is regrettable that in Germany some adherents to genetic psychiatry attempted to offer scicntific justification for the Nazi persecution of the Jews and the alleged superiority of the Aryan race. In the thirties for a few years the Berlin Psychoanalytic Institute, where didactic analysis was first introduced, acquired prestige. After World War II the various psychiatric trends have all been influenced by the existentialist movement, anticipated by the philosophers Husserl and Heidegger: the clinical contributions by H. Griihle, V. Gebsattel, V. Weizsacker, K. Kolle, as well as the so-called neopsychoanalytic movement of H. Schultz-Henke, the current centered around the journal *Psyche* (edited by A. Mitscherlich), the yearly "Lindauer Psychotherapeutic Week" organized by Speer and others. Mention should also be made of J. Schultz-Henke's "autogenic training," which combined Western and Eastern healing practices, the contributions to ethology by K. Lorenz and others (N. Tinbergen, C. Schiller, H. Hass), and the recent studies dealing with sociological (including Marxist) aspects of psychology, preceded by the pioneering work by T. Adorno in this country and then in Germany (especially his study on the authoritarian personality). Valuable historical studies on psychiatry have also appeared there.

In *Austria* basic concepts of mental hygiene anticipating psychodynamics advanced by E. von Feuchtcrslebcn (*Textbook of Medical Psychology*, 1845) and, later on, studies by the organicistic school (T. Meyncrt,

R. Krafft- Ebing) received impetus through the renown of the medical school of Vienna and the extension of the Austrian empire. For the past two decades or so the developments of Freud's ideas and of the psychoanalytic movement have been the subject of many studies in the United States. In Austria, however, Freud's role remained quite limited among his contemporaries, when compared with the success achieved by the Nobel Prize winner Wagner- Jauregg, discoverer of malaria therapy (1917) and, later on, by M. Sakel who introduced insulin therapy in the thirties. Almost all of Freud's pupils from Austria (as well as the sympathizer P. Sehilder, whose studies on the body image and on clinical applications of psychoanalysis have become largely known in this country) emigrated to the United States, with the exception of A. Aichhom, who did pioneering work on the psychoanalytic treatment of juvenile delinquents. In recent years, aside from academic psychiatry (mainly represented by A. Stransky and H. Hoff), recognition has been accorded to logotherapy (V. Frankl) " and so-called personalistic psychoanalysis (I. Caruso, W. Dain), which emphasizes values and the purpose of life rather than gratification of instincts. '

SwitzerIand has gained an important place in the development of modern psychiatry, probably owing to its geographical location, traditional neutrality, and multilingual background. In Geneva psychology was cultivated at the Institut Rousseau in succession by T. Flournay, E. Claparede, and J. Piaget (whose studies on the development of the child have become

universally known and have increasingly been compared with psychoanalysis). Except for the method of “sleep therapy” introduced by J. Klaesi in Bern in 1922, psychiatry, instead, has traditionally flourished in Zurich, mainly at the mental hospital of Burghholzli, directed in succession by A. Forel, E. Bleuler (who coined the term “schizophrenia”), " and then M. Bleuler. There A. Meyer received his first psychiatric training before moving to this country; the clinical application of psychoanalysis was first introduced by C. Jung (who wrote his famous works on dementia praecox and word associations early in this century); and H. Rorschach developed his test that soon became known the world over. Aside from Jung’s followers such as C. Meier, C. Kereny, and others, gathered around the Jung Institute in Zurich and the so-called Eranos meetings in Ascona, worth remembering are the names of the psychoanalysts R. De Saussure, C. Baudouin, O. Pfister, A. Maeder, E. Oberholzer (who moved to New York City, where he introduced the Rorschach test in the twenties), and H. Zulliger. In recent years existential analysis—mainly represented by L. Binswanger, M. Boss, G. Bally and a few others, all originally influenced by psychoanalysis—has acquired momentum. Aside from biological studies relevant to psychosomatic medicine and psychodynamics (R. Brun, A. Portmann) and eharaeterological studies (L. Klages, L. Szondi), two main trends have emerged in Switzerland: child psychiatry, mainly represented by A. Repond, M. Tramer, L. Bovet, J. Lutz, and H. Hanselmann (who initiated the movement of “Heilpiidogogik” on

therapeutic education), and known through the international journal *Acta Paedopsychiatrica;* and the psychotherapeutic treatment of schizophrenia, which, related to the pioneering contributions by C. Jung, E. Bleuler, and A. Storch, has been applied first by M. Seehe- haye with her technique of "symbolic realization" and then by C. Müller in Bern and by the Italian-born G. Benedetti in Basel. Finally mention should be made of the outstanding contributions made by some chemical companies of Basel to the development of psychopharmacology and of the role played by Switzerland in sponsoring international meetings (notably, the First International Congress on Therapeutic Education in 1939 and the Second World Congress of Psychiatry in 1957, both held in Zurich).

In *Scandinavian countries* psychiatry has been dependent on the German tradition up to World War II and on the English tradition thereafter. The psychodynamic influence has been limited; it is important mainly at the Erica Foundation for Child Guidance in Stockholm and at the Therapeia Foundation recently established in Helsinki by the Swiss-trained M. Siirala. In view of the stability of the social situation and the long-term absence of great military conflicts, research on hereditary factors in mental illness has received a great deal of attention (T. Sjogran, G. Langfeldt) in the context of a strongly supported organicistic framework in psychiatry, as evidenced by the studies published in the important journal *Acta Psychiatrica et Neurologica.* The broad-minded social legislation enacted in Scandinavian countries for

some time has brought about successful developments in community mental health.

Italy, Spain, and Portugal are presented together here because of close ethnic, religious, and cultural affinities that justifiably can be extended to psychiatry. In these countries care of the mentally ill has had an illustrious, centuries-old tradition, psychiatry has been predominantly organicistic and dependent on neurology, and psvchodynamics has been opposed by the Fascist and Franchist political regimes on various grounds. In *Italy* the pioneering reform in the treatment of mental patients introduced by V. Chiarugi in Florence at the end of the eighteenth century was soon forgotten. Instead more recognition was accorded to the histoneurological studies by the Nobel Prize winner C. Golgi and the pathographic studies by C. Lombroso —the founder of criminal anthropology—early in this century. At the University of Rome S. De Sanctis's notions on child psychosis (*Dementia praecocissima,* 1906) were soon overlooked, while electric shock introduced by U. Cerletti and L. Bini in the late thirties was applied everywhere. Recently interest in psychoanalysis and existentialism has increased.

Spain, considered "the cradle of psychiatry" because of the foundation of some pioneering mental hospitals in the fifteenth century, later on went through a long period of decline. Only at the beginning of this century ample recognition was granted to the studies on histopathology of the nervous

system by Ramon y Cajal and his school. In recent years psychodynamic and existentialist concepts have gained momentum there (J. Lopez-Ibor, R. Sarro), and psychiatry has been given more recognition, as evidenced by the Fourth World Congress of Psychiatry held in Madrid in 1966. Important studies on the history of psychiatry have been published there. *Portugal* has become known in psychiatry because of the introduction of frontal lobotomy there in 1936 by E. Moniz, who eventually received the Nobel Prize.

Among the various countries of the British Commonwealth, *Canada* has traditionally been in the unique position of economic and cultural dependence on the United States. In fact, developments in Canadian psychiatry have been often considered in conjunction with American psychiatry, and the interchange of professionals has always been very high (for example, C. Farrar from Toronto was for many years editor of the *American Journal of Psychiatry*, and E. Cameron was elected president of the American Psychiatric Association). The psychoanalytic movement, first introduced by E. Jones in Toronto early in the century and then dependent on the British association, gained autonomous status in the fifties. It has been heavily influenced by Catholic philosophy in the French province of Quebec (for example, by K. Stern in his *The Third Revolution* and by N. Mailloux at his Centre d'Orientation for delinquent adolescents in Montreal), where religious orders have taken care of institutionalized mental patients for the past two centuries. Academic psychiatry has been particularly cultivated in Toronto

(mainly at the Toronto General Hospital and at Clarke Institute founded in 1966) and in Montreal, where the Allen Memorial Institute at McGill University (opened by E. Cameron in 1944) has acquired prominence through the work by E. Wittkower on psychosomatic medicine and transcultural psychiatry, R. Cleghorn on neuroendocrinology, H. Lehmann on psychopharmacology, as well as through the participation of fine neurologists (W. Penfield, H. Jasper, F. Gibbs, E. Gibbs, and H. Selye, who described the general adaptation syndrome). Since the 1,600 practicing psychiatrists are mainly located on the east and west coasts, efforts have been made (for example, through the report *More for the Mind* published in 1963 by the Canadian Mental Health Association under the leadership of J. Griffin) to establish a network of services of community psychiatry throughout the whole nation. Such an endeavor, also supported by the Canadian Psychiatric Association (founded in 1951), has already led to considerable progress in some provinces, notably in Saskatchewan, as reported in the *Canadian Psychiatric Association Journal* published since 1956. The Third World Congress of Psychiatry was held in Montreal in 1961.

In *Australia* the 500 practicing psychiatrists are increasingly involved in a vast program of mental health services (following the project initially developed by the State of Victoria, where a Mental Health Research Institute has been operating under A. Stoller since 1955), while relatively few take part in the psychoanalytic movement (at the Melbourne Institute of

Psychotherapy).

In *South Africa, Hong Kong,* and other countries of the Commonwealth, aside from development of the Western practice of psychiatry, important research on transcultural psychiatry has been carried on.

Israel, a small and young nation, offers a great deal of interest for psychiatry. Even before that country officially became independent in 1948, some psychoanalysts practiced there: M. Eitington from Berlin, P. Wolff from Russia, and E. Neumann of the Jungian school. Since its founding Israel has become a fertile ground for psychiatry in three main areas: (1) coping with psychiatric problems of migration and acculturation, related to the rapid conglomeration of people from many parts of the world (for example, *Migration and Belonging* by A. Weinberg); (2) establishment of a decentralized program of community psychiatry (in general hospitals, special centers, "therapeutic communities," and "work villages") facilitated by the lack of a tradition of institutional psychiatry; (3) relevance for personality development and psychopathology of raising children in the collective form of the kibbutz, made the subject of many studies even by American authors. In the academic field psychiatry is cultivated at Tel Aviv University and Hadassah University in Jerusalem, and research is published in the *Israel Annals of Psychiatry and Related Disciplines.*

Psychiatry in *Latin America* offers a very complex and varied impression owing to marked differences in the ethnic composition (especially Indians), geographical and cultural situation, economic and social level in each country, in addition to the unstable political scene. Yet certain common trends can definitely be seen everywhere: Western psychiatry has tended to be practiced mainly in urban areas under the strict leadership of a university professor; the prevailing psychiatric orientation was dependent on the French tradition in the mid-nineteenth century, later on the German tradition, and after World War II on the American tradition; in many countries methods of indigenous psychological healing continued to be practiced in preliterate cultures, though increasingly influenced by Western civilization.

The efforts made toward improvement in the field of psychiatry by the Inter-American Council of Psychiatric Associations—including the American, the Canadian, and the Latin American Associations—have led to rather meager results thus far. In general, most of the broad long-range projects initiated in Latin America tend to achieve limited results because of social and political difficulties.

Puerto Rico is in a particular situation, since a considerable percentage of its population has relocated itself in the United States since the end of World War II. From the psychiatric perspective two main areas are thus identifiable: (1) the psychiatric problems presented by those who decided to

resettle in American communities, related to the dynamics of separation from their background and difficulties in acculturation (language barriers, loss of the extended family, stress of urbanization and industrialization, and so forth) and resulting in a colorful psychopathology characterized by the so-called Puerto Rican syndrome " (a sort of hysteric attack highlighted by sudden loss of control, falling to the floor, and hyperkinetic movements of various kinds), frequent suicide attempts, and a high percentage of psychosomatic (especially asthmatic) disorders, for which short-term psychotherapy and chemotherapy carried on in emergency services and storefront facilities appear most successful; (2) the psychiatric problems of the population remaining in Puerto Rico, taken care of by about 100 psychiatrists. Most work in institutional settings, and others are connected with the Puerto Rican Institute of Psychiatry, reorganized in 1958 with American help but functioning under local leadership (E. Maldonado, R. Fernandez, and others).

In *Mexico* the American influence has been particularly strong, both in the overall field of psychiatry (mainly represented by A. Millan, R. de LaFuente, J. Velasco Alzaga, and others) and in psychoanalysis (E. Fromm has been active since 1951), as evidenced by the Fifth World Congress of Psychiatry held in Mexico City at the end of 1971. Knowledge of the family and cultural background underlying individual psychopathology (extended family, masculinity of the man and dependence of the woman, formalistic expressions of social behavior, etc.) has been increased through the

anthropological books of O. Lewis *(Life in a Mexican Village,* 1951).

In *Cuba* the traditional American influence on psychiatry has been drastically reduced by the advent of the Marxist regime. A magazine on transcultural psychiatry *Revista de Psiquiatria Transcultural* is edited there by the leading psychiatrist, J. Bustamante. Likewise, it is difficult to assess the position of psychiatry in *Chile,* where psychodynamic concepts were introduced in the past (mainly by J. Matte-Blanco and C. Nassar), after the rise to power of the leftist government of the physician S. Allende, who was himself interested in mental health in the thirties.

In contrast, the situation has remained more conservative in *Colombia,* where C. Leon is the most active psychiatrist, and in *Peru,* where psychodynamic notions were introduced first by H. Delgado and later by C. Seguin and where an Institute of Social Psychiatry was founded in 1967 at the University of San Marcos in Lima, the oldest medical school in the American continent.

In *Brazil* psychiatry has developed mainly in the coastal cities, while in the interior—as in other Latin American countries—systems of healing are still carried on in the traditional framework of preliterate societies. In Rio de Janeiro after World War II the German-born W. Kemper introduced psychoanalysis and the Spanish-born E. Mira was active in various areas of

psychiatry. More recently impetus for psychiatry has been provided in Sao Paulo by A. Pacheco e Silva.

Finally in *Argentina* psychiatry and, in particular, psychoanalysis have acquired a great deal of acceptance, probably as a result of the immigration there of some Jews from Central Europe in the thirties, followed by many other immigrants in the late forties. All this overshadowed the fact that important pioneering work in psychiatry by some pupils of the Italian Lombroso had taken place there early in the century. The Argentine Psychoanalytic Association, founded in 1942, publishes the important *Revista de Psicoanalisis* of eclectic orientation (that is, influenced by Kleinian, Adlerian, and Jungian trends). Recently some have followed Pavlovian concepts. Among the professionals recognition has been won by A. Garma for his studies on peptic ulcer and by E. Krapf for his influence in the academic field. A National Institute of Mental Health, aimed at providing better facilities for the mentally ill throughout the whole country, was founded in 1957.

Russia and the communist countries offer a rather complex and varied picture from the historical perspective. Russia and Yugoslavia present a manifold background in terms of ethnic, linguistic, and religious dimensions; in most communist countries, with the exception of Czechoslovakia and, to a less extent, of Russia, an agricultural economy prevails. Also their allegiance to the Marxist doctrine is not homogeneous. In terms of psychiatry proper,

Western influences have always been prominent, first the German organicistic school in the mid-nineteenth century, then the French clinical school of hypnosis at the end of the century, followed by a short-term Freudian orientation in the twenties, and, from then on, by the Pavlovian doctrine. ”

Russian psychiatry remained virtually unknown to the United States because of the reciprocal attitude of diffidence and lack of contact. Since foreign travelers have been admitted to communist countries in the last decade, a number of reports (including an official one by a special mission of the American Psychiatric Association in 1967) have become available. It has been found that Russia has developed a network of services for mental patients, first at the level of the polyclinic (one for every 5,000 people), then the neuropsychiatric dispensary (one for every 500,000 people), and finally the district mental hospital, in all of which extensive work on prophylaxis, diagnosis, and rehabilitation takes place. Such work is possible because of the large number of physicians (more than 600,000 mostly women), nurses, and medical technicians (that is, paraprofessionals, called “feldshers”) available in community facilities as well as in mental hospitals (where the ratio of physicians to patients is 1:16). Therapy centers around social readaptation, by keeping patients as “vertical” as possible and by the eclectic use of short-term supportive relationship, chemotherapy, suggestion (up to hypnosis), and an extensive program of day care (initiated in 1930) and sheltered

workshops, often in conjunction with industries. In contrast to the United States, the conception of psychiatry from the narrow “medical” perspective (reinforced by the view of psychodynamics as linked to the bourgeois system), " with the consequent complete absence of the collateral fields of clinical psychology and social work, the limited research facilities (mainly at two centers in Moscow and Leningrad), and the recently established complacency of some psychiatric hospitals in certifying as mentally ill enemies of the regime have naturally been seen in a very negative light.

Despite this, Soviet psychiatry, in the past considered backward from the psychoanalytic viewpoint, has recently elicited a favorable or at least an interested attitude in this country for two reasons: from the perspective of therapy, because of the spread of behavior therapy, whose philosophy has been heavily influenced by Pavlovian notions; from the perspective of community psychiatry, because of the apparent success achieved in providing services for the mentally disturbed at the community and district level. Aside from the 20-year-old monograph on Soviet psychiatry by J. Wortis, the recent historical study by J. Brozek and D. Slobin, and some reports by Russian authors translated into English, much more direct knowledge of psychiatry, especially in relation both to the scientific attitude and the political dimension, is needed. It looks as if both the United States and Russia may gain from the reciprocal observation of their psychiatric systems.

The other *communist countries* present considerable differences from Russia because of the reasons mentioned above, in spite of the efforts made by them to introduce a national system of psychiatric services early in the fifties. *East Germany, Hungary, Czechoslovakia,* and the *Croatian part of Yugoslavia* tend to be heavily influenced by Western psychiatric concepts, which had a long tradition in each one of them. In *Poland* much of the care for the institutionalized mentally ill is still in the hands of Catholic orders, while in *Bulgaria* and *Runumia,* as in the rest of the communist countries, systems based on Pavlovian principles are reinforced under the pressure of political forces. Even more than for Russia, firsthand reports (with the exception of the books edited by A. Kiev and by J. Masserman, respectively) are lacking.

Psychiatry in the Countries of the Far Eastern Tradition

From an overall historical perspective—and taking into consideration the need to simplify matters in a short historical presentation—the countries of the Far Eastern tradition can roughly be divided into three types: (1) those that developed as part of the British Commonwealth (India, Ceylon, etc); (2) those in which psychiatry consisted of the amalgamation of autochthonous practices and Western concepts (Japan, Philippines, Taiwan); (3) and those in which indigenous practices were only very limitedly influenced by foreign notions.

In *India* official psychiatry was once represented by the Indian Division of Royal Medico-Psychological Association, which in 1947 became the Indian Psychiatric Society. Today there are about 200 psychiatrists for a population of more than 500 million. Psychiatric facilities tend to be undeveloped, and many mentally ill receive minimal care in their communities. Worth mentioning is the rapprochement between traditional Hindu concepts of the mind (yoga and others) and some contemporary Western systems.

In *Japan* academic psychiatry was in the past heavily influenced by the German school, while, in general, the attitude toward the mentally ill was rather punitive or neglectful (with some exceptions, such as the system of community care practiced at Iwakura, near Kyoto). In the late twenties the psychoanalytic movement had a number of followers there, especially in the large cities, although in retrospect it appears that Freudian notions were basically modified by local customs— childrearing, role of the woman, servile attitude toward the elders and, in particular, the Emperor, and, in general, ambivalence toward Western progress, admired but also hated (J. Moloney's *Understanding the Japanese Mind,* 1954). Around the same time the so-called Morita therapy (named after the Tokyo psychiatrist S. Morita) was introduced, with a moderate degree of success that has persisted to the present. Essentially intended for patients suffering from neuroses and compulsions (common in Japan because of the tendency of people to internalize conflicts), this method consists of a period of complete isolation in

bed, followed by progressive activity up to reinsertion in the community, carried on in a rigidly established situation of complete dependency by the patient on the doctor and the nurse (which has prompted the psychoanalytic view of Morita therapy as regression followed by "corrective ego experience"). As a result of the American involvement with Japan during World War II, firsthand anthropological studies were made on the whole Japanese culture by R. Benedict (*The Chrysanthemum and the Sword,* 1946), followed more recently by social psychological studies on attitudes and practices toward the mentally ill (mainly by W. Caudill, T. Doi, C. Schooler, and others). Since then Japanese psychiatry has been greatly influenced by American trends, also through joint meetings (such as the one between the American and Japanese Psychiatric Associations in 1963). Today many of the 4,000 psychiatrists tend to follow eclectically the organicistie and psychodynamic schools. Regardless of differences in orientation, the importance of cultural factors stands out: close, almost symbiotic, relationship between mother and child; intense repression of feelings; conflicts between individuality and collaterality of family members; and especially conflicts between allegiance to traditional values and identification with Western mores.

In *China,* a gigantic country relatively little influenced by Western civilization, attitudes toward the mentally ill depend heavily on autochthonous cultural beliefs. Proper behavior is related to Tao, mainly

based on reverence to the ancestors and on the public image of each individual; disregard for Tao may cause an imbalance between the two basic forces Yin and Yang, to which are subjected the various organs and channels connecting the inside to the periphery and the five constituents of the body, that is, earth, fire, water, wood, and metal. Since early times (such as in *The Yellow Emperor's Classic of Internal Medicine,* about 1,000 b.c.) the treatment of mental illness consisted of acupuncture and moxibustion (application of needles and of ignited substances at the surface of the body) to facilitate the flow of Yin and Yang along the proper channels. In the coastal cities of Canton, Shanghai, and a few others, Western practices were introduced a century ago mainly by American missionaries, so that the few psychiatrists came to be influenced by Meyer's psychobiology. Dr. K. Bowman, sent there in 1947 by the United Nations to help organize the National Neuropsychiatric Institute, reported that there were about 50 psychiatrists and 6,000 psychiatric beds. Since the communists took over in 1949, psychiatry has come to be seen from the Pavlovian perspective, although Mao Tse-Tung's writings are important in terms of prevention, as they stress priority of services to the masses, combination of mental hygiene and public health, and amalgamation of local and Western systems. Eventually the Chinese Society of Neurology and Psychiatry and the *Chinese Neurological and Psychiatric Journal* came into existence, psychiatric training was introduced in all 50 medical schools, and to the regularly trained physicians were added many paraprofessionals

("barefoot doctors" or "peasant-scientists"), especially in the rural areas. Regardless of the theoretical emphasis (strictly Pavlovian in the fifties when politically China was very close to Russia, more a combination of indigenous and Western practices from the mid-sixties on), milieu therapy focused on group sessions directed toward ideological discussions has received the primary emphasis, in addition to physical treatment and chemotherapy. This may be justified from a perspective that considers mental disorders essentially as social problems, but it leaves unanswered some basic questions related to the individual's inability to express feelings openly, even in his own family, and to the emotional transferal of areas of personal life to a society that is based on austerity and purposefulness of common ideals. These various points have many implications for mental health from the Western psychodynamic perspective and need further assessment.

Psychiatry at the International Level

As mentioned above, cross-cultural and transcultural psychiatry will be presented in detail in other parts of this work. Here it is enough to mention the change in the methodological approach to the study of non-Westem culture that has taken place during the period considered in this chapter, from the traditional psychoanalytic model of "culture and personality" (for example, E. Sapir, R. Benedict, M. Mead, C. DuBois, M. Opler, A. Kardiner, A. Kluckhohn and, among the opponents of psychoanalysis, B. Malinowski and A.

Krober) to a broader multidimensional perspective by interdisciplinary teams. As an example of this switch, the volume by Carothers on the African mind (1953), which he considered incapable of reaching the level of Western sophistication, is today already obsolete. Impetus toward research on mental disorders in other countries has come from the rapidly increasing contacts among people of different nations since the end of World War II and, even more, from the rise of many independent nations in the Afro-Asian areas.

In connection with this latter event governments all over the world are involved in making plans for prevention, treatment, and rehabilitation of the mentally ill, often relying on a combination of Western and local practices. The role of the United States has been so prominent in helping these various governments in this endeavor as to justify the separate presentation of this matter in the present section.

However, some essential preliminary points have to be mentioned on the basis of recent studies (such as the comprehensive survey by A. Kiev): the scientific approach attempts to explain *how,* folk attitudes *why* (e.g., influence of evil spirits) mental disorders occur; the incidence of severe psychopathology is constant everywhere, but the content (e.g., hallucinations or delusions) and the form (e.g., unusual syndromes due to altered states of consciousness) are different in each culture, according to its meaning (compensatory or pathoplastic) and methods of healing (e.g., cathartic);

depending on the social expectation of the role played by the mentally ill (G. Devereux), in each culture certain diagnoses are emphasized or not (e.g., alcoholism, homosexuality) and occur more often than others (e.g., frequent acute schizophrenic breakdown versus rare depressive conditions in Africa); in each culture are to be found healers of mental disorders, whose methods are based on a mixture of exorcism, drugs, and particular rituals, such as the interpretation of dreams; rapid social changes occurring mainly in Afro-Asian countries tend to result in stress that facilitates the rise of messianic and superstitious cults.

Taking these various points into consideration, it becomes understandable why it is difficult to establish common criteria to obtain epidemiological data on mental disorders in underdeveloped countries, where hospital facilities are rare, life expectancy is shorter, and migrations as well as political and social conflicts (urbanization, industrialization, etc.) are frequent. It also becomes understandable why in many countries the tendency has prevailed to combine local and Western practices in the handling of psychiatric disorders with the help of nurses and paraprofessionals and the support of indigenous leaders and groups, resulting in efficient types of care, for instance, at the Aro Mental Hospital in Abeokuta, Nigeria (opened in 1954 and described by T. Lambo and others), where a high percentage of patients live in villages under the supervision of trained personnel.

Three institutions have been particularly active in the organizational field of mental health: the World Federation for Mental Health, the World Health Organization, and the World Psychiatric Association.

Founded in 1948 in London (in connection with the Third International Congress in Mental Health), the World Federation for Mental Health, under the dedicated leadership of few professionals (first the British J. Rees, then the Swiss A. Repond, the Americans F. Freemont-Smith, O. Klineberg, G. Stevenson, J. Millet, and others), has been instrumental in providing publications, seminars, workshops, lectures, and research on various aspects of mental hygiene.

Likewise, meetings on many topics related to psychiatry have been sponsored by the World Health Organization (established as an agency of the United Nations in Geneva in 1949 and composed of five regional offices, one for each continent) with the support of an expert advisory panel and various study groups. In addition, the WHO has published important monographs on juvenile delinquency (by L. Bovet, 1951) on maternal care and mental health (by J. Bowlby, 1952), and on other subjects.

The World Psychiatric Association was founded in 1961, at the time of the Third World Congress of Psychiatry held in Montreal; the late E. Cameron was elected the first president. Through the dedication of many psychiatrists

(mainly the French J. Delay, H. Ey, and P. Sivadon, the Spanish J. Lopez-Ibor, the Swiss M. Bleuler, the British D. Leigh and J. Wing, and the American H. Tompkins, D. Blain, and F. Braceland), it has fostered the dissemination of professional information among 72 national psychiatric organizations, representing more than 63,000 practitioners throughout the world (as evidenced by the new *Directory of World Psychiatry,* edited by J. Gunn), and has organized technical sections, symposia, and regional meetings on various subjects.

Among the other worldwide organizations are the European Association of Child Psychiatrists, the International Society for Social Psychiatry, the International Association of Child Psychiatry, and the recently established Association of Psychiatrists in Africa (actually Pan-African Psychiatric Conferences have been held there since 1961). The *International Journal of Psychiatry* has been edited by J. Aronson in New York City since 1963, while, among the developing nations, the periodical *Pstjchopathologie Africaine* has appeared in Dakar since 1965.

Epilogue

In 1959, at the conclusion of the first edition of this chapter, the question of the responsibility of American psychiatry toward the mental health goals of the future was raised. That same year Karl Menninger, a senior psychiatrist, in his Academic Lecture entitled "Hope," reminded his audience of the words pronounced by Ernest Southard , a pioneer in broadening the scope of psychiatry, in 1919:

> "May we not rejoice that we [psychiatrists] . . . are to be equipped by training and experience better, perhaps, than any other men to see through the apparent terrors of anarchism, of violence, of destructiveness, or paranoia— whether these tendencies are showing in capitalists or in labor leaders, in universities or in tenements, in Congress or under deserted culverts. . . . Psychiatrists must carry their analytic powers, their ingrained optimism and their strength of purpose not merely into the narrow circle of frank disease, but, like Seguin of old, into education; like William James, into the sphere of morals; like Isaac Ray, into jurisprudence; and, above all, into economics and industry. I salute the coming years as high years for psychiatrists!"

It took half a century before American psychiatry woke up to its responsibility toward all the citizens of the nations. For the historian it is important to determine the main currents that have created this situation, beginning with the discussion on transcultural, cross-cultural, and international psychiatry in the previous section.

There it was established that American psychiatry had played an increasingly important role at the international level, first through research on transcultural and cross-cultural dimensions, followed by forms of assistance to European countries affected by World War II and, later on, to newly emerging Afro-Asian countries. Actually interest in international matters on the part of this country can be traced back to the establishment of the International Committee on Mental Hygiene in 1918 (preceded by the National Association for Mental Health, 1909), which organized the First International Congress for Mental Health in Washington, D.C., in 1930, and to involvement on the part of the American Psychiatric Association (through joint meetings with other national associations and the work of various committees), aside from the substantial support given to the United Nations.

Direct psychiatric influence at the international level can also be related to the pre-World War II practice of obtaining training in European facilities (mainly England) by a few American psychiatrists, and vice versa. Following the end of the war, with the help of various organizations, a good number of European physicians received training in this country in the fifties; in fact, some of them eventually settled permanently in this country. In the sixties the majority of the foreign physicians in training came from developing Far Eastern nations (India, Korea, Philippines); in fact, during the academic year 1967-1968 more than 30 percent of the psychiatric trainees were graduates of foreign medical schools. This puts this country in a position of ambiguous

responsibility: on the one hand, it allows foreign graduates to provide necessary manpower to poorly staffed public facilities; on the other hand, America has a commitment to developing countries to help train staff for their own programs.

The issue of the responsibility of American psychiatry at the international level increasingly has become related to the developments that have taken place in this country. Through a convergence of important studies (mainly J. Galbraith's *The Affluent Society,* 1958, and M. Harrington's *The Other America,* 1963), widely publicized campaigns (bus boycotts, ghetto riots, and the Poor People's March), and some important judicial and political actions (the 1954 Supreme Court decisions to outlaw segregation in public education, President Johnson's War on Poverty, etc.), this country has become aware, as never before, of large areas of poverty and deep racial and social conflicts. As a result of this new awareness, the community mental health movement, discussed in detail in another section of this chapter, has been taking place.

Such a movement, however, cannot be properly implemented only through legislation or allocation of funds, but requires the active participation of many people at various levels eager to modify the traditionally middle-class oriented psychiatric philosophy to be of more relevance to large segments of low-income population. Some modest attempts have already

been made, such as introducing proper therapeutic modalities (E. Auerswald, S. Minuchin, F. Riessman, and others), assessing community-based facilities in some areas (for example, in a section of New York City by L. Kolb and associates in *Urban Challenge to Psychiatry,* 1969), and encouraging well-motivated people to become paraprofessionals (or "indigenous workers or mental health expediters").

In view of all this, the situation of psychiatry in many other parts of the world, where poverty and social conflicts are endemic, has become quite relevant to this country. While, from the psychoanalytic perspective of the fifties, psychiatry in practically all the rest of the world was seen as inferior to American standards, from the perspective of the community mental health movement of the sixties, systems of care and treatment of the mentally ill used in underdeveloped countries as well as countries of the communist bloc may very well acquire a great deal of importance for American psychiatry. This ranges from a more tolerant attitude toward the mentally disturbed by the general population, to the development of community-based facilities, to the extensive use of paraprofessionals of all types. Therefore, the mission grandiosely held by American psychiatry on the wave of the military victory of World War II, of disseminating everywhere psychodynamic principles leading to intensive therapeutic relationships, has been replaced by a more modest philosophy of individual treatment and, by a thorough commitment toward prevention and help to many more people throughout the country.

Moreover, Western psychodynamic principles, seen from the broad cross-cultural perspective, have been found to share many similarities with indigenous forms of treatment based on public expression of feelings practiced in many countries by recognized healers; and, likewise, research in the context of other cultures (for example, on the phenomenology of the person in the Yoruba society by I. Laleye and on the African Oedipus by M. Ortigues and E. Ortigues) has pointed to the relativity of some dynamic notions traditionally held to be universal. Finally from the historical perspective the tendency toward internationalization of many issues (from youth revolt to drug abuse) and toward worldwide cooperation (e.g., in space exploration and in ecological projects) cannot but affect also the field of psychiatry.

In reference to history, the thesis recently presented in the volume *A Social History of Helping Services (*1970) by M. Levine and A. Levine that periods of prevailing "intrapsychic models of help" (that is, psychodynamic) in eras of political conservatism alternate to periods of prevailing "situational modes of help" (that is, community mental health) in eras of social reforms, may be debatable. The fact remains, however, that historically a definite change is taking place in the role of psychiatry from the viewpoint of the psychiatric profession itself, of the patient, and of the public at large.

In regard to the psychiatric profession, the aristocratic image presented

by psychiatrists in the past (R. Holt's *Personality Patterns of Psychiatrists,* 1958) is being challenged by the notion that there are few differences between psychoanalysts, psychiatrists, psychologists, and social workers (W. Henry, *et al., The Fifth Profession,* 1971), especially if psychotherapy is seen as "the purchase of a friendship" (W. Schofield). Most psychiatrists tend to be influenced by the organicistic, the individual, or the community model (E. Strauss, 1964), quite often in a rather narrow way (W. Freeman, 1968). In reality the first two models are the most pervasive, while thus far community action has not attracted many, as shown in the thorough study by A. Rogow. Claims of psychoanalytic contributions to community action (in D. Milman and G. Goldman's *The Psychoanalytic Contributions to Community Psychiatry,* 1971) or of substantial progress achieved through preventive programs (in *Crisis in Child Mental Health Challenge for the 1970s,* 1970, which is the report of the Joint Commission of Mental Health of Children) are far from being substantiated.

Very little has been said by patients in regard to their treatment. F. Redlich has been among the few who has attempted to answer the question of how a person finds a psychiatrist (*Harper's,* 1960). The results of his own research (with Hollingshead, 1959), that low-income people tend to receive organic treatment in institutions and middle-class people psychotherapy in outpatient clinics, have not been substantially modified by the follow-up study by J. Myers and L. Beam (1968). There is a need for studies along the

lines of H. Strupp's *Patients View Their Psychotherapy* (1969).

From the broad perspective of the public several studies are available, all pointing to the fact that the majority of people tend to turn for help to other kinds of healers (mainly clergymen) before going to psychiatrists (M. Krout's *Psychology, Psychiatry and the Public Interest,* 1956; J. Nunnally's *Popular Conceptions of Mental Health,* 1961; Elison's *Public Image of Mental Health Services,* 1967; C. Kadushin's *Why People Go to Psychiatrists,* 1969).

It is questionable whether the above trend depends on the shortage of psychiatrists or rather on the widespread ambiguity toward psychiatry. The shortage of psychiatric manpower is still grave, although psychiatry has become the third most frequent choice of specialty by young physicians after medicine and surgery, and there has been massive federal support of training programs and ingenious attempts to encourage students to enter this field (for example, with the booklet *Careers in Psychiatry,* published by the National Commission on Mental Health Manpower, 1968). Efforts to train paraprofessionals are certainly very laudable, although in reality their effectiveness is handicapped by the conflict between their identification with the values of the professionals and their allegiance to their own values.

The issue of values needs to be mentioned at this point. In the past psychiatry, as a field of medicine, has been seen from the traditional

perspective of medical ethics. The early psychoanalytic movement, stemming from a highly homogeneous patriarchal society, beginning with Freud assumed that values were not relevant to psychiatry. This notion was later challenged by many who became aware of the unconscious identification of the patient with the therapist's own values. In the fifties, during the short period of the rise of existentialism, values in psychiatry constituted the subject of considerable discussion (for example, C. Buhler's *Values in Psychotherapy,* 1962).

In the last decade the main issue in regard to values has shifted from medical ethics to a much broader perspective involving the responsibility of the psychiatrist as a professional and as a citizen. This shift has been influenced by several events: in the mental health field, the controversies generated by the many publications of T. Szasz indicating that psychiatrists perpetuate the "myth of mental illness" by supporting attitudes that place certain individuals in the role of the mentally ill; in the academic field, the bipolarity between Skinner's behavioristic model of personality and Allport's and Maslow's humanistic psychology; on a larger scale, the ambiguous image offered by psychiatry in relation to matters such as professional assessment of political figures (especially at the time of the 1964 Presidential election), the Vietnam War, the youth unrest, the spread of drug addiction, the fight against poverty, the ethnic conflicts, and the epidemics of violence.

The fact that many of these latter problems transcend the boundaries of our nation should not deter American psychiatrists from meaningful involvement, taking into consideration, of course, the possibility of conflict between confidentiality to the patient and service to the community. This is the position officially taken by the Group for the Advancement of Psychiatry in *Psychiatry and Public Affairs,* 1966.

Deep-seated attitudes are difficult to modify, even in psychiatrists, as recently shown, for instance, in J. Kovel's *White Racism: A Psychohistory* (1970) and in T. Thomas and J. Sillen's *Racism and Psychiatry* (1972). There is evidence, however, that a new breed of young psychiatrists is emerging, committed to alleviating people's miseries at every level quite at variance with the traditional cliche of the psychoanalyst exclusively involved with a sophisticated clientele. The publications by R. Coles on underprivileged children, by M. Dumont *(The Absurd Healer,* 1969), by R. Leifer *(In the Name of Mental Health,* 1969), and by others on the uncertain role of the psychiatrist at present are expressions of this trend. Also notable are the liberal attitude of some psychiatrists toward the use of drugs and toward sexual behavior (especially homosexuality), as evidenced by the research of R. Masters and V. Johnson at the Reproductive Biology Research Foundation in St. Louis. The American Psychiatric Association has sponsored studies on violence and current president, A. Freedman, has been elected with the support of the Committee for Concerned Psychiatrists, a newly formed group

directed toward social action.

All this points to the fact that in a matter of a few years a generation gap appears to have developed between the traditionally oriented psychiatrists, who still control many academic positions, and many socially committed psychiatrists. Certainly, on the one hand, the latter should realize that psychiatry (called "the uncertain science" in a thorough survey in a popular magazine, 1968) cannot be the answer to all problems, especially after J. Seeley has convincingly showed that increasingly psychiatry is expected to take over the roles left by the decline of traditional social and religious institutions. On the other hand, inactivity vis-a-vis urgent issues is in itself a decision, as cogently pointed out by S. Halleck in *The Politics of Therapy* (1971).

As stressed in an exceedingly stimulating paper by the distinguished historian, Stuart Hugues, at the 1969 convention of the American Psychiatric Association, society, rather than the patient, appears to be sick today. Yet the irrational expressions of many, up to despair, should not deter us from reason: "Sooner or later," he concluded, "the soft voice of reason will be heard once again."

These words appear to echo the prophetic statement made in 1944 by Alan Gregg, a great mentor of our profession, on the occasion of the centenary

of the American Psychiatric Association:

> "Psychiatry, along with the other natural sciences, leads to a life of reason. . . . Psychiatry gives us a sort of oneness-with- others, a kind of exquisite communion with all humanity, past, present and future. . . . Psychiatry makes possible a kind of sincere humanity and naturalness. . . . Psychiatry makes it possible *to bring to others* these things I have mentioned. . . . Also it makes one able to receive these same gifts."

Perhaps looking back at history may represent for American psychiatry a source of confidence in meeting the great challenge of the future. This interest in history may be essential for the rise of a new humanism to which psychiatry, imbued with science and humanity, can validly contribute.

Bibliography

In view of the historical and general character of this chapter, the following principles have been followed in the preparation of the bibliography:

1. Well-known books are cited in the text only, together with the name of their authors. They are not listed in the bibliography because the complete reference is given in other chapters dealing specifically with the topic to which the book refers.

2. Full reference is given in the bibliography to the books and articles that belong to the following categories:

    a. Historical material, especially if concerned with broad issues.

b. Surveys of a particular topic that of fer a view of its development.

c. Specific articles that historically represent the beginning of a new field.

d. Contributions by American authors.

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