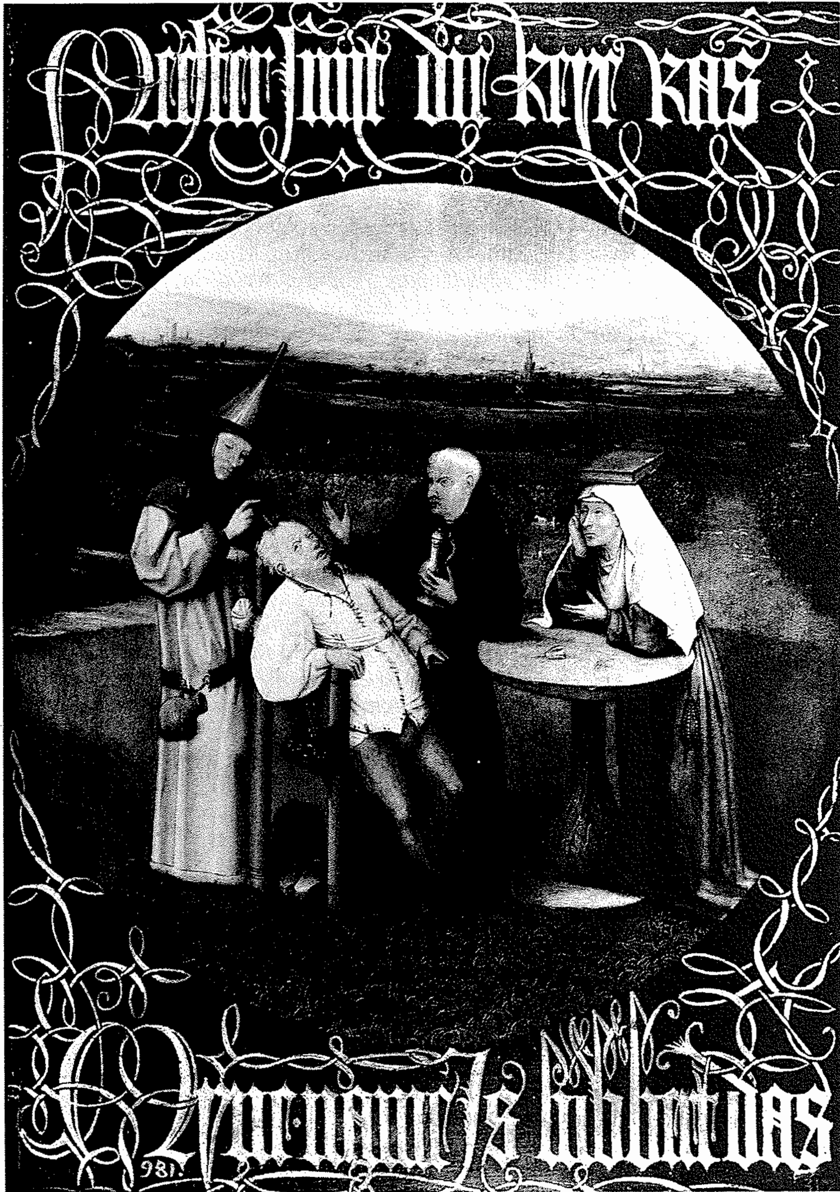

Over the centuries, human beings have resorted to everything from purges to Thorazine in an effort to cope with mental illness and emotional distress. England's King George III, who periodically lapsed into lunacy, was immobilized, beaten, stoned, and chained to a pole (to no avail). In this painting by Hieronymus Bosch (1450–1516), a quack doctor extracts the Stone of Madness from his patient's head.

Psychiatry in America

"To us he is no more a person/ Now but a whole climate of opinion." Poet W. H. Auden wrote those words after learning of Sigmund Freud's death in 1939. Freud's writings left their mark on many endeavors outside psychiatry, and nowhere more so than in the United States. Lacking familiarity with psychiatry and psychoanalysis, a visitor from Mars could make little sense of much of contemporary America. He would fail to understand the cartoons of Jules Feiffer, the movies of Woody Allen, the novels of D. M. Thomas or Philip Roth. His grasp of U.S. politics, education, and criminal justice would be incomplete. Psychiatry in America today is, by one estimate, a $20-billion-a-year industry. As a professional field, it is also unkempt and overgrown, with no regular boundaries. Practitioners cannot always agree on which forms of treatment "work" and which do not. And yet, ironically, in its broader social impact, psychiatry's intellectual disarray has long been irrelevant. Here, in a five-part essay, psychiatrist and neurologist Richard Restak surveys the state of the profession and its unusual role in American life.

by Richard M. Restak

Frederic Worden, a noted psychoanalyst and brain researcher, once observed that, unlike violinists, who all play violins and know what one looks like, psychiatrists "are not all playing the same instrument"; indeed, he said, "some are playing instruments that others disapprove of or disbelieve in or even, in some cases, instruments whose very existence is unknown to others in the group."

A lack of precision and rigor that most Americans would never accept from physicists and engineers has for years been widely tolerated when psychiatrists are involved. Thanks to such indulgence (especially by the news media), thanks to deliberate cessions of authority to psychiatrists by courts and legislatures, and thanks to lobbying and proselytizing by organized members of the profession, psychiatrists in America today probably have far more influence, direct and indirect, over the lives

of ordinary citizens than they do in any other nation on Earth.

If an American says or does something unusual, especially if it has legal consequences, he may be required to explain himself to a psychiatrist. If he is accused of a crime, a psychiatrist may be asked to determine whether he was or was not responsible for his actions. Psychiatric opinion may determine whether he gets a job, enters the armed forces, or prevails over his estranged mate for custody of the children. It may be used to deprive an individual of his liberty. All in all, concludes Jonas Robitscher in *The Powers of Psychiatry* (1980), "The psychiatrist is the most important nongovernmental decisionmaker in modern life."

Questions of sanity or emotional distress aside, we now ask psychiatrists how to educate our children, reduce crime, succeed at the office, achieve multiple orgasm. They are brought in to determine whether separate can be equal, whether might can make right, whether fat can be fun. By now accustomed to this expansive role—one, to be fair, often thrust upon them—some psychiatrists have ranged even further afield. Psychiatry, it would seem, is pertinent to everything. There now exists in Washington a thriving Institute for Psychiatry and Foreign Affairs, devoted to helping diplomats understand "the irrational aspects of human response." At last May's meeting of the American Psychiatric Association (APA), psychiatrist Milton Greenblatt proposed that a committee of mental health professionals be assigned routinely to the White House. "What security do we have," he asked, "that the [owner of the] hand that presses the button is sane and stable?"*

If a certain immodesty is apparent among psychiatrists, it is even more evident in the larger "psychotherapeutic community." In addition to some 32,000 psychiatrists working in the United States (one-third of all practicing psychiatrists in the world), there are now about 70,000 psychologists and hundreds

*The sanity of presidents appears to be a perennial source of concern. In 1964, a majority of the 2,417 psychiatrists polled by *Fact* agreed that presidential candidate Barry Goldwater showed signs of emotional instability. Goldwater won a lawsuit against the magazine, and the APA forbade members to participate in such long-distance analysis in the future.

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"Darling, what do you suppose they're going to tell their psychiatrists about us?" Every year, almost one million children under age 16 consult a psychiatrist.

of thousands of other mental health-care specialists, including trained nurses, social workers, and clergy, as well as a variety of marriage counselors, sex therapists, and others who may or may not have received any sort of professional certification. Millions of Americans are caught up in the worlds of Est and Esalen, of Transcendental Meditation and transactional analysis, Rolfing and rebirthing, biorhythms and biofeedback.

The ethos of psychiatry, its methods and its terminology, has trickled down to Everyman. Were the profession and its literature suddenly abolished, much of its language and not a few of its dogmas and heresies would endure for generations, preserved in popular culture. The *New York Times* best-seller list regularly features books of the "self-help" variety, offering advice on how to be your own best friend, win through intimidation, or look out for Number One. More than 100 "psychochatter" programs currently appear on television in the United States (there are many more on radio). Prominent public figures are now sculpted not only in stone but also in "psychobiographies" by "psychohistorians" such as Doris Kearns (*Lyndon Johnson and the American Dream*, 1976) and Fawn Brodie (*Richard Nixon: The Shaping of His Character*, 1981).

And yet, even as the psycho-saturation of U.S. culture appears to be nearly total, psychiatry as a profession is not in good health.

During the 1970s, the percentage of graduating medical students entering psychiatry dropped from 10 to four, thanks in part to encroachments by nonmedical personnel in the therapy

field and, more importantly, to a serious identity crisis within the profession itself, precipitated by the threat of "biologism" to the traditional "talk therapies."

The American public, meanwhile, despite its enduring fondness for individual self-analysis, has of late been reluctant to give psychiatrists free rein—evident in a 1982 Berkeley, California, referendum banning the use of electroshock therapy and in recent moves by insurance companies, led by Blue Cross/Blue Shield, to limit payments for psychiatric care. Books critical of the profession are appearing more frequently, taking their place on the shelf alongside Thomas Szasz's once-lonely *The Myth of Mental Illness* (1961). Even the U.S. Supreme Court has taken a swipe at the therapeutic society, ruling last April that "psychological stress" among area residents was both immeasurable and not germane in determining whether a nuclear power plant at Three Mile Island, near Harrisburg, Pennsylvania, could resume operation.

Solace for the Privileged

The very notion of psychiatry as a sound medical enterprise has increasingly been called into question as rival practitioners spar in public—often during celebrated trials, such as that of John W. Hinckley, Jr., in 1982 for his attempted assassination of President Reagan a year earlier—over the diagnosis of insanity. In the wake of the Hinckley trial, three of the men wounded in the assassination attempt brought a $14 million suit against Hinckley's psychiatrist, charging malpractice on the grounds that the doctor "knew or should have known" that his patient would become violent.

But the public distress over psychiatry cannot be blamed simply on a series of isolated mishaps or highly visible blunders. Nor is it "all in the mind." The unease can be traced to something that Harvard Law School's Roberto Unger touched on in an address to the annual meeting of the APA in 1980. "An unmistakable and unsettling fact about modern psychiatry," he told his audience, "and especially about psychotherapy, is that it flourishes in the rich countries of the contemporary Western World . . . where the privileged devote themselves to the expense of selfish and impotent cultivation of subjectivity."

Part of the problem with psychiatry, in other words, is that many Americans suspect its very success may be symptomatic of a social ailment. Psychotherapy, they fear, both reflects and panders to certain tendencies in American society, tendencies that do the country no good.

I

WHO ARE THESE PEOPLE?

The official, bare-bones definition is clear enough: According to the APA, psychiatrists comprise "all medical and osteopathic physicians who had psychiatric residency training experience, and/or whose primary compensated work was psychiatric in nature, and/or whose compensated work was in a mental health setting (or mental health component of a larger facility), and/or who presented themselves to the public as psychiatrists or neuropsychiatrists."

As noted, about 32,000 people in the United States meet this rather loose definition. Some 28,000 of them are members of the APA. The average American psychiatrist is roughly 48.5 years old. Like most doctors, he is probably a male Caucasian (only 15 percent of psychiatrists are women, only two percent are black), American-born and trained (though one-fifth are not), and lives in a big city on either coast. Washington, D.C., boasts the most psychiatrists per capita in the United States—44.8 per 100,000 population, thanks in part to the once-liberal mental health-care provisions in federal employees' insurance coverage—followed by Boston (43.6), New York (40.5), and San Francisco (38.3). According to the *Washington Post*, four times as many psychiatrists have offices in a single Connecticut Avenue apartment building in Washington, D.C., as in all of Wyoming.

Because few of his patients die during treatment, or call him up in the middle of the night, the average psychiatrist would seem to have an easy life. And yet for reasons that remain obscure—perhaps the type of individual drawn to the field in the first place, and the intense, introspective nature of the work—one out of every six (16.5 percent) psychiatrists dies a suicide. In a survey conducted several years ago in San Francisco, 68 percent of the psychiatrists queried agreed that they were afflicted with emotional problems that their nonpsychiatric colleagues were spared.

The typical psychiatrist works in a private office where he sees patients individually—this accounts for 71 percent of all clinical practice. He may spend part of his time working for a mental hospital, but if he is a white male, he probably does not.*

*Psychiatrists in 1980 earned an average of $65,100, which put them near the bottom rung of the medical ladder, just above pediatricians. But they spent less than half as much ($24,800) as other physicians did on rent, equipment, and supplies. And they worked almost five fewer hours per week—45.5, with seven of those hours devoted not to patient care but to teaching, lecturing, supervising other psychiatrists, writing articles, or giving advice to, say, the local school board or police department.

THE THERAPEUTIC SENSIBILITY

In his controversial The Culture of Narcissism *(1979), Christopher Lasch detected a pervasive spiritual malaise in the West, and blamed it in part on a post-Freudian "therapeutic sensibility." An excerpt:*

Plagued by anxiety, depression, vague discontents, a sense of inner emptiness, the "psychological man" of the twentieth century seeks neither individual self-aggrandizement nor spiritual transcendence but peace of mind, under conditions that increasingly militate against it. Therapists, not priests or popular preachers of self-help or models of success like the captains of industry, become his principal allies in the struggle for composure; he turns to them in the hope of achieving the modern equivalent of salvation, "mental health."

Therapy has established itself as the successor both to rugged individualism and to religion; but this does not mean that the "triumph of the therapeutic" has become a new religion in its own right. Therapy constitutes an antireligion, not always to be sure because it adheres to rational explanation or scientific methods of healing, as its practitioners would have us believe, but because modern society "has no future" and therefore gives no thought to anything beyond its immediate needs. Even when therapists speak of the need for "meaning" and "love," they define love and meaning simply as the fulfillment of the patient's emotional requirements. It hardly occurs to them . . . to encourage the subject to subordinate his needs and interests to those of others, to someone or some cause or tradition outside himself. "Love" as self-sacrifice or self-abasement, "meaning" as submission to a higher loyalty—these sublimations strike the therapeutic sensibility as intolerably oppressive, offensive to common sense and injurious to personal health and well-being.

Only one-third of psychiatrists are attached either full- or part-time to institutions, and these physicians are likely to be either women or foreign medical graduates (FMGs), mostly from Asia and Latin America. Fully 60 percent of all psychiatrists in public mental institutions are FMGs.

To judge from such documents as the 1977 report of the U.S. Commission on Mental Health, psychiatrists do not think their own numbers are sufficient. The commission recommended, in fact, that, in light of "unmet needs," psychiatry be designated by Congress a "medical shortage specialty." Do we really need more psychiatrists? The commission's estimate that 15 percent of all Americans are in need of "some form of mental health services" is undoubtedly soft. Yet other data seem to show that the U.S. mental health-care system is sorely taxed. Between 1955 and 1977, the number of inpatient and outpatient psychiatric

treatments, *excluding* private practice, rose from 1.7 million annually to 6.6 million. In 1979, there were 1.8 million "inpatient episodes." The average stay in a mental institution was 47 days.

One would be more sympathetic to psychiatrists' claims, however, if the people represented by such statistics were the ones with whom most practitioners spent most of their time. But, as a group, psychiatrists devote their energies to those who, as a group, need help least. The very young, the very old, alcoholics, drug abusers, sociopaths, the mentally retarded, those with brain disease, those hospitalized for long periods of time—these people receive little or no sustained psychiatric attention. Barely two percent—mostly women—of the nation's psychiatrists spend any appreciable amount of time with the elderly.

Their choice of patients is one reason why women psychiatrists (like women doctors generally) earn less money than men. The correlation between those persons in sudden or protracted need of psychiatric help and those persons with ample surplus income is not high. The 6.6 million "treatments" cited above account for only a fraction of the consultations with psychiatrists in any year.

Remaining are the millions who see a psychiatrist in his private office, often simply because they *want* to. (The National Center for Health Statistics estimated the number of office visits to psychiatrists at 16 million in 1981 but has no data on the number of patients involved.) Such people are mostly middle to upper middle-class whites. Women far outnumber men. By catering to the silk-stocking trade, American psychiatrists in effect have consigned most of the truly mentally ill to the "allied" mental health professionals. "The affluent and educated elite are surrounded by first-class healers," writes psychiatrist E. Fuller Torrey, "while the masses must make do with whatever second-class services are left over. It is a two-class profession."

II
THE ROOTS OF MADNESS

The discretionary, even fashionable, aspect of psychiatry was unknown in the United States until two generations ago. Before then, emotional distress was a stigma rather than a badge of sensitivity. In colonial days, madness was blamed not on "society" or other environmental factors (such as one's upbringing) but on unsavory agents—witches, the devil, lack of religious faith, "humors"—that besmirched the victim's own character.

Few public provisions were made in America for treating or housing the insane, and it was not until 1773 that the first mental hospital (in Williamsburg, Virginia) opened its doors.

By the turn of the century, however, the ideas of Benjamin Rush had begun to achieve recognition. Rush, a signer of the Declaration of Independence and the father of a boy who would today be considered psychotic, devoted much of his time to the mentally ill at Philadelphia's Pennsylvania Hospital. Unlike most European theorists (who, imbued with the spirit of the Age of Reason, attributed insanity exclusively to a distortion of rationality), Rush believed that mental illness—"moral derangement," he called it—could occur even in people who retained their normal faculties of reason.

Cold Water

He employed a vivid image in his *Medical Inquiries and Observations upon the Diseases of the Mind* (1812): "Exactly the same thing takes place in this disease of the will that occurs when the arm or foot is moved convulsively without an act of the will or even in spite of it."

The significance of Rush's beliefs lay in linking mental illness with physical processes. American physicians followed Rush's lead for a century, but they had little more success than Rush in tailoring effective medical treatments. Rush experimented with bloodletting, purging, and various forms of "ingenious intimidation." He also tried "moral therapy," imposing on his patients a regimen of strict discipline to help them conform to society's rules and values. In doing so, he anticipated later attempts to find "environmental"—social or psychological—solutions for what in many cases were physical problems.

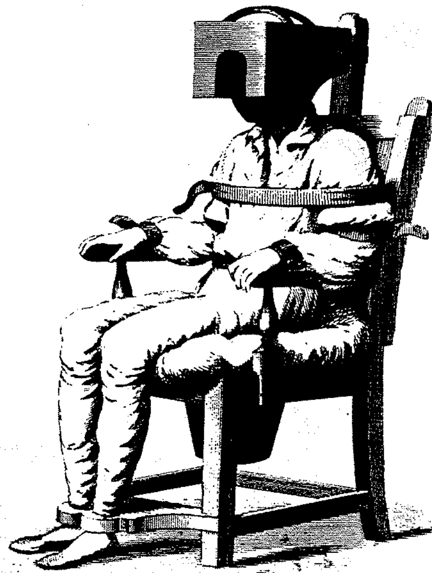
Ignorance of what exactly should be treated persisted for years, even as physicians tried to stand by the "medical model" of mental illness. In his *Treatise on the Medical Jurisprudence of Insanity* (1838), Isaac Ray confidently asserted that "No pathologic fact is better established than that deviations from the healthy structure are generally present in the brains of insane subjects." Therefore, it seemed reasonable to assume that almost anything that adversely affected the brain—a fall from a wagon, for example—might result in some form of insanity. And why limit etiology to *direct* causes?

It was common knowledge during the last century that diseases in parts of the body other than the brain could affect one's mental health: a bilious attack or stomach disorder, say. And yet, even stretching physical causation to its limits (masturba-

tion, for example, was frequently blamed), 19th-century physicians were forced to concede that *demonstrable* body illness accounted for only a tiny fraction of the cases of insanity.

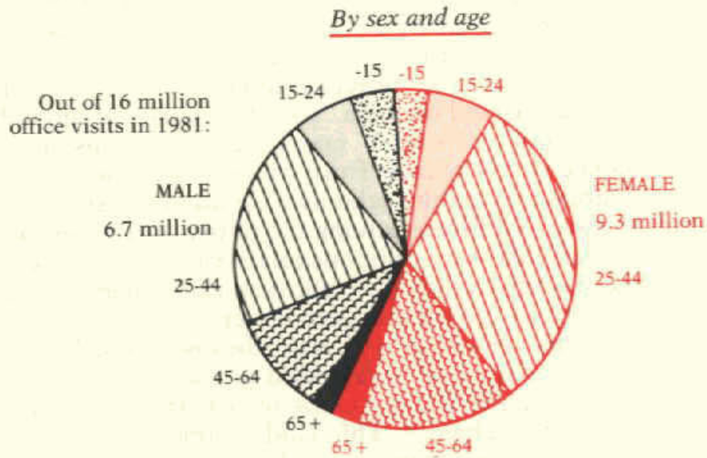
And so, while in theory never quite abandoning their physiological suspicions, in practice alienists (as "mind-doctors" were then called) fell back on "social" theories of mental illness and corresponding "social" cures. To explain insanity, physicians looked to everything from America's economic system to family habits and public schools. One alienist listed 43 distinct sources of mental illness among the patients at a New York City asylum. Included were religious anxiety (77 cases), loss of property (28), excessive study (25), political excitement (5), and a solitary instance of "going into cold water."

Given this view of things, what the doctors ordered in cases of psychiatric disorders was a kind of sociological prophylaxis —helping the patient, by means of a variety of therapies, to "learn" healthy behavior. This kind of treatment, doctors came to believe, was best administered within the special environment of the asylum. Although throughout the 19th century most of the mentally ill in the United States would be found in prisons, almshouses, or at home with their families, a mental hospital "movement" steadily gathered steam. In state after state, the

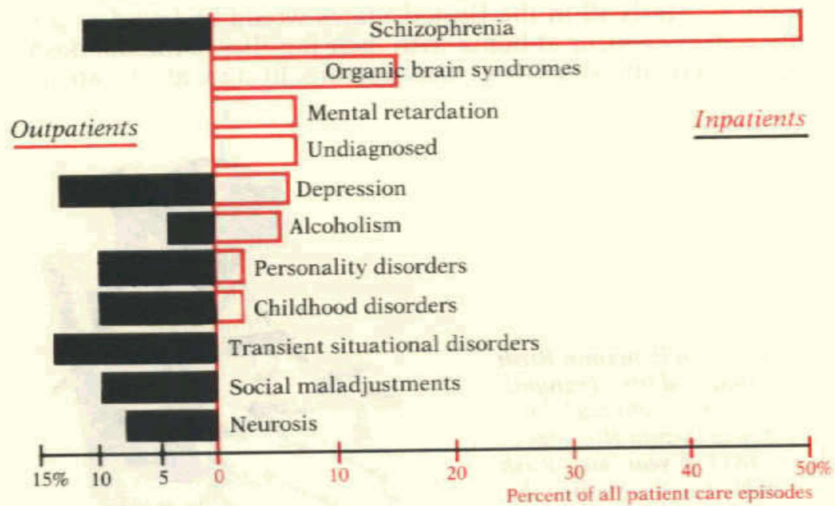


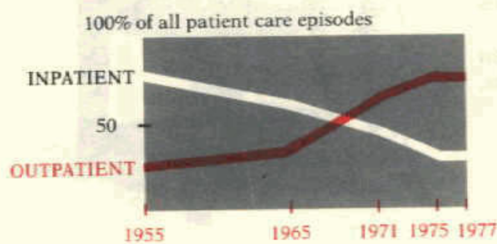
Physician Benjamin Rush introduced his "Tranquilizer" at Philadelphia's Pennsylvania Hospital in 1811. A year later, Rush published his Medical Inquiries and Observations upon the Diseases of the Mind, *the first American treatise on mental illness.*

WHO SEES PSYCHIATRISTS



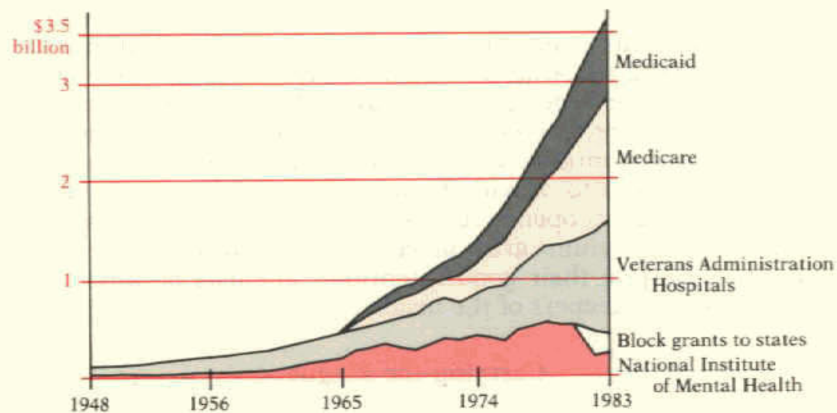
... AND WHY





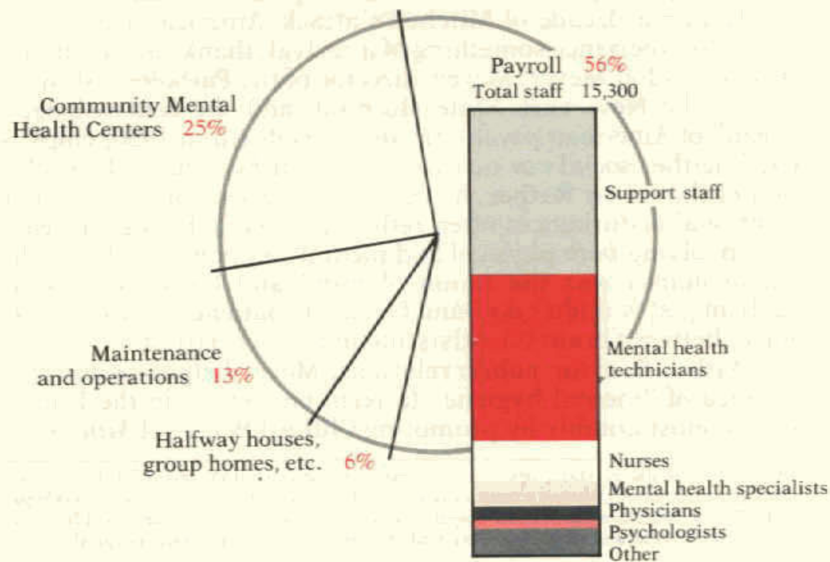
WHERE THE MENTALLY ILL ARE TREATED

MAJOR FEDERAL MENTAL HEALTH OUTLAYS, 1948–1983



Source: *Characteristics of Admissions to Selected Mental Health Facilities* (1975), National Institute of Mental Health; Illinois Department of Mental Health; U.S. Department of Health and Human Services; Veterans Administration.

WHAT ONE STATE SPENDS ON MENTAL HEALTH



publicly funded asylums, run by doctors, supplanted the old madhouses, run by lay entrepreneurs.*

The physicians moved quickly to consolidate their power. In 1844, 13 directors of state mental hospitals formed the Association of Medical Superintendents of American Institutions, renamed in 1892 the American Medico-Psychological Association and in 1921 the American Psychiatric Association. Physicians though they were, however, it is difficult to appreciate what alienists had in common with medical doctors. Nor, eventually, could they claim to provide humane care. As the century wore on, and the nation opened its doors to millions of European immigrants, the asylums grew more crowded and conditions deteriorated. Despite their good intentions, alienists became little more than gatekeepers of the insane.

Carrying the Plague

At the 1894 convention of the American Medico-Psychological Association, S. Weir Mitchell, a prominent neurologist, castigated alienists for isolating themselves from other physicians, and for their abysmal ignorance of the human brain: "We, neurologists, think you have fallen behind us, and this opinion is gaining ground outside of your own ranks, and is, in part at least, your own fault. . . . You live alone, uncriticized, unquestioned, out of the healthy conflicts and honest rivalries which keep us up to the mark of fullest possible competence."

Within a decade of Mitchell's attack, American psychiatry began to experience something of a revival, thanks in part to the efforts of Adolf Meyer. Meyer, director of the Pathological Institute of the New York State Hospital, and the acknowledged "dean" of American psychiatry until his death in 1950, emphasized neither social nor neurological contributions to the exclusion of the other. Rather, he advanced the sensible notion that emotional disturbances often reflected a psychobiological reaction involving *both* physical and mental components. His cardinal principal was the union of mind and body—Cartesian dualism just wouldn't do—and he had no patience for the antagonism between brain scientists and most psychiatrists.

With a flair for public relations, Meyer helped popularize the idea of "mental hygiene" (a term he coined) in the United States, most notably by promoting Clifford Beers's *A Mind That*

*By 1860, 28 of the 33 states operated at least one insane asylum, and 8,500 individuals were institutionalized. Almost a century later, in 1955, mental hospitals housed 558,000 patients. Today, there are 280 mental hospitals run by state or local governments, 136 facilities run by the Veterans Administration, and 184 privately run psychiatric hospitals.

Found Itself (1908), the most widely read book on mental illness ever penned by a layman. Americans had always had an appetite for self-improvement, and during the early decades of the new century, fueled by a new faith in medical progress, it proved insatiable. Scores of tracts, such as *The Healing Power of Mind*, appeared in bookstores. *Good Housekeeping* and the *Ladies Home Journal* vied in filling their pages with useful advice. Alienists became psychiatrists, and psychiatric programs were launched in prisons and juvenile homes.

This was the fertile ground in which psychoanalysis was sown. Sigmund Freud never liked the United States; he called it "a gigantic mistake." Yet as his ship neared New York in 1909, bringing him to North America for the first time, he reportedly worried about the effect his ideas would have. He felt, he told a companion, as if he were carrying the plague.

III

MORE THAN SCIENCE, MORE THAN ART

Freud (1856–1939) trained to be a neurologist, and his early studies on infantile cerebral palsy and aphasia are today considered classics in the field. As a neurologist, he frequently saw patients with psychiatric complaints, and he tried a number of treatments, including hypnotism, on some patients exhibiting symptoms of neurosis or hysteria.

In his quest for successful treatments, Freud eventually began urging his patients to recall forgotten thoughts and events, hoping to find in such recollections a back door to pathology. When one of his patients unexpectedly interrupted his queries and begged to be allowed to continue her discourse, Freud, following what he later termed an "obscure intuition," let her talk.

He began giving other patients the same freedom. As they reclined on the couch in his surgery at Berggasse 19 in Vienna, he would sit behind his patients, out of their sight, a geographical orientation that now has its own justifying literature, although he himself put it down to not being able to look at the human face for eight hours a day. And he would listen.

By allowing his patients to speak discursively in "free association," Freud hoped to glimpse their "unconscious" thoughts and motives. He came to believe, in biographer Ronald Clark's words, "that human actions were more governed by unconscious motives than had previously been thought possible; ... that repressed tendencies, pushed from the conscious mind and

Sigmund Freud and friends at the International Psychoanalytic Congress in Weimar, 1911. Otto Rank wears spectacles on the left, Carl Jung likewise on the right. To the left of Jung is Freud's biographer, Ernest Jones.

down in the unconscious, played a great and unsuspected role in human life." Freud eventually concluded—there is nothing to prove him wrong, and much to suggest that his intuitions were often correct—that the origin of many mental disorders lay in hidden emotional conflicts, often buried deep in the events of childhood.

For the sake of convenience, we can say that the Freudian Era commenced in 1900, at least in Europe, when his *Interpretation of Dreams* was published. In that study (perhaps his most influential, and certainly the one psychiatrists most often cite, along with *Civilization and its Discontents*, 1930, when asked why they chose their profession), Freud asserted that the unconscious mental activity sublimating dreams actually refracted, as though through a strange lens, conscious desires and thoughts.

Beyond a select circle of grateful patients and contentious disciples in central Europe, Freud's theories, particularly the notion of infantile sexuality, were not, at first, widely accepted. They had little effect on American psychiatry until 1909, when psychologist G. Stanley Hall invited Freud to lecture at Clark University in Worcester, Massachusetts. Psychoanalysis—as Freud's method of treatment was called—acquired its first

American converts.* By 1911, a New York Psychoanalytic Society had been founded. But the advance of psychoanalysis was slow. Encouraged by the conclusive link established between syphilis and insanity in 1913, and still smarting from the criticisms of men such as Mitchell, many American psychiatrists over the next couple of decades became avowed "organicists" and began experimenting with sometimes bizarre treatments: insulin coma, induced convulsions, electroshock therapy, sterilization, lobotomy, sleep therapy.

Ultimately, Adolf Hitler provided the chief impetus to psychoanalysis in the United States. The great majority of psychoanalysts in Europe were Jewish, and citizens of Germany or Austria. As the Third Reich extended its rule after 1936, hundreds of Freud's disciples—and Freud himself—fled to England or the United States. Most came to America. "Two Freudians together constituted a seminar, three a training institute," psychoanalyst Leslie Farber has recalled. "What they were promulgating was not psychiatry but psychoanalysis, which in Europe, under Freud's supervision, had already detached itself from medicine." It had not done so completely, however. Indeed, the Freudians' pursuit of psychosomatic medicine—applying psychoanalytic principles to medical problems that had clear emotional associations (peptic ulcers, hypertension, asthma, migraine headaches)—helped ease the acceptance of psychoanalysis among skeptical American psychiatrists.

After World War II, for a variety of reasons, psychoanalysis entered the Promised Land. Its methods were, in the first place, seductive, and they often seemed to work. Psychoanalysis appealed to a basic American belief in self-improvement; it also went hand in hand with "the pursuit of happiness." And there was an ideology to it, one that, as Paul Roazen has observed, appealed to intellectuals disillusioned with God and Marx.

"Not only has Freudian theory plugged the intellectual hole of Marxism," Roazen wrote, "but it has also provided for some a similar basis for radical aspiration. It is possible to find in Freud not merely a substructure for one's ideas, a central intellectual core, but also a moral criticism of the status quo." In his writ-

*According to the *Comprehensive Textbook of Psychiatry*, psychoanalysis, "as a technique for exploring the mental processes, includes the use of free association and the analysis and interpretation of dreams, resistances, and transferences. As a form of psychotherapy, it uses the investigative technique, guided by Freud's libido and instinct theories and by ego psychology, to gain insight into a person's unconscious motivations, conflicts, and symbols and thus to effect a change in his maladaptive behavior." Psychoanalysts in the United States must be physicians in order to belong to the American Psychoanalytic Association, whereas in Europe psychoanalysts may be psychologists, social workers, or other nonmedical practitioners. The issue of medical training has long been a controversial one, with Freud himself arguing that a psychoanalyst need not be a physician.

ings, Freud had leapt beyond the individual psyche and taken on grander themes, such as the origins of civilization. His ideas, or so it seemed to many psychiatrists, were as applicable to society as they were to patients. Moreover, the very figure of Freud inspired a kind of reverence. As sociologist Philip Rieff has noted, almost all of the psychoanalytic canon was written by one man: "It is as if Paul had composed the entire New Testament; or, more aptly, as if Moses had compiled the entire Pentateuch." Of the Freudian canon itself, Rieff says: "This is more than science, more than art—it is another sort of reality."

Another factor contributing to the popularity of psychoanalysis was money. In 1946, for the first time, the federal government entered the psychiatry business in a big way, setting up the National Institute of Mental Health (NIMH) and giving it, in its first year, $6 million to spend, a large sum in those days. NIMH earmarked much of its budget for psychoanalytic research and for training psychoanalysts and psychotherapists.

At the same time, the United States during the postwar era embarked on three decades of sustained prosperity. There soon existed (as there had not during the Depression) a large class of Americans with considerable surplus income. Psychiatry became a consumer good, more chic than many in some social circles. And as it did so, its center of gravity shifted even further away from the mental hospital—a trend apparent since the 1920s—and closer to the private office.

Competing Therapies

Freudian psychoanalysis is now the second most popular method of psychiatric treatment after individual psychotherapy, which is itself derived largely from psychoanalysis. Unlike psychoanalysis, which is rather strictly defined and closely follows the Freudian model, psychotherapy is a generic term for any number of verbal treatments for psychological disorders. (One practitioner has wryly characterized psychotherapy as "an undefined technique applied to unspecified cases with unpredictable results. For this technique, rigorous training is required.") Its evolution during the past half-century has been helter-skelter. Richie Herink's *The Psychotherapy Handbook* (1980) identifies more than 250 competing therapies: Jungian, Gestalt, Rankian, Adlerian, Rogerian, and so on.

Today, someone seeking treatment may find himself lying on a couch talking about childhood experiences or, in a form of Reichian therapy, lying face-down on the floor as a therapist walks over his back, all the while intoning, "Have you ever con-

sidered the possibility that your problems stem from your tendency to let people walk all over you?" He may be asked to participate in group swims in the nude, or encouraged to jump up and down on a pillow, which, he is asked to imagine, is his mother or father. The new therapies in part help to account for, and in part merely reflect, the proliferation of mental illnesses classified in the *Diagnostic and Statistical Manual* (1980).

Sharing and Caring

While psychiatrists in the past concerned themselves primarily with schizophrenia and "affect" (mood) disorders, today they can pick from a longer menu, including narcissism, tobacco abuse syndrome, and academic underachievement disorder. Melvin Sabshin, medical director and chief executive of the APA, had this sort of syndrome inflation in mind when he noted last May that "the boundaries of psychiatry in America are more broadly drawn than anyplace else in the world. . . . There are some psychiatrists who behave as if the prevalence of psychopathology in the United States is 100 percent."

More than half of all American psychiatrists today favor an eclectic approach to patient care, mixing several different therapeutic methods. At first glance, such an orientation sounds sensible: Take what is useful among a variety of possible treatments and discard what does not work.

But in practice, most psychiatrists fall back on the style of treatment in which they have been trained and with which they are most comfortable. They tend to apply the same methods to widely differing problems. To a psychoanalyst, a case of elevator phobia would require intensive discussions to uncover the hidden meaning of the patient's fear (was his father, perhaps, not upwardly mobile?). To a family therapist, the phobia would somehow tie in with problems of family life. To a behaviorist, neither the patient's nor the family's history would be of much interest; he would try to treat the problem simply by helping the patient to suppress his phobia.

Yet no single method of psychotherapy is demonstrably better than another. In 1980, Mary Lee Smith, Gene V. Glass, and Thomas I. Miller reported on 475 case studies of psychotherapy in their book, *The Benefits of Psychotherapy*. They concluded: "Differences in how psychotherapy is conducted (whether in groups or individually, by experienced or novice therapists, for long or short periods of time and the like) make very little difference in how beneficial it is."

When groups of patients receiving therapy are compared

with individuals in "control" groups who are not, psychotherapy does seem to help alleviate less serious disorders, ranging from anxiety to minor phobias or some sexual dysfunctions. But the data are remarkably spongy. Precisely what are patients responding *to*? Is it the particular therapeutic mode? Or is it something more generalized, such as emotional catharsis or the presence of a sympathetic listener? Our picture of psychotherapy's value may also be blurred by a tendency among patients, when interviewed by researchers, to exaggerate their progress. As for major mental disturbances, psychotherapy *alone* usually does not do much good.

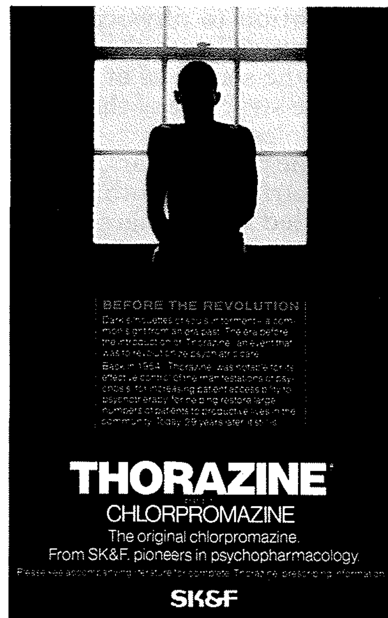
Nor is there any real expectation among psychiatrists that they can actually cure many of their patients. One problem is defining what "cure" means in a psychiatric context. A second is determining when the patient has met the definition. A third is getting him to that point: leading him through an often agonizing therapeutic process, fraught with opportunities (and temptations) for both doctor and patient to bow out.

Psychiatry today, whatever its merits, can scarcely be called a science. It is practiced by physicians who do very little medical work. Many of the conditions they attempt to treat do not correspond to "illness" in any accepted sense. The methods of psychiatry have been adopted by nonphysicians: clinical psychologists, psychiatric social workers, the clergy, and, if the term is sufficiently diluted, by bartenders and helpful neighbors. As a result, the American public tends to distinguish psychiatrists from all other doctors and treat them as a special breed.

Psychiatry's detachment will not last much longer, however. Earlier in this century, America saw the practice of psychiatry move from the insane asylum to the office building. Now it is finding a home in the laboratory as well.

IV
MEDICINE OF THE MIND

In 1948, an Australian psychiatrist named John Cade made a discovery. He learned that one of his patients, a "little wizened man of 51" who had been hospitalized in a state of manic excitement for five years, suddenly was able to function in society after treatment with lithium, an alkali metal that had been used to alleviate gout since the mid-19th century. Without lithium, the man had been "amiably restless, dirty, destructive, mischie-



In 1981, pharmacists in the United States filled 154 million prescriptions for psychoactive drugs. Average cost per prescription: $10. Almost half of these medications were for relief of simple anxiety.

vous, and interfering." Three months after lithium treatments began, the fellow was back at his job.

The discovery of lithium's psychotherapeutic value, soon followed by the introduction of chlorpromazine hydrochloride (Thorazine) and other major tranquilizers, and then by the major antidepressants, marked a revolution in the field of mental health. The new drugs dramatically reduced the number of patients who had to be sequestered in asylums (and often physically restrained). Ever larger numbers of the mentally ill could now remain in society and be treated privately or, in the United States, by psychiatrists in an expanding network of publicly funded Community Mental Health Centers.*

Uncrowding the asylums is an achievement of some note (even if not, as we shall see, an entirely benign one), but the fundamental significance of the biological revolution lies in redi-

*Under the Community Mental Health Act (1963), Washington provided grants to local groups wishing to establish and operate local psychiatric clinics; it also awarded grants to state governments to fund construction of facilities. The first Community Mental Health Center (CMHC) opened in 1965; by the end of 1966, there were 130 centers in operation; a year later, 331. There are now 768, located in all 50 states, Puerto Rico, the Virgin Islands, Guam, and the District of Columbia. (Total cost in 1981: almost $1.7 billion.) From the outset, CMHCs have had to contend not only with mental illness but also with all kinds of legal, moral, social, economic, and political issues. Inevitably, psychiatrists sought greener pastures; today, only one CMHC in five is run by a psychiatrist.

recting attention to physical processes. Put simply, if some patients "improve" with the help of psychoactive drugs, then it follows that the source of at least *some* forms of mental illness may be in the structure of the brain itself, rather than in, say, a traumatic adolescence.

During the past 20 years, the discovery of a variety of chemicals that contribute to both normal and abnormal brain functioning has led researchers to some novel theorizing about mental illness. In 1965, Harvard psychiatrist Joseph Schildkraut developed his influential "catecholamine hypothesis," arguing that some depressions may stem from a deficiency of catecholamines (a family of neurotransmitters) at receptors in the brain. Similarly, elation or mania may result from an excess of catecholamines. Today, as research continues into the biological nature of some mental illnesses, more serious disturbances than depression—schizophrenia, for example—now and then yield to new drugs aimed at restoring the proper balance of neurochemicals.

The Age Factor

One might think, given its track record, that biological psychiatry would quickly have made major inroads into traditional psychiatry. In fact, most psychiatrists (though not the National Institute of Mental Health) have resisted it. To be sure, psychiatrists who do not prescribe psychoactive drugs for at least a few patients (usually in conjunction with psychotherapy) are now a distinct minority. Almost one-half of the topics discussed at the 1983 meeting of the APA had a biological slant. The *American Journal of Psychiatry* and the *Archives of General Psychiatry* now devote almost one-third of their pages to biological psychiatry.

Yet beneath the surface, the historical gap between psychiatric theory and psychiatric practice endures. Fewer than one percent of the nation's psychiatrists claim that their principal method is organic or biological. Only 213 psychiatrists in the United States have completed residency training in neurology.

Part of the problem is age. While all psychiatrists are physicians, many are middle-aged physicians who have not dealt with physical illness on a daily basis for two decades. A 1977 study by C. W. Patterson revealed that 81 percent of psychiatrists do not perform physical examinations on their patients and do not refer their patients to other physicians for such examinations. One-third of those surveyed in another study admitted that they no longer knew how to perform a physical examination.

The reasons psychiatrists give for omitting physical exams

range from saving time to avoiding "transference" of emotions between patient and doctor, which could jeopardize psychotherapy. Some psychiatrists cite the erroneous notion that physical disorders are rarely the cause of mental illness. But in fact, mental illness and physical illness are so interrelated that it is often absurd to look initially for a psychological disorder.

Robert S. Hoffman, writing last year in the *Journal of the American Medical Association*, found that 41 percent of 215 patients admitted to a San Francisco hospital with psychiatric problems actually had obvious neurological complaints that could be treated with drugs. At government-run outpatient clinics, in one case out of 10, medical illness turns out to be the *sole* and *exclusive* cause of psychiatric symptoms.

Faking It

It is not unfair to conclude that many psychiatrists are willing to see psychiatric problems wherever they happen to look. If a patient is not mentally ill, their thinking seems to run, then why has he come to a psychiatrist? In 1973, David Rosenhan, a psychologist and law professor at Stanford University, set the psychiatric profession on its ear with an article in *Science* magazine, "On Being Sane in Insane Places." Rosenhan conducted an experiment to see whether eight people with no history of mental illness could gain admission to mental hospitals for psychiatric disorders. The "pseudopatients" gained admission to 12 different mental hospitals (11 public, one private) by pretending to have heard voices. Once admitted, the patients were instructed to behave normally. In every case but one, the pseudopatients were diagnosed as schizophrenic.

In a later study, Rosenhan forewarned the staff of one hospital that, at some time during the next three months, one or more impostors would attempt to gain admission. No one from Rosenhan's group appeared. Nevertheless, out of 193 patients admitted for psychiatric treatment, 23 were considered suspect by at least one psychiatrist. Rosenhan's conclusion: "Any diagnostic process that lends itself so readily to massive errors of this sort cannot be a very reliable one."

Such experiments and, more importantly, growing criticism from the biological wing of the profession have forced traditional psychotherapeutic psychiatrists at least to acknowledge the competition. One would have to be blind not to notice, at the more recent annual conventions of the APA, the hundreds of middle-aged practitioners shifting restlessly in their seats, doing their best to follow the arcane ruminations of

Dinner in the Asylum *(1916), by Ernst Ludwig Kirchner. On an average day in 1979, 232,073 people were in the nation's mental institutions. Fewer than 0.5 percent of those admitted as inpatients receive a diagnosis of "no mental disorder."*

some psychoneurologist on "The Search for the Lesion in Melancholia," wishing they were next door listening to another colleague—a real colleague—talk about cults and mass hysteria, or the clinical applications of psychodrama.

Doubtless, few of them will convert to biological psychiatry, for reasons with which one can only sympathize. "It takes a very special training to partake of that knowledge," psychiatrist Walter Reich observed recently in *Encounter*. "You have to know neurochemistry; and for that you have to know biochemistry; and for that you have to know organic chemistry; and for that inorganic chemistry; and for that you have to go to school, and for that you have to be young."

The generation gap is increasingly apparent. In 1973, Hagop Akiskal and William McKinney, Jr., published a survey of American psychiatrists in the *Archives of General Psychiatry*. They reported that psychiatrists trained since 1970, though still heavily oriented toward psychotherapy, were more apt to be "tough-headed"—to be better informed about the brain sciences, to practice some form of biological psychiatry, or to devote themselves to research—than were their predecessors. The

authors termed the older psychiatrists, trained before 1970 and more likely to practice some form of psychotherapy, "soft-headed." The "softheads" tended to be politically liberal and to emphasize the importance of the social environment in understanding mental illness.

The biological types have cause to be proud of some of their clinical accomplishments. They have no right to be cocky (although some are). No drug employed thus far, no matter how effective in treating the symptoms of certain mental disorders, actually *cures* those disorders. Moreover, some treatments have extremely deleterious side effects: "Tardive dyskinesia," for example, a severe involuntary movement disorder, results from prolonged use of antischizophrenic drugs.

The Revolving Door

There are less tangible, albeit no less worrisome, side effects as well. Biological psychiatry promises to reinforce the mechanistic, coldly scientific approach to health care that already characterizes so much of modern medicine. (Say what you will about psychotherapy, but the patient as an individual is still the center of attention, and the procedures themselves are thoroughly "humanistic.") Perhaps more troubling, biological psychiatry also panders to one of Americans' worst instincts: the belief in a "quick fix," a "simple, painless remedy."

A glance at the statistics on pill-popping in the United States shows the dimensions of one aspect of this problem: Sixteen percent of the U.S. adult population take some sort of psychotherapeutic medication every year on one or more occasions. Since 1964, the number of prescriptions filled annually for antidepressants has trebled. Biologically oriented psychiatrists do not, of course, condone pharmacological promiscuity—as it happens, physicians in general practice, who treat a far greater number of America's mentally ill than do psychiatrists (60 percent versus 20 percent, with the remainder untreated), write most of these prescriptions—but they certainly helped to create the climate that sustains it.

Finally, by helping mental hospitals to transfer hundreds of thousands of patients out of the wards and back into society, biological psychiatry solved one problem and created another. Today, in New York City alone, an estimated 34,000 former mental patients are crowded into halfway houses and single-occupancy hotel rooms. Such psychiatric ghettos now exist in virtually every American city. The former patients, heavily sedated or otherwise drugged, get little assistance in readjusting to life in

the "real world." They are among the more frequent victims of predatory crime. As time passes, many neglect to take their medicine and suffer relapses. In this respect, the biological revolution is really a revolving door.

V

CHANGING COURSE

In the present decade, as during the recent past, the softheads have largely defined for the American public the scope and practice of psychiatry. At least until the late 1970s, the softheads held most of the hospital chairmanships in psychiatry and most of the offices in local and national psychiatric societies. Three generations of Americans have acquired softhead jargon ("psychobabble," as its most adulterated form is known) at their mother's—or mother figure's—knee, and it is typically on pronouncements by softheads at the annual psychiatric conclaves that television and newspaper reporters do their stories.

The "toughheads" have at times gone overboard in both their claims and their criticisms, but they have rightly chastised their brethren on the other side of the aisle for their chronic willingness to issue advice on such topics as poverty, race, education, crime, politics, and arms control. Arnold Mandell, chairman of the department of psychiatry at the University of California, San Diego, put the matter bluntly at a meeting of science writers in 1974: "We made highly quotable, unsubstantiated statements, and they were quickly taken up by the media. . . . Many of the things we became famous for turned out to be things which were really in fact beyond our area of competence."

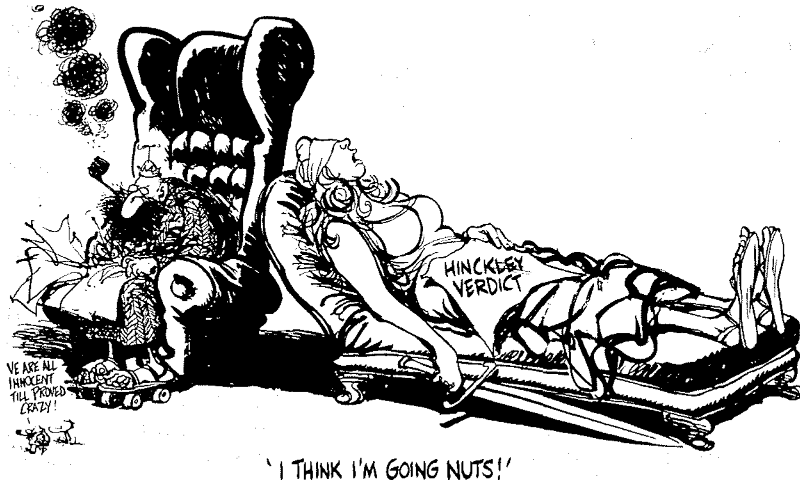
And yet, in the nine years since Mandell spoke, psychiatrists at the annual APA meeting have staked out positions and passed resolutions on issues as diverse as affirmative action, marijuana laws, abortion, desegregation, capital punishment, and the United Nations Draft Program against Racism, all on vague mental health grounds. The psychiatrists assembled in congress endorsed the Equal Rights Amendment in 1974, after the association's president, John Spiegel, declared that passage of the amendment, "clearly, will vastly improve the mental health of about one-half of our population."

It is hard to avoid the conclusion that personal preference continues to masquerade as clinical judgment, as it so often has in the past. During the Vietnam War, numerous psychiatrists aided young men anxious to avoid military service by submit-

ting negative "fitness" reports to local draft boards. Before the liberalization of the abortion laws, when women often needed psychiatric grounds to terminate a pregnancy legally, many psychiatrists were willing to supply them as a matter of routine. In both instances, ideology, not medical opinion, proved decisive. During my own training, I sat in on (but did not participate in) many diagnostic meetings that involved a question of abortion. I do not recall an instance when the patient's request was refused. "Until the law is more enlightened," a psychiatrist explained on one occasion, "we have to be willing to undertake the duty of helping women in these kinds of situations."

The issue here is not abortion or the draft or marijuana laws per se but rather the matter of standards. Psychiatry, after all, is a specialty within medical, not political, science. If psychiatric opinion is continually cited when social and political questions arise, why should not politics help define mental illness? Psychiatrists can no longer ignore this rude question. During the early 1970s, for example, after repeated disruptions of APA conventions by homosexual demonstrators, the association's membership succumbed to pressure and struck homosexuality from the roster of mental illnesses in the *Diagnostic and Statistical Manual*. Homosexuals hailed what they called an "instant cure."

Few of the incidents cited above, revealing though they are, were widely publicized or in the news for very long. This is not the case with sensational trials—those, for example, of Sirhan Sirhan, Patricia Hearst, and John Hinckley—when psychiatrists are invited to assay the sanity (in the legal sense) of a defendant.



Perhaps more than any other single factor, the public disputes of psychiatrists on the witness stand have undermined the average American's confidence in the psychiatric profession.

The 1982 Hinckley trial was one of the more damaging in recent memory. Because everyone conceded at the outset that John Hinckley had indeed pulled the trigger in an attempt on President Reagan's life, the substance of the trial consisted of psychiatric gossamer. For two weeks, teams of opposing psychiatrists floated different interpretations of what Hinckley had said and done, "plunging ever deeper into the realm of psychiatric jargon, inkblot tests, and learned theorizing," as the *New York Times* put it.

The jury reached agreement, even though the expert witnesses could not, and acquitted Hinckley by reason of insanity because he appeared to be "impaired to such extent that he lacked substantial capacity to conform his conduct to the law." Amid the ensuing uproar and angry calls for abolition of the insanity defense, the APA felt compelled to issue a strongly worded statement backing more stringent laws that would hold individuals with "antisocial" personalities legally accountable for their actions. The U.S. Justice Department, which had proclaimed Hinckley's sanity throughout the trial, now finds itself in the ironic position of having to use the evidence of insanity it had contested in order to keep the President's assailant confined at St. Elizabeth's Hospital in Washington, D.C.

A Brush with Bankruptcy

All in all, the situation that modern American psychiatry finds itself in today is roughly as follows:

First, a basic but little-publicized shift in the nature and practice of psychiatry—the emergence of biologism—has shaken the profession to its core.

Second, a series of embarrassing public episodes has chipped away at the profession's reputation and perhaps at its authority.

Third, the whole culture of psychotherapy, which has influenced everything from report cards to sermons, from welfare reform to the training of our soldiers, has become cloying, even disturbing. One is reminded of Rollo May's warning "that psychoanalysis and psychotherapy in general [could] become part of the neurosis of our day rather than part of the cure."

Yet, if the profession is in turmoil these days, that is a good thing and long overdue, like New York City's brush with bankruptcy during the 1970s. My own prognosis for psychiatry is

guardedly optimistic. It is clear today *where* reform is needed, and there is more willingness than before to undertake it. To me, the next few decades look like this:

¶ The new biological orientation in psychiatry, particularly among younger practitioners, will not be reversed. No new Freud will recapture the momentum for psychoanalysis or psychotherapy. This is not to say that psychodynamic therapies will not and should not continue. There is no question that they can be effective. "Let's face it," I remember one psychiatrist saying, "I've helped a lot of people over the years so I must have been doing something right." But the "medical model" of mental illness will emerge preeminent, permanently.

¶ Psychiatrists in the future, of whatever orientation, will have to make their treatments less *ad hoc* and experimental. Some of the pressure here is coming from the courts. Malpractice suits involving psychiatrists are arising more frequently, and the standard for adequacy of treatment laid down in *Rouse* v. *Cameron* (U.S. Court of Appeals, District of Columbia, 1966) is unequivocal: Treatment must be adequate *in light of present knowledge*. Psychiatrists will have to be real doctors, familiar with the possible biological aspects of a patient's disorders. Because no physician can be expected to know *everything*, we will therefore see psychiatrists dividing up their tasks far more than they have before.

¶ Finally, there will be new attempts to define what is and is not a mental illness. The most important distinction to make is between those who are truly ill and those we might call the "worried well." Today, the worried well—people who perhaps feel a little sad or "maladjusted," or who are fine and dandy but aspire to perfection—are the mainstay of private psychiatric practice. A century ago, psychiatry was not much of a profession, but psychiatrists were among the few people in the country who tried to help the insane and the seriously disturbed. *That* commitment needs to be revived.

Some critics would do away with psychiatry altogether, allowing it to be nibbled away by neurologists from one side and psychologists and social workers from the other. That would be a mistake. It is a unique profession, one whose members possess knowledge and skills that cannot be exactly duplicated by neuroscientists, clinical psychologists, or social workers. Only psychiatrists will be able to merge the new discoveries about the brain with older theories about how personality is shaped (and warped). Only psychiatrists, as medical doctors, stand a chance of radically improving the quality of care for the insane.

And psychiatrists are in the best position to begin "de-

psychologizing" America. The task is considerable: Large numbers of Americans are excessively preoccupied with what is going on inside their heads. "The old alchemical dream," Tom Wolfe has written, "was changing base metal into gold. The new alchemical dream is: changing one's personality—remaking, remodeling, elevating, and polishing one's very self . . . and observing, studying, and doting on it." Everyone does a little of this; millions of Americans do a lot. They pay others to help with the overhaul. In effect, they mortgage some part of their free will and autonomy when they look to specialists for definitive answers: Who am I? How can I be happy? Should I do this or that?

Psychiatry in and of itself is not responsible for this odd situation. Psychiatrists, along with psychologists, Eastern mystics, fitness experts, and others merely reaped a harvest that was already ripening. The long bibliography of self-improvement books published during the 19th century suggests that the "new alchemical dream" has been with us for some time. It was Henry David Thoreau, not Dr. Joyce Brothers, who asserted that "the unexamined life is not worth living." But since World War II, the popularization of psychiatry and the assumptions about self and society that go with it have made matters worse.

Even as traditional beliefs came under siege, psychotherapeutic notions encouraged individuals to make themselves (rather than God, society, or the family) the one overriding point of reference. That preoccupation undermines many things vital to any free society: a sense of community, shared values, strong families. It contributes to the erosion of basic distinctions—between rights and duties, collective and individual responsibilities. And ironically, as the "Me Generation" is beginning to find out, such self-indulgence does not make one any more independent, but simply dependent on something different.

By retreating from some of the terrain they have staked out over the years, by emphasizing that therapy is a limited form of treatment rather than a world view, and by talking less grandly in public, psychiatrists will be doing some good for their profession, their patients, and the larger American society.

PSYCHIATRY IN AMERICA

All societies, not just 20th-century America, confront the mysteries of the deranged, disturbed, or eccentric mind. In the past, they have variously responded by elevating the "touched" to positions of considerable influence or mystical significance, by ostracizing or killing them, or by subjecting them to harsh physical or psychological ordeals in the hope of effecting a cure.

The crucial question is: Who is really deranged?

"Every culture, to my knowledge, has some category that can be called 'madness', but madness is not always clearly distinguished from other categories of thought and behavior. At what point do we draw the line between innovative and insane, between visionary and psychotic?"

So writes Bennett Simon in **Mind and Madness in Ancient Greece** (Cornell, 1978, cloth; 1980, paper). Among the Greeks, "deviance" was often a relative matter. Plato, for example, assumed that any political dissident was by definition disturbed; he therefore proposed in his *Laws* that atheists, as dissidents, be placed for five years in a *sophronisterion*, or "house of sanity."

Whether symbolically in their myths, or explicitly in their medical and philosophical treatises, the ancient Greeks seem to have anticipated everything from psychotherapy and the interpretation of dreams to biological explanations of melancholy and hysteria.

Not surprisingly, Sigmund Freud (1856–1939) and other early European psychoanalysts felt the tug of Greek antiquity. As Simon observes, Freud "saw Sophocles' *Oedipus Rex* not merely as a convenient illustration of his newly discovered 'complex' but as an almost close-to-conscious attempt at analysis of the inner workings of the mind."

The influence of Freud on the practice of psychiatry is difficult to overestimate, and the Freudian literature is consequently immense.

The man's own work—beginning with a "Report on my Studies in Paris and Berlin" (1885) and ending with "Anti-Semitism in England" (1938)—is available in the 24-volume **Standard Edition of the Complete Psychological Works of Sigmund Freud** (Norton, 1976). Most of the better known monographs (e.g., **The Interpretation of Dreams**, 1900; **Totem and Taboo**, 1913; **Civilization and its Discontents**, 1930; **Moses and Monotheism**, 1939) are also available individually in paperback from W. W. Norton. Freud was a superb writer, whose prose style drew high praise from authors as diverse as Thomas Mann and Herman Hesse.

Freud was fortunate in his first biographer, Ernest Jones, whose hagiographical **The Life and Work of Sigmund Freud** (Basic, 1961, cloth & paper) helped place the Viennese psychoanalyst on the high pedestal he still occupies. Two recent biographies provide a more balanced perspective—Ronald W. Clark's **Freud: The Man and the Cause** (Cape and Weidenfeld & Nicholson, 1980) and Frank J. Sulloway's **Freud: Biologist of the Mind** (Basic, 1979).

One of the better overviews of Freud's ideas and their impact in the United States is **Psychiatry in Ameri-**

can Life (Little, Brown, 1963), a highly readable, though dated, collection of 15 essays edited by Charles Rolo. The book, whose contents originally appeared in the *Atlantic*, includes chapters by Brock Brower (on "The Contemporary Scene"), John Seeley (on "The Americanization of the Unconscious"), and Alfred Kazin (on "The Language of Pundits").

Kazin blames "Freudianism" for a deterioration in the quality of modern American fiction. "It is impossible," he writes, "for the haunted, the isolated, the increasingly self-absorbed and self-referring self to transcend itself sufficiently to create works of literature."

David Stannard has a different bone to pick. In **Shrinking History** (Oxford, 1980, cloth; 1982, paper), he looks askance at the influence of psychoanalysis on historiography. Among the gems he culls from the prose of the new psychohistorians is this one: "Bosch, of course, is just a more finicky da Vinci. And da Vinci is just [Martin] Luther with a talent for drawing."

Ironically, contends psychoanalyst Bruno Bettelheim in his latest book, **Freud and Man's Soul** (Knopf, 1983), the conventional interpretation of some of Freud's ideas may be the product in part of faulty translation. For instance, translators have customarily rendered Freud's *die Seele* into English as the coldly impersonal "mental apparatus," rather than as "the soul," as Freud intended.

Examples of such heavy-handedness are numerous. The inevitable result, in Bettelheim's view: Few readers of Freud in English appreciate that "he was a humanist in the best sense of the word."

Freud's ideas penetrated the United States in the years before World War I. But there was psychiatry in the United States long before there was Freud, and a mental health "establishment" was in existence by the mid-1800s. David Rothman, in **The Discovery of the Asylum** (Little, Brown, 1971, cloth; 1972, paper), and Gerald Grob, in **Mental Institutions in America** (Free Press, 1973), cover the period from colonial times to the beginning of the 20th century. Though bureaucratic histories in some respects, both books are clearly written and easily accessible to the lay reader.

The Psychiatric Society (Columbia, 1982), by Robert Castel, Françoise Castel, and Anne Lovell, brings the story up to the late 1970s, with particular emphasis on the evolving role of state and federal governments, and of organized psychiatry as a professional guild. The volume concludes with a critical survey of the broad array of "psy services," from gestalt therapy to primal scream to bioenergetics, now available in the United States.

What makes this book especially interesting is that it is written from an outsider's perspective (two of the authors are French) and with a European audience in mind (the book was first published in France). Noting that the United States is the country where psychiatry "has penetrated most deeply into the social fabric," the authors warn that "the American dream of mental health is not just a curiosity. . . . If we can learn to see it as in some ways a model of what is in store for us in Europe, perhaps we can keep it from becoming the nightmare of our tomorrows."

Among U.S. critics of psychiatry, the most prominent has long been Thomas Szasz. Szasz's argument is aptly summarized in the title of his first book, **The Myth of Mental Illness** (Harper, rev. ed., 1974). He con-

tends that, strictly speaking, the term "illness" refers to an abnormal biological condition; it should not, therefore, be applied to most forms of psychiatric distress.

Szasz attributes the "mental illness" notion partly to a tacit compact between the public and the psychiatrists, sealed during the 19th century.The latter agreed to regard certain types of individuals as "sick"—thereby providing a justification for putting these people away. The former agreed to regard the latter as "doctors." The compact was ratified by many patients, since it relieved them of personal responsibility for ethical or spiritual dilemmas.

Psychiatry is often viewed only in the abstract. Two staff writers for the *New Yorker* provide chapter and verse in a pair of recent books.

Janet Malcolm, in **Psychoanalysis: The Impossible Profession** (Knopf, 1981, cloth; Vintage, 1982, paper), profiles a pseudonymous New York analyst, Aaron Green, "a slight man with a vivid, impatient, unsmiling face." Green talked with Malcolm for weeks on end about his patients, himself, his colleagues, and the nature of his vocation.

Green compares psychoanalysis, when it works, to the end of *A Midsummer Night's Dream*, "when the human characters wake up and rub their eyes and aren't sure what has happened to them. They have the feeling that a great deal has occurred—that things have somehow changed for the better, but they don't know what caused the change."

There are no magical Pucks and Oberons in Susan Sheehan's **Is There No Place on Earth for Me?** (Houghton, 1982, cloth; Vintage, 1983, paper). Sheehan chronicles the life of a paranoid schizophrenic named Sylvia Frumkin, from grade school through adulthood in New York, in and out of mental hospitals, from one examining psychiatrist and round of drugs to the next. Sheehan was given complete access to Frumkin's psychiatric records and did most of her reporting on the scene.

The result is a solid indictment of contemporary mental health care in the United States. *No Place* is also a profoundly depressing story. One comes away from the book hoping only that psychotherapy and drugs, despite their current inadequacies, will one day be able to help the Frumkins of the earth.