CHAPTER

2

Mental Illness in History

Learning Objectives

After reading this chapter, students will be able to:

1. Provide examples of how prehistoric peoples may have understood mental illness.
2. Describe the emerging theories of physical causes of mental illness and how they related to religious views.
3. Summarize the components and significance of humors theory and other contributions of the classical civilizations of Greece and Rome.
4. Analyze the relationship between social organization and its understanding of mental illness.
5. Explain how social changes affected views on mental illness during the Renaissance and Enlightenment.
6. Describe the evolution of how early American society approached mental illness.
7. Outline the evolution of competing approaches and main theoretical streams of thought that accelerated the rise of psychiatry in the nineteenth century.
8. Discuss the wide range of changes in treating mental illness that occurred in the twentieth century.

> "One of the enduring staples in mad medicine has been the rise and fall of cures."
>
> —Robert Whitaker (2002)

Introduction

Because of its revelation of bizarre treatments and theories, the history of mental illness has long held the fascination of scholars and the public alike. How societies have responded to mental illness over the centuries is not always a pleasant reality to accept. Cruel punishments, inhumane confinements, and weird medical interventions largely characterized the treatment of the mentally ill well into the twentieth century.

Accumulating "factoids" recounting the strange practices of times past does not constitute a study of the history of mental illness treatments, however. We need context, and history provides that for us. What we will see by studying the history of mental illness is that people have wrestled with the same questions about sanity for centuries, and treatments and societal responses to mental illness have improved

but remain distanced from the "grand solution." We are no closer to a cure than we have ever been.

We learn two major lessons by looking at this history. First, current thought and practice do not lie in a cultural vacuum. How we see mental illness today is the result of the evolution of ideas that have taken millennia to develop. Second, history provides examples of how we socially construct ideas about psychological illness. As mentioned in Chapter 1, definitions of mental disorders are fluid, and societies of different types produce unique definitions and responses to mental illness. For example, a society that commands strict religious conformity usually has a religious explanation for insanity, whereas an advanced technological society relies on technical explanations and highly bureaucratized treatment methods.

Also important is that every historical explanation of mental illness was assumed to be correct by the members of society at that time, which means that given mental health's inexact definitions and treatments, a historical perspective can provide insights into understanding why and how people are labeled mentally ill. Mental illness, evidence suggests, is found in every human population in all places and times. The great variations in which peoples have dealt with these conditions are most interesting, and history reminds us that context determines whether a behavior is considered normal or abnormal (Farreras 2022). Perhaps José Bertolote (2008) best summarized the importance of studying the history of mental illness by stating that because mental health has a number of meanings and possesses poorly defined borders, a historical perspective provides insights into understanding our emotional troubles and coming to firm conclusions about what illness actually means.

Over time, beliefs about the origins of mental illness have fallen into three categories: **supernaturalism**, **somatogenic**, and **psychogenic** (Farreras 2022). Supernatural theories contend that mental illness is caused by demons, evil spirits, gods, or magic in the form of possession, temptation, or curses. Astrological explanations fall into this category—eclipses, lunar phases, and planetary alignments are believed in some cultures to account for unusual behavior.

Somatogenic theories argue that mental illnesses fare rooted in physiological dysfunctions. Brain injuries, "chemical imbalances," and genetics are frequently cited as causes of abnormal behavior. Lastly, psychogenic theories posit that traumatic or stressful experiences, poor social learning and development, and distorted perceptions lead to mental disorders (Farreras 2022).

These three groups of theories have been found, in one form or another, from the earliest of times. They typically co-occur; that is, we often find elements of two or three of these approaches at any one time and place. A society's theory or belief system drives its responses to abnormal behavior, and the theory is grounded in the type of society that produces it. As we will see in this and later chapters, social status also influences perception of mental illness. This process has been true throughout history and still is today.

Prehistory

Prior to the ancient Greeks and Romans, there is scant evidence of how people thought about mental illness. Judging from remains and artifacts uncovered by

archeologists and anthropologists, early cultures likely assigned supernatural causes to unusual behavior. Demonic influence or possession led individuals to act weirdly; therefore, shamans performed religious rituals to exorcise devils and free the troubled souls from the evil spirit that haunted them.

In addition to archeological data, prehistoric supernaturalism is also supported by encounters with nonwestern peoples who have minimal exposure to other cultures and continued to live somewhat uninterrupted or uncontaminated by outside influences. These traditional cultures' views of mental illness also rested on evil spirits, curses, or demonic possession. In many traditional sub-Saharan African cultures, for example, mental illness was the result of curses by enemies, sorcery, or supernatural beings that bewitched innocent victims (Akyeampong 2015; Patel 1995). In traditional Arab cultures, mental distress could be caused by the evil eye, satanic temptations to think or act improperly, or punishment by God (Bener and Ghuloum 2011)

Magic and rituals, however, may not have been prehistoric people's only remedies. It is possible that some attempted to relieve mental illness through a surgical technique called **trepanation**, a procedure of perforating the skull by drilling a hole or scraping off bone to reach the brain. Trepanation was perhaps conducted to relieve head pain caused perhaps by pressure from the build-up of blood after a head trauma. As improbable as it sounds, trepanation was likely successful on occasion in alleviating potentially fatal hematomas.

Archeological finds in Europe and Iran show that trepanation dates back 7,000 years to Neolithic times and was practiced in coastal Peru as early as 2,400 years ago, continuing in some areas of Africa into the twentieth century (Rawlings and Rossitch 1994). Trepanation was the world's first brain surgery; in addition to relieving blood build up, some believe it was conducted for magical purposes to create an exit for evil spirits to escape the body they possessed, thus relieving possessed victims of the disease or mental illness the spirit caused (Arani et al. 2012; Woods and Woods 2014).

Supernaturalism would continue for centuries and was more complicated than a simplistic "demons enter body" model. From their research on ancient Egypt, Okasha and Okasha (2000: 414–15) outlined the basic principles of magical practice in health and medicine. Through these precepts, magicians, "witch-doctors," and shamans created a system of belief that appeared rational in their culture—shamans' practices had to be consistent with the sensibilities of their culture to be accepted by their people. These principles are:

1. The belief in an "immaterial and impersonal force" that pervades the entire universe. This force holds all things together, and magicians can invoke or control this power to suit their needs.

2. In magic, logic and inferences are based on analogy and similarity. This means that two things are related and connected because they resemble one another in form or by name. The Oshakas give the example of a plant shaped like a body organ having healing powers over that organ.

3. The law of solidarity states that a body remains connected to any fragment separated from it. Based on this belief, it is possible to act on beings through locks of hair, nail clippings, used clothes, and so forth.
4. The last principle of magical healing is the notion that death is "protracted sleep." Deceased people continue to live, albeit in an altered state, and can revisit people they knew, descendants, or even strangers. These "ghosts," to use a popular term for these beings, can influence the mental health of the living, usually for the worse.

Though based on their study of ancient Egypt, the Okashas' guidelines for understanding magical thought are universally relevant. These qualities in "magic medicine" have persisted to modern times.

Early Civilizations

Most ancient peoples, such as the Hebrews, Egyptians, and Mesopotamians, believed that supernatural forces caused mental distress. If offended, gods or ghosts of deceased ancestors could curse the sinner with various afflictions. In ancient India, mental illness was thought to be caused by sinful behavior in a present or previous life.

Egypt, the dominant culture of the ancient Mediterranean world, produced great advances in architecture, arts, religion, and science, and became the leading producer and warehouse of knowledge prior to the Greeks. These advances in knowledge inspired Egyptian and Mesopotamian physicians to create a different mode of thinking about psychological disorders. While supernatural explanations for unusual behavior were most common, educated and literate thinkers began to explore somatogenic theories. Vestiges of one Egyptian theory remain with us. An Egyptian papyrus written around 1900 BCE describes a particular condition suffered uniquely by women in which the uterus wanders around the abdomen bumping into other organs and causing both bodily and emotional misery. The Greeks would later learn of the "roaming uterus" and incorporate it into their theories. Although the Greeks would eventually reject the notion that the uterus moves about the body, they would claim that the organ was the center of strong emotions in women and caused a condition called **hysteria**, a term derived from *hystera*, the old Greek word for uterus. Men were not thought to suffer from hysteria or histrionics until the nineteenth and early twentieth centuries when research showed that hysteria was not a female-only disorder (Tasca et al. 2012). The term "hysteria" remains in use to describe uncontrolled emotions and sudden excitability, and "histrionics" refers to an exaggerated need to be noticed and a self-esteem that requires external validation.

An interesting quality of ancient Egyptian thought is that Egyptian physicians distinguished between the causes and symptoms of mental illness (Okasha and Okasha 2000). While causes were attributed to the supernatural, symptoms were organic. For example, while delirium was due to feces in the heart and dementia was caused by certain poisons, it was supernatural forces that moved the feces and

applied the poisons. Similarly, forgetfulness and "perishing of the mind" originated from inhaling the breath of a priest, which would confuse the mind. Treatments, therefore, followed the theory. Magical and religious treatments were aimed at the causes, and practical treatments, such as prescriptions of minerals, animal fats, alcoholic beverages, and drugs made from various plants, targeted the symptoms (Okasha and Okasha 2000).

The Classical Era

The ancient Greeks would continue the intellectual school initiated by the Egyptians and begin to search for somatogenic causes of psychological distress. The great philosopher Plato (c. 429–348), for example, wrote that diseases of the soul were consequences of bodily dysfunctions (Sassi 2013). He defined immoral behavior as contrary to nature, but not necessarily a medical condition. For Plato, the soul needed to be kept in balance, just like the body needs balance to avoid illness (Seeskin 2008). Plato divided mental problems into two categories: mania and ignorance, both of which were due to an excess or deficiency of one of the primary elements of the body. Rejecting supernatural explanations, Greeks physicians, particularly Hippocrates (c. 460–370 BCE) developed the **Four Humors Theory**, perhaps the first coherent theory of both physical and mental illness. The four humors—blood, yellow bile, black bile, and phlegm—were thought to represent the four elements that composed all earthly matter, including the human body, and had qualities that affected mental well-being. For health, both physical and mental, the four humors needed to exist in a balanced state. Table 2.1 shows the humors, their qualities, and their relationship to human temperament.

According to Hippocrates' theory, each humor's physical quality corresponded to a different emotional characteristic, and the correct balance of the four fluids, all of which are found in the bloodstream, is necessary for health and well-being. Too much or too little of one of the fluids caused disease and mental illness. Excessive black bile led to melancholia, too much phlegm caused apathy, and yellow bile was associated with aggression. Mania was due to disproportionate amounts of blood or yellow bile (Smith 2008).

TABLE 2.1 The Four Humors

Humor	Element	Quality	Emotion	Temperament
Blood	Air	Hot and Wet	Sanguine	Courageous, Hopeful, Amorous
Phlegm	Water	Cold and Wet	Phlegmatic	Calm, Cool, Unemotional
Yellow Bile	Fire	Hot and Dry	Choleric	Bad-tempered
Black Bile	Earth	Cold and Dry	Melancholic	Despondent, Gloomy

The cause of nightmares provided another curious explanation. Humors theory presumed that too much blood made the body hot and wet. Therefore, a person suffering nightmares had excessive blood that heated the brain and caused frightening dreams during sleep. Treatments, therefore, involved relieving the body of the excessive blood. Bloodletting, a treatment that would last into the nineteenth century, was frequently recommended for treating psychological distress (and many diseases as well).

The Greeks prescribed a wide array of treatments of mental problems. Inducing elimination through the bowels using laxatives was a common remedy. But not all Grecian treatments were of such severity. More humane treatments, such as aromatherapies or vapors (steam, naturally occurring and intoxicating ethylene, and various pleasant fragrances), baths, and dietary changes, were advanced to balance the humors.

Humor theory was complex and included effects of the seasons and temperature, all acting in concert with the natural elements and the body. It would continue as a dominant paradigm for centuries and spread to other parts of the world including such faraway places as India. While humors theory sounds ridiculous to twenty-first century sensibilities, it was an important step in the history of mental illness. Humors theory was a wholly naturalistic framework for explaining and treating diseases and directed physicians away from supernatural explanations of earthly phenomena (Scull 2015). The Hippocratics, as Hippocrates and his theory's adherents were called, also introduced to western civilization the notion of balance, keeping our lives centered, and thinking holistically. Because of the Hippocratics, we still focus on having a balanced diet, living a balanced lifestyle, and engaging all things in moderation (Smith 2008).

Roman Era physicians and philosophers continued Greek intellectual traditions but expanded upon Hippocratic thinking. Several, particularly Asclepiades, Cicero, Soranus, Celsus, and Galen, made important contributions to western thinking on mental health. Asclepiades (171–110 BCE), although an ethnic Greek, rejected the Hipporcatics' humors theory and created a unified theory of health and mental illness rooted in systematic process and a rationalism that we would understand today as the scientific method. This theory centered on the notion that the body included networks of conduits (blood vessels and nerves) that, if clogged, would irritate the brain and cause mental problems. Various substances, including alcohol and opium, could congest the nervous system, leading to psychological disorders. Asclepiades was the first to distinguish between hallucinations, illusions, and delusions (Millon 2004). See Box 2.1 to learn about these terms.

Box 2.1 Delusions, Illusions, and Hallucinations

Asclepiades was the first to make the distinction between delusions, illusions, and hallucinations. In clinical settings, it is essential to know the difference because they refer to quite different phenomena and indicate different disorders and conditions. Therapists often find it difficult to decipher the differences

(Continued)

Box 2.1 Delusions, Illusions, and Hallucinations *(Continued)*

when their clients and patients present their experiences, but it is clinically important to sort them out.

Delusions are incorrect beliefs that do not match facts. People will maintain their delusional beliefs even when confronted by irrefutable and unassailable evidence, and they are not open to logical explanations. An example is paranoia such as when people arrive at the conclusion that they are being secretly stalked by covert government agents. These people *know* the world is threatening and that they are being persecuted.

Illusions are about perceptions rather than beliefs. Rather, they are misperceptions of real things. Modern magicians, who of course do not perform real magic, are masters of illusions. They trick our eyes. A person suffering from illusionary problems misreads actual stimuli. We all have had experiences with illusions such as when you saw a shadow that looked like someone was sneaking up on you or if you misjudge water depth because it appeared deeper that it really was.

Hallucinations are also about perceptions but imply perceiving things that are not real or present. They are false sensory perceptions. Hearing voices that no one else hears is perhaps the most common hallucination. Hallucinations are defining symptoms of schizophrenia but can occur with drug and alcohol abuse and other disorders.

From these basic definitions, it is easy to see why clinicians must sort out their patients' experiences.

The sociological aspects of these three concepts, however, are not so clear. There are times and places in which delusions and seeing and hearing things that others do not is not considered weird or pathological. Religious visions are often considered divine. Moses and Mohammed both said they spoke directly or indirectly to God. The French war hero of 1429, Saint Joan of Arc, claimed that she saw, heard, felt, and smelled deceased saints (Sackville-West 1936/1992). Other religions, including Hinduism and Buddhism, similarly incorporate divine experiences in the foundations of their faiths (Hastings 1991). Many who had divine guidance were and remain revered individuals who were chosen by their god to lead, inspire, or simply live good lives.

By medieval times, religious visions were so common that they were practically expected, forcing clerics and scholars to devise ways to separate the genuine from the false (Kemp 2019). By the late fifteenth Century, spiritual encounters were no longer accepted in the Christian world. The *Malleus Maleficarum*, the infamous "hammer of witches" written in 1486, served as the guidebook to witch-hunting and prosecution and attributed hallucinations to witchcraft and satanic influences (Liester 1998).

In today's time, differences in understanding hallucinations continue to exist. In many cultures, having visions and anomalous experiences, the term for benign hallucinations, lucid dreaming, past life experiences, dream reality, and the feeling of foreseeing the future are not considered troublesome behaviors. You may recall the conflict between Don Juan and Carlos Casteneda from Chapter 1 in which one perceived to have turned into a crow and flown, and the other in disbelief. What is the difference?

One proposed idea is the cultural source hypothesis (Maraldi and Krippner 2019). In this theory, these unusual experiences are legitimated because they are rooted in the belief in the existence of extraordinary phenomena that allow for and explain those experiences. There is no physiological basis to them, as westerners would typically understand hallucinations. Instead, there are cultural beliefs and expectations that the experience is real, which is why Carlos had such a difficult time believing that Don Juan turned himself into a crow. The interpretation of the peyote-derived hallucination was rooted in cultural beliefs in what is true.

The son of a wealthy Roman, Cicero (c. 106-43 BCE) established himself as a highly respected politician, lawyer, writer, and philosopher who addressed numerous subjects including health. Cicero's writings were influential on other scholars and elites, and intellectuals would read his ideas on mental health for centuries. He was among the first to argue that mental distress had **psychogenic causes** such as environmental conditions, unbridled emotions, and undisciplined thinking. Consequently, Cicero proposed treatments to teach disturbed individuals to think more clearly and rationally and to control emotions. Cicero's two other major contributions were to discover that emotional distress can lead to body pain and disease, a group of medical conditions now known as psychosomatic disorders, and he created perhaps the first questionnaire to identify psychosocial problems in individuals. His clinical instrument was widely used in its time and looks remarkably similar to current clinical assessment protocols (Millon 2004).

Soranus, who was ethnically Greek but practiced medicine in Rome, was born in the late first century of the Common Era. Soranus wrote several important texts including *On Acute and Chronic Diseases* in which he classified three types of madness: phrenitis, mania, and melancholy. Phrenitis was characterized by delirium due to fever and accompanied by a high pulse rate and convulsive movements. In phrenitis, he most likely was describing the psychological effects of various viral or bacterial infections or other health problems. Like today's use of the term, mania was characterized by chaotic thoughts, intense emotional expressions, and agitation. Melancholy presented like today's depression with feelings of sadness, fear, and dependency and social withdrawal.

Celsus (c. 25 BCE–50) was a prolific writer and encyclopedist who wrote extensively on medical theory and practice. He is regarded as among the first to instruct physicians on conducting plastic surgery on human faces using skin grafts, washing and sterilizing wounds with vinegar and thyme oil, which are mildly antiseptic, and identifying tissue inflammation. His works on mental illness, however, were less progressive. Celsus countered many of his fellow Roman physicians and philosophers by preserving humors theory, albeit with some modifications, and maintaining belief in the "wandering uterus." Celsus also firmly held that mental illness was of divine consequence, and his recommended treatments, notably starvation, intimidation, and bloodletting, are inhumane by modern standards (Millon 2004). Largely unknown during his lifetime, Celsus' theories on mental illness would become influential after the fall of Rome and into the Middle Ages.

Galen (129–210) was the most important physician of his time. A leader of intellectual thought throughout the Roman Empire, Galen's work, perhaps more than anyone else's, would reverberate throughout his civilization and have lasting influence on future physicians.

The concept of mental illness did not exist in ancient times, but Galen's theories moved us closer to conceptualizing unique fields in psychology and psychiatry. His concept of psychic pathology was based on a dysfunction in the physiology of the central nervous system, and pathological symptoms could be caused by toxins, humoral imbalances, emotions, and other internal conditions (Millon 2004). Galen also created a classification system to articulate distinctions among mental disorders. This taxonomy of disorders identified many types of depression, psychosis, and

hysteria. Most importantly, Galen brought all mental symptoms together into one medical rubric, linking them theoretically and physiologically unlike anyone in the ancient world (Ahonen 2019).

While these scholars and practitioners left complex writings on medicine and mental health and served emperors, senators, and generals in the field of battle, their work had scant influence in the homes and villages of everyday people with no wealth or who lived outside the major cities of the empire. Families provided care for individuals experiencing mental problems. When troubles became particularly stressful, families sought the advice of local priests or healers, whose knowledge was trusted but provincial. These healers generally defined problems in religious and supernatural terms, which made sense to villagers, and would prescribe various ritualistic treatments or plant-based remedies derived from local flora. Most individuals acting in bizarre or unusual ways were inhumanely treated during Roman times. Beatings, deprivations, bloodletting, and harsh physical restraints were common interventions throughout the Roman world. It was primarily the elites and "cultured classes" who received medical treatments based on civil and rational approaches. A few elites such as Asclepiades sought to end cruel treatments, but his reach was limited and had virtually no impact on the everyday life of Roman subjects.

Greek and Roman societies marked the beginning of western social organization and worldviews. The Greeks organized themselves into city-states that adopted democratic principles. They invested in education, and the Greek intelligentsia developed scientific methods and complex philosophical systems of thought that emphasized the notion that all things were composed of smaller parts, each having its own discrete properties and functions.

In comparison, Eastern philosophers, notably the Taoists and Confucians, saw everything as composed of a single substance. The world existed as a holistic mass in which harmony with nature and other people was central to mental health and overall well-being. In an East-Asian worldview, all things are connected and interdependent.

To illustrate this point, Nisbett wrote, "The Chinese philosopher would see a family with interrelated members where the Greek saw a collection of persons with attributes that were independent of any connections with others" (2003: 19). Because of the Greeks' curiosity and focus on categories of individual objects, western intellectuals would eventually discover atoms, genes, DNA, and bacteria and viruses, and their characteristics. They would also direct us to dissect mental processes into separate categories of thoughts, emotions, and behaviors, each with its own unique character and discrete meaning.

The theories and practices of the Greek and Roman physicians, though complex and rigorous for their time, were largely incorrect. Nevertheless, we continue to study them because they set the questions to ask about mental and psychological problems and helped form the boundaries of the study and treatment of mental illness. In the Classical Era, we see the beginning of contemporary perspective. Because people then faced the same basic life issues that confront us today, the Greeks and Romans started searching for causes and resolutions to those difficulties, setting in motion the way we think, reason, and solve problems. Modern scholarship is derived from classical rationality and builds off the successes and failures of its thinkers.

The Middle Ages

The period of European history called the Middle Ages was a critical time not only for Europeans, but for global history. During the millennium between roughly 500 and 1500, Europe floundered socially, economically, and technologically compared to other cultures in Africa, the Middle East, and Asia. After the fall of Rome and the Western Empire in 476 CE, most of Europe collapsed into political and social disorganization, and this lack of social cohesion had an injurious impact on every aspect of society and culture. The population declined, trade waned, and wars were seemingly constant. The downfall of the Roman Empire created a stark political void, leaving swaths of Europe without central governance and swamped with regional fiefdoms and "lords of the manor" who fought each other for control of lands, wealth, and strategic advantages.

As political institutions teetered, the Roman Catholic Church emerged as the one entity that transcended the national and ethnic boundaries of Europe. Except for parts of the Balkans, far north and eastern Europe, and Moorish Spain, virtually all of Europe had been Christianized by the year 1000. By 1200, Northern Europe was converted to Christianity, and the Moors would be driven out of Iberia later that century. Religious minorities, such as Jews, were ruthlessly persecuted, especially at the onset of the Inquisition in the 1490s, and were forced to convert, leave, or suffer brutal deaths as heretics. During the Middle Ages, the Church had become a unitary political and social voice that directed intellectual affairs, controlled great wealth, and held political influence over royal heads of state throughout the continent.

With images of chivalry, knights, and "damsels in distress," medieval life is often romanticized. In actuality, living during this time was hard, filthy, and violent. Only clerics and some aristocrats were literate (King John who signed the Magna Carta could neither read nor write). Most people were uneducated serfs, bound to their lords to work the fields, while a few were village or urban skilled workers and shopkeepers. These conditions produced poor health outcomes. Infant mortality was extraordinarily high, perhaps 30 percent, and life expectancy was in the 40s. Escaping childhood bode well for a long life, but childhood deaths were common, and males were often conscripted to fight wars in which women and children were too frequently unfortunate victims.

Public health was essentially nonexistent. Human and animal waste covered the streets and contaminated the water supplies of towns and feudal estates, and the floors of ordinary houses, usually made of grasses, were breeding grounds for various harmful viruses and bacteria and vermin. Infectious diseases were common and often fatal. Epidemics, such as the plagues that struck in the fourteenth and seventeenth centuries that killed 40 percent and 30 percent of the European population, respectively, decimated the social landscape and caused severe social despair and long-lasting problems that would require centuries to repair.

The health of the people during the Middle Ages reflected the times, and people commonly lived with both acute and chronic health problems including bad teeth and skin diseases, diarrhea and countless other infections, poorly treated injuries, and mental illness.

There is a temptation to say that because of these gloomy health conditions and the ascendancy of the Church in intellectual matters, the Middle Ages were a time of stagnation, the so-called Dark Ages. While that might be true of the Early Middle Ages, from 500 to about 1000 when Europeans produced very little new knowledge and art, especially compared to the Islamic world and the Chinese, the High (the middle period) and Late Middle Ages were centuries of grand advancement in architecture, art, music, and many technologies. The great universities of Italy, France, Germany, and Britain opened between 1000 and 1500 and fostered innovations in medicine such as the development of eyeglasses, expanded knowledge of anatomy and physiology, improved surgery and disinfectants, and created techniques for safer Caesarian births. Hospitals for the sick and infirm began to be erected in the Byzantine Empire and spread into the Christian world. Almost from the beginning, rooms dedicated for the insane were included in the construction.

Despite these advances, virtually no systematic study of medicine existed during the Middle Ages, and medicine remained a poorly developed field of knowledge and practice. Examinations of urine, for example, were a typical clinical assessment. Observable qualities in urine were associated with particular diseases. One diagnosis was that among elderly patients, white urine was considered a sign of frailty or childishness.

People who called themselves physicians were rarely trained and frequently ineffective. The cure rates of physicians who were educated, however, were not much better. Unsanitary conditions plus no conception of the causes of diseases led to physicians having low social status during this time. Barbers competed with physicians and often conducted surgeries, which led to the famed red, white, and blue striped poles still found outside barbershops today. The poles, which were later placed outside the shop as an advertising device, were originally positioned for patients to grab to remain still and help endure pain when barbers applied leeches for bloodletting, extracted a tooth, or conducted some other surgery, all without anesthesia (the pole's red stripe indicated blood and leeching, the white represented bandages, and the blue separated barbers from physicians, telling men they could also get a shave there!)

Few advancements in mental health were made during the Middle Ages in large part because the Church held an intellectual hegemony over affairs of the mind and heart. Consequently, it is also tempting to conclude that everyone believed that people who acted in nonconforming ways were tempted by the devil, possessed by demons, or being punished for their sins. Indeed, demon possession did exist as an explanation for erratic behaviors and conditions that we now label psychoses, personality disorders, and epilepsy, and exorcisms were occasionally performed (Espí Forcén et al. 2014).

Demons and magic, however, were not the only proposed causes of mental illness in the Middle Ages. In the eleventh and twelfth centuries, humors theory and Galenic ideas were still used by intellectual elites to account for eccentric behavior and bizarre thoughts (Høyersten 2007). Medieval cognitive psychology was based on an intersecting dualism of mind and body. The mind, the ephemeral and immortal intellect and soul, was distinguished from the material and mortal body, specifically the brain. The mind comprised peoples' thoughts, reasoning, and motives, which

were believed to be processed by the front and rear areas of the brain (Kemp 2019). Since thoughts and values—the stuff of the soul—were the province of the church and God-given, the mind could not be damaged. The ability to process the soul, however, relied on a healthy brain; therefore, a troubled soul was considered the result of a body dysfunction, environmental circumstances, bad habits, or temptations of the flesh by Satan.

Surviving records suggest that numerous causes of mental health problems were proposed in the Middle Ages. Eleventh-century writings from the Italian physician Constantine of Africa show worldly psychogenic origins of mental distress. He wrote that financial ruin and the loss of a child could lead to melancholia and that love-sickness was a disorder best treated by sex. Franciscan friar Bartholomeus Angelicus (c. 1203–1272) stated that poor dietary habits, overwork, and alcohol consumption caused melancholy and recommend listening to music to overcome it. Kroll and Bachrach (1984) studied 57 accounts of psychological impairments written during the Middle Ages and found that only nine attributed mental illness to sin or supernatural origins. They concluded that the literate elite of the time, most of whom were clerics, were aware of rational and earthly causes of mental distress. Nevertheless, uneducated ordinary people, along with many literate and knowledgeable elites, were more likely to hold religious and superstitious opinions about the origins of mental distress.

European and Islamic scholars and physicians engaged in academic and clinical exchanges throughout much of the latter Middle Ages, and the Europeans found that treatment of the mentally ill in Arabic and Islamic cultures, though similar in many respects, differed from their own. Europeans saw that Turks and Arabs held a more secular and tolerant perspective toward mental distress. Several factors may explain these differences. Unlike the Europeans, Islamic culture placed medicine atop the hierarchy of secular knowledge and considered the health and well-being of others a religious duty. As evidence of their more secular approach, Islamic physicians believed mental illness to have both physical and psychological causes and attributes (Amad and Thomas 2011; Sarhan 2018) and prescribed gentle treatments such as music and talk therapies, possibly inventing psychotherapy (Sarhan 2018), and therapeutic baths. Unlike in Europe where families tended to their mentally disturbed relatives, Islamic communities often provided care to those afflicted with more severe mental problems. Hospitals flourished in the Islamic world and by the late twelfth century, every town of any size had one. These hospitals, or *maristans* (meaning "place for the sick"), were secular organizations funded by donations and charitable contributions. They were well-ordered facilities with systematic medical practices featuring primarily humane treatments. Practitioners in the *maristans* separated sin from moral defects and illness and were optimistic about recovery and a return to health (Pérez et al. 2012).

Maristans, however, were not consistent, and treatments ranged from advanced clinical interventions to violence. Records show that treatments often followed Galen's recommendations and included diets, special baths with chamomile and various oils and ointments, and washing the head with milk to cool and moisten the body to neutralize the heating and drying effects of excessive blood or bile (Scull 2015). Other, more abusive treatments were also employed. Bleedings and induced

emesis and purging of the bowels, similar to European treatments, were sometimes recommended. Also, as in Europe, beatings were common to "beat sense" into patients thought to be deluded or confused (Scull 2015), and those patients who were hopelessly mad and out of control were chained to hospital walls.

As in Europe, Islamic peoples, particularly those in lower classes without access to centers of advanced knowledge, usually relied on supernatural explanations of nonconforming behavior. Different types of spirits, demons, and curses were commonly blamed. Religious rituals and trips to graves of saints to pray for interventions and cures, again as occurred in Europe, were common practices. Many insane persons were abandoned to roam the towns and countryside begging for their living.

The relationship between social and cultural conditions and the treatment of mentally ill persons is particularly visible in the Middle Ages in both Arab and European regions.

In the Middle East, treatment of mentally ill persons would not always remain progressive, as Amad and Thomas (2011) discovered. They found that in the Islamic sphere, when socioeconomic times were good, persons with mental distress were well-treated. When times were hard, that was not necessarily the case. The Mongol invasion into the Middle East in the thirteenth century, for example, disrupted social cohesion throughout the region and destroyed institutions, which led to a decline in care for people with mental illness. During these times, ill people were more likely kept in isolated detention, and social supports for their care diminished. In addition, when society entered a state of turmoil, beliefs in divine punishment as a cause of mental problems expanded and replaced medical approaches in many places (Amad and Thomas 2011).

Social life in Europe was often tumultuous during the Middle Ages. Wars, the Crusades, the Inquisition, epidemics, famines, and a hardscrabble daily life, plus the gradual transition from a rural agricultural economy to one of urban industry, migration to cities, and tensions between traditional aristocratic rule and liberal republican governance kept European social organization in a constant state of flux.

Consequently, the Middle Ages produced little toward improving the lot of the mentally ill in Europe. Mental hospitals operated differently and generally less humanely than their Arab counterparts. Run by religious groups, European hospitals evolved into warehouses to rid families, villages, and cities of people considered unwanted nuisances or were too difficult to handle. Treatments were repressive and punishing and reinforced the belief that mental illness was due to sin. Throughout the Middle Ages and into the Renaissance, attitudes toward persons with mental illness were, in general, hostile, and by the late Middle Ages and the Renaissance, mass confinements and lynchings of "lunatics" and witches, many of whom were mentally ill, began (Kroll 1973). One belief about the treatment of the mentally ill has been questioned, however. As Box 2.2 shows, the notion that mentally ill persons were put on ships and taken away to unknown places, the infamous Ships of Fools, may be false.

Box 2.2 Ship of Fools

In his important book *Madness and Civilization* (1965), Foucault described a tactic that communities commonly used in Europe during the fourteenth and fifteenth centuries to segregate themselves from mentally ill people. He wrote, quite elaborately in fact, that towns across Europe, especially in Germany, collected insane persons and loaded them onto ships, sending them to wander the seas and waterways on endless voyages never to return. Because of the influence of *Madness and Civilization*, many psychologists and psychiatrists included these ships of fools in their textbooks and other writings to illustrate attitudes toward mental illness during the Middle Ages.

The ships of fools, however, never happened, and their descriptions are imaginary. According to Maher and Maher (1982), there are no ship logs, diaries, marine records, sightings, or departure records (which were kept in detail for taxation purposes) to suggest that such ships with human cargos ever existed. So why would Foucault and others over the next 15–20 years perpetuate and even embellish the myth that the ships of fools were real?

The ship of fool was a common allegorical image of the Medieval Period. There are several paintings, woodcuttings, and books with references to the concept. Foucault may have inferred the literal ships of the insane from a book called *Das Narrenschiff*, written in 1494 by Sebastian Brant, a Dutch author, and a late fifteenth-century painting called the *Ship of Fools* by Hieronymus Bosch, who also was Dutch. Both are allegorical criticisms of un-Christian behavior. Brant's book is a collection of 112 poems that satirize human folly and the sinfulness of such behaviors as vanity, self-indulgence, deception, and immorality. Insanity is neither mentioned by Brant (Maher and Maher 1982) nor symbolized by Bosch.

So why did modern writers propagate this tale despite the absence of evidence? Maher and Maher argued that these accounts perpetuated beliefs that scholars had about madness in the Middle Ages, and their theories needed evidence. Structuralism, Foucault's theoretical orientation in this book, contends that ideas about culture and social things are best understood by their relationship to broad, overarching social organization, or structure. Foucault and others thought that with the beginnings of rationalism, medieval peoples cast their insane aboard ships and sent them to remote places or to just wander aimlessly to maintain and protect the new society based on reason and logic. Because they subscribed to the theory, these scholars assumed Foucault was correct in his depiction of the imagined popular image of the mentally ill. As Maher and Maher state, "The image of the storm-tossed soul cast adrift from rational society fills the bill [of the theories] perfectly. Since real ships of fools did not exist, it was necessary to invent them" (1982: 760).

The Renaissance and the Enlightenment

The Renaissance, roughly the 1400s and 1500s, followed by the Enlightenment period (seventeenth and eighteenth centuries) were transitions bridging the Middle Ages and the Modern Era. For scholars and their wealthy patrons, it was a time of adventurism and discovery. Many famous names that we equate with the origins of modern European civilization date to the Renaissance—da Vinci, Galileo, Hobbes, Chaucer, Michelangelo, and Descartes, among many others.

The Renaissance was fueled in large measure by the end of the Eastern Roman Empire, the Byzantine Empire, when Constantinople fell to the Ottoman Turks in 1453. Eastern scholars fled the invasion and moved westward into Europe, taking

their classical training and libraries with them. They revitalized Greek and Roman scholarship in Europe, which was facilitated by the Gutenberg printing press that allowed them to disperse classical knowledge throughout the continent. One of the rediscovered theories was the Hippocratics' approaches in medicine and mental health, which restored beliefs in bodily origins of insanity and rejected the supernatural.

Perhaps most critically for our story, the Renaissance, in addition to its resurgence in art and science, produced humanism, the philosophical belief that humans are the center of their world and that the human spirit is boundless and destined to master nature. The Renaissance scholars did not challenge the Church's authority over spiritual matters or abandon their own belief in the Christian god, but they did call for a revision of the image of the human self to possess the intellect to perceive and comprehend themselves, nature, and the essence of all things. The Renaissance writers contended that reason, mathematics, and logic were the central features of human consciousness, and that people were not simple beings acting on reflexes like the lower animals (Porter 2002). The humanist movement of the Renaissance is perhaps best summed up by Descartes famous argument, "*cognito, ergo sum*" or "I think, therefore I am."

From this new way of thinking, consciousness was the mind's natural proclivity toward rationality and sound reasoning. Insanity, it follows, is irrationality caused by some illness in the body that disrupts the mind's physical ability to reason. This formula made mental illness a valid topic for medical research and practice (Porter 2002).

Despite these advances, madness remained largely explained by mystical forces during the Renaissance. Satan was a literal and ever-present being roaming the earth looking for weak souls to tempt and inhabit. The Renaissance also produced, as Scull aptly stated, "a veritable epidemic of trials" (2015: 86), such as the infamous witch trials that occurred throughout Europe and spread to the North American colonies. The "witches," who were disproportionately marginalized or nonconforming women, were usually scapegoated for community troubles such as crop failures, diseases, bad weather, or other unusual and unfortunate events. In many cases, victims were people known or suspected to be mentally ill, but for the most part, they were ordinary people who were socially powerless and unprotected and easy marks for false accusations. The witch trials, of course, matched well with the beliefs that insanity was supernatural.

There were occasional public debates over specific cases of individuals charged with witchcraft where some learned person argued that a defendant was sick of body rather than in league with the devil. Johann Weyer (1515–1588), a Dutch physician, is often considered the first physician to specialize in mental illness, focused on melancholia. Weyer, who despite his own religious convictions that included a literal and material devil, fought against the witch trials. He frequently testified on behalf of those whom he knew to be melancholic and wrote books that criticized witch-hunting. Weyer made logic-based arguments that confessions of heresy, virtually always made under duress and torture, were not reliable representations of the truth. He and those like him, however, were often publicly challenged. On one such occasion, Jean Bodin, a famous sixteenth-century scholar and counselor to the

king of France, rebuked Weyer by saying that he (Weyer) should "stick to examining urine rather than intruding lofty territories of theology and jurisprudence" (Cavanaugh 2015). The Inquisition banned books written by Weyer and other like-minded progressive thinkers (Farreras 2022).

By the time of the Enlightenment (seventeenth and eighteenth centuries), changes in European society were increasingly rapid and dramatic. Whereas the Renaissance focused on human's artistic nature and creativity and introduced rationalism and individualism, the Enlightenment centered on the application of rationality in science, mathematics, and technology. Everything, including art and music, was rationally assessed and examined. One might say that the Enlightenment was the implementation of the Renaissance.

The Enlightenment, also called the Age of Reason, had its own worldview that centered on science, logic, and human rights (at least as they were defined then). Its ideals produced the American and French Revolutions and technological innovations that would change the world. The Age of Reason entrenched individualism as a cornerstone of western thought, but also led European nations to conquer much of the world outside the continent. They institutionalized slavery and indentured servitude to exploit the riches of their colonies and submitted indigenous peoples to barbaric imperial control, sowing the seeds of modern racism, segregation, and the systematic denial of certain peoples to the civil liberties and opportunities that the Enlightenment produced. This new ordering of peoples into a social hierarchy would have implications for psychological well-being that would last to the present time.

Three key ideas on mental illness arose from the Enlightenment. First, eighteenth-century physicians and scholars gradually won the freedom to investigate human nature without oversight or censorship by the state and the church (Weiner 2008). With the Enlightenment's concentration on rationality, reason, and individualism, intellectuals argued that individuals with psychological impairments had the same rights as healthy or "normal" people. Second, a theory that mental illness was a disease of the nerves and brain emerged, and that meant that physicians could devise a cure and return a deranged, alienated, or confused person back to sanity (Weiner 2008).

Third, with the rise of urban manufacturing and the Protestant Reformation taking hold in various areas and challenging the hegemony of the Roman Church, work became a moral duty, and idleness "the devil's workshop." The new economy was based on increasingly rational industrialization and trade, and as more people flocked to the cities, pressure increased to provide them with work and places to live. Those lucky enough to get jobs in the new manufacturing centers, however, faced horrible working conditions and unsafe machinery. Many workers suffered severe injuries, and unlike today where insurance and government support programs aid those who experienced work-related injuries, seventeenth- and eighteenth-century workers who were injured or permanently maimed at work were simply fired and quickly replaced with another person desperate to work.

The mores of the 1700s emphasized the morality of work and sinfulness of dependency. To handle the surplus of nonproductive people in the cities, many areas of Europe created institutions, sometimes called poorhouses, to imprison indigents

to punish them for their poverty and teach them the discipline to regain their productivity. The poor who were locked up were a diverse lot. Unproductive people included not only the poor, but also vision-impaired and maimed people, criminals, disreputable women including sex workers, and the insane. They were all treated essentially indistinguishably.

Madhouses proliferated in the Enlightenment period, and there is an image of them as dreadful places where patients were abandoned and treated horrifically. Some, such as Salpetriere founded in 1656 in Paris and London's Bethlem (1247), both of which still exist, were notorious for cruel treatment. Bethlem even charged admission for tourists to see the "exhibits" as if they were visiting a zoo. Though many of them were called hospitals, the large majority neither were headed by a physician nor provided medical care, such as it was then. Some were for-profit and catered to the genteel classes, while others were funded by the Crown. One asylum in Amsterdam was subsidized by a lottery!

The worst of the lunatic asylums were dreary places in which recovery to health was not likely. Considered to be more animal-like than human, patients were kept in dank cells with straw floors and without heat. At Bicêtre in France, patients were fed only a pound of bread in the morning, leaving them mad with hunger the rest of the day (Whitaker 2002). Patients were denied routine health care and exposure to the sun and were often beaten for any type of real or perceived offense.

The madhouses of the eighteenth century became the subject of many books and articles after philosopher Michel Foucault first wrote about them in the 1960s. Foucault (1965) championed the notion that throughout Europe in the 1700s, massive numbers of insane people were locked up involuntarily and subjected to harsh inhumane treatment. This so-called "Great Confinement," Foucault argued, was a deliberate strategy to reduce the political threats and social disruptions posed by the large numbers of unemployed and hungry urban dwellers. In addition, the idleness of the poor threatened the rational values of work championed by elites, and the best way to control a threat is to segregate people who were thought dangerous to the social order from those who conformed and followed the rules and contributed to the new economy of industrialization.

There are several criticisms of Foucault's work that cause us to rethink the notion of the Great Confinement. First, it is possible that the conditions of the asylums and the number of people actually held in them have been overstated. During and after the Enlightenment, authors, especially playwrights, frequently set their plays and other writings in asylums or wrote about people who had been placed in one. These plays are often cited as the main sources on asylum life. Nonfictional reports from the time, however, suggest that the asylums only locked up a relatively small percentage of people with mental illness. Second, there are several accounts written by people who were committed to an asylum, and these narratives indicate that their treatment was not insufferable, but therapeutic and humane. From these reports, we can conclude that some hospitals were better than others, a conclusion that counters the assumptions of the Great Confinement assertion. A third criticism of the Great Confinement concept is that if patients were confined because they had lost their way and were unable to work, then one might expect that patients would be

subjected to work programs in the hospitals. This might not be the case. According to Porter (2002), many of the asylums were for-profit enterprises that marketed (literally advertised) their services to wealthy families and patients. Rich patients would not be expected to toil in common conditions or be exposed to harsh treatments. There are also few records that indicated organized work programs at any madhouses.

As Porter contends, it would be too simplistic and perhaps even conspiratorial to say that these institutions arose as a tool of control to enforce the new norms of the nascent industrial society. People more likely entered the madhouses via their families in negotiations with the community and local officials and the directors of the asylums. Locking up the insane, especially when they became unmanageable, was not new to Medieval Europe or the seventeenth century. Families had long kept their insane kin in basements, barns, and pig pens. Wealthier families hid their mentally ill relatives under the charge of a servant (Porter 2002). The rise of asylums was in line with the rest of society—it was a more formal, bureaucratic, and rational approach to solving the family and community distress that an unproductive and burdensome individual posed. Box 2.3 tells the story of Nathaniel Lee and how he entered an asylum.

Box 2.3 Nathaniel Lee

Among their many contributions, scholars during the Renaissance also produced individualism, a way of thinking that centers on the moral value of each individual person. In individualism, people are autonomous, and their main objective is to discover and pursue their own interests and life goals. With individualism comes questioning society if the goals of the individual do not match society's or if society impedes progress toward one's ambitions. When people perceive society as a barrier to their personal interests, which often leads to feelings of helplessness, sadness, and hopelessness, common symptoms of depression, they will often criticize society as "crazy" for acting in a way that keeps people from freely living their lives and being happy. While this sounds like a twenty-first-century thought, the idea of blaming society for "being crazy" may have started in the 1600s.

Nathaniel Lee (c. 1653–1692), the son of a Presbyterian minister, was a successful Cambridge educated playwright who began to hang around with free-thinking members of the literati set, most notably John Wilmot, the 2nd Earl of Rochester, a highly regarded (and often censured) poet and war hero, who lived lavishly and decadently before dying from a sexually transmitted disease at the young age of 33. Nathaniel coveted and engaged in Wilmot's indulgent and licentious lifestyle, which tarnished his reputation and contributed to his excessive alcohol consumption and eventual psychological demise. He was then evaluated and sent to Bethlem Hospital for five years. Acting in his own defense, he famously questioned whether it was society that was mad for judging his behavior as wrong: "They called me mad, and I called them mad, and damn them, they outvoted me." Lee died young and in a drunken state on a street in London.

Mental Illness in American History

Records of mental illness date to the seventeenth century in the British colonies of North America. Data, however, are sparse and mostly come from court records, diaries, and personal correspondence (Eldridge 1996). Eldridge analyzed these chronicles and found enough cases and accounts of mental illness to give us a general idea of how the colonists dealt with these problems. He found that mental health issues were generally believed to be the result of supernatural or physical conditions. Cases of head trauma leading to behavioral changes were noted, but Satan's influence was also known to cause bizarre behavior.

In the colonial and early republic years, unrequited passions and one's basic disposition were also thought to bring on insanity. Madness, however, was also largely gendered and racialized. For example, environmental factors such as failed business ventures could release passions that drove White males to madness. For African Americans and women, on the other hand, their bodies were the source of uncontrollable emotions (Holland 2019). Benjamin Rush, though an abolitionist and student of the Enlightenment, was a man of his times and wrote in 1812: "in consequence of their bodies by menstruation, pregnancy, and parturition, and to their minds, by living so much alone with their families, [women] are more predisposed to madness than men" (quoted in Holland 2019).

Physicians, especially in the US South, often believed that African Americans as slaves rarely experienced mental illness. Blacks supposedly possessed an undeveloped nervous system and were not suited for independence and competing in a "civilized" society. As slaves, according to the belief, they lived a life of simple dependence, which better suited their biological constitution.

After emancipation, however, ideas changed, and by 1900, mental illness was "alarmingly common" among former slaves and their descendants (Hughes 1992). Following the Civil War, Blacks were disproportionately locked away in institutions where they were more likely to become malnourished and physically ill compared to institutionalized Whites, who received better care. In 1890, almost half of hospitalized African Americans died in the institution, compared to only 22 percent of Whites (Hughes 1992).

Many different behaviors were suspected of being illness in the colonies. Most any bizarre or irrational behavior or thinking implied mental illness, but so too was not conforming to mainstream religion and lisping.

Early American treatments for mental health problems are particularly telling of the state of knowledge. In addition to the conventional treatments of the day—prayer, fasting, bloodletting, and purging—Eldridge (1996) uncovered several rather unusual prescriptions:

1. An elixir of blood from a male cat's ear and milk from a woman suckling a male child.
2. Suppositories made of seeds from plants.

3. Pills of exact portions of castoria (which has a laxative effect), women's hair, and pine resin.
4. A living swallow halved and placed atop the shaved head of the patient.

Another treatment was Rush's tranquilizing chair. Physicians strapped patients into a chair, with a toilet bowl attached underneath, and a box covering their heads to deprive them of sensations. The theory was that brain inflammation caused madness, and the chair produced tranquility, thus reducing inflammation.

While the logic of these "cures" is not intuitive to twenty-first-century sensibilities, it would be reasonable to start with the Okashas' blueprint for magical logic outlined earlier in the chapter to understand them. Apparently, these plants, animals, and other substances had qualities that looked like something related to health or had religious significance. Perhaps some treatments, like the tranquillizing chair, were derived from humors theory. Regardless of their origins, they were probably ineffective.

Colonial and early republic White families cared for their ill relatives in consultation with the local physician. When individuals' health debilitated to the point that they were not manageable, colonial law required that communities build a facility for their care, though few of these places were constructed before independence. Psychologically distressed African Americans and American Indians were largely ignored or maltreated.

Religion and region also played a role in care provision. The Puritans of the northern colonies were averse to cruelty and tended to be more sympathetic than other religious groups. Northerners were more likely to live in towns and small communities, which facilitated community care. Conversely in the rural South, people were more spread out and lived on farms and plantations. Consequently, communities in the South provided less care for mentally ill persons (Eldridge 1996).

Beginning in 1820, asylums began to expand across the country, and eventually became the preferred course of action for families who could no longer care for their mentally ill relative. The asylums of nineteenth-century America had dual goals: to rehabilitate patients and set an example of how to behave and think rationally. Poor patients were taught to follow the behavioral examples of "proper" wealthy people. The notion that patients could improve their psychological health by changing their lifestyles suggests the belief that social conditions were thought to contribute to mental illness. Contemporary reports do cite that social factors, like loss of property, excessive study, and political excitement, contributed to mental distress.

The asylum movement failed in reaching these goals (Rothman 1971). They became unpleasant places, and little actual care or rehabilitation existed. Dorothea Dix, a nineteenth-century social worker and activist spoke and wrote on life within the asylums. She made a compassionate presentation to Massachusetts lawmakers attesting to those conditions saying, "I proceed, Gentlemen, briefly to call your attention to the present state of insane persons confined within this Commonwealth, in cages, closets, cellars, stalls, pens! Chained, naked, beaten with rods, and lashed into obedience!" (1843). In time, her advocacy led asylum officials to separate mentally ill persons from criminals and improve patient care.

The general mood of the first generation of American psychiatrists was one of optimism. For those that believed that social factors were the root of mental illness, the asylums would reform them. Those subscribing to medical causes were hopeful that finding the physiological problems that plagued their patients would lead them to an effective treatment. Autopsies to locate brain lesions and inflammation were common prior to the Civil War. The American scientific community in the 1800s shared Americans' optimism of technical and industrial growth, national expansion, and "Yankee know-how." This optimism was not held by all Americans, however. The industrial and agricultural poor, most minorities, and poor women who had few resources and no political empowerment were often subject to the worst care. There was little hope for them.

Reform and the Beginnings of Modern Psychiatry

The American and French Revolutions ushered in a new philosophy of applied humanism. Ideals such as the rule of law, personal liberties, and authority through consent were central to political movements in North America and western Europe. While these new principles did not apply equally to slaves, all ethnic groups, and women, they did have an impact on the way asylum patients were treated. By the late eighteenth century and early 1800s, asylum physicians and administrators slowly began to remove the chains that bound many patients. Led by reformers such as Philippe Pinel (1745–1826) in France, England's William Tuke (1732–1822), and America's Benjamin Rush (1745–1813) and Dorothea Dix (1802–1887), asylums embarked on a new course of treatment in which patients would be treated less like animals and more like human beings. These reformers believed that mental illnesses were due to either a physiological condition or psychological circumstances and stress. They unleashed patients and sought to provide basic human needs, including respect.

Moral treatment, as the new movement was known, differed from the usual treatment in madhouses. In the old system, the asylums themselves were the treatment (Spain 2018). It was a one-size-fits-all model. Under moral treatment, asylums were relatively more flexible and tried to provide the tools for relieving insanity. In the moral treatment model, curative care was more personalized and more humane.

Moral treatment began with Tuke, a well-respected Quaker merchant and philanthropist, who proposed a revision of asylum care after learning of the death of a mentally ill Quaker at the York Asylum and then witnessing patients in chains and manacles. As an alternative to the nearby brutal madhouse, he created the York Retreat. The Retreat was modeled on the family life of the wealthy and the peaceful precepts of the Quakers' faith.

Life and treatment at the York Retreat were unlike anything seen in the care of the mentally ill. Community life was emphasized: patients and staff lived together on the grounds and shared meals. The staff emphasized patients learning self-control with methods centered on love, sympathy, and esteem (Charland 2002). Violence and restraints were infrequent. When residents became rowdy or hard to manage, they

were secluded in a dark quiet room. Apparently, there was little cause to do that. It was rare that two residents needed to be segregated from the others at the same time (Whitaker 2002).

The York Retreat, according to their records, had an excellent success rate. Using relapsing to operationalize success and failure, 70 percent of York patients who had been ill for less than a year recovered, never again to develop symptoms, and 25 percent of chronically ill patients, those previously considered incurable, became symptom-free (Whitaker 2002).

Moral treatment spread throughout Europe and to the United States. While there were different approaches to moral treatment (Spain 2018), all had as centerpieces John Locke's sense of human rights and Tuke's insistence on humane care. Though York Retreat had a religious foundation, the leaders of the moral treatment movement used the word "moral" as we use "psychology" today (Charland 2002). Moral treatment physicians later became known as alienists, those who treat the "mentally alienated," and provided psychological care as opposed to the oppressive and ineffective tactics of typical madhouses (Frances 2016).

Pinel's theories and practices were inspired by the French Revolution's ideals of liberty, equality, and fraternity. Although it is often assumed that Pinel personally removed the chains of madhouse inmates, it is more likely that his theories inspired freeing mentally ill people from the neglect, custodial incarceration, and punishment that were the madhouses' primary curative strategies (Porter 2002, Scull 2015). Pinel became highly influential. He embraced the progressiveness of the Enlightenment, which led him to conclude that mental problems had to be handled psychologically. For Pinel and other advocates of moral treatment, madness was a breakdown of a person's rational self-control, and their psychological abilities and sensibilities had to be restored. Inner self-restraint replaced external coercion (Porter 2002). This modality, as Porter notes, meshed neatly with the social and political optimism of the American and French Revolutionary era.

The peaceful, gentle handling of mentally ill persons in the care of moral treatment physicians, however, should not be sentimentalized. While at the beginning, these asylums were somewhat idyllic, especially in comparison to the madhouses, they were considered hospitals, and patients were subjected to medical interventions (Frances 2016). As physicians gained more control of the asylums, moral treatment quickly morphed into a new form of asylums that increased in number and in census. The period beginning in the early 1800s and ending in the 1950s may be more accurately described as the real Great Confinement because admissions to mental hospitals skyrocketed to levels far exceeding any previous period (Scull 2005). Tuke's vision of moral treatment did not last long.

Why did moral treatment fail? After all, it was humane, kind, and according to accounts from the time, successful in preventing future symptoms. Why would the movement only last a couple of decades before transforming into a different mode of care? Moral treatment ended because physicians trained in the new biological sciences took over and rested control of the asylums from moral care administrators and physicians (Rothman 1971). Some consider the nineteenth-century asylum physicians as ushering in modern psychiatry because the mad doctors, as they were sometimes called, were working within a new medical paradigm based on systematic

observations and taxonomies of disorders. Physicians strove to classify patients into categories such as melancholia, mania (insanity), dementia, and idiotism. The mad doctors initiated the idea that alcohol abuse was a medical, not a moral, condition (Nathan et al. 2016).

In the nineteenth century, after the end of the moral treatment movement, asylums rather families were considered the best place for the insane, depressed, and disturbed. Patients were subjected to ineffectual medical interventions and were often abused. The alienists essentially ruled over warehouses of unwanted and unproductive people who were seen as threats to their families and communities. It was best, in physicians' eyes, to separate the mad from civilized society and use them as subjects to test their treatments.

Key Intellectual Developments of the Nineteenth Century

Three intellectual developments in the nineteenth century—Darwin's theory of evolution, **germ theory**, and **Social Darwinism**—moved mental health care toward a medical model that emphasized physiology over environmental causes. This new approach ended humors theory and supernaturalism as causes of madness, but it did not necessarily improve the lot of mentally ill persons.

Charles Darwin's observations of species evolving to adapt to their environment revolutionized the biological sciences. Though Darwin himself had little interest in human social dynamics, his rudimentary theories of genetics were adopted by other scholars attempting to explain mental illness. Their theory was straightforward: it is all genetics. Physicians and biologists believed that madness was due to a degenerate family trait passed from one generation to the next. More highly evolved individuals were free of mental illness, but others were genetically regressed and unable to cope physiologically or psychologically. These traits had physical indicators, such as particular facial features or skull shapes. **Degeneracy theory**, as this perspective was known, would linger until just after World War II and contribute to twentieth-century **eugenics** practices in Germany and the United States (Arboleda-Florez and Stuart 2012). Eugenics was an attempt to alter a population's genetic base by involuntarily sterilizing or killing persons with mental illness.

Germ theory was the second major intellectual stream of the nineteenth century. Infectious diseases such as cholera, typhoid fever, and influenza ravaged human populations and were the primary causes of deaths throughout the world. Anthrax, a persistently troublesome disease, terrorized ranchers because it could easily decimate herds of cattle and sheep. Identifying the bacteria and viruses that caused these and other diseases enacted profound changes on not only human health, but on social conditions. Localizing these pathogens gave solid evidence for public health and sanitation programs to provide clean water, remove human and animal waste, and create treatments and inoculations. Because of these achievements, biology emerged as the most successful scientific discipline in the 1800s. Since these discoveries reduced suffering and lengthened life expectancy to unprecedented levels, physicians began to associate microorganisms with all human health problems,

including mental health. The theory here was simple too: germs caused mental illness.

The bulk of early research on microorganisms rightfully focused on pressing life and death diseases such as cholera and anthrax and the benefits of sanitation, wound cleansings, and surgical sterilizations. Overall, germ theory had relatively little impact on our knowledge of mental illness, though it did inspire a few related discoveries. For example, untreated syphilis was linked to insanity, and vitamin deficiencies were connected to mental health troubles. Research continues in this area, however. Recent studies implicate infections in some cases of schizophrenia, bipolar disorder, and depression (Prusty et al. 2018).

The third important theme to emerge from the nineteenth century was Social Darwinism. Social Darwinism is an ideological framework that is not derived from Charles Darwin, who disapproved of it, but from Herbert Spencer, the English civil engineer turned philosopher. The term "survival of the fittest" was coined by Spencer in application of Darwin's idea of natural selection to humans and society. Darwin himself adamantly stated that survival of the fittest was an incorrect derivative of his theories of biology.

Nonetheless, Spencer maintained his position that society evolved similarly to Darwin's model of species and that what separates the rich and powerful from the poor and defenseless is genetic fitness. This position, therefore, justified policy decisions that sought to deny assistance to individuals and social groups that were not doing well socially. This framework was soon applied to mentally ill people.

Social Darwinism assumed that mental illness was organic and had no connection to psychological and social environmental factors. Because the environment had no influence on one's health, assistance, care, and education were considered unnatural interference (Albee 1996). The term *laissez-faire* originated from this perspective and means "hands off," that is, do not get involved in the affairs of the disadvantaged and upset the progression of natural evolution. Since recovery was hopeless, there was no need to help those who suffered from mental illness. Instead, nature should run its course and allow these people to simply die out and fade away.

Social Darwinism became a highly influential political force in the United States. It was used to justify withholding care and assistance to people in need, and in the twentieth century, it too was part of the rationale of the American eugenics movement.

The Twentieth Century

The twentieth century was unlike any other period in the history of mental illness. Theories of mental illness exploded into a cascade of diverse approaches and treatment modalities. The twentieth century, often called the "Age of Therapies," produced some 200 different psychotherapy models ranging from communing with nature to brain surgery. Doctors and patients relied heavily on pharmaceuticals to control symptoms of many severe disorders, and for the first time in over two centuries, the number of institutionalized people fell dramatically. The disciplines of psychology and sociology became influential disciplines and contributed deeply to

our understanding of mental illness. In addition, the twentieth century slowly democratized mental health treatments. The Civil Rights and Women's movements and the Cultural Revolution of the 1960s brought access to mental health services to disadvantaged people, and theories were developed to understand the mental health consequences of being socially and economically unfortunate. Access for the poor was and remains insufficient, but for the first time in history, attempts were made to understand the psychology of poverty and oppression.

Although much of the proliferation of twentieth century research and development will be discussed in later chapters, four important and interrelated trends should be mentioned here: the rise of talk therapies, increase in medications, **de-institutionalization**, and a new focus on the social environment, which will be discussed throughout this text.

Talk Therapies

The merits of talking about one's troubles appear sporadically in the history of mental illness, but as a modality of treatment, talk therapy, the method of intervention we most commonly attach to clinical psychology, social work, and related fields, had its true beginnings in the 1850s. English psychiatrist Walter Dendy introduced the term "psycho-therapeia" to describe the process in which patients and their physicians would try to sort through their difficulties in getting through life (Haggerty 2020). Psycho-therapeia, however, would not become a widely accepted method until the works of Austrian neurologist Sigmund Freud's first important work was published in 1900. Freud's theories were complex and comprehensive and would dominate clinical psychology, psychiatry, and other clinical disciplines for six decades.

In a nutshell, Freud believed that mental illness symptoms, as well as other behaviors such as smoking, overindulgence in food and drink, and misspeaking ("Freudian slips"), to be indicators and consequences of repressed and unresolved emotional conflicts. In Freud's view, psychologically distressed patients were unaware of these conflicts—they were stored in the subconscious mind. If analysands, those undergoing therapy, tapped into their unconscious thoughts and memories, the conflicts could be analyzed and resolved. To do this, Freud designed a complex technique called psychoanalysis. Unlike anything in history, psychoanalysis allowed patients to actively participate in their own treatment. They could choose to engage in self-discovery, or they could resist treatment by throwing up defenses to unlocking their inner-most memories and anxieties. Psychoanalysis was seen as liberating and revolutionary, and for over half a century, a clinician in training was likely studying Freudian techniques.

Freud's hegemony over psychiatry, psychology, and social work began to fade in the 1960s, and by the end of the century there were relatively few pure psychoanalysts remaining. A handful of clinical and research centers dedicated to traditional psychoanalysis remain in the United States and Europe, but for the most part, those working in the Freudian school, the neo-Freudians, practice new versions of the technique.

Of Freud's many contributions, none perhaps has been more lasting than institutionalizing talk therapy as the main intervention modality of nonmedical clinical treatments. All major psychological schools of thought, including behaviorism, cognitive, and gestalt, as well as other disciplines like social work and pastoral counseling have produced scores of talk therapy systems, each with an underlying theoretical foundation and treatment protocol.

The Rise of Pharmaceuticals and the Fall of Institutions

The asylum movement began in the Middle Ages, accelerated in the nineteenth century, and escalated deep into the twentieth century. In 1955, the peak admissions year, 560,000 people in the United States, or 385 per every 100,000 in the population, were admitted to public and private psychiatric institutions for long-term stays of two to three months or longer (Deas-Nesmith andMcLeod-Bryant 1992). By 2014, this number would fall to 170,000 (Lutterman et al. 2017). The latter number is somewhat misleading in that there were over 5.6 million hospitalizations for mental health diagnoses and another 1.5 million for substance use disorders in 2012. Note that stays in psychiatric wards and drug and alcohol units averaged less than seven days that year (Heslin et al. 2015). Long-term institutionalization had essentially come to an end by 2000.

How did this happen, and what were the consequences? People with many types of mental distress were admitted to long-term institutional stays for treatment and protection. Those who were institutionalized the longest had late-stage debilitating psychotic disorders such as schizophrenia or severe bipolar disorder. Most of these individuals were no longer capable of self-care and often posed a danger to themselves or others, or at least they were perceived as such. Their symptoms burdened their families to the point that their kin could no longer cope or provide for them.

Three factors caused de-institutionalization. First, the movement to release patients from long-term inpatient care began with the 1954 invention of **Thorazine** (chlorpromazine), the first successful antipsychotic drug for treating schizophrenia and the manic phase of bipolar disorder. Thorazine, though not a cure, allowed patients to control their symptoms, providing they took the medicine, and avoid institutional care. Second, 10 years after Thorazine was introduced, changes in funding policies shifted financial responsibility for mental health from the states to the federal government with the introduction of Medicare, Medicaid, and Social Security Disability insurance programs. These programs, however, did not pay for residential psychiatric institutions.

Lastly, de-institutionalization represented an ideological turn regarding patients' rights (Markowitz 2011). Along with civil rights activism on behalf of racial and ethnic groups and women came movements for patients and persons with disabilities that challenged involuntary and long-term confinements on civil liberties grounds. Several twentieth-century lawsuits led states to toughen their standards for involuntary confinement from almost any reason to strictly in cases of imminent endangerment to self or others.

The consequences of de-institutionalization have been profound. The rate of severe disorders has not changed significantly since 1955, so where did people with

severe mental illness go? Despite economic incapacities due to their illness, many were able to live on their own and take care of themselves. Most, however, were less fortunate. Prisons now house a disproportionately large population of people with mental illness, and others contributed to the rise in homelessness in the 1980s, living on the streets barely eking out their subsistence.

About the Quote

Whitaker's quote at the beginning of this chapter, "One of the enduring staples in mad medicine has been the rise and fall of cures," clearly illustrates the history of understanding mental health, as well as today's approaches. "Cures" come and go. None has yet been the answer, though the advocates of each theory were certain they were right. A so-called cure will catch on and get attention for a while before it is shown to be ineffective or even dangerous to patients.

Cures rise and fall, and so do diagnoses. Every few years there seems to be an ascendency of "fad diagnoses," or what some clinicians anecdotally call "diagnoses *du jour*." This phenomenon occurs when a particular disorder becomes popular, and clinicians begin to "see" it in everyone. The repressed memory movement of the 1980s is a good example. Repressed memories are a real but rare phenomenon in which an individual's memories of a traumatic experience are so painful that they are repressed or stored in the unconscious mind. In the 1980s, extracting repressed memories became a common therapeutic technique to help people in therapy identify the true cause of their emotional troubles. Many of these therapies assumed that adult problems were caused by repressed memories of childhood abuse. Through clinical practices designed to elicit these memories, individuals began to remember having been abused and many filed criminal charges against their alleged offenders. These charges usually came many years after the alleged abuse occurred, and many were imprisoned for child abuse. The trouble was these "memories" were usually false and in some cases even planted by therapists, leading judges to overturn many of the convictions.

Another "diagnosis *du jour*" was multiple personality disorder (MPD), an extraordinarily rare condition that became popular in the latter twentieth century. MPD is a condition in which people disassociate from themselves and fragment into two or more distinct personalities. The condition was popularized by the hit movie *The Three Faces of Eve* in 1957, the popular book *The Minds of Billy Milligan* (1981), and the book and Emmy award-winning TV miniseries *Sybil* (1973). In psychology and psychiatry, training workshops were taught nationwide, and an institute was founded in Kentucky to train psychiatrists to treat MPD. MPD is quite rare, but because of the training and the popularity, clinicians in droves began to see patients' "others." Eventually, it was shown that the surge in MPD cases were either based on inaccurate repressed memories, simply incorrect diagnoses, or, as in the case of "Sybil," allegedly manipulating patients into believing that "others" existed inside them (Nathan 2012). The social pressure brought on by the critics of MPD was so strong that the American Psychiatric Association removed it from the DSM and replaced it with dissociative identity disorder.

DISCUSSION QUESTIONS

1. Elaborate on Whitaker's quote that opened this chapter. What did he mean, and was he correct?

2. In his rebuke of Johann Weyer, what was Jean Bodin really saying about the study and public response to mental illness? What role did power and ideology play in his statement? Do you see any parallels in today's responses to mental health issues?

3. Most of the history of mental illness tells us that people with mental illness have been treated harshly and cruelly. Do you see vestiges of that history today?

4. In what ways can we trace our current thinking about mental illness through history?

KEY TERMS

Degeneracy theory 42
De-institutionalization 44
Eugenics 42
Germ theory 42
Four Humors Theory 24
Hysteria 23
Moral treatment 40
Psychogenic causes 27
Social Darwinism 42
Somatogenic theories 21
Supernaturalism 21
Thorazine 45
Trepanation 22