

## Sixty Years in Psychiatry

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In this article certain reminiscences from my past professional life and some aspects of the developments in psychiatry will at times be interwoven as I have witnessed many of the developments through personal experience and observation. I must, however, underscore the fact that in this paper, I shall try to discuss briefly some of those changes and developments within the context of the problem of identity of the psychiatrist. It would be beyond my intention and knowledge to try to discuss all aspects of psychiatric development which undoubtedly have been greatly influenced by the scientific, cultural, political and economic incidents and upheavals of our time. Having my M.D. degree from the Istanbul University Medical School, I started my residency training (specialty training) in psychiatry in 1954 in a major southern medical school in the United States where I had an eclectic training which could be considered rather typical of its time. After the completion of my residency training, I had two years of advanced training in psychoanalytical psychotherapy. The first half of the 20<sup>th</sup> Century has witnessed the great men of psychiatry and psychology who had made enormous theoretical and clinical contributions. It was undoubtedly on the basis of these

contributions that during the second half of the 20<sup>th</sup> Century, psychiatry has achieved great revolutionary changes and has confirmed its universal and unique status among the health sciences. I am one of those lucky people who have witnessed the major turning points as they occurred during the 20<sup>th</sup> Century. The major changes can be discussed under the following headings:

- A) Methods and tools of psychiatric assessment
- B) Diagnostic systems
- C) Treatment and rehabilitation modalities
- D) Training and research.

This period will be taken for discussion in two major stages, namely 1954-1980, which could be called the pre-DSM-III era and 1980- the DSM era (\*). The reason for specifying these two major stages is the well known worldwide impact of DSM-III and its later revisions on psychiatric theory and practice. I have specified 1954 which is the year when antipsychotic medicine, chlorpromazine began to be used in the United States.

(\*) DSM-III Diagnostic and Statistical Manual of Mental Disorders 1980.

Table 1. Major events or achievements during the last sixty years in psychiatry

The rise and development of psychopharmacology starting with chlorpromazine in 1952
Decline and fall of institutional psychiatry
Development of community oriented psychiatry (rising and expanding after the 1960's.)
Major diagnostic and classification systems (DSM-III, 1980 and ICD-10,1992)
Utilization of interview and assessment schedules in psychiatric interviewing
Anti-psychiatry movement of the 1960-1970
Advances in social psychiatry
Decline of psychoanalytic psychiatry (1970-)
Rise of cognitive-behavioral psychotherapy
Development of new brain imaging techniques
Major advances in neurosciences and molecular genetics
Development of principles and regulations of medical ethics

My presentation will not be a systematic review of the literature on the recent history of psychiatry, but rather a summary of my version of how I have perceived and evaluated the major changes. There is no doubt that the whole process might have been discussed in different contexts and ways, probably on the basis of one's training background and personal styles of looking at things. In trying to discuss comparatively the major changes during these two stages, I shall try to give more weight on some of the recently more neglected topics such as the diminishing interest on psychiatric interviewing techniques and doctor patient relationships. I shall also try to discuss point out some critical advantageous and disadvantageous aspects of major diagnostic systems as well as the effects of the dominance of the ever increasing influence of the neurobiological and psychopharmacological orientation in training and research.

### The Pre-Psychopharmacology Era

I shall start with a clinical vignette to give an impression of clinical psychiatry of the time. I remember an 18 year old man who had a psychotic delusion or a severe obsessional ideation that there was a hair growing on his palate. This rather introverted and isolated young man was persistently complaining of hair on the palate which was not substantiated by physical examinations. After a detailed life

history, psychological tests, clinical observation and a discussion on diagnosis and treatment, a diagnosis of schizophrenic reaction as it was then called was decided and in accordance with the diagnosis a treatment plan of deep insulin coma therapy (ICT) or electro-convulsive therapy (ECT) was planned. As a third year resident my preference was ECT while my senior insisted on ICT and these different preferences seemed to be based on the patient's history and clinical observation as well as on "clinical intuition." 16 deep ICT was to no avail and several weeks later 12 ECT had not created any change in the patient's thinking and in his withdrawn living. The patient's geographical and economic condition did not allow a plan for receiving psychotherapy.

I would like to draw your attention to several aspects of this clinical vignette: One is the diagnosis of "schizophrenic reaction" which was common in accordance with DSM-I (1952) and with the highly regarded American psychiatrist Nolan D. C. Lewis's statement "a trace of schizophrenia is schizophrenia". This diagnostic leaning was substantiated by the 1969 London-New York comparative study of diagnostic habits. It was clearly shown that many UK labeled affective or personality disorders could be diagnosed as schizophrenic reaction in the United States (Cooper et al 1972). The diagnosis of mental illness as a "reaction type" in accordance with DSM-I reflected a view of mental illness not as a disease but as a reaction to various psychobiological traumata or stresses of living. In accordance with this view, a detailed life history had to be taken for every patient. It is well known that in this approach the views of eminent figures like Adolf Meyer, Harry Stack Sullivan, Karl Menninger and many others in the widening circle of psychoanalytic schools have had major impact (Grob G 1999). Then of course, the commonly used insulin coma therapy which became almost extinct by the early sixties is another point of interest. Now, sixty years later, I wonder if our 21<sup>st</sup> Century chemical and/or somatic treatments would have ever affected this patient.

The third quarter of the 20<sup>th</sup> Century is an era of great effort to restore not only the physical world but also the educational, scientific and cultural damages caused by a highly destructive World War II. It is also a period of psychiatry's quest for an identity not only within the framework of medicine but also in social sciences and in society at large. In this pursuit of an acceptable identity as a branch in medicine, on one hand there were the enormous efforts

in the fields of pharmacological and biological studies to discover the etiology and treatment of mental disorders, in particular of schizophrenia.

After reviewing the many sources of errors of biochemical research of those years on the etiology of schizophrenia, then the well-known scientist Seymour Kety had stated in his classical article in *Science* in 1959: "...It would take many biochemists a long time to find a noisy circuit in a radio receiver if they restricted themselves to chemical techniques" (Kety S 1959).

On the non-biological side, however, there were the highly fashionable psychosocial and family studies most of which seemed to aim to the understanding of the psychosocial etiology of schizophrenia. These two trends seemed to have led to considerable splitting and role diffusion in the identity of the psychiatrist during those decades.

In 1950ies and 60ies, while in the United States the so called "psychodynamic psychiatry" which had psychoanalytic theory as its basis, had become prominent in training and in clinical practice and very popular in social life. European psychiatry seemed to be more influenced by developments in psychopharmacology as well as a growing interest toward eliminating asylum psychiatry of the 19<sup>th</sup> and early 20<sup>th</sup> Century. A major manifestation of this struggle for identity can be observed in the anti-psychiatry movement of the 1960'ies and 1970'ies under the prominent figures like R.D. Laing (1964) and Thomas Szasz (1974) who had become popular. Although the movement did not grow much beyond the 1980s, it did stimulate to question more extensively the various vicissitudes of psychiatry, in particular of intramural psychiatry and it also contributed to liberalizations, to greater sensitivity for the dignity of patients and to more conscientious critical concern with the correctness of professional practice (Tantam 1999).

Growing dissatisfaction with the ambiguity of criteria for psychiatric diagnosis and classification became more and more noticeable in training, in clinical practice and in research in the 1960'ies and 70'ies. On the other hand, the view of mental disorders as "reaction types" did not seem to be in conflict with the growing influence of sociological, anthropological concepts and the theory and practice of psychoanalysis. It has been my impression that European influence based mostly on Kraepelinian psychiatry was prevalent in many countries except probably in the Soviet Union and its allies and some far eastern countries.

A very important turning point in the second half of the Twentieth Century psychiatry occurred with the publication of DSM-III in 1980. DSM-III and its following revisions became so popular that in certain circles and by some professionals they were considered as the sole authority in psychiatry especially in training and research. If we look at the clinical research papers in widely read journals, it becomes clear that most clinical research publications seem to prefer using DSM's latest revisions. With its structured and clearly expressed diagnostic guidelines and criteria, its multi-axial diagnostic features and the high standard textbook quality of information provided in it, DSM-III and its later versions influenced many training centers to develop a consciousness on reliable and valid diagnoses in clinical practice.

It also became a great stimulus in promoting new interviewing and assessment instruments to be used in rapidly increasing epidemiological and clinical research. It also became a major impetus to develop a more internationally acceptable diagnostic system which lead to the complete revision of ICD-9 of WHO. After many international meetings, field trials and critical evaluations ICD-10 was published to be used worldwide. The Fifth Chapter of ICD-10 (1992) undoubtedly became a widely accepted manual in psychiatry, effectively used worldwide in training, research and in official nomenclature recordings. Like the DSM system, ICD-10 also stimulated structured assessment interview schedules like the Composite International Diagnostic Interview (CIDI) and SCAN and others. ICD-10's Diagnostic Criteria For Research (DCR-10) to be used in research and the shorter, simplified version for use in primary health care have been important contributions of the World Health Organization to the area of psychiatric assessment and classification (Cooper J, 1999).

The DSM-III and its later versions have received critical evaluations directed to its predominantly biological orientation in explaining mental disorder, to its suppleness upon exposure to some sort of societal pressures like lobbying or to economic pressures of the medical insurance forces and to its relative neglect of psychosocial and cultural factors. It has also been criticized for some of the unduly extended or rigid diagnostic criteria in certain disorders like multiple personality disorders, schizophrenia and some others (Cooper R (2004, Sorias S 2012).

Table 2. Psychiatric Evaluation

1954-1980	1980-2004
History of illness + + + +	History of illness + + + +
Life history + + + +	Life history ++
Family history + + + +	Family history ++
Interview more directed to establishing relationship (Non-structured interviews)	Interview more directed to eliciting symptoms (Structured or semi-structured interviews)
Battery of psychological tests Emphasis on projective tests	Emphasis on cognitive tests
Social history by social workers emphasized Lab. tests highly limited	Less emphasized Lab. tests highly limited

As we all know as psychiatrists, psychiatric interview is the most effective basic tool to evaluate a patient and to establish doctor-patient relationship. My observation is that a significant generalized change has occurred in psychiatric interviewing style during the DSM era at least in the United States and in my country. Table II is made to reflect some of the changes as I have observed over the course of years. The most important change has happened with the development and expansion of numerous structured or semi-structured diagnostic interviewing schedules or measurements since DSM-III, DSM-IV and ICD-10. Recognizing the vital importance of these interviewing tools in epidemiological and clinical research, I feel it is crucial to know that these tools have led to the encouragement of a symptom oriented interview and to the loss of relationship oriented interview. By these two kinds of relationship which I have described elsewhere (Öztürk, O.M. and Uluşahin, A. 2015), I have asserted that while a symptom oriented interview may well provide a thorough recognition of symptoms to make a diagnosis, it does not contribute much to the establishment of a relationship with the patient. On the other hand a relationship oriented interview may miss some symptoms for the sake of understanding the patient as a human being.

Table 3. Positive Contributions of DSM and ICD Diagnostic Systems

<p>Positive Contributions of DSM and ICD Diagnostic Systems</p> <ul style="list-style-type: none"> <li>Reliance on well defined criteria</li> <li>Systematic classification and coding</li> <li>Development of structured interviews and/or assessment schedules</li> <li>More reliable clinical data can be provided for epidemiological, clinical, pharmacological and biological research</li> <li>Treatments based on more objective diagnosis</li> </ul>
<p>Negative Consequences of DSM and ICD Diagnostic Systems</p> <ul style="list-style-type: none"> <li>Increased tendency to approach patients as categories of disorders and with a labeling tendency.</li> <li>Lack or loss of flexibility</li> <li>Expansion of symptom oriented interviewing</li> <li>Increased interest in eliciting symptoms and diminished interest in establishing relationship with the patient</li> <li>Diminished interest in psychosocial developmental history, in nonverbal communication and in the unconscious</li> <li>Growing dominance of nosological psychiatry in training and clinical practice.</li> </ul>

### Psychopharmacologic Revolution

As it is well recognized, another major revolutionary achievement has been in the area of pharmacological treatment of mental disorders. I remember the early hesitant introduction of chlorpromazine and how it became so widely used in the United States in the mid-fifties two years after its first trials in Europe. This new movement became a colossal revolution which on one hand led to the rapid growth at a dizzying pace of psychopharmacology and of neurosciences. The development of psychopharmacological agents used for many types of psychiatric disorders did not only become major tool for the clinician and it also lead to a worldwide boom in pharmaceutical industry

On the other hand a new era began, an era characterized with the diminishing patient population of the asylums and the growth and development of extramural community psychiatry and all practices associated with this concept (Jones K 1999, Freeman H 1999). It is well known that psychopharmacology has contributed greatly to the growth of extra-mural psychiatry by providing treatment of severely

disordered people to be handled in relatively short periods outside of the chronic institutional facilities. There have been, however, other contributing factors such as humanitarian, libertarian, economic, therapeutic and socio-cultural factors which have led to the dawn fall of the asylum psychiatry and the rise of community psychiatry. Even before the discovery of antipsychotic medications, it had become more or less clear that the gigantic mental hospitals were isolating patients from their communities and that they had become more or less un-therapeutic rather than therapeutic locations for a sizeable population of patients. Therefore, sporadic movements in the direction of extramural psychiatry in some of the developed countries were observed. It was in the sixties, however, that the idea of community psychiatry and the efforts directed to the implementation of closing down the asylums grew significantly in many developed countries. Success, however, has been relatively slow and limited depending on social, economic and political conditions of the country, but there have been sufficient achievements which the less developed countries can learn from. Less developed countries were never able to afford financially and morally to establish widespread asylum psychiatry. By morally I mean here a social morality which seems to lead to have willingness to maintain the patient within the family group while receiving any kind of modern or traditional treatment. I, therefore, believe that lack of large hospital facilities can be seen as an advantage for the less developed countries in the long run. This view is supported by the fact that the most affluent countries have not been able to eliminate thoroughly the dehumanized asylums in spite of the revolutionary triumphs of psychopharmacology and of the concept if not the practice of community psychiatry. Indeed, there is much to be commended for the achievements of the developed countries in reaching amazingly great number of patients being moved from the asylums to the extra-mural facilities and for promoting community psychiatry. A striking example from which we can learn a lot is the Italian experience based on Bassaglia's ideas of *psichiatria democratica* and of the mental health act of 1978 in Italy. With the impact of this law, within twenty years the number of mental hospital residents dropped to 7704 from 78,539. There have been many proponents and opponents of this act, but out-come studies have shown that in general, it has achieved

success in many ways in closing down the mental hospitals and in developing community oriented treatment and care services. (Girolamo G, Cozza M 2000).

During the second half of the 20<sup>th</sup> Century, other major achievements in neurosciences, in genetics of mental disorders, in expanded epidemiological studies have all contributed in some form or another on the problem of the psychiatrist's role being a specialist in a unique and universal field which struggles to reach a unified understanding of the body and the mind through extensive studies of the brain and human behavior. For a while there were disputes on the psychiatrist endeavors to deal with a "brainless mind" or with a "mindless brain". Fortunately, however, as we gain more insight into the nature of brain plasticity and of the broad interactive capacity of human genes with the experiential factors (Eisenberg L (2004), it has become more and more feasible to formulate integrative and unified theories and models of approach.. Among these endeavors serious attempts like those of the Nobel Prize winner Eric Kandel (1998, 1999), Joseph B. Martin (2002) and Glen O. Gabbard (2005) to build bridges between neuro-scientific and genetic findings, learning theories and psychotherapy including psychoanalysis have also attracted reputable attention.

### **Advances in Molecular Genetics and in Neurosciences**

- Molecular biology: Studies on neurotransmitters, receptors and signal transduction mechanisms
- Electrophysiology: Studies on ion channels, action potentials, cellular electrophysiology, EEG, evoked potentials, transcranial magnetic stimulation (TMS)
- Animal models: *Aplysia californica* (memory), behavioral models (Porsolt test for depression), lesion models (ventral hippocampal model for schizophrenia), various transgenic/knock out models
- Neuroimaging techniques: CT, MRI, SPECT, PET, fMRI, MRS
- Genetics: Human Genome Project, Linkage /association studies

### **Decline in Psychoanalytic Psychiatry**

As mentioned before, in the fifties and sixties in the United States of America, "dynamic psychiatry" which can also be named as "psychoanalytically oriented psychiatry" had a leading role in psychiatric

training and practice. With the introduction of DSM-III and with the developments in psychopharmacology and neurosciences in both Europe and United States the impact of psychoanalysis and its contributions to general psychiatry began to diminish as summarized below:

- Psychoanalysts lessened in psychiatry departments
- Diminished psychoanalytic concepts in psychiatric training
- Psychoanalysis became restricted to elite training institutes
- Major psychoanalytic contributions (ego psychology, self psychology and the theory of psychosocial development) now have little impact in the general course of psychiatry.

### **Developments in Psychiatric Ethics and Patient Rights**

Another major contribution of great importance if not the greatest in medicine and psychiatry after the 1960's has been the progress of ethical standards in the practice of psychiatry and research. World Medical and World Psychiatric Associations deserve to be praised on its efforts in this respect. Major achievements in this area are shown below:

- Helsinki Declaration of the World Medical Association (1964) and its amended versions
- Madrid Declaration on Ethical Standards for Psychiatric Practice by WPA (1996) and revised versions
- Worldwide authority of "Committees on Ethics" in medical practice and research.

### **CONCLUSION**

I have touched briefly on a few of the many highly important advances and changes in psychiatry during the last sixty years. There is no question that this period has been distinguished with great scientific achievements. As we question ourselves however, in regard with preventive measures, with our success in reducing mental disorders and their burden in terms of "Disability of Adjusted Life Years" or the amount of suffering caused by mental disorders, I find it very difficult to say that we have achieved much in these areas. I would like to conclude by touch again on the identity of the psychiatrist. The major changes some of which I have highlighted above, imposed new and heavy demands of the science, of the society, of our organizations and

of the individual patients upon the psychiatrist of our time. A psychiatrist has to be able to follow the advances of psychopharmacology, of neuroscience and of modern technology without losing much from that part of his identity as a psychiatrist who is also interested in what goes on in the doctor-patient relationship as two human beings with minds which function at conscious and unconscious levels. There would be no problem with the identity of a psychiatrist if he is solely interested in research in any specialized topic chosen. When it comes however, to being a clinician and often this is the case, it seems that a psychiatrist cannot define his identity adequately without integrating and assimilating the basic concepts of the bio-psychosocial model of medicine (Engel G 1977, 1980). This integrating and assimilating process has been more and more difficult under the alluring subject matter of biological psychiatry in alliance with the overriding influence of descriptive diagnostic systems which have so far dominated most training and clinical centers. There has been much lip service made for the adoption of the bio-psychosocial model in training and in clinical practice in all branches of medicine, but societal and economic pressures and developments in clinical psychiatry have brought us to a point which, at times seem to lead to some confusion in our identity. At this point, I wish to conclude with a clarifying quotation from an eminent figure in psychiatry, the Emeritus Editor-in-Chief of the American Journal of psychiatry, Nancy Andreasen wrote in 2001: "...Our unique contribution to medicine is our ability to evaluate the mental functions or dysfunctions of individual people who seek treatment for a variety of symptoms and complaints, in the context of their past history and their present interpersonal, social, economic, and family environment. We must retain this unique contribution. This is what each of our patients –whoever his or her problem- expects of us. Each of us, in whatever way we can, must fight against a variety of perverse ideas that denigrate or diminish this unique contribution: that a history can be obtained by a computerized checklist, or that recording a narrative history is a waste of time, or that the practice of psychiatry should be limited to prescribing medications or any of the injunctions that threaten to dehumanize or destroy the essence of psychiatric practice."

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