

The Rise and Fall of American Psychiatry

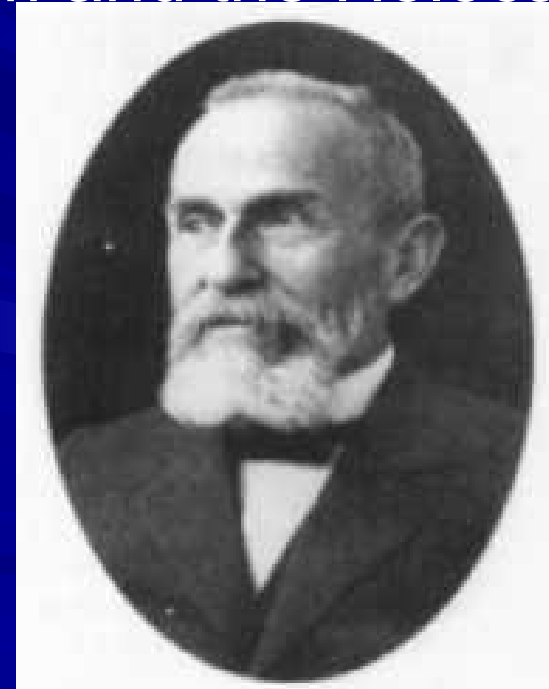
Maryland Psychiatric Society Psychopharmacology Update: 2025

Prof. Edward Shorter, PhD FRSC
Jason A Hannah Chair in the History of Medicine
Professor of Psychiatry
Temerty Faculty of Medicine
University of Toronto

Following WWII, the centre of gravity in Psychiatry shifts from Europe to the U.S.

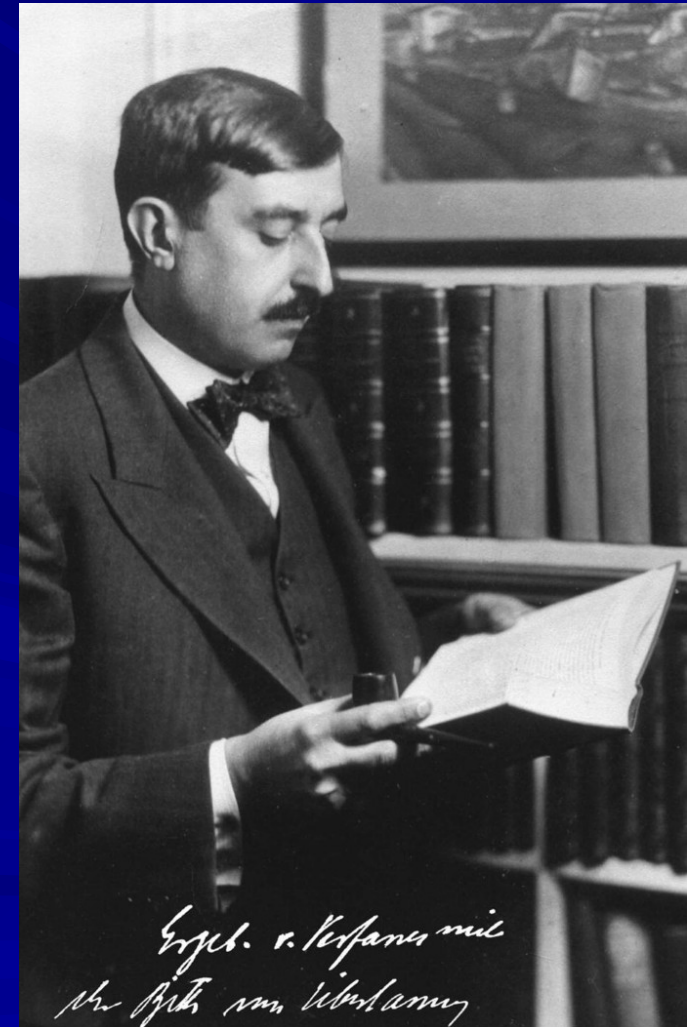
All aspects of the discipline were previously dominated by Europe, especially Germany and German-speaking countries. Everything changed in the wake of the disaster of Nazism and the Holocaust

- Psychiatric diagnosis/nosology
(here **Emil Kraepelin**, father of nosology)
- Asylum psychiatry (“alienists”)
- Psychoanalysis
- Psychopharmacology



Following WWII, the centre of gravity in Psychiatry shifts from Europe to the U.S.

- The language of psychiatry shifts from German to English.
- A vast body of knowledge is lost because relatively few read the 19th and 20th century founders of the discipline.
- Many major players (especially Jewish analysts and scientists) flee war-torn Europe, relocating to America. Germany is left intellectually impoverished
- Here Viennese psychoanalyst **Paul Schilder**, who moved to the US in 1928 because of rising antisemitism



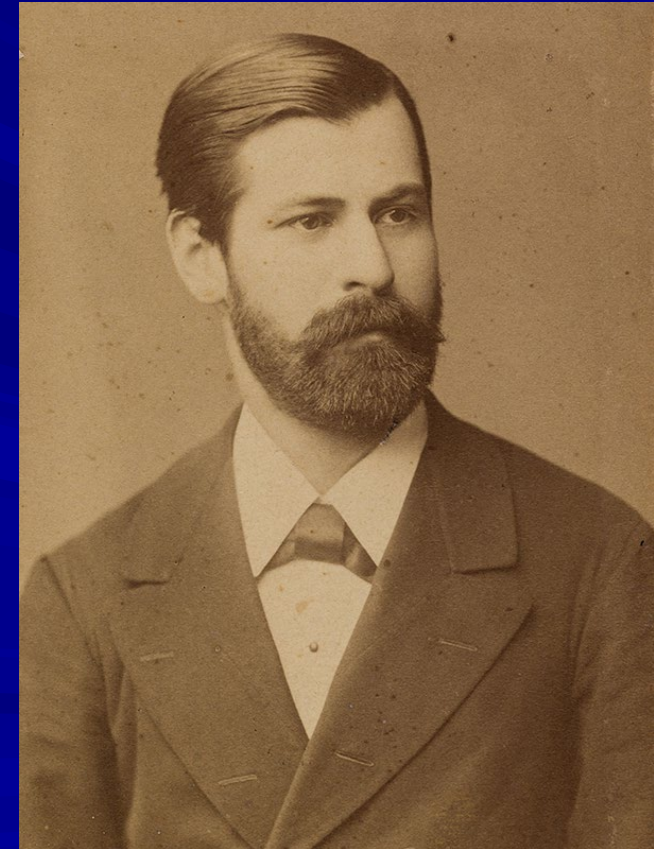
American Psychiatry at mid-century: two conflicting subspecialties

The Asylum: “Milledgeville”
Georgia’s Central State Hospital

Georgia State Asylum, Center Building, Milledgeville, Ga.



Main Street Manhattan:
The analyst’s couch (**Freud ca. 1885**)



American psychiatry at mid-century: conflicting specialties

Institutional Psychiatrists: used the available physical therapies and psychopharmaceuticals, all of European origin

The first barbiturate sedative, Barbitol “Veronal,” introduced by Bayer in 1904

- Convulsive therapies
 - Chemical: Laszlo Meduna (Hungary), Manfred Sakel (Poland)
 - ECT: Ugo Cerletti, Lucio Bini (Italy)
- Early psychopharmaceuticals (also widely used in community psychiatry & medicine)
 - Chloral hydrate (Germany, 1869)
 - **Barbiturates (Germany, 1900s+)**
 - Methamphetamine (Germany, 1938)



American psychiatry at mid-century: conflicting specialties

Psychoanalysts and analytically-oriented psychiatrists:

- ❖ **Shunned both** physical therapies and psychopharmacology. Only talk therapy produced cures.
- ❖ Drug treatment was dismissed as “taking a patient to a cocktail party” – **Elvin Semrad**, the influential psychoanalyst at Mass Mental Health Center, 1960s.
- ❖ Unlike his Viennese compatriots, Semrad was American-born and trained. US psychoanalysis begins to take off.



Most of the early psychopharmaceuticals were European imports. But some were developed in North America

- ❖ Barbiturates: Eli Lilly's amobarbital
"Amytal," 1924
- ❖ Amphetamines: SmithKline French's
"Benzedrine," 1936 (thus pre-dating the
German entry. Both were developed out of
the work of American chemist Gordon Alles)
- ❖ Both companies would go on to become
behemoths, launching some of the biggest-
selling drugs of all time

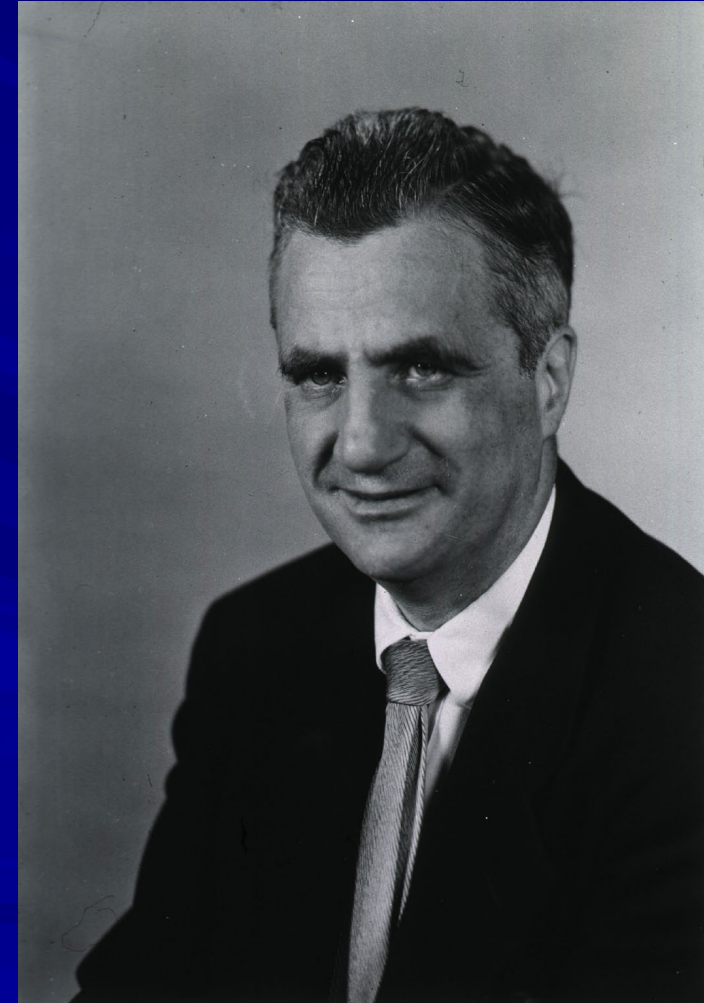
SKF's Benzedrine tablets, introduced in 1936



Post-war scientific developments

- ❖ The National Institute of Mental Health (NIMH) is established in 1949, part of the National Institutes of Health (NIH) in Bethesda, MD
- ❖ Pioneer biochemical pharmacologist **Bernard B. Brodie** founds and heads the Laboratory of Chemical Pharmacology at the National Heart Institute of NIH (1950-1970)
- ❖ Spectrophotofluorometry is introduced, 1955
- ❖ The key neurotransmitters: serotonin, dopamine, norepinephrine are identified

These developments, from Bethesda and elsewhere, lay the groundwork for the rise of modern psychopharmacology



At the point of departure:

American psychiatry and psychopharmacology are still poorly developed

Psychopharmacology as a discipline was launched at the **1st World Congress of Psychiatry** (Paris, 1950). At this point, psychiatry was a mature clinical specialty in Europe, with a 100-year history.

In the U.S. it was a fledgling sprout.



- ❑ The American Board of Psychiatry and Neurology was only founded in 1936
- ❑ The American Psychiatric Association had only 1,900 members, and only 6 universities had psychiatric residency programs
- ❑ The scientific developments on the Bethesda campus, as we have seen, are still in their infancy

The Rise of Psychopharmacology: The Cornucopia

The major drug classes begin to take form

Still mainly developed outside the US

- ❖ **Lithium** (John Cade, Australia, 1940); Trials, Mogens Schou, Denmark, 1954.
- ❖ Not licensed in the US until 1970.
- ❖ The premier mood-stabilizer.



The Rise of Psychopharmacology: The Cornucopia

The major drug classes begin to take form
Still mainly developed outside the US

- ❖ **Chlorpromazine/ “Thorazine”** (Laborit and Delay, France, 1954)
- ❖ German émigré Heinz Lehmann in Montreal introduces it in North America, 1954.
- ❖ The game-changing “antipsychotic”

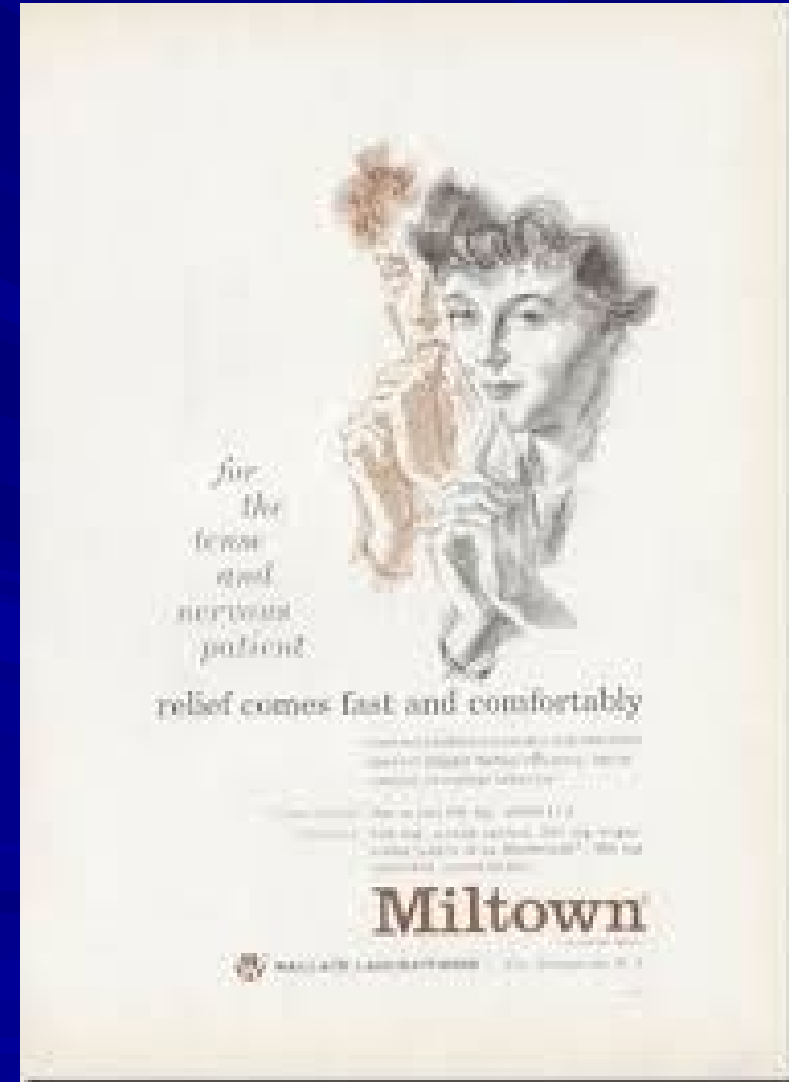


The Rise of Psychopharmacology: The Cornucopia

The major drug classes begin to take form

- ❖ **Meproamate/”Miltown”** (Frank Berger, Wallace Labs, US, 1955)
- ❖ Czech-born Berger’s discovery became the first blockbuster “tranquilizer”

(Although now based in the US, much of this drug development is still coming from European émigré scientists)



The Cornucopia Continues

- ❖ **Methylphenidate / “Ritalin”** (discovered 1944 by Italian chemist Leandro Panizzon at the Swiss firm Ciba-Geigy)
- ❖ Marketed in 1954
- ❖ Initially used for “chronic fatigue and mild depression” in adults
- ❖ Later becomes the blockbuster treatment for ADHD.

Ritalin[®]
(methylphenidate CIBA)
**sparks
energy**

**relieves chronic fatigue
and mild depression**

Certainly Ritalin isn't going to make a sprinter out of the man barely able to drag himself through the day. But this gentle stimulant can spark energy — and enthusiasm — in the chronically fatigued, mildly depressed patient. With vitality increased and outlook brightened, the patient finds daily tasks no longer loom so large, nor do life's problems seem so serious.

Unlike most antidepressants, Ritalin acts promptly — is less likely than amphetamines to cause excessive stimulation, sudden letdown, appetite suppression, alterations in pulse rate or blood pressure.

Ritalin is widely cited for its outstanding safety record: untoward effects on blood, urine, or liver and kidney function are not to be anticipated. Side effects, if they occur, are generally mild.

For prescribing information, please see following page.

C I B A

The Cornucopia Continues

- ❖ **Imipramine / “Tofranil”** (Roland Kuhn, Swiss, Geigy, 1957)
- ❖ First of the tricyclic antidepressants
- ❖ A major breakthrough in the treatment of melancholic depression

Why Tofranil-PM?

BECAUSE THE SADNESS AND HURTING WON'T STOP!



Help make it stop.
Prescribe Tofranil-PM[®].

When a TCA is the appropriate choice
Tofranil-PM[®]
imipramine pamoate
Powerful therapy for serious symptoms
75 mg · 100 mg · 125 mg · 150 mg

Important Safety Information—Suicidality in Children and Adolescents: Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of imipramine pamoate or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Tofranil-PM[®] is not approved for use in pediatric patients. (See Warnings and Precautions: Pediatric Use in attached brief summary.)

Tofranil-PM[®] Capsules are indicated for the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states. One to three weeks of treatment may be needed before optimal therapeutic effects are evident. Tofranil-PM[®] is contraindicated in patients receiving monoamine oxidase inhibiting compounds, or in patients who have taken such compounds within the preceding 14 days. Tofranil-PM[®] is also contraindicated during the acute recovery period after a myocardial infarction. Tofranil-PM[®] may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as operating an automobile or machinery, and should not be taken with alcohol.

Please see brief summary of Prescribing Information, including Black Box Warning, on adjacent page and full Prescribing Information.

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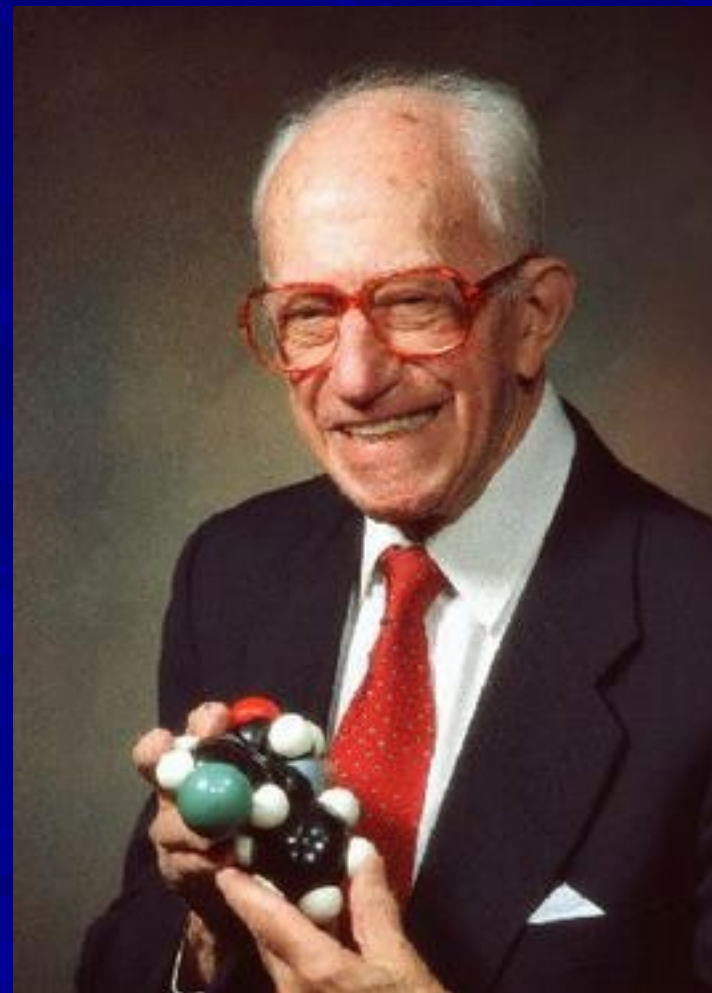


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The Cornucopia: Blockbuster Drugs

- ❖ **Benzodiazepine tranquilizers**, developed by Polish émigré chemist **Leo Sternbach** at Hoffmann-LaRoche (US)
- ❖ Chlordiazepoxide / Librium (launched 1960)
- ❖ Diazepam / Valium (1963)

This new class of anti-anxiety drugs quickly supplanted Miltown and went on to become the biggest sellers of all time – until they were (wrongly) discredited as dangerously addictive



A Displacement in Psychiatry

- ❖ Psychopharmacology basically takes over the field
- ❖ Psychoanalysis becomes neglected and even discredited
- ❖ 1980-87: Dr Ray Osheroff successfully sues Chestnut Lodge sanatorium for malpractice because they treated him with psychodynamic methods and no medication
- ❖ This case was a lesson for everybody



Some Abuses of the “New” Psychiatry

Rampant overdiagnosis and overprescribing: ADHD in children

The two main medications have both been “recycled” from other indications

- ❖ Ritalin/methylphenidate (originally a weak antidepressant)
- ❖ Adderall / amphetamine + dextroamphetamine (a rebranded diet drug), now being touted as a “study drug”



Some Abuses of the “New” Psychiatry

Rampant overdiagnosis and overprescribing:
“Major Depressive Disorder”

- ❖ The fateful combination of SSRIs and *DSM-III* beginning in the 1980s has resulted in an improbably high increase in “depressed” patients
- ❖ The huge distinction between melancholia (treatable with tricyclics) and everyday woes has been collapsed into single heterogeneous diagnosis

Edward Shorter
How
Everyone
Became
Depressed

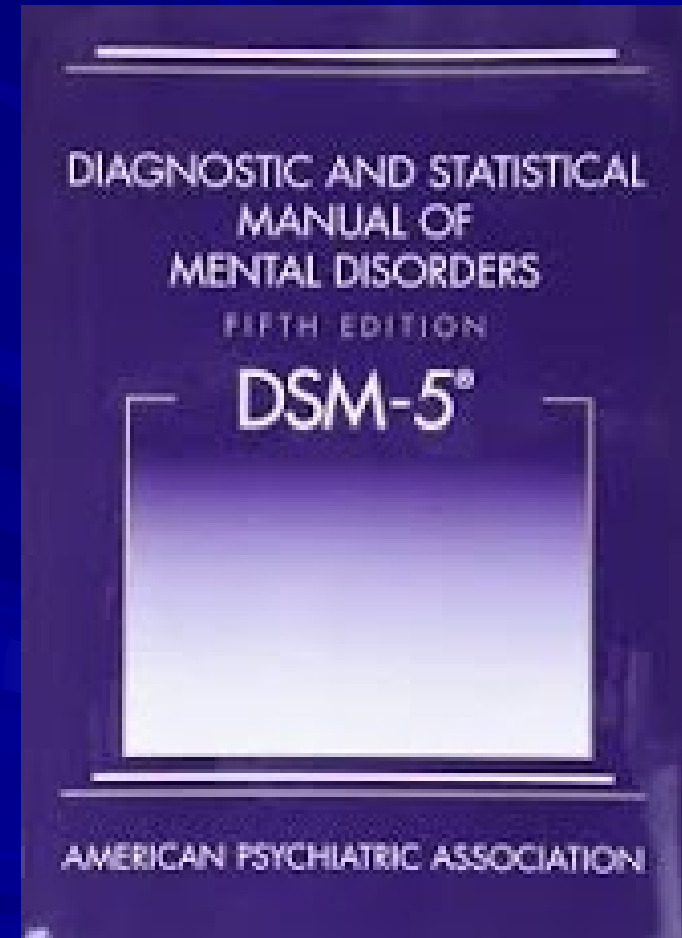
*The Rise and Fall of the
Nervous Breakdown*

Some Abuses of the “New” Psychiatry

The age of anxiety is overtaking us

- ❖ Under Kraepelin’s scheme, anxiety disappeared as a distinct disorder
- ❖ It has now made a dramatic resurgence with the DSM series: in DSM-5 we have 11 anxiety disorders plus a panic attack specifier that can be tacked on to other diagnoses.

Opposite problem to depression: too many flavours of anxiety



DSM III (1980) Creates a New Ballgame

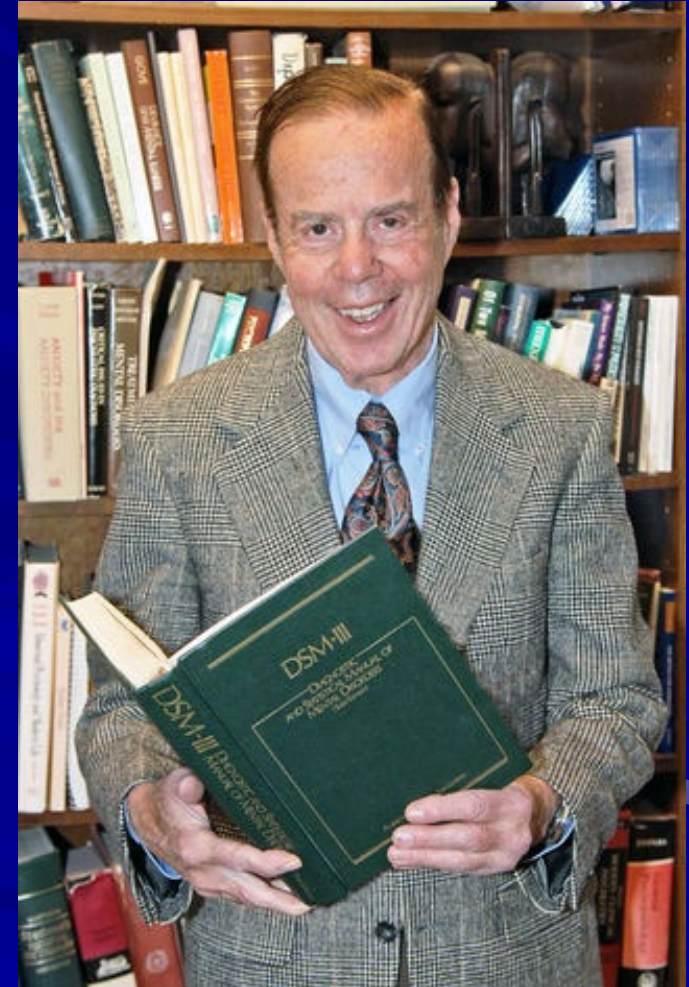
.... which continues to evolve with subsequent releases

- ❖ ADHD
- ❖ Major Depressive Disorder
- ❖ Bipolar Depression (as a distinct entity)

Here **Dr. Robert Spitzer**, its chief architect

Much of the problem is that the DSMs are created by committees and consensus.

This is not the way science works.



Progress Ends

After 1980, there are really no useful drugs *or* diagnoses

- ❖ SSRIs are applied across the depression – anxiety – mixed anxiety/depression spectrum
- ❖ “Atypical antipsychotics”: drugs in this group (risperidone, olanzapine, clozapine, quetiapine, etc) are marketed as antipsychotics, but actually have a wide range of applications.

The history of genuine innovation in psychiatry thus ends!



Atypical Antipsychotics Mnemonic: **CORAL Q ZIP**

- **C** - Clozapine
- **O** - Olanzapine
- **R** - Risperidone
- **A** - Asenapine
- **L** - Lurasidone
- **Q** - Quetiapine
- **Z** - Ziprasidone
- **I** - Iloperidone
- **P** - Paliperidone

An exam mnemonic listing the ever-growing roster of atypicals for learners