Foerschner, Allison M. (2010). "The History of Mental Illness: From 'Skull Drills' to 'Happy Pills'." *Student Pulse*, 2(09). Retrieved from: <http://www.studentpulse.com/a?id=283>

The History of Mental Illness: From "Skull Drills" to "Happy Pills"

By ALLISON M. FOERSCHNER
2010, VOL. 2 NO. 09

The limitlessly varied personalities of human beings have fascinated both scientists and fellow members of society throughout the existence of humankind. Of particular interest has been what happens when man's mind turns against him, and what can be done, if anything at all, to reverse this tragic event.

Attempts to treat mental illness date back as early as 5000 BCE as evidenced by the discovery of trephined skulls in regions that were home to ancient world cultures (Porter 10). Early man widely believed that mental illness was the result of supernatural phenomena such as spiritual or demonic possession, sorcery, the evil eye, or an angry deity and so responded with equally mystical, and sometimes brutal, treatments. Trephining (also referred to as trepanning) first occurred in Neolithic times. During this procedure, a hole, or trephine, was chipped into the skull using crude stone instruments. It was believed that through this opening the evil spirit(s)--thought to be inhabiting one's head and causing their psychopathology--would be released and the individual would be cured ("Measuring"). Some who underwent this procedure survived and may have lived for many years afterward as trephined skulls of primitive humans show signs of healing. Pressure on the brain may have also incidentally been relieved (Butcher 28). This procedure endured through the centuries to treat various ailments such as skull fractures and migraines as well as mental illness, albeit with more sophisticated tools such as skull saws and drills developed solely for this purpose ("Measuring").

In ancient Mesopotamia, priest-doctors treated the mentally ill with magico-religious rituals as mental pathology was believed to mask demonic possession (Alexander 19). Exorcisms, incantations, prayer, atonement, and other various mystical rituals were used to drive out the evil spirit. Other means attempted to appeal to the spirit with more human devices--threats, bribery, punishment, and sometimes submission, were hoped to be an effective cure (Alexander 8).

Hebrews believed that all illness was inflicted upon humans by God as punishment for committing sin, and even demons that were thought to cause some illnesses were attributed to God's wrath. Yet, God was also seen as the ultimate healer and, generally, Hebrew physicians were priests who had special ways of appealing to the higher power in order to cure sickness. Along the same spiritual lines, ancient Persians attributed illness to demons and believed that good health could be achieved through proper precautions to prevent and protect one from diseases. These included adequate hygiene and purity of the mind and body achieved through good deeds and thoughts (Alexander 20-22).

Ancient Egyptians seem to be the most forward-thinking in their treatment of mental illness as they recommended that those afflicted with mental pathology engage in recreational activities such as concerts, dances, and painting in order to relieve symptoms and achieve some sense of normalcy. The Egyptians were also very advanced in terms of medicine, surgery, and knowledge of the human body. Two papyri dating back to the sixteenth century BCE, the Edwin Smith papyrus and the Ebers papyrus, document early treatment of wounds, surgical operations, and identifies, very likely for the first time, the brain as the site of mental functions. These

papyri also show that, despite innovative thinking about disease, magic and incantations were used to treat illnesses that were of unknown origin, often thought to be caused by supernatural forces such as demons or disgruntled divine beings (Butcher 28). Ancient Egyptians also shared the early Greek belief that hysteria in women, now known as Conversion Disorder, was caused by a "wandering uterus," and so used fumigation of the vagina to lure the organ back into proper position (Alexander 21).

In all of these ancient civilizations, mental illness was attributed to some supernatural force, generally a displeased deity. Most illness, particularly mental illness, was thought to be afflicted upon an individual or group of peoples as punishment for their trespasses. In addition to the widespread use of exorcism and prayer, music was used a therapy to affect emotion, and the singing of charms and spells was performed in Babylonia, Assyria, the Mediterranean-Near East, and Egypt in hopes of achieving a cure (Rosen).

Beliefs about mental illness and proper treatments were altered, and in some cases advanced, by early European thinkers. Between the 5th and 3rd centuries BCE, Greek physician Hippocrates denied the long-held belief that mental illness was caused by supernatural forces and instead proposed that it stemmed from natural occurrences in the human body, particularly pathology in the brain. Hippocrates, and later the Roman physician Galen, introduced the concept of the four essential fluids of the human body—blood, phlegm, bile, and black bile—the combinations of which produced the unique personalities of individuals (Butcher 29). Through the Middles Ages, mental illness was believed to result from an imbalance of these humors. In order to bring the body back into equilibrium, patients were given emetics, laxatives, and were bled using leeches or cupping (MacDonald 187). Specific purges included a concoction developed by Ptolemy called *Hiera Logadii*, which combined aloes, black hellebore, and colocynth and was believed to cleanse one of melancholy. *Confectio Hamech* was another laxative developed by the Arabs that contained myrobalans, rhubarb, and senna (MacDonald 187). Later, tobacco imported from America was popularly used to induce vomiting (MacDonald 188). Other treatments to affect the humors consisted of extracting blood from the forehead or tapping the cephalic, saphenous, and/or hemorroidal veins to draw corrupted humors away from the brain (MacDonald 191). In addition to purging and bloodletting (also known as phlebotomy), customized diets were recommended. For example, "raving madmen" were told to follow diets that were "cooling and diluting," consisting of salad greens, barley water, and milk, and avoid wine and red meat (Porter 42).

Custody and care of the mentally ill were generally left to the individual's family, although some outside intervention occurred. The first mental hospital was established in 792 CE Baghdad and was soon followed by others in Aleppo and Damascus—mass establishment of asylums and institutionalization took place much later, though (Butcher 32). The mentally ill in the custody of family were widely abused and restrained, particularly in Christian Europe. Due to the shame and stigma attached to mental illness, many hid their mentally ill family members in cellars, caged them in pigpens, or put them under the control of servants (Porter 92). Others were abandoned by their families and left to a life of begging and vagrancy.

The social stigma attached to mental illness was, and to some extent still is, pronounced in countries that have strong ties to family honor and a reliance on marriages to create alliances and relieve families of burdensome daughters. In China, the mentally ill were concealed by their families for fear that the community would believe that the affliction was the result of immoral behavior by the individual and/or their relatives. The mentally ill were also thought to have "bad fate" that would negatively influence anyone who associated with the disturbed individual, scaring away potential suitors and leading to the idea that mental illness was contagious

(Phillips 10). Historically in Greece, "a mentally ill [family] member implies a hereditary, disabling condition in the bloodline and threatens [the family's] identity as an honorable unit," therefore treatment of the mentally ill in these cultures meant a life of hidden confinement or abandonment by one's family (Blue 305). Mentally ill vagrants were left alone to wander the streets so long as they did not cause any social disorder. Those who were deemed dangerous or unmanageable, both in family homes or on the streets, were given over to police and thrown in jails or dungeons, sometimes for life (Stigma 43). Particularly in Europe during the Middle Ages, beatings were administered to the mentally ill who acted out as punishment for the disturbances their behavior caused and as a means of "teaching" individuals out of their illnesses. Others who were considered nuisances were flogged out of town (Rosen).

Through the Middle Ages and until the mass establishment of asylums, treatments for mental illness were offered by humanistic physicians, medical astrologers, apothecaries, and folk or traditional healers (MacDonald 175). Aside from secular exorcisms, prayers, charms, amulets, and other mystical treatments were available. In the 17th century, astral talismans were popular and were easily made using brass or tin emblems with astrological signs etched into them and cast at astrologically significant times. These were worn around the neck of the afflicted while they recited prayers (MacDonald 213-214). Also worn around the neck were scraps of Latin liturgy wrapped in paper, bundled with a leaf of mugwort or St. John's Wort and tied with taffeta (MacDonald 214). Amulets were also used, supplemented by prayers and charms, to soothe troubled minds, prevent mystical infection, and protect against witches and evil spirits (MacDonald 214). Sedatives during the 17thcentury consisted of opium grains, unguents, and laudanum to "ease the torment" of mental illness (MacDonald 190).

Some treatment options existed beyond family custody and care, such as lodging the mentally ill in workhouses or checking them into general hospitals where they were frequently abandoned. The clergy also played a significant role in treating the mentally ill as "medical practice was a natural extension of ministers' duty to relieve the afflictions of their flocks" (Houston). Private madhouses were established and run by members of the clergy to treat the mentally afflicted who could afford such care. Catholic nations regularly staffed mental health facilities with clergy, and most mentally ill individuals in Russia were housed in monasteries until asylums spread to this region of the world in the mid-1800s (Porter). To relieve mental illness, regular attendance in church had been recommended for years as well as pilgrimages to religious shrines. Priests often solaced mentally disturbed individuals by encouraging them to repent their sins and seek refuge in God's mercy (MacDonald 176). Treatment in clergy-run facilities was a desirable alternative as the care was generally very humane, although these establishments could not treat the whole of the mentally ill population, especially as it seemed to grow in number.

In order to accommodate the burgeoning amount of mentally ill individuals, asylums were established around the world starting, most notably, from the sixteenth century onward. The first institution to open its doors in Europe is thought to be the Valencia mental hospital in Spain, 1406 CE (Butcher 36). Although not much is known about the treatment patients received at this particular site, asylums were notorious for the deplorable living conditions and cruel abuse endured by those admitted. For many years, asylums were not facilities aimed at helping the mentally ill achieve any sense of normalcy or otherwise overcome their illnesses. Instead, asylums were merely reformed penal institutions where the mentally ill were abandoned by relatives or sentenced by the law and faced a life of inhumane treatment, all for the sake of lifting the burden off of ashamed families and preventing any possible disturbance in the community.

The majority of asylums were staffed by gravely untrained, unqualified individuals who treated mentally ill patients like animals. A case study describes a typical scene at La Bicetre, a hospital in Paris, starting with patients shackled to the wall in dark, cramped cells. Iron cuffs and collars permitted just enough movement to allow patients to feed themselves but not enough to lie down at night, so they were forced to sleep upright. Little attention was paid to the quality of the food or whether patients were adequately fed. There were no visitors to the cell except to deliver food, and the rooms were never cleaned. Patients had to make do with a little amount of straw to cover the cold floor and were forced to sit amongst their own waste that was also never cleaned up (Butcher 37). These conditions were not all unique to La Bicetre, and this case study paints a fairly accurate picture of a typical scene in asylums around the world from approximately the 1500s to the mid-1800s, and in some places, the early 1900s.

The most infamous asylum was located in London, England—Saint Mary of Bethlehem. This monastery-turned-asylum began admitting the mentally ill in 1547 after Henry VIII announced its transformation. The institution soon earned the nickname "Bedlam" as its horrific conditions and practices were revealed. Violent patients were put on display like sideshow freaks for the public to peek at for the price of one penny; gentler patients were put out on the streets to beg for charity (Butcher 36).

Soon after the establishment of "Bedlam," other countries began to follow suit and founded their own mental health facilities. San Hipolito was built in Mexico 1566 and claims the title of the first asylum in the Americas. La Maison de Chareton was the first mental facility in France, founded in 1641 in a suburb of Paris. Constructed in 1784, the Lunatics' Tower in Vienna became a showplace. The elaborately decorated round tower contained square rooms in which the staff lived. The patients were housed in the spaces between the walls of the rooms and the wall of the tower and, like at Bedlam, were put on display for public amusement (Butcher 37).

When staff did attempt to cure the patients, they followed the practices typical of the time period—purging and bloodletting, the most common. Other treatments included dousing the patient in either hot or ice-cold water to shock their minds back into a normal state. The belief that patients needed to choose rationality over insanity led to techniques aiming to intimidate (Butcher 37). Blistering, physical restraints, threats, and straitjackets were employed to achieve this end. Powerful drugs were also administered, for example, to a hysterical patient in order to exhaust them (Butcher 37, Alexander 109). Around the mid-1700s, the Dutch Dr. Boerhaave invented the "gyrating chair" that became a popular tool in Europe and the United States. This instrument was intended to shake up the blood and tissues of the body to restore equilibrium, but instead resulted in rendering the patient unconscious without any recorded successes (Alexander 109).

Although cruel treatment in asylums surely felt to the patients as if it had been going on for ages, conditions began to improve in the mid-to- late 1800s as reforms were called for, and this shameful and unenlightened period was somewhat brief in relation to the span of world history. One of the earliest reforms occurred at an asylum in Devon, England. This facility had employed opium, leeches, and purges as cures for mental illness, but in the mid-1800s emphasized non-restraint methods to affect patients' health (Stigma 64).

One of the most significant asylum reforms was introduced by Philippe Pinel in Paris. During the year of 1792, Pinel took charge of La Bicetre to test his hypothesis that mentally ill patients would improve if they were treated with kindness and consideration. Filth,

noise, and abuse were eliminated quickly after patients were unchained, provided with sunny rooms, allowed to exercise freely on the asylum grounds, and were no longer treated like animals (Butcher 38).

The same reforms were undertaken around this time by an English Quaker, William Tuke. Founded in 1796, the York Retreat in York, England was run by Tuke and other Quakers who stressed the importance of treating all people with respect and compassion, even the mentally ill. In keeping faithful to this ideal, the York Retreat was a pleasant country house, modeled on a domestic lifestyle, that allowed patients to live, work, and rest in a warm and religious environment that emphasized mildness, reason, and humanity (Butcher 38, Porter 103-104).

This humanitarian movement spread across the Atlantic to the United States in the early 1800s. Stemming largely from the work of Pinel and Tuke, moral management emerged in America as "a wide-ranging method of treatment that focused on a patient's social, individual, and occupational needs" (Butcher 39). Applied to asylum care, moral management focused on the mentally ill individual's spiritual and moral development as well as the rehabilitation of their personal character to lessen their mental ailments. These goals were sought through encouraging the patient to engage in manual labor and spiritual discussion, always accompanied by humane treatment.

Although moral management was highly effective, it largely failed to continue through the late 1800s for several reasons. First, ethnic prejudice created tension between staff and patients as immigration increased. The leaders of the moral management movement also failed to pass along their teachings, so there was a lack of replacements. Third, supporters of this movement did not realize that bigger hospitals differed from smaller ones in more ways than just size, leading to an overextension of hospital facilities. Biomedical advances also led to the demise of moral management as most believed that medicine would soon be the cure-all for physical as well as mental afflictions and, therefore, psychological and social help was not necessary. Lastly, the rise of a new movement called Mental Hygiene focused solely on the patient's physical health and ignored their psychological disturbances. Although this new movement ended the effective reign of moral management and resulted in many patients becoming helpless and dependent, there were several humanitarian positives to Mental Hygeine (Butcher 39).

Dorothea Dix was a schoolteacher forced to retire early due to her bouts of tuberculosis. Soon after she began teaching in a women's prison and learned of the horrific conditions of jails, almshouses, and particularly mental health facilities, Dix commenced a forty-year long campaign to reform asylums called the Mental Hygiene movement. Although this movement did not directly affect patients' mental illnesses, it raised millions of dollars to build hospitals that were suitable for proper care and influenced twenty American states to respond to her pleas for change, resulting in greater physical comfort of the patients. Dix also managed to oversee the opening of two institutions in Canada and completely revamp the systems of mental health care in Scotland and several other countries (Butcher 40).

Improvements in asylum care continued in America and Europe, although sub-par conditions persisted in numerous American and European institutions. Many countries around the world were also slow, or failed completely, to implement sufficient reforms. For example, asylums in Nigeria, Africa were not even established until 1906 after citizens started complaining about the disruptive behavior of mentally ill individuals that were left to roam the streets and wander from village to village. Until that year, the mentally

ill were either sent to asylums in Sierra Leone or locked in the lunatic ward of local prisons. When asylums were finally established in Lagos and Abeokuta, the conditions were less than pleasant. Common complaints included dark, overcrowded cells, a lack of basic supplies, poor bathing facilities, and the use of chains to restrain patients. Very little treatment was offered to help the patients with their mental illnesses with the exception of minimal occupational therapy and agricultural work as well as the administration of sedatives to keep patients calm and under control—a practice that was likely more beneficial to the staff than the afflicted (Sadowsky 23-35).

Significant advances in psychological concepts after the mass establishment of asylums did not arise until the development of psychoanalysis by Sigmund Freud in the late 1800s to early 1900s. Examination of an earlier practice, Mesmerism, must be mentioned first though as it is commonly posited to have provided a foundation for later psychoanalytic techniques. Austrian physician Franz Mesmer believed that human bodies contained a magnetic fluid that was affected by the planets and determined one's health depending on its distribution. Mesmer concluded that all persons were capable of using their own magnetic forces to affect the magnetic fluid in others and considered himself to be powerful enough to cure illnesses with his "animal magnetism." Mesmer gained a large following when he opened a clinic in Paris 1778 and started practicing his "mesmerism." In order to affect cures, several patients at a time were seated around a tub containing various chemicals. Iron rods attached to the tub were applied to the afflicted parts of their body (as patients were generally hysterical and experiencing numbness or paralysis), after which Mesmer would emerge in light purple robe and circle around the room touching the patients either with his hand or with a wand. Although Mesmer's techniques reportedly were effective, he was branded a fraud by his medical colleagues, and his "cures" were later believed to be the result of hypnotism, a psychoanalytic practice (Butcher 47, Alexander 127).

Between the years of 1888 and 1939, Sigmund Freud, an Austrian neurologist and psychiatrist, published twenty-four volumes explaining his thoughts about personality and psychopathology called Psychoanalytic Theory. Freud believed that the human mind was structured in three divisions—the id, the ego, and the superego. The id functioned unconsciously, driven by the two main primal desires for sex and aggression. The superego functioned both consciously and unconsciously, demanding that the individual deny the id's impulses and instead live a virtuous life, striving to meet society's ideals. The ego also functioned both consciously and unconsciously and was deemed the mediator between an individual's id and superego, always working to find a balance between what one desired and what society considered acceptable. The unconscious was thought to be the seat of psychopathology as it contained unacceptable desires and painful memories that had been repressed by the two higher functions as they would have been too unsettling to acknowledge. Freud believed that anxiety arose as these three parts of the human mind battled each other, resulting in mental illness and that if the individual could only reveal and address the content of their unconscious, then their mental ailments would be cured (Myers 596-597).

The resulting treatments created by Freud are known as psychoanalysis, or "talking cures" and began with hypnosis, a revised form of mesmerism ("Timeline"). When this specific method did not prove to be effective, Freud turned to free association in which the patient was instructed to relax and share whatever thoughts came to mind, no matter how trivial or embarrassing they might have been. Freud believed that these thoughts would create a path that he could follow into the patient's unconscious, where he could then retrieve years of repressed thoughts and feelings. The unconscious was also thought to be revealed through an individual's beliefs, habits, and even slips of the tongue and pen, which came to be known as "Freudian slips." Dream analysis was another

popular method of treatment promoted by Freud. Patients were asked to record their dreams, sometimes every morning in a journal kept bedside. The psychoanalyst would then study the manifest content of the dream, or what was remembered by the patient, and search for latent content, or the unconscious materials that were thought to be censored by the conscious mind and instead encoded as symbols (Myers 597-598). Although Freud provoked many critics who considered his ideas pseudo-science, psychoanalysis was a very popular method of treating mental illness from the early to mid 1900s.

Also in development and widespread use during this time were somatic treatments for mental illness such as electroconvulsive therapy, psychosurgery, and psychopharmacology. These treatments were based on the biological model of mental pathology that assumes mental illness is the result of a biochemical imbalance in the body and can be compared to physical diseases. Therefore, somatic treatments were designed to correct an individual's chemical imbalance in order to restore their mental health.

Electroconvulsive therapy has roots in methods designed to shock the body but without the aid of electricity. In 1933, Manfred Sakel reported his first experimental findings, testing the efficacy of insulin-shock treatment on schizophrenic patients in Berlin, Germany. Insulin was administered to the patient in a dose high enough to induce coma, and although the treatment seemed to be beneficial to individuals in the early stages of schizophrenia, it was not proven to be useful in advanced cases of schizophrenia. Sakel's vague theoretical rationale for this specific method and the difficult regimen of care this treatment required also led to the abandonment of insulin-shock therapy (Alexander 280).

Ladislaus Joseph von Meduna experimented with shock therapy and schizophrenia in Budapest, Hungary, also during the year 1933. Instead of insulin, Meduna injected patients with Metrazol, a less toxic synthetic preparation of camphor. This treatment was soon abandoned as it possessed a period of unpredictable length between injection and convulsions, giving the patient just enough time to become fearful and uncooperative. It also often produced convulsions that were so severe as to cause fractures (Alexander 281).

Finally in 1938, Italian physicians Ugo Cerletti and Lucio Bini administered the first shock therapy using electricity to a schizophrenic patient and received successful results (Alexander 282). This treatment soon became widespread and was used most often in America and Europe. There is some history of abuse associated with electroconvulsive therapy (ECT) though, that took place in mental institutions. Because the idea of an electrical current being passed through one's head is undoubtedly frightening, ECT was used to intimidate, control, and punish patients, some of whom were subjected to this treatment over a hundred times ("Measuring"). Despite previous instances of abuse, this treatment is still used today, albeit with significant reforms. It is generally reserved only for the mentally ill who suffer from severe depression, especially of the variety accompanied by psychotic symptoms, and only as a last resort after the patient has not responded to any other treatments, including medication. Patients are also administered a general anesthetic and muscle relaxant prior to the treatment so that they do not suffer any discomfort and there is no danger of fractured bones. Electroconvulsive therapy is commonly performed on a patient three times a week until a dozen sessions are reached, although some patients may require more or less sessions to benefit. The only negative side effects reported are amnesia limited to the few hours before the session and disorientation; both disappear soon after ECT is stopped (Butcher 618-619).

When electroconvulsive therapy was not effective, patients were sometimes forced to undergo psychosurgery, a practice that developed and was widely practiced in the 1930s to 1950s. It was in Portugal, 1935, that Egas Moniz performed the first lobotomy with the aid of a neurosurgeon, Almeida Lima; Walter Freeman was responsible for popularizing lobotomies in America (Alexander 285). To execute this procedure, the patient was first shocked into a coma. The surgeon then hammered an instrument similar to an icepick through the top of each eye socket and severed the nerves connecting the frontal lobes to the emotion-controlling centers of the inner brain. The intended purpose of the lobotomy was to calm uncontrollably violent or emotional patients, and it did--at first--prove to be successful. Because of the preliminary positive results and the facts that it was easy, inexpensive, and the average time it took to complete the procedure was only about ten minutes, lobotomies quickly spread around the world as a popular practice for severely mentally ill patients who were resistant to other treatments. It was only after tens of thousands of patients worldwide had undergone this procedure during the following twenty years that people started to take notice of its undesirable side effects. Lobotomies generally produced personalities that were lethargic and immature (Myers 717-718). Aside from a twenty-five percent death rate, lobotomies also resulted in patients that were unable to control their impulses, were unnaturally calm and shallow, and/or exhibited a total absence of feeling (Butcher 620). Not surprisingly, this practice was quickly abandoned with the introduction of psychoactive drugs.

Since the late 1800s, substances such as chloryl hydrate, bromides, and barbiturates were administered to the mentally ill in order to sedate them, yet they were ineffective in treating the basic symptoms of psychosis (Alexander 286, "Timeline"). It was not until Australian psychiatrist J.F.J Cade introduced the psychotropic drug Lithium in 1949 that psychopharmacology really took off. A series of successful anti-psychotic drugs were introduced in the 1950s that did not cure psychosis but were able to control its symptoms. Chlorpromazine (commonly known as Thorazine) was the first of the anti-psychotic medications, discovered in France, 1952 ("Timeline"). Valium became the world's most prescribed tranquilizer in the 1960s, and Prozac, introduced in 1987, became the most prescribed antidepressant (Porter 206).

The introduction of psychopharmacology is arguably one of the most significant and successful contributions to mental illness treatment, although it did lead to a movement that has been devastating to mental health care systems around the world, especially in the United States. The advent of psychoactive drugs convinced many that all illnesses would soon be effectively managed with medication, leading to the deinstitutionalization movement that rapidly occurred starting in the 1960s. It was believed that numerous community-based facilities would be conveniently available to the mentally ill should they choose to seek it out, although this plan was never sufficiently realized. Instead, thousands of the mentally ill discharged from institutions were incapable of living independently, medicated or not, and became homeless as a result of inadequate housing and follow-up care. In the 1980s, it was estimated that one-third of all homeless individuals in America were considered severely mentally ill. Lack of support and guidance led to the incarceration of over 100,000 mentally ill individuals in America as well. A 1992 survey reported that 7.2 percent of the inmate population was "overtly and seriously mentally ill;" over one-fourth of that population was being detained without charges until beds became available in one of the country's few remaining mental hospitals ("Timeline").

Psychotropic medication has additionally allowed individuals to avoid directly confronting their mental health issues, for example through counseling. Despite successful advances in therapy, such as Roger's Client-Centered Counseling and Cognitive-Behavioral Therapy, among many others, mentally ill individuals have found it easier to avoid the shame associated with mental illness in

countries where psychopathology is profoundly stigmatized. For instance, since deinstitutionalization, community health centers, day-care facilities, short- and long-term residencies, vocational training programs, and mobile units have all been established in Greece, yet the majority of the mentally ill, aside from those suffering from severe psychosis, still treat themselves only with psychotropic medication as they find it easier to hide their mental ailments from their friends, family, and communities (Blue 312). Supernatural beliefs about mental illness persist in other countries around the world, motivating most individuals to consult traditional healers first to help restore their mental health before they seek out professional, medical assistance. Workers in Nigerian asylums claimed that individuals were often only admitted after traditional healers has exhausted all treatment possibilities, and even today this country is known for its ethnopsychiatry as its mental health facilities employ traditional healers and frequently incorporate their practices into more modern treatments (Sadowsky 111). It is also common in several countries that mental health is a grossly misunderstood and ignored problem, leading to serious underdevelopment of mental health facilities. Some countries in the Arab world have the highest income per capita, yet all have mental health systems that are severely lacking, including Morocco, Lebanon, the United Arab Emirates, and more. Individuals in these countries also continue to hold supernatural beliefs about mental illness and feel ashamed due to stigma, so they often consult traditional healers first with physical complaints, which are more likely psychosomatic symptoms (Okasha). China is another country whose mental health services are limited due to stigma and misunderstanding. Confucian ideals about social order allow no wiggle-room for mental illness. Those afflicted with psychopathology rush to traditional healers, seek out prescriptions for psychoactive medication, or are begrudgingly taken care of by family members; the mentally ill who become disruptive to society are likely to be incarcerated (Phillips 10-15).

This article has examined the major developments in mental health care as well as some interesting details about mental illness treatments throughout world history. Perceptions of mental health have changed greatly since the earliest civilizations and will continue to change as more is learned about the minds of humankind. Although significant advances have been made in this field of study that greatly benefit many individuals suffering from psychopathology, there remains much room for improvement. It will likely be ages before the workings of the human mind will be fully understood, if this is indeed an attainable goal.

References

Alexander, Franz G., and Sheldon T. Selesnick. The History of Psychiatry: An Evaluation of Psychiatric Thought and Practice from Prehistoric Times to the Present. New York City: Harper and Row, Publishers, 1966.

Blue, Amy V. "Greek Psychiatry's Transition from the Hospital to the Community." Medical Anthropology Quarterly 7.3 (Sept. 1993): 301-318.

Butcher, James N., Susan Mineka, and Jill M. Hooley. Abnormal Psychology. Ed. Susan Hartman. 13th ed. Boston: Pearson Education, Inc. , 2007.

Houston, R.A. “Clergy and the Care of the Insane in Eighteenth-Century Britain.” Church History 73.1 (March 2004): 114-138. World History Collection. EBSCO. Scarborough-Phillips Library, Austin, TX. 25 September 2007.

MacDonald, Michael. Mystical Bedlam: Madness, Anxiety, and Healing in Seventeenth-Century England. New York City: Cambridge University Press, 1981.

"Measuring the Unmeasurable: An Introduction to Psychology." Making the Modern World. 2004. ISB fund of the Treasury and the Cabinet Office. 6 Nov. 2007 <http://www.makingthemodernworld.org.uk/learning_modules/psychology/02.TU.04/?section=1>.

Myers, David G. Psychology. 2006. 8th ed. New York City: Worth Publishers, 2007.

Okasha, A. “Mental Health Services in the Arab World.” Arab Studies Quarterly 25.4 (Fall 2003): 39-52. World History Collection. EBSCO. Scarborough-Phillips Library, Austin, TX. 25 September 2007.

Phillips, Michael R. “The Transformation of China’s Mental Health Services.” The China Journal 39 (Jan. 1998): 1-36.

Porter, Roy. Madness: A Brief History. New York City: Oxford University Press, 2002.

Rosen, George. Madness in Society: Chapters in the Historical Sociology of Mental Illness. Chicago: The University of Chicago Press, 1968.

Sadowsky, Jonathan Hal. Imperial Bedlam : Institutions of Madness in Colonial Southwest Nigeria. Berkeley: Berkeley University of California Press, 1999. 24 Nov. 2007 <http://silver.stedwards.edu/search/XMental%20Illness+and+Treatment&SORT=D&m=z/XMental%20Illness+and+Treatment&SORT=D&m=z&SUBKEY=Mental%20Illness%20and%20Treatment/1,7,7,B/l856~b1043940&FF=XMental%20Illness+and+Treatment&SORT=D&m=z&5,5,,1,0>. Path: Library Home; Research Tools; Online Catalog. Stigma and Mental Illness. Ed. Paul Jay Fink and Allan Tasman. Washington DC: American Psychiatric Press, Inc. , 1992.

"Timeline: Treatments for Mental Illness." American Experience - A Brilliant Madness: Timeline. 1992-2002. PBS. 6 Nov. 2007 <http://www.pbs.org/wgbh/amex/nash/timeline/index.html>.