



# PILLS, PATIENTS, AND PROFITS PSYCHIATRIC DRUGS C. 1950 TO TODAY

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## Introduction

The short history of psychiatric drugs has caused many difficult issues that remain unresolved today. When the first effective psychiatric drug, chlorpromazine, was introduced in the 1950s, psychiatry experienced a revolution in the biological understanding and treatment of mental illness (Grob, 1994; Shorter, 1997, p. 346). Many patients, including those resistant to other treatments, experienced relief from their psychological ailments; psychiatrists were galvanized into conceptualizing mental illness as treatable (Duval and Goldman, 2000). Pharmaceutical companies then began to develop more effective compounds (Shen, 1999, p. 407). In the wake of this, however, psychiatric drugs also aggravated old issues and introduced new questions. Because psychiatrists were able to see greater numbers of patients, each patient received less individual care. The outpatient population increased due to the portability of drugs. This quickly led to major changes such as the deinstitutionalization of mental health care and the sudden eradication of past staples like lobotomy (Duval and Goldman, 2000, p. 330; Grob, 1994; Starks and Braslow, 2005).

This paper provides a historical perspective that traces the emergence of key issues in psychiatry. Where is the line between normal and pathology? What role should for-profit entities like pharmaceutical companies play in medicine? How do we balance the needs of patients and caregivers? I demonstrate that current quandaries, exhibited here by the debate over AD(H)D diagnosis and medication, have been shaped by the initial emergence of pharmaceutical treatments for mental disorders. Along the way, two arguments will be made. Firstly, profit motives have no place in medical research or practice, as the corporation-centric actions encouraged by a market model far outweigh the benefits conferred by competition. Secondly, this branch of medicine is no exception to the inseparable interplay between science and society. No scientific achievements are developed in a vacuum free of political limitations, lack of human forethought, or unanticipated consequences. Cultural beliefs and practices concerning mental health both

impacted and were impacted by the development of psychiatric drugs such as chlorpromazine.

### **Chlorpromazine**

Cross-pollination between diverse industries creating, testing, applying, and marketing man-made chemicals led to the creation of psychiatric drugs. The development of chlorpromazine began indirectly during the mid-nineteenth century, when the European dye industry flourished with a plethora of newly synthesized chemicals that would later be discovered to have therapeutic properties (Shen, 1999, p. 408; Whitaker, 2010, p. 48). New chemical innovations would also be brought on by circumstances of geopolitical scale, such as the lack of access during World War I and II to quinine, a tropical bark that was then the only effective anti-malarial (Shen, 1999, p. 407). These circumstances encouraged the practice of creating medicines in laboratories from components that were otherwise scant or non-existent. Pharmacies transformed from the apothecaries of former centuries to the giants of the current pharmaceutical industry, among them the French company Rhône-Poulenc.

In 1951, French military surgeon Henri Laborit was experimenting with a new compound: 4560 RP (Rhône-Poulenc). It would later be known as “chlorpromazine.” After finding that it produced a certain “uninterest” among his surgical patients, he tested it on a colleague and then convinced his colleagues to try it on their patients (Shorter, 1997, p. 247-249; Whitaker, 2010, p. 49-50). A manic patient named Jacques L. was administered chlorpromazine, in combination with an analgesic, barbiturate, and electroconvulsive therapy (ECT). Word of his recovery traveled along the Paris grapevine, interesting two famous psychiatrists, Jean Delay and Pierre Deniker. In 1952, they administered chlorpromazine to a series of patients (Whitaker, 2010, p. 50). The first was Giovanni A., who had been admitted to the Ste.-Anne mental hospital for making political speeches in cafés, walking around in public with a pot of flowers on his head, raving about his love of liberty, and assaulting strangers. He became the first reported chlorpromazine

patient. Giovanni A. was discharged in three weeks, and chlorpromazine was deemed better, less dangerous, and more patient-friendly than other physical therapies like ECT. (Shorter, 1997, p. 250). This case, along with the similar recovery of Delay and Deniker’s other patients, astonished the psychiatric community (Shen, 1999, p. 408). Spurred by its success among actual psychiatrists and patients, Rhône-Poulenc released chlorpromazine in 1952, only a year later.

Chlorpromazine went international when clinicians in other countries learned of the effects of the drug and experimented with it on their own. However, the pharmaceutical industry was the ultimate force causing the spread of the drug. Heinz Lehmann, commonly credited for introducing chlorpromazine to North America, obtained the drug from a Rhône-Poulenc sales representative (Shorter, 1997, p. 250-252). Lehmann experimented with the samples and reported his results in a major medical journal in 1953. Patient testimony read: “It was like a chairman taking control of a meeting where everybody had been shouting at once” (Shorter, 1997, p. 250). This sentiment captured psychiatrists’ attention. Lehmann and a colleague also noticed side effects of the drug: a stiff gait and mask-like face resembling Parkinsonism. These were named extrapyramidal symptoms (later tardive dyskinesia or “delayed, abnormal movement”). These side effects were initially ignored, which would become a disastrous mistake (Duval and Goldman, 2000, p. 328; Shorter, 1997, p. 253).

### **Profit**

A constant thread through the early history of chlorpromazine is the involvement of industry with the goal of monetary gain. Chlorpromazine shortly became and remained a major source of profits for drug companies, primarily because of a large market of dependent patients. The four million American patients taking chlorpromazine yielded a profit of \$75 million in 1955 alone (Starks and Braslow, 2005, p. 181). The development of the compounds that would lead to chlorpromazine originated from industry backing. Though government efforts were also present, governmental in-

involvement in these compounds was less direct and later faded into the background; meanwhile, pharmaceutical companies remained on the front lines of drug development and promotion. The aggressive promotional efforts of those working for Rhône-Poulenc were instrumental in disseminating chlorpromazine into psychiatric practice. Moreover, it was a drug company, Smith, Klein and French, that introduced chlorpromazine to the American market in 1954 (Grob, 1994; Shen, 1999, p. 208-209). Although the company bought it as an antiemetic from Rhône-Poulenc and did not conduct extensive trials because of budgetary concerns, it secured chlorpromazine's standing in academic medicine by inspiring outside psychiatrists to run trials. In addition, Smith Klein and French formed a chlorpromazine task force to market the drug to state legislators as a means of saving money in state asylums; the company saw the half million residents of state hospitals as captive potential consumers (Starks and Braslow, 2005, p. 181). Though this was at a time when the dominant paradigm in American psychiatry was psychoanalysis—which was incompatible and sometimes hostile towards biological psychiatry—they succeeded in having both state asylums and private clinics adopt chlorpromazine (Grob, 1994; Shorter, 1997, p. 272-277). Smith Klein and French even targeted the public, producing a television program with the American Medical Association called *The March of Medicine* that covered the wonder of the new drugs (Whitaker, 2010, p. 57-58).

With chlorpromazine, the interconnection between psychiatric drugs and the pharmaceutical industry only became more inextricable. Whereas the names of medical practitioners, academic researchers, and government institutes are prevalent in the history of general medicine, pharmaceutical companies were the agents in psychiatry who raced to discover and market new drugs. Major changes in government responsibility for medications took place during the 1950s when psychiatric drugs went on the market. The American Medical Association (AMA) was formed at the turn of the twentieth century as a pharmaceutical watchdog organization of physicians, publishing a public assessment of drugs as either approved or “quackery” in

lieu of government involvement (Whitaker, 2010, p. 55). In 1938, however, a new law required that pharmaceutical companies must have their wares approved by the Food and Drug Administration (FDA) for safety (not effectiveness). A 1951 amendment stipulated that a doctor's prescription be necessary for purchasing “prescription” drugs. The financial interests were now aligned between medical professionals and the companies whose products patients paid them to access. The AMA began to cease its watchdog program in 1952, and, coincidentally, began taking paid advertisements for drugs instead (Whitaker, 2010, p. 56). A Harvard Medical School professor testified to Congress that the AMA became “sissy” (ibid.).

#### *Profits: Patients*

Patients may be the only stake-holding party that did not enjoy a net profit, in a broad sense of the word, from psychiatric drugs. Even though—or perhaps because—the drugs made it easier for psychiatrists to effectively and simultaneously treat many patients, the quality of individual care for each patient deteriorated, lapsing into a quick, impersonal discussion of the drugs' effects and symptoms (Shorter, 1997, p. 278). While psychiatric drugs were an improvement on past physical therapies, patients did not benefit for long. A National Institutes of Mental Health (NIMH) study on the outcomes of schizophrenia patients (Carpenter et. al., 1977) reveals that medications were actually damaging. The patients treated with drugs were discharged later than those who were treated without drugs. Forty-five percent of the medicated patients relapsed within a year compared to 35% of the non-medicated patients. The non-medicated patients exhibited less depression, blunted emotions, and slowed movements. They also told the researchers that they felt their psychotic episodes were “gratifying and informative,” and the report concluded that medicating patients robbed them of an important educational experience that made them better able to cope with subsequent life stresses in the long term (Whitaker, 2010, p. 100). In other words, reliance on drugs is its own handicap, compounding the problems caused by the condition itself.

In addition, the drugs themselves caused serious consequences, some of which were not limited to their medical side effects. While the seeds had been planted long before, the introduction of chlorpromazine to the American market marked the initiation of deinstitutionalization. Psychiatric drugs made it possible for mental patients to be removed from the hospital and put into the community, where, in theory, they could continue to receive treatment. In the 1960s, legal questions arose about the legitimacy and quality of forced institutionalization, and courts made institutionalization guidelines less restrictive (Grob, 1994). Societal pressures such as the antipsychiatry movement, a social movement that also began in the 1960s, drove even the patients who could not receive outpatient care out of institutions (Shorter, 1997, p. 272-273). In addition, the applicability of federal entitlement programs, such as Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI), to the disabled mentally ill incentivized states to discharge patients (Grob, 1994).

While this was occurring, the public imagined that patients would be better off in the community. This was not always the case. It was “discharge and be damned” according to a British psychiatrist who worked in the United States during the 1950s (Shorter, 1997:, p. 281). For instance, immediately after Medicaid was passed in 1965, states began to relocate elderly patients from mental hospitals to chronic care nursing facilities because their costs were largely the responsibility of the federal government; this move was followed by an increase in the patient death rate (Grob, 1994). For many younger patients, the only option outside of institutions was the streets. Indeed, it is estimated that 25% of the homeless have a severe mental illness, often compounded by substance abuse (Whitaker, 2010, p. 246). Many patients preferred to avoid the side effects caused by chlorpromazine and other first-generation neuroleptics, such as Parkinsonian-like symptoms, tardive dyskinesia, muscle spasms, emotional flatness, loss of motivation, social disengagement, and learning impairment (Whitaker, 2010, p. 104-105). These side effects were discussed during the 1955 Seventh Mental

Hospital Institute Discussion in Washington D.C., the transcripts of which serve as a unique primary source documenting changes occurring among American psychiatrists immediately after chlorpromazine became available. In the talk, participants such as Lehmann and other psychiatrists dismissed these side effects as “not too difficult” (Duval and Goldman, 2000, p. 329). However, this became a large social and medical problem when these patients, many psychotic, became dangerous while they were unmedicated.

Psychiatric drugs did, however, promise a great number of benefits, especially for psychiatrists. The Seventh Mental Hospital Institute evaluated the benefits of chlorpromazine and reserpine, another new drug. Among participants’ discussion of the drugs’ effects on hospital budgets, they cited their new ability to medicate outpatients, significantly reducing the per capita cost to \$12.24 per month, as well as the reduced need to pay for physical restraints, supervision, and the destruction of facilities by patients (Duval and Goldman, 1956, p. 328-331). Moreover, these drugs far outperformed other available treatments. Alternative physical therapies that were potentially more dangerous for the patient and inconvenient for the psychiatrist, especially lobotomy, disappeared almost overnight (Starks and Braslow, 2005). Psychiatrists at California’s Stockton State Hospital completely ceased to perform lobotomies on June 16, 1954—not because of a deliberate decision, but because they had received their first shipment of chlorpromazine. The hospital continued to contemplate surgery but found it unnecessary because of the effectiveness of the new method (Starks and Braslow, 2005, p. 182, 186). These benefits explain why American state asylums readily adopted chlorpromazine when marketed by Smith French and Klein as a money-saving mechanism.

In addition, psychiatrists benefited from psychiatric drugs in more abstract ways. The drugs gave psychiatry a more prestigious, scientific standing and distinguished it from other, non-biological paradigms such as psychoanalysis. The discovery of chlorpromazine set off the search for other psychoactive substances with therapeutic uses and caused the study of psy-

chopharmacology to flourish (Shorter, 1997, p. 255). In addition, scientific advancements were made using the drugs themselves. Schizophrenia and anxiety were thought to be part of the same spectrum of disorder in psychoanalytic theory. However, this was disproven in 1959 by Donald Klein, a psychiatrist at the Hillside Hospital. Klein began treating a group of patients who were often anxious and panicky with chlorpromazine, but the treatment was not effective. On the other hand, chlorpromazine was effective for schizophrenic patients, who often also manifested signs of anxiety (Shorter, 1997, p. 176). Just as one can prove that pneumonia and colds have different etiologies because penicillin works on one but not the other, this meant that schizophrenia and anxiety were two distinct disease entities. Klein criticized the psychiatric diagnostic system for being unable to account for the outcome of treatment with psychiatric drugs (Klein and Oaks, 1967, p. 118). This established that psychiatric illnesses were not an ill-defined continuum but could be subject to the same definition that had occurred in general medicine.

In addition, psychiatric drugs contributed to a new era of optimism in psychiatry and helped eradicate the therapeutic nihilism that had previously pervaded the field. One psychiatrist named Felix Post wrote about his transformation after the new cornucopia of psychiatric drugs: “I started as a lone doctor bewildered and frightened by the multitude of apparently hopelessly ill and deteriorating patients. I ended as a member of a professional team and with the certainty of being able to help, to an important extent, almost all my patients” (Shorter, 1997, p. 261). The drugs were thus valuable in transforming psychiatrists’ attitudes towards their profession and patients. The patients, too, were uplifted by the effectiveness of the new drugs. When Roland Kuhn was testing a new drug for depression in 1955, he noted that his patients would jump out of bed in the morning, socialize easily, amuse themselves, and generally become livelier and more content (Shorter, 1997, p. 258). Though their lives were compounded by the negative consequences of psychiatric drugs—the side effects, the addiction—many patients

attributed their recovery primarily to the drugs. The drugs also helped to phase out more potentially harmful treatments such as ECT, which was less easily tolerated by patients and had the possible side effect of temporary or, more rarely, permanent memory loss (Shorter, 1997, p. 275). Prior to 1954, 63% of psychotic patients were treated with ECT. After chlorpromazine was introduced, only 9% received ECT, 28% received ECT and drugs, and 47% received drugs alone (Starks and Braslow, 2005, p. 186). Psychiatric drugs have thus changed the entire therapeutic landscape of psychiatry.

Perhaps most importantly, psychiatric drugs also made it more socially acceptable to be treated for mental illness. The number of non-psychotic mental patients has risen dramatically since the 1950s, coinciding with the release of these drugs (Starks and Braslow, 2005). Because psychiatric illness was reduced from pathology to everyday troubles, one could take psychiatric drugs to make life’s stresses evaporate. The lowering of the threshold between pathological and normal psychology resulted in the addition of entirely new patients who would not have been treated previously for mental illness. These patients were treated with both physical therapy and psychiatric drugs, signaling that the psychiatrists saw social problems as having a biological cure (Starks and Braslow, 2005, p. 187). This suggests that the public understanding of mental health simplified psychiatric mental illnesses and had the side effect of reducing the fears of and stigmas against psychiatric patients. *Newsweek* said in 1994 that “Prozac has attained the familiarity of Kleenex and the social status of spring water. The drug has shattered old stigmas...[Americans have been] swapping stories about it at dinner parties” (Shorter, 1997, p. 324).

### Contemporary Quandaries

As demonstrated above, the history of psychiatric drugs is interspersed with moments of scientific euphoria mixed with sobering realizations of the scientific hurdles and social problems that have yet to be handled. This paper now comes to the present day, where medicine and society alike are evaluating what has been left after the wake of psychiatric diseases-

es and medication. Jonathan Cole, former head of the National Institute of Mental Health's Psychopharmacology Service Center, asked in a 1977 article "Is the Cure Worse than the Disease?" (Whitaker, 2010, p. 369). Answering this question is more than an academic exercise, as many of the issues created by psychiatric drugs are still relevant.

Changes in standards of psychiatric disease have led to increasing numbers of patients. Between the fiscal year 1934-1935 and fiscal year 1959-1960, the admission numbers of non-psychotic first-time patients in Stockton State Hospital, for example, rose from 63 to 2,736—an increase of 4,243%. Meanwhile, the number of psychotic first-time patients increased at almost exactly the same rate as overall first admissions (246%), increasing from 1,821 in 1945-35 to 6,130—an increase of 237% (Braslow and Starks, 2005, p. 179). The disabled mentally ill who are listed on SSI or SSDI receive stipends from the government (Whitaker, 2010, p. 7). Beginning in 1987, when the FDA approved Prozac, the number of patients listed to receive SSI and SSDI payments rose to 3.97 million in 2007, twice the rate in 1987 and six times the rate in 1955 (Whitaker, 2010, p. 6). These increases seem to be linked directly to the release of psychiatric drugs: people actually *wanted* to be prescribed drugs for the illnesses they perceived themselves to have. Alarming, a physician at Beth Israel Medical Center in Manhattan said, "Our phone rings off the hook every time someone does a story about Prozac. People want to try it. *If you tell them they're not depressed they say, 'Sure I am!'*" (Shorter, 1997, p. 320, emphasis added).

How could psychologically healthy people assert that they have a mental illness and require psychiatric drugs? Most of the answer lies in the trivializing of psychiatric illness and the application of psychological explanations for everyday life, which subsequently lead individuals to seek these "magic bullets" as solutions to their non-pathological problems. In a 1958 essay revisiting the predictions of his novel, *Brave New World*, Aldous Huxley compared chlorpromazine and Miltown, a tranquilizer, to the fictional soma which tranquilizes the population of his totalitarian society. "Miltown

and chlorpromazine are not yet soma; but they come fairly near to being one of the aspects of that mythical drug"—the drugs' ability to dim the world of problems insofar as a constant supply of them is available to the population (Huxley, 1958, p. 278).

Another part of the explanation is in the appeal of the drugs themselves. Prozac was discovered to have weight loss as a side effect. After the Eli Lilly Company, its manufacturer, mentioned this in a report in 1985, its stock soared; investors realized the side effect would appeal to the innumerable numbers of people trying to lose weight (Shorter, 1997, p. 314). Many drugs entered popular culture, such as the tranquilizer Miltown, which was so popular that drug stores and pharmacists put signs saying "Out of Miltown" or "Yes, we have Miltown!" (Shorter, 1997, p. 316). Miltown's distributors marketed it aggressively. Wallace Laboratories, one distributor, even hired Salvador Dalí to create an exhibition about the wonder of their new drug (Whitaker, 2010, p. 59). The comedian Milton Berle started referring to himself as "Miltown" (Whitaker, 2010, p. 59).

One of several other questions concerns the acceptability of treating patients who are sub-threshold but feel they are psychologically ill. Psychiatrists have directly played a role in encouraging these ballooning patient populations. This lowered threshold was made official in the 1952 *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I) of the American Psychiatric Association, which included the listing "inadequate personality" that is characterized by a number of social failings, not medical lesions (Starks and Braslow, 2005, p. 189). The 1957 records of Herbert Bailey, a patient at Stockholm State Hospital who intentionally crafted a botched armed robbery to justify his desperate seeking of institutionalization, show that the psychiatrists were aware of their changing patient pool. The psychiatrist who admitted him recorded that "he is a dull normal person at best," which was followed by a description of his difficult relationship with his wife and inability to support his four children (Braslow and Starks, 2005, p. 283). Herbert was one of many patients admitted for social failures rather than

medical problems. What role, if any, should psychiatrists and the psychiatric profession play in dissuading people who have non-medical problems from seeking medical treatment?

### ADHD

This previous question raises another issue: whether psychiatric drug use is holistically doing more harm than good to patients at both the individual (micro) and societal (macro) levels. The best example of this is attention-deficit hyperactivity disorder (ADHD). ADHD is currently contentious because of divergent public and professional opinions regarding whether it is a “real” disorder or a “cultural construct” and whether it should be medicated (Diller, 1996). This may be partially due to contradicting information on the disorder. Diagnostic standards vary greatly because the symptoms remain ambiguous, although the American Academy of Pediatrics published guidelines for more rigorous diagnoses (Diller, 1996, p. 12; Singh, 2005, p. 35). Estimates of prevalence rates range from 0.5% to 26% (Timimi and Taylor, 2004, p. 8), and the estimates of the number of children using stimulants in 1980 varied from 270,000 to 541,000 (Diller, 1996, p. 12). There is also confusion over whether ADHD is a medically valid disorder. All of the studies done in the 1990s cherry picked by Robert Whitaker—the writer of a popular 2010 book called *Anatomy of an Epidemic*—claim to demonstrate that there is no biological substrate for ADHD and medications are not effective or are in fact damaging (p. 216-262). However, more recent research generally agrees on a combination of biological and social factors and, more specifically, genetic influences in interaction with the environment (Diller, 1996, p. 15; Singh, 2005, p. 34; Timimi and Taylor, 2004, p. 9).

This situation worsens when considering psychiatric drug use. The former market leader, Ritalin, is often abused by those who have not been diagnosed with ADHD, such as students who use it to study for exams (Diller, 1996, p. 16). In addition to obtaining medication, the disability benefits conferred with ADHD in schools and the workplace may encourage individ-

uals to actively seek diagnosis for the disorder (Diller, 1996, p. 15). Parents or teachers with difficult-to-control homes or classrooms seek ADHD medication as a “quick fix” (Diller, 1996; Singh, 2005). The profits from ADHD drugs incentivize pharmaceutical companies to “maintain market share” by reducing the threshold of pathology in children (Shorter, 1997, p. 293). Because of the number of people who file claims for disorders like ADHD, disability insurance has been made too expensive for many to obtain (Diller, 1996, p. 14). One wonders if this flooding of society’s institutions makes it more difficult for those who truly need services to obtain them. ADHD thus represents the convergence of several issues – the profit motive, standards of diagnosis for mental illness, intentional pathologizing of oneself or one’s patients, and the need to resolve the contradictions between patient and caregiver needs.

### Discussion

#### *The Patient*

In considering ADHD, one has the advantage of seeing the unfolding of a dilemma that is inextricably connected with not only science but also with cultural mores and standards. For instance, the fact that one is labeling someone as abnormally attention-deficit and hyperactive implies that there is a shared set of standards among a society about the parameters of how behavior is normally exhibited. Science may inform these assumptions by discovering data that might bolster or contradict them, but I argue that it cannot be separated from ways of thinking. Data must be both collected and interpreted by a human mind. A 1971 study showed that American psychiatrists diagnosed schizophrenia 69% of the time after watching a short video of a patient exhibiting abnormal behavior, while British psychiatrists diagnosed schizophrenia only 2% of the time from the same video (Shorter, 1997, p. 256). This same phenomenon may be at work with statistics that show that medicating ADHD is a uniquely American phenomenon. In 1999, Americans used 85% of the world’s methylphenidate, which is commonly used to treat ADHD (Singh, 2004, p. 1193).

A central issue is the struggle for control over the patient's *self*, the entity that the patient feels to be the essence of his or her being. Psychiatric drugs can be seen as a resource for controlling and altering the self, not only because they moderate or remove the symptoms of the disease but also because they do so in a way that does not require the patient's own volition (Singh, 2005, p. 42). When parents or teachers refer a child under their care for ADHD medication, they may be seen as fulfilling their own needs for non-disruptive behavior. Singh records that mothers conceptualize the afflicted child and ADHD separately, understanding medication as acting only on the latter (Singh, 2004, p. 1202). However, some patients are concerned that the drugs also change their core selves. Through interviews with ADHD patients, Loe and Cuttino (2008) found that pharmaceutical use created internal conflicts for patients between an "authentic," un-medicated self and an "ideal," medicated self. For example, one of their subjects said:

I don't like the idea...that the person I'm most like is the person who I am when I am taking medication...when there's chemicals that are running through my [body]...that aren't naturally there. But I find more and more, that when I don't take it, I don't act as someone that I think that I am or who I'd like to be... I feel like I can't do anything. (Loe and Cuttino, 2008, p. 315)

These findings validate concerns by Kramer, Brock, Fukuyama and Taylor (in Singh 2005) and Diller (1996) that ADHD medication undermines patients' autonomy, self-reliance, and personal development, especially for children who lack decision-making power.

This mentality can be seen in historical accounts. In the Seventh Mental Hospital Institute discussion on the administrative aspects of the new drugs, one interlocutor remarked that "we must first treat the illness and then rehabilitate the patient," showing that psychiatrists at this time also conceived of mental illness as separate from the patient's self (Duval and Goldman, 2000, p. 331). A major part of these efforts was to create patient freedom as outpatients and increase community resources. However, they

neglected the patient in their vision when the subsequent deinstitutionalization created problems for the patients, who did not have a say in the process. In light of this, I would argue that psychiatrists and other caregivers must avoid decontextualizing mental illness by being attentive to the patients themselves and considering what consequences treatment might have on how the patients view and understand themselves. Because patients are often not in a position to advocate on their own behalf, either due to their condition, youth, or both, medical professionals must take it upon themselves to moderate the power disparity.

Society may prime individuals for mental illness and subsequent treatment with psychiatric drugs. There is a historical correspondence between lowered threshold of mental illness (and rising numbers of psychiatric patients) with raised societal standards of success (Diller, 1996, p. 16). For instance, in the 1990s, societal factors instilled a message that learning should begin earlier, while shifts such as the increasing number of women in the workplace increased preschool enrollment. Children who were not yet well-adapted to the structured school environment were seen as needing medication—not because the state of children overall had declined, but rather because expectations of how a "normal" child should act had changed (Diller, 1996, p. 13). Higher expectations of performance due to increased competition for jobs may also be responsible for ADHD medication abuse (Diller, 1996, p. 13). Thus, a person stating "sure I am [depressed]!" may not only be a desire for Prozac itself but a need to escape the mounting societal pressures on one's performance by subscribing to the ideology that failure is treatable with drugs. This type of attitude is not dissimilar to the one voiced by Herbert Bailey, the patient who contrived a failed armed robbery. Herbert actively sought the mental hospital as an alternative to the outside world, where he failed to live up to his social responsibilities. That he was taken in and treated by psychiatrists likely only validated his feelings of inadequacy by reinforcing his need for medical treatment. However, I do not believe that one should deny patients the belief that their failures are medical

problems because this would only transfer the blame from their biology to themselves. The solution is then not to turn away patients or tell them that they fail to meet scientific diagnostic criteria but to address the societal factors that cause them to feel disabled or ill.

### *Solutions*

Capitalist societies thrive on the profit motive for constantly engineered progress. Without this incentive, chlorpromazine may not have been created at all, let alone have sparked the genesis of modern psychiatry itself and subsequent advances in biological understandings of mental illnesses. “It is fashionable at the moment to excoriate the pharmaceutical industry as one that takes advantage of the sick,” said writer Andrew Solomon in *The Noonday Demon* (2000, p. 13), an atlas of depression. “My experience has been that the people in the industry are both capitalists and idealists—people keen on profit but also optimistic that their work may benefit the world, that they may enable important discoveries that will put specific illnesses into obsolescence” (Solomon, 2000, p. 13). This paper does not argue that pharmaceutical companies are evil. The problem is that any medical company is inherently a business—not a charity. Perhaps the solution is that the industry continues their advancements while others take the human side of medicine.

This can begin by decreasing the power of pharmaceutical companies. The psychiatric drugs they peddle are essentially marketed as a new self, especially because of how they were understood in the post-chlorpromazine era by psychiatrists and lay people treating non-medical problems. The pharmaceutical companies were able to reconstitute what it meant to be mentally ill and what psychiatric drugs could do. They expanded the market by ballooning the possible applications of their drugs in the media or marketing their drug for off-label purposes to primary care physicians (Shorter, 1997, p. 301).

However, one must also acknowledge that they began the operation of making and testing the compounds that would go on to become the world’s

first psychiatric drugs where other agents, such as the government, did not. Thus, one needs to look for alternative institutions to taper the reign of the industry. An alternative choice is having exclusive government control of pharmaceutical synthesizing and marketing, though this stifles productivity and faces many of the same problems as in industry. In addition, the structure and practices of the government are not conducive to stable, long-term action. Administrative changes drastically alter the funding given to mental health institutions like the National Institute of Mental Health and evoke polarized party conflict (Grob, 1994). Perhaps patient activist groups provide a better alternative. Starting in 1979, when it was founded, the National Alliance for the Mentally Ill successfully campaigned for recognition that schizophrenia is a biological condition, not caused by schizophrenogenic mothers. The National Coalition of Psychiatrists Against Motorcoach Therapy was founded in 1985 to stop the practice of giving “one-way bus fares” to undesirable, long-term patients (Shorter, 1997, p. 325). Such organizations are an effective lobbying base, acting as the voice of the patients who would otherwise be unable to speak for themselves to make their interests known to the pharmaceutical companies who generate their medications and the medical professionals who care for them.

### **Conclusion**

This paper has discussed the history and contemporary status of psychiatric drugs, examining the issues that have arisen and been exacerbated through their marketing by pharmaceutical companies, their use in psychiatric care, and their standing in society. More than the presence of certain historical trends, however, one should notice what the historical records lack: patients’ opinions. Most of these historical issues, such as the lowering of the psychiatric threshold and the role of the profit motive, have been discussed in terms of the medical and societal consequences, ignoring individual patients. Patients’ voices were rarely heard in psychiatrists’ reports and were drowned out by the pharmaceutical industry’s profiteering.

The past can provide answers to better direct the future by raising

greater awareness of the inextricable links between science and society. For instance, there should be more widespread concern in society and among scientists over the disconcerting effects that psychiatric drugs can have on patients' notions of selfhood and identity. Since psychiatric patients are a uniquely vulnerable population, other members of society, such as patient activist groups and professional psychiatry associations, must be the catalyst for change. As Loe and Cuttino write: "One thing is certain: the continual project of self-construction in late modernity is changing shape in the pharmaceutical era" (2008, p. 323). To this I would add that it is not only the pharmaceutical drugs that have the potential to alter patients' identities, but also that the patients have the capability to redirect the direction of pharmaceuticals.

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