*Social History of Medicine* Vol. 21, No. 3 pp. 541–559

## Roy Porter Student Essay Prize Winner

# Psychiatry Limited: Hyperactivity and the Evolution of American Psychiatry, 1957–1980

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**Summary.** Hyperactivity is the most commonly diagnosed childhood psychiatric disorder in north America. Most physicians believe that the disorder is a neurological dysfunction which is best treated with stimulants, such as ritalin. Accounts of the history of hyperactivity written by physicians, psychologists and even historians suggest that the disorder was always conceived as such. This paper argues that, on the contrary, the notion that hyperactivity was a neurological condition only emerged after vigorous debate during the 1960s between three competing fields within American psychiatry: specifically psychoanalysis, social psychiatry and biological psychiatry. Biological psychiatry won the debate, not because its approach to hyperactivity was more scientifically valid, but rather because its explanations and methods fit the prevailing social context more readily than that of its rivals. American psychiatry's refusal to draw pluralistic conclusions about hyperactivity undermined the development of a deeper understanding of the disorder. The history of hyperactivity provides an ideal lens through which to view the evolution of psychiatry from a field dominated by Freudian psychoanalysis to one rooted in the neurosciences.

**Keywords:** history of psychiatry; United States; childhood; hyperactivity; psychoanalysis; social psychiatry; biological psychiatry; ADHD; mental health

A 2002 report by the American Center for Disease Control and Prevention announced that at least 7 per cent of all elementary school children during 1997–8 had been diagnosed with attention-deficit/hyperactivity disorder (ADHD), or what has commonly been known as hyperactivity.[1] Most psychiatrists currently believe that hyperactivity is a neurological impairment characterised by not only hyperactive behaviour, but also

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[1]The term 'hyperactivity' is used here instead of ADHD, partly because it is more historically relevant, but also for simplicity's sake. Although the disorder has been described using many terms during the past half century (for example, hyperkinetic impulse disorder, hyperkinetic reaction, minimal brain dysfunction and attention-deficit disorder in the period 1957–80), hyperactivity has and continues to be the most widely accepted term. Pastor and Reuben 2000, p. 3.

 DOI 10.1093/shm/hkn060
Advance Access published 20 October 2008

impulsivity, distractibility, defiance and aggression.[2] Psychiatrists suspect that hyperactivity is either caused by genetic neurological dysfunction, or less often, brain trauma. Although psychiatrists and allied health professionals often suggest that the disorder be treated with a combination of pharmacotherapy, cognitive-behaviour therapy and family counselling, in the majority of cases, stimulant drugs such as ritalin (methylphenidate) are the core, if not the only, aspect of the treatment regimen.

Child psychiatry texts and hyperactivity primers often trace the history of hyperactivity back to the early twentieth century, but a closer look at the medical literature reveals that what most physicians today would identify as hyperactivity did not emerge until 1957, when a pair of articles by Rhode Island psychiatrists Maurice Laufer and Eric Denhoff, one of which was co-authored with Gerald Solomons, were published.[3] Described as 'hyperkinetic impulse disorder', the condition depicted bore all the hallmarks of what is now recognised as hyperactivity.[4] More importantly, however, the cultural recognition of hyperactivity as a disorder of epidemic proportions did not emerge until after the work of Laufer and his colleagues, as geopolitical, demographic and educational changes converged to provide a social environment in which the disorder they described could be readily applied.

Despite the fact that the social and medical significance of hyperactivity has prompted a great deal of popular speculation about how the disorder should be treated, what causes it and if it even exists, sociologists and, especially, historians have been reluctant to explore its origins.[5] Two early exceptions are the books of Schrag and Divoky in 1975 and Conrad in 1976, both of which take a social constructivist approach to understanding hyperactivity. While Schrag and Divoky stress the role of overt social control from various levels of government in constructing the disorder, Conrad emphasises the more inadvertent role of larger social forces during the 1960s, such as the advance of pharmaceutical technology and the growing interest in child mental health.[6] More recently, Brancaccio has examined the early twentieth-century social and educational factors that led to hyperactivity being recognised as pathological behaviour.[7] Brancaccio's juxtaposition of hyperactivity's emergence during this period and the rise of compulsory schooling, however, overlooks evidence that hyperactivity research was extremely sporadic and that much of it, including the commonly cited work of Bradley in 1937, addressed

[2]Ingersoll 1998, pp. 1–22; Wender 2000, pp. 34–55.

[3]In the often-cited observations of Sir George Still in 1902, for example, hyperactive behaviour in children is mentioned briefly, only to be eclipsed by Still's concerns about disturbing instances of violent behaviour and self-harm in children. Other episodes cited as part of the history of hyperactivity, for example the descriptions of post-encephalitic disorder during the 1920s and minimal brain damage during the 1940s and 1950s, differ from those after 1957 partly because of the stress on different symptoms, but also because such disorders could be linked to a specific cause, namely brain trauma following infection or injury. Nevertheless, as Adam Rafalovich has noted, what these episodes do highlight is the emerging association of childhood behaviour problems and neurological dysfunction. Still 1902; Ebaugh 1923; Strauss and Werner 1942; Rafalovich 2001, p. 107.

[4]Laufer and Denhoff 1957; Laufer *et al.* 1957.

[5]Many of the critiques of hyperactivity have been written by health care professionals. For example, Breggin 1998; Diller 1998; DeGrandpre 1999.

[6]Schrag and Divoky 1981, p. 38. Conrad 1976, p. 13.

[7]Brancaccio 2000, pp. 171–6.

small numbers of institutionalised children, and not schoolchildren.[8] Other research has been undertaken by sociologists, such as Singh, Rafalovich and Lakoff, and has contributed to the understanding of how people affected with hyperactivity conceptualise, negotiate and cope with their diagnosis.[9]

Although these scholars have outlined some aspects of the history of hyperactivity, one is left with the impression that hyperactivity entered the medical scene during the 1970s fully-formed as a neurological disorder best treated with stimulants.[10] This paper argues that, instead, hyperactivity emerged as a neurological disorder only after vigorous debate between three competing fields within psychiatry, specifically, psychoanalysis, social psychiatry and biological psychiatry.[11] Proponents of biological psychiatry (who pointed to neurological and genetic causes of hyperactivity), social psychiatry (who blamed socio-economic deprivation) and psychoanalysis (whose explanations were rooted in intra-family dynamics) competed with one another to produce an account of the disorder that would eclipse that of the others. Biological psychiatry won the debate not so much because its approach to hyperactivity was more scientifically valid, but rather because its methods were less expensive, time-consuming and complicated than those of its rivals. The refusal to collaborate or draw pluralistic conclusions about hyperactivity undermined the development of a deeper understanding of the disorder, and left unanswered questions about why it was thought to be such a serious problem and whether or not it should be treated.

By describing the history of how American psychiatry came to conceptualise and treat hyperactivity between 1957, when research into the disorder started in earnest, and 1980, when it was included in the third edition of the *Diagnostic and Statistical Manual* (*DSM-III*), this paper also traces the evolution of psychiatry, from a field dominated by Freudian psychoanalysis to one firmly entrenched in neurology.[12] The term 'evolution', however, does not imply that biological psychiatry was somehow superior to psychoanalysis or social psychiatry. Rather, the biological psychiatry that emerged during the 1970s, one of many mutations in psychiatry, best fit the circumstances thrust upon it during that period; as circumstances continue to change, so too will psychiatry.[13]

[8]Bradley 1937.

[9]Lakoff 2000; Rafalovich 2001, 2004; Singh 2002, 2003, 2004; Mayes and Rafalovich 2007.

[10]Lakoff 2000, pp. 149–53; Singh 2002, pp. 584–8; Rafalovich 2004, pp. 21–34; Mayes and Rafalovich 2007.

[11]These terms, although not representative of all psychiatrists researching hyperactivity, do reflect the most common classifications found in contemporary psychiatric literature. Historians of psychiatry who have examined this period have also used these terms to describe such divisions in psychiatry. For example, Grob 1991, pp. 403–4.

[12]This most recent evolution in the history of psychiatry has also been explored by historians such as Mark Micale and Edward Shorter. While Shorter's emphasis on how psychoanalysis declined into a 'dinosaur ideolog[y]' in the wake of biological psychiatry's 'smashing success' contains a strong element of possibly short-sighted progressivism, Micale's more nuanced exploration of the 'mind–body paradigm' acknowledges instead how psychiatric understanding is subject to 'powerful social, cultural, and professional determinants'. Shorter 1997, pp. vii, 305–13; Micale in Cooter and Pickstone (eds) 2000, pp. 336–45.

[13]Among the more recent chips in the armour of biological psychiatry have been ongoing concerns about not only the safety of anti-depressant drugs, but the efficacy of such medication. For example, Kirsch *et al.* 2008.

## Social Psychiatry

Biological psychiatry's dominance of the profession today belies the interdisciplinary competition that raged during the 1960s between it, social psychiatry and psychoanalysis. If President Kennedy's 1963 Message to the United States Congress on Mental Illness and Mental Retardation is any indication, social psychiatry, not biological psychiatry, seemed poised to challenge psychoanalysis for the hegemony it enjoyed during the post-war period. Kennedy's emphasis on eliminating the environmental causes of mental illness, especially poverty, mirrored the preventive strategies of social psychiatry.[14] He also stressed less reliance on massive, isolated state hospitals, a system he called 'social quarantine', and, instead, a shift towards the more numerous, smaller and localised community mental health centres that social psychiatry promoted.[15] Following Kennedy's assassination by Lee Harvey Oswald in late 1963, Congress passed the Community Mental Health Centers Construction Act (nicknamed the 'Oswald Bill', because of the belief that the Act might have prevented Oswald's actions), which helped to realise some of the President's ambitions.[16] While biological psychiatrists and psychoanalysts facilitated this move, by providing drugs that allowed institutionalised patients to move back into their communities with the added provision of counselling, the new community focus rested on the foundations of social psychiatry.

The theory behind social psychiatry in the 1960s was that mental illness was caused primarily by socio-economic factors and, therefore, could be prevented by alleviating poverty, overcrowding, crime and substance abuse.[17] Despite this seemingly radical premise, such prophylactic strategies reflected the beliefs of many psychiatrists during the 1960s and, indeed, the official policy of the American Psychiatric Association (APA), especially with respect to children and adolescents.[18] Presidents of the APA during the 1960s supported the tenets of social psychiatry and urged their colleagues to study the pathological effects of social problems.[19] Taken in the context of the 1960s, in the midst of the Civil Rights movement, protests against the Vietnam War and the New Frontier and Great Society social policy initiatives of Presidents Kennedy and Johnson, it is understandable that many psychiatrists would be interested in the preventative concepts of social psychiatry.

Furthermore, by the 1960s, research indicated that preventive social strategies could help to explain and address hyperactivity in children. Researchers such as Gardner, Malone and Grootenboer found that children brought up in poverty and exposed to vices such as petty crime, prostitution and violence were much more likely to be hyperactive, impulsive and distractible in school and succumb to mental illness later on in life.[20] Chess and her colleagues also claimed that environmental factors could cause childhood behavioural disorders like hyperactivity.[21] Research suggested that

[14] Kennedy 1963/1964, pp. 734–5.
[15] Kennedy 1963/1964, pp. 730–2.
[16] Bernstein 1991, p. 243.
[17] Solnit 1966, pp. 7–8.
[18] Conley *et al.* 1967/1968, p. 761; Stickney 1967/1968, pp. 1407–9; APA 1968/1969, 1197–1203.
[19] Ewalt 1959/1960, p. 980; Branch 1963/1964, p. 10; Blain 1965/1966, p. 4; Brosin 1968/1969, p. 7; Waggoner Sr. 1970/1971, p. 1.
[20] Grootenboer 1962/1963, p. 471; Malone 1963, pp. 22–3; Gardner 1971/1972, p. 446.
[21] Chess *et al.* 1963/1964, p. 147.

hyperactivity was most commonly diagnosed in poor children, often representing marginalised visible minorities.[22] For many, such as Spiegel and Brosin, it was the psychiatrist's duty to get politically involved and fight to eliminate such pathogenic conditions.[23] Psychiatrists should advocate public housing projects, improved schools and employment programmes in order to prevent mental illness among society's disadvantaged.[24] The social psychiatrist's role was often as political as it was medical.[25]

Moreover, the Joint Commission on the Mental Health of Children (JCMHC), a task force created following the passage of the Oswald Bill, emphasised that eliminating the socio-economic hardships faced by children was a key factor in preventing mental illness.[26] Reginald S. Lourie, who headed the JCMHC, was willing to 'recommend a radical reconstruction of the present system' in order to solve the mental health problems of children.[27] The APA agreed, saying that the recommendations of the JCMHC would 'strengthen the nation's resolve and capacity to deal with its awesome problems'.[28] Joseph D. Noshpitz, an associate editor for the *Journal of the American Academy of Child Psychiatry* (*JAACP*), echoed the APA's plea to American national interests by contending that the mental health of children should be the government's primary commitment.[29] Even outside observers like Judge David L. Bazelon, who served on the JCMHC, concurred that the mental health needs of children were best served by providing healthy homes and improved schools.[30]

Some biological psychiatrists also acknowledged that social psychiatry had an important role. Leon Eisenberg, for example, strongly supported social psychiatry's principles, despite also being largely responsible for encouraging pharmaceutical research into hyperactivity.[31] His research on stimulants at Johns Hopkins University during the mid-1960s, generously supported by the National Institute of Mental Health (NIMH), yielded positive results and proved, along with the work by Conners at Harvard, to be a catalyst for a tremendous amount of subsequent research.[32] Despite this research, Eisenberg also believed that '[t]he severe and chronic deprivation experienced by the pre-delinquent child can only be dealt with by large scale forceful community efforts'.[33]

[22]Chess *et al.* 1967, p. 330; Berlin in Berlin and Szurek (eds) 1965, p. 66.
[23]Brosin 1967/1968, p. 7; Spiegel 1968/1969.
[24]Solnit 1966, p. 8.
[25]Duhl 1966/1967, pp. 710–11.
[26]APA 1968/1969, pp. 1197–203.
[27]Lourie 1965/1966, p. 1280.
[28]APA 1968/1969.
[29]Noshpitz 1974, p. 390.
[30]Bazelon 1974, p. 199.
[31]It might be argued that Eisenberg is an atypical biological psychiatrist, especially when his later career is considered. He served, for instance, as chair of Harvard Medical School's Department of Social Medicine and Health Policy and worked towards founding other such departments. Moreover, in his foreword to a recent volume on the history of paediatrics, he decried the fact that medical students only know socially active physicians such as Rudolf Virchow and Abraham Jacobi for their medical contributions and not their ideas about the social causes of illness. Nevertheless, Eisenberg's pioneering work on stimulant drugs and hyperactivity indicates that while he might not be representative of biological psychiatry, he certainly contributed to the neurological theory of hyperactivity. Eisenberg in Stern and Markel (eds) 2002, pp. xiii–xvi.
[32]Schrag and Divoky 1981, p. 103.
[33]Goldstein and Eisenberg 1964/1965, pp. 655–6.

Eisenberg was also concerned that he and other psychiatrists had 'neglected prevention in our preoccupation with treatment',[34] a view that reflected Kennedy's agenda.[35] With regard to hyperactivity specifically, he stressed that '[m]uch of the difficult behaviour seen in association with brain damage syndrome [a 1960s term for hyperactivity] stems not from the anatomical deficits, but from the social consequences of personality development'.[36] Finally, in a symposium with other prominent psychiatrists on whether they had a role in pushing for social change, Eisenberg urged that they could and should be a powerful lobby that addressed a variety of social problems.[37]

Similarly, many psychoanalysts believed that the anxieties associated with poverty made children more susceptible to ego dysfunction and subsequent problems like hyperactivity.[38] Psychoanalyst Eleanor Pavenstedt, the inaugural editor for *JAACP*, stressed the need for more research on the psychological effects of poverty, substance abuse, prostitution, violence and crime.[39] Likewise, Malone stated that 'disorganized' family situations characterised by brutality, alcoholism, illegitimacy, crime, delinquency and neglect led to 'acting out', a psychoanalytic term for hyperactivity. Malone believed that in the 'normless world' impulses like petty crime, prostitution, public urination and fighting were not fantasised by children, but actually carried out.[40]

Psychiatry's interest in social problems, however, was not a mere reflection of contemporary political sentiment. Instead, social psychiatric theory, while it reflected many of the socially progressive ideals of the 1960s, was also based on utilitarian aims. Indeed, Kennedy's message to Congress stated that his arguments for preventive psychiatry were based on both compassion and utility.[41] Moreover, as psychiatrists, politicians and the American public grew increasingly alarmed about the increasing numbers of mentally troubled children, it became clear that psychotherapy could not be the only solution.[42] Psychotherapy was popular as a vocation for psychiatrists and as a treatment with patients, but it was also expensive, emotionally-invasive and time-consuming, and there were not enough psychotherapists to treat the millions of American children believed to be in need of therapy.[43] Of the 'extraordinary numbers of emotionally disturbed children in the country . . . the vast majority of children currently needing clinical care [did] not receive it'.[44] In poorer communities, as the 'Medical News' column of the *Journal of the American Medical Association* (*JAMA*) suggested in 1969, 30 per cent of children required psychiatric help.[45] Regardless, many psychiatrists argued that even if there were enough psychoanalysts, the efficacy of psychotherapy had not been

[34]Eisenberg 1966, p. 23.
[35]Kennedy 1963/1964, p. 730.
[36]Eisenberg quoted in Schrager *et al.* 1966, p. 530.
[37]Philips *et al.* 1971/1972, p. 684.
[38]Berlin in Berlin and Szurek (eds) 1965, pp. 65–6.
[39]Pavenstedt 1962, pp. 7–8, 1971, pp. 101–5.
[40]Malone 1963, pp. 22–3.
[41]Kennedy 1963/1964, p. 737.
[42]Cunningham 1964, pp. 9–12; Berlin in Berlin and Szurek (eds) 1965, p. 64; Hersch 1971, p. 411.
[43]Solnit 1966, p. 4.
[44]Hersch 1971, p. 411.
[45]Anonymous 1969, p. 356.

established.[46] As a result, parents seeking psychiatric services for their children were stymied by long waiting lists and uncertain results when they finally reached the front of the queue. Preventing disorders such as hyperactivity, therefore, was thought to be crucial in order to stem the perceived increases in childhood mental illness.

Despite strong support for social psychiatry, its approach to preventing hyperactivity was ambitious, idealistic and revolutionary, requiring an enormous amount of political, social and economic change at all levels of government and society. Unfortunately, as Solnit noted, politicians, not psychiatrists, had the power to prevent the environmental causes of mental illness.[47] Reflecting on how contemporary psychiatrists felt about social psychiatry, Solnit (quoting poet Robert Lowell) admitted that '[o]ne side of me is a conventional liberal, concerned with causes, agitated with peace and justice, and equality. ... My other side is deeply conservative, wanting to get at the root of things'.[48] In other words, while many psychiatrists believed that the improvement of social conditions was an efficacious psychiatric strategy, most were unwilling to commit as fully to social psychiatry's prescriptions as the discipline demanded. Indeed, many rejected the notion that psychiatrists should get involved in politics altogether.[49] Others feared that social psychiatry's stress on socio-economic conditions, not to mention its endorsement of cooperation between psychiatry and other allied health professions, would damage psychiatry's always tenuous reputation and status as a legitimate medical profession.[50]

Moreover, as the revolutionary atmosphere of the 1960s began to wane, so too did enthusiasm for social psychiatry, even amongst its enthusiasts. Indicative of this trend was Brosin's 'Presidential Address' to the APA in 1968/1969. In his 'Response to the Presidential Address' the previous year, Brosin enthused that the prospects of reducing poverty and improving health and education looked promising.[51] A year later, Brosin's comments were much more cautious. He noted that American involvement in Vietnam was drawing resources away from mental health programmes and that difficult choices must be made regarding the direction of American psychiatry's focus.[52] Quoting John W. Gardner, the Secretary of State for Health, Education, and Welfare, Brosin indicated that a 'crunch between expectations and resources' was occurring, especially with regards to 'early childhood education, work with handicapped children, [and] special education for the disadvantaged'.[53] Resources notwithstanding, other commentators were growing disillusioned with the reforms of the 1960s generally. In an oddly alliterative, yet apparently serious critique of social psychiatry's faith in human nature, psychoanalyst Charles Hersch argued that '[t]he community control concept has been presented as the panacea for the present plight of the poor. But in its practice the poverty population persistently portrays the same proclivities towards power politics

[46]Cole *et al.* 1961/1962, p. 1004.
[47]Solnit 1966, p. 7.
[48]Solnit 1966, p. 2.
[49]Markey 1963, p. 375; Eisendrath 1966/1967, p. 708; Nuffield 1968, pp. 217–21; Philips *et al.* 1971/1972, pp. 680–4.
[50]Bartemeir 1959/1960, p. 978.
[51]Brosin 1967/1968, p. 7.
[52]Brosin 1968/1969, p. 5.
[53]Gardner in Brosin 1968/1969, p. 5.

that previously has been the prerogative of the privileged'. Hersch went on to state that social psychiatry's stress on alleviating poverty was simplistic, naïve and unlikely to prevent mental illness.[54]

Despite the endorsement of social psychiatry by President Kennedy and many high profile psychiatrists, the impracticality of its complex and revolutionary remedy for hyperactivity impeded it from becoming a viable alternative. While social psychiatry's explanations for hyperactivity were plausible to many, its preventive socio-economic remedies were nearly impossible to employ, difficult to substantiate through scientific trials and unlikely to satisfy those seeking an immediate solution, namely children with hyperactivity, their families and their psychiatrists. Its theories about preventing mental illness faded from the pages of the major psychiatric journals by the late 1970s and have not since re-emerged as a force within the profession. With the demise of social psychiatry, American psychiatry lost its major proponent of preventive, proactive psychiatry and, instead, reactive strategies became the primary way in which psychiatry dealt with hyperactivity and other disorders.

## Psychoanalytic Psychiatry

If social psychiatry had the most to gain from Kennedy's interest in mental illness, then psychoanalysis had the most to lose. During the 1950s and 1960s, psychoanalysis held the premier position in American psychiatry. The following quotation illustrates the influence of psychoanalysis during the 1960s, but also the fact that its influence was beginning to be questioned. The writer, psychiatrist Mark A. Stewart, was annoyed that jobs advertised in the APA's 'Mail Pouch' required a psychoanalytic orientation, and stated that '[t]his phenomenon, which unhappily is symptomatic of the general situation of psychiatry today, can make our profession seem ridiculous to other physicians and to scientists in general'.[55]

Unfortunately for Stewart, however, most psychiatrists during this period were psychoanalytically trained and descriptive psychoanalytic case studies dominated the pages of journals. This was especially true of child psychiatrists. Psychoanalytic research eclipsed that of other psychiatric fields in *JAACP*, whose editorial staff during the 1960s consisted primarily of psychoanalysts. In a special series on 'acting out', for example, all articles were based in psychoanalytic theory, including those by Eveoleen Rexford, the series editor.[56] Psychoanalytic explanations for hyperactivity were also found in *DSM-II*.[57] For many psychiatrists, there was no 'magical belief in some kind of correspondence between psychical processes and central nervous processes'.[58] Nevertheless, the 'wholly new approach' to psychiatry espoused by President Kennedy, which focused on social and biological psychiatry, threatened psychoanalysis.[59] Although psychoanalysts

[54]Hersch 1971, pp. 413–16.
[55]Stewart 1960/1961, p. 85.
[56]Rexford 1963, p. 6.
[57]Jenkins 1968/1969, pp. 1032–3.
[58]Lofgren 1959/1960, pp. 83–4.
[59]Council of the American Psychiatric Academy 1963/1964, unnumbered addendum between pp. 728 and 729.

would indubitably have a part to play, the amount of power they would have to share with the other fields was unclear.

If the story of social psychiatry represents how a novel approach proved to be too radical a solution for American psychiatry, the decline of psychoanalysis in the 1970s demonstrates the failure of the status quo. While social psychiatry promised one socio-economic cure for hyperactivity, psychoanalytic theory limited its adherents to address the disorder one case at a time. In the words of an anonymous letter-writer to the *American Journal of Psychiatry* (*AJP*) in response to social psychiatric theory, '[i]ndividual psychotherapy is the only treatment that roots out the trouble. You can't apply this on a mass basis'.[60] The aetiologies of mental illness, while rooted in Freudian theory, were as numerous as the number of patients. It was the vicissitudes of human development that led to unresolved psychic conflict, not the inequities of a Dickensian social structure. The roots of hyperactivity were not found on the overcrowded and violent streets of the urban slums, but were mired in the core of the patient's unconscious. And in order to tap into the unconscious of a hyperactive child, thorough investigation and individual psychotherapy was required.

The psychoanalytic approach to hyperactivity helps to explain why the discipline failed to remain the most authoritative, legitimate and relevant branch of psychiatry during the 1970s. In particular, it illuminates the most pressing conundrum for psychoanalysts; namely, the difficulty in bridging the gap between theory and practice. While psychoanalysts provided many rational explanations for hyperactive behaviour, it was more difficult for them to treat the disorder effectively. The psychotherapeutic process required a patient to concentrate, be reflective and follow dutifully the psychotherapist's suggestions. Understandably, these were arduous requirements for hyperactive children. One psychoanalyst described that her patient's 'hyperactivity increased and all in a manner of a few minutes, she sat on my desk, wrote on the blackboard, and picked her nose excessively'.[61] In a market saturated with potential patients, many psychiatrists accused psychoanalysts of turning away hyperactive children.[62] Moreover, very few families could afford the time or money required for psychoanalysis.[63] As Eisenberg explained, there were 'more people struggling in the stream of life than we can rescue with our present tactics [of psychoanalysis]'.[64]

Regardless of the difficulties inherent in treating hyperactive patients, many psychoanalysts researched the disorder. Although superego dysfunction was cited as a general cause, understanding the specific reasons for why it existed in each case was required in order for effective psychotherapeutic treatment. As a result, most of the psychoanalytic articles found in psychiatric journals during the 1960s about hyperactivity were written in the form of case studies featuring the clinical observations of a single patient. The patient would be introduced along with a detailed description of his or

[60]Anonymous in Davidson 1963/1964, p. 192.
[61]Kernberg 1969, p. 537.
[62]Eisenberg *et al.* 1959/1960, p. 1092; Berman 1964, p. 24; Kal 1968/1969, p. 1128; Rapoport *et al.* 1971, p. 531.
[63]Rexford 1962, p. 381.
[64]Eisenberg 1966, p. 23.

her behaviours, personality, history and family situation. The author would then describe how he/she was able to unravel the reasons for the patient's hyperactivity and describe the course of psychotherapy. One instance of this is found in the 1960 edition of the *Archives of General Psychiatry* in which the story of 'Jean' was told. Jean was a 12 year-old girl whose impulsive behaviour, her psychiatrist determined, was the result of penis envy stemming from the relationship she had with her father. Jean's impulsivity ceased only when she was able to come to terms with this explanation.[65] The root causes of hyperactivity in other children could also originate in the child's weaning, toilet training or adjustment to a new sibling.[66]

Despite specific aetiological differences, psychoanalytic theories about hyperactivity shared two important commonalities that affected how the rest of the psychiatric community received such theories. First, psychoanalysts stressed the uniqueness of each patient and his/her specific course of therapy.[67] Psychoanalysts who treated hyperactivity promised no magic bullets, in marked contrast to both social and biological psychiatrists. Therefore, it required both a great deal of faith in its efficacy and a substantial degree of patience on the part of both the psychoanalyst and his or her patient. Secondly, psychoanalysts described hyperactivity as being a psychological, as opposed to a neurological, phenomenon. Superego impairment caused a child's id to dominate the ego, leading to the impulsive behaviours characterised by hyperactivity. Psychoanalysis was the only way to free the ego from the unwanted oppression exerted by the uncontrolled id.[68] Even when the role of neurology in mental illness was beginning to be emphasised, psychoanalysts insisted that understanding the unconscious was more important. For example, Rogers suggested to his fellow psychoanalysts that the calming and motivating effects of ritalin might lead to more efficient psychotherapy.[69]

While these two axioms helped psychoanalysts understand hyperactivity, they were also the means by which biological psychiatrists were able to challenge and discredit their approach to hyperactivity and replace it with their own. First, the psychoanalytic insistence on pinpointing the aetiological explanations for hyperactivity in each patient was seen by biological psychiatrists as excessive, perhaps even contravening their role as a healer, since it supplanted the provision of pharmaceuticals.[70] Furthermore, some psychiatrists believed that not only was psychotherapy for hyperactivity 'fruitless and frustrating', when 'misdirected ... it [could] be every bit as dangerous as misdirected surgery'.[71]

The psychoanalytic belief that hyperactivity was a mental phenomenon also alienated the field from mainstream medicine and, for many psychiatrists, undermined the

[65]Weinreb and Counts 1960, pp. 549–50.
[66]Thomas *et al.* 1959/1960, p. 798.
[67]Rexford 1963, pp. 6, 9–17; Reiser 1963, pp. 53, 67; Heinicke and Strassman 1975, p. 569.
[68]Rexford 1963, pp. 6–9; Schrager *et al.* 1966, p. 529; Leventhal 1968.
[69]Rogers 1960/1961, p. 549. Some biological psychiatrists also stressed that pharmacotherapy was merely a means to the end of improved counselling sessions. Smith 1964/1965, p. 703.
[70]Cole *et al.* 1961/1962, p. 1004; Sargant 1964/1965, p. xxviii; Eisenberg 1966, p. 19; Rapoport *et al.* 1971, p. 524.
[71]Levy 1971, p. 1865.

discipline's scientific legitimacy.[72] This defied American psychiatrists' long-standing desire to be perceived as members of a legitimate and authoritative medical profession.[73] Eisenberg, for example, suggested that if psychoanalysis was to be employed by any mental health professionals, it should be social workers and psychologists, not psychiatrists.[74] Moreover, the popularity of anti-psychotics like thorazine and anti-depressants like miltown rekindled the idea that psychiatric magic bullets could exist and ritalin seemed to be a suitable candidate for hyperactivity. Pharmaceutical companies fuelled these beliefs by increasingly advertising in medical journals and courting psychiatrists to prescribe their products.

By the 1970s, psychoanalysis seemed anachronistic in an American society that consistently looked to technology to solve its problems. No longer was there to be a 'twisted thought without a twisted molecule'.[75] For American psychiatry, psychoanalysis could not logistically address the alarming pandemic of hyperactivity and it ignored developments in neurology and pharmacology. It also appeared to be an approach that championed theoretical understanding over efficacious patient treatment. In sum, psychoanalytical treatment of hyperactivity proved to be unattractive for both patients and psychiatrists and with its demise, the biological explanation for the disorder remained.

## Biological Psychiatry

Among psychiatrists, those who looked to neurological explanations for mental illness had the longest history of investigating hyperactivity, but this does not explain why the biological psychiatry that emerged in the post-war period was able to dominate research into the disorder by 1980. A handful of psychiatrists had investigated symptoms resembling hyperactivity since the early twentieth century, but up until 1957, such research was sporadic, consisting of a few articles per decade, and often concentrated on small sample populations of institutionalised children. When hyperactivity emerged as a major problem in the 1960s, psychoanalytical explanations for the disorder dominated and social psychiatric theories also commanded attention. The failure of these approaches, in the late 1960s and early 1970s, to deal with hyperactivity in an expedient, efficient and inexpensive manner was paramount in allowing biological explanations and treatments to dominate by the mid-1970s. Notwithstanding this factor, others also played a role in buttressing biological explanations for hyperactivity during the period. These included the quick, inexpensive and seemingly efficacious stimulant treatment biological psychiatrists offered and the cautiously optimistic attitude biological psychiatrists adopted when presenting hyperactivity research.

In contrast to psychotherapy or radical social change, the pharmaceutical treatment of hyperactivity was remarkably inexpensive, quick and simple. Parents, frustrated by other forms of treatment, found ritalin an easy and immediate alternative. Its efficacy was

[72]Kahn 1960/1961, p. 755; Marmor 1968/1969, p. 679.
[73]American psychiatry's struggle for legitimacy has been well documented by Gerald Grob. Grob 1991, pp. 51, 279.
[74]Eisenberg 1966, p. 20.
[75]Langdell 1967, p. 166.

demonstrated in dozens of studies and many psychiatrists were so convinced that it worked that they used it as a clinical diagnostic tool; if the child in their office responded to ritalin, then he/she was hyperactive.[76] Confidence in ritalin reflected a larger trend in psychiatry towards pharmacotherapy and, by the late 1960s, pharmacotherapy had become increasingly common and actively marketed.[77] A quick look through the pages of *JAMA* during the 1960s and 1970s also indicates that the marketing of psychoactive drugs was not only widespread, but aggressive, featuring creative, full-page advertisements that graphically depicted the horrors of mental illness and the benefits of drugs.[78]

It would be a mistake, however, to believe that ritalin was the wonder drug the advertisements portrayed. The effects of ritalin were nearly instantaneous, but the drug did not cure nor prevent hyperactivity; it only controlled symptoms temporarily. Stimulants worked for only 80 per cent of patients and their effectiveness faded with time, requiring increasingly larger doses.[79] With millions of diagnosed children, 20 per cent amounted to a substantial population of untreated patients. Biological psychiatrists also had a great deal of difficulty explaining the perplexing paradox of why stimulants calmed hyperactive children.[80] They also often ignored or downplayed the side-effects associated with ritalin, including growth inhibition, irritability, insomnia, anorexia, heart palpitations and hallucinations.[81] The strong sales of ritalin from the mid-1960s to the present day indicate that psychiatrists, as well as parents, were willing to accept these shortcomings, chiefly because stimulants did what psychotherapy could not do: they calmed hyperactive children down in a matter of minutes.[82]

Another reason such side-effects might have been tolerated is that biological psychiatrists were careful to describe their research in a cautiously optimistic fashion that left room for improvement. Ritalin might not cure hyperactivity and might induce troubling side effects, but with more research, it was believed that its efficacy would continue to improve. An example of this somewhat deterministic attitude is found in a 1971 article entitled 'Psychopharmacology: The Picture is not Entirely Rosy' by psychiatrist Joseph

[76] Millichap 1968, p. 1528.

[77] By the early 1960s, in fact, some psychiatrists were complaining about the extent to which pharmaceutical companies 'bombarded' psychiatrists with advertising. Cammer 1961/1962, p. 448.

[78] One such advertisement from *JAMA* featured a gaunt, exhausted PhD student whose thesis is described as being 'in progress'. The solution to the stress he feels, with which any PhD student would identify, was a prescription for valium. The message in this advertisement that the stress of intensive study can be alleviated with valium was directed both at physicians, who might recall such stress from their student days, and PhD and MD students who might have cause to read *JAMA* for their research. Higher learning, as this advertisement suggested, was a pathological activity. *AMA* 209 (1969), pp. 609–10.

[79] Tec 1970/1971, p. 1424.

[80] Schnackenberg 1973; Silver 1976, p. 253; Werry 1977, p. 452.

[81] Laufer in Anonymous 1970, p. 2261; Lucas and Weiss 1971; Garfinkel *et al.* 1975, p. 723; Firestone *et al.* 1978, p. 446. One reason for ritalin's popularity was that its side-effects, though serious, paled in comparison to that of amphetamines, anti-depressants and tranquilisers. Zrull *et al.* 1964/1965. This notwithstanding, some psychiatrists also suggested that ritalin's growth inhibitory effect was so serious that the prescription of growth hormones to hyperactive children taking the drug was warranted. Puig-Antich *et al.* 1978, p. 457.

[82] In 1971, for example, ritalin made $13 million for CIBA, amounting to 15 per cent of its profits. Conrad 1976, p. 15.

O. Cole. Despite its ostensibly pessimistic theme, the article actually demonstrated confidence in the future of psychopharmacology. Cole suggested that while there was plenty of work yet to be done, psychiatric ambitions of miracle pills would be realised eventually.[83] Nevertheless, Cole stressed that the only way to achieve these goals was by conducting persistent research and not getting discouraged by setbacks or the criticisms of otherwise-inclined psychiatrists. The underlying theme of Cole's article is that biological psychiatry, while not quite able to provide miraculous cures, was on the right path and would do so eventually. In order to reinforce this notion, a great many articles presenting stimulant research traced the history of such research back to Bradley's original work in 1937. This strategy conveyed to readers a false sense of the history of hyperactivity, since very few articles were written on hyperactivity between 1937 and 1957, but also implied that research into stimulant treatment was always progressing and improving.

Such researchers, however, were also careful to reinforce the idea that their work on hyperactivity, though progressing, was not yet conclusive. When Camilla Anderson's *Society Pays: The High Cost of Minimal Brain Damage in America* was published in 1973 (minimal brain damage being an earlier term for hyperactivity), prominent hyperactivity researcher and biological psychiatrist Paul Wender gave it a negative review. His criticisms did not focus on the stark eugenic message in Anderson's book, but rather on its lack of evidence, overly bold statements about the genetic and neurological basis of minimal brain damage and Anderson's rejection of any possibility that hyperactivity could be affected by environmental factors.[84]

As the 1970s wore on, however, biological psychiatrists grew somewhat more optimistic, and less cautious. Increasingly, biological psychiatrists stressed that their approach to hyperactivity was the most scientific and, thus, gave psychiatry the medical and scientific status they had lost when psychoanalysis had been dominant. Gone from the psychiatry journals were the descriptive case studies that characterised the psychoanalytic clinical research of hyperactivity. In their place were the laconic accounts of double-blind trials that tested the efficacy of particular drugs for the disorder. By the late 1970s, it was becoming clear that psychoanalytic explanations for hyperactivity, and other mental illnesses, would be left out of *DSM-III*, to be published in 1980.[85] Indeed, socially-oriented psychiatrists Rutter and Shaffer noted, rather gloomily, that *DSM-III* would be a scientific coming of age for psychiatry.[86] Biological psychiatrists like Werry, in contrast, enthused that *DSM-III* meant that psychiatrists could once again take their place amongst scientists.[87] But did psychiatry's embracing of neurology really mean that the profession had finally earned its place in the medical establishment? Ironically, when American psychiatry determined that hyperactivity was a neurological disorder, it opened the door for other mental health professionals, such as neuro-psychologists, to test for and diagnose the

[83]Cole 1971, p. 225.

[84]Although not mentioned explicitly, Wender might have also been annoyed that Anderson stressed the genetic aetiology of hyperactivity, but used the term minimal brain 'damage', a term that implied brain injury as the primary cause of the condition. Anderson 1972; Wender 1973.

[85]Cantwell *et al.* 1979, p. 452; Spitzer and Cantwell 1979, p. 363.

[86]Rutter and Shafer 1979, p. 372.

[87]Werry 1982, p. 3.

condition. These professionals could not prescribe drugs to treat hyperactivity, but neither were they forced to refer their clients to a psychiatrist for a prescription; a general practitioner or paediatrician could suffice as well.

## Conclusion

This history of hyperactivity and American psychiatry has attempted to demonstrate that hyperactivity's emergence as a neurological, pharmaceutically-treated condition was not as simple as previous accounts have inferred, but rather the result of a spirited debate between rival fields within American psychiatry. More questions remain, however, regarding how hyperactivity became the most common childhood mental illness of the late twentieth century. These include why hyperactive behaviour, especially in academic settings, became pathologised during the post-war period, the role of the pharmaceutical industry in the disorder's spread and the disorder's particular prominence in North America. The work of Healy, Rose and others on not only the proliferation of psychopharmaceuticals, but also the parallel growth in the rates of psychiatric illness, can provide significant insight into these issues.[88] As in this study, further research into hyperactivity's history will likely reveal as much about psychiatry and the society in which it operates, as it does about the disorder itself.

In 1964, Robert H. Felix, the first director of the NIMH, wrote an article for *AJP* entitled 'The Image of the Psychiatrist: Past, Present, and Future'. He described an American psychiatric profession that had fought for a generation, since the 1930s, for recognition and respect from the medical community. He decried the divisiveness between neurologically and psychologically-oriented psychiatrists and saw an opportunity for a 'warm, human [and] down to earth' psychiatric profession that would be 'civilly active', 'serve the community' and have both psychological and biological grounding.[89] In the 1960s, this vision of a holistic, complementary and comprehensive psychiatry, also espoused by President Kennedy, was a possibility, but by the 1970s, as the history of hyperactivity suggests, this vision never materialised. Social, psychoanalytic and biological psychiatrists researching and treating hyperactive children criticised one another's understandings of hyperactivity and competed to develop authoritative explanations and treatments for the disorder. Biological psychiatrists achieved success in these debates not because their approach was more scientific, but rather because it was more practical, efficient, inexpensive and, in some ways, more cautious, than that of its rivals. As social and psychoanalytic theories of hyperactivity were cast aside, notions of its social and emotional complexity were also abandoned.

The reluctance of psychiatry to evolve into a more complex, multi-dimensional field is reflected in prominent child psychiatrist Justin Call's thoughts in 1976 about how hyperactivity itself exemplified the desire for simplicity in psychiatry. Call mused that the 'label of hyperactivity owes its popularity to the soothing effect such simple conceptions have upon issues of great cognitive complexity. Such labels ... bring cognitive comfort'.[90] A similar statement might be made about American psychiatry during the 1960s and

[88]Healy 2003; Rose 2007.
[89]Felix 1964/1965.
[90]Call 1976, p. 156.

1970s in general. The biological psychiatric theory of hyperactivity that evolved during this period was certainly simpler, but that did not make it more satisfactory. It is likely that if Felix's vision had been realised, a more sophisticated and constructive understanding of hyperactivity would have emerged.

## Acknowledgements

I would like to thank Mark Jackson, Lesley Cormack, Patricia Prestwich and Susan L. Smith, as well as the anonymous reviewers, for their helpful suggestions. My research is funded by the Wellcome Trust and the Social Sciences and Humanities Research Council of Canada.

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