Rethinking psychiatry

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In 2013, the American Psychiatric Association (APA) will publish the fifth edition of its *Diagnostic and Statistical Manual of Mental Disorders*, a thick, well-respected publication that contains the latest diagnostic criteria, drawn from rigorous scientific studies. But only a few decades ago, the slender DSM-II reflected a very different field, with vague definitions of psychiatric illnesses based on scanty scientific data. Everywhere, psychiatry departments were dominated by psychoanalysts, who focused on Freudian theory.

"I remember one meeting, when I told a psychiatry professor about a study I had read showing that no two psychiatrists could agree better than chance on diagnosis," says retired Washington University psychiatrist George E. Murphy, MD. "He said, 'But then our diagnoses don't mean anything,' and I replied, 'That's exactly true.' And he never spoke to me again, because that was too bitter a pill to swallow."

In their profound disagreement with the psychoanalytic model — and their determination to forge a new, evidence-based brand of psychiatry — Washington University psychiatrists stood virtually alone. At scientific meetings, they were often shunned, their papers ignored; they faced rejection upon rejection in applying for research grants. But they persevered.

"There was a spirit in that department of open thinking about psychiatric illness, a kind of free-floating intellectual energy," says Charles F. Zorumski, MD, the Samuel B. Guze Professor and head of the Department of Psychiatry at Washington University School of Medicine

in St. Louis. “The faculty were very bright and very articulate, and the place became a magnet for these creative people to come together.”

Through their efforts, these university psychiatrists moved their field toward a new “medical model” of psychiatry that culminated in the publication of the DSM-III in 1980. For the first time, this psychiatric bible contained specific diagnostic criteria for all 200 categories of mental disorder — and omitted psychoanalytic concepts, such as “neurosis,” that had previously been part of the psychiatric lexicon.

“The DSM-III was the completion of a major paradigm shift,” says Eugene H. Rubin, MD, PhD, professor of psychiatry. “It was a new way of thinking, and that shift became profoundly influential.”

A new approach

In 1942, Washington University’s combined Department of Psychiatry and Neurology attracted a new head, Edwin F. Gildea, MD, a Yale psychiatrist and dedicated researcher. A Harvard colleague, Mandel Cohen, MD, was delighted at Gildea’s appointment. A staunch foe of psychoanalysis in a city dominated by analysts, Cohen was eager to spread his scientific approach, and he urged a talented protégé, Eli Robins, MD, to accept an appointment in Gildea’s department.

Robins arrived at the university in 1949 with his wife, Lee Nelken Robins, PhD, later a key founder of psychiatric epidemiology. In 1954 came George Winokur, MD, a strident enemy of psychoanalysis, followed the next year by Samuel B. Guze, MD, a skilled internist who shifted to psychiatry. These three worked closely and collegially, joined by others: Murphy, Richard W. Hudgens, MD, Robert A. Woodruff Jr., MD, Paula J. Clayton, MD, Ferris N. Pitts, MD, Donald W. Goodwin, MD, and Rodrigo A. Muñoz, MD.

"I really revered Eli Robins," says Hudgens, professor of psychiatry. "He was brilliant and exceptionally kind. He was a wonderful teacher, broadly read, who taught both by precept and by example."

The department's accomplishments

In the mid-1950s, Robins, Guze and Winokur persuaded Gildea to let them take over the educational aspects of the department; in 1963, Robins became head. Soon the three began making changes: Each resident would have to do some research. Residents, and eventually medical students, would learn an evidence-based approach to clinical psychiatry.

"What are your data? That became the question. Freud would say something, and it became like Moses saying it," says Hudgens, a 1956 graduate who returned in 1963. "There was a whole concept of orthodoxy in psychoanalysis. Well, here they didn't have anything to do with that kind of 'because I said so it's so' thinking."

While using the latest clinical tools — medication, electroconvulsive therapy, psychotherapy — faculty members also embarked on groundbreaking research. Together, Robins and Murphy conducted a major study of suicide, but when they tried to publish the results in the *American Journal of Psychiatry*, the editor — a psychoanalyst — expunged all the diagnostic terms from the paper.

"That would have ruined the paper," says Murphy, "except that Eli was smarter than that, and he put the diagnostic terms in the legends for the figures and drawings. So we got it out there after all."

In 1972, they achieved an important milestone: the publication of a seminal paper, "Diagnostic Criteria for Use in Psychiatric Research" by resident John P. Feighner, MD, et al., which established 15 major

categories of diagnosis. Then a 1974 book — Psychiatric Diagnosis, written by Woodruff, Goodwin and Guze — further codified these ideas. Many Washington University residents took jobs around the country and became missionaries for this effort.

DSM-III

In the 1970s, psychiatrist Robert L. Spitzer, MD, of Columbia University, was asked to chair the APA task force charged with developing a DSM-III. Among its 19 members, he appointed five who had trained or taught at Washington University. With his colleagues, Spitzer, who had already worked with Eli Robins on expanding the Feighner categories, believed that the time had come for the use of operational criteria for psychiatric diagnosis.

As successive drafts of the DSM-III made the rounds of the psychiatric community for field testing, the committee was surprised by the reaction. Few readers focused on the inclusion of diagnostic criteria; instead, they irately objected to the elimination of psychoanalytic concepts. However, the committee persisted and, with only a few compromises, the APA ratified the book's publication.

Proponents cheered the DSM-III as a victory for science. Now clinical practice and research would center on psychiatric diagnosis, and psychiatrists worldwide would speak a common language.

"For the first time, when someone in England said that you have schizophrenia and someone here said you have schizophrenia, they were talking about the same disorder," Rubin says. "The DSM-III standardized things."

The future

Today, the Department of Psychiatry has ambitious plans on the horizon. Though DSM-V is in process, they are more focused on DSM-VI, some 15 years ahead. By then, they will have functional information about brain structures from a major brain-mapping project soon to be undertaken by David C. Van Essen, PhD, professor and head of anatomy and neurobiology. Through his work, they hope to understand the breakdown of brain systems in psychiatric disorders and design targeted therapies to treat them.

"Our job — what we have inherited — is to be troublemakers, and I like that," Zorumski says. "We want to keep reminding people that we haven't done enough and to keep asking: 'Where is the next thing coming from?'"

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