Morningside podcast
DSM 1 Episode SCRIPT

Kristin - Welcome, listeners, to our Morningside Hospital podcast Episode #2!
I'm Kristin Yarris. And I'm Mary Wood.
On this episode, we are going to talk about the diagnosis and treatment of mental disorders at Morningside hospital. In other words, what criteria did the psychiatrists and other clinicians practicing at Morningside use to evaluate patients and determine proper course of treatment? As we know, patients at Morningside were vastly diverse – they were men and women, old and young, some spoke English and some didn't, some may have been from Native Alaskan communities, others were Eastern European immigrants to the then-territory of Alaska working in extractive industries, such as mining, logging, or fishing. Other patients were from Oregon or other parts of the Pacific Northwest. Some patients came to Morningside after spending time in TB sanitoria, since tuberculosis was prevalent in the 1950s and TB patients were often quarantined in hospitals. So, given this diversity, how did the psychiatrists at Morningside make sense of the mental distress patients presented? And how did they make decisions about treatment and discharge?

Well, it just so happens that during the time of our study something significant happened in the world of American Psychiatry- the first edition of the Diagnostic and Statistical Manual of mental disorders, DSM 1, was released, in 1952. In the Foreword to this document, the American Psychiatric Association stated that one of the aims of DSM 1 was to standardize the classification of symptoms of mental disorder, that is, to more consistently name and categorize mental illness, but also to allow for better classification and statistical accounting of mental disease in the U.S.

Specifically, the authors of DSM 1 stated that their aim was "To provide a classification system consistent with the concepts of modern psychiatry and neurology." This was, and remains, important for professional Psychiatry. The collection of such morbidity statistics – through a field now called psychiatric epidemiology – allows for the comparison of the prevalence of mental conditions across different subsets of the U.S. population, but also across different countries.

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[Mary]. One important piece of this history is that DSM 1 built on previous attempts to categorize mental illness in the post- WWII period, particularly by physicians and psychiatrists working with veterans of the first and second world wars.

Kristin – That's right. In fact, in the Foreword to DSM 1, its authors are very clear that this manual builds on the classifications developed by psychiatrists working with soldiers and veterans in the US military.

Mary – it's something to keep in mind, as we consider how mental diagnoses are categorized or labeled, that many of these DSM 1 categories reflect the legacies of the world wars and the types of psychiatric trauma and distress that soldiers and veterans experienced.

Kristin – Yes, for instance, DSM 1 lists both "acute" and "Chronic brain syndrome" due to trauma as diagnostic categories. Another section of DSM 1 that is interesting to consider is "Disorders of Psychogenic origin, or without clearly defined physical cause or structural change in the brain." Listed herein are the so-called "schizophrenias," all of which are referred to as "reactions," for instance, "schizophrenic reaction, catatonic type."

Mary – that is really interesting, because at the time, in the 1950s, American psychiatry was juggling two different influences: one, which derived from more Freudian or psychoanalytic / psychodynamic tendencies, and tended to see mental illness as a product of interpersonal, familial relationships or social dynamics, and another, a newly-emerging tendency in Psychiatry to consider brain chemistry or neurobiology as the source of mental disturbance.

Kristin – Right. In fact, what we have observed in the archival record related to Morningside is that the clinicians/psychiatrists practicing at the hospital were tacking back and forth between these different tendencies. Specifically, looking at meeting minutes of attending psychiatrists from 1955-58, that is, in the five or so years after DSM 1 was issued, we can see their attempts to apply DSM 1 diagnostic criteria. We can also observe the limitations of those criteria for the treatment and possible discharge of Morningside patients.

Mary – Maybe it would help illustrate some of these tensions if we look at some of the data from those meeting minutes?

Kristin – For sure. So, in the records of a meeting from April 21, 1955, we are introduced to a female patient, aged "mid-60s", who we'll call Diane. That's all we know of her -her origin or place of residence is unclear. The doctors have described her diagnosis as "depression," but added that she is "approaching senility." This description would fall under the DSM 1 category of "Chronic Brain Syndrome associated with disturbance of metabolism, growth, or nutrition," which includes a specific diagnostic label of "presenile brain disease; with psychotic reaction."

Mary – That's really interesting. First, that there was no specific category in DSM 1 for what we now call dementia or even more specifically Alzheimer disease. But also because the disease label of "chronic brain syndrome" seems to mirror a neuro-biological view of this woman's depression. That is to say, that her depression resulted from some "disturbance of growth," namely, aging.

Kristin – Yes, but the attending psychiatrist also noted that this patient had a possible "differential diagnosis," meaning an alternative explanation for her condition. He stated: "differential diagnosis between chronic brain syndrome, possibility of long term involutional psychotic reaction, or a psychotic agitated depression."

Mary – this seems to suggest that the doctors really weren't sure what was going on with this patient, or which diagnosis was the accurate one.

Kristin – In fact, this is one pattern we can see in the archival minutes; psychiatrists seemed to use the DSM 1 labels tentatively at times, like they were trying them on for size, but maybe they would change their diagnosis later, if the patients' situations or symptom presentation changed.

Kristin – At other times, the diagnosis seems less relevant to the attending doctors than do their concerns over patient behavior, family relationships, and plans for discharge.

For example,
In the minutes from August 11, 1955, Dr. Thompson reported on a patient we'll call Henry Klum, a 55 year old "chronic schizophrenic" who was admitted in September 1934. That is, the patient had been living at Morningside for over twenty years! The doctor reported that Henry's delusions were "centered fairly tightly around his family", noting that "Any mention of his brothers, sisters, ex-wife or child cause him acute distress and paranoid thinking, with hostility and resentment. There is no other area that particularly disturbs him, but even a letter from his family blows him up. He has for the last year insisted that his family is dead and wants no more to do with them". On more than one occasion, Henry had "absented himself," that is, abandoned Morningside, but had struggled to maintain employment or housing in the community. Now, the doctors discussed what they should do with Henry – release or maintain him in the hospital.

Mary – yes, In fact, what they are worried about is whether Henry will become violent against his family members if he is released. One of the doctors noted that they had a responsibility to inform the family upon Henry's release, apparently in order to protect themselves from him.

Kristin – Right. In fact, in their conversation in the minutes on August 11, 1955, we see the doctors moving from their diagnosis of "chronic schizophrenic," to "paranoid schizophrenic," with one doctor saying Henry suffers from "true paranoia," distinguished by the fact that, in the Dr.'s words, "paranoia patients only make threats they intend to carry out."

Mary – I think this whole discussion of Mr. Henry Klum also hints at the concern the doctors had over how patients would fare after they left Morningside, that is, in part, their concerns over discharge and Henry's family relationships take precedence over the diagnosis itself.

Kristin – Great point. We both agree that the doctors express these sorts of humanistic concerns about their patients. And yet, they also are administering powerful treatments with potentially harmful effects. Let's go back to "Diane," the 60 something year old woman with some sort of depression that we talked about earlier. When we look at the treatments that the Morningside doctors were using for Diane, we see three things listed in the minutes: Thorazine, amytal, and fifty-eight rounds of electro convulsive therapy.

Mary – 58 rounds!? That seems really excessive. I think that medical consensus at the time was that 8-12 rounds of ECT was appropriate. These treatment options are based on a biological model of disease and there is no clearly established relationship between the treatments administered and the diagnostic labels. Is there any indication in the minutes that this so-called treatment was working for this patient, Diane?

Kristin – Not really, but unfortunately, we can't follow her experience over time, because the meeting minutes we have access to in the archives tend to present just a snapshot of patients, at one particular point in time.

Mary – But we do know that these treatments – especially Thorazine and ECT – were part of the standard psychiatric toolkit in the mid-20th century. Thorazine had just been "discovered," and was being used for all sorts of psychiatric symptoms, from depression to psychosis.

Kristin – yes, again, this is what we see in the Morningside records we've consulted. The doctors administer Thorazine for patients with a range of diagnoses, from depression or affective (mood) disorders, to psychosis, or schizophrenia.

Mary – What about non-pharmaceutical or non-invasive treatments or therapies, is there any evidence that the doctors at Morningside were trying other types of therapies, things we might consider in line with the psychodynamic model we talked about earlier? In other words, were there pro-social, or other therapies that indicated the psychiatrists were more inclined to view patients' problems as tied to family relations or social dynamics?

Kristin – Yes, in fact, one thing our research team has noted from the archival record is there are many cases where the psychiatrists refer patients to "vocational therapy," or "occupational rehabilitation." For instance, referring patients to a volunteer job at the Portland Goodwill, to help them gain skills needed for independent living post-release.

Mary – Right. That seems to indicate that the doctors were in fact concerned about the patients' social wellbeing, sort of like we saw with Henry, the patient we talked about earlier.

Kristin – Yes, overall, these examples show that, while psychiatrists at Morningside were in fact using DSM 1 diagnostic labels to describe their patients' behaviors and symptoms, sometimes those diagnoses seemed to matter less to patient care than did other factors, like treatment availability, family relationships, or social care options outside the hospital.

Mary - Intro to next Episode: So in our next episode, we are going to look more in detail at how the doctors at Morningside talked about their patients, and how they referred to the broader social and historical circumstances causing the hospital to come under increasing political oversight and public scrutiny.

Kristin – Great! We'll see you next time!