

University of Michigan Department of Psychiatry from 1955 to 2014

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In 1955, the Department of Psychiatry at the University of Michigan ushered in two new initiatives that brought it national attention.¹ The first was the opening of the Children's Psychiatric Hospital (CPH), a stand-alone center to provide care for behaviorally and emotionally disturbed children that was intended to be the first wing of a comprehensive children's hospital.² The second was the establishment of the Mental Health Research Institute (MHRI) which housed a multidisciplinary group of investigators dedicated to exploring every level of human activity from the social to the molecular.³ Both of these new projects reflected the assumption of the time that psychiatry offered essential insights into all human science and medical care.

Five decades after these initiatives, the department celebrated its centennial and opened a building to house both ambulatory psychiatry and a new program, a comprehensive Depression Center. The Depression Center was conceived as way to facilitate an interdisciplinary approach toward a focused research and clinical problem: depression and related disorders. Although the Depression Center, like the older programs, garnered national attention for the department, it also illustrated the major reconceptualization that had happened within psychiatry over the

¹ "Children's Mental Hospital, *Time*, 20 February 1956. See also, Toni Shears, "Reflecting on a Lifetime of Mending Minds," *Advance* (Ann Arbor, MI), Winter/Spring 1993.

² Laura D. Hirshbein, "'Our Little Patients': A History of Hospitalized Children at the University of Michigan, 1890-2011," *Journal of Family History* 38 (2013): 321-343. The first children were admitted to CPH in December of 1955, though the building was not formally dedicated until February of 1956. The chairman of the time, Raymond Waggoner, later claimed that this was the first stand-alone children's psychiatric center. It is not clear, however, whether this claim is justified. It was certainly part of a growing movement to take care of disturbed children in a residential setting. See Deborah Blythe Doroshow, "Emotionally Disturbed: Residential Treatment, Child Psychiatry, and the Creation of Normal Children in Mid-Twentieth Century America" (PhD dissertation, Yale University, 2012).

³ Mental Health Research Institute Records, 1955-1995, Bentley Historical Library, University of Michigan, Ann Arbor, MI. The Michigan legislature approved the formation of MHRI – and the faculty traveled to Ann Arbor to begin their positions – in 1955, though the building to house the institute was not completed until 1960.

intervening half century.⁴ Instead of highlighting the broad application of mental health insights to all aspects of medicine and society, the Depression Center focused on specific psychiatric illnesses and their significance for worldwide morbidity and mortality.

As has been true for other departments at the University of Michigan Health System, the Department of Psychiatry has grown – especially in the last half century – in number of faculty, trainees, multidisciplinary participants, and possibilities for treating patients. But members of the department have also been engaged with the larger profession about the definition – and redefinition – of psychiatry itself. In the 1950s, the chairman of the department had been trained as a neurologist but presided over a substantial number of psychoanalytically-inspired faculty who treated a small, relatively affluent patient population. By the 1970s, the analyst-trained chairman expanded the treatment modalities regularly used within the department and increasingly recruited biologically-oriented faculty for research and clinical work. And the last two chairmen have been researchers themselves who worked to uncover brain mechanisms of disease and have directed a faculty who treated a diverse patient population within the financial limits imposed by third party payers. Psychiatry as a field in the early twenty-first century bears little resemblance to its predecessor half a century before, and changes within the University of Michigan Department of Psychiatry offer a window into that transformation.

Expansion of Michigan Psychiatry from the beginning to 1970

When the Department of Nervous and Mental Diseases was organized in 1906 through the construction of the State Psychopathic Institute (SPH), the department's scope was relatively

⁴ For an overview of the history of psychiatry in America, see Gerald N. Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983); ———, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991); ———, *The Mad Among Us: A History of the Care of America's Mentally Ill* (Cambridge: Harvard University Press, 1994); Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997).

modest.⁵ Albert Barrett, the first chairman who had trained in what we would now identify as neurology, was responsible for overseeing the SPH and its population of patients, primarily referrals from the state mental hospital system (the structure for psychiatric care during the time period).⁶ Barrett and his small group of faculty evaluated patients with neurological deficits and severe mental illness within what was seen at the time as a short time frame (30 days). The counties within the state responsible for referrals to the SPH assumed the cost, while a few of the 40 beds of the hospital were taken up with private pay patients. The department began with a research mission – to conduct brain autopsies of deceased patients from the state hospitals at a time when there was a great deal of optimism about the power of pathology to uncover mechanisms of disease.⁷ From the beginning, the department trained residents (initially just one at a time) who took care of the patients at the SPH, and faculty also worked with medical students. The Department of Nervous and Mental Diseases split into separate departments of Psychiatry and Neurology in 1920. Barrett, who was president of the American Psychiatric Association (APA) at the time, was offered a choice between becoming the chair of psychiatry or neurology. He chose psychiatry, but conducted research in brain pathology and went on later to become the president of the American Neurological Association.⁸

Barrett held the position of chair of psychiatry until his death in 1936. His successor, Raymond Waggoner, had a similar background of training in neuroanatomy and pathology. But Waggoner was in many ways a much more ambitious and politically savvy chair than his

⁵ The first professor of what could be considered psychiatry was William Herdman who began teaching in Nervous Diseases and Electrotherapeutics in the 1870s. The department as such did not take formal shape until the construction of the SPH. Raymond W. Waggoner, "The Department of Psychiatry," in Wilfred B. Shaw, editor, *The University of Michigan: An Encyclopedic Survey* (Ann Arbor: University of Michigan Press, 1951), 926-930.

⁶ The distinction between neurology and psychiatry was not recognized at the time in the same way it is conceptualized now. See Andrew Abbott, *The System of Professions: An Essay on the Division of Expert Labor* (Chicago: University of Chicago Press, 1988).

⁷ See for example, Jacques M. Quen, "Asylum Psychiatry, Neurology, Social Work, and Mental Hygiene: An Exploratory Study in Interprofessional History," *Journal of the History of the Behavioral Sciences* 13 (1977): 3-11.

⁸ Albert M. Barrett Papers, 1900-1937, Bentley Historical Library.

predecessor had been. At the time that Waggoner was appointed – which apparently happened by the medical school dean's fiat while Waggoner himself was out of the country – the department primarily consisted of a crumbling old hospital (the SPH) and a small outpatient clinic.

Waggoner quickly helped usher in a new building (the Neuropsychiatric Institute, NPI) and spent the next thirty years expanding and developing the department in almost every conceivable way.

Waggoner cultivated his relationships with the academic leadership at the University of Michigan. He also famously developed close connections with members of the state legislature (probably helped along by the fact that his brother-in-law was one of them) and managed to get separate funding for his programs from the state.⁹ Waggoner used relationships he made while serving in the military during World War II to expand the influence of the department members by helping them onto national committees. His own professional influence culminated in his succession to the post of APA president in 1970.

Waggoner's vision for psychiatry was one that lent itself to broad expansion and program building. Although he had been trained in pathological anatomy, Waggoner became an enthusiast for a new kind of approach toward patients – psychoanalysis. This framework for understanding mental health and disease was imported from Europe through the work of disciples of Sigmund Freud.¹⁰ Though the American interpretations of psychoanalysis were different from the European ones – and the Midwest adaptations tended to be more eclectic than the more doctrinaire East Coast versions – early adherents of this approach argued that psychoanalysis was a scientific method by which psychiatrists could investigate and treat patients.¹¹

Psychoanalysis became influential in the U.S. during WWII when a large number of servicemen

⁹ The department had an individual line item in the state budget. See NPI Budget folder, Waggoner Papers, Box 6.

¹⁰ Nathan G. Hale, Jr., *The Rise and Crisis of Psychoanalysis in the United States: Freud and the Americans, 1917-1985* (New York: Oxford University Press, 1995).

¹¹ George J. Makari, *Revolution in Mind: The Creation of Psychoanalysis* (New York: Harper, 2008).

unexpectedly suffered emotional breakdowns. Interpretations of these phenomena helped guide intervention for suffering soldiers and challenged existing models of both medicine and psychiatry. After the war, psychiatrists promised that a psychoanalytic point of view could similarly help society as a whole.¹²

At Michigan, psychiatry expanded its patient base and offered psychodynamic treatments. Adherents of psychoanalysis believed that unconscious conflicts represented the etiology of mental illness. Practitioners wanted structures in place to allow for long-term, intensive psychotherapy to give patients the opportunity to work through these conflicts and achieve a higher ability to function. And psychoanalytic work in academic centers was focused on helping trainees do therapy with patients and complete their own analyses. Thus for Waggoner and his faculty at the University of Michigan in the decades after WWII, the research, clinical, and educational missions of the department were combined within an expanding, psychodynamically-focused program.

The NPI, located adjacent to University Hospital, used its bed capacity from the 1940s through the late 1970s to conduct inpatient psychoanalysis of patients (with an average length of stay of several months). A growing outpatient division also conducted long-term psychoanalysis, and trainees (primarily residents) spent their time with a small number of patients whom they saw multiple times a week.¹³ And a consultation service built by Waggoner applied a psychoanalytic interpretation to some medical issues – a common feature of a psychosomatic approach toward diseases such as asthma, cancer, and heart disease at the time.¹⁴

¹² Rebecca Jo Plant, "William Menninger and American Psychoanalysis, 1946-48," *History of Psychiatry* 16 (2005): 181-202.

¹³ See "Residency Training in Psychiatry," American Medical Association/Association of American Medical Colleges Report 1958, Box 1, Raymond W. Waggoner Papers, Bentley Historical Library.

¹⁴ Waggoner was sympathetic to the views of psychosomatic leader Franz Alexander. For more on Alexander, see Erika S. Schmidt, "The Berlin Tradition in Chicago: Franz Alexander and the Chicago Institute for Psychoanalysis," *Psychoanalysis and History* 12 (2010): 69-83.

Although psychoanalytic enthusiasts believed that they were improving society by promoting the power and importance of the psychoanalysis, the treatment itself often appeared as a luxury available to a select few. In 1948, the department opened a new facility, the Veterans Readjustment Center (VRC), to help returning servicemen with intensive psychoanalysis available on both an inpatient and outpatient setting. A growing number of psychiatry residents were trained within the building, as they needed long-term stable populations of patients in order to learn psychoanalysis. The state government was supportive of the VRC, especially as the governor of the time, Harry F. Kelly, had been a WWI veteran (and lost a leg in combat). Until 1962, when the funds for the program evaporated, the VRC offered a relaxing, spa-like atmosphere with therapy, a swimming pool, and tennis courts. Thousands of patients were treated at the VRC, primarily through intensive psychoanalytic methods.¹⁵

The highest value within the department from the 1940s through the 1970s was placed on psychoanalysis, though some faculty were employed in doing somatic therapies or combining psychoanalysis with biological interventions such as insulin coma therapy or electroconvulsive therapy (ECT).¹⁶ While psychoanalysis later seemed antithetical to biological approaches, practitioners in the 1950s and 1960s did not necessarily perceive a conflict.¹⁷ Annual reports of the department listed the many procedures completed with patients, including shock therapies and even a rare lobotomy in the 1950s.¹⁸ And some Michigan faculty also conducted research on

¹⁵ Interview with Dr. Prasanna K. Pati, conducted by Laura Hirshbein, 16 September 2005; Interview with Marvin Brandwin, conducted by Laura Hirshbein, 24 May 2000.

¹⁶ For the early history of these interventions, see Joel T. Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997).

¹⁷ For ways in which psychoanalysis and biological treatments came together, see Jonathan Sadowsky, "Beyond the Metaphor of the Pendulum: Electroconvulsive Therapy, Psychoanalysis, and the Styles of American Psychiatry," *Journal of the History of Medicine & Allied Sciences* 61 (2006): 1-25; Mical Raz, "Between the Ego and the Icepick: Psychosurgery, Psychoanalysis, and Psychiatric Discourse," *Bulletin of the History of Medicine* 82 (2008): 387-420.

¹⁸ For a fine perspective on the respectability of lobotomy at the time, see Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (New York: Cambridge University Press, 1998). It appears that most of the lobotomies in Michigan were at state hospitals in collaboration with surgeons. See for example, David G.

neuroanatomy and investigation through electroencephalography (EEG) in psychiatric patients.¹⁹

But the residents were aware that a hierarchy existed within the department, and though they were exposed to biological treatments their goal as trainees was to master the theories and techniques of psychodynamic therapy.²⁰

The Michigan psychiatry department was well within the mainstream of academic programs in terms of the focus on psychodynamic theories. But one area in which Michigan's department helped to expand the academic profession was in the area of children. Child psychiatry as a field emerged in the early twentieth century in the United States through both child guidance and child psychoanalysis.²¹ At Michigan in the 1940s, one floor of the NPI was dedicated to children, though it became quickly apparent that this space was not adequate.²² And the space problem for the care of children was medical-center wide. The chairman of the pediatrics department in the 1940s and 1950s complained about the lack of a separate children's hospital, though one had been promised during these decades. In the early 1950s, Waggoner made a successful argument to hospital administrators that a children's psychiatric hospital would be a good place to start in order to create a comprehensive children's health center, a place to address all manifestations of children's illness from the emotional to the physical. The building

Freeman, Ivan A. LaCore, Robert C. Bassett, "A Summary of Results of Prefrontal Lobotomy Performed Upon Sixty-Five Cases of Intractable Psychosis at Ypsilanti State Hospital," *Medical Bulletin (Ann Arbor)* 19 (1953): 151-153.

¹⁹ The Neurology Department did not take over the EEG program until the 1980s.

²⁰ Not everyone came out of the program as a fully trained psychoanalyst, however. Residents who wished to pursue this track had to do additional training.

²¹ On the child guidance movement, see Margo Horn, *Before It's Too Late: The Child Guidance Movement in the United States, 1922-1945* (Philadelphia: Temple University Press, 1989); Theresa R. Richardson, *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada* (Albany: State University of New York Press, 1989); Kathleen W. Jones, *Taming the Troublesome Child: American Families, Child Guidance, and the Limits of Psychiatric Authority* (Cambridge: Harvard University Press, 1999). Child psychoanalysis was a specialized area within the broader psychoanalytic movement in which psychiatrists looked to Anna Freud and others to understand the intrapsychic conflicts that appeared to lead to faulty behavior in children. For more on Anna Freud and her work on the professionalization of child psychiatry, see Elisabeth Young-Bruehl, *Anna Freud: A Biography*, Second ed. (New Haven: Yale University Press, 2008).

²² "The Neuropsychiatric Institute," University of Michigan, 25 October 1939.

for the Children's Psychiatric Hospital (CPH) opened in 1955 and was designed to allow for the easy addition of a pediatrics hospital, with a wall designed to be torn down for future construction. Although hospital officials were initially optimistic that the general pediatrics section of the hospital would be built, the funding never came through.²³ But CPH became well known for its faculty, its programs, and its intensive work with children.

Faculty and staff at CPH remained busy over the decades of the operation of CPH as they took in dozens of emotionally and behaviorally disturbed children at a time, and treated them for prolonged periods (up to several years). CPH pioneered with special teacher interactions and psychoanalytically-based treatment by a multidisciplinary staff, as well as pet therapy.²⁴ CPH boasted internationally known child psychiatrists, and its leaders were well connected in national professional circles. Ralph Rabinovitch, who was the first director of CPH (with his wife Sara Dubo as associate director), left in 1956 to help found the Hawthorn Center for disturbed children in Northville, Michigan. His successor Stuart Finch was a prolific writer and educator of psychiatrists, pediatricians, and the public.²⁵ And Finch helped to recruit an expanding division of faculty who believed that intensive treatment of children would help individuals and also expand knowledge about childhood.

Waggoner not only helped construct an innovative program in child psychiatry, but also he brought together investigators who expanded the scope of research in the psychiatry in general. He recruited renowned neurophysiologist Ralph Waldo Gerard to collaborate with James Miller and Anatol Rapoport to build a multidisciplinary research institute that would

²³ Instead, the Pediatrics Department approached the Mott Foundation and obtained funding for a separate children's hospital. Hirshbein, ""Our Little Patients."

²⁴ Elizabeth Yates, *Skeezer: Dog With a Mission* (Irvington-on-Hudson, NY: Harvey House, 1973).

²⁵ See for example, Stuart M. Finch, *Fundamentals of Child Psychiatry* (New York: W.W. Norton & Company, 1960); O. Spurgeon English and Stuart M. Finch, *Introduction to Psychiatry*, 3rd ed. (New York: W.W. Norton & Company, 1964); Stuart M. Finch and John F. McDermott, *Psychiatry for the Pediatrician* (New York: Norton, 1970); O. Spurgeon English and Stuart M. Finch, *Emotional Problems of Growing Up* (Chicago: Science Research Associates, 1951).

explore all aspects of mental health.²⁶ With the creation of the Mental Health Research Institute (MHRI), faculty specializing in multiple areas of inquiry from history and sociology to microbiology were optimistic that they could uncover key truths about areas ranging from brain function to social organization. Faculty at MHRI went on to important national positions and published extensive research.²⁷

Another way in which members of the department participated in broader trends within psychiatry was in the area of nosology, the classification of mental illnesses. Early psychiatric classification systems essentially considered only patients in psychiatric hospitals and divided them based on presumed etiology of illness (such as head injury or infection).²⁸ But psychiatrists in the decades after WWII were treating a much wider range of patients, including veterans, unhappy housewives, young men with adjustment issues, as well as patients with problems integrating reality. These patients were not easily classified, nor was the etiology of their difficulties readily apparent. A small committee within the APA created the first edition of the *Diagnostic and Statistical Manual* (DSM) in 1952 to try to capture and account for the expanded patient base within psychiatric practice.²⁹ Moses Frohlich, one of the faculty in the University of Michigan Department of Psychiatry, was on the nomenclature committee that created the first DSM (a position he acquired because of some contacts he made during his WWII army stint) and was also involved in the question of how to revise it in the late 1950s and early 1960s.

Frohlich's career reflected some of the potential flexibility – and tension – within psychiatry of the time, even within a predominant focus on psychoanalysis. Frohlich trained as

²⁶ Seymour S. Kety, "Ralph Waldo Gerard, October 7, 1900-February 17, 1974," *National Academy of Sciences Biographical Memoirs* 53 (1982): 179-210.

²⁷ Mental Health Research Institute Papers, Bentley Historical Library.

²⁸ See for example, Committee on Statistics of the American Medico-Psychological Association and Bureau of Statistics of the National Committee for Mental Hygiene, *Statistical Manual for the Use of Institutions for the Insane* (New York: National Committee for Mental Hygiene, 1918).

²⁹ Gerald N. Grob, "Origins of DSM-I: A Study in Appearance and Reality," *American Journal of Psychiatry* 148 (1991): 421-430.

both an internist and a psychiatrist, and was recruited by Waggoner to run the department's EEG program before the war. Frohlich was also the faculty member responsible for biological treatments such as insulin and metrazol shock therapies, as well as electroconvulsive therapy, at the same time that he was also training in psychoanalysis through the Detroit Psychoanalytic Institute. Frohlich also began work on statistics in psychiatry, and used an early version of an IBM counting machine to keep tabulations of patients seen by the department.³⁰ And Frohlich, with the assistance of Michigan Department of Psychiatry psychologist Marvin Brandwin, reached out to psychiatrists across the country to survey their impressions of how well the DSM captured the spirit and scope of psychiatry as the framers of the manual attempted to balance psychoanalytic ideas with older phenomena such as organic brain problems.³¹

Though psychiatrists such as Waggoner had been optimistic in the 1950s that psychiatry would contribute to all areas of human activity, by the 1960s critics were increasingly pointing out the problems within the most concrete and obvious system of psychiatric care – the state psychiatric hospital system.³² This led to a broad movement to deinstitutionalize psychiatric patients, including those in Michigan. And though the Michigan psychiatry department had been only peripherally involved with seriously ill patients, Michigan faculty were leaders in the effort to interpret President John F. Kennedy's Mental Health Centers Act in the mid-1960s to create a community mental health program in the state to take the place of long-term large hospitals.³³

One of the challenges was that it was not clear how to define the patient population to be served by the mental health centers. In Washtenaw County, the Ypsilanti Regional Psychiatric

³⁰ Moses M. Frohlich Papers, Bentley Historical Library.

³¹ Document authored by Marvin Brandwin, 1956, on survey results regarding the first *DSM*. Used with permission from Professor Brandwin.

³² Gerald N. Grob, "Deinstitutionalization: The Illusion of Policy," *Journal of Policy History* 9 (1997): 48-73.

³³ Raymond Waggoner, Stuart Finch, and Moses Frohlich were all involved on the national, state, and local level in this area. See MI Community Mental Health Centers Task Force, 1963, Box 4, Waggoner Papers, Bentley Historical Library. For more on the context of the time, see Henry A. Foley, *Community Mental Health Legislation: The Formative Process* (Lexington, Mass.: Lexington Books, 1975).

Hospital (YRPH) had served thousands of seriously ill patients. Although practitioners at YRPH had some collaborative relationships with faculty at the University of Michigan, for the most part the patient population served by the University of Michigan did not overlap with that of the state hospital. When psychiatry faculty helped to create new community structures for services for patients, it was not apparent whether the patients who were being helped were the ones intended for assistance by Kennedy's program – a problem replicated in centers around the country.³⁴

The disconnect between the University of Michigan psychiatry faculty focus and the state hospital system represented one of several challenges to psychiatry by the 1960s. In research as well, the department's goals did not necessarily map out onto the reality of patient care structures. At the MHRI, for example, the faculty and projects were almost entirely separate from the clinical activities of the department. Ralph Waldo Gerard was well known within research circles as a pioneer in schizophrenia research, but his research at the University of Michigan was peripheral to the patients cared for by the department. Instead, Gerard collaborated with staff at YRPH to connect his basic science theories to clinical care.³⁵ The psychiatry department's attempts to cast a net broadly to encompass large social problems and research methods were limited by the realities of access to care and the logistics of research.

Within the realm of clinical care, there was even more of a disconnect between the idea that Michigan could lead in treatment and the actual number of patients who were able to access care. For children, the mission of CPH was to provide comprehensive care to seriously emotionally and behaviorally disturbed patients within a multidisciplinary framework, with support through structure in the facility and activities for the children. Further, CPH was

³⁴ Gerald N. Grob and Howard H. Goldman, *The Dilemma of Federal Mental Health Policy: Radical Reform or Incremental Change?* (New Brunswick: Rutgers University Press, 2006).

³⁵ See for example, R.W. Gerard, "The Nosology of Schizophrenia," *American Journal of Psychiatry* 120 (1963): 16-29).

designed with the idea that exposure to child psychiatric concepts would help other practitioners, including pediatricians, with their ongoing work. But in practice the very long length of stay for CPH patients (averaging about 300 days) meant that relatively few children were actually treated. And the separate program at CPH appeared not to have much of an effect on the Department of Pediatrics.

On the adult side, there were long waiting lists for the intensive psychoanalytic treatment offered on the inpatient unit while even longer wait times limited outpatient treatment. And trainees faced increasing challenges as the VRC closed and the requirements to be certified in analysis became more rigid. Meanwhile, medical students were getting very little exposure to psychiatric patients – though they were vulnerable to being analyzed by psychiatric faculty as a group.³⁶ And as student activism heated up in the politically charged atmosphere of Ann Arbor in the 1960s, there was increasing polarization between administration and students. This even affected the psychiatry department when a member of the faculty drew the ire of the medical school dean by supporting students in protests and speaking out on political issues.³⁷

In American society as a whole, the grand vision of psychiatry (as articulated by Waggoner and others) came under increasing attack during the 1960s as many complained about what was perceived as psychiatrists' attempts to claim authority over all aspects of the human condition. Critics such as R.D. Laing and Thomas Szasz accused psychiatrists of making up concepts such as mental illness for purposes of social control.³⁸ Others argued that psychiatric authority badly applied had led to narrow judgments about "normal" behavior and social

³⁶ Raymond W. Waggoner and Thornton Woodward Zeigler, "Psychiatric Factors in Medical Students in Difficulty: A Follow-Up Study," *American Journal of Psychiatry* 117 (1961): 727-731.

³⁷ Letter from W.N. Hubbard, Dean, to Waggoner, 17 March 1965. On politics in Ann Arbor during this time period, see Todd Gitlin, *The Sixties: Years of Hope, Days of Rage* (New York: Bantam Books, 1987).

³⁸ Michael E. Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948-1980* (Chicago: University of Chicago Press, 2011).

interactions.³⁹ But the critiques of psychiatry were not just outside the profession as Michigan's chair discovered. When Waggoner became the president of the APA in 1969, he faced many challenges to psychiatric authority. One, a confrontation with an angry group of African-American psychiatrists who demanded greater representation in the all-white leadership of the APA, made the national papers.⁴⁰ Waggoner reflected on the social turmoil of the times in 1970 during his APA presidential address in which he called on the profession to address issues of conflict and take responsibility for solving some problems in society, especially the challenges of the behavior of the nation's youth.⁴¹

After the expiration of his term as APA president, Waggoner stepped down as chairman of the Department of Psychiatry, and it became clear that the breadth, scope, and funding of the department had been held together because of Waggoner's particular personality and political influences. Albert Silverman, a Canadian who had trained at McGill University before becoming the first psychiatry chairman at Rutgers University, was appointed chair to succeed Waggoner. Silverman found that many aspects of the department were coming apart, and he faced the unenviable challenge of trying to articulate a new vision of psychiatry in the context of social, political, and economic difficulties. Silverman's major accomplishments in the department were to look beyond a psychodynamic view of psychiatry and expand the department's approaches to research problems, clinical care, and education. But Silverman presided over a divided and angry department that reflected the increasing controversies inside and outside psychiatry in an era of growing financial challenges.

³⁹ Norman Dain, "Psychiatry and Anti-Psychiatry in the United States," in *Discovering the History of Psychiatry*, ed. Mark S. Micale and Roy Porter (New York: Oxford University Press, 1994), 415-444.

⁴⁰ "Racism is Called Major Problem of Mental Health in the Nation," *Medical Tribune and Medical News*, 29 May 1969. See also Walter E. Barton, *The History and Influence of the American Psychiatric Association* (Washington, DC: American Psychiatric Press, 1987), 296.

⁴¹ Raymond W. Waggoner, "The Presidential Address: Cultural Dissonance and Psychiatry," *American Journal of Psychiatry* 127 (1970): 1-8. See also Lucas Richert, "'Therapy Means Political Change, Not Peanut Butter': American Radical Psychiatry, 1968-1975," *Social History of Medicine* 27 (2013): 104-121.

Expansion and Redefinition, 1970-1995

Silverman took over the leadership of the department during a decade in which a series of national economic crises led states to cut back on multiple programs.⁴² Silverman had to make a difficult decision regarding the state of Michigan appropriation to the department. Although many in the department were under the impression that the state's line item for the University of Michigan Department of Psychiatry would exist in perpetuity, Silverman was informed by state officials that departmental funding would continue only under the umbrella of another program. Silverman was given the choice of including the department within the budget of the state's Department of Mental Health (of which the academic program would be one beneficiary among many mental health centers) or into the University of Michigan's education appropriation. Silverman chose the latter, with the reasoning that the university would be a better partner and more trustworthy source of support for future endeavors. Unfortunately, his faculty was unable to fully comprehend the limits of Silverman's choice regarding state funding and interpreted his actions as somehow giving up an important element of the department finances.⁴³

Silverman's change with regard to the funding stream was only one of his efforts to bring the psychiatry department up to date with the realities of the medical world in the 1970s. Like many of the chairs of psychiatry across the country at this time period, Silverman's training and early career experiences took place within a dominant psychoanalytic framework.⁴⁴ Yet the leaders of this era increasingly recognized that psychoanalysis was limiting the profession in its

⁴² For the context of the 1970s, see Bruce J. Schulman, *The Seventies: The Great Shift in American Culture, Society, and Politics* (Cambridge: Da Capo Press, 2001); Thomas Borstelmann, *The 1970s: A New Global History From Civil Rights to Economic Inequality* (Princeton: Princeton University Press, 2012); Jefferson Cowie, *Stayin' Alive: The 1970s and the Last Days of the Working Class* (New York: New Press, 2010); Philip Jenkins, *Decade of Nightmares: The End of the Sixties and the Making of Eighties America* (New York: Oxford University Press, 2006).

⁴³ Interview with Albert J. Silverman, conducted by Cynthia S. Pomerleau, 12-13 November 1991.

⁴⁴ Grob, *From Asylum to Community: Mental Health Policy in Modern America*.

scientific standing, its ability to treat more than small numbers of patients, and its difficulty in recruiting students into the field. Instead of insisting that psychiatry was special because of its power to influence other fields, Silverman articulated a vision of psychiatry as a medical specialty, with relationships to basic science research, clinical treatment beyond the limited number of patients who could pay for psychoanalysis, and education of students and residents to include multiple perspectives. The department would become further integrated into the medical center as a whole.

Within MHRI, Silverman emphasized research to expand relevance to clinical care and helped investigation take place within clinical settings. He recruited key faculty, particularly in the area of depression, and created a Clinical Studies Unit (CSU) within NPI that participated in many of the studies of depression and anxiety that were going on during the 1970s. Important researchers in this area, including Bernard Carroll, George Curtis, and John Greden joined the department in the 1970s.⁴⁵ While engaged in research at the UMHS, Carroll developed the Dexamethasone Suppression Test (DST), a way of exploring the biological connection between stress and depression that had a profound effect on future lines of investigation.⁴⁶

Shifts within the research priorities were significant under Silverman's leadership. But even more striking was the organization of clinical care. Although there were important biological interventions for patients available (including an ongoing electroconvulsive therapy program), at the beginning of Silverman's time as chair most patients were receiving intensive

⁴⁵ For more context on studies of depression and anxiety, see Laura D. Hirshbein, *American Melancholy: Constructions of Depression in the Twentieth Century* (New Brunswick, NJ: Rutgers University Press, 2009); David Herzberg, *Happy Pills in America: From Miltown to Prozac* (Baltimore: Johns Hopkins University Press, 2009); Andrea Tone, *The Age of Anxiety: A History of America's Turbulent Affair with Tranquilizers* (New York: Basic Books, 2008).

⁴⁶ For more on Carroll, see Edward Shorter, *Before Prozac: The Troubled History of Mood Disorders in Psychiatry* (Oxford: Oxford University Press, 2009).

psychoanalysis.⁴⁷ The inpatient unit was so focused on this type of therapy that there had not been medical students on a psychiatry rotation for years as it was not really possible to include students in the dyad of psychoanalysis. In the early years of his chairmanship, Silverman shifted the focus of inpatient treatment, created a medical student rotation on the inpatient unit, and encouraged faculty to explore new treatment modalities, including the medications that were changing the face of psychiatry across the nation.⁴⁸

One of the consequences of the psychoanalytic bent of the faculty was that many of them had been only devoting part of their effort to their university appointment; the rest was spent in private practice in long-term analysis with patients. At the University of Michigan, as with other medical schools around the country, administrators had for many decades insisted that faculty devote all of their time to the school in order to further the mission of the institution. However, a significant number of the faculty (especially in the child division) had been given permission for part-time appointments to augment their income with private patients.⁴⁹ By the 1970s, this practice was no longer acceptable to either the medical center or the chair. Medical school administrators had begun to put pressure on Waggoner to change the status of his part-time faculty before his retirement, but it fell to Silverman to enforce the full-time faculty standard.⁵⁰ Silverman gave faculty a choice to drop their private work and become full time at the University or leave their faculty appointments. This primarily affected psychoanalysts whose private practices were filled with long-term patients. Many of the psychoanalytically-inclined faculty

⁴⁷ Interview with George Curtis, conducted by Laura Hirshbein, 16 March 2000.

⁴⁸ David Healy, *The Creation of Psychopharmacology* (Cambridge: Harvard University Press, 2002).

⁴⁹ On the push for fulltime faculty in academic medical centers, see Kenneth M. Ludmerer, *Learning to Heal: The Development of American Medical Education* (New York: Basic Books, 1985).

⁵⁰ See folder Psychiatry 1968-1974, Box 165, University of Michigan Medical School Papers, Bentley Historical Library.

chose to leave, unfortunately with much grumbling and bad will. This included a large number of child faculty by the 1980s.

The process of moving the department away from a psychoanalytic focus was slow, and initially was manifest through augmentation of the psychodynamic point of view. As Silverman pointed out in a departmental bulletin in 1976, the department's psychodynamic philosophy included "the insights of genetics and neurochemistry, neurophysiology and psychophysiology, the laws of perception and learning, the influences of early and later experiences, and the modulating and shaping forces of family and culture."⁵¹ It was not apparent at that time, though, that social, professional, and therapeutic changes were going to translate into a seismic shift within psychiatry. Over the next two decades, psychoanalytic perspectives would be largely marginalized.

Residency training during this time period reflected the uneasy mingling of multiple perspectives on patient care. A residency education director position had been created in 1968, and by the mid-1970s it was clear that part of the challenge for the training director and the residents was to find a way to talk to the psychoanalysts, the biologically-oriented psychiatrists, and the social psychiatrists. As the training director commented in 1974, it was not possible to reconcile them all – the residents had to make their own way while navigating at least some familiarity with each camp.⁵² Relationships with patients, processed through supervision with faculty, were the foundation of resident education, and even residents who worked in the emergency services were encouraged to do short term work with patients (up to ten sessions) before considering a referral out to a longer-term provider.⁵³

⁵¹ [Bulletin], Department of Psychiatry, The University of Michigan Medical Center, April 1976.

⁵² Memo from Dr. Alexander Guiora, Director of Resident Education, 1 July 1974.

⁵³ [Bulletin], Department of Psychiatry, The University of Michigan Medical Center, April 1976.

While in hindsight Silverman's efforts to shift the department away from a primary focus on psychodynamics was slow and only partly completed, the perceived rapidity of the change proved to be too much for the faculty by the late 1970s and early 1980s. Silverman was unable to unite his fractious and suspicious faculty around a shared vision of progress. (Indeed, the atmosphere had become so tense that an administrator for one group of conflicted faculty actually murdered an administrator from an opposing unit. Although the murder was as much personal as related to work, those who recalled the event linked it to the tensions that were in the department.⁵⁴) In 1979, the medical center reviewed the department and much of the blame fell on the negative feelings that faculty harbored toward Silverman's leadership. Silverman officially retired in 1981, and for the next three years a series of temporary chairmen attempted to manage. Both Bernard Carroll and George Curtis acted as interim. Curtis stayed on as regular faculty after his interim term expired, but Carroll left to become the chair at Duke University. After an exhaustive search, Virginia psychiatrist Robert Friedel briefly assumed the position in 1984 but lasted only nine months and managed to generate even more animosity from the faculty, especially as he never seemed particularly committed to the university.⁵⁵

In the early 1980s, psychiatry both locally and nationally appeared to be in a state of upheaval. The APA had just published a new diagnostic manual that for the first time spelled out specific criteria for mental illness. Although the publication of *DSM-III* was hailed as a critical advance by many researchers and biologically-oriented clinicians, a significant number inside and outside the profession were critical of the fact that the manual included definitions of disorders for what seemed to be problems of living. And psychodynamically-oriented

⁵⁴ Interview with George Curtis, conducted by Laura Hirshbein, 16 March 2000; Interview with Oliver Cameron, conducted by Laura Hirshbein, 4 April 2000.

⁵⁵ Interview with Oliver Cameron, conducted by Laura Hirshbein, 4 April 2000.

psychiatrists were dismayed by the DSM approach to diagnosis.⁵⁶ On the department level, Carroll – who had actively participated in the creation of the *DSM-III* diagnosis of major depression – pointed out that trainees faced challenges as they tried to integrate all the different points of view of their supervisors. Carroll emphasized that residents had responsibility for their own education, and remarked that, "They are encouraged to recognize and accept the limits of current knowledge, not to retreat behind theoretical formulations that mask current ignorance. They are expected to develop a sense of the limits of biological determinism, the limits of psychological determinism and the limits of social determinism."⁵⁷ Carroll did not openly criticize psychoanalysis – at least in the resident recruitment materials – but made it clear that things were too much in flux to be able to count on one model.

John Greden's appointment as chair of psychiatry in 1985 signaled not only a more coherent direction for the department but also increasing clarity about the psychiatry of the future. Greden, whose career was focused primarily on biological approaches to depression, was also celebrated for his ability to work harmoniously with others. Greden was able to rally the faculty behind a further move toward biological approaches to mental illness and a broader research focus. When Greden took over as chair, he took a characteristically optimistic approach toward the department. As a cheerleader for both science and psychiatry, Greden enthused, "Intellectual stimulation is everywhere. Perhaps most importantly, our field is flexible and fun. Despite periodic cries of distress from within, these are pleasantly-challenging times, and we are proud to be part of them."⁵⁸ Though Greden was not Republican in his politics (he openly

⁵⁶ Stuart A. Kirk and Herb Kutchins, *The Selling of DSM: The Rhetoric of Science in Psychiatry* (New York: Aldine de Gruyter, 1992); Hannah S. Decker, *The Making of DSM-III: A Diagnostic Manual's Conquest of American Psychiatry* (New York: Oxford University Press, 2013); Herb Kutchins and Stuart A. Kirk, *Making Us Crazy: DSM, The Psychiatric Bible and the Creation of Mental Disorders* (New York: Free Press, 1997).

⁵⁷ [Bulletin], University of Michigan, Department of Psychiatry, [1983].

⁵⁸ [Bulletin], University of Michigan, Department of Psychiatry, 1987.

supported Democratic candidates for office from time to time), his optimism and emphasis on the value of hard work to solve problems echoed the broader political tone enshrined by the Presidential administration of Ronald Reagan.⁵⁹ Greden, like others in the 1980s, wanted to banish the squabbles and infighting of the 1970s and look to a bright – though challenging – future.

In his first decade as chair, Greden celebrated expansion and integration with other areas of research and clinical care, and cheered faculty as they garnered ever larger grant portfolios. The work of the MHRI was highlighted and put forward more with the work of the department, instead of being a program set aside with a different set of relationships. And with expansions in psychiatry's programs locally, faculty also enjoyed greater national visibility. For example, in 1990, Elissa Benedek became the second woman to hold the position of president of the APA.⁶⁰ Within the department, it seemed possible to take on any and all problems, from the emerging challenges associated with the AIDS epidemic to ongoing issues around substance abuse. And Greden refused to allow psychiatry to languish in what he consistently (and negatively) referred to as a silo. Instead, he pushed for increasing collaboration between the department and other programs and facilities to strengthen recognition and treatment of psychiatric disorders. Greden's vision was at least as grand as Waggoner's – and he grew the faculty, the programs, the education program, and the research centers beyond what Waggoner could have imagined.

The physical landscape of the medical center helped reinforce the idea of expanded opportunities with the new University Hospital that was completed in 1986. Within the old NPI, psychiatry was technically in a separate building (though it abutted the main hospital) and CPH was also physically separated. With the new hospital, adult inpatient psychiatry moved to the

⁵⁹ Jenkins, *Decade of Nightmares*.

⁶⁰ Michelle Riba, another pioneering woman president of the APA, took office in 2004.

eighth and ninth floors within the same building as the rest of the medical and surgical units, while in 1990 the separate CPH building closed and the child and adolescent units were moved to the Maternal/Child Health Center (attached to the medical center complex). The number of adult beds shrank somewhat to a total of 45 on three units, while the number of beds for children and adolescents significantly decreased. At the same time, the emphasis on ambulatory work continued to grow, and the outpatient division subdivided into specialty areas, including anxiety, eating disorders, personality disorders, and schizophrenia.

Although the 1980s seemed to be full of optimism and promise for psychiatry, there were a number of challenges. Greden had inherited a department that had largely shifted away from a predominantly psychoanalytic focus, but the child division took longer to recover from the departure of the part-time, psychoanalytic faculty. In the late 1980s, Greden hired a researcher to head the child division, the first time a non-analyst had filled the role. The child division still struggled to define itself and it took decades to rebuild. Further, decades of rising health care costs around the nation led to a rise of managed care. Third party payers began to manage costs through setting limits on levels of care and psychiatric providers had to begin to defend treatment decisions to payers.⁶¹ And payment issues also affected residency education as decreasing reimbursement for inpatient settings began to push patients toward ambulatory care. This kind of shift highlighted for many that there were new realities in psychiatry – as in medicine in general. No longer would it be possible to expand, to go anywhere and make grand promises about the future. Instead, the lesson of the 1990s was that it was imperative to learn to be efficient.

Brain Disease in an Era of Dwindling Resources, 1995 to the present

⁶¹ Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989).

In his State of the Department address in 1996, Greden outlined what he called a "new psychiatry" in which the department – and the profession as a whole – would strive to integrate as a specialty into the rest of medicine, not stay on the sideline and expect patients to come into psychiatry's spaces. He outlined a new organizational table for the department and explained that the goal of the department was going to continue to be academic and that inquiry and patient care needed to take place within cost-effective structures. Like other health care providers of the time, Greden emphasized efficiency of diagnosis and treatment, as well as the appropriate inclusion of research discoveries into clinical work. As was typical, Greden kept the focus positive as he tried to reassure the faculty that taking measures such as incorporating outpatient treatment into the Medical Center wide Faculty Group Practice organization was not detrimental to the department.⁶² The goal was to continue to do excellent work, but at the same time to be mindful of the restrictions of time, space, and finances.

Greden's vision of psychiatry was not just limited to the administrative structure of the department. And this was a very different kind of specialty and department than the one promoted by Waggoner and his colleagues decades before. The older model of psychiatry was based on an expectation that psychoanalytic insights would benefit all patients, an approach that emphasized the profession's value to understanding patients rather than a set of specific diseases. By the 1990s, however, an even more expanded edition of the APA's *Diagnostic and Statistical Manual (DSM-IV)* and enhanced epidemiology of mental illness suggested that psychiatry was a specialty responsible for a large number of important diseases.⁶³ In both local and national venues, Greden and other members of the department articulated the idea that psychiatry was

⁶² John F. Greden, "State of the Department of Psychiatry (Mid-Year)," 12 June 1996.

⁶³ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Fourth ed. (Washington, DC: American Psychiatric Association, 1994).

important not because it was a tool but because psychiatric illness was a major factor in morbidity and mortality around the world.

By the 1990s, research in psychiatric illness drew both financial and public support from the federal government initiative of the Decade of the Brain.⁶⁴ And research was increasingly focused on brain mechanisms. At MHRI, which was renamed the Molecular and Behavioral Neuroscience Institute (MBNI) in 2005, research continued into ways in which the complex interactions of the brain might become psychiatric disease.⁶⁵ Elizabeth Young conducted important investigation on the interactions among stress, stress hormones, and depression. MHRI co-leads Huda Akil and Stanley Watson developed a research program that garnered them countless publications and awards through the decades. New techniques in neuroimaging and genetics helped foster a sense of excitement in the department that research could uncover the molecular basis of psychiatric illness.

Although research endeavors in the department were led by internationally known and well funded investigators, the funding environment became increasingly narrow and competitive by the beginning of the twenty-first century. The psychiatry department retained a fairly robust portfolio of basic science and health services research, but a gap emerged in the area of translational research, especially clinical trials that could help bridge the distance between laboratory findings and clinical care. For decades, much of that kind of research nationwide had been financed by pharmaceutical companies.⁶⁶ But increasing discomfort with pharmaceutical industry research practice (including exclusive control of raw data) led the medical center and

⁶⁴ See <http://www.loc.gov/loc/brain/>, accessed 14 November 2014.

⁶⁵ John Greden, State of the University of Michigan Department of Psychiatry, The University of Michigan Comprehensive Depression Center, and the Molecular and Behavioral Neuroscience Institute, 21 March 2007.

⁶⁶ This was true for fields outside of psychiatry as well. See Jeremy A. Greene, *Prescribing by Numbers: Drugs and the Definition of Disease* (Baltimore: Johns Hopkins University Press, 2007).

the department at the University of Michigan to decrease interactions with industry and manage them more carefully.

The pharmaceutical industry was no doubt responsible for some of the surge of demand for psychiatric treatments by the second half of the 1990s. Blockbuster medications such as fluoxetine (Prozac, manufactured by Lilly) and sertraline (Zoloft, made by Pfizer) were promoted in direct-to-consumer advertisements and helped to publicize not only the treatments but also the existence of psychiatric illness such as depression.⁶⁷ But demand for psychiatric services also increased because of the consistent message that mental illnesses were similar to medical illnesses and should be treated as such. Department of psychiatry faculty, especially Greden, campaigned tirelessly about the importance of psychiatric disease and its treatment. Greden emphasized again and again that psychiatric illness was brain disease and needed to be recognized and treated on those terms.

At the same time that patient demand for psychiatry increased, continued changes in health care financing led to even more restrictive reimbursement criteria for high cost care, especially inpatient treatment. As a result, both the adult and child inpatient units decreased the number of beds. It also became clear that neither intellectual curiosity nor patient demand could support certain kinds of structures. In the late 1990s, the inpatient eating disorder and inpatient substance abuse programs were closed due to a lack of reimbursement. But the department was able to sustain some clinical partnerships. For example, the department collaborated with the Washtenaw Community Mental Health organization (renamed Community Supports and Treatment Services, CSTS) in Psychiatric Emergency Services (PES) and a clozapine clinic. And

⁶⁷ For a critical view of the pharmaceutical industry in this area, see for example, David Healy, *Let Them Eat Prozac: The Unhealthy Relationship Between the Pharmaceutical Industry and Depression* (New York: New York University Press, 2004); Christopher Lane, *Shyness: How Normal Behavior Became a Sickness* (New Haven: Yale University Press, 2007).

the department continued its long-standing partnership with the Veterans Administration Hospital in Ann Arbor. University of Michigan faculty had long had appointments at the VA and residents had the opportunity to train there, though the focus was on group therapy process through much of the 1970s and 1980s, and the length of stay for inpatients was a month. By the 1990s, the VA mental health service increasingly resembled the main hospital psychiatric unit with shorter stays and focus on medications, and faculty and residents approached patients and problems in similar fashion in both units.

With the growth of demand for psychiatric care and the shift away from inpatient settings, the ambulatory division of the department moved out of Riverview (a renovated motel that had been acquired by the department during Silverman's tenure) to a rented facility on Commonwealth Boulevard. The ambulatory service continued to struggle through the decade with the legacy of long-term patient care in the department, in which patients expected to remain involved with the clinic in perpetuity while ongoing demand for consultation and expert opinion for patients pushed toward a different kind of model for service.

During this time period, there were also important changes in the educational programs in the department. Between the late 1970s when the department ushered in a four year residency program and the mid-1990s, educational offerings had continued to expand. The residency classes grew to about 10-12 residents per year, while the department also sponsored a number of fellowships, including addiction, anxiety, consultation-liaison, depression, evolution and psychiatry, geropsychiatry, personality disorders, schizophrenia, and sleep.⁶⁸ But in 1996, the Balanced Budget Amendment cut Medicare spending that had also helped to fund graduate medical education. As a result, there were new restrictions on reimbursement for trainee activities and limits on money available to academic health centers for graduate medical

⁶⁸ See University of Michigan Department of Psychiatry Bulletin, 1994.

education.⁶⁹ At Michigan, the number and type of fellowship positions decreased and the role of faculty in direct patient care increased as reimbursement requirements shifted responsibility to faculty and away from residents.

While the role of residents diminished relative to previous years, the department retained an active focus on education and training opportunities. In 1997, the residency education office gained an associate chair as well as a long-standing training director (the post is still held by Michael Jibson as of this writing). And the department continued to offer a research track, which became federally funded through the efforts of research faculty, to allow residents to extend their training for a year to include research time throughout their residency.⁷⁰ The educational program continued to offer residents an opportunity to grapple with biological, social, and psychodynamic approaches to patients. On a national level, Michigan psychiatry faculty also became leaders in educational research and reform. At the same time that residency education was changing, members of the psychiatry department were also working on educational issues for other kinds of students and trainees. Two different psychiatry faculty (Rachel Glick and Tamara Gay) acted in the role of Dean of Students for the medical school. Nursing faculty entered into partnerships with clinical areas such that nursing students had meaningful interactions with faculty and staff while they were rotating through psychiatry.⁷¹ And social workers within the department were key in supervising social work interns in behavioral health.

Into the twenty-first century, the department remained diverse and open to a variety of approaches to patient care. But the most clear manifestation of psychiatry's redefinition during

⁶⁹ Funding had been available to academic medical centers for graduate medical training since the inception of Medicare in 1965. Kenneth M. Ludmerer, *Let Me Heal: The Opportunity to Preserve Excellence in American Medicine* (New York: Oxford University Press, 2015).

⁷⁰ The research track was established in 1983. University of Michigan Department of Psychiatry Bulletin, 1994.

⁷¹ Interview with Val Barrie, conducted by Laura Hirshbein, 30 July 2014; Interview with Jody Berney, conducted by Laura Hirshbein, 15 March 2012.

this time period came to fruition through Greden's conceptualization of the Depression Center, a multidisciplinary research and outreach organization intended to spread recognition of and treatment for depression around the country. Greden was challenged to mobilize external support, both through the expansion of philanthropy and awareness of the extensive problems of depression. Greden succeeded not only in meeting the health center demand for a significant portion of the funding, but also in reducing the stigma around mental illness. The result, the beautiful Rachel Upjohn Building, opened in 2006 to house both ambulatory psychiatry and the Depression Center.

As the department celebrated its centennial in 2006 with the opening of a new building, it was apparent that the role of chairman had changed since the inauguration of the SPH. In the early decades of the department, administrative duties could be easily incorporated into an academic position that also included patient care and research. A century later, however, the chair was responsible for more than a hundred faculty, a substantial budget, numerous buildings and programs, and a much more complex administrative structure. As Greden took on a larger role in promoting depression research and treatment, it became challenging to manage all of the other aspects of the chair position. In 2007, Greden stepped down as chair of psychiatry in order to devote all of his effort to the development of the Depression Center, as well as a network of similar centers around the country.

Gregory Dalack, who had been the head of the VA Psychiatry Service and then Vice-Chair of the Department, assumed the interim chair position after Greden's departure. In the process of searching for a new chair over the subsequent few years, members of the department asked themselves hard questions about the nature of psychiatry, the role of the department vis-à-vis the medical center as a whole, and the respective places of research, education, and clinical

care. Was psychiatry a form of primary care and should psychiatrists be working in general medical clinics or was it a specialty in which psychiatrists only took on complex patients? Should the department focus on a particular kind of patient or research problem, or would that be logistically too difficult in a small city such as Ann Arbor? Should research endeavors in the department have closer ties to the pharmaceutical industry? Should education be a major focus or follow from research activities? In the end, the faculty and medical center administration chose Dalack, who brought research experience, administrative capabilities, a passion for education, as well as compassionate care for patients, to the chair position in 2010.

The More Things Change

In many ways, the view of psychiatry in the second decade of the twenty-first century is entirely different from the origins of the specialty in the middle of the nineteenth century. Certainly the University of Michigan Department of Psychiatry has been transformed since its beginning. While Barrett's department had a handful of faculty, Dalack's department has hundreds of faculty and staff who take care of thousands of patients a year with medication and evidence-based therapies informed by research. Individuals with mental illness are enrolled as subjects in research trials to explore the neurobiology of their ailments, and increasingly sophisticated genetics programs hint that we might eventually uncover the biological basis of at least susceptibility to mental illness. Our expectations for psychiatric treatment are also different, as we emphasize recovery and management of chronic illness.

Though some aspects of psychiatric treatment are entirely dissimilar, other challenges remain the same. We are still in the dark about the etiology of most mental illness and our treatments come with side effects. Although many understand mental illness to be brain disease,

there are still significant groups of people in the United States and around the world who are fundamentally opposed to psychiatry and its interventions.⁷² And we continue to run into challenges managing the divide between medical and psychiatric care on both a theoretical and an organizational level. (There has been active discussion about the need for a medical-psychiatric inpatient unit at the University of Michigan Hospital for over four decades!) Finally, we continue to be constrained by reimbursement issues, especially as insurance coverage for psychiatric care remains less than adequate.

Not only have external forces mandated changes – and innovation – in clinical care, but also the shape of education has changed. For decades psychiatry, along with other departments at the medical center, managed trainees by having them participate in clinical care and offering them teaching in exchange for work they could perform in clinical settings. Traditionally, the bulk of the clinical work was done by residents with supervision by faculty, while students participated by completing documentation. As a result of a series of changes in federal health care financing rules, however, the role of faculty in clinical care has steadily increased over the last two decades, while opportunities for student and resident participation have decreased. In most recent years, resident work hours limitations – intended to ensure patient safety and to protect residents from crippling workloads – have resulted in even further shifts of work to faculty. Meanwhile students' roles have been severely curtailed. As a result of these limitations, departments across the medical center – including psychiatry – have had to innovate educational programs to make sure that trainees of all kinds learn the skills they need to progress to the next

⁷² See for example, Linda Andre, *Doctors of Deception: What They Don't Want You to Know About Shock Treatment* (New Brunswick, NJ: Rutgers University Press, 2009).

level.⁷³ At the medical school, the dean's office is working on a new kind of curriculum design to shape students into active learners instead of just apprentices within medicine. And in psychiatry the elimination of the oral examination for the American Board of Psychiatry and Neurology has created the opportunity for new kinds of resident teaching and evaluation.

The medical center as a whole and the department of psychiatry have also addressed some of the emerging problems around potential conflict of interest with the sponsorship of research by pharmaceutical companies. Nationwide, it has become increasingly obvious that some of the published literature about the merits of pharmaceutical remedies for disease are potentially biased because of investigators' relationships to the companies that make the pharmaceuticals. Although this has been a concern for most specialties in the last few decades, psychiatry has come under even more scrutiny as pharmaceutical companies have appeared to even influence how practitioners diagnose and treat patients.⁷⁴ At the University of Michigan, the medical school made a policy of full disclosure, with a goal of reducing (or eliminating) ties to pharmaceutical companies. The Department of Psychiatry participated in this shift. At a time when other psychiatry departments – including the one at Harvard University – have faced significant criticism on this issue, the University of Michigan is an innovator in responsible conduct of research.⁷⁵

The Department of Psychiatry continues to wrestle with the challenges of acting as both a tertiary care referral center and a community provider in a relatively small center more than an

⁷³ See for example, Gregory W. Dalack and Michael D. Jibson, "Clinical Skills Verification, Formative Feedback, and Psychiatry Residency Trainees," *Academic Psychiatry* 36 (2012): 122-125; Divy Ravindranath, Tamara L. Gay, and Michelle B. Riba, "Trainees as Teachers in Team-Based Learning," *Academic Psychiatry* 34 (2010): 294-297.

⁷⁴ Marcia Angell, *The Truth About the Drug Companies: How They Deceive Us and What to Do About It* (New York: Random House, 2004); Allen Frances, *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (New York: HarperCollins, 2013).

⁷⁵ Daniel J. Carlat, *Unhinged: The Trouble with Psychiatry - A Doctor's Revelations About a Profession in Crisis* (New York: Free Press, 2010).

hour away from the nearest major city. Throughout the history of the University of Michigan Medical Center, geography has played a role in shaping the mission of medical practice and the center's role in the state and the nation.⁷⁶ The psychiatry department excels in education, research, and clinical care. But in an era of limited resources and difficult decisions about priorities, the department will have to continue to make strategic decisions in a caring – but responsible – way.

⁷⁶ Horace W. Davenport, *Not Just Any Medical School: The Science, Practice, and Teaching of Medicine at the University of Michigan, 1850-1941* (Ann Arbor: University of Michigan Press, 1999).