

A History of Psychiatry in the United States of America

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Abstract

Objectives: In this general review, we provide a timeline of how psychiatry in the United States of America has evolved and developed since the nation's inception in the 18th century. **Methods:** Besides our life time experiences in receiving training, teaching, and practicing psychiatry, we collected information from the literature pertinent to the history of development of American psychiatry in this review. **Results:** In this review, we have highlighted some of the more cardinal events in American history – the shift from asylums to deinstitutionalization of patients in chronic state hospitals; the birth and evolution of *the Diagnostic and Statistical of Mental Disorders* by the American Psychiatric Association inspired by a dire need to unite a field; the revolutionary discovery of psychotropic medications and the galvanization of pharmaceutical research, development, and use of psychotropic medications in America; and the growing passion for psychiatry over the last several years among senior medical students. **Conclusion:** In tandem with their colleagues in other countries, American psychiatrists have overcome many trials and tribulations in their endeavor to ease the suffering of the mentally ill in the United States. We are optimistic for the future of American psychiatry as exemplified by a growing passion for psychiatry among American senior medical students, the expansion of US psychiatry residencies, the continued commitment by the National Institute of Mental Health to fund psychiatric research, and the exciting and thoughtful research of our colleagues domestically and abroad.

Key words: America, deinstitutionalization, development of psychotropic medications, *the Diagnostic and Statistical of Mental Disorders*
Taiwanese Journal of Psychiatry (Taipei) 2020; 34: 59-66

Introduction

Before establishment of hospitals in the United States of America, the mentally ill were typically cared for by family members. In severe cases, if family members were unable to manage their loved ones at home, they would be sent to jails or almshouses.

The first general hospital in the United States was established in 1753 in Pennsylvania. This was followed by the New York Hospital which opened in 1791. The first of their kind in the new world, both hospitals made provisions for the mentally ill [1]. The first institution designed specifically for the care of the mentally ill was opened in Williamsburg, Virginia, in 1773 under the title “The Court of Directors of the Public Hospital for Persons of Insane and Disordered mind” [1]. Dr. John Minson Galt was appointed to the office of Medical Superintendent of the Eastern Lunatic Asylum at Williamsburg.

US sentiment toward the mentally ill was relatively indistinguishable to that of their English counterparts across the Atlantic during this early period. A signee of the US Declaration of Independence, Benjamin Rush of Pennsylvania, is widely regarded as the father of American psychiatry whose likeness can still be found on the American Psychiatric Association (APA)'s emblematic seal although his portrait was removed from the official logo of the APA in recent years. In 1812, Rush published the first textbook of mental illness in the US titled *Medical Inquiries and Observations upon the Diseases of the Mind* Rush held that mental illnesses were the result of medical causes such as disrupted arterial circulation and thus prescribed physical remedies. His prescriptions included purging, bleeding, as well as inventions of his own design such

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Received: Apr. 6, 2020 revised: Apr. 15, 2020 accepted: Apr. 16, 2020
 date published: Jun. 26, 2020

Access this article online

Quick Response Code:



Website:
www.e-tjp.org

DOI:
 10.4103/TPSY.TPSY_12_20

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How to cite this article: Truong AH, Maguire GE, Maguire GA. A history of psychiatry in the United States of America. *Taiwan J Psychiatry* 2020;34:59-66.

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as a tranquilizing chair to dampen an overstimulated sensory system and a centrifugal rotation chair to restore disrupted blood flow [2].

Similar to Pinel in Europe, Rush advocated for the restructuring of mental institutions to more humane conditions and catalyzed Pennsylvania to establish the first of such mental wards in the US [2].

The beginning of the 19th century saw American psychiatry being greatly influenced by the influx of new ideas and attitudes brought over by European immigrants. This period saw a rise in larger institutions whose mission is was to care for the chronically mentally ill. By 1844, the US had 22 public and private institutions for the mentally ill [1]. A major figure during this expansion of mental hospitals was Dorothea Dix. A retired teacher, Dix visited a local jail to teach Sunday school and was dismayed to discover the living conditions the inmates and mentally ill had. She set about on a crusade that would lead to the improvement of living conditions for the mentally ill and the expansion of mental hospitals across the US. Her advocacy efforts played a role in the establishment of 32 state mental hospitals in the US [1, 3-5].

In 1844, the Association of Medical Superintendents of American institutions for the Insane was established in Philadelphia. This association would later change its name to the American Medico-Psychological Association in 1892 and lastly the APA in 1921. The mission of the Association was “to communicate their experiences to each other, cooperate in collecting statistical information relating to insanity, and assist each other in improving the treatment of the insane” [6].

Through the casualties of the American Civil War (1861–1865), neurology was developed as an independent specialty. Naturally, this role led to a greater focus on the central nervous system and subsequently mental illnesses [7].

The turn of the 20th century gave rise to a more progressive stance on mental health. A notable psychiatrist of this time was Adolf Meyer who practiced psychiatry with an emphasis on psychobiology and the influence of environmental, constitutional, and developmental factors on mental health. Meyer endeavored to create comprehensive histories and physicals on his patients which included social, mental, physical, and developmental history [8, 9]. With World War II, there was an influx of psychiatrists trained in psychoanalysis immigrating to the US. Several decades later, psychoanalysis took root in the shape of the American Psychoanalysis Association (APsaA). In the 1940s, the APsaA encouraged its followers to push for the integration of psychoanalysis into medical schools and academic institutions. The result of this push would be the occupation of nearly every major psychiatry position by a psychoanalytic trained psychiatrist by the 1960s. For much of the 20th century, American Academic Psychiatry would be dominated by practitioners of psychoanalysis and post-Freudian psychiatry [10-15].

William Menninger, a notable psychoanalytic psychiatrist, would gain the prestige of not only being featured in *Time* magazine, but also meeting President Harry Truman who stated “never have we had a more pressing need for experts in

human engineering. The greatest prerequisite for peace must be sanity, which permits clear thinking of the part of all citizens. We must continue to look to experts in the field of psychiatry and other mental sciences for guidance” [16, 17]. President Truman would establish the National Institute of Mental Health (NIMH) in 1949 following the passage of the National Mental Health Act in 1946. Menninger endeavored to reform the APsaA and American psychoanalysts to his own vision of a socially oriented and psychodynamic psychiatry [18, 19].

Commitment Law to Protect the Human Rights of the Mentally Ill

In 1948, the Group for the Advancement of Psychiatry, headed by Menninger, studied the nation’s commitment laws and found that six states had no provisions for voluntary hospital admissions and 23 states had no provisions for emergency admissions. As a result of that study, the NIMH in 1952 proposed two criteria for involuntary admission: that the person is likely to injure self or others or is in need of treatment but lacks the capacity to make an application for admission. The NIMH proposed that commitments be in effect for an indefinite period of time and that hospital superintendents could discharge patients on indefinite convalescent leave. California adopted most of the provisions [20, 21].

The California legislative subcommittee on mental health services began hearings in 1966 and found that involuntary mental health patients lost more civil rights than convicted felons. The subcommittee then began to take a broader look at mental health laws and identified two dilemmas – that the basic objectives of treating the individual and protecting the public are often in conflict as well as the need to provide prompt treatment yet insure no loss of liberty with due process of law. The subcommittee also looked at the population in California’s state hospitals. About 28% of the patients were over the age of 65 years and more than half of all admissions were either elderly (over 65 years) or were admitted because of alcohol problems. These findings led to developing the new concept of “grave disability” – that is, the inability to provide for one’s own food, clothing, or shelter (www.moorlack.cssrc.us).

Based on its findings, the subcommittee developed the Lanterman-Petris-Short (LPS) Act which became law in 1969. It was described at the time as “revolutionizing” the care of the mentally disordered. The act changed commitment criteria from the need for treatment (in professional opinion) to behavioral evidence – dangerousness or grave disability. It ended indefinite commitments and convalescent leave, emphasized short-term treatment in the community and restored the civil rights of patients (www.moorlack.cssrc.us).

Those changes in the law took place in part because the subcommittee believed that 14 days of involuntary treatment were “sufficient and effective for the vast majority of cases” and that conditions in state hospitals were responsible for much of the “unnecessary crippling” associated with serious mental disorders. The subcommittee was convinced that patients would “seek out” services if the services were available. Grave

disability was intended to apply to older persons or persons who were physically debilitated from alcohol dependence and not to younger persons with persistent mental disorder. During periods of involuntary treatment, the subcommittee believed that legal oversight should take the place of medical decisions [22].

By the end of the 1970s, nearly every state had adopted many of the provisions of the LPS Act. After 50 years, the LPS Act remains essentially as it was written [23].

Development of the Diagnostic and Statistical of Mental Disorders-I and Diagnostic and Statistical of Mental Disorders-II

The creation of the first *Diagnostic and Statistics Manual of Mental Disorders* in 1952 had humble roots in the US Census. The vastness of mental illnesses was tabulated on the 1840 US census as a binary option of either “Insanity and Idiotic” or not. In the early 20th century, the US Census had expanded to begin collecting census data on the inmate population in mental institutions. But a major obstacle revealed itself in the form of nonstandardized categorization of mental illnesses. In 1917, the American Medico-Psychological Association (the predecessor to the APA) tasked its statistics committee with establishing a uniform system by which to collect data from all mental institutions in America. The fruits of their labor would be published as *The Statistical Manual for the Use of Institutions for the Insane* or the *Standard*. Several decades later, the US military would bring us one step closer to the *Diagnostic and Statistical of Mental Disorders (DSM)* with the publication of *Medical 203* in 1943. *Medical 203* was commissioned by the US military as a comprehensive system by which the mental health of new recruits could be evaluated. The *Medical 203* included sixty disorders and was the first of its kind to encompass every form of mental illness seen today [24, 25]. Despite this, *Medical 203* was largely ignored by American psychiatrists at this time. Wary of undermining the credibility of the psychiatric profession due to wide variability of diagnoses among psychiatrists, in 1950, the APA formed a committee on nomenclature and statistics entrusted with the task of developing a diagnostic system for mental illness.

Two years later in 1952, the committee published the very first *DSM-I*, which included 106 mental disorders [26]. Though *DSM 1* provided a standardized diagnostic schema, the classifications were formed without scientific evidence or empirical research. The second edition of *DSM (DSM-II)* was published in 1968 without much fanfare and was expanded to include 182 disorders [27].

Antipsychiatric Forces in the US

The 1960s gave rise to skeptics of psychiatry from both internal and external sources [28]. Undermining the belief that mental illnesses were indeed medical illnesses, Thomas Szasz, a psychiatrist would publish *The Myth of Mental*

Illness, in which he argued that mental illnesses were not medical illnesses but fabrications by psychiatrists to justify treatment with unscientific therapies of questionable efficacy [28, 29]. The Church of Scientology joined forces with Szasz to form the Citizens Commission on Human Rights (CCHR) whose vision entailed the condemnation of psychiatry and its treatments. Szasz was the first of many antipsychiatrists who would go on to inspire a movement of antipsychiatrists who may be found demonstrating outside of the APA annual meeting every year since 1968. The critically acclaimed movie, *One Flew Over the Cuckoo's Nest*, would further damage the image of American psychiatry through its vivid depictions of electroconvulsive therapy (ECT) and lobotomies performed on the protagonist [30, 31].

A few short years later, controversy would strike American psychiatry in the form of an exposé in the journal *Science*. David Rosenhan, a lawyer and psychologist, had published an experiment titled, “On being sane in insane places.” Rosenhan’s experiment involved answering the question “If sanity and insanity exist, how shall we know them?” He answered this question by hiring actors to infiltrate 12 different mental hospitals with the chief complaints of auditory hallucinations. After their initial encounter, these actors would then act completely normal – all would be diagnosed with either schizophrenia or manic-depressive illness. Rosenhan’s experiment set the field on fire with great concern from the general public and defensive rebukes from psychiatrists [30, 31].

The tumultuous nature of the 1960s and 1970s would set the stage for a radical change in American psychiatry. The 1960s gave rise to community psychiatry and treatment through psychopharmacology. Community psychiatry emphasized “de-institutionalization” and a multidisciplinary cast of professionals and nonprofessionals to support the mentally ill as they re-entered society [32]. Beginning with discoveries in the 1950s, psychopharmacology would begin to make a major impact on the practice of American psychiatry with a re-emphasis on symptom-based treatment. With the advent of psychopharmacology, Kraepelinian and biological psychiatry would enjoy a revival that would endure into the present.

Revitalization of the Diagnostic and Statistical of Mental Disorders: from Diagnostic and Statistical of Mental Disorders-III to Diagnostic and Statistical of Mental Disorders-5

In the 1970s, Dr. Robert Spitzer, chief architect of the *DSM-III*, revolutionized psychiatry with his complete overhaul of the *DSM*. Before this massive undertaking, Dr. Spitzer first worked on declassifying homosexuality as a mental disorder when he organized a panel at the APA annual meeting in 1973. In the context of an antipsychiatry movement and the claims that all of psychiatry were a social construct, Spitzer carefully navigated removing homosexuality as a mental

disorder by arguing that if a patient's condition did not cause him emotional distress, impaired his ability to function, and if that patient insisted he was well, then a diagnosis of illness should not be made. By year's end, Spitzer's recommendation would be adopted as an official revision and homosexuality was removed from *the DSM-II*. Through a resurrection of Kraepelinian research on mental illness focused on symptoms and course, Spitzer would lead *the DSM-III* task force in revitalizing American psychiatry [30, 33].

In 1972, John Feighner and colleagues published what would colloquially be known as the Feighner criteria for use in psychiatric research [35]. Feighner's work was the distillation of the review of thousands of published articles on mental health disorders with a focus on specific symptoms and course [36]. Equipped with the Feighner criteria as a foundation, Spitzer would embark on the momentous task of completely reworking *the DSM* to reflect a scientific and research-driven approach to the diagnosis of mental illnesses. The major changes reflected in *the DSM-III* included removing the criterion of etiology in favor of two new diagnostic criteria:

- The symptoms must be distressing to the individual or the symptoms must impair the individual's ability to function (subjective distress),
- The symptoms must be enduring.

In June 1976, Spitzer revealed the first public draft of his new *DSM* and was soon met with wave after wave of criticism. The most vocal of these critics were the American Psychological Association and the American Psychoanalytic Association (APsaA) [33]. On May 12, 1979, after a 6-year meticulous review of the available research and data, Spitzer offered up his *DSM-III* final draft to the annual APA meeting for ratification. From the 182 mental disorder categories in *the DSM-II*, the *DSM-III* expanded to 265 (Table 1), and removed the term "neurosis." The ratification of *the DSM-III* marked a changing of the guard and the role of psychoanalysis in American psychiatry would be greatly diminished thereafter in favor of a more biological approach [27, 33, 34].

Published in 1994, *the DSM-IV* expanded the number of mental disorder categories to 297 from the 265 in *DSM-III*. *DSM-IV* included culture-bound syndromes to account for cultural variability and its impact on mental health and illnesses [34, 36].

Work on *the DSM-5* began in 2006 with the appointment of a new *DSM* Task Force with David Kupfer and Darrel Regier as chair and vice chair, respectively. The APA and the new taskforce were met with criticism from both internal and external forces. From the outside, there were antipsychiatrists which included the Church of Scientology. But what was unexpected was that Robert Spitzer and Allen Frances, chairs of the *DSM-III* and *the DSM-IV*, respectively, would join the fray. Chief among the concerns of Spitzer and Frances was the lack of transparency in the process and the confidentiality agreements that Kupfer and Regier had mandated in their taskforce. The APA appointed an oversight committee in 2009 who discovered that there were some legitimate concerns regarding the direction and organization of *the DSM-5*. Two

Table 1. Chronology of versions of the *Diagnostical and Statistical Manual of Mental Disorders* published by the American Psychiatric Association [27, 36, 37]

	Year published	Number of diagnoses
<i>DSM-I</i>	1952	106
<i>DSM-II</i>	1968	182
<i>DSM-III</i>	1980	265
<i>DSM-III-R</i>	1987	292
<i>DSM-IV</i>	1994	297
<i>DSM-IV-R</i>	2000	365
<i>DSM-5</i>	2013	265

All data are from references [27, 36, 37]

ad hoc review committees were formed with the task for reviewing the scientific evidence behind proposed changes and reviewing the clinical and public health implications of these proposed changes. As shown in Table 1, *The DSM-5* was published in May of 2013 with a reduction of mental health diagnoses from the 297 in *DSM-IV* to 265 [30, 37].

Data from the 2018 annual survey collected by the Substance Abuse and Mental Health Services Administration (SAMHSA) allow us a glimpse into the current state of mental health in the US. In 2018, about 47.6 million adults aged 18 years or older reported any mental illness (AMI) as defined by any mental, behavioral, or emotional disorder in the past year that met the *DSM-IV* criteria. The 47.6 million adults aged 18 years or older were further categorized into serious mental illness (SMI) as defined by the presence of any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities – of which there is roughly 11.4 million adults aged 18 or older with SMI. The 47.6 million adults with AMI roughly correspond to 19.1% of the adult population in the US – that is to say that roughly one in five Americans have a mental illness (www.samhsa.gov).

In 2018, roughly 37.1 million adults or 15% of the entire adult population aged 18 years or older received treatment for a mental illness – corresponding to roughly one in seven adults receiving mental health treatment. Of adults aged 18 years or older with AMI, less than half, 20.6 million or 43.3%, received mental health services in the past year. Per SAMHSA, among adults 18 years and older with a SMI, roughly 64.1% have received mental health treatment in the past year (www.samhsa.gov).

Evolution of Psychiatric Treatment in the US

The evolution of psychiatric treatment in the US has followed in tandem with our European colleagues. For much of the 17th, 18th, and 19th centuries, the only available treatment to the mentally ill was institutionalization. Before the humanizing work of Pinel in the 1700s, Rush in the 1800s, and Dix in the mid-1800s, the mentally ill were often housed in deplorable conditions next to the handicapped, vagrants, and delinquents. In the most severe cases, the mentally ill were chained and shackled to walls. At the turn of the 19th century, there were 150,000 patients in asylums. This number

swelled to 560,000 by 1955 [30, 38, 39]. Without any viable treatments, American patients had no other option, but to spend their days in mental hospitals.

The first breakthrough in the treatment of psychiatric symptoms came in the early 20th century when Julius Wagner-Jauregg won the Nobel prize in medicine in the field of psychiatry for pyrotherapy. Pyrotherapy involved intentionally infecting the mentally ill with pathogens to elicit an immune response. Wagner-Jauregg would win the Nobel prize in 1927 “for his discovery of the therapeutic value of malaria inoculation in the treatment of dementia paralytica.” Wagner-Jauregg reported that “six of the nine cases (patients with neurosyphilis treated with malariotherapy) showed extensive remission, and in three of those cases, the remission proved enduring.” Malariotherapy in the US was first prescribed in 1922 and would see an increase following Wagner-Jauregg’s Nobel prize win in 1927 [40-44].

In the 1940s, Manfred Sakel, an Austrian neurophysiologist and psychiatrist, pioneered the use of insulin to induce hypoglycemic comas in the mentally ill to alleviate behavioral symptoms. Sakel’s observations from accidental hypoglycemia during the treatment of drug addiction inspired him to test his theories on the seriously mentally ill. Sakel’s insulin shock therapy would be adopted for use in mental hospitals in the US [45-48].

In the 1930s, Antonio Egas Moniz hypothesized that intentionally forming lesions in the frontal lobe would induce changes in behaviors and emotions. Applying that hypothesis to psychiatric symptoms, Moniz recruited a neurosurgeon to perform a “leucotomy” an operation by which lesions could be created in the frontal lobe. Moniz’s leucotomies would earn him the Nobel prize in 1949 “for his discovery of the therapeutic value of leucotomy in certain psychosis”. In the US, Walter Freeman, a neurologist, would pioneer the transorbital lobotomy. The transorbital lobotomy was different in its methodology and involved inserting an ice-pick-like instrument through the transorbital by the way of the eyelid to access the cranial cavity. Lobotomized patients were subdued, less aggressive, and overall, more easily managed than their untethered counterparts. Patients who survived their lobotomies would often be subdued and more manageable [49-52].

In 1934, the psychiatrist Ladislav J. Meduna, induced seizures through the use of camphor, a food additive and embalming fluid, and later metrazol, a stimulant that could cause seizures at high doses. Coined convulsive therapy, Meduna’s treatments were prescribed for schizophrenia, however were rather dangerous as metrazol-induced seizures were violent, uncontrollable, and could lead to fractures of the vertebrae [30, 53-55].

Ugo Cerletti, Italian neuropsychiatrist, enlisted the help of Lucino Bini to devise an instrument to deliver a targeted electrical shock to induce a seizure in 1938. By the 1940s, Cerletti’s ECT was a superior method to induce a seizure in psychiatric patients. Lothar Kalinowsky, a German immigrant, pioneered the use of ECT in the US for the treatment of

schizophrenia. ECT would gain more wide use in comparison pharmacologic-induced seizures. But ECT would decline in use shortly afterward with the discovery of psychopharmacologic agents [55-57].

Introduction of chlorpromazine

In 1949, Henri Laborit, French surgeon, discovered the benefits of chlorpromazine as an antipsychotic when he noticed that it appeared to have a calming effect on his surgical patients. In 1952, intravenous chlorpromazine was given to a psychotic patient resulting in the miraculous amelioration of his psychosis. Chlorpromazine was trademarked as Thorazine® in the US and was advertised to state facilities as a means to deinstitutionalize patients and return them to the community. In the US, Thorazine® was widely prescribed and played a pivotal role in the deinstitutionalization of the mentally ill. The discovery of chlorpromazine is a seminal advancement in psychiatry and to this day remains an essential medication on the World Health Organization’s list of “Essential Medications” [58-60].

Though lithium had been available for use in the 1940s and 1950s in Europe, it would not gain popularity in the United States until the 1960s–1970s. Funded by the NIMH, Samuel Gershon and Arthur Yuwiler published the first North American publication on lithium. In the 1960s and 1970s, a plethora of US studies on lithium existed for the management of mania, depression, and relapse. In 1970, the US Food and Drug Administration approved the use of lithium in mania and later in 1974 for the maintenance treatment of bipolar disorder [61, 62].

Advent of antidepressants

In 1955, a pharmaceutical company enlisted the help of Swiss psychiatrist, Ronald Kuhn, in the discovery/trial of medications that were chemically similar to chlorpromazine. Kuhn tested compound G22355 on schizophrenic patients and noticed that it seemed to have an antidepressant effect. G22355 would later be named imipramine and was the first tricyclic antidepressant discovered. Subsequently, imipramine would be available for the treatment of depression in the US in 1959 [63-65].

In 1974, Eli Lilly researchers – Ray W. Fuller, David T. Wong, and Bryan B. Molloy – reported their research on fluoxetine, the first serotonin-reuptake inhibitor (SSRI). Fluoxetine was approved for use by the US FDA in 1987 and released in 1988. Marketed as Prozac® by Eli Lilly, fluoxetine was pivotal in the treatment of depression and became instrumental to outpatient psychiatrists and played a significant role in ushering in the primary care treatment of psychiatric disorders. Similar to the status of chlorpromazine, fluoxetine to this day remains on the World Health Organization’s list of Essential Medications [60, 65-68].

The re-discovery of clozapine

Clozapine was the first “atypical” antipsychotic discovered and entered the US market in February 1990. Its initial reception in the world was overall slow as there was a widely

held belief that a medication’s antipsychotic effect and degree of extrapyramidal side effects went hand in hand. Clozapine initiation was further stymied by concerns for agranulocytosis from studies in Finland [69]. This led to the suspension of all research and development on clozapine, including studies for clozapine’s drug application to the FDA in 1976 [70]. Sandoz, the proprietors of clozapine, faced an uphill battle with the FDA New Drug Application in the US as they were required to prove (personal communication with G. Honigfeld, 2005):

- That clozapine works in this treatment-refractory population,
- That clozapine works better than standard antipsychotic medications.

Sandoz’s Clozapine studies began in 1984 across 16 different sites across the US. Sandoz’s study showed that clozapine outperformed chlorpromazine in the reduction of both positive and negative symptoms [70]. Clozapine received formal FDA approval in September 1989 under the trade name Clozaril® [71].

In the wake of clozapine, the first “atypical,” the 1990s gave rise to risperidone in 1994, olanzapine in 1996, quetiapine in 1997, and ziprasidone in 2001. Antipsychotic drugs are widely used today and account for in excess of \$13 billion in the US domestics annually as of 2007 [73]. Overall, the newer second-generation antipsychotics have enjoyed higher use in part due to their reduced potential for extrapyramidal symptoms as well as their equitable efficacy to the first-generation antipsychotics [72-74]. Beyond their FDA-approved uses for schizophrenia spectrum diseases and bipolar disorder, over the years, second-generation antipsychotics have been used for a myriad of mental health disorders. In patients with major depressive disorder, the addition of a second generation antipsychotic such as quetiapine or aripiprazole as augmentation has shown benefit. In individuals who suffer from stuttering, atypical antipsychotic therapy such as risperidone has shown efficacy in reducing the severity of the condition [75].

The American Psychiatric Association

As stated previously in this review, the Association of Medical Superintendents of American institutions for the Insane was established in Philadelphia in 1844. This association later changed its name to the American Medico-Psychological Association in 1892 and lastly the APA in 1921.

As of 2020, the APA has had 147 presidents with the majority serving a 1-year term. APA membership numbers at roughly 38,800 and have direct vote in electing APA presidents – elect through a online-in ballot. After serving 1 year, the APA presidents-elect are automatically promoted to APA presidents at the close end of the APA annual meeting. With a combined 73 branches and state associations, the APA has a presence in many states across the country (www.psychiatry.org).

Furthermore, APA members may join available caucuses with special focus and attention to minority/underepresented populations – American Indian/Alaska Native/Native Hawaiian, Asian-American, Black, Hispanic, international

medical graduates, lesbian/gay/bisexual/transgender/and queer or questioning (LGBTQ), as well as women.

The APA annual meeting garners over 15,000 attendees yearly and provides a forum for educational sessions, continuing medical education, research presentations, poster presentation by medical students and residents, and networking opportunities for hopeful residency applicants.

Conclusion

Psychiatry in the US has evolved a great deal over the last several centuries. From almshouses to asylums to deinstitutionalization. From shackles to marlariotherapy to lobotomies to risperidone. The breadth of knowledge discovered and yet to uncover remains wide. The present and future of American psychiatry is bright. Interest in psychiatry is at an all-time high among American medical students as can be seen in the unprecedented number of US. Interest among graduating US allopathic medical students has never been higher. New psychiatric residencies are developing with a growth in programs from 211 in 2015 to 310 in 2020. This growth in programs reflects an increase from 1,353 PGY-1 psychiatric residency positions available in 2015 to 1,858 in 2020. In 2015, of all US MD seniors applying for a PGY-1 position, 4.88% applied for a categorical psychiatry position. As shown in Figure 1, this past March 2020, this number would increase to 6.8% (www.nrmp.org).

Beyond academic psychiatry, the US government has continued to support psychiatric research through the NIMH, which is reflected in an increase in the annual budget from US\$1.48 billion in 2010 to US\$1.63 billion in 2020. Overall, we are optimistic that the field of psychiatry will continue to grow in the US with greater awareness, more research, and a growing armoire of treatments to ease the suffering of our patients.

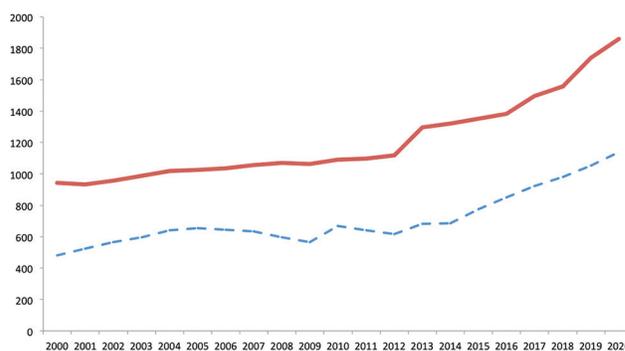


Figure 1. Recent trends of psychiatry residency matching in the US. Vertical axis is the number of individuals or PGY-1 positions offered. Horizontal axis is year. The growing number of US postgraduate year 1 psychiatry residency positions (in solid line) in tandem with the growing number of US medical seniors matching into psychiatry (in dot line) as a career choice. Source: National Residency Matching Program Match Data in the US from 2000 to 2020 (NRMP, 2000-2020, <http://www.nrmp.org/wp-content/uploads/2015/05/Main-Match-Results-and-Data->).

Acknowledgment

The opinions expressed by the authors are their own and are not expressed on behalf of any organization.

Financial Support and Sponsorship

The authors report no financial support in writing this report.

Conflicts of Interest

The authors declare no conflicts of interest in writing this report.

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