GERALD N. GROB

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For my father and the memory of my mother

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PREFACE

MUCH OF THE historical literature about American social policy reflects contemporary issues and concerns. This is especially true of works that discuss the ways in which American society dealt with the problem of mental illness in the past. Thus many scholars have uncritically accepted the allegation that mental hospital care was a disaster, and they have therefore attempted to shed light on the origins of institutional failure.

In general, the historical literature dealing with the care and treatment of the mentally ill falls into two broad categories. The first—the traditional or liberal—was developed by scholars who celebrated mental hospitals and other antebellum institutions as proof of human progress, humanitarianism, and progressive sentiment. Albert Deutsch's classic *The Mentally Ill in America* (1937) accepted at face value the optimistic claims of psychiatrists and their definitions of mental disease. Conceding that institutional care of the mentally ill was far from successful, Deutsch placed responsibility for past failures upon American society for not providing sufficient material resources. Even in 1948, when he wrote a devastating exposé of public mental hospitals (*The Shame of the States*), he did not despair or conclude that institutional care and treatment was predestined to fail. On the contrary, he upheld the *theory* of institutional practice and urged his fellow citizens to band together "to participate in the common drive toward improved mental hygiene facilities," and to insist that government at all levels provide appropriate funding.

The second (or revisionist) interpretation emerged in its most mature form in the 1960s. Influenced by the critics of orthodox psychiatry, contemporary Marxist theory, and the sociological concept of the total institution, revisionist scholars insisted that mental hospitals were inherently repressive. In their eyes mental illness was not an objective description of a disease within the conventional meaning of the term; it was rather an abstraction designed to rationalize the confinement of individuals who manifested disruptive and aberrant behavior. Mental hospitals, such scholars argued, were established for one of two reasons: either the generalized fear of social disorder, or because of the rise of

market capitalism and its concommitant demand for greater productivity. The primary function of mental hospitals, according to this approach, was to confine social deviants and/or unproductive persons. Despite differences in approach and methodology, such scholars as Michel Foucault, David J. Rothman, Andrew Scull, Richard T. Fox, Michael B. Katz, and Christopher Lasch all have one element in common: a critical if not hostile view of psychiatry and mental hospitals.

Curiously enough, there were striking differences between the traditionalist and revisionist approaches. Both began with the assumption that many institutions failed to achieve their purposes. Whereas traditionalists viewed this failure as transitory, revisionists saw it as an inevitable consequence of institutional solutions.

Although yielding rich insights and employing certain kinds of primary source materials hitherto ignored, the traditionalist/revisionist approach had several undesirable side-effects. The use of a presentist framework and the resort to social science models assumed that past problems and policies were not fundamentally dissimilar from present-day ones. The result was a form of scholarship that was essentially ahistorical; the dynamic of change was missing, and there was a tendency to describe the past in monolithic terms. In recent years, for example, some historians have dealt with institutions in terms of their common characteristics and inferred generalizations about the nature of the society that created them. Such an approach, however, avoided certain key questions. Was it appropriate to classify within a single category various kinds of institutions as though there were few significant dissimilarities among them? Were the experiences of patient populations in mental hospitals similar or comparable? Did levels and sources of support, geographical location, and different legal, administrative, and intellectual environments and other phenomena give rise to mental hospitals that were neither as unchanging or monolithic as these scholars assumed?

On another level, much of the scholarship pertaining to the mentally ill rested on a narrow empirical base. Only in recent years have historians begun to plumb the rich and varied collections of printed and unprinted materials on the subject that have survived. In fact, many of the familiar generalizations common to the historiography of the mentally ill still reflect the absence of comprehensive research. Too often generalizations lack a body

of supporting data. In the future it is more than likely that many widely held interpretations will be undermined by new data.

In writing this book I have attempted to avoid the pitfall of overgeneralizing without the support of accompanying evidence. The perennial problem of the practicing historian is to place events within some sort of framework of meaning, and, at the same time, to account for the complex and often contradictory nature of human behavior. I have yet to be persuaded that human experience can be explained easily or that all phenomena are necessarily linked within a single comprehensive system.

Because complexity rather than simplicity is characteristic of historical development, a brief discussion of some of the major conclusions of this book is in order at this point. First, mental hospitals—despite their very real shortcomings and failures—did provide *minimum* levels of care for individuals unable to survive by themselves. Moreover, the development of these institutions was shaped not only by psychiatrists and other external professional and social groups, but also by the nature and behavior of their patients and the interactions between patients and staff. Second, by the end of the nineteenth century American psychiatry faced a severe internal crisis. Conceived as a managerial and administrative specialty, its members found themselves moving increasingly away from the mainstream of medicine, which underwent a sharp change of direction toward the end of the century. In seeking to integrate their specialty with scientific medicine, psychiatrists were unaware that their efforts would lead them to modify their commitment to institutional care. More and more they focused on disease rather than on individuals, and therapy rather than care. At the same time they extended their specialty into the community, creating a mental hygiene movement, developing new roles for themselves, and formulating an ideology of professionalism that justified their demands for autonomy insofar as the care and treatment of mental illness was concerned. Third, at precisely the same time that psychiatrists were modifying their commitment to institutional practice, the nature of the patient population changed drastically. Before 1890 the patient population of mental hospitals included a large proportion of acute cases institutionalized for less than twelve months. Between 1890 and 1940, on the other hand, aged persons and individuals suffering from somatic disorders with accompanying behavioral symptoms began to constitute the bulk of hospital patients. These patients tended to remain institutionalized until they died.

By 1923, for example, 54 percent of patients in mental hospitals had been there five years or more; only 17.4 percent had been institutionalized for less than twelve months. For the chronic mentally ill specific treatment was nonexistent; most required comprehensive care. Ironically, as the need for care was magnified, the psychiatric legitimation of this function grew thinner. Fourth, public policy decisions at both the state and local level greatly affected patients, psychiatrists, and mental hospitals. Levels and sources of funding as well as differing structural and administrative systems also played a role in shaping the ways in which the mentally ill would be treated. Yet public policy often reflected professional and political concerns rather than patient needs. Finally, and perhaps most important, the central issue was not access to therapy or therapeutic effectiveness, but rather decent and humane *care* of patients whose physical and mental conditions precluded the possibility that they could care for themselves.

I would be less than honest if I did not speak of some personal views which undoubtedly influence my understanding of the past. I have never been especially impressed by the modern belief that human beings can mold and control their world in predetermined and predictable ways. This is not to argue that we are totally powerless to control our destiny. It is only to insist both upon our fallibility and our inability to predict all the consequences of what we do. Nor do I think that human behavior can be reduced to a set of quasi-deterministic laws or generalizations, or that solutions are available for all problems. Tragedy is a recurring theme in human affairs, and defines perhaps the very parameters of our existence. I have tried, therefore, to deal sympathetically with our predecessors who grappled—so often unsuccessfully, as we still do ourselves—with their own distinct problems. If nothing else, I hope that my work can help to refocus the debate about the care of the mentally ill by a clearer and more accurate understanding of the past.

No book, of course, is the result of the labor of one individual, and mine is surely no exception. I have drawn upon the work of many other scholars. If I have disagreed with them, it has been only after lengthy and serious thought. A number of very good friends—George A. Billias, David Mechanic, Jacques M. Quen, James Reed, and Barbara G. Rosenkrantz—have taken time from their own busy schedules to read successive drafts and to offer me the benefits of their insights; this book would have been much the worse had it not been for their penetrating and insightful

comments. I would also like to express my deep appreciation for the assistance provided by Richard H. Kohn, Jonathan Lurie, John C. Burnham, Richard L. McCormick, Kathleen Jones, and Paul E. G. Clemens.

All scholars benefit from the arduous but indispensable work of the many librarians and archivists who collect and organize materials without which history could not be written. A complete list of such individuals and institutions would be impossible, for my research has carried me to libraries throughout the United States. I am also deeply indebted to the Public Health Service, National Library of Medicine (HHR), which supported my work with a generous research grant (No. 2306) without in any way infringing upon my freedom. A fellowship from the American Council of Learned Societies made possible a leave of absence from teaching to gather data during the early stages of this project. Another fellowship from the John Simon Guggenheim Memorial Foundation and an invitation from the Rockefeller Foundation's Bellagio Study and Conference Center, Lake Como, Italy, gave me time to write. Finally, I have incurred a debt to my family that cannot be repaid; they created an atmosphere characterized by patience, understanding, and love.

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September, 1982

ABBREVIATIONS USED IN TEXT

AAPSW	American Association of Psychiatric Social Workers
AMA	American Medical Association
AMSAII	Association of Medical Superintendents of American Institutions for the Insane (1844-1892)
AMPA	American Medico-Psychological Association (1892-1921)
APA	American Psychiatric Association (1921-)
ANA	American Neurological Association
NCCC	National Conference of Charities and Correction
NCMH	National Committee for Mental Hygiene
PHS	Public Health Service

MENTAL ILLNESS AND AMERICAN SOCIETY, 1875-1940

PROLOGUE

DURING THE FIRST HALF of the nineteenth century Americans created an elaborate institutional network to provide care and treatment for the mentally ill.* After 1800 numerous changes in American society undermined traditional ways of caring for poor and dependent persons. During the colonial and early national period, the family and community had accepted responsibility for such individuals. But rapid population growth, urbanization, immigration, and high rates of geographical mobility changed this tradition. Americans increasingly resorted to quasi-public or public institutions for the care of the insane.** The mental hospital, along with the almshouse, poor farm, and house of refuge, became the institutional solution by which American society fulfilled its obligations toward dependent persons incapable of surviving by themselves. Mental hospitals, according to their defenders, benefited the community, the family, and the individual by offering treatment or furnishing custodial care for the chronic insane. In providing for the mentally ill and other dependent groups, the state met its ethical and moral responsibilities, and, at the same time, contributed to the general welfare by limiting, if not eliminating, the spread of disease and dependency.[1]

In their early years, mental hospitals enjoyed a certain measure of success and public acceptance. The first generation of superintendents in the 1830s and 1840s invariably imparted to their institutions a sense of optimism which, coupled with a relatively small patient population, presumably helped patients either to improve or recover. The founding of mental hospitals, a distinguished psychiatrist observed in 1852, "the spread of their reports,

* I have dealt with this subject in *Mental Institutions in America: Social Policy to 1875* (New York, 1973), which is in effect the predecessor to this book.

** No doubt some readers will be offended by the constant use of the terms "insane" and "insanity" as contrasted with "mentally ill" and "mental illness." Although the former two have acquired an odious reputation, they were perfectly good terms in the past. Nor was "insanity" a legal term. Between 1844 and 1921 the *American Journal of Psychiatry* was published under the title *American Journal of Insanity*. My usage, therefore, is a historical one and has no derogatory intent. Indeed, it is entirely probable that the word "mental illness" will in the future be looked down upon with the same hostility as "insanity" is at present.

the extension of the knowledge of their character, power, and usefulness, by the means of the patients that they protect and cure, have created, and continue to create, more and more interest in the subject of insanity, and more confidence in its curability. Consequently, more and more persons and families, who . . . formerly kept their insane friends and relations at home . . . now believe that they can be restored, or improved, or, at least made more comfortable in these public institutions.'"[2]

By 1880 the dreams of early American psychiatric activists such as Horace Mann and Dorothea L. Dix seemingly had been realized. At that time there were almost 140 public and private mental hospitals caring for nearly 41,000 patients.[3] The overwhelming majority of patients were in public institutions, a graphic demonstration of the moral and financial commitment of Americans to the mentally ill. Virtually every state and territory had at least one mental hospital, and many had established several in order to provide equal access for all. That the number of mentally ill patients exceeded available facilities was not an occasion for despair; it was seen rather as an indication of the work that remained to be done.

This impressive institutional facade, however, concealed many problems and unresolved issues. During the second half of the nineteenth century the structure and functions of mental hospitals had undergone a gradual transformation. At the time of their founding, mental hospitals were presumed to be providing restorative therapy (although the first generation of superintendents accepted without hesitation responsibility for caring for the chronic insane). But from the very beginnings hospitals retained large numbers of individuals who failed to show any improvement. The retention of chronic cases, in turn, restricted the efforts to offer therapy to the remaining patients. In their early days mental hospitals had also been designed for small numbers of patients in order to encourage close relationships considered necessary for sound treatment. Hospitals, however, grew in size either because states placed higher ceilings on the number of patients or did not take steps to build new facilities. In theory all patients were to receive the same quality of care; in practice class, race, and ethnicity promoted a different quality of care for different patients. The functions of superintendents were supposed to be defined in medical terms; they became, in fact, hospital administrators deeply immersed in managerial problems.

Between the 1880s and the outbreak of World War II, the foun-

dation was laid for a profound change toward and perceptions of mental hospitals. Prior to that time mental institutions were looked upon favorably as the best means of coping with the problems of mental illness. After that time, however, the reputation and public image of mental hospitals declined precipitously. Ironically, this development occurred at the same time that the patient population was mounting. By the middle of the twentieth century, mental hospitals were widely regarded as the institutional remnants of an earlier social order—outdated institutions that disregarded the rights of sick and dependent persons by isolating and subjecting them to cruel abuse. The result was a renewed interest in other alternatives to institutional care, or—to use modern terminology—toward a policy of "deinstitutionalization." The rejection of the idea of mental hospital care proved to be a development of the utmost social significance. It affected not only the nearly 450,000 patients in public mental hospitals in 1940 but families, psychiatrists and other mental health professionals, legislators, public officials, and the general public.

The purpose of this study, simply put, is to describe and analyze the experiences of American society in seeking to deal effectively with mental illness as both a social and medical problem. In so doing I will describe the complex interrelationships that existed between patients, psychiatrists, institutions, and government. A secondary purpose is to gain a better understanding of the process of change that led to a reversal of the attitudes toward mental hospitals from one of support to one of antipathy.

My narrative cannot be reduced to any single all-encompassing thesis. No particular group had either the authority or autonomy to determine the direction of events, if only because the responses of other interested groups limited the ability to shape policy. The final outcome resulted from the idiosyncratic actions of all involved parties. The most important but least recognized group that affected changes were the institutionalized patients themselves; their presence helped more than any other factor to mold the nature of hospitals. The composition of the patient population, moreover, underwent a basic change during these decades. After 1900 the proportion of aged senile persons residing in hospitals increased sharply, thus altering the functions of an institution that had been designed for quite different purposes.

Equally significant was the change in the specialty of psychiatry, which originally had been conceived and grown to maturity within a hospital setting. But by the beginning of the twentieth

century, the intimate relationship between physicians treating the mentally ill and mental hospitals had begun to disintegrate. This development helped to prepare the way for the emergence of new career patterns for psychiatrists and to alter the nature of the specialty itself. Mental institutions, as a result, were left in a more vulnerable position, if only because the legitimacy that they had acquired because of their links with the medical profession was partially undermined.

Nor were patients and psychiatrists the sole determinants of change. Both existed within a particular social setting and political culture. The decentralized nature of the American political system and the division of responsibility between local communities and states had an enduring impact upon both patients and hospitals. Changes in the sources and levels of funding, for example, had a subtle but significant influence upon mental hospitals in different communities, states, and regions.

Few individuals and groups were completely aware of the part they were playing in the evolution of public policy toward the mentally ill. All were persuaded that they were right in their analyses and prescription for change. But intent and outcome were often far removed from each other; the ability to control events, affect changes, and shape behavior was limited in scope. Indeed, the success of the critics of institutional care between the 1950s and 1970s left an equally troubling legacy. During these years thousands of patients were discharged from hospitals and returned to communities that were unwilling and unprepared to accept them. History in a sense had repeated itself; in many instances the treatment of the mentally ill in modern America was similar to the one depicted by Dorothea L. Dix in her famous petitions in the 1840s and 1850s demanding the establishment of public mental hospitals. By the beginning of the 1980s Americans were forced to confront the results of the policy of deinstitutionalization.

The rejection of the idea of institutional care for the mentally ill that occurred after World War II did not develop suddenly or precipitously; its foundations were laid between 1880 and 1940. In order to understand the circumstances that led to this profound reversal in attitudes and practices, it is first necessary to describe the status of mental institutions, psychiatry, and public policy toward the mentally ill in the closing decades of the nineteenth century.

CHAPTER ONE

The Mental Hospital

By the 1870s mental hospitals had assumed the form that they would retain in succeeding decades. Their outwardly simple organizational structure, however, concealed a complex and turbulent reality. Although superintendents spoke and wrote as though their personal decisions relating to governance, care, and treatment were decisive, the character of hospitals more often than not was shaped by patient behavior and the nature of staff-patient relationships. To a considerable extent, psychiatrists and supporting staff reacted and adjusted to the actions of their wards. The internal environment of hospitals was therefore marked by a precarious balance between the psychiatric goal of maintaining order and stability, on the one hand, and patient behavior that was often arbitrary, unsettling, and unpredictable, on the other.

That the control of psychiatrists over mental hospitals was less than complete was only partially recognized. Many groups having direct or peripheral responsibility for the mentally ill—psychiatrists, neurologists, public officials, social workers, lawyers, and the informed public—had only a partial understanding of the issues. Their knowledge about mental disease, composition of the mentally ill population, and care and treatment was often filtered through preconceived perceptions and assumptions. Consequently, the debates and conflicts among these groups over policy were not always relevant to the needs of institutionalized mentally ill persons.

Relatively few superintendents of mental hospitals in the late nineteenth century were able to bridge the gap between psychiatric theory and institutional reality. Legally they possessed authority, which enabled them to issue orders within certain prescribed limits. But, like others in comparable positions, superintendents found that there was a fundamental distinction between authority to issue directives and power to ensure their implementation. To establish institutional goals was relatively simple; to control events with any degree of precision was far more difficult, if not impossible. This is not to insist that the

destiny of individuals was determined by inexorable or impersonal forces. It is only to say that the choices of individuals and groups were often transformed by considerations that were never perceived to be relevant. This was particularly true of mental hospitals, which reflected all of the contingencies and ambiguities characteristic of human institutions and human behavior. Before we deal with the events and conflicts that shaped the development of mental hospitals from about 1875 to World War II, however, it is first necessary to sketch their character and organization as they existed toward the end of the nineteenth century.

I

According to the census of 1880 there were 91,997 insane persons out of a total American population of 50,000,000. Thirty years earlier the comparable statistics were 15,610 out of 21,000,000, suggesting to some contemporaries that the rate of insanity had more than doubled. Out of the total number of insane persons in 1880, nearly 52 percent were female, 71 percent native born, 93 percent white, and 7 percent black. About 9,300 were kept in almshouses. Of the remainder, half were cared for in mental hospitals and the other half in their own homes. The hospital population was composed of an equal number of males and females; 62 percent were native born and about 96 percent white. In the 74,184 cases in which the form of the disease was listed, the census showed the following breakdown: 38 percent were suffering from mania, 19 percent from melancholia, 2 percent each from monomania and paresis, 28 percent from dementia, 1 percent from dipsomania, and about 9 percent were epileptics. The average age of the mentally ill population, institutionalized or at home, was 43.5. But more than 17 percent of them were 60 years of age or older. Unmarried persons constituted 54 percent of the institutionalized population; 37 percent were married; 9 percent widowed; and less than 1 percent were divorced.[1]

These aggregate statistics, even granting gross inaccuracies arising from shortcomings in census procedures, revealed relatively little about the lives and experiences of the mentally ill. Confinement in any kind of institution was often a deeply emotional experience for an individual as well as a social process, and affected human relationships between family members. Aggregate data, unfortunately, sheds little light on the human dimensions of the problem.

Generally speaking, confinement during the nineteenth century was neither a simple nor an automatic process. Individuals who eventually ended up in asylums usually manifested some form of extreme behavior, including violent, suicidal, and occasionally homicidal acts, hallucinations, excitement, agitation, delusions, and deep depression. Alcoholism was itself not a sufficient cause for commitment. Nineteenth-century psychiatric nosology suggested that institutionalization involved extreme rather than marginal behavioral symptoms.[2]

The diagnosis of insanity often did not involve the community. Nor were most commitments begun by law enforcement personnel. Proceedings were usually initiated by members of the immediate family. Confronted with behavior that threatened the integrity of the family or situations with which they could not cope, relatives began the process of institutionalization as a last resort and with a vague understanding that it was the lesser of two evils. "I reluctantly enclose application filled out for admission of my mother," wrote a respected bank employee to the superintendent of the Wisconsin Hospital for the Insane in 1875.

> Of late she has grown materially worse, so that we deem it unsafe for the female portion of the family to be left alone with her during the day and especially unsafe for the little 2 year old that is obliged to remain continually there, as she has stated several times of late that she or the children must be sacrificed. Should she destroy another us [*sic*] could never forgive ourselves if the state has a place provided for their comfort and possible need.[3]

Other families were reluctant to accept discharged patients for fear that the conditions that led originally to their commitment would be repeated.

Nineteenth-century psychiatrists were aware of the crucial role of the family. Their annual reports were often written with an eye to assuring anxious relatives that their loved ones would receive kind and humane care as well as good medical treatment. Whether or not families believed what they were told, they resorted to institutionalization as a means of resolving internal crises. In 1846 and 1847, 75 percent of all commitments to the Utica State Lunatic Asylum were begun by the family and only 20.6 percent by public authorities; four decades later, the respective percentages were 57.9 and 38.6. An analysis of commitment proceedings in San Francisco in the early twentieth century dem-

onstrated that 57 percent were begun by relatives, 21 percent by physicians, and only 8 percent by the police. Books written by patients—many of which reflected hostility toward their hospital experiences—also revealed that institutionalization invariably was instituted by the family.[4]

For many families mental illness raised severe economic problems. The afflicted individual was usually unable to work, and the family was obliged to provide continuous care. Mental illness as a result was intimately related to the problem of dependency. The care of the aged insane was a case in point. Most of them were suffering from some form of senility. Some had no families, or else families lacked either the means or the will to care for them. In any case, responsibility for the aged insane was usually divided between local almshouses and mental hospitals. Both of these institutions served in part as old age homes in the late nineteenth century. In 1880 and 1890, for example, the insane constituted nearly a quarter of the total almshouse population. No data is available for the age distribution of all of the mentally ill, but of the almshouse population as a whole 33 percent in 1880 and 40 percent a decade later were 60 years or older. In Massachusetts, where some data are available, more than 60 percent of the insane in almshouses in 1893 were 50 years or older—a statistic which indicates that almshouses provided care for a substantial number of aged insane persons. Similarly, many hospitals cared for significant numbers of elderly patients. Between 1851 and 1898 nearly 10 percent of California's institutionalized insane was 60 years or older; the figures elsewhere ranged from a low of 1.7 percent in Arizona in 1900 to a high in Massachusetts of 12.1 percent between 1880 and 1886.[5]

To commit an individual was seemingly a complex process. In 1892 five states empowered justices of the peace to commit mentally ill persons to hospitals; eighteen granted this authority to judges; five required a lay jury trial; and three others stipulated that at least one member of the jury had to be a physician. Three states utilized a court-appointed commission, and two an asylum board; nine others required merely a medical certificate. Where the power to commit rested with a court, provision was usually made for a medical examination by a physician whose findings were viewed as advisory. In a few states, however, medical findings were binding, and the court simply recorded the decision.[6]

Despite the complexity of the system, the overwhelming majority of families did not find commitment a difficult undertaking

or one that involved lawyers and protracted conflict. Where a prominent person was involved, a particular episode might receive national publicity. But such cases were relatively infrequent. On a different level, the legal and psychiatric professions fought bitterly over commitment procedures. This struggle usually involved varying theoretical assumptions about the nature of individual responsibility, human behavior, and mental illness. Although laws tended to become more specific toward the end of the century, they posed no serious obstacle to commitment. Given a family seeking institutionalization for one of its members, or an individual with severe behavioral symptoms but without a family, legal procedures were administered in a loose and informal manner. The problem of commitment was for the most part perceived in human rather than strictly legal terms.

II

Once committed, the individual was admitted to the nearest public mental hospital. But this did not mean that the experiences of patients were similar; hospitals varied in size, organization, and quality of care and treatment. In 1883 the average number of patients in 83 local and state hospitals and one federal institution (excluding private and newly established institutions) was 544. The range, however, was significant; 9 of the largest hospitals had an average population of 1,254, and the 9 smallest about 139. Institutional size depended partly on public policy within political jurisdictions. California and New York City had only 2 hospitals each; Georgia and Indiana 1; all contained more than 1,000 patients. States with a developed hospital system dating back to the mid-nineteenth century, including Illinois, Kentucky, Massachusetts, New York (excluding the Willard Asylum, which originally was intended for chronic cases), Ohio, and Wisconsin, tended more toward the mean.[7]

The typical state hospital of the nineteenth century was constructed according to the "Kirkbride Plan," which had the official endorsement of the Association of Medical Superintendents of American Institutions for the Insane (AMSAII). A center building housed the kitchen, store rooms, reception areas, business and medical offices, chapel, library, and living quarters for the medical officers. Extending laterally on both sides were the patient wings, one for males and the other for females. If additional accommodations were required, a similar structure could be built, either

joining existing wings at right angles or else lapping on at the other end and extending on a parallel line. Each wing in turn contained separate wards for the different types of patients. Such a structure in many ways reflected prevailing psychiatric ideology: separation of patients from the community; creation of a new therapeutic environment; the importance of classifying patients; the dominant and controlling role of the psychiatrist-superintendent; and reassurance to the family and community that patients would be cared for in a secure moral and medical environment that would promote their comfort, happiness, and even recovery.[8]

The State Lunatic Asylum at Utica, New York, was in many respects a typical institution. In 1884 it had slightly over 600 patients, 2 percent of whom slept on the floor because the total population exceeded the bed capacity. The wings housing males and females were divided into three departments (each one corresponding to a floor). The departments, in turn, were divided into twelve wards, each intended for a different class of patients. The female department, for example, had two convalescent wards (one for mild cases of melancholia), two for quiet patients (including one for chronic cases), one for demented persons, one for melancholics, one for a mixed group; the remainder were for noisy and disturbed individuals. The men's wing was organized in a comparable manner: one convalescent ward; five for quiet patients (including two for chronic cases); one for suicidal persons; and the remainder for demented, disturbed, or filthy patients. The wards varied in size. They contained as few as 15 patients and as many as 43, the average being about 27. Male wards had slightly more attendants present than female wards (8.4 as compared with 7.9), and disturbed wards for both sexes had more attendants than quiet wards.[9]

The elaborate system of wards had two goals: to retain in the same ward those who were least likely to injure others and those most likely to help each other. Proper classification, therefore, became the first step. Equally crucial was appropriate care and treatment of patients. Generally speaking, nineteenth-century treatment in mental hospitals tended to be eclectic and nonspecific. Given the absence of empirical data that might relate etiology, symptomatology, and physiology, superintendents followed older and more traditional medical practices. Like their colleagues in private practice, they accepted the view that all parts of the body were interdependent, and that health and disease resulted

from the interaction of individuals with their environment. The aim of treatment, then, was to restore the normal balance, which would in turn contribute to the alleviation or cure of mental disease. "The theory of localization of brain function," observed Edward C. Mann in a textbook published in 1883, "does not throw as much light as we could wish, or lead to much practical benefit in the treatment of cerebral diseases. In treating such diseases we must look upon the brain as a whole, and our medicines must be calculated to act upon it through the general system." Therapy included a balanced diet that would rebuild the digestive tract and nervous system, a healthful environment, exercise, fresh air, sunlight, as well as the use of tonics and cathartics. There was also a decided receptivity toward novel and experimental therapies. Thyroid extract began to be used in the mid-1890s, along with the administration of electricity. If impaired physiological processes and mental diseases were related, then psychiatrists felt that they could not afford to ignore general advances in the medical sciences relating to the former.[10]

The holistic view which typified the specialty unified care and treatment. Indeed, even the concept of "management"—a word that appeared regularly in nineteenth-century psychiatric literature—was imbued with medical overtones. The physician, by manipulating the environment and patient, could overcome the past associations that had led to the disease and create an atmosphere in which the natural restorative elements could reassert themselves. For this reason, employment of patients, religious observances, and appropriate amusements were also considered crucial elements in the therapeutic regimen.

Although medical treatments for psychiatric and nonpsychiatric patients were similar, hospital physicians were particularly attracted to drugs that tended to calm noisy and troublesome patients. Behavior of such patients hampered their own recovery as well as that of others. Consequently, various sedatives and hypnotics were regularly employed. Hyoscyamin, opium, morphine, various bromide derivatives, chloral hydrate, paraldehyde, sulphonal, calomel, and digitalis were among the most commonly prescribed drugs. The use of such drugs was by no means unique to mental hospitals; opium and its derivatives were used in all medical practice.

Within mental hospitals reliance on sedatives and hypnotics varied considerably. A report to the Massachusetts legislature in 1875 noted that medication constituted "a very important agency

in the cure of the insane," even though other means had assumed relatively greater significance in more recent times. The committee, however, was struck by the wide variations in the use of drugs in Massachusetts hospitals. Some institutions spent two to three times as much for drugs as others; one or two expended five to six times the state average. Such variations were characteristic of the country as a whole, suggesting that in some hospitals the use of drugs became an end in itself. The administration of drugs was determined exclusively by the medical staff without any external restraints. Oftentimes the goal was to quiet unruly patients in order to facilitate the efficient management of a complex social institution. Faced with managerial problems that were related to disruptive behavior of patients, a substantial number of hospital superintendents turned to medication as a palliative. In 1881 Dr. H. B. Wilbur noted that the use of mechanical restraint and "chemical restraint" were directly related; the more mechanical restraints were employed, the greater reliance there was on sedatives and narcotics.[11]

For institutionalized patients, the future was not especially promising. By the late nineteenth century the hospital was a place of last resort. Its patients often had long histories of behavioral signs, and many had been institutionalized on more than one occasion. Observations by early nineteenth-century psychiatrists that the longer the duration of the disease, the less the chances for recovery, seemed to hold true for the latter part of the century as well. The bulk of patients discharged as recovered tended to be among those with a relatively brief institutional confinement. Of 310 patients discharged as recovered from all Pennsylvania hospitals in 1876, 90 percent had been institutionalized for no more than a year, and 62 percent for six months or less. Moreover, the bulk of this group of patients had shown no symptoms for more than six months preceding their commitment. Those who recovered tended to be between the ages of 20 and 40; the chances for recovery declined with advancing age. Those who failed to recover or improve to the point where they were able to leave were likely to remain in a mental hospital or local welfare facility for extended periods. After examining American and British statistics for a thirty-year period, John B. Chapin estimated in 1877 that of every hundred cases, based upon the number of admissions, 34 percent would recover by the end of one year, 29 percent would die, and 36 percent would remain at a stationary level. A certain proportion of the recovered group would also find their way back

to an institution after suffering a relapse. The implications were obvious: mental hospitals, despite their therapeutic goals, were actually providing long-term custodial care for many of their inmates.[12]

III

Admission to a mental hospital in the late nineteenth century was a frightening experience for most patients. Cut off from familiar circumstances, they were thrust into a complex institution with its own behavioral norms. Mental hospitals, after all, were coercive institutions. A large proportion of their total population was involuntarily confined, and force—either in legal or physical form—was the primary means of confining patients and maintaining internal discipline.[13] To emphasize only the coercive aspects of hospitals, however, is to disregard not only the historical context in which they functioned, but also the degree to which their internal character was a function of a mutual interaction among physicians, staff, and patients. Indeed, the internal environment of mental hospitals was at least partially molded by the character of their inmates. Nor can it be assumed that mental institutions were monolithic and static; like other complex organizations they passed through a variety of stages.

The typical late nineteenth-century hospital was structured along authoritarian and hierarchical lines. At the peak was the superintendent. All decisions pertaining to hospital life, including care, treatment, or architectural changes, were subject to his approval, if only because medical treatment of the insane involved the creation of a new environment. Directly under and responsible to the superintendent were the assistant physicians. They supervised the departments and wards, and were responsible for the day-to-day care of patients. At the bottom of the managerial hierarchy were the nurses and attendents: this group represented the institution to the patients and remained in constant contact with them. In addition to the medical staff, most hospitals had a salaried force of employees performing a variety of administrative functions—purchasing supplies, processing paperwork—as well as those preparing meals and maintaining the physical plant.

In theory the mental hospital was presumed to be a harmonious and efficient social organization. Its staff, medical and supporting, shared the same goal; to serve the needs of patients in order to promote their recovery. In practice, however, few hospitals ever

corresponded to this ideal. As with virtually all human institutions, the ability to control the environment was severely restricted by both internal and external constraints. What emerged instead was an institution that reflected the human condition, with all of its strengths and weaknesses.

The most significant element in shaping the character of mental hospitals was the nature of their patient population. The patients, more than the medical and attending staff, created the internal environment to which others reacted. Admittedly, patients were also affected by a partially coercive atmosphere in which they were deprived of many liberties and forced to conform to certain behavioral norms. But, as a group, patients were by no means quiescent or accommodating; their behavior sometimes revealed an inability or refusal to conform. The character of the hospital, then, reflected an uneasy and sometimes hostile relationship between patients and staff.

More so than at most institutions, the behavior of many inmates tended toward social disorganization, if not anarchy. The ward structure reflected this centrifugal tendency, for it corresponded with certain behavioral patterns that ranged from total withdrawal to bizarre and violent conduct. Much of the time and energy of the staff was spent in dealing with immediate problems relating to patient behavior. As a result, the therapeutic aims of many institutions receded into the background as its managers struggled to maintain routine, discipline, and order—traits that mark many functioning organizations that are mission-oriented.

Consider, for example, the problems posed by patients often described as the "filthy insane." Virtually all hospitals had their share of such persons, many of whom represented cases of long standing. Upon entering their wards in the early morning, reported Dr. Stephen Smith, who served as a State Commissioner in Lunacy in New York during the 1880s, "the sight was most repulsive, and the odors intolerably sickening. . . . Some of the patients were literally wallowing in their own excrements. They had besmeared their beds, their heads and faces, and even the floors and walls of their rooms." In some instances three or four attendants were required to overcome the resistance of such patients and to wash and dress them. The result was "unfavorable in every respect." Other patients lapsed into habits of uncleanliness, and the time and energy of attendants was spent restoring some measure of hygiene.[14] Patient populations included the excited and

violent, on the one hand, and the senile and paretic on the other. In all these cases, the institution was forced to adjust accordingly.

The conflict between institutional routine and patient behavior often resulted in the use of devices to restrain violent and excited patients. According to the census of 1880 (which provided detailed data by state and institution), about 5 percent of patients in mental hospitals were restrained in some way. Strait jackets were used for 44 percent of these cases; muffs (21 percent), straps (22 percent), cribs (5 percent), and handcuffs (7 percent) accounted for the remainder. The employment of such devices demonstrated no clear pattern; neither geographic location nor demographic variables were significant factors. The key element may very well have been the attitude of the individual superintendent or previous institutional practices.[15]

During the 1880s certain states and institutions moved to limit if not to abolish the use of mechanical restraints. In Alabama Peter M. Bryce reported considerable success with the nonrestraint system; Alice Bennett reported comparable results at the Women's Department of the Pennsylvania Hospital for the Insane in Norristown. A survey of the frequency of restraint conducted in 1891 by Clark Bell, a lawyer opposed to the practice, hinted that restraint enjoyed diminished popularity among superintendents.[16]

Restraint was one of the most controversial issues in nineteenth-century psychiatry. In England John Conolly had transformed nonrestraint into a virtual crusade in the 1840s and 1850s. In the United States the issue became equally divisive, and involved such key figures as Isaac Ray and Thomas S. Kirkbride. To mid-nineteenth-century superintendents, the decision to employ restraint involved a pragmatic judgment. If patients threatened their own or the well-being of others, the practice was necessary and permissible. Others insisted that the authority of the superintendent had to be limited by a recognition of the inalienable rights possessed by all patients. Although the controversy remained muted in the decades before 1860, its presence served as a reminder that the potential for conflict between institutional needs and individual autonomy had by no means been resolved.[17]

By the late nineteenth century restraint had once again become a source of friction. To critics of mental hospitals—a diverse group drawn from the fields of law, medicine, welfare, and philanthropy—the use of mechanical restraint was the ultimate symbol of failure. Dr. Joseph L. Bodine, for example, charged that the

practice of restraint was intended to reinforce patient conformity to organizational rules; the consequence was aggravation of the malady and the creation of "a hopeless lunatic." To others, mechanical restraint violated the rights of patients, ran counter to progressive psychiatric thought, disregarded empirical data pertaining to the effectiveness of the practice, and even reinforced the behavior that it was intended to inhibit or prevent. Still other critics pointed to the example of England, which claimed to have abolished the use of restraining apparatus with beneficial results for all concerned. When the distinguished British psychiatrist John C. Bucknill travelled through the United States in the mid-1870s, his critical comments about the secrecy with which mental hospitals were administered, the lack of adequate external supervision, and the commitment of his American brethren to the idea of restraint, aroused a fiery controversy on both sides of the Atlantic.[18]

Within the ranks of American hospital superintendents, restraint remained a sensitive issue. Virtually no psychiatrist defended its indiscriminate use. The consensus among most psychiatrists was that its abolition, although desirable in theory, was impractical. Indeed, some emphasized that institutionalization itself was a form of restraint. Others pointed to the need to restrain patients who represented a threat to themselves or others. A smaller group insisted that the practice was completely unwarranted.[19]

The context in which the debate took place, however, suggested that the differences between the contending parties were not as fundamental as they thought. Both were concerned with the effects of disruptive behavior within institutions. Those who favored its abolition insisted that the more effective means of management could diminish or eliminate such behavior, and that restraints actually promoted the very type of behavior that it was intended to eliminate. "I am led to believe," observed Alice Bennett after evaluating the experiment of discontinuing restraints at the Women's Department of the Pennsylvania Hospital for the Insane,

> that much of the paraphernalia of the approved hospital for the insane—heavily barred windows, massive immovable furniture and the like—has too much the tendency to surround the patient with an atmosphere of suspicion, against which he naturally places himself in an attitude of defense, or even of offense; and, further, that to a much greater extent than has been

> supposed, these expensive material "guards" can be substituted by moral agencies, which shall encourage, rather than repress, self-respect and self-control, often dormant, but almost never wholly extinct. . . .
>
> One thought comes to me in closing: There is no more inexorable law, nor one of wider application, than that "action and reaction are equal," each to each.[20]

Those who were opposed to the discontinuance of restraint, on the other hand, indicated that in certain cases an institution had no alternative. Undoubtedly there was an element of truth in the claims of both sides. Behavior of some individuals led to restraint; in other instances the use or threat of restraint proved to be counterproductive. In any case, the existence of the practice shed some light on the disorder within hospitals and the limits of the power of their managers.

The disintegrative tendencies within mental hospitals were also evident in the relationship between attendants and nurses, on the one hand, and patients, on the other. Unlike physicians who saw patients only briefly and often irregularly, attendants and patients were in constant contact, and the interaction between them generally shaped the character of the institution. The crucial role of attendants, in part, was simply a function of numbers. In 1894 the nine state hospitals in New York employed fifty-four physicians. The doctor-patient ratio in individual institutions ranged from a low of 1:107 at Rochester State Hospital to a high of 1:240 at Willard; the statewide average was 1:171. By way of contrast, these same institutions had about one attendant for every seven patients. Throughout the nation the proportion of attendants to patients was about 1:12, but the breakdown in sectional terms was revealing. The East had the most favorable ratio (1:9), followed by the West (1:12.6), the South (1:15.2), and the Pacific region (1:18.8).[21]

Cognizant of the crucial role of attendants, superintendents conceded that their caliber left something to be desired. Long hours, arduous duty in wards filled with difficult patients, and relatively low pay made it difficult to attract or to retain high quality personnel. The resulting high turnover rates further undermined institutional stability. Indeed, even the possible attraction of regular employment was not a sufficient inducement at a time when periodic economic depressions created either irregular employment or unemployment. "It is impossible," charged the

Tennessee Board of State Charities in words echoed by many, "to secure a cultured or refined person as attendant upon the insane for the compensation provided." A less than competent attendant corps, superintendents insisted, was responsible for the frequent cases of brutal treatment of patients and the inability to create and to maintain a desirable therapeutic environment. Over a five-year period, Pennsylvania hospitals summarily dismissed 215 attendants, or an average of 9 per year per institution. Such dismissals constituted a little over 7 percent of the total number employed. Nevertheless, that such action was taken only in extreme cases involving "personal assaults upon patients, or for harsh conduct and improper language" suggested that most institutions in the state and elsewhere faced serious problems. Indeed, the inability to recruit better replacements undoubtedly acted as an effective brake upon a more liberal dismissal policy.[22]

In order to upgrade the skills of nurses and attendants, some institutions began to experiment with training schools. The first such school was opened in 1882 at the McLean Hospital, a private institution affiliated with the Massachusetts General Hospital in Boston. Two years later Buffalo State Hospital in New York followed suit, and by 1895 more than thirty such schools existed in the United States. Previously nurses and attendants had received what amounted to on-the-job training. Schools provided such staff with a somewhat more structured course of study generally lasting about two years. During their working hours, students attended a prescribed course of lectures, which were supplemented by appropriate reading materials. A few schools experimented with entrance requirements, and most gave examinations in order to weed out incompetents. At the end of the two-year period, students received a diploma, which presumably led to higher status and pay as well as the prospect of promotion to supervisory positions. Although such hospital positions were open to men and women alike, the women predominated because males resisted nursing as a career.[23]

Generally speaking, the efforts to upgrade the quality of nurses and attendants did not meet with overwhelming success. Turnover rates remained high. More importantly, the brutal treatment of patients remained an endemic problem. In 1906 the Massachusetts State Board of Insanity reported that recruitment was becoming more rather than less difficult. "It has been barely possible at times during the past year," it noted, "to procure respectable persons enough to do absolutely necessary work in caring for

patients and safeguarding against danger." High turnover rates, it noted, even forced hospitals to send agents to employment offices to search for employees. In a fourteen-month period no less than 861 different men occupied 241 nursing positions (an average of 3.6 persons per job); 737 women filled 318 jobs (an average of 2.3).[24]

Undoubtedly relatively low wages and long hours acted as a deterrent to improvement of staff quality. Equally significant was the fact that work in a mental hospital for most individuals was difficult and at times unpleasant. Nurses and attendants cared for patients with a variety of needs: some were unable or unwilling to maintain personal hygiene; some were physically debilitated and infirm; and some behaved in seemingly bizarre ways. The result was either sporadic levels of hostility, conflict, or neglect—all of which worked at odds with institutional goals. Some outstanding nurses and attendants managed to surmount the problems that they faced and dealt with patients in a way that fostered close and trusting relationships. Others managed self-control and performed their duties in a responsible manner. But a few resorted to violent and brutal methods. To enforce discipline they employed extralegal sanctions, including the ducking of patients in water and other forcible disciplinary measures.[25]

In some extreme cases such staff actions resulted in the death of patients. Most of the cases receiving publicity did not involve systematic degradation of inmates, but rather an immediate emotional response by some attendant. In one instance a large and powerful paretic male was confined in separate quarters because of the dangers that he posed to others. Although the superintendent had left orders that no person was to enter the room alone, an attendant did so to clean up the room. A violent struggle ensued after the patient attacked the attendant. A second attendant, hearing the struggle, entered the room. The first attendant, according to the report, "being enraged, kicked and jumped upon the patient, inflicting comminuted fractures of the lower jaw-bone, fracture of a rib and extensive bruises and lacerations of the face, neck, shoulders and chest." Eventually the patient died, and the attendant was indicted and brought to trial.[26]

Superintendents and officials were by no means unaware of or insensitive to brutality and neglect. Whenever evidence of such behavior came to light, the erring attendant was usually dismissed. Nevertheless, the problem remained tenacious, for it involved complex human relationships. "Attendants are human and

their work is arduous and exacting," noted a state supervisory board. "Some patients are trying, to the last degree; taking a malicious delight in annoying the attendants, and even taking advantage of the knowledge that they cannot be held accountable." A few institutions experimented with more open wards and greater personal liberty. These measures sometimes helped, but they did not eliminate the harsher aspects of institutional life. Violence, moreover, went in two directions, and patient attacks upon staff were not uncommon. A number of superintendents (including George Cook and John P. Gray), assistant physicians, and attendants were wounded or lost their lives as a result of patient assaults.[27] The human frailties of patients, attendants, and physicians created a precarious balance that was easily upset; the threat of disruption and disintegration was ever-present.

Although superintendents were concerned with interpersonal relationships within their hospitals, they were less sensitive to the social distance that separated them from their patients. Social, educational, and ethnic differences often created barriers to the development of close and trusting relationships. Superintendents in general were relatively well educated, came from a predominantly Protestant culture, and were overwhelmingly native born. A large proportion of patients, on the other hand, came from a very different social and cultural milieu. In 1880, for example, more than 15,000 out of nearly 41,000 patients in mental hospitals were foreign born. Even though the anti-immigrant sentiment that was so prominent among psychiatrists before the Civil War diminished toward the end of the nineteenth century, the social distance between doctor and patient often inhibited close personal relationships. When added to the paternalistic character of mental hospitals, social and class differences contributed still further to the disintegrative tendencies that lay immediately beneath the facade of institutional stability.[28]

Staff-patient relationships were not the only element that shaped the character of an institution; equally significant were relationships among patients. The ward system itself was a recognition of this fact. Assignments of patients to wards were not simply based on behavior and prognosis, but took into account such elements as race, ethnicity, education, and age. It was assumed that the behavior of patients was not totally unrelated to their backgrounds. Racial stereotypes, for example, produced friction among patients in those institutions that did not rigidly segregate whites and blacks. The superintendent of the Arkansas Lunatic Asylum

observed that racial "incompatibility" often resulted in conflict among patients. "In this expression no discrimination is intended," he added. "It is only meant that each should be assigned to circumstances and surroundings that would be more agreeable and congenial to both, and therefore much more likely to conduce to desirable results in the treatment of their special maladies."[29]

Strict racial segregation, in fact, did not always guarantee harmony. One former patient recalled an instance in which a white patient wandered into an area reserved for black inmates and began to abuse them verbally. One black patient struck the white man and began to pursue him. The white patients, "though lunatic to a man, with the exception of the keepers, at this occurrence seemed to feel all the rancor of racial hatred rising within them. So long as their fellow-lunatic was so manifestly in the wrong they had shown no disposition to interfere with a chastisement so justly inflicted. But to see a white man fleeing before a negro foe, and the latter audaciously pursuing him into the midst of his friends, was too much for their self-control." The result was a violent fight involving patients and attendants.[30] Similarly, age, ethnic, and educational differences, which no ward system could completely overcome, also produced conflict among patients.

Most institutions attempted to offset the disorganization and monotony of hospital life by employing patients. Work was regarded as a critical element in creating a therapeutic environment. Inaction was considered harmful even to the normal mind, according to most psychiatrists, and in mentally ill persons its results were devastating. Wherever possible hospitals assigned male patients to their farms or to do maintenance work. Female patients were generally given household tasks such as sewing and cleaning, thereby reinforcing the sex-based division of labor characteristic of the larger society that had created a separate sphere for women in the home and effectively barred them from entering many occupations. Although patient labor had some minor impact on institutional finances, economic considerations played a decidedly minor role. Virtually no one suggested that patients be required to work in order to pay for their upkeep and thus relieve the fiscal burden on the state. On the contrary, work was important because of its therapeutic effect; financial gains were simply a desirable but not a necessary byproduct.

Work, however, never proved the hoped-for panacea. Many hospitals lacked facilities for other than routine labor. Attempts to

induce legislatures to appropriate funds for the construction of workshops were often unsuccessful. Despite support from the state's central regulatory agency, the Michigan legislature turned down requests for funds for workshops. Equally important, many patients, for reasons of physical condition or age, were unable to work. Out of a total patient population of 4,944 in 1890 in all Pennsylvania hospitals, only 1,886 (39 percent) were employed. The hospital at Norristown had the highest proportion of employed patients (48 percent); the Dixmont hospital the lowest (11 percent).[31]

Compounding the problem of disintegrative tendencies within mental institutions was the imbalance between the numbers of patients and the capacity and quality of the physical plants to sustain them. During the 1880s a tenuous balance seemed to exist between total hospital capacity and the actual number of patients. A study by the Pennsylvania Committee on Lunacy in 1883 found that mental hospitals, which had facilities for 51,913 patients, had a total population of 51,815. This balance, however, was more apparent than real. In most states admissions, over which officials had little control, threatened to overwhelm the institutions. The desired balance between admissions and discharges was a fiction, if only because institutional populations were composed largely of chronic cases confined for long-standing periods of time. Few states had hospital facilities that were not strained. Crowding, in turn, intensified internal problems among patients and between staff and patients. Deteriorating physical plants, which resulted in part from the behavior of patients and the reluctance of states to improve or to replace existing facilities, exacerbated the problems of crowding. Two decades after it opened in 1833, the trustees of the Worcester Lunatic Hospital condemned the original plant as obsolete and recommended that it be replaced. Yet the institution remained in existence for an additional century despite its obvious deficiencies.[32]

To alleviate crowding, most hospitals resorted to a variety of practices. Some patients were discharged and sent back to their communities; some were transferred to local welfare facilities; those who did not have a legal residence were returned to other jurisdictions; and some were paroled on a trial basis. Oftentimes the result was a cycle of admissions and readmissions, with the availability of space playing a crucial role.

Most institutions, in fact, developed various legal subterfuges to minimize the effects of crowding. Parole was a case in point.

In New York State, for example, superintendents (excluding those in New York City and Kings County) did not have the legal right to discharge patients; actual power remained in the hands of boards of managers or judicial officials. Before taking such action, officials had to receive a written certification by the superintendent that the patient in question had recovered, or was incurable or harmless. For a variety of reasons, superintendents found the system slow and cumbersome, and some were reluctant to certify future behavior. But if the law restricted discharges, it said nothing about paroles. Hence superintendents proceeded to parole patients and then to forget about discharging them. In Pennsylvania a similar situation developed. In 1883 the legislature authorized parole for hospital patients not to exceed thirty days, provided that it was advantageous and that no harm would follow. Superintendents not only used the procedure liberally, but also renewed paroles until either the patient recovered and was finally discharged, or else was forced to return to the institution. When the Pennsylvania Attorney General ruled that parole could be extended only if the patient was returned to the hospital for an examination, its use declined precipitously. Families were usually reluctant to spend the time and money involved in travel to and from the hospital.[33]

The system of parole did in fact alleviate crowding in the late nineteenth century. It also provided hospitals with a legal means of demonstrating to patients that—as a Rhode Island agency put it in describing a new law authorizing parole in 1898—"self-control" would be rewarded and that sequestration "is but a means to an end, and that end, restoration to their homes."[34]

IV

Just as the experiences of individual patients differed, so too did institutional care vary widely in quality. In the early 1890s the average annual expenditure per patient at fifty-three hospitals was $179. There were, however, significant regional differences. Five Southern hospitals spent $129, as compared with $200 at Eastern and $167 at Western institutions. Nor were these differences simply a function of differential living costs. The Alabama Insane Hospital spent $24 per patient per year for food, as compared with $80 at one of the Ohio state hospitals. Similarly, staff-patient ratios and quality of physical plant varied in the extreme, depending upon the level of funding authorized by the legislature.[35]

In general, there were significant regional differences among hospitals. The South provided a lower standard of care as compared with other sections. In 1875 Alabama, Louisiana, Mississippi, North Carolina, South Carolina, and Tennessee each had one mental hospital, and as a group spent less than their Northern or Western counterparts. Southern hospitals also allocated funds along racial lines; facilities provided for white patients at the same institutions were superior to those given blacks. In 1884 the superintendent of the Alabama Insane Hospital noted that his institution had ample room for whites, but lacked sufficient and adequate facilities for blacks. Even when Southern states set up separate institutions for blacks, expenditures were not equal. In 1907 North Carolina spent $155 and $185 per patient per year at each of its white hospitals, but only $111 at the Goldsboro institution, which was restricted to black patients. Southern superintendents often acknowledged, directly and indirectly, the relative inferiority of their hospitals. When seeking a superintendent of nurses at his proposed training school, Dr. J. W. Babcock of South Carolina offered the position to a woman nearing completion of her training at the Massachusetts General Hospital in Boston. "As compared with Northern hospitals," he frankly conceded, "there will be many obstacles to contend with, as you can readily understand."[36]

Even greater differences existed between state mental hospitals and similar institutions established by urban governments. The origins of this dual system dated back to the early nineteenth century. When states established the first mental hospitals, they located them in the geographical center of the state to provide equal access to residents. In practice, however, hospitals tended to draw a disporportionate number of patients from adjacent areas. Urban areas, on the other hand, were usually located along the coast or near navigable waterways at some distance from the geographical center. Consequently, many cities, including Boston, New York, Brooklyn, Philadelphia, Chicago, Cincinnati, St. Louis, Detroit, and Milwaukee, established their own municipal mental hospitals during the nineteenth century.[37]

Urban hospitals from their very beginnings provided a significantly lower quality of care than their state counterparts. Some cities built their mental hospitals adjacent to their welfare and penal institutions in order to use inmate labor. New York City employed its convict population as attendants for the mentally ill. Given rapid population growth, the absence of a mature gov-

ernmental administrative structure, and budgetary pressures related to other needs, public officials often paid little attention to their mental hospitals. At the Lunatic Asylum on Blackwell's Island in New York in 1877, the superintendent was the only paid medical officer for its more than fourteen hundred female patients crowded into quarters designed for slightly over nine hundred persons. Consequently, the institution faced severe problems: the crowding created a disruptive environment; the absence of employment reinforced high levels of conflict and tension; and the lack of effective supervision resulted in relative chaos. A decade later the situation had changed but little. Conditions were hardly different in the Kings County (Brooklyn) institution. Its superintendent insisted that in some respects convicts were more contented than his patients. "If one thinks for a moment," he noted,

> they must realize how they would feel if they were locked up in an asylum, month after month, and perhaps year after year, without any occupation whatever, and very little liberty. This is a most distressing condition for the insane to be in, and it is one of the principal reasons why patients are unhappy, and always wanting to go out, because it is worse than prison, for in prison they have to work.

Nor did patients find a more hospitable environment at the Philadelphia Hospital, which was part of the municipal almshouse, or at institutions in Cincinnati and St. Louis.[38]

Few institutions, however, could match the dismal conditions at the Cook County Lunatic Asylum in Chicago. The origins of this Asylum dated back to the 1850s when it was part of the county poorhouse. In 1870 a new brick building for two hundred insane patients had been constructed, and during the remainder of the decade the institution's rapid growth paralleled Chicago's rise to prominence. Before 1883 the Asylum received relatively little publicity. In that year, however, Dr. S. V. Clevenger, one of the more colorful figures in late nineteenth-century psychiatry, was appointed as a special pathologist. At the beginning Clevenger set about to gather patient data, a task made difficult because of the destruction of institutional records during the great Chicago fire of 1871.[39]

Within six months Clevenger realized that the inner workings of the Asylum were far different from the impressions left after brief and superficial visits. Lice abounded; patients died without receiving medical attention; and restraints were used indiscrim-

inately and without any controls upon attendants. Whiskey and drugs were freely prescribed, and a serious drug addiction problem existed among patients. There was even evidence that the superintendent and a female supervisor were having an affair. The appointment of a new medical superintendent shortly after Clevenger arrived made little difference: the warden, who had political connections, controlled the domestic and financial management of the institution. Nor were conditions the result of inadequate funding. In 1884 the Asylum received an allocation of $332 per patient per year, as compared with $184 at the four Illinois state hospitals. Clevenger ultimately resigned his position and induced the Chicago Citizens' Association to undertake an investigation. With the cooperation of the state Attorney General's office, a number of county commissioners were first indicted and then convicted of corruption and theft.[40]

Considerable variations were also common among hospitals in a particular region and even within a given state. In some cases long-established traditions—some harmful to patients, some beneficial—accounted for institutional differences. In other cases leadership proved a crucial factor in molding the character of the institution. In still others the demographic composition of the patient population set the tone within the hospital. But, whatever their deficiencies, hospitals at the very least provided thousands of patients with a guaranteed subsistence level that was often superior to the level they would have confronted in their community. Indeed, institutionalized patients were shielded from the threat of starvation that grew out of the high unemployment that prevailed from the 1870s to the 1890s.

V

Although the proponents of institutional care for the mentally ill seemingly carried the day, their triumph was less than complete. Despite large investments made by states in constructing and maintaining mental hospitals, the number of patients exceeded capacity at any given moment. Nor was the quality of care and treatment equal, either within states or among regions. Most importantly, the tensions between patients, physicians, and attendants always inhibited the full realization of the goals embodied in the founding of institutions. From the very moment that hospital care became the accepted norm, therefore, American society faced new and puzzling dilemmas relating to the care of the men-

tally ill. Was institutional care as effective as its proponents claimed? Were there more effective solutions to this seemingly intractable social and medical problem? Was it necessary to impose limits on the autonomy and authority of the young but influential specialty of psychiatry? Similarly, to what extent was it desirable to permit public regulatory agencies to intrude into the internal affairs of hospitals? And who would represent the interests of the mentally ill? That such questions were even raised suggested that definitive answers were not yet available.