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THE FORGOTTEN HISTORY: THE DEINSTITUTIONALIZATION MOVEMENT IN
THE MENTAL HEALTH CARE SYSTEM IN THE UNITED STATES

by

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A thesis submitted in partial fulfillment
of the requirements for the degree of
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Nana Tuntiya

ABSTRACT

The development of ideas on deinstitutionalization of mental patients has a much longer history in the United States than is commonly acknowledged. Evidence of intense discussion on the rights of the mentally disturbed, curative as opposed to control measures in their treatment, and the drawbacks of congregating the afflicted in large institutions can be found as early as the middle of the 19th century. This discussion was provoked by dissemination of knowledge about the oldest community care program of all: the colony of mental patients in Gheel, Belgium. Based on document analysis of publications in the *American Journal of Insanity* from 1844 to 1921, this study attempts to trace how this discussion resulted in the first wave of deinstitutionalization in the American mental health care system, and the successful implementation of the alternative of hospital treatment.

My study further documents how the development of this program was inhibited by the need of psychiatry to attain professional legitimation. In its struggle to acquire public respect and occupational authority, the profession focused on somatic explanations of disease that could justify categorization of psychiatry as a branch of medical science.

While this claim was not decisively supported by laboratory findings, or the ability to cure patients, psychiatry put forward genetic explanations of mental disorder. This took the profession to the extreme of the eugenics movement, and eventually positioned it as an institution of social control instead of medical authority. Having thus failed to achieve the ultimate professional legitimation in the medical field, psychiatry was exposed to a new wave of criticism in the 1960s, which led to the second wave of deinstitutionalization. History repeated itself with the same outcome. In the absence of overall support within psychiatric circles, and a lack of appreciation of family care as a viable alternative to hospital treatment among social scientists, deinstitutionalization could not but fail again. The contribution of the study lies in the areas of deinstitutionalization, professionalization of expert labor, and the social construction of mental illness and deviance.

Introduction

The deinstitutionalization movement in the late 1960s in the United States received a lot of scholarly attention. Yet a number of important issues pertaining to this subject almost entirely escaped the interest of social scientists. Among them are the history and practice of community care programs for the mentally disturbed that were successfully implemented in America in the past. Even more surprising is that the oldest example of community care for mental patients, the historic colony for mental patients in Gheel¹, Belgium, never became a part of the discussion about deinstitutionalization in the 1960s. Most of the studies that mention Gheel, with rare exceptions such as Roosens' (1979), are written by psychiatrists and published in psychiatry journals. Apparently, the intense discussion among social scientists about the advantages and disadvantages of community care alternatives neglected the powerful evidence of eight centuries of actual community treatment. This study intends to fill this gap in the literature and reassess the deinstitutionalization movement in light of its largely forgotten or misunderstood historic development. Special attention will be devoted to investigation of the reasons which undermined wider use of community care programs for mentally ill persons, and the role of dynamics within the psychiatric profession in shaping institutional responses and public attitudes toward mental illness.

¹ This spelling, as compared to the later version "Geel", dominated at the time of our interest and will be used throughout the manuscript.

My study is based on a document analysis of publications in the *American Journal of Insanity* over a period of seventy-eight years (1844 to 1921) with the exception of volumes 65, 67, and 68 which were not accessible². This journal was published from July 1844 to April 1894 by the New York State Lunatic Asylum, Utica and from July 1894 to April 1921 by the American Medico-Psychological Association. Continued as the *American Journal of Psychiatry*, the official Journal of the American Psychiatric Association, it proved to be one of the most influential publications in the field. Serving as a medium for professional and intellectual exchange among the leading psychiatrists of the time, the *American Journal of Insanity* published information on new methods of treatment, the latest innovations in asylum management, diagnostic criteria, and a wide variety of issues related to ethical, social, and forensic problems. The choice of this source is grounded in an understanding that this journal was a core publication reflecting the development of ideas in the field of psychiatry. Incidentally, it also provides insights into factors influencing response to certain treatment alternatives, and the interplay between the needs of professionalization in psychiatry and the development of the mental health care system in the United States.

In my research I reviewed all articles that appeared in the *American Journal of Insanity* during this period of time and selected for in-depth study ones that contained the following themes: Gheel, free-air treatment, the rights of mental patients, colony system, therapeutic communities, provision for the insane, and topics related to these. I tried to reconstruct the history of the first programs based on free-air, or family, treatment, and the possible explanations why they were not more widely implemented but, on the

² Given that only 3 volumes out of 78 were missing, along with the strength an abundance of evidence in support of my findings, these missing data are not likely to change the conclusions of this study.

contrary, virtually ceased to exist. As the connection of these developments with the growing professionalization of psychiatry became apparent, I devoted extra time and attention to learning the context of dominant ideas and stereotypes, professional needs, and the changes in institutional policies that were characteristic of psychiatry during the time of my interest. Other issues that became salient in my research were the multiple ways in which mental illness was constructed and reconstructed in the face of new evidence provided by alternative treatment, and, later, based on a painful lack of professional legitimacy.

In the first chapter I will examine the period around the middle of the 19th century, when the largely underappreciated humanitarian movement in psychiatry known as “moral treatment” initiated a wide discussion of the rights of hospital inmates, which later resulted in many initiatives in asylum life and the first attempts at community care for mental patients. The role of Gheel’s example in initiating and promoting this first wave of deinstitutionalization in the American health care system are also discussed in this section. The second chapter will focus on an exploration of the reasons these arguably positive changes were reversed. In the concluding chapter I will attempt to draw parallels between two waves of deinstitutionalization in mental health care in the United States and the lessons from the psychiatric past that might change our present understanding of community treatment’s potential.

Chapter One

“Moral Treatment”, Gheel, and the Origins of Community Care

As is widely known, the anti-psychiatry movement of the 1960's radically reassessed the history of incarceration of the mentally ill in the context of the development of new social control mechanisms in society (Rothman 1971), investigated harmful effects of total institutions on personality (Goffman 1961), and questioned diagnostic criteria (Mechanic 1967) and, indeed, the mere existence of mental illness (Szasz 1967).

In this trend toward rejection of standard medical practice, some major accomplishments of psychiatry's past went unnoticed or underappreciated. For instance, concepts of “moral treatment” and “non-restraint”, associated with the names of such major humanitarian reformers as Pinel and Tuke, were often criticized as “gigantic moral imprisonment” (Foucault 1965: 278), or “tactful manipulation and ambiguous ‘kindness’” (Scull 1989: 16). More importantly, even social scientists who admitted the positive effect of these progressive ideas (Mechanic 1969: 51-52; Brill 1960: 8-10) failed to acknowledge that the scope of reforms was far greater than just the improvement of asylum life. Thus, the proceedings of the Research Conference in Therapeutic Community (1960: 11) held at Manhattan State Hospital in March 1959 reveal that the historic perspective on therapeutic communities was understood as “a liberal, humane,

democratic, all embracing regime of hospital management for therapeutic purposes, the concept of a community of the mentally ill socially structured for therapeutic effect”.

There is no evidence in the conference proceedings of the awareness of the previous century’s experience at implementing alternative programs for caring for the mentally ill, some of which were placed in *real* communities outside the hospital. The major point that was missing in the 1960’s evaluation of the 19th century asylum reform was the actual deinstitutionalization movement that occurred as a result of this first wave of criticism of hospital treatment, and the establishment of the first alternative, community-based programs.

David Mechanic’s “Mental Health and Social Policy”, published in 1969, boldly states that “The community care ideology developed from the growing realization that the mental health hospital as it existed did much to isolate the patient from the community, to undermine his motivation to return, to retard his skills, and, in general, to induce a level of disability above and beyond that resulting from the patient’s condition” (1969: 63). Fair enough, although this assessment could just as easily summarize the essence of the much earlier debate that occurred close to the second half of the 19th century. The evidence of it is abundant in early issues of the *American Journal of Insanity*. This chapter traces the development of this debate and its connection to one of the earliest examples of community care – the historic colony for mental patients in Gheel, Belgium.

Quite similarly to the circumstances that predisposed liberal reforms in 1960s, the mid-19th century could be characterized as a period of disillusionment for American psychiatry. A shift to a more humanitarian perspective was partly prepared by growing disappointment in the curative potential of hospital treatment. It is clearly expressed in

the following passage from Dr. Palmer's speech at the Meeting of the Association of Medical Superintendents of American Institutions for the Insane in Detroit in June 1887 (1887: 157): “The profession, in the primitive days of asylums in this country, entertained the belief that seventy to eighty per cent of the insane would recover, if placed early under treatment; indeed, the reports issued in those days go far to establish such gratifying results. As patients are now presented for treatment, not over thirty per cent get well, and but few institutions are able to make even so favorable a showing.”

It became clear that the mere improvement of conditions in American asylums and the introduction of modern modes of treatment could not disguise the truth: confinement in large institutions in many cases aggravated the condition of the afflicted (*A Village of Lunatics* 1848; Galt 1855; Palmer 1887). The monotony of life in asylums, the disturbing influence of noise, exposure to other patients in much inferior condition were far from beneficial to those who needed special care in a peaceful environment. The legitimate doubt in the efficacy of such a treatment was clearly expressed by many, for instance, Dr. Parigot (1863: 335), the former inspector of the colony in Gheel: "I must state my convictions that such constructions and plans are opposed to real therapeutical success. Is it an axiom, that to treat the insane they must be quartered by hundreds? People suppose it is a great benefit to have large establishments capable of keeping and maintaining with comfort, one or two thousand patients. Now I would inquire if this is also for the interest of the patients themselves?"

The likely answer was no, since one of the major considerations in the asylums' operation was minimizing the cost of their maintenance. Complaints about overcrowded asylums were common among psychiatrists (Van Deusen 1872; *Review of Asylum*

Reports 1878; Ostrander 1900). Pliny Earle (1868), a prominent figure in American Psychiatry, acknowledged the fact that pecuniary interests played a leading role in establishing such a practice. Expenditures often were brought down by increasing the number of patients in any individual hospital, or separation of curables from incurables, and, hence, depriving the latter of treatment options they allegedly did not need.

Another way of decreasing expenditures was found in hiring fewer attendants (*Unlocked Doors in Asylums* 1880). This resulted in a growing number of accidents, and, consequently, wider application of restraint. It was of little help: hospital treatment remained too expensive a provision for growing numbers of mentally ill in the United States. Taxpayers could not support building newer and newer asylums while the country was recovering from the Civil War (Earle 1868). Existing asylums could not accept all of those who needed care. The appalling information that nearly half of the mentally ill in the United States were not provided for in any of the existing facilities, such as hospitals or even alms-houses, appeared in the *American Journal of Insanity* in 1864 (Mitchell 1864). Four years later Pliny Earle (1868) addressed this subject again in order to draw public attention to the thirty to thirty five thousand mentally ill deprived of hospital care. The necessity of change made medical professionals look for alternative ways of treatment. The answer came from a small Belgian town with unique traditions of caring for the mentally ill. Most of the community care programs established in Europe and later in the United States were modeled after this system. Its history is most remarkable.

The special attitude of Gheelians towards the mentally ill was based on a religious cult practiced in the community. Its origin dates back to 600 A. D. According to legend, an Irish princess called Dymphna fled to the area close to Gheel from her father, the

pagan king. Overtaken by incestuous desires, he determined to marry her after his wife was deceased. Brought up as a devout Christian by her mother, Dymphna was preparing to become a bride of the church. She was terrified by the unnatural proposition of her father and tried to escape with support of her religious counselor, a priest Geburnus (in other versions Gerebern). The king followed them and soon found the fugitives in their refuge. The priest was immediately killed. After her continual refusal to submit to the king's power, Dymphna was also beheaded and both were buried at the site.

Since in her death Dymphna was able to overcome the insane, diabolic desires of her father, the martyred princess became a Saint and a patroness of all the mentally afflicted. That started the pilgrimage to the shrine and later the development of the therapeutic community.

This is the most common version of the legend, which can be found in one of the earliest publications on the subject that appeared in English (Earle 1851). It also appears to be the most accurate, since it agrees with the carvings depicting St. Dymphna's life in the church of the Saint (Earle 1851). Other historic facts that can be considered reliable are that Dymphna was canonized in 1247 as a result of a report by a commission sent to Gheel by the Archbishop of Cambrai, France (Kilgour 1936), and that the first written patient records are dated 1693 (Aring 1974). We also know that to commemorate the holy Dymphna the church was erected in 1340 (Pilgrim 1886).

At first patients seeking relief from mental maladies were kept directly inside the church for nine days' exorcism ritual. When rumors about the healing power of the shrine spread around the country, the building of an additional cottage attached to the church was necessitated. That happened in 1430 (Aring 1974), but soon even the added facility

was not sufficient to accommodate all of the patients. The Church asked Gheel's residents to provide temporary housing for those waiting for treatment and, thus, the tradition of boarding the mentally disturbed with the local families was initiated. The colony existed under religious auspices until 1852, then was taken over by the state (Aring 1974). Further improvements regarding medical supervision of the patients were also implemented. Such was the beginning of the first known system of alternative treatment for the mentally disturbed.

All of the above facts comprise the necessary background for further discussion of the main point of interest here: how the reports of observers of Gheel's system gradually promoted the acceptance and subsequent implementation of deinstitutionalization ideas in the United States.

As was pointed out earlier, the first accounts of Gheel's colony started to appear in American journals close to the mid-19th century. It gradually encouraged more and more psychiatrists to visit Gheel and similar establishments in Europe to see in person how individuals with serious mental disorders live with a minimum of restraint among other residents of the community. The visitors' impressions of the system varied greatly, but the discussion they initiated was much more important than their personal opinion of the program.

One of the most important conclusions immediately apparent in the early discussion is the realization that "the insane, generally, are susceptible of a much more extended liberty than they are now allowed." This citation from John M. Galt (1855: 353) was impressed on him by Gheel, where "Lunatics have nearly the same freedom as the citizens of the commune, going at large everywhere" (1855: 354). Having arrived at the

conclusion that the system should be implemented more widely, he quotes in support of his position another visitor of the famous colony, Dr. N. F. Cumming.

The latter had recently published a work describing his experience in Gheel. Among the most important lessons of Gheel's system he cites "the fact that the insane may live in the enjoyment of almost unrestrained liberty, not only with little danger to the community which harbors them, but even as useful members of that community. How much misery might the due appreciation of this truth have saved the misfortunate lunatics of Europe during the last forty years! Cooped up within their dungeon-walls, how many have dragged out a miserable existence uncheered by the glorious light of day and the fresh breezes of heaven! Gheel has also this great advantage, that the self-respect of the lunatic is not wounded by an array of guards and prison-walls: he feels himself a free man, and instead of being cut off from the society, he mingles with his more fortunate fellow-men. Nor is this liberty frequently abused..." (Galt 1855: 354).

This emotional reaction clearly shows the fascination of the author with the newly learned method of treatment. But even more conspicuous in Dr. Cumming's speech is the emphasis on the well-being of "lunatics" rather than community interests. Here, long before the liberal movements of the 1960s, the rights of mental patients are not only openly discussed, but put forward against the tendency of the larger society to distance itself from mental maladies and their victims.

However, not everyone at that early time agreed with such a progressive view. The issues of the *American Journal of Insanity* are full of contrary examples. Consider, for instance, an article under the eloquent title *Protection of the Insane, or of the Sane?* reprinted in July of 1882 from *Philadelphia Medical Times* (pp. 85-86). Heavily angered

by the activities of the newly founded National Association for the Protection of the Insane, the author proclaimed: "It will not be possible to have a flourishing society to protect the sane against the insane; but assuredly the sane suffer more from the insane than do the insane from the sane" (1882: 86). After a list of horror stories about the victims of the mentally disturbed he concluded: "Legislators seemed to have thought only of preserving the liberty of the insane, never the lives and hopes of the sane. ... Assuredly, when a person is really insane and in law not responsible, the law should hold some one responsible that this person is so guarded and watched that the community shall not suffer" (1882: 86). Ironically, the article is followed by a description of interesting cases of self-injury among asylum patients (Shüle 1882). Granted the importance of informational exchange among psychiatrists, the article still conveys a notion of the dangerousness of the hospital inmates.

The same volume of the *American Journal of Insanity* had published a response by Dr. N. Roe Bradner (1883) to the earlier article *Lunatics at Large*. The author was offended by the tone of the above article. As can be seen in the following citation, it mostly depicted mental patients as violent monsters: "I see this man constantly on the street and expect nothing else than to find some of these days he will become violent, and treat us to a massacre in true lunatic style" (Bradner 1883: 476). Criticizing this and also the opposite trend to scare the public with stories about the unjustly incarcerated sane persons, Dr. Bradner advised media to avoid sensational publications and leave the privilege of judgment on mental disorders to medical professionals.

Dr. Bradner's concern about the presentation of psychiatric care in the media was quite legitimate. Considering the contents of the current issues of the *American Journal*

of Insanity, the profession had definite public relations problems. Memory of the terrible conditions that existed in asylums in the past was still very vivid. Psychiatrists tried to distance themselves from "those dark ages of lunacy", in the expression of A.M. Shew (1879: 18), the Superintendent of Middletown Hospital for the Insane. The only valid excuse he could provide for his predecessors was a belief in supernatural causes of mental disorders incompatible with Christian conscience. His confidence in this explanation is evident: "On no other supposition can we account for the apathy existing among civilized nations, and the cruel, yea, barbarous provision made for this afflicted class, up to the close of the last century" (Shew 1879: 18). And even greater was his surprise that at that remote time the common abuse of rights of mental patients had a single exception - the Colony of Gheel.

However, it should be admitted that the roots of public distrust were not entirely in the time of old Bedlam. Two issues regarding personal liberty had found their way into the pages of the same journal. The first is illegal confinement, and the second is the use of restraint in asylums.

It is apparent that illegal confinement was one of the main reasons for unfavorable public attitudes towards the asylums. The discussion of this topic, in combination with other critical comments on the organization of hospitals, not only led to improvement of the latter, but also prepared the ground for the development of community programs as less harmful to the liberty of patients.

Fear of illegal confinement existing at the time is quite understandable. The mere nature of a disease lacking organic changes provided broad possibilities for abuse. In combination with the loss in status and basic rights of the confined, it put a huge burden

of responsibility on professional judgment. John B. Chapin (1883: 38) from the Willard Asylum for the Insane notes: "The asylums, instead of being regarded as hospitals and asylums for the medical treatment of a disordered condition, have come to be regarded as objects of suspicion; as convenient places for the 'incarceration' of persons by designing relatives, and lunatic prisons, proper only for the detention of the criminal and dangerous insane". He supposes a disagreement among medical professionals reflected in the medical press as well as the regular newspapers is the ultimate cause of the negative image of hospitals and "frequent, causeless, undeserved and unexpected" attacks on asylums (Chapin 1883: 33, 41).

The question is whether those attacks were so entirely groundless as the author tried to assure the audience. Indirect evidence of the opposite can be found in his own article. Dr. Chapin (1883: 35) recollects that "thirteen official inquiries or investigations into the management of asylums of different States have been prosecuted by legislative authority during the past few years, though the actual number was probably much greater". The outcome of these investigations was "the recommendation, or enactment, of more stringent laws for the commitment of the insane to asylums, or so-called personal liberty bills" (Chapin 1883: 45). It is very unlikely that the State Board of Charities and the State Commissioner in Lunacy would resolve to take such measures unless the situation really required some major improvements.

The example of a legislative action aimed at the prevention of illegal confinement was a requirement by the State of New York that two medical certificates were necessary to confine a person (*The Rights of the Insane* 1883). In addition, the law demanded that "the certificates must be approved within five days by a judge residing within a district;

and as a further protection of the rights of the insane, the judge, in his discretion, may call a jury and take testimony to satisfy himself of the necessity of those proceedings" (*The Rights of the Insane* 1883: 414). Even after such a rigorous provision, the decision still could be appealed to the Supreme Court.

In practice, a careful supervision of confinement was entirely justified on the grounds that there was no simple way to get out of an asylum once a person was accepted for treatment. A small passage by a Judge Lawrence reprinted from the *New York Times* illustrates the unwillingness of the court to release patients on demand of their relatives (*Judge Lawrence on the Release of Lunatics* 1884). In the Judge's opinion, the court should assume responsibility for all the possible negative consequences of such a decision and be extremely conservative in its judgment. As we can see by his comments, the violent image of mental patients still persists.

In this light it is no wonder that the liberty the mentally ill enjoyed in Gheel's Colony impressed many visitors. It was a great argument in the debate regarding the amount of restraint needed in asylums. Although Pinel "struck off the chains and shackles from the unfortunate lunatics of Paris" as early as 1792 (Bissell 1912: 271), it took another century for the idea to catch on. In spite of efforts by Pinel's disciple Esquirol in France, and William Tuke in England and an overall acceptance of the concept of "moral treatment", the abuse of patients' liberty was profound for many more years to come (Cowles 1894). Thus, in the United States the first instance of "the absolute abolition of mechanical restraint in a public institution for the insane" was dated January 1, 1879, initiated by Carlos F. Macdonald, the superintendent of Auburn asylum for insane criminals at that time (Macdonald 1902: 417). Three years earlier he found that: "each

ward of that institution had a complete outfit of these appliances – the so-called mechanical restraints – and each outfit was in almost constant use” (Macdonald 1902: 416).

Gradually though, psychiatrists agreed that "the *minimum* of restraint is what all medical officers aim at" (*The Rights of the Insane* 1883: 424). But there was no general consensus on what the actual meaning of the "minimum" was. Dr. Rutherford (1880: 94) from the Barony Parochial Asylum at Woodilee, near Glasgow, advocated an open-door asylum arrangement: "by the diminution of apparent restrictions upon liberty, greater quietness and contentment are secured, which has its effect in promoting recovery and contentment". An editorial from the *American Journal of Insanity* (1880: 94), though, gave a decidedly critical evaluation of the system: "the open-door system is merely a pretentious myth, for it is, of course, obvious that an asylum might be so arranged that a very small number of locks might entail a very large amount of restrictions of liberty".

Even Gheel did not completely escape such a fate. A lot of times its visitors would give quite different opinions of the restraint they observed there. Some of them noted a presence of restraint apparatuses in the houses of host families that could be applied by caretakers "as they please or deem necessary" (*Gheel* 1884: 521). Others admitted that instances of actual use of restraint were quite rare (Earle 1851). In general, one of the major sources of distrust of the system lay in the impression that it was much more prone to abuse than other establishments.

Interestingly, apart from the instances of corruption in the past (arrangements through so called "middle-men") (Earle 1868: 56), the opponents of the Colony could not provide any evidence of abuse. They just thought it might very well happen, since there

was no system for extensive supervision of patients, or the caretakers. What those critics did not take in account was the fact that there was constant public surveillance in the community in regard to the patients. Since the latter could go everywhere unaccompanied, and freely communicate with other residents, the life of host families was completely transparent and subjected to social control within the community. Therefore, Herman Ostrander's (1900: 444) conclusion makes much sense: "The objections offered to the plan have so far been made mainly on theoretical grounds and by those who have had no practical knowledge of the system".

As to the issue of the actual use of restraint in Gheel, it should be noted that originally no system of screening incoming patients existed. The application of restraint was unavoidable in case of violent or suicidal patients. Over time and especially after the Colony was placed under medical supervision, it was minimized, based on the assertion of Dr. J.A. Peeters, director of the Colony. He pointed out that: "the patients mingle more and more with the community in which they live, and that their liberty is greater than formerly. Thanks to a stricter oversight, the patient has been put more on the footing of the family that cares for him; he always eats at the same table, when it is possible; he goes to church with them, works along with them, and rather less than they do; and at the week's end the head of the household gives him as to his own children, a larger or smaller payment" (Peeters 1895: 540). Overall Dr. Peeters' report assures that the list of improvements to the system over the years was quite extensive. It gives an interesting focus to the discussion analyzed here. Apparently, in addition to the promotion of alternative forms of treatment in the United States, critical debate also served as a source

of feedback for the original system. Indeed, critical comments expressed by its opponents worked to the benefit of the further development of the Colony.

As to the efficacy of the system, the crucial evidence in its favor was identified by Herman Ostrander (1900: 444): "Experience seems to have demonstrated that the patients once established in homes have no desire to return to asylum-life". Based on his six years' experience as a resident physician in Michigan Asylum Colony, the author maintains: "the removal from the bustle and confusion of institutional life, the absence of institutional features, the complete isolation from the asylum world, so to speak, have permitted almost unlimited freedom. In some few cases the confidence reposed has been betrayed, but in the majority of cases it has been appreciated and habits of self-reliance and self-control have developed" (Ostrander 1900: 448). He goes even further, proposing that the colony accept more disturbed patients, which contradicted an established practice of the time: "I believe that many of them would become more comfortable and tractable by a change to the colony and would eventually be able to be transferred to the quiet class; indeed, some of our most disturbed patients have developed into trustworthy farm-workers who are able to live in an open-door cottage" (1900: 452).

The positive influence of change was commonly mentioned among the advantages of the system. Thus, John M. Galt (1855: 356) states that "change of scene and air in disease has been a fact so generally acknowledged in medicine". But the magnitude of the impact, in his opinion, should be much greater in case of removal from overcrowded wards of asylum to the normal life in a family circle. Besides the well established therapeutic effect, most supporters of the system underline the importance of patients' contentment. This theme, closely connected to the notion of the rights of the

mentally ill, can be found in many of the reports. R. M. Brinkerhoff (1896: 599) includes it in his impressions from his examination of Gheel and other foreign establishments: "In this enjoyment of comparative liberty, and of what is called the free air treatment, these patients are, on the whole, contented, tranquil, and healthy". However, as was rightly noted by Dr. Parigot (1863: 341): "this element of self-satisfaction *or enjoyment* is not taken into consideration by my opponents".

The following quotation provides stark evidence of that neglect: "To make use of the sentimental argument that such patients are happier under surroundings which most nearly approach home life is puerile, for, as has been said, they are not in a condition to appreciate their environment. And to claim that they are as well cared for in houses without any of the modern conveniences, by those whose intelligence, in some cases, seems but little above their own, as they would be in a well-managed, well-constructed hospital under the immediate care of watchful physicians and skilled attendants, I can not believe to be the case from the evidence which my visit gave" (Pilgrim 1886: 327).

It is easy to detect which of the above authors speaks from a more humanitarian perspective, but part of the explanation may be the fact that most of the psychiatrists cited here represent hospitals and asylums where they probably spent most of their careers. To accept the idea of the inferiority of a system they defended for their whole life might be inconceivable for some of those respected professionals.

To demonstrate that statements about the therapeutic effect of free-air treatment were not just optimistic exaggerations of its advocates, we can refer to the numbers supplied by Dr. Peeters, director of Gheel's Colony. His report on the current situation in Gheel was given at the Meeting of the Belgian Society of Mental Medicine in 1894.

According to him, on January 1, 1894 the Colony accommodated 1,875 patients, which constituted more than one-fifth of all in the Kingdom" (Peeters 1895: 540). The population of Gheel itself was slightly over 4,000 persons as estimated by Dr. Tucker (1884) ten years earlier. This figure, however, does not include residents of the adjacent farms and small villages, which would significantly raise the total. Though unable to determine the exact ratio of patients to other residents of the Commune, these statistics make obvious that the number of patients distributed throughout the district was unprecedented.

The information we can derive from Dr. Peeters' report pertains to recovery rates for the patients of the Colony: "The proportion of recoveries is, then, 21 per cent; adding the cases of marked improvements (48 in all), which often turn out to be complete recoveries, we reach a total of 25.4 per cent, or more than a fourth part" (Peeters 1895: 541).

To evaluate this information it should be compared with similar figures from other institutions. The *Review of Asylum Reports*, regularly published in the *American Journal of Insanity*, is a reliable source for such a comparison. For instance, in 1877 the percentage of recoveries of the number of patients admitted to the Maine Insane Hospital in Augusta was 37.6; at the State Lunatic Hospital in Northampton 23.9; at the Worcester Lunatic Hospital 20.3; and at the State Lunatic Hospital at Taunton 2.28 (*Review of Asylum Reports* 1878). But probably the most remarkable results were achieved at the Willard Asylum for the Insane under the supervision of John B. Chapin, superintendent, who was so upset about public distrust of asylums. In this establishment out of 221

admitted during the year, only two patients were discharged recovered, while 79 died (*Review of Asylum Reports* 1878)!

This information is presented not in order to blame the hospitals for poor treatment, but to demonstrate that even in direct comparison Gheel shows favorable results in terms of treatment outcome. What is even more impressive, though, is the fact Gheel historically received almost exclusively incurable, chronic cases. In this light, the number of recoveries in the Colony can be considered a major success of psychiatric care of the time.

What were the other objections against a system with such a curative potential? One of the most common complaints was the bad accommodation provided for the patients. Thus, Dr. Tucker (1884: 520) gives a very negative evaluation of the village, where he found "smoke, dirt, want of space, deficiency of wholesome or even decent accommodation and comfort; universal wretchedness and sordid misery". Especially shocking for the visitors to the Colony appeared to be a lack of bathing facilities - an "important therapeutical and hygienic measure" (Pilgrim 1886:326). The response of supporters of the system was "As the patients and peasants all fare alike in this respect, there can be no ground for complaint" (Shew 1879: 22).

It should be noted that almost every report from Gheel or other similar establishments acknowledged that community care programs, whether colonies, farms, or cottages, proved to be much more cost-effective. Savings were obtained by using patients' labor on farms, meager payments to host families or by charging patients' friends or relatives for care in families. Relatively low expenditures for running those facilities became the single biggest argument in favor of the system. In spite of this obvious

advantage, especially as a provision for the incurable, chronic class of patients, who did not require intensive treatment, some of the psychiatrists expressed their concern that savings are acquired as a result of inferior care (Tuke 1870). On the other hand, they realized it could not be counted as a fault of a system: if so much success was achieved with such low investment, it only showed the greater potential of this type of arrangement.

Realizing that the program was going to develop in the direction of specialized care for chronic cases, superintendents of asylums worried how it would influence hospital life. They expected that "the hospitals themselves are rendered more noisy and less desirable for the treatment of acute cases by the withdrawal of this quiet class" (*Review of Asylum Reports* 1878: 546). Moreover, hospitals would lose those patients as "useful workers" (Stedman 1890: 334). Those arguments, though, were discounted by "the reflection whether the mild and more appreciative cases although chronic should not rightly serve some other purpose than a quieting influence on the excited" (Stedman 1890: 335). This shows that the humanistic approach was consistently present in the discussion at least during the second half of the 19th century. It balanced prejudiced comments of more conservative psychiatrists, as for instance in the following examples of speculations on the idea of the dangerousness of mentally ill.

This theme comes up relatively often not only in publications of general interest in the *American Journal of Insanity*, but also in articles by leading psychiatrists. Along with the movement to lessen restraint, the violent image of the mentally disturbed had considerably faded away. Statements to that effect were not completely acceptable by the standards of the time. That is why they were often disguised under concern for the safety

of the general public. The following is a typical example of such a sentiment from trustees of one of the institutions: “How gladly would we unlock the doors, and give the largest liberty to these unfortunate beings, were we not satisfied from our observation and experience, that such a step would be attended with the direful consequences. We have the highest respect for the kindness of heart which promotes those philanthropists who feel that they are divinely appointed to point out the true mode of alleviating the insane, to say, 'Throw off all restraint', 'unlock your doors', and 'let them go at large'. ... But to unbar the doors and allow the patients indiscriminately to run and roam, we are certain would be attended with consequences of which the trustees ought only to be ‘acquitted by reason of insanity’” (*Review of Asylum Reports* 1878: 547).

Another version of a similar concern in respect to the operation of the colonies was stated by Herman Ostrander (1900: 444): "the most valid objection to my mind is one that should condemn the whole system, namely, that constant association with the insane has a demoralizing effect on the sane, especially the young". Henry R. Stedman (1890: 328) made a similar assessment adding that, in reverse, it can also "react upon the patients". Responding to this accusation, Dr. J. Parigot (1863) pointed out that such a negative influence would be much greater in overcrowded asylum wards than on the farm. He also assured his opponents that mental illness was no more common in Gheel than elsewhere in Belgium.

These were the most common arguments in the discussion on deinstitutionalization of mental patients that became a prominent feature of asylum reform during the second half of the 19th century in the U.S. As the analysis suggests, the new methods of treatment were in line with recently acknowledged concepts of “moral

treatment” and “non-restraint”. This fact did not save community care programs from the harsh criticism of the more conservative psychiatrists. Probably, some of these negative evaluations were truly deserved, since Gheel itself was in a process of evolution and needed much improvement at the time. Overall sentiment toward the system was rather cautious, but along the lines of our discussion we can see how even the most determined opponents of Gheel admitted that some of its features deserved appreciation.

It should be noted that at the time of debate, variations of the program were already in operation in many European countries and had started their advancement in several American states. Descriptions of different plans based on free-air treatment appear among other publications on the subject. The examples were numerous: the Farm of St. Anne and other insane colonies in France, boarding-out system and placement in private dwellings in Scotland, colonies in Gheel and the Walloon district of Belgium, colonies for epileptic patients in Pennsylvania and New York (*Pennsylvania Epileptic Hospital and Colony Farm* 1896; *Colonies for Epileptic Patients* 1897), the cottage system in Michigan, Oregon, and Massachusetts. Needless to say, they were all modeled after Gheel's system.

Psychiatrists involved in running those facilities had published their detailed accounts on all the practical matters of the organization and operation of the colonies, along with advice on how minor imperfections could be removed to maximize the positive effect of the treatment. It brought the argument from the theoretical to the practical level and helped to convert more people into supporters of the program: "For if an unexpected amount of good has been accomplished under imperfect conditions, and this cannot be justly denied to the former regime, how much greater improvement must

we expect under the more acceptable methods recently inaugurated" (Stedman 1890: 331).

One of the most important conclusions that can be derived from this analysis is the consistency of argument on community treatment over time. It illustrates its relevance to at least two generations of psychiatrists who started incorporating this knowledge into their professional views and everyday practice. In spite of the obvious division within the profession into supporters and opponents of the program, the presence of the issue in publications of *American Journal of Insanity* was too conspicuous to ignore. The trend that seemed to be observed was toward the gradual acceptance of the Gheelous plan, which was supported by frequent examples of outpatient programs started by newly converted psychiatrists. Many of the latter experienced the Gheel system in person, while some learned through scholarly publications. In neither case can the role of Gheel in initiating the discussion and setting the precedent for future reference be discounted. However, the seemingly winning humanitarian approach encountered some obstacles that proved to be much deadlier for the future of family care than stereotyping and prejudice of the conservative part of psychiatric circles. It was an urgent need of the establishment of the psychiatric profession institutionally and, most importantly, in the public view. How psychiatry earned, or rather tried to earn, public respect, and what impact it had on alternative treatment of mental patients will be examined in the next chapter.

Chapter Two

A Quest for Legitimation

On the fiftieth anniversary of the American Medico-Psychological Association Edward Cowles (1894: 10) made the following statement: “The stories of Pinel and Tuke, and what they did one hundred years ago, are our household words; for them it was reserved to make the beginnings of a true reform, not only by taking humane care of the insane, but by treating them as subjects of bodily disease”. This citation signifies the most important shift in priorities that gradually occurred in psychiatry close to the turn of the 20th century: the change of focus from moral to medical treatment. It is apparent in the way the contribution of the founders of moral treatment is reevaluated: “While Pinel had advanced the care and treatment of the insane, he knew little of pathology and got his psychology chiefly from the philosophers. Esquirol advanced the pathology of insanity, and was the prime mover in the second phase of the great reform” (Cowles 1894: 11). It resulted, among other changes, in “building new asylums, with proper treatment by physicians in charge” (Cowles 1894: 11). Indeed, the profession’s primary concern was not an improvement of life for “poor lunatics”, as it may appear from the previous chapter. Paradoxically, it could be claimed that support of the rights of mental patients and multiple improvements of asylum life were partly necessitated by the need to whitewash a negative image of hospitals and psychiatry in general. In spite of wide discussion and actual legislative initiatives (official acceptance of family care in

Massachusetts in 1885, and later in all other states), most of the “humane” changes that were implemented served the establishment of psychiatry as a profession, rather than the welfare of hospital inmates. Institutional changes require institutional decisions; therefore the decisions were made and results were obtained to the ultimate benefit of psychiatry based on the vision and concerns of its current members.

According to the theory of professionalization of expert labor (Starr 1982; Abbott 1988), the consolidation of professional authority in the American health care system mostly occurred between 1850 and 1920. Paul Starr brilliantly describes how the medical profession clawed its way up from powerlessness and insecurity to solidarity and occupational control. The major benchmarks along this journey were the start of licensing and medical education, which supported the claim for esoteric knowledge, reconstitution of the hospital as “an institution of medical science rather than social welfare” (Starr 1982: 147), and an increasing division of labor along with growing prestige, all of which led to the ultimate acquisition of authority.

The history of the development of American Psychiatry seems to closely follow this general pattern. However, a closer look into the dynamics of the profession reveals that its claim for legitimacy went terribly wrong. The *American Journal of Insanity* proves to be an excellent source of data on the professional development of psychiatry, since it was established the same year (1844) as the Association of Superintendents of American Asylums for the Insane was founded. At the time there were only “twenty institutions for the insane in the United States – nine of these were founded in the preceding five years” (Cowles 1894: 20). As was pointed out by Harry Solomon, the President of The American Psychiatric Association in 1958 (p. 1): “The volumes of the

American Journal of Insanity which later became the *American Journal of Psychiatry*, are our best single source reference for tracing the development of organized psychiatry over the years.”

As was shown in the previous chapter, psychiatrists’ concerns about the lack of professional legitimacy and public distrust of the asylums became one of the main motivations for implementing the system of non-restraint, improving living conditions in hospitals, and establishing the first alternative programs. In fact, more humane treatment of mental disease did result in the first positive changes in public attitudes toward asylums. Thus, Dr. Pilgrim (1900: 50, 49) noted in 1900 that “hospitals for the insane are to-day regarded much more favorably than they were even a decade ago”, which was evidenced by the fact “that cases are sent to the hospital much earlier than they used to be”. A similar assessment is expressed by Frederick Hills (1901: 160): “This would seem to demonstrate that the efforts put forth to emphasize the hospital idea and toward improvement in the care and treatment of the insane have in a measure had their effect upon the community and that the Insane Hospital being now looked upon with less dread, its good offices are sought somewhat earlier in the course of the disease”.

However, legitimation of the profession required much more than positive public opinion in regard to hospitals. The critical issue in this process was to establish professional authority in the recognition and treatment of disease. Unfortunately, moral treatment did not provide serious grounds for such a claim: an emphasis on spontaneous recovery as opposed to cure, and the denial of the benefits of medication, carried a threat to the medical profession and its dominance in the field (Scull 1989). Indeed, if simple placement in families of uneducated farmers results in recovery rates comparable to the

best equipped hospitals under the care of trained physicians, then the next question is whether psychiatry and psychiatrists are needed at all.

Medical practice as exercised in the hospitals at the time did not promote professional recognition either: indiscriminate blood-letting in order to elevate nervous and mental conditions (justified by “depletion theory”), counter-irritation through blisters that were considered “beneficial in mania as revulsives, and as useful in melancholia by their irritation serving to divert the mind from its morbid train of thought” (Cowles 1894: 13-16) are only some of the examples of the barbarous experimental treatment utilized. There was an urgent need to establish scientific grounds for the claim of expert knowledge, in fact to completely redefine psychiatry as a medical science.

Very much in line with Paul Starr’s ideas, first came institutional changes. The profession consolidated its effort to secure legislative grounds for its authority. In 1890 the State Care Act was passed. Among other important changes, it instituted training schools for nurses in all the hospitals, and the designation of state institutions as hospitals. The latter was by no means an incidental legislative initiative: it was promoted by the constant efforts of many leading psychiatrists. For instance, Dr. G. Alder Blumer, the superintendent of the Utica State Hospital and the editor of the *American Journal of Insanity* for many years after 1886, by the journal’s description “was fully imbued with what has sometimes been called the ‘hospital idea’, and he at once set about the ‘hospitalization’ of the Asylum. He was active in securing the legislature which eliminated the word ‘asylum’ from the laws and institutions of the State, and in every way emphasized the medical character of his work” (*Notes and Comment* 1902: 155). He also “made a prolonged and determined but vain resistance” to “conferring executive

powers upon” the State Commission in Lunacy created a year earlier (*Notes and Comment* 1902: 155).

Although disappointed by a loss of exclusive authority, psychiatrists gained in influence. From that point on, initiatives originating within the American Medico-Psychiatric Association had a major impact on the state legislature. It was one step forward in the establishment of occupational control. But there were many more victories. One of them was pointed out by P.M. Wise (1900:81), the President of the New York State Commission in Lunacy: “There is to-day in the State of New York no acknowledged dependent insane person in an almshouse, penitentiary, jail, reformatory, or any place of custody other than a State hospital”. At least the exclusivity of a place of treatment was finally achieved. This result was facilitated by the leadership of the State Commission in Lunacy, which, in Wise’s (1900: 82) assessment, had “the great end in view – the most effective treatment and care of the insane in the most economical way” which required “a certain degree of uniformity in method and administrative practice”.

Another accomplishment in the promotion of psychiatry as a medical science was the establishment of pathological laboratories in every hospital for mental patients. This “‘scientific work’ was deliberately undertaken” in order “to take part in the general movement for progress in medicine” (*A Review of Scientific Work* 1902: 164). Based on the following quote, these efforts did not prove very successful: “Since the introduction of laboratory methods into asylums for the care of insane, the secretions and excretions of insane patients have been subjected to various chemical and physical tests. In the beginning the majority of cases were examined for scientific purposes to determine, if possible, whether any cause could be found in blood, urine or glandular secretions to

account for the mental alienation. While the microscope thus far has failed to reveal the ultimate cause of insanity, all of these investigations have been of use clinically and of decided benefit to the patients themselves” (Allen 1901: 261). However, these “minor” disappointments did not prevent Henry Hurd from proclaiming in 1913 (p. 476):

“Provision for the insane in the United States has now reached the era of scientific care.”

As can be expected, so called “scientific care” required an acknowledgement of mental conditions as bodily disease. This was readily done, as can be observed in the following citations: “psychological phenomena run parallel with physiological facts” (*A Review of Scientific Work* 1902: 165), and “insanity is always a disorder or disease of the human organism” (Blumer 1894: 539). The most eloquent quote belongs to L. Vernon Briggs (1913: 467), a Member of the Massachusetts State Board of Insanity: “I believe that this society would do well to take some action tending to eliminate the use of the term, ‘insane’, as connected with hospitals and their patients. If mental conditions are (as most of us expect will soon be proved) only symptoms or results of physical disease, the terms insane, mentally ill and mental disease will have to be done away with...”.

That was very true: the scientific legitimation of psychiatry was entirely based on speculation, as was admitted on the pages of the same journal: “we have no knowledge of the relation between normal mental functions and the anatomical arrangements of the brain” (*A Review of Scientific Work* 1902: 165). Moreover, in some sort of perverted logic the proof of a physical-mental connection was based on the earlier achievement of the Association itself, such as acknowledging asylums as medical institutions: “The general conviction of insanity as a disease is shown in the modern tendency to change the old name, lunatic asylums, to that of hospitals for the insane by legislative enactment.”

The above statement was made by Dr. Blumer (1894: 539), whose persistent efforts enabled this exact legislative change. Thus, the desire of psychiatrists to acquire an objective basis for their claims to medical authority became a self-fulfilling prophecy: in the absence of solid evidence they started acting like such evidence existed, and soon no one tried to challenge their unsupported claims.

In any case, as Andrew Scull noted, the “assumptions about the *somatic* basis of mental disturbance have played a quite crucial role in legitimizing medical claims to exclusive jurisdiction over the mad throughout the nineteenth and twentieth centuries and have proved similarly crucial in the determination of therapeutic practices during this period” (Scull 1989: 120). The only problem psychiatrists were facing was that acquiring the role of medical professionals, who were specifically trained to deal with mental disease, carried an expectation of their being able to actually *cure* it. Unfortunately, that was exactly what they were not able to do. On the contrary, with all the “scientific” treatment recovery rates were going down, which was considered an effect of civilization on the human organism (Jones 1904). Being on shaky grounds in terms of recovery rates, psychiatry had to come up with an explanation for the low effectiveness of hospital treatment. A brilliant reason was soon found: heredity.

The convenience of this explanation lay in the fact that regardless of psychiatrists’ training or level of expertise, there was little that could be done to cure inherited conditions. The disease was in the genes. To establish this connection, patients’ family histories were reexamined. In some cases “evidence” was readily available: an alcohol or drug habit of a patient or his ancestors (Pilgrim 1900). In others it was not clearly apparent. Therefore heredity started being defined more and more broadly. Among the

“predisposing” factors were named immorality (Pilgrim 1900), and a family record of “epilepsy, chronic nervous disease, rheumatism, tuberculosis, cancer and, in short, any disease attended by a prolonged lowered bodily vitality” (Hills 1901: 158).

Characteristically, “bad” family history was not limited to physical conditions. Poverty, crime, self-indulgence, poor nutrition, lack of hygiene, and overwork were all linked to insanity (Jones 1904). Considering all that, whose family history would not include factors related to mental problems? Over time, though, predisposing factors moved more and more toward social “evils” rather than physical conditions. An obvious contradiction between this trend and the simultaneous claim that mental disease is caused by physical abnormalities was unavoidable. An insistence on the interpretation of heredity as a history of any physical disease in a family would put *everyone* in the category of mentally ill.

Thus, the notion of inheritance became a matter of interpretation, and mental disease itself gradually moved into an area of increasingly vague definition. Unable to cure mental conditions, psychiatrists had to justify their right to be considered medical professionals. The only area that was left at their disposal apart from the failing treatment was *prevention*, as “the chief end of all medicine” (Blumer 1903: 13). The striking obsession with this idea was incredibly common in psychiatric circles at the time. It was taken to the extreme by saying that “prevention is of more importance than is the treatment of those already suffering” (Kraepelin 1900: 236). So, the claim of understanding a disease itself was replaced by the claim of understanding its consequences for the society. A showcase of a profession’s esoteric knowledge, it

involved much effort to convey the seriousness of a problem and to educate the public on the severe consequences of spreading mental illness and “degeneracy”.

In order to demonstrate their warnings of “degeneracy of race” and its cost to the nation (Macdonald 1908), psychiatrists relied on statistics showing a dramatic increase in mental illness in the population. Although some doubts as to the actual meaning of this evidence were voiced, such as suspicion it was due to more ready recognition of mental disease or to greater willingness to seek hospital help (Pilgrim 1900), these doubts were soon discarded. In addition, new groups were constantly added to the list of the mentally afflicted. Evidence of this is abundant (*Proceedings of the Sixty-Ninth Annual Meeting* 1913: 236, 237; Fernald 1914: 741; Bowers 1917:85, 79; *The Remedy for Anarchism* 1902: 162):

- “prostitutes as a class are mentally deficient”,
- “sociologists searching for the cause of poverty have given little thought to mental defect”,
- “once the relation between feeble-mindedness, criminality and the lesser derelictions can be impressed upon the public...”
- “the significance of feeble-mindedness as an antecedent and cause of delinquency, crime, pauperism and other social diseases”,
- “not all expressions of homo-sexuality are to be regarded as evidences of insanity; yet it may be safely said that the majority of sexual perverts are psychopathic individuals”,
- “epilepsy is responsible for a vast number of pathological offences”,
- anarchism “is a form of mental disease”.

This new explanation of deviance as mental deficiency drew on the stereotypes of the general public, and quickly earned much support among psychiatrists who themselves were far from unprejudiced. In addition, it allowed almost unlimited extension of the group of mental patients, which supported the need to build new asylums and train more professionals to work in them. Psychiatry quickly responded to every social problem: an increase in immigration at the turn of the century led to the growth of the proportion of incarcerated immigrants. For instance, in the state of New York, 69 per cent of patients were foreign-born (Elliot 1907). Emancipation resulted in “the large increase of insanity among the negroes”, which in the author’s opinion was “part of the price they had to pay for their new condition” (*Proceedings of the Association* 1893: 257). But the most amazing was an invention of a new category of degeneracy, the so-called ‘moron’ type. Even the proponents of this new addition to the classification scheme admitted that it was almost impossible to distinguish it from normal variations of human intelligence (Fernald 1914). In the difficult task of identifying the “moron” type it was advised to take into account physical appearance: “As a rule, mental defectives are not physically attractive or pleasing in appearance”, and also “They often lack the physical grace and charm of well-formed normal youth” (Fernald 1914: 743). Another guideline was to check for “vicarious manifestations of family inferiority”, such as “epilepsy, ... criminality, immorality, social and economic inferiority” (Fernald 1914: 744). The author’s conclusion was that “the ability of a man to earn a living, to maintain himself independently in the station of life in which he is born is the one supreme test of mental normality” (Fernald 1914: 751).

This last quote is the most significant. It demonstrates an increasing interpretation of mental disease as social and economic maladjustment. But if “the highest test of sanity be ‘the ability to adapt self to environment’” (Work 1912: 14), the connection between mental illness and deviance becomes even more salient. The argument psychiatrists put forward in their quest for legitimacy was in fact much more potent than they were given credit for by social scientists. They did not treat all mentally ill as deviants. Instead, they redefined all deviance as mental illness. And they possessed an exclusive right to identify and manage this ever growing group.

The beauty of this approach lay in the fact that psychiatry created the need for its own existence. Borrowing Szasz’ expression (1970: 75), it succeeded in the ability to transform its “judgment into social reality.” Amazingly, it was accomplished by consistent efforts of a very small number of people. Harry Solomon presents in his presidential address in 1958 a membership count of the American Psychiatric Association between 1844 and 1957, part of which is replicated below:

Year	Count
1844	13
1854	24
1864	23
1874	58
1884	65
1894	346
1904	589

1914	726
1924	1,131

It should be noted that a large increase in 1894 is mainly due to the “reorganization in 1892, when its membership became more general” (May 1917: 129). It is easy to agree with Solomon that “It is very remarkable that an organization of such small size could have such a marked influence upon the course of development of psychiatric care” (Solomon 1958: 2). But the strength of the Association was in its unity. Proceedings of the annual meetings of the Association bear almost no evidence of disagreement even in cases when the most outrageous ideas were voiced. No wonder, as was stated by Charles Burr (1918: 415): “A pseudo-psychiatrist is one who does not agree with me.” In a professional community of such a small size, being excluded probably involved some unpleasant consequences for the career and employment opportunities of its members.

The issue that has to be addressed is how preventive psychiatry dealt with the notion of heredity. Indeed, if mental conditions were inherited, and were “an end-product” (Smith 1915: 4), then how could they possibly be prevented? The answer was simple and unemotional: everyone who was suspected to have mental illness or had a potential to develop it in future (infamous family history test!) had to be segregated for life or sterilized in order to prevent him or her from reproducing “their kind”. In this group liable to involuntary sterilization were placed all epileptics, alcoholics, prostitutes, criminals, imbeciles, and mentally disturbed. In other words, everyone who was, in Association members’ views, a “by-product of the human family” (Work 1912: 4),

“overwhelming sub-normal output” (Smith 1915: 4), or simply “protoplasmatically wrong” (Burr 1918: 416). The category “constitutionally inferior (inebriates, criminals, prostitutes, chronic dependants, etc.)” openly appears on a clinical classification of “abnormal cases” (Rosanoff 1917: 158). Thus, by the second decade of the 20th century the discourse on mental illness within the psychiatric community was clearly transformed into the powerful eugenics movement. Every Presidential Address, the long-term tradition of the Association, as well as proceedings of the annual meetings almost entirely focused on the new mission the Association had undertaken: protection of society (Macdonald 1914) with the ultimate goal to provide “for the race a better ancestry, made possible only by eliminating the unfit” (*Proceedings of the Sixty-Ninth Annual Meeting* 1913: 237).

The Association was by no means humble in pursuing this mission. The newly organized Committee on Applied Eugenics and the Committee on Immigration stepped forward with numerous legislative initiatives, many of which were successful. Due to constant efforts of the Association over the years, 27 states considered legislation on sterilization, and 11 states had actually enacted it (*Proceedings of the Sixty-Ninth Annual Meeting* 1913). The Committee on Immigration recommended amendments to the U.S. Immigration Law for “better protection against the admission of insane or defective immigrants” (*Proceedings of the Sixty-Ninth Annual Meeting* 1913:231). Other proposals concerned public school inspections and “segregation of backward children” (*Proceedings of the Sixty-Ninth Annual Meeting* 1913:233).

As can be observed, the Association and its committees had a lot of work. As was pointed out earlier: “The field of mental defect has been so broadened and extended as to

include large groups of persons who would not have been so included even a decade ago” (Fernald 1914). And although some doubt still existed as to "whether the increase of the mentally diseased is real or apparent” (Smith 1915: 2), agreement was reached on the basic assumptions of the necessity of protective measures and the great value of sterilization.

In the difficult decision between segregation and sterilization the latter was usually favored due to the obvious cost savings. The public, however, did not share psychiatrists’ confidence in this type of approach. G. Alder Blumer (1903: 15) first expressed his greatest surprise for this general disagreement in the early nineteen hundreds: “It is amazing how far behind the scientific enlightenment of the age public opinion is in this obvious exigency”. But even a decade later, the gap between public and psychiatric understanding of the issue had not narrowed. Politicians often hesitated to enact sterilization laws in fear of public disapproval. A reasonable doubt as to the appropriateness of sterilization in relation to human rights, liberty of patients, and religious implications lingered in the society. Moreover, legal aspects of the issue were not entirely settled. Samuel Smith (1915: 7) describes the situation regarding legalized sterilization in his home state in the following way: “In my own state of Indiana, where in 1907 legal recognition was first given it,....it has not advanced in public favor as rapidly as was expected. Even after eight years it must be applied with discretion and caution, because, lacking in popular support, the threat and danger of raising the question of constitutionality, a test it can never endure, eternally hangs over it. Paradoxically as it is, the very enactment of the law has stopped in a manner the campaign of education in favor

of its underlying principle, because, having secured the law, continued discussion with doubtful support and lack of appreciation of its purpose and value endangers it”.

Being used to meeting challenges to their profession, psychiatrists were able to rationalize this obvious contradiction with the underlying principles of the American Constitution: “The insane, as the other citizens of our great country, have the inborn right to liberty and the pursuit of happiness. If this undeniable right can be restored to them by the use of the knife, we are indeed remiss to duty if we do not use it” (Witte 1906: 465).

And they *did* use it. Hubert Work cites the narration by Dr. Sharp of his 10-year practice of sterilization which was applied to 456 patients: “This operation is very simple and easy to perform. I do it without administering an anesthetic either general or local. It requires about three minutes’ time to perform the operation and the subject returns to his work immediately, suffering no inconvenience, and is in no way hampered in his pursuit of life, liberty and happiness, *but* is effectively sterilized” (Work 1912: 10).

The application of the “knife treatment” was not limited to the narrow field of sterilization. Instances of the use of gynecologic surgeries with the removal of normal organs “with the sole view of influencing the mental state of the patients” (Broun 1906: 410) are also described in the journal. The only indications for these surgeries were the hallucinations related to the pelvic organs. The hallucinations were hardly diminished as a result of the operation. This evidence suggests once again the failure of psychiatry in establishing scientific grounds for medical practice. As can be derived from the above citations, treatment of mental patients remained as experimental and non-scientific as the blisters and blood-letting which were used a century ago. Unfortunately, the subjects in these experiments were human beings.

All of the above suggests that in its quest for legitimacy psychiatry went down a treacherous path and found itself again too far from the mainstream of public opinion. This time though the difference was not flattering for the profession. Having started as promoters of more humane treatment of the mentally disturbed, they ended up switching places with laymen in demonstrating the most extreme prejudice. Unable to understand or treat the “disease” they completed the vicious circle by going back to the old idea of segregation, the 17th to 19th century practice. This time around the rationale was even more cynical: “Humanitarian motives originally and mainly have prompted and justified the segregation of the insane for treatment and custody and led, by reason of the immensity of the cost, into our system of state care. It was not established and developed as an eugenic movement, although we are coming more and more to appreciate its eugenic value” (Smith 1915: 4). Therefore, they openly admitted they cannot cure, just control, which positioned them as part of a social control mechanism in the society instead of achieving their desired appreciation as medical professionals.

The frustration of failed professional legitimation was sweetened by “increasing respect and demand for the services” (Russell 1916: 159) psychiatry provided. Too bad the reasons for that demand were suspect: “The state hospital is still, by perhaps the majority of people, regarded merely as one of the resources which have been provided to enable the social body to relieve itself of objectionable members, and the interest and support given it are too often based on this view” (Russell 1916: 158). With unbeatable optimism and persistence psychiatry set out to explore new avenues of “professional” activities, such as “The classification of industrial applicants” (detection of the unfit and

classification of the fit) (Stearns 1920), and the study of “Malingering and simulation of disease in warfare” (Williams 1921), to name a few.

It can be easily imagined that family care based on the Gheel model did not fit very well with the described occupational dynamic. It did not use surgical procedures and pathological lab tests. It did not justify building new asylums and hiring more psychiatrists. It simply cured those disposed from medical institutions as chronic and hopeless. It helped them to develop self-reliance and improve social adjustment. It was cheap. It was almost impossible to criticize.

An experience of family care in Massachusetts demonstrated the point. As evidenced by Owen Copp, an executive officer at the Massachusetts State Board of Insanity, 27 per cent of patients became self supporting, 7 per cent “passed to the care of friends” whose interest was stimulated by positive results of the program, and finally, 18.2 per cent “went to the same families without public aid” (Copp 1902: 310). All of these patients had a history of long hospital stays and multiple commitments. A strong tendency was observed for patients to remain permanently with the same families. They found friends and developed social ties within the community. Copp noted a high demand for patients in local families, which was never completely satisfied by available placements. But “the newly created Board of Insanity, which assumed its duties in October, 1898, engrossed in the details of organization and the formulation of a general policy, was not able to give immediate attention to the study and extension of this method of care” (Copp 1902: 299).

However, even five years later the program’s potential was still not realized, and above all limited to one state’s experience. Speculating on the reasons for the reluctance

to implement such a successful and cost-effective program, Copp (1907: 363) admitted: “To be sure, boarding out a patient removes immediately or remotely a floor bed from crowded halls or corridors, but the coincident loss of a comfortable, perhaps helpful inmate, dampens the ardor of active promotion of the cause; while the altruism stimulating to discharge of every patient whose happiness, welfare or mental state may allow, easily lies dormant in the busy preoccupation of the medical staff in other more pressing duties”. He added that: “In the last analysis it appears that the State has the only direct and paramount incentive to forward this movement, because it facilitates discharge of patients, tends to prolong their stay outside, reduces the amount of public provision necessary for their care, and does not increase the cost of their maintenance” (Copp 1907: 363). However, the State was already hard pressed to meet expenses associated with mental health care. In Massachusetts, building a new one million dollar hospital every four years was necessary (Copp 1907: 367). Ironically, less than a hundred and fifty years ago, in Boston, Massachusetts authorities declined a legacy left for the erection of an asylum because “there were not enough insane persons in the province” (Frost 1912: 302). Other states struggled with similar problems. For instance, New York had to allocate one-sixth of the state’s total expenditures “for the care of the insane” (Work 1912: 3). This was an indirect consequence of the growing army of “mentally ill” supplied by psychiatry’s new vision of deviance as mental deficiency.

Nevertheless, the state provided legislation for the implementation of the program if not sufficient funding (Wise 1901: 94). The State Board of Insanity supported the idea of wider use of family care. But a treatment plan based on the individual approach had to be supported by the personal efforts of hospital personnel. And this is exactly where it

stumbled. The proponents of confinement for life and sterilization could not support the idea of outpatient treatment. In addition, the issue of the loss of “valuable working patients” was not resolved (Rosanoff and Cusack 1920: 151). There is evidence that even recovered patients were kept in the institutions partly due to inertia, partly due to the open staff opposition to their release as described by Rosanoff and Cusack (1920). The difficulties in establishing a parole system, which by their estimation could be applied to at least 20 per cent of hospital inmates, lay in the following dynamic: “Active opposition to the point even of threats of resigning is apt to be met with when patients are about to be removed who have been familiarized with some important part of the routine work and trained to perform it automatically and without supervision” (Rosanoff and Cusack 1920: 151). This opposition was a significant obstacle even when the program was run under the auspices of the State Board of Insanity. However, in 1905 the Board shared its authority with the trustees of hospitals and asylums (Copp 1907). In 1915 additional legislative changes were enacted. They completely turned the power of administering boarding-out programs over to individual institutions (Kline 1917: 574). It finalized their control over the implementation of the program, which now depended solely on the free will of institutions to participate in community care.

It has to be acknowledged that individual psychiatrists still were raising their voices in support of the Gheel system. Ironically, it never completely disappeared from the discourse. An explanation for that probably lies in the high efficacy of the system, which was hard to challenge. But it rarely went beyond a discussion of its potential and extraordinary cost savings. Instead, psychiatry extracted from the system some features that fit the general direction of the profession’s development. Passing to the family and

boarding out aspects of Gheel's experience, the idea of a colony was adopted and increasingly implemented. Psychiatrists foresaw the great potential of this type of arrangement as almost indefinitely expandable and able to accommodate growing numbers of patients. With a strong trend toward mass as opposed to individual treatment, every institution had recently grown to the size of "a thriving town of from 1000 to 3000 people" (Wagner 1903). The goals of psychiatric treatment were adjusted accordingly: "The patient is no longer regarded simply as a separate individual, but also as a social unit, whose cure cannot be considered complete until he has been restored to social adaptability and efficiency. Thus the purely humane and individualistic period in hospital development has given place to a period in which the broader needs of social hygiene and of social efficiency are understood, and the work is being shaped so as to meet more fully the vital issues both in individual and in community life" (White 1913: 460).

The Colony, or Cottage system fit perfectly well with this vision. It still carried some advantages of the original system: it was cheaper than conventional hospital treatment, allowing patients to contribute to the cost of their maintenance with their useful labor. And it was free-air treatment too, which made it possible to draw parallels to the Gheel's plan and ensure support of those who favored the program.

Thus, the dynamic within the psychiatric profession undermined the successful development of the first community care programs for the mentally disturbed. Luckily, they were still tried in actual psychiatric practice, although on a limited basis. Their history can serve as an invaluable source of information on the practical application of the system, and dispel most of the objections based on ignorance, stereotypes, or open prejudice. Sadly, psychiatry turned from the direction it could have taken and maintained,

namely helping the most disadvantaged and powerless group in the society, to the pursuit of the role of an institution of social control. In that, and only that, it ultimately succeeded. Meanwhile, its claim for legitimacy as a respectable medical profession appears to have miserably failed.

Summarizing the conclusions of this chapter, it can be said that in its quest for professional legitimation, psychiatry went through several important stages. First, it tried to establish the idea of the somatic basis of mental illness, which would stress both the medical and the scientific character of psychiatric work. Unable to prove this connection or, most importantly, treat the “disease”, the profession put forward an explanation of the hereditary nature of mental conditions. Since the conditions were inherited they could not be cured, so all the professional efforts turned toward preventive psychiatry. Educating the public about the severe consequences of the spread of mental illness, psychiatry claimed more and more groups as falling under its direct jurisdiction, redefining deviance and social maladjustment as mental illness. Eventually, it transformed psychiatry’s agenda into propaganda and the practical application of eugenics in the form of involuntary sterilization of broadly defined deviant groups. This positioned psychiatry too far from the mainstream of public opinion and finally established it as an institution of social control instead of a medical profession, which further undermined the public trust and occupational legitimacy it sought.

Chapter Three

Déjà Vu: Rediscover of the Drawbacks of Institutional Treatment, 1960s

One of the most striking observations is that the deinstitutionalization movement of the 1960s seems to have started completely independently of its previous history. Issues concerning the rights of mental patients were discussed as if this were the first time society acknowledged the grotesque inadequacy of their treatment and the burning problem of discrimination. In spite of their existence, the early community care programs were largely eliminated from the later discourse as evidenced in the following citation from Andrew Scull: “These obstacles presented an absolute barrier to the development of a plausible alternative, community-based response to the problem of insanity – in fact none of the critics of the asylum was ever able to suggest even the basis of such a program: a *sine qua non* of their objections receiving serious considerations” (Scull 1977: 130). However, as my research findings show, there *was* an alternative that was not only proposed but actually tried, and very successfully. The fact that it was not more widely implemented should not inhibit an acknowledgement of the indisputable quality of the program. After all, if the development of psychiatry had taken a different path, family care might have played a much more prominent role in the rehabilitation of mental patients. Although this study is limited to the time period between 1844 and 1921, and therefore can only cover the history of the first wave of deinstitutionalization, it is

tempting to speculate on the implications of its findings and draw parallels to the events of the 1960s.

According to Paul Starr the mandate of authority of American medicine expired in the 1970s. However, it was very different in the case of psychiatry. The detailed analysis of the professionalization movement in the mental health care system, provided in the second chapter, shows how the slow growth in public trust associated with more humane treatment of the mental patients was swept away by the eugenics movement. In its struggle for legitimacy, psychiatry failed to establish its medical authority, instead it developed into a powerful mechanism of a social control, a role it readily embraced. The resulting “contribution” of psychiatry to the social construction of mental illness and deviance in American society cannot be overestimated.

However, the perfection in the construction of reality could not save psychiatry from public criticism. The very ideas they promoted proved to be to their disadvantage, for instance, incurability, unclear definitions of mental illness, the unlimited growth of institutions, which was a heavy burden on the state budget, and the violations of human rights and liberty of hospital inmates. Public dissatisfaction eventually resulted in a new wave of deinstitutionalization that practically swept the United States. The scope of changes it brought was quite impressive: over half of the mental patients were released and some of the hospitals were consequently closed (Linn et al. 1980: 129). It appears that the initial failure to reach the status of medical authority made psychiatry go through this process again. It can also be claimed that part of the reason this movement occurred was that the public had clearly recognized the meaning of the profession as a controlling force but not a charitable or medical institution.

Interestingly, even the points of criticism of mental health care were identical in these two waves of deinstitutionalization: the disillusionment with hospital treatment, an absence of curative effect, negative institutional influence, human rights violations, and the like. Unexpected support within psychiatric circles and fast implementation of deinstitutionalization policies in both cases was due to the same reason too, namely financial considerations (Coelho and Stoffelmayr 1983). The difference lies in the role of psychoactive drugs developed in the late 1950s that enabled the discharge of large numbers of patients into the community (Mechanic 1969). It brings an interesting focus to the issue of the legitimation of psychiatry. All the criticism it received over the centuries did not undermine its growing power as a mechanism of social control. Quite the contrary, drugs that were initially used for “managing” patients only *within* institutions, spread outside and became not only a part of outpatient treatment, but actually a part of everyday life. A vast number of individuals were “restored to social adaptability and efficiency” (White 1913: 460), so that the mission of the Association could be fulfilled.

Comparing the results of deinstitutionalization in 19th and 20th century in the United States, one more similarity becomes obvious. Both waves of deinstitutionalization failed to realize the potential of family care, the only program that actually had positive effects on patients’ conditions. It was not because of lack of information on practical implementation of the program. Although on a limited basis, family care (also known as foster care) was used by the Veterans Administration and other agencies in the second wave of deinstitutionalization too. A number of studies were conducted to compare the outcomes of family care with conventional treatment. They showed significant

improvement in social functioning and adjustment in patients randomly assigned to foster homes as compared to those assigned to continued hospitalization (Linn and Caffey 1977; Linn et al. 1980; Christenfeld et al. 1985). But once again institutional reasons prevented wider application of the program. As J. Rogers, the former president of the American Medico-Psychiatric Association, once pointed out: “State policy, however, overrides the plans of scientific philanthropy and the actual trend is toward larger congregation and less cost” (Rogers 1900: 4). Most of the patients released from hospitals in 1960s went to community nursing homes or to welfare hotels, since these were the only options covered by Medicare or Medicaid (Linn et al. 1980). The conditions in these facilities were far from desirable in terms of number of patients and lack of adequate professional supervision, which caused the practice to be criticized as reinstitutionalization instead of deinstitutionalization. Foster care was considered a much more appropriate placement but open only to those patients who had sufficient resources of their own (Linn et al. 1980). Thus, the mentally ill ended up in the new century’s equivalent of the alms house, the place from which they started before the era of the “discovery of the asylum” (Rothman 1971).

It is not surprising. The publications in the *American Journal of Insanity* over more than seventy years of its existence clearly show that the program could hardly expect overwhelming support from psychiatrists. Patients could not be a very effective lobbying group in protecting their rights either (Scull 1989). We can only speculate what future the program could have had if it were more widely noticed and appreciated by social scientists, and all the effort in condemnation of institutional treatment were coupled with the promotion of its alternative. In the absence of a valid community based

program, as Andrew Scull (1977; 1989) noted, the deinstitutionalization movement did not have much of a chance. Financial constrictions coupled with community opposition had finally resulted in termination of most of the programs. Frustrations associated with the practical reality of deinstitutionalization somewhat decreased enthusiasm among its supporters. Deinstitutionalization remained a great humanitarian ideal, however, commonly regarded as controversial in terms of its practical implementation. That is where it becomes apparent that the failure to take into account historic evidence undermined an adequate evaluation of this emerging alternative of care for mental patients. As that evidence suggests, family care, like that practiced at Gheel, was the only program psychiatric care might proudly present today as an accomplishment in preserving the rights and liberty of mental patients, while contributing to their cure. Then, if family care proved effective, there would be less demand for psychiatrists' services whether as supervisors of asylums or dispensers of drug prescriptions. The fate of their profession is tied to the prevalence and persistence of mental illness. For them, the Gheel model just might prove too fatefull.

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