The Transformation of the Mental Hospital in the United States

GERALD N. GROB
Rutgers University

FAMILY AND COMMUNITY CARE

In seventeenth- and eighteenth-century America insanity was not perceived as a major medical problem or a matter of pressing social concern. The number of mentally ill persons was small. The low population density characteristic of rural and agricultural societies ensured their dispersal. The insane as a group did not for the most part exist. Insanity was largely an individual rather than a social problem. Indeed, the colonial period was notable for the virtual absence of physicians or hospitals specializing in the care and treatment of the mentally ill.

The absence of institutions, however, did not imply that no provision would be made for "lunatics" or "distracted" persons (as this group was commonly known). Before the nineteenth century the family was primarily responsible for the welfare of any of its members who became mentally ill. Yet the local community was never able to remain completely aloof from the problems relating to insanity. Certain forms of abnormal behavior seemed to threaten public security and safety, and therefore dictated the adoption of protective measures. In other instances mental illness created economic dependency, thus making the individual a public charge. If the family possessed inadeqauate resources, the community was legally bound to intercede because of its obligations to care for indigent dependent persons. Finally, the issue of guardianship often involved the community, for the afflicted individual might be declared legally incompetent to manage property. Neverthe-

Author's Note: *This work was supported by Grant MH 39030 from the National Institute of Mental Health, Public Health Service, U.S. Department of Health and Human Services.*

AMERICAN BEHAVIORAL SCIENTIST, Vol. 28 No. 5, May/June 1985 639-654

less, reliance on familial and community traditions and practices rendered it unnecessary to consider structural changes. Consequently, the very concept of social policy—which involved the conscious creation of new public institutions or procedures on a regional or national basis to replace traditional means of dealing with distress—was largely absent (Grob, 1973: 1-34).

INSTITUTIONAL CARE

After 1800 new circumstances created conditions that stimulated reliance on institutional care of the mentally ill. Demographic changes (including population growth, geographical mobility, urbanization, immigration), a growing awareness of social and medical problems, a surge in philanthropic giving by elite groups, knowledge of medical and psychiatric innovations in France and England, and religious and intellectual changes all combined to give rise to a movement to establish institutions specializing in the care and treatment of the insane. The transformation of insanity into a social problem requiring state intervention (as contrasted with familial and community responsibility) was by no means unique; the nineteenth century was notable for the proliferation of institutional solutions and the transfer of functions from families to public or quasi-public structures. In 1820 only one state mental hospital existed; by the Civil War virtually every state had established one or more institutions (Grob, 1973: 35-131).

One of the most significant byproducts of the founding of mental hospitals was the creation of the specialty of psychiatry. Early mental hospital superintendents (i.e., psychiatrists) quickly developed an elaborate system of thought about the nature, etiology, and treatment of mental illness. Most believed that knowledge came to the brain through sensory organs. If the senses (or the brain) were impaired, false impressions would be conveyed to the mind, leading in turn to faulty thinking and abnormal behavior. Mental illness, therefore, was a somatic disease that involved lesions of the brain (the organ of the mind). Such reasoning provided psychiatrists with a model of mental illness that was especially compatible with a psychological and environmental etiology. In their eyes disease followed the violation of the natural laws governing human behavior. In other words, mental illness, although somatic in nature, could have psychological, hereditary, or physical origins.

To define the nature and etiology of mental illness was only a beginning, not an end. The goal of psychiatry—like that of medicine generally—was the alleviation and cure of disease. Despite their recognition that disease processes remained shrouded in mystery, most psychiatrists believed that mental illness could be cured. Since insanity was in large part a product of improper behavioral patterns associated with a deficient environment, it followed that treatment had to begin with the creation of a new and presumably appropriate environment. Therapy was thus synonymous with institutionalization, for it was essential to break with the harmful environment from which the patient had come. Once in a hospital, the individual could be exposed to medical and moral treatment. The first was intended to rebuild the body in order to improve the mental state. Tonics, cathartics, laxatives, and drugs (especially narcotics to calm violent behavior) were widely used. Warm and cold baths, cold head compresses, and special diets were also part of the medical regimen.

Medical treatment of mental illness, however, was but an aid and adjunct to what in the nineteenth century was known as moral treatment. Susceptible to many interpretations, moral treatment meant kind, individualized care in a small hospital; the use of occupational therapy, religious exercises, amusements, and games; repudiation in large measure of all threats of physical violence; and only rare and infrequent application of mechanical restraints. Moral treatment, in effect, involved the reeducation of the patient within a proper moral atmosphere (Grob, 1973: 165-171).

Surviving evidence suggests that moral treatment achieved—even by contemporary standards—some striking successes. Although claims about curability rates were undoubtedly exaggerated, there is little doubt that many individuals benefited from hospitalization. In the 1880s the superintendent of the Worcester hospital undertook a follow-up study of over a thousand patients discharged as recovered on their only or last admission. The project took over a decade to complete; in the end data were accumulated on 984 individuals. Of these, 317 were alive and well at the time of their reply, while an additional 251 who had died had never again been institutionalized. Thus nearly 58% of those discharged as recovered had functioned in a community setting without a relapse (Worcester State Lunatic Hospital, 1893: 70; Grob, 1966: 76-77).

The emphasis on moral treatment gave mid-nineteenth-century psychiatry a distinctive character. First, it implied legitimation of custodial as well as therapeutic functions. Moral treatment, after all,

was based on the presumption that under certain conditions care was a form of treatment, although in other respects care (i.e., food, clothing, and shelter) was distinct in its own right. In other words, moral treatment imparted to psychiatry an administrative and managerial character. The very concept of moral treatment, after all, was synonymous with the creation of a specific environment that would facilitate recovery. Consequently, the imperatives of the hospital as a social system became the dominating factor. The size and structure of an institution, the physical plant, patterns of authority, and relationships between physician and attendant, as well as between staff and patients, were all crucial. The omnipresent danger of social disorganization caused by the tensions arising out of the social distance between physician and patient and the unpredictable character of patient behavior, reinforced the preoccupation with administration and management. Such concern was evident at the very founding of the Association of Medical Superintendents of American Institutions for the Insane in 1844 (today the American Psychiatric Association). In 1851 and 1853 it adopted a series of propositions that codified in great detail the proper size, location, construction, organization, and governance of hospitals (American Journal of Insanity, 1851: 79-81; 1853: 67-69).

STATE POLICIES AND HOSPITALS

The fortuitous circumstances that created the conditions for therapeutic successes, however, proved relatively short-lived. By the latter half of the nineteenth century the structure and functions of mental hospitals—and therefore of the specialty of psychiatry—had begun to undergo a gradual transformation. Mental hospitals were originally founded to provide restorative therapy; custodial or caring functions, although never rejected, were clearly subordinate. But from the outset hospitals retained individuals who failed to recover or improve. The retention of chronic cases, in turn, hampered efforts to provide therapy to the remaining patients. In their early days hospitals had also been designed for small numbers of patients to encourage close relationships deemed necessary for sound treatment. Hospitals, however, grew in size either because states placed higher ceilings on the number of patients or did not take steps to build new facilities. In theory all patients were supposed to receive the same quality of care; in practice, class, race, and ethnicity affected the quality of care received by different patients. The

functions of psychiatrists were supposed to be defined in medical terms; they were, in fact, hospital administrators immersed in managerial problems, and considerations of order and efficiency sometimes overshadowed therapeutic concerns. The founding generation's charismatic personalities often checked and modified strictly bureaucratic tendencies. Later generations of psychiatrists, however, lacked such charisma, and the institutional regime often acquired a life of its own quite apart from any therapeutic considerations (Grob, 1973: 174-256).

Moreover, the mental hospital was not a self-contained medical institution; it never retained any significant degree of isolation from the larger society in which it existed. Public policy remained a legislative responsibility, and hospital officials found that their autonomy was limited in significant ways by the general legal, administrative, and fiscal environment in which they functioned. The decentralized and prebureaucratic nature of mid-nineteenth-century American society inhibited the formulation of consistent and coherent policies; mental hospitals were often caught up in the vortex of change and confusion and saw their goals transformed by circumstances beyond the control of their officials.

The establishment of hospitals, for example, did not reflect systematic policy formulation and social planning. On the contrary, most state legislatures were not yet institutionalized in their operations. The tenure of their members was often brief, and a high proportion served only a single term. No internal division of labor existed within legislatures; the complex structures that developed in the twentieth century were absent throughout much of the nineteenth. Precedent and rules were vague, and there was often little continuity either in personnel or deliberations from session to session. Bills were frequently introduced by petitions or memorials from private individuals or organizations; rarely did the enactment of specific pieces of legislation reflect broad currents of public opinion. Standing committees were not especially effective, and the inexperience of their membership and lack of any permanent staff limited their autonomy and importance. There were also few supporting services; most legislatures had neither a legal staff nor a reference or research division. The relative lack of institutionalization within legislatures gave rise to laws that reflected only individual and immediate concerns.

In the early nineteenth century the legislative process did not rely heavily upon professional expertise and bureaucratic personnel. Although legislators were aware of the need for data that would serve as the basis for rational policymaking, the personnel, procedures, and even

theories of social planning simply were not available. The relatively unsophisticated nature of the information-gathering process was not simply a matter of being unable to amass the necessary data. The absence of broad theoretical models relating to public policy made it difficult to gather or to use empirical data in a meaningful way. As a result, legislative decisions often reflected external factors or assumptions that were never questioned. This is not to imply that nineteenth-century legislators and administrators were deficient or malevolent. Rather, the lack of theory and methodology often led to policies whose results in the long run were at variance with the goals envisaged when the original legislation was passed.

Admittedly, most nineteenth-century legislators *were* responsive to demands by constituents for such things as land grants, charters, and special acts of incorporation. But these demands were usually formulated not by broad social or political coalitions but by individuals or small and transient interest groups. Too often historians have identified individuals as symbols of social movements when no such movements existed. The success of a Dorothea L. Dix in persuading state legislatures to establish mental hospitals may have been due to the fact that although a particular group benefitted from government action, the costs were so widely distributed that those who paid had little or no incentive to oppose such projects and therefore remained indifferent or ignorant. The result was often a series of individual legislative acts, each having little or no connection with what preceded or followed their enactment. The broad framework of public policy, therefore, for the most part was not the conscious choice of legislators and officials but rather the sum total of a series of unrelated decisions. Consequently, the incremental nature of policy formulation often gave rise to laws that generally bore little or no relationship to expectations of either legislators or the public. Moreover, the decentralized political structure that divided authority and responsibility between levels of government created in turn significant geographical variations. Public policy in the nineteenth century, then, was pluralistic rather than national.

Nor did the establishment of hospitals imply that state governments would assume all responsibility for the care and treatment of insane persons. On the contrary, public welfare was still largely regarded as a local responsibility, a tradition that dated back to pre-Elizabethan and Elizabethan England. Many mentally ill persons, therefore, continued to be kept in local almshouses, most of which were undifferentiated welfare institutions controlled and financed by local communities. Moreover, most states provided only the capital funds necessary for the

acquisition of a site and the construction of a hospital. Operating revenues, on the other hand, were supposed to come from the community in which a patient had a legal residence or from the families of private patients. Such a dual system encouraged conflict between local communities and state officials, since it was generally less expesive to care for individuals in almshouses than it was to send them to a state hospital.

The location of most state hospitals in the geographical center of a state to assure equal access introduced a further complication into public policy. The center of population rarely coincided with the geographical center. The first public hospital in New York State was located in Utica rather than New York City, which in turn created its own municipal mental hospital. The problem of access was further exacerbated by the fact that hospitals drew a disproportionately large percentage of their patients from the immediate geographical area; communities distantly located found themselves the objects of inadvertent discrimination. In practice, then, a system designed to serve all equally served some better than others.

As the number of state hospitals expanded, the strains that followed an incremental policymaking process magnified. By the 1860s some states—notably Massachusetts and New York—established the first state boards of charity. At the time of their founding these organizations were intended to introduce greater efficiency and rationality into public welfare and even to dismantle a public welfare system that seemed to be enlarging. In practice, on the other hand, they evolved into elaborate bureaucratic regulatory structures. The absence of any clear legislative policy and guidelines and the tendency to deal with problems through an incremental decision-making process ultimately enhanced the ability of board members to make independent judgments and exercise authority (Grob, 1966, 1973).

PHYSICIANS AND HOSPITALS

The thrust toward centralization of authority that began at the state level occurred at precisely the same time that the structure of medicine was changing. After 1870 medical practice underwent a fundamental transformation. Increasingly, it became identified with bacteriology and other biological and physical sciences. In turn the doctor-patient relationship—which traditionally presupposed some form of equality—was altered, the patient becoming dependent on the specialized training

and knowledge of the physician. At the same time the general hospital began to assume its modern form, and authority slowly shifted from lay-trustees to physicians. This trend mirrored the transformation of the general hospital from an institution providing care for socially marginal groups to one reflecting a new emphasis on science and technology and catering to more affluent groups capable of paying the high costs involved (Rosenberg, 1979; Vogel, 1980).

The emergence of modern scientific medicine had a subtle but significant impact upon psychiatry. In the mid-nineteenth century psychiatrists enjoyed high status; they remained aloof from the bitter sectarian rivalries that divided physicians into hostile and warring camps. Indeed, when the American Medical Association was founded in 1847, it made several efforts to induce the Association of Medical Superintendents of American Institutions for the Insane to affiliate (American Journal of Insanity, 1853: 85; American Medical Association, 1866: 121ff.; 1867: 399ff.; 1868: 161ff.; 1871: 101-109). These efforts were rebuffed by psychiatrists, who felt that they had distinct interests and could gain nothing by joining with physicians with a distinctly subordinate status. By the turn of the century, on the other hand, the respective roles of physicians and psychiatrists had been reversed. The identification of medicine with science and technology and the reorganization of medical education combined to elevate the status of physicians. As the status and prestige of medicine rose, that of psychiatry declined, and the specialty began to be perceived as a medical backwater.

At about the same time that the status of psychiatry was declining, the nature of the patient population in mental hospitals was undergoing profound changes. In simple terms, more and more patients began to fall into the chronic category. Before 1880, patient populations at public hospitals included large numbers of acute cases institutionalized for less than 12 months. Although national data are lacking, a sample of individual institutions reveals that their custodial function had not yet become paramount. In 1842, a decade after its opening, 46.4% of the patients at the Worcester hospital had been institutionalized for less than a year; only 13.2% had been in the hospital for five or more years. In 1870 the comparable figures were 49.6% and 13.9%. And Worcester was not atypical. In 1850, 41.1% of patients at the Virginia Western Lunatic Asylum had been institutionalized for less than a year and 29.6% for five years or more; the respective figures for the California Insane Asylum in 1860 were 40.2% and 0.1%. Although exceptions were by no means uncommon, most hospitals before 1890 included large

numbers of patients who were admitted and discharged in less than a year (Worcester State Lunatic Hospital, 1842: 17-27; 1870: 38-60; Virginia Western Lunatic Asylum, 1850: 14-23; California Insane Asylum, 1860: 16-32).

By the turn of the century the pattern began to be reversed as the proportion of short-term cases fell and long-term cases increased. In 1904, 27.8% of the total patient population in the United States had been confined for less than 12 months. By 1910 this total had fallen to 12.7%, although it rose to 17.4% in 1923. The greatest change came among patients institutionalized for five years or more. In 1904, 39.2% of patients fell into this category; in 1910 and 1923 the respective percentages were 52.0% and 54.0%. Although data for the United States as a whole were unavailable after 1923, the experience of Massachusetts was perhaps typical. By the 1930s nearly 80% of the available beds in its mental hospitals were occupied by chronic patients (U.S. Census Bureau, 1906b: 37; 1914: 59; 1926: 36; Dayton, 1940: 414-439).

The shift toward a predominantly custodial institution whose inmate population was made up of long-term chronic cases reflected non-psychiatric determinants. The growing number of aged persons in mental hospitals is a case in point. Before 1890 relatively few older persons (persons over 60) were confined in public mental hospitals. In those cases where aged persons were destitute or without families willing and able to provide care, they were generally sent to local almshouses. Throughout much of the nineteenth century, almshouses served as undifferentiated welfare institutions; one of their primary functions was the care of aged dependent persons, many of whom were undoubtedly senile or frail.

Between 1880 and 1920, however, the almshouse declined in significance as a public institution. Admissions fell from 99.5 to 58.4 per 100,000 between 1904 and 1922. The decline in the number of mentally ill persons aged 60 and over was even sharper; by 1923 only 5.6% of the almshouse population fell into this category. The decline, nevertheless, was more apparent than real, for the number of aged mentally ill persons committed to mental hospitals was rising steadily (U.S. Census Bureau, 1906a: 182, 184; 1906b: 29; 1915: 42-43; 1926: 27; 1925: 5, 8, 33). What occurred, in effect, was not a deinstitutionalization movement but rather a transfer of individuals between different types of institutions.

The shift was less a function of medical or humanitarian concerns (although these were by no means absent) than a consequence of financial considerations. As states moved to accept fiscal responsibility for all insane persons in the late nineteenth and early twentieth

centuries, local public officials seized upon the fiscal advantage inherent in redefining senility in psychiatric terms. If senile persons were cared for in state hospitals rather than local and county almshouses, the burden of support would be transferred to the state (Grob, 1983: 91-92, 180-181). For many families, confinement in a hospital may have been preferable to almshouse care. Not only did hospitals provide better care but, paradoxically, the stigma of insanity—especially if an aged person was involved—may have seemed less than that of pauperism.

The history of public policy in New York State in the latter part of the nineteenth century offers an illustrative case study. Four years after Massachusetts established the first Board of State Charities, New York followed suit. In 1869 it introduced a second innovation when the Willard Asylum for the Insane opened. The original law, enacted in 1865, stipulated that all chronic pauper insane persons previously confined in county poorhouses, and all insane persons discharged by state hospitals as incurable, be sent to Willard. The goal was twofold: to raise standards of care, and to permit state hospitals to emphasize a therapeutic rather than a custodial function.

Neither innovation, however, worked in the way they had been originally designed to work. Willard quickly filled to capacity, forcing the legislature to exempt many counties from the requirement that they send their chronic insane to the institution. The comprehensive approach to dependency also failed to live up to expectations, and in 1873 and 1874 new legislation created the position of Commissioner in Lunacy, and assigned to that office responsibility for the mentally ill.

The first commissioner, John Ordronaux, did not use his office as a vehicle for change; he believed in local rather than state responsibility. In his eyes local officials were closer to their constituents than were remote state authorities and hence were better equipped to care for insane residents. But in 1882 Ordronaux was succeeded by Dr. Stephen Smith, an individual who had played a prominent role in creating New York City's Metropolitan Board of Health during the cholera epidemic of 1866. Smith believed that a system that divided authority between state and community was neither rational nor defensible. He therefore proceeded to forge a coalition to secure legislation that mandated total state responsibility. By 1890 his efforts were rewarded when the legislature enacted the famous State Care Act, which ended dual responsibility for the care of the insane. Under the provisions of this law all insane persons were to be sent to state hospitals; all county asylums reverted to the status of poorhouse (Grob, 1983: 86-92).

Centralization of responsibility for the mentally ill in New York (and elsewhere) produced similar—but not planned—results. It tended to promote more uniform standards of care and administration throughout the system. More important, the transfer of fiscal responsibility to the state led to a dramatic change in both the character of the patient population and size of hospitals. The source of funding, as a matter of fact, was probably the single most important element in determining the kind of institution in which mentally ill persons were placed. Throughout much of the nineteenth century dependent persons received care in local almshouses. But when communities were no longer required to assume the burden of supporting mentally ill residents, their officials, in effect, reclassified senility in psychiatric terms. This move facilitated the admission of many aged persons to mental hospitals, thereby shifting the burden of support to the state. Finally, the change in the age distribution of the institutional population (a reflection in part of national demographic shifts) also contributed to the dramatic increase in the size of hospitals. In the decade following the passage of the State Care Act, the hospital population increased from 5402 to 21,815. As the establishment of new institutions lagged behind the growth in the patient population, the average daily population of individual hospitals also rose sharply. By 1940 the average daily population in the state's 13 regular mental hospitals was more than 5400 each; in 1890, by way of contrast, the state's 6 hospitals had a total population of 5402, of which over 2000 were in Willard and nearly 1100 in Binghampton State Hospital (N.Y. State Board of Charities, 1890: 22; N.Y. State Commission in Lunacy, 1900: 103-105; N.Y. State Department of Mental Hygiene, 1939-1940: 208-212). During the first half of the twentieth century, public policy in most states followed the New York State pattern.

Between 1880 and 1940, the proportion of aged persons in mental hospitals mounted rapidly. In New York, to offer a specific illustration, 18% of all first admissions to state mental hospitals in 1920 were diagnosed as psychotic because of senility or arteriosclerosis. By 1940 this category accounted for nearly 31% of all first admissions. In 1950, 40% of all first admissions were aged 60 and over, as compared with only 13.2% of New York State's total population. Nor was New York unique in this respect; the data for such states as Pennsylvania, Massachusetts, and Illinois exhibited similar patterns (Malzberg, 1949, 1954; N.Y. State Department of Mental Hygiene, 1939-1940: 174-175; Kramer, 1955: 10; Landis and Farwell, 1944).

Not only did the number of aged persons in mental hospitals increase, but age-specific admission rates for older persons, as compared with younger persons, rose markedly as institutions such as almshouses declined. In their classic study of rates of institutionalization covering more than a century, Goldhamer and Marshall found that the greatest increase occurred in the category of those aged 60 and over. In 1885 the age-specific first admission rate in Massachusetts for persons aged 60 and over was 70.4 for males and 65.5 for females (per 100,000). By the beginning of World War II, the corresponding figures were 279.5 and 223.0 (Goldhamer and Marshall, 1953: 54, 91).

In addition to aged persons, mental hospitals cared for large numbers of individuals whose behavioral peculiarities were related to an underlying somatic etiology. Paresis (the tertiary stage of syphilis) was one such case. Between 1911 and 1919, for example, about 20% of all first admissions to New York State mental hospitals were cases of general paresis. Given the nature of the disease, few households were willing or prepared to cope with paretic cases. Despite the relative absence of aged persons among paretic patients, its prognosis was decidely negative. In 1920, for example, 825 such cases were admitted for the first time to New York State mental hospitals. Of this number, 322 (39%) died in less than 6 months, 113 (13.7%) between 6 and 11 months, and most of the remainder between one and four years after their admission. Between 1913 and 1922, 87.7% of all first admission paretics in the state died during their confinement (Pollock, 1941: 93-109; New York State Department of Mental Hygiene, 1939-1940: 176).

Generally speaking, at least one-third and probably one-half or more of all first admissions to state mental hospitals represented cases where behavioral symptoms were probably of known somatic origins. In 1922, 52,472 persons were admitted to state mental hospitals for the first time. Of this number, 3356 were without any evidence of psychoses; they were admitted because of epilepsy, alcoholism, drug addiction, psychopathic personality, or mental deficiency. Of the remaining 49,116 first admissions, 16,407 suffered from a variety of identifiable somatic conditions, including senility, cerebral arteriosclerosis, general paresis, Huntington's chorea, pellagra, and brain tumors. Between 1922 and 1940, the proportion of patients admitted for the first time with such somatic conditions increased from 33.4% to 42.4%.

If we assume that many individuals in the functional categories also suffered from a variety of conditions with a somatic origin—an assumption that may be warranted from other present-day data—it is

evident that mental hospitals provided care for a patient population with severe physical as well as mental problems. The fact that the somatic group had higher death rates, as compared with the lower death rates for the functional psychoses, suggested that the diagnoses were not inaccurate. In 1940, for example, the somatic group accounted for 19,357 deaths out of a total of 31,417, or 61.6% (U.S. Census Bureau, 1926, 1930, 1943).

A significant proportion of the total institutionalized population, in other words, included individuals suffering from physical disabilities that also involved behavioral symptoms. Whether or not the mental hospital was the appropriate place for them was beside the point; most of these patients required some form of comprehensive care. It is true that it was theoretically possible to care for such individuals within a home environment. Nevertheless, such a solution was not always feasible. In many cases, home care proved disruptive; in others no home existed. Ultimately many families accepted hospitalization as an unwelcome but necessary last resort.

The changes in the demographic characteristics of the patient population contributed to changes in the structure and functions of mental hospitals. Simply put, mental hospitals began to provide custodial care for dependent groups. Indeed, the debate as to whether certain groups (such as the aged senile) belonged in mental hospitals was beside the point; some form of care for such patients was required, irrespective of the setting in which it was provided. That mental hospitals came to offer such care was not a novel development. State governments, after all, traditionally funded such institutions, and early and mid-nineteenth-century psychiatrists always insisted that the care of the chronic insane was a legitimate function. The decline and disappearance of the almshouse in the late nineteenth and early twentieth century created a void. Given the absence of alternative sources of funding from the federal government or private sector as well as the shift away from community responsibility, it was not surprising that many turned to the mental hospital to meet a perceived need.

The shift toward an overwhelmingly chronic population had a decidedly major impact upon hospitals themselves. The presence of so many patients whose behavioral disorders were related to an underlying somatic pathology contributed to the depressed and deadening atmosphere at many hospitals. Indeed, the character of the patient population strengthened the centrifugal forces that were always present, and conflict and disorganization often lay directly below the surface at many institutions.

PSYCHIATRY AND HOSPITALS

As mental hospitals changed, their links with psychiatry became less and less attractive, if only because psychiatry—when compared with modern scientific medicine—seemed hopelessly obsolete because of its custodial (as contrasted with its therapeutic) role. Ultimately psychiatrists came to the conclusion that they would have to redefine their function and mission if they had any hope of regaining the position of eminence they had enjoyed before 1870; otherwise they ran the risk of extinction.

Between the 1880s and 1950s American psychiatry underwent a fundamental transformation. Its members moved outside the institutions in which their specialty had been conceived and to which they had been wedded for more than half a century. Influenced by the theoretical and institutional changes within medical science as well as those social and intellectual currents that gave rise to efforts to transform American society, they redefined not only concepts of mental disease and treatment but the very context in which they practiced. In so doing, psychiatrists implicitly posited a conflict between the traditional mental hospital and its function of providing custodial care for large numbers of chronic patients and the imperatives of modern psychiatry. The founders of American psychiatry had defined their specialty within an institutional context; the function of a mental hospital was to provide care *and* treatment. They never rejected the caring function, which was integral to their work. Their twentieth-century successors, on the other hand, identified with the larger medical profession and were less prone to act as the representative of the institutionalized mentally ill. Indeed, by the middle of the twentieth century the role of state hospital psychiatrists in the American Psychiatric Association (APA) was sharply reduced. In 1895 virtually all members were in hospital practice. By 1956 only about 17% of the 10,000 or so members of the APA were employed in state mental hospital or Veterans Administration facilities; the remainder were either in private practice or employed in various governmental and educational institutions, including community clinics (American Psychiatric Association, 1958). The breaking of the ties between psychiatry and mental hospitals and the subsequent emphasis on deinstitutionalization left unresolved the fate of the hundreds of thousands of chronic patients traditionally cared for in mental hospitals. Now, in the 1980s, the American people are once again confronting the grave problems of caring for the chronic mentally ill.

REFERENCES

American Journal of Insanity (1853) Vol. 10 (July).
———(1851) Vol. 8 (July).
American Medical Association Transactions (1871) Vol. 22.
———(1868) Vol. 19.
———(1867) Vol. 18.
———(1866) Vol. 17.
American Psychiatric Association (1958) Biographical Directory of Fellows and Members of the American Psychiatric Association as of October 1, 1957. New York: R. R. Bowker.
California Insane Asylum (1860) Annual Report 8.
DAYTON, N. A. (1940) New Facts on Mental Disorders: Study of 89,190 Cases. Springfield, IL: Charles C Thomas.
GOLDHAMER, H. and A. W. MARSHALL (1953) Psychosis and Civilization: Two Studies in the Frequency of Mental Disorder. New York: Free Press.
GROB, G. N. (1983) Mental Illness and American Society, 1875-1940. Princeton: Princeton Univ. Press.
———(1973) Mental Insitutions in America: Social Policy to 1875. New York: Free Press.
———(1966) The State and the Mentally Ill: A History of Worcester State Hospital in Massachusetts, 1830-1920. Chapel Hill: Univ. of North Carolina Press.
KRAMER, M. et al. (1955) A Historical Study of the Disposition of First Admissions to a State Mental Hospital: Experiences of the Warren State Hospital During the Period 1916-50. Washington, DC: Government Printing Office.
LANDIS, C. and J. E. FARWELL (1944) "A trend analysis of age at first-admission, age at death, and years of residence for state mental hospitals: 1913-1941." J. of Abnormal and Social Psychology 39 (January): 3-23.
MALZBERG, B. (1954) "A comparison of first admissions to the New York civil state hospitals during 1919-1921 and 1949-1951." Psychiatric Q. 28 (2): 312-319.
———(1949) "A statistical analysis of the ages of first admissions to hospitals for mental disease in New York State." Psychiatric Q. 23 (2): 344-366.
New York State Board of Charities (1890) Annual Report 24.
New York State Commission in Lunacy (1900) Annual Report 12.
New York State Department of Mental Hygiene (1939-1940) Annual Report 52.
POLLOCK, H. M. (1941) Mental Disease and Social Welfare. Utica, NY: State Hospitals Press.
ROSENBERG, C. E. (1979) "Inward vision and outward glance: the shaping of the American hospital, 1880-1914." Bull. of the History of Medicine 53 (Fall): 346-391.
U.S. Bureau of the Census (1943) Patients in Mental Hospitals 1940. Washington, DC: Government Printing Office.
———(1930) Mental Patients in State Hospitals 1926 and 1927. Washington, DC: Government Printing Office.
———(1926) Patients in Hospitals for Mental Disease 1923. Washington, DC: Government Printing Office.
———(1925) Paupers in Almshouses 1923. Washington, DC: Government Printing Office.
———(1915) Paupers in Almshouses 1910. Washington, DC: Government Printing Office.

———(1914) Insane and Feeble-Minded in Institutions 1910. Washington, DC: Government Printing Office.
———(1906a) Paupers in Almshouses 1904. Washington, DC: Government Printing Office.
———(1906b) Insane and Feeble-Minded in Hospitals and Institutions 1904. Washington, DC: Government Printing Office.
Virginia Western Lunatic Asylum (1850) Annual Report 23.
VOGEL, M. J. (1980) The Invention of the Modern Hospital: Boston 1870-1930. Chicago: Univ. of Chicago Press.
Worcester State Lunatic Hospital (1893) Annual Report 61.
———(1870) Annual Report 38.
———(1842) Annual Report 10.