MENTAL HEALTH AND IDEALS OF CITIZENSHIP:
PATIENT CARE AT ST. ELIZABETHS HOSPITAL IN WASHINGTON, D.C., 1903-1962

BY

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DISSE chrATION

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ABSTRACT

In this thesis, I argue that U.S. psychiatry’s cultural project in the first half of the twentieth century was the reconstitution of mentally-distressed men and women for proper citizenship. This enterprise is visible on the wards, in the consulting rooms, and in the outpatient clinics of St. Elizabeths Hospital in Washington, D.C., one of the most widely-respected institutions of the era. Through an intensive analysis of patient care at St. Elizabeths, I identify two fundamental tensions in psychiatry’s cultural project. First, while physicians maintained high therapeutic aspirations for their patients, many of the men and women at the hospital received little more than custodial care. Second, despite the concept of citizenship’s egalitarian overtones, physicians at St. Elizabeths promoted a highly gendered and racialized vision of American life. By making it their mission to restore patients to a productive role in society, psychiatrists entered a contested terrain in which Americans continually refashioned the moral contours of U.S. citizenship.

Originally founded as the Government Hospital for the Insane in 1855, St. Elizabeths embodied nearly all of the aspirations and contradictions of the nineteenth-century asylum. Not long after his arrival in 1903, superintendent William Alanson White articulated an expansive program for psychiatry in which shared values could be interpreted through the lens of mental health and illness. White identified psychological well-being primarily with the male social role, and his evolutionary framework paved the way for representations of black Americans as primitive and culturally atavistic. Patients experienced psychological impairment primarily as a form of civic estrangement, with unfamiliar patterns of thought and behavior undermining their ability to meet the obligations of American citizenship. While treatment at St. Elizabeths ran the gamut from individual psychotherapy to prefrontal lobotomy, most psychiatrists saw little overt
tension between psychological and physiological rationales. If physicians could not restore all of
the men and women under their care to independence, they hoped that patients would at least
become “good institutional citizens,” capable of getting along with others and following the rules
that governed their existence at the institution.

The post-World War II era witnessed important changes in both psychiatrists’ vision of
U.S. citizenship and the institutional culture at St. Elizabeths. Physicians took an increasingly
liberal view of race relations under Winfred Overholser, who succeeded White as superintendent
in 1937 and was prompted by national developments to integrate the hospital in 1954. These
same psychiatrists promoted a restrictive domestic ideal for their female patients, in spite of the
fact that middle-class married women were entering the labor market in unprecedented numbers.
Physicians charted a cautious middle path in debates on homosexuality, maintaining that same-
sex desires signified deep psychological maladjustment even as they protested policies
criminalizing consensual sexual contact between adults. These developments occurred in the
context of a general liberalization of institutional culture in the postwar decades. Through their
own efforts as well as through innovations in clinical psychiatry, patients in the 1940s and 1950s
found new opportunities for self-expression and began to articulate a novel sense of shared
identity. By the time the major tranquilizers appeared, the appropriateness of long-term custodial
care for psychologically-impaired men and women had already come into question.
Born into race and nation,
Accept family and obligation.
I’m not a citizen,
I’m not a citizen.

Fugazi, “The Kill” (1993)
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INTRODUCTION: MENTAL HEALTH, MENTAL ILLNESS, AND IDEALS OF CITIZENSHIP

Mental illness occupies a contradictory place in modern American society. It is a challenge located at the intersection of biomedical thought and social welfare, two domains in which the United States made substantial strides in the twentieth century. Yet its intractability is evidence of our limitations in each of these fields. Mental illness is neither wholly public nor purely private in nature, a point that is underscored by the liminal position of the many homeless men and women with cognitive and emotional difficulties who reside in our major cities. Until recently, the vast majority of Americans with serious and persistent mental illnesses occupied a network of state hospitals that first emerged in the nineteenth century to care for those who could not care for themselves. The development of these institutions and the experiences of those who lived and worked in them reveal a great deal about the social meaning that we have historically assigned to mental illness. This is particularly true for the twentieth century, when “the psychological” first emerged as a common category of understanding and when American psychiatry assumed the form with which we are familiar today.

The history of medical perspectives on madness and of patients’ experiences with mental health care remind us that psychiatry is as much a social enterprise as it is a narrowly biomedical discipline. Mental illness has traditionally been grounds for denial of some of the most basic liberties accorded to U.S. citizens, and it has fallen to psychiatrists to restore such persons to their reason and their rightful place in society. In the pages that follow, I aim to situate psychological impairment in the context of men’s and women’s aspirations and perceived responsibilities as American citizens. When did individuals first begin to think that something might be seriously wrong? What did their families and friends see that led them to seek medical attention? How did patients’ encounters with psychiatry intersect with their relations with civil
authorities and the state? Additionally, I attempt to discern physicians’ unspoken assumptions about their patients in both health and disease. Once an individual was admitted to St. Elizabeths, what were the criteria by which a psychiatrists measured his or her prospects for release? And how did such social identifiers as race, ethnicity, gender, and sexuality—identifiers central not only to our self-understanding but also to assigned meanings from the wider society—inform physicians’ expectations for their patients?

I argue that American psychiatrists in the first half of the twentieth century sought to restore mentally-distressed men and women to proper citizenship. This cultural project is visible on the wards, in the consulting rooms, and in the outpatient clinics of St. Elizabeths Hospital in Washington, D.C., one of the most widely-respected institutions of the era. By claiming that American psychiatry had a “cultural project,” I do not mean to suggest that a singular or deliberate effort existed through which medical professionals attempted to impose their worldview on an unsuspecting public. Nor do I mean to imply that the cultural dimensions of psychological medicine made it somehow unscientific; indeed, culture permeates all domains of medicine in ways that many physicians fail to appreciate. Rather, I use the phrase to signify the manner in which psychiatry’s social role can be conceptualized in terms of contemporary debates about U.S. national identity. For physicians and laypeople alike, “good citizenship” and “good mental health” overlapped in important respects.

By making it their mission to restore their patients to a productive role in society, psychiatrists entered a contested terrain in which Americans continually refashioned the moral contours of U.S. citizenship. Neither good citizenship nor good mental health has a fixed or universally agreed-upon definition. Previous scholarship has focused overwhelmingly on the variability of the criteria by which disordered behavior, impaired reasoning, and loss of touch
with reality have been defined across cultures and historical epochs. Given that the social boundaries of mental illness are inevitably the product of local circumstance, my interest lies less in the social construction of mental illness than in the social construction of mental health. “In this matter of mental ailments,” observed the anthropologist Ruth Benedict long ago, “we must face the fact that even our normality is man-made, and is of our own seeking.” Our concepts of illness and health, moreover, are mutually constitutive—it is impossible to imagine one without reflecting implicitly on the meaning of the other. Americans have historically displayed marked differences in their attitudes on such topics as work, family, and leisure, each of which informs notions of mental health and proper citizenship in equal measure. Ultimately, notions of mental health and proper citizenship are rooted in deeply-held beliefs about personal morality and civic responsibility, often in ways that reflect the categories and inherited biases of our culture.

The concept of citizenship represents a useful analytical lens through which to examine changing definitions of mental health and illness. Mental derangement has performed an important (albeit largely unacknowledged) role in the liberal political tradition, serving as the paradigmatic example of a condition that excludes an individual from full membership in a rights-bearing citizenry. In one common formulation, a citizen is one who rules and is ruled in turn—citizenship, that is, involves active participation in the governing process as well as deference to the decisions of the polity. Men and women with persistent cognitive or emotional difficulties occupy a peculiar position in the logic of this system. According to John Locke, the

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3 This is the central lesson of historian and philosopher Georges Canguilhem’s path-breaking The Normal and the Pathological, trans. Carolyn R. Fawcett (New York: Zone Books, 1989 [1978]).
absence of reason renders one incapable of the sort of personal autonomy that lies at the heart of a democratic society. Similarly, for John Stuart Mill, citizens must be capable of participating in free and equal debate if they are to take advantage of the liberties that are fundamental to human progress. Drawing on his extensive work with the historian and philosopher Michel Foucault, theorist Colin Gordon has identified a fundamental link between this tradition and the origins of modern medical thought on madness: “The beginnings of psychiatry are bound up not only with the cultural ethos of the Enlightenment, but also with the political roots of modern liberalism and democracy, and their basis in the shaping of distinctive norms of political citizenship.”

Citizenship involves both formal and informal dimensions, each of which contributes to our understanding of mental health and illness. In its formal dimensions, citizenship implies full and equal standing among one’s fellows and vis-à-vis the state; in a constitutional democracy, the term carries distinctly egalitarian overtones. Citizens of a nation enjoy a legitimacy within its borders that is denied to non-citizens. All residents of the United States must pay taxes and obey civil and criminal laws; only citizens, however, possess an active voice in the political and legislative process. In exchange, they are obliged to fulfill certain prescribed duties, including service on juries and—for some, under specific circumstances—service in the military. Serious

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4 John Locke, *Two Treatises of Government*, 2nd ed. (London: Cambridge University Press, 1967), 325-326 (§60). Locke goes on to cite the sixteenth-century Anglican legal scholar Richard Hooker: “Madmen, which for the present cannot possibly have the use of right reason to guide themselves, have for their guide, the reason that guideth other men which are tutors over them, to seek and procure their good for them.” Ibid., 326. My understanding of Locke is derived from Judith Lynn Failer, *Who Qualifies for Rights?: Homelessness, Mental Illness, and Civil Commitment* (Ithaca, New York: Cornell University Press, 2002), 30-32.


psychological impairment changes this equation in important respects. Legal traditions have historically set those with cognitive and emotional difficulties apart from their peers. Mentally ill men and women received officially-sanctioned support and care well before the advent of the modern welfare state. They have been exempted from standard civic obligations, and their accountability in criminal and civil proceedings is limited. But a finding of *non compos mentis* has also served as the basis for a suspension of fundamental American rights and privileges.

Foremost among these is the loss of personal freedom involved in civil commitment. Restrictions on voting became increasingly common over the course of the nineteenth century, and in the years that followed state legislators introduced strict limits on marriage, parental rights and professional licensure.

While the formal dimensions of citizenship are far from trivial, the concept’s informal moral components reveal mental illness to be more than a personal tragedy. Mental illness is also widely understood as a form of civic failure, an inability to live up to the responsibilities of American life. Both personal ethics and a capacity to act in the interests of the community are essential to good citizenship. Good citizens, as the political philosopher Judith Shklar has observed, are assumed to be “decent people … with a sense of obligation to the social environment.” This understanding is “an internalized part of a democratic order that relies on the

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self-direction and responsibility of its citizens rather than on their mere obedience.”10 In the American context, citizenship encompasses an array of virtues and aspirations that are closely allied to our understanding of mental health—a belief in the value of work, a commitment to stable domestic life, a dedication to public order. Such values are essential to the well-being of the imagined national community, most of whose members will never interact directly with one another but who nevertheless share a common sense of history and destiny.11 Failure to live up to such ideals places an individual beyond the pale of American national identity, serving as a justification for the distinctive legal status assigned to men and women with cognitive and emotional difficulties and further contributing to the widespread stigma they face.

An examination of St. Elizabeths Hospital in Washington, D.C. provides an excellent window into the development of modern American psychiatry. Originally established as the Government Hospital for the Insane in 1855, St. Elizabeths has been one of the most important psychiatric facilities in U.S. history. Past superintendents have played an influential role in the development of the psychiatric profession and the formation of mental health care policy. William Alanson White, who administered the institution from 1903 to 1937, authored a standard textbook in the field and played a central role in the mental hygiene movement. His successor Winfred Overholer, who served as superintendent from 1937 to 1962, became a leading authority in forensic psychiatry and helped craft U.S. military guidelines on mental health during World War II. Unlike many chronically underfunded state institutions, St. Elizabeths maintained an active research program into the causes and treatment of mental illness, producing well-regarded work in psychiatry, psychology, and neuropathology. The hospital also

served as a teaching institution for generations of physicians, many of whom came to Washington, D.C. specifically because of its national reputation. Even as U.S. psychiatry began to look beyond the large-scale asylum in the early decades of the twentieth century, St. Elizabeths remained an anchor for the profession’s institutional wing, embodying much of the traditional mental hospital’s potential as well as its limitations.12

While it has always been a prominent institution, St. Elizabeths never served as an exclusive or highly-specialized facility. With a census that surpassed seven thousand residents at its peak in the 1950s, the hospital has seen an enormous number of men and women pass through its doors. For most of the institution’s history, this population was composed primarily of District residents, visitors to the city, and members or veterans of the U.S. Armed Forces. Because of its unique federal status, St. Elizabeths also received employees of government agencies and U.S. prisoners whose sanity came into question. At times the hospital provided care to American Indian patients from federal reservations.13 St. Elizabeths has seen its share of famous patients as well, including the poet Ezra Pound during the 1940s and 1950s and would-be presidential assassin John Hinckley from the 1980s to the present.14 When it came to their symptoms and their diagnoses, men and women at St. Elizabeths resembled those at any other large-scale U.S. psychiatric facility. The public nature and sheer size of St. Elizabeths virtually guaranteed that its

13 St. Elizabeths also received employees of the Foreign Service as well as men and women from the Canal Zone and the Virgin Islands. The majority of the hospital’s patients, however, were always District residents and those associated with the U.S. Armed Forces.
wards encompassed the whole spectrum of patients, policies, and practices characteristic of American psychiatry.

The history of St. Elizabeths reveals two important tensions in psychiatry’s cultural project. First, despite its therapeutic and restorative mission, St. Elizabeths offered little more than custodial care for many of the men and women it received. If a patient did not leave the hospital within a few weeks or months of arriving, the likelihood that he or she would spend a lifetime there increased dramatically. This is reflected in the term “institutional citizenship,” which first appeared in the lexicon of psychiatrists in the early decades of the twentieth century. Institutional citizenship denoted a degree of social adjustment appropriate for the limited environment of the hospital but inadequate for full civic autonomy and the freedom it entailed. By this point, the optimism of earlier generations of asylum physicians had long since given way to a pragmatic administrative stance. Beginning in the 1950s, a combination of new drug therapies and environmental reforms would revitalize the field, but before then even a leading hospital like St. Elizabeths had little to offer most patients in the way of truly effective therapies.

For those familiar with the historiography of psychiatry, this tension between treatment and custodialism should not come as a surprise. For many years, the single most important debate in the field centered on whether nineteenth-century asylum physicians ever intended to return patients to independence or mental hospitals functioned instead as a means of sequestering those who posed a challenge to the status quo. According to David Rothman, the asylum represented one response among many by Jacksonian Americans to a mounting sense of social disarray. Through its emphasis on punctuality and steady labor, the asylum would serve as a model for how society ought to be ordered.15 In his account of British developments, Andrew

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Scull has suggested that the earliest asylum physicians based their profession on a shift in moral consciousness attendant upon the rise of industrial capitalism. Psychiatry, in this account, represents an indirect instrument of state control, with the state conceived largely in classical Marxist fashion as the organized interests of the bourgeoisie.16 Departing from Rothman as well as Scull, Gerald Grob has argued that urbanization and the rise of the wage labor system transformed family economies in ways that prevented Americans from continuing to care for dependent members within the home. Assessing mental hospitals’ overall failure to live up to their stated objectives, Grob has concluded that “the most impressive fact is the relative absence of malevolence, or for that matter, consistency of behavior.”17

Though historians have in many respects moved on to other concerns, this debate nevertheless encompassed fundamental questions about mental health and mental illness in American society. What marks some categories of human behavior as specifically pathological rather than merely deviant? What can the peculiar set of social pressures and political interests that originally gave rise to the asylum tell us about psychiatry’s social functions? And given the profession’s historical inability to produce a lasting cure for mental illness, where else might the foundations for its claim to social authority lie?

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16 For a good overview of Scull’s perspective, see his *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven, Connecticut: Yale University Press, 1993), 1-45. This is a revised and substantially expanded version of his earlier *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London: Allen Lane, 1979).

Similar themes have recently reemerged in a dispute between historians Elizabeth Lunbeck and Jack Pressman on the origins of modern U.S. psychiatry. Lunbeck has argued that the profession as we know it emerged not from the asylum but from the outpatient clinics and psychopathic hospitals—urban facilities devoted to evaluation, short-term treatment, and disposition rather than indefinite custodial care—that first appeared at the beginning of the twentieth century. These sites provided the basis for a “psychiatry of everyday life,” concerned less with insanity than with marriage, sexual morality, employment, and childrearing. By focusing on these domains, Lunbeck suggests, we can better appreciate the extent to which the emerging psychiatric worldview drew upon the experience of native-born white men.18

Pressman, in contrast, has maintained that any account of psychiatry’s origins must begin with the problem of serious and persistent mental illness. While he agrees that the profession underwent a profound transformation in the early decades of the twentieth century, his concern is less with the links between these changes and gender politics or race relations than with the intellectual and structural developments that made them possible.19

The dispute between Lunbeck and Pressman calls attention to the second major tension that marked psychiatry’s cultural project. Psychiatrists at St. Elizabeths promulgated a highly inequitarian vision of American citizenship. In the years leading up to World War I, they identified civic autonomy with a vigorous, masculine form of social engagement. These physicians reserved full citizenship for native-born white Americans, assuming blacks to be so culturally atavistic as to remain ineligible for full inclusion in the national community. In the years that followed, changing ideas about race and culture—as well as the political agitation of

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black men and women—led many psychiatrists to reconsider such assumptions. Gender attitudes, in contrast, became increasingly rigid and misogynistic. In the years after World War II, psychoanalytically-inclined physicians emphasized the ways in which women’s activities in the home and beyond endangered the psychological well-being of the nation. Sexuality, too, became an important category of analysis, with psychiatrists campaigning against the criminalization of homosexuality but never going so far as to press for full recognition of gay men and women as American citizens.

It is now widely acknowledged that the nation is a product of history and culture rather than an organic or timeless entity. Often, nations have drawn on existing ethnoracial affiliations to create national sentiment and a coherent sense of shared identity. Such processes of cultural self-definition all too frequently involved assertions of superiority vis-à-vis an internal or external other. Gender, too, figures prominently in this equation. When the national self-image is explicitly racialized, women become responsible for the link to future generations; as a result, their sexuality and reproductive capacities are tightly monitored. Even in the most egalitarian of nationalist enterprises, constructions of citizenship have reflected the interests and worldview of those in power. “[T]he founding moments of democratic advance,” write historians Geoff Eley and Ronald Grigor Suny, “became predicated on the gendering of political capacities, on the social qualification and limitation of citizenship, and on the exploitative domination of some peoples over others.”

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These generalizations take on more concrete meaning in the American context. Despite its egalitarian founding principles, the United States has long embraced an alternative tradition involving a racialized and gendered vision of civic identity. According to political scientist Rogers Smith, American national sentiment has historically relied upon an ascriptive impulse to unify an otherwise heterogeneous native-born white male polity through the exclusion of women, immigrants, and blacks.21 Legally-sanctioned hierarchies dominated the social landscape from the outset, consigning those of African descent to chattel slavery and severely restricting the freedoms of women and non land-owning men. Property requirements for white male voters had largely disappeared by the middle of the nineteenth century; women, however, lacked the franchise until the Nineteenth Amendment, and for many years married women’s civil identities remained an extension of their husbands’. Following the Civil War and the brief social experiment of Reconstruction, Jim Crow segregation laws returned black men and women to the margins of public life. Immigrants, too, faced both formal and informal obstacles to inclusion, particularly if they happened to be of non-Western European extraction.22 Expanding the boundaries of American national identity required major political and legal battles. As historian Linda Kerber has noted, “[t]he definition of ‘citizen’ is single and egalitarian, but Americans have had many different experiences of what it means to be a citizen.”23

Against this backdrop, St. Elizabeths’ location in the nation’s capital makes it a particularly worthy object of study. It is difficult to imagine a city in which debates about citizenship and national identity might be more salient. The hospital lies just a short distance from some of the most noteworthy symbols of national culture, including the White House, the Capitol Building, and the Washington Monument. Though the District never received the massive influx of European immigrants that cities like Boston and New York did, poor black Southerners arrived in large numbers as part of their migration northward during the early decades of the twentieth century. Major protest movements aimed at broadening the boundaries of U.S. citizenship have focused on the District for its symbolic importance, including the movement for women’s suffrage in 1913 and the modern civil rights movement in 1963. District residents have waged a long and difficult campaign for municipal autonomy and full voting rights; the city’s large black population makes the issue one of more than local importance. St. Elizabeths’ location in the mid-Atlantic region also makes it a useful corrective to accounts of U.S. psychiatry’s origins that have focused exclusively on the northeast.

Finally, psychiatry and the allied mental health professions played an integral role in the transformation of state power that occurred in the early decades of the twentieth century. Faced with the consequences of rapid industrialization and urbanization, advocates for the poor argued that civic participation required a baseline of economic security and meaningful opportunities for

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self-improvement. Workmen’s compensation, provision for maternal and child health, and old age insurance each represented claims on a new domain of what sociologist T. H. Marshall has called “social rights.” Government involvement in the administration of public welfare marked a departure from traditional notions of private charity, entailing a new form of civil existence. “The individual was to be integrated into society in the form of a citizen with social needs,” writes theorist Nikolas Rose, “in a contract in which individual and society would have mutual claims and obligations.” Nowhere does Rose’s observation achieve greater truth than in the care of those with cognitive and emotional difficulties, where mental health represented a careful balance between personal autonomy and social responsibility. In this model, Rose continues, “[c]itizens should want to regulate their conduct and existence for their own welfare, that of their families, and that of society as a whole.”

This transformation produced new forms of self-understanding, which in turn became subject to official inspection. Critics such as Rose see in the rise of the mental health professions a manufacture of new anxieties and desires that men and women gradually accepted as a natural part of their emotional lives. This laid the foundations for a broadly therapeutic culture in which the search for personal fulfillment triumphed over communitarian thinking. Alliances between psychiatry and the state—both formal and informal—opened the most intimate details of citizens’ lives to inspection and management by civil officials. Facilitated and supported by

27 Under the rubric of social rights, Marshall includes “the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in the society.” T. H. Marshall, “Citizenship and Social Class,” in Citizenship and Social Class and Other Essays (Cambridge: Cambridge University Press, 1950), 11.
29 Rose, Governing the Soul. See also Rose’s essays in Miller and Rose, eds., Power of Psychiatry. As my choice of words indicates, Rose’s critique echoes many of the observations made by Philip Rieff in his The Triumph of the Therapeutic: Uses of Faith after Freud. (New York: Harper and Row, 1966).
mental health professionals and social service workers, private relationships between men and women became “charged with a ‘civic’ function and made possible by constant state assistance.”\textsuperscript{30} As members of an overwhelmingly male profession with its roots in the white middle class, psychiatrists could not help but bring their own biases and prejudices to this task. The consequences were far from trivial. As Marshall recognized long ago, potentially invidious social distinctions may receive the imprimatur of legitimacy when state services are stratified according to characteristics of the recipient.\textsuperscript{31}

In the pages that follow, I seek to explore the dominant tensions in psychiatry’s cultural project through an examination of developments at St. Elizabeths Hospital in the first half of the twentieth century. Much of what transpired on the hospital’s wards is explicable in these terms. With Pressman, I maintain that serious and persistent psychological impairment must lie at the center of any account of psychiatry’s origins. Prior to World War II, most psychiatrists worked in large-scale institutional settings; even those who did not typically received much of their training in such facilities. To the extent that psychiatrists gradually shifted their focus from severe mental illness to problems of everyday life, they did so with the understanding that the latter, if left unaddressed, might easily progress to the former. And yet with Lunbeck, I agree that we must take seriously the ways in which physicians’ vision of mental health assigned women as well as racial and ethnic minorities to subordinate social positions. While it would be naïve to suggest that psychiatrists somehow remained impervious to the biases and cultural hierarchies of the world in which they lived, it is not enough merely to acknowledge this fact. If we are ever to overcome the marked disparities that exist within the field, we must fully interrogate the impact


of racial and gender norms in the history of mental health care. As we shall see, these norms routinely reinforced broader cultural patterns and shaped the care that individual men and women received.

My first chapter examines the origins of St. Elizabeths in the nineteenth century and the arrival of William Alanson White at the beginning of the twentieth. Originally founded as the Government Hospital for the Insane in 1855, St. Elizabeths embodied nearly all of the aspirations and contradictions of the nineteenth-century asylum. The institution played an influential role from the outset, intended as a model for other facilities around the nation. The organization that would ultimately become the American Psychiatric Association (APA) elected each of St. Elizabeths’ first three superintendents to serve as president. When White arrived in Washington in 1903 as the hospital’s fourth superintendent, he launched a series of reforms intended to place psychiatry on a firm scientific foundation. White developed an expansive social vision for the profession in which shared values could be interpreted through the lens of mental health and mental illness, casting the latter as a form of psychological inefficiency and social failure. He and his staff identified mental health primarily with the male social role, relegating women to a dependent and distinctly secondary position. Though White himself occupied a moderate position on race, his social evolutionary framework paved the way for depictions of black men and women as psychologically inferior and culturally atavistic, implicitly justifying the political subordination they endured.

In the second chapter, I offer a detailed portrait of the paths that led individual patients to St. Elizabeths and the social world that received them there in the early decades of the twentieth century. Psychological impairment, I suggest, represented a form of civic estrangement in which men and women found themselves unable to meet the obligations of American citizenship. This
was true for civil as well as military patients, who made up a demographically distinct group but occupied a similarly tenuous position vis-à-vis the state. I then turn to the hospital’s highly gendered and racialized system of work and recreation, which administrators intended to mirror arrangements outside its walls. Physicians hoped that all able-bodied patients would work in some capacity. For men, this typically meant labor on the hospital grounds, on the farm, or in its industrial shops. Women worked in the laundry or in sewing rooms on the wards. Labor became an opportunity for men to prove themselves capable of handling freedom of the grounds; women, in contrast, remained confined to the wards. In each case, physicians proved far more willing to grant such privileges to white patients than black patients. When it came to recreation, the arrival of the American Red Cross in 1919 marked a transition from an ad hoc to a formalized pattern of racial segregation in patient-patient interaction. Building on a system of segregated wards that extended back to the hospital’s origins, these arrangements prioritized the well-being of the overwhelmingly white and male population of military patients. Physicians at St. Elizabeths also began to employ the term “institutional citizenship” in this period. Though the hospital’s aims were explicitly therapeutic, physicians recognized that adjustment to the limited social world of the asylum might be the best they could hope for with many of their patients.

This did not mean that psychiatrists abandoned treatment altogether. My third chapter examines the series of increasingly radical somatic interventions physicians employed in the first half of the twentieth century. Though these treatments acted directly on the body, psychiatrists had little difficulty integrating them into an increasingly psychological therapeutic rationale. Hydrotherapy represented an opportunity for active intervention in acute cases, particularly among agitated patients or those who threatened violence to themselves or others. Malarial fever therapy for general paresis (neurosyphilis)—first introduced in the United States at St. Elizabeths
in 1922—reveals the extent to which physicians privileged the health of those with recognizable social resources over the well-being of their less fortunate peers. Among the “shock therapies” of the 1930s and 1940s, insulin coma and metrazol shock never achieved the same level of acceptance at St. Elizabeths as electroshock. All three therapies, however, demonstrate the ease with which psychiatrists proved capable of reconciling psychodynamic and physiological explanations for a treatment’s efficacy. Finally, St. Elizabeths played a distinctive role in the history of psychosurgery (lobotomy), whose foremost U.S. advocate had served on the hospital’s medical staff for many years. Though physicians at St. Elizabeths expressed conservatism about the procedure and recognized its psychic costs, they nevertheless proceeded with lobotomy in more than two hundred cases at midcentury.

In the fifth chapter, I situate psychiatrists’ racialized and gendered vision of U.S. citizenship in the context of the embattled liberal political culture of the 1940s and 1950s, when new and intense concerns about sexuality entered the picture as well. Attitudes toward race changed dramatically in the interwar years, with many physicians at St. Elizabeths embracing a form of racial liberalism that recognized the injustice facing black Americans. Hospital administrators implemented the federal desegregation order in 1954 without incident, though physicians remained troubled by the prospect of cross-racial liaisons among their patients. Gender attitudes became increasingly conservative in the post-World War II period, largely under the influence of psychoanalytically-inclined psychiatrists. Though physicians at St. Elizabeths proved more flexible than some of their more outspoken peers, they remained well within the psychiatric mainstream in their willingness to evaluate women in terms of their responsibilities as wives and mothers. Male and female patients alike understood their circumstances in gendered terms, with men expressing concern about their ability to fulfill the
breadwinner role and women frequently indicating a desire to return home to their children. Anxieties about homosexuality also increased dramatically among patients in the 1940s and 1950s. Psychiatrists remained sympathetic to those who found themselves attracted to others of the same sex, but ultimately failed to question the psychodynamic axiom that such impulses signified deep underlying psychological maladjustment.

My final chapter places the advent of the major tranquilizers in the context of the changes in institutional culture that transformed St. Elizabeths in the 1950s. Today’s psychiatrists often regard the phenothiazines’ introduction as the critical event in the reversal of a decades-long trend toward rising psychiatric hospital populations. Yet a series of scandals in the immediate postwar period along with increased funding in the years that followed led many hospitals to implement reforms well before the new drugs appeared. At St. Elizabeths, a psychodynamic emphasis on self-examination joined with the Cold War valorization of American freedoms to produce a rich and varied patient culture. Dance therapy, art therapy, and group therapy, along with institutional newspapers and patient self-government, created new opportunities for therapeutic interaction and patient solidarity. Sociologist Erving Goffman also conducted the field work for his 1961 study *Asylums* at St. Elizabeths in this period. Though Goffman documented important elements of institutional culture, I depart from his conclusion that no authentic community existed among patients. Finally, I return to the advent of chlorpromazine and reserpine at St. Elizabeths in 1954. While the new medications produced dramatic improvements in a few cases, physicians quickly realized that they did not represent a panacea. More often, drug treatment led to incomplete and only partially satisfying results.

Throughout this work, I seek to strike a balance between the experiences of individual men and women admitted to St. Elizabeths and generalizations about their care. It would be a
grave disservice to reduce the particularities of these patients’ lives to formulaic pronouncements about the past. The cognitive and emotional difficulties they faced were very real, as were the uncertainty and alienation they endured. For some patients, mental illness represented the dominant fact of their existence, altering their capacities in fundamental ways and calling forth a patterned set of responses from the wider community. Yet psychological impairment was rarely the *only* fact of their existence. Men and women at St. Elizabeths remained enmeshed in a complex network of social relationships, organized around such pervasive identifiers as age, gender, race, ethnicity, and economic standing. Regardless of whether they ever became psychiatric patients, men and women occupied distinctive social worlds, and the life experience of white Americans differed in important respects from that of blacks. Ultimately, my interest lies in the ways that medical responses to cognitive and emotional impairment both reflected and reinforced contemporary social hierarchies. Recovery from mental illness was difficult under even the best of circumstances. The added burdens of adhering to a complex, shifting, and highly inegalitarian civic vision could only have magnified the obstacles these men and women faced in their efforts to regain their former lives.
CHAPTER ONE: “A MODEL INSTITUTION”:
ST. ELIZABETHS AND THE ORIGINS OF U.S. PSYCHIATRY

INTRODUCTION

When William Alanson White assumed the superintendency at St. Elizabeths in 1903, he found an institution that had, as he later recalled, “jogged along through the years at a comfortable pace, controlled and dominated by the humanitarian spirit.”¹ Given its unique federal status, its location in the nation’s capital, and its responsibility for military veterans, White felt the hospital should be a showcase institution for officials and policy-makers around the country. White received his training at a time of rapid change in the theory and practice of medicine; once in Washington, he sought to place the hospital on what he saw as a firm scientific foundation. Eight years later, when the American Medico-Psychological Association (forerunner of the American Psychiatric Association) met in the District of Columbia, St. Elizabeths hosted one of the conference’s afternoon panels. White used the opportunity to highlight many of the changes he had introduced; he was particularly proud of the institution’s new research facilities and its links to regional medical schools. White also emphasized these developments in an article in the profession’s leading journal. “The unique position in which the Government Hospital stands in the country,” he wrote, “is such that its possibilities for usefulness are very great.”²

White’s aspirations for St. Elizabeths echoed the goals of its founders. From its inception, the hospital was meant to be, in the words of Secretary of the Interior Alexander H. H. Stuart, “a model institution, embracing all the improvements which science, skill, and experience, have

¹ William A. White, Forty Years of Psychiatry (New York: Nervous and Mental Disease Publishing Company, 1933), 28.
introduced into modern establishments.”3 White’s assessment notwithstanding, the hospital already boasted a long and distinguished record. Each of the superintendents who preceded him had been elected as president of the organization that would ultimately become the American Psychiatric Association (APA); professional leaders around the country looked to St. Elizabeths as an exemplar of how the state might provide mental health care for those in need. St. Elizabeths embodied many of the ambitions, limitations, and contradictions found at other, less high-profile institutions across the country. Its position of leadership, however, meant that developments there would have an impact well beyond the hospital’s walls.

In the sections that follow, I argue that St. Elizabeths both illustrates and influenced the development of modern U.S. psychiatry. I begin with the hospital’s founding in 1855 through the combined efforts of local physicians and reformer Dorothea Lynde Dix. During its early years, superintendent Charles Nichols struggled to reconcile the grand therapeutic optimism on which the hospital was based with the reality that many of the men and women admitted to St. Elizabeths failed to recover. Following a series of political setbacks, Nichols resigned in 1877 and was replaced by William Whitney Godding. Godding adopted a more flexible outlook that proved well-suited to the needs of a growing institution. His approach, however, came at the cost of reduced therapeutic ambitions, and by the end of the nineteenth century the hospital offered little more than custodial care. From there I turn to William A. White’s program for St. Elizabeths and for U.S. psychiatry in the early decades of the twentieth century. White advanced a new and distinctly psychological understanding of mental health and illness. By identifying universal patterns of psychic function, he and his colleagues created a continuum extending from serious and disabling conditions at one end to problems of everyday life at the other. Through his

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involvement in the mental hygiene movement, White brought this vision to a wider audience and helped shape public thought on the psychological dimensions of human conduct. St. Elizabeths, however, continued to care primarily for seriously disabled men and women unable to function independently in the community.

Officials at St. Elizabeths also promoted a highly gendered and racialized vision of U.S. society. Initially, the Victorian family provided the hospital’s guiding metaphor, with patients living under the authority of a firm but loving patriarch in the form of the superintendent. The theory of moral treatment on which the asylum was founded involved a careful balance of humane care and social regimentation, implemented in ways that reflected the prevailing doctrine of separate spheres. Patients resided in segregated quarters according to sex and race; black men and women occupied separate buildings at a distance from the hospital’s administrative center. As the institution grew, its units became both less centralized and more interdependent; gradually, the metaphor of the family gave way to one of a village or small community. This provided the context in which William A. White developed his theory of mental health as social adjustment. White identified psychological well-being with a masculine mode of engagement in the world, casting women’s contributions primarily in terms of their roles as wives and mothers. By drawing heavily on social evolutionary theory, physicians at St. Elizabeths also reinforced the existing system of racial inequality; indeed, racial stereotypes provided the backdrop against which the image of the mentally healthy and socially productive American citizen became visible. As we shall see, assumptions about gender and race were not the only factors that influenced the historical trajectory of St. Elizabeths. Nevertheless, these concerns remained central to psychiatry’s cultural project—the reconstitution of mentally distressed men and women for proper citizenship.
“THE MOST HUMANE CARE AND ENLIGHTENED CURATIVE TREATMENT”:
ST. ELIZABETHS HOSPITAL IN THE NINETEENTH CENTURY

Madness and insanity have not always fallen under the province of physicians, nor have they always been identified with large-scale institutions in American history. During the colonial era, “distracted” men and women generally remained within the community. When family members could not shoulder the burden, local officials might place a dependent member out in the homes of other townsfolk at public expense. For those with a history of aggression or agitation, confinement to a room was not unusual. Occasionally such individuals ended up in jails or almshouses, but these instances were the exception rather than the rule.4

Institutional responses became more common during the post-revolutionary period, and by the early nineteenth century American physicians were addressing the problem of mental derangement directly. In the nation’s growing cities, confinement often meant a segregated wing in the local almshouse. Elsewhere, however, specialized facilities began to appear. In either case, the rise of wage labor and changing patterns of family life made it increasingly difficult to accommodate bizarre or unusual behavior within the home.5 In this context, American physicians began to postulate a fundamentally physiological basis for mental disease. In his Medical Inquiries and Observations upon the Diseases of the Mind (1812), Philadelphia’s Benjamin Rush located the causes of insanity in the blood vessels, advocating an aggressive therapeutic program of bleeding and depletion in cases of mania and tonics and restoratives in

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cases of melancholia. Rush’s framework nevertheless remained deeply religious, with a goal in each case “to restore the disjointed or debilitated faculties of the mind of a fellow creature to their natural order and offices, and to revive in him the knowledge of himself, his family, and his God.”

Beginning in the 1830s and 1840s, a wave of asylum-building swept the nation. While five public and four semi-public institutions had opened prior to 1830, sixteen more appeared in the succeeding two decades and another forty-four by the mid-1870s. Most of the physicians in charge of these hospitals were members of the Association of Medical Superintendents of American Institutions for the Insane (AMSAII), founded in 1844 and a precursor of the APA. Asylum physicians received unexpected assistance from the advocacy of Dorothea Lynde Dix, a former Massachusetts schoolteacher whose personal investigation of county jails and almshouses revealed the inadequacy of existing facilities for the mentally ill. Dix worked closely with the first generation of asylum superintendents, sharing their vision of care for the psychologically infirm as a religious vocation. Dix promoted the cause at every opportunity, working with local officials in nearly every state and frequently addressing legislatures directly. Dix’s status as a woman of genteel background imbued her cause with a special moral urgency. Dix was also a

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7 “Although the surge in the founding of state mental hospitals followed the action of Massachusetts in opening the Worcester hospital in 1833, several states had created such institutions earlier. Yet the public institutions in existence before 1830 had few of the characteristics deemed necessary and appropriate for the proper conduct of mental hospitals.” Grob, Mental Institutions in America, 343. For the dates of opening of U.S. mental institutions to 1873, see ibid., 373-395.

shrewd political actor, cultivating alliances by focusing on mental health reform and avoiding the explosive topic of slavery.⁹

The medical superintendents of these institutions placed a new emphasis on the psychological dimensions of mental illness. Insanity, they suggested, represented a functional disorder of the nervous system. Following Philippe Pinel, American physicians accorded new importance to the “moral” causes of mental disease, including such personal missteps as excessive study, reckless business enterprise, and misguided religious enthusiasm. Here the term “moral” did not necessarily signify an ethical lapse, but rather encompassed the whole range of human aspiration and experience.¹⁰ The real innovation among this generation of physicians lay in their vision of therapeutics. Drawing from Enlightenment principles on the perfectibility of man as well as the religious optimism of the Second Great Awakening, they maintained that proper care in a well-ordered institutional environment could restore a person’s psychic equilibrium. With early treatment, physicians insisted, remarkable cures remained possible.¹¹

Most mentally ill men and women had not fully lost the capacity for reason; their caretakers thus ought to treat them with dignity and respect. Asylum physicians such as Pliny Earle and Samuel Woodward engaged their patients through a steady regimen of work, recreation and religious observances. This represented an American version of Pinel’s traitement moral, filtered through the influential model of care that William Tuke pioneered at the York Retreat in England.¹²

¹¹ Grob, Mad Among Us, 25, 30; Grob, Mental Institutions in America, 48-50.
Though more humane than the care available in jails and almshouses, moral treatment nevertheless involved absolute submission to the authority of the superintendent. The Victorian family provided the dominant metaphor for care within the asylum, with the superintendent assuming the role of a stern but beneficent patriarch capable of guiding his wayward children. The well-ordered institution could even become a substitute for a patient’s biological kin.

“[H]ospital life seems as normal … to the insane,” argued officials at St. Elizabeths, “as the institution of the family is to the social life of the sane.”13 Physicians employed the asylum’s highly-structured daily regimen to create an internalized sense of discipline among their patients, a sense that many observers felt was lacking in the wider society. The prevailing patterns of work and recreation also reflected the emerging ideology of “separate spheres,” which cast productive labor and public life as distinctively masculine enterprises and linked femininity to domestic responsibilities and the private world of the family.14

This was the social and political context from which the Government Hospital for the Insane emerged in 1855. Washington remained a provincial city at the time, with a correspondingly small number of residents suffering from serious cognitive or emotional difficulties. But it was also served as a home for large numbers of transient poor, including many aged and infirm men who had served in the U.S. military. During the 1840s, federal officials arranged for members of both groups to receive care in one of a dozen beds at a new public


13 Annual Report 1860, 537.

hospital or at the Maryland Hospital for the Insane in nearby Baltimore. These measures remained unpopular with government officials as well as the local medical community. Dorothea Dix’s arrival in Washington and her efforts on behalf of federal asylum legislation further highlighted the absence of a municipal institution. Local physicians took advantage of her presence to press the issue. By August of 1852, they had convinced Congress to make an initial appropriation. Though the buildings remained incomplete, the Government Hospital for the Insane received its first patients in January of 1855 (Figure 1.1). Its mission, according to the founding legislation, was to provide “the most humane care and enlightened curative treatment” to members of the U.S. military and residents of the District of Columbia.15

Federal officials and leading physicians agreed that the Government Hospital ought to serve as “a model in regime and detail, after which the hundreds of institutions to come may be wisely conformed.”16 Dix’s personal friendship with Millard Fillmore allowed her to influence the institution’s planning, including the selection of Charles Nichols as the first superintendent. Nichols had served as assistant physician at the Utica State Lunatic Asylum in New York and then as resident physician at that state’s Bloomingdale Asylum. Dix and Nichols worked closely in their selection of a site for the new hospital, ultimately settling on a prominence that overlooked the city and the convergence of the Anacostia and Potomac Rivers. They agreed that the institution should follow the Kirkbride plan, an architectural arrangement developed by Philadelphia hospital superintendent Thomas Story Kirkbride and endorsed by members of the AMSAII. Two separate wings of patient wards would extend in opposing directions from a central structure housing administrative offices, recreational facilities for patients, and living quarters for the superintendent. As the patient population increased, officials could add sections

16 Luther V. Bell quoted in Millikan, “Wards of the Nation,” 39.
Figure 1.1. Proposal for Center Building, Government Hospital for the Insane (1852).

on to the ends of the existing wings. This allowed for maximum exposure of each room to sunlight and fresh air—a central principle of nineteenth-century hospital architecture—and promoted classification of patients according to their behavior. The most severely disturbed patients would reside in those wards furthest from the hospital’s administrative center; as they improved, patients would move to the convalescent wards immediately adjacent to the superintendent’s apartment.17

The hospital’s architecture also reflected the gendered and racially-stratified organization of U.S. society in the middle decades of the nineteenth century. By placing male patients in one wing and female patients in the other, the Kirkbride plan achieved a high degree of gender segregation in a manner consistent with the doctrine of separate spheres. By foregoing a central courtyard, the Kirkbride plan eliminated opportunities for male and female patients to view one another, thereby preventing inappropriate cross-gender interaction that might hinder an individual’s recovery. When it came to race, the very fact that the Government Hospital accepted black patients proved somewhat forward-thinking; many of the nation’s earliest hospitals refused admission to black men and women altogether.18 Nichols strove to create a permissive environment free of prejudice, which he believed would interfere with the treatment of “persons of all colors, religions and nativities.”19 Nevertheless, the care of black patients remained “a subordinate feature” of the hospital’s mission.20 Black men and women at the Government Hospital occupied segregated wards in buildings separate from the rest of the institution, located even further from its administrative center than the wards reserved for the most disturbed white

17 For details of the Kirkbride plan, see Thomas Story Kirkbride, On the Construction, Organization, and General Arrangements of Hospitals for the Insane, 2nd ed. (New York: Arno Press, 1973 [1880]). See also Tomes, Art of Asylum-Keeping, 141-143. For a good general account of the buildings and the tract on which they were situated, see Annual Report 1860, 546-550. For an evocative description of the Government Hospital’s architecture and internal milieu, see Brad Edmondson, “Beautiful Minds,” Preservation 56 (2004): 26-32.
18 Grob, Mental Institutions in America, 245.
20 Annual Report 1859, 892.
male and female patients. Such an arrangement reinforced the social distance between black and white Americans, with black patients occupying a position inferior to that of even the most degraded white citizens. The very separateness of the buildings called into question the possibility that psychologically impaired black men and women might improve sufficiently to achieve equal status with white Americans.21

During the hospital’s early years, the rhythms of patient life embodied the classic principles of moral treatment. Many of the able-bodied patients worked in jobs that mirrored traditional gender roles. Men labored on the hospital farm and assisted in the garden, stables, boiler room, kitchen and machine shop, while women worked in the laundry room and repaired garments on the wards.22 Patients gathered twice a week for lectures accompanied by drawings, experiments or lantern slides; religious services took place every Sunday. During the summer months, Nichols introduced a program of dances and outdoor band concerts, though dramatic and musical groups from Washington visited the hospital throughout the year.23 The degree to which black men and women participated in these events alongside white patients remains unclear. Physicians likely permitted black men and women who they deemed well enough to join in on informal basis; black patients probably remained on the margins of such affairs, with both formal and informal social pressures enforcing the code of proper conduct.24 Black men and women were aware of the tenuousness of any privileges they enjoyed in the antebellum South. Given the degree of supervision at such activities, it is possible that some black patients elected to remain among their peers rather than risking punishment for an unintended transgression.

21 On the racial dimensions of the hospital’s early organization, see Kathleen Brian, “‘Special Provisions for Patients of Colour’: Race, Shared Space, and Differential Diagnosis at the Government Hospital for the Insane, 1855-1870” (paper presented at the Annual Meeting of the American Association for the History of Medicine, Rochester, Minnesota, 1 May 2010).
23 Annual Reports 1867, 499; 1873, 803; 1874, 776; 1875, 934.
Nichols faced serious challenges in his attempts to maintain a therapeutic environment at St. Elizabeths. From the outset, construction costs exceeded officials’ expectations; many buildings remained incomplete when the asylum accepted its first patients. Outbreak of the Civil War six years later created new strains. The Union Army requisitioned the hospital’s still-unfinished east wing as a general hospital for wounded soldiers, while the Navy used the building intended for black male patients as a quarantine unit.25 Soldiers recovering at the 250-bed army facility did not like to acknowledge they were convalescing in an institution for the insane. In their correspondence, they began referring to their quarters instead as the St. Elizabeths hospital, after the name of the colonial land tract on which it was situated. While the institution’s official name remained the Government Hospital for the Insane until 1916, patients, their families, physicians and federal officials rapidly came to know it simply as St. Elizabeths.26

The Civil War marked a turning point in the hospital’s early history, producing a major shift in the patient population and setting the stage for political controversy. During its initial years, St. Elizabth's served primarily as a municipal institution. The Union Army’s expansion, however, meant that large numbers of veterans—overwhelmingly white and almost exclusively male—now became eligible for federal care.27 With the postbellum migration of freed slaves into the city, the number of black men and women at the hospital increased as well, though the proportion of black civil patients consistently remained below the percentage of black men and women in the District.28 While Nichols and his medical staff sought to visit each ward on a daily

27 “[I]t is not probable that any generation of living men will witness the preponderance in our wards of the civil over the military cases,” wrote an official in 1865, “which marked the status ante bellum.” Annual Report 1865, 823.
28 In 1870, blacks made up approximately 33% of the District population. That same year black patients represented just 18% of the civil admissions to St. Elizabth's and 14% of the resident population. Ten years later they made up 34% of the District population, but constituted only 23% of civil admissions and 27% of the resident population. It is
basis, patients inevitably interacted far more frequently with attendants and supervisors on the wards. By this point, Nichols had become a leader in the profession, serving as president of the AMSAII from 1873 to 1879. This did not, however, shield him from the partisan environment of the nation’s capital. Nichols faced congressional scrutiny in 1869 over allegations of disloyalty to the Union and again in 1876 over charges of mismanagement and abuse. Though he erected new buildings in 1869 and 1871, the patient population continued to outstrip the institution’s capacity. Officials cleared Nichols of any wrong-doing in the 1876 investigation, but the proceedings nevertheless represented a major blow to the hospital’s reputation, and he resigned the following year.²⁹

The difficulties that Nichols encountered reflected a broader crisis of confidence facing asylum medicine during the latter decades of the nineteenth century. Institutional populations grew rapidly in these years, as families who might formerly have maintained a mildly disturbed member in the home began to see mental hospitals as a viable alternative. Municipal officials, meanwhile, found they were able to escape the financial burden of caring for elderly and disabled residents in the local almshouse by transferring them to state facilities. During the 1850s, AMSAII members had agreed that a superintendent could not administer a properly therapeutic institution if it had more than 250 beds. In 1866, asylum physicians raised this limit to six hundred beds, a number they reaffirmed ten years later.³⁰ The accumulation of large numbers of men and women who failed to improve over the course of weeks, months, and even

³⁰ The period between 1890 and 1940 saw no corresponding effort to control the size of institutions, with William A. White endorsing hospitals of up to 5,000 beds in 1927. Grob, Mental Institutions in America, 236.
years undermined the therapeutic optimism that lay at the heart of the original asylum movement. With the shift to custodial care, local politicians and the public at large began to question the benign character of these institutions, leaving asylum physicians to wonder about the extent of their medical role.

A resurgence of interest in the hereditary origins of insanity accompanied this decline. Evolutionary models of behavior and social development gained new currency in the latter decades of the nineteenth century. These theories seemed to suggest that society would always be burdened with a “degenerate” pauper class; this in turn explained the low recovery rates in state hospitals and justified a narrowly custodial approach. The perception that immigrants made up a disproportionately high percentage of asylum inmates lent further support to such a view. By the 1880s and 1890s, increasingly deterministic racial theories characterized the “new immigrants” from southern and eastern Europe as especially susceptible to mental illness and dependency—and thus an unnecessary burden on the social welfare system. Though physicians were rarely of a single mind on these topics, the prevailing climate of nativism made it all that much easier for elected officials to neglect the needs of state hospitals caring for the poor, widely identified with a racially inferior immigrant class.31

The greatest hope for progress in these years appeared to lie in the laboratory methods that had been revolutionizing medicine since midcentury. Developments in germ theory, cellular pathology and cerebral localization convinced many asylum physicians that the origin of mental illness lay in lesions of the brain. Asylum physicians spent far more time grappling with problems of institutional management than conducting scientific research in this period; when it

came to neuroanatomical and neuropathological investigation, members of the AMSAII arrived rather late in the game. Utica State Hospital superintendent John P. Gray appointed the first pathologist at a U.S. mental hospital in 1869, but by the 1890s many physicians still felt that American psychiatry lacked the scientific foundations expected of a medical specialty. Even when physicians did make a concerted attempt to support laboratory research, their efforts failed to produce therapeutically useful findings and became increasingly difficult to justify in an environment of economic uncertainty and fiscal constraint.  

The history of St. Elizabeths embodies nearly all of the major developments transforming institutional psychiatry in this period. When Nichols left the hospital in 1877, William Whitney Godding assumed the superintendency. Godding, who had previously served as assistant physician from 1863 to 1870, confronted the same pressures of institutional growth, fiscal limitations, and partisan politics that had hastened Nichols’ departure. Godding, however, proved more politically adept than his predecessor and more flexible in his vision of institutional care. By the time he became superintendent, overcrowding had reached crisis proportions. Godding convinced Congress to allocate funds for several new buildings, minimizing costs through simplified architecture and dormitory-style housing. By the mid-1880s he was publicly advocating a shift to the “cottage plan” for public mental hospitals. This controversial departure from Kirkbride’s original design involved smaller and more home-like buildings that officials

could erect individually as the patient population increased. Such an approach also facilitated officials’ efforts to group patients together according to mental, behavioral and social status.33

The cottage plan represented an implicit recognition that many of the men and women admitted to St. Elizabeths would spend their remaining days at the institution. The accumulation of permanently disabled patients was an inescapable reality of Godding’s administration; an 1882 law opening the institution to transfers from branches of the National Home for Disabled Volunteer Soldiers reinforced the trend.34 “[I]t is doubtful,” officials concluded in 1888, “if we ought to claim that more than one-fourth of those now taken insane will ever be permanently restored to reason under the most favorable surroundings.”35 Godding continued to speak of the hospital routine as a form of moral treatment, but late nineteenth-century asylum life differed in critical respects from the intensive and personalized regimen of an earlier era.36 As the historian Frank Millikan has observed, “[h]elping patients adjust to life at the hospital, not the life outside, had become an enduring feature of the asylum physician’s job.”37

Changing patterns of care dictated a shift away from the domestic metaphor that had guided an earlier generation of asylum physicians. Though Godding continued to fulfill a broadly paternalistic role, officials began to employ a language of kinship through community to describe the hospital and its facilities. “St. Elizabeths is not a house, but a village,” reported the Board of Visitors—“a village of the insane who are wards of the nation.”38 This represented a natural response to the increasing size and complexity of the institution. Godding oversaw the erection

33 This departed from the AMSAII’s official position that a superintendent could not adequately oversee all elements of patient life on a large, decentralized campus. Instead, as the population of a state increased, members recommended building more 250-bed Kirkbride-style facilities to serve smaller geographic catchment areas. Millikan, “Wards of the Nation,” 126.
34 Annual Report 1880, 464.
35 Annual Report 1888, 509.
36 Millikan, “Wards of the Nation,” 148-149.
37 Ibid., 165.
38 Annual Reports 1895, 755; 1898, 876.
of new buildings for laboring male patients, chronically disabled female patients, epileptic men and women, the criminal insane, and Civil War veterans. He also introduced infirmary-type medical care in two new buildings and established a farming colony several miles from the main campus. This growth brought with it increased demands on the hospital laundry, kitchens, dining service, and power supply. Soon patients and employees were linked in a form of collective interdependence similar to that found in any burgeoning rural community.

In this context, patient labor occupied an increasingly important position in the hospital’s therapeutic program. Regular employment had always been a central component of moral treatment, but officials traditionally insisted that work might not be appropriate for everyone. “[M]any of the insane who have the intelligence and will to engage in some industrial employment would, if put to work, be irrecoverably injured by it,” explained the Board of Visitors in 1876.39 As the hospital grew, however, their attitudes began to change. Soon Godding sought to create “[a] pervading spirit throughout the whole establishment that everybody who is physically able should do something[.]”40 Hospital officials preferred outdoor work for male patients, whether on the farm, in the gardens, or as part of the labor gangs around campus responsible for mending roads, excavating for new buildings, and digging in the vineyard.41 Men also labored in workshops devoted to tailoring, carpentry, shoe repair, and mattress repair; female patients continued to work in the kitchen, laundry and mending rooms.42 Despite Godding’s efforts, many patients resisted efforts to make them work. “Labor,” reported the Board of Visitors, “is still regarded as the ‘primal curse’ by the majority of our inmates[.]”43

40 Annual Report 1894, 564.
41 Annual Reports 1884, 440; 1885, 678; 1886, 741; 1889, 54.
42 On the hospital workshops, see Annual Reports 1884, 440; 1887, 1248. On the labor of female patients, see Annual Report 1886, 741.
43 Annual Report 1882, 966.
Occasionally patients received token wages for their work; more often, they received incentives such as ground parole, trips to the city, better clothing, and special lunches.44

As race relations in the nation’s capital approached a new nadir, the growing patient population at St. Elizabeths began to strain the hospital’s system of racial segregation. Ignoring calls for civic equality from the black community, District officials collaborated with white residents in the 1880s to lay the groundwork for a legal doctrine of “separate but equal”—a system that would ultimately marginalize and oppress black Americans for more than half a century.45 As we have seen, black patients lived separately from white patients from the hospital’s earliest days. In the decades that followed, however, inadequate facilities meant that black men and women sometimes resided “wherever in our crowded wards lodgings can be found. This is not pleasant to the white patients,” officials cautioned in 1886, “any more than it is to the colored.”46 In hard economic times, the influx of black men and women from rural Maryland and Virginia further taxed the institution’s capacities.47 As it did for other patients, the expansion of facilities for black men and women often meant dormitory-style living rather than single rooms. Officials justified this shift in terms of racial stereotypes, explaining that “[t]he African is gregarious in habits, and the social character of this arrangement suits him.”48

Godding’s recognition that mental hospitals served an important caretaking function did not prevent him from keeping up with developments in the field. Over the course of his tenure,

44 Millikan, “Wards of the Nation,” 146; Annual Reports 1886, 741; 1894, 564. Godding occasionally complained that military patients did not believe they should have to work and that those with pensions were able to afford such niceties without engaging in labor. Annual Report 1894, 564-565.
45 Green, Secret City, 119-154.
46 Annual Report 1886, 743. See also Annual Reports 1887, 1245; 1897, 695. A renewed commitment to racial segregation was part of a larger administrative effort at St. Elizabeths in the late nineteenth century to improve patient care by proper classification and separation of distinct groups. Officials thus used the term “segregation” to describe separate facilities for epileptic patients, disturbed patients, and elderly and infirm patients as well as for black men and women. The formalization of racial segregation throughout the country during this period, however, and the social inequalities that it reinforced, mark the separation of black and white patients at the hospital as more than a simple fact of asylum management.
47 Annual Report 1897, 695.
48 Annual Report 1887, 1245.
Godding sought to minimize physical restraint and increase the number of patients with ground privileges. During the 1880s, he pressed for increased pay for attendants, and in 1894 he established a training school for nurses as a low-cost method of raising staff levels. Occupation, recreation and a nourishing diet remained the pillars of the hospital’s therapeutic regimen, but Godding also sanctioned the use of drugs to restore physical health, reduce agitation, and promote sleep. Godding achieved a new level of national prominence in 1881 as a witness for the defense in the trial of presidential assassin Charles Guiteau, who had shot and killed James A. Garfield earlier that year. Evidence of structural lesions in Guiteau’s brain at autopsy convinced Godding of the need for basic scientific research; as a result, he appointed pathologist I. W. Blackburn to the hospital staff in 1884. As it did for Nichols before him, Godding’s high-profile position at St. Elizabeths facilitated his ascent within the profession, and he served as president of the AMSAI from 1889 to 1890.

Despite his best efforts, Godding proved incapable of resolving the perennial problem of overcrowding at St. Elizabeths. Under his administration the residential population rose from 765 to 1,938 patients. As a result, Godding oversaw the erection of eighteen new buildings for patient care. When he died unexpectedly in 1899, the population once again exceeded the institution’s maximum capacity—this time by almost four hundred patients. The rapid growth of the Army and Navy at the outbreak of the Spanish-American and Philippine-American Wars meant a dramatic increase in the number of soldiers and sailors eligible for federal care. The

49 Millikan, “Wards of the Nation,” 144.
50 Millikan, “Wards of the Nation,” 151-152; Annual Reports 1888, 512; 1895, 753.
52 On Godding’s involvement with the trial, see Rosenberg, Trial of the Assassin Guiteau, 134-135, 150, 227, 229.
54 Annual Reports 1877, 881; 1899, 297.
55 Millikan, “Wards of the Nation,” 139.
problem proved particularly serious on wards for the most agitated and disruptive patients.\(^{56}\) Overcrowding meant little privacy and frequent altercations—both among patients and between patients and ward attendants. As the nineteenth century drew to a close, St. Elizabeths’ prospects as a “model institution” seemed less than certain. If any consolation was to be found, it lay in the fact that few state hospitals elsewhere fared any better.

**WILLIAM A. WHITE AND THE MAKING OF THE MODERN AMERICAN CITIZEN**

When William Alanson White arrived in Washington in 1903, he inherited a daunting array of clinical and administrative challenges (Figure 1.2). White came to the District from New York, where he had served as an assistant physician at the Binghamton State Hospital. Following Godding’s death, federal officials appointed Alonzo B. Richardson as superintendent at St. Elizabeths. Richardson garnered the funds for a major expansion of the hospital campus, but he, too, died unexpectedly in 1903. White picked up where Richardson had left off, relying on his own judgment in the many instances where the former superintendent left no explicit record of his plans.\(^{57}\) At the end of White’s first year, St. Elizabeths maintained 2,492 patients on its rolls. Of this number, fully 1,092 were servicemen or veterans; most of these men (1053) were white, though a few (39) were black. Among the remaining 1,400 civil patients, 55.4% were male and 44.6% were female; 68.5% of civil patients were white and 31.5% were black (Figure 1.3).\(^{58}\) The growth of the hospital campus dominated much of White’s agenda in his earliest years as superintendent, with a principle of separation among patients by race, gender, and diagnostic

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\(^{56}\) *Annual Report* 1900, 327.


\(^{58}\) Data derived from *Annual Report* 1904.
Figure 1.2. William Alanson White (1870-1937).

Source: Centennial Commission of St. Elizabeths Hospital, ed.,
Centennial Papers: St. Elizabeths Hospital, 1855-1955 (Baltimore,
Figure 1.3: Patient Population by Race, Gender, and Administrative Category (1904).

Source: Annual Report, 1904.
category guiding the process. By 1905, the buildings were largely complete, including an elaborate new administrative center as well as admission and acute care facilities for white male and female patients.59

Both the District of Columbia and American society stood on the verge of profound transformations at the beginning of the twentieth century. As a relatively small city of some 279,000 residents, Washington, D.C. remained a marginal player in the country’s increasingly integrated commercial and industrial networks. With the arrival of large-scale corporations as a central fact of public life, however, and with the ever-present threat of labor unrest looming in the background, Americans began to look toward government agencies and the federal courts rather than state or local officials as guarantors of social stability. Concerned citizens also became involved in a congeries of what historian Daniel T. Rodgers has described as “shifting, ideologically-fluid, issue-focused coalitions, all competing for the reshaping of American society.”60 The aspirations of these groups—running the gamut from women’s suffrage and protective labor legislation at one end of a complex political spectrum to immigration restriction and social purity campaigns at the other—reflected a steady growth of national consciousness, a trend that paralleled the erosion of local and informal associations as the central frame of American life. The outpouring of patriotism around the Spanish-American and Philippine-American Wars renewed the capital’s symbolic importance on the national landscape. The experience of World War I reinforced this importance; the war simultaneously brought an influx of new workers into the city and projected the United States onto the world stage.

As the range of political movements that sprang up in this period attests, men and women in the Progressive Era vigorously debated what it meant to be a proper American citizen. Women

59 Annual Report 1905, 760, 768.
of all backgrounds began to demand a new degree of social emancipation and political inclusion.

Whether they framed their arguments in terms of women’s fundamental equality to men or the unique differences that set them apart, these women were not content to limit themselves to the domestic sphere as it had traditionally been defined.61 When it came to race relations, political leaders in Washington failed to challenge the legal edifice of segregation or the informal regime of intimidation and violence under which most Southern blacks lived. Yet important new models of self-assertion emerged from the black community in this period, particularly in the writings of W. E. B. DuBois and the legal activism of the National Association for the Advancement of Colored People (NAACP).62 In the nation’s burgeoning cities, the influx of immigrants from southern and eastern Europe sparked Americanization campaigns aimed as much at neutralizing labor radicalism as they were at acculturating the recent arrivals.63 For residents of the District of Columbia—including the physicians at St. Elizabeths—the absence of a well-developed industrial sector reliant upon immigrant labor meant that debates over gender and race took priority over those centering on ethnicity and social class. As we shall see, this environment

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proved central to the development of modern American psychiatry as it took shape at St. Elizabeths.

Psychiatry as we currently know it emerged largely from a series of changes that took place in the first two decades of the twentieth century. Frustrated by what they saw as a lack of opportunity in the provincial asylum, professional leaders such as Adolf Meyer and William A. White began to formulate a model of human behavior in which shared values could be interpreted through the lens of mental health and mental illness. Psychiatrists represented one element in the rise of a broad system of professionals—physicians, lawyers, social scientists, social workers, educators, and engineers—who based their claim to authority on an ability to impart order and stability to a rapidly-changing world. Though they never fully eschewed biological factors, physicians with an interest in mental illness looked increasingly toward the personal histories of their patients and the role that life circumstances played in their difficulties. New facilities emerged within which these physicians could practice, including outpatient clinics, psychiatric wards in general hospitals, and psychopathic hospitals. The latter in particular engendered considerable professional enthusiasm, providing evaluation and short-term care to patients of all sorts—including many whose symptoms did not justify admission to a traditional state hospital. Psychiatrists also began laying the groundwork for alliances with such

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social institutions as the schools, the courts, and the military.67 The early decades of the
twentieth century thus witnessed a substantial expansion of medicine’s jurisdiction over
Americans’ inner lives, as the term “psychiatrist”—as opposed to asylum physician or alienist—
first came into common usage in this period. 68

Under White’s leadership, St. Elizabeths remained at the forefront of these developments.
Shortly after his arrival, White established links with the local medical community; soon he and
his staff began offering both didactic and practical instruction to students at the city’s medical
schools. Limited facilities at the Washington Asylum Hospital meant that the admissions service
at St. Elizabeths served as a de facto psychopathic pavilion for the District. In this context, White
appointed physician Edward Kempf to a position involving primarily psychotherapeutic duties—
an administrative decision almost without precedent among hospitals of St. Elizabeths’ size.69
White expanded the institution’s social service division, and for several years the hospital
maintained an outpatient department and off-site mental hygiene clinic.70 White also cultivated a
spirit of scientific inquiry at St. Elizabeths that set it apart from most of its peers. He introduced a
psychological laboratory, devoted substantial resources to research in pathology and
neurophysiology, and encouraged his staff to experiment with new treatments. Over the course
of psychologist S. I. Franz’s tenure at the hospital, he supervised projects by such future
luminaries as Grace Kent, Edwin Boring, and Karl Lashley, and the pathological laboratory
continued to produce reliable and well-regarded work.71 By ensuring that the hospital’s various

68 Sicherman, “New Psychiatry,” 22; Pressman, Last Resort, 18-21. See also Lunbeck, Psychiatric Persuasion;
70 “Our Outpatient Department,” Sun Dial 2, no. 3 (Jan 1924): 11-13.
Kanhouwa and Gorelick, “Century of Pathology.”
administrative units pursued independent yet overlapping objectives, White maintained the vitality of St. Elizabeths at a time when most large-scale psychiatric institutions were in decline.

White also introduced innovations that helped St. Elizabeths fulfill its traditional mission. He proved to be a skilled administrator, rearranging lines of authority and communication to improve organizational efficiency. White also developed a highly-structured format for patient histories and standardized clinical records along the lines suggested by the National Committee for Mental Hygiene (NCMH), of which he was a member. White introduced regular case conferences where the staff gathered to discuss diagnoses for new admissions as well as privileges or discharge for long-term patients. He revitalized the institution’s school of psychiatric nursing, pressing the ward staff to undergo formal training if they wished to advance their careers.72 St. Elizabeths became one of the only psychiatric hospitals in the country to maintain a fully-functioning medical hospital on its grounds, and in 1924 the institution received accreditation from the American Medical Association and the American College of Surgeons for the training of medical interns.73 White’s leadership attracted an ambitious and highly capable medical staff, including many who would go on to shape the development of the profession (Figure 1.4). These included, at various times, such notable figures as Harry Stack Sullivan, Arthur P. Noyes, Walter Freeman, William Menninger, and Nolan D. C. Lewis.74

The combination of White’s hard work and his position as superintendent of a leading federal psychiatric institution allowed him to rise rapidly in the ranks of the profession. He

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72 Details on White’s early career at St. Elizabeths can be found in White, *Forty Years*, 28-65; White, *Autobiography*, 80-152. See also Arcangelo R. T. D’Amore, ed., *William Alanson White: The Washington Years, 1903-1937* (Washington, D.C.: U.S. Department of Health, Education and Welfare, 1976). Innovations typically appear in the Annual Reports that the hospital administration submitted to federal officials at the end of each fiscal year. Because these reports cover six months from each of two calendar years, it is often difficult to date specific developments with precision.


74 These developments and appointments can be followed in St. Elizabeths’ Annual Reports. See also White, *Forty Years*; White, *Autobiography*. 
Figure 1.4: St. Elizabeths Hospital Medical Staff (~1919/20). Seated (left to right): Samuel A. Silk, John E. Lind, Daniel C. Main, Arthur P. Noyes, William A. White, Sheppard Ivory Franz, Mary O’Malley, Watson W. Eldridge, Samuel Bogdanoff. Standing (left to right): D. J. Murphy, Phillip Trentsch, Harold Palmer, Albert Smith, Roscoe W. Hall, Mildred Sheetz, Lois Hubbard, J. P. Fuller, Lucille Dooley, Benjamin Karpman, Forrest Harrison, Vernon Branham (?), Herman P. Hyder, Theodore C. C. Fong, Gertrude Davies.

Source: NARA RG 418: Entry 72 (General Photographic File: Series P, Box 5).
became an early and enthusiastic proponent of European psychoanalysis. Together with his lifelong friend and colleague Smith Ely Jelliffe, White published an English translation of one of the first explicitly psychotherapeutic texts—the Swiss neurologist Paul Dubois’ *Psychic Treatment of Nervous Disorders* (1905). The development of White’s thinking is visible in his *Outlines of Psychiatry*, an influential textbook that first appeared in 1907 and ran through fourteen subsequent editions. In 1913, he and Jelliffe launched the *Psychoanalytic Review*, which rapidly became a standard journal in the field. White wrote extensively for both professional and popular audiences, achieving even greater public recognition through his testimony in the highly-sensationalized 1924 Chicago murder trial of Nathan Leopold and Richard Loeb. That year he served as president of the APA; four years later he served as president of the American Psychoanalytic Association. By the 1930s, White was widely regarded as one of the most influential physicians of his generation.

This is not to say that St. Elizabeths did not undergo strains during White’s administration. As the hospital grew, it became increasingly difficult for physicians to remain familiar with all of their patients. In 1917, White launched an institutional newspaper, the *Sun Dial*, to foster better communication, but men and women at the hospital still complained that their physicians knew little about their lives on the wards. The institution faced congressional

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78 For some indication of the breadth of White’s work, see the extensive bibliography reproduced in his *Autobiography*, 277-293.
79 William A. White, “The Problem of the Individual Patient in Large Hospitals,” *American Journal of Psychiatry* 74 (1918): 405-407; “Contributions from our Patients: Suggestions,” *Sun Dial* 1, no. 3 (June 1917): 5-6. Unlike other institutional newspaper, the *Sun Dial* remained primarily a staff publication, oriented along lines which White and his colleagues felt would be therapeutic to the patients. The publication appeared intermittently for thirteen years after its inception; a complete set is available at St. Elizabeths Hospital’s Health Sciences Library in
scrutiny in 1906, 1919, and 1926 on charges of abuse, neglect, and mismanagement, but each
time White emerged unscathed, managing even to secure increased funds for the hospital. The
First World War and the ensuing influx of servicemen and veterans further strained the
institution’s capacities, with overcrowding remaining a problem on many of the wards. Disease,
too, took its toll, particularly tuberculosis, malaria, and the deadly influenza epidemic of 1918-
19. Nevertheless, compared to other large-scale psychiatric facilities during the period, St.
Elizabeths’ reputation as one of the best mental hospitals in the country was not undeserved.80

The full scope of White’s vision for psychiatry is evident in a series of popular and
professional works he completed between 1910 and 1930. White developed a social evolutionary
theory of mental health and illness that he hoped would provide a new basis for the field.
Drawing from the nineteenth-century British sociologist Herbert Spencer as well as the French
philosopher Henri Bergson, White argued that all human behavior could be understood as the
product of successively higher levels of integration achieved in response to stimuli from the
environment. “Adaptation” provided the central metaphor for this framework. Just as the fitness
of individual members of a species could be evaluated according to their adaptability to a
changing physical environment, the mental health of individual citizens could be assessed in
terms of their capacity to meet the challenges of a shifting social environment. This process of

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80 In addition to the hospital’s Annual Reports, see House Special Committee on Investigation of the Government Hospital for the Insane, Report of the Special Committee on Investigation of the Government Hospital for the Insane, 2 vols., 59th Cong., 2nd sess., 18 Feb 1907, H. Rep. 7644; House Committee on the Judiciary, Investigation of St. Elizabeths Hospital, report prepared by the Comptroller General of the United States, 69th Cong., 2nd sess., 16 Dec 1926, H. Doc. 605.
adaptation, White maintained, occurred through a pattern of psychological reactions whose viability could be expressed in terms of mental efficiency. Against this backdrop, socially unacceptable behavior—the hallmark of criminality, mental illness or feeblemindedness—resulted from an individual’s inability to make an adequate psychological adjustment. Institutionalized populations represented “social failures,” men and women incapable of dealing with the complexities of life outside a highly-structured milieu. The mentally healthy subject, in contrast, was a model citizen—autonomous, self-directed, and morally-upright.81

White’s reliance on a familiar model of social evolution allowed him to incorporate some of the radical insights of European psychoanalysis in a manner that made them more palatable to his American audience. The language of evolution first emerged among social theorists in the United States during the Gilded Age; by White’s time, educated Americans were already familiar with naturalistic explanations of human behavior. The concept of social evolution had become increasingly anachronistic in intellectual circles, but White continued to employ it as a framework within which to situate the findings of Freud, Adler, and Jung. Like many of his American colleagues, White generalized and desexualized the libido, transforming it into a vaguely-defined biological life-force that could be redirected toward positive social pursuits. Psychological reactions, he argued, inevitably reflect a tension between self-preservation and the desire to contribute to the greater good. Impulses based solely on self-preservation tend to be

short-sighted and unimaginative; authentic personal achievement, in contrast, occurs through the promotion of laudable social ideals. White effectively redefined sublimation in terms of the socialization of instinct, making it a precondition for both good citizenship and social progress. His recognition of interdependence represented a departure from the individualism of classical nineteenth-century Social Darwinism. Nevertheless, White’s vision of progress left little room for radical social transformation. He spoke regularly of the individual’s duty to conform to social expectations, and a 1918 reviewer went so far as to characterize him as “one of the most conservative of the American students of Freud.”

The overtly racialist elements of White’s framework further facilitated its acceptance among educated white Americans. Psychologists such as James Mark Baldwin and G. Stanley Hall had long argued that the process of childhood learning and development recapitulated the natural history of the human mind; thus the psychology of the child resembled the concrete and animistic thinking of “primitive” groups. While Hall occasionally broached the topic of psychopathology, White made it his central target. He argued that the psychic mechanisms involved in mental illness represented a reversion to immature, primitive patterns of thinking in the face of challenges from the social environment. White’s understanding of the unconscious as

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a locus of instinct and intuition owed as much to Jung’s developing notion of the racial unconscious as it did to Freud. This approach rested on a widely-shared view of cultural development in which the progress of civilization depended on the mastery of elementary impulses and the proper channeling of creative energies. Though anthropologist Franz Boas and his students were beginning to call biologically-determined notions of race and culture into question in this period, White looked instead to such figures as James George Frazer, author of *The Golden Bough*. It is not unreasonable to assume that White’s position resonated with the intuitions of native-born white Americans, many of whom viewed those of non Anglo-Saxon descent as incapable and undeserving of full membership in the national community.

Most Americans learned of White’s theories through his involvement in the mental hygiene movement. Originally conceived by patient-activist Clifford Beers as a means of improving conditions in the nation’s state hospitals, the movement ultimately evolved into a network of physicians and lay reformers dedicated to promoting a broadly psychiatric vision of social life. In the fall of 1912, the National Committee on Mental Hygiene (NCMH) launched a

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86 My account of the mental hygiene movement is derived primarily from Johannes Coenraad Pols, “Managing the Mind: The Culture of American Mental Hygiene, 1910-1950” (Ph.D. dissertation, University of Pennsylvania,
traveling exhibition modeled after contemporary public health campaigns. At each stop, physicians and local advocates arranged newspaper coverage and organized an accompanying series of public lectures and conferences. In this manner, many Americans encountered the new language of habit formation, mental efficiency, and social adjustment for the first time. White participated enthusiastically in the movement. He and his colleagues called public attention to the psychological dimensions of human conduct, as well as their relevance to such topical issues as delinquency, prostitution, and eugenics. White’s work appeared regularly in the movement’s eponymous journal, and when the First International Congress on Mental Hygiene met in Washington, D.C. in 1930 he served as president of the assembly.87

In his *Principles of Mental Hygiene* (1917), White recommended an expansive social role for the mental health professions. White conceptualized psychology as an adjunct to the art of right living, encouraging his readers to interpret their experience in these terms.88 For the individual, mental hygiene could help one to obtain “the maximum good from life;” at the social level, White explained, “it is the task of mental hygiene to find less wasteful, more efficient means for dealing with the problems that arise … and, when found, to urge such measures unceasingly upon those who make and administer our laws and direct the trends of public thought.”89 Nearly everything, it seemed, could be framed as a problem of mental hygiene—and therefore as lying within the jurisdiction of psychiatry. White also placed a distinctively American emphasis on self-reliance and industriousness as essential to personal and social well-

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88 White, *Principles of Mental Hygiene*, 9-10, 97-98.

89 Ibid., 32.
being. “A good citizen,” he wrote, quoting the maxim by educator David Starr Jordan, “is one who can take care of himself and has something left over for the common welfare.”

Though his recommendations included much of what appeared to be common sense, White’s faith in scientific and social progress also required a measure of deference to expert knowledge as an element of good citizenship. More than anyone else, White believed, psychiatrists had the ability to ensure a generation of mentally fit and socially-productive citizens.

Though White often wrote as if he were speaking about all Americans, he and his medical staff inevitably portrayed the ideal citizen in terms of a masculine, voluntaristic engagement with the world. This proved true for the many female physicians at the hospital as well as the men; institutional psychiatry remained remarkable for the number of women among its ranks, largely because of its traditionally low status and the opportunity to work exclusively with female patients on sex-segregated wards. For male and female physicians alike at St. Elizabeths, mental health involved facing life squarely and not shirking one’s responsibilities. “The successful accomplishment of a hard task brings reward in a feeling of self-reliance,” White explained, “that makes not only for happiness but is a character builder in itself.”

Reflecting on the immense variability found among human personalities, St. Elizabeths physician John P. H. Murphy praised “the wise, good man” who “utilizes the means at his disposal for the benefit of himself and others[.]” White went so far as to identify the advance of Western civilization with its spirit of exuberant extroversion; psychologist Winifred Richmond

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90 Ibid., 164. At times, the physicians on White’s staff were even more explicit about the connection between an ability to support oneself and the entitlement to “freedom and liberty.” Alfred Glascock, “The Value of Occupation,” Sun Dial 1, no. 1 (March 1917): 6-7; Samuel A. Silk, “Helpful Hints Leading to the Road of Recovery,” Sun Dial 1, no. 4 (Aug 1917): 5.
similarly observed that the extroverted rather than the introverted personality “receives social approval, especially in this country. … Our ideal is the ‘man of action[.]’” St. Elizabeths officials thus echoed the popular prescriptive literature of such figures as Orison Swett Marden, whose gospel of “hard work, dedication, and relentless sublimation” allowed men with little chance of overt social achievement to feel like a successes through the cultivation of manly character. In an overwhelmingly masculinist cultural environment, White’s tendency to frame psychological well-being in terms of male achievement effectively broadened the concept’s appeal. For male patients who had broken down under the strain of life, however, White’s description of mental illness as “social inadequacy”—originally meant to reduce the stigma associated with the term insanity—must have represented a challenge not only to their identities as American citizens but also to their identities as men.

The consequences of this viewpoint for women proved complex and contradictory. For White and many of his colleagues, psychoanalysis helped to legitimate female sexual desire. Radical activists like Emma Goldman saw psychoanalysis as a valuable tool in the emancipation of women, and the clinical staff at St. Elizabeths showed little patience for the willful ignorance and sexual double standard they associated with the Victorian era. They accepted the model of companionate marriage that educated women had long promoted, emphasizing egalitarian relations between husbands and wives as an alternative to an earlier, explicitly hierarchical arrangement. The hospital’s physicians and psychologists were far from sexual revolutionaries,

however, and most continued to assume that the natural culmination of women’s desire lay in a monogamous relationship with her husband. Psychologist Winifred Richmond described one young woman who “had no real wish to marry.” “[S]he was lazy, pleasure-loving, and possessed of poor powers of inhibition—‘weak-willed,’” Richmond wrote with evident disdain. “She was fickle by nature and had never cared for any of her lovers with an unselfish devotion.”

Physicians thus viewed women’s contributions as citizens overwhelmingly in terms of their roles as wives and mothers. Following Freud, White suggested that “all human motives may be reduced to two great instincts—the instinct of self-preservation and the instinct of race-preservation.” For men, the “instinct of race-preservation” covered any form of personal achievement that contributed, however marginally, to the greater good; typically this involved paid labor or some other mode of engagement in civic life. For women, however, race-preservation entailed the far more concrete responsibilities of childbearing and childrearing. In an otherwise sympathetic essay on “Why Women Fail,” former St. Elizabeths psychiatrist Anita Mühl declared that “[employment] is, for the majority of them, only a substitute activity for the great job for which nature molded them.” Physicians at St. Elizabeths were not alone in casting women in these terms. Indeed, the dominant wing of the women’s movement in the early decades of the twentieth century adopted a similar ideological stance, employing the rhetoric of maternalism to garner an expanded role in politics and public life. Nevertheless, the clinical staff at St. Elizabeths continued to find evidence of psychological maladjustment in women’s failure to embrace the expectations of motherhood.

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102 See e.g. Richmond, *The Adolescent Girl*, 68.
Against this backdrop, the prospect that women might withdraw from heterosexual relations altogether became a source of considerable anxiety. Again following Freud, most of the physicians and psychologists at St. Elizabeths regarded adult homosexuality as a symptom of arrested psychological development. “For some reason [the homosexual woman] has failed to pass through the homosexual stage,” wrote Richmond, “and to develop the interests and make the adjustments essential to normal adult life; no matter how brilliant or talented she may be or what her emotional accomplishments, her emotional life is childish and insecure.”

Psychoanalytic theory rendered same-sex desire similarly problematic among men, but for males the possibility remained of leading a bachelor’s life and still contributing to the greater good. Since the prospect of childbearing dominated women’s civic identities, however, female homosexuality carried far graver consequences. As historian Nancy Cott has observed, the affectively-expressive friendships common among middle-class women in the nineteenth century might now be read as indicators of serious psychological disequilibrium. In principle, White and his colleagues viewed women as full and equal citizens, free to pursue ambitions outside the home. In practice, however, this shift in attitudes toward female homosocial relationships cast “the woman who failed to mate heterosexually as a social danger … [and] constituted an emphatic backlash against the idea and practice of independent women.”

If the physicians at St. Elizabeths remained caught in a transitional period in American gender ideology, their embrace of inegalitarian racial attitudes proved far less equivocal. White indicated his sympathies for poor Southern blacks, but he nevertheless failed to distinguish

103 Ibid., 127.
104 Cott, *Grounding of Modern Feminism*, 158-162.
105 White, *Principles of Mental Hygiene*, 231-239.
106 Cott, *Grounding of Modern Feminism*, 160.
between innate capacities and the limitations imposed by poverty and lack of education.\footnote{For White’s thoughts on the situation of Southern blacks, see his correspondence with Effie Knowles in NARA RG 418: Entry 7 (WAW Personal Correspondence: 1928-1929 K-M).}

As asked during the 1906 investigation about the propriety of different kinds of labor for patients at St. Elizabeths, he responded that “for … the negroes … [physical labor] is the natural form of work to engage in. That is what they can do; what they are accustomed to do, and practically all they can do.”\footnote{House Special Committee, Report, 876.} Later, when asked about the high per capita cost of care for his patients compared to a Virginia institution for poor blacks, White responded that “it is absolutely absurd and ridiculous to compare an institution for the care of pauper negroes with an institution like the Government Hospital for the Insane.”\footnote{Ibid., 887.}

For White, as for his predecessors, the care and treatment of black men and women remained a distinctly secondary component of the hospital’s mission. If White shared the prejudices of his day, however, he does not appear to have ever explicitly theorized the racial inferiority of black Americans. Given the opportunity, he emphasized the qualities common to all men and women, priding himself on recognizing ability wherever he found it. White spoke at the predominantly-black Howard University’s School of Medicine in 1910, and black students from Howard regularly attended his lectures at St. Elizabeths.\footnote{Annual Report 1911, 460.}

Only after officials from George Washington University expressed their opposition to integrated sessions did White introduce separate instruction, assigning a well-regarded young member of his staff to cover the lectures for black students.\footnote{On White’s instruction of black students and the objections of George Washington University officials, see the correspondence collected in Gerald N. Grob, The Inner World of American Psychiatry, 1890-1940: Selected Correspondence (New Brunswick, New Jersey: Rutgers University Press, 1985), 270-273.}

White’s medical staff embraced a far more racially-stratified vision of American society. Though black men and women represented a relatively small percentage of their patients (Figure 1.5), physicians at St. Elizabeths devoted a substantial amount of time and energy to the question

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\footnote{For White’s thoughts on the situation of Southern blacks, see his correspondence with Effie Knowles in NARA RG 418: Entry 7 (WAW Personal Correspondence: 1928-1929 K-M).}

\footnote{House Special Committee, Report, 876.}

\footnote{Ibid., 887.}

\footnote{Annual Report 1911, 460.}

\footnote{On White’s instruction of black students and the objections of George Washington University officials, see the correspondence collected in Gerald N. Grob, The Inner World of American Psychiatry, 1890-1940: Selected Correspondence (New Brunswick, New Jersey: Rutgers University Press, 1985), 270-273.}
of black mental illness. Indeed, the institution rapidly became a center for research in what became known as “comparative psychiatry.” Some physicians worked explicitly within White’s social evolutionary framework, which accommodated their racist assumptions without difficulty; their publications frequently appeared in White and Jelliffe’s *Psychoanalytic Review*. An independent tradition of racialist psychiatric theory also existed upon which these psychiatrists could draw, however, and it would be a mistake to credit all of their work to White’s influence. 

Ever since the end of the Civil War, observers had debated the cause and consequences of a perceived increase in black mental illness; most agreed that freedom from bondage was a major source of the problem.  

The question of their influences notwithstanding, many of the physicians at St. Elizabeth framed the issue in terms that easily could have come from White himself. “[The negro] must now think for himself, and exercise forethought if he and his family are to live at all,” wrote psychiatrist Arrah B. Evarts, “two things which had so far not been demanded, and for which there was no racial preparation. … We are beginning to think of insanity as a failure on the part of the individual to adjust to the demands of his environment. With this in mind, we can understand why insanity should be on the increase in the colored race, for of it is being demanded an adjustment much harder to make … than any other race has yet been called upon to attempt.”

Psychiatrists produced a portrait of black Americans as subjects incapable of self-government and therefore unfit for full citizenship. Blacks were credulous and amoral, lacking

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113 Arrah B Evarts, “Dementia Precox in the Colored Race,” *Psychoanalytic Review* 1 (1914): 388-403. See also Gambino, “‘These Strangers Within Our Gates’.”
Figures 1.5 and 1.6: Patient Population by Race and Gender (1900-1940). These numbers reflect all patients on the hospital rolls, including those on visit or elopement. In addition to African Americans, the non-white category includes small numbers of American Indian, Central and South American, Caribbean and Asian patients.

Source: Annual Reports, 1900-1940.
the capacity for sustained and reflective deliberation. “Previous experience has little influence in
governing their daily conduct,” wrote St. Elizabeths physician Mary O’Malley. “[T]hey dwell in
the present and neither the past nor the future is taken into account.” Psychiatrists had
difficulty making an accurate diagnosis in patients whose premorbid state they already viewed as
pathological. Commenting on the high rates of dementia precox (a conceptual forerunner of
schizophrenia) among black admissions, physician W. M. Bevis explained that “this is not
surprising when their racial character make-up and the atmosphere of superstition in which they
move are considered. Much of their usual behavior seems only a step from the simpler types of
this classification.” O’Malley similarly saw no reason for surprise at the high proportion of
mental deficiency among black patients, since “the individuals of this race are intellectually
much nearer the level of the feebleminded” than most whites. Psychiatrist John Lind went so
far as to develop a specialized version of White’s standardized examination for black patients,
designed to take their psychological inferiority into account.

Racial stereotypes shaped psychiatric views on the nature of mental illness among black
Americans. In dementia precox, physicians argued that blacks’ inferiority entailed a distinctive
presentation of the disease. “During its years of savagery, the race had learned no lessons in
emotional control, and what they attained during their few generations of slavery left them
unstable,” explained Evarts. “For this reason we find deterioration in the emotional sphere most

114 Mary O’Malley, “Psychoses in the Colored Race: A Study in Comparative Psychiatry,” American Journal of
115 W. M. Bevis, “Psychological Traits of the Southern Negro, with Observations as to Some of His Psychoses,”
American Journal of Psychiatry 78 (1921): 74. See also O’Malley, “Psychoses in the Colored Race,” 323.
205-218.
often an early and a persistent manifestation.” Doctors’ views on the inherent depravity of blacks led them to dismiss the importance of psychosexual conflicts in their black patients. Even men and women’s failure to exhibit such extreme behaviors on the wards as public masturbation and smearing of feces became evidence of their inferiority. “As this race exists in Africa, its sexual instincts are peculiarly unrestrained,” wrote Evarts, “and although they have learned much moderation, these desires are usually fully satisfied with no feeling of having done wrong. This will account for the fact that the ordinary sexual perversions are seen among precox patients of the colored race much less frequently than among those of the white race.” When they did attend to the inner psychic mechanisms of their black patients, physicians tended to focus on the perceived psychology of race relations. Lind argued that nearly all blacks felt dissatisfied with the color of their skin; their blackness, after all, was the primary marker which set them apart. This “color complex” dominated the thinking of psychologically impaired black men and women, where it “very often moulds largely the topography of the delusionary field.” Lind suggested that race-denial represented a delusional identification with the socially-favored race; O’Malley interpreted such beliefs as wish-fulfillment in a severely disabled psyche.

Psychiatrists at St. Elizabeths equivocated on the relative contributions of individual life-history and the cumulative weight of the racial past. Primitive groups represented arrested stages of racial development for White and his staff, so physicians combed ethnological accounts for insight into both the psychology of the black men and women they were treating and the structure of the historical racial unconscious. O’Malley suggested that the ancestors of American blacks were inferior to other African societies; when Europeans first took them into slavery, she

118 Evarts, “Dementia Precox,” 396.
119 Ibid., 397.
explained, they were “naked dwellers on the west coast of Africa, where they had been driven by the superior negro tribes who occupied the eastern coast as well as the interior.”  

Lind linked the cosmology of West African tribes to the symptoms he observed in black men and women. Such shared patterns as beliefs in sorcery and witchcraft, hearing the voices of deceased relatives, and experiencing visions of animals provided evidence, according to Lind, of “the savage heart beneath the civilized exterior.”

Since black patients were “only one degree removed from extremely primitive levels,” the presence of identical symptoms in white patients signified a much deeper level of psychological regression. Evarts departed from her colleagues’ emphasis on the historical racial unconscious, calling attention instead to the many folk beliefs that governed the daily lives of poor blacks. With the help of a lucid prisoner patient, Evarts documented a series of widespread practices which she felt might easily have been misattributed to past historical epochs.

Racist stereotypes formed the backdrop against which the clinical staff at St. Elizabeths formulated their image of the ideal citizen. Where the ideal citizen was sober and reflective, blacks were juvenile and impetuous; where the ideal citizen was rational and strong-willed, blacks were superstitious and easily-swayed; and where the ideal citizen was self-directed and morally autonomous, blacks were inherently passive and dependent. All of these traits became even more exaggerated in black mental illness. Physicians viewed blacks as atavistic and socially inadequate; their “primitive” psychological development proved interesting primarily as a reminder of just how far the human race had progressed under the banner of American civilization. Even in the best of circumstances, they maintained, black Americans resembled


\[124\] Ibid., 330.

children or savages rather than the sort of mature citizens needed to carry the nation forward.\(^{126}\)

The lesson seemed inescapable: even in mental health, black Americans were a far cry from the sort of responsible and morally upright citizenry which psychiatry sought to produce. Black men and women represented, in the words of Arrah Evarts, “strangers within our gates.”\(^{127}\)

CONCLUSION

By the time White assumed the presidency of the American Psychiatric Association in 1924, both St. Elizabeths Hospital and the U.S. psychiatric profession looked very different from when he arrived as superintendent more than two decades earlier. White’s peers once again regarded the institution as among the most progressive and well-managed facilities in the country. While the influx of soldiers and veterans around World War I placed severe strains on its administrative capacity, large numbers of transfers to Veterans Administration facilities in the mid-1920s marked a return to normalcy on most of the hospital’s wards. Experience with “shell-shocked” veterans stimulated interest in psychologically-based approaches to treatment across the nation, and the enthusiasm for psychoanalysis in the ensuing years legitimated White’s early embrace of Freudian concepts. Though White again came under Congressional scrutiny in 1926 on accusations of mismanagement, the subsequent report cleared him of any wrong-doing. The hospital routinely hosted eminent European physicians during their visits to the United States and continued to attract accomplished clinicians and researchers from around the country.

White’s vision of mental health and illness provided a new language of self-understanding for educated Americans at a time of rapid social and cultural change. The vocabulary of mental efficiency and social adjustment represented a novel frame through which

men and women could interpret both interpersonal relations and their inner psychic lives. Though his framework remained distinctly secular, White continued to emphasize personal responsibility and civic duty, refashioning them in terms of psychological well-being rather than moral obligation. In theory, White and his colleagues identified mental health with a genderless form of self-reliance, tempered by consciousness of the general welfare. In practice, however, the physicians at St. Elizabeths privileged masculine achievement and identified women primarily with their obligations as wives and mothers. These views placed White well within the mainstream of Progressive Era thought. White’s social evolutionary framework also supported a racialized worldview in which black men and women represented the antithesis of the proper American citizen. By allowing educated white Americans to rationalize the social inequality and political oppression under which black men and women labored, White’s framework provided them with a new way of thinking about themselves without fundamentally challenging the privileges they enjoyed.

Perhaps the most important innovation by White and his colleagues lay in their assertion that mental health and mental illness existed along a continuum, with minor problems of living at one end of a spectrum that extended to include severe and incapacitating states at the other. By positing shared underlying mechanisms as causes of these conditions, physicians imparted a new gravity to prosaic complaints such as marital strain, occupational difficulties, and the challenges associated with child-rearing. Problems like these, they suggested, could signify deep, unaddressed conflicts—conflicts that might ultimately be the undoing of less fortunate men and women. Physicians also drew upon a long tradition of self-improvement and a belief in the perfectibility of man, arguing that psychiatry could simultaneously help individual Americans achieve the most from life and address pressing social problems. Yet White and his colleagues
spent most of their days working in hospitals filled with severely disabled men and women, many of whom would require institutional care for the rest of their lives. The psychotic conditions and organic brain disorders from which most patients at St. Elizabeths suffered made them poor candidates for individual psychotherapy; the highly intensive nature of psychoanalytic treatment, moreover, made it impractical for use in large-scale public institutions. In the following chapter, I will examine the circumstances that brought individual patients to St. Elizabeths and the therapeutic program that took shape there. Its expansive aspirations notwithstanding, White’s program for American psychiatry faced serious challenges.
CHAPTER TWO. MENTAL HEALTH, MENTAL ILLNESS, AND THE MEANING OF CITIZENSHIP, 1900-1930

INTRODUCTION

A wide variety of circumstances brought men and women to St. Elizabeths. In its early stages, mental disorder produced confusion and uncertainty. Patients and their families struggled to make sense of interactions that were as incomprehensible as they were unexpected. Hospitalization generally became an option only when aberrations of thought and behavior became so severe that they interfered with an individual’s obligations in the home or in the workplace. Men and women did not always recognize the changes in their personality that appeared so obvious to their family members and friends. Even when they did acknowledge that all might not be well, patients resented the additional burdens imposed by hospitalization. Institutionalization was a dramatic step, with the full force of the state being brought to bear on what most took to be private decisions and individual liberties. Many of the men and women admitted to St. Elizabeths thus experienced their condition as a combination of personal alienation and civic estrangement.

The realities of institutional care represented a challenge to both White’s vision of psychiatry and patients’ understanding of their place in American society. “The aim of the hospital should be … to get the patient well and to turn him back into the community a useful citizen,” White maintained. “[Nevertheless,] the capacity of many a patient is not equal to an independent social existence. For such patients the hospital must create an environment in which they can live … at their maximum efficiency.”¹ Men and women admitted to St. Elizabeths often spent months, years, or even decades at the institution, largely cut off from association with friends and family members. Their movements were restricted, their communications were

¹ White, Principles of Mental Hygiene, 116 (emphasis in original).
monitored, and—with the finding of incompetency attendant upon commitment—their civil rights were suspended. This meant that patients lost the legal capacity to enter into contracts, vote, or, later, hold a driver’s license.²

In this context, physicians came to view many of their patients as “institutional citizens.” Hospital officials employed this parallel language of civic identity to describe men and women who worked steadily, avoided conflicts, and cooperated with the rules governing their movement. Gender and racial norms proved central to this assessment. The system of labor and recreation at St. Elizabeths reflected what officials took to be a consensual set of values about the proper organization of society, including distinctive roles for men and women as well as a firm commitment to racial segregation. Physicians recognized that many patients capable of making an “institutional adjustment” nevertheless remained unlikely to return to their former lives.³ In addition to signifying a patient’s tractability and engagement with the hospital routine, institutional citizenship carried a meaning similar to that of “nationality.” Just as one could not properly belong to more than one nation at a time, one could not reside for long periods in a psychiatric institution and remain an American citizen in the fullest sense. According to this logic, patients had given up the rights and responsibilities of U.S. citizenship in favor of a more circumscribed set of freedoms and obligations associated with the asylum.


³ The term “institutional adjustment” was a commonplace in the published and unpublished writings of St. Elizabeths officials. For uses of the term “institutional citizen,” see William M. Kenna, “Occupational Activities at St. Elizabeths Hospital,” Archives of Occupational Therapy 3 (1924): 361; Herbert C. Woolley, “Treatment of Disease by Employment at St. Elizabeths Hospital,” Modern Hospital 20 (1923): 198.
In the sections that follow, I offer a detailed portrait of the patient population at St. Elizabeths and the world in which they lived. I begin with the circumstances that first brought these men and women to medical attention and the paths they followed to the institution. I then turn to the patterns of labor and recreation that dominated patient life in the early decades of the twentieth century, patterns that reflected a profoundly gendered and racialized vision of the United States and its citizenry. Throughout this chapter, I dwell at some length on the experiences of individual men and women, both to impart a sense of immediacy to the material and to do justice to a historically marginalized group of Americans. Too often, historical accounts of psychiatry represent patients only as minor players in a drama whose main actors are physicians and other professionals. Even when historians do include patients in a meaningful way, they frequently erase the complexities of patients’ lives in the service of a particular ideological stance. The clinical records that form the basis of my analysis are not, of course, transparent accounts of lived experience. Nevertheless, they often provide insight into patients’ views of their conditions and the care they received. While these records demonstrate that men and women at St. Elizabeths endured real problems of thought, mood, and behavior, my analysis also shows how deeply their experiences were embedded in the social and political environment of the time.  

Each file contains a medical folder and a correspondence folder; I have employed documents from both. For individuals admitted seventy-five years ago or more, patient files are publicly accessible at the NARA in Washington, D.C. as Entry 66 in Record Group (RG) 418: Records of St. Elizabeths Hospital. In the analysis that follows, I have nevertheless chosen to employ pseudonyms which maintain the first letters of each patient or family member’s given name and surname. On the use of clinical records as historical documents, see Guenter B. Risse and John Harley Warner, “Reconstructing Clinical Activities: Patient Records in Medical History,” Social History of Medicine 5 (1992): 183-205; Geoffrey Reaume, “Keep Your Labels Off My Mind! Or ‘Now I am Going to Pretend I Am Craze but Dont Be a Bit Alarmed’: Psychiatric History from the Patients’ Perspectives,” Canadian Bulletin of Medical History 11 (1994): 397-424.
The civil patient population at St. Elizabeths was composed primarily of men and women from the District of Columbia and the surrounding counties in Maryland and Virginia. The city’s commitment laws required that families or civil officials first take a patient to the Washington Asylum Hospital (later Gallinger Municipal Hospital), where they remained for a period of one to six weeks. If their symptoms did not abate, physicians made the necessary arrangements for transfer to St. Elizabeths. Within a few weeks of their admission, patients appeared before the local court, where physicians and family members gave testimony on their behavior and mental state. Having made it this far into the system, most patients received a formal adjudication of insanity and returned to the hospital. Among the cases reviewed for this chapter, the average age among civil admissions was 43.8 years (median 40.0 years) (Table 2.1), though more than half were between 26 and 50 (Figure 2.1a).<sup>5</sup> Men composed 58.8% of this group; women made up the remaining 41.2%. Black patients are slightly overrepresented; though they made up between 25% and 31% of the District population in this period, black men and women composed 36.8% of the admissions in my sample. This is particularly striking in view of the historical underrepresentation of black men and women on the hospital rolls.<sup>6</sup>

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<sup>5</sup> My statistical generalizations are drawn from a sample of 135 patients representing 2.5% of all admissions to St. Elizabeths in 1900, 1905, 1910, 1915, 1920, 1925, and 1930. The records of patients admitted in years other than these five-year increments were destroyed shortly after being turned over to the NARA. For this study, patient files were randomly selected within each year on the basis of case number. Hospital administrators assigned these sequential numbers at the time of a patient’s admission, with readmissions receiving a new number each time they returned to the hospital. Not all of the cases selected in this manner were available, so I continued employing the cases numbers produced by the random number generator until I had collected the requisite 2.5% of all admissions. (The approximate percentage of files that were available in each year were as follows: 1900 – 92%; 1905 – 96%; 1910 – 96%; 1915 – 100%; 1920 – 96%; 1925 – 100%; 1930 – 80%.) Admissions from 1900 were inadvertently oversampled during the initial stages of data collection, so my qualitative analysis reflects an additional eight cases from that year. In addition, one patient admitted in 1910 was readmitted in 1920. I have included the file from his second admission in my qualitative analysis as well.

<sup>6</sup> According to census data, blacks made up 31% of the District’s population in 1900, 29% in 1910, 25% in 1920, and 27% in 1930. Green, *Secret City*, 200. Among the resident population at St. Elizabeths, black men and women made up 18% in 1900, 22% in 1910, 23% in 1920, and 27% in 1930.
<table>
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<tr>
<th>Category</th>
<th>Number (Percent)</th>
<th>Age on Admission (years)</th>
<th>Time in Hospital (years, months, days)¹</th>
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<td></td>
<td></td>
<td>Mean</td>
<td>Median</td>
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<tr>
<td></td>
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<td></td>
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<td>(1 y, 4 m, 26 d)</td>
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<td>28 (41.2%)</td>
<td>44.7</td>
<td>41.0</td>
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<td></td>
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<td>(5 y, 2 m, 23 d)</td>
<td>(1 y, 9 m, 1 d)</td>
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<td></td>
<td>43 (63.2%)</td>
<td>44.0</td>
<td>40.0</td>
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<td>(5 y, 8 m, 27 d)</td>
<td>(1 y, 7 m, 14 d)</td>
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<td>25 (36.8%)</td>
<td>43.4</td>
<td>40.0</td>
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<td>68 (100.0%)</td>
<td>43.8</td>
<td>40.0</td>
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<td>Military All Male Patients</td>
<td>64 (100.0%)</td>
<td>33.5</td>
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<td></td>
<td></td>
<td>(2 y, 2 m, 16 d)</td>
<td>(7 m, 22 d)</td>
</tr>
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</table>

1. An approximation excluding time on visits, convalescent leave, and elopement. (1 y = 365.25 d; 1 m = 30.4 d)
2. Including Public Health Service patients.
3. Includes two additional male patients, one of mixed Portuguese and Hawaiian descent and the other of Filipino descent.

Table 2.1: Age and Time in Hospital among Sampled Patient Population (Admitted 1900-1930). The data in this chart reflects 2.5% of all admissions to St. Elizabeths in 1900, 1905, 1910, 1915, 1920, 1925, and 1930. Each case represents a single admission; some patients had prior or subsequent admissions. Time in hospital should not be interpreted in terms of recovery, as large numbers of patients either died at the institution. The small sample size invites further caution in interpretation.

Source: NARA RG 418 Entry 66 (Case Records).
Figures 2.1a-2.1c: Age on Admission in Sampled Patient Population (Admitted 1900-1930). As we would expect, military patients tend to cluster in the 20-35 age range, while civil patients show a much broader distribution of age on admission.

Source: NARA RG 418 Entry 66 (Case Records).
The absence of a meaningful social safety net in the early decades of the twentieth century meant that civil patients came from all walks of life. Many occupied a relatively marginal economic status, barely scraping by in jobs as common laborers, clerks, and domestic servants. When their illnesses began to interfere with their ability to work, these men and women had few resources on which to fall back. Some called upon the assistance of family members, but this could put an enormous strain on the household. Edmond Black had a history of seizures but was able to help his family run a saloon in New York for many years. When his mother died, the 25-year-old moved to Washington, D.C. to live with a married sister. Black’s seizures, however, soon became increasingly debilitating. His sister was not able to look after him in the home, and in 1915 she initiated proceedings to have Black committed.7 Women proved especially vulnerable to the combined effects of illness and economic dependency. Shortly after Astrid Rogaland’s husband abandoned her, the 31-year-old Norwegian immigrant began talking to imaginary people, believing herself capable of communication with the president via wireless telegraphy. Within a few months Rogaland had lost her home and her children. When she complained to the police, they took her to the Washington Asylum Hospital; soon thereafter, officials sent her on to St. Elizabeths.8

Families with greater resources generally had more options. Financially-secure patients often sought treatment in one of the many private facilities that catered to men and women of their station. Maintaining a family member at a private facility could be expensive, though, and many of those who did not recover ultimately ended up at St. Elizabeths. Elizabeth Hayes initially became distraught over the death of her sister-in-law in 1913. When the 40-year-old white clerk became even more anxious following a failed relationship, her family began to worry

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7 Case 22506: initial assessment (5 Jan 1915).
8 Case 15518: medical certificate (n.d. [1905]); initial assessment (n.d. [1905]).
that she might do herself harm. Hayes spent a total of three months at private sanitarium before moving in with her sister under the care of a private attendant. Ultimately this proved untenable, however, and she arrived at St. Elizabeths in 1915. “I am fully aware that her case is pitiful and distressing,” her sister wrote in a letter to a physician the following year, “but she was not admitted to the Government Hospital until every means to help her had been exhausted.”

Though they lived alongside civil patients at St. Elizabeths, military patients made up a distinctive demographic group. Military admissions increased around the Spanish-American and Philippine-American Wars and again during and after World War I. As one might expect, these patients were exclusively male, overwhelmingly white, and significantly younger than the civil patient population (average age: 33.5 years; median age: 27.0 years) (Table 2.1; Figure 2.1a). By the time they reached St. Elizabeths, most had already spent a period of weeks or even months in military hospitals and U.S. Public Health Service facilities. Alfred Koch first began to fear that his peers were poisoning him while stationed in the Philippines in 1904; the 37-year-old German immigrant subsequently threatened suicide and wandered away from his base camp. Officials admitted Koch to a military hospital overseas, then sent him to a facility in Arizona before transferring him to St. Elizabeths in 1905. The level of impairment among enlistees was often quite high; those experiencing a minor episode frequently recovered long before they reached St. Elizabeths. Military patients also came to the institution from branches of the National Home for Disabled Volunteer Soldiers (NHDVS); these men were generally much older and often showed signs of advanced dementia. Paul Moore, a 72-year-old white farmer who had served in the Civil War, came to St. Elizabeths after claiming to be a Federal Marshal in charge of the National Home at Leavenworth, Kansas. The final straw for administrators there came when his affections

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9 Case 22072: initial assessment (n.d. [1915]); information from sister (26 June 1915); Anna Frederick to Mary O’Malley (27 April 1916).
10 Case 15362: medical certificate (9 June 1905).
for a nurse on his ward became unmanageable.\textsuperscript{11} Young or old, veteran patients were more likely to hail from a rural background than civil patients and to have a lower overall degree of education. Immigrants were more common among servicemen and veterans as well, having seized upon military service as a route to citizenship and financial security.

Patients and their families desperately wanted to know why such a strange and inscrutable condition had struck in the manner that it did. After learning that Navy officials sent her younger brother Seth to the hospital in 1920, Fanny Jarrett wrote that “[w]e were more than shocked when we received news of his illness[.] … What do you think is or was the cause of his condition? … Seth has always been a good, clean-minded boy and I can hardly understand [his] present condition.”\textsuperscript{12} Families often looked to injuries or episodes of physical illness to explain changes in their relatives’ behavior. Henrietta DuBois inquired whether her husband’s symptoms might have originated with a blow to the head he received shortly before becoming ill, while Janet Chamberlin explained to hospital officials that her son had “never been right” since an episode of pneumonia.\textsuperscript{13} In the 1910s and 1920s patients and their families looked increasingly to psychological and social stressors as a cause. When Meredith Berger experienced what her family described as a “nervous breakdown” in 1915, the 38-year-old white homemaker attributed it to worry over familial difficulties. “My husband was out of work for about ten months,” Berger explained, “and what little money we had saved was used up[.] … I tried to keep everything going. Really, I think these things are what started me being sick.”\textsuperscript{14}

\textsuperscript{11} Case 18553: medical certificate (30 April 1910).
\textsuperscript{12} Case 28226: Mrs. Edgar Jarrett to William A. White (n.d. [\textemdash 2 Dec 1920]).
\textsuperscript{13} Case 11755: Henrietta W. DuBois to Alonzo B. Richardson (n.d. [1902]); case 18534: Form H (Naval Hospital, Chelsea, Massachusetts) (6 May 1910). See also case 32148: ward notes (4 Feb 1925); case 15280: H. C. McFadden to William A. White (13 Feb 1908).
\textsuperscript{14} Case 22405: initial assessment (9 Nov 1915). See also case 32578: clinical record (17 Jan 1928; 19 June 1929)
For many patients and their families, a diagnosis of mental illness represented evidence of immoral conduct. Young white men often expressed concerns about sexual imprudence as a cause of their condition. Francis McCafferty speculated that his troubles “might have been due to masturbation[,] as he masturbated about three times a week” during the period when he first began to worry excessively. \(^\text{15}\) Intemperance represented another common avenue of self-reproach; Roswell Courtwright attributed his troubles directly to “imagination and drinking.” \(^\text{16}\)

Many families disliked admitting that they had a relative in a hospital for the insane. Alexis Gibbins wrote from Lexington, Kentucky with “a request to make of the hospital—please don’t put the name of it on the outside of my letters as I have some men rooming here … who are quite familiar with Washington and would no doubt know about it.” \(^\text{17}\)

The social meaning of mental illness became inextricably intertwined with the decision to hospitalize a patient. Among civil admissions, family members often initiated the process. This could be an intensely alienating experience for men and women whose identities were bound up with their familial responsibilities. Occasionally, such symptoms as bizarre thinking and conversations with imaginary voices became sufficiently alarming for relatives to call upon medical intervention. When Sandra Mullis visited her estranged husband in 1925, the 39-year-old black laborer claimed that the passengers aboard the Titanic had not drowned but were now hiding in various countries. He spoke nonsensically again the next time she saw him, so Mullis contacted the Board of Charities to recommend that they take him to Gallinger. \(^\text{18}\) Far more often, families tolerated their relatives’ eccentricities until their presence in the home proved an unbearable burden or their behavior became dangerous or unpredictable. Alfred Ross quit his job

\(^{15}\) Case 21956: admission note (6 May 1915).

\(^{16}\) Case 18378: initial assessment (28 Feb 1909). See also case 22511: clinical record (28 Feb 1915).

\(^{17}\) Case 32088: Mrs. A. T. Gibbins to William A. White (12 Feb 1925).

\(^{18}\) Case 32906: information from wife (6 Jan 1926).
in 1919 because of difficulty with his legs; his physician informed him that his symptoms represented the early stages of general paresis (neurosyphilis). Ross’s mother and sister cared for the 42-year-old white baker for more than a year as his condition deteriorated. In October of 1920, however, he suddenly became uncharacteristically foul-tempered and violent. Prior to this change, the physicians at St. Elizabeths noted, his mother “wouldn’t think of his being sent to this hospital, in spite of his sister’s advice.”\(^{19}\) In some cases, a patient’s behavior became outrageous enough that family members called upon the police for assistance. Richard Tyler had been having difficulty with his memory and behaving erratically for some time when he grabbed an axe one evening and broke out the windows of a local candy store. His wife immediately contacted the police, who later found the 48-year-old black laborer pounding on the railroad tracks at a nearby intersection.\(^{20}\)

Those men and women destined for St. Elizabeths who did not live with their families were even more likely to come to medical attention through contact with civil officials. Sometimes patients became involved in a public disturbance or altercation. When Rex McCray fired a revolver into the ceiling of the room in which he was staying, the police arrested him and took him to the hospital. The 47-year-old white real estate agent believed himself to be under the influence of some unknown gang by means of electrical machinery.\(^{21}\) In other instances, patients approached civil officials to make bizarre complaints. Shortly after moving to Washington, D.C. in 1924, Emily Steubens started thinking that a medium she had consulted was persecuting her in spiritual form. When the 60-year-old Welsh seamstress sought protection from the police, they initially told her that they would help her to set things right. Instead, however, they took her to

\(^{19}\) Case 28205: initial assessment (29 Oct 1920). Elderly patients dependent on their adult children often followed a similar path to the institution. See e.g. case 11879: medical certificate (n.d. [1900]); case 27423: initial assessment (28 Feb 1920).

\(^{20}\) Case 32298: information from wife (26 April 1925), initial assessment (4 May 1925).

\(^{21}\) Case 21878: case history (18 March 1915); clinical record (25 March 1915).
A final group of men and women came into contact with civil officials after traveling to the nation’s capital because of some unique connection they felt they had with the president or on a mission to save the country. John Medina arrived from California in 1915 to assume the presidency, believing himself to be Adam, “the first man,” destined to lead the nation and the world. When the 40-year-old Portuguese laborer announced his intentions at the White House, police promptly arrested him and sent him to Washington Asylum Hospital. Hospital officials designated these patients “White House Cases,” and representatives of the federal government maintained a separate file on their activities.

Involvement of the police and courts in a patient’s admission inevitably heightened the sense of civic estrangement associated with psychological impairment. A police officer accompanied each patient to the hospital in an ambulance or patrol wagon; sometimes the men and women whose sanity was in question arrived in handcuffs. Officials frequently relied upon subterfuge of the sort they had employed with Emily Steubens, to which patients inevitably responded with a sense of betrayal. As we have seen, the law required that patients appear before a jury prior to their commitment, a practice which White and his colleagues deplored. “It is humiliating to both [the patients and their families],” White wrote in 1905. “Nothing appears to indicate that the unfortunate person is committed to the institution for his welfare … and if possible restored to sanity and useful citizenship[.]” Though the laws originally served as a safeguard against improper committal, medical officials insisted that they effectively

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22 Case 32359: medical certificate (11 May 1925). Police did not always respond by taking mentally ill men and women to the hospital. In several instances, patients complained of imaginary persecutions and were turned away, only to be taken to the hospital later by family members. See e.g. case 32092: initial assessment (n.d. [1925]).
23 Case 22374: initial assessment (27 Oct 1915).
24 Case 22510: clinical record (4 Dec 1915).
criminalized mental illness and discouraged people from seeking treatment. The fact that local newspapers reported on these proceedings only made matters worse.\textsuperscript{26} White’s protestations notwithstanding, this procedure remained in place until 1938.\textsuperscript{27}

Though they came to St. Elizabeths by a different route, military patients experienced their condition as a form of civic alienation as well. Having come to think of themselves as serving the nation in a noble task, these men suddenly found themselves confined and treated as incapable of even the most basic forms of self-care. Some were relatively recent recruits, while others had served multiple enlistments before encountering difficulties.\textsuperscript{28} As we have seen, elderly veterans sometimes came to St. Elizabeths in their final years. Many of the military patients admitted to St. Elizabeths had never seen combat; among those who had, few linked these experiences to their breakdowns. Occasionally, however, they drew such a connection. David Hill served for twelve months in France during World War I before becoming depressed and disinterested in his surroundings. When physicians inquired about his condition, the 26-year-old white soldier responded that his “brain was addled” and that he was “shell-shocked.” Hill became increasingly withdrawn and seclusive during his time at St. Elizabeths, and at times attendants had to monitor him closely for fear that he might injure himself.\textsuperscript{29}

\begin{footnotes}
\footnote{\textit{District of Columbia Code}, 1940 edition, sec. 21.308-21.316. See also Winfred Overholser and Henry Weihofen, “Commitment of the Mentally Ill,” \textit{American Journal of Psychiatry} 102 (1946): 760-761. Jury trials in cases of alleged insanity first began to appear in the 1870s, inspired in part by the crusading efforts of Elizabeth Packard, a former patient in Illinois who maintained that she had been unjustly confined through the machinations of her husband. On the history of civil commitment laws, see Failer, \textit{Who Qualifies for Rights?}, 68-91.}
\footnote{For an example of the former, see case 27400: initial assessment (1 Dec 1919); ward notes (10 Feb 1920); for the latter, see case 18378: initial assessment (n.d. [Feb 1920]).}
\footnote{Case 28074: summarized report of clinical history (n.d. [1920]); clinical record (12 March 1924). Occasionally, families looked to war service to explain a relative’s illness as well. “I can never understand what caused his mental trouble,” wrote Seth Parker’s sister, “unless it was his service to his country at war time.” Case 28226: Mrs. Edgar Jarrett to St. Elizabeths Hospital (21 Aug 1921).}
\end{footnotes}
During the acute phase of their illnesses, patients tended not to see that anything might be wrong with them. Rex McCray became outraged when he realized that a physician did not believe him. “[W]ith great feeling and in a very loud voice,” wrote the psychiatrist, “[he] shouted his epithets of denunciation … in such a constant stream that further conversation was impossible.”30 When another physician interviewed Kent Gibbins in 1925, the 23-year-old white sailor responded with puzzlement and irritation:

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was it right that you should have been sent here?</td>
<td>It absolutely was not. I can prove before any jury that I’m not insane. …</td>
</tr>
<tr>
<td>Did someone have it in for you?</td>
<td>Yes, and I don’t think about it, I know it. …</td>
</tr>
<tr>
<td>Do people speak to you or about you?</td>
<td>Yes, certainly, I’m speaking to you now.</td>
</tr>
<tr>
<td>What do they say?</td>
<td>Anything.</td>
</tr>
<tr>
<td>Do the voices call you bad names?</td>
<td>Now lady, you know anybody that’s as old as I am has had bad names called at them. …</td>
</tr>
<tr>
<td>Do you ever hear the angels speaking to you?</td>
<td>No. You know it’s wrong to ask such silly questions.</td>
</tr>
</tbody>
</table>

Prior to his hospitalization Gibbins had assaulted a fellow sailor and then attacked a military physician; two years after his mother removed him from St. Elizabeths, he entered a state hospital in his native Kentucky. “The neighborhoods in which he has lived are all very much afraid of him,” wrote an official there, “and beg us to see that he is not allowed at large.”31 In instances like these, patients were clearly not the best judge of their condition.

At times patients expressed themselves in ways that defied reason but nevertheless reflected their lived experience. During her twenty-two years at St. Elizabeths, the white former seamstress Jennie Mae Schofield referred to William A. White as “Daddy White,” accurately

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30 Case 21878: clinical record (25 March 1915). For a similar case involving a 37-year-old black laborer, see case 18885: mental examination (31 Jan 1911).
31 Case 32088: initial assessment (9 Feb 1925); information from mother (19 Feb 1925); W. R. Thompson to William A. White (30 July 1927).
capturing the paternal role he occupied in the lives of many men and women at the hospital.\textsuperscript{32} Patients’ conditions shaped their relationships with actual family members as well. Forty-six-year-old Wilson Ashby’s marriage became increasingly strained during the course of his long confinement. At one point the white former salesman wrote a series of defamatory letters about his wife to friends, colleagues, and public officials in the town where she worked. Ashby recognized his wife’s unwillingness to care for him in the home, but failed to appreciate the role that his own emotional lability and bizarre behavior played in her decision. “He is angry with me because I don’t take him away and have him with me,” she explained to hospital officials, “which in his condition is an impossibility as you know[,] … I wish it would be so that I could come and he would be kind to me again.”\textsuperscript{33}

Some patients acknowledged abnormal patterns of thought and behavior. Floyd Olsen began experiencing difficulties while stationed in the Philippines in 1900. At St. Elizabeths, the 24-year-old white soldier struggled to discern where reality ended and his hallucinations began. “Says he hears imaginary voices and [it] is difficult for him to believe that they are not real,” observed an attendant. “At times has … [seen] pictures and objects on [the] wall which he realizes afterward were not there.”\textsuperscript{34} Given the stigma of insanity, it could be difficult for patients to admit that anything had ever been the matter with their minds. Richard Parker attempted to cut his throat with a razor in 1920; when he arrived at St. Elizabeths, the 25-year-old white sailor indicated that the wealthy were plotting to take his life. Several months later, after his condition had improved, Parker’s physician wrote that “[h]e rather grudgingly admits

\textsuperscript{32} Case 18345: clinical record (16 May 1930); ward notes (16 May 1930).
\textsuperscript{33} Case 32578: Caroline Ashby to William A. White (22 May 1927).
\textsuperscript{34} Case 12055: ward notes (22 Oct 1900). See also case 18345: initial assessment (1 Feb 1910); clinical record (22 June 1911).
some of the ideas mentioned previously.”35 Patients tended to be more comfortable interpreting their condition in terms of “nervousness” than insanity. “I never get out of my head, but I do get nervous,” explained 21-year-old Donald Barclay. “I am not sick[.] … I have always been like I am now. I only need watching when I get nervous.”36

Men and women with a long history of difficulties often resigned themselves to making the best of their situation. Some patients who had come to expect occasional periods of instability but who remained capable of living on their own regarded their situation philosophically. Shortly after Julius Humphrey arrived at St. Elizabeths, his physicians made a transcription of the 59-year-old black sailor’s rambling and disconnected speech. Humphrey cleared up over the course of the next two months, and when the physician read the transcript back to him Humphrey laughed and explained that he had been hospitalized during similar episodes in the past. “What’s in the bones,” he later observed, “can never come out.”37 Patients who remained at St. Elizabeths for years on end tended to be less sanguine. Even if they did not agree that they were incapable of living independently, however, many of these men and women remained cognizant of their limitations. During a clinical interview in 1910—a full decade after his admission—Byron DuBois intimated that a particular physician planned to have him murdered. When pressed, the 38-year-old white former engineer merely “laughed and said that it must be one of his crazy notions.”38 Others learned to use their symptoms to carve out a degree of independence. Over the course of her many years at the hospital, Claire Hausmann could at times be recalcitrant and uncooperative. Seven years after the elderly white divorcee’s arrival, an

35 Case 27639: initial assessment (25 May 1920); clinical record (15 May 1920; 24 Aug 1920); ward notes (18 May 1920). See also case 22272: clinical record (24 May 1916; 16 Oct 1916).
36 Case 27707: initial assessment (n.d. [1920]). See also case 22405: initial assessment (9 Nov 1915); case 27620: clinical record (31 July 1920); case 32648: clinical record (10 Sept 1925); case 32251: initial assessment (3 April 1925); case 32288: ward notes (21 April 1925); case 22489: ward notes (24 Nov 1915).
37 Case 22511: clinical record (28 Feb 1915; 24 April 1916).
38 Case 11755: clinical assessment (19 Nov 1910). See also case 15340: ward notes (6 June 1905).
attendant observed that, “When asked why she does things, [she] will say, ‘Well, I am crazy, it
doesn’t make any difference what I do.’”39

Patients experienced their conditions in ways that reflected the gender norms and
racialized identities that dominated early twentieth-century American culture. Young white men
in particular tended to speak in terms that revealed their anxieties about living up to prevailing
standards of manhood. Often they used the same masculinist language of mental health as the
hospital’s physicians, a language structured around industriousness, personal ambition, and
steadiness of purpose. Kent Gibbins expressed this sentiment succinctly when asked how he felt
during his initial interview. “I feel like I’d like to go to work,” he told the physician, “and get out
in the world and be a man.”40 Daniel McGovern was only seventeen when his mother brought
him to St. Elizabeths over concerns about his erratic and deceptive conduct. Hospital officials
ultimately declared McGovern sane, but he nevertheless suggested that his time at St. Elizabeths
had been productive. “Before I came here I had a lot of foolishness in my head, I used to fly from
one thing to another like a kid,” he explained. “I feel more like a man now and I intend to settle
down to one thing and stick to it.”41

Male patients also articulated their ideas about masculinity in explicitly sexual terms.
Sexual potency served as an important measure of one’s manhood; perceived failure could thus
be a locus of considerable anxiety. Edmund Mann first began having difficulty thinking clearly
after his return from service in World War I. When he arrived at St. Elizabeths in 1925, he
remained preoccupied with an episode six years earlier in which he had been unable to perform
sexually. “It’s a blow to a man, not to be a man any more,” the 30-year-old white veteran told his

39 Case 27602: ward notes (13 June 1927). See also case 11755: clinical record (21 Aug 1907).
40 Case 32088: initial assessment (9 Feb 1925).
41 Case 18360: initial assessment (25 March 1911).
examining physician. Same-sex desires could become a source of concern as well, particularly for those in the all-male environment of the military. Wesley Morris first realized that he found men more attractive than women during his teenage years. This worried him considerably, but the white 26-year-old telephone operator found an abundance of peers during his time in the service. Morris became severely depressed, however, and began to think people were influencing him through the telephone switchboard. While at St. Elizabeths, he claimed that other men on the ward exerted strange influences that caused him to become aroused; frequently he became involved in physical altercations on this basis. Anxieties centering on homosexuality were a sufficiently common feature of patients’ illnesses that physician Edward Kempf collected these cases under the rubric of a new clinical entity. In Kempf’s formulation, the “acute homosexual panic” represented a response to the psychic conflict patients experienced between their latent same-sex desires and the cultural proscriptions they had internalized; these episodes occurred all the more frequently in such stressful sex-segregated environments as the military.

In an era when women’s claims to citizenship hinged on their contributions as wives and mothers, it is perhaps not surprising that children occupied a central position in the symptoms of many female patients. In some cases, patients’ delusions centered on real members of their families. Meredith Berger initially believed that her husband and two children had been murdered, and while Sarah Gould at times did not recognize her children, she nevertheless expressed intensely protective sentiments about them during the course of her four decade confinement.

Jennie Mae Schofield claimed in 1913 that babies were being murdered in

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42 Case 32429: admission note (15 June 1925); initial assessment (22 June 1925).
45 Case 22405: medical certificate (26 Oct 1915); case 15488: ward notes (1 Dec 1906; 24 Dec 1932); Mary F. Reed to St. Elizabeths Hospital (9 Jan 1942).
another building on the grounds. “Imagines she hears little children’s voices in I Bldg.,” an attendant reported. “Says they are burning them and she could have saved them if she had only tried.” Many years later, Schofield came to believe that she was the guilty party: “Jennie says that she burned her baby alive and now she can see babies sailing around in the sky.”46 The caretaker role was a powerful cultural trope in the early decades of the twentieth century; long-term female patients occasionally carried a rag doll or cloth dolly about with them and cared for it as if it were really a child.47

Women’s experiences also reflected the prevailing cultural ambivalence toward female autonomy. Not long after 17-year-old Natalie Waxman moved to Washington, D.C., her increasingly active social life became a source of tension within the family. When her brother forbade her from attending a particular event in 1915, she “became somewhat hysterical, crying and screaming.” At St. Elizabeths, the young white woman spoke to imaginary voices and mistook the nurses for her friends. Waxman’s behavior also suggested a rejection of the sort of moral subordination under which she labored at home; frequently she exposed herself on the ward and to passers-by, taking great pleasure in the use of “vulgar and profane language.”48 In a few instances, young women’s encounters with psychiatric authority resulted less from mental difficulties than a social environment that viewed their assertions of independence as pathological. Valerie Pierce had been living on her own for several years when officials discovered the white 16-year-old with a soldier in 1919 and charged her with fornication. While on probation she chafed under the strict supervision of her employer and ran away; soon, however, she ended up in the House of Detention, where she cried constantly and refused to eat.

46 Case 18345: ward notes (13 April 1913; n.d. [~1927]).
47 See e.g. case 27423: clinical record (1 July 1921, 5 July 1922); ward notes (8 Aug 1922). While delusions and hallucinations centering on children were not unheard of among male patients, they occurred far less frequently than among female patients. See e.g. case 15521: ward notes (6 May 1910); case 22342: initial assessment (28 Oct 1915).
48 Case 22304: initial assessment (17 Sept 1915; 9 Oct 1915); ward notes (23 Nov 1915; 29 Nov 1915).
The physicians at St. Elizabeths deemed the girl sane, but they nevertheless judged her “mentally subnormal” before releasing her to her employer.49

White men and women frequently interpreted their experiences in terms of a racist worldview consistent with the inegalitarian social environment in which they lived. Often this emerged in a sense of privilege among patients dissatisfied with their surroundings. Seventy-four-year-old Civil War veteran Medford Barr complained in 1914 that he wasn’t “treated like a white man,” and when an examining physician asked Lukas Heffler whether he wanted to leave the hospital the 44-year-old Bavarian immigrant responded, “Yes. This is no place to live for white people[.]”50 White patients also expressed anxieties about maintaining their position of superiority, often through themes of domination, subordination, and powerlessness. Following a one-year stay at St. Elizabeths, Walter Dewhurst went to work for his father in Maryland. In 1925, however, the 28-year-old veteran again became fearful and paranoid. “At the coal yard of his father he was in perpetual fear that the negroes there would boss him instead of the reverse,” his physician recorded. “He says that they used to get the best of him at every turn.”51 During the course of Bart Williams’ twelve-year confinement, physicians observed that the former Marine “doesn’t want his strength stolen by niggers.”52 White patients who believed they were being persecuted frequently identified their tormentors in racialized terms as well. Sarah Gould told the

49 Case 27565: memorandum from [illegible] to Mildred E. Sheetz (16 April 1920); clinical record (25 April 1920). Historian Elizabeth Lunbeck argues that cases like these were central to psychiatry’s emerging professional identity. See Lunbeck, *Psychiatric Persuasion*, 184-207.

50 Case 11965: clinical record (8 May 1914); case 12129: clinical record (19 Oct 1906). See also case 27418: ward notes (21 Sept 1920).

51 Case 32251: admission note (23 March 1925); initial assessment (3 April 1925).

52 Case 28288: clinical record (22 May 1924).
physicians that “a big black man and some felons tried to kill her,” while Alfred Ross believed
prior to his admission that a “colored man” was “in [the] house stealing his things.”53

Black men and women, too, experienced their conditions in terms that reflect the
importance of race as a cultural category during the Jim Crow era. Both black and white patients
with general paresis tended to express grandiose ideas about their achievements and financial
worth. Black patients, however, often did so in terms that both recognized and implicitly
subverted the prevailing racial hierarchies. When Jacob Jeffries first arrived at the hospital in
1910, the 37-year-old musician claimed to be the “wisest coon in the world;” later he maintained
that “the white world is living on his money.”54 Forty-eight-year-old laborer Richard Tyler told
the physicians in 1925 that he had “the prettiest brain of any man in the world—colored or
white,” and that he had killed a hundred members of the Ku Klux Klan.55 Elderly patients often
spoke in terms of a racialized social identity as well. Seventy-two-year-old Sally Jackson
attributed her difficulty walking to an incident in which the Klan had “shot her down on the
street,” though she did not appear to have experienced any such episode. During her time at the
hospital Jackson heard voices cursing her and calling her “nigger;” at times she would respond in
kind. “Patient will often accuse some one of talking about her when they are not even saying a
word to her,” wrote an attendant in. “Will say, ‘I heard what you said. If I am a negro you are
one, too, and if I get on you someone will have to pull me off because I will tear you to
pieces.”56

53 Case 15488: clinical record (20 May 1916); case 28205: medical certificate (26 Oct 1920). For a later example,
see patient MR 69980 (abstract of record for research study, n.d. [1954]), NARA RG 418: Entry 7 (Administrative
Files: Serpasil).
54 Case 18762: medical certificate (n.d. [1910]); ward notes (8 Dec 1910); clinical record (2 March 1917).
55 Case 32298: admission note (18 April 1925); initial assessment (4 May 1925).
56 Case 32092: medical certificate (10 Jan 1925); ward notes (6 Jan 1928; 17 July 1928).
The length of time any given patient spent at St. Elizabeths varied enormously. Civil patients tended to remain at the institution considerably longer than military patients (Table 2.1; Figure 2.2a). Among civil patients, women appear to have remained in the hospital slightly longer than men, and white patients somewhat longer than black patients (Table 2.1; Figures 2.2b-2.2c). Yet patients of all backgrounds tended either to leave the institution in one way or another within a few months or years of their arrival or face the possibility of a lifetime in the hospital (Figures 2.2a-2.2c). Length of stay should not be interpreted exclusively in terms of release; an extraordinarily high percentage of men and women in this sample ultimately died at St. Elizabeths (Figures 2.3a-2.3c). Some were already severely ill before they arrived; others became sick or received a mortal injury at the institution; still others simply grew old and expired at an otherwise reasonable age. It is likely that some patients ultimately returned to St. Elizabeths after their release, and officials transferred a significant percentage directly to other institutions upon their discharge. Transfers occurred primarily among chronically impaired men and women from regions other than the District of Columbia and military patients whose families wished to be able to visit them at a facility closer to home.57

While the degree of a patient’s impairment represented one factor in his or her length of stay, other elements of the social matrix within which hospitalization occurred played a role as well. Interested family members who could advocate on a patient’s behalf and pledge to take responsibility for him or her in the community might shorten a patient’s stay dramatically. While physicians had the legal authority to retain civilly-committed patients against the wishes of their

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57 In a few cases, the presence of a patient’s name on the hospital rolls did not necessarily mean that he or she continued to reside within the institution. Though the numbers here have been adjusted accordingly, officials often did not grant a formal discharge until several months had passed after elopement, the term employed when a patient left the hospital without permission. Additionally, patients sometimes went on extended visits to the homes of their relatives that could last weeks or even months prior to their release.
Figures 2.2a-2.2c: Length of Hospitalization in Sampled Patient Population (Admitted 1900-1930). Many patients left the hospital in one way or another within a year of their arrival. If they did not—and particularly if they remained longer than five years—they faced the prospect of a lifetime in the institution.

Source: NARA RG 418 Entry 66 (Case Records).
Figures 2.3a-2.3c: Outcomes among Sampled Patient Population (Admitted 1900-1930). As these figures indicate, an extraordinary number of men and women admitted to St. Elizabeths died at the institution. Many were seriously ill when they arrived; others died from acute illness, natural causes at the end of life, or, occasionally, injuries sustained at the hospital—whether through accident or at the hands of another patient. Military patients fared somewhat better in this regard, though the large number of transfers and elopements among these men makes comparison difficult. For all groups, the rate of full recovery was dismal. Once again, the small sample size invites caution in interpretation.

Source: NARA RG 418 Entry 66 (Case Records).
families, the courts made it clear that the hospital had no claim over military patients once they had received their discharge. In practice, officials exercised considerable discretion through ready assent or bureaucratic resistance to demands for a patient’s release. When military patients’ families became dissatisfied, they did not hesitate to call upon their representatives in Congress for assistance. Elected officials frequently wrote to William A. White on their behalf, asking him to consider a patient’s transfer or release. Patients themselves might obtain their freedom on writs of habeas corpus. Much to the consternation of the medical staff, local attorneys sometimes solicited the business of patients directly. The assistance of an experienced lawyer certainly improved a patient’s chances of success. Not everyone, however, could afford such services, and local papers frequently covered these proceedings. Speaking with his physician in 1911, Daniel McGovern reported that “[a]bout six months ago I had a letter from Attorney Evans asking me if I wanted to be released on Habeas Corpus proceedings, but I didn’t care for the notoriety; besides he told me I would have to lay down fifty plunks to start with him.”  

Though prejudices among staff members do not appear to have led to any simple relation between sex, race, or social status and the need for confinement, such attitudes inevitably played a role in decisions to release a patient. In some cases, physicians’ expectations that a mentally healthy young man ought to be self-supporting translated into a reluctance to discharge male patients. A ward physician complained that 26-year-old white soldier David Hill remained “evasive” and would not discuss his troubles. “[H]e was told,” the physician continued, “that he

could not be allowed to be a burden to his family for support.” Conversely, physicians sometimes allowed female patients to leave the hospital under the supervision of their husbands even when their condition remained tenuous. Debating the propriety of allowing 41-year-old white homemaker Erma Eason to go on automobile rides with her husband in 1926, one physician reasoned that “if her husband’s authority over her is as they say it is, it will be attended with success.” Physicians’ racial attitudes similarly shaped their views on whether patients would be able to function in the environment that received them. When the medical staff met in 1920 to consider the case of John Simon, a 24-year-old black veteran from rural Tennessee, at least one psychiatrist doubted whether “he could be cared for under conditions such as probably exist at his home.”

When commitment proceedings involved a family member or relatives had prior experience with a patient’s condition, they tended to defer to medical judgment on the propriety of institutional care. Robert Smith had gone through several episodes of excitement and confusion in the past, so when his cousin in Pennsylvania learned that the 45-year-old white laborer was again wandering about he notified the city police. Soon they found Smith sitting on a bridge talking to himself and took him to the hospital. In 1923, Smith’s brother wrote to follow up on Smith’s request that he be transferred to the National Soldiers’ Home at Hampton, Virginia: “I would be satisfied for this to be done providing your decision was that this would be the best thing for him. I know he is unable to cope with the hardships of life and if thrown on his

59 Case 28074: clinical record (17 Nov 1920).
60 Case 32648: clinical record (29 June 1926). The influence of these attitudes among physicians should not be overstated. As the data in Table 2.1 indicate, female patients generally remained at the hospital slightly longer than their male counterparts. Yet cases like Eason’s suggest that this may have been for reasons other than a desire on the part of physicians to maintain female patients within the institution.
61 Case 28067: clinical record (3 Dec 1920; 17 Aug 1926). Here, too, one must be cautious in assessing the importance of these attitudes. We might just as easily think that physicians’ low expectations for their black patients and their tendency to view them as less deserving of state services might lead to earlier discharges.
own resources he will only [have to] be returned shortly.”

In a few instances, family members proved even more intent on maintaining a patient in the institution than physicians. Thirty-nine-year-old Chadwick Pendleton had written a series of threatening and sexually explicit letters to his sister before the courts sent him to St. Elizabeths in 1900. “If you knew the horror I am in of him all the time you would have pity on me I am sure,” his sister wrote. “I beg and beseech of you he be kept close[.]”

Challenges from family members arose more frequently when patients came to the hospital through channels that excluded their relatives’ involvement. Often this occurred in cases involving military patients whose families had not seen them since they left home. Carl McCafferty wrote to St. Elizabeths in 1915 demanding to know why military officials had sent his son Francis to an asylum. A physician explained that the 25-year-old white soldier had been depressed and seclusive, harboring strange ideas about his limbs changing shape. McCafferty, however, refused to believe that anything might be seriously wrong with his son. “As to his strange conduct … I am not in the least surprised,” he wrote. “I consider this nothing more than the result of being held by the government contrary to his desire.” Such cases could also reveal disagreements within a family. Army officials sent Wright Dougherty to St. Elizabeths in 1900 because they feared that the 27-year-old white soldier might shoot one of his peers. Dougherty’s mother inquired regularly about her son and even wrote to the president to request that he be sent home to St. Louis. Dougherty’s brother-in-law, however, sent a letter marked “confidential” in

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62 Case 27756: initial assessment (n.d. [1920]); W. B. Smith to St. Elizabeths Hospital (11 Jan 1921); Gregory M. Smith to St. Elizabeths Hospital (15 Nov 1923). See also case 32148: clinical record (16 Dec 1925).
63 Case 11785: Martha E. Pendleton to Alonzo B. Richardson (11 Sept 1901).
64 Case 21956: Carl McCafferty to William A. White (23 April 1915); William A. White to Carl McCafferty (29 April 1915); Carl McCafferty to William A. White (17 May 1915).
which he requested that Dougherty not be released; in the past, he maintained, Dougherty had been truculent and unmanageable in his mother’s home.65

Families often insisted that their relatives would recover better in the company of their parents, siblings, and children than among strangers in an impersonal institution. A patient’s release against hospital officials’ better judgment led to mixed results. Some men and women proved capable of living and working effectively in their home environments. Others, however, failed to improve. Shortly after garnering his son’s release on a visit, Miles Kent wrote from Pennsylvania to inquire about returning him to St. Elizabeths. “He is not getting much better,” Kent explained, “and I think it is best to send him back to your hospital.” Officials at St. Elizabeths do not appear to have responded, but when they followed up several years later Kent wrote that he had been forced to send his son to the poorhouse. “I [am] heartbroken [ever] since at what I done,” Kent wrote. “He [was] complete[ly] out of his mind … [and I] could do nothing with him.”66

Occasionally, patients accepted institutional care without protest. A few men and women actively sought treatment at St. Elizabeths. Harold Jones placed himself under medical care in 1900 after becoming despondent over financial difficulties. The 55-year-old black laborer had experienced a disconcerting episode of excitement twelve years earlier, and once at St. Elizabeths Jones nervously informed the physicians that it had been his wish to come there.67 In other instances, patients grew comfortable with the hospital’s routine. When a physician interviewed Bull Cleets in 1924, the 28-year-old white veteran explained that he had initially

65 Case 11911: medical certificate (n.d. [1900]); Mrs. B. Dougherty to William McKinley, President of the United States (29 Nov 1900); Gareth F. Michaels to Alonzo B. Richardson (11 Sept 1901).
66 Officials’ failure to respond likely represented an administrative oversight around the time of superintendent Alonzo Richardson’s death. Case 12000: Miles Kent to Alonzo B. Richardson (29 Aug 1901); Miles Kent to Alonzo B. Richardson (25 Feb 1907).
67 Case 12228: medical certificate (n.d. [1900]); ward notes (21 Dec 1900). See also case 32251: admission note (23 March 1925).
come to the hospital to “rest up” and smiled as he acknowledged “resting nearly four years.” “Well, I guess I am about like the rest of them around here,” he continued, “find it easier to sit around this place than to go out and get work.” When officials admitted Fanny Cook for the second time in 1905, the 30-year-old black domestic initially insisted that she wished to go home. Over the course of the next three years, however, Cook regularly attended amusements and church services, occasionally assisting with the ward work as well. Like many black patients, Cook became irritable when members of the medical staff persisted in questioning her, but she voiced few complaints about the hospital and even compared it favorably to a hotel. Life could be difficult among the poor under even the best of circumstances. With the additional burdens of psychological impairment, some may have decided that St. Elizabeths had its own distinct advantages.

Far more often, however, patients resented their detention. “I call [this place] a prison,” declared Abraham Tibbs in 1911. “Some say it ain’t, [but] all I can see is bricks and wood and wires and iron.” Patients from a wide variety of backgrounds agreed with the 37-year-old black laborer’s assessment; many interpreted their situation as a form of unwarranted incarceration. In a routine evaluation, a physician observed matter-of-factly that 39-year-old Russian immigrant Edgar Malikov “thinks … he is unjustly confined and desires to return to his home.” Some imagined there must be some inscrutable reason for their detention. Roswell Courtwright informed his attendants he was willing to “do time” if guilty of some offense, but that he would first like to know the nature of the accusation. The loss of freedom and control over one’s daily

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68 Case 28355: clinical record (4 Sept 1924).
69 Case 15250: medical certificate (n.d. [1905]); clinical record (20 April 1905; 2 June 1906; 17 March 1908); ward notes (15 April 1907).
70 For further evidence on this point, see case 15521: ward notes (12 June 1906).
71 Case 18885: mental examination (31 Jan 1911); initial assessment (n.d.).
72 Case 27964: clinical record (2 Nov 1921).
73 Case 18378: ward notes (20 March 1910).
routine involved in civil commitment could be deeply demoralizing. Some patients invoked a metaphor even grimmer than imprisonment. Walter Young complained after just six months that he “might as well be dead as live this way,” while Irish widower Leopold Mettler demanded that officials return him to the almshouse, insisting that he “would prefer being in a graveyard to such a place.”

A few patients articulated their discontent in a specifically American language of rights and freedoms. When Mettler demanded “liberty or death” in 1900, he invoked the same tradition of legitimate resistance to political oppression that underpinned Byron Dubois’s threats to “[resort] to violent means to obtain his liberty.” Military patients became especially incensed at what they saw as an abuse of federal authority; physicians observed that 31-year-old white veteran Walter Young “has a marked antagonism toward the government [for] holding him here.” Chadwick Pendleton, who had studied constitutional law prior to his confinement as a federal prisoner, became one of the hospital’s most articulate critics of civil commitment. “It is a violation of the thirteenth amendment,” he argued, “to hold anyone … on the supposition that they are liable to commit some crime.” Though his sister implored physicians not to release him, Pendleton denied he was dangerous and accused the administration of withholding fundamental American rights and opportunities. “I want nothing but what the law allows me,” Pendleton maintained. “I need life, liberty, [and] the freedom of speech. I want to get rich and enjoy the

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74 Case 27454: clinical record (4 Sept 1920); case 12009: ward notes (31 Jan 1901; 1 April 1914). See also case 22072: ward notes (8 July 1915) and the poem by patient S. C. C. entitled “Captivity” in *Sun Dial* 1, no. 5 (April 1918): 10-11, as well as physician Samuel A. Silk’s recognition that many patients resented hospital policies that restricted them to their wards (“Helpful Hints,” *Sun Dial* 1, no. 4 [Aug 1917]: 7).
75 Case 12009: ward notes (19 Jan 1901); case 11755: ward notes (27 March 1901). See also case 28179: initial assessment (17 Oct 1920).
76 Case 27454: clinical record (9 Nov 1922). See also ward notes (1 Sept 1921; 9 March 1922).
‘pursuit of happiness[.]’” Pendleton’s efforts proved unsuccessful, however, and he remained confined at the institution until his death in 1916.  

For many men and women, the mistrust engendered by forced confinement ran so deep that it colored all of their interactions with the hospital staff. Whenever officials considered a patient for freedom of the grounds, visits home, or discharge from the institution, a psychiatrist familiar with the case presented him or her before a conference of the medical staff. At times, patients remained in the room during the discussion that followed. Physicians recognized that men and women regarded these conferences with “a certain dread.” “It is not a court martial or a trial or anything of that kind,” wrote an official in the *Sun Dial*, “although it is sometimes looked upon in this light.” Once patients left on trial visits to their homes, social workers from the hospital’s outpatient division checked in on them to monitor their progress. The purpose, according to White, was to “bridge the gap between total dependence on the hospital and finally getting back into life as efficient citizens.” Patients, however, often preferred not to maintain any link to the institution. “[S]ome think it is [our] duty,” wrote a member of the social service staff, “after you are well enough to go home, to watch and bring patients back at the least sign of ill health.” While the author insisted that this was not the case, many former patients remained skeptical.

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77 Case 11785: Chadwick N. Pendleton to Alonzo B. Richardson (22 Feb 1902); Chadwick N. Pendleton to J. C. Simpson (27 Oct 1901).
“INSTITUTIONAL CITIZENS”: LABOR, RECREATION, AND PATTERNS OF DAILY LIFE IN THE MENTAL HOSPITAL

Once they had come to terms with their admission, patients settled into a social world modeled after but distinct from the wider society. Most were already familiar with the norms governing the institution’s gendered system of labor and separation of patients by race. Other features proved unique to hospital life. Gender segregation on the wards meant that most patients had only limited contact with their peers of the opposite sex. In this sense, St. Elizabeths resembled other institutions for the chronically ill, including tuberculosis sanitariums, leprosy hospitals, and, later, polio rehabilitation facilities.81 Yet at St. Elizabeths, administrative authority rather than physical debility typically restricted the mobility of residents. In this respect, the hospital bore greater resemblance to residential schools for the blind or deaf, homes for the cognitively disabled, or even carceral institutions.82

For most patients at St. Elizabeths, the wards on which they lived determined the daily circumstances of their lives. Physicians initially assigned men and women to wards in a receiving service—one for white patients, the other for blacks—on the basis of their conduct (Figure 2.4). Though recently-admitted patients sometimes went on staff-supervised walks about the grounds, most spent their time within the confines of the building. Patients who did not improve within a few weeks or months found themselves transferred from an acute to a chronic service. Cooperative individuals sometimes worked their way up to a privileged ward, where those willing and able to work might receive “parole” to wander the hospital’s grounds.

Figure 2.4. Map of the St. Elizabeths Hospital campus (1904), modified to indicate the system of racial segregation in place at that time. White structures were reserved for white patients; black structures were reserved for black patients. Those buildings with a hash-mark pattern housed both black and white patients, albeit on separate wards. Administrative facilities and other buildings not used in patient care are colored gray. While white women of “all classes” occupied Retreat (1), it is revealing that the other structures containing both black and white patients were reserved for prisoners (Howard Hall [7]) and the “disturbed class” of patients (P Building, Q Building).

Source: Annual Report, 1904.
unattended. With time and good behavior, this might be extended to include freedom to run errands in a nearby neighborhood or even spend the day downtown. In each case, patients received a “parole card” indicating the extent of their freedoms. Officials typically restricted assaultive patients and those incapable of caring for themselves to wards with fewer amenities. Administrators shifted patients laterally among wards as well, often for reasons of administrative convenience that remained inscrutable to patients.\(^{83}\)

Officials in the early decades of the twentieth century placed a renewed emphasis on labor and recreation as elements of hospital life. Ward work and the basic tasks associated with the emerging field of occupational therapy represented stepping-stones to more complex endeavors and the possibility of a regular work assignment. The influx of servicemen and veterans after World War I prompted an expansion and formalization of recreation at the institution. The American Red Cross first established a post at St. Elizabeths in 1919, ultimately assuming responsibility for all recreational activities there.\(^{84}\) Though White insisted that they not discriminate between military and civil patients, veterans remained the Red Cross’s top priority.\(^{85}\) Very few men and women proved so impaired that they did not seek some form of activity to occupy their time at the hospital. As we shall see, however, white male patients tended to derive the most benefit from the system—both ideologically and materially.

Physicians at St. Elizabeths hoped that patient labor would cultivate the sorts of traits required to function as a good citizen in American society. For many men and women, occupation served primarily to fill “hours that would otherwise hang heavy” and prevent

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83 The ward system was an enduring feature of institutional life, structuring the lives of patients well into the middle decades of the twentieth century. See Goffman, *Asylums*, 361 fn. 30.
84 *Annual Report* 1919, 789; 1920, 23; 1926, 8; 1931, 5; 1936, 396. On the Red Cross’s provision of recreation and social work services in military and veterans hospitals, see Ann Elizabeth James, “American Red Cross Therapeutic Recreation Service in Military Hospitals” (Ph.D. dissertation, University of New Mexico, 1978), ch. 2.
85 Annual Report of the American Red Cross Activities from July 1st, 1938 to July 1st 1939, p. 6. NARA RG 418: Entry 7 (Administrative Files: Red Cross [Annual Reports, 1931-1946])
“emotional or ideational deterioration.” Yet officials also hoped that employment would promote concentration and help patients develop habits of industry. Efforts had been underway since 1917 to increase the number of men and women engaged in useful occupation; the wartime pressure to conserve manpower provided further incentives. By 1926, physician William Kenna estimated that 40% of non-medical patients were engaged in some sort of work. Frequently this took the form of assistance with minor tasks on the wards and in the institution’s many dining rooms, but patients also worked on the grounds, on the hospital farm, and in its kitchens and laundry. Under the auspices of the Federal Board for Vocational Training, officials experimented with formal education and career training for veterans. Soon, however, they had to curtail their ambitions. “The ideals of the training center rather shot above the mark,” reported Kenna in 1924, “so that … special instruction is now limited mainly to weaving, toys, wood-working, farm and poultry projects and to other crafts.” Many of the Vocational Center’s efforts were thus subsumed by the ward-based program of occupational therapy, which prepared patients for more complex forms of employment in the tailor shop, shoe shop, mending room, and other “hospital industries.” During the 1930s, the system achieved an even greater degree

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88 *Annual Report* 1917, 654; 1918, 688, 689; 1919, 789.
of formalization when physicians on the male services established “occupational index” cards to better monitor and systematize patient labor.92

Physicians similarly hoped that recreation would promote the forms of sociability necessary for proper citizenship. Some elements of the hospital program remained largely passive, including lawn concerts, motion pictures, and off-campus trips to theaters and the baseball park. Many of these activities, physicians acknowledged, were intended simply to “make life brighter” for the patients; in this respect, patterns of daily life resembled those at other institutions for the chronically ill.93 Yet recreation also became an avenue through which physicians assessed and even sought to improve patients’ well-being. “The mentally distressed person is too highly individualized to get along with his associates,” wrote a Washington Post reporter after visiting the institution in 1928. “[A]ll activities of the hospital are designed to break down this intense individualism. So personal competitions are avoided and team play is stressed.”94 Male patients particularly enjoyed baseball, and the hospital regularly fielded a team in the District’s amateur leagues.95 With an increasing number of men and women receiving parole of the hospital grounds, sites such as the patients’ library and especially the Red Cross House became “safe havens” within which patients enjoyed the freedom to pursue their own interests.96 For the most withdrawn patients, recreation workers used ward parties, special

performances, and periodic hospital-wide events to encourage interaction with their peers.  

Beginning in 1934, physicians permitted men and women at the hospital dances to select their own partners; previously, the administration had mandated that patients dance only with nurses and hospital attendants.  

Labor at St. Elizabeths involved a gendered and racially-stratified vision of the sorts of roles that patients ought to embrace if they were to function effectively as a member of the wider society. Work within the institution mirrored the gendered organization of the outside labor market. Some male patients performed skilled tasks in the tailor shop, carpentry shop, mattress-making shop, or shoe shop (Figure 2.5), while others worked in the hospital garden, on the farm, or on the grounds (Figure 2.6). Female patients frequently did needlework on the wards or labored in mending and sewing rooms within their buildings; others worked in the hospital laundry (Figure 2.7). The rigidity of this system should not be overstated; the preponderance of male patients meant that the hospital’s dining rooms and kitchen employed large numbers of men as well (Figure 2.8). Nurses and attendants, moreover, encouraged able-bodied patients of both sexes to assist with domestic tasks and daily chores on the wards. And yet when it came to occupational therapy, officials assigned gender-specific tasks at each level of the program. Those who performed well could advance to more specialized and demanding courses. The “trade industrial classes” represented the highest level of advancement, but officials offered these

98 Report of the American Red Cross Unit as of June 30th, 1935, p. 3. NARA RG 418: Entry 7 (Administrative Files: Red Cross [Annual Reports, 1931-1946]). Male and female nursing students continued to attend the dances, however, with the understanding that they would “remember the wall flowers and try to draw them out.” Memorandum from Margaret Hagan to Winfred Overholser, re: The Attendance and Activities of the Nursing Personnel at the Patients’ Dances (12 Aug 1939). NARA RG 418: Entry 7 (Administrative Files: Red Cross [1937-1941]).
Figure 2.5: **Patients working in shoe shop under employee supervision (1920s).** The accompanying caption in the hospital scrapbook reads, “Male patients make shoes and slippers for the use of those patients who work outdoors, and also for some indoor patients.”

*Source:* NARA RG 418: Entry 72 (General Photographic File: Series P, Box 4).

Figure 2.6: **Ground crew (1920s).** The text in the hospital scrapbook reads, “A group of colored patients photographed while at work raking up leaves and twigs on the lawns. … Many of these patients also work on the roads (macadam) when the latter need repair.”

*Source:* NARA RG 418: Entry 72 (General Photographic File: Series P, Box 2).
Figure 2.7: Black female patients in the laundry (1920s). The text accompanying a nearly identical image reads, “In 12 years the work of the laundry has increased by 33 1/3 percent, while the number of paid employees has decreased by the same percent.”

Source: NARA RG 418: Entry 72 (General Photographic File: Series P, Box 3).

Figure 2.8: Male workers in the hospital kitchen (1920s). It is likely that the white man in the center is either a hospital employee or a patient-supervisor.

Source: NARA RG 418: Entry 72 (General Photographic File: Series P, Box 7).
classes only to men. Even among male patients, not everyone enjoyed the same opportunity to
develop new skills. Physicians proved far more likely to assign black male patients to tasks
involving unskilled labor than white men; only when they came to St. Elizabeths as veterans
could black men expect to participate in the hospital’s occupational therapy program.

Officials at St. Elizabeths interpreted men’s willingness to work as an important sign of
their mental health. Outside the hospital, ownership of one’s labor represented a central element
of men’s civic autonomy; when psychological instability called an individual’s capacity to
function independently into question, labor became an especially important sphere of
assessment. The medical and nursing staff routinely faulted able-bodied male patients for
refusing to occupy themselves in useful pursuits. Shortly after Winston Lindholm arrived at the
hospital, an attendant wrote that the 29-year-old white sailor “spend[s] the greater part of his
time in absolute idleness or playing solitaire.” “He is not very industrious,” observed another
member of the staff, “and often stays away from the ward to get out of work.” Officials
closely monitored black men’s willingness to work as well. While terms such as “apathy” and
“lack of initiative” loomed large in their assessment of white men, however, physicians
sometimes failed to recognize the loss of motivation involved in severe disorders as a symptom
among black men, viewing it instead as evidence of their natural indolence.

When it came to female patients, hospital officials’ attitudes toward employment varied
according to a woman’s ethnicity and race. For native-born white women, engagement in casual

100 See e.g. the role of patient labor in case 35858. Though the 1926 investigation gives no indication of vocational
activities on the wards for black male patients, physicians noted that veteran John Simon “works in the occupational
therapy class” in 1922. House Committee on the Judiciary, Investigation of St. Elizabeths Hospital, 47; case 28067:
clinical record (30 Dec 1922).
101 Case 32814: ward notes (18 Jan 1926; 15 March 1926). See also case 32088: ward notes (4 April 1925; 21 April
1925; 14 May 1925); case 35973: clinical record (18 Aug 1930), ward notes (10 June 1930; 11 Oct 1930).
102 See e.g. case 18423: clinical record (May 1910); case 22511: clinical record (20 June 1916).
103 Contrast the language used in cases 15280, 18895, 27965, 32429, and 36304 (white men) with the language used
in cases 18885, 28331, and 35858 (black men).
work about the ward could be an indicator of improvement. Yet physicians and attendants rarely criticized these patients for failing to pursue gainful employment. Physicians placed greater emphasis on labor among immigrant women and especially black women; at times work even became an explicitly therapeutic prescription. Like most white Americans, clinicians at St. Elizabeths assumed that black women would work outside the home. These expectations carried over easily into evaluations of patients’ behavior. Harriet Cross’s physician observed that the 36-year-old was “not making a very good adjustment[.] … [She] will not help with the ward work and interferes with other patients and their company.” Bethany Jones, in contrast, became something of a favorite. “[She is] a hard worker,” a nurse noted of the 30-year-old domestic. “Nothing is too hard or too dirty for Bethany. She states that that kind of work is for her and ‘nurses with more knowledge and understanding have to give medicine.’”

Just as men faced greater pressure to work at St. Elizabeths than women, male patients’ participation in the hospital economy carried greater opportunities for freedom than it did among female patients. Many of the tasks that men performed involved arduous labor, such as the construction of a new shop and storehouse building on the grounds in the late 1910s. Yet labor of this sort also represented an opportunity to be outdoors in what amounted to a temporary respite from “the anemic time of our indoor rooms.” Working women, in contrast, remained indoors—on their wards, in their buildings, or in the hospital’s kitchens and laundry. A willingness to work could serve as a stepping-stone for male patients to parole of the grounds or

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104 See e.g. cases 22304, 22489 and 32849.
105 Case 36023: clinical record (11 June 1930). Contrast the recommendation in this case with case 32849: clinical record (29 Nov 1925).
107 Case 28137: clinical record (26 Oct 1920).
108 Case 36339: ward notes (19 Oct 1930).
109 Annual Report 1918, 687; 1919, 781.
110 The phrase is from an essay by Belgian playwright Maurice Maeterlink which was reprinted as an editorial entitled “The Measure of the Hours” in Sun Dial 1, no. 2 (April 1917): 1.
even permission to visit the city, though white male patients enjoyed far greater opportunity in this regard than black male patients. In 1926, 41.3% of white men and 39.8% of black men at St. Elizabeths worked in some capacity; among white men, 19.7% had parole, while only 8.3% of black men did. Among female patients that same year, 29.5% of white women and 37.3% of black women worked. Even when employed, female patients remained far less likely to enjoy freedom of the grounds or permission to leave the institution; just 8.0% of white women and a stunning 1.9% of black women had parole of some kind.\textsuperscript{111}

Ultimately, the source of these gender-based discrepancies lay in a view of women as inherently dependent creatures whose civic identities were an extension of their husbands’. For men, labor represented an opportunity to demonstrate their independence; since most physicians viewed women as incapable of full civic autonomy, little reason existed to provide them with a similar opportunity.\textsuperscript{112} Female patients often moved directly from the custody of the hospital to the oversight of their husbands, where work within the home became the major focus of evaluation. There physicians and social workers deferred to the assessment offered by husbands of their wives’ well-being. Two months after Christophe Hayburn arrived drunk to take his 49-year-old wife Mabel on a visit in 1927, a physician dutifully recorded the white chiropractor’s report that she was “in very good condition, housekeeping, cooking, etc., and in general making a very good adjustment.”\textsuperscript{113} Occasionally, mothers and daughters played a similar role in helping physicians assess a young son or elderly father’s condition. For the most part, however,

\textsuperscript{111} These statistics are derived from the rates of employment and parole on the hospital services reported in the 1926 investigation, excluding those wards in Howard Hall for criminal and homicidal patients. House Committee on the Judiciary, \textit{Investigation of St. Elizabeths Hospital}, 51-72. The connection between a work assignment and parole of the grounds persisted until midcentury. See Goffman, \textit{Asylums}, 287.


\textsuperscript{113} Case 32849: clinical record (14 Jan 1928). See also case 32648: clinical record (19 Oct 1927).
psychiatrists accorded female relatives far less authority than the husbands who supervised their wives.\textsuperscript{114}

The contrasting cases of Jennie Mae Schofield and Elizabeth Hayes reveal the complex attitudes among the medical staff at St. Elizabeths on gender, labor, and autonomy. During the course of her twenty-two year confinement, Schofield obtained more freedom than many of her peers. Though she at times denied her own identity and feared she would be burned alive, physicians allowed Schofield to leave the institution to care for her ailing mother or—once her mother became a patient at the hospital—assist with her care in another building. Since a daughter’s caretaking work existed outside the formal labor market, Schofield’s performance did not signify a capacity for independence in the same way that labor did for men. As a result, hospital officials remained unlikely to interpret Schofield’s work as an argument for her release.\textsuperscript{115} As we have seen, Elizabeth Hayes came to the institution only after her family’s attempts to care for her in the home and at a private facility proved unsuccessful. When Hayes finally began to improve in 1917, physicians encouraged her to work in the hospital’s stenographic department. Three months later White offered to put her on the payroll, but she opted instead to return to her former job at the Post Office Department. Officials’ appreciation of Hayes’ autonomy underscores the flexibility of their vision and a degree of progressiveness in

\textsuperscript{114} See e.g. the relatively marginal role patients’ wives played in cases 32288 and 36289. For an episode in which a wife’s report contradicted that of her mother-in-law, see case 32578: Caroline Ashby to William A. White (8 March 1929); Arthur P. Noyes to Caroline Ashby (11 March 1929). For an example of a daughter who took her elderly father out for automobile rides, see case 35853: clinical record (10 April 1930). Among unmarried young male patients, siblings (especially brothers) often played an important role in decisions about a patient’s care. See e.g. case 27756: Gregory M. Smith to St. Elizabeths Hospital (1 Sept 1924); case 28226: clinical record (14 Dec 1921); ward notes (16 Dec 1921); Mrs. Edgar Jarrett to William A. White (n.d. [\textsuperscript{2 Dec 1920}]); Ephraim P. Allen to St. Elizabeths Hospital (29 March 1932); case 35858: clinical record (6 June 1932; 14 Nov 1932); and case 36225: clinical record (16 Oct 1930).

\textsuperscript{115} Case 18345: clinical record (19 July 1923; 17 Oct 1925; 2 Sept 2 1926; 16 April 1929).
their thought. Yet they arrived at this position only in the case of an unmarried, middle-aged woman who remained unlikely to start a family upon her release.116

Despite the pressures they faced, patients participated in the system of labor at St. Elizabeths largely on their own terms. Aside from their level of physical disability, patients’ willingness to work represented the most important factor in whether or not they took up employment. Some men and women kept busy to reassure both themselves and their physicians that they remained capable of returning to society. Shortly after undergoing surgery in the institution’s medical division in 1931, Bethany Jones informed the nurses that she planned “to work and try to get well so she can soon get out of the hospital.”117 Among long-term patients, employment could be a source of self-respect and a way of distinguishing themselves within the asylum. Even after Wilson Ashby’s condition forced officials to withdraw his parole of the grounds, he continued to stop the physicians during their daily rounds to remind them that he had once been an assistant to the gatekeeper at the hospital entrance.118

Patients exercised a degree of control over the sorts of tasks in which they engaged. During his second admission in 1925, Austrian immigrant Julius Kraus “would not accept a job in [the] dining room washing dishes.” The 58-year-old wanted to work, however, and since he had previously made his living as a tailor, he willingly accepted a placement in the hospital’s tailor shop.119 Female patients, too, favored some tasks over others. As physician Lois Hubbard observed in 1928, “women who have spent their lives in the midst of household drudgery

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116 Case 22072: clinical record (30 April 1917; 15 July 1917; 30 July 1917).
117 Case 36339: ward notes (9 May 1931). See also case 36225: ward notes (2 Sept 1930). In some cases, patients wanted to work but were unable because of their physical limitations. See e.g. case 27909: ward notes (27 June 1921); case 36025: ward notes (21 June 1930; 7 July 1930). The moral value of work also appears in Little Annie, “Contributions from Patients: A Spring Idyll,” Sun Dial 1, no. 5 (April 1918): 9-10.
118 Case 32578: clinical record (9 April 1931; 28 July 1931; 21 Dec 1931). See also Erving Goffman’s acknowledgment many years later that employment could help patients carve out a measure of autonomy within the institution. Goffman, Asylums, 90 fn. 157.
119 Case 32605: ward notes (19 Sept 1925; 26 Sept 1925).
welcome the opportunity of learning to make dainty embroidered articles and attractive baskets.”  

Even those with little enthusiasm for their work sometimes joined in simply to have something to do. Shortly after Chester Mason began basket-weaving and rug-weaving as part of an occupational therapy class, the 28-year-old white veteran told the nursing staff that “it helps him to pass away the time and break the monotony of his environment.”

Patients also used employment as a means of negotiating privileges and pursuing their own ends. Participation in the hospital economy came with concrete benefits. “[I]f while working [the patient] observes necessary rules and does not come into conflict with his immediate associates,” explained physician Alfred Glascock in the *Sun Dial*, “he proves that he is worthy of being entrusted with extended liberties.” Privileges took the form of ground parole, increased access to recreational activities, and temporary passes to the city. Once they had obtained parole, however, some patients saw little need to continue working. “It is somewhat despairing,” complained William Kenna, “to find so often that when a parole is granted, the recipient immediately shows a disinclination to employ himself and searches mainly for amusement and recreation.” Unfortunately, participation in the hospital economy did not always lead to the rewards that patients anticipated. Adele Beranek worked furiously on the wards throughout her confinement in the 1930s. Because her visions of annoying spirits continued to get her into trouble with her peers, however, physicians remained reluctant to release the middle-aged Czechoslovakian immigrant to her husband for home visits. “Both she and her husband speak very poor English,” noted the ward physician, “and it is hard to make

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120 Hubbard, “Congenial Occupation,” 226.
121 Case 32148: ward notes (15 Nov 1925). See also case 32429: ward notes (21 July 1925; 4 Jan 1926; 5 Feb 1926).
them understand why privileges are not extended. She usually keeps repeating, ‘I work here and why can’t I go out?’”

Some patients sought employment in order to circumvent hospital regulations. Walter Dewhurst worked efficiently at the laboratory for several months, but ultimately the director requested that his physician discontinue the assignment. Dewhurst had become “quite troublesome by interfering with women in the personnel there.” And 24-year-old white veteran Harold Rockwell repeatedly used his job in the administration building to try to obtain his case file. “One night when I was Officer of the Day,” complained a physician, “he went to the telephone operator and gave her the number of his record but not the name and told her I had sent him for it[.] … He has made several attempts like that. The situation ought to be protected, I think, if he works here.” Occasionally, male patients eloped from the hospital while attendants transported them in groups to and from their work assignments about the grounds.

Patients recognized the contradictions involved in working without pay while confined at an institution devoted to their recovery. Some remained unwilling to work at all. Brendan Dixon, a 20-year-old Jewish clerk in the Army, told an attendant that he “didn’t come here to work, especially on Friday as it was his day of worship.” Five years later, Claire Hausmann informed the staff that “she did all kinds of work when she was at home but did not [want] to

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125 Case 32251: ward notes (4 Aug 1925); clinical record (15 Jan 1926).
126 Case 35973: clinical record (17 Oct 1930).
127 See e.g. case 27707: clinical record (2 March 1921). On patients’ use of hospital employment for their own ends in the 1950s, see Goffman, Asylums, 171-320.
128 Case 28179: ward notes (1 Nov 1920). See also the record of Bull Cleets, who irritated physicians in 1920 by telling other patients “that if they work and are too useful here they will never get away,” and the record of Winston Lindholm, who “[gave] his reason for not working that he does not intend to stay here long.” Case 28355: clinical record (16 Jan 1925); case 32814: clinical record (20 Jan 1926).
work in this hospital.” Others preferred to develop their own initiatives. After working at the hospital fairly regularly for almost a decade, Robert Smith abandoned his assignment in the late 1920s and began selling newspapers and candy about the grounds, using the money he earned to fund occasional trips into the city. When the Canton Asylum for Insane Indians in South Dakota closed in 1933, the Bureau of Indian Affairs transferred seventy-one of its patients to St. Elizabeths. Five years later, a group of American Indian patients requested materials for native craftwork. “Money is appropriated for it every year [by the Bureau],” they explained to the physician in charge of their division, “and we would like to make things to sell. … White people go crazy over these things and we bet they [will] sell like hotcakes.”

When it came to the question of compensation for their labor, black patients proved especially willing to raise the issue. As early as 1907, government officials concluded that “the white people who go to the institution from the District of Columbia are averse to performing anything in the nature of manual labor, as they are inclined to think that such labor should be

129 Case 27602: ward notes (16 March 1925). Hausmann was not alone in her sentiment. “Patients will often argue that they have worked all their lives,” observed Hubbard in 1928, “and now they have earned a rest.” Hubbard, “Congenial Occupation,” 226. Patients from a more genteel background, in contrast, often resented being asked to work at the hospital. John P. H. Murphy, “Occupation and Cooperation,” *Sun Dial* 2, no. 3 (Jan 1924): 6.

130 Case 27756: clinical record (16 April 1930; 8 Oct 1930; 29 April 1931); ward notes (19 May 1929).

131 Officials sent American Indian patients to St. Elizabeths fairly regularly in the late nineteenth century, but this policy ended around 1899 when the U.S. government established the Canton Asylum. Former St. Elizabeths physician Harry Hummer administered the hospital for many years. Conditions there were notoriously bad, however, and on several occasions the institution was the focus of federal investigation. In 1933 Commissioner of Indian Affairs John Collier elected to close the asylum and transfer those who could not be released to St. Elizabeths. American Indian men – who made up the bulk of these patients – occupied their own ward, while the women appear to have been housed alongside white patients. Government officials also appear to have returned to the earlier policy of sending American Indian patients from federal reservations to St. Elizabeths. Though they never did so in great numbers, this policy remained in place until at least 1957. On the history of the Canton Asylum and its links to St. Elizabeths, see Todd E. Leahy, “The Canton Asylum: Indians, Psychiatrists, and Government Policy, 1899-1934” (Ph.D. dissertation, Oklahoma State University, 2006). See also the material in NARA RG 418: Entry 13 (Department of the Interior: Indian Insane, 1929 and 1933); *Annual Report* 1938, 376; memorandum from Elizabeth R. Vann to Jay L. Hoffman, Subject: Desegregation, 16 Sept 1954, NARA RG 418: Entry 7 (Administrative Files: Memoranda, Incoming [1953-1956]). At one point White suggested that the medical staff was preparing to undertake a comparative study of psychopathology among American Indian and black patients, but I have not been able to find any further reference to such a project. *Annual Report*, 1934, 376.

132 Charles C. Benton, Walter Matheson, Edgar Carpenter, Jessup Clinton, Milton Baker, Jr., and Robert Starr to William Cushard (22 Nov 1938). After much administrative confusion, it appears that the Indian patients did receive the materials they sought. It is unclear, however, whether they were able to sell the products for profit. RG 418: Entry 13 (Department of the Interior: Indian Insane, General Correspondence).
performed by the colored inhabitants of the institution. On the other hand, the colored inhabitants of the institution are averse to performing labor because they feel that all labor is entitled to pay.” Abraham Tibbs complained that “[t]he onliest time I got good sense is when I’m working for nothing, but when I ask for pay like you would, then I am out of my mind and insane.” Many of these men and women were just a generation or two removed from slavery and thus intensely aware that ownership of one’s labor represented a crucial element of their freedom. The issue became particularly acute during hard economic times. Forty-year old Vera Higgs initially did everything she could to assist on the wards. Eventually, though, she grew frustrated. “She is rather irritable,” observed a physician in 1931, “and wants to be paid for her work.” After Edmond Payne left the hospital on a visit in 1932, he returned for several interviews at the request of the medical staff before receiving his final discharge. Payne related his difficulty finding work on the outside. “He tells at length about the work he did in the dining room on Howard Hall,” noted the physician, “and inquires whether or not he might receive some pay for this work[.]”

As with the system of labor, recreation at St. Elizabeths reflected a particular gendered and racialized vision of society. The preponderance of white male patients—together with their disproportionately high rates of parole—allowed them to dominate such quasi-public spaces as the patient library and the Red Cross House. When hospital administrators moved the library into a renovated building in 1929, they initially established separate reading rooms for men and women. Soon, however, they abandoned this policy, probably because so few female patients

134 Case 18885: mental examination (31 Jan 1911).
137 Case 35858: clinical record (14 May 1933). Though white patients were far less likely to raise the issue of compensation, it was by no means unheard of for them to do so. See e.g. case 27454: ward notes (12 June 1925).
enjoyed parole of the grounds.\textsuperscript{138} The Red Cross House remained open for much of the day throughout the week, providing music, games, and opportunities for informal social interaction. The presence of young female hostesses trained to lend a sympathetic ear drew male patients to the Red Cross House, marking it as a masculine social space. Accounts of Red Cross activities highlighted the work of volunteers whose patience and understanding assuaged the concerns of idiosyncratic but harmless young men.\textsuperscript{139} Though this privileging of male patients emerged in part from the Red Cross’s mission to serve veteran patients, the original arrangement had stipulated that Red Cross activities would be open to all patients—regardless of military or civil status.\textsuperscript{140} Official policy may not have excluded female patients from socialization in the Red Cross House, but the end result remained the same.

For supervised activities among non-paroled patients, the dominant distinction proved to be one of race rather than gender. Indeed, the recreational program at St. Elizabeths became a major site for the institutionalization of racial segregation in the interwar period. When the number of black patients remained relatively small in the 1910s, they appear to have participated alongside white patients in band concerts and movies on the hospital campus as well as carriage and automobile rides into the city.\textsuperscript{141} Following the Red Cross’s arrival, however, racial segregation became increasingly formalized.\textsuperscript{142} Workers held separate dances and parties at the

\textsuperscript{138} Annual Report 1929, 3-4; 1930, 4.
\textsuperscript{139} Bolles, “Red Cross Makes Life Brighter.” Field Director Margaret Hagan recalled a conversation in which White identified the Red Cross House as “the sanctuary, the safety valve” of the hospital: “You let the patients come in there and cuss and complain and relieve their feelings. … And by a gentleman’s agreement you say nothing to me or the Hospital about it. … You just listen and reinterpret if and when you can.” Margaret Hagan, “William Alanson White – A Personal Appreciation,” Red Cross Courier 16 (May 1937): 29.
\textsuperscript{140} Annual Report of the American Red Cross Activities from July 1st, 1938 to July 1st, 1939, p. 6. NARA RG 418: Entry 7 (Administrative Files: Red Cross [Annual Reports, 1931-1946]).
\textsuperscript{141} See e.g. case 15250: ward notes (15 April 1907); case 18585: ward notes (15 Jan 1913; 15 April 1913).
\textsuperscript{142} Racial segregation was common among social welfare organizations during this period. Some groups, including the Young Women’s Christian Association, began questioning this policy as early as the 1920s. Others, however, such as the more conservative Young Men’s Christian Association, maintained a firmer policy of separation among the races. See Nancy Marie Robertson, Christian Sisterhood, Race Relations, and the YWCA, 1906-46 (Urbana, Illinois: University of Illinois Press, 2007); Helen Laville, “’If the Time is not Ripe, Then it is Your Job to Ripen the
Red Cross House, thereby eliminating one context in which interracial cross-gender contact might have occurred.\textsuperscript{143} Black men and women continued to attend movies, field day exercises, and sports games. Since the individual ward remained the hospital’s basic unit of social organization, however, most events likely remained segregated as a matter of fact if not of official policy.\textsuperscript{144} During the 1930s, with the assistance of black civic groups and representatives of the Works Progress Administration, an entirely separate program emerged to serve black men and women.\textsuperscript{145} Black patients at other public institutions often lacked even the most basic opportunities for recreation; nevertheless, this parallel program reinforced racial boundaries at the hospital and justified the exclusion of black men and women from events for white patients. The well-being of white patients, moreover, remained the hospital’s top priority. When long-term black patients began to outnumber recently-admitted white servicemen in their use of the Red Cross House in the late 1930s, officials responded by limiting the hours during which the building was open to black patients.\textsuperscript{146}

Ultimately, the extent to which men and women at St. Elizabeths participated in the hospital’s recreational program proved as varied as the patients themselves. While some remained too preoccupied with their difficulties to engage in such pursuits, others who had

\textsuperscript{143} On the Red Cross’s segregated program for black patients, see the documents in NARA RG 418: Entry 7 (Administrative Files: Red Cross [Annual Reports, 1931-1946], Red Cross [1937-1941] and Red Cross [Schedule of Activities 1937-1942]).

\textsuperscript{144} Remarks on the informal interaction of black and white patients are based in part on a 1938 photograph of spectators at an intramural baseball game and an undated photo (probably from a slightly later period) of a ping-pong tournament in Howard Hall. NARA RG 418: Entry 72 (General Photographic File: Series P, Box 4).

\textsuperscript{145} Christmas Program of Recreation Week Beginning December 20, 1937. NARA RG 418: Entry 7 (Administrative Files: Red Cross [Schedule of Activities 1937-1942]); Report of American Red Cross Activities from July 1st, 1937 to July 1st, 1938, pp. 5, 9. NARA RG 418: Entry 7 (Administrative Files: Red Cross [Annual Reports, 1931-1946]).

\textsuperscript{146} Annual Report of the American Red Cross Activities from July 1st, 1938 to July 1st, 1939, p. 6. NARA RG 418: Entry 7 (Administrative Files: Red Cross [Annual Reports, 1931-1946]).
initially been reluctant to attend hospital events gradually came to enjoy them. ¹⁴⁷ For several
years, Claire Hausmann refused to leave the ward and seemed to fear nearly everyone with
whom she came into contact. Eventually, however, Hausmann began attending movies and band
concerts, if only to add a bit of variety to an otherwise limited existence.¹⁴⁸ Habits of recreation
never became as central to psychiatric views of mental health as habits of industry, so officials
generally recorded little more than whether or not a patient routinely attended events.¹⁴⁹ When
an individual took particular pleasure in hospital activities, however, staff members noticed. A
nurse described 55-year-old William Gaston as “very enthusiastic over [the] dance[.]” “I’m
stepping out tonight,” the retired Irish sergeant informed the staff in 1930. “I’m a good dancer
and I can get the partners.”¹⁵⁰ Musically-inclined patients participated in hospital performances
as well; black patients put on minstrel shows, while American Indian patients performed
traditional dances.¹⁵¹ As with their work assignments, some men and women used recreational
activities to pursue their own ends. Walter Young tried to escape from his ward several times,
but physicians still permitted him to attend dances at the Red Cross House. Predictably, at one
such event in 1924, Young “eloped by walking out [the] front door.”¹⁵²

¹⁴⁷ Case 28331: clinical record (16 Jan 1922).
¹⁴⁸ Case 27602: clinical record (10 Jan 1922; 15 Nov 1925; 1 Oct 1928); ward notes (20 Feb 1924; 10 May 1932).
See also case 32148: ward notes (29 Nov 1925).
¹⁴⁹ Case 28288: ward notes (14 Nov 1924); case 27620: ward notes (27 Sept 1920); case 32228: ward notes (8 July
1932); case 32088: ward notes (21 April 1925); case 32814: ward notes (15 March 1926); case 36304: ward notes
(21 Nov 1930); case 36339: ward notes (12 Jan 1931); case 35973: ward notes (19 April 1930).
¹⁵⁰ Case 35865: ward notes (1 April 1930). See also the staff’s observation that Fridays were “a busy day” in the
newly-established beauty parlor for female patients since “everyone needs attention before the dance.” “More
Publicity for St. Elizabeths,” Sun Dial 3, no. 3 (Nov 1928): 11.
¹⁵¹ Red Cross Recreational Programs (21 Feb 1938; 27 Oct 1940). NARA RG 418: Entry 7 (Administrative Files:
Red Cross [Schedule of Activities 1937-1942]).
¹⁵² Case 27454: ward notes (6 Jan 1924).
CONCLUSION

For most of the patients at St. Elizabeths, psychological impairment involved far more than a change in one’s individual mental state. As we have seen, these men and women first encountered the social dimensions of their illness through interaction with either family and colleagues or representatives of the state. For those already struggling with patterns of thought and emotion that made it difficult to live up to their social obligations, conflicts with civil officials imparted an additional element of civic estrangement. Despite any difficulties they might have been experiencing, most of these men and women viewed their confinement as a far more immediate problem. Family members played a critical role in determining the fate of an individual admitted to the hospital. If patients did not improve enough to receive their discharge within a relatively short period, and if they did not have family or friends to advocate for their release, these men and women faced the possibility of spending their remaining days at St. Elizabeths or another similar institution. Patients recognized this discouraging fact. When a physician asked one young man in 1917 why he was not keeping up with the news of the world, he responded, “What is the use? I will never get out of here anyhow.”\textsuperscript{153}

Patients at St. Elizabeths resided in a world that reflected both the depth of hospital officials’ commitment to White’s program for psychiatry and the limitations of that vision. Physicians assessed patients in terms of their adjustment to the hospital environment, particularly their level of involvement with its system of labor and recreation. As we have seen, both enterprises embodied a gendered and racialized understanding of American citizenship. For white male patients, a willingness to participate in the hospital’s economy led to greater independence; white female patients faced less pressure to work, but they endured correspondingly greater restrictions on their mobility. Labor did not carry the same promise of

\textsuperscript{153} Silk, “Helpful Hints,” 5.
autonomy for black patients. Even when black men and women did achieve a measure of independence, racial segregation in the hospital’s recreational program further limited their opportunities. Within these parameters, patients exercised a degree of agency in selecting how they would spend their time and energy. In theory, a patient’s ability to function within the hospital served as an index of how well he or she might be able to perform on the outside. The category of “institutional citizenship,” however, called this equation into question. In the absence of dramatic therapeutic innovation, many physicians doubted whether these men and women would ever fulfill their aspirations for a full, accomplished, and independent life beyond the walls of St. Elizabeths.
CHAPTER THREE. BODY AND SOUL: SOMATIC TREATMENT AT ST. ELIZABETHS

INTRODUCTION

Despite labor and recreation’s importance in the hospital regimen, officials could not always convince patients and their families that they represented medical treatment for the conditions that brought men and women to the institution. Public expectations of medicine were changing rapidly in the early decades of the twentieth century. As the general hospital became a major site for clinical procedures, the encounter with medical technology became increasingly important to perceptions of appropriate care.¹ Even as psychiatry’s leadership sought to establish the legitimacy of extramural practice, most of the profession continued to work in the nation’s extensive network of state hospitals. Psychiatrists remained acutely aware of their marginal status within the medical profession, as well as the potential for encroachment from such allied groups as clinical psychology and psychiatric social work. In this context, institutional psychiatrists sought to affirm their medical identity by reinvesting in biological approaches to the treatment of mental illness.²

A combination of professional and institutional imperatives thus led psychiatrists to adopt an increasingly radical array of somatic interventions in the first half of the twentieth century. Over the course of the past fifteen years, historians have produced a rich and well-developed literature on this topic. Hydrotherapy, malarial fever therapy, insulin coma, metrazol shock, electroshock treatment, and psychosurgery (lobotomy) have all, in varying degrees, been the

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² Grob, Mental Illness and American Society, 243-264, 266-269, 291-308.
focus of intensive historical analysis.\textsuperscript{3} Though historians have differed on what these treatments meant for patients, most have agreed that they became central to clinical practice in this period.

Physicians at St. Elizabeths employed each of these treatments. Given White’s early and enduring interest in psychoanalysis, this may seem counterintuitive. As we have seen, White created positions in the 1910s involving primarily psychotherapeutic duties; physicians Edward Kempf and Lucile Dooley held weekly clinics for patients “who desire assistance in the solution of their personal problems.”\textsuperscript{4} Yet when officials celebrated the twenty-fifth anniversary of White’s superintendency in 1928, they placed malarial fever therapy alongside psychotherapy as the most important innovations that had taken place at St. Elizabeths in the last quarter-century.\textsuperscript{5} Indeed, psychological and somatic approaches represented complementary aspects of a unified clinical vision for most institutional psychiatrists.\textsuperscript{6} While the resolution of intrapsychic conflicts would become increasingly important in the office-based psychiatry that emerged after World War II, physicians’ goals for their hospitalized patients in the first half of the twentieth century remained far more pragmatic. “The target was not to heal a sick body or set a broken mind,”

\begin{itemize}
\item \textsuperscript{5} Arthur P. Noyes, “A Quarter of a Century of Service,” \textit{Sun Dial} 3, no. 2 (Oct 1928): 2.
\item \textsuperscript{6} See e.g. the emphasis on physiology in Kempf’s \textit{Psychopathology} as well as the diversity of research carried out by his successor, Nolan D. C. Lewis. Lewis’s publications can be followed in the hospital’s \textit{Annual Reports} during his tenure there from 1922 to 1935.
\end{itemize}
writes historian Jack Pressman, “so much as to restore an individual to proper functioning within the larger body politic.” Psychiatrists might disagree on the ultimate causes of mental illness, but the clinical imperative to do something demanded that they remain flexible in their approach. As Jonathan Sadowsky, Nicolas Rasmussen, and Mical Raz have all recently argued, the tension between psychological and biological perspectives may have been far less central to the daily practice of psychiatry than has been previously supposed.

In the sections that follow, I provide an overview of somatic treatment at St. Elizabeths in the first half of the twentieth century. I begin with hydrotherapy, perhaps the most common form of corporeal treatment in public mental hospitals between 1900 and 1940. Though its rationale evolved considerably, the basic practice and aims of hydrotherapy remained remarkably consistent. I then turn to an intensive examination of malarial fever therapy for general paresis (neurosyphilis), a treatment that made its North American debut at St. Elizabeths in 1922. Paresis represented perhaps the most extreme example of mental illness as biological disorder. Even here, however, White found room for a psychological interpretation of patients’ symptoms. I conclude with a section on the shock therapies (metrazol, insulin coma therapy, and electroshock) and lobotomy. Among these interventions, only electroshock became a regular component of the hospital’s therapeutic armamentarium. While St. Elizabeths played an important role in the early history of lobotomy, physicians there approached the procedure cautiously and employed it only on a limited basis.

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7 Pressman, _Last Resort_, 222, 223.
9 In addition to the records of patients admitted to St. Elizabeths between 1900 and 1930 (described in ch. 2, fn. 5 above), in the sections that follow I also employ a set of case files from men and women admitted between 1945 and 1960. St. Elizabeths’ clinical records from the post-1940 period remain under the authority of the institution; they are located at the Washington National Records Center in Suitland, Maryland and in the hospital’s Medical Records.
HYDROTHERAPY AND THE VIRTUES OF SELF-GOVERNMENT

The therapeutic use of water has long been a part of American attitudes toward health and disease. At the height of mid-nineteenth-century medical sectarianism, hydropathy represented one among many schools of thought opposed to the rigidity and harsh methods of allopathic medicine. Water spas and retreats proliferated, catering especially to patients suffering from nervous ailments. By the postbellum era, however, a combination of political infighting, pressure from the medical profession, and changing ideas about health and leisure had begun to undermine hydropathy’s appeal. By the 1890s, regular physicians had incorporated many of the methods of hydropathy into their armamentarium, recommending water as one element in the management of complex disorders. From there it proved just a short step to introduce these methods into the mental hospital.

Recast as hydrotherapy, water treatment allowed asylum physicians to display their command over a highly technical body of knowledge at a time when medical authority drew increasingly upon new technologies in the general hospital. Physicians’ orders included precise attention to the type, temperature, and length of treatment. These orders, moreover, typically

Department. I again selected patient records with the assistance of a random number generator and the hospital’s sequentially-assigned case numbers for men and women admitted in 1945, 1950, 1955, and 1960. (Unavailability of the 1940 admission log prevented inclusion of this year.) Because of the increased admission rate in the post-World War II period, I collected only 1.25% of admissions, rather than the 2.50% collected for the 1900-1930 period. Photo editing software allowed me to create a limited data set from these records in which the sixteen categories of direct identifiers defined by 45 CFR § 164.514(e) – including patients’ names, addresses, social security numbers, and medical record numbers – were removed from document images. As was the case with the pre-1940 records, not all of the selected cases were available, so I again continued employing numbers from the random number generator to select records until I had collected the requisite percentage. (The approximate percentage of files that were available in each year were as follows: 1945 – 92%; 1950 – 91%; 1955 – 68%; 1960 – 86%.) Many of these men and women had multiple admissions to the hospital. I have included each of these in my analysis, though typically the ward notes appear to have been discarded from all files except the most recent. This gave me a total of 98 patients with 159 separate admissions. While I have endeavored to assign pseudonyms that reflect patients’ ethnic backgrounds, these names do not bear a systematic relation to the patients’ actual names as they do for the pre-1940 period. In a few instances where it appeared likely that a case might have received newspaper coverage, I have also altered inessential details that would permit identification by other means.

appeared alongside prescriptions for more traditional forms of medicine in the patient’s record. “[W]ater is an important integral part of our Materia Medica,” wrote physician and hydrotherapy pioneer Simon Baruch in 1920, “requiring the same careful preparation, exact dosage, and precise administration as do drugs.”

Physicians at St. Elizabeths became some of the first in the country to incorporate hydrotherapy into their practice. As early as 1897, assistant physician George Foster began employing wet sheet packs and continuous baths on the wards for white male patients. Foster received instruction from Baruch himself, who credited “the phenomenally rapid adoption of hydrotherapy in asylum practice” to Foster’s “able clinical demonstration.” When the new receiving buildings for white male and female patients opened in 1905, they included facilities for water treatment. Black female patients gained access to hydrotherapy in 1904 when officials moved them into the building where Foster had originally pursued his work; the wards for black male patients, however, lacked even the most elementary equipment for another twenty years.

Throughout the early editions of his textbook, White described hydrotherapy as “one of the more valuable of the recent additions to the means of treating insanity.” “[W]e know of no other single item,” he wrote in his Annual Report for 1919, “that has done more to add to the comfort of the patients and relieve them when restless and disturbed than the proper use of the hydrotherapeutic apparatus.”

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13 O’Malley, “Hydrotherapy,” 143; *Annual Report* 1903, 341; 1905, 768; 1926, 8; 1927, 6.
15 *Annual Report* 1919, 799.
When it came to decisions about when and for whom to prescribe hydrotherapy, physicians drew in equal measure upon clinical values, administrative imperatives, and social assumptions. Restoration of self-control represented the overriding goal, with control over one’s behavior serving as the foundation for individual self-government. Hydrotherapy thus became particularly important for men and women in the midst of an acute episode of excitement, serving as an alternative to drug sedation or physical restraint. Patients often received hydrotherapy shortly after admission, when officials remained most hopeful about the prospect of recovery. Once they became “chronic” cases, in contrast, patients were far less likely to receive the treatment unless they unexpectedly became disruptive on the wards.

The theoretical rationale for hydrotherapy evolved over the course of the first half of the twentieth century. Early advocates such as Baruch emphasized its effects on physiological autoregulation and the excretory functions of the skin.16 In the 1910s and 1920s, physicians at St. Elizabeths documented the physiological processes at work in hydrotherapy but refrained from offering speculative explanations for its efficacy. The treatment had rapidly proven its value in hospitals across the country, rendering the underlying mechanism by which it worked largely irrelevant. Nevertheless, in 1921, White opened up a new line of explanation: “The continuous bath, in spite of all that has been written about its physiology, to my mind accomplishes its results psychotherapeutically[.]”17 Physician Lois Hubbard further elaborated White’s view: “[T]he continuous bath provides the illusion of that … much-desired intra-uterine existence, thus leaving the entire personality free to attend to the problems underlying the psychoses.”18

16 Simon Baruch, The Uses of Water in Modern Medicine, 2 vols. (Detroit, Michigan: George S. Davis, 1892). See also Foster, “Hydric Treatment,” 640.
Physiological principles continued to dominate the thinking of physicians elsewhere.\textsuperscript{19} While St. Elizabeths psychiatrist Jay Hoffman acknowledged the physiological action of hydrotherapy in 1939, he insisted that “there is also a psychological or suggestive beneficial action which is extremely important. … [T]he patient benefits because he becomes the center of attention and this satisfies to some extent his unconscious desire for self-love.”\textsuperscript{20}

This changing rationale notwithstanding, the basic methods physicians at St. Elizabeths employed remained largely the same from their introduction in the 1890s until their gradual abandonment in the 1950s. The continuous bath and wet sheet pack represented the staples of hydrotherapy. In the \textit{continuous bath}, a patient lay suspended in a hammock within a large tub equipped to allow water to flow through at a constant temperature (Figure 3.1). At many institutions, attendants fastened a patient in the bath with a canvas sheet or camisole. White and his colleagues, however, insisted that such measures could both be unsafe (because an unattended patient would be unable to leave the tub if the temperature rose unexpectedly) and anti-therapeutic (because of the perception of restraint).\textsuperscript{21} The \textit{wet sheet pack}, which physicians prescribed in hot or cold versions, involved wrapping the patient in sheets that had been dipped in water of a specified temperature and wrung out. Attendants then enfolded patients in blankets and a rubber sheet, maintaining them in this state for twenty minutes to two hours (Figure 3.2).

Other methods existed as well. While the \textit{shower bath} resembled a conventional shower, the \textit{needle spray} required a more specialized apparatus, in which small, laterally-directed jets of water struck patient from four directions at once (Figure 3.3). In the \textit{Scotch douche}, attendants applied a strong jet of water to the spinal column from a distance of fifteen feet (Figure 3.3). In

\textsuperscript{19} See e.g. Rebekah Wright, \textit{Hydrotherapy in Hospitals for Mental Diseases} (Boston, Massachusetts: Tudor Press, 1932).

\textsuperscript{20} Jay L. Hoffman, “Hydrotherapy in the Treatment of Mental Disease,” \textit{Medical Record} 49 (7 June 1939): 384-385.

Figure 3.1. Nurse exhibiting patient in continuous bath (1910s).

Source: NARA RG 418: Entry 72 (General Photographic File: Series P, Box 3).

Figure 3.2. Patients in wet sheet packs (1910s).

Source: NARA RG 418: Entry 72 (General Photographic File: Series P, Box 7).
Figure 3.3. This patient stands in an apparatus that combined the shower bath and needle spray, while an attendant operates the Scotch douche (1910s).

Source: NARA RG 418: Entry 72 (General Photographic File: Series P, Box 3).

Figure 3.4. Patients in sauna bath (1910s).

Source: NARA RG 418: Entry 72 (General Photographic File: Series P, Box 3).
the *sitz* bath, patients sat with their pelvises immersed in a small chair-shaped bath with continuously-flowing water. Physicians also regarded the *hot air cabinet* as an element of hydrotherapy (Figure 3.4). Patients sat in a small cabinet that closed around them with their heads protruding from a hole in the top; attendants applied a cold towel to the patient’s neck while raising the temperature in the cabinet to bring about extensive perspiration.\(^{22}\)

Psychiatrists at St. Elizabeths prescribed hydrotherapy primarily for men and women shortly after their arrival. The therapeutic objective was self-control in the broadest sense—not just command over one’s speech and behavior, but an ability to modulate the social extension of one’s will and interact productively with others. Physicians associated a few modes of treatment with specific illnesses; the Scotch douche, for instance, seemed particularly useful in the psychoneuroses and cases of catatonic dementia precox (schizophrenia).\(^{23}\) For the most part, however, diagnostic categories proved less important than the amount of time a patient had spent at the institution.\(^{24}\) Even those for whom physicians held out little hope of recovery sometimes received hydrotherapy during their initial weeks at the hospital. Alfred Ross had already received a diagnosis of paresis when he arrived at St. Elizabeths in 1920; his interviewing physician rapidly concluded that the 43-year-old white baker “is now so dilapidated that nothing can be brought out.” Ross nevertheless received daily treatments in the hydrotherapy department throughout his first month.\(^{25}\) In these cases, the treatment served primarily as a means of

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\(^{22}\) The best description of methods employed at St. Elizabeths is Mary O’Malley’s “Hydrotherapy,” 149-152. See also Lois D. Hubbard, “Hydrotherapy in the Mental Hospital,” *American Journal of Nursing* 27 (1927): 642-644; Hoffman, “Hydrotherapy in the Treatment of Mental Disease,” 382-385.


\(^{24}\) Most cases of acute illness at the hospital were recent admissions. Not all recently-admitted patients, however, were acutely ill. As we have seen, many had been experiencing symptoms or deteriorating gradually for months or even years prior to their admission; some had spent time at other institutions before coming to St. Elizabeths.

\(^{25}\) Case 28205: initial assessment (29 Oct 1920); ward notes (19 Nov 1920).
reassuring patients and their families that concrete therapeutic measures were being undertaken, though the suggestive element likely played an important role as well.  

For patients who remained seriously impaired after a few weeks or months at the hospital, physicians used hydrotherapy less to restore health than to enforce the minimal behavioral standards necessary to function in an institutional environment. “Institutional citizenship” rather than full civic autonomy provided the dominant framework. While both the wet sheet pack and, to a lesser extent, the continuous bath involved immobilizing patients for long periods, physicians insisted that these measures represented more than mere methods of restraint. Officials allowed patients to try out the treatment on their own terms, and some appear to have rejected it without obvious repercussions. Nevertheless, on the hospital’s unruly back wards, pacification could become an end unto itself. Six months after Adele Beranek’s admission, a nurse wrote that the 48-year-old Czechoslovakian immigrant “has been very noisy” and that “[s]ometimes [she] has to have two cold packs per day.” Because hydrotherapy often meant removing an excited or disruptive patient from the ward, it could also help to maintain a therapeutic atmosphere for others. Through the proper use of hydrotherapy, O’Malley observed, “the contagion of excitements is obviated.”

For some patients, the innocuousness of water eased any anxieties they may have had about hydrotherapy. Physicians eagerly highlighted the experiences of men and women who responded positively to the treatment. “So greatly is hydrotherapy appreciated by patients who

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26 Hoffman, “Hydrotherapy in the Treatment of Mental Disease,” 384.
28 Case 35973: ward notes (2 Aug 1930); case 18345: clinical record (15 Sept 1929).
have recovered with its help,” reported Hubbard, “that they often return to the hospital years after discharge to ask for treatments to help them through some period of strain or fatigue.” Clinical records confirm that some patients found themselves rejuvenated by the institution’s baths, showers and sprays. Elliot Hornby struggled with fatigue and ill-defined physical complaints for several years before being arriving at St. Elizabeths in 1920. Two months later, the 31-year-old white motorman reported that hydrotherapy had “diminished his nervousness” and that “the pains in his chest and his breathlessness are not as troublesome as they were[.]” A few even appear to have found hydrotherapy pleasurable. A month after Brendan Dixon arrived at the hospital, a physician set out to interview the 20-year-old Jewish military clerk. “He was in a pack and did not seem to mind the treatment,” his interviewer noted. “On being taken out … he skipped gaily to the shower, which he enjoyed immensely.”

Others, however, regarded hydrotherapy as a form of punishment or restraint. Physicians acknowledged that in some cases a certain amount of compulsion might be necessary. Shortly after Chester Mason’s admission, the 28-year-old white veteran threatened a female physician. The staff responded by placing him in a pack. “Resisted treatment all along,” a nurse observed, “and persuasion was necessary to [gain] his cooperation.” Physicians argued that hydrotherapy should never serve as a response to wrongdoing; at times, however, attendants employed it as precisely that. Mabel Hayburn remained unpleasant and occasionally assaultive during her time as a patient, developing a particular dislike for one of the nurses on her ward. One day, the 49-year-old white homemaker cornered the nurse in a bathroom to berate her, “[calling] her all the

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32 Case 32288: clinical record (19 June 1925).
34 Case 32148: ward notes (17 Feb 1925).
profane names she could.” Later that afternoon, when Hayburn refused to attend hydrotherapy, the staff opted to take her there by force. As in other, similar facilities, officials tended to view maintenance of institutional order as a precondition for their therapeutic and administrative goals. The line between persuasion and coercion could become vanishingly thin; in this context, patients proved far more likely to interpret hydrotherapy as a form of abuse than as a legitimate treatment.

Black women at St. Elizabeths shared the ambivalence of their white peers toward hydrotherapy. Some regarded the treatment neutrally or even enjoyed their time in the baths. Others, however, resented the measures. “A noisy depressed patient … regarded the bath as one of the numerous tortures imposed upon her for her sins,” wrote Lois Hubbard, “and she reacted with appropriate shrieks. She … showed no quieting effects afterward, so the treatment was discontinued.” Hubbard’s account of hydrotherapy on the wards for black women reveals the same tension between coaxing and compulsion that appears elsewhere in the hospital records. Though she insisted that hydrotherapy “is practically devoid of therapeutic effect and perhaps even harmful … [when] the patient undergoes it with an antagonistic attitude,” Hubbard went on to describe episodes in which the staff placed patients bodily into the tubs and even ducked them underwater. While officials allowed patients to refuse hydrotherapy if they resisted strongly enough, in these instances the struggle itself almost certainly dominated one’s experience.

The absence of hydrotherapy facilities for black men contributed to higher rates of restraint and seclusion on these wards. Black patients resided in older buildings at St. Elizabeths and therefore did not benefit as readily from innovations that depended on architectural design.

35 Case 32849: ward notes (20 Jan 1926). 36 See e.g. Lerner, Contagion and Confinement, 116-139. 37 Hubbard, “The Continuous Bath and the Affective Psychoses,” 104. 38 Ibid. 39 Ibid., 103.
Between 1919 and 1922, incidents of seclusion and restraint occurred with a 50% greater frequency among black men than among white male patients.\(^{40}\) When Warren Lange began to attack those around him, attendants placed the 38-year-old black veteran in a secure room by himself; while attendants may ultimately have secluded a white patient under similar circumstances, they likely would have tried a wet sheet pack or continuous bath first.\(^ {41}\) Similarly, when Richard Tyler became uncooperative while returning from his allotted time on the lawn, the attendants opted to bring the 48-year-old inside by force; once inside, they placed him in seclusion.\(^ {42}\) Had it been a white patient in this scenario, attendants might have called upon a physician to request an order for hydrotherapy. For a black male patient, however, coercion and seclusion constituted the natural response. When black men at the hospital finally gained access to hydrotherapy in the 1920s, officials prioritized the care of black veterans, who by one common standard had earned recognition as citizens through their military service.\(^ {43}\)

Physicians thus created a self-fulfilling prophecy in which material circumstances produced what they assumed to be natural behaviors among black men. The number of patients on the wards for black men and women in 1926 exceeded the wards’ original capacity by an average of 40.7%, compared to 32.6% on white wards.\(^ {44}\) That year, an attendant described 29-year-old black veteran John Simon as “sullen, obstinate, and threatening.”\(^ {45}\) Against the backdrop of daily conflicts on the wards, Simon’s physicians likely viewed his behavior as

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\(^{40}\) Data derived from *Annual Report* 1919-1922. These are the only years during which rates of restraint and seclusion were reported by race.

\(^{41}\) Case 28331: Arthur P. Noyes to Carson Lange (28 Dec 1921).

\(^{42}\) Case 32298: ward notes (20 April 1925).


\(^{44}\) The disparity is even greater when we use the “adjusted capacity” rather than the “normal capacity” for each ward: black male wards exceeded their adjusted capacity by 7.0%, while white male wards were actually 5.8% under capacity. These figures are derived from a detailed statistical portrait of each ward on 30 June 1926 in House Committee on the Judiciary, *Investigation of St. Elizabeths Hospital*, 53-67. I have excluded wards in the hospital’s internal medicine department as well as those two wards (one for tubercular patients and one for “juvenile defectives”) which contained both black and white patients.

\(^{45}\) Case 28067: clinical record (22 May 1926).
falling within the range of clinical acceptability. Even after hydrotherapy became available, racial assumptions built into the hospital’s administrative structure continued to shape black patients’ care. Edmond Payne stopped eating six months after his admission to St. Elizabeths in 1930. Soon the ward staff began holding the 27-year-old cook down to administer tube feedings, but Payne remained defiant at every opportunity. Ultimately officials transferred him to Howard Hall, the hospital’s highly-secure division for the criminally insane.⁴⁶ Though officials at times transferred white patients to another service because of their conduct, they only rarely sent such men to Howard Hall.⁴⁷ Black male patients, however, received care as part of the same administrative unit responsible for criminal male patients of both races—an arrangement which surely facilitated the more rapid transfer of black patients like Payne to Howard Hall.⁴⁸

FEVERED DECISIONS: THE MALARIAL TREATMENT OF NEUROSYPHILIS

Perhaps the most novel therapy that physicians at St. Elizabeths introduced in this period was the malarial treatment of general paresis, a form of neurosyphilis also known as general paralysis of the insane. Malarial fever therapy originated with Austrian psychiatrist Julius Wagner-Jauregg’s observation that patients who contracted high fevers sometimes improved after recovering from the illness. Beginning in the late 1880s, Wagner-Jauregg experimented with a variety of fever-inducing agents, including erysipelas and tuberculin. Despite discouraging early results, Wagner-Jauregg persisted, narrowing his focus to paresis because so few spontaneous recoveries occurred. When he tried malaria in 1917, the results proved far more encouraging. Wagner-Jauregg initially published his findings in German in 1918, then again in

⁴⁷ See e.g. case 32148: clinical record (19 Feb 1925); ward notes (17 Feb 1925); case 28226: clinical record (4 Dec 1920).
⁴⁸ House Committee on the Judiciary, *Investigation of St. Elizabeths Hospital*, 41, 65-67; *Annual Report* 1936, 399; Winfred Overholser, Memorandum in Regard to Rearrangement of the Medical Services, 22 Sept 1939, NARA RG 418: Entry 7 (Administrative Files: Orders from Superintendent [1937-1945]).
English four years later. Researchers theorized that the paroxysmal fevers associated with malaria arrested the syphilitic process either by heightening the immune response or by killing the heat-sensitive spirochetes directly. William A. White first learned of the procedure through his associate Smith Ely Jelliffe, who had visited Wagner-Jauregg’s clinic during a trip to Europe. In the winter of 1922, White traveled to New York to hear a German colleague lecture on the subject. While he did not hold “any great optimism” about the method, White nevertheless encouraged his staff to investigate its potential.

Though it appeared in only a small percentage of men and women who contracted syphilis, paresis nevertheless represented a terrifying diagnosis with an almost invariably terminal outcome. Symptoms first appeared between five and twenty years after initial infection, often in the form of reduced motivation, impaired judgment, and characteristic neurological signs. For White, the prototypical patient was an educated man of some means—“a previously respected citizen, father of a family, occupying an enviable social position”—in whom the illness gradually eroded his ability to perform the obligations of citizenship:

There is a beginning failure on the part of the patient to continuously apply himself to his work[;] … memory is not quite so good and business engagements and the details of business are soon forgotten, the morale of the patient is apt to undergo alteration, and he may go to excess in drinking and associate with lewd women[.] Soon patients began seeing or hearing things not there or expressing bizarre beliefs; often these delusions centered on their great imagined wealth and prestige. The condition progressed


53 Ibid., 146. These passages were not unique to the 1921 edition, recurring from the textbook’s initial appearance in 1907 through the final edition in 1935.
inexorably toward physical debility and dementia. Patients lost the ability to speak and walk, with seizures of increasing frequency and severity marking their decline. Acutely-ill patients typically died within eighteen to thirty-six months of the onset of neurological symptoms, though White acknowledged that some patients lived much longer.

Leading psychiatrists disagreed on whether paresis ought to serve as a model for understanding other mental conditions. Rockefeller Foundation researchers Hideyo Noguchi and J. W. Moore confirmed the syphilitic origins of the disease in 1913 when they identified the spirochete in the brains of paretic patients at autopsy. For somatically-inclined psychiatrists, this suggested that laboratory methods might revolutionize the field along the same lines that they were transforming general medicine, with symptom-based classification giving way to specific disease entities based on etiology.54 Others remained less certain. According to Adolf Meyer, psychological impairment represented the outcome of a complex chain of life events—even in cases involving general paresis.55 White acknowledged the syphilitic origins of the disease, but emphasized the dynamic psychological matrix from which symptoms emerged. “The destructive luetic process produces as it advances an ever increasing mental inefficiency,” he wrote, “which is compensated for in the only possible way because of its organic basis, namely by fantasy.” Drawing from the psychoanalytic theories of Alfred Adler, White suggested that “[t]he patient begins to build up delusions of power to compensate for the progressing weakness[.]”56 Here, as elsewhere, somatic and psychic perspectives on mental illness proved remarkably compatible.

Medical advances and public health campaigns did little to reduce the stigma associated with paresis in the early decades of the twentieth century. By the 1910s, most physicians had

54 Grob, Mental Illness and American Society, 112, 120, 132-133.
access to relatively reliable diagnostic tests (particularly the Wassermann complement fixation test) as well as Paul Ehrlich’s widely-hailed drugs arsphenamine and, later, neoarsphenamine. Though of little use once the disease entered the central nervous system, these drugs proved moderately effective at the time of initial infection. Social reformers and public health activists launched an intensive campaign to break the “conspiracy of silence” surrounding sexually-transmitted diseases; mobilization for World War I made the issue a national priority, with public recognition of the problem achieving unprecedented levels. Most physicians and reformers remained committed to a conservative sexual morality, however, which ultimately undercut public education and access to medical care. Federal resources became increasingly scarce in the 1920s, a reality that many social observers overlooked when they attributed rising rates of sexually-transmitted disease to a loosening of sexual mores.  

Paresis represented one of the most common diagnoses among patients at St. Elizabeths. Between 1909 and 1918, paresis and cerebral syphilis made up an average of 10.4% of all admissions to the hospital; between 1925 and 1930, they comprised an average of 14.9% of first admissions. Like many hospitals, St. Elizabeths maintained an autonomous syphilology clinic, administered for many years by physician Theodore Fong. Despite the hospital’s commitment to active treatment, many patients arrived late in the disease with little hope of recovery. Such


58 Only dementia precox (schizophrenia) (37.0%; 43.8%) and occasionally the various forms of senile dementia (17.5%; 13.1%) made up a greater proportion of cases. *Annual Reports* 1909-1918, 1925-1930.

59 Some patients were uncomfortable at the prospect of receiving treatment from a doctor of foreign extraction; 45-year-old white businessman Wilson Ashby initially refused Fong’s care, going so far as to call upon Secretary of the Interior Hubert Work to register his complaints in 1926. Eventually, however, Ashby came to trust Fong and even bragged that he had been among his first patients. Case 32578: clinical record (3 Feb 1926; 15 Jan 1931); ward notes (12 Jan 1926; 13 Dec 1928); memorandum from William A. White to Hubert Work, In re: W. H. Ashby, 13 Jan 1926; Hubert Work to Mrs. W. H. Ashby (15 Jan 1926); Caroline Ashby to William A. White (5 Feb 1926).
was the case for 39-year-old black laborer Jedidiah Mullis, who one physician described as "obviously shattered."\(^{60}\) Often the staff could offer little more than comfort and sympathy.

Frederick Evars brought his young son Ronald to St. Elizabeths in 1925. Emily Evars, the boy’s mother, had arrived at the hospital several months earlier and was responding well to treatment. When it came to her son’s congenital cerebral syphilis, however, the staff held out little hope for recovery. The admitting physician observed that the white 12-year-old “appears to be less in contact with his surroundings than a six month old baby,” while another doctor described him as “merely a spinal cord animal.” In the months that followed, the boy deteriorated still further, ultimately dying within a year of his admission.\(^{61}\)

For many white observers, the disproportionately high rates of syphilis in the black community prompted speculation about the links among race, disease, and sexual morality. White’s prototypical patient notwithstanding, black patients exhibited far higher rates of general paresis than white patients at St. Elizabeths. Between 1925 and 1930, black men and women made up just 25% of all first admissions, but they constituted 43% of cases diagnosed with paresis or cerebral syphilis.\(^{62}\) This resulted in part from the lower rates among servicemen and recent veterans. Soldiers and sailors received intensive instruction on how to avoid exposure during their service; if they believed themselves to have been exposed, these men had ready access to prophylactic measures.\(^{63}\) Few psychiatrists appreciated this complex interplay of

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\(^{60}\) Case 32906: initial assessment (28 Dec 1925).

\(^{61}\) Case 32612: admission note (31 Aug 1925); unidentified document (n.d.); ward notes (10 July 1926).

\(^{62}\) Put another way, the average percent of first admissions diagnosed with paresis or cerebral syphilis between 1925 and 1930 was 10.6% for white patients and 24.8% for black patients. Data derived from *Annual Report* 1925-1930. While stereotypes about black sexuality may have contributed to physicians’ willingness to diagnose black patients with paresis, the condition often presented with well-characterized neurological symptoms that were difficult to miss. Hospital officials had begun experimenting with the Wassermann test in 1909, moreover, and by the mid-1910s it was a routine element of medical practice. *Annual Reports* 1909-1910, 1912.

\(^{63}\) There were other reasons, as well, to expect lower rates of paresis among veterans. Even if they had been exposed to syphilis during the First World War, few of the young servicemen admitted to St. Elizabeths would have passed through the extensive latency period that preceded the condition’s onset. And while a history of venereal infection
variables, however, and many likely agreed with physician Mary O’Malley’s 1914 assertion that the root of the problem lay with blacks’ inherent licentiousness. “Before their animal appetites all barriers which society has raised in the instance of the white race go down,” she declared, “as though without power of frustrating them. These appetites are gratified to such a degree that the result of these vices is a factor which has probably done more than all others to produce mental disease.”

The differential rates at St. Elizabeths also reflected an epidemiological reality sufficiently alarming to attract the attention of philanthropic groups and federal officials. With increased migration in search of labor and the resulting expansion of sexual networks, it is likely that sexually-transmitted diseases were increasing in the black community. Poverty, lack of education, and inadequate access to health care—all products of a pervasive system of racial injustice—could only magnify the problem. When the Rosenwald Fund sponsored a survey of syphilis rates in the rural South in 1929, researchers found an extraordinarily high prevalence in some areas. This became the basis for the infamous U.S. Public Health Service study at Tuskegee, Alabama. In 1932, researchers began monitoring the condition of black men with syphilis in Macon County, Alabama, ultimately hoping to chart the natural history of the disease. By some accounts, officials actively prevented these men from receiving treatment, even once penicillin became available in the 1940s. Physicians at St. Elizabeths proved far less cavalier was no longer officially grounds for rejection from the service, many white draftees were nevertheless excused on this basis. Finally, military officials often denied disability benefits to veterans suffering from the complications of venereal infection, though it is unclear whether this meant they were always ineligible for care at St. Elizabeths. 

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about syphilis than their counterparts at the U.S. Public Health Service, perhaps because of their familiarity with one of the worst possible outcomes when the disease remained unaddressed. During the course of White’s administration, they appear to have treated syphilis aggressively at all stages—regardless of a patient’s race.

St. Elizabeths physicians nevertheless agreed with Public Health Service officials that the disease followed a different course in white and black patients. In the process, they employed both biological and psychological arguments in their accounts of black inferiority. Researchers elsewhere sometimes suggested that blacks were less susceptible to the ravages of neurosyphilis than whites, a line of reasoning that echoed O’Malley’s assertion that blacks’ less “highly-organized” nervous system protected them from some conditions. Yet in Lois Hubbard’s comparative study of black and white paretic women, the St. Elizabeths physician looked to psychological rather than biological factors to explain differences in presentation. Hubbard wondered if there might be “some qualitative difference in the personality of the negro, a stolidity or apathy” that obscured the early features of the condition. Physicians’ tendency to minimize blacks’ intellectual capacities shaped Hubbard’s perception as well. White women often became confused, she concluded, whereas black women tended to become elated and euphoric. Once again, psychological and biological perspectives on mental illness intertwined seamlessly at the level of clinical practice.

For white patients and their families, paresis’s association with a form of racialized sexual immorality further magnified the stigma of insanity. For some, a diagnosis of syphilis
could be sufficiently distressing to prompt thoughts of suicide. Jackson Cuthbert received a positive Wassermann test in 1929 following a drinking spree in Shanghai. The 34-year-old sailor became despondent over having brought shame on the family; shortly thereafter he attempted to cut his wrists and throat.\textsuperscript{70} Physicians walked a fine line when communicating with employers, friends and family about the cause of a patient’s illness. When Reginald Whitt’s cousin wrote in 1920 to inquire about his condition, officials responded that the 33-year-old former sheet metal worker suffered from “a condition known as ‘dementia paralytica’ which is the result of a specific chronic blood disease.”\textsuperscript{71} A diagnosis of neurosyphilis could be particularly mortifying for the female spouses of male patients, not least because they realized that they, too, might be infected. Caroline Ashby described her husband’s admission in 1925 as “quite a shock,” but she nevertheless learned all she could about his condition and pressed for the best care available. As her husband’s mental state deteriorated, their relationship grew strained. Ultimately, she sought a divorce. “I cannot endure longer the life I have been compelled to live,” she wrote in 1929. “His condition has so upset me that I am unable to do justice to myself.”\textsuperscript{72}

While black patients and their families took a somewhat more pragmatic approach to a diagnosis of syphilis, this did not necessarily obviate the stigma surrounding mental illness. The pioneering black sociologist Charles Johnson found that poor Southern blacks drew little distinction between the symptoms of syphilis and those of the many other conditions they endured, tending to view all physical illness with a sense of resignation.\textsuperscript{73} The manifestations of the disease in its later stages, however, remained an entirely different matter. In some cases, the

\textsuperscript{70} Case 36225: initial assessment (19 Sept 1930); information from aunt and brother (26 July 1930).
\textsuperscript{71} Case 27912: Arthur P. Noyes to Jocelyn Dean Aveggio (22 Oct 1920). Familial concern over the social consequences of the diagnosis persisted into the 1940s. See e.g. case 1945/25: Evelyn Davis to Winfred Overholser (19 June 1946).
\textsuperscript{72} Case 32578: Caroline Ashby to William A. White (20 Aug 1925; 26 May 1929).
merely fact of past psychiatric treatment could alienate a patient from the wider community.

Officials at Gallinger described Vera Higgs as “very demented” when they sent the 40-year-old domestic to St. Elizabeths, but physicians there found that she had difficulty only with her gait. Social workers nevertheless encountered obstacles when they tried to find Higgs a home. Her friend Minnie Dint expressed sympathy, but “declared she would not feel safe to have Vera in her home, especially since she herself is an elderly woman and lives all alone.” Higgs knew the sorts of attitudes she faced. “Vera would prefer to work for white people,” reported the social worker, “because they will not talk about her illness and point her out as an object of curiosity.”

Given the nature and extent of the problem, physicians at St. Elizabeths proved receptive to European reports of improvement in paretic patients following malarial inoculation. White appointed a committee to investigate the treatment in December of 1922. Members surveyed the hospital’s population of paretic patients and wrote to families requesting permission to include them in a trial; later that month they began inoculating their first series of sixty-eight men and women with blood from a malarial sailor at the U.S. Naval Hospital. Though the committee’s criteria of selection remain unclear, early case reports included individuals of both sexes and races who ranged from nearly normal in appearance to those in the advanced stages of neurosyphilis. Within two weeks, most began exhibiting the requisite paroxysmal fevers. In some, the fevers resolved spontaneously; when they did not, or when a patient appeared at risk of

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74 Case 36025: admission note (n.d.); clinical record (13 Oct 1930).
physical collapse, physicians administered quinine to bring them to a halt.\textsuperscript{77} Once patients cleared the malarial parasites, they returned to their wards, where physicians followed their condition closely. Soon officials initiated a second series. Follow-up studies found ample evidence of improvement; even among those who did not gain much ground, the fevers appeared to arrest the disease’s progress. Malarial fever therapy carried serious risks. Reviewing the data several years later, White acknowledged a mortality rate of approximately 4.3%—a figure that did not include deaths from intercurrent disease hastened by malarial infection.\textsuperscript{78} In view of the otherwise grim prognosis associated with general paresis, however, physicians at St. Elizabeths decided that the benefits outweighed the risks.

Malarial fever therapy spread rapidly throughout American psychiatry. Soon physicians began experimenting with the procedure in New York, Minnesota, and Michigan; in a discussion at the American Medical Association’s annual meeting in 1927, Eldridge vigorously asserted St. Elizabeths’ claim to priority.\textsuperscript{79} Malarial fever therapy allowed physicians to demonstrate in dramatic fashion their commitment to active treatment in a group who many regarded as hopeless. Psychiatrists’ ability to induce and then terminate the fever with quinine represented an affirmation of their medical identity. The ease of administering malaria to large groups of patients made it particularly attractive, as did its apparently unassailable scientific pedigree.\textsuperscript{80}

Wagner-Jauregg’s 1927 receipt of the Nobel Prize in Medicine further legitimated malarial fever therapy, and by the end of the decade it had become the standard response to paresis. Soon physicians began experimenting with other methods of producing fevers, sometimes in

\textsuperscript{77} Eldridge, “Treatment of Paresis,” 1098.
\textsuperscript{78} White, “Malarial Therapy (2),” 65. In an earlier series that did include such cases, Nolan D. C. Lewis placed the mortality rate at closer to 25%. Lewis, “Present Status,” 348.
\textsuperscript{80} Grob, \textit{Mental Illness and American Society}, 293.
conditions other than paresis. Researchers launched an annual conference in 1931; six years later, the First International Conference on Fever Therapy met in New York City. Fever therapy never achieved the same success in other conditions that it did with paresis, however, for which it remained the first-line treatment into the early 1950s.

Assessing improvement after malarial fever therapy proved to be a complicated task. Among the many patients who did not fully recover, physicians sometimes noted that their hallucinations and bizarre beliefs took a new form; psychoanalytically-inclined psychiatrists sought to account for this in terms of unconscious drives and conflicts. Men made up the majority of paretic patients, so criteria of improvement resonated with St. Elizabeths physicians’ overall tendency to privilege masculine virtues—particularly self-reliance and economic independence. Physicians Armando Ferraro and Theodore Fong spoke of “social recoveries” in which the patient exhibited “a relative degree of mental and physical recovery which will enable [him] … to return to his previous occupation or to some other form of labor which will assure him a living.” White expressed even greater optimism, noting that a few former patients had even “received promotions and made progress in their respective occupations[]” Ferraro and Fong remained more circumspect, explaining that “when a detailed and careful examination is performed, there can always be detected a slight degree of defective judgment or insight[]”

81 Ibid., 294.
83 Annual Report 1930, 8.
85 Ferraro and Fong, “The Malaria Treatment of General Paresis,” 235. Elsewhere White himself gave a more balanced assessment. “The patient is cured insofar as their active depredations are concerned,” he wrote in a 1932
Recovery thus became a relative affair, reflecting assumptions about both the social aspirations of individual classes of patients and the place of men and women with cognitive and emotional difficulties in American civic life. White and his colleagues accepted the existing class structure without comment, viewing patients less in terms of their capacities than their current social position.87 Physicians often underappreciated the psychological complexity of their working-class patients, identifying recovery with a basic ability to perform wage labor. Speaking to a journalist in 1927, White explained that “I recently ran into one of my first cases operating an elevator in a large downtown hotel. He was well and happy and doing beautifully in a self-supporting job.”88 Not all patients would achieve full independence; without familial support, physicians acknowledged, many would remain within the confines of the institution. Nevertheless, they insisted, these cases showed real improvement. “In the hospital … their behavior is without any abnormality,” wrote White. “They are usefully employed, enjoy ground and city parole and behave like normal citizens.”89 Even those incapable of contributing to the general welfare often adhered more closely to the behavioral norms governing institutional citizenship. “Although of no value in the routine work of the wards,” wrote Ferraro and Fong,
“these patients have become tidy, neat in dress and habits and as a rule cooperative in the routine examinations.”

Patients and their families actively sought access to malarial fever therapy. Medical science held tremendous popular appeal in this period; men and women facing serious illness often proved eager to receive the latest treatment. Whenever malarial fever therapy appeared in newspaper or magazine accounts, inquiries arrived at the hospital from across the country. Following her husband’s admission in 1925, Caroline Ashby did everything she could to ensure that he would receive the treatment. The hospital staff had temporarily lost the malarial strain, so she put them in touch with a physician friend in Mississippi who she thought might be able to procure it. Wagner-Jauregg’s receipt of the Nobel Prize further stimulated public interest, as did science writer Paul De Kruif’s decision to feature the Austrian physician in a collection of popular essays. White reported in 1931 that patients in the community had begun coming to the hospital explicitly seeking malarial fever therapy. That same year a man writing from Florida explained that he had already received one course of treatment. “I derived considerable benefit,” he reported, “or I wouldn’t be sufficiently sane at this time to be writing this letter.” If anything, this man’s hopes proved even greater than the realities malarial fever therapy offered. Though he appeared to be without major impairment, he still felt that the results remained incomplete and wrote seeking information on alternative methods of inducing fever.

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90 Ferraro and Fong, “The Malaria Treatment of General Paresis,” 235. See also “Notes on the Effect of the Malarial Inoculation Method on the Mental Aspect of General Paresis” and “Malaria Treated Cases Discharged from the Hospital” (both from late 1927) in RG 418: Entry 18 (Treatment Files: Inoculations with Quartan Malaria).
93 White, “Malarial Therapy (2),” 47.
94 M. D. Hathaway to Herbert C. Woolley (25 Feb 1931), NARA RG 418: Entry 18 (Treatment Files: General Paresis).
Malarial fever therapy raised a host of ethical issues, foremost among them the question of informed consent. Physicians in the early decades of the twentieth century felt justified in carrying out therapeutic experimentation in the name of a patient’s well-being, especially when no obvious alternatives existed. A series of high-profile cases in the years leading up to World War I brought the topic into sharper focus. The issue became particularly acute in Washington, D.C., where Jacob Gallinger, Chair of the Senate Committee on the District of Columbia, led several inquiries centering on the ethics of human research.95 Many of the candidates for malarial fever therapy at St. Elizabeths were severely ill; in some cases, it is likely that their condition compromised their decision-making capacity. Even among those aware of their situation, however, the legal finding of incompetence involved in their commitment meant that responsibility for treatment decisions fell to the patient’s nearest relative. Physicians at St. Elizabeths adopted a cautious approach. At least until 1925, they obtained formal approval from relatives in each case before administering malarial fever therapy.96 While it is impossible to know just how thoroughly physicians educated patients’ relatives about the treatment and its risks, they would have had little reason to exaggerate the gravity of the situation.

The question of who ought to serve as a malarial blood donor proved even more complex. From the outset, White insisted that his staff only use blood from Wassermann-negative patients

96 See e.g. case 32906: untitled document (7 Jan 1925 [1926]) and case 32578: clinical record (12 Sept 1925); Mrs. W. H. Ashby to William A. White (14 Sept 1925). All of the cases in my sample who received malarial fever therapy were civil cases, and it is thus unclear whether physicians were as conscientious in obtaining familial consent from patients who remained under the jurisdiction of the military. Nevertheless, the evidence appears to support Watson Eldridge’s 1960 recollection that “consent of patients’ relatives was obtained in every case, where there were relatives.” Watson W. Eldridge, “History of the Medical and Surgical Branch, St. Elizabeths Hospital,” 10, NARA RG 418 Entry 7 (Administrative Files: History of SEH, Material on). By 1930 hospital officials no longer required familial permission. See e.g. case 36025 and case 36372. On the history medical attitudes toward patient autonomy more generally, see Martin Pernick, “The Patient’s Role in Medical Decisionmaking: A Social History of Informed Consent in Medical Therapy,” in Making Healthcare Decisions: Studies on the Foundations of Informed Consent, ed. U.S. President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, vol. 3 (Washington, D.C.: Government Printing Office, 1982), 1-35.
for malarial inoculation. This ruled out the common practice of inoculating one paretic patient with the blood of another already under treatment. “I was not only convinced of the possibilities of errors of diagnosis,” White later recalled, “but of the impossibility of explaining away an alleged inoculation of syphilis even though it might not occur.”97 In practice, this meant that whenever physicians could not locate a case of malaria in a Wassermann-negative patient, treatment came to a halt.98 This frustrated some members of the medical staff to no end. When they lost the malarial strain in 1930, internist Watson Eldridge wrote to White that he would “like again to raise the question of inoculating with malaria from paretic to paretic, as is done in all other places in this country[.]” White refused to countenance the procedure. The disadvantages, he responded tersely, “seem to me, as they always have, of such a nature that I cannot consent to incurring them[.]”99

While a waiting list occasionally meant delayed treatment, the true cost of White’s caution only becomes apparent when we turn to the methods physicians employed to maintain the malarial strain. Some research centers cultivated colonies of mosquitoes for this purpose, but few public mental hospitals proved capable of such an undertaking.100 Instead, physicians at St. Elizabeths deliberately infected non-syphilitic patients with the malaria parasite in order to use

97 William A. White, “The Malarial Therapy of Paresis (1),” *International Clinics* 3, 41st series (1931): 299. There were other arguments against patient-to-patient inoculation as well, including the possibility of transmitting a new strain of syphilis or other blood-borne diseases to the recipient. For these and other reasons, patient-to-patient inoculation was prohibited by law in Britain. Humphreys, “Whose Body? Which Disease?,“ 57.
98 For White’s efforts to locate a case of malaria in a Wassermann-negative patient, see William A. White to Hugh S. Cummings, Surgeon General (12 Aug 1926) and Harold G. Palmer to William A. White (30 Dec 1927) in NARA RG 418: Entry 18 (Treatment Files: Blood). When a local newspaper mentioned the problem in 1927, a District woman who had been battling malaria offered to make herself available in exchange for treatment. White encouraged her to contact the physicians in charge of malarial fever therapy at St. Elizabeths, but she received treatment on her own in the interim. Miss Edith Newsom to William A. White (18 Dec 1927); William A. White to Miss Edith Newsm (28 Dec 1927); Miss Edith Newsome to Watson W. Eldridge (8 Jan 1928), NARA RG 418: Entry 18 (Treatment Files: Malaria).
100 Humphreys, “Whose Body? Which Disease?,“ 56-58. St. Elizabeths physicians experimented with mosquito inoculation of patients, but found the results “far from satisfactory.” Memorandum from W. W. Eldridge and T. C. Fong to Winfred Overholser, 30 Aug 1940, NARA RG 418 Entry 18 (Treatment Files: Malaria).
them as reservoirs in the treatment of other patients—a modified form of patient-to-patient
inoculation that apparently met White’s concerns. When Eldridge wrote to White in 1930, he
complained that “[t]he last two malaria control cases which were inoculated about ten days ago
have as yet shown no paroxysms[.].”\textsuperscript{101} Eldridge’s use of the term “control” might initially
suggest a comparison group to be used for evaluation of the treatment. Yet none of the
publications on malarial fever therapy from St. Elizabeths mention such a methodological
innovation; indeed, medical reformers in this period still encountered difficulty convincing
physicians of the need to include controls in their clinical research.\textsuperscript{102} The practice of
maintaining non-paretic patients as malarial donors remained in place for approximately fifteen
years. White’s successor Winfred Overholser appears to have overruled White’s policy against
paretic-to-paretic inoculation soon after his arrival in 1937, so there would have been little need
to maintain non-syphilitic patients with the disease.\textsuperscript{103}

The implications of this practice emerge most clearly in the remarkable case of Haroun
Hussein, who physicians employed as a reservoir for malaria throughout the 1930s. Hussein first
came to the attention of medical officials in 1929 at a Public Health Service hospital in New
York, where the 27-year-old merchant seaman complained that people were trying to kill him.\textsuperscript{104}
At St. Elizabeths, the medical staff initially described Hussein as “a dusky-colored Filipino male
… whose long, straight dark hair and wild-eyed expression make him look like a wild man

\textsuperscript{101} Grob, \textit{Inner World}, 124.
\textsuperscript{102} This is based on a review of all publications relating to malarial fever therapy listed in the hospital’s \textit{Annual
Reports} between 1922 and 1940. For the broader context of methodological reforms in clinical research, see Harry
M. Marks, \textit{The Progress of Experiment: Science and Therapeutic Reform in the United States, 1900-1990}
\textsuperscript{103} Winfred Overholser to Louis Belinson (6 Jan 1939); Ernesto Quintero to Riley H. Guthrie (28 April 1941),
NARA RG 418: Entry 18 (Treatment Files: Blood); Theodore C. C. Fong, “Therapeutic Quartan Malaria in the
Therapy of Neurosyphilis among Negroes,” \textit{American Journal of Syphilis, Gonorrhea, and Venereal Diseases} 24
(1940): 133-147.
\textsuperscript{104} Hussein also reported hearing voices in French and Turkish and variously maintained that he was King George of
England and the boxer Jack Dempsey. While the question of Hussein’s impairment was never seriously in doubt, the
issues raised by his case nevertheless remain salient. Case 36038: admission note (12 May 1930); clinical record (1
July 1930). All references in the following account are to this case.
indeed.”

Over the course of the ensuing years, physicians variously identified him as white, Mexican, Hawaiian, and Filipino, though he consistently resided on wards for white patients. At times the challenge Hussein represented to conventional racial categories became a source of consternation for the staff. “He is a source of great annoyance in the dining room,” complained a physician, “constantly running about, waving his arms and screaming, and inasmuch as he certainly presents the appearance of a negro I would recommend that he be transferred to some other service[.]” Hussein claimed that his family lived in England or the Netherlands, but his confusion prevented physicians from obtaining a complete history. Linguistic barriers further complicated Hussein’s care; though able to communicate with physicians upon his admission, his English became more tenuous over the course of his nearly twelve-year residence at the hospital.

Hussein’s case reveals the extent to which physicians privileged the well-being of those with recognizable social resources over the welfare of their less fortunate peers. The medical staff at St. Elizabeths quickly ruled out paresis as the cause of Hussein’s condition. Nevertheless, they inoculated him with malaria in 1931, 1934, and 1938; each time, they intended to use his blood to infect other, paretic patients. The records reveal little about physicians’ reasons for selecting Hussein. His good physical health likely played a role in their decision, as did the absence of locally-accessible family members or an interested federal agency to whom physicians would have to report. There is no evidence that the staff sought Hussein’s permission for the procedure. This omission became even more egregious after 1932, when a representative

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105 Initial assessment (25 Sept 1930).
106 Hussein himself does not ever appear to have claimed Filipino ancestry. For the various accounts of Hussein’s ethnicity, see clinical record (7 July 1933; 2 March 1937; 16 Oct 1935; 11 Oct 1940).
107 Clinical record (12 Dec 1939).
108 Initial assessment (25 Sept 1930); clinical record (17 March 1938; 27 Sept 1938). Shortly after Hussein’s arrival, officials sent a letter to a friend whose name appeared in his transfer papers, but the letter was returned to the hospital unopened. Information sheet (n.d.).
109 Clinical record (27 March 1931; 21 April 1931; 9 April 1934; 11 April 1934; 7 Feb 1938).
of the Veterans Administration forwarded a letter from Hussein’s mother to the hospital. Officials reported delivering the letter to Hussein, but did not follow up on the inquiry or make any effort to contact her. Even by the standards of the day, this represented an ethical transgression of serious proportions. Malarial fever therapy carried a nontrivial risk of injury or death, a fact that physicians around the country recognized. Other patients served as malarial “controls” as well. The practice of using patients as reservoirs, with no immediate prospect of bringing about an improvement in their condition, was a steep price to pay for White’s high-minded refusal to risk communicating syphilis to a non-paretic patient.

While the medical staff at St. Elizabeths agreed that malarial fever therapy represented an important innovation, they also encountered large numbers of patients who failed to develop the requisite fevers after inoculation. Black patients in particular appeared immune to malarial infection. “The percentage of takes [in] white males is quite large, around 85%,” wrote an official in 1931. “The percentage of takes in negroes is, on the other hand, very small, not over 10%.” Researchers elsewhere encountered similar difficulties. Physicians found the situation particularly frustrating in view of the high rates of paresis among black patients. Malarial fever therapy brought a measure of optimism to the treatment of a highly-stigmatized class of patients with a previously-dismal prognosis; historian Joel Braslow has found that physicians regarded their paretic patients far more sympathetically once malarial fever therapy

110 Case 32578: L. Marks to E. P. Van Hise (11 July 1932).
111 By 1930 physicians at St. Elizabeths were confident that they could avoid serious complications by excluding debilitated patients from treatment. Nevertheless, the risk of physical collapse persisted. See William A. White to T. J. Hughes (19 July 1930) and Riley H. Guthrie to Clifford D. Moore (28 Sept 1941) (NARA RG 418: Entry 18 [Treatment Files: General Paresis; Blood]).
112 In Wilson Ashby’s case file, physicians identified the individual who served as a source for his malarial inoculation by name in a manner that suggests a greater level of familiarity than if he were not a patient in the hospital. Case 32578: clinical record (4 Dec 1925).
114 This was almost certainly due to the absence of a critical protein on the red blood cells of black patients through which P. vivax enters the cell, though researchers did not recognize this until many years later. Humphreys, “Whose Body? Which Disease?,” 64, 66.
entered the therapeutic arsenal. Against this backdrop, it is likely that some physicians came to view their black paretic patients as “therapeutic failures,” with an outlook all the more bleak compared to white patients who responded to the treatment. Black men and women themselves occasionally expressed irritation that they had to remain at the hospital for repeated courses of a treatment that did not seem to work.

Black patients thus figured prominently in researchers’ efforts to find an alternative means of inducing fevers. Physicians at St. Elizabeths experimented with a variety of agents, including typhoid vaccine, sodoku, and relapsing fever. Beginning in 1928, they also employed a technique known as diathermy, using high-frequency alternating electrical current to induce a rise in temperature. The results, however, proved dismal. In a series of fifty patients (forty of whom were black), just nine demonstrated improvement, while eighteen remained stationary and twenty-three died—including three whose deaths resulted directly from the procedure. In 1932, physicians began experimenting with quartan (*P. malariae*) rather than benign tertian (*P. vivax*) malaria. Previously, researchers had insisted on the importance of using only *P. vivax*; indeed, Wagner-Jauregg’s inadvertent use of malignant tertian (*P. falciparum*) malaria in 1918 had produced three fatalities. With quartan malaria the fevers did not spike as high and sometimes proved difficult to terminate, but far more black patients responded with the requisite paroxysms. Fever therapy by quartan malaria continued to carry risks, including a

115 Braslow, *Mental Ills and Bodily Cures*, 72, 93.
117 *Annual Report* 1934, 375; Fong, “Therapeutic Quartan Malaria,” 134.
mortality rate of about 2.5%. Theodore Fong nevertheless concluded in 1940 that it represented a valuable option for black paretic patients unlikely to respond to the tertian strain.120

The introduction of penicillin in the 1940s marked the beginning of the end for malarial fever therapy, though its decline proved anything but precipitous. Physicians at St. Elizabeths initially gained access to penicillin in 1944 as part of a U.S. Public Health Service study; the federal government’s decision the following year to release the drug for unrestricted civilian distribution paved the way for further research.121 The medical staff soon concluded that optimal results came from a combination of penicillin and malarial fever therapy, followed by conventional pharmacotherapy.122 St. Elizabeths appears to have continued using malarial fever therapy until 1952 or 1953, at which point the treatment gave way entirely to penicillin. The therapeutic efficacy of the drug was an important factor in this shift, though the decline of new cases of paresis as penicillin became standard treatment for early infection was probably even more important.123 While present-day commentators remain divided on the question of malarial fever therapy’s efficacy, there is little doubt of its importance to institutional psychiatry during its time.124

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120 Fong, “Therapeutic Quartan Malaria in the Therapy of Neurosyphilis among Negroes.”
121 Winfred Overholser to F. H. Zimmerman (2 Jan 1947 [1948]), NARA RG 418: Entry 7 (Administrative Files: Syphilis, Treatment of); Memorandum from Eli Lilly and Company to All Hospitals, Subject: Penicillin, 1 March 1945, NARA RG 418: Entry 7 (Administrative Files: Penicillin).
124 Gayle Davis suggests that not all cases of paresis may have been as hopeless as early twentieth-century clinicians seemed to think; physicians may therefore have misinterpreted spontaneous remissions as evidence of malarial fever therapy’s promise. Among the Scottish patients in her sample, those who received little or no treatment often fared best. Davis fails to consider, however, that the most severely ill patients would likely have been among the first treated, thereby making it difficult to compare the samples properly with respect to outcome. Davis, “‘Lovers and Madmen,’” 218-219; 285-286. Austin, Stolley, and Lasky’s assertion that we simply cannot know the extent of the treatment’s effectiveness is more convincing, though their tone suggests they remain deeply skeptical. Austin, Stolley, and Lasky, “History of Malariotherapy,” 516. See also the responses that their study elicited: Magda Whitrow, letter to the editor, Journal of the American Medical Association 271 (2 Feb 1994): 348; Henry J. Heimlich, letter to the editor, Journal of the American Medical Association 269 (13 Jan 1993): 211.
DESPERATE MEASURES: SHOCK THERAPY AND LOBOTOMY

Despite the flurry of experimentation at malarial fever therapy’s peak, physicians never came to see it as an effective treatment for anything other than general paresis. In this sense, one of the therapy’s chief virtues—its specificity—also represented a serious practical limitation. Paretic patients made up a substantial component of men and women in the nation’s mental hospitals, but the most common diagnosis remained dementia precox, later known as schizophrenia. Between 1925 and 1930, 43.8% of first admissions to St. Elizabeths received this diagnosis; a 1937 Washington Post article reported that fully half of the hospital’s 5,700 patients suffered from the condition. Unlike those with general paresis or elderly men and women suffering from senile dementia, most patients with dementia precox remained in otherwise good health. For those who proved incapable of supporting themselves in the community or whose families could not or would not care for them, this meant a lifetime in the confines of the institution. The aging population of patients with dementia precox played an increasingly important role in the growth of public institutions in the first half of the twentieth century.

First described by German psychiatrist Emil Kraepelin in 1893, dementia precox rapidly became central to most physicians’ understanding of mental illness. Kraepelin identified the condition as one of young adulthood, distinguishable from manic-depressive psychosis by its slow and progressive decline. Kraepelin also divided it into three subtypes: paranoid, hebephrenic (involving disorganized thinking and child-like responses), and catatonic (rendering patients stuporous or confused and excited). Swiss psychiatrist Eugen Bleuler reformulated dementia precox as schizophrenia in 1911, suggesting that the condition might just as easily

125 Annual Reports 1925-1930; “‘Shock’ for Dementia Praecox to be Tried at St. Elizabeths,” Washington Post, 10 Aug 1937, 1, 20.
appear later in life as in young adulthood and that it did not invariably terminate in dementia. In his 1928 *Lectures on Psychiatry*, William A. White deemed dementia precox “the most important of all of the psychoses because it supplies the greatest number.” He went on to characterize it as an essentially regressive condition, in which the patient employed archaic and immature psychological responses to life’s challenges. Many American psychiatrists adopted Adolf Meyer’s version of dementia precox as a form of social maladjustment resulting from disorganized and improper habits early in life. By locating the causes of dementia precox in the same patterns of thought and behavior that produced problems of living, physicians suggested that leaving such difficulties unaddressed might ultimately result in serious and incapacitating illness.

Dementia precox represented a baffling and worrisome change in an individual’s pattern of thought and behavior. Many of the patients we have encountered thus far received this diagnosis, including John Medina, who traveled to Washington on a divine mission to assume the presidency, and Adele Beranek, who heard the voices of her female relatives calling her names and saw annoying spirits coming from the ground. Often these men and women failed to recognize anything unusual about their thinking, a situation that engendered tensions within families and hostility toward the hospital staff. Though physicians remained skeptical about the prospect of these patients returning to their former lives, some nevertheless cleared sufficiently to be discharged as improved or even recovered. Others, however, remained severely impaired for the remainder of their days. Edna Colemen first began acting odd at twenty-five, refusing to

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129 Case 22374: clinical record (25 Feb 1916); case 36023: clinical record (11 June 1930).
leave her room and talking to the clock and chairs. Coleman’s family cared for her within the home for nearly her entire adult life; after her parents died she moved in with a younger sister. In her seventies, however, Coleman began having seizures of increasing frequency and severity. Finally, her sister initiated proceedings to place Coleman at St. Elizabeths, where she remained until her death nearly six years later.130

Beginning in the 1930s, several dramatic new therapies for schizophrenia emerged from European psychiatry. Developed by Austrian physician Manfred Sakel between 1928 and 1933, insulin coma therapy involved administering large doses of the hormone to maintain patients in a profound hypoglycemic state. In metrazol shock, a technique pioneered by Hungarian psychiatrist Ladislas von Meduna, physicians used the cardiac stimulant metrazol (penta-methylenetetrazol) to induce seizures. Researchers initially used these “pharmacological shock therapies” specifically in the treatment of schizophrenia; Sakel suggested a variety of possible mechanisms over the course of his career to explain the treatment, while Meduna posited a fundamental biological antagonism between schizophrenia and epilepsy.131 Electroshock treatment (EST), which originated in 1938 with the experiments of Italian physicians Ugo Cerletti and Lucio Bini, similarly targeted the disease.132 Around the same time, Washington, D.C. neurologist Walter Freeman—formerly the director of laboratories at St. Elizabeths—began experimenting with the surgical methods of Portuguese physician Egas Moniz, who introduced the treatment that would ultimately be known as lobotomy. Though Freeman and his partner

130 Case 1950/16: information from sister (12 May 1950); clinical record (20 Oct 1953; 11 March 1956).
132 Shorter and Healy, Shock Therapy, 31-82.
James Watts initially focused on anxiety and depression, psychiatrists soon concluded that lobotomy’s greatest potential lay in long-standing cases of schizophrenia.\footnote{Pressman, \textit{Last Resort}, 71-85, 120-125.}

Officials at St. Elizabeths first considered insulin coma in 1936, when physician Jay Hoffman sought White’s permission to try the procedure. Hoffman acknowledged that past innovations had often turned out to be less effective than their proponents supposed, but the early data nevertheless appeared promising.\footnote{Jay L. Hoffman to William A. White, 1 Dec 1936, NARA RG 418: Entry 7 (Insulin Treatment).} Sakel himself visited St. Elizabeths in February of 1937 to deliver a talk, but White’s death less than a month later delayed any further action.\footnote{Annual Report 1937, 374.} That summer, acting superintendent Roscoe Hall sent staff members to the New York State Psychiatric Institute to learn how to administer insulin shock; while there, physician Alexander Simon also observed metrazol shock.\footnote{Jay L. Hoffman to Roscoe W. Hall, 21 June 1937; Alexander Simon to Roscoe W. Hall, 26 July 1937; Freddie O. Jones to Edith Haydon, 30 July 1937, NARA RG 418: Entry 7 (Insulin Treatment).} Physicians at St. Elizabeths launched their first series of patients in September, selecting six men and six women from the recently-opened receiving services for white patients.\footnote{According to Overholser, hospital officials sought the permission of each patient’s nearest relative before administering the treatment. Winfred Overholser to Mrs. Katherine Morgan, 22 Sept 1938, NARA RG 418: Entry 18 (Treatment Files: Insulin). Most patients involved in the study were admitted in the mid-1930s. Because of the NARA’s seventy-five year rule on records containing protected health information, clinical files from patients admitted in 1935 remain inaccessible until 2010; the research project’s full records remain closed until at least 2014. While the initial group of patients involved white men and women, physicians appear to have included black patients in the study as well. We know this only because at least one of the patients who died during treatment was a black woman. Accidents, Injuries, Complaints, etc.: Metrazol-Insulin Clinic, 1938/1939, NARA RG 418: Entry 18 (Treatment Files: Metrazol).} The insulin and metrazol shock ward remained in operation through the following spring, with physicians treating around one hundred patients. Officials halted work in the summer months because of the heat, but reopened the unit in September of 1938 and treated another 125 patients before again suspending work in May of 1939. The pharmacological shock therapies received extensive coverage in the popular press, and St.
Elizabeths routinely received inquiries from family members who wanted to know more about the treatment and its availability.  

As historian Deborah Doroshow has convincingly argued, the technical and highly-ritualized environment of the hospital’s insulin unit reinforced psychiatrists’ sense of involvement in a distinctly medical enterprise. Each morning, patients came to a special ward devoted exclusively to the pharmacological shock therapies. There physicians administered enough insulin to render them unconscious for a period of one hour before terminating the coma with a glucose solution. Nurses carefully monitored their state, ready to intervene if anything went awry. The clinical staff kept the room quiet and still; at other institutions, the staff frequently reduced the lighting and even wore special soft-soled shoes. Upon awakening, some patients who had previously been severely out of touch with their surroundings spoke coherently with their caretakers. Researchers hoped that these periods of lucidity would grow longer with each episode; most patients underwent thirty-five to forty shocks before physicians discontinued the treatment. Psychiatrists shifted some patients who did not respond to insulin coma to a regimen of metrazol shock; others underwent metrazol shock by itself or concomitantly with insulin coma rather than sequentially. By 1940, however, physicians had increasingly come to see metrazol as a treatment for mood disorders rather than schizophrenia.

Though insulin coma and metrazol shock both targeted the body, psychiatrists suggested that they might just as easily produce improvement by psychological means. Patients undergoing insulin coma became the focus of an intensive and highly-coordinated regimen, with attentive

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138 See the inquiries in NARA RG 418: Entry 7 (Administrative Files: Insulin Treatment) and Entry 18 (Treatment Files: Insulin).
139 Doroshow, “Performing a Cure.”
140 Ibid., 224.
141 Winfred Overholser to Lilly Research Laboratories, 13 July 1940, NARA RG 418: Entry 18 (Treatment Files: Insulin); Katzenelbogen, “Critical Appraisal III,” 418.
staff members eagerly anticipating recovery. Such an environment could only increase a patient’s chances of improvement. Psychiatrists recognized that the procedure rendered patients dependent on the staff in a way that might build rapport, thereby making them more receptive to other elements of the hospital routine.142 Alternately, insulin coma might work by a more straightforward psychological route. “[P]atients often [say] that during the twilight state after termination they feel as if they were fighting their way back from death,” wrote a group of St. Elizabeths physicians in 1939. “This fear of death may be a potent psychologic factor to improvement.”143 Researchers theorized that metrazol shock might work by a similar mechanism. Patients described a feeling of terror and impending death prior to losing consciousness; many proved unwilling to endure multiple episodes. Metrazol-induced seizures thus offered even greater material for psychodynamic interpretation than insulin coma. “That the psychoanalytic implications of the treatment are far-reaching is undeniable,” wrote physician Zigmond Lebensohn, “and already some explanations (e.g. the convulsion as orgastic discharge) have been offered.”144

Clinical and institutional imperatives converged to prevent St. Elizabeths psychiatrists from adopting the pharmacological shock therapies on a greater scale. The physicians in charge of the ward argued in 1939 that a combination of insulin and metrazol produced better results than either treatment alone.145 The hospital administration, however, remained unimpressed, declining to reopen the clinic that autumn. Winfred Overholser, White’s successor, wrote two years later that “the results of insulin and metrazol therapy … have not been especially

145 Alexander Simon to Evelyn B. Reichenbach, 24 June 1939, NARA RG 418: Entry 18 (Treatment Files: Metrazol).
The low recovery rate was especially discouraging in light of the associated risks. Metrazol-induced convulsions sometimes produced dislocations and broken bones, including fractures of the vertebrae. Both treatments also carried a small but very real danger of mortality. Indeed, three deaths occurred during the course of pharmacological shock therapy, including two attributable directly to the treatment. The outbreak of World War II and the ensuing strain on resources made it increasingly difficult to justify insulin coma’s labor-intensive approach, while the rise of electroshock treatment further displaced metrazol shock. St. Elizabeths physician Leon Salzman noted in 1946 that the increased likelihood of readmission for patients treated by pharmacological shock negated any reduction in length of initial stay. Overall, he concluded, the evidence made for “a very unconvincing picture.”

This did not, however, spell the end of insulin treatment at St. Elizabeths entirely. Though they rejected insulin coma for large-scale use, physicians continued to employ the treatment in selected cases. From the late 1940s through the mid-1960s, psychiatrists also administered insulin in what they described as “subshock doses”—enough to produce tremors, flushing, perspiration, and sedation, but not enough to render patients unconscious. When they could, some physicians employed the environmental elements seen in insulin coma therapy, including a dimly-lit unit away from the main wards and a staff of specially-trained personnel.

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146 Annual Report 1941, 4.
147 Accidents, Injuries, Complaints, etc.: Metrazol-Insulin Clinic, 1938/1939; Winfred Overholser to J. L. Kinsey, 13 July 1940, NARA RG 418: Entry 18 (Treatment Files: Metrazol).
149 Winfred Overholser to Ernest S. Klein, 9 April 1952, NARA RG 418: Entry 7 (Administrative Files: Insulin Treatment). See also case 1950/19: admission note (15 Sept 1950); clinical record (2 Oct 1950; 1 Nov 1950; 22 Nov 1950); Winfred Overholser to Frederick L. McDaniel, 18 July 1951, NARA RG 418: Entry 7 (Administrative Files: Treatment, Miscellaneous [1951-1955]).
150 Memorandum from Morris Kleinerman to Addison M. Duval, 11 March 1946, NARA RG 418: Entry 7 (Administrative Files: Insulin [Sub-Coma Treatment]).
Because of the lower doses involved, the procedure remained less labor-intensive and carried far fewer risks than insulin coma treatment. Psychiatrists also used the treatment for a wider variety of conditions.¹⁵¹ Perhaps more than any other somatic treatment, subshock insulin proved as amenable to psychoanalytic formulation as it did physiological interpretation. “We found by experience,” wrote physician Michael Woodbury in a 1955 report, “that as soon as the patient accepted his dependency needs or regressive tendencies, the acute psychotic symptoms, such as delusions and/or hallucinations, soon tended to subside.”¹⁵²

Unlike insulin coma and metrazol, electroshock treatment (EST) rapidly became a staple of the psychiatric armamentarium at St. Elizabeths. Though Cerletti and Bini had envisioned EST as a treatment for schizophrenia, clinicians in the United States rapidly came to see it as most effective in cases involving severe depression or, less commonly, profound excitement. Physicians at midcentury employed the term “depression” to signify slowed mental function and social withdrawal as much as a subjective sense of sadness. As historian Laura Hirshbein has shown, psychiatrists did not conceive of depression as a distinct disease entity; rather, it could be a symptom of any number of disorders, including schizophrenia, manic-depressive psychosis, and involitional melancholia.¹⁵³

Both severely depressed and highly agitated patients at St. Elizabeths received electroshock treatment. Joseph Stroupe represented a paradigmatic example of the depressive state. Stroupe became apathetic and unresponsive following an episode of scarlet fever in 1945; a

¹⁵¹ Memorandum from Michael A. Woodbury to Manson B. Pettit and Stephen Klinger, Subject: Summary of Insulin Subshock Program, 11 April 1955, NARA RG 418 Entry 7 (Administrative Files: Memoranda, Miscellaneous [1953-1956]).
¹⁵² Ibid.
psychiatrist at St. Elizabeths described the 17-year-old white sailor as mute, stuporous, and inaccessible. After receiving permission from Stroupe’s father, physicians administered a series of twelve electroshock treatments. 

Patients at the opposite end of the behavioral spectrum received EST as well. Three years after Sandra Levickis came to Washington, D.C., her employers at the Pentagon found her fearful, confused, and rambling. At St. Elizabeths, she spoke of being “worked upon by electrons;” often the 28-year-old white clerk screamed aloud and attacked other patients. After receiving a series of five electroshock treatments, however, Levickis showed signs of improvement. “This patient … is in perfect contact with reality,” reported her physician in 1945, “and when questioned about earlier phases of her illness only remembers vague scattered incidents[.]”

Both in their publications and in internal memoranda, physicians at St. Elizabeths counseled caution in the use of electroshock. Grand mal seizures were the goal in each case. Though its advocates insisted that the procedure did not carry any serious risks, psychiatrists at St. Elizabeths remained unsure. One of their patients died after EST in the mid-1940s. Reporting on this case, a group of physicians warned that the question of irreversible brain damage associated with EST had not yet been adequately resolved. Much of the present enthusiasm, they suggested, resulted from the treatment’s ease of administration in overcrowded, understaffed state hospitals. Overholser continued to favor hydrotherapy over EST as a method of calming restless and disturbed patients. In 1953, Jay Hoffman sought clarification on the hospital’s

154 Case 1945/13: clinical record (14 Jan 1946; 16 April 1946)
155 Case 1945/24: information from former employer (9 June 1945); clinical record (3 Aug 1945; 25 Sept 1945); ward notes (7 June 1945; 8 June 1945).
157 Annual Report 1952, 5; Winfred Overholser to W. L. Patterson, 14 Dec 1953, NARA RG 418: Entry 7 (Administrative Files: Treatment, Miscellaneous [1951-1955]). This is confirmed by the recollections of the psychologist Kay Redfield Jamison. Jamison first visited the hospital in 1961 as a candy striper, where she asked the
policy on “maintenance shock treatment.” For persistently agitated patients, some authorities recommended routine sessions “running into the hundreds of individual treatments.” Hoffman wondered if it might not be permissible to use a series of shocks in some patients once a year to reduce the level of excitement on a ward, thereby allowing the nurses to attend to all of their patients equally. Overholser reluctantly agreed. “My personal opinion of [the procedure] is not high—it is sublimated clubbing over the head!” he wrote in a hasty response. “But … I realize that it has some acceptation. Should select cases carefully, however.”

While physicians acknowledged using EST to control highly agitated patients, individual case files support their claim of therapeutic conservatism. Psychiatrists at St. Elizabeths described a subset of their earliest EST patients as “behavior problems” for whom other measures had proven unsuccessful. “Our hope primarily was to modify the behavior of these patients in order to make them more amenable to hospital routine,” wrote physicians Alfred Bauer and Joyce Perrin. “We frankly did not expect recovery.” In these instances, EST became an element of what historian Joel Braslow has described as “therapeutic discipline”—a mode of practice in which physicians identified the control of disordered behavior with the treatment of disease. And yet not all of the most recalcitrant patients at St. Elizabeths received EST. It is difficult to imagine a more challenging patient than Louise Lowry. During her periodic episodes of excitation, the 27-year-old black homemaker destroyed windows, doors, light fixtures, toilets, radiators, and even the plaster walls of her rooms. “When asked about her destructive behavior,” reported a physician in 1947, “she says when she cannot sleep she does...”

staff how they protected themselves against agitated patients: “There were, [the nurse] said, drugs that could control most of the patients, but, now and again, it became necessary to ‘hose them down.’” Kay Redfield Jamison, An Unquiet Mind: A Memoir of Moods and Madness (New York: Vintage Books, 1995), 23.

158 Memorandum from Jay L. Hoffman to Winfred Overholser, Subject: “Maintenance” Electroshock Treatment, 17 Nov 1953, NARA RG 418: Entry 7 (Administrative Files: Memoranda, Outgoing [1953-1955]).


160 Braslow, Mental Ills and Bodily Cures, 9, 104-111.
not care what she does so she just takes the place to pieces.” Physicians tried hydrotherapy, drug sedation, and insulin subshock treatment, but none exhibited a lasting effect. Eventually, they prepared a “cemented room” with a boarded window and specially-protected light bulb.

Remarkably, while Lowry’s mother gave the physicians permission to try EST in 1946, no indication exists that they ever used it—perhaps because she only rarely became assaultive or seriously threatened to harm herself.\footnote{Case 1960/21a: clinical record (16 Sept 1942; 5 Oct 1942; 5 Nov 1942; 27 Jan 1944; 2 Feb 1944; 18 April 1945; 1 June 1945; 6 Sept 1946; 8 Dec 1947). But contrast this case with the episode related in Monthly Report for December 1953, NARA RG 418: Entry 7 (Administrative Files: Monthly Reports [1945-1957]).}

The clinical environment into which EST entered played as important a role in its acceptance as did any of the competing theories about its mode of action. As with other forms of treatment, physicians drew equally upon psychological and organic arguments to explain EST’s efficacy. When Lawrence Russo arrived at St. Elizabeths, the 28-year-old white veteran was bewildered and confused; he agreed that he felt “weary, pepless and down in the dumps.”\footnote{Case 1945/35: admission note (1 Feb 1945); initial assessment (13 March 1945).}

Halfway through his second series of shock treatments, Russo began to improve, but his physician decided to continue with the treatments. Invoking the therapeutic power of suggestion, Russo’s doctor reported that “[i]t was told to the patient each time … that treatment was to be continued until he had reached a point from which he would not relapse.” Yet this same physician relied on somatic arguments as well. “The other aspect is that reports in the literature … tend to show that if confusion of an apparently organic type develops during shock treatment, the chance for maintenance of recovery status is better.”\footnote{Case 1945/35: clinical record (30 April 1945). See also Solomon Katzenelbogen, Alfred K. Baur, and Anna R. M. Coyne, “Electric Shock Therapy: Clinical, Biochemical, and Morphologic Studies,” Archives of Neurology and Psychiatry 52 (1944): 326.}

Psychiatrists’ familiarity with metrazol (and, to a lesser extent, insulin) had prepared them for the possibility that induced
seizures might prove beneficial.\textsuperscript{164} The long history of hydrotherapy, moreover, helped frame the inhibition of disruptive behavior as a form of treatment.\textsuperscript{165} Against this backdrop, EST’s apparent ability to restore withdrawn and stuporous patients to a state of lucidity proved more than enough to guarantee its acceptance into the therapeutic armamentarium.

Patients remained ambivalent about electroshock treatment. Men and women undergoing EST reported none of the terror associated with metrazol shock; the resulting amnesia, moreover, often erased any memories of anxiety that preceded the treatment.\textsuperscript{166} Depressed patients sometimes expressed amazement at how well EST had worked for them. Physicians described Russo as “alert, bright and smiling, happy and eulogistic about the benefits of shock.”\textsuperscript{167} Those who had received EST during a period of agitation sometimes felt differently. William Clement was a large man, capable of causing quite a disturbance when at his most combative. During his time at a Naval hospital in Philadelphia, the white attorney received an extensive series of shocks aimed at controlling his behavior. Subsequently he found that he had to relearn much of what he had studied in law school. Clement blamed the treatments for his memory loss. “Electroshock has given me a fear of psychiatry and doctors,” he explained to his physician at St. Elizabeths. “I don’t like this as I know that doctors can help me.”\textsuperscript{168} Patients with no experience of EST often expressed deep reservations as well. Bette Maxberry associated EST with what she saw as the

\textsuperscript{164} Initially, most physicians saw seizures as a dangerous complication of insulin coma treatment and a reason to terminate the session. During the course of a rancorous priority dispute with Meduna, however, Sakel came to emphasize their therapeutic role. Shorter and Healy, \textit{Shock Therapy}, 17-18.

\textsuperscript{165} Braslow, \textit{Mental Ills and Bodily Cures}, 51, 104-105.

\textsuperscript{166} Winfred Overholser to Clarence O. Cheney, 21 Feb 1947, NARA RG 418: Entry 7 (Administrative Files: Electroshock Treatment [1941-1947]); Memorandum from Manson B. Pettit to Addison M. Duval, Subject: Brief Stimulus Demonstration, 11 Dec 1948, NARA RG 418: Entry 7 (Administrative Files: Electroshock Treatment [1947-1953]).

\textsuperscript{167} Case 1945/35: initial assessment (13 March 1945). See also the case of Sarah Holtzmann, who having once before improved after a series of EST again sought out the treatment in 1950. Case 1950/08: information from brother (17 Aug 1950).

\textsuperscript{168} Clement preferred hydrotherapy and individual psychotherapy during his episodes of pending excitation. Case 1960/22a: initial assessment (9 May 1944); clinical record (11 July 1944); case 1960/22b: admission note (25 Aug 1950); psychiatric case study (25 Sept 1950); clinical record (1 Oct 1950; 4 Oct 1950; 20 Nov 1950).
staff’s efforts to do her harm. “[T]he authorities put me in here for no reason,” the 45-year-old white saleswoman insisted. “[T]he doctors and nurses are trying to hurt me, but they are not going to give me any electric shock treatments!”

Families, too, expressed conflicting sentiments about electroshock. Though early researchers tried to temper public expectations, popular accounts dramatized EST’s therapeutic potential. As with other treatments, St. Elizabeths received letters from family members around the country inquiring about the therapy. Some relatives signed the permission forms for EST without comment or delay. Others, however, remained reluctant, perhaps because of the well-known dangers of electricity and its use in the execution of criminals. When Everett Dreyfus’s mother learned of her son’s admission, she reported that the 18-year-old white sailor had always been a rather nervous young man. Dreyfus was disoriented and had difficulty with his memory; occasionally he assumed bizarre postures. His mother refused permission to administer EST, however, fearing that the procedure would further terrify him. Together with the reservations of physicians and patients, such attitudes call into question the assertion by historians Edward Shorter and David Healy that the early history of EST was one of universal acceptance and acclaim.

Prefrontal lobotomy represented the final and most radical somatic treatment in American psychiatry in this period. St. Elizabeths played a unique role in the history of this dramatic and controversial intervention. Inspired by the work of Portuguese physician Egas Moniz, District of Columbia neurologist Walter Freeman and neurosurgeon James Watts first began experimenting

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171 A. Levy to Winfred Overholser, St. Elizabeths Hospital, 11 June 1941; M. L. Campbell to St. Elizabeths Hospital, 21 Nov 1944, NARA RG 418: Entry 7 (Administrative Files: Electroshock Treatment [1941-1947]).
172 Case 1945/26: admission note (20 Aug 1945); Frances R. Leavitt to Winfred Overholser, 18 Oct 1945.
173 Shorter and Healy, Shock Therapy, 82.
with the procedure in 1936.\textsuperscript{174} Freeman had served as neuropathologist and director of laboratories at St. Elizabeths from 1924 to 1933, where his experience on the hospital’s back wards convinced him of the need for bold innovation (Figure 3.5).\textsuperscript{175} When Freeman approached William A. White about trying lobotomy at the institution, however, White flatly refused. In an oft-quoted response not long before his death, White told Freeman that “it will be a hell of a long time before I let you operate on any of my patients.”\textsuperscript{176} Freeman continued his campaign, however, and in the years after World War II lobotomy gained increasingly widespread acceptance. Between 1942 and 1955, Winfred Overholser allowed a limited number of St. Elizabeths patients to undergo the procedure, though he insisted that physicians exhaust every other available option before considering surgery.\textsuperscript{177}

Physicians at St. Elizabeths remained uncertain about lobotomy’s value, acknowledging the limited therapeutic aspirations associated with the procedure. In lobotomy, wrote Harold Stevens and Abraham Mosovich, “[a]n organic syndrome [is] substituted for the psychosis. Restitution of the patient’s prepsychotic state should not be expected.”\textsuperscript{178} The reduction in psychic torment brought about by the procedure, many psychiatrists agreed, often represented a positive gain. More importantly, lobotomy became a sort of “human salvage operation” that rendered the most hopeless and demanding cases more tractable, at times even restoring patients to a “useful” (albeit limited) existence.\textsuperscript{179} St. Elizabeths physicians never followed Freeman and

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\textsuperscript{174} Pressman, \textit{Last Resort}, 77-78. \\
\textsuperscript{175} Jack El-Hai, \textit{The Lobotomist: A Maverick Medical Genius and his Tragic Quest to Rid the World of Mental Illness} (Hoboken, New Jersey: J. Wiley, 2005), 61, 237. \\
\textsuperscript{176} Walter Freeman, \textit{The Psychiatrist: Personalities and Patterns} (New York: Grune and Stratton, 1968), 57. \\
\textsuperscript{177} Winfred Overholser, “Prefrontal Lobotomy,” letter to the editor, \textit{Journal of the American Medical Association} 147 (10 Nov 1951): 1092. Later, as the technique evolved, Overholser refused permission for Freeman’s transorbital method, though he acknowledged in 1952 that one patient underwent the procedure under extraordinary (but unspecified) conditions. \textit{Annual Report} 1952, 5. \\
\textsuperscript{178} Harold Stevens and Abraham Mosovich, “Clinical and EEG Investigation of Prefrontal Lobotomy Patients,” \textit{American Journal of Psychiatry} 104 (1947): 80. \\
\textsuperscript{179} Pressman, \textit{Last Resort}, 205-215.
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Figure 3.5. Scientific staff at St. Elizabeths posing on the steps of the Blackburn Laboratory (late 1920s or early 1930s). Walter Freeman is seated at the lower right.

other enthusiasts who increasingly recommended surgery for those who did not require long-term institutional care. “Lobotomy will undoubtedly eliminate disturbed behavior and is probably justified when all other available forms of therapy have failed and the patient remains so disturbed as to endanger either his own life or that of others,” Overholser wrote in 1953. Yet “[o]ne must always keep in mind that the patient, without having been consulted about it, pays the price in reduced initiative and reduced capacity for experiencing, forever afterwards, the emotional gratifications that make living worthwhile for most of the rest of us.”

Overholser’s protestations of conservatism notwithstanding, at least 212 men and women underwent lobotomies at St. Elizabeths. According to physicians George Weickhardt and Addison Duval, these were “chronically ill, unmanageable patients who failed to respond to more conservative treatment and who seemed destined for lifelong institutional care.” In their account of thirty lobotomy patients, Stevens and Mosovich found that they had been ill for an average of 10.1 years (SD = 5.73) and in the hospital for an average of 5.5 years (SD = 2.70). Often they attacked others or tried to end their own lives; some refused to eat and regularly required tube feeding. Physicians tended to highlight cases like that of Charles Sutherland, who had been out of touch with his surroundings for eight years and developed pulmonary tuberculosis during his time as a patient. Sutherland routinely threatened those around him and raced about the ward, coughing and spitting without restraint. Even as his physical condition

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180 Winfred Overholser to W. L. Patterson, 14 Dec 1953, NARA RG 418: Entry 7 (Administrative Files: Treatment, Miscellaneous [1951-1955]).
181 This includes the eighty-four patients reported in George D. Weickhardt and Addison M. Duval, “Adjustment Levels in Hospitalized Schizophrenic Patients Following Prefrontal Lobotomy,” Diseases of the Nervous System 10 (1949): 306-309, as well as the 128 reported in Annual Reports 1950-1955.
183 Stevens and Mosovich, “Clinical and EEG Investigation,” 74.
184 Ibid., 73. Among twenty-three patients, the medical staff diagnosed nine with dementia precox, five with manic-depressive psychosis, seven with other psychotic disorders, and two with severe psychoneuroses. This breakdown directly contradicts Weickhardt and Duval’s later assertion that all patients who received lobotomies at St. Elizabeths were diagnosed with schizophrenia. Weickhardt and Duval, “Adjustment Levels,” 306.
deteriorated, Sutherland refused to cooperate with medical treatment. In cases like these, lobotomy may quite literally have saved a patient’s life. Yet Stevens and Mosovich acknowledged that only about half of the patients in their report were frankly dangerous, and just nine had received shock therapy prior to undergoing lobotomy. While some may have been suffering from medical conditions that made them poor candidates for EST, these statistics nevertheless call into question the extent to which Overholser’s public caution influenced individual decisions on the wards.

While the racial and gender breakdown of patients who received lobotomy at St. Elizabeths remains unclear, it is likely that both factors played a role in the selection of patients. When Overholser investigated an increase in restraint and seclusion at the hospital in 1949, the psychiatrist in charge of a division for black women reported that in many of the cases requiring constant seclusion she had already requested permission from relatives for lobotomy. In view of the inferior material conditions and disproportionate overcrowding on black wards, it does not strain credulity to wonder if physicians might have performed fewer lobotomies on black patients if they had enjoyed the same access to resources as white men and women. If St. Elizabeths was anything like other hospitals at midcentury, female patients likely made up a disproportionately high percentage of candidates for the procedure. A 1949 U.S. Public Health Service survey found that physicians performed lobotomies on nearly twice as many women as

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185 Stevens and Mosovich, “Clinical and EEG Investigation,” 73. (Only the patient’s initials appear in this article; I have employed a pseudonym in the text.)
186 In the records reviewed for this chapter, the only individual for whom physicians recommended lobotomy was Shirley Anderson, a terminally ill cancer patient suffering from intense pain in addition to persecutory delusions. Administrative officials were unable to obtain permission from Anderson’s family for the procedure, however, and she ultimately died before they were able to carry it out. Case 1955/25: memorandum from Homer B. Matthews to Winfred Overholser, Subject: Recommendation for Prefrontal Lobotomy, 19 May 1955; Addison M. Duval to Harriet Friedman, 13 June 1955; Addison M. Duval Harriet Friedman, 29 June 1955.
187 Memorandum from Lois D. Hubbard to Evelyn B. Reichenbach, Subject: Seclusions and Restraints (Mechanical and Chemical) and Measures Taken to Reduce Same, 18 March 1949, NARA RG 418: Entry 7 (Administrative Files: Restraint and Seclusion).
they did on men. Based on an exhaustive analysis of the process by which physicians selected patients for lobotomy at another leading institution, historian Jack Pressman has concluded that a widespread belief that women’s work required less intelligence than men’s almost certainly played a role in this discrepancy.

By the early 1950s, physicians at St. Elizabeths had become increasingly skeptical of lobotomy. Early reports indicated good results, but later cases did not seem to show the same degree of improvement. Other leading medical centers began to question the procedure’s value as well. The immediate post-World War II era also represented the heyday of psychoanalysis in American psychiatry. While many physicians had little difficulty reconciling somatic and psychic perspectives in practice, orthodox psychoanalysts remained among the most persistent and forceful critics of lobotomy. Freeman’s personal relationship with St. Elizabeths became strained when a 1952 article in the *Evening Star* mistakenly reported that he had performed many of his operations at the institution. Overholser was incensed, blaming Freeman for the error. Though Freeman ultimately obtained a correction, Overholser nevertheless terminated his appointment as a neurological consultant. Two years later, during the planning stages for the hospital’s centenary celebration, a physician called to inquire whether there would be a neurologist on one of the proposed panels. “He suggested Walter Freeman,” reported Jay Hoffman in a memorandum to Overholser, “and I suggested Walter would probably not be

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189 Ibid., 304. Pressman devotes barely three pages of his 555-page monograph to the question of gender bias in the history of lobotomy. While Joel Braslow is far more attentive to the issue in his *Mental Ills and Bodily Cures* (pp. 152-170), ultimately it is Pressman’s off-hand insight that I believe lies at the heart of the discrepancy.
invited.” St. Elizabeths appears to have performed its last lobotomy in 1954. That same year the major tranquilizers made their debut, further marginalizing the procedure.  

CONCLUSION

Psychiatrists at St. Elizabeths proved remarkably adept at integrating psychological and biological perspectives on mental illness. In some instances, this occurred at the level of theoretical formulation, as in White’s psychoanalytic interpretation of the grandiose beliefs common in paretic patients. In others, physicians drew upon psychological principles to explain the mechanism by which an unambiguously corporeal treatment worked, as with hydrotherapy, insulin coma treatment, and, to a lesser extent, metrazol shock. Tensions between psychodynamic and somatic approaches dissolved in the context of daily practice; theoretical rationales for a particular treatment often proved less important than institutional pressures and the clinical imperative to do something. Failure to bring about recovery soon after a patient’s admission might mean a lifetime in the institution. While conditions on many of St. Elizabeths’ wards remained better than those at other hospitals, few physicians would have wished this fate on the men and women under their care.

These treatments can thus be understood in terms of both physicians’ need to maintain institutional order and their desire to assert their identities as medical practitioners. Persistent overcrowding and understaffing strained the institution’s administrative capacity. Against this backdrop, physicians came to see maintaining order as a precondition for their clinical and therapeutic goals. Disruptive patients who threatened to divert resources from their peers became

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191 Memorandum from Jay Hoffman to Winfred Overholser, 14 March 1955, NARA RG 418: Entry 7 (Administrative Files: Centennial Celebration A).
vulnerable to harsh measures such as hydrotherapy, electroshock therapy, and lobotomy.¹⁹³

These treatments represented an affirmation of physicians’ medical identity. Each involved a set of highly technical considerations that psychiatrists claimed as expert knowledge—from the temperature and duration of a hydrotherapy session to the exact timing of glucose administration necessary to end a hypoglycemic coma. These therapies also provided opportunities for intensive metabolic and electrophysiological monitoring, further reinforcing psychiatry’s identification with laboratory-based scientific medicine.

Somatic treatment at St. Elizabeths also reflected the stratified vision of American citizenship that guided U.S. psychiatry as a social enterprise. The absence of hydrotherapy facilities on the wards for black men meant that agitated behavior elicited seclusion or physical restraint more frequently than on white wards. While officials adopted a more egalitarian approach with malarial fever therapy, this did not prevent them from blaming the high rates of neurosyphilis among black patients on their inherent sexual immorality. And as Haroun Hussein’s experience illustrates, those on the margins of American life remained uniquely vulnerable to medical exploitation. The implications of racial and gender attitudes for the shock therapies and lobotomy remain less clear. To the extent that physicians reserved these methods for seriously disruptive and violent patients, it is reasonable to assume that they employed them more frequently with black men and women on the hospital’s overcrowded wards—though as the case of Louise Lowry reveals, this did not always prove to be the case. As we shall see, psychiatrists during the 1940s and 1950s promoted a highly restrictive model of domesticity for American women, encouraging wives to embrace a distinctly subordinate position vis-à-vis their husbands. It therefore does not strain credulity to suppose that female patients may have received

¹⁹³ As Erving Goffman observed, “the medical action is presented to the patient and his relatives as an individual service, but what is being serviced here is the institution[.]” Goffman, Asylums, 383.
a disproportionate number of the lobotomies performed at St. Elizabeths, as happened throughout the United States. Again, however, the available data remain inconclusive.

Finally, the therapies I have outlined here further underscore the limited autonomy that men and women with a degree of psychological impairment have historically enjoyed in the United States. The legal finding of incompetence involved in civil commitment meant that patients had little say in decisions about their treatment—even when it came to dangerous and irreversible procedures such as lobotomy. Physicians at St. Elizabeths proved more cautious than many of their colleagues, seeking permission whenever a therapy remained experimental or carried a non-trivial risk. Unless the individual had come to St. Elizabeths as a voluntary admission, however, physicians turned to family members for permission rather than negotiate directly with patients. The absence of any routine administrative protocol designed to maximize self-determination meant that these men and women effectively gave up control over their bodies once they entered the institution. Occasionally, patients successfully refused treatments that physicians viewed as tentative or inessential. And for some patients, the severity of their impairment would have made shared decision-making impossible. The fact remains, however, that for many of the patients admitted to St. Elizabeths, even a single episode of instability carried the possibility of total loss of control over one’s fate.
INTRODUCTION

American psychiatrists at midcentury remained committed to the project of reconstituting mentally-distressed men and women for proper citizenship. Though their views on what it meant to be a well-adjusted member of society departed in important respects from those of their predecessors, these physicians continued to promote a highly racialized and gendered vision of U.S. national identity. In this chapter, I argue that the views of psychiatrists at St. Elizabeths in the 1940s and 1950s are best understood in terms of the liberal politics of the period. Classically formulated as a creed of individual rights and freedoms, liberalism in the American context has traditionally been an ideology of professed egalitarianism, mutual tolerance, and faith in rational critique. The economic instability of the 1930s prompted liberal intellectuals to advocate a positive role for the state in promoting social and economic welfare as well. The scope of liberal opinion narrowed considerably in the postwar era, however, as the social democratic left that had taken shape during the Depression withered under the pressure of Cold War anti-communism. The specter of an expansive and belligerent Soviet Union led many Americans to prioritize foreign affairs over domestic politics, casting suspicion on anyone who questioned the justice of the American economic system.1

The social attitudes and political outlook among physicians at St. Elizabeths represented a distinctive form of psychiatric liberalism in midcentury American culture. I borrow this term from historian Naoko Wake, who has employed it in her biographical study of physician Harry Stack Sullivan to capture the reformist and racially egalitarian impulse of his work during the interwar years. In the sections that follow, I expand on Wake’s usage to signify psychiatrists’ efforts to strengthen American democracy in the 1940s and 1950s through the judicious use of psychological expertise. While previous studies have focused on the discourse of intellectuals in this period or the place of psychology in popular culture, my focus remains on the day-to-day clinical interactions between psychiatrists and their patients. Liberal-minded physicians at St. Elizabeths sought to create a psychologically resilient citizenry capable of negotiating the unique perils of modern life. In the process, psychiatrists advocated a delicate balance of individual freedom, personal responsibility, and social tolerance, all the while keeping the demands of the wider society in mind. For many Americans, the experience of fighting fascism and opposing Soviet totalitarianism prompted a greater awareness of the role they played in fashioning the content of U.S. democracy. At St. Elizabeths, psychiatrists routinely provided guidance on complex situations involving race relations, gender conflict, and sexual morality—all issues at the center of debates about American national identity in the postwar period.

Physicians at St. Elizabeths occupied a cautious position within the liberal mainstream in these debates. Changing ideas about race and culture led many psychiatrists to reconsider the

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2 Sullivan was an influential figure in American psychiatry, with important early ties to St. Elizabeths. His strain of liberalism, however, declined precipitously after World War II, as he became increasingly sympathetic to a hierarchical global outlook in which the United States would play a leading role. Naoko Wake, “Private Practices: Harry Stack Sullivan, Homosexuality, and the Limits of Psychiatric Liberalism” (Ph.D. dissertation, Indiana University, 2005), 9-11, 249-250, 259-261, 305-306.

symptoms of their black patients. Rather than searching for insight into an imagined racial past, they began looking to the current repressive environment for explanations of black mental illness. As a federal institution, St. Elizabeths was among the first in the country to begin racial desegregation following the Supreme Court’s landmark decision in 1954. Officials proceeded only within tightly-specified limits, however, and subtler forms of racism persisted in the years that followed. Psychiatrists proved far less willing to challenge conventional views on gender than on race. The ascendancy of psychoanalysis in postwar psychiatry meant that physicians tended to identify masculinity with the active role in society, reinforcing male privilege at every opportunity. While psychiatrists at St. Elizabeths accepted women’s increasing participation in the workforce largely without comment, they continued to believe that their female patients would find greater fulfillment in the home. When men broke down, physicians turned the conversation back to women, blaming mothers for failing to allow their sons to achieve emotional maturity. Finally, at a time when many Americans identified gay men and lesbians as a threat to national security, physicians at St. Elizabeths counseled tolerance and restraint, actively campaigning against policies that criminalized same-sex sexual conduct. Psychiatrists themselves, however, had laid the groundwork for the postwar hysteria they sought to contain, treating homosexuality as diagnostically equivalent to a variety of sexual perversions and crimes. Though sympathetic to the plight of men and women who struggled with same-sex desires, psychiatrists failed to question whether these desires truly represented evidence of psychopathology. In this sense, psychiatrists situated gay men and lesbians irrevocably outside the moral boundaries of U.S. citizenship.
Winfred Overholser came to St. Elizabeths from Massachusetts, where he had worked in the state hospital system for many years and served as Commissioner of Mental Diseases (Figure 4.1). Following White’s death in 1937, Secretary of the Interior Harold Ickes called upon the leadership of the American Psychiatric Association (APA) to recommend a new superintendent for St. Elizabeths Hospital. Overholser had recently been on the losing end of a dispute with the Massachusetts governor, so the committee included his name on their list of recommendations. Ickes interviewed only Overholser, appointing him to replace White that fall.4 Overholser never developed as comprehensive a vision of psychiatry as White, but he nevertheless rose to a position of professional and public esteem. Overholser’s expertise lay at the intersection of psychiatry and the law—both civil and criminal. During his time in Massachusetts, he vigorously promoted the recently-enacted Briggs Law (which provided for psychiatric examination of criminal defendants) and ultimately received the APA’s first annual Isaac Ray Award for contributions to the field.5 In his position as chairman of the National Resource Council’s Committee on Neuropsychiatry, Overholser helped create military guidelines for the psychiatric examination of draftees during World War II, advising officials on how best to prevent gay men from entering the service and how to deal with those who did.6 Overholser published widely in forensic psychiatry and mental health policy, serving as president of the APA in 1947-1948. During the 1940s and 1950s, he frequently authored the sections on forensic, administrative and military psychiatry in the American Journal of Psychiatry’s annual Review of Psychiatric Progress.

5 Lebensohn, “Winfred Overholser.”
Figure 4.1. Winfred Overholser (1892-1964).

When Overholser arrived at St. Elizabeths in 1937, the hospital had more than 5,600 patients on its rolls.\(^7\) White had overseen the erection of additional facilities during his final years; officials opened a new Men’s Receiving Building in 1934 and a Women’s Receiving Building in 1936, both reserved for white patients. Between 1933 and 1945, hospital administrators replaced several of the older structures with a series of eight “continuous treatment” buildings for long-term patients. Despite this expansion, World War II again strained the hospital’s capacities. Army officials took advantage of the network of Veterans Affairs hospitals established during the interwar period, but the Navy (including the Marine Corps) continued to send large numbers of servicemen to St. Elizabeths.\(^8\) Military furloughs among the hospital’s medical personnel left many divisions understaffed, and lucrative jobs in the war industries made it difficult to retain qualified attendants on the wards. Material shortages introduced further challenges. St. Elizabeths did not fare as badly as state institutions, which had already been suffering from neglect in the harsh economic climate of the 1930s.\(^9\) Nevertheless, a series of suicides and accidental deaths—including one incident in which a grand jury indicted three attendants for the murder of a Navy patient—highlighted the crowded conditions and inadequate staffing on many of the hospital’s wards. In 1946, federal officials abruptly terminated St. Elizabeths’ historic relationship with the military.\(^10\)

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7 This account of intramural developments at St. Elizabeths is based on material in Annual Reports 1934-1947.
9 Grob, From Asylum to Community, 71-72.
The end of hostilities in 1945 marked the beginning of a return to normalcy and a steady improvement in hospital conditions. Postwar optimism, widespread faith in psychiatry as a branch of medical science, and renewed federal largesse converged to make the ensuing years a high point in public regard for St. Elizabeths. Enthusiasm for psychoanalytic theories of human behavior led men and women who would not previously have considered seeking psychiatric advice to enter the hospital, though many more received care through private physicians and the city’s proliferating outpatient facilities. Congress had replaced the existing jury trial system with an informal administrative hearing aimed at determining the need for civil commitment in 1938, but Overholser and others continued to criticize the District’s admission laws as cumbersome and an unnecessary barrier to treatment.\textsuperscript{11} A new law proposed by the Federal Security Agency (under whose authority St. Elizabeths operated in the 1940s) and backed by the District of Columbia Medical Society opened the hospital to voluntary admissions in 1948, allowing patients to receive care without automatically losing their civil rights. Another law introduced direct admissions without an intervening period at Gallinger Municipal Hospital.\textsuperscript{12} Though they rarely made up more than 10\% of admissions, the presence of voluntary patients reinforced an emerging trend toward what Overholser described as a “policy of increasing permissiveness” in institutional life.\textsuperscript{13}


\textsuperscript{13} \textit{Annual Report 1957}, 3; Memorandum from Jay L. Hoffman to Addison M. Duval and Winfred Overholser, Subject: Extension of Ground Privileges to More Patients, 17 Jan 1956, NARA RG 418: Entry 7 (Administrative Files: Memoranda, Outgoing [1956]). See also the liberalization of policies concerning ground parole during the mid-1950s cited in Goffman, \textit{Asylums}, 287; memorandum from Jay L. Hoffman to Addison M. Duval and Winfred
The termination of St. Elizabeths’ connection with the U.S. Navy represented a turning point in the hospital’s gradual transformation into a municipal institution. The District of Columbia’s rapid expansion in the New Deal era contributed to this shift, as did the interwar growth of Public Health Service and Veterans Affairs hospitals for military patients. In 1946, military patients made up just 17% of men and women at St. Elizabeths; ten years later, that number had dropped still further to 11% (Figure 4.2a-b). After 1946, military officials no longer sent acutely-ill patients to the hospital; many of those who had already been there for some time received transfers to facilities closer to their homes. Men and women living in, working in, or visiting Washington, D.C. composed the vast majority of patients at St. Elizabeths in the post-World War II period—75% in 1946 and 77% in 1956 (Figure 4.2a-b). As a result, the hospital’s gender and racial distribution increasingly reflected the demographics of the District. By 1960, patients were nearly evenly split along gender lines (Figure 4.3a), with white patients continuing to make up a slight majority (Figure 4.3b). That year white patients made up 56% of the hospital population, while black patients made up 44%. In the District as a whole, white men and women represented 46% of the population, while blacks composed 54%.

Many of the men and women who came to St. Elizabeths arrived in an acute episode of psychological distress. Among servicemen during the war years, a few appear to have been experiencing the delayed psychic effects of combat. Most such men, however, received short-term care overseas or at Naval facilities elsewhere in the United States. More commonly, military patients at St. Elizabeths had responded poorly to the rigors of training or non-combat service; officials sent some there for evaluation after they had deserted. Among civil patients,

Overholser, Subject: Extension of Ground Privileges to More Patients, 17 Jan 1956, NARA RG 418: Entry 7 (Administrative Files: Memoranda, Outgoing [1956]).


Green, Secret City, 321.
Figures 4.2a and 4.2b: St. Elizabeths Hospital Patient Population in the Postwar Era.

Source: Annual Reports, 1946, 1956.
Figures 4.3a and 4.3b: St. Elizabeths Hospital Patient Population by Gender and Race in the Postwar Era.

men and women came to the hospital under circumstances as varied as their lives. Some broke down under the stress of work or in the context of domestic discord; others could identify no immediate precipitant for their distress. While men and women in the postwar period often proved more willing than their predecessors to seek psychiatric care on their own initiative, encounters with civil authorities remained a frequent precipitant for admission—particularly in the increasing number of cases complicated by alcohol or substance abuse. Outcomes among patients discharged in the postwar era support the observation that many patients came to St. Elizabeths in the midst of an acute episode of impairment, with officials designating nearly 29.58% of these men and women either fully recovered or at least capable of caring for themselves at discharge (Figure 4.4).

St. Elizabeths also continued to serve large numbers of men and women whose difficulties represented part of a more persistent condition. Among both civil and military patients, many had trouble thinking clearly or getting along with others in ways that made it impossible for them to live independently. Frequently these patients received a diagnosis of dementia precox (schizophrenia). Such a condition did not necessarily mean that a patient would not leave the hospital. Among those who did not improve, however, physicians agreed that schizophrenia was a leading cause. Men and women suffering from recognizably organic brain damage similarly failed to recover in most cases. Though the number of patients with paresis declined precipitously after the introduction of penicillin, elderly men and women with advanced forms of arteriosclerotic or Alzheimer’s dementia represented an increasing proportion of admissions. Indeed, the number of older patients at St. Elizabeths rose steadily in the postwar decades; by 1958, fully 30% of the
Figure 4.4: Outcomes among St. Elizabeths Patients Discharged in the Postwar Era.

Source: Annual Reports, 1945-1960.
hospital’s population was over 65.16 The end of military admissions contributed to this shift, but
the change also reflected the increasing lifespan of all Americans and an accumulation of
psychologically impaired but otherwise healthy men and women—realities that were not unique
to St. Elizabeths.17 If seriously and persistently impaired patients did leave the hospital—often
through a transfer to another facility—physicians generally deemed them unimproved (13.9%) or
perhaps improved enough to live in the community with assistance but not enough to justify full
restoration of their civil rights (23.9%) (Figure 4.4).

St. Elizabeths harbored perhaps its most famous patient during the postwar period, the
pioneering modernist poet Ezra Pound.18 Always an irascible and deeply eccentric figure, Pound
lived much of his adult life as an American expatriate in Europe, moving first to London, then
Paris and Italy in 1924. There he became an admirer of Mussolini and his National Fascist Party.
During World War II, Pound’s idiosyncratic economic theories and increasingly virulent anti-
Semitism prompted him to make a series of propagandistic broadcasts for the Italian government.
Americans responded with outrage, and in 1943 a District court indicted Pound for treason. After
the war, military officials held him for several months at a detention center near Pisa, where he
appeared to experience a nervous breakdown. Soon officials sent Pound on to Washington, D.C.
and the District of Columbia jail. When his lawyer protested that Pound suffered from a mental
illness, officials transferred him to Gallinger Municipal Hospital. In the weeks that followed,
Winfred Overholser and three other psychiatrists examined Pound. According to E. Fuller
Torrey, Overholser convinced his colleagues to join him in issuing a consensus report that

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17 *Annual Reports* 1948, 667; 1951, 3.
Figure 4.5: Ezra Pound at St. Elizabeths (1955).

December. In it, they indicated that Pound suffered from a paranoid state of long-standing, that
his condition rendered him incapable of assisting in his own defense, and that a trial would likely precipitate another breakdown. Each of the physicians affirmed this opinion at a hearing two months later, at which point the court found Pound unfit for trial and sent him to St. Elizabeths (Figure 4.5). There he would remain for more than twelve years until his release in 1948.

While it is clear that Pound lived well at St. Elizabeths, the question of his sanity has remained a source of considerable controversy. Following an initial year in Howard Hall, Pound moved to a spacious room on one of the hospital’s best wards. There he enjoyed freedom of the grounds as well as access to reading material and the tools for writing. Pound entertained a steady parade of visitors over the course of his confinement; indeed, the pilgrimage to St. Elizabeths became a rite of passage for aspiring young writers. Pound also remained remarkably productive, completing two new books of poetry and extensive translation work. He kept up a lively correspondence and remained marginally engaged in politics, mentoring the youthful white-supremacist and radical segregationist John Kasper at the outset of his short public career in the 1950s. Aside from occasional interviews by physicians, Pound tolerated minimal interference from the staff. Most of the physicians who examined him found Pound brilliant, peculiar, and unimaginably arrogant; very few, however, felt he was seriously impaired or out of touch with reality. Indeed, having reviewed Pound’s record, Torrey has concluded he was “eminently capable of standing trial and in assisting in his own defense.”19 Others have been less certain, suggesting that while Pound may have functioned well at times, he also experienced episodes of serious emotional disturbance.20 Pound’s biographer agreed that he was insane at the

19 Torrey, Roots of Treason, 205.
20 This was the conclusion of physician Harold Pincus, a Special Assistant to the Director at the National Institute of Mental Health when Torrey’s book appeared. Pincus was tasked to review Pound’s file and determine whether any effort had been undertaken to shelter him from prosecution. Ultimately, he concluded that Pound did in fact suffer
time of his admission, citing the poet’s “exuberantly grandiose talk” and the disjointed letters he sent to his attorney.\textsuperscript{21}

An extraordinary case such as Pound’s makes explicit the kinds of political judgments that often lie beneath the surface in psychiatric evaluation. Physicians at St. Elizabeths had to distinguish between political extremism and mental illness in other instances as well. Loretta Mitchell was a white Montana homemaker in the 1950s who became progressively more involved in what she later described as “several right wing organizations.”\textsuperscript{22} In 1954, the Department of Justice indicted Mitchell after she and her husband openly refused to pay taxes or recognize the authority of the U.S. government. The judge in her case questioned Mitchell’s mental stability, ultimately sending her to St. Elizabeths for evaluation. After six weeks, Overholser and his colleagues declared Mitchell competent to stand trial. Physician Jay Hoffman cut to the heart of the matter. “I disagree with almost every aspect of her social and political views,” he declared in the discussion following her presentation at a clinical conference, “but I feel strongly that we must grant people of different views freedom to express such views within our framework of law.” Radicalism, Hoffman concluded, did not necessarily signify insanity: “If there is a doubt in a case like this, the benefit belongs to the patient.” Ironically, the psychiatric liberalism that underpinned Hoffman’s assessment elicited little more than contempt from Mitchell and her compatriots, many of whom viewed the profession with a suspicion composed of equal parts radical libertarianism and crass anti-Semitism. Following her conviction and sentencing, Mitchell went on to call attention to Pound’s plight at St. Elizabeths, suggesting that

\textsuperscript{21} Wilhelm, \textit{Ezra Pound}, 260-261.
\textsuperscript{22} The limited records associated with this case appear in the hospital’s general administrative files. As such, access to these records is not restricted. Because they contain protected health information, however, I have elected to employ a pseudonym for the patient involved. Additionally, since the case generated extensive coverage by the national press (upon which I have also drawn), I have changed a number of important details so as to maintain anonymity. See the material in NARA RG 418: Entry 7 (Administrative Files: Mitchell, Loretta [1955]).
the government was holding him prisoner without trial for his political views. Pound himself, however, finally obtained his release in 1958, when, on the strength of Overholser’s affidavit, a federal judge dismissed the original indictments and allowed him to return to Italy.23

“THE ORDINARY PRIVILEGES OF DEMOCRACY”: PSYCHIATRY AND RACIAL LIBERALISM

Midcentury psychiatric liberalism reached its highest point in the profession’s views on race, which changed considerably during the interwar period. As we have seen, William Alanson White and his staff encountered little difficulty reconciling the environmentalism of psychoanalysis with existing stereotypes about black Americans. Subsequent generations, however, began to examine race relations in terms of existing social structures rather than biological and cultural inheritance. These changes are visible in the career of Harry Stack Sullivan, who served as a liaison officer for the Veterans Bureau at St. Elizabeths in 1921-1922 and subsequently developed his influential theory of interpersonal psychiatry at nearby private hospitals in Maryland.24 Sullivan admired White and publicly credited him with shaping his outlook. As early as the 1920s, however, Sullivan expressed doubts that the patterns of thought involved in mental illness represented a reversion to racially primitive ways of thinking. “[T]hat there is any necessity for accepting the notion of phyletic regression of mind structure,” he wrote in 1924, “is not proven.”25 Like many of his psychoanalytically-inclined peers, Sullivan became increasingly interested in sociological and anthropological perspectives on human behavior. By

23 Torrey, Roots of Treason, 257, 262.
24 Wake, “Private Practices.”
the end of the 1930s, he concluded that most of the traits white observers attributed to blacks were in fact products of the unjust circumstances under which black men and women lived.26 Psychiatrists at St. Elizabeths followed a similar trajectory. As early as 1930, Philip Graven concluded his case report on a black patient with the observation that “[n]othing characteristically ‘negro,’ such as race inferiority, can be deduced from this case. The type of conflict and reaction could equally well have been found in a ‘white’ case.”27 In what appears to be the only article from St. Elizabeths to address the question of race relations directly in the postwar period, physicians Henry J. Myers and Leon Yochelson distanced themselves from the work of O’Malley, Bevis, and others. “Stereotypic thinking … and the prejudice of particular authors,” they wrote in 1948, “have influenced many articles[.] … Naturally, little contribution to the understanding of the Negro and his problems can be expected from such sources.”28 By this point American psychologists and behavioral scientists were turning in increasing numbers to the study of prejudice. Inspired initially by the wartime encounter with Nazi anti-Semitism, researchers shifted focus in the ensuing years to the domestic phenomenon of anti-black racism.29 Myers and Yochelson drew explicitly upon this work, as well as a parallel literature addressing the psychic impact of racial injustice.30 In the process, they analyzed the chronic frustration and anxiety among black men and women, one result of the contradiction between their “theoretical role as … free and equal [members] of American society and [their] actual role as [members] of an inferior caste.”31 While Myers and Yochelson’s primary interest lay in the

29 Herman, Romance of American Psychology, 57-66, 181-186.
31 Myers and Yochelson, “Color Denial,” 40.
effect of color consciousness within the black community, the authors nevertheless recognized and condemned the effects of white racism on their black patients.

Clinical records confirm that psychoanalytically-inclined psychiatrists recognized the impossibility of the situations in which many black patients found themselves. Leonard Baldwin was working two jobs at District hotels in 1955 in an effort to support his family. Occasionally, white guests made unreasonable demands of him, but the 27-year-old’s employer warned him never to express his frustrations publicly. When Baldwin confessed to starting several small fires in the rooms of guests who harassed him, police sent him to St. Elizabeths for evaluation. There the staff focused on Baldwin’s tendency to suppress his anger rather than process it, encouraging him (rather naively) to speak with his manager if circumstances again became overwhelming.32

At times, physicians’ interest in their black patients’ psychic lives extended even to those with recognizable organic impairments. Kenneth Wilson began having trouble thinking clearly in 1955. Within a few months police arrested the 49-year-old park attendant for tampering with a car and then for pulling a fire alarm without reason. At St. Elizabeths, physicians found Wilson to be in the advanced stages of neurosyphilis. They nevertheless listened carefully to his story, interpreting events in the same manner that they did among white patients. “He gives an account of his present illness by saying he felt depressed, he went to a fire box and set the alarm,” observed a psychiatrist on his ward. “This was interesting in view of the fact that he probably was seeking help and was alarmed, and it may have been quite symbolic.”33

Employment policies at St. Elizabeths changed gradually in the years leading up to formal desegregation. Within a year of Overholser’s arrival, officials hired several black

attendants and nurses to work on wards for black patients. Integrated facilities remained rare in the city, and when St. Elizabeths began training black nursing students from Howard University in 1938 officials refused to allow them to eat lunch alongside white employees. Segregation among employees persisted during World War II. At a time when resources of all sorts were becoming increasingly scarce, officials went out of their way to create separate restrooms and locker rooms for black men and women. Black medical students from Howard continued to receive instruction at St. Elizabeths in the 1940s, as did students from the university’s school of social work. By the mid-1940s it was not unusual for black staff members to care for white patients in the most intimate of contexts. Sarah Gould had been at the hospital for almost forty years when she began coming into greater contact with black employees. “She often objects to a bath, especially if one of the colored employees starts to give it to her,” observed a physician in 1944, “but usually makes no trouble when a white girl bathes her.” By the 1950s the institution employed several black social workers, though they appear to have worked exclusively with black patients until 1954. That year St. Elizabeths accepted the first black physician into its residency program, Luther D. Robinson, who would ultimately make his career at the hospital and serve as superintendent in the 1970s.

34 Annual Report 1938, 381.
36 Annual Reports 1941, 5; 1943, 51.
37 Case 15488: clinical record (10 May 1944).
38 Memorandum from Blanche Parcell to Jay L. Hoffman, 29 July 1954, NARA RG 418: Entry 7 (Administrative Files: Admission Services Consolidation).
39 “Luther D. Robinson, M.D.,” John Howard Journal 21, nos. 9 & 10 (Sept/Oct 1969): n.p. Robinson recalled a black medical student from Howard University working alongside him as an extern on the (all-white) Men’s Receiving Service around that time, and the following year the hospital also agreed to accept a resident from Howard University for a three-month training period. Author’s interview with Luther Robinson, April 2004; Winfred Overholser to E. Y. Williams (27 June 1955), NARA RG 418: Entry 7 (Administrative Files: Residents [1953-1957]).
A new level of consciousness and political organization among black men and women facilitated these changes. As early as 1933, black professionals in Washington, D.C. organized the New Negro Alliance to boycott businesses that refused to employ black workers. Eight years later, black labor leader A. Philip Randolph’s planned march on the city convinced Franklin Delano Roosevelt to introduce a policy of nondiscrimination in wartime government contracts. The experience of fighting fascism and oppressive racial doctrines abroad encouraged many black Americans to question conditions on the home front; black veterans in particular resented treatment as second-class citizens after having served their country. Though government officials gradually dismantled some of the barriers facing educated black men and women in Washington, D.C., interracial organizations like the Citizens Committee on Race Relations and the National Committee on Segregation in the Nation’s Capital pressed them to do more. Activism within the black community lay at the heart of these groups’ success, but civil rights groups also drew on a tradition of racial egalitarianism among white labor radicals and left-leaning religious groups. By the 1950s an attitude of self-conscious racial liberalism took hold not only in Jewish and Quaker groups but also in Protestant and Catholic congregations throughout the North.

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At St. Elizabeths, black patients increasingly began to frame their demands in the language of American citizenship. Dominick Bell, whose distorted beliefs led him to shoot and nearly kill his attorney in Baltimore, nevertheless displayed keen insight into the existing system of racial injustice. During an initial interview, Bell insisted that the hospital was denying him “the ordinary privileges of democracy” and suggested that “were he allowed to go to some other part of the United States or to one of the Central or South American countries in which racial prejudice is less marked … he would have no difficulty in getting along.”

Others, too, couched their critiques in terms of a racialized national identity. Myers and Yochelson reported on a patient who wrote to his physicians “demand[ing] his rights as an American-born citizen, ‘although a Negro (Black Race)[.]’” Even when they did not specifically invoke the language of citizenship, black patients implicitly referenced the racism and violence that dominated the lives of black Americans. When a physician asked about one male patient’s symptoms in 1954, the patient denied experiencing hallucinations but acknowledged having “a persecution complex, as any Negro would have.”

Another patient began shouting at the examiner and “stated he was angry because I had been lynching him.”

By the time of the Supreme Court’s 1954 decision invalidating the legal foundations of segregation, the movement for the integration of Washington, D.C. was already well under way. A wide array of groups employed petitions, pickets, and sit-ins on behalf of civil rights, and in 1952 Dwight Eisenhower campaigned on a promise to end segregation in the nation’s capital. Local groups led the fight for integration at lunch counters, restaurants, and hotels, culminating...

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44 Case 1945/06: initial assessment (25 Aug 1945). See also Dominick Bell to Winfred Overholser (5 Feb 1946).
45 Myers and Yochelson, “Color Denial,” 43.
46 Patient HH 69994 (abstracts of records for research study, n.d. [1954]), NARA RG 418: Entry 7 (Administrative Files: Serpasil).
in a 1953 Supreme Court decision upholding Reconstruction era civil rights legislation in the city. Eisenhower made this case a top priority for the Department of Justice. That November, District commissioners banned discrimination in employment and the use of public facilities. By the time the court handed down its decision in Brown v. Board of Education in May of the following year, many felt that school desegregation in the District was inevitable. Implementation moved forward with surprisingly little conflict. These victories, however, did not transform social relations in the capital overnight. Black residents continued to face discrimination in housing, employment, and social services. Residual tensions left critics on both sides dissatisfied, and in the ensuing years many white residents left the District for its suburbs in Maryland and Virginia.48

Desegregation at St. Elizabeths proceeded remarkably smoothly. Overholser appears to have begun planning in the late spring of 1954, probably as a direct result of the Supreme Court’s decision. That summer the administration announced that it would consolidate the hospital’s admission services, opening the Men’s and Women’s Receiving Buildings to black patients as well as whites.49 Whenever possible, officials carried out integration “to meet a definite need”—such as the opening of a new ward or to move working patients closer to their occupational assignment—“and not just for the sake of integration per se.”50 Luther Robinson’s supervisors remarked on the black intern’s emotional maturity and ability to communicate with patients’ families, noting that “he will be quite an asset ... during the coming integration.”51

49 See the correspondence in NARA RG 418: Entry 7 (Administrative Files: Consolidation of Admission Services).
Some physicians displayed more initiative than others, proceeding from integrated multi-ward parties for patients to full-scale transfers over the course of several months. From the administration’s perspective, the hospital managed to avoid any “untoward incidents.” “Integration, apparently, has been well accepted by patients, personnel, and relatives,” reported Jay Hoffman in November. “No fanfare attended this move, and it would appear that the people concerned have been appropriately conditioned and oriented by the public press[.]”\textsuperscript{52} A physician in charge of a division formerly limited to black patients reported that “a number of the relatives of white patients transferred to West Lodge Service were quite disturbed by the transfers, not so much because of the mixing of the races as because of the relatively poor physical facilities on the wards.”\textsuperscript{53} By 1956, when the hospital opened a new admissions pavilion for black and white patients of both sexes, the process of racial integration was largely complete.\textsuperscript{54}

Just as the end of \textit{de jure} segregation did not immediately transform race relations within the District, the elimination of formal barriers did not necessarily erase long-standing attitudes and practices at St. Elizabeths. As was the case outside the institution’s walls, black men and women remained concentrated in many of the hospital’s least prestigious jobs.\textsuperscript{55} Racism could take many forms, as when officials placed greater emphasis in the clinical record on “politeness” or “surliness” among black patients than whites; some black patients proved “obedient to

\textsuperscript{52} Monthly Report for October 1954, NARA RG 418: Entry 7 (Administrative Files: Monthly Reports [1945-1957]).
\textsuperscript{53} Monthly Report for July 1955, NARA RG 418: Entry 7 (Administrative Files: Monthly Reports [1945-1957]).
\textsuperscript{55} Goffman, \textit{Asylums}, 122.
requests,” while others cooperated only “if a firm attitude is displayed.” One group therapist addressed a black patient’s complaints about race relations “by telling the patient that he must ask himself why he, among all the other Negroes present, chose this particular moment to express this feeling, and what this expression could mean about him as a person, apart from the state of race relations in the hospital at the time.” Administrative practices continued to reinforce racial distinctions as well. When Jay Hoffman requested permission to modify the institution’s nineteenth-century census board to identify patients solely by sex, Overholser demurred, writing that “the distribution by color is as interesting as that by sex.” Hoffman also called physician Francis Tartaglino’s attention to the fact that in the records on his division the term “colored” still appeared after black patients’ names, noting that “[t]here does not seem to be any useful purpose served by this designation.” Well into the 1960s, the hospital’s medical records department continued to record black patients’ demographic information on blue index cards, using white index cards for white patients.

56 Case 1945/06: admission note (26 April 1945); clinical record (24 Sept 1945; 1 Oct 1946); case 1945/09: clinical record (30 June 1950); case 1950/11: ward notes (28 Jan 1952); case 1950/03: summary (30 July 1950); case 1950/15: ward notes (3 Oct 1950).
57 Goffman, Asylums, 377. Occasional racial conflict was a fact of life at St. Elizabeths. Just a few years before desegregation, physicians attributed a spike in the rate of restraint and seclusion on one service to “markedly increased racial tensions,” and it is likely that similar episodes occurred in the years that followed. Memorandum from Bernard Cruvant to Francis J. Tartaglino, Subject: Restraints and Seclusions, West Side Service, 5 April 1949, NARA RG 418: Entry 7 (Administrative Files: Restraint and Seclusion). See also memorandum from Isabelle Schaffner to Jay L. Hoffman, Subject: Request for supply of Frenquel for administration to four patients in Nichols Building, 24 Sept 1954, NARA RG 418: Entry 7 (Administrative Files: Drugs [Individual Agents]).
58 Memorandum from Jay L. Hoffman to Winfred Overholser, Subject: Census Board in A Building Lobby, 23 Sept 1954, NARA RG 418: Entry 7 (Administrative Files: Memoranda, Outgoing [1953-1955]). Administrative physician Addison Duval had served as a delegate to the actively pro-segregationist Federation of Citizens’ Associations in the District of Columbia, and while there is no evidence that Duval actively opposed integration, it is likely that he represented a voice of conservatism within the administration. Harold J. Hall, “Designer of Well-Being: An Interpretation of the Life and Works of Dr. Addison M. Duval,” Howard Hall Journal unknown volume (Jan 1954): 12; Gillette, Jr., Between Justice and Beauty, 147, 149, 160.
60 Physician Roger Peele recalled a widespread perception that buildings which had historically housed black patients continued to receive fewer resources in the 1960s. This may have reflected the tendency that Luther Robinson recalled for administrators to allocate a disproportionate amount of time and money to wards for acutely-
The limits of hospital administrators’ racial liberalism emerged most prominently in cases involving interaction between male and female patients. Officials tolerated a degree of cross-racial flirtation and dating in the years immediately following desegregation; with the equalization of gender and racial distributions, such interactions were to be expected. “[O]ld-line white attendants and old-line patients” responded negatively, but administrators and most younger patients found little reason to complain.61 Nevertheless, in February of 1957, Overholser abruptly banned mixed-race dancing at the hospital.62 The immediate impetus appears to have involved illicit sexual contact between patients. Officials had always worked to minimize “inappropriate petting” at dances, but the prospect that such contact might occur openly between black male and white female patients may have finally prompted them to administrative action. Overholser’s ruling created outrage throughout the hospital. Hoffman reported “considerable unrest among several of the services,” and one nursing supervisor banned dances altogether rather than ask her already overburdened staff to monitor the activity of individual men and women at such events.63 Patients immediately requested that Overholser clarify his decision. “We would be much obliged if you could come over and explain the matter to us,” wrote a group of female patients, “[W]e have nothing else to look forward to. Tell us why did you make such a drastic move?”64

Despite the dissatisfaction, Overholser felt that his decision must stand. At a series of meetings throughout the hospital, staff members expressed views on both sides of the issue.

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62 Unless otherwise noted, the account that follows is derived from material in NARA RG 418: Entry 7 (Administrative Files: Memoranda, Outgoing [1957]).
63 Memorandum from Jay L. Hoffman to Addison M. Duval and Winfred Overholser, 2 March 1957, NARA RG 418: Entry 7 (Administrative Files: Memoranda, Outgoing [1957]).
64 Michelle Doyle et al. to Winfred Overholser, n.d. (~28 Feb 1957), NARA RG 418: Entry 7 (Administrative Files: Memoranda, Outgoing [1957]).
Mixed-race events remained permissible, administrators explained, “so long as there was no
dancing or other close body contact between people of different races.” Not everyone found
such a policy acceptable. The hospital’s Residents’ Association was particularly incensed. “This
policy of racially-segregated dances … will seriously interfere with the welfare and treatment of
the patients,” they wrote, “We all feel that segregated dancing at unsegregated parties is both
unworkable and a possible source of friction.” Overholser remained firm. “There are some
aspects of a hospital’s policy that are best worked out through the democratic process,” he noted
in his response. This, however, was not one of them. “Until there is a change in the clearly
expressed will of the community I am of the opinion that I, as Superintendent, must carry the
responsibility for making [this] decision[.]” With time, it appears that most of the staff
accepted the policy. Hospital administrators enlisted the aid of patient governments to explain
their reasoning on the wards, but the long-term response among men and women living at the
hospital remains unclear. It is similarly unclear how long this policy persisted, though it appears
to have remained in place at least through 1960.

White anxieties about black anger also informed perspectives on mental illness in this
period. Black men represented a disproportionate percentage of patients in the hospital’s forensic
division. Changing racial demographics in the District played a role in this disparity, as did the
biases inherent in an overwhelmingly white metropolitan police force. Judicial efforts to make
the insanity defense available to minorities further reinforced the trend; many defendants who
previously would have gone directly to jail now went to St. Elizabeths for evaluation and

65 Memorandum from Jay L. Hoffman to Addison M. Duval and Winfred Overholser, Subject: Staff Meeting, Chiefs
of Service and Clinical Directors, 6 March 1957, NARA RG 418: Entry 7 (Administrative Files: Memoranda, Outgoing [1957]).
66 Memorandum from Residents’ Association to Winfred Overholser, Subject: Recent Order Restricting Social
Dancing for Patients, 7 March 1957, NARA RG 418: Entry 7 (Administrative Files: Residents [1953-1957]).
67 Winfred Overholser to Thomas D. Reynolds, 12 March 1957, NARA RG 418: Entry 7 (Administrative Files: Residents [1953-1957]).
treatment. For some, the high number of black men in Howard Hall provided evidence of a connection between aggression, violent crime and black mental illness. One physician reported an episode in 1954 in which a black male patient “sat down momentarily and then sprang at [the] examiner in animal-like fashion.” By invoking the metaphor of “animal-like” behavior, this physician echoed a long tradition of viewing black men and women as less than fully human—and of viewing black men in particular as akin to wild beasts. These associations between aggression and black mental illness appeared in the popular press as well. A 1955 photo essay about St. Elizabeths in *Look* magazine featured a shirtless “criminally insane” black man pounding a punching bag (Figure 4.6). “Patients with assaultive tendencies,” the caption explained, “are encouraged to work off their aggressiveness by punching a bag in an improvised gym.” Such images are consistent with the findings of historian Jonathan Metzl, who has argued that aggressive self-assertion among black men became increasingly central to perceptions of schizophrenia over the course of the early civil rights era.

By the end of the 1950s, physicians and patients had laid the foundations for a major transformation of race relations at St. Elizabeths. Compared to the attitudes and policies in place just a few decades earlier, these changes were as remarkable as they were overdue; the end of formal segregation and the new availability of hospital facilities to black patients represented a momentous step. Important changes occurred in the views of psychiatrists as well. Despite

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Figure 4.6: For psychiatrists and popular observers alike, aggressive self-assertion among black men remained threatening. In this photo, a black male patient in Howard Hall pounds a punching bag. “Patients with assaultive tendencies,” the original caption explained, “are encouraged to work off their aggressiveness by punching a bag in an improvised gym.”

lingering elements of conservatism, most physicians now recognized the deleterious impact of white racism and the psychological importance of dignity and self-respect for their black patients. These changes proved to be just the initial steps in a protracted struggle for meaningful racial equality—at St. Elizabeths, in Washington, D.C., and throughout the country. In retrospect, the assumption among white physicians that their efforts would be sufficient to reverse decades of oppression appears naïve and perhaps even arrogant. As racial consciousness grew among black Americans, some physicians adopted an increasingly defensive social posture. Ultimately, tensions surrounding race relations would shape the development of both St. Elizabeths and U.S. psychiatry well into the civil rights era and beyond.

“THE PROPERTY OF HER HUSBAND”: GENDER AND THE LIMITS OF PSYCHIATRIC LIBERALISM

If psychiatrists gradually came to question many of their earlier assumptions about racial difference in the years leading up to World War II, they remained profoundly ambivalent about the role of women in American society. As we have seen, White’s early enthusiasm for psychoanalysis entailed an acceptance of female sexuality at a time when many others hesitated to discuss the topic. In principle, he and his colleagues acknowledged women’s full civic autonomy. In a 1932 address before the local chapter of the National Woman’s Party, White noted important differences between the sexes, but nevertheless concluded that “no adequate knowledge” existed “on which to base restrictive and prohibitive laws applicable to women but not to men.”74 In practice, psychiatrists continued to regard their female patients largely in terms of their fathers, husbands, and sons. When the Washington Post reported on Mary O’Malley’s 1934 finding that more single women than married women expressed satisfaction with their

74 “Dr. White is Heard by Women’s Party,” Washington Post, 7 March 1932, 14.
lives, the author added that O’Malley “isn’t exactly pleased with her conclusions[.] … She believes everyone should be married, since it is a more normal way of living.”75

World War II represented a transformative event for the generation who lived through it, with ramifications not only for international politics but also for such basic elements of American life as the family and relations between the sexes. Men’s wartime service meant that women entered the workforce in unprecedented numbers. Often women performed jobs in manufacturing that had previously been off-limits; large numbers served in the Women’s Army Corps (WACs) and the Navy’s Women Accepted for Volunteer Emergency Service (WAVES) as well. For many, wartime employment and military service were an affirmation of their value as citizens. With demobilization and the shift to a peacetime economy, however, returning veterans displaced women from high-paying jobs in heavy industry. Women continued to enter the labor market in large numbers, but most found their opportunities limited to such fields as secretarial work and the service industries.

Gender roles in the postwar period combined nostalgia for the past with a self-consciously modern set of attitudes about work, marriage and family. Against the backdrop of growing concerns about nuclear conflict, many Americans turned to the home as a source of stability—particularly among the middle class in the nation’s growing suburbs. The home represented an important bulwark against communism; as historian Elaine Tyler May has observed, devotion to a domestic ideal became a form of patriotic expression. With the return of economic prosperity and the shift to a consumer economy, the home became a site of idealized psychological fulfillment.76 Popular images of the family continued to feature a male-breadwinner model, with husbands shouldering the burden of material provision while wives

maintained the household and raised the children. Couples also placed a renewed emphasis on the affective elements of marriage, emphasizing mutual understanding and egalitarian relations between husbands and wives. Sexual fulfillment became a particularly important element of this ideal, with experts counseling open communication and reciprocal gratification of each partner’s desires.77

Women in the postwar period thus faced conflicting messages about their place in American society. On the one hand, virtually no one questioned women’s formal civic autonomy or the validity of their claim to such rights as property-ownership and the vote. Popular magazines often highlighted the activities of women who sought careers in politics or otherwise achieved success outside the home. Even here, however, representations of women emphasized a highly stylized notion of femininity and achievements involving self-sacrifice rather than self-promotion.78 A wide array of experts continued to laud women’s domestic role, often in tones whose intensity belied the underlying trend toward participation in the workforce by middle-class married women. Psychiatry as a whole and psychoanalysis in particular became increasingly conservative on gender issues. An earlier generation of theorists had suggested that recognition of women’s sexual desires would free them from subordination position. While psychoanalysts in the 1940s and 1950s took female sexuality for granted, however, they continued to maintain that women’s contributions to national well-being lay primarily in their service to their husbands and children.79 Given the reality of increased entry by married women into the labor market, psychiatry’s public conservatism on gender issues is best understood as a

79 Gordon, Woman’s Body, Woman’s Right, 273.
rearguard action, reflecting widespread anxieties about social change rather than actual events on the ground.\footnote{Buhle, \textit{Feminism and Its Discontents}, 158-161, 163-164.}

Overholser and his colleagues occupied a cautious position well within the liberal mainstream on issues of gender. Overholser shared the concerns of other commentators about the number of hasty unions into which Americans had entered during the war.\footnote{Winfred Overholser, “Women and Modern Stress,” \textit{Mental Hygiene} 30 (1946): 552-553.} When two individuals seemed poorly suited to one another, however, psychiatrists increasingly accepted divorce as a legitimate option—perhaps because Americans held such high expectations for marriage are a source of fulfillment. Amelia Stenton petitioned for formal discharge from St. Elizabeths while on extended leave in 1944. At the time, the 29-year-old white former waitress was contemplating a divorce from her 49-year-old husband, whom she had once described as having “never had a real good time in his life.”\footnote{Case 1950/04a: psychiatric case study (10 Feb 1943).} The physicians doubted that Stenton had recovered entirely, but were nevertheless sympathetic to her plight. “I can fully see why the marriage is not a happy one,” noted Anna Coyne, “because if any two people are incompatible, these two certainly are.” Ultimately, first assistant physician Riley Guthrie’s opinion carried the day. “I don’t believe we know a great deal about the family relations,” he concluded. “[T]he marital situation is a legal problem … and I would prefer that it would be settled in a court rather than a psychiatric conference room.”\footnote{Case 1950/04a: clinical record (21 April 1944).} Two weeks later Stenton received her discharge, carrying with it full restoration of civil rights and the ability to press for a divorce in the courts.\footnote{Case 1950/04a: clinical record (2 May 1944). See also case 1950/06: admission note (29 May 1950); psychiatric case study (25 July 1950); clinical record (6 Sept 1950); case 1955/09: clinical record (26 Jan 1956).}

While some psychiatrists responded to women’s increased participation in the workforce with alarm, physicians at St. Elizabeths remained confident in the appeal of traditional gender
roles. Benjamin Karpman recommended in 1942 that the wives of G.I.’s occupy themselves with volunteer work or even forego pay for their labor in the wartime industries. Unlike paid labor, he reasoned, such a sacrifice would allow a woman to “lavish on her work the emotional energy that is pent up within her.” Karpman was suggesting not only that women could achieve fulfillment solely through self-sacrifice, but also that such service represented a substitute for women’s natural domestic role rather than an independent contribution to the nation in a time of need.

With the cessation of hostilities, Overholser indicated his faith that conventional family structures would continue to shape men’s and women’s life choices. Overholser acknowledged that gender bias remained pervasive in American society and objected to the shrill tone of journalist Ferdinand Lundberg and psychoanalyst Marynia Farnham’s Modern Woman: The Lost Sex (1947), which condemned women’s pursuit of careers at the expense of their historic domestic role. Nevertheless, when a journalist solicited Overholser’s thoughts on how women might respond to husbands who had received a psychiatric discharge from the military, he suggested that “a wife, if employed, [should] quit working and devote herself to her husband’s readjustment[.]” Though he framed women’s “return to the fireside” as a choice, Overholser continued to describe their domestic work first and foremost as a duty, masking its contingency and presenting the gendered division of labor as an inevitable fact of life.

Psychiatrists recognized that their prescriptions of domesticity carried little weight for most working families. In his advice to the wives of returning veterans, Overholser included a
caveat that women should give up their jobs only “when this is economically possible.” 90 As was the case under White, St. Elizabeths officials offered few criticisms of their black, immigrant, and working-class female patients’ participation in the labor market; indeed, physicians and social workers expected most of these women to work outside the home. When 26-year-old Virginia Hooke came to the hospital as a voluntary admission in 1957, the medical staff expressed surprise that “[h]er only occupation was once working a month or so when she was about twenty-two, wrapping gifts around the Christmas season.” Though she was white, Hooke remained unmarried, and her family had little money. Had this not been the case, physicians might have been less taken aback at her lack of employment. 91

Perhaps surprisingly, Overholser and his colleagues appear to have quickly come to terms with the increasing number of white middle-class women who sought employment outside the home. By the 1950s, female patients pursuing professional careers failed to elicit condemnation or criticism, even when they did so in place of marriage or a family. Frances Poellman came to St. Elizabeths as a voluntary patient in 1955 when she began acting erratically after a surgical procedure. The 49-year-old long-time employee at the Patent Bureau had never married, though her paramour of several years visited her regularly. Soon officials deemed Poellman well enough for discharge, not once commenting on the challenge she represented to the domestic ideal. 92

Unfortunately, the sample of cases reviewed for this chapter does not include any female patients who stayed in the workforce after marriage—the group where much of the demographic change

90 “Don’t Pamper Psychotic GIs,” 5.
92 Case 1955/21: admission note (13 July 1955); information from friend (21 July 1955); psychiatric case study (19 July 1955); psychological assessment (1 Aug 1955); clinical record (18 Aug 1955). As we have seen, there was some precedent for episodes such as these. See e.g. the case of Elizabeth Hayes, discussed in ch. 2 above.
was occurring and which engendered most of the popular discussion.\textsuperscript{93} Though most of them remained unmarried, the large number of female psychiatrists and nurses at the hospital may have communicated an implicit recognition that women’s employment outside the home could be a legitimate and gratifying option.

Overholser also occupied a position well within the liberal mainstream in his endorsement of the “mother-blaming” that suffused psychiatric thinking in this period. As historian Mari Jo Buhle has shown, the rise of ego psychology at midcentury shifted the emphasis within psychoanalysis away from the all-powerful figure of the father and toward the influence of the mother in early childhood development. Within a few short years, psychoanalysts had “transformed mothers into the principal agents of children’s disorders and the maladies that plagued the nation.”\textsuperscript{94} Popular writer Philip Wylie first gave voice to these views in his polemical \textit{Generation of Vipers} (1942).\textsuperscript{95} Soon, though, mother-blaming found medical legitimation in psychiatrist Edward Strecker’s \textit{Their Mother’s Sons} (1946), where Strecker ascribed the high rate of U.S. neuropsychiatric casualties during World War II to mothers who had not allowed their sons to achieve emotional maturity.\textsuperscript{96} In a review for the \textit{Sunday Star}, Overholser concluded that Strecker’s book “is not one which you should pick out

\textsuperscript{93} In their 1955 performance dramatizing the life of Dorothea Lynde Dix, patients devoted a full scene to Dix’s decision to end her engagement rather than give up her teaching career and repeatedly emphasized the obstacles she faced as a woman speaking the public sphere. “The St. Elizabeths Players Present ‘Cry of Humanity,’” NARA RG 418: Entry 7 (Administrative Files: Dance Therapy).


Psychiatrists and social workers at St. Elizabeths took it as an article of faith that mothers could wreak havoc on the emotional lives of their children, laying the groundwork for future psychological instability. Overholser was particularly sensitive to the impact of “overdominant mothers … who fail to untie the silver cord.” Sitting in on a case conference in 1944, he concluded that the patient was “a keen fellow intellectually and a thoroughly spoiled Navy junior. His father has been away a great deal and he has suffered from a very dominating, overprotective mother.”

The postwar gender ideology involved expectations for men as well as for women, with many observers identifying a “crisis of masculinity” in the early Cold War era. Despite Wylie and Strecker’s criticism of mothers, their real concern lay with an enervated and devitalized American manhood. For some, the problem involved a need to reassert male dominance in a domestic sphere that had been left unsupervised while husbands and fathers were fighting for democracy overseas. Middle-class men returning from the war confronted a domestic world dominated by mass consumption and a labor market where jobs increasingly involved conformist labor in large-scale corporations. The new visibility of gay enclaves in the nation’s cities further called into question the fitness of American manhood. The stakes, most Americans agreed, were high. Gendered imagery suffused Cold War political culture, which called for a manly, tough-minded approach to combat the threat of communism at home and abroad. Similar concerns

97 Winfred Overholser, “‘Mother’s Boy’ Has Made Mom a Problem for the American Psychiatrist,” review of Their Mothers’ Sons, by Edward A. Strecker, Sunday Star, 10 Nov 1946, C3.
98 See especially case 1945/17: clinical record (6 March 1946), as well as case 1945/16: Lucille C. Andrews (American Red Cross [ARC] St. Elizabeths Branch) to Winfred Overholser (2 Aug 1945); Mrs. Arthur H. Richter (ARC Leflore County, Mississippi Chapter) to Miss Miriam L. Gaertner (ARC St. Elizabeths Branch) (23 July 1945); case 1945/05: Marcella A. Taumbin (ARC St. Elizabeths Branch) to Winfred Overholser (23 April 1945).
99 Overholser, “‘Mother’s Boy’.”
100 Case 1960/22a: clinical record (11 July 1944). On the guilt that such attitudes generated in mothers, see case 1945/13: Miss Martha Kane (ARC Worcester, Massachusetts Branch) to Miss Margaret Hagan (ARC St. Elizabeths Branch) (6 Aug 1946).
informed the self-understanding of black Americans involved in the emerging civil rights movement.  

Against this backdrop, it is not surprising that both white and black men at St. Elizabeths frequently interpreted their current state as a failure to live up to a manly ideal of engagement, self-assertion, and virility. In some cases, male patients drew an explicit connection between their difficulties and their self-image as men. Bertram Samuelson spent several years at a hospital in Louisiana prior to his admission to St. Elizabeths in 1959. “I am a man, but I do not have a man’s pep,” the 27-year-old black veteran explained to a physician in Louisiana. “I feel like an old, old man.” Other men’s views were more diffuse. Victor Tompkins became confused and increasingly fearful in the winter of 1950 that people thought him guilty of crimes in the neighborhood. The 40-year-old white veteran had been drinking heavily since his discharge five years earlier and remained unemployed, living at home and helping his mother run a boarding house. At St. Elizabeths, Tompkins expressed disgust with the course his life had taken. “He states that he just simply does not have the ambition now that he formerly had,” reported a physician. “[H]e does not like the way he is living. It is more like existing than really living.” Though Tompkins did not directly invoke the notion of masculine independence, the implication was clear—at his age, real men ought not live at home with their mothers and drink their days away.

Men who had seen combat during World War II experienced a particularly intense set of gendered cultural expectations. Given the historical tendency to regard battle as a proving-

102 Case 1960/27a: copy of mental examination from Jackson State Mental Hospital (Louisiana) (20 Jan 1954).
103 Case 1950/17: information from mother (1 May 1950); psychiatric case study (9 May 1950).
ground for masculinity, it is reasonable to assume that some men who broke down under the strain interpreted their condition in terms of a failure of manhood. Among the veterans in this sample suffering from the delayed psychic effects of combat, none drew an explicit connection between their symptoms and their self-image as men. Such concerns, however, were always in the background.  

104 Ronald Howell endured some of the most brutal and exhausting campaigns in the Pacific Theater. Back in the United States, the 24-year-old white Marine had recurrent combat dreams and began hearing the voices of men calling his name at all hours. Howell was also physically worn down, having acquired a parasitic infection overseas. The sum of these experiences left him a shell of his former self. “I can’t get along with people. I just like to be by myself,” Howell reported. “I do crazy things[.] … I think I’m losing my mind.” When a St. Elizabeths physician asked about complications from his infection, Howell explained that “I didn’t have any trouble with potency when I came back, but I’m not the way I was when I left.” Howell’s self-assessment also drew upon a long-held belief about the debilitating effects of the tropics on white men, unaccustomed as they were to the unique strains of the environment. “I used to worry about myself because I was a wreck from the tropics,” he continued. “I just know I won’t [ever be the same again].”  

105 In the years that followed, the breadwinner role became particularly important to male patients’ gendered self-understanding. When confusion or irritability interfered with their ability to hold down a job, these men responded with frustration and at times even questioned their own

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worth. Edgar Diggs began having trouble thinking clearly in 1950 and grew concerned about the consequences of his “fast living.” Diggs’ wife left him that August, and when she saw him the following month she suggested he seek help. The 27-year-old black veteran agreed, fearing that “there was something wrong with him, since he couldn’t make his mind work and couldn’t support his family.” Recurrent conflict with civil authorities also led men to reflect on the gendered dimensions of their difficulties. When Edward Skilling overdosed on stimulants in 1960, he already had a long history of arrests and hospitalizations. The white 41-year-old house painter had recently remarried, however, and was trying to turn his life around. “He … is making what he regards as a last ditch trial of his manhood,” observed a physician, “in attempting to support a wife and stay on an even keel.” Cases like these suggest that men took their role as husband and provider quite seriously—or at least they felt they ought to if they were to be regarded as good citizens.

Women experiencing an episode of psychological instability did so in ways that reflected their gender identity as well. “Today [women] feel under almost as great a pressure to get married as did their pre-emancipation ancestors,” observed sociologist David Riesman in 1949. “In a certain way, they are under greater pressure, since all sorts of psychological aspersions are cast at them if they stay single too long.” Winifred Rodemaker was one such woman. Born in 1880, the white schoolteacher never married and struggled with “nervousness” throughout her adult life. When Rodemaker entered St. Elizabeths in 1950, she was resentful and wary of the staff. “Asked if she were married, she screamed out that that statement was made to keep her

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106 Case 1950/13: admission note (18 Sept 1950); information from wife (16 Nov 1950); psychiatric case study (20 Nov 1950).
109 Quoted in Reumann, American Sexual Character, 134-135.
“upset,” reported a male physician. “She became extremely belligerent and noisy and refused to cooperate any longer with the interview.”\textsuperscript{110} While the unwed female schoolteacher was not an unusual figure at the turn of the century, by age seventy Rodemaker had evidently had enough of being asked why she remained husbandless. Other patients found that family life provided no guarantee of mental health. Twenty-three-year-old Dolores Beckett married for the second time in 1942, but soon the young white homemaker realized she was less than content. Beckett lived with her mother and cared for her children while her husband was overseas; later she told a physician that “she wanted to go out and go dancing but never could allow herself to as she did not think it would be proper or right.” Shortly after her husband returned in 1945, Beckett became increasingly anxious and began staring off into the distance without explanation. “She had an idea that someone was trying to kidnap her baby,” her husband reported, “and she would cling to it, scream that they were about to kill it, and finally became so disturbed it was necessary to have her admitted[.]”\textsuperscript{111}

Psychiatrists regularly inquired about their young male patients’ plans for the future, gauging men’s degree of impairment or recovery by both the practicality of their plans and their ability to live up to gendered social expectations. In this sense physicians adopted a much broader vision of their male patients’ role in American society than their female patients, particularly among white veterans in the immediate postwar period. Some men, including 20-year-old sailor Loren Hays, took these questions in stride. “When asked about plans for the future,” his physician reported, “the patient states that he wants to get a job on a ranch out west

\textsuperscript{110} Case 1950/21b: admission note (4 April 1950); information from husband of patient’s niece (5 April 1950); clinical record (16 Jan 1951). Other patients fabricated tales of their sons’ involvement in World War II and lied about the health of their marriage, providing further evidence of the pressures that many women felt to define themselves in terms of the men in their lives. See case 1945/28: clinical summary (10 Aug 1945); case 1960/25: admission note (21 April 1960); psychiatric case study (21 July 1960); clinical record (3 Aug 1960).

\textsuperscript{111} Case 1945/23b: admission note (11 Dec 1945); information from husband (23 Dec 1945); clinical record (20 Dec 1945).
and fish until he gets tired of fishing and then hunt until he gets tired of hunting and then … get a
girl and have relations with her until he gets tired of that. After that he is not sure what he will
do.”112 Not all men responded so enthusiastically, but most agreed that labor was essential to a
full recovery. Nineteen-year-old Major Rodacker planned to work on his parents’ farm before
pursuing work on the state highway system, while 33-year-old Jacob Stark hoped to return to
graduate school or perhaps pursue industrial work in chemistry.113 Occasionally, physicians
emphasized marriage, too, as part of a mature psychological adjustment. When an examiner
asked Charles Moore about the sources of happiness in life, Moore emphasized a “decent job”
and a comfortable standard of living. “Asked whether he considered marriage a major part of his
satisfaction,” the physician wrote, “he responded, ‘I suppose so.’”114 Any other answer would
have been at odds with the postwar vision of social well-being, perhaps even casting doubt on
Moore’s attraction to women.

When it came to their female patients, the medical staff at St. Elizabeths tended to focus
on physical appearance rather than ask about plans for the future. Self-care had long been an
important domain of psychiatric assessment; seriously-impaired patients of both sexes often
neglected basic tasks of grooming, and increased attention to hygiene could be an early indicator
of improvement. For women, however, appearance played a role similar to that of social
engagement or personal initiative in the evaluation of men. Hospital administrators first
introduced a small beauty parlor for white women in the 1920s, a service they extended to black
women in the late 1930s.115 As American beauty culture intensified in the years after World War

112 Case 1954/31: admission note (20 Aug 1945).
113 Case 1945/30: clinical record (10 Sept 1945); case 1945/12: clinical record (11 June 1945). See also case
1945/04: admission note (23 June 1945); ward notes 9 (23 Aug 1945); case 1945/35: ward notes (22 April 1945).
115 Annual Reports 1928, 7; 1932, 13-14; 1938, 375. See also “Scores of Women Patients at St. Elizabeths Use
II, so too did physical appearance receive increasing emphasis in the records of female patients. Nurses and attendants noticed whenever a patient began “taking more pride in her appearance” and carefully documented whether or not she “seem[ed] interested in … being attractively attired.”116 In the 1950s officials even introduced a “charm class” for a small number of young white women. Such classes were a commonplace of the period, and many of the women responded enthusiastically to the increased opportunity for self-expression in what was otherwise an extremely limited social environment.117

Physicians and social workers also assessed women’s overall social demeanor as an index of their mental health. Psychiatrists expected that female patients would present themselves in a manner pleasing to the men in their lives. As we have seen, the physicians at St. Elizabeths ultimately recognized that Amelia Stenton and her husband might not be well suited for one another. As long as they remained married, however, the medical staff expected her to adhere to gendered norms of conduct. One psychiatrist effortlessly combined a cheerful attitude, social graces, and emotional equilibrium in a 1943 report on Stenton’s improvement. Her obscene speech had “entirely cleared up,” the physician noted. “She has now changed her attitude toward her husband … and has been pleasant and agreeable with him on her visits.”118 Even among women estranged from their husbands, physicians expected certain standards of comportment. Irene Jenkins’ relatives brought her to the hospital in 1945 not long after her husband kicked her out of the home. At St. Elizabeths, the 34-year-old black laundress was suspicious and seclusive, often remaining mute and standing in one position for hours on end. Finally, after nearly five years, she began speaking up in group sessions. “There is mild irritability present,” observed the

118 Case 1950/04a: clinical record (9 May 1943).
physician who ran these sessions. “[H]owever, her emotions are held in good control and she is usually quite ladylike and quite restrained.”

Family members, physicians, and other members of the hospital staff all viewed women’s ability and desire to care for their children as important indicators of their psychological well-being. Mary Anne Sadler became suspicious that her husband was having an affair in the late 1950s; soon the 38-year-old black typist began to think that she too had had an affair. Only after her discipline of the children became unusually severe, however, did her husband begin to think that something was seriously amiss. “She had threatened to hit one of the children with a baseball bat,” reported a social worker, “and indeed said that she had done so, but the husband found no physical evidence of this.”

Once women entered the hospital, the staff carefully monitored their attitudes toward their children. During interviews with her physicians, 29-year-old white prisoner-patient Valerie Hopkins repeatedly declared her wish to return to her young son and daughter. The ward staff, however, remained unconvinced. “She often speaks of wanting to see her children,” wrote an attendant in 1958, “but to visit only, not to ever live with them. Don’t want to be tied down[.]”

The expectation that female patients would embrace the domestic role followed them after their discharge. When a social worker visited Dolores Beckett at her home in 1946, he found that she was doing well. “Sunburned and rested, Mrs. Beckett gave the impression of a vivacious, happy mother,” the social worker wrote, “as proud as a peacock about their clean, [tastefully]-furnished new home. She said that she does all the necessary work for the four-room house and the children.”

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120 Case 1960/09: social service note (13 May 1960).
122 Case 1945/23b: clinical record (26 Aug 1946). See also case 1950/05: information from husband (7 Aug 1950); clinical record (30 April 1957); ward notes (11 Feb 1951; 8 March 1956); case 1955/09: Addison Duval to Mrs. Anne Weeks (10 Jan 1956); case 1955/13: clinical record (27 Sept 1957).
While men did not escape psychiatric scrutiny for their failures as fathers and husbands, physicians regarded men’s behavior as less fully within their moral jurisdiction than women’s conduct. Men came in for censure for their irresponsibility or their absence rather than for any overt acts that might damage a child’s psychic development. A physician who examined 27-year-old Virginia Hooke deemed her “one of many children in a socially marginal family with an alcoholic father and martyred mother, [who] has for many years reacted by schizoid withdrawal from interpersonal problems.”¹²³ On this view, Hooke’s father had failed to raise his family out of poverty, but her mother bore chief responsibility for the unhealthy psychological environment in which she was raised. Occasionally, however, men gave such an unfavorable impression that physicians could not help but remark on their failings. When Flora Mercer’s husband came to St. Elizabeths in 1957, the interviewing physician became annoyed by the young white Marine’s one-sided portrayal of their troubles. “Although the informant bitterly criticizes his wife for her neglect of the children and her poor housekeeping, he indicates by his comments that he never thought it appropriate to do any of these things himself,” the physician wrote, “and stated at one point that he had yet to change his first diaper.”¹²⁴ Such criticisms also reflected the class difference between Mercer’s physician and her husband, with models of domestically-engaged fatherhood achieving greater currency among middle-class professionals at midcentury than the working men and women who made up so many of their clients.

Physicians at St. Elizabeths proved far less likely to interrogate male patient about their attitudes toward their children than female patients. Martin Ullman came to the hospital in 1945 from a brig in San Francisco, where officials had detained him for abandonment without leave. There the 29-year-old white sailor became sufficiently confused that his superiors sent him to St.

¹²³ Case 1960/16b: psychiatric case study (19 April 1957).
¹²⁴ Case 1955/09: information from husband (4 Jan 1956).
Elizabeths. Ullman claimed to have left his unit to find his wife, who he said was pregnant by another man. Upon investigation, however, officials found little evidence to support his story, learning that Ullman had a long history of failing to support his family. In the end, physicians deemed him “not insane” and therefore competent to stand trial for desertion. There is no indication that they ever confronted him with his lies or directly addressed the question of his conduct’s impact on his family. Female patients’ attitudes toward their children, in contrast, often provided an important touchstone for psychological assessment. When Dolores Beckett returned to St. Elizabeths in 1945, she sat rigidly in her admission interview and remained unresponsive until physicians administered a barbiturate. “She denied hearing voices but said that she could hear babies cry—apparently her own babies because nobody loved them,” wrote the examining psychiatrist. “She did not answer the question as to whether she loved them.”

Psychiatrists’ response to violence in the home underscored the extent to which they continued to privilege male authority. The widespread shift to a psychoanalytic framework led many physicians and social workers to seek the roots of family violence in the psychological infirmity of its female victims, implicitly excusing male perpetrators of any responsibility. At a public lecture in 1945, St. Elizabeths clinical director Addison Duval “called on the wives of former servicemen to be ‘very tolerant and understanding’ of their husbands as one way to diminish the number of wife-beating cases in the District.” “‘A wife who … attempts to adjust herself to her husband’s emotional needs,’” Duval suggested, “‘may prove to be the only personal assistance needed by the uneasy veteran.’” Some non-St. Elizabeths physicians went so far as

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125 Case 1945/29: information from patient, patient’s wife and mother, patient’s Naval record (7 Sept 1945); Irving M. Ryckoff (ARC St. Elizabeths Branch) to Winfred Overholser (1 Sept 1945); clinical record (22 Sept 1945; 15 Oct 1945).
126 Case 1945/23b: admission note (11 Dec 1945).
to validate men’s anger and the violence it inspired. “Dr. Andrew Browne Evans … placed a good share of the blame on the wives,” reported a journalist covering the event. “‘Women who don’t want to go back to being housewives are bringing a lot of friction into the home[.]’”¹²⁸ The 1940s and 1950s truly were, as historian Linda Gordon has observed, “[a] low point in awareness of family-violence problems.”¹²⁹

Rather than viewing domestic violence as an issue worth addressing in its own right, psychiatrists at St. Elizabethts viewed it primarily as a symptom of underlying psychic conflict. Physicians recognized that female patients sometimes faced exploitation and battery. They knew that Bette Maxberry’s husband was a major source of the 45-year-old white sales clerk’s troubles, frequently deserting her only to return for money or other favors. Their focus, however, remained on Maxberry’s alcoholism and dependency—even after her husband fractured her arm in 1955.¹³⁰ When a perpetrator sought care at the hospital, physicians navigated a fine line between their obligation to him as a patient and their broader moral and legal responsibilities. During the course of his many stays at St. Elizabethts, attorney William Clement severely abused both his first and second wives. “The last several visits home have ended in a brutal beating of Mrs. Clement,” a physician wrote in 1951. “He slaps her around even when he is comparatively well, but when he becomes ill he is openly brutal[.]”¹³¹ Nine years later, after they had separated, Elizabeth Clement wrote to Overholser requesting that hospital officials contact her before releasing her husband. “I realize, in as much as I am not living with Bill, that this is an unusual request,” she explained. “But due to his actions … and threats he made to me personally … I

¹²⁸ “Be Tolerant, Understanding,” 1, 3.
have reason to be frightened of this man.”132 Officials appear to have cooperated as much as they could with Clement’s wife and mother. Nevertheless, his habit of abusing the women in his life does not appear to have been a major focus of his rehabilitation.133

Few cases illuminate the complex interplay of gender inequality and psychological impairment better than that of 46-year-old Mira Rothbaum. The Jewish homemaker’s husband first became concerned when she returned from a movie in 1944 to announce that she had never loved him and that she was carrying on a relationship with the film’s hero. In the months that followed, Rothbaum experienced several episodes of confusion and spent time at hospitals in Washington, D.C. and New York. Though she initially seemed to recover, the following year Rothbaum again began expressing strange ideas. Her husband maintained a small grocery store in an area of the city where most residents were poor and black, with the family residing in a small apartment in the rear of the building. Rothbaum had always been mistrustful of the store’s black patrons, but by 1945 she had become convinced that they were spying on her and that she would be raped—a common fear among white middle class women in the 1950s, but one which Rothbaum took to an unreasonable extreme. Soon she insisted that strange gases were being sprayed into her home. When she began singing and playing the piano at all hours of the night, her husband decided that hospitalization might again be necessary.134 Over the course of the next five years, Rothbaum spent nearly as much time at St. Elizabeths as she did in her home, alternating between stretches of relative calm and episodes of intense disturbance during which her family would return her to the hospital.

133 This claim is based on a comprehensive review of Clement’s records at St. Elizabeths (cases 1960/22a, 1960/22b, 1960/22c, and 1960/22d), covering approximately six years of inpatient care and nine months on visit or extended leave from the institution. See also case 1950/09: information from wife (17 Sept 1950; 1 Oct 1950); psychiatric case study (30 Oct 1950).
134 Case 1945/17: admission note (12 Feb 1945); initial history (3 March 1945).
Rothbaum used her unique vantage point as a mental patient to formulate an incisive critique of male authority. It quickly became clear that Rothbaum had been dissatisfied with her life long before her breakdown. Raised by exceedingly strict Eastern European immigrant parents, she did not enjoy much freedom as a child and married her husband largely at her father’s behest. “My married life has been one of just obeying a man as I have obeyed my parents,” she declared. “A wife is just the property of her husband.” While home on an extended visit, Rothbaum informed a social worker that she did not wish to reestablish contact with her friends “as long as her husband can put her … into [an institution] whenever he has the whim to do so.” Isaac Rothbaum acknowledged that he could be a demanding and at times inflexible husband; eventually he even attended weekly sessions with a therapist to learn how he could better get along with his wife and sons. Soon he moved the family to a larger home. His wife, however, remained resentful, decrying “the oppressiveness of having to live in a house in which she was a ‘servant’ and a ‘mechanical instrument’ to build a perfect dream house for her husband.” Rothbaum gave voice to a sense of alienation and outrage that would not find widespread popular expression for another sixteen years, when Betty Friedan published her momentous *Feminine Mystique* (1963). Later in the interview, Rothbaum “burst out shouting that this house was just a plot of ‘Lizzie’ (St. Elizabeths)[,] … saying that the hospital was more interested in the house and didn’t care whether she was being made crazy by working in such a place.” Rothbaum had identified a fundamental tension in the postwar vision of women’s

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135 Case 1945/17: initial history (3 March 1945).
136 Case 1945/17: clinical record (6 March 1946).
137 Case 1945/17: clinical record (16 Jan 1948).
140 Case 1945/17: clinical record (24 April 1947).
psychological well-being: why should she have to adapt to an environment that restricted her freedoms in order to prove her mental health?

Though shot through with gendered inequalities, Rothbaum’s case does not represent a simple pathologization of protest. She became understandably angry when the courts found her legally incompetent, reducing her to “a thing without rights.”\(^{141}\) Her commitment, however, resulted not from some desire by her husband to be rid of her, but from her family’s inability to cope with her increasingly bizarre and disruptive behavior. Neighbors, not family members, made the initial complaint in each of the earliest episodes. In addition to her habit of singing and playing the piano loudly while everyone else slept, Rothbaum carried a milk bottle to protect her from the Chinese-American family who had previously occupied their home and occasionally lay prone on the floor to listen to the electrical outlets.\(^{142}\) The situation became even more fraught when Rothbaum’s 22-year-old son began showing signs of a serious mental illness.\(^{143}\) Speaking with a social worker in 1948, her other son declared that “if he had his way he would keep the patient in the hospital until she was completely better for ‘she causes so much strain on everybody in the family.’”\(^{144}\) Despite her declarations of persecution, Rothbaum took pride in her ability to fulfill the role of homemaker and at times seems to have relished her new home.\(^{145}\) Rothbaum and her family disappear from the historical record in 1950, by which point she had improved sufficiently to remain out of the hospital. Her gendered critique of domesticity notwithstanding, Rothbaum and her family appear to have settled into a strained but sustainable pattern in which each member found a tolerable role.

\(^{141}\) Case 1945/17: clinical record (6 March 1946).
\(^{142}\) Case 1945/17: clinical record (15 May 1947; 20 March 1947; April 1948).
\(^{143}\) Case 1945/17: clinical record (30 May 1947).
\(^{144}\) Case 1945/17: clinical record (16 June 1948). This did not mean that her family took pleasure in committing her. When the son and a social worker approached Isaac Rothbaum on another occasion to suggest returning her to the hospital, he “said he had ‘no objections to returning the patient except that it probably meant that all his hopes were dashed and he might as well be dead.’” Case 1945/17: clinical record (May 15 1947).
\(^{145}\) Case 1945/17: clinical record (9 Sept 1945; 6 March 1946).
Gender relations played a central role in postwar U.S. psychiatry’s social vision. The profession’s success in establishing a measure of cultural authority during the interwar years positioned them well to address public anxieties about gender roles and family structure that emerged after World War II. When men and women broke down—or even when they simply found themselves inexplicably ill at ease—they turned in increasing numbers to psychiatrists for relief. Much of this occurred on an outpatient basis. Most seriously-impaired men and women, however, continued to receive care at large-scale institutions like St. Elizabeths, which provided the foundational training experience for all psychiatrists. Physicians expected male patients to get to work and carry the nation forward; if they proved incapable, the fault may very well lay with their mothers. Women contemplating their future encountered a classic double bind. Those who embraced domesticity faced criticism for their selfish and psychologically-damaging habits of child-rearing, while those who elected not to marry or raise children risked castigation for turning their back on their natural role. Psychiatric attitudes toward women were not monolithic, and many physicians proved capable of accepting women’s participation in the workforce without fully endorsing it. Nevertheless, domestic strictures facing U.S. women intensified dramatically in the postwar period. Their professed egalitarianism notwithstanding, psychiatrists continued to accept male privilege as a natural and even desirable fact.

“THE UNITED STATES IS AGAINST HOMOSEXUALS”: SEXUAL IDENTITY AS PSYCHOPATHOLOGY

Though closely linked to gender identity, sexuality emerged as a consideration in its own right by midcentury in both the day-to-day operations at St. Elizabeths and in debates about the moral components of American citizenship. As we have seen, some patients in earlier years struggled mightily with same-sex desires. Though psychoanalysis provided a novel framework
for discussing the links between psychic development and sexual behavior, most psychiatrists remained uncertain just how to regard men and women whose primary romantic interest lay with those of the same sex. World War II represented a watershed moment, placing the question of sexuality at the center of discussions of psychological and social adjustment. Mass mobilization wrenched thousands of young men and women from their home towns, introducing them to new forms of sexual liberalism in the nation’s burgeoning urban centers and in port cities overseas. In the sex-segregated environment of the military, men and women who did not fit into traditional heteronormative categories encountered others like themselves—many for the first time. Though not every soldier or sailor who engaged in intimate same-sex conduct would go on to self-identify as homosexual, for many men and women World War II truly represented “something of a nationwide ‘coming out’ experience.”

While physicians first began to conceive of gay men and women as a distinct type in the late nineteenth century, their views changed dramatically over the course of the twentieth century’s first half. Sexologists initially drew a distinction between sexual inversion, a fixed degenerative state in which individuals adopted the mannerisms of the opposite sex and sought romantic relationships with members of their own sex, and sexual perversions, discrete acts or habits including but not limited to homosexual contact. By the 1910s, this distinction had begun to break down, with medical experts increasingly maintaining that any such contact represented evidence of an underlying homosexual disposition. By the 1940s, homosexuality had become a form of sexual psychopathy, which included “various inadequacies and deviations in the personality structure of individuals who are ... unable to participate in satisfactory social relations

or to conform to culturally acceptable usages.”

Alongside homosexuality, one standard American textbook—written by a former St. Elizabeths physician—identified sadism, masochism, and exhibitionism as common forms of sexual psychopathy. In later editions, voyeurism, rape, and pedophilia joined the list as well.

Medical perspectives on sexuality achieved a new level of institutional authority when military officials began turning to psychiatrists for assistance in their preparation for World War II. On the question of gay men and women in the military, policymakers walked a fine line between the perceived need to keep such individuals out of the service and the risk that large numbers of men would declare themselves homosexual to avoid the draft. At the center of this historic opportunity for the psychiatric profession stood Winfred Overholser and Harry Stack Sullivan, formerly a student of William A. White and now an eminent figure in his own right. Sullivan, himself a gay man, initially proposed a psychiatric exam emphasizing general psychological fitness that made no mention of homosexuality. As the exam made its way through the circles of military command, however, others suggested revisions aimed specifically at screening out gay recruits. Sullivan resigned his post in 1941, when it became clear that the new


150 My account in the paragraphs that follow is derived from Bérubé, Coming Out Under Fire. Here I focus primarily on the experiences of gay men, since they were the population with whom military physicians and policymakers were most concerned. For the experience of lesbian women serving in the military, see Leisa D. Meyer, Creating GI Jane: Sexuality and Power in the Women's Army Corps during World War II (New York: Columbia University Press, 1998); Bérubé, Coming Out Under Fire, 28-33, 102-108, 142.
Director of Selective Service did not welcome his input. New regulations issued the following year declared that “[p]ersons habitually or occasionally engaged in homosexual or other perverse sexual practices” did not meet the minimum standards for service, nor did any man with “a record as a pervert.” Unlike Sullivan, Overholser remained involved in military policy for the balance of the war, through the National Research Council’s Committee on Neuropsychiatry and as a member of the American Psychiatric Association’s Military Mobilization Committee.

Overholser’s belief that homosexuality represented a form of mental illness led him to challenge the military’s long-standing penal approach to same-sex sexual conduct. As the demand for manpower increased, some officials began to question the advisability of a hard-line stance. While many gay men and women managed to avoid problems by remaining discreet, the military occasionally brought the full force of its criminal code to bear on those who officials suspected of homosexuality. Upon conviction, these servicemen and women faced not only a dishonorable discharge, but the likelihood of prison time as well. Overholser and his colleagues regarded this system as antiquated and inhumane. Together with a group of reform-minded generals and prison wardens, they recommended replacing prosecution with psychiatric evaluation and administrative discharge. Under the pressure of wartime exigencies, military officials ultimately adopted a three-pronged approach. In cases involving the use of force or contact with a minor, a serviceman would continue to face prosecution; this applied to heterosexual as well as homosexual contact. If upon evaluation officials found that a serviceman had engaged in casual or first-time same-sex sexual contact, he might receive treatment and reassignment to another unit. Military officials continued to regard “confirmed homosexuals” as

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152 Quoted in Bérubé, Coming Out Under Fire, 19.
unfit for service, however, typically recommending dismissal of such individuals with an undesirable discharge.

Though Overholser and his allies promoted these measures as an alternative to prosecution, the military’s new approach effectively broadened their commitment to policing homosexuality and reinforced the associated stigma. Following the psychiatrists’ lead, military officials identified a new kind of person as undesirable for the service. This approach opened the way for dismissal based solely on acknowledgement of one’s inclinations or even suspicions of homosexuality by one’s peers. These changes also made it easier to dismiss servicewomen suspected of homosexuality, since military courts had historically proven reluctant to prosecute women for individual sexual acts. More troubling from the perspective of military officials, the new system appeared to provide an easy exit for those seeking a way out of the service. Recognizing this possibility, Overholser conceded that gay servicemen ought to receive an undesirable rather than a medical discharge. This meant giving up one’s service awards, rank, medals and uniform. Upon returning home, servicemen had to report to their local draft board and explain the circumstances of their dismissal, virtually guaranteeing that this information would become public. Overholser’s concession reveals the limits of psychiatrists’ liberalism and of their commitment to the welfare of their gay patients. Despite their protestations that homosexuality was not a crime, Overholser and his colleagues remained deeply complicit in the reinscription of negative social attitudes toward same-sex sexual conduct.

Though well-versed in the literature on homosexuality, Overholser likely owed many of his views to the influence of St. Elizabeths physician Benjamin Karpman. Karpman was a Russian Jewish émigré who spent his entire professional career at St. Elizabeths, beginning as a ward physician in 1920 and rising to senior medical officer and ultimately a position as “Chief
Psychotherapist.”153 Like other dynamically-inclined physicians, Karpman believed that homosexuality represented a fixation or distortion of psychosexual development at an immature stage. Most psychiatrists agreed that such individuals never achieved the coping strategies of a mature and healthy adult; the associated conflicts led to alcoholism, paranoia, and panic states.154 In his comprehensive *The Sexual Offender and His Offenses* (1954), Karpman equivocated on the social implications of homosexuality, suggesting at one point that those who willfully transgressed sexual conventions were more likely to violate other social rules.155 Yet Karpman also argued that men and women with sexual inclinations at odds with prevailing norms could function as good citizens. “Though an individual may be perverted in the sexual field,” he wrote, “this reaction and the psychology concomitant with it need not prevent him from being an otherwise useful and entirely honorable member of the community[.]”156 Karpman agreed that latent homosexual impulses formed the root of many species of psychopathology, as well as such divergent sexual practices as rape and the sexual exploitation of children. His answer to the problem, however, was to decriminalize homosexuality, thereby attenuating latent conflicts and reducing the likelihood of descent into neurosis or frank psychosis.157

While Karpman advocated a greater degree of social tolerance than most, the limits of his broad-mindedness reflected the constraints within which the psychiatric community approached homosexuality. Karpman continued to identify sex-sex eroticism among adults as a form of

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156 Ibid., xi.
157 Ibid., 327.
psychopathology, albeit one for which physicians could offer little in the way of treatment.\textsuperscript{158} This stood in marked contrast to the approach of researchers such as Alfred Kinsey, who described homosexuality as a normal variant of human sexual expression, and Evelyn Hooker, who found little evidence of maladjustment among her gay male subjects.\textsuperscript{159} Karpman insisted that categorizing homosexuality as a form of psychopathology did not justify the social opprobrium it typically called forth; only non-consensual or directly harmful sexual acts truly counted as immoral.\textsuperscript{160} Few outside a small community of liberal-minded clinicians and researchers, however, proved willing to invest in this distinction.\textsuperscript{161} Policing the boundaries of psychosexual adjustment had become a major component of psychiatry’s social jurisdiction. Indeed, Karpman’s productive career rested largely on this fact. To redefine homosexuality as difference rather than pathology would have been to risk surrendering an important sector of psychiatrists’ professional domain. The dominant psychoanalytic opinion remained clear—homosexuality was by definition a form of psychopathology.\textsuperscript{162}

St. Elizabeths physicians routinely asked their patients about same-sex sexual conduct and their attitudes toward those who identified as homosexual. Given the importance of psychosexual development in the Freudian model, homosexuality could be an important clue to the sort of condition with which physicians were dealing. Some patients may have anticipated such questions. The increased visibility of gay communities in the nation’s cities made homosexuality a common (if fraught) topic of public discourse, and popular enthusiasm for

\textsuperscript{158} Ibid., 302-315; 609-612.
\textsuperscript{160} Karpman, \textit{The Sexual Offender}, 418.
\textsuperscript{161} On the path by which psychiatrist Karl Bowman arrived at a similar position, see Justin Suran, “Psychiatric Professionalism and Sexual Liberalism in the Age of McCarthy” (paper presented at the Annual Meeting of the American Association for the History of Medicine, Montreal, Quebec, 6 May 2007).
\textsuperscript{162} This was also the conclusion of conservative researcher Irving Bieber, who reviewed the psychoanalytic literature at the outset of his \textit{Homosexuality: A Psychoanalytic Study} (New York: Basic Books, 1962), 1-18.
psychoanalysis turned sexuality and the unconscious into fashionable subjects of conversation. Others, however, found such questions intrusive, inexplicable, or even offensive—particularly older and more religiously-inclined patients. Mary Washington worked as a domestic in the District for most of her adult life. In 1946, however, the devout black Methodist began having seizures, and she declined steadily over the course of the next ten years. Washington had difficulty maintaining an intelligible conversation by the time she arrived at St. Elizabeths in 1955. Nevertheless, her examining physician noted that the 64-year-old former cook and seamstress “[w]as shocked when asked about homosexual experiences.”

Among younger patients, these questions revealed attitudes ranging from indifference to outright revulsion. Most men and women knew that same-sex sexual conduct occurred, particularly in the military and prisons. Typically patients simply denied that they had ever engaged in such acts. Occasionally, however, their responses suggested a marked uneasiness. When physicians queried Charles Moore about his sexual history, he “responded that he found [homosexuals] very repulsive but usually managed their overtures with a civilized rebuff.” Edward Skilling denied any homosexual contacts, but reported that men had solicited him in the past and that “he has, on occasion, attacked them for this.” Some men even expressed anxiety about being seduced or dominated by gay men. After a brutal mugging and a bout of pneumonia in 1950, Oscar Harris became increasingly paranoid and ultimately accused his wife of running a prostitution ring out of their home. At St. Elizabeths, the 41-year-old white laboratory technician told his physician that he had recently taken up reading about sexual topics to make up for his long-standing ignorance on the subject. As a result, his physician recorded, he had developed “a

163 Case 1955/05: information from daughter (14 March 1955); notes for psychiatric case study (n.d.).
165 Case 1960/03a: psychiatric case study (27 Sept 1953).
certain fear of homosexuals because he doesn’t know ‘who will master the situation, who will outtalk whom.’”

Though inflected by his impaired reasoning, Harris’s fears echoed a broader concern about homosexuality in the postwar period. A vibrant gay cultural life first emerged in Washington, D.C. during the 1930s, supported initially by the proliferation of New Deal civil service jobs and then by the federal bureaucracy’s expansion during World War II. Limited housing options together with a widespread sense of uncertainty about the future created an atmosphere of sexual freedom in the early 1940s. Soon after the cessation of hostilities, however, Americans began to wonder aloud about the apparent moral laxity into which they had descended. A series of sensationalistically-reported sex crimes prompted many to focus on the sexual psychopath as the most important domestic threat facing the nation. District officials launched a crackdown on sex crimes and pressed for stricter laws governing sexual offenses; the Miller Sexual Psychopath Act of 1948 increased the penalty for sexual contact with children, codified the common law definition of sodomy, and mandated indefinite detention at St. Elizabeths for recidivists. Though local activists emphasized the vulnerability of women and children, the statute’s reliance on the vague category of sexual psychopathy opened the door to a wave of repression against gay men and women. In the years that followed, anti-communist crusaders specifically targeted gay federal employees in their efforts to purge the government of unreliable or undesirable elements. “To some people [this campaign] was a tactic in a political

166 Case 1950/09: admission note (15 Sept 1950); psychiatric case study (17 Oct 1950).
169 Johnson, The Lavender Scare, 55-64. See also Freedman, “‘Uncontrolled Desires’,” 92-94.
struggle to turn back the New Deal,” writes historian David Johnson. “To others it was a necessary measure to protect national security and counter what they saw as a nation in moral decline. But to gay and lesbian civil servants, it represented a real threat to their economic, social, and psychological well-being.”

Against this backdrop, it is perhaps not surprising that patients at St. Elizabeths frequently articulated their distress in terms of concerns about their sexual identity. Soldiers and sailors in particular revealed deep anxieties about their sexuality, as St. Elizabeths physician Edward Kempf had documented nearly a quarter century earlier. Servicemen who broke down in the stressful all-male environment of the military often feared that their peers thought they were gay or heard voices accusing them of same-sex sexual conduct. Lawrence Russo first began experiencing difficulties in the fall of 1944, complaining of difficulty concentrating, trouble with his memory, and an inability to sleep. At St. Elizabeths, the 28-year-old white corporal acknowledged that he heard people talking about him, explaining that they “accuse him of stealing and call him a ‘queer.’” Women, too, at times feared that others thought them guilty of sexual immorality. Carol Lowry moved to Washington, D.C. in 1944 after joining the Coast Guard Women’s Reserves. The following year, the 28-year-old white clerical worker began having trouble at her job and started thinking people were talking about her. At St. Elizabeths, Lowry acknowledged hearing a voice that accused her of having sex with women and of being a

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171 Johnson, *The Lavender Scare*, 149.
173 Case 1945/35: admission note (1 Feb 1945); initial assessment (31 March 1945). Russo’s case was one among many at St. Elizabeths. See also case 1945/01: admission Note (7 March 1945); initial assessment (24 March 1945); case 1945/13: clinical record (14 Jan 1945); case 1945/31: summary of record (U.S. Naval Hospital at Portsmouth, Virginia) (30 June 1945); ward notes (17 Jan 1946).
prostitute. Prior to shooting an attorney who he mistakenly thought was trying to frame him for a sex crime, Dominick Bell became convinced that two female boarders in his mother’s home were spreading rumors that he was “a ‘hermaphrodite’ or ‘homosexual’”—though the 23-year-old black clerk simultaneously believed that the two women were interested in him romantically.\footnote{Case 1945/06: admission note (26 April 1945).}

As reaction set in during the 1950s, it became increasingly common for men who identified as homosexual to arrive at St. Elizabeths with difficulties attributable at least in part to the stress of living in such a repressive climate. Thomas Brady entered the hospital voluntarily in 1960, worried that others could read his mind. “[M]ostly what he fears,” wrote his examining physician, “is that they might find out that he is a homosexual.” The 18-year-old white student had developed elaborate psychological strategies to suppress his sexual desires, routinely telling himself that the men he encountered socially were women and that the women he met were men. In this context, his feelings of guilt, anxiety, and persecution do not appear entirely illogical.\footnote{Case 1960/19a: admission note (19 April 1960).}

The complex case of José Fernandez illustrates a similar point. Born in Puerto Rico, Fernandez regarded himself as homosexual ever since he was a teenager. This became a major source of anxiety for him, however, and by his mid-twenties Fernandez had started drinking heavily and hearing voices that criticized him for his poor job performance. In the late 1950s, Fernandez received treatment at hospitals in Connecticut and New York, where he told physicians “that the United States [is] against homosexuals.” Following his discharge, Fernandez came to Washington, D.C. Soon the metropolitan police arrested him for throwing a brick at a military vehicle, apparently out of frustration with White House officials’ failure to believe he was to be crowned King of Spain. Though his symptoms appeared far more dramatic than Brady’s, it is not
unreasonable to suppose that a malignant social environment contributed to Fernandez’s
condition as well. Indeed, the repressive cultural climate of the 1950s could only have been that
much more alienating for a gay man of Puerto Rican descent.177

While psychiatrists sought to remove some of the more punitive elements of the public
response to homosexuality, their approach nevertheless continued to situate gay men and women
beyond the pale of proper American citizenship. Physicians saw themselves as bringing a degree
of judiciousness and professional sobriety to a topic that too often prompted irrational and
emotionally-charged debates. As we have seen, Overholser pressed for reform of the military’s
traditional penal approach during the war. In the years that followed, however, he supported city
officials’ efforts to tighten the laws concerning sex crimes. Overholser argued that offenders
ought to receive treatment at St. Elizabeths rather than face prison.178 As a practical matter, the
Miller Act became the basis for an expanded campaign of harassment and intimidation aimed at
gay men in the District. Offenders sent to St. Elizabeths faced what amounted to an
indeterminate sentence; only the examining psychiatrist could determine when such an
individual no longer represented a threat to society.179 Benjamin Karpman went further than
Overholser, suggesting at Congressional hearings in 1948 that many of the behaviors associated
with sexual psychopathy ought not fall under the jurisdiction of the courts. Few among his
audience, however, proved receptive to his views.180

Ultimately, neither Overholser nor Karpman questioned the basic premise that
homosexuality represented a form of mental illness. In this respect their views echoed the official

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177 Case 1960/26: admission note (28 Jan 1960); summary (22 April 1960); clinical record (5 May 1960).
179 Johnson, The Lavender Scare, 55-63.
180 Edward F. Ryan, “400% Sex Offense Jump Here in 7 Years is Cited at Hearing,” Washington Post, 21 Feb 1948,
B1; Johnson, The Lavender Scare, 57-58.
stance of the American Psychiatric Association. Many of these men and women, psychiatrists reasoned, could not control their actions. Reframing homosexuality as psychopathology rather than willful misconduct, they felt, ought to remove it from the realm of moral consideration. Yet mental illness carried an aura of profound stigma in its own right. From this perspective, physicians’ limited advocacy resembles a cynical manipulation of public opinion, further extending their professional jurisdiction. It is difficult to imagine psychiatrists adopting a more liberal position than Karpman, who went on to address Washington, D.C.’s homophile Mattachine Society in the late 1950s. As physicians, psychopathology was their raison d’être—any suggestion that homosexuality represented a natural variant of human sexual expression would remove it from their purview entirely. Psychiatrists’ motivations notwithstanding, their strategy guaranteed that the question of pathology would continue to weigh heavily on gay men and women in the decades that followed. By the 1960s, the status of homosexuality as a form of psychopathology had become a central target of the increasingly militant homophile movement, with one activist declaring that it represented “the greatest obstacle in the path of the homosexual community’s fight for full citizenship in our Republic.”

CONCLUSION

Psychiatric liberalism at midcentury shared important features with American liberalism more generally. As black men and women increasingly framed their demands in terms of fundamental American rights and freedoms, physicians at St. Elizabeths joined white liberals throughout the country in their cautious endorsement of reform. Hospitals officials hardly represented the vanguard of the movement for racial integration; as we have seen, senior

181 Johnson, The Lavender Scare, 173.
182 Quoted in Bayer, Homosexuality and American Psychiatry, 88.
administrators remained uncomfortable at the prospect of cross-racial sexual liaisons.

Nevertheless, they did not resist desegregation as it advanced through the nation’s capital. While World War II challenged many basic American assumptions about gender, no fundamental reexamination of the relations between the sexes occurred in the years that followed. Even as middle-class women entered the workforce in unprecedented numbers, psychiatrists promoted a cult of domesticity that restricted women to the home. Physicians at St. Elizabeths did not prove as reactionary as some of the profession’s more sensationalistic public spokesmen, but they continued to prioritize male concerns in both the public and private spheres. Psychiatrists were not alone in this regard; the condition of women remained a low priority for much of the liberal male political leadership. Among the views surveyed here, only psychiatrists’ attitudes toward gay men and lesbians proved more progressive than that of the liberal mainstream. During the war, same-sex sexual conduct could lead to prosecution and imprisonment; by the 1950s, rumors of homosexuality had become tantamount to an accusation of treason. Psychiatrists at St. Elizabeths worked to change the military’s system and combat the stigma associated with same-sex eroticism. Ultimately, however, they failed to question homosexuality’s status as a form of psychopathology, thereby maintaining aberrant sexual behavior well within psychiatry’s professional jurisdiction.

In the years that followed, psychiatry’s critics tended to identify the profession with its most conservative elements. In this sense psychiatric liberalism shared the fate of American liberalism more generally. With the maturation of the civil rights movement, the growth of student antiwar groups, and the shift toward an identity-based politics, a new generation of political activists repudiated the perceived conservatism of their forefathers. In the process, they minimized postwar liberals’ distance from the reactionary forces also at work at midcentury. So
too did a new generation of critics find much in psychiatry’s past to interrogate. Critics from the
black community questioned psychiatrists’ and psychologists’ tendency to overemphasize the
damage wrought by inequality, calling attention instead to the resourcefulness and psychic
resilience of black men and women. Feminists challenged the rank misogyny of American
psychoanalysis, which all too often employed the language of drives, inhibitions, and
psychosexual development to reinforce male privilege. A newly-emboldened generation of gay
and lesbian activists broke with their former medical allies, confronting conservative
psychoanalysts who maintained that homosexuality represented not only a form of
psychopathology but a particularly crippling and dangerous one at that. For many Americans,
psychiatry came to represent the very embodiment of oppressive authority in a deeply anti-
authoritarian era. By the 1960s, the legitimacy of the asylum itself had come into question, for
reasons worth examining in their own right.
CHAPTER FIVE. “A NEW ERA IN MENTAL HOSPITALS”: INSTITUTIONAL CULTURE, DRUG TREATMENT, AND THE ORIGINS OF DEINSTITUTIONALIZATION

INTRODUCTION

In the autumn of 1955, Winfred Overholser stood before an international audience of physicians and researchers in Paris to address the question, “Has Chlorpromazine Inaugurated a New Era in Mental Hospitals?” Marketed as Thorazine in the United States, chlorpromazine made its debut in English-language medical journals in February of 1954. Around the same time, another promising agent—reserpine, an alkaloid of the Indian root Rauwolfia sold primarily under the trade name Serpasil—appeared on the market. Overholser echoed many of his colleagues when he described chlorpromazine’s “unusual quality of bringing about sedation and quiet without substantial impairment of consciousness;” reserpine exhibited similar, though “less dramatic,” effects.

Overholser went on to address the new drugs’ salutary impact on the atmosphere of the wards, as well as their dramatic promise for patients’ families and the community at large. His answer to the question that provided the title for his lecture was decidedly affirmative. “There have been many swings of the pendulum in psychiatric treatment,” Overholser concluded. “Now the pendulum appears to have swung again, this time into a

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4 Overholser, “Has Chlorpromazine Inaugurated a New Era in Mental Hospitals?”
pharmacologic era.”⁵ At the time, Overholser treated the question of the drugs’ impact on hospital populations cautiously: “This is something which must wait for a later evaluation.”⁶ Eighteen months later, however, the verdict was in. “[I]n 1956 the institutions of the country reported a drop of 7,000 patients,” he wrote, “as against the usual annual increase of about 12,000!”⁷ Here, at last, was definitive evidence of the new drugs’ importance for psychiatry.

While the link between the advent of the major tranquilizers and the reversal of a decades-long trend toward increased mental hospital populations may have seemed self-evident, subsequent research has not borne out this claim. The connection had an obvious and immediate appeal. Few doubted the new drugs’ ability to control seriously disturbed patients, so it seemed reasonable to think that these men and women would leave the hospital earlier and in greater numbers. And yet at St. Elizabeths, at least one of Overholser’s contemporaries expressed doubts. “[How many] of the benefits being reported in mental hospitals throughout the country are due to the drugs … and how many are due to more enlightened attitudes of psychiatric staffs and the community[?]” asked first assistant physician Jay Hoffman in 1957, not long before his untimely death. “How much of the increased discharge rates … is due to [the major tranquilizers] and how much is due to the increased appropriations which most states have been receiving[?]”⁸ Detailed statistical analysis has exploded the myth that modern drug treatment was the only factor at work in the deinstitutionalization of mentally ill men and women in the United States.⁹

⁵ Ibid., 201.
⁶ Ibid., 199.
Community-based care emerged from many roots, including the postwar psychodynamic emphasis on the environment as well as the federal government’s expanding role in social welfare in the decades that followed.

In this chapter, I situate the major tranquilizers’ advent in the context of the changes in institutional culture transforming St. Elizabeths in the late 1940s and 1950s. While the new drugs represented an essential element in the postwar reorientation of U.S. psychiatry, they did not initiate the movement toward greater freedom in patient care. Rather, they reinforced an existing trend, which emerged as much from the demands of patients as it did from changing ideas among hospital staff. I begin my account of midcentury institutional culture with group therapy, originally intended as an economical alternative to individual psychotherapy. Patients found the experience of relying on one another for advice and support authentically therapeutic; in the process, group therapy created lateral social bonds in an environment that had previously worked against such relationships. In psychodrama, dance therapy, and art therapy, patients similarly learned to take their concerns, aspirations, and achievements seriously. In the institutional newspapers they founded in the 1940s, patients began to articulate a new sense of themselves as a community. Self-assertion reached its highest point in the patient governments that emerged in the postwar period, in which men and women at the hospital formed a parallel administrative structure to help run the wards and communicate their wishes to the staff.

Chlorpromazine and reserpine thus entered a dramatically different environment in 1954 than had existed at St. Elizabeths just ten years earlier. While both drugs proved capable of reducing disruptive behavior, physicians quickly recognized that they did not represent a panacea. Some men and women appeared to clear entirely; far more often, patients showed only

limited improvement. Even these patients, however, became more receptive to the sorts of social measures already transforming the hospital. Without these initiatives, it is unlikely that mental hospital populations would have reversed their decades-long increase at midcentury.

Much of my account in the pages that follow implicitly engages sociologist Erving Goffman’s *Asylums* (1961), which he based largely on fieldwork at St. Elizabeths in 1955-1956. Goffman came to the hospital through a National Institute of Mental Health (NIMH) fellowship, working unobtrusively as a recreation aide. In his book, Goffman called attention to the dehumanizing and oppressive elements of institutional life, identifying mental hospitals as “total institutions” akin to prisons and concentration camps. Perhaps the most commonly-repeated criticism of the work is that Goffman failed to acknowledge the impact of mental illness on patients and its role in shaping the world in which they lived. Instead, he emphasized the stress and deprivation of life in a total institution as causes of disordered behavior. Though this critique carries much weight, I would like to focus instead on the ways in which Goffman may have underestimated the changes occurring around him and the potential that lay beneath the surface in the community he studied. The portrait of patient culture that emerges from *Asylums* is an anemic one, with only the barest of solidaristic bonds holding men and women together.

Reflecting on the place of musical performances, holiday parties, religious services and sporting events at a hospital like St. Elizabeths, Goffman writes that “[a] total institution perhaps needs collective ceremonies because it is something more than a formal organization; but its ceremonies are often pious and flat, perhaps because it is something less than a community.” In the sections that follow, I hope to demonstrate the incompleteness of such an account.10

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10 Goffman, *Asylums*, quotation on p. 110. This was Goffman’s most popular and influential work outside sociological circles. As William Gronfein has observed, however, it is the only one of his major studies to emphasize institutional rather than interpersonal influences on the self. Goffman later addressed symptoms in their own right as a factor shaping social responses to mental illness after witnessing the ravages of mental illness in a
GROUP THERAPY, PATIENT SOLIDARITY AND THE PSYCHOLOGY OF 
SELF-EXPRESSION

As historian Nathan Hale has observed, the two decades after the end of World War II represented a “golden age” for psychoanalysis in American culture. Freudian principles made inroads in American medicine during the 1920s and 1930s, but the widespread discovery during World War II that traumatized soldiers responded well to talk therapy elevated psychoanalysis to a new position of importance within the profession. Its prestige rose still further with the arrival of large numbers of émigré analysts who fled Europe during the war. Returning soldiers who pursued psychiatric training on the G. I. Bill tended to view psychoanalysis as the most forceful and direct route to an understanding of the human mind; by the 1950s, large sectors of the public seemed to agree. Patients increasingly began interpreting their relationships and personal affairs in terms of drives, inhibitions, complexes, and neuroses, and those with adequate resources sought advice from the rapidly-increasing number of psychiatrists in private practice.

For many physicians and patients, individual psychotherapy represented the treatment of choice for mental illness. This created problems for the overburdened medical staff of an institution like St. Elizabeths, where many of the patients suffered from conditions that did not respond well to intensive psychoanalysis. Overholser encouraged his physicians to devote as much time as they could to individual therapy, all the while pressing budget officials for more staff. At Chestnut Lodge, a private psychiatric facility in nearby Rockville, Maryland, Frieda


12 Hale, Jr., Rise and Crisis of Psychoanalysis, 187-210, 245-256; Grob, From Asylum to Community, 5-43.
Fromm-Reichmann and Harry Stack Sullivan worked to extend the methods of psychoanalysis to those severely-disabled patients who even Freud despaired of reaching. At St. Elizabeths, the few men and women who received individual therapy often found it rewarding, even if they hesitated to acknowledge this among their peers. Most physicians lacked the time to devote themselves with such singular intensity to each patient. For a patient to receive individual therapy, physicians had to deem him or her an “interesting case” or a good teaching opportunity for psychiatrists in training. Good ego strength, an openness to self-examination, and psychological difficulties that resonated with the principles of psychoanalysis could all make an individual a candidate for psychotherapy; these factors appear to have outweighed such traits as race, sex, and diagnosis, though physicians generally showed far more interest in younger patients than their elderly peers. It is remarkable that any patients at all received this kind of care at a public psychiatric facility. Most, however, did not. Erving Goffman estimated that just one hundred of the roughly seven thousand patients at St. Elizabeths received individual psychotherapy in any given year.

Against this backdrop, group methods represented a natural and appealing alternative. Though the actual origins of group therapy remain obscure, such methods became increasingly common during World War II among British military psychiatrists. Physicians at St. Elizabeths almost certainly knew of these developments, which appeared in an important series of articles in the *Bulletin of the Menninger Clinic*. An independent tradition also existed at the institution

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15 My comments here are based on those patients in my sample who received individual psychotherapy at some point during their time at St. Elizabeths (case 1945/05; case 1945/06; case 1955/08b; case 1960/16b; case 1960/19b; case 1960/21c; case 1960/22b; case 1960/22c; case 1960/22f; case 1960/25.)
17 See the articles in *Bulletin of the Menninger Clinic* 10 (1946): 66-100, which laid the groundwork for what later became known as the “therapeutic community.” Grob, *From Asylum to Community*, 337 fn. 34.
upon which these physicians could draw. During the 1920s, physician Edward Lazell had experimented with didactic lectures encouraging young male patients to interpret their difficulties in psychodynamic terms, and in 1932 William A. White presided over a roundtable discussion of group methods at the American Psychiatric Association’s annual meeting. In 1939, Overholser sent a group of staff members to physician and theorist Jacob Moreno’s “theater of psychodrama” in New York. There they learned the basic principles of Moreno’s work, a form of group therapy involving role-playing and guided discussion that emphasized spontaneity and creative responses to problematic social scenarios.

Group methods spread rapidly at St. Elizabeths. Under the guidance of “psychodramatists” Frances Herriott and James Enneis, workers initially used Moreno’s techniques with white and black servicemen, preparing them for the challenges they would face upon discharge (Figures 5.1-5.2). Around the same time, physician Joseph Abrahams began holding group sessions among recently-admitted black men in the hospital’s forensic division. In Abraham’s “group interactive” approach, patients provided the starting point for discussion as well as feedback and advice to their peers (Figure 5.3). When Alcoholics Anonymous started holding meetings at the hospital in 1952, officials decided that it, too, fell under the rubric of group treatment. By this point the hospital’s psychodrama program had expanded to include

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Figure 5.1: Patients exploring a potentially difficult social scenario through psychodrama (1944). The original caption reads, “The patient pretends he is hiring a secretary. A typical instance of the methods by which the psychodramatic theater helps veterans overcome one of their commonest war neuroses: ‘Will I be able to get a job?’”

Figure 5.2: Winfred Overholser illustrating the dynamics at work in psychodrama (1951)
According to the original caption, “In psychodrama, patients act out their problems, ease mental conflicts.”

Figure 5.3: Physician Joseph Abrahams leading a group session for criminal offenders in Howard Hall (1949).

mixed-sex sessions for both acutely and chronically-ill patients as well as racially-integrated sessions for men admitted under the Miller Sexual Psychopath Act. By 1958, an internal survey found twenty-eight groups of various sorts meeting at the hospital.

Group therapy involved a new constellation of clinical values, one that placed a premium on individual self-expression, shared experience, and active participation in the therapeutic process. Physicians hoped that hearing other patients discuss their problems might help erode the isolation with which many men and women at the hospital struggled. “The basic philosophy of psychodrama,” wrote two members of the staff, “is that increased growth, creativity, and productivity result from the fullness of one’s relationships to others. Therefore, it is the aim of psychodrama sessions to establish a group climate within which intensive communication may take place.” While the content of individual sessions varied, patients consistently determined the path that discussion would follow. Members of the hospital staff encouraged group identification, believing that status among one’s peers could serve as an incentive to improvement. More prosaically, feedback from other patients could reinforce the boundaries of objective reality. Whatever its function, recognition of the peer group as a therapeutic resource

24 Arnold Peterson, “Report on the Survey of Group Activities,” St. Elizabeths Bulletin 2, no. 2 (April 1958): 4. The St. Elizabeths Bulletin appeared intermittently from 1957-1960 and then again in 1965. It was an internal publication centered on group work at the hospital and should not be confused with the Bulletin of the Government Hospital for the Insane, which officials published at intervals from 1909 to 1913 and then again in 1930-1931 as the Bulletin of St. Elizabeths Hospital. This latter publication was aimed at disseminating news of the research conducted at the institution to a wider professional audience. Both publications are available in the Special Collections Room of the Health Sciences Library at St. Elizabeths Hospital.
represented a major departure from the sort of deference to expert authority involved in White’s vision of mental health care.

Many patients found group therapy both beneficial and empowering. A black male patient in the late 1940s praised group therapy for its “value in affording members of the group an emotional outlet for pent-up feelings which might have been willfully suppressed[.].” Some patients discovered that sharing stories and offering advice could be surprisingly therapeutic. “By helping each other,” wrote a patient in 1961, “we are able to help ourselves.” Another participant confirmed the staff’s observation that group sessions could be valuable for those whose difficulties tended to isolate them from others. “I found that many of the patients understood and shared my own feelings of depression, anxiety, and despair,” he wrote. “I would certainly not discount the suggestions of fellow patients who have been through one or more bouts of mental or emotional illness.” Even when they did not fully accept the idea of sharing their personal problems in such an atmosphere, some patients enthusiastically attended group meetings—if only for the chance to spend time with patients of the opposite sex.

Solidarity among patients had its limits, however, and some men and women grew tired of groups. When the discussion ventured into morally-contentious terrain, patients could have difficulty identifying with their peers. The individual who found that others shared his problems nevertheless did not “feel any ‘togetherness’ with patients whose current problems are

28 G. W., untitled contribution, Elizabethan Anthology, 64. Published in 1949, the Elizabethan Anthology is a collection of works that originally appeared in the hospital’s two patient newspapers during the 1940s, the Elizabethan and the Howard Hall Journal, both of which will be discussed below. The Elizabethan Anthology is available in the collection of the National Library of Medicine (Bethesda, Maryland) and the Library of Congress (Washington, D.C.). The patients who authored these submissions were identified only by their initials; unless they were identified by ward or additional clues appeared in the piece, it is thus impossible to know the sex of any particular author with certainty.
31 Goffman, Asylums, 225, 226.
illegitimate children, drug addiction, [or] homosexuality[.]

Others believed that group therapy could only do so much. Preparing for discharge, Louise Lowry told her physician that she did not anticipate a recurrence of the sorts of difficulties that had occurred in the past, attributing her new attitude to insights she had gained in group therapy and psychodrama. Upon her return to the hospital the following year, however, Lowry found psychodrama “rather depressing.” “Mrs. Lowry has discontinued attendance … because she said she felt she was ready for ‘individual help,’” reported a social worker. “She had got to the point where she disliked hearing other patients’ ‘troubles.’” While Lowry acknowledged that these sessions had helped her in the past, she no longer felt they benefited her enough to warrant her attendance.

Despite these limits, I have found scant evidence to support Goffman’s description of group therapy as resembling “small-group indoctrination methods.”

Group therapy, according to Goffman, represented little more than an opportunity for physicians to break down the native worldview of their patients and rebuild it in a fashion consistent with their own understanding of human nature. Goffman found it particularly outrageous that physicians would seek to convince a patient that “the problems he feels he is having with the institution—or with kin, society, and so forth—are really his problems; the therapist suggests that he attack these problems by rearranging his own internal world, not by attempting to alter the action of these other agents.”

While it is true that such an approach could be used to minimize social and political criticism, the postwar shift toward a psychodynamic interpretation of interpersonal relations was much broader and deeper than Goffman implies. Given the suffusion of popular culture with psychological concepts, it is likely that most patients at St. Elizabeths already had some familiarity with this

35 Goffman, Asylums, 377 fn. 44.
36 Ibid., 376.
style of reasoning well before they entered the hospital. 37 Goffman leads us to believe that such
dynamics dominated group sessions to the exclusion of all other forms of interaction. In the
process, he neglects the possibility that group therapy sessions may have promoted meaningful
social relationships among patients.

The shift toward an expressive and analytic culture in postwar American psychiatry
found its most powerful articulation at St. Elizabeths in dance and art therapy. Professional
dancer and dance instructor Marian Chace first began volunteering at the hospital in 1942,
becoming a full-time staff member five years later. 38 Chace relied on both traditional and
modern styles in her efforts to promote communication among patients (Figures 5.4-5.5). Dance
sessions, she suggested, allowed men and women to form new bonds and provided opportunities
for self-expression through rhythm and motion. “Basic dance is the externalization of those inner
feelings which cannot be expressed in rational speech,” she wrote, “but can only be shared in
rhythmic, symbolic action.” 39 Artist Prentiss Taylor started working with small groups of
patients in 1943, becoming a member of the psychotherapeutic staff five years later. Taylor
sought to avoid “the sentimental excesses of the emotional release school of art,” aiming instead
for work involving a balance of formal and affective elements. 40 “[I]t is in this sense
of integration with its larger implication of order in living,” he wrote, “that I think creative

37 On psychology and psychoanalysis in postwar popular culture, see Regenhardt, “Psychology of Democracy.”
38 Marian Chace, “Dancing Helps Patients Make Initial Contacts,” Mental Hospitals 5 (1954): 6. See also accounts
of Chace’s early work at the hospital in NARA RG 418: Entry 7 (Administrative Files: Psychodrama, Annual
Reports [1942-1946]).
39 Marian Chace and Warren R. Johnson, “Our Real Lives are Lived in Rhythm and Movement,” Journal of Health,
Physical Education, Recreation 32 (Nov 1961): 30. Chace was one of the founders of modern dance therapy. She
went on to receive training at the Washington School of Psychiatry and worked with patients at Chestnut Lodge,
continuing her work there even after retiring from St. Elizabeths in 1966. See Susan L. Sandel, Sharon Chaiklin, and
Ann Lohn, eds., Foundations of Dance/Movement Therapy: The Life and Work of Marian Chace (Columbia,
Maryland: Marian Chace Memorial Fund of the American Dance Therapy Association, 1993).
Figure 5.4: Dance therapist Marian Chace and two nurse assistants lead a session for female patients (1954).

Figure 5.5: Marian Chace working with male patients at St. Elizabeths (1955). The original caption reads, “As a ‘silent’ patient responds to dance therapist [sic], he slowly begins primitive rhythmic movements. In a short time, he learns to move with a group; finally the goal is achieved: He speaks.”

expression has a particular value for the mentally ill.” Symbolic expression nevertheless
remained an important element of art therapy. Taylor allowed patients to pursue their own
imaginative aspirations, acknowledging that artwork could furnish valuable material for
discussions between a patient and his or her therapist.

Though dance and art therapy reached only a small number of patients, these sessions
nevertheless gave men and women an opportunity for individual recognition at the hospital.
When a journalist visited St. Elizabeths in 1951, one patient reported that dance allowed her to
“be myself,” while another explained that, “When I dance I’m somebody.” Occasionally, dance
provided a niche through which patients could contribute to the care of others. Valerie Hopkins
came to St. Elizabeths in 1953 after suffering a breakdown at the Federal Reformatory for
Women, where the white 25-year-old former homemaker was serving a term for killing her
husband. At St. Elizabeths, Hopkins took an active interest in painting and dance. She displayed
considerable talent, and during a second admission several years later Hopkins regularly helped
Chace lead sessions with some of the more severely ill patients. Prentiss Taylor acknowledged
that the percentage of patients with a serious interest in the arts typically did not exceed the
percentage among the general public. Yet many of those who participated took pride in their
work, and at least one male patient in the hospital’s forensic division found meaning in Taylor’s
aesthetic outlook. “An excellent picture is not possible without the proper blending of light and
shadow,” he wrote. “A meaningful life cannot be achieved without pleasures and satisfactions in
addition to sorrows and difficulties.”

41 Ibid., 605.
42 Ibid., 600-601, 603-604.
44 Case 1950/08a: clinical record (12 June 1954; 14 Jan 1955); case 1950/08b: clinical record (25 Jan 1957; 14 July
1958).
46 A. E. R., untitled prose, in Elizabethan Anthology, 40.
Public enthusiasm for the creative endeavors of patients underscored the changes that had occurred in American culture since White’s tenure. During the 1920s, those few accounts of patient activities in the local press tended to highlight the therapeutic value of labor. In the 1940s and 1950s, however, newspapers and magazines enthusiastically reported on the role of art and dance at the institution. Even as the political culture became increasingly intolerant under the aegis of Cold War anti-communism, some commentators began to extol the virtues of free and uninhibited self-expression among mental patients. One reporter described a 1952 exhibition of artwork as “not unlike many other museum showings of modern art.”47 James Enneis’ work in psychodrama and Marian Chace’s dance therapy sessions received regular attention as well.48

“Pure Democracy Produces a Show at St. Elizabeths,” declared the Washington Daily News when patients wrote and directed a theatrical production in 1955.49 Though they found the attention flattering, patients remained wary of exploitation. That autumn, psychodrama and dance therapy figured prominently in a photo essay on St. Elizabeths in Look magazine. When the author solicited feedback, patients proved more than willing to share their thoughts.50 “Since you called the article ‘The Mentally Ill Tell Their Own Story,’ then let ‘The Mentally Ill Give

Their Own Criticisms,” wrote a group of Chace’s patients. “As a group we feel you should have been more insistent in your plea to the public to treat recovered mental patients like any other convalescent. … [T]he story made interesting reading and no doubt satisfied the curiosity of the outside public, but from our standpoint fell short of its goal.”

NEGOTIATING AMERICAN FREEDOMS: INSTITUTIONAL NEWSPAPERS AND PATIENT SELF-GOVERNMENT

Self-expression took more concrete form in the two institutional newspapers that patients established at St. Elizabeths in the 1940s. Red Cross Field Director Margaret Hagan raised the possibility of a patient newspaper as early as 1938. “We have noticed that many of the patients like to write,” she reported in a memorandum to Overholser, “and that some of them write very well. We feel that the hospital should publish a little paper, or do something to encourage the patients about their writing.” A traditional of institutional newspapers extended back to the origins of the asylum itself; in the twentieth century, these periodicals began appearing with increasing frequency at mental hospitals as well as institutions for other chronic illnesses.

Overholser initially suggested reviving the Sun Dial under the auspices of the occupational therapy department, but limitations of staffing and space prevented any further action until

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1941. That year patients launched the *Elizabethan*, which would remain in print for another four decades (Figure 5.6). Several years later, men attending the weekly group meetings in Howard Hall began to consider publishing their own paper. In March of 1948 the first edition of the *Howard Hall Journal* appeared, and the paper remained in print (later as the *John Howard Journal*) through the end of the 1960s.

These newspapers represented a major departure from the model that had guided earlier efforts. During William A. White’s tenure, the *Sun Dial* had served primarily as a vehicle by which the staff could communicate with large numbers of patients. Often, the papers’ physician-editors struggled to convince men and women at the institution to submit their work. The *Elizabethan* and *Howard Hall Journal*, in contrast, emerged overwhelmingly from the energies and interests of the patient community. The *Elizabethan*’s masthead announced that it was “a paper by and for the patients,” while the editors of the *Howard Hall Journal* proclaimed its mission to be one of “mutual encouragement and rehabilitation.”

While the extent to which these newspapers can be interpreted as forms of free self-expression has been debated extensively, it is clear that they at least partially represented the perspective of an autonomous patient community. Goffman identified the *Elizabethan* and *Howard Hall Journal* as “house organs,” emphasizing the ways in which they remained under

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54 Memorandum from Arvilla D. Merrill to Monie Sanger, 25 June 1941, NARA RG 418: Entry 7 (Administrative Files: Reports and Memos, Occupational Therapy).
56 N. S. Haseltine, “Monthly Journal is Outlet for the Violently Insane,” *Washington Post*, 25 July 1948, B8; James R. Snyder, “The Birth and Progress of the *John Howard Journal,***” *John Howard Journal* 20, nos. 4-5 (April/May 1968): 4-7. Copies of the *Elizabethan* and the *John Howard Journal* are available at a variety of locations in Washington, D.C., including the Washingtoniana Division of the Martin Luther King, Jr. Memorial Library, the Winfred Overholser papers at the Library of Congress, and especially the Health Sciences Library at St. Elizabeths Hospital. Whenever possible, I have provided complete citations for each item. Many pieces lack authors or titles, however, and some archival holdings are only clippings that do not include the volume and number of the edition in which an article appears.
Figure 5.6: The cover of an early edition of *The Elizabethan* (1947). The building in the upper right corner is the Red Cross House, the center of much patient social life at the hospital. In the “coming events” listed at the bottom of the page, the party for West Lodge and Q Service is a segregated affair for black patients.
staff control and implicitly served institutional functions.\textsuperscript{58} Other students of such newspapers have been less than fully convinced by Goffman’s account. Literary scholar Benjamin Reiss has identified a “public transcript” of official asylum ideology in these papers as well as a “hidden transcript” that gives occasional insight into patients’ responses to their environment. For Reiss, institutional newspapers represent “a space in which authority and its subjects [speak] to each other and the outside world[,] [albeit] on heavily unequal terms.”\textsuperscript{59} Goffman himself recognized that his conclusions might not tell the whole story. “[I]nmates … introduce whatever open criticism of the institution the censors will permit,” he acknowledged. “[T]hey add to this by means of oblique or veiled writing, or pointed cartoons; and, among their cronies, they may take a cynical view of their contribution[.].”\textsuperscript{60} While the material in these periodicals cannot be taken as a straightforward depiction of everyday life at the hospital, the \textit{Elizabethan} and \textit{Howard Hall Journal} nevertheless represent a unique and important vantage point on institutional culture.

As a practical matter, men and women at the hospital printed these newspapers with varying levels of assistance and oversight from the staff. Patients initially produced the \textit{Elizabethan} in the print shop that the hospital’s occupational therapy department had established in the mid-1930s.\textsuperscript{61} During the paper’s early years, a Red Cross recreation worker served as an advisor, assisting whenever capable patient volunteers became scarce.\textsuperscript{62} Hospital officials had also opened an occupational therapy shop in Howard Hall in 1946, where prisoner patients used

\textsuperscript{58} Goffman, \textit{Asylums}, 95-96.


\textsuperscript{60} Goffman, \textit{Asylums}, 96.

\textsuperscript{61} \textit{Annual Reports} 1934, 365; 1938, 386; 1939, 400. See also the correspondence in NARA RG 418: Entry 7 (Administrative Files: Reports and Memos [Occupational Therapy]).

the mimeograph machine to produce the earliest issues of the *Howard Hall Journal*.63 When the Red Cross withdrew most of its workers in 1952, patients continued to put out the *Elizabethan* under the auspices of the newly-constituted Special Services Branch, with an office in the hospital’s recreation building.64 “Here they could enjoy not only the work conditions of any small business office staff but also the expectation that other patients would not intrude without good reason,” Goffman noted.65 While the circulation of each paper remains unknown, it is clear that both the *Elizabethan* and *Howard Hall Journal* reached large numbers of men and women on both acute and chronic wards. The patient-editors also appear to have participated in exchanges with similar papers at other institutions, and they likely sent copies to former patients, family members, and other interested members of the community as well.

Much remains uncertain about the publication schedule and content of these papers, owing primarily to the dearth of surviving issues from this period. While large numbers of editions from the 1960s and 1970s have survived, only a handful from the immediate postwar period remain available. The *Elizabethan* appears to have run from eight to twelve pages in length. Originally a monthly affair, the paper became a weekly with the assistance of Red Cross workers in 1946; weekly editions continued to appear in the early 1960s, but soon the paper reverted to a monthly and sometimes bimonthly schedule. Initially the *Howard Hall Journal* ran to a similar length, but by the 1960s it often filled twenty-five or thirty pages. For most of its existence the *Journal* remained on a monthly schedule, though it, too, occasionally shifted to a bimonthly basis in its later years. Hospital news, gossip, humor, and schedules of sports and recreational activities filled the *Elizabethan*, alongside poetry, prose, and opinion pieces from the

64 *Annual Reports* 1947, 480; 1950, 11; 1953, 261; 1956, 6.
readership. The *Journal* carried similar material, though it focused primarily on the forensic division. At times, *Journal* staff members also reported on recent developments at the intersection of psychiatry and the law.\textsuperscript{66}

While the *Elizabethan* and *Howard Hall Journal*’s editors sought to serve as broad a readership as possible, certain biases inevitably shaped their efforts. Early issues of the *Elizabethan* featured a section entitled “Voice of the Patients” in which men and women throughout the hospital wrote and shared their views. It is reasonable to assume that contributors to both papers tended to be the most functional among the severely-disabled patients at St. Elizabeths. Those whose difficulties did not prove especially incapacitating would have been unlikely to remain at the hospital long enough to become involved, while those who were profoundly disconnected from their environment would not have been able to contribute in a structured and coherent manner. Regular contributors sometimes suffered a relapse that prevented them from writing; at one point, nearly all of the staff at the *Elizabethan* found themselves restricted to locked wards.\textsuperscript{67} When it came to race relations, the papers initially adopted a remarkably conscientious stance. At the *Elizabethan*, an editor boasted that “efforts to have as great a ward representation on the paper as possible have been highly successful,” and in the early years of the *Journal* patients elected a four-member administrative board “equally representative of both white and colored wards.”\textsuperscript{68} While contributions from identifiably black patients appeared in both papers, differences in education among District residents likely led the editors to privilege the views of white patients. Black patients at St. Elizabeths never followed

\textsuperscript{66} Because so few editions remain available for the 1940s and 1950s, I have relied extensively on the *Elizabethan Anthology* (fn. 27 above) as well as a 1968 issue of the *John Howard Journal* celebrating the paper’s twentieth anniversary which includes a number of articles originally published in the immediate postwar period.


the path of their peers at institutions like the Central State Hospital in Milledgeville, Georgia, however, where black men and women maintained their own intramural newspaper.  

The patient-editors at these newspapers charted a fine line between freedom of expression and administrative control. Despite the liberalizing trends at work, mental hospitals remained highly structured and authoritarian institutions. To the extent that censorship existed at the *Elizabethan*, it appears to have been largely self-imposed. Reflecting back on her experience as chief of the recreational therapy section many years later, Ann Bushart recalled that “one rule of the *Elizabethan* was and still is not to have any religious or political controversy in its articles[.]” The *Howard Hall Journal* faced similar pressures, and as the journal’s style changed the degree of staff surveillance increased. In the 1940s and 1950s, officials tolerated patients’ tendency to “gripe (mildly) about their confinement.” By the 1960s, however, the paper had adopted the tough-minded and uncompromising style of prison journalism. Hospital officials soon became uneasy about this development and started monitoring the paper more carefully. “We have had several articles submitted for the journal that have been rejected by the staff as unsuitable for publication,” wrote the editors in 1965. “It was explained to us that they merely complained of conditions and situations … and further, the patient had included nothing constructive[.]”  

For many of the contributors to these newspapers, their submissions represented an opportunity to articulate a shared identity built around psychological impairment and the sense of social marginalization that followed from it. Some patients used prose to make sense of their struggles. “I am a mental patient,” one man wrote, “and when I yell I am not screaming at you

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71 Haseltine, “Monthly Journal.”  
personally—I am crying out at the world.”73 Others used poetry to articulate the feeling of estrangement they faced, at times experimenting with formal techniques in ways that echoed the experience of being out of touch with reality.74 Contributors in the 1940s and 1950s typically referred to their conditions as illnesses, often with the goal of mitigating the stigma associated with insanity and hospitalization. “We should not be ashamed of being patients,” wrote another male patient. “Everyone at some time or other is ill in their life—illness is illness, irrespective of the type or nature[.]”75 Contributors cautioned those who had improved enough to leave the institution that more challenges lay ahead. Such seemingly simple tasks as finding employment and a place to live could appear overwhelmingly to a former patient—particularly with “the hindrance of a hospital record.”76 Against this backdrop, humor became a constant source of support. “Do you hear voices?” asked the editors of the Elizabethan in a satirical advertisement. “Are they clear and distinct? If not, buy one of our handy portable … amplifiers and those bodiless voices will be clear and resonant.”77

The collective identity among patients in this period also emerged from patterns of everyday life at the institution. Contributors reported regularly on the ward parties, book discussions, holiday celebrations, and performances by musical and theater groups that sustained the social networks within which these men and women lived. Total gender segregation remained in place on the wards, so periodic dances in the Red Cross House represented a highly-
valued opportunity for male and female patients to interact.78 “I happily curled my hair, manicured my nails, and did all the other things little girls do for a grand occasion,” reported one young female patient after a Red Cross dance.

We all filed into the dressing room and removed our wraps, powdered our noses, and straightened our hair. … A handsome man approached and asked me if I cared to dance, so I consented as graciously as I could[.] … There were quite a number of attractive looking men who danced and conversed with me with ease.79

When successful, these occasions became an opportunity for heterosexual patients to demonstrate their adherence to gender norms, reassuring themselves that they were normal men and women whose condition represented a temporary setback rather than a fatal flaw setting them apart from the rest of society.

Sporting events and other forms of entertainment also served as frequent topics of commentary. Baseball games provided camaraderie and recognition for individual players as well as entertainment for the large number of patients who participated as spectators. Baseball teams remained racially segregated well into the 1940s, though it appears that blacks and whites intermingled in the stands.80 For those without parole of the grounds, the advent of television brightened life on the wards considerably. “In pausing to consider the significant role TV plays in our shut-in world,” wrote a Howard Hall patient in 1954, “one can readily agree that this ingenious little box should never be taken for granted or underestimated.”81 Patients also used their newspapers to discuss activities during time away from the institution. One woman related her experience seeing “The Snake Pit” during a visit downtown in 1948; at the time, the widely-

79 L. E. L., untitled article, Elizabethan Anthology, 21-22.
discussed movie was introducing audiences across the country to the grim conditions found in many of the nation’s mental hospitals. “I felt right at home, and it was my first remark as soon as I got seated,” she reported. “I was hushed up after that remark.” For others, the film became a reference point for discussions of conditions at the hospital. “Some people have said to me: The lady who wrote ‘The Snake Pit’ was here on ward 8. I replied: Indeed, she was not! Even here on ward 8, no one is subjected to such treatment at St. E’s!”

Patients also used their newspapers to critique the institutional policies governing their lives. They joked that “psychiatrists are prejudiced against sunshine and wide open spaces,” but the denial of one’s liberty for long periods could be deeply demoralizing. “I live in a place where they pray for the dead / and bury the living,” wrote one patient. “From our coffins with glass windows / We look out, starving for the right to live.” Some protested the loss of rights involved in civil commitment. “Isn’t that some bunk, by the way,” complained another man. “Not allowing us to vote. Look at some of the nuts outside who can’t distinguish a Democrat or a Republican from a Unitarian.” Others focused on such seemingly arbitrary bureaucratic indignities as the ban on viewing one’s own medical record. “Why shouldn’t the patient be encouraged to review his file, which contains the views and opinions of others?” asked a Howard Hall patient in 1949. “We feel that the patient would progress more rapidly if, at a ‘stage’ in his treatment, he were to sit down with a member of the staff and review his file.”

While most contributors remained sympathetic to the staff, this did not stop them from remaining actively involved in their treatment. Most of the articles and poems centering on

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physicians and nurses exhibited a laudatory tone; given the self-selecting nature of the contributors and the presence of staff oversight, this should not come as a surprise. Yet physicians occupied a position of genuine cultural prestige in the postwar period. The Howard Hall patient who argued that he and his peers ought to be able to view their own files did so on the grounds that their records contained “the medical views … of men … who are far more qualified to express opinions than the patient himself.” Full knowledge of his physician’s views, this patient suggested, could only assist in one’s recovery. Nevertheless, when they felt that doctors and nurses acted in an unhelpful or unfair manner, patients did not hesitate to say so. Often they couched their criticisms in humor, as when one woman used a parody of a speech in Shakespeare’s *As You Like It* to call attention to the “indifference” of the nurses and the rigidity of the physician in charge of her ward. Patients’ respect for the medical staff did not mean they remained passive or uninformed about their treatment. In June of 1947, the *Elizabethan* carried a brief notice on the availability of penicillin, which was revolutionizing the treatment of neurosyphilis at that time.

Though the lack of surviving editions makes it impossible to provide a full account, patients also used the *Elizabethan* and *Howard Hall Journal* to discuss social and political issues beyond the hospital’s walls. As citizens elsewhere did throughout the Cold War, men and women at St. Elizabeths framed many of these debates in terms of a specifically American national identity. Just a few years before Senator Joseph McCarthy rose to power, one female patient submitted an editorial on Cardinal József Mindszenty’s 1949 trial for treason by the Hungarian

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government. “In contrast to this unjust law, it seems appropriate to recall our American Constitution,” she wrote. “Our trials at law are open to all. Our press is free. … Let us watch our own laws that they may not lapse into such a misconception of the true will of the people as has been the case … in Hungary.” Patients’ awareness of the world around them did not end when they entered the hospital. Given the racial desegregation of both the institution and the city in 1954, the absence of issues from these years is particularly unfortunate. If later trends are any indication, however, it is likely that race relations and the question of civil rights made more than a passing appearance in the newspapers’ pages.

The spontaneous emergence of patient governments at St. Elizabeths provides especially compelling evidence of patients’ engagement in the therapeutic program at midcentury. Similar developments had occurred in the early 1940s among British servicemen at Northfield Hospital near Birmingham and later at Boston Psychopathic Hospital in Massachusetts. Not long after physicians at St. Elizabeths introduced group therapy in Howard Hall, they found that complaints about hospital policies tended to dominate the physician-led sessions. In response, officials set up separate weekly “administrative group meetings” devoted to common problems on the wards. Patients responded with unexpected enthusiasm, electing officers and adopting

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parliamentary procedure for their meetings; soon they established a Food and Welfare Committee to investigate the quality and quantity of food they received. Between 1949 and 1951, the group evolved into a Patients’ Administrative Group (PAG), consisting of an executive committee and delegates selected by each of the wards.95 Within a few years, analogous developments were underway on the hospital’s non-forensic wards. In February of 1956, Jay Hoffman reported that “[a] number of … patient government groups have been spontaneously organized on several services.” Hoffman identified at least a dozen groups, including “the ‘daddy’ of all such groups—those in Howard Hall.”96

At times, the boundary between patient government and group therapy grew indistinct. Some staff members used the language of therapeutic self-expression to describe democratic participation in patient-run meetings, while others invoked ideals of civic virtue to describe physician-administered sessions with explicitly therapeutic goals.97 As long as leaders maintained a respectful atmosphere, the staff suggested, individual men and women could gain a greater sense of their own identity as part of a group. This did not preclude a healthy measure of disagreement, as in one gathering where “some straight-from-the-shoulder, good old American free speech was brought into action[.]”98 Here the patient reporting on this episode associated self-expression and group participation with national identity, explicitly linking such practices to uniquely American freedoms.

While patient government necessarily operated within the hospital’s administrative purview, for many patients the experience seems to have given them a greater sense of

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98 Untitled article, *Elizabethan Anthology*, 63.
accountability to one another rather than to an inscrutable bureaucratic regime. In April of 1957, men and women formed a Patients’ Federation representing all of the hospital’s wards, with Director of Special Services Ellen Hollweck serving as a liaison to the administrative staff. “The representatives from the services are taking this very seriously,” Hollweck wrote, “with the understanding that hospital rules must be observed.” By 1958, patients conducted “privileges committee meetings” in several of the clinical divisions. Patients presented their requests for parole or city privileges to a board of their peers, who questioned them and subsequently made a recommendation to the medical staff. Here, as elsewhere, patients operated within fairly circumscribed boundaries, and the staff could choose to overrule the board’s recommendations. Yet many patients appear to have found involvement in ward decision-making a genuinely empowering experience. Following the organization of a patients’ council on one ward, a nurse familiar with the group discerned a greater feeling of dignity and self-respect among the patients as well as an increased sense of confidence and responsibility.

Though a few members of the staff initially opposed these developments, most saw them as an opportunity to cultivate the habits of citizenship necessary for a return to society. At first, some physicians and nurses refused to allow patients on their wards to attend meetings of the Patients’ Federation. “I think this might mean headaches for all of us,” wrote one psychiatrist

102 Memorandum from [illegible] to Frances Tartaglino (4 April 1957), Subject: Hospital Federation of Patient Representatives, NARA RG 418: Entry 7 (Administrative Files: Memoranda from Superintendent to Branch Heads, Etc., 1957).
in 1957, “and stir up some tough administrative problems.” Once Overholser circulated a memorandum indicating his approval, however, the staff proved more willing to cooperate. Physicians familiar with recent developments in British social psychiatry interpreted the emergence of patient self-government in terms of the concept of the “therapeutic community.” Maxwell Jones first published his *Social Psychiatry* in 1952, and many physicians at St. Elizabeths knew of his work. The administrative officials who had met with the Patients’ Federation and prepared an initial draft of Overholser’s memorandum maintained high hopes for the organization. “The purpose of this federation is to provide a forum for discussion by the patients of hospital matters, living conditions, administration and recreation,” they wrote, “permitting the exchange of ideas [and] growth of patient civic participation as well as [providing] a source to the hospital of suggestions and recommendations.”

The men and women involved in patient government were often proved to be charismatic individuals already engaged in hospital life. During her first admission in 1953, Valerie Hopkins distinguished herself through her artistic work and participation in a patient-directed play. Though she had little formal education, Hopkins revealed herself to be intelligent and hard-working; she was also remarkably attractive, having supported herself as a model as a teenager. When Hopkins returned in 1955, she took an active role in patient government. Prior admissions might provide a good understanding of how the institution worked, which could be an important asset within the hospital community. Edward Skilling had already spent time at St. Elizabeths on five previous occasions when he arrived in 1962. He thus knew how to negotiate

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103 The physician’s initials that appear beneath this comment are illegible. Route Slip, 22 April 1957, NARA RG 418: Entry 7 (Administrative Files: Memoranda from Superintendent to Branch Heads, Etc., 1957).
effectively with the medical staff for privileges and went out of his way to assist his peers. For his efforts, patients elected him chairman of the patient government on his ward.\textsuperscript{107} In some cases, patients elevated one of their own to a position of leadership on the basis of qualities that the staff deemed unhealthy. Lynn Rothman was estranged from her family and consistently evaded conversations about her drinking when she arrived at St. Elizabeths in 1960. Once her physical condition improved, the 47-year-old white bookkeeper threw herself into the interests of others, occupying her time with work on the ward and errands for her fellow patients, all the while continuing to avoid a frank discussion of her difficulties. Rothman’s fellow patients nevertheless appreciated her work, regularly electing her chairman of the ward’s patient government.\textsuperscript{108}

Though the evidence is limited, the hospital’s desegregation in 1954 paradoxically appears to have worked against black men and women when it came to patient self-government. While it is likely that some black patients participated in ward councils and privilege committees, none did so among the clinical records that I have reviewed. As we have seen, efforts in the 1940s to achieve broad hospital representation at the Elizabethan and Howard Hall Journal meant that the editors actively sought out representatives and contributors from black wards. After the desegregation order, it likely became increasingly difficult for black men and women to rise to a position of leadership and respect on wards dominated by white patients. In addition, patient governments appear to have tolerated forms of racism that alienated black patients. Over the course of his six admissions between 1944 and 1965, William Clement became highly involved in hospital life. A member of the ward staff casually noted in 1950 that Clement “has racial prejudice,” and thirteen years later another observed that “he has a tendency

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\textsuperscript{107} Case 1960/03f: admission note (5 Feb 1962); clinical record (8 March 1962; 23 Nov 1962; 5 Aug 1963).
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to keep other patients upset when expressing his ideas concerning race and how he feels the ward should be operated.” Nevertheless, Clement’s education, energy, and experience made him a natural leader among white patients, and they elected him as chairman of the Patients’ Congress in 1960.  

Despite the high aspirations of the 1950s, patient government remained a ward-based enterprise throughout most of the institution. The history of the Patients’ Federation after 1960 remains unclear, as does the subsequent fate of the privileges committees. On many wards, the emerging ideology of the therapeutic community appears to have overtaken patient self-government. As the pace of deinstitutionalization accelerated in the 1960s under Overholser’s successor Dale Cameron, the patient community lost many of its most capable and dynamic leaders. Physician Luther Robinson recalled the Patients’ Federation being dissolved around the middle of the decade; patient self-privileges committees and administrative groups did not appear at all in the 1965 and 1967 editions of the hospital’s intramural journal devoted to group work. By the end of the decade, those patient councils that remained appear to have limited themselves largely to organizing social functions and extramural trips, though the importance of patient involvement in ward decision-making at any level should not be underestimated.

The one exception to these generalizations lies with the achievements of the newly-renamed Patients’ Administrative Council (PAC) in the hospital’s forensic division, which remained an important element of hospital life. During the 1950s, the PAC became a

110 Author’s interview with Luther D. Robinson, April 2004. These were the final issues of the St. Elizabeths Bulletin, two in 1965 and one in 1967.
sophisticated and effective advocate for improved living conditions and expanded facilities.\textsuperscript{112} Though a liberalizing trend was already well underway, it is unlikely that patients would have achieved quite so many gains if they had not been represented by such a well-organized group. The District courts also became increasingly liberal in this period, sending defendants to St. Elizabeths for evaluation and treatment rather than directly to jail.\textsuperscript{113} The hospital’s forensic division thus held large numbers of highly-functional men motivated to improve the conditions of their confinement. In the 1960s, the PAC lobbied successfully for a parole ward, more permissive visiting regulations, and a circulating library; they also helped create a Legal Assistance Pilot Project for all patients at the hospital.\textsuperscript{114} The PAC did not always achieve its goals, however, and often it occupied a tenuous position between the patient population and the hospital administration. “Many times requests are denied by the administration of John Howard,” explained one writer, “only to pave the way for future negotiations and perhaps even more valuable privileges. This has been true of the majority of the privileges enjoyed by us all.”\textsuperscript{115}

“A PHARMACOLOGIC ERA”: THE ADVENT OF THE MAJOR TRANQUILIZERS

This was the context into which chlorpromazine and reserpine entered at St. Elizabeths in the mid-1950s. A pharmacological approach to psychosis was not without precedent; indeed, a

\textsuperscript{112} James R. Snyder, “Exodus Plus Seven,” \textit{John Howard Journal} 18, no. 9 (Sept 1966): 6a-6b.
\textsuperscript{114} These developments can be followed in the “JHP Scripts” column and “PAC Report” that appear in each issue of the \textit{John Howard Journal} in the mid-1960s.
tradition of drug treatment stretched back to the origins of the asylum, when American physicians employed a variety of tonics, purgatives, cathartics, and hypnotics alongside moral therapy.\textsuperscript{116} Physicians in the interwar period relied on barbiturates and opiates in cases requiring sedation, though few saw these medications as genuinely therapeutic.\textsuperscript{117} Overholser and his staff regarded most such drugs as “chemical restraints,” preferring hydrotherapy whenever possible. Nevertheless, sedatives continued to play an important role in the management of agitated or disruptive patients.\textsuperscript{118} During the 1940s, physicians also began to administer barbiturates as an adjunct in their initial interviews with patients or, with servicemen, in an attempt to get them to relate the traumatic memories which presumably lay at the heart of their difficulties.\textsuperscript{119} Advances in biochemistry led researchers to ask whether mental illness might have an endocrinologic etiology. St. Elizabeths Director of Laboratories Solomon Katzenelbogen carefully monitored a variety of metabolic parameters in his research on insulin coma therapy, and in the early 1950s he and his staff collaborated with the pharmaceutical firm Merck to investigate cortisol in the treatment of schizophrenia.\textsuperscript{120}

\textsuperscript{117} Case 36556: ward notes (1 Nov 1932); case 36372: clinical record (6 Feb 1931). Grob, \textit{Mental Illness and American Society}, 292, 296.
\textsuperscript{118} See especially case 1960/21a: clinical record (16 Sept 1942; 21 Sept 1942; 1 Oct 1942); treatment record (1942) and case 1945/19: clinical record (9 April 1946; 10 April 1946; treatment record (July 1945; Aug 1945; 28 Nov 1945; May 1946). See also case 1945/24: ward notes (7 June 1945; 8 June 1945; 9 June 1945; 10 June 1945); treatment record (June 1945); case 1945/25: clinical record (19 Feb 1945); ward notes (7 Nov 1945); case 1945/33: clinical record (4 March 1955); ward notes (Dec 1954; Jan 1955; Feb 1955); case 1955/25: clinical record (20 May 1941); case 1960/22a: admission note (5 April 1944); ward notes (5 April 1944; 7 April 1944; 9 April 1944).
\textsuperscript{119} Case 1945/05: clinical record (8 Feb 1945; 12 Feb 1945); case 1945/13 (14 Jan 1945); case 1945/14: clinical record (17 Jan 1945); case 1945/22: admission note (27 July 1945); ward notes (27 July 1945); case 1945/23b: admission note (11 Dec 1945); case 1945/26: admission note (20 Aug 1945); ward notes (21 Aug 1945). Katzenelbogen went on to experiment with methamphetamine and LSD-25 in a similar manner. See Solomon Katzenelbogen and Ai Ding Fang, “Narcosynthesis Effects of Sodium Amytal, Methedrine and LSD-25,” \textit{Diseases of the Nervous System} 14 (March 1953): 85-88.
By the time the companies who owned the U.S. rights to chlorpromazine and reserpine approached Overholser in 1953 about studying the drugs at St. Elizabeths, collaborative enterprises of this sort had become commonplace. As the drug industry grew during the interwar years, firms worked to establish relationships with leading physicians and reputable clinical researchers. Interested physicians might prove willing to try a new drug on the firm’s target patient population. If promising results reached print, the firm could use these studies in its application to the American Medical Association’s Council on Pharmacy and Chemistry, the gatekeepers who regulated drug-makers’ claims in medical advertising until the federal government took over the role in 1938.121 During his time at Johns Hopkins in the 1930s, Katzenelbogen had collaborated with Smith, Kline and French (SK&F) on amphetamine as an antidepressant. Later, St. Elizabeths physicians carried out research on Rabellon (a mixture of belladonna alkaloids) as a treatment for Parkinson’s disease with the support of the firm Sharp and Dohme, though hospital officials declined to conduct research on the company’s newest barbiturate.122 These collaborations increased exponentially after World War II, at St. Elizabeths and throughout American medicine. “The 1940s and 1950s … were a pivotal period for the prescription drug industry,” writes historian Jeremy Greene, “as novel and efficacious medicines began to pump out of a suddenly vibrant research pipeline.”123

Chlorpromazine and reserpine emerged almost simultaneously in the mid-1950s, albeit from very different backgrounds. The French pharmaceutical firm Rhône-Poulenc originally developed chlorpromazine in the course of their research on the management of surgical shock,

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122 See the correspondence in associated with Rabellon and Delvinal in NARA RG 418: Entry 7 (Administrative Files: Drugs [General Correspondence]).
but physicians rapidly recognized its unique tranquilizing effect. Parisian psychiatrists Pierre Deniker and Jean Delay published the first systematic evaluation of chlorpromazine’s psychotropic activity in 1952; that year Rhône-Poulenc began approaching U.S. drug firms about acquiring the rights for the drug. Soon SK&F agreed and named the drug Thorazine, though their initial interest lay in its potential as an antiemetic. Following promotional efforts by both Rhône-Poulenc and SK&F, psychiatrists in Canada and the United States confirmed the drug’s psychotropic effects and began to spread the word among their colleagues.¹²⁴ Unlike chlorpromazine, reserpine was an alkaloid of the plant *Rauwolfia serpentine*, which had been used for centuries in traditional remedies in India. Researchers knew that the plant could lower blood pressure and produce sedation; in 1952, investigators at Ciba identified reserpine (marketed in the U.S. as Serpasil) as the primary active agent. Following Indian reports on *Rauwolfia*’s use in psychiatry, Ciba approached New York psychiatrist Nathan Kline. Kline tried both *Rauwolfia* and reserpine in psychologically impaired patients, first publishing his encouraging results in 1954. Because drug companies at the time could patent processes rather than compounds, Ciba faced stiff competition. Several other firms quickly brought their own preparations of *Rauwolfia* to market. Regardless of their branding, psychiatrists and researchers in the mid-1950s agreed that both chlorpromazine and reserpine held enormous promise.¹²⁵

At St. Elizabeths, officials from SK&F and Ciba facilitated the trials of chlorpromazine and reserpine from the outset. Writing to Overholser in May of 1953, SK&F’s representative specifically referenced the company’s prior collaboration with Katzenelbogen, offering to cover any expenses involved in a preliminary study as well as a grant-in-aid should further investigation prove warranted. Ciba pressed Overholser repeatedly, hoping to collect data for

their Food and Drug Administration (FDA) submission later that year. Overholser approved the projects, with hospital administrators consulting representatives from both companies in their efforts to design proper trials for the drugs. Though scheduled to begin that fall, the studies encountered a series of administrative and bureaucratic delays. By the summer of 1954, several physicians started experimenting with the drugs independently. “While Dr. Fong and Dr. Pettit are to be commended for their initiative,” wrote first assistant physician Jay Hoffman to Overholser, “I am a little uneasy when new drugs are introduced without my prior knowledge. I have requested the several psychiatric services to consult with me in the future before introducing new drugs.”126 Officials finally launched a small-scale study of chlorpromazine in July of 1954, dramatically increasing the number of patients involved that October. That month they also initiated a sophisticated, multi-service study of serpasil. SK&F and Ciba supplied the drug as well as placeboes for these studies; while it is unclear whether SK&F ever followed through on their offer of a grant-in-aid, Ciba happily provided a small sum to a psychology graduate student working on the project so that he could support his family.127

Almost from the beginning, hospital officials saw unexpectedly positive results. Not long after chlorpromazine’s introduction, Hoffman found some of the wards for disturbed patients “unrecognizable because of the unwonted quiet and peace there.”128 Nurses on another ward offered to pool their money to continue purchasing reserpine for patients who had responded particularly well but whose trial had ended.129 Physicians marveled at the drugs’ ability to sedate

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127 The correspondence relating to the initial trials of Serpasil and Thorazine can be found in NARA RG 418: Entry 7: (Administrative Files: Serpasil, Thorazine-1, and Thorazine-2).
patients without rendering them unconscious, as the barbiturates inevitably did.\textsuperscript{130} By July of 1955, physicians had started 284 patients on chlorpromazine, 139 on reserpine, and three on both; officials now purchased the drugs directly rather than relying solely on research samples.\textsuperscript{131} On Ciba’s prompting (and with their reimbursement), Hoffman and his colleague Leon Konchegul presented preliminary results on reserpine at a symposium the company organized at the New York Academy of Sciences in February of 1955.\textsuperscript{132} Overholser and Hoffman declined SK&F’s offer to include them on a list of experts willing to speak on the new drugs’ behalf at the company’s expense.\textsuperscript{133} They continued, however, to promote both drugs independently at professional conferences. In November of 1955, hospital officials presented a comprehensive overview of their experience with the new drugs to the District of Columbia Medical Society.

“Our staff received these drugs initially with some considerable skepticism and lack of enthusiasm,” Hoffman explained. “Most of us looked … upon chlorpromazine and reserpine as … ‘two more sedatives.’ However, it is [now] evident that these drugs represent a different and new type of chemical agent.”\textsuperscript{134}

The new drugs’ perceived effectiveness resulted largely from their ability to calm highly agitated or disruptive patients. Physicians targeted such men and women from the outset. “Our criteria of selection of patients,” wrote the physician in charge of the project on the Women’s Receiving Service, “were mainly those who were very overactive and disturbed and required

\textsuperscript{130} Memorandum from Jay L. Hoffman to M. K. Madden, Subject: Program Operations (25 May 1955) NARA RG 418: Entry 7 (Administrative Files: Memoranda, Outgoing [1953-1955]).

\textsuperscript{131} Monthly Report for July 1955, NARA RG 418: Entry 7 (Administrative Files: Monthly Reports [1945-1957]).


\textsuperscript{134} Overholser et al., “Chlorpromazine and Reserpine,” 267.
Physicians interpreted the precipitous decline in the number of men and women in seclusion as one important indicator of the drugs’ effectiveness; the increasing number of patients who nurses deemed eligible for recreational activities represented another important marker. Often, physicians highlighted particularly dramatic cases, such as one patient who had refused to eat and been tube fed regularly for seven years. After starting the new medications, he abruptly began eating on his own initiative. Clinical records confirm that some patients exhibited a rapid and marked improvement. When Valerie Hopkins came to St. Elizabeths in 1953, she spent much of her time in seclusion because of her tendency to attack those around her and throw furniture on the ward. Hopkins started receiving Thorazine on July 19, 1954. “From almost the first day, there was a change noted,” wrote her ward physician. “She became quite drowsy on the medication; became more cooperative, easier to manage; she remained quite confused … but had apparently lost her assaultive drive. … [A]s time went on she spent less time in seclusion and … became quite sociable and rational, ate and slept well.”

Some patients showed more than a simple reduction of overactivity in response to the drugs, a result over which physicians puzzled. While most exhibited at least some improvement, approximately one-third seemed to clear entirely. When Claire Pemberton came to the hospital in 1950, the 35-year-old white homemaker believed she was in contact with Scotland Yard and

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138 Case 1955/08a: clinical record (5 Oct 1954). This is consistent with Healy’s finding that for physician-researchers in the mid-1950s, “the emphasis was still primarily on sedation.” Healy, Creation of Psychopharmacology, 116.

the heads of several governments. She remained confused for the next five years, failing to recognize her family when they visited. On Thorazine, however, she began taking pleasure in her mother and children’s company and denied any of the bizarre beliefs she had formerly held.140

When Hoffman asked another patient about her earlier beliefs, she responded that they were “preposterous, just preposterous.”141 Physicians debated the mechanism by which the new drugs worked, calling upon psychodynamic as well as physiological principles. “Although the modus operandi is not known,” wrote physician F. Regis Riesenman, “[chlorpromazine] apparently facilitates repressive mechanisms … and creates a feeling of emotional indifference, so that patients appear to be no longer concerned with their problems, and the anxiety is relieved.”

Riesenman continued with a description that other physicians repeated in the drug’s early years: “In this respect, it acts as a chemical lobotomy.”142 Riesenman’s comparison, however, remained highly metaphorical. In Hoffman and Konchegul’s earliest report on reserpine, they specifically noted that “no patient should be considered for psychosurgery until he has first been given a trial with this drug.”143

Whatever their thoughts on the new drugs’ mechanism of action, physicians agreed that more patients now stood to benefit from socioenvironmental therapy and support. Men and women who previously had little interest in their surroundings now began to take notice of the daily deprivations they endured. “The patients who were once on disturbed wards now complain about the type of furniture on these wards,” wrote physician Evelyn Reichenbach. “We have a dearth of material to occupy these patients with, which seems quite a tragedy when they are in

140 Case 1950/05: admission note (28 July 1950); clinical record (17 Aug 1951; 9 Aug 1955; 30 April 1957).
142 Overholser et al., “Chlorpromazine and Reserpine,” 259. See also Otis Farley’s comment on p. 266, as well as Winkelman, Jr., “Chlorpromazine,” 20. For the broader context, see Matthew Gambino, “‘A Euphoric Quietude’: Pharmacological Sedation in American Psychiatry, 1820-1956” (seminar paper, University of Illinois at Urbana-Champaign, 1998); Pressman, Last Resort, 421-422.
such a receptive mood[.].” Patients often became more amenable to psychotherapy. Physician Raymond Ridenour found that with the assistance of chlorpromazine, he could establish rapport with seriously-impaired patients in about a month, whereas previously it often took as long as a year. Increasing numbers of men and women now proved receptive to group therapy, as well as dance, art, and music therapy. The demand for such intensive work further strained an already overcommitted medical staff. “When the people from the Bureau of the Budget … ask why—in the face of a decreasing Hospital population—our requests for personnel [do] not also diminish,” Hoffman wrote in a memorandum to Overholser, “I think that we must reply … that improvement in the condition of the patients demands more personnel rather than less.”

Within five years of chlorpromazine and reserpine’s appearance, the evaluation of new drugs had become a major component of St. Elizabeths’ mission. Physicians participated eagerly in this work, which provided an opportunity to publish in a field that appeared to be revolutionizing psychiatry. When a pharmaceutical company approached the hospital about a new drug, administrators typically surveyed the senior staff to assess their interest. If they proved receptive, physicians first tried the drug on a dozen or so patients to determine whether it exhibited sufficient therapeutic potential. For particularly promising drugs, they might agree to a larger-scale study funded through a grant-in-aid from the pharmaceutical firm. Some of these drugs bore an important chemical resemblance to chlorpromazine; between 1957 and 1959, officials carried out extensive studies of promazine and prochlorperazine, as well as smaller-

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scale studies of perphenazine and triflupromazine. Psychiatrists at St. Elizabeths also continued to study chlorpromazine, and conducted research on the minor tranquilizer meprobamate, the antidepressant iproniazid, the anti-parkinsonian drug procyclidine, and the stimulants pipradrol and methylphenidate. Hospital officials frequently declined pharmaceutical companies’ solicitations as well, whether out of caution about a new drug or simply because they lacked adequate personnel to carry out the studies. Clinical trials also reinvigorated other avenues of research at the hospital. In 1957, officials opened the Clinical Neuropharmacology Research Center, a collaborative enterprise between St. Elizabeths and the NIMH under the leadership of pioneering psychopharmacologist Joel Elkes.

As psychiatrists began administering chlorpromazine and reserpine to a broader range of patients, they quickly came to appreciate the new drugs’ limitations. By November of 1955, St. Elizabeths officials had treated nearly two thousand patients with chlorpromazine, reserpine, or both. Many of the men and women whose conduct improved nevertheless failed to show a corresponding improvement in their thinking. “Although these patients showed a definite


tranquilizing effect with respect to some of their more obvious symptoms,” wrote physician Francis Waldrop, “examination still revealed … hallucinations, delusions, confusion, disorientation, and faulty emotional responses.”\(^{150}\) Officials initially hoped that a single six- to eight-week course would produce permanent improvement. While some men and women did seem to recover, most required a maintenance dose.\(^{151}\) By 1957, Hoffman concluded that “[the] symptomatic improvement under the tranquilizing drugs is generally rather superficial. At first glance the patient may seem to be symptomatically quite well. But the patient has not developed any greater ego strength than she had before the onset of symptoms.”\(^{152}\) Often patients did well enough to leave the hospital, but many again experienced difficulties when they encountered the same familial tensions and social obstacles that had initially contributed to their breakdown. Without intensive aftercare provisions, these men and women typically returned to the hospital within a matter of months.\(^{153}\)

More than anyone else, first assistant physician Jay Hoffman recognized that the new drugs’ effectiveness could not easily be disentangled from the environmental reforms already underway. Discussing the patient who began eating of his own accord after seven years of tube feeding, Hoffman explained that “[t]he doctors on the Service have been taking a great deal of interest in [him] and we would like to think that, at least, the change in behavior resulted from

\(^{150}\) Overholser et al., “Chlorpromazine and Reserpine,” 256.
\(^{152}\) Memorandum from Jay L. Hoffman to unspecified, Subject: Aspects of Aftercare of Patients Receiving Tranquilizing Drugs (5 Feb 1957).
the combined action of drugs and psychotherapeutic intervention.”154 Hoffman approached the
statistics on seclusion with caution as well. When a service of one thousand patients reported
only a single episode of seclusion during July of 1955, he noted that “[i]n part, it is due to the
moderate use of Serpasil and Thorazine, but in large part, also, it must be attributed to the greater
use of milieu or environmental or attitude therapy.”155 Hoffman appreciated the drugs’
importance, having seen first hand their “revolutionizing impact.”156 Nevertheless, as we have
seen, when mental hospital populations began to fall, he remained uncertain about the link
between the new drug therapies and this welcome change.157

While some patients acknowledged that the new medications helped them think more
clearly, they rarely exhibited much enthusiasm. Deborah Kucharski made several trips to
Washington, D.C. in the early 1960s to warn federal officials about the outlandish activities in
which her Communist ex-husband had been involved. Each time, physicians restarted the
middle-aged white homemaker on medication and returned her to Pennsylvania. “She believes
she has been helped by her medication,” noted a physician during her fourth admission, “which
slowed down her thinking.”158 Valerie Hopkins reported benefits as well. “She feels Thorazine
has helped her a lot,” her physician wrote. “[B]efore that she was very tense and she did not
know that anything was wrong with her[.]”159 Patients knew that physicians hoped to hear
testimonials of this sort, however, and such pronouncements must be interpreted with caution.
When Hopkins returned a year later, she again indicated her willingness to start drug treatment.

154 Monthly Report for February 1956, NARA RG 418: Entry 7 (Administrative Files: Monthly Reports [1945-
1957]).
156 Memorandum from Jay L. Hoffman to Winfred Overholser, Subject: Letter from Mr. Searcher (4 Feb 1957),
NARA RG 418: Entry 7 (Administrative Files: Memoranda, Outgoing [1957]).
157 Ibid.
after physicians agreed to take her off the medications, Hopkins claimed that she felt better without them. “I can think things out better,” she declared, “especially since I’ve been off the Thorazine. I can sift the important things out from the unimportant.”\textsuperscript{160} This ambivalence toward the major tranquilizers stands in marked contrast to patients’ enthusiasm for the minor tranquilizer meprobamate. Men and women at the hospital regularly reported that the drug eased their tension. “[T]hose three little white pills quiet me down,” reported one 63-year-old white female patient. “If I didn’t take this medication I wouldn’t sleep a wink.”\textsuperscript{161}

Often, adherence to the prescribed regimen became a symbolic battleground for control between patients and the medical staff. Individual men and women frequently refused their medication, insisting that the drugs were poisonous or made them nauseous and drowsy.\textsuperscript{162} Some hid the pills in their mouths until they thought the nurses were no longer looking. In cases like these, physicians typically gave patients the choice of consuming the drug ground up and dissolved in a glass of water or through an intramuscular injection by force.\textsuperscript{163} Psychiatrists often withheld privileges if a patient refused his or her medications; patients, in turn, sometimes convinced their physicians to reduce their dose by threatening to stop taking them altogether.\textsuperscript{164} At times, physicians sought to engage patients’ families in their efforts to convince patients to stay on their medications. “One of the difficulties with your aunt is that she seems convinced that these medications are not helpful to her, and when she does improve she discontinues taking them,” wrote Addison Duval to one patient’s family in 1959. “Until such time as we can …

\textsuperscript{160} Case 1955/08b: clinical record (14 July 1958; Nov 10 1958).
\textsuperscript{162} Case 1960/03b: ward notes (6 March 1958). See also case 1960/07a: clinical record (31 May 1962).
\textsuperscript{163} Case 1950/15a: ward notes (3 June 1956; 8 Jan 1957; 31 March 1958).
\textsuperscript{164} Case 1960/07a: clinical record (31 May 1962); case 1955 08b: ward notes (30 June 1957).
convince her of the advantage of taking these medications, it will be difficult to set a date when
she might be able to go to one or another relative’s home.”

Side effects represented more than a figment of patients’ imagination. Men and women
receiving chlorpromazine or reserpine became exceedingly drowsy during the first few weeks, a
fact that could only have made the drugs more attractive to physicians who sought to control
disruptive behavior. Patients also complained of tremors and difficulty moving, though
physicians quickly added other medications to counteract these effects. Reserpine could lower
patients’ blood pressure dramatically. All of the drugs could make patients dizzy or even lose
consciousness if they rose too quickly, and chlorpromazine at times caused a serious skin
reaction. Although psychiatrists would not recognize these complaints as side effects until later,
patients also described an intense restlessness or involuntary movements of the mouth and
tongue. Several patients receiving chlorpromazine developed jaundice; exploratory surgery in
one such case led to infection and critical illness. Patients also experienced potentially-fatal
immune compromise; one patient died while receiving a related drug in 1956. Psychiatrists
knew that a history of gastrointestinal ulcers should be a contraindication for treatment with
reserpine. Nevertheless, one woman whose ulcer remained undetected ultimately died after a

166 Case 1945/09: clinical record (11 May 1959); ward notes (2 July 1964).
168 Case 1945/06: clinical record (29 Feb 1956); ward notes (31 July 1965); case 1960/15b: Wilhelmina Carlyle to
169 Case 1945/06: ward notes (2 Aug 1965; 11 Dec 1965); case 1950/05: ward notes (4 Jan 1972; 23 Feb 1972).
170 Overholser et al., “Chlorpromazine and Reserpine,” 265.
171 Case 1945/06: clinical record (21 Aug 1956); Doris J. Woodward and James D. Solomon, “Fatal Agranulocytosis
Occurring during Promazine (Sparine) Therapy,” Journal of the American Medical Association 162 (1956): 1308-
1309. When physicians began monitoring patients’ blood count in the 1960s to prevent such catastrophic responses,
patients living in the community often resented having to come to the hospital to have their blood drawn on a regular
perforation. Not long after reserpine’s introduction, case reports began appearing that suggested the drug might produce depression serious enough to lead to suicide. In 1957, an influential piece appeared in the American Journal of Psychiatry warning of this risk, and physicians at St. Elizabeths appear to have stopped using the drug shortly thereafter.

Though patients expressed ambivalence about the new drugs, many of them shared the hope that psychopharmacology might represent the key to curing mental illness. The details of the hospital’s early trials remain obscure, so it is impossible to how conscientiously physicians sought informed consent from their patients. Nevertheless, some patients placed great faith in drug treatment. Dominick Bell started on chlorpromazine in 1956, but remained seriously impaired. The following year he complained that he was not improving as rapidly as he felt he should. “Often asking for a change in medicine,” noted a nurse on his ward. “Feels that he is not able to do anything at times.” By the 1960s, patients’ expectations for drug therapy had become even greater. Thomas Brady, who struggled with intense anxiety as well as his sexuality, explicitly preferred medical treatment and hoped to participate in a research study. “He appears interested in psychotherapy,” his physician wrote in 1964, “although he made it quite clear that he strongly believes that it is the drugs that will cure him.” William Clement, who had obtained a degree in chemistry prior to pursuing a career in law, remained open to both psychotherapy and drug therapy. In 1965, well before most psychiatrists in the United States seriously considered using lithium as a treatment, Clement contacted his former physician to inquire about recent reports concerning its potential. “I am concerned with … the reluctance to

172 Memorandum from Homer B. Matthews to Jay L. Hoffman, Subject: Death of patient Flora M. Lucock, who was receiving reserpine (3 March 1955), NARA RG 418: Entry 7: (Administrative Files: Serpasil); Overholser et al., “Chlorpromazine and Reserpine,” 264.  
173 Healy and Savage, “Reserpine Exhumed.”  
174 Case 1945/06: clinical record (29 Feb 1956; 26 May 1956); ward notes (21 Nov 1957).  
advice which most psychiatrists have when [the] suggestion comes from the patient,” he wrote. “After all, although I am not an M.D., I have over twenty years experience with this cyclothymic disturbance.”

Perhaps more than any other case, the experience of Claire Pemberton reveals the limits of these medications “See this bracelet? That proves I’m Scotland Yard,” she told a physician at St. Elizabeths in 1950. “I have made science with that bracelet. I am Queen Mary Elizabeth and I rule the world.” Though she remained quiet and passively cooperative, Pemberton required assistance with even the most basic tasks of self-care during her first five years at the hospital. As we have seen, however, she became far more lucid after starting chlorpromazine. “My mind is clearer [and] my memory is coming back,” she told a physician in 1958. “For some time I have not been able to remember anything.” Pemberton began attending psychodrama, educational classes, and a sewing group; soon she began going home on regular visits. Whenever she stopped taking her medications, however, she would again begin hearing voices. Even with the assistance of the new drugs, Pemberton easily became confused and relied on the hospital to structure her days. She performed poorly on vocational tests in the 1960s, but officials managed to place her in a foster home in 1968. Pemberton had difficulty navigating the public transportation system and returned to St. Elizabeths several times for support. She nevertheless enjoyed the freedom, informing her psychologist in 1972 that she “[found] being in a foster home much more enjoyable than being in the hospital.” For Pemberton, as for many others, the major tranquilizers helped control the overt manifestations of her impairment. They failed, however, to address the more deeply-rooted difficulties she experienced in thinking. While living in a highly

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176 Case 1960/22f: William Clement to David W. Harris (n.d. [~July 1965]).
177 Case 1950/05: quotations from psychiatric case study (8 Sept 1950); clinical record (26 June 1958; 7 Nov 1972).

restrictive environment for many years undoubtedly contributed to Pemberton’s dependency, her case nevertheless illustrates the equivocal gains achieved with the major tranquilizers.

CONCLUSION

Drug therapy rapidly became an integral element of care at St. Elizabeths. Within a year of chlorpromazine and reserpine’s introduction, officials modified their booklet for patients’ families to include the new drugs as one element of the treatment their loved ones might receive. By 1960, an array of psychotropic drugs had reached the market, including new medications aimed at depression as well as the minor tranquilizers for anxiety and alcohol withdrawal. Building on chlorpromazine’s success, pharmaceutical firms also introduced a variety of additional major tranquilizers. Drug treatment opened novel avenues for research, at St. Elizabeths and throughout the profession. Ultimately, the new drugs would provide the foundation for neurotransmitter-based theories of mental illness and a resurgence of biological psychiatry in the latter half of the twentieth century.

And yet, as we have seen, much transpired on the wards and in the outpatient clinics at St. Elizabeths in these years independently of the new drugs. Psychodrama, art therapy, and dance therapy created an environment that valued individual self-expression. The Elizabethan and Howard Hall Journal gave patients an opportunity to articulate publicly a new sense of shared identification. Men and women at the hospital established social relationships through group therapy that formed the basis for ward-based self-government. In the process, they learned to expect to be treated with dignity and respect by their physicians and to be taken seriously by hospital administrators. The Cold War context—of which patients remained well informed

179 Healy, Creation of Psychopharmacology; Shorter, History of Psychiatry, 255-272.
during their time at the hospital—imparted a new depth to patients’ struggles for freedom, whether freedom from the burden of mental illness or simply a greater voice in determining policies on their wards. These developments belie Erving Goffman’s characterization of life at St. Elizabeths as constituting “something less than a community.”180 Patient governments represented an unprecedented assertion by psychiatric patients of their capacity for self-determination, providing a model for future generations of mental health activism.

Drug treatment represented an important advance for many of the patients at St. Elizabeths, bringing them within the range of these expectations and interventions. Few of these men and women, however, found a cure for what ailed them in the new medications. To the extent that psychiatrists interpreted recovery solely in terms of their predecessors’ notion of institutional citizenship, the major tranquilizers proved effective indeed. This, however, would not be enough—for patients even more so than for their physicians. Without the accompanying transformation of institutional culture, it remains unlikely that the major tranquilizers alone would have reduced mental hospital populations, much less paved the way for community-based alternatives in the decades that followed.

180 Goffman, Asylums, 110.
CONCLUSION:
“WHAT IS PAST IS PROLOGUE”

In the midst of the changes transforming St. Elizabeths at midcentury, officials prepared to celebrate the hospital’s centennial in 1955. Overholser and his staff approached the task with a robust sense of history. Even as they implemented racial desegregation and began experimenting with the major tranquilizers, administrators laid the groundwork for a year-long celebration that would simultaneously highlight the institution’s achievements and place them in the context of broader developments in American mental health care. “The hospital itself seeks no undue mention of its name nor any glorification of its accomplishments,” the planning committee wrote. “Yet St. Elizabeths is eager that its centennial serve as a powerful vehicle for promoting the progress of other organizations and institutions engaged in the broad field of mental health.”

Officials hoped to use the event to advance public understanding of mental illness and call attention to the need for further investment in treatment and research. They accordingly targeted a wide variety of audiences, ranging from physicians and allied mental health professionals to politicians, policy-makers, and the courts.

Progress became a dominant theme for the centennial. Officials highlighted “[t]he heartening improvement in the institutional treatment of mental illness during the past hundred years, including the role played by St. Elizabeths Hospital in this progress.” In May of 1955, the institution hosted a professional conference that gathered eminent alumni alongside current...

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2 In order to defray expenses for the celebration, hospital officials incorporated the Centennial Commission of St. Elizabeths Hospital to solicit tax-free donations. Ultimately, they received extensive financial support from the Ford Foundation, the Smith, Kline and French Foundation, members of the Medical Society of St. Elizabeths Hospital, and many individual donors. Winfred Overholser, “Preface: A Note on the Centennial,” in Centennial Papers, ed. Centennial Commission of St. Elizabeths Hospital, vii. On the centennial generally, see the memoranda and correspondence in NARA RG 418: Entry 7 (Administrative Files: Centennial Celebration – A and Centennial Celebration – B).
leaders in the field and representatives from Washington, D.C.’s political elite. Speakers discussed the contributions to U.S. psychiatry that had emerged from St. Elizabeths, reflecting on the many advances since the institution received its first patients.\(^4\) The American Psychiatric Association devoted a special historical issue of its journal *Mental Hospitals* to the institutions celebrating their centenary that year, granting St. Elizabeths a particular place of honor.\(^5\) The committee in charge of the centennial launched a successful media campaign that led to articles in each of the local newspapers as well as leading national periodicals.\(^6\) Officials highlighted Dorothea Lynde Dix’s role in establishing the institution, pressing the U.S. Postmaster General to issue a commemorative stamp in her honor.\(^7\)

Dix also provided the inspiration for the centennial’s most successful event, a public performance written and directed by patients dramatizing the hospital matriarch’s life and work. A group of men and women working with dance therapist Marian Chace had produced a successful revue the preceding year. When the committee approached them about a performance for the centennial, the patients elected to tell the story of Dix’s upbringing and arrival at her chosen cause.\(^8\) Entitled “Cry of Humanity,” the patients’ performance received extensive coverage in the local and national press. “The patients themselves decided on the form, content,

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\(^4\) The proceedings of the meeting were published as Centennial Commission of St. Elizabeths Hospital, ed., *Centennial Papers: St. Elizabeths Hospital, 1855-1955* (Baltimore, Maryland: Waverly Press, 1956).

\(^5\) *Mental Hospitals* 6 (May 1955).


\(^7\) Olveta Culp Hobby to Arthur E. Summerfield (8 June 1954) (copy), NARA RG 418: Entry 7 (Administrative Files: Centennial Celebration – B).

and dramatic highlights,” noted the Washington Post’s drama critic.9 Whenever disagreements arose about the script or its production, the cast put the question to a vote. “From what I can glean,” the reviewer continued, “there was far less bickering and temperament than most … professional plays[.]”10 In addition to their performances for their fellow patients, the cast presented the play for local dignitaries and theater critics, attendees at the centennial’s professional conference, the APA’s annual Mental Hospitals Institute, and the public at large.11

While “Cry of Humanity” emphasized the progress that had been made in the treatment of mental illness, it also implicitly challenged existing public attitudes. The script took Dix’s memorials seriously; its most dramatic scenes depicted the wretched and inhumane treatment that psychologically-impaired men and women endured in nineteenth-century jails and almshouses. The contrast between the miserable conditions Dix described and the well-maintained campus of St. Elizabeths could not have been more stark. Patients performed both sides of these encounters, including the exaggerated stereotype of the lunatic—caged like an animal, rolling in filth, and howling in anguish. The spectacle of mental patients playing lunatics in one scene and proper Victorian ladies and gentlemen in another forced the audience to confront their assumptions about the mentally ill, their capacities, and their place in society. Less than a year after the end of formal racial segregation, the performance featured black men and women alongside their white peers, interacting on equal footing. The script also emphasized the many obstacles Dix faced as a woman seeking access to the male-dominated public sphere. Patients devoted an entire scene to her fiancée’s decision to break off their engagement rather than allow her to keep teaching; later, the Massachusetts legislature proved a hostile audience for

10 Ibid.
11 See generally the correspondence in NARA RG 418: Entry 7 (Administrative Files: Centennial Celebration – A; Centennial Celebration – B; and Dance Therapy).
her earliest petition. “She shouldn’t be allowed in here,” declared one senator. “A woman’s place is in the home,” insisted another.\(^\text{12}\)

When St. Elizabeths patients performed key scenes from the play as part of a nationally-broadcast television program later that year, the producers pressed them into the service of larger professional and corporate interests. The scenes appeared as part of NBC’s *March of Medicine* series, sponsored by the American Medical Association and Smith, Kline and French Laboratories (SK&F).\(^\text{13}\) Both organizations’ influence proved unmistakable. When the patient-narrator introduced the piece, he repeated many of the lines from the original script. “[Y]ou will learn from us,” he explained, “how mental patients used to be treated[.]” Departing from the initial performance, however, the show also highlighted “the conditions of our hospitals today, and the new hope that we have now to get well again.” The episode featured footage of an overcrowded state hospital in New Jersey, where patients, nurses, physicians, administrators, and finally the state governor called for greater public investment in treatment and research. The narrative then shifted to New York and one woman’s remarkable improvement “after the doctors gave me some medicine to help me.” In a monologue on the lawns of St. Elizabeths, Winfred Overholser repeated his claim about chlorpromazine and reserpine’s importance: “Now with the advent of these new tranquilizing drugs, it seems not too much to say that we’re on the verge of an entirely new era in the treatment of mental illness.” To be sure, patients’ decision to appear publicly without any effort to disguise their identities represented an important advance in the

\(^{12}\) The original script is available in NARA RG 418: Entry 7 (Administrative Files: Dance Therapy). My comments on the racial make-up of the cast are derived from the segments featured in “We, the Mentally Ill,” discussed below.\(^\text{13}\) “For 14 hours daily for five days,” a local journalist wrote, “[the cast] stood patiently by while the NBC crew … shot the picture.” Jay Carmody, “Mental Patients Take Their Play to Video,” *Star*, 4 May 1955 (MLK-WD Vertical Files: Hospitals, St. Elizabeths, 1950-1959). See also “Patients to Perform Medical Drama,” *Washington Post and Times Herald*, 15 May 1955, J3. The quotations that follow are from “We, the Mentally Ill,” *The March of Medicine*, NBC, 15 May 1955. An original 16 mm copy of this show is available in the Special Collections Room of the Library of the Health Sciences at St. Elizabeths Hospital; a VHS copy is available at the National Library of Medicine. For comparison see the original script in NARA RG 418: Entry 7 (Administrative Files: Dance Therapy).
battle against social prejudice. But the convergence of public education about mental illness with pharmaceutical advertising raised troubling ethical questions that would reemerge prominently in the closing decades of the twentieth century.14

From today’s perspective, the centennial committee’s emphasis on the progress achieved during the hospital’s first hundred years may appear misguided. At the Government Hospital for the Insane, as elsewhere, officials’ original vision of an intimate and intensively therapeutic environment rapidly gave way to segregative control and the most basic of custodial care. Despite his expansive vision of psychiatry, William Alanson White recognized that many of the men and women at St. Elizabeths would never leave the hospital. Subsequent generations would characterize the late nineteenth and early twentieth century as a benighted era, identifying the advent of drug treatment as the beginning of a truly scientific and enlightened psychiatry.15 The postwar period witnessed important advances and a general liberalizing trend in the institutional care of men and women with cognitive and emotional difficulties. Even then, however, many patients remained beyond the reach of these reforms. Erving Goffman sounded an important cautionary note. “I have seen mental patients from good wards give a well-advertised, public stage performance of conditions which presumably used to prevail in backward mental hospitals,” he wrote. “A few buildings away from where the audience sat, equally bad conditions could be observed in the flesh.”16

When it came time for Winfred Overholser to address the hospital’s centennial, he did so with a remarkable degree of humility. Asked to contribute an introductory essay to the special historical issue of Mental Hospitals published in 1955, Overholser entitled his piece “What is

15 See e.g. Shorter, History of Psychiatry.  
16 Goffman, Asylums, 100 fn. 173.
Past is Prologue”—a quotation lifted from Shakespeare’s The Tempest.\(^{17}\) “A Centennial is a particularly tempting occasion to regard ourselves in the context of history,” he wrote. “[W]e may be tempted to arrogance, for despite the illustrious past we have learned much in these hundred years.”\(^{18}\) Research had provided new insights into the anatomy, physiology, and pathology of the nervous system, as well as the basic psychological mechanisms underlying human behavior. The new drug therapies, electroshock, insulin treatment, and individual and group psychotherapy all represented important advances. And yet thousands of patients continued to languish in state hospitals across the country. In the community, mentally ill men and women faced persistent discrimination and hardship. “Possibly, then, our colleagues both of the past and of the future might call us to account,” Overholser mused, “for having accomplished but little during our century, despite our brave new tools.”\(^{19}\) He went on to offer some speculative predictions about what the next hundred years might hold for psychiatry. Drug treatment, he reasoned, would become an increasingly important element of psychiatry, and briefer forms of psychotherapy would likely prove essential. Overholser also foresaw a decline in the mental hospital’s importance, as outpatient clinics, day hospitalization, and psychiatric units in general hospitals replaced full-time institutional care.\(^{20}\)

While many of Overholser’s predictions proved prescient, he could not have imagined the swiftness with which they would occur. By the time he retired in 1962, many of these changes were already underway. As we have seen, a wide variety of new medications became available in the late 1950s; more drugs entered the psychiatric armamentarium in the early 1960s. The year after his retirement, Congress passed the Community Mental Health Centers

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\(^{17}\) This quotation also adorns the base of a statue in Washington, D.C. outside the NARA, where most of the historical documents associated with St. Elizabeths are held.


\(^{19}\) Ibid., 2.

\(^{20}\) Ibid.
Act, which laid the foundations for federal involvement in community-based mental health services. This legislation represented the culmination of a fifteen-year movement within psychiatry to provide alternatives to institutional care. Overholser’s successor, Dale Cameron, maintained the respect of his medical staff, but quickly earned a reputation for making discharges his top priority. From a national policy perspective, the 1965 passage of Medicare and Medicaid proved even more important than the Community Mental Health Centers Act in shifting care away from large-scale institutions. This legislation specifically discouraged psychiatric treatment in mental hospitals. As a result, state governments transferred thousands of elderly and infirm patients from psychiatric facilities to private nursing homes, thereby shifting the financial burden to the federal government.

Administrative changes in the 1960s highlighted the stark contrasts in patient care at St. Elizabeths. Psychiatrists embraced the ideals of the community mental health movement, explicitly repudiating earlier models of care. Between 1955 and 1965, the hospital population dropped by more than a thousand, despite an increase in annual admissions of about six hundred. “We used to say the society does not understand you, you don’t understand the society, we understand you, we love you, we will protect you. They got the message and became good hospital citizens,” explained physician Leon Konchegul. “Now we encourage them to return to the community.” For many of those who stayed, custodial care remained the rule. Though hospital officials opened three new buildings in the 1950s, overcrowding and

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21 Grob, *From Asylum to Community*, 157-238.
understaffing persisted. Administrators encountered increasing budgetary constraints in the 1960s; the falling patient population thus failed to resolve these problems. Officials pointed repeatedly to the burden of elderly patients who required extensive nursing care, as well as the difficulty of placing long-term patients in foster homes at District-mandated rates. NIMH director Stanley Yolles was “shocked” to learn in 1968 that nearly a third of the hospital’s patients had been there for more than fifteen years and a fifth for more than twenty-five.

Meanwhile, the gaps between the hospital’s back wards and its showpiece admissions building and research units widened. Daily per-patient costs ranged from $11.48 in the services for long-term patients to $26.50 in the receiving service and as much as $52.00 in the NIMH-administered research unit.

St. Elizabeths also became embroiled in a decades long dispute between the city government and federal officials over who ought to control the institution. While the federal government first suggested shifting the hospital to municipal control as early as 1947, little action was taken.

By the mid-1960s, District officials had begun petitioning for a more active role in its administration, particularly since they contributed $18 million of St. Elizabeths’ $29 million budget. The gaps between the hospital’s wards and its research units widened. Daily per-patient costs ranged from $11.48 in the services for long-term patients to $26.50 in the receiving service and as much as $52.00 in the NIMH-administered research unit.

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million annual budget. Given the District Health Department’s inadequacies, however, hospital administrators and mental health advocates remained wary of the city’s ambitions. In 1967, the Department of Health, Education and Welfare shifted responsibility for the hospital directly to the NIMH, who promised to transform it into a state-of-the-art community-based facility and turn it over to the District within ten years. NIMH never followed through on its promises, however, and federal officials abruptly decided to transfer the hospital to the District in 1969. This move sparked a groundswell of public opposition, which officials answered by forming yet another in a long series of committees aimed at discerning the best way forward. The federal government raised the prospect of transferring the hospital repeatedly in the 1970s, but the city, operating under the principle of home rule after 1973, became increasingly reluctant to take responsibility for an institution that had declined rapidly in prestige and administrative capacity. Between 1975 and 1979, the institution operated without certification by the Joint Commission on Hospital Accreditation. The landmark Dixon legal decision requiring St.

Elizabeths to provide care in the least restrictive environment introduced further challenges for the already overtaxed hospital administration.37

Even as the inpatient population dropped precipitously, administrative disarray began to take a toll on patient care. In the two decades after Cameron’s departure in 1967, seven different physician-administrators rotated through the office of superintendent.38 The institution managed to open a day hospital and successfully maintained a community mental health center on its grounds in cooperation with the District government. By 1970, St. Elizabeths had just 4,330 patients in the hospital, with another 2,180 receiving outpatient care.39 On many wards, however, conditions remained grim. An outbreak of a previously-unknown form of pneumonia killed fourteen patients in 1965.40 In the context of inadequate staffing, attempts to intermingle patients of varying ages and levels of impairment proved disastrous—at least six men and women died violently at the hands of other patients in the 1970s.41 Violence also struck the hospital staff, when a patient smuggled a gun into John Howard Pavilion in 1976 and killed a long-time attendant.42 Federal officials initially threatened to close St. Elizabeths in the early 1980s, but ultimately slashed its budget and forced more than 225 layoffs.43 By 1984, the hospital’s

38 These were David W. Harris (acting) (1967-68); Louis Jacobs (1968-69); Luther Robinson (acting) (1969-72), Luther Robinson (1972-75); Roger Peele (acting) (1975-77); Charles Meredith (1977-79); William H. Dobbs (acting) (1979-81); William H. Dobbs (1981-84); and William G. Prescott (1984-87).
inpatient population had declined to 1,738; many observers felt that it was beyond physical and administrative repair.\textsuperscript{44} “St. Elizabeths,” concluded the \textit{Washington Post}, “should be dismantled.”\textsuperscript{45} Federal and city officials finally came to an agreement, however, transferring control to the District’s Department of Mental Health in October of 1987.\textsuperscript{46}

Though much about St. Elizabeths’ circumstances made its experience unique, the transformation it underwent in the years following Overholser’s retirement reflected general trends in U.S. psychiatry. The rise of community psychiatry and widespread criticism of mental hospitals as inherently oppressive institutions pushed institutional practice to the margins of the profession. A vigorous legal movement centering on mental patients’ civil rights and a burgeoning rights movement among patients forced many psychiatrists to rethink their traditional paternalistic approach. The interests of civil libertarian lawyers soon converged with fiscal conservatives, who sought to scale back government spending on social welfare. All too often, a reduction in mental hospital populations became the sole index of success or failure. In the

\textsuperscript{44} St. Elizabeths Hospital Information Systems Branch, \textit{Annual Statistical Report}, 1984, 16.


\textsuperscript{46} Margaret Engel, “St. E’s Takeover Plan Assailed,” \textit{Washington Post}, 23 Nov 1985; Patrick Boyle, “St. Elizabeths Placed in District’s Charge,” \textit{Washington Times}, 2 Oct 1987 (MLK-WD Vertical Files: Hospitals, St. Elizabeths, 1982-87). Few, however, proved happy with the arrangement. Indeed, ten years later, the Department of Mental Health went into court-ordered receivership over its failure to implement community-based alternatives to inpatient treatment, only emerging from this status again in 2002. A series of violent deaths in 2004 prompted investigation by the U.S. Department of Justice, who documented serious shortcomings in care as well as widespread civil rights violations.


absence of thoughtful planning or substantive investment, community-based facilities failed to provide the necessary services for men and women suffering from serious psychological difficulties. Short-term care often took place in psychiatric wards in general hospitals, but long-term care relied on a haphazard and poorly-coordinated system of halfway houses, group homes, nursing homes, and dramatically scaled-back state institutions. When the federal government further reduced welfare benefits and affordable housing options in the 1980s, many mentally ill men and women faced homelessness. Gradually, the foundation of civil commitment shifted from *parens patriae* to the police powers of the state. Forensic units became increasingly central to those public institutions that survived; among those that did not, some became prisons.47

These changes coincided and at times intersected with a major rethinking of social relations around race, gender, and sexuality in the United States. The civil rights movement’s early focus on legal obstacles to equality made medical racism a low priority; as the movement shifted to a more identity-based politics, however, black men and women began to question the propriety of white prescriptions for mental health. The women’s movement targeted psychiatry from the outset, producing a blistering critique of psychoanalytic chauvinism. Gay men and women increasingly came to see psychiatry as an obstacle to their full inclusion in American society. The proliferation of rights discourses entered the community of psychiatric patients as well. Emboldened by their alliances with civil libertarian legal reformers, advocacy groups became increasingly vocal in their demands for a greater measure of autonomy and respect. Few accepted the limited vision of institutional citizenship that had dominated their care in the first

half of the twentieth century. Though they often differed on questions of etiology and treatment, activists agreed on the fundamental premise that psychiatric patients ought to have a greater role in their own treatment.

Ultimately, however, these debates left unresolved the question of mentally ill men and women’s place in U.S. society. Despite the advocacy community’s efforts, the structural and economic obstacles facing seriously-impaired men and women remain substantial. Negotiating complex medical and social welfare systems can be challenging under even the best of circumstances; the added burdens of mental illness can only make such tasks more difficult. For their part, psychiatrists have turned increasingly toward a narrow biomedical understanding of cognitive and emotional impairment. While biomedical perspectives hold enormous promise, they also run the risk of obscuring the social processes involved in the onset, treatment, and ultimate prognosis of mental illness. Critics have focused primarily on the attenuation of psychological thinking that has marked U.S. psychiatry in the past fifty years. As I have argued, however, mental illness is as much a social phenomenon as it is a psychic or biological entity. Individual men and women have experienced impairment in terms of their relationships with others, often in highly gendered and racialized terms. Physicians and patients alike approached the problem of recovery with prevailing social expectations in mind. By situating this fact in the context of evolving debates about the contours of U.S. national identity, we may ultimately arrive at an improved understanding of the complex relationship between mental health, mental illness, and ideals of American citizenship.
APPENDIX A:
A NOTE ON SOURCES

Most of the primary sources on which I have drawn in this work fall into one of four categories. First, the physicians and administrators at St. Elizabeths left an extensive record of their thoughts and activities in professional publications. Often this took the form of articles in such periodicals as the American Journal of Psychiatry, the Psychoanalytic Review, and the Journal of Nervous and Mental Disease. Some also produced full-length monographs, which provide important insight into psychiatry as it was conceptualized and practiced at the hospital.

Newspapers and popular magazines represent the second major category of material on which I relied. The same physicians who wrote in professional journals occasionally addressed a broader audience, whether in local newspapers or in magazines with a wider readership. District of Columbia journalists routinely reported on developments at St. Elizabeths as well, and special events often prompted coverage in the national press. I have particularly benefited from the holdings of Washington, D.C.’s Martin Luther King, Jr. Memorial Library, whose Washingtoniana Division maintains a collection of newspaper clippings on St. Elizabeths extending back to the earliest decades of the twentieth century. And while the Washington Post was not always the city’s dominant newspaper, I have nevertheless profited enormously from that paper’s decision to digitize and index all of their past issues, thereby making them accessible to researchers around the world.

Because St. Elizabeths was a federal institution for much of its history, the details of its operation have been documented in a series of Annual Reports submitted each year to the U.S. Congress. These, along with a handful of other government documents, constitute a third major category of resources on which I have drawn. The hospital’s Annual Reports are widely available at research libraries throughout the country, as evidenced by a brief search using the WorldCat
database. A full collection is available in the Special Collections Room at St. Elizabeths Hospital’s Health Sciences Library. Typically these documents also appeared as part of a comprehensive report submitted to Congress each year by the hospital’s parent agency; through 1920, St. Elizabeths’ *Annual Reports* are thus available as part of the Department of the Interior’s report in the U.S. Congressional Serial Set. I have further drawn on government documents associated with two Congressional investigations of the hospital. The first, which took place in 1906, involved lengthy public hearings whose proceedings were published in full; the second, in 1926, produced a consensus report by the investigating committee. Both the full 1906 hearings and the 1926 report are available in the U.S. Congressional Serial Set, as are all federal laws pertaining to the hospital and its operations.

Finally, I have drawn upon St. Elizabeths Hospital’s extensive archival holdings. These documents fall into three subgroups. Physicians, administrators, and patients produced several intramural publications over the course of the twentieth century. Most of the patient newspapers I have utilized—the *Sun Dial* (1917-1930), the *Elizabethan* (1941-1983?), and the *Howard Hall Journal / John Howard Journal* (1948-1969?)—can be found in the Special Collections Room at St. Elizabeths’ Health Sciences Library. The *Elizabethan Anthology*, a 1948 collection of submissions to the *Elizabethan* and *Howard Hall Journal* during their early years, is available in the general holdings of the National Library of Medicine in Bethesda, Maryland. A few isolated articles and issues can also be found throughout the hospital’s administrative holdings at the National Archives and Records Administration (NARA), in the limited collection of Winfred Overholser’s personal papers at the Library of Congress, and in the files on St. Elizabeths at the Martin Luther King, Jr. Memorial Library’s Washingtoniana Division. Additional intramural publications, including the *Bulletin of the Government Hospital for the Insane / Bulletin of St.
Elizabeths Hospital (devoted to research at the institution, 1909-1913, 1930-1931) and the St. Elizabeths Bulletin (on the theory and practice of group work, 1957-1965), can be found in the Special Collections Room at St. Elizabeths’ Health Sciences Library.

The vast majority of the surviving documents from St. Elizabeths’ past are available in Record Group 418 at the NARA in Washington, D.C. These holdings cover a period extending roughly from the hospital’s origins in the 1850s through the troubled era of deinstitutionalization in the 1960s. I have relied heavily upon the general administrative records in this collection, as well as the files on individual treatment modalities. This collection also includes the personal holdings of William Alanson White. Though some photographs and still images are included in the NARA’s holdings in Washington, D.C. (“Archives I”), most are available at their Special Media Archives Services Division at the NARA site in College Park, Maryland (“Archives II”).

The clinical records that lie at the heart of this study—and the strategies I have employed with them—require a fuller discussion. The case files of patients admitted to St. Elizabeths through 1940 are part of the NARA’s holdings in Washington, D.C. All clinical records created prior to 1900 remain intact. Unfortunately, the records of patients admitted after 1900 are only available in five-year increments (1900, 1905, 1910, etc.). With a few exceptions, records from the intervening years were destroyed not long after their transfer. In order to protect the privacy of patients and their families, the NARA has adopted a seventy-five year rule with respect to these files. This means that clinical records only become available to researchers seventy-five years after a patient was admitted to the hospital. The one exception lies in the possibility that a patient can be shown to be deceased; since the admission logs are subject to the same rule, however, this would require a preexisting knowledge that the individual in question was admitted in one of the years for which records remain available.
For the first half this study, I collected a sample of clinical records representing 2.5% of all admissions to St. Elizabeths in 1900, 1905, 1910, 1915, 1920, 1925, and 1930. Each patient entering the hospital received a sequentially-assigned identification number; those who were discharged but subsequently returned received a new number. By identifying the first and last number assigned via the hospital admission logs, I was able to determine how many admissions occurred in a given year. I then used an online number generator to select a random sample of patients within the range of numbers assigned for that year. Most, but not all, of the files corresponding to these numbers were in place; it is not clear why some had been removed. (The approximate percentages of files available in each year were as follows: 1900 – 92%; 1905 – 96%; 1910 – 96%; 1915 – 100%; 1920 – 96%; 1925 – 100%; 1930 – 80%.) I continued to pull randomly-selected cases until I had collected 2.5% of all admissions for each year, giving me a total of 135 patients. While some of these men and women had previously been patients at the hospital or would return in later years, the incompleteness of the NARA collection prevented me from following most of these leads. One patient admitted in 1910, however, was readmitted in 1920, and I have elected to include his second admission in my qualitative analysis as well. Finally, clinical records from 1900 were inadvertently oversampled during the initial stages of data collection, so my qualitative analysis reflects an additional eight cases from that year, giving me a total of 143 unique patients with 144 separate admissions between 1900 and 1930. Though these records remain publicly available, I have elected to employ pseudonyms in each case that preserve the first letter of each individual’s given name and surname. Whenever possible, I have attempted to preserve the cultural tenor of each patient’s name, relying on internet web sites devoted to names from a variety of ethnic backgrounds. My citations in each case identify the patient by the original medical record number.
The records of patients admitted after 1940 remain under the administrative authority of St. Elizabeths Hospital. While most of these records are stored at the Washington National Records Center (WNRC) in Suitland, Maryland, some—generally those from patients who continued to reside at St. Elizabeths well into the 1990s—remain in the hospital’s Medical Records Division on its main campus. These documents have not been processed for archival holding and are not open to the public. After studying the laws governing human subjects research and access to protected health information, however, and through close cooperation with the institutional review boards at the University of Illinois at Urbana-Champaign and St. Elizabeths Hospital, I developed a methodology that allowed me to employ these documents for historical scholarship—a topic to which I will return in a moment.

My sampling technique for clinical records from post-World War II period was similar to the technique I employed with the NARA holdings. Because the number of new patients each year rose dramatically at midcentury, however, I limited my sample to 1.25% of admissions to St. Elizabeths in 1945, 1950, 1955, and 1960. Not all of the files selected in this manner were present. (The approximate percentages of files available in each year were as follows: 1945 – 92%; 1950 – 91%; 1955 – 68%; 1960 – 86%.) As I did at NARA, I continued to pull randomly-selected cases until I had collected 1.25% of the admissions for each year. Many of these men and women were admitted to St. Elizabeths more than once. Because the WNRC collection remained fully intact, I was able to follow these patients backward and forward in time through multiple admissions, though the daily progress notes written by nurses and ward attendants were often missing from the files associated with all admissions except the final one. Ultimately, this gave me a total of 105 patients with 158 separate admissions; most of these admissions occurred
between 1945 and 1960, but some extended back to the early decades of the twentieth century or forward to the 1960s and 1970s.

Protecting the privacy of the men and women identified in these clinical records became a top priority. During the course of my work, I acted in two distinct capacities. First, with the approval of the institutional review boards at the University of Illinois at Urbana-Champaign and at St. Elizabeths Hospital, I created a *limited data set* by scanning patient records and using image editing software to remove direct identifiers as defined by 45 CFR § 164.514(e). This meant removing patients’ names, addresses, social security numbers, and medical record numbers from the images as they were scanned. Second, I collected and analyzed these deidentified documents in a manner identical to that employed with the documents at the NARA. Where individual cases have proven so remarkable as to attract local or national media attention, I have altered inessential details in my narrative in a manner that preserves the interpretive point but allows me to obscure the identity of the individual. While the pseudonyms I employ bear no relation to the patients’ actual names, I have again attempted to preserve the ethnic cast whenever possible. By deidentifying these records, I have unfortunately made it impossible for future scholars to track down the original documents in my citations and verify my claims. This, I believe, represents an acceptable price for gaining access to such a rich trove of material, and maintaining patient privacy must ultimately take priority over academic conventions of this sort.
APPENDIX B:
HISTORIOGRAPHIC ESSAY

Few fields in the history of medicine have seen as much ferment over the course of recent generation as the history of psychiatry. This activity stems from a variety of sources, including contemporaneous policy debates on the care of the mentally ill, cultural criticism surrounding what has been termed the “therapeutic liberal state,” feminist critiques of medical paternalism, and the emergence of patient activism. More generally, much of this research derives from a critical engagement among intellectuals with problems of power and institutional authority, a project that took on new urgency during the 1960s and 1970s. The resulting literature spans disciplinary boundaries, and in many instances represents an admirable fusion of historical methods with the insights of the social and behavioral sciences. The outcome has been a remarkably rich but also highly polemical body of work on the origins and social function of the psychiatric profession and on the nature of mental illness itself.

The earliest generation of scholars in this critical reexamination of the past argued that madness represented a basic challenge to the social order. Psychiatry, these critics maintained, was an essentially conservative enterprise designed to promote stability and reaffirm the status quo—in short, an instrument of social control. Though sociologists originally coined the term to describe a variety of formal and informal mechanisms intended to minimize conflict and promote harmony, later authors used social control to signify punitive responses to deviance and the enforcement of social conformity.\(^1\) Institutional innovations that had previously been regarded as

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part of the march of human progress come under new scrutiny, with critics calling attention to
the ways in which reforms reflected the biases and interests of the reformers themselves.²

Often these arguments emerged from the class politics of Marxist thought. In his account
of British developments, Andrew Scull has argued that modern psychiatry’s origins lie with the
asylum, which first appeared when local social welfare responses to dependency broke down
under the pressure of growing national and international markets. Early institutions contained a
promiscuous admixture of destitute, debilitated, and deranged men and women. Psychiatry
established itself in part by answering the need for separate facilities to hold those who were
incapable of adhering to the highly-structured daily regimen of the workhouse. These “mad-
doctors” exploited a shift in moral consciousness attendant upon the rise of industrial capitalism,
in which human intervention came to be seen as capable of restoring men and women to the
bourgeois ideal of rationality and the capacity for productive labor. Psychiatry, in this account,
represents an indirect instrument of state control, with the state conceived largely in classical
Marxist fashion as the organized interests of the bourgeoisie.³

Others have similarly emphasized the conservatism of the asylum movement. David
Rothman has identified a widely-shared sense of crisis among Jacksonian Americans centering
on the perceived breakdown of a traditional deferential order. Everywhere they looked, Rothman
argues, Americans saw rising rates of dependency, crime, and insanity, and they feared for the

² Some of the classical social control accounts include Frances Fox Piven and Richard A. Cloward, *Regulating the
School Reform: Educational Innovation in Mid-Nineteenth Century Massachusetts* (Cambridge, Massachusetts:
Harvard University Press, 1969); Anthony M. Platt, *The Child Savers: The Invention of Delinquency* (Chicago,

³ For a good overview of Scull’s perspective, see his *Most Solitary of Afflictions*, 1-45. This is a revised and
substantially expanded version of his earlier *Museums of Madness*. See also Stanley Cohen and Andrew Scull,
“Introduction: Social Control in History and Sociology,” in *Social Control and the State: Historical and
Comparative Essays*, ed. Cohen and Scull (Oxford: Martin Robertson, 1983), 1-14; Scull, *Social Order/Mental
Disorder*; Scull, “Psychiatry and Social Control in the Nineteenth and Twentieth Centuries,” *History of Psychiatry* 2
(1991): 149-169. For a comparative account based on many of the same premises, see Klaus Döerner, *Madmen and
the Bourgeoisie: A Social History of Insanity and Psychiatry*, trans. Joachim Neugroschel and Jean Steinberg
future of the young republic. They responded by turning to institutional solutions of all sorts, including almshouses, prisons, and children’s homes as well as asylums for the mentally ill. In addition to rehabilitating men and women who had fallen into crime and dependency, these institutions were intended—through their emphasis on punctuality and steady labor—to serve as a model for how society ought to be organized. The link to class interest and the exigencies of capitalism is less direct for Rothman than for Scull. Yet both agree on the willful blindness of medical reformers to the limitations of their vision, holding them partially accountable for the subsequent deterioration of asylums into custodial and repressive institutions.

These accounts have been subject to sustained criticism from Gerald Grob, a historian of mental health and social welfare policy who has simultaneously taken asylum physicians’ stated ambitions seriously and questioned the extent to which their vision was ever fully realized. Grob agrees that the asylum originated largely as a social welfare institution. Urbanization and the rise of the wage labor system, he argues, transformed family structure in a manner that made it impossible for men and women to continue caring for dependent members within the home. According to Grob, the asylum emerged as much from a religiously-inspired faith in the possibility of social uplift as it did from fears of social disorder. Changing views about philanthropy and the responsibilities of state government led officials to establish large-scale public institutions. Soon, severely and persistently ill patients who did not respond to the therapeutic regimen began to accumulate in these facilities, as did patients suffering from dementias associated with disease and the complications of aging. Grob acknowledges that

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legislative parsimony caused conditions to deteriorate rapidly and that treatment was often
governed by social prejudice. Nevertheless, in assessing the overall failure of mental hospitals to
live up to their stated objectives, Grob concludes that “the most impressive fact is the relative
absence of malevolence, or for that matter, consistency of behavior.”5

By examining the operation of individual institutions in detail, others have similarly
complicated the portrait offered by proponents of the social control thesis. In her study of the
Pennsylvania Hospital in Philadelphia during the nineteenth century, Nancy Tomes has shown
that the vast majority of patients brought to the hospital were committed by members of their
own families rather than agents of the state. The Pennsylvania Hospital was a private hospital,
and it is unlikely that these relatively well-off patients would have been viewed as part of the
“dangerous classes.” In her discussion of the correspondence between patients’ families and
Thomas Story Kirkbride, the asylum’s superintendent from 1840 to 1883, Tomes recreates
something of the desperation engendered by an encounter with what many considered a grave
and shameful affliction.6 Ellen Dwyer has reached similar conclusions in her comparative
account of the Utica and Willard Asylums in nineteenth-century New York. Public mental

5 Grob, “Rediscovering Asylums,” 153. See also his Mental Institutions in America; Mental Illness and American Society; From Asylum to Community. For Grob’s explicit engagement with the social control debate, see the essay cited above as well as his “Reflections on the History of Social Policy in America”; “Marxian Analysis and Mental Illness.” While social control theorists have characterized Grob as an apologist, their criticisms have not generally been convincing. Andrew Scull, “Humanitarianism or Control? Some Observations on the Historiography of Anglo-American Psychiatry,” in Social Order/Mental Disorder, 31-53; Scull, Most Solitary of Afflictions, 38-42; Rothman, “Introduction to the 1990 Edition,” xxvi n. 19, xxxv. More telling is Michael MacDonald’s observation that Grob insists so heavily on the complexity and particularity of historical developments that he fails to offer a compelling interpretive vision of his own. Michael MacDonald, “Madness and Healing in Nineteenth-Century America,” review of A Generous Confidence, by Nancy Tomes, Reviews in American History 13 (1985): 212.

hospitals, she argues, served as an option of last resort for families exhausted by the unpredictable and occasionally violent behavior of one of their members. Patients were generally poor, but for many their poverty was a recent product of illness rather than a life-long condition. Public mental hospitals thus served a variety of classes, a reality at odds with social control theorists’ image of them as instruments of repression directed against the poor. While internal conditions were sometimes dismal, Dwyer concludes that the medical and social functions these institutions served cannot easily be disentangled.7

Their tendency to reduce asylum medicine to an embodiment of state authority notwithstanding, proponents of the social control thesis have nevertheless made an important contribution to our understanding of psychiatry’s historical role. First and foremost, they have reoriented the literature away from the often self-serving accounts written by physicians that once dominated the field. These narratives tended to identify all medical reforms with a spirit of benevolent humanism and interpreted the past in terms that reinforced the current position of the psychiatric profession. Historical ideas and practices thus became either the product of ignorance and superstition or prophetic antecedents of latter-day approaches to mental illness.8 Even non-clinician historians tended to take physicians at their word on institutional psychiatry’s origins.


In his classic *The Mentally Ill in America* (1937), the journalist and reformer Albert Deutsch did not hesitate to call attention to the miserable conditions in many late nineteenth-century state hospitals. Rather than condemn institutional care altogether, however, Deutsch pressed for increased funding and better public understanding of mental illness.⁹ Social control theorists have taken a more critical approach, highlighting those episodes in which physicians acted in accordance with their own professional aspirations rather than the interests of their patients. Though they have not always succeeded in linking such motivations to broader social forces, social control theorists have nevertheless succeeded in placing psychiatry in its proper social context.¹⁰

Social control theorists have also challenged us to rethink the basis of the psychiatric profession’s normative power, particularly in view of the massive inequalities that marked the society from which it emerged. Many of these writers were influenced by the injunctions of the “new social history,” which made the operation of power in the lives of ordinary working men and women a legitimate topic of scholarly inquiry.¹¹ The asylum’s emphasis on discipline,

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punctuality, and steady labor reflected the cultural aspirations of a particular segment of society, and were sometimes at odds with the traditions of the laboring classes. While the focus of social control theorists has traditionally been on interaction across class lines, similar concerns in the development of women’s history opened the field to analyses of gender inequality and medicine’s tendency to naturalize restrictive sex roles. Any such analysis must recognize that the imposition of authority was neither total nor complete; the process by which norms were negotiated and redeployed in local contexts is itself a valid field of inquiry. Nevertheless, understanding the links between psychiatry and social hierarchies remains an important task. This is particularly true for the twentieth century, when psychiatry moved beyond the walls of the asylum and achieved a remarkable and largely invisible degree of influence in all aspects of our lives.

Critics of psychiatry have also challenged our assumptions about mental illness as a category, calling attention to the inadequacy of diagnostic labels as descriptions of complex social, psychological, and cultural realities. In its initial stages during the 1960s, this literature spoke to policy debates on deinstitutionalization and the proper locus of care, highlighting the

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traditional mental hospital’s many flaws. Though their basic premises differed in fundamental respects, the radical psychiatrists R. D. Laing and Thomas Szasz each offered far-reaching critiques of the asylum and the biomedical approach to insanity. Drawing from existential theory as well as the prevailing counterculture, Laing characterized psychosis as an “inner journey” from which a patient might ultimately emerge with a stronger and more authentic sense of self. Laing felt that the psychiatrist should merely adopt a facilitative role in this process, favoring anarchic therapeutic communities over the customary regimentation of the mental hospital.\textsuperscript{14}

Szasz, too, mistrusted large institutions, and viewed involuntary commitment as a grave violation of civil liberties. Mental disorders, he insisted, did not meet the criteria by which we conventionally define disease. As applied to social conduct, the language of illness undermines our moral autonomy, circumscribing our freedoms and inappropriately limiting the responsibilities that flow from them.\textsuperscript{15}

Sociologists proved less interested in challenging the validity of mental illness than in calling attention to its embeddedness in a network of social processes. Both the act of diagnosis and the consequences that followed, they maintained, could be analyzed productively without reference to psychological or cognitive impairment. Erving Goffman developed his famous account of the asylum as a total institution on the basis of fieldwork conducted at St. Elizabeths in the 1950s. The hospital’s daily routine, he noted, deliberately encompassed all aspects of a


patient’s social existence. In the process, the hospital denied the men and women who resided there any opportunity to cultivate or even maintain their premorbid identities. Much of the alienation on display could thus be explained as a response to the institutional environment. Thomas Scheff drew from similar fieldwork in the California state hospital system to arrive at what became known as the labeling theory of madness. Given the high prevalence of superficially abnormal behaviors in any society, Scheff suggested, mental illness is best understood as a social role adopted by individual patients only after they have been diagnosed. The series of interpersonal and institutional contingencies initiated by the diagnostic act effectively stabilizes a person’s behavior in ways that reflect cultural expectations of what it means to be mentally ill. Scheff professed agnosticism on the role of intrapsychic factors, cautioning that his analysis should be read primarily as a corrective to accounts which inappropriately neglected social causation. Nevertheless, his and Goffman’s work represented a serious challenge to traditional medical perspectives on mental illness.

Subsequent studies often centered on the extent to which mental illness is “socially constructed,” a term whose seeming omnipresence signaled both its widespread applicability and the varying ways in which it was understood. At times, these debates have merely recapitulated long-standing arguments about the epistemic and ontological status of disease, the nature of the relationship between illness and health, and the distinguishing features of mental as opposed to

16 Goffman, *Asylums.* This was Goffman’s most popular and influential work outside sociological circles. As William Gronfein has observed, however, it is the only one of his major studies to emphasize institutional rather than interpersonal influences on the self. Goffman later came to address symptoms in their own right as a factor shaping social responses to mental illness and displayed greater sensitivity to their impact after witnessing the ravages of mental illness in a family member. Goffman, “The Insanity of Place”; Gronfein, “Sundered Selves”; Gronfein, “Goffman’s *Asylums.*” For incidental perspectives on Goffman’s time at St. Elizabeths, see the correspondence in NARA RG 418 Entry 7 (Administrative Files: Russell Sage Foundation). For an interesting follow-up study, see Peele et al., “*Asylums Revisited.*”

physical disorders. Yet important insights have also emerged from these discussions. Some observers have criticized the psychiatric profession for inadequately addressing social processes as a factor in the onset of mental illness, suggesting that psychological distress may be the result of social alienation and structural inequalities rather than early childhood experience or biochemical imbalances. This line of reasoning has proven especially productive for analyses along class and gender lines, which have tended to adopt a strategy of normalizing redescription in which seemingly irrational behaviors are shown to make sense in local context. Others have shown how psychiatrists employ the neutral language of medical science to obscure the role that value judgments play in diagnosis and treatment, thereby forestalling criticisms that they might be acting in their own interest or that some interventions might actually make the patient worse.


At the heart of the social constructionist argument is the claim that our present understanding of mental illness is not inevitable.\textsuperscript{20} The very idea of madness as a form of illness, for instance, is a product of historical and political developments beginning in the eighteenth century.\textsuperscript{21} As both lived experience and a category of understanding, mental illness is embedded in a complex social matrix. What counts as disordered behavior, impaired reasoning, and loss of touch with reality varies widely according to cultural standards. Most authors now agree that severe mental impairment has been recognized as a distinctive form of experience across cultures and historical epochs; even the most ardent critics do not deny the reality of patients’ suffering or the existence of apparently inscrutable forms of conduct.\textsuperscript{22} But the texture and particularities of these experiences are deeply context-specific, as are the meanings that we attribute to them. In addition to these relatively stable forms of impairment, a variety of psychic and behavioral states have also been described which quite literally do not seem to exist outside of their cultural and historical contexts. The most recent edition of the American Psychiatric Association’s 

\textit{Diagnostic and Statistical Manual} describes these conditions as “culture-bound syndromes.” It is significant, however, that most of the disorders in this section occur in non-Western societies, while Western mental ailments are assumed to be universal.\textsuperscript{23}

\textsuperscript{20} My account of social constructionism is indebted to Ian Hacking’s lucid exposition in \textit{The Social Construction of What?}, chs. 1-4.

\textsuperscript{21} See, e.g., the multiplicity of competing perspectives outlined in H. C. Erik Midelfort, \textit{A History of Madness in Sixteenth-Century Germany} (Palo Alto, California: Stanford University Press, 2000) and Michael MacDonald, \textit{Mystical Bedlam: Madness, Anxiety and Healing in Seventeenth-Century England} (Cambridge: Cambridge University Press, 1981). Because my project takes place in the twentieth century, I have chosen to speak for the most part of \textit{mental illness} rather than \textit{insanity}, \textit{madness}, or \textit{lunacy}. Where it is appropriate, however, I distinguish between the language of patients and clinicians, especially when patients employed such terms as \textit{nervous} or \textit{exhausted} rather than \textit{mentally ill} to describe their state.


Perhaps the most important contribution made by proponents of the social constructionist thesis has been their success in calling attention to the ways in which power relations influence our understanding of mental disorders. Historians and social scientists have highlighted the complex political processes involved in the creation of diagnostic categories. At times this has occurred in the context of arcane debates internal to the psychiatric universe, motivated by conflicting agendas for the profession and status within the medical community. In more than one instance, diagnostic categories have caught on because they allowed physicians to address new problems and expand their professional domain, or because they legitimated emerging therapeutic modalities which psychiatrists viewed as shoring up their medical credentials. More importantly, the social process involved in the construction and deconstruction of a diagnosis can be an element of larger social debates. The boundaries of these debates are limited only by the prevailing political culture; often they center on such highly-charged topics as sexual morality, gender roles, and personal responsibility. In each case, critics remind us that psychiatric diagnoses are more than an unproblematic description of disease.24

I have, up to this point, deliberately avoided any statement on the contributions of the eminent philosopher of the human sciences Michel Foucault. This should not be read to signify Foucault’s lack of importance for these debates; rather, his contributions have been so extensive

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and varied that they often defy the categorizations I have employed thus far. In his enormously influential *Madness and Civilization* (1965), Foucault suggested that our understanding of madness has changed profoundly over the course of the modern era. In the initial acts of confinement that took place during the seventeenth century, Foucault argued, madness was denied its former place alongside reason. At the same time, it became associated with a new sort of moral transgression linked to idleness and the madman’s failure to conform to the ideals of the rising bourgeois order. When the madman achieved partial reintegration into society during the eighteenth century, it was only to the extent that he was to be held accountable for the transgression that his condition represented. Where most authors hailed such figures as Philippe Pinel and William Tuke as models of enlightened humanism, Foucault turned the narrative on its head and emphasized the coercive elements involved in their model of care. He agreed that Pinel and Tuke represented the inauguration of a new tradition—one that reached its culmination in Freudian psychoanalysis at the turn of the twentieth century—but he viewed the end result of this tradition as “the ultimate form of alienation in our society[,] … the constitution of the individual subject as the locus of pathology.”

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25 As Andrew Scull noted in 1989, “most of the best work in the field for the past fifteen or twenty years can be seen as responding, at least in part, to the intellectual challenges [Foucault] threw down.” Scull, *Social Order/Mental Disorder*, 13.


Foucault’s account has been viewed in terms of both social control and social construction, but neither concept accurately captures the nuances of his work. Historians reading Foucault in terms of social control have tended to criticize him for his casual use of evidence. Roy Porter has taken him to task for drawing unwarranted generalizations on the basis of the French experience, and H. C. Erik Midelfort has criticized Foucault’s willingness to conflate literary imagery and empirical facts in the service of an argument. Social constructionist readings have tended to focus on Foucault’s romantic account of the madman in the Middle Ages and on the liberation of creative energies Foucault sees in the madness of such figures as Van Gogh, Artaud, and Nietzsche. Both of these readings fail to consider the subsequent development of Foucault’s thought, particularly his evolving views on the relationship between knowledge and the exercise of power. Foucault’s later efforts moved beyond the asylum to address the ways in which psychiatry creates the very categories through which we comprehend our experience. In a series of essays and monographs in the 1970s, Foucault famously introduced a new understanding of power, characterizing its operation as *disciplinary* rather than *juridical* in modern Western societies. Foucault distanced himself from theorists of state power whose chief concern lay with conventional forms of repression. Rather than framing his critique in Marxist terms of false consciousness, Foucault sought to provide an analysis of the “microphysics of power” and its operation through norms of behavior and modes of self-understanding promulgated by the human sciences.

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While my understanding of psychiatric power might be characterized as Foucauldian in the broadest sense, I depart from his framework in several respects. Many of the most important insights of the past generation of scholarship can be discerned in Foucault’s dense and philosophically-sophisticated prose. He recognized that any discussion of madness must be historically-situated, and that “mental illness” is a relatively recent invention. Foucault also called our attention to psychiatry’s involvement in the definition of the normal as well as the pathological, a line of argument indebted to the work of his mentor Georges Canguilhem.30 Foucault’s flexible and diffuse conceptualization of power has proven extremely useful for my analysis of the operation of psychiatric norms in the lives of ordinary men and women. Despite his observation that, in the modern era, “virtue, too, is an affair of state,” Foucault remained reluctant to link his criticism to conventional analyses of political and civic affairs.31 By framing my argument in terms of citizenship, I use Foucault’s notion of power to argue that we can, in fact, theorize the relationship between self-government, professional knowledge, and the nation-state without viewing psychiatry simply as an instrument of repression. My thinking on this point is indebted to the work of the sociologist Nikolas Rose, who has argued that psychiatric authority

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30 Canguilhem, The Normal and the Pathological.
31 Foucault, Madness and Civilization, 61.
represents a transformation rather than an extension of state power in modern liberal democracies.\(^{32}\)

More importantly, I depart from Foucault in placing the encounter with mental illness at the center of my analysis. Foucault’s interest in the “experience” of madness remained limited to the cultural frameworks through which it was articulated over time, and never extended to the struggles of ordinary men and women with a condition that they and their families often regarded as shameful, foreign, and terrifying.\(^{33}\) Though the boundaries of psychiatric thinking expanded remarkably during the twentieth century, serious and persistent mental illness continued to provide the conceptual anchor for the profession’s social and cultural authority. For most Americans, the continuum model of mental health and illness meant that fears of losing one’s mind always lurked in the background of discussions centering social maladjustment or unconscious drives and impulses. My position does not entail an uncritical acceptance of psychiatric concepts; both the symptoms physicians recognized and the ideals of mental health they promoted were shaped by their understanding of American citizenship. But it does mandate that we take physicians, patients, and their families seriously when they used the language of illness, impairment, and disability to describe these states.\(^{34}\)


\(^{34}\) A shared language of illness might seem to confirm Foucault’s argument on the impossibility of escaping dominant discursive formations. Nevertheless, I remain less than fully convinced of the totalizing nature of these formations. While it differs in important respects from Foucault’s notion of power, Antonio Gramsci’s concept of hegemony might provide an alternative model for understanding psychiatry’s cultural role. Antonio Gramsci, *Selections from the Prison Notebooks*, ed. Quintin Hoare and Geoffrey Nowell Smith (New York: International
By doing so, it is possible to give a richer account of the history of mental illness than previous studies have been able to provide. While historians of other medical fields have produced admirable patient-centered accounts of illness, suffering, and healthcare, we have seen surprisingly little of this work in the historiography of psychiatry.\(^{35}\) If clinical concerns dominated the field, we might explain this in terms of psychiatrists’ tendency to interpret their patients’ words as “speech productions,” devoid of meaning and relevant only as a component of the total symptomological portrait.\(^{36}\) But this is no longer the case. To the extent that historians have focused on the words of mentally ill men and women, they have tended to emphasize the perspective of those who challenged medical authority and questioned their diagnoses. This is important work, particularly for the attention it has called to the role patients played in negotiating the terms of their own care. Yet we must not allow the cultural malleability of mental illness to obscure the reality of patients’ suffering; nor should we allow contemporary historiographic concerns dictate the idiom through which mentally ill men and women are allowed to speak.\(^{37}\) Historical documents such as patient records and institutional newspapers do not, of course, give us unmediated access to the inner world of madness. When approached


\(^{36}\) Roy Porter makes this point in his *A Social History of Madness: The World Through the Eyes of the Insane* (London: Weidenfeld and Nicolson, 1987). Porter’s work is admirable in many respects, but his sources are drawn overwhelmingly from the most articulate—and hence most economically advantaged—strata of society.

critically, however, they can nevertheless provide insight into what psychiatric patients thought about their illnesses, their treatment, and the world in which they lived.\textsuperscript{38}

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