

**Personal Tragedies: Mental Illness,
Deinstitutionalization, and Homelessness**

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Introduction

Every book has a starting point, the moment where the author finds himself saying, “This could be an interesting story to tell.” Sometimes, if the issue is critical enough, you say, “This is a story that *must* be told.” It may be five years or ten years, or even forty years from when you have that “Aha” moment to the day that you start researching it, but for this book, that moment was in 1977. I was not ready to write this book then—but I knew that something was terribly, terribly wrong, and something needed to be done. I just didn’t know what.

I had gone looking for my older brother in a seedy hotel in downtown Los Angeles—what most people then would have called a flophouse. In 1900, this was probably a first class hotel. As I walked through the halls, the smell of urine was nauseating. Sitting in the lobby, a group of men from their 20s to their 60s passively sat in front of a television; most were smoking cigarettes. They had nowhere to go, and no reason to go anywhere, either. As the month progressed, many of these men—and a few women—would run out of money and would be out on the street. As depressing as this rundown hotel was, it was better than sleeping on park benches, or hoping to find one of the beds at the Salvation Army, or another rescue mission. Shortly after the first of the month, when Social Security Disability checks arrived at General Delivery in the nearest post office, they would again be solvent, and back in a flophouse.

As a billboard for the Boise Rescue Mission says, “Not a bum—but someone’s grandfather.” True, but the full story is a bit more complicated than that. Except during the Depression, when many men (and some women) rode the rails, looking for work,¹

¹ Tom H. Watkins, *The Hungry Years: A Narrative History of the Great Depression in America* (New

American society saw “bums” or “hoboes” as lazy, or morally weak, because it was easier to focus on those problems, instead of learning how these people had ended up where they were. These homeless people—largely, but not exclusively men—were usually homeless because they were mentally ill. Often alcoholism or drug abuse aggravated their mental illness.

Occasionally, popular songs or movies romanticized them as “free spirits,” unwilling to be tied down to conventional stability. Think of Roger Miller’s 1960s hit “King of the Road”:

Third boxcar, midnight train
Destination...Bangor, Maine.
Old worn out clothes and shoes,
I don't pay no union dues,
I smoke old stogies I have found
Short, but not too big around
I'm a man of means by no means
King of the road.

Further romanticizing these “free spirits” was the counterculture of the 1960s, idolized in the movie *Easy Rider*. But unlike a generation who had the option of living free of conventional job and living arrangements—but who settled down to fairly conventional lives in the 1970s—these homeless people had no choice.

In the 1980s, the homeless were reimagined again, not as lazy, and not as free spirits, but as victims of the heartlessness of capitalism, and specifically Reaganomics, as liberals castigated President Reagan’s supply side tax cut policies. Only reluctantly did the activists who demanded that the government do more for the homeless admit that mental illness was widespread in this group—and even then, there was a strange causal inversion, claiming that homelessness caused mental illness—not the other way around. Although prolonged homelessness may aggravate existing or latent mental illness problems, the mental illness usually comes first.

York: Macmillan, 2000), 68-72.

Alcohol and drug abuse are not the only layers of complexity on top of mental illness. Sometimes mental illness leads to criminal behavior. In the late 1990s, a rather strange character showed up at the church we attended in Rohnert Park, California. Jim had been sleeping in the fields on the edge of town with his dog, getting around by bicycle with a little trailer for the pooch. He carried an impressive wad of cash, the fruits of a \$600 a month Social Security disability check—and no rent to pay. Our pastor had worked in a homeless shelter, but this man did not quite fit the mold, so he asked me to talk to Jim.

Jim told a story of governmental oppression that for the first few minutes, while far-fetched, was not utterly impossible. His kids had been taken from him. His wife was locked up in a mental hospital. It was all a vast conspiracy! The more we talked, however, the more apparent it was that his thought processes, while not completely chaotic, were scattered and confused. Then he showed me the paperwork that had taken away his children. Jim was so confused that he did not realize what it showed.

Jim's wife had been committed to a mental hospital, apparently because she had physically abused their children, and been found not guilty by reason of insanity. After her hospitalization, Jim had been showing pornographic films to his five year old and his three year old, then molesting them. Jim's parental rights had been permanently terminated by court order. Why didn't the district attorney prosecute Jim? The documents provided no information, but my guess is that the prosecutor realized that a trial would require two small children to testify about sexual abuse by their father—having already lost their mother to mental illness. Under the best of conditions, this would have been a hard case to win in court, and it would certainly have been traumatic for the children.

In 1950, Jim's mental illness would very likely have led to a commitment to a state mental hospital for the criminally insane. A judge would certainly have committed Jim

based on the testimony of a psychiatrist, and the evidence of even a few minutes of conversation. Not today. Instead, Jim wandered the streets, telling his tale of woe. The best that we could hope for is that his mentally disordered thinking would be obvious enough to prevent anyone from putting their children at risk from Jim.

For those of us who came of age in the 1970s, one of the most shocking aspects of the 1980s and 1990s was the rise of “spree killers”: people who went into shopping malls, churches, schools, and restaurants, and murdered complete strangers, often ending in suicide. What was shocking when James Huberty did it in a McDonald’s in San Ysidro, California, in 1984—no longer surprises us. Almost without exception, these spree killers had histories of mental illness, and most had already come to the attention of the criminal justice or mental health systems before they became headlines. For a while, it was fashionable to blame Prozac, or gun availability for this ugly change in American life—and there were some bizarre conspiracy theories as well, involving government mind control experiments and chemicals released from jets (“ChemTrails”).

The encounter with Jim was not the reason for this book. Nor were the mentally ill spree killers. Had it not been for my brother, I might well have scratched my head at these seemingly isolated events and looked for meaning in the popular theories of the time. If not for my brother Ronald, I suspect that I would be just as perplexed by homelessness, and the ugly degradation of urban life that became so common in the 1980s.

As an adult, I met others who were mentally ill, but inevitably, these contacts were fleeting. For these other sufferers, I had less information from which to draw conclusions. Without my brother's suffering—and the shadows it cast in the lives of my parents and siblings—I rather doubt that I would ever have seen the patterns that have caused me to research this problem.

My brother put a face on this tragedy—that of someone whom I had grown up admiring and loving, who taught me to read, who took me on my first plane flight. He was part of the first generation to suffer a psychotic breakdown in the era of deinstitutionalization—the conscious decision that the severely mentally ill, with a few exceptions, would not be hospitalized against their will.

1. My Brother Ron's Breakdown

My brother had always been a bit different. He was really smart—certainly smarter than me. But like some very smart people, he was quite introverted. From what we now know (or think we know) about the possible causes, he may have had a genetic predisposition towards schizophrenia.¹ While genetics may predispose some towards schizophrenia, it is not the only factor. If one identical twin has schizophrenia, there is a 48% chance that the other twin will have it as well—and a child of two schizophrenic parents has a 46% chance of developing schizophrenia—which also means that a majority of those with genetics working against them will *not* come down with the disease. Other environmental factors almost certainly play some part.²

We had worried a bit about Ron when his draft notice came in 1966—but when the Army saw his intelligence test results, they gave him a rather remarkable opportunity: an honorable discharge the day after they drafted him, conditional on volunteering. As a draftee, he would almost certainly have gone to Vietnam. As a volunteer, the recruiter could guarantee him a chance to go for training as an electronic technician—and Ron made that choice. While many other young men were dying and suffering in the jungles of Southeast Asia, Ron went to Redstone Arsenal in Huntsville, Alabama. After completing electronics technician school at the top of his class, instead of shipping out to Germany, where he would have been repairing Nike-Hercules fire control computers,

¹ L.M. Brzustowicz, K.A. Hodgkinson, E.W. Chow, W.G. Honer, A.S. Bassett, "Location of a major susceptibility locus for familial schizophrenia on chromosome 1q21-q22," *Science* [April 28, 2000] 288(5466):678-82, abstract available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=20247438&dopt=Citation, last accessed August 16, 2006.

² Irwin G. Sarason and Barbara R. Sarason, *Abnormal Psychology: The Problem of Maladaptive Behavior*, 10th ed. (Upper Saddle River, N.J.: Prentice-Hall, 2002), 359-69.

they made him an instructor at the school he had just completed.

At the time, it seemed a remarkable piece of good luck that Ron, unlike many of his peers who were shipping out to Vietnam, had a safe assignment. But that safety, in retrospect, may have been somewhat illusory. Like many young people of his generation, he dabbled in marijuana and LSD while he was in the Army. After his enlistment expired, Ron worked at a number of jobs in the growing electronics industry of Southern California. At one point in 1972, he made the decision to save up his money, take advantage of the GI Bill, and complete college.

My brother's fall into schizophrenia was, I suspect, not so different from many others of that time. His LSD and marijuana use when he was in the Army and afterwards may have pushed that predisposition towards schizophrenia over the edge. There is a persuasive correlation between increases in drug use in the late 1960s and increases in psychotic and mood disorder admissions to mental hospitals three to five years later.³ There is another significant correlation between marijuana use and a 40 percent increased risk of psychosis later in life.⁴ (Complicating such studies, those suffering from mental illness are more likely to use mind-altering drugs, including alcohol, as a way of dealing with their problems.) The apparent similarity of the LSD trip to the symptoms of schizophrenia is one reason that scientists experimented with LSD into the 1960s. While the parallels were intriguing, it soon became apparent that LSD was not a path to a cure.⁵

³ Nashaat N. Boutros, Malcolm B. Bowers, Jr., and Donald Quinlan, "Chronological Association Between Increases in Drug Abuse and Psychosis in Connecticut State Hospitals," *Journal of Neuropsychiatry and Clinical Neurosciences* [February 1998] 10:48-54, available at <http://neuro.psychiatryonline.org/cgi/content/full/10/1/48>, last accessed August 16, 2006.

⁴ Kathleen Doheny, "Pot And Psychosis: Possible Link?" *CBS News*, July 26, 2007, http://www.cbsnews.com/stories/2007/07/26/health/webmd/main3102653.shtml?source=mostpop_story, last accessed August 25, 2007.

⁵ E. Dyck, "Flashback: psychiatric experimentation with LSD in historical perspective," *Canadian Journal of Psychiatry* [June 2005] 50(7):381-8, abstract available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=16086535&query_hl=3&itool=pubmed_docsum, last accessed August 16, 2006.

While most scientists recognized the dangers of LSD, many young people did not, and began to engage in their own very uncontrolled “experiments” with it.

The year was 1973, and I was in my senior year of high school. I was the youngest of five children. I was born late in life for both of my parents, and my older siblings had all left the nest by the time I was in junior high. We rented a modest house in a lower middle class section of Santa Monica—which was a much more working class community than it is today. My father’s health declined while I was in high school, and he retired on a disability pension. When it came time to apply for financial aid for college, I was amused to find out that we were just barely below the poverty line. I knew that we weren’t rich, but I had no idea that we could be called poor. Poor we might have been, but it was a family in love with learning, thinking, and talking about important subjects.

Ron taught me to read when I was about 3 ½ or 4. Soon I was reading adult books, such as Ron’s high school chemistry text. I later found out that my older sisters found me an amusing novelty to have around—the little Einstein they could show off to their friends.

My mother worked for the library system. By the time I was in fourth grade, I was no longer reading books from the children’s library. My mother regularly brought a dozen or more non-fiction books a week home for me to read, and within a few years, there was nothing left in the science and technology section. I started gobbling my way through the biography and history sections.

I had been only a so-so student until the end of ninth grade, when an infatuation with a classmate who was always on the honor roll finally motivated me to use my abilities. I went from a student who seldom earned an A (except in science classes, where my previous reading meant that I had little to learn) to getting nearly straight As in high

school. My future looked bright; my SAT scores were exceptional; I applied to elite schools such as Harvey Mudd College; there seemed to be nothing to prevent me from becoming a research chemist.

Then my brother's spiral downward started. Ron was taking classes at UCLA, and doing very well in them: honors calculus, honors physics, honors chemistry, and a remedial English composition class. The first trimester went well for him. Suddenly, during his second trimester, he withdrew from classes.

Over perhaps six weeks, his behavior became increasingly difficult to understand. During this brief period, he stood with one foot in the world of the sane and another foot in the realm of the psychotic. He told my parents that he was seeing patches of color appearing on walls. He was disturbed by it, and so were my parents, but no one knew what it meant. One evening, he invited my parents and me over to his apartment in Mar Vista to show off a new stereo. For some reason, he kept changing the station every few seconds—and gave very strange explanations for why he did so.

His behavior to my sisters—who he regarded as having married men unsuitable to them—became increasingly odd. One night he visited my sister Marilyn, and kept missing the hint from Marilyn and her husband that it was bedtime, and he should be getting on his way. To express his disapproval of the choices my sisters had made, he suddenly started dating a black woman (which in the early 1970s, was still rather a daring act). My parents were disturbed by how transparently this was done to shock and offend them; Stracey seemed like a nice young lady, and my parents were concerned about Ron's use of Stracey for this purpose, not Stracey's color.

Perhaps seeking answers for what he was experiencing, my brother became involved with various unusual religious groups of the time, one of which was Nichiren Shoshu. It all came to nothing, and soon, he no longer seemed concerned about things that he did

not understand. As his problems became more severe, he moved back in with my parents, because he either could not, or would not hold a job.

Up to this point, I was not aware of the extent of my brother's mental difficulties. My parents saw no reason to let me know that Ron was having problems, and for the most part, other than his apparent lack of interest in school or work, he seemed much like the older brother up to whom I had always looked.

Then, one afternoon, the brother that I thought that I knew became someone else. My father, my brother, and I went to the local Safeway for some shopping. While my father was in the store, my brother suddenly leaped out of the car, grabbed an old man sitting on a bench, and yelled at him, "What did you say?"

The old man, in terror, responded, "Nothing, nothing!"

My brother yelled, "Well, you better not say it again!" When he returned to the car, Ron was grinning as wide as the Cheshire cat. "I sure showed him!" I was not yet afraid of my brother, but I was worried. What would he do next?

All of this had been odd, disturbing, and unfortunate. The moment that the world shattered down around our family came one evening when Ron decided that there *was* something wrong with him. On his own, he called the mental health outpatient clinic near where we lived in Santa Monica, California, and then walked there, a mile or so away. It is a night etched in pain for me, even now. My mother drove down to the clinic, with me in tow.

After a brief conversation with the staff, the full extent of Ron's problem became apparent, and the psychiatrist decided that Ron needed to be hospitalized—immediately. Ron was starting to have second thoughts, and left. The staff asked the police to find Ron. About the time that my mother and I arrived, the police returned Ron to the clinic.

An ambulance arrived. For their own safety, the attendants wanted to restrain him on

the way to the locked, psychiatric ward of St. John's Hospital. My brother did not want that—and began yelling and cursing his disapproval. (This was a long time ago, when adults did not use language like that in front of children.)

My mother, already fearful of what was wrong with Ron, tried to persuade the attendants to dispense with the straps. Her well-meaning intervention was not making anything easier on the doctor or the ambulance attendants, and the doctor told my mother to butt out of this situation, or he would send Ron home with her instead. Eventually, Ron was forcibly restrained, and hospitalized. My mother was emotionally overwhelmed by this scene, as you might expect, and so was I. My mother spent what seemed like an eternity screaming herself to sleep, loud enough that I am sure that many of our neighbors could hear—and we lived in a house, not an apartment. I cried myself to sleep that night.

What had happened to Ron? Would he be cured?

2. What Is Mental Illness?

If you have never been close to someone suffering from it, and you've never studied the subject in school, you are probably wondering, "What is mental illness?" I am astonished at how many well-educated people do not understand the various types of mental illness.

Broadly speaking, psychiatrists *used* to divide mental illness into psychosis and neurosis. Since 1980, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* no longer uses the term neurosis—but psychosis vs. neurosis still a useful, though not terribly precise distinction. Neurosis and psychosis are not mutually exclusive; there are persons suffering from both psychoses and neuroses.

Neurosis consists of a wide range of mental difficulties from mild to severe, including mood disorders such as depression or bipolar disorder. Depression's symptoms can be so mild that it may not be recognized to so severe that the sufferer spends twelve or more hours per day asleep—and yet still has no energy or interest in life when awake. Depression often leads to suicide—and in spite of what you might think, antidepressants sometimes give the severely depressed enough energy to plan and carry out their suicide. Neuroses can also be relatively mild—such as the narcissistic, trivial emotional problems that Woody Allen's movies used to satirize, and that the messy details of Woody Allen's 1990s affair with his stepdaughter seem to exemplify. While a neurotic patient may have quite serious problems that require professional attention, their grasp on reality is not impaired.

Psychosis, however, consists of mental disorders such as schizophrenia that impair a patient's grasp on reality, which unsurprisingly, makes it difficult for the patient to work and socially interact with others. Untreated psychotics have trouble holding onto jobs, except for the least demanding work, and even when they can hold a job, they tend not to

do so. This may be because the work is boring, or because the difference in pay between this and disability is so small.

The dividing line between psychosis and neurosis is a bit fuzzy. Bipolar disorder is a neurosis—but occasionally, people with severe bipolar disorder develop psychotic symptoms, such as hallucinations that break their connection to reality. Very severe depression, another neurosis, sometimes makes it impossible to work. Similarly, some mild forms of schizophrenia do not break the sufferer’s ability to understand that what they are seeing or hearing is a hallucination.

This book focuses heavily on psychoses, not because mood disorders and other neuroses are unimportant, but because the psychoses appears to be disproportionately involved in the tragedies that are most visible on the streets of our cities—and because of my brother. In the early 1980s, there were about two million chronically mentally ill people in the United States, with 93 percent living outside mental hospitals. The largest diagnosis for the chronically mentally ill is schizophrenia, which afflicts about 1 percent of the population,¹ or about 1.5 percent of adult Americans.

Schizophrenia is very costly. In 1991, it was estimated to cost the United States about \$65 billion in direct and indirect costs. The \$19 billion in direct costs included the criminal justice system dealing with a few spectacular and terrifying crimes, and a myriad of infractions, arrests, and short periods of observation.² A 1999 study found that 16.2% of state prison inmates, 7.4% of federal prison inmates, and 16.3% of jail inmates, were mentally ill.³ In spite of the enormous number of patients who are not actively treated,

¹ Evelyn J. Bromet and Herbert C. Schulberg, “Special Problem Populations: The Chronically Mentally Ill, Elderly, Children, Minorities, and Substance Abusers,” 67-68, in David A. Rochefort, ed., *Handbook on Mental Health Policy in the United States* (Westport, Conn.: Greenwood Press, 1989).

² R. J. Wyatt, I. Henter, M. C. Leary and E. Taylor, “An economic evaluation of schizophrenia-1991,” *Social Psychiatry and Psychiatric Epidemiology* 30:5 [September 1995], 196-205, abstract available at <http://www.springerlink.com/content/wj15686263364413/>, accessed August 16, 2006.

³ Paula M. Ditton, Bureau of Justice Statistics, “Mental Health and Treatment of Inmates and Probationers,” (Washington: U.S. Department of Justice, 1999), NCJ 174463.

schizophrenia treatment consumes about 2.5% of all U.S. health care expenditures, or about \$50 billion a year, and is responsible for more of than 10% of *all* disabilities—not just mental disabilities. Government disability payments to schizophrenics in 2005 totaled more than \$8 billion.⁴

We know something of what schizophrenics experience because about 30% recover spontaneously, and are able to tell us what life is like in a world that seems like a *Twilight Zone* episode. Schizophrenia is sometimes divided into positive or negative symptoms (sometimes called “Type I” and “Type II” symptoms). Positive symptoms include “delusions, hallucinations, thought disorder” and seem to be especially responsive to neuroleptic drugs (the antipsychotic medications that have a calming effect). Negative symptoms include what psychiatrists call “flat affect”—the apparent lack of any strong emotions, or inappropriate emotions for the circumstances, and “poverty of speech.”⁵ The negative symptoms do not respond as well to neuroleptic treatment.⁶ Because the side effects of antipsychotic medications often produce behaviors similar to the negative symptoms, and the positive symptoms are more typical of the early stages of schizophrenia, it is unclear if the negative symptoms are part of the disease, or a result of the medications.⁷

Schizophrenia may not be one illness, but a collection of symptoms that have something in common⁸—and most importantly, there is some evidence of a biochemical,

⁴ National Quality Measures Clearinghouse, “Schizophrenia: percent of patients with severe symptoms or side effects and no recent medication treatment change to address these problems,” February 25, 2008, http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?ss=1&doc_id=418, last accessed February 29, 2008; U.S. Social Security Administration Office of Policy, “Annual Statistical Supplement, 2006,” Table 5.A4, <http://www.socialsecurity.gov/policy/docs/statcomps/supplement/2006/5a.html#table5.a4>, last accessed March 9, 2008; Samuel L. Baker, “U.S. national health spending, 2005,” August 26, 2007, <http://hspm.sph.sc.edu/Courses/Econ/Classes/nhe00/> last accessed March 9, 2008.

⁵ Lamb, *Homeless Mentally Ill*, 204-8; Sarason and Sarason, *Abnormal Psychology*, 354-9.

⁶ Lamb, *Homeless Mentally Ill*, 204-8.

⁷ Sarason and Sarason, *Abnormal Psychology*, 354, 359.

⁸ Lamb, *Homeless Mentally Ill*, 204-8; Sarason and Sarason, *Abnormal Psychology*, 350.

inherited trait.⁹ (Even more interesting—the most recent research suggests a common genetic cause for schizophrenia and bipolar disorder, with environmental factors perhaps determining both *if* an individual carrying these genes will become ill, and *which* disease will manifest itself.)¹⁰ Unfortunately, the common genetic cause appears to involve a staggeringly large number of genes that individually contribute to both illnesses¹¹—and mean that there will likely be no simple solution to developing a cure.

Contrary to what used to be commonly accepted with the psychiatric profession, we now know that family and social factors do *not* play a large role in causing schizophrenia. At the same time, while genes may set some people up for schizophrenia, genetics alone is not enough. The environmental factors that may play a role are likely delayed consequences of in utero or delivery complications, and perhaps viral infections.¹² The most recent research attempting to identify the genetic factors at play suggest that at least some of the problem may be associated with the major histocompatibility complex (MHC) region on chromosome 6—an area that has long been associated with genetic predispositions towards infection and autoimmune diseases.¹³

In the popular consciousness, hallucinations are the symptom that is most strongly associated with psychosis. Hallucinations are sensory inputs that “exist in the absence of external stimulation. The most common are auditory hallucinations in which voices are

⁹ Lamb, *Homeless Mentally Ill*, 204-8; Sarason and Sarason, *Abnormal Psychology*, 359-64.

¹⁰ Blackwood, “Are Some Genetic Risk Factors Common to Schizophrenia, Bipolar Disorder and Depression?”, 73-83; Hamid Mostafavi Abdolmaleky, Kuang-hung Cheng, Stephen V. Faraone, Marsha Wilcox, Stephen J. Glatt, Fangming Gao, Cassandra L. Smith, Rahim Shafa, Batol Aeali, Julie Carnevale, Hongjie Pan, Panagiotis Papageorgis, Jose F. Ponte, Vadivelu Sivaraman, Ming T. Tsuang and Sam Thiagalangam, “Hypomethylation of *MB-COMT* promoter is a major risk factor for schizophrenia and bipolar disorder,” *Human Molecular Genetics* 15:21 (2006) 3132-45; there are hundreds of other recent studies examining the connection between these two mental illness.

¹¹ International Schizophrenia Consortium, “Common polygenic variation contributes to risk of schizophrenia and bipolar disorder,” *Nature* 460[August 6, 2009] 750-1.

¹² J. Allan Hobson and Jonathan A. Leonard, *Out Of Its Mind: Psychiatry in Crisis* (Cambridge, Mass.: Perseus Publishing Group, 2001), 188-9.

¹³ Hreinn Stefansson, Roel A. Ophoff, Stacy Steinberg, *et al.*, “Common variants conferring risk of schizophrenia,” *Nature* 460[August 6, 2009] 744-5.

heard from outside one's head." The fictional (sometimes humorous) portrayal of crazy people "hearing voices" is based on truth: some schizophrenics hear sounds that are not there—and those sounds are just as real to a schizophrenic as when you or I turn on a radio. Like the person who takes LSD, and sees things that are not there—indeed, cannot be there—a schizophrenic's visual senses may show him things that are not there. These sensory distortions can affect vision, hearing, smell, and touch.¹⁴

Sometimes hallucinations may not be a completely imagined sensory input. A schizophrenic's sense of smell or of hearing may actually be more acute than normal; sometimes his senses are distorted. For example, my brother went through a phase where he took long showers several times a day. This is not an uncommon schizophrenic behavior; they are convinced that they smell strongly, perhaps because their sense of smell is exaggerating or distorting actual sensations. The belief that one's body is on fire, or that there are bugs crawling under the skin, are other examples of how the senses betray schizophrenics. It does no good to tell him that there is nothing there—the feeling is just as real as if there really are bugs there.

Delusions are "a faulty interpretation of reality that cannot be shaken despite clear evidence to the contrary."¹⁵ These delusions can develop as a result of those untrustworthy sensory inputs. Imagine how strange your behavior would become if you saw and heard things that weren't actually present. "The most common types of delusions in schizophrenia include thought broadcasting, or the belief that one's thoughts are broadcast to the outside world so that other people can hear them." Some forms of schizophrenic can also include catatonia, with the person apparently unable to move,¹⁶ or an agitated state of "extreme psychomotor excitement, talking and shouting almost

¹⁴ Sarah Rosenfield, "Psychiatric Epidemiology: An Overview of Methods and Findings," 46-7, in Rochefort, *Handbook on Mental Health Policy in the United States*.

¹⁵ Sarason and Sarason, *Abnormal Psychology*, 355.

¹⁶ Rosenfield, "Psychiatric Epidemiology," 46-7.

continuously.”¹⁷

This makes it sound as though schizophrenia, like other serious mental illnesses, has a simple and clear-cut diagnosis. Sometimes yes, sometimes no. Many people seem to suffer from some of the symptoms, but not all, and those symptoms may change over time. Hobson and Leonard argue that because the causes are a mixture of several continuously variable brain characteristics, “many normal and abnormal states appear continuous with one another.” Hence, the person who is schizophrenic for several years, and then recovers, or fails to fit into a single diagnostic category.¹⁸ I have a nephew whose diagnosis changed several times from his teens to his early 30s, sometimes diagnosed with schizophrenia, and sometimes with bipolar disorder.

Schizophrenia often strikes during the teen years or early adulthood.¹⁹ Informed speculation suggests that the reason may be related to how the frontal lobes of the brain develop. The frontal lobes continue to develop into one’s mid-twenties. Because the brain engages in “pruning,” or removal of unneeded neurons, there may be an interaction between the ending of development and the pruning process that causes the failure.²⁰

Because schizophrenia has such a low cure rate—*perhaps* aggravated by failure to treat the illness early enough²¹—and because most schizophrenics, when first afflicted, have fifty years of life left—it produces extraordinary social costs. Until deinstitutionalization, it was common for half of *all* hospital beds (not just *mental* hospital beds) to be occupied by schizophrenics. Once sick, most schizophrenics never recovered, living decades in institutional settings. Today, many of them live somewhat shorter lives under bridges, in park benches, and on steam grates. Some die when their delusions lead them to acts of violence against the wrong person. A frighteningly large

¹⁷ Sarason and Sarason, *Abnormal Psychology*, 354.

¹⁸ Hobson and Leonard, *Out of Its Mind*, 238-9.

¹⁹ Rosenfield, “Psychiatric Epidemiology,” 46-7.

²⁰ Hobson and Leonard, *Out of Its Mind*, 202-3.

²¹ Sarason and Sarason, *Abnormal Psychology*, 378.

number end up in prison for these acts.

Schizophrenia would be a tragedy if it hit people of completely normal intelligence. But there are curious connections between schizophrenia and creativity that make the tragedy especially destructive on our society. It has long been noticed that insanity and creativity are linked—but why? Studies of creative people find that their brains are less likely to filter out incoming stimuli. A process called “latent inhibition” allows the brains of most people to ignore information that they have learned from long experience is not necessary. It appears that latent inhibition is less present among creative people. This allows creative sorts to sense things that normal people no longer can. Creative sorts are thus able to take a fresh look at problems or ideas that less creative sorts cannot. Creative people still have *some* latent inhibition protecting their senses from being overrun with too much information. Latent inhibition disappears at the start of schizophrenia—perhaps leading to delusions and hallucinations as the brain is overwhelmed with more stimuli than it can handle.²² An interesting speculation is that the normal brain uses latent inhibition to protect itself from too much information because it lacks the processing power to handle the full bandwidth available to it.²³ Intelligent people may have less latent inhibition because they have the capability to handle the extra information.

Mental illness is a tremendously costly problem, destructive to individuals, and destructive to the larger society. The problem has been recognized throughout human history, and different societies have dealt with it in different ways. Throughout American history, those who have seen themselves as concerned about the suffering and afflicted have worked to provide treatment or assistance to the mentally ill. What is remarkable about recent history is how the traditional advocates of the downtrodden played a major although unwitting role in putting the mentally ill into conditions that would have

²² “Illness,” *ScienceDaily*, October 1, 2003, <http://www.sciencedaily.com/releases/2003/10/031001061055.htm>, last accessed February 29, 2008.

²³ Hobson and Leonard, *Out Of Its Mind*, 83-84.

shocked previous generations of Americans.

3. Ron Was Not Alone

I saw Ron's spiral down into mental illness. Because he is my brother, I've seen the tragedy—sometimes close at hand, sometimes from a distance—for decades. Over the years, I've had greater and lesser opportunities to see the damage done in the lives of others.

A close friend in the late 1970s was a young lady I'll call Joan. We went to high school together—but seemingly never met until after we had graduated. I met Joan as a result of what I jokingly call a double blind date—a blind woman that was a mutual friend set us up! Joan was a sweet and intelligent person, and most of the time, you would not think that she was disabled. Joan had simple schizophrenia, which meant that she was having hallucinations—but she was still sufficiently in touch with reality to know that they were hallucinations.

I soon learned why she lived in a tiny apartment on the beach, instead of living at home. Joan's mother worked for the Social Security Administration, and knew the ins and outs of the disability process. (Joan's mother didn't pull any strings—she just understood how to navigate the system for Joan.) As a result, Joan received a disability check sufficient to maintain a tiny apartment of her own. Had she lived at home, her parents' assets and income would have reduced the size of the government's checks. Joan did not work, nor did she go to college—and in retrospect, I wonder how much of this was because of the amotivational symptoms of schizophrenia, and how much was that the disability check took away a reason to work or advance.

Joan's mental problems were certainly aggravated by some traumatic experiences, and substance abuse. She was still under the legal drinking age, but drank to excess, in spite of the efforts of her friends and me to persuade her otherwise. One occasion, she and a girlfriend spent the night drinking one of the over the counter cough syrups—to the

point where both were exhausted—but claimed that they were physically unable to close their eyes. On another occasion, I saw her snort cocaine (or what, more realistically, was probably baby powder with a few dozen cocaine molecules scattered here and there). This substance abuse would have been a bad idea for someone who wasn't fighting with schizophrenia; I'm sure that it was aggravating her problems.

At one point in 1977, Joan had spent two days unable to sleep, because the voices were screaming, "Kill yourself." Contrary to the widely held belief that the mentally ill were wandering the streets because of budget cuts, when Joan went to the same mental health clinic as Ron, she was immediately sent to Camarillo State Hospital, about fifty miles away from Santa Monica. What was the difference? She checked herself into the mental hospital; there was no need to persuade a judge that she was a threat to herself or others.

Because she was a voluntary admission, Joan was also free to check herself out. She called me two days after she arrived, and begged me to come and get her. The mental hospital was not sex-segregated, and one of the male patients, whom she described as big and strong, was demanding that she submit sexually to him. Her choice was simple: submit, or he would take what he wanted by force. Joan had no confidence that the staff would protect her, and she was tiny: 5'2" and slight of build.

As appalling as this sounds—consider the situation of the staff. You have a person in your hospital who admitted herself because of voices that were not there—and now you have to decide which of two people who are mentally disturbed is telling the truth. (Adding to the complexity of the problem was that the patient who was demanding Joan's sexual submission was black, and the staff was doubtless afraid of being accused of racism.)

Under the best of conditions, a mental hospital is a sad place. I can remember visiting Ron with my parents in the locked ward of St. John's Hospital, a private and very well maintained facility. The people who worked there seemed to be genuinely concerned

with improving the condition of their patients. Still, other patients would approach us, just to have someone with whom to talk. They gave us the impression that there was no one coming to see them.

As I drove out to rescue Joan, I had considerable apprehension. Camarillo State Hospital had a fearsomely bad reputation in the mid-1960s. I can remember reading incredibly depressing accounts of the conditions there, and at other state mental hospitals—accounts that were deeply disturbing to me, even at age ten: peeling paint (a real problem for patients prone to eating whatever they found); severely retarded adults left for hours or even days in soiled diapers; inadequate numbers of staff to supervise patients who were often a hazard to each other, or to themselves.

I expected, when I went to pick up Joan, that things would be much better at Camarillo a decade after these horrifying exposes. I had already seen more of mental hospitals by twenty than most of my peers. One of my sisters had spent three and a half months in a private mental hospital in Los Angeles after a suicide attempt a few years earlier, and it was, as near as I could tell, exactly what a mental hospital should be: a place of hope and care. (Fortunately, there was no question if she was a danger to herself; her suicide attempt at age 16 had been quite serious. More importantly, she was a minor, and it was 1967. There was as yet no question about whether she could be hospitalized on the say-so of her parents.)

When I arrived at Camarillo to pick up Joan, I was depressed to find that while conditions were not quite as bad as those mid-1960s newspaper accounts, I could see that money was not being spent on maintenance. There were a shocking number of broken windows. The paint was peeling. The interior of the ward in which Joan was located was astonishingly dark—conditions that might have depressed a healthy person confined there. Had I not been picking up Joan to take her back to her apartment, I might well have started to cry.

I still have a bittersweet memory of our last date, to see Jackson Browne in concert at

the Universal Amphitheater. Joan was an enormous fan of Jackson Browne's often depressing music (which both conformed to, and perhaps amplified her own feelings), and I had bought tickets as soon as they went on sale. The night of the concert, she mixed beer and prescription medicines to the point that she passed out in her seat just as Jackson Browne came on stage. When she came to—as Browne walked off stage—the combination of alcohol and drugs caused her to fall forward into the next row of seats. Once she was again vertical, she fell backward in the seats behind us. Along the way, she vomited on my shoes.

I was frustrated by that evening. I felt sorry for Joan, who was a sweet person, and quite a bit of fun—when she wasn't self-medicating, or suffering from hallucinations. But I also knew that I couldn't help her, and it became increasingly clear that whatever her path was in life, it wasn't the same as the road that I was taking. The wise saying, "Never sleep with anyone crazier than yourself" turned out to be good advice.

Over the next several years, Joan moved to Santa Cruz; I stayed where I was in Los Angeles, and so our relationship declined. When I last visited her in Santa Cruz, she was again a voluntary inmate of a mental hospital—and again, there was no problem finding a bed for her, because she was well enough to realize that she was not well.

By the late 1970s, where I lived in Santa Monica was awash in mentally ill people living on the streets. Santa Monica was an especially good place for homeless people in the Los Angeles basin. Being on the ocean meant that the climate was temperate. Crime rates were lower than a lot of regions further inland, where you did not need to be paranoid to be concerned about your safety when sleeping out of doors. In the area of Santa Monica where I lived, near the post office and Lincoln Park, there were perhaps a dozen "regulars" who I would see sleeping in any spot that would not attract police attention. Most of them were men—scruffy, and sometimes quite scary, especially when they were begging. I sometimes tried to open conversations with them, while bringing them sandwiches or giving them money, but it was difficult to get anything more than,

“Thanks” from most of them.

Rarer than homeless men, at least then and there, were homeless women. One woman in her late 20s specialized in graffiti that mixed Bible verses with vaguely apocalyptic concerns. It made very little sense, and having become a Christian at about that time, I tried very hard to see where her writing was taking her. Her thinking was so disordered, and her paranoia was so high, that it was impossible to have a conversation with her.

There was another homeless woman that I remember from those years who was not so paranoid, who called herself Rosie. Until we knew her name, the woman who became my wife (and who joined me on some of my late night sandwich deliveries to the homeless) called her “The Rouge Lady.” Like many homeless people, bathing was a difficult situation, and both her skin and her clothes were dirty—but she somehow always had money for some makeup. She had rather overemphasized rouge on her cheeks, and continuously walked on tiptoe.

For a long time, Rosie slept in the lobby of the main post office in Santa Monica, which was open all night. I first started to talk to her when I would walk the few blocks from my home to mail letters at night. Usually by about 8:30 in the evening, Rosie was camped out there. She knew that she had a mental problem, but when I would press her about seeking help at the mental health clinic, she became uncomfortable. She was not defiant or angry—but there was some reason that she was reluctant to take that path.

For a few months, Rosie disappeared. In truth, I did not even notice that she was gone. Then she was back. Someone, whom she did not make clear, had helped her to get off the street, and get an apartment of her own. But, “I couldn’t keep it together,” and she was again out on the street. Eventually, the post office made it clear that she was not to loiter in the lobby. Up to this point, the post office had been open all hours in Santa Monica. Now the doors were locked in the late evening. Rosie no longer had a warm place to sleep at night. She continued to sleep outdoors around the post office, but

eventually, she disappeared.

It was apparent to me, even then, that overwhelmingly, the homeless of Santa Monica had mental problems. My brother Ron was at least at times homeless, and his mental illness was part of it. Yet I never drew a causal connection between their mental illness and their homelessness—perhaps because I was still a little too self-absorbed at the time.

This change in Santa Monica—and as it turned out, across America—happened while I watched. In a period of about ten years, Santa Monica went from a place with no visible homelessness to a permanent population of dirty, sometimes scary people, some of whom were not above armed robbery. The faces changed. Some, like Rosie, would talk. Others would accept what aid you offered them, but clearly had no interest in communicating. And it seemed as though there was nothing that any of us could do for them.

Why were these mentally ill people living on the streets? Where were they ten years before? As with most tragedies, there is a bit of history that goes into it. Understanding how we reached this point requires us to know where we started.

4. Mental Illness & Civil Commitment in Colonial America

Unsurprisingly, considering the English origins of the American colonies, the English model for treating the mentally ill inspired American laws.¹ English law at least as early as 1690 recognized that if “one that is *Non compos mentis* or an Ideot kill a Man; this is no Felony, for they have not knowledge of good and evil, nor can have Felonious intent, nor a will or mind to do harm.”² Even before the American Revolution, English law distinguished between mental illness and mental retardation with respect to both criminal liability, and competence to manage one’s affairs.³ Similarly, English law before the Revolution defined legal insanity as requiring that the patient had a “belief of facts which no rational person would have believed, and in the inability to be reasoned out of such belief...” Yet the law recognized that religious beliefs, no matter how peculiar, were not sufficient to qualify as legal insanity, such as a belief “entirely within the domain of opinion or faith...”⁴ Unlike England, which had insane asylums as early as the fourteenth century, there appears to have been little need for institutionalization of the mentally ill until the last few years before the American Revolution.

In New England, where historians have done the most thorough research, mentally ill colonists seldom appear to be a matter of legal action. The law did occasionally lock up a mentally ill person who committed a serious crime for the safety of the community. The few examples from the records are somewhat startling for their compassionate, family-

¹ Gerald N. Grob, *The Mad Among Us: A History of the Care of the America's Mentally Ill* (New York: The Free Press, 1994), 6-7.

² Michael Dalton. *The Country Justice: Containing The Practice, Duty And Power Of The Justices Of The Peace....* (London: William Rawlins and Samuel Roycroft, assigns of Richard and Edward Atkyns, 1690), ch. 147, in *Archives of Maryland*, 153:350.

³ Henry F. Buswell, *The Law of Insanity In Its Application to the Civil Rights and Capacities and Criminal Responsibility of the Citizen* (Boston: Little, Brown & Co., 1885), 1-13.

⁴ Buswell, *The Law of Insanity*, 15-18.

based approach. Connecticut, for example, tried one Roger Humphry, who “while a soldier in the army in the year 1757, become delirious and distracted and in his distraction killed his mother....” At trial in Hartford, he “was found not guilty altogether on the account of his distraction....”⁵ Roger was at first confined to the jail in Hartford, but upon the request of Roger’s father Benajah Humphry, the legislature granted permission for Benajah to take his son home to Symsbury. Benajah was “hereby directed and ordered to take and safely keep said Roger and provide for him.” The legislature directed the Symsbury town government to supervise the securing of Roger. Benajah was to pay for keeping his son secure—but the legislature granted him £40 to help—a sizeable grant, equivalent to roughly a year’s wages.

This must have been a very painful situation—Benajah’s wife was dead; his son was insane; and he had taken it upon himself (with a little help from the colonial government) to maintain, effectively, an insane asylum for one.⁶ We have similar examples of public funds to build individual insane asylums in Amesland, Pennsylvania in 1676 and in Braintree, Massachusetts in 1688.⁷

Another example of the limited nature of institutionalization from the Colonial period is Connecticut’s orders concerning Mary Hall, whose behavior had become worrisome as she wandered “from town to town and place to place, to the great disquiet of many people where she goes by reason of her ill behaviour.” In 1758, the legislature directed that if she was found outside her home town of Wallingford, she was to be arrested and returned to Wallingford—and Wallingford would be charged the costs.⁸ There’s no detail on exactly what Mary Hall did as she wandered, but it seems likely that her behavior was more than just strange or boorish.

⁵ *Public Records of the Colony of Connecticut*, 11:318.

⁶ *Public Records of the Colony of Connecticut*, 11:318. In 1761, Benajah again requested assistance from the legislature in caring for his son, and they gave him twenty pounds more. *Ibid.*, 11:590-1.

⁷ Grob, *Mad Among Us*, 15.

⁸ *Public Records of the Colony of Connecticut*, 11:111-12.

There are no similar orders in *The Public Records of the Colony of Connecticut*, and New Englanders were often extremely tolerant of non-aggressive mentally ill members of the society. Samuel Coolidge, schoolmaster of Watertown, Massachusetts, was known for appearing in public half-dressed or not dressed at all. While he was dragged out of commencement at his alma mater of Harvard for disrupting the event, there was no apparent interest in locking him up—and he kept his job as schoolmaster.⁹ He was, however, “warned out” of Boston in 1742 and 1744 for being “in a Distracted Condition & very likely to be a Town Charge.”¹⁰

This tolerance for odd behavior included a quite astonishing willingness to pay salaries to people whose job performance, from the contemporary accounts, would seem deficient. After 1738 Rev. Joseph Moody of York, Massachusetts, would only appear in public with a handkerchief over his mouth—and soon he could not bear to even face his congregation while preaching. It took three years for his congregants to replace him.¹¹ Whether Moody was mentally ill in any modern sense of the word seems arguable. An 1891 account of Moody’s behavior indicated that he had accidentally killed a close friend in his youth, but showed no indications of eccentricity until he was 38 years old.

He had been the cause of his young friend's death; it made his blood run cold; he hid his countenance, and as a token of his grief, he determined to wear a veil during the rest of his life. Accordingly, he wore, ever after, a silk handkerchief drawn over his face, and was called “Handkerchief Moody” till his death.¹²

Rev. Samuel Checkley was at first “unable to speak without weeping”—but then progressed to preaching in gibberish. Even then, his congregation, rather than fire him,

⁹ Mary Ann Jimenez, “Madness In Early American History: Insanity In Massachusetts From 1700 To 1830,” *Journal of Social History* [Fall 86] 20:1, 25-26.

¹⁰ Boston [Mass.] Registry Department, *A Report of the Record Commissioners of the City of Boston, Containing the Records of Boston Selectmen, 1736 to 1742* (Boston: Rockwell and Churchill, 1886), 15:366, Boston [Mass.] Registry Department, *A Report of the Record Commissioners of the City of Boston, Containing the Records of Boston Selectmen, 1736 to 1742* (Boston: Rockwell and Churchill, 1887), 17:97.

¹¹ Jimenez, “Madness In Early American History,” 25-26.

¹² Maine Historical Society, *Collections and Proceedings of the Maine Historical Society*, 2nd ser., 5:99-101 (1894).

hired an “assistant” to help him. Even actions that were clearly blasphemous, such as carrying a sign that claimed, “I am God,” when performed by someone who was clearly mentally ill, seem not to have led to incarceration.¹³

For the mentally ill who were not dangerous to others, the law concerned itself primarily with matters of finance: Who would take care of a mentally ill person if they lacked the means to care for themselves? There were two different categories of people, the indigent mentally ill and those with property. While only the indigent were a direct financial concern to the community, if the government took no steps to preserve the assets of members of the propertied class, even the wealthy might easily end up dependent on the community.

As a result, while there are a few surviving examples of Colonial governments ordering confinement of specific mentally ill people, much of the legislative activity associated with mental illness was concerned with guardianship. Colonial legislatures passed laws to protect the property of the mentally ill, directing town government to manage the mentally ill person’s property so that it would provide for the owner’s needs. For the indigent resident, near relatives were required to provide at least some support. Non-residents who were mentally ill were often “warned out” to prevent them from becoming a financial burden on the town, in the same way that the poor laws required non-resident poor in both America and England to return to their place of birth to seek relief.¹⁴

Still, we should not exaggerate the economic calculation of these concerns. Distracted persons were also friends and neighbors, and we have examples such as

¹³ Jimenez, “Madness In Early American History,” 25-26.

¹⁴ *Public Records of the Colony of Connecticut*, 4:285-6, 5:503; Gerald N. Grob, *Mental Institutions in America: Social Policy to 1875* (New York: The Free Press, 1973), 12-13; Grob, *Mad Among Us*, 16-17; Albert Deutsch, *The Mentally Ill in America: A History of Their Care and Treatment from Colonial Times*, 2nd ed. (New York: Columbia University Press, 1949), 40-50. Deutsch’s work has been widely criticized as presenting a darker account of Colonial treatment of the mentally ill than his own evidence shows; see Grob, *Mental Institutions in America*, 12 n. 9.

Providence Colony's response to "a distracted person" named Mrs. Weston in 1651, and providing both money and labor to assist Mr. Pike in caring for his "distracted" wife in 1655. Even such blasphemous and shocking behavior as Charles Leonard cutting in half and burning a Bible in Taunton, Massachusetts, did not prevent the town from supporting him.¹⁵ Colonial newspapers occasionally mention the actions of "lunaticks" who committed "outrages" but seem to recognize the limited responsibility that the insane bore for their actions,¹⁶ or identify a suicide as "lunatick."¹⁷ Ads also seek the return of wandering mentally ill family members.¹⁸

In the middle of the eighteenth century, a few of the larger cities were building institutions to house the insane—but that could not be called mental hospitals or insane asylums in any modern sense. In Boston, the workhouse confined together paupers, retarded, insane, and in some cases, those with contagious diseases.¹⁹ Philadelphia's almshouse, established in 1732, confined the physically sick and the insane together for the same purpose.²⁰ This was not a good situation for the sick, the poor, or the insane.

Philadelphia's first public hospital, organized in 1751 with a combination of private and public funds—and the active involvement of Benjamin Franklin—still housed both the physically and mentally ill within one building. The cells for the insane "were damp and unhealthy, and a number of patients died of pulmonary disease."²¹ While the hospital was clearly intended to care for both physical and mental illnesses, the concern about the mentally ill seems to have been strongest selling point—at least as judged by the petition requesting governmental assistance. The petition to the Pennsylvania Assembly showed

¹⁵ Grob, *Mad Among Us*, 13-15.

¹⁶ "The same Evening Joseph Watson a Lunatick..." *South Carolina Gazette*, January 1, 1737.

¹⁷ "Extract of a letter," *Pennsylvania Gazette*, August 22, 1765.

¹⁸ "Hannah Abraham," *Pennsylvania Gazette*, August 20, 1767, "James Lewis," August 30, 1753, "Tamer Way," January 22, 1783.

¹⁹ Grob, *Mental Institutions in America*, 13-31; Grob, *Mad Among Us*, 18-19.

²⁰ James V. May, *Mental Diseases: A Public Health Problem* (Boston: Richard G. Badger, 1922), 34.

²¹ Grob, *Mental Institutions in America*, 13-31; Grob, *Mad Among Us*, 18-19.

concern for both the well-being of the mentally ill, and the dangers to the community as a whole:

That with the numbers of people the number of lunaticks, or persons distempered in mind, and deprived of their rational faculties, hath greatly increased in this province.

That some of them going at large, are a terrour to their neighbours, who are daily apprehensive of the violences they may commit; and others are continually wasting their substance, to the great injury of themselves and families, ill disposed persons wickedly taking advantage of their unhappy condition, and drawing them into unreasonable bargains, &c.²²

A sign of the potential for cure—and why involuntary commitment was necessary—is that the petition also observed that:

"That few or none of them are so sensible of their condition as to submit voluntarily to the treatment their respective cases require, and therefore continue in the same deplorable state during their lives; whereas it has been found, by the experience of many years, that above two thirds of the mad people received into Bethlehem Hospital, and there treated properly, have been perfectly cured."²³

Franklin also observed something that promoters of deinstitutionalization two centuries later missed—that the mentally ill often had homes “yet were therein but badly accommodated in sickness, and could be no so well and so easily taken care of in their separate habitations, as they might be in one convenient house, under one inspection, and in the hands of skilful practitioners....”²⁴

The Pennsylvania Hospital admitted only those physically ill who were deemed “curable”—but this was not required for the mentally ill.²⁵ While Colonial thought did not consider mental illness a permanent condition for *every* sufferer, most of those who wrote on the subject knew that at least for many, once it took hold, mental illness was a lifelong problem.²⁶ The first two years of operation for the hospital shows a total of eighteen admitted with a diagnosis of “Lunacy,” of whom two were released as “Cured,” three “Relieved,” four as “Incurable,” six taken away by their friends, and three still remained. A note explains that most of the “lunaticks taken in had been many years

²² Benjamin Franklin, *Some Account of the Pennsylvania Hospital From Its First Rise to the Beginning of the Fifth Month, Called May, 1754* (Philadelphia: United States' Gazette, 1817), 4-5.

²³ May, *Mental Diseases*, 35-36.

²⁴ Franklin, *Some Account of the Pennsylvania Hospital*, 3.

²⁵ Franklin, *Some Account of the Pennsylvania Hospital*, 45.

²⁶ Grob, *Mental Institutions in America*, 13-31; Grob, *Mad Among Us*, 18-19.

disordered” and were not considered likely to be cured. Those taken away by their friends were removed before an opportunity had been given for a cure—and therefore, the hospital had decided that it would no longer accept mental patients unless they would be hospitalized at least twelve months, or until cured.²⁷

What did Colonial Americans think mental illness was? While some historians have emphasized the overlap between witchcraft, sin, and mental illness—a position that was certainly widespread in continental Europe, as late as the nineteenth century among German doctors,²⁸ most Colonial Americans seem to have understood that at least some forms of mental illness were physical in nature. The eminent Puritan minister Cotton Mather wrote in 1702 that madness was a result of Satan's temptations—and yet by 1724, his unpublished *The Angel of Bethesda* recognized that mania and melancholia had physical causes, for which medicine, not prayer, was the appropriate cure. Nor was Mather alone in this; throughout the eighteenth century, Enlightenment thinking was moving the causes of mental illness from the supernatural to the natural.²⁹ That Colonial Americans by the eighteenth century regarded mental illness as analogous to physical ailments can be inferred from how they treated those who were temporarily afflicted with madness. Upon recovery—and sometimes even while still insane—politicians such as James Otis, Jr. and ministers such as Daniel Kirtland and Joseph Moody were able to hold offices and acquire new ones.³⁰ Yet what evidence exists suggests that the mentally ill were primarily looked after, since there was no particular treatment in the medical toolbox for mental illness.³¹

Complicating our understanding of Colonial treatment policies is the confusing variety of terms used. “Idiot” in many of the laws refers to the mentally retarded.

²⁷ Franklin, *Some Account of the Pennsylvania Hospital*, 65-66.

²⁸ Deutsch, *Mentally Ill in America*, 31-38.

²⁹ Grob, *Mad Among Us*, 9-12.

³⁰ Grob, *Mad Among Us*, 14.

³¹ Grob, *Mental Institutions in America*, 39-47; Deutsch, *Mentally Ill in America*, 77-81.

“Maniac” at first glance suggests the extreme mania phase of bipolar disorder today. More than a few colonists were “distracted,” which suggests severe depression, perhaps hebephrenic schizophrenia, or conceivably Alzheimer’s. “Lunatic” appears frequently in the Colonial laws in a sense that implies a break from reality.

Civil commitment—that is, locking up persons against their will because of mental illness—was a fairly informal procedure under Colonial law, which borrowed from both English common law and statutes. The “furiously insane” could be arrested by anyone,³² and perhaps because of the low rate of psychosis in the Colonial period (to be discussed later), there is no evidence of complaints of abuse of this process.

By the close of the Colonial period, some governments had created institutions specifically to house the mentally ill. Virginia opened the first American institution for the mentally ill in 1773—and designated it as a hospital, not an asylum. This was an important distinction; the goal of a hospital was to cure the patient, not simply hold him for his own safety.³³ Still, the rules governing what patients would be accepted demonstrate that public safety was very much at the forefront of the colony’s concerns: nonviolent, chronically ill patients were not to be admitted. Unlike the rather informal commitment procedures that were still in effect elsewhere, the act creating the hospital required several magistrates to agree that a person properly should be committed to the hospital. The goal was to deal with acute mental illness—effect a cure—and then release the patient back into society.³⁴

Much of what drove this development was that a few of America’s larger towns became cities. In a small town, everyone knew everyone else, and if Mr. Jones or Mrs. Smith occasionally acted oddly, it was not a surprise. Everyone in town knew Mr. Jones

³² Deutsch, *Mentally Ill in America*, 419-20.

³³ May, *Mental Diseases*, 36-37.

³⁴ Shomer S. Zwelling, *Quest For A Cure: The Public Hospital In Williamsburg, 1773-1885* (Williamsburg, Va.: Colonial Williamsburg Foundation, 1985), 8-12.

or Mrs. Smith well enough to know what they might do—and would probably keep deadly implements away from someone regarded as dangerous. A mentally ill person who was violent or suicidal might be locked up; those whose behavior was abnormal but peaceful would create no fear.

In cities, where tens of thousands of people lived cheek-by-jowl, the chances were high that you knew only some of your neighbors. A stranger acting oddly might well cause concern or fear—what might he do next? Another area of difference between cities and small towns was that “an extraordinarily high rate of geographic mobility tended to limit social cohesion and the efficacy of informal and traditional means of dealing with distress.” The less you knew your neighbors, the easier it was to regard Mrs. Smith’s difficulties as not your problem.³⁵

Urbanization may not simply have been a factor in making Americans more wary of their mentally ill neighbors; it may have increased mental illness rates as well. While we do not know if this was true in the eighteenth century, some recent studies suggest that being born or growing up in an urban area increases one’s risk of developing schizophrenia and other psychoses.³⁶ In the twentieth century, comparison of insanity rates revealed that urban areas had much higher rates of mental hospital admissions for schizophrenia and bipolar disorder—almost twice as high for New York City compared to the rest of New York State. State by state comparisons in the nineteenth and twentieth centuries also revealed that more urban states, such as California and the northeastern

³⁵ Grob, *Mental Institutions in America*, 37.

³⁶ G. Lewis, A. David, S. Andreasson, P. Allebeck, “Schizophrenia and city life,” *Lancet*, [July 18, 1992] 340(8812):137-40, abstract available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=1352565, last accessed September 13, 2006; M. Marcelis, F. Navarro-Mateu, R. Murray, J.P. Seltén, J. Van Os, “Urbanization and psychosis: a study of 1942-1978 birth cohorts in The Netherlands,” *Psychological Medicine*, [July 1998] 28(4):871-9, abstract available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=9723142, last accessed September 13, 2006. E. Fuller Torrey and Judy Miller, *The Invisible Plague: The Rise of Mental Illness from 1750 to the Present* (New Brunswick, N.J.: Rutgers University Press, 2001), 122.

states, had much higher rates of mental illness.³⁷

Older statistical examinations of mental hospital admissions argue that at least in the period from 1840 to 1940, while mental hospital admissions increased (because of increased availability), there was no large and obvious increase in insanity.³⁸ A more recent study of mental illness data shows, much more persuasively, that psychosis rates rose quite dramatically between 1807 and 1961 in the United States, England & Wales, Ireland, and the Canadian Atlantic provinces. A study of Buckinghamshire, England shows that there was more than ten-fold increase in psychosis rates from the beginning of the seventeenth century to 1986.³⁹ Urban life today is not the same as urban life then, and even the scale of what constitutes “urban” is dramatically different—but it is an intriguing possibility that the increased rates of mental illness at the close of the Colonial period were the result of urbanization.

Irish immigration may also have played a role in the increasing development of mental hospitals in America. It was widely believed in the 1830s that Irish immigrants were disproportionately present among the insane. Ireland’s rates of insanity throughout the nineteenth and twentieth centuries were usually twice or more than that of the United States, England, and Wales. Irish immigrants were also overrepresented in insane asylums in the United States, England, Australia, and Canada at the close of the nineteenth century.⁴⁰

There is something gloriously idyllic about Colonial America and its treatment of the mentally ill. It was a place where mental illness appears to have been rare, and small town life tolerated all but the “furiously mad” to live in the community. There might be

³⁷ Torrey and Miller, *The Invisible Plague*, 291-2.

³⁸ Herbert Goldhamer and Andrew W. Marshall, *Psychosis and Civilization: Two Studies in the Frequency of Mental Disease* (Glencoe, Ill.: The Free Press, 1953). Torrey and Miller, *The Invisible Plague*, 295-297, discusses the many problems with Goldhamer and Marshall’s use of the data.

³⁹ Torrey and Miller, *The Invisible Plague*, 120-123, 298-9.

⁴⁰ Torrey and Miller, *The Invisible Plague*, frontispiece and 124-47.

little prospect of effective treatment, but for those who recovered—and even for those who were still struggling with mental illness—the community was patient and accepting. America was about to change.