The following is a preview of the full book.

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My Brother Ron

A Personal and Social History of Deinstitutionalization of the Mentally Ill

BOOKS BY CLAYTON E. CRAMER

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For my mother, who has watched out for Ron all these years

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Every book represents the kind assistance of many people. This book, more than most, is a family project. I have spent many hours talking to my mother, my sisters Susan, Marilyn, and Carolyn, and to the extent that he is able to communicate effectively about the past, my brother Ron. Unsurprisingly, we have different perspectives on the past, and different views of the best way of solving the problems that deinstitutionalization created. I have done my best, where there were differing memories of these painful events involving Ron, to write a consensus account.

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Clayton E. Cramer
June, 2012

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 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 ranging in age 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 residents of this hotel, including my brother, would run out of money and end up 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, these homeless people would again be solvent, and be 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] American society has traditionally seen "bums" or "hoboes" as lazy, or morally weak. It was easier to focus on those explanations, instead of learning how and why these people had ended up where they were. These homeless people — largely, but not exclusively men — were often homeless because they were mentally ill. Alcoholism or drug abuse often aggravated their mental illness and their financial problems.

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*. 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," the label that liberals used to castigate President Reagan's supply side tax cut policies.[2] 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

inversion of causality, 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.) Alcohol and drug abuse are additional layers that aggravate and sometimes cause mental illness.[3]

One of my own experiences illustrates the relationship between mental illness and criminal behavior. In the late 1990s, a rather strange character showed up at the church my wife and I 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 his pet. 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 knew something was wrong, but he was not quite sure, so he asked me to talk to Jim.

Jim told a story of governmental oppression that for the first minute or two, 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 Jim showed me the paperwork that had taken away his children. Jim was so confused that he did not realize what it revealed.

In one of California's Central Valley counties, Jim's wife had been committed to a mental hospital because she had physically abused their children, and been found not guilty by reason of insanity. After her hospitalization, Jim started 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, such a criminal case would have been a hard case to win in court, and it would certainly have been traumatic for the children, certainly harder than terminating his parental rights in family court.

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 statements of police and 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 to anyone talking to him; obvious enough that no one would put their children at risk by allowing Jim any contact.

For those of us who came of age in the 1970s and before, 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. (Nor were these tragedies a uniquely American problem; they happened across the Western world.) What shocked people in 1984 when James Huberty did it in a McDonald's in San Ysidro, California no longer surprises us. Generally, these spree killers have histories of mental illness, and have already come to the attention of the criminal justice or mental health systems before they become headlines. For a while, it was fashionable to blame Prozac, or gun availability — and in some circles bizarre government conspiracy theories as well.[4]

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. Similarly, the explosion of homelessness, and the ugly degradation of urban life that became so common in the 1980s, would have seemed like just another set of random bad news. Something had gone wrong in America — but what?

If not for my brother Ron, I suspect that I would be just as perplexed by these seemingly disconnected tragedies as most other Americans. As an adult, I met others who were mentally ill, but inevitably, most of 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 limited exceptions, would never again be hospitalized against their will.

1. 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 predisposes some towards schizophrenia, it is not the only factor. If one identical twin has schizophrenia, there is a 48 percent chance that the other twin will have it as well. Similarly, a child of two schizophrenic parents has a 46 percent chance of developing schizophrenia. While this strongly suggests a genetic origin, it 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]

RON AT AGE 15

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 electronics 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, the Army 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, was a little deceptive.

RON AT MARCH AIR FORCE BASE, ABOUT TO LEAVE THE ARMY IN 1968

My brother's fall into schizophrenia was, I suspect, not so different from many others of that time. Like many young people of his generation, he used marijuana and LSD while he was in the Army and afterwards. This use, in combination with a predisposition towards schizophrenia, may have pushed him over the edge. There is a persuasive correlation between increases in

drug abuse in the late 1960s and increases in psychotic and mood disorder admissions to mental hospitals three to five years later.[3] More recently, researchers have demonstrated another statistically significant correlation specifically between marijuana use and an increased risk of psychosis later in life.[4]

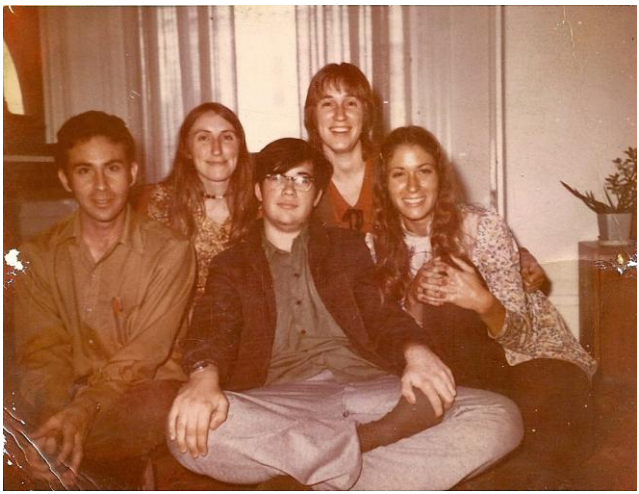
Complicating such studies, those suffering from mental illness are more likely to use mind-altering drugs, including alcohol, as a way of dealing with their mental problems. This is commonly called "self-medicating." Because of this, several studies have attempted to distinguish "mental illness causes marijuana use" from "marijuana use causes mental illness" by looking for evidence of mental illness symptoms and personality characteristics before the subjects started use of marijuana. One study found a doubling of the risk of schizophreniform disorders (those illnesses that have the symptoms of schizophrenia) among those who were casual users of marijuana, even controlling for these pre-existing characteristics and symptoms. Other longitudinal studies have found these correlations hold true even when adjusted for signs of mental illness before starting marijuana use.[5]

Ron had used LSD as well when he was in the Army — and here the connection to schizophrenia seems a bit more obvious. The apparent similarity of the LSD trip to the symptoms of schizophrenia is one reason that scientists experimented with LSD into the 1960s. Some studies conclude that LSD does not just mimic schizophrenia, but can cause it.[6] While the parallels were intriguing, it soon became apparent that LSD was not a path to a cure.[7] 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 flown the nest by the time I was in junior high. We rented a modest house in a lower middle class section of Santa Monica, California, 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 somewhat 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 and thinking.

Here's a picture from one of those of last happy moments before everything fell apart for Ron, taken in August of 1973, just as I was entering twelfth grade and starting classes at UCLA.



AUGUST 1973: RON, CAROLYN, SUSAN, MARILYN, AND ME

My brother's spiral downward began when I was starting my senior year of high school. 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. 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 towards my sisters, whom 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; 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. The pursuit of spiritual knowledge 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. It is a night etched in pain for me, even now. On his own, he called the mental health outpatient clinic near where we lived, and then walked there, a mile or so away. 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 had 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 stay 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 ever be well again?

2. WHAT IS MENTAL ILLNESS?

If you have never been close to someone suffering from it, and you have never studied the subject, 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 divide mental illness into psychotic disorders and mood disorders (roughly replacing the older terms psychosis and neurosis, respectively). Mood disorders consist of a wide range of mental difficulties from mild to severe, including depression or bipolar disorder. Depression's symptoms can be so mild that it may not be recognized, or 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 sometimes lead to suicide — and in spite of what you might think, antidepressants may increase the risk of suicide: they give a severely depressed person enough energy to plan and carry out their own death.[1]

Mood disorders 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 person with a mood disorder may have quite serious problems that require professional attention, he knows what is real, and what is not.

By comparison, psychotic disorders such as schizophrenia can 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 these low-end jobs and disability payments is so small.

The dividing line between psychosis and mood disorder is a bit fuzzy. Bipolar disorder is a mood disorder — but occasionally, people with severe bipolar disorder develop psychotic symptoms, such as hallucinations that break their connection to reality. Similarly, some mild forms of schizophrenia do not impair the sufferer's ability to understand that what he is seeing or hearing is a hallucination.

This book focuses heavily on psychotic disorders, not because mood disorders 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, or about 1.5 percent of adult Americans.[2]

Because an enormous number of sufferers are not consistently treated, schizophrenia is a very costly illness. A 1991 estimate was that it costs the United States about $65 billion in direct and indirect costs,[3] declining to $62.5 billion by 2002.[4] In spite of the enormous number of patients who are not actively treated, schizophrenia treatment consumes about 2.5 percent of *all* U.S. health care expenditures, or about $50 billion a year. Schizophrenia is also responsible for more than 10 percent of *all* disabilities — not just mental disabilities. Government disability payments to schizophrenics in 2005 totaled more than $8 billion.[5]

The $19 billion in direct costs includes the criminal justice system dealing with a few spectacular and terrifying crimes, and a myriad of infractions, arrests, and short periods of observation.[6] A 1999 study found that 16.2 percent of state prison inmates, 7.4 percent of federal prison inmates, and 16.3 percent of jail inmates, were mentally ill.[7] As of 2002, about 26,000 inmates in state prisons across the United States who were convicted of murder were also mentally ill. A detailed examination of Indiana prison inmates convicted of murder found that 18 percent were diagnosed with "schizophrenia or other psychotic disorder, major depression, mania, or bipolar disorder."[8]

We know something of what schizophrenics experience

because about 30 percent recover spontaneously, and are able to tell us what life is like in a world that seems like a *Twilight Zone* episode. Schizophrenia has both positive and 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."[9] The negative symptoms do not respond as well to pharmaceutical treatment.[10] 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. (And as with most illnesses, not everyone with schizophrenia suffers the same mixture of symptoms.)[11]

Schizophrenia may not be one illness, but a collection (or "constellation," as mental health professionals prefer) of symptoms that have something in common[12] — and most importantly, there is some evidence of a biochemical, inherited trait.[13] 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 appear.[14] Unfortunately, the common genetic cause appears to involve a staggeringly large number of mutations that individually contribute to both illnesses.[15] This means that there will likely be no simple path to developing a cure.

Contrary to what used to be commonly accepted within the psychiatric profession, we now know that family and social factors do *not* play a large role in causing schizophrenia, if they play any role at all. One recent study grew neurons from stem cells using genetic material from schizophrenics. These lab-grown neurons had the same distinctive responses as the schizophrenic cells, and the same distinctive reactions to the common antipsychotic medicines. These neurons clearly could not blame bad parenting for their problems.[16]

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 could be delayed consequences of in utero or delivery complications, or perhaps viral infections.[17] 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 six. This is an area that has long been associated with genetic predispositions towards infection and autoimmune diseases.[18]

There is also some suspicion that a particular endogenous retrovirus, HERV-W, already present in much of the human population, when activated by infection and with the appropriate mutations, causes schizophrenia, bipolar disorder, or multiple sclerosis. This explains why schizophrenics are disproportionately born in the winter and early spring months; infections are more common in winter, and may activate this virus.[19] (Endogenous retroviruses are believed to be ancient viral infections that have integrated themselves into the human genetic code.)[20]

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 heard from outside one's head." The fictional 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.[21]

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. A person with schizophrenia may find that his senses have betrayed him; he may believe that his body is on fire, or that there are bugs crawling under the skin. It does no good to tell a schizophrenic that this is a hallucination — the feeling is just as real as if there really are bugs there.

Another common set of symptoms are delusions: "a faulty interpretation of reality that cannot be shaken despite clear evidence to the contrary."[22] Paranoia, the belief that someone is out to get you, is a very common such delusion. Delusions of grandeur are the belief that the sufferer is far more important than he really is. These can combine together to cause a schizophrenic to believe that the CIA or FBI is out to get him. These delusions can develop as a result of those untrustworthy sensory inputs. Try to magine how strange your thinking and 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 schizophrenia can also include catatonia, with the person apparently unable to move,[23] or an agitated state of "extreme psychomotor excitement, talking and shouting almost continuously."[24]

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 the sum of several brain characteristics that can vary over large ranges, "many normal and abnormal states appear continuous with one another." This explains the person who is schizophrenic for several years and then recovers, or fails to fit into a single diagnostic category.[25] I have a relative 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.[26] 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.[27] In light of the apparent connections between alcohol and marijuana use and the development of schizophrenia, the old joke about drinking "killing brain cells" might be closer to the truth than anyone realized.

Because schizophrenia has such a low cure rate — *perhaps* aggravated by failure to treat the illness early enough[28] or

consistently enough[29] — and because most schizophrenics, when first afflicted, have fifty years of life left, this produces extraordinary social costs. Until deinstitutionalization, it was common for almost half of *all* hospital beds (not just mental hospital beds) to be occupied by the mentally ill.[30] Many of these institutionalized mentally ill were 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 number end up in prison.

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 types 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.[31]

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.[32] Intelligent people may have less latent inhibition because they have the capability to handle the extra information, but even intelligent people have limits on how much information their brains can handle. Exceeding those limits may be like a computer that cannot stop the flow of incoming data long enough to respond to the user's commands. This may explain why apparently destructive defects such as schizophrenia and bipolar disorder can survive in the gene pool. For those who carry the gene but do not develop the disease, this creativity and intelligence may provide a

powerful advantage over those who do not.

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 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.

I had a girlfriend in the late 1970s who I will call Joan. We went to high school together, but seemingly never met until after we had graduated. (Our graduating class had a thousand students.) I met Joan as a result of what I call a double blind date: a blind woman that was a mutual friend set us up, sight unseen by all parties! 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 while she had hallucinations, she was still sufficiently in touch with reality to know that they *were* hallucinations.

Joan lived in a tiny studio apartment, a block from the beach, yet her parents lived in a very nice home in one of the best neighborhoods in Santa Monica less than two miles away. Why? 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 symptom of schizophrenia (which reduce interest in doing much of anything), 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 me and her other friends to persuade her otherwise. On one occasion, Joan and a girlfriend spent the night drinking one of the over the counter cough syrups, to the point where both were exhausted, but both 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 aggravated her problems.

At one point in 1977, Joan had spent two days unable to sleep, because the voices in her head 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 in Santa Monica where Ron had gone on that painful night, 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 hallucinations — and now you have to decide which of two mentally disturbed people is telling the truth, or even knows what the truth is. Under the best of conditions, a mental hospital is a sad place for those inside it, and for family members visiting. 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.

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, 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 and a psychiatrist.)

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: severely retarded adults left for hours or even days in soiled diapers; peeling paint (a real problem for retarded patients prone to eating whatever they found); 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 exposés. 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 resided 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 until she passed out in her seat, just as Jackson Browne came on stage. She came to as Browne walked off stage, but 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.

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 wore bright pink 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 seek that help.

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 lobby 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 the homeless of Santa Monica overwhelmingly had mental problems. My brother Ron was, 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. It seemed as though there was nothing that any of us could do for them besides provide the most fleeting of assistance.

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. COLONIAL AMERICA (1607-1775)

Considering the English origins of the American colonies, it is unsurprising that American laws for treating the mentally ill inspired followed the English model.[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; a belief "entirely within the domain of opinion or faith" was not sufficient reason for the law to define someone as insane.[4]

While the legal structure was taken over without changes from England, there was one quite dramatic difference: 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. The reasons are both curious and startlingly humane.

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-based approach. One example is Connecticut, which 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 also instructed 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 help from the colonial government) to maintain, effectively, an insane asylum for one.[6] We have similar examples of public funds to build family-operated individual insane asylums in Amesland, Pennsylvania in 1676[7] and in Braintree, Massachusetts in 1689 and in 1699.[8]

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 hometown of Wallingford, she was to be arrested and returned home — and Wallingford would be charged the costs.[9] 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.

There are doubtless many more instances of persons whose mental illness, while serious, did not prevent them from being cared for at home. John Howard, born in 1733, came from a comfortable family in Maine and showed great promise. But during the French & Indian War, while on an expedition to Canada, he

> fired on one occasion when in the woods at what he supposed to be a bear; it proved to be one of the party, and that he had

> unfortunately taken his life. No blame was imputed to Howard, but the occurrence so affected him that he sank into hopeless insanity. "He lived long at the fort, gentle and inoffensive, but possessed of immense imaginary wealth."[10]

In a few cases, we find evidence that the courts committed persons if they were perceived as mentally ill — but the nature of these accounts suggests that they were more than just eccentric in their behavior. A Jonathan Wyat was brought before Judge Joshua Hempstead in New London, Connecticut, in December of 1739 by the town and found to be "Disorderly Idle Distracted or worse & Sentenced him to the work-house." Another account from Hempstead's diary, while less detailed, reports that he spent part of March 22, 1731 "Examining a Distracted woman & Committing her." [11] In Massachusetts, 1676 and 1694 statutes directed town governments and overseers of the poor to care for "Idiots and Distracted Persons" with concern that the mentally ill might otherwise "damnify [injure] others."[12]

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 some years after his graduation for disrupting the event, there was no apparent interest in locking him up — and he kept his job as schoolmaster.[13] He was, however, "warned out" of Boston in 1742 and 1744 for being "in a Distracted Condition & very likely to be a Town Charge."[14] A more detailed biographical sketch suggests that by his late 20s, he was showing some indications of odd and inappropriate behavior — but that his problems were recognized not as immorality, but mental disturbance.[15]

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.[16] Exactly in what way Moody was mentally ill, as opposed to eccentric, is debatable. 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.[17]

Another example was the Rev. Samuel Checkley, who was at first "unable to speak without weeping" — but then progressed to preaching in gibberish. Even then, his congregation, rather than fire him, 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.[18]

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 he lacked the means to care for himself? 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 particular mentally ill people, much of the legislative activity in this area concerned 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.

In contrast, towns would often "warn out" mentally ill non-residents 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.[19] However, those "warned out" might be able to avoid removal if they or someone else posted a bond protecting the town from financial obligation to support such a person.[20] Depending on the colony, a person had to be "warned out" within some specified period of time, either three months or twelve

months (in the case of Massachusetts Bay Colony) or the town was obligated to provide for such a person under the poor laws.[21]

Still, we should not exaggerate the economic calculation of these concerns. Distracted persons were also friends and neighbors, and we have examples such as Providence Colony's response to "a distracted person" named Mrs. Weston in 1650. The Colony was to take charge of "what is left of hers" and provide her with the necessities of life.[22] They also provided both money and labor to assist Mr. Pike in caring for his "distracted" wife in 1655, and this was not the first time that the government provided such help.[23]

Still, the system did not lock up those who were not perceived as a threat to others, even when the consequences might be severe. Margaret Goodwin in January of 1651 was "given into the keeping of six reputable citizens of the town" who were to care for her and her estate "during the period of her distraction."[24] She left the house during a thunderstorm shortly thereafter. A coroner's inquest in March of 1651 concluded that she died of "either the terribleness of the crack of thunder… or the coldness of the night, being she was naked."[25]

The compassion and understanding of colonial governments is sometimes quite surprising. 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.[26] Colonial newspapers occasionally mention the actions of "lunaticks" who committed "outrages" but seemed to recognize the limited responsibility that the insane bore for their actions,[27] or identified a suicide as "lunatick."[28] Ads also seek the return of wandering mentally ill family members.[29]

In the middle of the eighteenth century, a few of the larger cities built institutions that housed the insane — but these were not 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.[30] Philadelphia's first publicly funded almshouse, established in 1732, confined the physically sick and the insane together for the same purpose.[31] 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."[32]

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 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.[33]

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.[34]

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 not 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…."[35]

While Colonial Americans 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.[36] As a consequence, while the Pennsylvania Hospital admitted only those physically ill who were deemed "curable," this was not required for the mentally ill.[37] 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 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.[38]

What did Colonial Americans think mental illness was? Some historians have emphasized the overlap between witchcraft, sin, and mental illness, a position that was certainly widespread as late as the nineteenth century among German doctors.[39] 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. Yet by 1724, his unpublished *The Angel of Bethesda* recognized that mania and melancholia had physical causes as well, for which a medicine such as St. John's Wort (a plant whose value for treating depression is now making a comeback), 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.[40]

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.[41] 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.[42]

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. "Maniac" suggests the extreme

mania phase of bipolar disorder today. More than a few colonists were "distracted," which suggests severe depression, perhaps hebephrenic schizophrenia (characterized by "incoherence, wild excitement alternating with tearfulness and depression")[43], 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, based on both English common law and statutes. The "furiously insane" could be arrested by anyone,[44] 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. The low rates of psychosis may also be why so few murders seem to have been committed by the mentally ill. Marietta and Rowe's detailed examination of Pennsylvania murders in the years 1682-1800 lists surprisingly few cases of clear insanity: there are only five murderers whose actions were driven by depression or delusions — out of 513 surviving accusations. (The first Pennsylvania verdict of not guilty by reason of insanity involved Terrence Rogers' murder of Edward Swainey in 1743.)[45]

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.[46] 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.[47]

Much of what drove this development of specifically mental hospitals 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 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 in cities "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.[48]

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.[49] 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 states, had much higher rates of mental illness.[50]

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.[51] 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 more than a ten-fold increase in psychosis rates from the beginning of the seventeenth century to 1986.[52] In 1764, Thomas Hancock left £600 to the city of Boston to build a mental hospital for the inhabitants of Massachusetts. The city declined to accept this gift, on the grounds that there were not enough insane persons to justify building such a facility.[53] Massachusetts had a population between 188,000 and 235,000 in 1764; if the population of the time suffered the same schizophrenia rates as today, that would mean that there

were about 2000 schizophrenics in the province.[54] Even accounting for the greater tolerance of small town life for the mentally ill, this lends credence to Torrey and Miller's claim of rising psychosis rates. 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. More recent analysis shows that throughout the nineteenth and twentieth centuries, Ireland's rates of insanity were 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.[55]

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 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.

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