

Book Review: Mental Health Policy in Modern America

Gerald N. Grob. 1991. *From Asylum to Community: Mental Health Policy in Modern America*. Princeton: Princeton University Press. xv + 406 pp. \$31.25.

Whilst in ordinary life every shopkeeper is very well able to distinguish between what someone professes to be and what he really is, our historians have not yet won even this trivial insight. They take every epoch at its word and believe that everything it says and imagines about itself is true.

Karl Marx and Frederick Engels
The German Ideology

DURING THE PAST QUARTER CENTURY, A NEW generation of historical studies has provided us with rich insights into the rise of the nineteenth-century asylum and the associated consolidation of mental medicine (see, e.g., Castel 1975, 1988; Doerner 1969, 1981; Scull 1989, 1991, in press; Digby 1985; Goldstein 1987; Dowbiggin 1991). In an American context, two historians, Gerald Grob (1966, 1973a) and David Rothman (1971) have emerged as the most prominent figures in the field, proceeding from radically different starting points to provide sharply contrasting assessments of the rise of segregative responses to madness. Where Grob provided a sophisticated reworking of traditional meliorist interpretations of the discovery of the asylum, attempting in the process to rescue the reputation of lunacy reformers for humanitarianism and benevolence, Rothman saw their schemes as fatally flawed from the outset, and embraced the Goffmanian vision of mental hospitals as inevitably disabling and dehumanizing "total institutions" (Goffman 1961), irredeemably awful and incapable of fundamental change.

Notwithstanding their fundamental intellectual differences, and the contempt and hostility the two men offered each other in print (particularly visible in Grob 1973b, 1977, and in Rothman 1976), there are, oddly enough, some curious formal symmetries in their work: in their respective accounts both emphasize the stated intentions and more or less acknowledged motivations of the lunacy reformers themselves, while insufficiently examining the larger social and political order within which change occurs; and both offer remarkably solipsistic and ethnocentric accounts, apparently indifferent to European influences upon (and parallels with) American developments and almost equally neglectful of the relevant contemporary European historiography. (For elaboration of these points, see Fox 1976; Muraskin 1976; Davis 1980; Scull 1989: 95–117, 250–66.) On another level, too, Grob's and Rothman's intellectual careers have remained closely intertwined: having examined its origins, both went on to provide (inevitably contrasting) examinations of the fate of the asylum in the Progressive era (Grob 1983; Rothman 1980); most recently, both have ventured into unfamiliar territory for historians—the sharply contested terrain of contemporary policy making.

Significantly, Rothman did so as a historian turned public activist, convinced by his prior researches that the essential precondition for progress was the destruction of the dismal and decaying “museums of madness” that were our tainted inheritance from a prior generation of reformers. *The Willowbrook Wars* (Rothman and Rothman 1984) did not masquerade as a dispassionate and even-handed scholarly monograph. Rather, it provided an indictment of the horrors of institutional provision for the mentally retarded in contemporary New York, at once a piece of social *reportage* and a fierce polemic against segregative and institutionally based responses to mental disorder and deficiency. Gerald Grob, as one might expect, has not been tempted to stray down similar pathways. His new book (Grob 1991), as I shall show, provides the same sort of bowdlerized and “responsible” history that has won his previous work a warm welcome from the psychiatric powers-that-be—a book that, for whatever reason, curtails its temporal focus so as to avoid examining the worst failures of contemporary mental health policy; and in other ways averts its gaze from events that might force him to move beyond the trite conclusion that all human actions have unintended consequences, which “tend to be complex and unpredictable” (Grob 1991:303). As usual, Grob instead rushes to remind us (whenever criti-

cal assessment seems inescapable) that “reality rarely corresponds with ideals sought” (Grob 1991:239); that benevolent intentions are uniformly at work in the world; and that progress is unmistakable, whatever flaws and imperfections may yet remain.

In assessing Grob’s contribution to our understanding of the post-World War II era, I must stress at the outset that, for all the recent explosion of interest in the history of psychiatry, twentieth-century developments have remained largely unexplored territory, constituting in most respects “a wild and uncultivated region, an intellectual Africa” (as Sir Richard Blackmore [1724:263] once termed the state of knowledge about madness itself). Even the least historically informed among us is aware, however, that the last half-century has seen dramatic, even revolutionary, changes in our society’s basic responses to the problems posed by grave mental illness and disability. The Victorian bins to which we once consigned the mad, to be dealt with like so much human waste or detritus, have been substantially replaced by facilities that were at first proclaimed to be new forms of community “care,” but that now increasingly seem to be alternative, yet quite possibly equally hideous, policies of “privatized” malign neglect—whether at the hands of speculators in human misery in board-and-care homes or on street corners and in gutters, the new resting place for our society’s unwashed and unwanted. People who bother to read the newspapers, or who involuntarily share urban public space with some of the “beneficiaries” of the latest triumph in the march of psychiatric progress, may be forgiven for questioning whether we are witnessing the doubtful contribution to the sum of human happiness of still another twentieth-century revolution. Equally, of course, they may ask what explains the emergence and—as important—the persistence of such radical departures in public policy, in the face of accumulating evidence of their disastrous impact on the lives of persons they are allegedly designed to succor and save.

The third volume in Grob’s trilogy (Grob 1973a, 1983, 1991) purports to provide us with a nuanced and historically informed answer to these questions. His book jacket promises us a careful analysis of “the post-World War II policy shift that moved many severely mentally ill patients from large state hospitals to nursing homes, families, and subsidized hotel rooms—and also, most disastrously, to the streets.” His opening paragraphs announce his fascination with “the ways in which public policy is defined, formulated, and implemented” and proclaim that “this book . . . is deliberately focused on the severely and espe-

cially the chronically mentally ill” (Grob 1991:xiv) On virtually all counts, I shall suggest that this is false and misleading advertising. In fact, the fate of the deinstitutionalized is accorded a scant dozen sanitized pages, toward the close of 300 pages largely devoted to the minutiae of intra- and interprofessional squabbles and bureaucratic infighting; no adequate account is provided of the policy shifts that prompted the abandonment of segregative approaches to the severely and chronically mentally disabled. Grob’s artificial and never justified decision to bring his account to a close in 1970 enables him to avoid the crucial question of why the massive reassignment of patients has persisted even as it would appear that the problems associated with deinstitutionalization grow ever more serious and impossible to ignore.

No one can doubt that the half-century since World War II has witnessed some remarkable developments in American psychiatry. Mental illness, once almost exclusively a responsibility of the individual states, has increasingly attracted a substantial federal presence—directly, following the passage in 1946 of the National Mental Health Act, through the programs and activities of the National Institute of Mental Health (NIMH); but also (and in many ways still more decisively) *indirectly*, through transformations in social welfare policies and the often unintended effects of the shifting character of the federal safety net. The psychiatric profession itself, after an intense romance with psychoanalytic theorizing and therapies, which dominated it for a quarter-century, has grown weary of their charms, and has re-embraced the more medically respectable attractions of biological reductionism and psychopharmacology. Simultaneously, it has sought to broaden the market for its wares, reaching out beyond the clinically hopeless, socially deprived, often physically decrepit and always grossly stigmatized specimens who traditionally languished on the back wards of the state hospitals to provide advice to the neurotic and the well-to-do (or at least those covered by insurance policies), who are nevertheless unfulfilled and unhappy; to the battered and the batterers; to the divorced and the delinquent; and to the alcoholic and the drug addicted. (In the process, psychiatry has encountered increasingly fierce competition—intellectual and financial—from nonmedically trained rivals, most notably clinical psychologists and social workers.) A federally financed flirtation with community mental health centers, temporarily underwritten by subsidies from Washington

and linked to spurious claims about psychiatry's ability to utilize early intervention to forestall the development of psychoses, has come and gone, with neither the construction nor the demise of the centers being related in any discernible way to the fate of the formerly institutionalized.

Meanwhile, state hospital populations, which had continued to rise, at least at the national level, from the mid-nineteenth century through the mid-1950s, have fallen precipitously in the succeeding decades. The chronically crazy themselves, bereft of the social supports that might make their existence bearable, have suffered extremes of neglect. Organized psychiatry has increasingly handed over the task of coping with the permanently psychotic to the ill-regulated operators of nursing homes, board houses, and welfare hotels (where the ex-patients have not joined the ranks of the homeless sidewalk psychotics), limiting its own involvement with such unrewarding and dispiriting cases to the occasional prescription of antipsychotic "depot drugs." Furthermore, the political system has proved almost wholly unresponsive to the resulting crisis, notwithstanding the manifest and ever more visible failures of a policy of community "care."

For Grob, the explanation of this constellation of changes is ultimately to be sought in the transformative impact of the Second World War on what he portrays as a previously isolated and insular specialty, largely devoted to the institutional care of an increasingly geriatric and organically impaired inpatient population. The war, he suggests, marked "a watershed" in mental health policy, and in the evolution of the psychiatric profession itself. For the mental hospitals, it immediately brought further deterioration from the already attenuated support levels characteristic of the Depression years: overcrowding; acute shortages of medical and other personnel; decaying buildings; abused and neglected patients. For the psychiatric profession, however, the war had very different effects. Previously marginal men, whose "expertise" was lightly regarded by fellow professionals and laymen alike (where, indeed, it was acknowledged at all), American psychiatrists now hastened to put their talents in the nation's service, finding an apparently credulous audience in the war machine. Mass screening of military recruits, it was suggested, could identify persons at risk of mental breakdown under the stress of combat, and largely obviate the enormous costs, psychic and material, of a new epidemic of "shell shock." Subsequently, when such gains proved illusory, and neuropsychiatric casualties mounted anyway,

psychiatrists instead proffered their services in the prevention of further outbreaks, and, where necessary, in the rapid treatment and return to action of soldiers afflicted with what came to be called "combat neurosis."

These developments coincided with, indeed helped to produce, a sizeable expansion in the number of physicians specializing in the treatment of mental disorders. More important, in Grob's view, they created a "basic intellectual shift" in psychiatry: toward an emphasis on early intervention and treatment; the expansion of professional jurisdiction to capture an ambulatory, albeit symptom-bearing, population of neurotics, who could be dealt with in family and community settings rather than isolated and remote institutions; increased recognition of the seriousness of the public health problem that mental illnesses represented, along with greater optimism about the possibilities for effective intervention; and a growing fascination with psychodynamic theories and therapies. At the same time, the parlous state of the traditional mental hospitals left them vulnerable to scandal, a potential that was soon realized thanks to the efforts of muckraking journalists and crusading reformers.

Clearly, there is something to all these claims. Just as surely, however, there are difficulties and problems even with this portion of Grob's analysis. In the first place, many of the transformations he attributes to the Second World War were already underway decades before. Attempts by elite specialists in "nervous disorders" to carve out office- and clinic-based practices, and to distance themselves from the deficiencies and failures of institutional psychiatry, were increasingly manifest on both sides of the Atlantic during the last third of the nineteenth century. In the United States, these efforts were often, though not always, closely associated with the development of the rival profession of neurology (Blustein 1979, 1981, 1991; Sicherman 1977; Abbott 1982, 1988; for English developments, see Turner 1988; Oppenheim 1991; Scull in press: chaps. 5, 6, and 8). Such endeavors acquired additional momentum in the early twentieth century in association with the advent of new systems of "psychotherapeutics," most notably psychoanalysis (Hale 1971; Sicherman 1967; Hinshelwood 1991; Pines 1991). Far more important, however, was the impact of the *First* (not the Second) World War, for it was this militarily inspired epidemic of mass psychiatric illness that at once called into question the hereditarian and somatic approaches that had hitherto dominated institutional psychiatry, and brought the problems of psychiatric and emotional illness into

new and startling prominence (Abbott 1982:266-74, 459-70; Stone 1985a,b; Showalter 1985: chap. 7).

During the interwar years, therefore, the intellectual center of gravity of American psychiatry was already shifting away from the institution. The concern with prevention, which had been a prominent theme among elite "nerve-doctors" from the late 1860s onward (Sicherman 1967; Rosenberg 1962), acquired a new prominence in the 1920s. Spurred on by the Commonwealth Fund and by the National Committee for Mental Hygiene (founded by an ex-patient, Clifford Beers, in 1909, and directed by Thomas Salmon) (Dain 1981), psychiatry moved, for instance, to capture jurisdiction over the problem of juvenile delinquency (Salmon 1920) and to establish control over a new network of child guidance clinics (Horn 1989; Jones 1988; White 1925; Stevenson and Smith 1934). Salmon was particularly vocal, but represented a growing constituency within the profession when he insisted on the need for psychiatry to reach out beyond the walls of the mental hospital and to involve itself in the treatment of alcoholics, in the prevention of crime, prostitution, and dependency, in the treatment of criminals, and in providing advice on eugenics and mental hygiene (Salmon 1917, 1924; Rosanoff 1917). And with respect to more conventional targets of psychiatric intervention, with the foundation of psychopathic hospitals, efforts were made to locate and treat, often as outpatients, the "not insane," the "not yet insane," and "early and incipient cases of mental diseases," all pictured as patients capable of being "restored to useful lives by early treatment" (Southard 1916). The blurring of the boundaries between the normal and the pathological, and the rise of the notion that mental health and illness formed a continuum (developments Grob is eager to attribute to the impact of the war with Hitler and Hirohito) were already psychiatric beliefs that were taken for granted decades earlier. As Cyril Burt (1935:5) testified, "It was perhaps the First World War that most effectively brought home the artificiality of the distinction between the normal mind on the one hand and its abnormal conditions on the other. In the military hospitals the study of so-called shell shock revealed that symptoms quite as serious as the well-defined psychoses might arise through simple [*sic*] stress and strain and yet prove quickly curable by psychotherapeutic means. And thus, it gradually became apparent that much of what had been considered abnormal might be discovered in the brain of the average man." Psychodynamic ideas

and psychotherapeutic approaches were already spreading rapidly in the 1920s and 1930s, particularly among the professional elite (Abbott 1982:324–30, 377–87); and, led by Alan Gregg, from the early 1930s the Rockefeller Foundation was providing funding to institutionalize psychoanalytic training in the United States (Gregg n.d.; Brown 1987).

Nor was the involvement of psychiatry in the Second World War a resounding success. Mass screening of recruits angered the military apparatus because the rejection on psychiatric grounds of some 1.75 million men interfered with the effort to maximize military manpower. Worse still, it did nothing whatsoever to stem the epidemic of war-related psychiatric disabilities, once the supposedly prescreened soldiers experienced combat. Efforts at prevention were similarly unavailing, and although Grob refers to the psychiatric treatment of war neuroses as a success, the evidence for this proposition is weak at best. Data collected at the time suggested, in fact, that the less psychiatric treatment a soldier received, the better his chances of avoiding permanent mental incapacity. Soldiers dealt with at the front, who were given no more than warm food and a sedative to secure a night's sleep, typically recovered and resumed fighting; those sent back behind the lines for a few days of more extended psychotherapy were generally unable to return to combat, although often they were not totally disabled; but those sent to a rear echelon base hospital for more extensive treatment seldom reappeared, with fewer than 10 percent returning to active duty. These outcomes were scarcely rousing testimony to the success of psychiatric treatment, although, as Grob points out, military psychiatrists put the best face possible on these data, and tried to convince themselves and others that they were proof of the efficacy of early intervention.

Conditions in state mental hospitals during the war and in the immediate postwar era were undoubtedly appalling, and Grob devotes chapter 4 of his book to the exposés and withering criticism that these inspired. Novelists and film makers vied with journalists and sociologists to document the manifold failures of asylums as therapeutic institutions. Here again, however, one must ask what all these assaults amounted to, in what respects they were novel, and how far they contributed to the dissolution of the segregative approach to mental illness. Grob (1991:71) himself sees a “crisis of unprecedented proportions” linked in part to the havoc wreaked on the system by the Great Depression and by the war itself, but deriving also from a transformation in

the hospitals' functions and patient population, which he claims began in the early twentieth century. "Throughout the nineteenth century," he argues, "patient populations were made up largely of acute cases institutionalized for less than a year . . . the bulk of patients were discharged in twelve months or less" (Grob 1991:5). All this changed for the worse, he asserts, beginning around 1890, when the closing of almshouses precipitated the mass transfer of elderly and senile inmates, transforming mental hospitals into "institutions that provided long-term custodial care for an overwhelmingly chronic population. . . ." (Grob 1991:6).

This is an odd piece of revisionism. Careful recent studies of admission to and discharge from nineteenth-century asylums (both large public bins and elite private asylums) have certainly modified to a limited extent an earlier portrait that depicted them as little more than cemeteries for the still breathing. We now know that a significant minority of each year's admissions tended to be released within the first 12 months after their arrival, ranging between 25 and perhaps 45 percent (although this fraction tended to decline over time). Adding in deaths and transfers, perhaps 50 or 55 percent of admissions were "resolved" within a year (for England, see Ray 1981; MacKenzie 1985; Walton 1985; for the United States, Dwyer 1987). This is very far, however, from being "the bulk" of a given year's admissions. Moreover, simple arithmetic ensured that, over time, an increasingly large fraction of asylums' total population consisted of chronic patients, as each year's contribution of therapeutic failures lingered on to swell the hospital census. At Utica State Hospital in New York, for instance, recoveries calculated on total numbers resident never rose above 16 percent after 1856, and by 1890, had fallen below 11 percent (Dwyer 1987:150). Notwithstanding some turnover at the margin, therefore, by the last third of the nineteenth century, *pace* Grob, the overwhelming bulk of mental hospital populations consisted of the chronically crazy, and the asylum had already been publicly identified—fairly or not—as an almost exclusively custodial institution. David Rothman's work (1971: especially chap. 11; 1980: chaps. 9 and 10), for instance, has documented some of the dimensions of the "dramatic decline from a reform to a custodial operation"—most notably "overcrowding . . . the breakdown of classification systems, the demise of work therapy, and an increase in the use of mechanical restraints and harsh punishments to maintain order" even as early as the 1850s. Still more awkwardly for Grob's revisionist case, his own earlier study of nine-

teenth-century developments (Grob 1973a:306–8, 238) reached essentially the same conclusions: “After 1860, . . . the continuous rise in the number of chronic patients had all but obliterated the therapeutic goals of many hospitals . . . virtually every hospital in the nation was confronted with a problem whose magnitude was clearly increasing rather than diminishing . . . overcrowded conditions and the accumulation of chronic patients” were increasingly the norm, as “the transformation of mental hospitals into strictly welfare institutions as far as their funding and reputation were concerned” solidified “their custodial character.”

By the 1870s, moreover, mental hospitals were subjected to *savage* criticism, being increasingly seen as actively harmful to those they purported to cure. Henry Maudsley (1871:432), for instance, the leading English alienist of the age, confessed that “I cannot help feeling, from my experience, that one effect of asylums is to make permanent lunatics.” Spitzka (1878), Hammond (1879), and Mitchell (1894:19), among the leading American neurologists of the Gilded Age, were equally emphatic, complaining of the pernicious effects of incarceration, and of “the sadness . . . of the wards . . . [in which] the insane, who have lost even the memory of hope, sit in rows, too dull to know despair, watched by attendants, silent, grewsome [*sic*] machines which eat and sleep, sleep and eat.” Lay critics were even less inhibited, denouncing the hospitals’ failings, calling into question the superintendents’ claims to expertise, and claiming that mistreatment and abuse were routine. (The short-lived National Association for the Protection of the Insane and the Prevention of Insanity was particularly vocal in this regard, but others [e.g., Packard 1873; Eaton 1881] were still more virulent in their criticisms.)

Neither the existence nor the content of the post-World War II exposés was novel, therefore, as even Grob (1991:72) ultimately concedes. In explaining why they mattered more on the present occasion, he is reduced to muttering vaguely about the changed setting in which the recycled critiques emerged. *This* time around, he asserts (Grob 1991:72–3), with more than a trace of desperation, they counted, because “intellectual, cultural, and social currents converged to create a receptivity toward innovation.”

Given that scandals about mental hospitals had routinely surfaced throughout their history, the more skeptical among us might be inclined to question how important new variations on this well-worn theme actually were in finally pushing the system toward massive

change. Skepticism deepens when one scrutinizes the examples Grob provides. Take, for example, the most famous exposés of the late 1940s: Albert Deutsch's (1948) series on American mental hospitals for the New York newspaper, *PM* (subsequently reworked as the best-selling *The Shame of the States*); Albert Maisel's (1946) famous *Life* essay on "Bedlam 1946"; the revelations published by conscientious objectors "sentenced" to provide alternative service on mental hospital wards during the war (Wright 1947); and Mary Jane Ward's (1946) best-selling novel, *The Snake Pit* (serialized in *Reader's Digest* and made into one of the five most popular films of 1949)—all these texts shared a common stance toward the institutions of which they were apparently so fiercely critical. All portrayed the hospitals (and those who ran them) as making "a genuine effort to care for and heal the mentally ill" (*PM*, May 27, 1947, quoted in Grob 1991:77), and, as Grob (1991:74) concedes, each and every one of them was emphatically "intended neither to discredit mental hospitals nor to undermine their legitimacy." Quite the contrary, their explicit agenda was to pressure politicians to spend more money on the system, so as "to put an end to concentration camps that masquerade as hospitals and to make cure rather than incarceration the goal" (Albert Q. Maisel, quoted in Grob 1991:75).

Grob is convinced of the importance of rhetoric and faith in producing social change and he repeatedly invokes their "power" as a major explanatory factor (e.g., Grob 1991:92, 171, 176–7, 189, 224). But here, as elsewhere, this conviction lands him in the soup. For how can political speeches, reform propaganda, policy statements, and public relations prevarications be the motor of change when they repeatedly propose and reinforce traditional notions about the necessity for funneling patients into mental hospitals? He grudgingly admits (Grob 1991:92) that among the "curious coalition" of reformers he focuses on—"activist psychodynamic and psychoanalytic psychiatrists, journalists, political leaders, and lay and professional organizations . . . the long-standing commitment to an institution-based system remained outwardly unchanged." (Inwardly too, so far as we can tell: despite ransacking private papers and correspondence, Grob cannot demonstrate even a behind-the-scenes commitment to tear down the fabric of asylumdom.)

Three later chapters on developments from the mid-1950s to the mid-1960s are similarly unsatisfactory. Grob gives great prominence to the activities of the Joint Commission on Mental Illness and Health (1961), which appeared on the scene in 1955, and issued its final report,

Action for Mental Health, in 1961. It is not clear why. Never adequately funded, operating with the vaguest of mandates and objectives, and riddled with internal ambivalence and confusion, the commission sponsored an undistinguished series of monographs on a haphazard array of topics. Its own synthesizing final report was similarly unhelpful. Largely written by a specialist in public relations, it proclaimed with typically overblown and vacuous rhetoric that “*the time is at hand and their courage is such that modern legislators may make history by adopting a new policy of action for mental health*” (Joint Commission 1961:295).

Leaving aside its shopworn phrases, however, the report was essentially an empty exercise, failing, as Grob (1991:209) himself concedes, “to offer a precise blueprint that could serve as the basis for legislative action.” Its call for further expansion of NIMH was doubtless appreciated by that agency (which had substantially underwritten the commission’s costs), but high-level officials at the institute were privately scathing about the mouse that six years of labor had brought forth. Shown a prepublication draft, Philip Sapir (chief of NIMH’s Research and Fellowships Branch) dismissed it scornfully as “pedestrian, platitudinous, rehashes of previous statements, half-truths, or untruths . . . so incredibly bad that there seems almost no point in making specific criticisms” (quoted in Grob 1991:217).

The one new federal policy initiative that postdated the report derived, not from the commission’s recommendations, but from proposals independently put forward by the NIMH. The NIMH program involved the establishment of a network of community mental health centers, subsidized by the federal government, overseen and advised by the institute. These were to be devoted to prevention and early treatment, a piece of empire building NIMH sold to its political masters by promising that their program would make it possible “*for the mental hospital as it is now known to disappear from the scene within the next twenty-five years*” (NIMH internal task force report, quoted in Grob 1991:222).

Given the long-entrenched connections of traditional mental hospitals with the political system at the state level, it should come as no surprise that the emerging federal mental health bureaucracy from the outset attempted to carve out a different role for itself. It funded, for instance, a massive expansion of the involvement of the social and behavioral sciences in the mental health complex (by 1964, 55 percent of NIMH principal investigators were psychologists and a further 7 percent were sociologists, anthropologists, and epidemiologists—who collec-

tively spent 60 percent of the research funds awarded—whereas psychiatrists were 12 percent of the researchers, spending only 15 percent of the funds). It underwrote a similar expansion of programs to train professionals (most of whom promptly entered private practice). It sought to create a new network of treatment facilities that depended upon federal dollars (thereby justifying an expansion of the territory administered by federal bureaucrats). None of this, however, necessarily spelled the end of an entrenched reliance on segregative responses to serious forms of mental disorder.

In fact, we have known for many years now (see Chu and Trotter 1974; Gronfein 1985; Windle and Scully 1976; Kirk and Thierren 1975; Rose 1979) that the centers established under the Mental Retardation and Community Mental Health Centers Act of 1963, and successive legislation modifying this program, were quite simply irrelevant to the deinstitutionalization of the population of the traditional state hospitals. From the outset, administrators of these centers displayed a pronounced preference for treating “‘good patients’ [rather] than chronic schizophrenics, alcoholics, or senile psychotics” (Rieder 1974:11)—in other words, a determination *not* to treat patients being discharged from state hospitals. Unsurprisingly, this deliberate policy of discrimination against ex-state-hospital patients and refusal to address their needs was, unlike most psychiatric interventions, highly effective in practice, producing precisely the outcome the professionals sought, at the price of leaving chronic psychotics bereft of treatment and care.

In the circumstances, it is surely misguided for anyone centrally concerned with the fate of “the seriously and especially the chronically mentally ill” (Grob 1991:xiii) to focus minute attention either on the internal politics of the formation and functioning of the Joint Commission on Mental Illness and Health, or on the bureaucratic and political maneuvering surrounding the passage of the Community Mental Health Centers Act. Ironically, Grob (1991:420) himself concedes the essential point here: “To be sure, resident populations of mental hospitals declined rapidly after 1965. . . . This dramatic change, however, was not related to the establishment of [community mental health] centers. On the contrary, the transformation of the character and functions of mental hospitals was shaped by other developments.” *Precisely*. Yet these mysterious “other developments,” which ought surely to be the primary focus of his analysis, receive only the most glancing of attention. Other data, moreover, confirm the centers’ irrelevance, even to the profession

itself. As Grob (1991:256) notes, within just over a decade of the system's creation, "the relationship between the specialty of psychiatry and centers became problematical. . . . Centers were largely staffed by clinical psychologists, social workers, or non-professional staff—groups that had neither interest in nor experience with the severely mentally ill."

However, this myopia, this failure to place developments in the mental health arena in a larger social and political context, is the defining characteristic of Grob's approach to the territory he has indicated he wishes to explore. Elsewhere, for example, he displays a similarly misplaced obsession with every twist and turn of professional and bureaucratic squabbles and conflicts whose relevance, his own account suggests, is marginal to the central issues at hand. His second chapter, for instance, is largely taken up with surveying, in excruciating detail, the professional infighting during the years immediately after the Second World War between old-line institutional psychiatrists, enraptured with lobotomies and shock therapies, and the psychodynamically oriented Young Turks, who banded together to form the Group for the Advancement of Psychiatry (GAP). To be sure, this led to the public airing of some very dirty professional linen, but when "intraorganizational differences threatened to undermine public respect and confidence and thus destroy the very legitimacy essential to the well-being of any professional group" the reform movement fizzled, the schisms were papered over, and GAP essentially gave up on "the idea of transforming psychiatry, [and] became the vehicle for liberal and activist psychiatrists to express their views on a whole range of social and medical problems." Mysteriously, Grob (1991:38–9, 41) claims that this outcome meant that GAP "may have lost the battle, but . . . surely won the war." He refers here to the growing postwar activism of psychiatry, the temporary increase in the influence of psychoanalysis among the professional elite, and the disengagement of the specialty from the public sector. However, the contention that the increasingly feeble apparatus of GAP was a precondition for (or even significantly related to) these developments is never demonstrated and seems highly doubtful.

Here, and in subsequent chapters on the politics of federal intervention and on conflicts between psychiatry and other mental health professions, Grob seems to believe that an exhaustive reading of internal documents and, more especially, of the private correspondence of psychiatrists will somehow provide the key to understanding broad shifts in public policy. This is to assume, however, that deinstitutionalization

flowed from conscious legislative efforts to accomplish this end, and involved rational planning to allocate the necessary resources for community-based care—assertions that find little support in either the literature or, more important, in the historical record itself (which suggests rather that expediency ruled) (see Lerman 1982). Furthermore, it implicitly accords a larger and more determinative role for the opinions of professional experts than is remotely plausible.

Grob clearly wants to attribute the shift away from the traditional reliance on institutions to the activities and opinions of these elites. For him (Grob 1991:92), “the foundations for change [were], in effect, a curious coalition formed in the decade following the end of World War II. Composed of activist psychodynamic and psychoanalytic psychiatrists, journalists, political leaders, and lay and professional organizations, its members endorsed prescriptions for change.” This line of argument quickly collapses under any sort of scrutiny, however, for Grob’s “curious coalition” was completely unable to agree on what sort of change to propose, much less muster the political muscle to secure enactment of a program of reform. Grob acknowledges as much: “This coalition was by no means unified around a common program.” Unfortunately for his argument, however, its difficulties are graver still, for his “coalition” *did* agree on the continued necessity of the traditional mental hospital. (As Grob delicately phrases it, “the long-standing commitment to an institution-based system remained outwardly [*sic*] unchanged.”) Having demolished his own case, Grob is now reduced to clutching at straws. Desperately, he insists, “Nevertheless, by defining a problem and shaping an agenda, [the coalition’s] members helped to set in motion a process that in the future would help to change the ways in which American society apprehended and responded to the problems posed by mental illness.”

This is all rather sad. Grob (1991:125, 179, 181, 216) may be willing to rest content with such banalities as the claim that these ruminations led to a “receptivity to community alternatives,” and that, in turn, fueled by “the excitement, sense of urgency, and optimism characteristic of the postwar years . . . ,” such receptivity created dramatic changes in public policy when “the time was ripe.” But to halt the analysis at this point is to beg the essential questions in a cloud of wishful and unconvincing rhetoric.

Although the reader of *From Asylum to Community* is never apprised of it, time must have been ripening almost simultaneously in

many different national settings. In Britain, for instance, the mental hospital census peaked a year earlier than in the United States, and by the early 1960s the central government was explicitly committed to closing inpatient treatment facilities. To be sure, deinstitutionalization had a different pace and rhythm across the Atlantic, and some of the most distinctive features of the American mental health scene (most notably the growth of what I have elsewhere called [Scull 1981] "a new trade in lunacy") have developed much more slowly and haltingly there. Still, the parallels are sufficient to cast serious doubt on a line of explanation that places most weight on parochial and personal factors.

The differences in the timing and intensity of the shift away from mental hospitals also provide us with clues about what has been driving the process. In both countries, admissions to mental hospitals were rising sharply in the postwar years. At the same time, the ramshackle barracks asylums inherited from the Victorian age were visibly decaying, potentially requiring massive infusions of capital for repair and expansion. Worse still, the tighter postwar labor market and the impact of unionization were sharply raising operating costs. Not surprisingly, therefore, policy makers in both countries were attracted by the possibility of shifting the locus of care away from increasingly costly traditional mental hospitals.

In the United States, however, the process of emptying out the mental hospitals proceeded far more rapidly than in Britain, and at an earlier stage the discharge of the senile and the elderly formed a much larger fraction of patients decanted into the new community alternatives. Although there were marked variations from state to state in the timing of deinstitutionalization, national data make clear that there were two periods when the pace of discharges accelerated markedly in the United States, while no comparable shifts can be seen in the British data. The first of these occurred from 1965 onward, and consisted disproportionately of inmates over the age of 65. The second, more broadly based and geographically widespread, dates from 1973, outside the self-imposed time limits of Grob's study, but after the major drawbacks of deinstitutionalization had come to be widely apparent.

Briefly, Grob (1991:261) concedes that what he acknowledges was a "precipitous" fall in state hospital populations after 1965 occurred "largely because changes in funding patterns led to a sharp decline in elderly and chronic patients." It was, it transpires (Grob 1991:267), "a series of far-reaching changes in the Social Security system [that] had a

dramatic, though inadvertent, impact on mental health policy. . . ,” most especially the passage of Medicare and Medicaid. Elsewhere, his Rutgers colleague, Paul Lerman (1982:209), has documented the intimate connections between the further acceleration in discharges from 1973 onward and the advent of the Supplemental Security Income program in 1972, a change in eligibility rules that meant “states [were] able to rely on non-matching federal grants to subsidize patient releases.”

Lerman (1982:79, 209) correctly points out that “the federal government could not—and did not—mandate that categorical grant-in-aid programs be used to depopulate state institutions. States had to discover and use this option.” Interstate variations in the pace of deinstitutionalization in substantial measure reflect how rapidly individual administrations grasped and exploited this opportunity: “States whose leaders exhibited entrepreneurial skills, and who were supported by executives and legislators willing to risk increased spending to gain long-term fiscal benefits via deferred construction and maintenance of facilities, displayed marked population reductions by 1969. Laggard states waited until Supplemental Security Income was passed in 1972 [allowing 100 percent federal financing].” It was developments of this sort, permitting the transfer of costs from the state to the federal level, and providing fiscal incentives for “community” treatment, that I and others (Scull 1984; Rose 1979; Gronfein 1985; Lerman 1982) have previously identified as the key to understanding why governments at last proved receptive to criticisms of traditional institutions and eager to adopt alternative policies. (In Britain, of course, the unitary political structure meant that there were no such built-in incentives to transfer costs among levels of government, which helps to account for the different shape of deinstitutionalization policies there.)

The impact of these alternatives on the lives of psychotics is by now only too apparent. Detailing the failures of community care as briefly and gingerly as possible, Grob (1991:210) insists they are the unfortunate outcome of “a policy designed to improve the lives of the mentally ill,” one that he reluctantly concedes “had unforeseen and sometimes [*sic*] unwelcome consequences.” (Most observers would reverse this judgment: it is the *welcome* consequences that have *sometimes* been realized, and the *unwelcome* ones that have been the norm.) Once again, as in the two previous volumes in his trilogy, Grob is reduced to insisting on the benevolence of policy makers’ intentions, and the ironies of unintended consequences and historical accident: “The ideals that peo-

ple pursue in seeking social change and the realities that subsequently emerge rarely correspond. . . . The consequences of human activities . . . tend to be complex and unpredictable; ambiguity—not clarity or consistency is often characteristic” (Grob 1991:209, 303). To be sure, “The consequences of the innovations that transformed the mental health system, like those of all human activities, were at best mixed,” and in some instances, “the subtle shifts . . . were to have tragic consequences for many chronically and severely mentally ill persons most in need of assistance” (Grob 1991:271, 304). However, this merely reflects the one sort of historical inevitability Grob (1991:304) seems ready to countenance: “Human triumphs invariably incorporate elements of tragedy as well.”

I know of few other observers of the contemporary mental health scene who would associate the changes of the last 35 years with the idea of “triumph.” Most would more readily concur with the complaints of a recent president of the American Psychiatric Association (Langsley 1980; see also Borus 1981; Mollica 1983), who denounced “the wholesale neglect of the mentally ill, especially the chronic patient and the deinstitutionalized.” In the circumstances, I suggest that rather than uttering Panglossian platitudes about “reform” and “profound transformation[s] in mental health policy” (Grob 1991:5), we might better occupy ourselves with the urgent task of understanding the full dimensions of “the demise of state responsibility for the seriously mentally ill and the current crisis of abandonment” (Gruenberg and Archer 1979). *From Asylum to Community*, notwithstanding its author’s claims to the contrary, fails lamentably to advance us very far in that direction.

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