ROCHESTER HISTORY

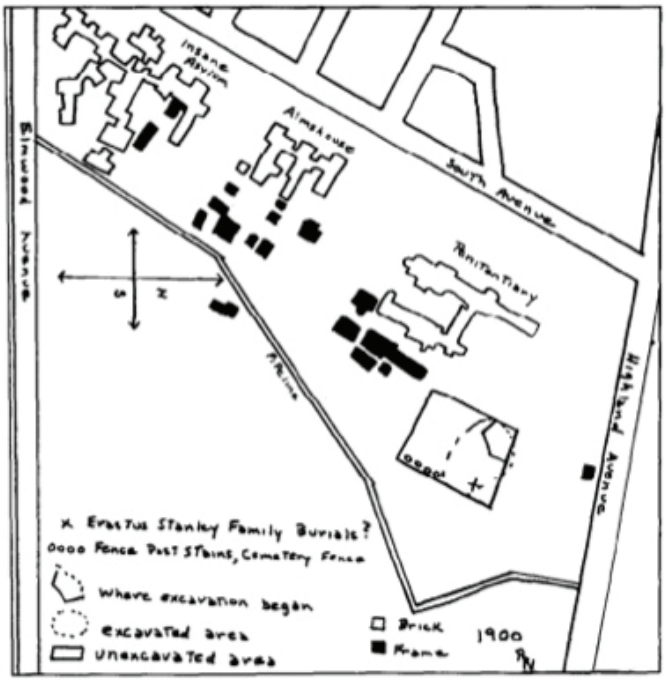
A History of Mental Health Care in Rochester, 1826–1975

by Jacob Gordon, Laurence B. Guttmacher,
Peter G. L. Juviler, and Robert Riley

Vol. 79 No. 2 *Special Double Issue* Vol. 80 No. 1

Central Library of Rochester & Monroe County
Monroe County Library System

A Publication of the Central Library of Rochester & Monroe County



Top: *The plaque commemorating the burial ground site in Highland Park. Photograph courtesy of Dr. Peter Juviler, 2016.*

Bottom: *Map of the burial ground excavation in what is now Highland Park. From Ruth Rosenberg-Naparsteck, "Life and Death in Nineteenth Century Rochester,"* Rochester History *45, nos. 1&2 (January and April 1983).*

Front Cover: *The Rochester State Hospital at the northeast corner of South and Elmwood avenues, ca. 1907–1914. Founded in 1857 as the Monroe County Insane Asylum, the institution was renamed the Rochester State Hospital in 1891; it became the Rochester Psychiatric Center in 1974.*

ROCHESTER HISTORY

Dear *Rochester History* Reader,

The topic of this double issue, caring for the mentally ill in Rochester, is a significant, yet lesser discussed part of our city's history. The narrative provides a historical account of the nature and form of care given to our most vulnerable community members, beginning with the almshouse of the nineteenth century and concluding with the remarkable twentieth century advances in psychotherapy and pharmacology, which humanized the treatment provided to those suffering from mental illness. In the pages that follow, you will find a detailed profile of one such individual, which lends some humanity to the historical narrative, and also encounter compassionate physicians who worked tirelessly to advance the care of their patients. I hope that these articles deepen your understanding of this important chapter of Rochester's past while heightening your awareness of and empathy towards the continuing challenges faced by those with mental illness in our community.

Patricia Uttaro, Library Director

About *Rochester History*

Rochester History is a scholarly journal that provides informative and entertaining articles about the history and culture of Rochester, Monroe County, and the Genesee Valley. In January 1939, Assistant City Historian Blake McKelvey published the first quarterly edition of *Rochester History*. Subjects researched and written by him and other scholars were edited, published, and distributed by McKelvey with the goal of expanding the knowledge of local history. Studying local history as a microcosm of U.S. history has brought insight and understanding to scholars and researchers around the globe.

Today *Rochester History* is published biannually (spring and fall) by the Central Library of Rochester and Monroe County. The journal is funded in part by the Frances Kenyon Publication Fund, established in memory of Ms. Kenyon's sister, Florence Taber Kenyon, and her friend Thelma Jeffries.

Rochester History invites submissions of manuscripts of 6,000-7,000 words that further its mission of increasing knowledge of and interest in local history and culture and of placing local issues into a national or global context. To receive a copy of the journal's complete submission guidelines, send a request to HistoryJournal@libraryweb.org or call (585) 428-8095.

Annual subscriptions to *Rochester History* are available for $8.00. Send a letter and a check, payable to the "Rochester Public Library," to:

Rochester Public Library
Attn: Acquisitions Department
115 South Avenue
Rochester, NY 14604-1896

If you have a comment, a correction, or more you would like to add to this story, please e-mail the editors at HistoryJournal@libraryweb.org.

Published December 2022

Part I
From Almshouse to County Asylum: Caring for the Mentally Ill in Rochester, 1826-1891

by Laurence B. Guttmacher, Peter G. L. Juviler, and Robert Riley

In 1984, a construction project in Highland Park uncovered 305 bodies in shallow graves.[1] The long-forgotten dead had once been residents of the Monroe County Almshouse. Established in 1826, the Almshouse was a tripartite institution that cared for criminals, the poor, and the insane. In these unmarked graves, the mentally ill were indistinguishable from prisoner and pauper, buried without enough care to name them, but with a deliberate effort to separate them from the rest of society. Today, the idea of burying the mentally ill and other marginalized groups in unmarked graves is unconscionable, but in the early nineteenth century there was little understanding of, let alone any standard of care for, the mentally ill in the United States.

Society's response to people with mental illnesses has shifted over time alongside changing social values, economic forces, and technologies. Our reactions to, and care of, the mentally ill thus offer a unique insight into our social fabric. In the nineteenth and early twentieth centuries, mental health care facilities across the country evolved from almshouses to insane asylums to state hospitals. The same was true in Rochester. The Monroe County Almshouse opened in 1826, and by 1857 the Monroe County Insane Asylum had been constructed to better house and treat a growing population

of mentally ill individuals. The asylum operated until 1891 when it became the Rochester State Hospital; it assumed its current incarnation as the Rochester Psychiatric Center in 1974. As these different facilities emerged, the methods and standards of care and treatment changed. In Rochester, treatment shifted from segregating the acutely mentally ill with paupers and criminals, to placing them in rural retreats removed from the pressures of family and urban life, to keeping them in overcrowded facilities with little active treatment, and finally to the current therapy model that emphasizes reintegration into the community.

Much of the evolution of Rochester's care of the mentally ill came from the combination of two forces: the necessity of addressing the increasing number of mentally ill individuals on a local level and a growing awareness about the treatment of this population on a national level. This national awareness was brought forth by the grit of a few emboldened advocates who recognized the need for higher standards of care, while local leaders followed through on the community level. Thus, the history of mental health care in Rochester elucidates statewide and nationwide trends beginning in the early nineteenth century.

Early Mental Health Care and the Monroe County Almshouse

While there were isolated examples of asylums for the mentally ill in Boston, Philadelphia, and a few other cities before the early nineteenth century, the average community did not have a specialized place to send people who were deemed "mad."[2] Private psychiatric facilities *did* exist in

the northeastern United States in the early 1800s, but their paucity and high cost limited the general availability of such care. Private psychiatric hospitals often were tethered to religious institutions, and their conditions were not ideal; treatment often amounted to confinement. Until the early to mid-nineteenth century, many towns did not have formal facilities of any kind for the mentally ill, so patients were sent to poorhouses and prisons. This was a relatively easy solution for communities since they were channeling their mentally ill into preexisting institutions. However, this method targeted the social and economic complications of mental illness without addressing any of the individual's underlying problems. Poorhouses, or almshouses, eventually developed specific wards for those with psychological maladies, but they received no special treatment beyond being segregated from other residents.[3]

Consistent with the national trend, Rochester's first method of addressing mental illness was to place its afflicted citizens in the county almshouse. During the 1820s, care of the poor became secularized, and poverty was no longer considered God's will; rather, the poor were considered subjects who might benefit from government-initiated reform. With this in mind, New York Secretary of State John Van Ness Yates traveled across the state examining the treatment of this population. His resulting report led to the Act to Provide for the Establishment of County Poorhouses of 1824, which required each county to use public funds to build a poorhouse and to provide a superintendent to oversee daily functioning.[4] The pressure from the state undoubtedly led to the construction of Rochester's poorhouse, reflecting the interplay between local and state policies; a community need led to a state

policy that in turn shaped local procedure.

The Monroe County Almshouse was built in 1826 about three miles from the center of Rochester on the site of what is now Highland Park. A county resident was able to apply for a spot in the poorhouse, and once accepted, it was the superintendent's job to "require and compel all persons committed to his care or custody . . . to perform such work, labor and service, towards defraying the expense of their maintenance and support."[5] The law also required that individuals convicted as "disorderly persons" be committed to the poorhouse for the duration of their sentences.[6] Residents of the poorhouse worked to offset the cost of their living, but much of their room and board was still covered by public funds. Those who were disorderly or refused to work were subject to the poorhouse superintendent's discipline. Superintendents were allowed to "keep each and every [disobedient] person in solitary confinement in some part of the same house, and feed him, her or them, with bread and water only."[7] Armed with this level of authority, untrained superintendents may have relied on confinement as a default method of managing a population with which they had little experience. As such, it is possible that "disorderly persons" in this era spent a significant amount of time in solitude.

When the Monroe County Almshouse opened in 1826, Rochester had a population of 7,669 people but was beginning to boom. In 1827, just 35 people were living in a building constructed to house 100, but occupancy shot past capacity as Rochester grew from a frontier village into an agricultural and industrial center. Construction of the Erie Canal beginning in 1817 had led to

rapid urbanization and a dramatic surge in population, with a corresponding rise in the number of transients and immigrants in the area.[8] As Rochester's urban makeup shifted, societal stressors increased. Family members could no longer insulate their mentally ill relatives from the community by caring for them at home.[9] Those without family were left to roam, often unable to care for themselves.

The almshouse was the first in a sequence of the community's responses to the growing need for public care of the mentally ill population; however, the need for more specialized treatment became apparent not only in Rochester, but across the state and in similar institutions across the country. Historian David Rothman contends that:

> The response in the Jacksonian period to the deviant and the dependent was first and foremost a vigorous attempt to promote the stability of the society at a moment when traditional ideas and practices appeared outmoded, constricted, and ineffective. The almshouse and the orphan asylum, the penitentiary, the reformatory, and the insane asylum all represented an effort to insure [*sic*] the cohesion of the community in new and changing circumstances. . . . The nation faced unprecedented dangers and unprecedented opportunities.[10]

Almshouses had succeeded in extruding and confining the mentally ill from the community, but they offered nothing in the way of treatment.

A national wave of optimism surrounding the treatment of the mentally ill arose in the years leading up to mid-century. Historian Albert

Deutsch notes that the period was marked by a "cult of curability," the belief that nearly all mental illness could be cured.[11] Dorothea Dix was one of the more prominent activists who sought to ameliorate the lives of those with mental illness in this era. She not only helped bring the topic into the national popular consciousness, but she also undertook studies that led to reforms in the treatment of this population. As a young adult, Dix had volunteered to work with prisoners in Cambridge, Massachusetts. Appalled by the conditions she saw and by the fact that the mentally ill were housed with criminals, she successfully petitioned the Massachusetts Legislature for funding. Emboldened by this victory, she set off around the country lobbying for better treatment for the mentally ill.[12] In 1844, she presented a report to the New York State Legislature in which she described the condition of major establishments housing the mentally ill, including the Monroe County Almshouse.

Dix began her report by denouncing the State's general neglect of those with a "total incapacity for self-care and self-government," presenting them as "Wards of the State" instead of the responsibility of the counties.[13] She wrote that those capable of being cured were left without treatment, and those who did not appear to be curable were, "permitted to fall into states of the most shocking and brutalizing degradation—pitiable objects . . . exposed to exciting irritation from the reckless sports of the idle and vicious."[14] Dix was also distressed that "insane women . . . become mothers without consciousness of maternity, and without capacity in any way to provide for their offspring."[15] This made the conditions problematic for the individual but also left families

in distress.

Dix believed that poor treatment and brutality toward the mentally ill was the result of the general difficulty that came with caring for this population rather than malice. Her reviews of conditions across New York were passionate, scathingly direct, and largely negative; however, when she arrived in Rochester, she was pleased in comparison to other parts of the state. Dix reported that the overall conditions in the local county house were good and "no neglects were apparent." She noted that the Monroe County Almshouse was "large and in general well and neatly arranged" and that residents suffering from mental illness lived in "decent cells of pretty good size, furnished with a bed."[16]

But while Dix was relatively impressed with Rochester's facility in general, she did raise some concerns. She viewed the institution's substantial economic support as a potential hindrance to progress. She feared that the astounding amount of fuel, clothing, and food provided for the poor in Rochester, by both public and private entities, led to dependence and argued that the largely foreign-born poor population needed to be assisted with a long-term plan to increase independence instead of "supplying urgent wants."[17] Though all capable almshouse residents worked to help support themselves, Dix believed the program should be expanded, thereby increasing residents' self-respect while removing some of the burden from public services.

Dix also was dismayed by the treatment of the almshouse's mentally ill residents. She observed several men who were "dragging a chain and heavy

Dorothea Lynde Dix (1802–1857). Dix's activist efforts in the nineteenth century led to the creation of specialized institutions to treat those suffering from mental illness and helped shift the public perception of this population. From the Library of Congress Prints and Photographs Division, Washington, D.C.

iron ball attached" to keep them from escaping, including one who found humor in his captivity, saying that "the exercise of dragging his ball and chain [had] much improved his health." Although the mentally ill in Rochester fared better than their peers in other states, many of whom were simply placed in jail, they nevertheless appeared to be held captive and were referred to as "inmates."[18] Dix concluded that no matter how often the inspectors of the city of Rochester, or of any city, surveyed the residences of the insane, New York State itself should be able to confirm that its mentally ill citizens were being housed and treated humanely.[19]

In no small measure in response to Dix's efforts, the state implemented an oversight program that sent investigators to conduct site visits at city and county poorhouses "to examine into [their] condition . . . their receipts and expenditures, their methods of instruction, and the government, treatment, and management of the inmates, the conduct of the trustees, [and] directors."[20] A resulting 1857 state report added detail to Dix's initial investigation of the local poorhouse, offering greater specificity regarding the number and condition of its mentally ill residents, while noting the negative impact of overcrowding at the facility.

In 1857, the Monroe County Almshouse was at capacity: 280 inmates lived on the campus, which consisted of two brick edifices, a wood building, and a farm of 134 acres.[21] Twenty-eight residents were considered "lunatics," with 18 of them confined to cells located in the basement.* These inmates were overseen by the almshouse keeper and a few other almshouse residents charged with their care. Handcuffs were occasionally used as a means of restraint, but not much else was done for their care. The inspectors determined that "lunatics at this house, with its present facilities can by no means receive proper treatment," and even though inmates were occasionally sent to the specialized, state-run asylum at Utica, where better treatment was available, they were not always accepted for admission, since it was the only such public facility in New York.[22] Care at Utica, which opened in 1843, ended up costing counties more than maintaining patients nearer to home. On the other hand, there was a greater promise of cure, and so Rochester and Monroe County looked to it as a model.[23]

Monroe County Insane Asylum

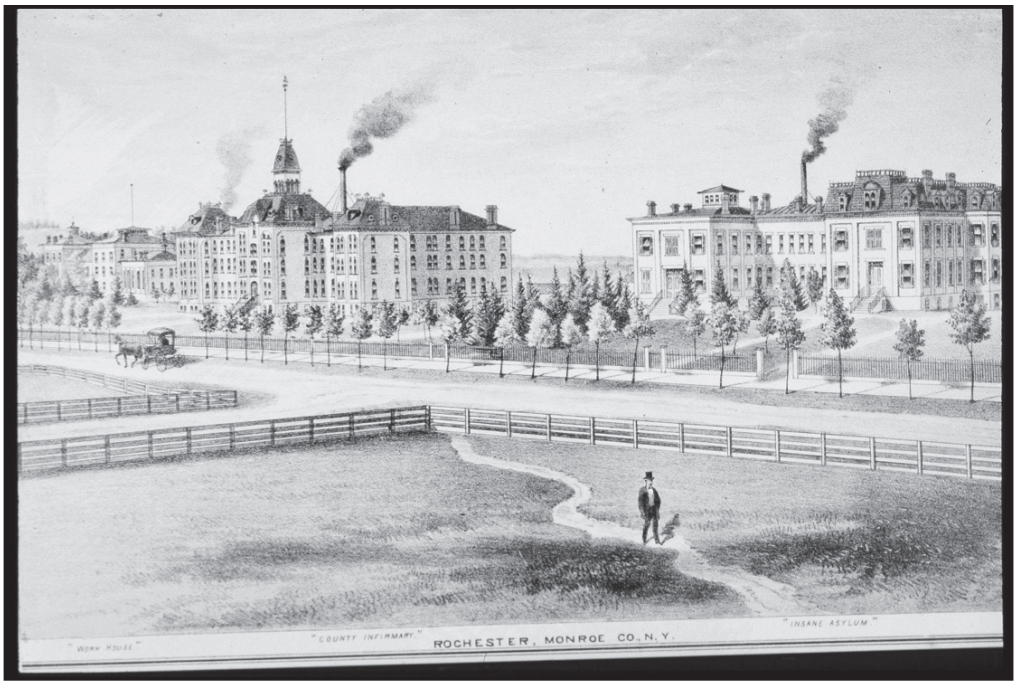
The first public insane asylum in the United States was founded in Williamsburg, Virginia, in 1773. It offered little in the way of treatment other than shackles and restraints for its unhappy residents. Both Utica and Rochester were part of the new push for "moral treatment," which had its first American incarnation in Worcester, Massachusetts, in 1833.[24] Enlightened

*The term "lunatic" was used for centuries, based upon a fallacious belief correlating lunar cycles and madness. It finally gave way to inmate (obvious connotation), then to patient (medicalized) and more recently to consumer or recipient (demedicalized/depaternalized).

treatment for the mentally ill in the early nineteenth century centered on an approach developed by Philippe Pinel in Paris at the time of the French Revolution. Prior to Pinel, the mentally ill were considered wild animals, devoid of reason or morality, who were best managed by removing them from society at large. Moral treatment focused primarily on reducing stress from patients' lives through a variety of methods and extracting them from the environment that was deemed to be the cause of their mental distress.[25]

Faced with overcrowding and lack of adequate mental health care in its almshouse, Monroe County opened its own insane asylum in 1857 in what is now Highland Park, fourteen years after the first State Lunatic Asylum opened in Utica in 1843. Both were built in response to the growing need for specialized care of the mentally ill. The need was so great that the Rochester facility met its 48-occupant maximum soon after it opened.[26] Following the "moral treatment" philosophy, the asylums at Utica and Rochester were located in rural areas away from the pressures of urban life but close enough to the city for access to personnel and supplies, and they were outfitted with walking paths and outdoor leisure space. Those who had been maintained in chains were freed. Quiet, structure, exercise, and staff who could serve as moral examples were the foundations of treatment, and facilities across the country developed campuses whose form fit their intended function of alleviating stress. They were to be well-ordered institutions that would bring discipline to the victims of a disordered society.[27]

Since the Utica facility received patients from across the state, it maintained a policy on treatment duration: if a patient was not cured in two



The complex of Monroe County institutions circa the 1880s. From left to right: the Monroe County Work House, the Monroe County Infirmary, and the Monroe County Insane Asylum. From Records of the Monroe County Insane Asylum (1857–1891), Edward G. Miner Library, University of Rochester.

years, he or she would be sent back to the county almshouse to make room for a new patient. The intent to cure, and the overall healing philosophy of the new insane asylums, marked a national shift from the almshouse, which functioned merely as a holding place that separated the mentally ill from others. Utica rapidly became overwhelmed with patients. In 1865, the State Legislature passed the Willard Act, which mandated the creation of a 1,500-bed hospital for the chronically insane. Counties would be billed for their care. Three counties—New York, Kings, and Monroe—were exempted from this mandate on the grounds that they were satisfactorily caring for their chronically insane population.[28]

Since many patients, like former almshouse residents, were often

unable to pay for treatment in an asylum, a Certificate of Lunacy allowed the "indigent" insane to be funded by the county under Chapter 446 of the Laws of 1874. A judge issued the order for a certificate; a doctor was required to sign off on a person's insanity and give a rationale for the decision. Once a patient was certified, he or she was committed to the asylum or hospital until a doctor approved their release. All patients were required to have a Certificate of Lunacy as, without a certificate, imprisoning a person due to mental illness in an almshouse, asylum, or hospital was illegal.[29]

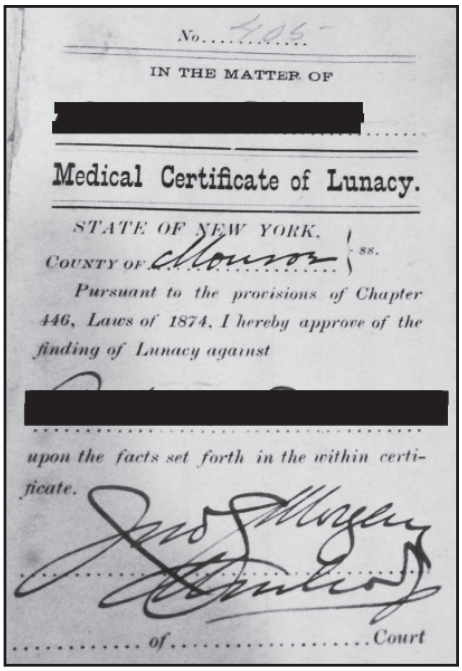
Though many of these residents were poor, more well-to-do individuals also found their way to the asylum. As historian Edward Shorter noted, prior to the nineteenth century:

> Mad relatives in upper-class families were most commonly retained at home [because] the family was based more on ties of property and lineage than sentiment. It had little intimacy to disrupt and did not celebrate its unity about the dinner table or at other private moments. . . . Late in the eighteenth century, however, the sentimental climate of family life began to change. . . . Insane relatives no longer fit into this picture of bliss.[30]

Though many patients came from the county almshouse, most people entering mental hospitals were committed by their families. Other than their method of payment, there was no overt difference in the treatment of patients from different socioeconomic backgrounds.[31]

The number of patients trended upwards at the Monroe County Insane

Asylum as new wings were built for both patients and the attendants who worked there. Dr. M.L. Lord, who became superintendent in 1868, did as much as he could with the space available, but the asylum quickly reached capacity with each new addition. In 1870, men were sleeping on the floor in hallways, and Dr. Lord began sending all new cases to Utica. That year, a new wing provided accommodations for an additional 25 patients, bringing the patient total to 70; within a year, there were 100 residents.



No. 496

IN THE MATTER OF

[redacted]

Medical Certificate of Lunacy.

STATE OF NEW YORK, } ss.
COUNTY OF Monroe }

Pursuant to the provisions of Chapter 446, Laws of 1874, I hereby approve of the finding of Lunacy against

[redacted]

upon the facts set forth in the within certificate.

Jno S Morgan
A Ogden

..... of ..... Court

A circa 1874 Certificate of Lunacy. From Records of the Monroe County Insane Asylum (1857–1891), Edward G. Miner Library, University of Rochester.

A new main edifice with 41 additional beds was built in 1872. By the fall of 1873, the asylum had 143 residents. There never seemed to be enough beds. The constant demand was, in part, consistent with Pinel's model of care, which took a long-term approach to patient healing.[32] The increase also reflected Rochester's booming population.

Despite overpopulation at the Monroe County Insane Asylum, it was well managed and had a reputation for excellent patient care. This was due in large part to the leadership of Dr. Eugene H. Howard, a graduate of the University of Buffalo Medical College who had worked as a warden and physician at the Monroe County Almshouse from 1875 to 1880.[33] After spending five years in private practice in Rochester, Dr. Howard

Eugene Henry Howard, M.D. Superintendent of the Rochester State Hospital from 1891 to 1927. From Records of the Rochester State Hospital, Edward G. Miner Library, University of Rochester.

returned to work in the public domain as the Superintendent of the Monroe County Insane Asylum in 1885. He remained until his death in 1927. He led the asylum's transition to a state-run entity when, in 1890, due in no small measure to the considerable variability in quality of the county asylums, New York moved to create a network of state-run psychiatric hospitals. This system decreased the power of local superintendents and attempted to standardize care across New York State.[34] The State bought the Monroe County Insane Asylum, and the facility became the Rochester State Hospital on July 1, 1891.[35]

In his nearly 42 years of service, Dr. Howard was a mental health champion who was involved in nearly every aspect of the hospital's operation: he coordinated construction, managed the hiring of new attendants, and oversaw much of the hospital's administration, all while maintaining a relationship with his patients. It would not be an overstatement to refer to him as a local legend in the realm of mental healthcare. Dr. Howard's dominance reflected the fact that late nineteenth-century hospitals were typically organized along hierarchical and authoritarian lines.[36] Since the hospital environment was integral to mental healthcare, it was incumbent on

the facility's director to watch over every detail. He, and it was always a he, was aided by assistant physicians who, in turn, were assisted by nurses and attendants.* Historian Ellen Dwyer maintains that superintendents morphed from loving fathers to remote biblical patriarchs as the institutions grew.[37]

Even though the rise in the number of residents was a product of Pinel's moral treatment approach, which involved long-term care, the ever-increasing number of patients undermined the approach itself: as the patient population grew, individualized care became more difficult to provide.[38] Howard combated this as best he could with meticulous attention to the details of his patients and his hospital. A letter book containing Dr. Howard's correspondences shows how involved he truly was. The superintendent wrote letters dealing with patient payment, building repairs and additions, and employment. He appears to have personally responded to each employment inquiry, and in at least one case, when there were no available jobs at the hospital, he recommended an applicant to the area orphan asylum and industrial school without prompting. The hospital steward wrote most of the letters pertaining to stocking the kitchen or ordering new supplies, but these letters were found in Dr. Howard's letter book, too, so he must have at least been aware of, and likely approved, these day-to-day orders.[39]

Along with letters concerning operational details, Dr. Howard often corresponded with family members and friends to alert them of a patient's admission, update them on a patient's condition, and inform them of anything

*There was, for the era, a surprising number of female physicians at the Rochester State Hospital. However, with the notable exception of the Director of Nursing, no women served in leadership positions.

that might benefit the patient. Most importantly, Dr. Howard advocated for his patients. To one patient's friend he wrote, "she is a very pleasant patient to meet, and if you could visit her at any time, she would be much pleased." To another, "today she gave me your name and said she would like to hear from you," and to a patient's sister, "she would enjoy receiving a letter from you."[40] He penned the following to the husband of one of his patients:

> Dear Sir –
>
> Your wife . . . has expressed a desire for a white dress and skirt, she is willing to make them herself and the cost of the cloth will not exceed two dollars. I think her wishes in the matter should be gratified as it is about the first thing . . . that she has taken an interest in. . . . The store where you purchase the goods will probably be willing to deliver them. She is anxious to begin work immediately.
>
> Yours respectfully,
>
> Dr. E.H. Howard[41]

Dr. Howard working in his office. From Records of the Rochester State Hospital, Edward G. Miner Library, University of Rochester.

Dr. Howard must have known his patient and listened to her, and he must have been sufficiently interested in her wishes and wellness to send the request to her husband. A request like

The School of Nursing's graduating class of 1896. From Records of the Rochester State Hospital, Edward G. Miner Library, University of Rochester.

this might seem trivial, but in the larger scheme of managing a hospital, it illustrates the extent to which Dr. Howard knew his patients and the effort he made on their behalf. In this way, he embodied the ideals of moral treatment. Dr. Howard also chose his staff carefully and treated them well. Amidst high national psychiatric attendant attrition, he opened the Training School for Nurses on the Rochester State Hospital grounds in 1890.[42] This allowed Dr. Howard to train and maintain quality attendants who were familiar with the hospital.

From October 1, 1888, to the end of September 1892, five percent of patients were discharged as recovered and eight percent died; the rest continued to live their lives under the care of doctors and attendants at the Rochester State Hospital.[43] Annual reports indicate that patients were not

often considered fully recovered during a hospital stay. Instead, an admission was most likely the beginning of a new life that was as consistent with moral treatment as possible given the increasing patient population: rest, structure, and meaningful activities were emphasized. Immigrants were over-represented among the patient population. According to the 1890 census, Rochester counted 133,896 residents, of whom 39,775, or 29.7 percent, were foreign-born.[44] In the same timeframe, almost half of those admitted to the Rochester State Hospital were foreign-born, and nearly 70 percent of patients had at least one foreign-born parent.[45]

Both the low discharge rate and the high proportion of foreign patients represented nationwide trends of the era: many patients remained in psychiatric facilities for life, and many of these patients were immigrants or the children of immigrants. Recovery was ill-defined and cure rates were difficult to calculate. A significant patient population in need of chronic care made it less likely for a patient to be discharged after entry to an insane asylum or psychiatric hospital, although some hospitals, like Utica's, had higher discharge rates (largely due to time-limited admissions with transfer to another hospital rather than discharge to the community).[46] Reflecting the prejudices of the era, the high levels of mental illness among immigrants often was attributed to their alleged "backward" cultural traits and bad personal habits. More likely, the separation from family and social supports while facing the stresses of a new country and culture contributed to their admissions.[47] Dwyer noted that single foreign-born unskilled laborers,

especially women, living without family support, were especially likely to be hospitalized.[48]

A Local Case Study

One patient who resided at the Monroe County Insane Asylum during Dr. Howard's tenure was a German immigrant named Ria Floss.* Floss was transferred from the Buffalo State Asylum to the Monroe County Insane Asylum on May 29, 1886, when she was 34 years old.[49] Her husband lived in Rochester with their three children, where he worked as a saloonkeeper. Floss had finished common school where she studied reading, writing, math, history, and geography. She worked as a housekeeper until she experienced an attack that was diagnosed as "dementia following mania," for which she was treated in Buffalo for three years. In the nineteenth century, "dementia" was used to refer to delusions and hallucinations with disorganized thinking, rather than a decline in mental acuity.[50] Floss's change in behavior was not assigned a cause nor did she have a history of mental illness.

It is slightly unusual that the cause of Floss's behavior was not identified. While doctors in this era could not provide a link between behaviors and brain physiology, they based their diagnoses on their patients' actions. The most commonly identified causes of mental illness in the nineteenth century included intemperance, marital problems, overwork, domestic difficulties, faulty education, jealousy, and pride.[51] Around the time of Floss's admission, domestic adversity and overwork were among the top causes of

*Patient names have been changed to protect privacy.

insanity assigned to patients in Rochester and the country at large. Domestic adversity was second in frequency to intemperance; other causes of insanity included business adversity, nostalgia, disappointed affections, and vicious indulgence.[52] Because Floss had no known family history of mental illness, the origins of her behavior changes were deemed "unascertained."

It is possible that Floss's gender played a role in her admission, diagnosis, and ensuing treatment. Women consistently outnumbered men in local mental health facilities, representing between 53 and 64 percent of area patients between 1860 and 1891. Phyllis Chesler, a noted feminist psychologist, wrote that "adjustment to the 'feminine' role was *the* measure of female morality, mental health, and psychiatric progress."[53] Given women's social position and lack of political and legal autonomy in the nineteenth century, women could be confined to institutions for contradicting or diverging from society's expectations. Did Floss chafe at social and familial expectations for her as a woman, or was she placed in the asylum at the will of her husband or another? There isn't sufficient evidence in Floss's case to confirm how or why she was committed. However, firsthand accounts from female patients did include instances of improper admission, unwarranted confinement, and mistreatment, which they attributed to their gender. In some cases, these outcomes were the result of a man's word or social position trumping that of a woman's. Even with today's increasingly precise definitions of mental illness, value judgments and subjectivity are part of the diagnostic process. Floss's psychiatric evaluation undoubtedly reflected the values of the dominant culture.[54]

Like many other patients of her era, Floss never improved enough to leave the facility; she died there in 1908 at the age of 56. Her story gives insight into the life and experience of a patient in Rochester. When she first arrived at the asylum, Floss was quiet and tearful, but she was able to do some kitchen work under attendant supervision. In the next year she demonstrated occasional violence and lost interest in her work, but she remained in good physical health. After several manic episodes in which she exhibited violence towards attendants and patients, Floss was transferred to two different wards before she began to settle in while taking an interest in sewing and observing plant life around the hospital grounds.

Relocating Floss from ward to ward helped separate her from conflicts with others, but as Superintendent Howard proposed, adding a new patient to a ward was good for both the incoming and existing patients: the calm, adjusted patients already living on the ward served as positive role models for new patients, and the incoming patient added novelty to the existing patients' established routines. Variation that sparked human curiosity was thought to be good for long-term

Rochester State Hospital farmland where patients worked to grow fresh produce for the kitchen. From Records of the Rochester State Hospital, Edward G. Miner Library, University of Rochester.

patients, and, in turn, those more experienced residents served as good examples for new residents. This practice suggests that Dr. Howard examined patient environments carefully; like other superintendents of his time, he knew that the relationships formed in the hospital would likely determine how a patient felt about their stay and could influence healing and hope.[55]

After three years in the asylum, Floss had grown averse to conversing, needed assistance at mealtimes, and had momentary outbursts of shouting and hand flapping throughout the day, but she continued to be industrious in her work even as her temperament oscillated. Sewing became a passion of Floss's, but daily care such as bathing or changing her clothing was difficult for her, and she occasionally struck those who attempted to help. She was almost never violent while she was working, and this corroborated the benefit of the industrial and educational system that Dr. Howard supported. Able patients were given routine work in the hospital, on the farm, and in a variety of trades, and Dr. Howard promoted this program as an effective means of therapy.[56]

Despite her reticent nature, Floss was always happy to see her husband and children when they came to visit. As much as she enjoyed seeing her family, her husband could not provide the same level of attention that she received at the asylum, so it was not feasible for her to return home. After five years of care in Rochester, Floss appeared adjusted to life there, but still had occasional bursts of violence. She would act well for months, and then she would assault an attendant or another patient. During a dinner service in March 1891, Floss smashed plates, cutting her hand and wrist. She became increasingly irritable after this incident, so much so that it was deemed unsafe for her to work around others. Violent

patients would have been especially challenging due to overcrowding at the asylum, which by this time had transitioned to the Rochester State Hospital. Board of Managers member Leonard Burritt reported in October 1891 that there were 366 patients living in the hospital that apparently had room for 300, but he commended Dr. Howard on his ingenuity under the circumstances, like his idea to use ironing tables as makeshift dining tables.[57]

The new wing of the Rochester State Hospital, constructed in the late nineteenth century. From Records of the Rochester State Hospital, Edward G. Miner Library, University of Rochester.

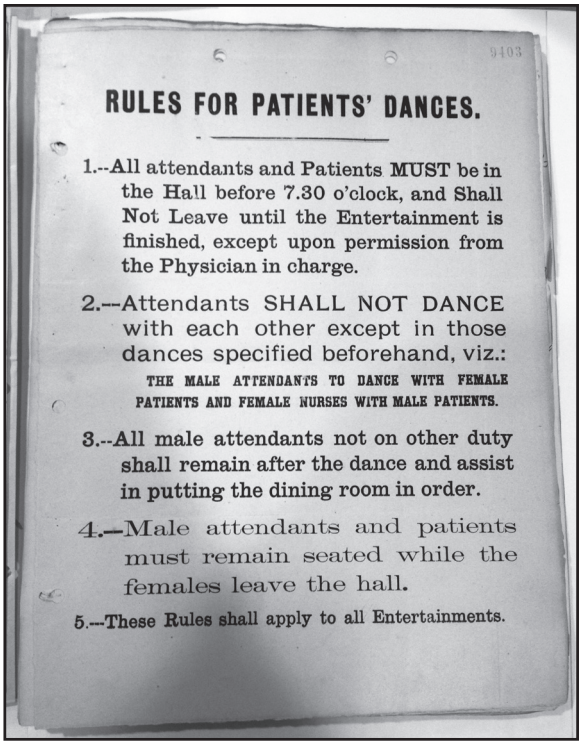
Floss continued to require help bathing and dressing, and the addition of a "spraying bath" in November 1891, which was generally well-received by the patients, may have made washing easier; at the very least, she would not have to share bath water with other patients. Around this time, Christmas greens were hung in the dining room and bedrooms, and new rocking chairs were installed as part of the continued effort to make the patients' surroundings more pleasing.[58] Floss spent much of her time sitting alone and speaking to herself in German that winter. Over the next year, Floss slowly returned to work. By September 1893, she was no longer violent and responded to inquiries with a smile. In the next few months her temper continued to improve, and she started to work in the kitchen in addition to her sewing.[59] In a letter dated April 13, 1893, Dr. Howard wrote to Floss's husband, informing him that the gingham dresses he brought her were

"quite satisfactory" to her, and that she would appreciate a few more.[60]

Floss probably also benefitted from both the hospital's built and social environments. In addition to the land used for farming and other forms of outdoor work provided for patients, there were walking paths and landscaping designed for leisurely enjoyment. Dr. Howard advocated for the calm that nature inspired, and this theme fit with Pinel's approach to caring for the mentally ill. During her inspections, Board of Managers member Jane E. Rochester often commented on how the patients seemed to be enjoying the hospital grounds. On September 30, 1891, she noted that, "one of the most commendable features [of the hospital] is the patients' ability to spend time in the open air."[61] When the weather was favorable, a large proportion of patients walked about the grounds, by themselves or with companions, relishing the day outdoors. The State Hospital also hosted regular performances, often musical, presented by friends of the hospital and largely organized by members of the Board of Managers. Jane Rochester attended the entertainment one evening, and remarked that it was, "wonderfully well-adapted for the benefit of the patients, the audience were evidently pleased without being excited."[62]

The facility also held weekly dances. In 1895, Dr. Howard sent letters inquiring about dance rules to several State Hospital superintendents, and he received a range of replies. The overwhelming response to what might seem like a request of minor importance suggests that Howard's dedication to patients was shared by his colleagues and that there was also a mutual respect among superintendents that led to communication and sharing of information. The reply from the Superintendent of the Buffalo State Hospital outlines how their dances

worked, citing that they lasted about two hours, they "insist that attendants shall dance with patients a majority of the time," and they "select carefully those patients who are allowed to go." The superintendent added that "occasionally a patient becomes a little hilarious" and that they have had to "restrict some of the more boisterous dances" because they had led to animated behavior from patients and attendants alike; however, dances generally went well.[63]



9403

RULES FOR PATIENTS' DANCES.

1.--All attendants and Patients MUST be in the Hall before 7.30 o'clock, and Shall Not Leave until the Entertainment is finished, except upon permission from the Physician in charge.

2.--Attendants SHALL NOT DANCE with each other except in those dances specified beforehand, viz.:

THE MALE ATTENDANTS TO DANCE WITH FEMALE PATIENTS AND FEMALE NURSES WITH MALE PATIENTS.

3.--All male attendants not on other duty shall remain after the dance and assist in putting the dining room in order.

4.--Male attendants and patients must remain seated while the females leave the hall.

5.--These Rules shall apply to all Entertainments.

Rules for Patients' Dances written by Dr. Howard, 1895. From Records of the Rochester State Hospital, Edward G. Miner Library, University of Rochester.

The Medical Superintendent of the Middletown State Homeopathic Hospital sent his two-hour program or "Order of Dances," which included the waltz, the polka, and a relative of American square dancing called the quadrille.[64] The head of St. Lawrence State Hospital wrote: "The only rule we have for dances is to have a dance."[65] Seemingly based on these replies and others, Dr. Howard constructed a list of rules for dances at his facility.[66] The regulations noted that male employees were permitted to dance with female patients and vice versa and, to lend an air of gentility (though perhaps also out of safety concerns), also required that all the men in attendance remain seated while the women left the

dance hall at the end of the evening. The list highlights Dr. Howard's continued attention to detail and his desire to maintain a high-quality living environment for his patients, a priority evidently shared by a number of his colleagues.

Significantly, the correspondence demonstrates that superintendents of State Hospitals were in regular contact with each other. These communication networks allowed for input from other professionals and more standardized care. Although the *American Journal of Insanity* (today the *American Journal of Psychiatry*) published its first issue in Utica in 1844, letters were a faster, more personal way to be in contact with colleagues and become familiar with their practices. Such communication proved integral to the development and improvement of mental healthcare in the nineteenth century.

The Rochester experience demonstrates the complex interplay between local, state, and national policy. Local options for treatment of mental illness followed the arc of care across the country. Rochester's institutionalized mentally ill first resided in the Monroe County Almshouse, where the "insane" population was grouped with the poor and others who were unable to support themselves. The Monroe County Insane Asylum was constructed as a retreat that offered support and protection from the bustle of daily life. The Rochester State Hospital, which followed, signaled a shift from viewing "inmates" with mental illness as morally corrupt to seeing them as patients with conditions that could be treated. In the twentieth century, state legislation eventually trumped local policy with significant impact. The hospital would be renamed yet again to indicate that practice had moved away from stigmatizing people with mental health conditions, while emphasizing the sentiment that the hospital was a "center" where people gathered for care.

Notes

Ruth Rosenberg-Naparsteck, “Life and Death in Nineteenth Century Rochester,” *Rochester History* 45, nos.1 and 2 (January and April 1983), 13.

Albert Deutsch, *The Mentally Ill in America: A History of their Care and Treatment from Colonial Times* (Garden City, NY: Doubleday, Doran & Company, 1937).

Gerald N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 1994),15 and 31–32.

“1824 New York State Poor House Law,” Inmates of Willard 1870 to 1890: A Genealogy Resource, https://inmatesofwillard.com/2013/10/03/1824-new-york-state-poor-house-law/?fb_source=pubv1.

“1824 New York State Poor House Law.”

Deutsch, 128.

“1824 New York State Poor House Law.”

W. H. McIntosh, *History of Monroe County, New York; With Illustrations Descriptive of Its Scenery, Palatial Residences, Public Buildings, Fine Blocks, and Important Manufactories, From Original Sketches By Artists Of The Highest Ability* (Philadelphia: Everts, Ensign & Everts, 1877), 1 and 45–47; Paul E. Johnson, *A Shopkeeper’s Millennium: Society and Revivals in Rochester, New York, 1815–1837* (New York: Hill and Wang, 1978).

Grob, 6.

Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little, Brown, 1971), xviii.

Deutsch, 132.

For an in-depth account of Dorothea Dix’s mental health activism, see David L. Gollaher, *Voices for the Mad: The Life of Dorothea Dix* (New York: The Free Press, 1995).

Dorothea Dix, “Memorial, to the Honorable the Legislature of the State of New-York,” (Albany, NY:1844), 3, https://collections.nlm.nih.gov/bookviewer?PID=nlm:nlmuid-66420620R-bk#page/1/mode/2up.

Dix, 3.

Dix, 3–4.

Dix, 21.

Dix, 21.

Dix, 21.

Dix, 22.

Report of Select Committee Appointed to Visit Charitable Institutions Supported by the State and all City and County Poor and Work Houses and Jails of the State of New York: transmitted to the legislature, January 9, 1857. (Albany, NY: C. Van Benthuysen, 1857), 1, https://archive.org/details/60620940R.nlm.nih.gov.

Report of Select Committee Appointed to Visit Charitable Institutions, 59.

Report of Select Committee Appointed to Visit Charitable Institutions, 60.

Ellen Dwyer, *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums* (New Brunswick, NJ: Rutgers University Press, 1987).

Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), 45.

Shorter, 11–13.

McIntosh, 4.

Grob, 71–72; Rothman, *The Discovery of the Asylum*, 137–38.

McIntosh, 3; Deutsch, 260.

The New York State Reporter, Volume XVI (Albany, NY: W.C. Little, 1888), 40–43, https://www.google.com/books/edition/The_New_York_State_Reporter/WPQaAAAAYAAJ?hl=en&gbpv=1&dq=The+New+York+State+Reporter,+Volume+16&printsec=frontcover.; Certificates of Lunacy, box 1, Records of the Monroe County Insane Asylum (1857–1891), Edward G. Miner Library, University of Rochester; John Ordronaux, *Commentaries on the Lunacy Laws of New York: And on the Judicial Aspects of Insanity at Common Law and in Equity, Including Procedure, as Expounded in England and the United States* (Albany, NY: JD Parsons, Jr., 1878), 77–78, https://books.google.com/books/about/Commentaries_on_the_Lunacy_Laws_of_New_Y.

html?id=JTc0AQAAMAAJ.

Shorter, 50.

Grob, 80; *Democrat & Chronicle*, "Insane Asylum—Report of Trustees," November 19, 1884.

Union & Advertiser, "Is Lunacy Increasing?," October 24, 1870; McIntosh, 4.

John Devoy, *Rochester and the Post Express: A History of the City of Rochester from the Earliest Times.The Pioneers and their Predecessors—Frontier Life in the Genesee Country—Biographical Sketches* (Rochester, NY: The Post Express Printing Company, 1895), 111.

Devoy, *Rochester and the Post Express*, 111.

This era of state control will be discussed in "The Rochester State Hospital, 1891–1975: A Case Study in the History of American Psychiatry," beginning on page 33.

Rochester *Democrat & Chronicle*, August 25, 1927; Devoy, 111; Bill D'Anza, "From Almshouse to Asylum: The Early History of Rochester Psychiatric Center," *Mental Health World* (Spring 2004), 19–20; Gerald N. Grob, *Mental Illness and American Society, 1875–1940* (Princeton, NJ: Princeton University Press, 1983), 15.

Dwyer, 57.

Grob, *Mad Among Us,* 91.

Letter Copy Book, 1890–1895, Operational Records, Records of the Rochester State Hospital, 14–16, 41, and 62, Edward G. Miner Library, University of Rochester.

Letter Copy Book, 13, 54, and 62.

Letter Copy Book, 12.

Grob, *Mad Among Us*, 93–94.

Annual Report of the Managers of the Rochester State Hospital to the State Commission in Lunacy for the Year Ending September 30, 1892 (Rochester, NY: Union and Advertiser Press, 1893), 18.

"Nativity of the Population for the 50 Largest Urban Places: 1870 to 1990," U.S. Bureau of the Census, https://census.gov/population/www/documentation/twps0029/tab19.html.

Annual Report of the Managers of the Rochester State Hospital, 29.

Grob, *Mad Among Us,* 91–101.

Rothman, 283; Grob, *Mad Among Us*, 62 and 87–88.

Dwyer, 115.

Personal Medical Histories, Volume 1: October 1, 1886–May 14, 1889, Records of the Monroe County Insane Asylum, 248, Edward G. Miner Library, University of Rochester.

Shorter, 62.

Grob, *Mad Among Us,* 59, and 60; *Annual Report of the Managers of the Rochester State Hospital*, 17.

Annual Report of the Managers of the Rochester State Hospital, 17.

Phyllis Chesler, quoted in, Jeffrey L. Geller and Maxine Harris, *Women of the Asylum: Voices from Behind the Walls, 1840–1945* (New York: Anchor Books, 1994), xix.

Treatment also reflected such values. Men and women were housed on separate wards within the same buildings and treated in accordance with the traditional gender roles of the time. Women had sewing classes. Men might work in the fields or other conventional male milieus. See Geller and Harris, *Women of the Asylum*, 89–90; Katherine Pouba and Ashley Tianen, "Lunacy in the 19th Century: Women's Admission to Asylums in United States of America," *Oshkosh Scholar* 1 (2006), 95–103; Nellie Bly, *Ten Days in a Madhouse* (New York: Ian L. Munro, 1887), http://digital.library.upenn.edu/women/bly/madhouse/madhouse.html; Denise Russell, *Women, Madness & Medicine* (Oxford, UK: Polity Press, 1995), 28.

Annual Report of the Managers of the Rochester State Hospital, 11–12; Grob, *Mad Among Us,* 82–83.

Annual Report of the Managers of the Rochester State Hospital, 7.

Board of Managers' Inspection Log, 1891–1948, October 20, 1891, 3, Operational Records, Records of the Rochester State Hospital, Edward G. Miner Library, University of Rochester.

Board of Managers' Inspection Log, 1891–1948, November 27,1891, December 12, 1891, and January 16, 1892, 4–5, Operational Records, Records of the Rochester State Hospital,

Edward G. Miner Library, University of Rochester.

Patient Case Histories Volume 2: Women's Records July 1, 1891–December 15, 1892, 192 and 459, Clinical Records, Records of the Rochester State Hospital, Edward G. Miner Library, University of Rochester.

Letter Copy Book, 628.

Board of Managers' Inspection Log, 1891–1948, September 30, 1891, 2.

Board of Managers' Inspection Log, 1891–1948, February 6, 1902, 70.

Dr. Eugene Howard to Dr. Arthur Hurd, Medical Superintendent at Buffalo State Hospital, November 6, 1895, Box 4, 9401, Miscellaneous Documents, Records of the Rochester State Hospital, Edward G. Miner Library, University of Rochester.

Dr. Eugene Howard to Superintendent of Middletown State Homeopathic Hospital, November 6, 1895, Box 4, 9400, Miscellaneous Documents, Records of the Rochester State Hospital, Edward G. Miner Library, University of Rochester.

Dr. Eugene Howard to Superintendent of St. Lawrence State Hospital, 1895, Box 4, 9398, Miscellaneous Documents, Records of the Rochester State Hospital, Edward G. Miner Library, University of Rochester.

"Rules for Patients' Dances," Box 4, 9403, Miscellaneous Documents, Records of the Rochester State Hospital, Edward G. Miner Library, University of Rochester.

Part II
The Rochester State Hospital, 1891–1975: A Case Study in the History of American Psychiatry

by Dr. Jacob Gordon, Dr. Laurence B. Guttmacher, and Robert Riley

Today, the modern incarnation of Rochester's public mental health services occupies a few dozen acres at the corner of South and Elmwood avenues, about two miles from downtown, not far from the site of the original Monroe County Insane Asylum. A series of sleek, modern hospital buildings are centered among outpatient facilities and residential buildings designed for patients transitioning from inpatient care back into the community. Together, these facilities comprise the Rochester Psychiatric Center, operated by the New York State Office of Mental Health. Here, the expectation is that most patients will receive treatment that will allow them to live and function freely in the outside world. Institutionalization is the exception rather than the rule.

Surrounding buildings tell a different story. The operational part of the Psychiatric Center is surrounded by derelict structures. Decayed, forgotten housing for staff and disused patient wards dating from the 1930s, when the institution was known as the Rochester State Hospital, litter the campus. The abandoned forensics unit, beige and strung with razor wire, extends from the back of the hospital like a barnacle. Empty and forlorn Terrence Tower, sixteen stories high and once the home of more than a thousand patients, looms bleakly over Elmwood Avenue. Impregnated with asbestos and as-of-yet impervious to demolition, the tower is a reminder of how different

psychiatric care used to be in this city, New York State, and the nation. Of the many thousands of patients who lived and received treatment on these grounds, less than two hundred remain, and the number of staff has diminished proportionately. The abandoned structures are like flotsam washed up on the shore of history. They illustrate how a small county-run mental hospital grew into a massive presence on the southern edge of Rochester, like a miniature city, before gradually fading to what it is today. Using archival records, we can shed light on this local story, as well as on broader themes in the history of American psychiatry.

Creating the Rochester State Hospital, 1891–1920

The Rochester State Hospital was established in 1891, when the State of New York purchased the Monroe County Insane Asylum, which along with the county jail and the workhouse formed a complex of public institutions on South Avenue. In those days, "going down to South Avenue" was a euphemism for having been driven to debt, crime, or madness. The change in ownership was the result of the New York State Care Act of 1890, which provided for a network of state mental hospitals to replace the independent county asylums. The act accomplished several goals, according to journalist Albert Deutsch:

> (1) It provided for the removal of the insane poor from the poorhouses; (2) it carried out the principle of state care to its ultimate conclusion, namely, the support of all the indigent insane (except those in private institutions) in state hospitals at state expense; (3) by districting the

> state, and by obliging each state hospital to admit all the insane in its district, it abolished the legal distinction between acute and chronic cases; (4) by specifically ordering the substitution of the term 'hospital' for 'asylum' in all the public institutions of the insane, it inaugurated a significant change in nomenclature, symbolizing the new ideal of having such institutions curative in name and intent.[1]

Deutsch called the State Care Act the "culminating point of a great movement" across the United States to reform institutional care in America. The movement had been led by activists such as Dorothea Dix, who published exposés and testified before state legislatures and congress in the mid-nineteenth century on the poor condition of provincial insane asylums where patients were mistreated, abused, and neglected. In New York, Dix's voice was heard by the state government, who convened an investigatory board in 1867 to advise the state on the feasibility of a mental health system. This board would become the New York State Commission in Lunacy, which "placed itself on record as unqualifiedly in favor of state care [of mental patients]."[2]

When the newly rechristened Rochester State Hospital opened in 1891, it was a perfect example of the criteria set out by the New York State Care Act. It was a direct replacement of the insane asylum, retaining the existing buildings, staff, and patients, but with new funding, a new mission, and a new name. The hospital's superintendent in 1891 was Dr. Eugene Howard, who had previously run the Monroe County Insane Asylum. The portrait of Dr. Howard that emerges from the collected letters and administrative documents

archived at the University of Rochester's Miner Library, resembles a CEO more than a clinical doctor. Howard negotiated the construction of buildings with contractors, hired staff, and arranged the budget with the hospital's accountant.[3] Physicians on staff were responsible for both the physical and mental health of the patients, but it is unlikely that they had received psychiatric training prior to their employment, as this type of education was uncommon at the turn of the century.

The treatment patients received was a form of custodial care that had evolved from the principles of early nineteenth-century French psychiatrist Philippe Pinel, in which the main therapy was seclusion from general society in a peaceful, structured environment where "the day is occupied in salutary and refreshing exercises, which are interrupted only by intervals of rest and relaxation."[4] These exercises included farm work, sewing, laundering, carpentry, and other common trades, none of which turned a profit for the hospital but which helped defray the cost of caring for patients and provided them with occupations and pastimes. Although the details of pharmaceutical treatment were not recorded in Rochester State Hospital's annual reports, historian Gerald N. Grob notes that a laundry list of sedatives and analgesics were used ubiquitously in mental and other hospitals in the late nineteenth century, including hyoscyamine, opium, morphine, various bromide derivatives, chloral hydrate, paraldehyde, sulphonal, calomel, and digitalis.[5]

During the institution's first ten years, hospital staff treated a variety of patients, a disproportionate number of whom were immigrants. According to historian Elizabeth Lunbeck:

Demographic Data 1890-1900

	City of Rochester	Rochester State Hospital
Under Age 20	33.5%	3.0%
Over Age 60	4.34%	16.0%
White Immigrants	25.0%	39.0%
Male to Female Ratio	0.91	0.95

Source: Demographic data for Rochester State Hospital from Annual Reports, 1890–1910. Data for City of Rochester from the 1910 U.S. Census. The census reported four immigration categories in 1910: 'native white - native parentage', 'native white - foreign or mixed parentage', 'foreign-born white', and 'negro.' Because foreign-born non-white was not typically reported, and because it was a small minority when it was reported, 'foreign-born white' is employed as a proxy for all immigrants.

Contemporary commentators—psychiatrists, eugenic propagandists, and legislators—were certain that the foreign-born and their children were more prone to insanity than Americans of old stock. Many commentators marshaled figures that purported to show the former disproportionately represented in institutional populations. As early as 1903 it was pointed out that because both immigrants and the insane were concentrated in the older portions of the population (those who entered the country as immigrants tended to be older than the native-born population, and few young people were committed to institutions), population figures should be corrected for age . . . but the practice of doing so did not become standard until much later. . . . Early twentieth-century data are further skewed because both immigrants and those likely to be hospitalized clustered in urban areas where they were more likely to come to the attention of authorities and where there were facilities—hospitals, asylums, almshouse—to hold them.[6]

The stresses of being an immigrant likely also contributed to mental illness. Adapting to a new society with different family and gender roles, learning a new language, facing economic disadvantages, and dealing with societal racism and xenophobia all presented significant challenges to new residents.

Patients hailed from diverse occupations. White-collar professionals such as lawyers, doctors, and business administrators were represented alongside blue-collar workers such as farmers, skilled trade workers, and servants. It is difficult to characterize the socioeconomic status of women who were admitted at this time, as many were lumped into the category of "housewives," and as Lunbeck noted, "an imperfect measure in the case of men, occupation as a proxy for economic power is even more problematic in the case of women."[7] Women were (and are) less likely to receive equal pay to male counterparts, and were (and are) underrepresented in higher-income professions.[8]

An 1874 act passed by the New York State Assembly mandated that patients could be admitted voluntarily or committed by two physicians who "under oath would set forth the insanity of such persons. . . . This shall include every species of insanity and extend to every deranged person and to all of unsound mind other than idiots."[9] The asylum was given five days after admitting a patient to receive approval from the courts. The Certificates of Lunacy on file at the Miner Library vary greatly in terms of the richness of clinical detail provided. Patients were admitted to the Rochester State Hospital for a variety of diagnoses, some of which are familiar and others strange to

us today. For example, in 1892, patients were admitted with diagnoses of mania, melancholia, alternating (circular) insanity, general paralysis, primary dementia, general dementia, epilepsy, imbecility, and idiocy.[10] These diseases overlap with the modern diagnoses of bipolar disorder, major depression, schizophrenia, Alzheimer's disease, and so on.[11] General paralysis, also known as paresis, is currently known as neurosyphilis, the neurologic and psychiatric manifestation of long standing infection by the bacterium *Treponema pallidum* such that the bacteria have colonized the brain.

An early champion of diagnostic reform was Dr. Adolf Meyer, director of the New York State Pathological Institute, which guided the state mental hospitals on the science of psychiatry and how to diagnose and treat mental

The School for Dementia Praecox, circa 1909. From Annual Report of Rochester State Hospital, 1909.

illness. Meyer followed the school of thought of Dr. Emil Kraepelin, a German psychiatrist who held that diagnoses were best made by taking a careful history and then following the patient over a long period of time. Meyer also popularized Kraepelin's new diagnosis of "dementia praecox," now termed schizophrenia. Meyer made room for dementia praecox in the admissions criteria by shifting chronically psychotic patients away from the diagnoses of mania and melancholia, explaining that:

> These conditions have been grouped together by Kraepelin under the term Dementia Praecox, embracing derangements which very often tend to end in peculiar defect conditions, ranging from the not infrequent cases of simple disappointment of parental hopes by apparently promising individuals who fail to make their mark, to cases with rather characteristic mental upsets, and characteristic, usually progressive, apathetic dementia. . . . These cases do indeed make a group worth distinguishing as a nosological entity and they offer certain common and characteristic traits always carrying a warning that the tendency is towards deteriorating. . . . The picture as a whole makes the diagnosis. There are no decisively pathognomic facts. The deterioration gives the disorder its name.[12]

Despite the pessimistic opinions of Drs. Kraepelin and Meyer, Rochester State Hospital established a treatment program for dementia praecox under the initiative and direction of Dr. Charles La Moure in the hopes that not all of these patients were incurable. The School for Dementia

Praecox, as it came to be known, primarily involved recreational therapy, using play to stimulate mental wellness. In his introduction to the *Annual Report of the Rochester State Hospital* for 1909, Dr. Howard wrote:

> These cases were careless about their appearance, apparently indifferent to their surroundings, also apathetic, and spent most of their time in idleness. At first it was necessary to stimulate their activities, and to do this a basket ball [sic] was made use of, and they were taught to catch the ball and then throw it back. This was a slow process, but it was successful. They were then taught to march, dance, play games, and to sing. All this took time, but everyone in the class was taught all these things. Gymnasium apparatus was put in use and is a source of amusement as well as benefit to all. Sewing, fancy work, basket weaving, and rug making are features of this school.[13]

In spite of the best efforts of the School for Dementia Praecox, Rochester State Hospital struggled to care for the large volume of patients with chronic mental illness. Overcrowding was a constant problem. Admissions always

Rochester State Hospital staff in the 1910s. Superintendent Eugene Howard is front-center-left. Head women's physician Dr. Eveline Ballantine is rear-center-right. Housing was provided to staff, who lived with their families on the hospital campus. From Records of the Monroe County Insane Asylum (1857–1891), Edward G. Miner Library, University of Rochester.

The men's ward of the Rochester State Hospital in the early twentieth century. From Annual Report of Rochester State Hospital, 1909.

exceeded discharges, such that by 1910 the patient population had risen from the initial 357 residents to 1,398.[14] In the 1910s, the facility had a staff of nine physicians, including three to four (depending on the year) women, headed by Dr. Eveline Ballantine, providing medical care for a female population that had grown to 60 percent of the hospital's residents.[15]

Some of the residents of the women's ward of the Rochester State Hospital. From Annual Report of Rochester State Hospital, 1909.

The treatment of male and female patients had some key differences in the early years of Rochester State Hospital. As illustrated in the accompanying photographs, men and women were

segregated into different wards. Women often were given jobs in the laundry department, while men were more often employed on the farm. When the School for Dementia Praecox was established, hydrotherapy was used solely for female patients, then offered to the entire patient population many years later. Used to calm agitated patients, hydrotherapy involved forced bathing in a tub with a canvas cover outfitted with a hole that allowed the bather's head to remain above water. After the hydrotherapy baths in the men's ward were broken, women again became the sole recipients of this treatment. Women were admitted at a greater rate than men, remained in the hospital longer on average than men, and were discharged at a lower or equivalent rate. When female patients were discharged, they were more likely than men to be discharged as "improved" or "not improved," as opposed to "recovered."[16] These many differences indicate how social interpretations of mental illness and institutionalized sexism may have contributed to biased treatment of women during the formative years of Rochester State Hospital.[17]

The Great Depression: An Era of Expansion and Experimentation

By the 1920s, Rochester State Hospital had entirely outgrown its former geographic footprint as a county asylum. A cluster of buildings built to house 350 patients had evolved into a comprehensive campus with medical, surgical, and dental facilities, recreational and assembly halls, a large farm, carpentry and crafts workshops, and even a small retreat on the shores of Lake Ontario, which provided patients with relief and adventure during the summer months. The population surged throughout the 1920s, driven by transfers

The hospital's lake farm, which both convalescent patients and those with acute cases visited during the summer months. From Annual Report of Rochester State Hospital, 1909.

from more rural facilities and Rochester's emergence as an industrial center.[18] Compared to farming, industrial jobs drew families away from the house for long hours, making it costly, in terms of lost wages, to care for sick relatives at home. Compounding these factors, the population was also aging rapidly—in 1890, the life expectancy from birth in the United States was 44 years, compared to 58.7 years in 1930.[19]

Within the hospital, overcrowding became a tremendous burden. The patient population grew from 1,500 to 1,800 people in the 1920s, in facilities designed to safely house roughly 1,300.[20] Residents were increasingly older, with the percentage of patients above 60 years of age rising steadily throughout the 1920s and 1930s and plateauing in the 1940s at roughly 60 percent of the inpatients. Some of these older patients were new admissions, diagnosed with mental diseases that were more common in the elderly, such as dementia.[21] Others were chronically mentally ill patients who had been

admitted in their youth and had remained there for many years, unable to be safely discharged.

During the Great Depression, the pressure upon social safety net institutions like Rochester State Hospital increased. The 1930s saw a construction boom on campus—new residence halls and facilities, expanded roads and beautification of the grounds, and improvements to the power plant and other infrastructure. Funding for these projects came from the state of New York as well as federal programs, including the Works Progress Administration.[22] However, money petered out by the mid-1930s. A contractor hired to build new residence halls went bankrupt, and a plan to increase hospital beds never materialized. Even as the patient population climbed toward 4,000 people, the rated capacity stalled at 2,740.[23] How did the staff mitigate the burden of overpopulation? A small number of patients, between 200 and 300, were deemed suitable for convalescent care, meaning they lived at home or in a boarding house but returned regularly to the hospital or to an outpatient clinic in Batavia for treatment. Meanwhile, the vast majority were still being treated in the nineteenth-century fashion, with occupational therapy, recreational therapy, and sedatives.

A number of medical and pharmacological breakthroughs, most notably in the treatment of syphilis and schizophrenia, would prove invaluable to addressing the problem of hospital overcrowding in the twentieth century. In the early 1900s, multiple developments were made in the detection and treatment of syphilis—the Wassermann diagnostic test debuted at Rochester State Hospital in 1922, and the Salvarsan antibiotic treatment was introduced

shortly thereafter.[24] Dr. Paul Ehrlich won the 1908 Nobel Prize in medicine for his experimentation with arsenic-based compounds for the treatment of syphilis. These eventually led to the discovery of the "magic bullet," Salvarsan, a weak antibiotic that required a series of injections to be effective. Interestingly, another metal, mercury, predated the use of arsenic in the treatment of syphilis—leading to the old saying, "one night with Venus, a lifetime with Mercury."[25]

Given that roughly a third of new admissions to Rochester State Hospital and to mental hospitals throughout the United States were for general paralysis (neurosyphilis), a definitive remedy was much sought after. The 1920s witnessed the development of a new treatment for the disease. By infecting syphilitic patients with the blood of a malarial patient, a massive fever was induced in the syphilitic, sufficient to wipe out the *Treponema pallidum* bacteria. This treatment, termed pyrotherapy, won the 1927 Nobel Prize in Medicine for its discoverer, the Austrian psychiatrist Dr. Julius Wagner-Juaregg.[26] Nine years later, Rochester State Hospital launched its own pyrotherapy program.[27] Due to the risks of the procedure, treatment of Rochester State Hospital patients required collaboration with Strong Memorial Hospital, which supplied the staff and facilities to care for these critically feverish patients. This marked an early example of a partnership that would grow over time to eventually include a wide range of collaboration between the University of Rochester and Rochester State Hospital. Psychiatry residents at the state hospital rotated at the University of Rochester in the 1950s; today University of Rochester psychiatry residents rotate at Rochester Psychiatric

Center.[28] And perhaps most notably, Dr. John Romano, former Chair of Psychiatry at the University of Rochester, rounded on patients at Rochester State Hospital starting in the 1950s and became the namesake of the John Romano Alternative Living Residence on the Rochester Psychiatric Center's current campus.

The success of pyrotherapy inspired other biologic interventions whereby a medical crisis was induced in a patient to treat mental illness. In the late 1930s, Rochester State Hospital introduced two new treatment programs for psychosis, first insulin shock therapy and later electroconvulsive therapy (ECT). The goal of these treatments was to induce seizures in psychotic patients as a definitive cure. While the other aforementioned therapies have fallen by the wayside, ECT remains an effective treatment for select patients. How this theory was first arrived at, and how it evolved into a common practice at state mental hospitals, is a twisting and turning tale originating with Hungarian physician Dr. Ladislas Meduna's discovery that the brains of deceased schizophrenic patients had abnormally low numbers of glial cells (which support the neurons), while the brains of deceased epileptic patients had abnormally high numbers of glial cells. This led him to believe that inducing seizures in schizophrenic patients could potentially repair their brains by inducing the proliferation of glial cells.[29] He further believed, incorrectly, that schizophrenia and epilepsy coexisted only rarely. His method, with which he reported some initial success, was to treat catatonic or psychotic patients with multiple injections of camphor oil, and later Metrazol, which induced seizures.

By the time Meduna's discovery reached the United States, a newer

and safer technique had been developed—the use of electricity to induce convulsions. Electroconvulsive therapy was pioneered by the Italian scientists Drs. Ugo Cerletti and Lucio Bini, who researched how to induce seizures without the use of drugs in order to study brain tissue unaffected by any toxin. Electrically induced seizures were much more predictable than those induced by Metrazol injection and quickly became the gold standard for seizure induction.[30] At the same time as Meduna's discovery, the Austrian scientist Dr. Manfred Sakel noticed that psychotic patients who lapsed into diabetic comas appeared to have improved mental clarity when they recovered. He inferred that using insulin injections to induce diabetic comas was a promising treatment for psychotic patients. Sakel also observed seizure activity due to his treatment, noting, "on the sixth day of treatment the patient experiences a strong hypoglycemic reaction with somnolence and the onset of coma, also with a huge outpouring of sweat. . . . In the third week of treatment, with no warning signs, the patient experiences a major attack of epilepsy one and a half hours after an injection of 50 units of insulin, displaying tonic-clonic convulsions and biting his tongue."[31]

Comparing insulin shock therapy to Metrazol and electroconvulsive therapies, which were grounded in the glial cell hypothesis, historian Gerald N. Grob noted that "despite encouraging results with insulin, a marked sense of uneasiness persisted among psychiatrists. The puzzle of employing a therapy that could not be reconciled with theory or any known physiological data remained troubling."[32] Nevertheless, both therapies became popular in New York State by 1940. Given that psychiatrists were faced with countless

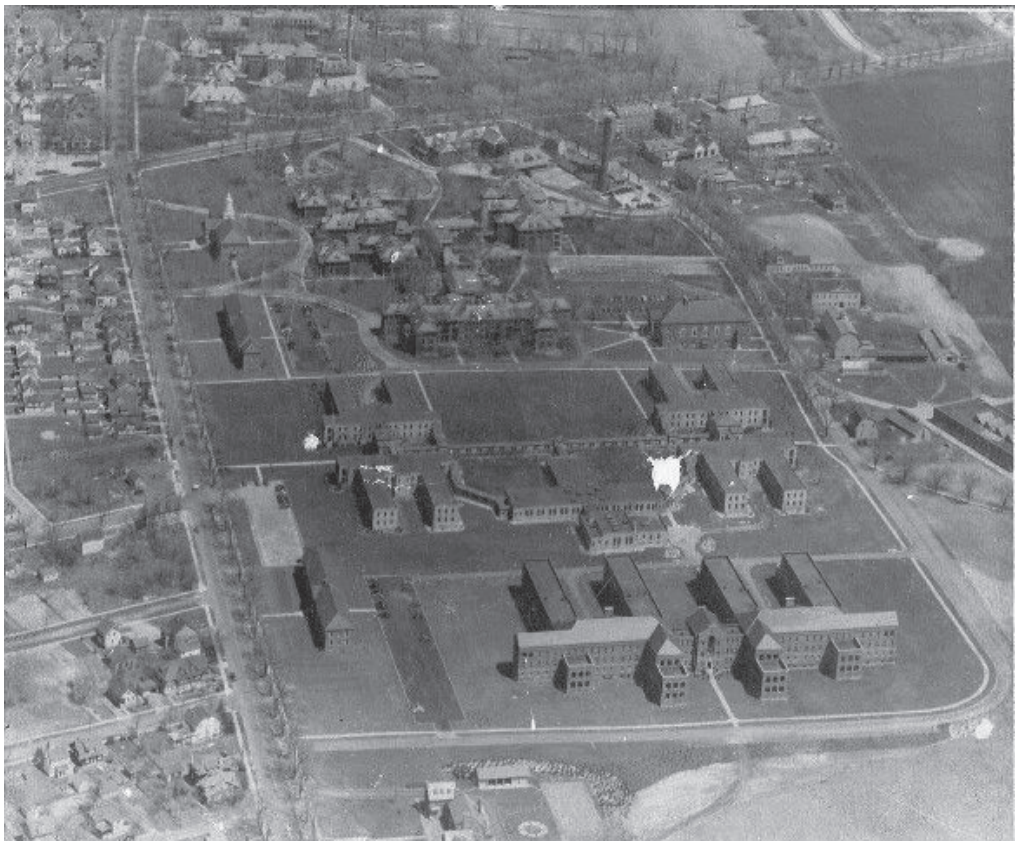
chronic patients who seemed destined to remain institutionalized for the rest of their lives, it is understandable that many opted to employ such remedies, even if they were somewhat experimental.[33]

At Rochester State Hospital, an emerging goal of therapy was to discharge the patient. In the initial statistics compiled in the annual reports, the patients

Combination insulin/Metrazol shock therapy at Rochester State Hospital		
Year	**Number Treated**	**Reported Success Rate**
1938	62	29.0%
1939	59	42.4%
1940	67	37.3%
1941	53	56.6%
1942	42	16.7%
Total	283	37.1%

Electroconvulsive therapy at Rochester State Hospital		
Year	**Number Treated**	**Perceived Success Rate**
1943	70	60.0%
1944	178	67.4%
Total	248	64.5%

Efficacy of various 'shock' therapies. Success was reported based on subjective clinical assessments of patients. The ECT program continued at Rochester State Hospital, but success rates were not recorded in the annual reports. From Annual Reports of Rochester State Hospital.



The Rochester State Hospital in the 1940s. From Records of the Monroe County Insane Asylum (1857–1891), Edward G. Miner Library, University of Rochester.

described as "improved" or "much improved" by the various shock therapies were almost always discharged, and this became an effective tool against overcrowding. The ECT program would become a model for future treatment programs, first the lobotomy, and later, antipsychotic medications. Each new therapy underwent a trial conducted on a small group of patients. If a large portion of them improved enough to be discharged, then the therapy was offered to a wider range of patients.

During World War II, Rochester State Hospital experienced a staffing shortage, as roughly half of all the medical staff joined the war effort.[34] Some of the staff were replaced with conscientious objectors, who were assigned

to hospitals in lieu of military service. Journalist Albert Deutsch consulted conscientious objectors as sources for his 1948 exposé, *The Shame of the States*, which described mental hospitals across the United States.[35] Lack of funding and staff at these facilities, combined with few effective treatments for mental illness, had made conditions at mental hospitals unbearably unsustainable. While Deutsch did not discuss Rochester State Hospital, it is not hard to imagine how overcrowding and decreased numbers of staff resulted in dangerous deficiencies in patient care. At sister institutions, Rockland State Hospital and Manhattan State Hospital, Deutsch found that patients who were old and frail were at particular risk of violence from both attendants and fellow patients, suffering injuries ranging from fractures and lacerations to accidental death.[36] Meanwhile in Rochester, the Monroe County District Attorney began an investigation into patient abuse and neglect at Rochester State Hospital in 1947, but charges were never brought. The investigation was sparked by two accidental deaths or suicides among patients.[37] The lamentable conditions experienced at mental hospitals across the country would begin to shift in the post-war era.

New Therapies, New Society

Historian Gerald N. Grob has argued that World War II, more than any event, was the catalyst of change in the field of psychiatry. More than 2,000 physicians were pressed into military service, an experience which highlighted that mental illness was "far more pervasive and serious than had previously been recognized, that environmental stress associated with combat contributed to mental maladjustment, and that early and purposeful treatment in non-institutional settings produced favorable outcomes."[38] Wartime psychiatrists developed an effective

treatment regimen for acute stress brought on by combat: identify affected soldiers and remove them from the combat zone, then treat them with sedatives, a night of good sleep, and hot food before returning them to the frontlines within a week. More serious cases were returned to the United States for further treatment in military and Veterans Administration hospitals. Notably, this type of psychiatric care could be delivered to soldiers in "aid stations" just behind the front lines—less than a quarter of the soldiers treated during World War II were hospitalized.[39]

Psychiatrists returning to civilian hospitals in the postwar period came back convinced that they should fundamentally alter the manner in which they addressed the needs of those suffering from mental illness. A specific goal was to identify patients who were at risk for chronic mental illnesses such as schizophrenia and intervene early in a community setting, avoiding the need for lengthy hospitalization. The drive to find new ways to treat the mentally ill spawned many successes, including antipsychotic medications and advances in psychotherapy. But it also resulted in some disastrous failures, the worst among them being the lobotomy.

A lobotomy is the dissection of brain tissue from the frontal lobe. It was first developed in Portugal by the neurologist António Egas Moniz in 1935. At the time, it was believed to disrupt the pathological connections in the brain that caused schizophrenia and other mental illnesses. A barnstorming physician by the name of Walter Freeman dubiously championed the practice in the United States and toured the country demonstrating his technique in front of audiences like a showman. He performed the procedure on more than 2,500 patients in his career.[40] At Rochester State Hospital, staff surgeons lobotomized more than 300

patients between 1949 and 1954.[41] Unlike Freeman's patients, who were often not even mentally ill, and unlike the portrayal of lobotomy in Ken Kesey's 1962 novel, *One Flew Over the Cuckoo's Nest*, where it was used as a punishment for disobedient patients, the bulk of the Rochester patients who underwent the procedure were elderly schizophrenic women who had been deemed refractory to other treatment.[42] Unlike electroconvulsive therapy, lobotomy did not often result in patient discharge. Most lobotomized women continued to live on campus, some of them working in the facility's two hair salons where they cut and styled the hair of other patients as part of their occupational therapy.[43]

Nonetheless, Dr. Benjamin Pollack, who became the assistant director of the Rochester State Hospital in 1950, defended the role of lobotomy as a means of pacifying patients and allowing them to return to their families. He noted in 1955, "lobotomy has controlled their restlessness and their emotional instability,

Results on Disturbed Patients Post-Lobotomy

	Before Operation	After Operation
Restraint	58%	4%
Assultive	92%	10%
Destructive	60%	6%
Wetting	52%	18%
Soiling	34%	4%
Idle	90%	52%
Employed	8%	52%

Statistical report on the pacifying effect of lobotomy at Rochester State Hospital. From Dr Benjamin Pollack, "Psychosurgery: a 5 Year Follow-Up Report on 200 Patients," Medical Times *83, no. 4 (April 1955).*

and very often has removed their paranoid delusional states, so that they can live at home with moderate supervision."[44] Despite Pollack's rosy assessment, the lobotomy program was abruptly discontinued that year after the introduction of the first antipsychotic drug, chlorpromazine (brand name Thorazine). At that time, the inpatient population was above 3,500 people (the highwater mark would be 3,717 in 1956), with a rated capacity of 2,740.[45] To the staff at mental hospitals, the effect of the antipsychotics must have felt like a pharmacological miracle; patients who had been utterly refractory to all treatments were now freed from the chains of their mental illness. As Pollack explained:

> An attempt was made to evaluate the use of Thorazine as a prognostic test for patients upon whom prefrontal lobotomy operations were contemplated. It would appear that Thorazine is a valuable aid in determining the choice of patients for such operations; but as a matter of fact, lobotomies have been indefinitely deferred for some patients because of the marked improvement in them following treatment with Thorazine. It is important to realize that these patients had previously been treated with insulin, electroshock, or other types of therapy—with temporary, slight, or no results. Some patients were treated who had demonstrated only transient improvement following prefrontal lobotomies and who had continued with their disturbed behavior or their delusional ideas. A number of such patients have been maintained in a stable state by Thorazine.[46]

The same year, Rochester State Hospital's Director, Dr. Christopher Terrence, wrote in the annual report: "the impact [of Thorazine] upon the hospital personnel and upon the patients has been noteworthy, in that almost universal acceptance

of the program has resulted . . . in a resurgence of interest in medical and other therapeutic efforts, and less upon custodial care. By the end of the fiscal year, over 500 patients had been treated with either Thorazine or Reserpine [another early antipsychotic]. Most of the studies were concerned with Thorazine since it appeared to produce such a rapid and dramatic result."[47] By 1957, little more than two years after the introduction of these medications, more than half of the patients at Rochester State Hospital were being treated with antipsychotics.[48]

Psychotherapy also proved beneficial to patients. In 1951, Rochester State Hospital hired its first staff psychologist and began offering individual and group psychotherapy to its patients. Though psychotherapy had made inroads among Europeans in the nineteenth century, it did not gain widespread currency in the United States until the economically prosperous postwar era. The treatment had been effective with soldiers during World War II and proved appealing to a growing number of middle-class Americans who were not only receptive to psychological explanations and Freudian theories, but also able to afford such therapeutic services.[49] Over the course of the 1950s and 1960s, Rochester State Hospital's psychotherapy program expanded steadily, until the modern combination of psychotherapy and pharmacotherapy was available to every patient.[50]

While admissions still exceeded discharges, an increasing number of patients were "paroled" to the community, meaning they lived at home or in transitional residences while receiving weekly or monthly treatments at the hospital's outpatient clinic (or the smaller outpatient clinic in Batavia). In 1959, Terrence reported that 90 percent of patients under the age of 50 were able to

be treated and released back to the community for outpatient care within a year of admission. However, physical ailments often prevented the release of elderly patients, and hospital administrators anticipated that the inpatient population would remain high and planned accordingly.

In December 1959, Terrence presided over the opening of a modern new hospital building named in his honor. The 16-story medical-surgical building with 1,100 beds stood tall above scattered hospital buildings to the west and empty farmland to the east. “It is a skyscraper,” Terrence announced, “proclaiming to the community that in the fight against the ills that plague mankind’s physical and mental being, a long giant step has been taken in meeting and conquering those ills.”[51] Access to new pharmacological treatments meant that the patients who lived in Terrence Tower were calmer, less symptomatic, more responsive to pharmacotherapy and psychotherapy, and exhibited an increasing need for occupation and recreation to pass the time and provide a sense of fulfillment. Television sets in the wards, first a luxury, were now a necessity.

Terrence Tower was never meant to stand alone. Ten years earlier, when it was first proposed as a solution to overcrowding at Rochester State Hospital, the administration expected that many such buildings would fill out a modern campus. Each edifice would have housing for thousands of patients, along with recreation halls, cafeterias, medical and surgical facilities, and a morgue. But that was not to be. The Rochester State Hospital was entering a new era. By 1975, the inpatient population had dwindled to 1,731 residents, less than half the number of residents who had been there when the tower opened in 1959.

An Outpatient Model for Mental Health Care

By the mid-1960s, a "deinstitutionalization" movement was well under way in the United States, spearheaded by a series of federal initiatives, including the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (abbreviated as the Community Mental Health Care Act). According to historian Dr. E. Fuller Torrey, the architect of the Community Mental Health Care Act, Dr. Robert Felix, planned to replace "overcrowded state mental hospitals with 'properly staffed out-patient clinics.'"[52] These clinics were intended to provide preventative medicine. They screened patients at risk for mental illness and treated them primarily with psychotherapy, with the belief that this would prevent the progression of symptoms and avoid the need for hospitalization. There was a hope among the architects, including Stanley Yolles, director of the National Institute of Mental Health from 1949 to 1972, that mental hospitals would become obsolete. According to Torrey, "Yolles hated the state hospitals and wanted to shut down those goddamn warehouses."[53]

The passage of Medicare and Medicaid in 1965, combined with the federalization of Supplemental Security Income (SSI) in 1974, had an even more profound effect. With the federal government increasingly shouldering the cost of health care for people with chronic disabilities, states had a financial incentive for emptying their mental hospitals. Consider, for example, that New York spent $13,835 per year to provide care for someone in a state hospital. If such a person was to be discharged to live in a group home or boarding house, the state's financial burden would be reduced to $4,600 because federal SSI would pay that person's living expenses. This meant that the state could save more than $9,000

per year for every person it discharged. It would not take long for the states to figure out the rules of the game.[54]

In addition to these economic factors, advancements in the legal rights of individuals with mental illness also contributed to massive deinstitutionalization in the final decades of the twentieth century. In 1972, a federal district court in Milwaukee ruled that people with mental illness had the right to the least restrictive treatment and that involuntary commitment was a legal alternative to outpatient treatment only when "there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others."[55] The arrival of effective pharmacotherapy, the financial incentives for relocating residents of mental health facilities, and the court restriction on involuntary commitment all had the effect of pushing patients out of the state hospitals and into the community.

Discussing this time period when so many patients were discharged from, or transferred out of, large state hospitals, Grob claimed that, "what had occurred was not a deinstitutionalization movement, but rather a lateral shift of patients among institutions. Aged (as well as younger) persons diagnosed as mentally disordered were now being sent to nursing homes rather than state hospitals simply because the passages of [Medicare and Medicaid] made possible a substitution of federal for state funds."[56] Other mentally ill people wound up incarcerated, in group homes, in shelters, or on the streets. Various studies conducted in the United States in the 1980s estimated that 30 to 50 percent of the homeless population and 8 to 20 percent of the prison population suffered from severe mental illness; twenty-first century studies put the number of mentally ill prisoners at closer to 50 percent.[57] In 1987, former University of Rochester Chair of Psychiatry Dr. John

Romano described what he had seen in New York City: "All of a sudden these patients were out in the community. . . . [The state said], 'isn't it great? They're out of the nut house.' Well, they were on the street, eating garbage, hallucinating, thieves stealing their checks. . . . That sort of disastrous thing happened in big cities."[58]

During this era, many of the state mental hospitals closed. A few of these large campuses, formerly home to thousands of patients, found new life as drug treatment centers, homes for children and adults with mental illness, or prisons, but many simply shut down. Rochester State Hospital absorbed transfers from around the state and became useful as a provider of care for special populations—first a tuberculosis unit in 1957, then a unit for alcoholic patients in 1962.[59] In 1975, the New York Office of Mental Health rebranded the remaining state hospitals as "psychiatric centers." Today, the facilities are hubs coordinating the delivery of all state mental health services, both inpatient and outpatient. Rochester Psychiatric Center continues to provide psychiatric care for Monroe, Genesee, Livingston, Orleans, Wayne, and Wyoming counties in Western New York in its civilian and forensic inpatient units, as well as its transitional and long-term residences for adults and adolescents. Terrence Tower was closed and abandoned in 1995, a relic of the past, but the Rochester Psychiatric Center remains. As a provider of mental health care, it is irreplaceable. As a monument to our past, it is indelible.

Notes

Albert Deutsch, *The Mentally Ill in America - A History of Their Care and Treatment from Colonial Times*, (Garden City, NY: Doubleday, Duran & Company, 1937), 259–61.

Deutsch, *The Mentally Ill in America,* 257–58.

Dr. Eugene Howard's correspondence files, History of Medicine Collection, Edward G. Miner Library, University of Rochester.

Philippe Pinel, *A Treatise on Insanity*, trans. D.D. Davis (New York: Hafner Publishing Company, 1962), 193–95.

Gerald N. Grob, *Mental Illness & American Society* (Princeton, NJ: Princeton University Press, 1983), 292.

Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton, NJ: Princeton University Press, 1995), 311.

Lunbeck, Ibid.

Paul Gabriel, "Gender Differences in Occupational Distributions among Workers," *Monthly Labor Review* (June 2007), 19–24.

New York (State), *The Revised Statutes of the State of New York: Together with All the Other General Statutes (except the Civil, Criminal, and Penal Codes) as Amended and in Force on January 1, 1896, with an Index, in One Alphabetical Arrangement, to the Constitution of All of the Statutes Including the Codes, 3* (New York: Banks & Brothers, 1896), 295–96.

In the nineteenth century, "idiocy" was the term used for the lowest rank of intelligence and functional ability, while "imbecility" referred to a medium rank of intelligence and functional ability.

Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1892).

Adolf Meyer, "The Dynamic Interpretation of Dementia Praecox," *The American Journal of Psychology* 21, no. 3 (1910), 385.

Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1909).

Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1910).

Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1910).

Annual Reports of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1916–1920).

Elizabeth Lunbeck found that women were also treated differently from men in Boston-area mental hospitals during the 1900s but noted the difficulty of separating bias on the basis of sex from other confounders such as socioeconomic status, marital status, and

whether one lived alone or with family. See Lunbeck, 311–18.
Carolyn Stewart, "US Census Bureau Publications-Census of Population and Housing," Census Bureau QuickFacts, United States Census Bureau, August 19, 2011, https://www.census.gov/prod/www/decennial.html.
"Life Expectancy from Birth in the United States, 1860–2020," Statista, accessed June 30, 2022, https://www.statista.com/statistics/1040079/life-expectancy-united-states-all-time/#:~:text=Over%20the%20past%20160%20years,to%2078.9%20years%20in%202020.
Annual Reports of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1925–1930).
Annual Reports of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1920–1940).
Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1935).
Annual Reports of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1930–1945).
Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1922).
Anne Harrington, *Mind Fixers: Psychiatry's Troubled Search for the Biology of Mental Illness* (New York: W.W. Norton, 2020).
Grob, *Mental Illness & American Society,* 293–94.
Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1938).
Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1953).
Max Fink, *Electroconvulsive Therapy: A Guide for Professionals and Their Patients* (New York: Raven Press, 1979), 8–9.
Edward Shorter and David Healy, *Shock Therapy: A History of Electroconvulsive Treatment in Mental Illness* (New Brunswick, NJ: Rutgers University Press, 2013), 35.
Shorter and Healy, 37–43.
Grob, *From Asylum to Community* (Princeton, NJ: Princeton University Press, 2016), 303.
Grob, *Mental Illness and American Society,* 297–98.
Annual Reports of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1940–1945).
Albert Deutsch, *The Shame of the States* (New York: Arno Press, 1973), 44.
Deutsch, *The Shame of the States,* 85–86.
"Text of Visitors' Report on State Hospital," *Democrat and Chronicle*, March 13, 1947;
Annual Reports of the Rochester State Hospital (Rochester, NY: Rochester State Hospital,

1948–1949).

Grob, *The Mad Among Us: A History of the Care of Americas Mentally Ill*, (New York: Free Press, 2011), 191.

Grob, *Mad Among Us*, 194.

Michele Norris, "'My Lobotomy': Howard Dully's Journey," November 16, 2005, in *All Things Considered*, produced by NPR, podcast, MP3 audio 22:49, www.npr.org/2005/11/16/5014080/my-lobotomy-howard-dullys-journey.

Annual Reports of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1950–1955).

Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1955).

Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1954).

Benjamin Pollack, "Psychosurgery: A Five Year Follow Up Report on 200 Patients," *Medical Times* (April 1955), 170.

Annual Reports of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1955, 1956)

Benjamin Pollack, "Preliminary Report on 500 Patients Treated with Thorazine at Rochester State Hospital," *The Psychiatric Quarterly* 29, nos. 1–4 (1955), 439–56.

Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1955).

Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1958).

Grob, *Mad Among Us*, 224.

Annual Report of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1952).

"State Hospital Sets New Unit to Aid the Aged," *Democrat & Chronicle*, November 28, 1959.

E. Fuller Torrey, *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (New York: Oxford University Press, 2014), 17.

Torrey, 63.

Torrey, 87.

Lessard v. Schmidt, 379 F. Supp. 1376 (E.D. Wis.1974).

Grob, *Mad Among Us*, 266.

Torrey, *American Psychosis*, 123–24.; "Department of Justice Study: Mental Illness of Prison Inmates Worse Than Past Estimates," *National Alliance on Mental Illness*, September 6, 2006, www.nami.org/Press-Media/Press-Releases/2006/Department-of-Justice-Study-Mental-Illness-of-Pris.

Susan J. Smith, "Man of the Mind," Rochester *Times-Union,* April 1, 1987.

Annual Reports of the Rochester State Hospital (Rochester, NY: Rochester State Hospital, 1958, 1963).

Acknowledgements

The authors would like to thank Christopher Hoolihan, Librarian of the History of Medicine Collection at Edward G. Miner Library, University of Rochester. These articles build on early work by William D'Anza. We are grateful for his contributions to the history of the Rochester Psychiatric Center.

About the Authors

Peter G. L. Juviler, M.D., is a resident physician in surgery at the University of Rochester and a 2019 graduate of the University of Rochester School of Medicine. He graduated from Colgate University in 2015 where, in addition to science courses, he studied creative writing.

Jacob Gordon, M.D., is a third-year resident physician training in family medicine in Lawrence, Massachusetts. He earned his medical degree at the University of Rochester School of Medicine and Dentistry. While in medical school he also worked on projects researching health care delivery to the homeless population in Rochester. His current interests include addiction medicine, geriatrics, and palliative care.

Laurence B. Guttmacher, M.D., is an Emeritus Professor of Psychiatry and Medical Humanities at the University of Rochester School of Medicine. At various times he has directed resident and medical student education in psychiatry and served as an Associate Dean in the medical school and was, for many years, the Clinical Director of Rochester Psychiatric Center. Long fascinated by the history of medicine, he led the George Washington Corner Society for the History of Medicine.

Robert Riley, M.P.H., has been on staff at the Rochester Psychiatric Center since 1981. He is currently the Assistant to the Executive Director. As part of his administrative duties, he has been responsible for the historical records of the Rochester Psychiatric Center and its predecessor the Rochester State Hospital for more than 30 years. He is an Adjunct Instructor in Medical Humanities and Bioethics at the University of Rochester School of Medicine and Dentistry. He holds a master's degree in Public Health from Columbia University and a B.A. in History from St. John Fisher College.

Terrence Tower in the mid-1960s. Originally named the Medical-Surgical Building, it was renamed Terrence Tower in 1987 to recognize Dr. Charles Terrence, director of Rochester State Hospital from 1959 to 1987. From Rochester Psychiatric Center Archives.

Central Library of Rochester & Monroe County
Monroe County Library System

City of Rochester, NY
Malik D. Evans, Mayor
Rochester City Council