Census Enumeration of the Mentally Ill and the Mentally Retarded in the Nineteenth Century

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Enumerations of the mentally ill and mentally retarded were included in the six U.S. censuses conducted between 1840 and 1890. Inclusion of these categories reflected the new concern for the mentally ill and mentally retarded that was emerging at that time as part of a new social consciousness. Dr. Gorwitz analyzes these census results, considers the limitations of the data, and discusses the factors that led to discontinuation of the enumerations of the two groups after the 1890 census.

CENSUS PROGRAMS to count the number of mentally ill and mentally retarded grew out of the provision of Section 2, Article 1, of the U.S. Constitution which states that "The actual [census] enumeration shall be made within three years after the first meeting of the Congress of the United States, and within every subsequent term of ten years, in such manner as they shall by law direct." The underlying purpose of this enumeration was to provide the population figures necessary for the decennial apportionment of the U.S. House of Representatives. On the basis of this provision, a U.S. census has been conducted at least once during every 10-year-period.

Historical Background

Until 1850 the U.S. censuses were conducted under the direction of the Secretary of State. In that year they were transferred to the newly established Department of the Interior, where a permanent census bureau was created in 1880. Before that a temporary bureau had been established for each census, which would conduct the enumeration, make the necessary tabulations, submit a printed report, and then disband. In these early censuses the published data were summaries of tabulations submitted by local U.S. marshals, who served as enumerators. Printed instructions for the marshals' use were not provided until 1850. The Census Bureau has been part of the Department of Commerce (Commerce and Labor until 1913) since 1903.

From 1790 until 1820 the data collected were mainly designed to measure such basic population characteristics as age, race, sex, and place of residence. In 1830, for the first time, efforts were made to expand these data by measuring the fre-

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quency of some physical disabilities in the population, and the U.S. marshals were asked to count the number of persons blind and deaf. In 1840 a category called "insane and idiotic" was added, and these persons were divided into those under "public or private charge." No effort was made to separate the insane from the retarded, and no definitions of these terms (or of the terms "blind" and "deaf") were provided for the enumerators. Each U.S. marshal, in effect, was free to include or exclude as he saw fit. It is therefore not surprising that in 1843 the recently established American Statistical Association sent an official protest to the U.S. House of Representatives which stated that "The most glaring and remarkable errors are found in the statements respecting nosology, prevalence of insanity, blindness, deafness and dumbness, among the people of this nation. . . . In many towns, all the colored population are stated to be insane; in very many others, two-thirds, one-third, one-fourth or one-tenth of this ill-starred race are reported to be thus afflicted. . . . The errors of the census are as certain, in regard to insanity among the whites, as among the colored population" (*1*).

There is no evidence of remedial actions resulting from the protest, and Federal efforts to enumerate the insane and the retarded continued uninterrupted until the 1890 census. Beginning in 1850 separate tabulations were made in respect to insanity and retardation. Also the division into "private or public charge" was eliminated. Definitions were not supplied until 1870, when the printed schedule provided the enumerators stated: "Only undoubted insanity is intended in this inquiry. The fact of idiocy will be better determined by the common consent of the neighborhood than by attempting to supply any scientific measure to the weakness of the mind or will" (*2*).

An official, permanent census bureau was established preceding the 1880 census. At that time a determined effort was made to make the enumeration of the insane and retarded as complete as possible. For this purpose Frederick Howard Wines, a distinguished statistician who had devoted a lifetime to the social welfare field, was appointed a special agent of the Census Bureau to head the section dealing with the defective, dependent, and delinquent classes. In his native Illinois he served as secretary of the Board of State Commissioners of Public Charities from 1869 to 1899. In this capacity he was responsible for construction of the first cottage-type psychiatric hospital in the United States (the Eastern State Hospital for the Insane at Kankakee—1877). He also drafted the Illinois Lunacy Law, which served as a model for similar legislation by many other States.

As stated in the census report, the method of enumeration in 1880 was as follows (*3a*):

> . . . first, that the basis of the present investigation was a list of institutions throughout the United States, prepared with great care in advance of the actual taking of the census, so that it is demonstrable that few, if any, of the important charitable and correctional institutions of the country failed to be accurately reported. Second, a system of special schedules was devised, one for each separate class; and every enumerator was required not merely to enter upon the general population schedule the name of every defective person enumerated by him, but also to transfer the name of every such person to its appropriate special schedule and upon the schedule to answer certain definite questions, applicable to him as a member of the class to which he was supposed to belong. For this extra service the enumerator was offered additional compensation; and it was impressed upon him that he should exert himself to find these defective persons, and make a full report of each case. He was instructed to counsel with physicians upon this point, to make inquiries of neighbors, and to report all defectives, whether the information respecting them should be derived from the family to which they belonged or from other sources, if in his judgment it was worthy of confidence. By this method it was sought to obtain approximately as complete an enumeration of defectives outside of institutions as of the inmates of such institutions. Third, with respect to the idiots and the insane, the work of the enumerators was supplemented by correspondence with physicians, in all part of the United States, to the number of nearly 100,000, all of whom were furnished with blank forms to return, and were invited and urged to report to the Census Office all idiots and lunatics within the sphere of their personal knowledge. Four-fifths of them responded to this invitation; a result which, while it redounds to the credit of the medical profession, illustrates the remarkable interest felt by the public in this census, and it is in itself a tribute to the genius of popular institutions. . . .

The data for 17 percent of the insane who were enumerated in 1880 were based on information obtained solely from physicians. In addition to counting the number of deaf, blind, insane, and retarded, the 1880 census also sought to enumerate such groups as convicts, paupers, and prostitutes and such facilities as brothels and saloons. Apparently the primary motive for these efforts was to measure the extent of the States' responsibility for care of the "dependent, defective and delinquent" classes. In the words of Wines (*3b*):

> To my own mind the entire subject is one. The causes at work in modern society, with its high degree of organization and development, which tend to hasten the growth of either of the forms of misfortune included

Table 1. Proportion of total population reported as mentally ill in each State or territory and region, 1840–90 censuses

Region and State	Rate per 100,000 total population					
	1840	1850	1860	1870	1880	1890
Total	50.7	67.3	76.6	97.1	183.3	169.7
New England	98.4	141.7	147.6	166.8	277.9	255.9
Connecticut	108.6	126.8	71.9	143.6	276.7	275.5
Maine	62.0	96.2	112.1	126.3	237.6	196.5
Massachusetts	117.2	168.9	171.0	132.7	287.5	272.6
New Hampshire	92.1	118.9	155.2	172.2	304.3	255.0
Rhode Island	130.2	147.1	164.9	143.5	147.4	229.2
Vermont	91.8	178.3	219.9	218.1	305.5	247.6
North Atlantic	62.2	82.3	101.9	126.3	236.1	232.6
Delaware	43.6	74.3	53.5	52.0	135.1	116.9
District of Columbia	30.6	44.5	271.7	363.7	528.1	684.1
Maryland	65.5	93.6	81.5	93.9	198.6	157.9
New Jersey	56.2	77.4	87.6	101.3	212.6	218.9
New York	58.0	81.4	111.2	145.0	276.5	297.3
Pennsylvania	70.0	82.8	95.0	110.6	193.9	161.3
South Atlantic	38.9	52.2	59.5	66.3	131.1	108.3
Florida	9.5	12.6	17.8	15.4	93.9	89.7
Georgia	20.3	35.8	46.4	53.5	110.0	98.8
North Carolina	41.6	58.7	66.5	72.7	144.9	106.6
South Carolina	35.9	37.2	45.0	47.2	111.7	98.2
Virginia	52.1	68.2	73.9	91.8	159.4	155.3
South	25.2	33.2	35.5	54.4	120.9	89.7
Alabama	19.8	30.2	26.7	55.7	120.5	97.1
Arkansas	23.9	30.0	20.0	32.2	98.3	69.9
Louisiana	15.2	38.6	23.9	62.0	106.6	81.4
Mississippi	19.5	21.3	34.4	29.6	101.5	85.5
Tennessee	33.3	40.6	57.7	73.5	155.9	104.4
East Midwest	33.9	49.3	64.5	86.5	180.9	172,7
Illinois	24.3	28.0	39.9	64.0	166.8	173.5
Indiana	30.7	57.0	76.6	89.5	179.3	150.1
Michigan	12.6	33.4	33.4	68.7	170.8	177.8
Minnesota		16.5	14.5	68.7	146.6	169.3
Missouri	29.8	8.4	65.1	73.4	152.6	127.5
Ohio	40.0	66.5	98.0	128.1	227.8	206.9
West Virginia				84.6	158.8	141.5
Wisconsin	13.0	17.7	36.5	80.2	192.0	208.1
West Mid West	43.4	48.4	42.6	71.2	141.0	135.5
Kansas			9.3	35.9	100.4	125.6
Kentucky	45.9	53.6	53.9	94.2	168.9	146.8
Iowa	7.9	21.9	29.8	62.1	156.6	167.2
Nebraska			17.3	22.8	99.5	88.0
North Dakota				21.2	53.3	14.3
South Dakota						94.3
Southwest		18.6	22.8	33.2	98.1	82.1
Arizona				10.4	51.9	99.0
Nevada				4.7	49.8	382.4
New Mexico		17.9	29.9	54.4	128.0	43.0
Oklahoma						11.3
Texas		17.4	20.7	33.0	98.3	74.6
Utah		3.9	37.2	28.8	104.9	79.4
Northwest				17.7	62.0	92.5
Colorado				30.1	50.9	79.1
Idaho				6.7	49.1	97.2
Montana				9.7	150.7	141.5
Wyoming					19.2	62.6
Far West		6.2	108.5	191.2	270.6	244.6
California		2.2	120.0	204.6	289.5	297.5
Oregon		41.3	43.8	134.2	216.3	197.0
Washington			25.9	96.0	179.7	107.6

SOURCE: Office of Publications and Reports, U.S. Bureau of the Census.

Table 2. Proportion of total population reported as mentally retarded in each State or territory and region, 1840–90 census

Region and State	Rate per 100,000 total population					
	1840	1850	1860	1870	1880	1890
Total	51.5	68.1	60.3	63.6	153.3	152.6
New England	61.6	88.7	74.6	72.2	147.4	168.0
Connecticut	66.3	77.4	58.0	63.4	131.2	161.9
Maine	63.7	98.9	104.9	100.2	204.2	240.7
Massachusetts	55.1	79.5	57.8	53.4	113.9	130.8
New Hampshire	85.4	110.4	103.0	102.1	202.6	206.9
Rhode Island	68.4	77.3	57.8	56.6	84.6	141.2
Vermont	49.0	95.2	83.5	98.3	241.7	271.0
North Atlantic	46.1	61.1	59.0	57.4	130.4	139.7
Delaware	58.9	100.5	59.7	55.2	183.5	130.6
District of Columbia	17.4	25.2	36.0	38.0	60.2	113.3
Maryland	47.0	67.1	44.4	46.4	141.1	148.6
New Jersey	62.2	85.6	54.3	48.1	93.4	112.9
New York	38.3	53.8	59.6	56.7	119.7	122.3
Pennsylvania	53.7	63.5	63.4	63.9	150.6	166.5
South Atlantic	57.0	76.5	76.9	81.0	180.5	168.1
Florida	30.9	41.2	48.4	53.3	136.9	127.7
Georgia	41.6	73.3	68.5	73.6	157.8	119.2
North Carolina	64.7	91.4	98.7	91.1	224.5	222.3
South Carolina	50.4	52.1	57.3	65.9	159.5	156.8
Virginia	63.4	83.1	80.1	92.2	184.7	186.6
South	44.8	59.0	52.9	66.9	171.9	152.2
Alabama	40.5	61.7	55.7	72.3	176.1	141.5
Arkansa	43.7	54.8	40.4	59.7	171.2	148.1
Louisiana	13.2	33.6	34.9	39.3	110.0	104.9
Mississippi	33.2	36.6	35.3	58.6	139.5	136.2
Tennessee	69.3	84.4	79.4	86.7	458.1	203.1
East Midwest	43.5	63.4	53.5	63.6	167.8	171.4
Illinois	37.0	42.6	34.3	49.0	135.5	131.2
Indiana	51.2	94.9	67.2	80.9	238.8	254.0
Michigan	18.0	47.5	44.5	51.8	133.2	153.7
Minnesota	...	16.5	18.0	30.5	93.4	111.5
Missouri	40.6	52.3	44.2	45.3	155.5	144.9
Ohio	45.5	68.7	76.4	87.7	202.0	218.8
West Virginia	...	...	...	96.6	221.0	187.5
Wisconsin	22.5	30.8	33.1	53.1	135.7	142.4
West Midwest	76.4	85.2	69.4	60.0	151.2	152.9
Kansas	...	...	15.9	29.9	108.7	142.9
Kentucky	79.1	92.3	91.5	86.4	213.1	195.6
Iowa	17.6	48.9	42.8	44.6	142.4	170.6
Nebraska	...	...	10.4	20.3	78.7	90.6
North Dakota	...	...	20.7	21.2	59.2	73.9
South Dakota	...	...	...	...	...	86.7
Southwest	...	52.2	33.3	49.7	131.5	151.5
Arizona	...	...	...	...	23.2	21.8
Nevada	...	...	...	4.7	28.9	48.1
New Mexico	...	71.5	42.8	50.1	102.0	82.7
Oklahoma	...	...	...	...	...	55.0
Texas	...	48.9	33.3	55.1	143.0	123.6
Utah	...	8.8	12.4	26.5	102.8	88.0
Northwest	...	...	...	5.9	40.8	45.4
Colorado	...	...	...	7.5	39.6	46.6
Idaho	...	...	...	6.7	70.5	65.2
Montana	...	...	...	4.9	38.3	39.3
Wyoming	...	...	...	...	9.6	23.1
Far West	...	10.5	12.8	21.8	65.9	69.5
California	...	7.6	11.1	15.5	58.6	72.8
Oregon	...	33.1	28.6	60.5	103.6	90.2
Washington	...	...	...	20.9	62.6	72.8

SOURCE: Office of Publications and Reports, U.S. Bureau of the Census.

in this inquiry, affect the growth of all of them. The physical and moral causes which are the occasion of insanity in one man excite another to crime. . . .

It is important," he continued, "for the information of legislatures" that the whole extent of the evil to be contended against "be known and accessible in a single report, in order that they may make adequate provisions for its care or alleviation. The subject demands a degree of interest and attention which it is difficult to secure for it" (*4*).

Other commentary by Wines in the 1880 census report showed a similar understanding and insight, which surely is equally required today. In evaluating forces in the community that tended to breed various forms of dependency and in describing conditions in institutions, he stated: "The causes which produce [these conditions] are very obscure in many instances, and not easily traced. There are few effects in nature which are not the result of a multiplicity of causes. . . . There is a distinction, too often overlooked, between the cause and occasion of misfortune, and the latter is often put for the former." He noted that "it is very likely that many persons are reported to be homicidal or suicidal who are neither; this tendency often exists only in the tender imagination of the reporter." On the subject of the use of restraint, Wines expressed the hope that with the adoption of improved methods of care "it may very materially diminish" (*3b*).

The census of 1890 represented a major retreat from the aims of the 1880 census. It was compiled by Dr. John S. Billings, a physician and librarian who was then Deputy Surgeon General of the U.S. Army. The query of physicians was omitted, and much of the evaluative comment that distinguished the earlier census was discontinued. It is therefore not surprising that, as I mention later, the reported rates of mental illness declined in 8 of the 9 regions, 32 of the 45 States, and in the country as a whole. Beginning with a special census (in 1903), this concept of national enumeration was discontinued, and data collection was limited to counting the inmates in psychiatric hospitals and institutions.

The special census of 1903 was directed by John Koren, a prominent statistician and publicist. It was based on census schedules for each institution, which were filled out by an employee of the facility, who was designated a special agent of the Census Bureau. The insane and retarded outside of psychiatric hospitals and institutions were omitted because of the expressed belief that "until their number can be determined it is not the function of a statistical bureau to inquire into the subtler aspects of insanity as a disease"(*4*). The report on the 1903 census also pointed out that even the 1880 census, despite its relative completeness, had reported some variations that could only be explained by underenumeration (*4*). The census of patients was repeated in 1910, 1920, and 1923. Annual collection of data from these institutions was begun in 1927 for the year 1926. This responsibility was transferred in 1946 to the newly established National Institute of Mental Health.

Efforts to enumerate other segments of the "defective, delinquent and dependent classes" continued for some time after 1927. Thus, for example, questions pertaining to blindness were included in every census from 1830 until 1930,

Table 3. Number of enumerated mentally ill and number of mentally ill in hospitals and asylums, 1840–90

Year	Census-enumerated population	Census-enumerated mentally ill	Mentally ill in hospitals and asylums	Proportion of total population in hospitals and asylums[1]	Percent of enumerated mentally ill in hospitals and asylums
1840	17,062,566	[2]8,651	2,561	15.1	29.6
1850	23,190,675	15,610	4,730	20.4	30.3
1860	31,402,187	24,042	8,500	27.1	35.4
1870	38,558,371	37,432	17,735	46.0	47.4
1880	50,155,783	91,959	38,047	75.9	41.4
1890	62,947,714	106,485	74,028	117.6	69.5

[1] Per 100,000.
[2] Separate figures on mentally ill and mentally retarded not available. Estimated by applying ratios reported by 1850 census.

SOURCE: U.S. Bureau of the Census and Reference 6a, p. 232.

probably because some types of disability could be more accurately identified than either insanity or retardation.

Analysis of Data

The reported number of mentally ill and mentally retarded in each State and region for each census from 1840 to 1890 is shown in tables 1 and 2. Table 3 shows for each census the number of enumerated mentally ill, the number of mentally ill in hospitals and asylums, the proportion of the total population in hospitals and asylums, and the percent of the enumerated mentally ill in hospitals and asylums.

The reported rate of mental illness increased in each census, reaching a level in 1880 of 183.3 per 100,000 population, roughly 3.6 times the rate reported in 1840 (50.7). It declined 7 percent (to 169.7) in 1890 because of reduced efforts at data collection among the noninstitutionalized. It is interesting that the highest rates were consistently reported by the New England States, while the lowest were equally consistently reported by the States of the South. In New England the rate of mental illness exceeded the rates of mental retardation, while the reverse was generally the case among residents of the South. Unusually high rates of mental illness for the District of Columbia from 1860 on undoubtedly were caused by the location there of the federally operated St. Elizabeth's Hospital. The rates of mental retardation reported for the District were, however, relatively low. I believe that one factor related to these low rates was that retarded patients hospitalized at St. Elizabeth's were counted as mentally ill. Another may have been that a sizable proportion of the District's population was comprised of adults who had migrated to the District to seek public employment.

The reported rates of mental retardation in the United States did not follow the same pattern as the rates of mental illness. They increased one-third between 1840 and 1850, declined one-tenth by 1860, and then rose 5 percent by 1870. They went up 2½ times by 1880 and remained at this level in 1890. Record high rates, however, were reported in the 1890 census for 7 of 9 U.S. regions and for 27 of the 45 States.

The rates of mental illness reported by the various States varied much more than the rates of mental retardation. This divergence probably reflected the greater consistency during this period in accepted definitions of mental retardation as compared with those of mental illness. In 1890, if we omit the recently admitted sparsely populated States of the West, we find more than a fourfold difference between the highest reported rate of mental illness (297.3 in New York) and the lowest (69.9 in Arkansas). In the mental retardation rates for 1890, there is less than a threefold difference between the highest (254.0 in Indiana) and the lowest (90.6 in Nebraska). If the States in the West are omitted, 22 of the remaining 35 States had a rate of mental retardation in 1890 within 25 percent of the national rate. Only 14 of these 35 States had a rate of mental illness within 25 percent of the national rate.

The proportion of the total population in hospitals and asylums increased nearly eightfold between 1840 and 1890, from a low of 15.1 per 100,000 total population to 117.6, partly because of the States' assumption of responsibiility for care of the mentally ill and the resultant widespread construction or expansion of facilities. The percent of all enumerated mentally ill persons in hospitals and asylums gradually rose, from 29.6 in 1840 to 69.5 in 1890. The only decline occurred in 1880—the result of a greater effort to enumerate the mentally ill residing in the community. As noted before, the 1890 census represented a considerable retreat from the thoroughness achieved in 1880. In 1880 a total of 53,912 mentally ill persons (58.6 percent of those enumerated) reportedly were not in hospitals or asylums. In 1890 this number had decreased to 32,457 (30.5 percent of the enumerated mentally ill) while the number of the hospitalized mentally ill nearly doubled, from 38,047 in 1880 to 74,028 in 1890. That is, in 1880, 6 of every 10 of the mentally ill were reported to be in the community and 4 of 10 under institutional care. In 1890 these ratios had changed to 3 of 10 in the community and 7 of 10 in institutions.

Discussion

Census programs to enumerate the mentally ill and mentally retarded were one manifestation of a ferment in the mental health field in the decade 1840 to 1850 that led to the first practical efforts to provide systematic and responsible care for appreciable numbers of the mentally ill.

In 1841, for example, Dorothea Lynde Dix took her Sunday-school class to the House of Correction at East Cambridge, Mass. The sight there induced her to write her famous memorial to the Commonwealth of Massachusetts in behalf of the

"insane persons confined within this commonwealth in cages, closets, cellars, stalls, pens; chained, naked, beaten with rods and lashed into obedience" (*5*). It also led to a lifelong effort on behalf of the mentally ill which, until her death in Trenton, N.J., on July 17, 1887, took her to every part of the United States and to many foreign countries. Her effort to obtain Federal funds for mental illness programs through the sale of 12 million acres of Government-owned land succeeded in Congress, but in 1854 President Pierce vetoed the bill to implement this measure.

In 1843 the first asylum for the insane operated by the State of New York was opened at Utica with Dr. Amariah Brigham as superintendent. Detailed reports on the patients admitted and released from this facility were published annually from its early days. The pattern developed in these reports emphasized movement of patients by county of residence, age on admission, nativity, and cause of insanity. In 1844 Brigham founded the American Journal of Insanity. It is interesting that one of the six articles in the first issue was entitled "Number of the Insane and Idiotic, With Brief Notices of the Lunatic Asylums in the United States." The article provided a summary for each State of the number of hospitalized resident patients, admissions, discharges, and deaths. The title of the journal was changed in 1922 to the American Journal of Psychiatry.

In 1844 the Association of Medical Superintendents of American Institutions for the Insane was founded in Philadelphia as the first national society of medical men in the United States. In its first year, and again in 1851, it adopted resolutions to the effect that the preferred maximum size for a mental hospital was 200 patients. Its name was changed to "American Medico-Psychological Association" in 1893 and to "American Psychiatric Association" in 1921. At the association's founding a committee on statistics was established. Its chairman was Dr. Samuel B. Woodward, superintendent of the Worcester (Mass.) State Hospital and the first president of the association (*6b*).

In 1849 Dr. Isaac Ray of Rhode Island presented a paper before the Association of Medical Superintendents of American Institutions for the Insane that dealt with problems of mental health statistics (*7*). In this paper Ray suggested that "to make our statistics profitable, they should embrace such facts only as are intrinsically important, and free from all admixture with mere opinion." Using as a basis statistics on patient recovery presented in hospital reports, he pointed out the difficulty of securing accurate comparative data which would represent the relative success of institutions in the treatment of mental cases. Ray concluded that the number of recoveries was a strong indication of the financial situation of friends and relatives of the patients and their perseverance in getting the patients discharged. Thus "any degree of merit which may accrue from the number of recoveries must be shared by the institution with the community itself."

Overseas, England's Lunacy Act was adopted in 1845. In 1841 William Farr of England's Registrar General's Office pioneered in the application of life table methods to data on asylum patients to determine the "probability of recovery and the probability of a fatal termination in any given time" (*8*).

This concern with the mentally ill resulted from an unusual series of circumstances. Its initial impetus was the widely publicized effort to treat King George III of England for periodic attacks of mental illness. It was another event, however, that produced a more immediate reaction. Captain Basil Hall, a retired officer of the British Royal Navy, who had made a tour through North America in the year 1827–28, subsequently wrote a book on his travels. Like a number of similar publications, it was most contemptuous of prevailing American manners, customs, and institutions (*9*). One of Hall's few positive observations related to the Hartford Retreat, a privately maintained hospital for the mentally ill in Connecticut. Hall noted from its report for 1827 that "during the last year, there have been admitted twenty-three recent cases, of which twenty-one recovered, a number equivalent to 91 3/10 percent." Captain Hall compared this result most favorably with the 34 to 54 percent cure rates for recent cases reported by leading institutions in Great Britain.

Hall's remarks on the Hartford Retreat were quoted repeatedly by U.S. newspapers and periodicals and rapidly led to a rivalry for increasingly high recovery rates by the various existing hospitals. Reported success rates of 80 percent and more were common. One direct result was a frequently expressed belief that "with appropriate medical and moral treatment insanity yields with more readiness than ordinary disease" (*10*). It surely is not surprising that this highly optimistic

concept, more than anything else, led to an emotional and highly colored concern with the mentally ill.

The fallacy of these statistics was not fully recognized for some time, and the "cult of curability" was not fully exposed until almost 50 years later. Dr. Pliny Earle, one of the initial exponents of the cult, wrote a book in 1887 showing that the remarkable rates were primarily due to improper use of the word "recovered" (*11*). He noted that it was fairly common for the same person to be discharged repeatedly as recovered, often within the same year. There was usually no indication that several recovered cases might in fact relate to the same person. The record for number of recoveries was undoubtedly held by a woman who ultimately died in a mental hospital. She contributed to these statistics by being discharged from the same facility as recovered 46 times.

A remarkable study at the Worcester State Hospital in Massachusetts contradicted Earle's conclusion that insanity was, in general, incurable (*12*). It showed that recovery rates, while not as high as previously noted, were considerably above the deflated figures reported by Earle. The study, a followup in the period 1882–93 of 1,173 patients discharged from the hospital during the years 1833 to 1846, showed that nearly half (48 percent) never had a relapse after release while 30 percent were either still mentally ill or had died mentally ill. The study was not published or reported in the literature and therefore did not have the impact of Earle's book.

Earle's book thoroughly deflated the optimism that had previously prevailed and contributed to a reversal in attitude in the direction of stressing the need for long-term care. It undoubtedly was one factor in the construction of increasingly large facilities primarily for the provision of custodial services for the extended care of patients. The relative isolation of patients in massive facilities in turn contributed to the low release rates (usually less than 10 percent per year) that prevailed until the 1950s.

The resultant gradual increase in the number of hospitalized patients was monotonously noted in annual published reports. A high of 558,000 was reported for 1955. Factors responsible for the decrease since that year have been exhaustively discussed in the literature. Currently, mental hospitals operated by States and counties probably have a daily average of less than 300,000 patients, or slightly more than half the comparable 1955 figure. Although figures representing an unduplicated count of patients are not available, I estimate the annual number of persons under care in these facilities, on the basis of figures on admissions and resident patients, to be in excess of 600,000. The equivalent rate (about 290 per 100,000) is considerably higher than the census figures reported in the nineteenth century. Whether or not this current rate represents a true increase in the rate of mental illness can patently not be determined. Studies focusing on this issue have, I believe, come up with inconclusive findings (*13*). In part, the rise is due to the increase in the proportion of older residents. Primarily, however, it undoubtedly indicates that many persons are now hospitalized for disturbances that were not recognized or defined as mental illnesses 100 years ago.

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