THERAPEUTIC INTERVENTION & SOCIAL FORCES

HISTORICAL PERSPECTIVES

David F. Musto

American Handbook of Psychiatry

THERAPEUTIC INTERVENTION AND SOCIAL FORCES

HISTORICAL PERSPECTIVES

David F. Musto

e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 5* edited by Silvano Arieti, Daniel X. Freedman, Jarl E. Dyrud

Table of Contents

Therapeutic Intervention and Social Forces:

Historical Perspectives

Therapeutic intervention rests on widely-accepted responses to abnormal behavior, psychiatric institutions sanctioned by society, and social forces that influence where that intervention is focused. This usual harmony between social forces and scientific institutions has not been sufficiently analyzed, probably because concord seems natural (at least to contemporaries), and to dissect it may be not only uncomfortable, but seem pointless as well. Historically, however, the most severe distortions of professional objectivity arise from the unquestioned beliefs that permeate society in a particular era. For example, if various minorities are generally thought to be a source of intergroup tensions or antisocial activity, they may prompt explanation or treatment by the psychiatric profession. Not infrequently, public officials or community leaders call upon psychiatrists to explain and sometimes to modify a subgroup's "inherently" dangerous, recalcitrant, or abnormal state. (In the United States these groups have included such disparate categories as Negroes, the Irish, Communists, and drug addicts.) Psychiatrists who shared these dominant social fears of certain subgroups have at times found themselves providing the appearance of scientific support for what are merely widely held and often transitory public

attitudes.

Nevertheless, the profession's integration with broad social forces is not necessarily destructive; its response to current social reality makes effective delivery of service and communication with patients possible. A profession is part of society, not an isolated observer. In the tension between conformity and the acquisition of new knowledge lies both the chance for progress and the possibility of holding a mirror to contemporary culture.

The Dangers of Social Forces

The danger of social forces to the profession arises from the ease with which the necessary integration with society induces practitioners to confirm current, powerful prejudices rather than to question them. An example from the 19th century concerns psychiatric opinion about American Negroes: because of manipulated 1840 census statistics, Southern Negroes appeared to have the lowest rate of insanity in the nation (Deutsch, 1840; Prudhomme, 1973). Some experts argued that their low insanity rate must be due to the institution of slavery, since the rates ranged from lowest to highest almost along ascending parallels of latitude, from Louisiana to Maine. Ex-president John Quincy Adams, then a representative in Congress, vigorously challenged the census, as did other antislavery critics. Medical statisticians and psychiatrists such as Edward Jarvis of Massachusetts also presented

convincing objections (1842; 1852). Nevertheless, officials of the federal government, popular American writers, and European specialists continued to use the census for what would now be termed racist purposes.

Although the change in rate of insanity between slave and free states was a new twist in the debate over slavery, that Negroes had a naturally lower insanity rate than Caucasians was generally accepted. The relatively high rate of insanity found in Western nations in the nineteenth century had been attributed by authorities to a correspondingly high level of civilization, and it seemed appropriate, therefore, that American Negroes, considered savages, would have a low rate of insanity. Yet after the Civil War, when the recorded insanity rate of Negroes began to rise, medical writers did not describe this as a sign of progress toward a higher civilization. Rather, these new statistics were interpreted as further proof of the Negro's inherent deficiency as he unsuccessfully struggled with freedom's responsibilities. The mainstream of psychiatry concurred with society's assumption that Negroes were intellectually and morally inferior, and wondered whether elevation of a Negro's psychological state was possible (Witmer, 1891). One physician in a southern asylum opined that a Negro's cranial sutures closed more quickly than a Caucasian's, thereby naturally limiting intellectual development (Buchanan, 1886). It is not surprising that these assertions met little professional resistance, for psychiatrists were reared and trained in a conforming milieu. Eventually, scientific and educational leadership rejected

such explanations and asserted that, given equal opportunity and social experience, the races are equal.

Blacks have not been the only group subject to a cultural denigration supported by leading medical authorities. Prominent American psychiatrists, now revered, advocated separate but equal mental-health facilities for the Irish in the mid-nineteenth century. Ironically, one advocate of this policy was the same Edward Jarvis who had angrily attacked suspicious census statistics dealing with the Negro insanity rate. Jarvis, a Massachusetts resident, was as impressed by the apparent deficiencies of the nearby Irish immigrants as he was doubtful of claims for slavery's benefits to Negro mental health in the South. Irish immigration to Massachusetts in the 1840s added many patients to the state's charitable institutions, which had previously claimed as much as a 90 percent cure rate. The Irish, however, did not seem to trust the "Yankee" hospital staff. For that reason (or other reasons such as a rising patient/doctor ratio) they did not respond favorably to the "moral therapy" that had appeared to be so efficacious for earlier immigrants to New England. After surveying the "Irish problem," along with other retardation and psychiatric questions for the state, Jarvis concluded that the Irish were constitutionally inferior and subject to mental derangement from the vicissitudes of civilization (Jarvis, 1971). Following publication of Jarvis' report, Isaac Ray, a pioneer of American forensic psychiatry, recommended separate but equal facilities in order to isolate the Irish in familiar

surroundings. Ray hoped this scheme would create an affinity between staff and patients that would make moral therapy effective. His suggestion was not adopted; a new hospital would have been expensive (Ray, 1856).

These episodes from the nineteenth century illustrate a profession's difficulty in maintaining an objectivity able to transcend the surrounding cultural milieu, even when that profession is concerned with the study of environment and its effects on mental processes. A more recent example illustrates another way in which psychiatry may be drawn into areas of broad social concern as an instrument of society's will. Those who recall the 1950s will appreciate the difficulty psychiatrists would have felt in refusing aid to a fearful nation, particularly since such a request was an affirmation of professional expertise. And during the late 1940s and early 1950s, most Americans believed communism to be the greatest direct threat to their way of life. In order to understand this threat, leading psychoanalysts in various parts of the United States were enlisted in the "Appeals of Communism Project" based at Princeton University. The project directors hoped that these therapists, selected "by reputation, position, or published papers . . . in social science research," would be able to explain the- role of communist beliefs in the defensive structure of their analysands who had been attracted to that ideology. The study also sought to define the typical family constellation that bred left-wing analysands. Based on thirty-five psychoanalytic cases, the study concluded that communism permitted the individuals to "express

hostility or submission without feelings of guilt." Further research was planned on "those aspects of family structure—sex-role conflict and intellectuality—that have been highlighted in the discussion of the psychoanalytic data . . . Such an investigation . . . would . . . provide some germane hypotheses about the susceptibility to Communism of intellectuals." Of the psychoanalysts asked, about half declined to participate, but it was not always clear "whether their refusal was based on lack of pertinent case records or on lack of willingness to cooperate" (Krugman, 1953).

Characteristics of Eighteenth-Century Medicine

Psychiatry in the mid-twentieth century holds some similarities to general medicine around 1850. The transition from a theoretical harmony in 18th-century medicine to a more rigorous experimental and scientific medicine a hundred or more years later developed after several generations of painful chaos. During that difficult time medicine was assailed from within and without, and critics demanded its abolishment, an end to chemical therapies, surgery, and theory-making. Revulsion to experimentation and even vaccination threatened a profession that had lost the serenity of concensus and was not yet firmly established on an effective and optimistic foundation. Research that eventually laid the groundwork for modern medicine had to persevere quietly while the waves of extremism found temporary popularity and power. Physicians today owe a great debt to those

who a century ago could tolerate uncertainty while responsibly building scientific medicine and humanely responding to their patients.

During the eighteenth century the leadership of American medicine concurred on general principles of theory, treatment, and education. Usually disease was conceptualized as a general imbalance in the body's functions, perhaps located either in the solid or the liquid parts or else in a specific system such as the circulatory or nervous systems. Treatment consisted of phlebotomy (the withdrawal of blood from a patient), or of purges brought on by calomel (a mercury preparation) or botanicals such as jalap. These and other treatments such as blistering were designed to restore health by rebalancing the body's disharmony. Greek and Roman authors were quite relevant to the educated physician. Without a familiarity with, say, Celsus or Hippocrates, a physician lacked important information useful in daily practice. The ideal physician required formal training to prescribe effective treatment and to interpret properly the theory under which he functioned. In order to protect the public from the untrained, the educated physicians persuaded most states to adopt a system of licensure. Graduation from a chartered medical school or examination by a medical society generally conferred the legal right to practice.

Benjamin Rush (1746-1813) illustrates the general characteristics of eighteenth-century medicine. A controversial public figure, a signer of the

Declaration of Independence, and one of the four original professors at the University of Pennsylvania medical school, he is now acclaimed as the "Father of American Psychiatry." Like a number of his contemporaries, he established his own system of medicine. He postulated that all disease has as its fundamental dysfunction the constriction of the arterioles in a part, or in all, of the body. Treatment consisted of purges and bleedings to reduce the arterioles' tension and reestablish a healthy balance. Although Rush felt he had put medicine on a new footing, his theory was deeply rooted in the medical ideology of the 18th century.

The psychological role of medical theory in practice was apparent in letters he wrote during Philadelphia's catastrophic yellow-fever epidemic of 1793. During that year, about 10 percent of the population of the nation's then largest city died from a disease that had no known pathology, origins, or effective treatment. Yet theory gave Rush a basis for action, verified the need for a highly trained professional, and rewarded him with a sense of hard work well done. (These results were achieved, in fact, by a theory and a practice that undoubtedly weakened the victim's natural resistances.) At the height of the epidemic Rush wrote to his wife Julia:

> Alive! and though I slept but three or four hours last night, am still through divine goodness in perfect health. Yesterday was a day of triumph to mercury, jalap, and bleeding. I am satisfied that they saved, in my hands only, nearly one hundred lives. . . (1891, p. 663).

Attacks on the Profession

During the next several decades, such professional confidence came under attack on three levels: from social movements; from research; and from rival theories. The success of these attacks caused the 18th-century framework to collapse. This in turn ushered in a period of transition and confusion in the medical profession that was similar in a number of ways to the mental health professions in our own time.

Egalitarian Movements

The first heresies to confront the medical profession, Thomsonianism and Eclecticism, were denounced by medical leaders as "mere empiricism." (Kett, 1968) Samuel Thomson (1769-1843) stressed botanical treatment as opposed to the mineral and bleeding techniques in medical vogue. He advocated simple theories that would allow anyone to be his own physician, eliminating any requirement for an organized medical profession, an elaborate medical education, and state licensure. Thomson patented his own system of medicine and sold rights to those who would practice it. He suggested that ideally the mother should be physician to her family, the family being his key unit in the practice of medicine. This suggestion combined feminism, opposition to the highly trained physician, and self-reliance of the family unit—an important element in a migratory society. He opposed physicians of the academy, whom he termed "learned quacks." His

movement as a whole reacted against the overdevelopment of theory that characterized the eighteenth century. As an empirical reaction to theory it had features in common with many such movements in the history of medicine, dating back to the Hippocratic School itself. The Thomsonians and their simple methods found a widespread response among the lower and middle classes of America in the early decades of the 19th century.

This botanical trend was also fostered by a Connecticut physician, Wooster Beach (1794-1868), who founded a school of medical thought termed Eclecticism. Again it was chiefly botanical, but it was even more associated with political radicalism than the Thomsonian school. Beach wrote extensively in newly founded journals against "King-Craft, Priest-Craft, Lawyer-Craft and Doctor-Craft." Both movements were deeply involved with such causes as equal rights for women and the plight of the common man, and stood against the establishment represented by the educated physician.

These movements, like not a few of those within the mental health professions today, appeared in the guise of rival medical theories. In fact, they were not just attacks on the medical profession but were a part of popular social protests. "Regular" physicians, as the traditionally-educated termed themselves, went on the defensive under these egalitarian assaults. Contemporary physicians angrily commented on this turn of events, as in the following statement by a New York physician:

> Empiricism is everywhere rife, and was never more arrogant, and the people love to have it so. That restless agrarian spirit, that would always be leveling down, has so long kept up a hue and cry against calomel and the lancet, that the prejudices of the community are excited against it: and their confidence in the medical profession greatly impaired . . . (Shryock, 1930, p. 316).

The lay movement was not confined to journals. It expanded into associations and to the establishment of homes where these principles were carefully followed and one could be assured of the absence of regular physicians. These homes, reminiscent of some current therapeutic communities, conducted life in a most healthy manner, emphasizing hygienic and often vegetarian foods, regular hours, exercise and uplifting conversation. One of the great leaders of the lay hygiene movement was Sylvester Graham (1794- 1851), who was quite successful in promulgating his views on health foods and natural cures for illness and moral defects. Today his memory is perpetuated by a humble cracker, which represents the kind of food that was once provided in the "grahamite" houses scattered about the land.

The Paris School

The second blow to the medical profession's unity in the United States was the arrival from Paris of research findings that arose from new instruments and a new methodology (Ackerknecht, 1967). The most unsettling results of the Paris research and observations were not any particular theories attached to them but the very facts themselves, bereft of

theory, which did not seem to fit established ideas. For example, the perfection of the stethoscope, which seems so rudimentary to us, revolutionized the diagnosis of chest diseases. Prior to the use of the stethoscope, pulmonary diseases were classified according to generalized reactions of the body such as pulse, fever, chills, and so on. The stethoscope made possible a diagnosis based on conditions actually prevailing within the chest; this supported the concept of local disease (as opposed to a general body imbalance), as well as permitting detection of internal bodily processes.

The Paris School also introduced the statistical method. Although this often meant nothing more than counting, nevertheless it permitted some objective testing of rival therapies. For example, such studies suggested that blood-letting was not a generally effective treatment for disease.

Reevaluation of traditional treatments, a growing conviction that disease was often localized, and a realization of how extremely complicated physiological processes must be, all encouraged a distaste for broad explanatory theories. Grand theories, it seemed, must be wrong, since there was so little certain knowledge upon which one could construct any theory. Not only theorizing, however, was endangered by these new findings: the medical profession's special contribution to society—therapeutics—was also put in doubt. A prevailing skeptical attitude maintained that the physician should support nature by prescribing light food and a warm bed, rather than

by employing some treatment that was unproven and perhaps harmful.

The research and skepticism of the Paris hospitals were extremely disquieting to the American medical profession. These new ideas could not be ridiculed as popular frenzy, as could those of the Thomsonians, for they came from revered centers of medicine.

Homeopathy

The third attack on the medical profession in the early 19th century came from a new but incompatible medical theory, homeopathy (Holmes, 1891; Kett, 1968). The inspiration of Samuel Hahnemann (1755-1843), homeopathy differed from the antiestablishmentarian botanical systems and the new data and therapeutic skepticism of the Paris School in that it was an all-encompassing theory like Rush's. Homeopathy favored vitalism—a conviction that the body has a nonmaterial ability to change food into body parts—and was associated with a broader definition of "soul." The best known feature of Hahnemann's system was the belief that one should use drugs that evoked the same symptoms as the disease one wished to treat. In addition, it was believed that the more dilute the drug, the more powerful the effect on the body. Dilutions of millions, billions, and even trillions of a particular drug would be carefully administered.

One of the most remarkable actions of the homeopaths was to discount

the whole tribe of regular professionals by giving them a new name with a negative connotation—and almost making it stick. There had been something reassuring about a "regular" physician; but the homeopaths announced that non-homeopaths were in reality "allopaths," practitioners who might try anything and who lacked the unity of therapy that came with a true theory encompassing the whole of medical practice. Traditional physicians were enraged but confounded by this turn of events. Although homeopathy seemed laughable, it had attracted the endorsement of respectable people such as Emerson and the Beechers. Unlike the social attitudes that were part of the lay-led botanical systems, homeopathy was something of an elitist movement. The homeopathic practitioner required education for the careful interpretation of an involved system.

Since the therapy employed by the homeopaths was usually without physiological effect, and since it was applied with complete confidence, the results compared favorably with the best treatments of the regular physicians, who favored what they termed the "heroic" method of treatment: massive doses of mineral and plant medicine, bleeding, and blistering. Some physicians recognized that this heroic style might seem excessive, but they argued that America was a young, vigorous land with tough diseases that required measures of equally heroic proportions. Traditional medical treatment, therefore, helped create a willing clientele for those who instead treated mildly and supportively.

Other Nineteenth-Century Changes

By the mid-nineteenth century, licensure of medical practitioners was no longer effective in the United States (Shryock, 1930). Social movements, research, and rival theories had destroyed the system in force since the eighteenth century. The legislatures could do no better than the patients in distinguishing sects and cults from true science, and thought it best not to try. Anyone could claim to be a practitioner and set up practice. Although malpractice suits remained a possibility, they were difficult to pursue.

A corollary to the confusion among practitioners was the layman's increased activity in medical matters. Aside from the Graham movement and other hygienic associations, great strides were made in psychiatry by nonphysicians, particularly in the development of "moral treatment" and the establishment of asylums. Through their enthusiasm for the idea that the insane could be cured if treated by moral therapy in special institutions, they urged on the asylum movement. These mental institutions were built in state after state, with the promise of great rewards for society. Legislators being asked to put up money for an institution were assured that they would be saving money as well as behaving humanely, because lives would be rescued and returned to productive work. Almost all new cases, it was maintained, could be cured if they were caught in time, treated with dignity, and encouraged along the principles of moral therapy. Upon these arguments

money was appropriated and the institutions built.

Perhaps this would be an appropriate place to mention a problem that eventually dampened some of the enthusiasm for the asylum movement. It became increasingly apparent that as each asylum functioned, it gradually built up a population of chronic patients, either as permanent or repeated residents. Because the program was sold to legislatures on a very optimistic forecast of the efficacy of psychiatric treatment in the asylums, such a turn of events was discouraging both to those who put up the money and those who staffed the institutions. Therefore when St. Elizabeth's Hospital opened in the mid-1850s, the Board of Visitors decided to warn the public that an accretion of chronic patients would occur and reach levels of, say, 30-40 percent (1855). They had recognized that initially extravagant therapeutic optimism would at first seem to be vindicated, but that later statistics could lead to a damaging pessimism on the part of the hospital's supporters.

In fact, the pessimism that eventually gripped the asylum movement had occurred earlier among regular physicians and medical students. A student's thesis in 1842 contained these dour words:

> Writers have indulged in various speculations, but we are, I apprehend, in the present state of knowledge most profoundly ignorant, and more than this I see no reason to believe that it will ever be otherwise (Haile, 1842, p. 2.).

Two years later, a leading practitioner addressed a State Medical Society on the gloomy topic: "The Respect Due to the Medical Profession and the Reasons that It Is Not Awarded by the Community." He complained that:

> Never have the opinions of the people been so thoroughly unsettled in regard to different remedies and modes of practice; and the remark is heard every day, even from men of intelligence, 'in medicine I know not what to believe.' (Hooker, 1844, pp. 22- 23.)

How was the crisis in nineteenth-century medicine resolved? The confusion in the profession was cleared away by the gradual transference of confidence from the broad theories of the 18th century to the rigidly organic models arising from chemistry, histopathology, and bacteriology—a far swing of the pendulum, which later had to be balanced by an appreciation of psychological and social factors in disease. The regular medical schools were transformed into essential centers of teaching and research and were reestablished as the key element in medical education. Once again society agreed that esoteric knowledge obtained from the academy was the hallmark of the reputable physician.

The above comments on nineteenth-century medicine have been, of necessity, brief and simplified. Detailed analyses of specific periods and issues can be greatly enlightening and should be sought out by the reader. Increasingly, such studies have been undertaken by qualified historians; their perspective on present issues in psychiatry ought not to be ignored. John C.

Burnham's excellent studies of physicians and paramedical personnel in American psychiatry, as well as his illuminating description of the introduction of psychoanalysis to America, clarify the immediate past that is responsible for so much of psychiatry's current goal and style (1967; 1974). Also valuable is Charles E. Rosenberg's presentation of forensic psychiatry and politics in the late 19th century, as seen in the trial of the presidential assassin Guiteau (Rosenberg, 1968). These and many other studies (which are described in greater detail in Vol. I of this *Handbook)* speak to our own time in a language of rational perspective, not claiming to offer answers to our present questions, yet suggesting a broader spectrum against which to judge contemporary alternatives.

Concluding Remarks

The path of medicine, although it eventually led to enormous practical benefits for individual patients as well as whole communities, was often obscured by shifting popular social and political movements. This observation is made easily in retrospect, but could any methodology at the time have disclosed such extrascientific influences on a profession? The question inescapably arises: how much does contemporary psychiatric judgment reflect scientific "truth," and how much does it merely reflect beliefs and attitudes already held by general society? Following the halcyon days of the 1960s, this question has been raised with vigor and increasing

harshness, both from within and without the psychiatric profession.

Recent distrust of therapeutic intervention grows out of an awareness that the definitions of mental illness and the criteria for commitment and observation are affected by social forces that are using psychiatry, so to speak, instrumentally. The attack on psychiatry for using these biased standards coincided with the changes in attitude toward civil rights and liberties that marked the 1960s. In a climate of public opinion becoming more aware of injustices to the person, critics have also found instances where arbitrary social forces such as racial prejudice or bureaucratic laziness lead to discriminatory treatment or prolonged incarceration. With the intimate relationship between psychiatric practice and contemporary mores thus being made manifest—and nineteenth-century American psychiatry is also a rich field for instances of the close and (at the time) unrecognized connection between the two—it is small wonder that the profession's social role can be assailed. Perhaps psychiatrists should be among the first to expect that the attack would become broader than the base of actual injustices upon which it rests.

The best antidote to an excessive influence by society on the scientific aspect of psychiatry is a recognition of that influence, rather than a mere hope that the mental health professions can somehow be exempt from it. One wishes to believe that Jarvis, who reported that the Irish were

constitutionally inferior beings, would have been delighted to discover his mistake and would have worked diligently to understand how his error occurred. Naturally, objective evaluations of social pressures are not popular when they place the science of psychiatry at odds with psychiatry's expedient social interests as a practicing profession. Yet despite present and anticipated turbulence within the profession, the dispute over the extent to which social forces affect psychiatric intervention can be one of the healthy episodes in the history of American psychiatry. In many instances during the last two centuries, psychiatrists have espoused "medical" or "psychological" insights as their own that in fact were merely the norm of the dominant culture. No one would defend a specious professional belief discovered to have existed in the 19th century; where a similar congruence of a professional belief with contemporary social prejudices is found to exist now, it should also be so described. The outcome may be an alteration in practice and in professional goals.

Growing doubts, among the public and the profession, of psychiatry's claims to preeminence in social reform could return the model practice of psychiatrists to a more strictly medical style of individual treatment, supported by recent advances in organic psychiatry as well as by attainments in the dynamic tradition. Those who remain in the larger social arena may become better able to contribute to the resolution of community problems through an increased sensitivity to cultural influences on their own

professional judgments. Perhaps we should view society's influence on therapeutic intervention as the individual's unconscious, powerful but unnoticed, and the recognition of it as a humbling and painful step toward maturity.

Bibliography

Ackerknecht, E. H. *Medicine at the Paris Hospital*: 1794-1848, p. 129. Baltimore: The Johns Hopkins Press, 1967.

Almond, G. A. *The Appeals of Communism*. Princeton: Princeton University Press, 1954.

Board of Visitors of the Government Hospital for the insane. "Minutes of the Meetings, July, 1855," Archives, St. Elizabeth's Hospital, Washington, D.C.

Buchanan, J. M. "Insanity in the Colored Race," *N.Y. Med. J.,* 44 (1886), 67-70.

Burnham, J. C. "Psychoanalysis and American Medicine, 1894-1918: Medicine, Science, and Culture," *Psychol. Issues*, 5 (1967), Monograph no. 20.

----. "The Struggle between Physicians and Paramedical Personnel in American Psychiatry: 1917-1941," *J. Hist. Med*., 29 (1974). 93-106.

Deutsch, A. "The First U.S. Census of the Insane (1840) and Its Use as Pro-slavery Propaganda," *Bull. Hist. Med*., 15 (1944), 469-482.

Haile, A. B. "On the Causes of Diseases." Unpublished doctoral thesis, p. 2. New Haven: Yale Medical College, 1842.

Holmes, O. W. "Homeopathy and Its Kindred Delusions," in *Medical Essays*: 1842- 1882. Boston: Houghton Mifflin, 1891.

Hooker, W. *Dissertation on the Respect Due to the Medical Profession and the Reasons that It Is not*

Awarded by the Community, pp. 22-23. Norwich, Conn.: Cooley, 1844.

Jarvis, E. "Statistics of Insanity in the United States," *Boston Med. Surg. J.*, 27 (1842), 116-121, 281-282.

----. "Insanity among the Colored Population of the Free States," *Am. J. Insanity*, 8 (1852), 268-282.

----. (1855) *Insanity and Idiocy in Massachusetts: Report of the Commission on Lunacy*. Cambridge, Mass.: Harvard University Press, 1971.

Kett, J. F. *The Formation of the American Medical Profession*, p. 97. New Haven: Yale University Press, 1968.

Krugman, H. E. "The Role of Hostility in the Appeal of Communism in the United States," *Psychiatry*, 16 (1953), 253-261.

Prudhomme, C. and D. F. Musto. "Historical Perspectives on Mental Health and Racism in the United States," in C. V. Willie, B. M. Kramer, and B. S. Brown, eds., *Racism and Mental Health: Essays*, pp. 25-57. Pittsburgh: University of Pittsburgh Press, 1973.

Ray, I. "Review of E. Jarvis 'Insanity and Idiocy . . .'," *N. Am. Rev.*, 82 (1856), 95- 96.

Rosenberg, C. E. *The Trial of the Assassin Guiteau*. Chicago: University of Chicago Press, 1968.

Rush, B. "Letter of Rush to Julia Rush, 13 September 1793," in L. H. Butterfield, ed., *Letters of Benjamin Rush*, Vol. 2, p. 663. Princeton: Princeton University Press, 1951.

Shryock, R. H. "Public Relations of the Medical Profession in Great Britain and the United States: 1600-1870," *Ann. Med. Hist.*, 2 (1930), 308-339.

----. *Medical Licensing in America: 1650-1965*, pp. 41-42. Baltimore: The Johns Hopkins Press, 1967.

Witmer, A. H. "Insanity in the Colored Race in the United States," *Alien. Neurol.*, 12 (1891), 19-30.