

Social, Motivational, and Symptomatic Diversity: An Analysis of the Patient Population of the Phipps Psychiatric Clinic at Johns Hopkins Hospital, 1913–1917

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Abstract. In the five years after the Phipps Psychiatric Clinic opened in 1913 at Johns Hopkins, its 88 beds were consistently in high demand. Exploiting the biographical information and the particularly descriptive medical narratives in the hospital records of Phipps patients, this study explores the social composition of the patient population, the various avenues by which patients were admitted, and the decision-making processes of families and communities confronting the vicissitudes of mental illness. Quantitative and qualitative analyses of all admissions between 1913 and 1917 reveal that, contrary to scholarly myth, this population was highly diverse socially, motivationally, and symptomatically.

Keywords. Phipps Psychiatric Clinic, Adolf Meyer, Johns Hopkins, psychiatric patient records

Résumé. Lors des 5 années suivant l'ouverture de la Phipps Psychiatric Clinic de l'hôpital Johns Hopkins en 1913, tous ses 88 lits demeurèrent occupés. En utilisant les informations biographiques et les récits cliniques particulièrement descriptifs des dossiers médicaux des patients, cette étude explore la composition sociale des patients admis, les diverses avenues qui les y ont menées, et les décisions prises par les familles et les communautés confrontées aux maladies mentales. Une analyse quantitative et qualitative des dossiers d'admission entre 1913 et 1917 a permis de révéler que, contrairement aux idées véhiculées, la population utilisant la clinique était diversifiée socialement, symptomatiquement, et par motivation.

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On 1 May 1913, the much-anticipated Phipps Psychiatric Clinic opened its doors at Johns Hopkins Hospital. The *Baltimore Sun* reported that day that a single patient was admitted—a 51-year-old man from the city whose wife brought him to the hospital. Recently, he had lost consciousness and awoken confused on several occasions, including once on the streetcar on his way to work.¹ Presumably, he had the undivided attentions of the nurses, attendants, psychiatrists, and medical students that night in the Admission Ward. More patients followed, however, and by summer's end the clinic's 88 beds were filled.

Eight years earlier, William Osler, the hospital's inaugural Chief of Medicine, had denounced the state of American psychiatry, calling it a "bagatelle" compared to psychopathic clinics connected with universities in Germany. He publicly challenged Johns Hopkins—the country's foremost medical research and teaching institution—to take the lead in building a serious discipline of mental medicine in the United States.² In 1908, the steel magnate Henry Phipps pledged over half a million dollars to build a psychiatric clinic at Johns Hopkins. Adolf Meyer, a Swiss-born psychiatrist with a reputation for modernizing outmoded state mental asylums, was offered the job of planning and directing the new Henry Phipps Psychiatric Clinic, and establishing the first academic center of psychiatric teaching and research in North America.³

In the absence of any historical research on the Phipps Clinic or its patients, there has been a tendency to assume either that it operated as a sanctuary offering discrete rest cures to middle- and upper-class invalids, or, that it was simply the newest stop on the grand tour of American and European health tourism—a network of spas that catered to moneyed health-seekers (sometimes called the "worried well") who sought fashionable treatments from an eminent "nerve doctor."⁴ This impression exists largely because of the clinic's small size, urban location, well-appointed décor, modern hospital facilities, and affiliation with university medicine—traits that contrast (once again, impressionistically in some cases) to those associated with the 19th-century mental asylum: confinement of the poorest and most insane individuals in mammoth, remote institutions, unconnected with scientific research.

Quantitative and qualitative analyses of all admissions to the Phipps Clinic between 1913 and 1917, however, reveal that the psychiatric hospital at Johns Hopkins attracted and admitted a socially diverse group of patients with a wide range of motivations for using the new institution. Blending statistical data with the rich narratives found in the medical records of Phipps Clinic patients—in the form of clinical notations

by staff as well as correspondence between patients, their families, local physicians, and Phipps psychiatrists—I explore the social composition of the clinic's patient population, the various avenues by which patients were admitted to the Phipps, and the decision-making processes of families and communities confronting the vicissitudes of mental illness. These data show that, contrary to scholarly myth, this population was highly diverse economically, motivationally, and symptomatically.

The Phipps Clinic opened at a pivotal moment in the history of American medicine. In the middle of the 19th century, the general hospital began a fundamental transformation from a place of respite for the poor to an institution defined by medical and technological expertise, and newly patronized by the middling classes. No longer a site of passive care and stewardship, the hospital became a locus of active treatment and the workplace of specialized practitioners. By the beginning of the 20th century, the university hospital epitomized a "scientific ideal" that pervaded American society and was equated with social progress and improved medical care.⁵ The establishment of the Johns Hopkins hospital and medical school in the 1890s—widely publicized as the nation's first medical university to emphasize laboratory research and clinical teaching—was an exceptionally conspicuous embodiment of this cultural valuation of science, technology, and professional expertise.⁶

The American mental asylum, however, did not participate in this transformation. Indeed, it loomed in the public imagination as archaic, dangerous, and terrifying. Overcrowding in state asylums had transformed the once-positive public perception of mental hospitals.⁷ This was due to steadily increasing numbers of patients deemed incurably insane. Institutionalization in a mental hospital, moreover, required a legal declaration of insanity, something that was associated with a hopeless prognosis.⁸ Concurrently, the ominous specter of hereditary "degeneration" was widely disseminated as a scientific explanation for human ills such as alcoholism, sexual perversion, criminality, and insanity. While physicians themselves largely had discarded the notion by 1913, much of middle-class America remained horrified by the threat of degeneration and its potential to weaken the genetic health of the human species.⁹

Two very powerful and menacing ideas, then, shaped popular notions of mental illness at the beginning of the 20th century: the brutality and finality of the state asylum and the indelible hereditary "stigma" of insanity in the family tree. The director of the new Department of Psychiatry at Johns Hopkins was interested in changing public perceptions. "Neither the mere fact of mental disorder nor the duration," Adolf Meyer railed in 1914, "should provoke the idea of stigma because many of the hereditary disorders are eminently recoverable."¹⁰

He shared this optimistic view with a small vanguard of like-minded psychiatrists who reframed the notion of incurable insanity as potentially correctable "maladjustment," a conceptual shift that resonated in an age inspired by hopes of social progress and deeply concerned about genetic decay.¹¹ By virtue of its well-known parent institution, the opening of the Phipps Clinic in 1913 shone a spotlight on this nascent psychiatric reform movement already underway.

"The general plan," Meyer informed journalists in 1912, was to provide "a clinic for the treatment of those afflicted with mental disorders, just as clinics for the treatment of those needing surgical attention have already been provided at this university."¹² The comparison between surgery and psychiatric treatment was an obvious one. Once considered a last resort with limited scope, surgery had been revolutionized by the use of anesthesia (which allowed surgeons to journey deep into the viscera) and by aseptic procedures (which radically reduced deaths by infection). As a result, surgery had recently undergone a fundamental transformation within the public consciousness as a synthesis of craft, science, and healing.¹³ For most Americans in this period, the hereditary taint of insanity and the irrevocability of an asylum commitment remained as terrifying as the old amputation saw before the advent of hospital operations. The new Phipps Clinic at Johns Hopkins with its associations to modern hospital methods, technology, and expertise represented an acceptable or appealing source of medical help for individuals faced with managing mental disorders in the decade before World War I.

With the clinic's opening still months away, Meyer received a letter from a man who explained that for over a decade he had endured mental suffering. "I have been waiting four years for the Phipps Psychiatric Clinic to open," he confided, "so that I might take treatment."¹⁴ A year later, readers of the *Baltimore Sun* saw the headline "Big Demand On Phipps Clinic."¹⁵ And in his annual report of 1915, Meyer informed Hopkins authorities that "the demand for accommodation has been more than could be satisfied."¹⁶

In addition to old fears of the asylum and a new faith in scientific medicine, a confluence of other broad historical factors help to explain this demand: the pervasive perception that the fast-paced environment of civilized man was dangerous to one's health, popularized by neurologist George Beard's books on neurasthenia in the 1880s; America's preoccupation with self-improvement and self-fulfillment in this period, which created a marketplace for spiritual and medical "talking cures" (psychotherapy); the advent of novel discourses of the individual, the personality, the unconscious, and psychoanalysis; and the emergence of a new medical specialist, the psychiatrist, whose professional domain appeared to consolidate the treatment of all mental troubles, from

insanity to nervousness, previously dispersed among general practitioners, asylum physicians, neurologists, and the ubiquitous nerve nostrum.¹⁷

These prevalent and interconnected contexts did much to shape general attitudes toward the small number of urban psychiatric hospitals that appeared before World War I.¹⁸ Analyzing their early reception and use by individuals will help to elucidate their proliferation later in the century. The aim of this study is twofold: to delineate who, more precisely, utilized the Phipps Psychiatric Clinic between 1913 and 1917, and to examine the decision-making processes of individual users. By compiling the demographic and medical information recorded by Phipps staff on standardized discharge forms completed at the end of each admission, I created a data set of 1897 cases representing 1772 individuals (some patients were admitted more than once in this five-year period). In addition to biographical details, these summaries include admission and discharge dates, assigned ward(s), an impression of the patient's condition at discharge, and a non-standardized diagnostic sketch. Quantitative and qualitative analyses of the Phipps patient records yield definitive results that shed light on who used this new medical and social institution and why.

It was the recognition of abnormal behaviour or diminished functioning, ultimately, that prompted people to consider the Phipps as a source of information, help, or medical treatment. In some cases, an individual's appreciation of his or her own odd thinking, uncontrollable conduct, or debilitation triggered a personal decision to contact Adolf Meyer or to visit the clinic. Other times those close to an individual—family, employer, or physician—initiated contact after having a peculiar conversation or witnessing disconcerting behaviour. Twenty-six year-old Steffi, for example, was fired from her manufacturing job because of her odd conduct and boisterous outbursts. She had informed the mayor and governor in writing that "a spell had been cast on her by the machinery of a noisy factory across the street from where she lives [that] interfered with her thoughts and compelled her to do things over which she had no control." Such "things," presumably, are what brought Steffi to the attention of the neighbourhood police on several occasions; when her family kept her indoors, however, "she sat and stared into space, brooding, or laughing foolishly and unaccountably to herself." Steffi's mother worried that local authorities would insist that her daughter be committed to the public asylum and hoped that doctors at the new "nervous hospital" at Johns Hopkins might cure her. She and Steffi walked to the clinic only a few blocks away from their house.¹⁹

Indeed, Phipps patients were far more likely to have travelled to the clinic by Baltimore's famous streetcars than by Pullman car. Of the 1897 admissions during the first five years of its operation, 49% were from

the City of Baltimore while another 11% were Marylanders outside the city. This emphasis on local use was intentional. Like its parent institution, Johns Hopkins Hospital, the Phipps was expected to serve the urban, often impoverished population surrounding it. In 1914, Meyer reported to colleagues that over 100 of the 370 admissions were free patients and that 25 paid less than \$10 a week.²⁰ By comparison, the Mount Hope Retreat outside Baltimore City charged between \$8 and \$15 per week, and also provided care to some individuals without cost.²¹ "Many applications have had to be refused," reported David Henderson, the clinic's chief resident psychiatrist. But, he emphasized with pride, "no patient from Baltimore has as yet been refused admission because he could not afford to pay."²² As a department of Johns Hopkins Hospital, and because the maladjustment model of mental illness called for early and ongoing medical intervention, the clinic's municipal function was a priority.

With Baltimore and Maryland constituting 60% of the admissions, the remaining 40% represented mainly the neighbouring states of Virginia, Pennsylvania, West Virginia, New York, North Carolina and Washington, D.C. Patients from outside Maryland were charged \$25 per week and, along with free and subsidized local patients, were admitted to one of two public wards.²³ Meyer was sufficiently confident in this communal option to assure a concerned husband, worried about the cost of his wife's treatment, that "I would not hesitate much in recommending it to any member of my family."²⁴ He would not have dared to make such a claim about any of his former places of employment—congested mental asylums that required families to declare publicly the insanity within their lineage.

Facilitating this local use was as an out-patient department. The opening of the Phipps Dispensary, a walk-in clinic, in 1913 created an alternative for Maryland families like Steffi's to the traditional choice between simply enduring the disruption (and sometimes dangers) of mental impairment, on the one hand, or an asylum commitment on the other. Meyer envisioned a psychiatric dispensary as merely one essential component of a network of social and medical institutions that facilitated the readjustment of a maladapted individual. For him, one of its key local functions was to provide accessible medical advice about psychiatric illness to both this network and to the public. According to the annual Superintendent's Report for the Johns Hopkins Hospital, 552 individuals visited the Phipps Dispensary 2142 times in its first year of operation, an average of 3.8 visits each; by 1915, the number had risen to 743.²⁵ Because the dispensary records are not available, the precise number of out-patient visits that became hospital admissions is unknown; the extant in-patient records, however, confirm that this was a common path to admission.

When Steffi and her mother arrived at the small clinic behind the famous domed hospital, they entered a side door and descended a marble staircase to the waiting room of the new Phipps Dispensary. Psychiatrist Esther Richards spoke with them in an examination room where Steffi calmly explained that electricity from Baltimore's streetcars was used by people she did not know as a means to control and implant disgusting thoughts in her mind. Asked what her medical complaint was, she said, "nervous troubles and flightiness." Richards recommended hospitalization and Steffi was admitted to a public ward at no charge.²⁶

Another worried mother convinced her 32-year-old son, Wally, to go to the Phipps Dispensary when a decade of sporadic but volatile behaviour culminated in a terrifying incident involving his youngest brother. "While sitting at table and nobody saying anything," Wally's sister told the dispensary physician, "he suddenly jumped up from the table and grabbed a butcher knife [and] took [him] by the back of the neck." Other family members intervened before physical harm was done to the boy. During lucid periods, this rural Maryland farmer was intelligent and hard-working, and his mother's struggle over what to do about his unpredictable outbursts is manifest in a letter she sent to the clinic: "Knowing that he is not actually insane I cannot bring myself to consign him to an asylum for such people. At the same time, I cannot but feel afraid of the possible consequences if he should return home. I can scarcely hold my pencil to write at all and beg allowance for this scrawl."²⁷ As Meyer told his Hopkins colleagues in 1914, the stigmatization that accompanied the legal declaration of insanity demanded by mental institutions was "a painful deterrent" for both sufferer and family—"and, therefore, a hindrance to early care and treatment."²⁸ Cases such as Steffi's and Wally's indicate that, as Meyer hoped, without the prerequisite of the legal declaration and the risk of stigma, Maryland families viewed the out-patient dispensary as an acceptable source of medical help.

Securing the individual's consent to hospitalization was an important criterion for admission to the Phipps Clinic. According to Meyer, a willingness to receive medical treatment for nervous troubles signalled an earlier stage of illness and an increased probability for adjusting maladaptive behaviour or arresting symptoms. Meyer believed that chances for recovery were increased if the patient was still agreeable to medical intervention.²⁹ Phipps patients signed a promissory note by which they agreed to abide by the rules "and the detention thereby enforced," and to provide "at least three days' notice of my desire to leave the hospital."³⁰ In 1914, Meyer boasted to colleagues that "only twelve out of 370 patients were held under commitment."³¹ He reasoned that a general hospital

acts on the principle that a patient who ceases to cooperate well should be discharged and sent elsewhere. If we made our criterion of admission absolute submissiveness, we should have to eliminate many of those cases who today fare very poorly, but who are not at all less hopeful and grateful patients in the end for having perhaps gone through a somewhat noisy and objectionable phase.³²

He likened his authority to confine disobliging patients to that of the general hospital physician who was required by law to detain persons diagnosed with typhoid fever.³³ He concluded that the notion of “stigma” would be diminished if, instead of a legal ruling, “the matter of treatment of mental cases were left in the hands of sufficiently trained physicians—like any other issue of quarantine.”³⁴ Most important, according to Meyer, was that the decision to hospitalize without the patient’s consent be a medical one and not a legal one.

For some, however—despite its kinship to the modern general hospital—an admission to “the Phipps” engendered the same terror and disgrace associated with the insane asylum. In an extreme example, the *Baltimore Sun* reported that a 24-year-old woman, suffering from “nervousness that had prevented her working for several months,” bolted from her parents’ home, screaming, when she overheard that she would be admitted to the Phipps Clinic. According to the newspaper, she “ran screaming for several blocks with a crowd and a policeman after her” until she tired and was taken to a nearby general hospital. There, she spent a few quiet days resting until, once again, the Phipps was suggested. The *Sun’s* headline reveals the story’s grim ending: “Hysteria Victim Leaps from Hospital Window.”³⁵

The factors that shaped deliberations about using the Phipps Clinic were different for each family. Some looked to Phipps psychiatrists to adjudicate the necessity of institutionalization. At the beginning of the 20th century, American newspapers and magazines brimmed with items about familiar maladies such as neurasthenia, as well as newly described afflictions being studied in Europe. A wealthy couple from New York City brought their son to see Meyer hoping that the Hopkins expert would pronounce institutionalization unnecessary. Each suggested to him a diagnosis that, in their minds, did not necessitate hospitalization or legal commitment. The mother told Meyer that “her son is a neurasthenic as he is constantly complaining of terrible pains all over and is always tired,” while her husband declared, “I know he is abnormal, but I am convinced that it is more or less what is called psycho-stenia, which I believe is misplaced will rather than a case of insanity.” Meyer explained that, to his mind, hospitalization preceded diagnosis and that the latter did not determine the former.³⁶ The young man was admitted.³⁷

Other families contacted the clinic in response to a patient’s own request. “My sister has just called me up informing me that she has

received a letter from the Phips [sic] Institute, advising her of a vacancy," one man wrote to Meyer, "she is very anxious to enter the Institute and I believe that a stay there will have beneficial results."³⁸ In another case, a 56-year-old cobbler—convinced that "his wife and son were plotting to shoot him and get him out of the way"—awoke another son at five in the morning and "begged for help—that he was sick and something should be done for him." He appeared at the dispensary unaccompanied a few hours later.³⁹

Indeed, most individuals admitted to the Phipps Clinic between 1913 and 1917 decided to enter the hospital in consultation with family, though the circumstances and decision-making process of each family were unique. One Midwestern couple brought their son, Beryl, to consult Meyer about the young man's compulsive and debilitating delusion that a hazardous odour emanated from his genitals. After the meeting the three returned to their Baltimore hotel to discuss Meyer's recommendation that the boy be admitted. A few hours later, Beryl bade farewell to his parents and took a taxi alone to the clinic.⁴⁰ John, a 54-year-old minister and farmer from a southern state, was accompanied by his uncle who, on the way to the clinic, harangued John about his many shortcomings and, once there, declared to the physician that "if he had had more whippings as a young boy, he wouldn't be here." The uncle also made clear that he resented his familial obligation to pay for his nephew's hospital treatment.⁴¹ A woman who had worked in a few nearby asylums took the streetcar to the clinic accompanied by her sister, but once there she sobbed for fear that she would be sent to an asylum herself after which everyone would know about her trouble. Her sister convinced her, however, of the value of hospitalization at the Phipps.⁴²

It was not uncommon, nonetheless, for relatives to arrange for hospitalization without the patient's input or knowledge. For example, one man asked Meyer to visit his mother, Harriet, at the Mount Hope Retreat, a hospital outside Baltimore run by the Sisters of Charity. Harriet was a wealthy widow who, because of debilitating attacks of excitability and despair, had resided at Mount Hope for over a decade. Meyer found her emaciated (from refusing to eat), but lucid, and thought she might benefit from treatment at the Phipps. Soon after, her son wrote to confirm that he possessed the written permission of the committee legally responsible "for her person" (of which he was a member) "to remove her to Johns Hopkins or any place I should choose. I desire to place her under your treatment as soon as possible." His letter arrived "just as we obtained a vacancy on the private ward," Meyer told him, "kindly arrange the transfer of your mother and inform us of the probable time of her arrival."⁴³ Harriet was installed in a private room on the fourth floor of the clinic and her commitment papers were appended to her medical record. Although Meyer observed a marked

improvement at first, she later deteriorated steadily and was transferred back to Mount Hope after seven months at the Phipps.

Of the total 1897 admissions, 889 (47%) were women and 1008 (53%) were men. As the clinic's 88 beds were evenly divided between female and male wards—and because it rarely had an empty bed before World War I—these data reveal little about the correlates of gender and admission decisions at the Phipps. They do indicate that female patients overall were being admitted and discharged at a slightly slower rate than their male counterparts. The shortest length of admission was a single day while the longest was that of a 39-year-old taxi driver from Maryland hospitalized for 1015 days. The average length of admission was 56 days. Admissions under 60 days were more likely to be men whereas those between three months and one year were, by a slight margin, more often female patients. The distribution of cases by marital status was 785 single (41%), 905 married (48%), 90 widowed (5%), 49 separated (3%), 6 divorced (less than 1%) and 62 not listed (3%). The youngest patient was 10 years old and the oldest 76 years old.

Eighteen Phipps beds were allocated for the private patients of Meyer and occupied single rooms or shared suites on the fourth floor of the clinic. Private patients were seen daily by Meyer or a member of his senior staff, whereas free or subsidized patients were seen twice weekly. When a North Carolina physician wanted one of his patients admitted as a private patient, Meyer advised him that “the more moderate rate rooms at \$6 and \$7.50 a day are usually occupied so that only the \$10 rooms with bath are available for patients coming for shorter periods.” On the other hand, he added, private patients could opt for the public ward. He added that “my own consultation charge varies, according to time consumed and circumstances of the patient, from \$25 to \$100.”⁴⁴ Although the discharge summaries included a field to record the ward assignment of the patient, this information was entered only sporadically before 1915. Data derived from 80% of these records show that 14% of the admissions were to private rooms. There was no way to identify patients who occupied a bed on the public ward and concurrently paid Meyer private fees.

For patients and families, the choice between a public or private bed was yet another way they were forced to negotiate how they would utilize this new type of psychiatric institution. A 30-year-old minister, for instance, was eager to follow his physician's recommendation to enter Meyer's hospital. When he presented himself at the Phipps Clinic, however, he faced a dilemma. He simply assumed that, like a private sanitarium, he would be assigned a room of his own. Nevertheless, he could not afford a private room. For two hours, “he and his mother talked over the question of a ward,” the Phipps psychiatrist noted, before he decided to take a bed in the open public ward. Once

there, he was "quite willing to cooperate and therefore proceeded to do so very conscientiously."⁴⁵ The "private patient revolution" that had helped to transform the general hospital in the 20th century had increased middle-class expectations of medical services and hospital accommodations.⁴⁶

John, the farmer-clergyman, initially entered the clinic as a private patient of Meyer's using the funds advanced by his uncle (who promised no further financial help would be forthcoming). John's wife sent Meyer regular reminders about the financial pressures of her husband's hospitalization; while she was eager to have him recovered, she assured Meyer, both she and her husband worried because money was running out. After one month in a private room, Meyer informed her that "your husband has been changed during the last week to the general ward so as to reduce expenses."⁴⁷ Meyer viewed the reduction of hospital fees, nevertheless, as a therapeutic rather than economic tactic—he had no trouble filling beds, public or private.

Kinship and community networks beyond those of the immediate family also utilized the new clinic as a resource for dealing with the mentally disordered. Mabel felt she bore much of the burden of her household. Unmarried, menopausal, and always "nervous," she wrote to her long-time friend in Baltimore to lament that she did not earn her own living. Her friend suggested that she come to the city from Pennsylvania to do "shut in work" at a hospice for invalids nearby, which Mabel did. Her first night at "the Home," however, Mabel "walked the floor all night." She sobbed, talked of suicide, and locked herself in her room. With the help of the Matron of the establishment, her friend successfully convinced her to go to the Phipps Clinic "for a rest." Both women accompanied Mabel downtown the next morning where the three waited in the sitting room in the main lobby to see a doctor. As he entered, the Phipps psychiatrist noted later in her hospital record, Mabel "was stretched out on the couch paying no attention to anything about her, hat off—the picture of utter dejection and despair."⁴⁸ She refused to speak with him or her own associates, but she assented silently to hospitalization in the clinic.

The manager of a utilities company summoned his employee's brother and cousin "to bring him to the hospital" after "the sudden falling off of his work and the appearance of odd behavior." The 20-year-old telegraph operator suspected his coworkers of misdoings and barged "into the main office and said that the boys were after him."⁴⁹ Another man, a carpenter from Baltimore, was sent to the Phipps Dispensary by a local charitable agency "because he behaved queerly in their office."⁵⁰ After its opening in 1913, then, citizens and agencies within the city of Baltimore and the state of Maryland began to utilize the Phipps Clinic as a resource for managing the mentally troubled in the community.

Just because a community member persuaded or instructed an individual to appear at the clinic, however, did not necessarily mean that he or she was eager to see the doctors there. For example, a 27-year-old artisan from Switzerland who worked for his uncle in Baltimore reported to the Phipps Dispensary when "his dentist noticed that he talked peculiarly about religious matters and sent him to the hospital." The young craftsman, Kasper, made a noteworthy impression on the Phipps staff when he arrived:

The patient walked into the Dispensary this morning unattended, having come on the advice of Dr. B. a dentist. He carried a letter from Dr. B. to Dr. Meyer, stating that Dr. B. would call up later about the patient. The manner of his entrance to the Dispensary was very dramatic. He walked in with his hat pulled down over his eyes, a handkerchief bound over his eyes as a mask, and with one hand in his pocket. He later explained this by saying that his eyes had been hypnotized and he wore the mask to prevent others from knowing it.⁵¹

The patient explained that his dentist "gave me the address of a hospital" telling him "you better take care of yourself."⁵² Kasper reported dutifully at the address as instructed, but he paced in front of the clinic for a few hours, perhaps contemplating the implication of the stone tablet above its door: *Henry Phipps Psychiatric Clinic*. "After some argument," the psychiatrist recorded in Kasper's hospital record, "he was persuaded to come into the Dispensary, and about 4 p.m. was admitted."⁵³ It required some effort, evidently, to convince Kasper of either the safety or value (or both) of speaking to the kind of doctor that might practise in such a hospital.

Within a framework in which mental dysfunction was equated with maladjustment to one's environment, Meyer deemed it crucial that severely disordered individuals were seduced, not forced, to enter the hospital. He told fellow physicians that when confronted with "the cocksureness of a person with a beginning paranoid development, cooperation becomes clearly possible only if we succeed in making our help attractive and acceptable even to the shaken or twisted confidence of our patients."⁵⁴ He traded on his conviction that a modern hospital environment would appeal as genuine medical help, even to patients experiencing delusions or hallucinations, and he felt strongly that the creative physician could make hospitalization appear advantageous to most patients. "I realize the difficulty, but I rather think it is best that physicians should have to exert some efforts and exercise their imagination." Too many physicians, he complained, elected "the easy road of clamming a man in line by a more than medical step" (legal commitment).⁵⁵

Indeed, this analysis of Phipps admissions shows that paranoid or hallucinating individuals were able to maintain a deep conviction

of conspiracy or persecution and simultaneously conceptualize their experiences as nervous troubles amenable to medical intervention. The generalization that sufferers of paranoia in this period did not utilize new voluntary psychiatric institutions because they were reluctant to seek medical help is not borne out by these case histories.⁵⁶ Like Kasper, individuals who were psychotic and paranoid regularly engaged with Phipps psychiatrists—either by actively seeking out or by passively tolerating the psychiatric treatment they offered.

Joe, for example, a 34-year-old bookkeeper from Atlanta, spent several years travelling from city to city in an attempt to outrun a secret society whose members hounded and tormented him wherever he went. When this conspiratorial surveillance continued in Baltimore, he sought assistance at the Phipps Dispensary. In a written account of his experiences entitled “Statement to the Public” and appended to his hospital chart, he explained:

One day when I was standing on a corner in St. Louis I noticed that every time a member of the street cleaning department got opposite me he would spit & make up some sound to attract my attention. Of course they were put up to it by the boss who I found out was a member of this lodge. Now at first this may seem absurd. But let it go on for months & months & you would find it surprising the way it will affect one.⁵⁷

Joe wished the public to know that he was “willing to admit that I have always been very nervous and have been treated for it at Johns Hopkins Hospital at Baltimore by a Dr. Burrow.” He acknowledged that many people might attribute his worries to “the imagination of a disordered mind” and, he reassured his readers, “that’s what I am afraid of, so am writing this before I do lose my mind through worry.” Concerned, then, that the stressful effects of constant surveillance were taxing his nerves and threatening his overall health, he sought medical treatment. He visited psychiatrist Trigant Burrow at the out-patient dispensary periodically for 18 months and he improved somewhat, but when he relapsed and his paranoid delusions intensified, Burrow convinced him to sign the voluntary admission agreement and enter the clinic for in-patient treatment.

From his bed in the Admission Ward, he explained to Meyer that “I was one year with Dr. Burrow, which nearly cured me.” Nevertheless, due to the torment of the secret society and its cronies, he explained, “I have not had a good night’s sleep now for about four months.” The Phipps staff noted that “most of his time on the ward was spent in bed with [the] bedclothes pulled over his head” and he “would not talk about his condition.” Seven days after he was admitted, Joe penned a simple but unequivocal request on Johns Hopkins Hospital note paper addressed to no one in particular: “You told me when I entered this

Hospital I could leave if I would give three days notice. I, herewith, wish to give this notice." He was discharged and it is unknown whether he continued to use the dispensary.⁵⁸

There are several important points to be gleaned from this snapshot. First, believing that at every turn a secret society conspired against him, Joe looked to the psychiatric dispensary and its physician as legitimate sources of help. He may have been directed there after seeking aid elsewhere—at the police station or general hospital—but ultimately he decided that a psychiatrist might be of some assistance. Second, not only did Joe conceive of his predicament as amenable to medical intervention, he clearly valued the *out-patient* treatment he received since he utilized the dispensary for over a year and asserted that Dr. Burrow "nearly cured me." Nevertheless, despite Meyer's strong recommendation to remain in the hospital, he declined *in-patient* treatment. Third, then, Joe himself chose the manner in which he utilized this new psychiatric institution.

Finally, Joe's discharge makes clear that it would be a mistake to assume that queer behaviour alone warranted hospitalization in the Phipps Clinic or a forcible transfer to a large asylum. Similarly, a 45-year-old waiter was admitted with delusions, hallucinations, and paranoia. It was noted that he had a "well systematized philosophy in which he comes from the sun" and "is a higher being persecuted by the Theophians." He entered the clinic voluntarily but, after two weeks in the clinic, he "politely insisted on leaving" and was discharged.⁵⁹

Another young man struggling with paranoid thinking was one of the many patients who ventured to the clinic alone. One Saturday morning, Saul, a 21-year-old bank teller working in New York City, took the train to Baltimore because he wanted to talk with psychiatrists at Johns Hopkins. Of late, he had become convinced that his mother was poisoning him and carrying on an illicit affair with his uncle (who lived in the family home). He also suspected that his superiors at work, as well as several other powerful financiers, were joined in a conspiracy to prevent his advancement in the banking world. The Phipps psychiatrist noted that the "patient feels that he is confused—perhaps over-suspicious, and feels extremely worried and muddled." Saul traveled 200 miles to Johns Hopkins for one reason, he told the doctor: "to know whether he is crazy or not."⁶⁰ The Phipps psychiatrist recommended hospitalization and Saul returned the following Wednesday to admit himself.

Saul, a bank teller, and Joe, a bookkeeper, were part of a group of clerical workers that accounted for 8% of admissions, one of four occupational categories that emerge as statistically significant among those patients who engaged in paid work. Nine percent of patients occupied a trade like Kasper, a craftsman, and this group included bakers,

carpenters, printers, butchers, and tailors.⁶¹ Professionals such as physicians, lawyers, engineers, and teachers also represented 9% of admissions, while labourers like Steffi who worked in factories and dockyards, made deliveries, or operated machinery accounted for 8%. The remaining 29% of income-earning patients included business owners and merchants, farmers and clergy, and sales and service workers.

By far the largest occupational group, however—30%—was comprised of female patients who performed unpaid work in the home. On the discharge summaries, the occupation of these individuals was described variously as “housewife,” “housework,” or “none.” Like the overall population, these patients represented great social diversity and a broad spectrum of motivations for using the clinic, making it problematic to draw conclusive correlations between being a woman and utilizing the Phipps Clinic. Some women, for instance, complained of nervous troubles caused by stressful domestic situations or existential crises. Rose, the wife of an insurance agent, visited the Phipps Dispensary around 3:30 one afternoon and told the doctor there, “I want a rest. I have been nervous and run down since my last child was born—and my husband called me a bad name (hell-cat).” Things were confused in her mind, she explained, and she thought a stay in the hospital could give her a “change of air” and a separation from her husband. “I was nervous, hysterical at different times, depressed,” she later recalled of the day she admitted herself, “despondent I suppose you would call it.”⁶² Agnes, unmarried and 36, lived with her family close to the clinic and visited its dispensary “irregularly” for two months prior to her admission because life appeared “dull and gloomy to her.”⁶³

In other cases, women sought medical help for strange symptoms that interrupted daily life. Diana worked in a toy factory for 12 years before getting married at 30 to a carpenter. Asked why she sought medical advice, she explained that “I’m so conscientious, it just harasses me to death, the smallest thing worries me.” After her first child was born a few years earlier, she began to worry that “when she goes to confession she is afraid she will confess something not true and also afraid that she will omit to confess what she should.” This self-doubt escalated to where she could not leave a store without being reassured by the shopkeeper that she had paid for her purchases, even though she knew she had done so. “I’m just never sure of myself about anything,” she lamented to one of the Phipps nurses, “and that looks like I’m losing my mind.” Diana was admitted to a public ward but left after four days because “she did not feel the treatment was helping.”⁶⁴

Like Steffi, the factory worker who walked with her mother to the clinic, 24% of female patients were members of the paid workforce. Five months before her admission, Jacqueline, a young French immigrant, began working as a nurse at the city’s Bay View Hospital. According to

her Phipps record, at Bay View she became “attached” to a male patient who was also French (and a morphine addict); the friendship drew suspicion from her superiors and Jacqueline was redeployed to another ward. A few days later, doctors noticed that her speech was increasingly incoherent; several weeks later, fellow nurses found her standing in front of her bedroom window, naked and waving to attract passersby. She was legally committed as a patient to the “insane ward” at Bay View where she was volatile toward the nurses, answered imaginary voices, and was “quiet and lachrymose.” Physicians there decided that, given the sudden onset of her symptoms, she should be evaluated by Adolf Meyer at Johns Hopkins. She was transported the short distance from Bay View to the Phipps in a horse-drawn ambulance (accompanied by its coachman and a fellow nurse) and admitted.⁶⁵

Other general hospitals in Baltimore City, as well as private and state asylums within Maryland, also utilized the new university clinic in this way—sending patients to the Phipps Clinic for diagnostic evaluation and specialized care. Richard, for example, the 19-year-old son of a hardware store owner, spent 10 days at a local sanitarium in Maryland after becoming abusive and profane with his father and the customers at the family shop. Although Richard “improved nicely” while under his care, the owner of the private asylum recommended he be examined by Meyer and all three men traveled to the Phipps Clinic together to make arrangements for an admission.⁶⁶ Ruth’s family took her to the Baltimore Women’s Hospital because “she frequently aroused the neighbors by screaming during the night” and “contrary to advice, the family refused to commit her to any mental institution.” The unmarried, middle-aged daughter of a prosperous Jewish family in Maryland, Ruth rarely ate and was emaciated. Her longtime family doctor described her typical demeanour as “erratic, inclined to be grandiose” and he informed Phipps staff that she had been successfully treated for a “morphine habit” at a private sanitarium. Women’s Hospital, however, was not equipped to cope with severely agitated patients and she was “so noisy and hard to manage” that she was transferred to the psychiatric hospital at Johns Hopkins.⁶⁷

Ruth’s was one of many Jewish families to utilize the clinic. The discharge summaries included fields labeled “Religious Denomination” and “Nationality” (including the nationality of both parents), although denominational information was recorded on only 79% of the total number of records. Jewish and Catholic patients constituted 12% and 13% respectively of these admissions, and those listed as Protestant and Methodist/Episcopal accounted for 23% and 24% respectively. Other religions listed, albeit represented by far smaller numbers, were Greek Orthodox, Dunkard, Christian Science, Quaker, and Mennonite. There was also a field on the template labeled “Race” although, once again,

Phipps physicians entered this information sporadically (53% of the time); of these, the majority of patients were described as “white,” while a considerable number were identified racially as “Hebrew,” and a small number as “Russian,” “Bohemian” or “Irish.”⁶⁸

Other patients were referred to Meyer or to the Phipps Dispensary by their family physician or local specialist. One Baltimore doctor wrote to Meyer about his patient, a 30-year-old clergyman. “He is very agitated mentally and a violent love affair seems to be the exciting factor,” he explained. He told Meyer pointedly that “I felt that he needed to be taken actively in hand.”⁶⁹ It was common for the family physician to arrange admission to the clinic on behalf of the family, including travel or private nursing arrangements, as well as all financial and medical decisions. Beryl’s parents arrived with a letter of introduction from their long-time family doctor. “These are very good friends of ours,” he wrote to Meyer, “and I shall certainly consider a personal favor the kind and personal attention which I know you will give them.”⁷⁰

The national prominence of the clinic, by virtue of its affiliation with Johns Hopkins, meant that Meyer received requests for advice and pleas for help from sufferers and their families from all over the country. On the day the clinic opened, the *Baltimore Sun* reported that “there have been hundreds of applications for admission.”⁷¹ Within the medical profession Meyer was, like his fellow Johns Hopkins specialists, a conspicuous authority. In one instance, a physician of national repute travelled from the Midwest with his daughter (who was in a violent psychotic state) to admit her to the Phipps as a private patient of Meyer’s.⁷² Having seen an article about the new Phipps Clinic in his local paper, one man wrote: “I thought I would write to you and ask your assistance. I am suffering with nervous trouble so bad that life has no charms for me. I am living with my mother who is a widow and it is only for her sake that I am trying hard to forget my suffering.”⁷³ Another man claimed that his local doctor had told him “the Phipps Clinic is the only place for him” because his case was difficult to diagnose.⁷⁴

Individuals, families, physicians, and community agencies continued to place a high demand on the Phipps Clinic between the years 1913 and 1917. As this analysis of the institution’s medical records shows, moreover, its patient population was socially, motivationally, and symptomatically diverse. In accordance with the broader mandate of its parent institution, Johns Hopkins Hospital, the Phipps Clinic subsidized the treatment of low-income patients from Maryland in addition to admitting patients willing to pay fees for private accommodation and consultation. For Marylanders, its out-patient dispensary, especially, facilitated access to psychiatric medical expertise without a trip to the state asylum which required a legal declaration of insanity before consulting with the asylum physician inside—an option that previously

had been available only to families who could afford the fees of a private specialist. Nearby hospitals and community organizations also utilized the new clinic, referring individuals deemed in need of specialized care, facilities, or diagnosis. Finally, because of its associations to the modern hospital and scientific progress, the Phipps Clinic represented a culturally conducive source of help in the management of mental illness in the opening decades of the 20th century.

Many Phipps patients were eventually transferred to their local asylum for long-term (though not necessarily indefinite) care. Others were instructed to report to the dispensary on a regular basis for treatment as an out-patient. Still others returned home under the supervision of family members and general physicians who remained in contact with Phipps psychiatrists. It is only natural to wonder if this novel mode of psychiatric institutionalization benefitted patients—i.e., *did it work?*—but this question is beyond the scope of this examination of those who utilized the clinic and their reasons for doing so; indeed, it may be unanswerable given the historical sources available.

After World War I, more and more clinics and university departments of psychiatry were established in North American cities. Unlike the general hospital a generation earlier, however, the urban psychiatric clinic never supplanted its predecessor, the mental asylum, in terms of patient care—nor did it instigate the widespread deinstitutionalization of asylum patients several generations later. Rather, it became an integral part of an expanding network of social and medical institutions that managed and treated mental illness in the 20th century. From the perspective of psychiatrists, on the other hand, the story is quite different. By the end of the 19th century, the custodial duties of the asylum physician were considered incompatible with scientific research, and the asylum itself incongruous with hospital medicine, clinical teaching, and therapeutic advance. As I explore in my forthcoming book on Adolf Meyer and the Phipps Clinic, the psychiatric clinic was a new institutional base that reified psychiatry's claim as a science-based medical specialty. The geographical and conceptual shift from asylum to clinic at the turn of the century facilitated significant changes within American psychiatry that allowed the specialty to align its professional organization, research programs, and clinical practices with those of other medical disciplines—making it an important subject for further research and consideration.

NOTES

- 1 *Baltimore Sun*, 1 May 1913, p. 4.
- 2 William Osler, "The Fixed Period" in William Osler, *Aequanimitas With Other Addresses to Medical Students, Nurses and Practitioners of Medicine*, 2nd Edition with Three Additional Addresses (London: Lewis, 1906): 389-411.

- 3 Adolf Meyer to Hermann Meyer, 12 June 1908. IV/3/122, Adolf Meyer Collection, Alan Chesney Medical Archives, Johns Hopkins Medical Institutions, Baltimore, MD (hereafter AMC).
- 4 Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 1994), p. 148-49; Elizabeth Lunbeck, *Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton: Princeton University Press, 1994), p. 46-47 and p. 329 n. 2.
- 5 See Joel D. Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore: The Johns Hopkins University Press, 1995); Stanley Joel Reiser, *Medicine and the Reign of Technology* (Cambridge: Cambridge University Press, 1978), p. 144-57; Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: The Johns Hopkins University Press, 1987); John Harley Warner, *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820-1885* (Princeton: Princeton University Press, 1997); and John Harley Warner, "Science in Medicine," *Osiris*, (Second Series) I (1985): 37-58.
- 6 The influence that Johns Hopkins exercised within American medicine is well-known but understudied. For an overview, see *A Model of Its Kind*, Susan L. Abrams et al., eds., (Baltimore: The Johns Hopkins University Press, 1989). See also Michael Bliss, *William Osler: A Life in Medicine* (Toronto: University of Toronto Press, 1999); Donald Fleming, *William H. Welch and the Rise of Modern Medicine* (Boston: Little Brown, 1954); Kenneth Ludmerer, *Learning To Heal: The Development of American Medical Education* (New York: Basic Books, 1985); and Richard Shryock, *The Unique Influence of the Johns Hopkins University in American Medicine* (Copenhagen: Ejnar Munksgaard, 1953).
- 7 The historical scholarship on the development of the American asylum is voluminous and contentious. For critical and comprehensive overviews, see the essays in Mark Micale and Roy Porter, eds., *Discovering the History of Psychiatry* (New York: Oxford University Press, 1994).
- 8 Grob, *Mad Among Us*, p. 127.
- 9 Anne Harrington, *Medicine, Mind, and the Double Brain* (Princeton: Princeton University Press, 1987): 102-3; Robert Nye, "Sociology and Degeneration: The Irony of Progress," in J. Edward Chamberlain and Sander Gilman, eds., *Degeneration: The Dark Side of Progress* (New York: Columbia University Press, 1985): 49-71; and Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley, 1997), p. 98.
- 10 Adolf Meyer, "Plans for Work in the Phipps Psychiatric Clinic," (1914), in Eunice E. Winters, ed., *The Collected Papers of Adolf Meyer*, vol. II (Baltimore: The Johns Hopkins University Press, 1951), p. 191, n. 1. Originally published in *Modern Hospital*, 1 (1913-1914): 69-76; and in *Johns Hopkins Alumni Magazine*, 1 (1913): 387-95.
- 11 Grob, *Mad Among Us*, p. 142; Lunbeck, *Psychiatric Persuasion*, p. 11-24.
- 12 *New York Times*, 23 June 1908, p. 1.
- 13 See Christopher Lawrence, "Anaesthesia in the Age of Reform," *History of Anaesthesia Proceedings*, 20 (1997): 11-16; Owsei Temkin, "The Role of Surgery in the Rise of Modern Medical Thought," *Bulletin of the History of Medicine*, 25 (1951): 248-59.
- 14 Adolf Meyer, Private Correspondence, Box A2, Series XV, AMC.
- 15 *Baltimore Sun*, 27 June 1914, p. 4.
- 16 *Twenty-Seventh Report of the Superintendent of the Johns Hopkins Hospital for the year ending January 31, 1916* (Baltimore: The Johns Hopkins University Press, 1916).
- 17 For Beard and neurasthenia, see Stephen Kern, *The Culture of Time and Space 1880-1918* (Cambridge: Harvard University Press, 1983); the essays in Marijke Gijswijt-Hofstra and Roy Porter, eds., *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam: Rodopi, 2001); and Charles Rosenberg, "The Place of George M. Beard in Nineteenth-Century Psychiatry," *Bulletin of the History of Medicine*, 36 (1962): 245-59. For self-help, talk therapy, and discourses of the individual, see John C. Burnham,

- "Psychiatry, Psychology, and the Progressive Movement," *American Quarterly*, 12 (1960): 457-65; Eric Caplan, *Mind Games: American Culture and the Birth of Psychotherapy* (Berkeley: University of California Press, 1998); Henri Ellenberger, *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry* (New York: Basic Books, 1970); and Eva Moskowitz, *In Therapy We Trust: America's Obsession with Self Fulfillment* (Baltimore: The Johns Hopkins University Press, 2001). For psychoanalysis, see Burnham, *Psychoanalysis and American Medicine, 1894-1918* (New York: International Universities Press, 1967); and Nathan Hale, *Freud and the Americans: The Beginnings of Psychoanalysis in the United States 1876-1917* (Oxford: Oxford University Press, 1990). For professionalization of American psychiatry, see Gerald Grob, *The Inner World of American Psychiatry 1890-1940* (New Brunswick, N.J.: Rutgers University Press, 1985); Lunbeck, *Psychiatric Persuasion*; and Jack Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 1998).
- 18 Urban institutions termed "psychopathic hospitals" opened in Ann Arbor in 1906 and in Boston in 1912. Both were located near a university with the (often successful) aim of stimulating a reciprocal relationship. Ultimately, however, they were government institutions beholden to the needs of the state. The Phipps Clinic did not accept individuals delivered to its doorstep by local authorities or legal courts, nor was it a diagnostic centre that centralized admissions to a state asylum system. See Henry Hurd, *Institutional Care of the Insane in the United States and Canada* (Baltimore: The Johns Hopkins University Press, 1916); Eric Engstrom, *Clinical Psychiatry in Imperial Germany: A History of Psychiatric Practice* (Ithaca, N.Y.: Cornell University Press, 2003), p. 121-143; and Lunbeck, *Psychiatric Persuasion*.
 - 19 Case CGV 482. When I have drawn on a particular patient's medical record, I have substituted suitable alternatives for some biographical data to preserve his or her anonymity. These pseudonyms preserve the patient's gender, social status, and ethnicity, and comply with U.S. federal regulations on privacy. Medical records are cited using an alphanumeric code, randomly generated and bearing no relation to the identity of the patient or to the original Phipps case number.
 - 20 Meyer, "Organization of the Work of the Henry Phipps Psychiatric Clinic," *Transactions of the American Medico-Psychological Association Seventieth Annual Meeting*, 21 (1914): 397-403. Quote on p. 400.
 - 21 Walter O. Jahrreiss, *History of Mount Hope Retreat: The Growth of a Mental Hospital in Maryland, 1840-1940* (Baltimore: Thompsen-Ellis-Hutton, 1940); *Directory of the Charitable and Beneficent Organizations of Baltimore*, 1901.
 - 22 David K. Henderson, "Remarks on Cases Received in the Henry Phipps Psychiatric Clinic," *Bulletin of the Johns Hopkins Hospital*, 25/277 (1914): 69-72.
 - 23 Meyer, "Organization of Work," p. 400.
 - 24 Box B4, Series XV, AMC.
 - 25 *Twenty-Seventh Report of the Superintendent of the Johns Hopkins Hospital for the year ending January 31, 1916* (Baltimore: The Johns Hopkins University Press, 1916).
 - 26 Case CVG 482.
 - 27 Case NDA 687.
 - 28 Meyer, "Plans for Work," p. 186.
 - 29 Meyer, "The Aims of a Psychiatric Clinic" (1913), in *Collected Papers*, vol. II, p. 201. Originally published in *Transactions of the Seventeenth International Congress of Medicine, 1913* (Section 12, Part 1): 1-11.
 - 30 Copy in the record of Case WSR 288.
 - 31 Meyer, "Organization of Work," p. 398.
 - 32 Meyer, "Plans for Work," p. 191, n. 1.
 - 33 Meyer, "Organization of Work," p. 398.
 - 34 Meyer, "Plans for Work," p. 191, n. 1.

- 35 *Baltimore Sun*, 10 January 1917, p. 12.
- 36 This comment reflects Meyer's disenchantment with what he considered the over-reliance by American psychiatrists on Emil Kraepelin's new diagnostic classifications in order to determine whether hospitalization was appropriate.
- 37 Case EBF 175.
- 38 Case DAU 952.
- 39 Case SGM 137.
- 40 Case JGC 374.
- 41 Case RZG 112.
- 42 Case WSR 288.
- 43 Case QES 174.
- 44 Case AAM 522.
- 45 Case DVE 705.
- 46 Rosenberg, *Care of Strangers*, p. 244-48.
- 47 Case RZG 112.
- 48 Case ARA 909.
- 49 Case ZWF 362.
- 50 Case NUY 166.
- 51 Case ARD 545.
- 52 Case ARD 545.
- 53 Case ARD 545.
- 54 Meyer, "Aims of a Psychiatric Clinic," p. 195.
- 55 Meyer to Charles P. Emerson, 2 January 1914. Quoted in Grob, *Inner World*, p. 82.
- 56 Ian Dowbiggin, "Delusional Diagnosis? The History of Paranoia as a Disease Concept in the Modern Era," *History of Psychiatry*, 11 (2000): 37-69.
- 57 Case WTQ 149.
- 58 Case WTQ 149.
- 59 Case SUG 561.
- 60 Case OLR 652.
- 61 One third of all trades people admitted to the Phipps in this period were identified as a tailor or seamstresses, a number disproportionate to the general population. In 1910, tailors and seamstresses constituted 2% of this group nationally, and 6% in Baltimore City. See the Occupation Statistics for the *Thirteenth Census of the United States: 1910*, vol. 4 (Washington D.C.: Bureau of the Census, 1914), tables I and III respectively.
- 62 Case FYN 934.
- 63 Case EAF 170.
- 64 Case AMX 381.
- 65 Case PCH 129.
- 66 Case LFM 844.
- 67 Case RCZ 156.
- 68 Unlike the Johns Hopkins Hospital, the Phipps Clinic did not admit "colored" patients. In 1912, the Crownsville Asylum for the Colored Insane opened in Maryland and its construction may have influenced this decision. See Hurd, *Institutional Care of the Insane*, vol. 2, p. 541-46.
- 69 Case DVE 705.
- 70 Physician to Meyer, 1 August 1917, Box, A2, Series XV, AMC.
- 71 *Baltimore Sun*, 1 May 1913, p. 4.
- 72 Case AHY 275.
- 73 Box, A2, Series XV, AMC.
- 74 Case RZG 112.