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"Am I Sick or Just Discarded?" : Psychiatry, Health Care Reform, and the Rise of Geriatrics in America, 1931-1954

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To my professors in the History of Science, Medicine, and Public Health Program and at the Yale School of Public Health — You have all taught me to not simply take history as it is, but to question it, re-evaluate it, and make an effort to spotlight the voices of marginalized individuals who have previously been silenced. Among the professors I would like to thank are Jasmine Abrams, Miriam Rich, Joanna Radin, Joan Monin, Leah Ferrucci, and Laura Bothwell.

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To Nanaji — This thesis is dedicated to my late Nanaji (translation: maternal grandfather in Hindi), Dr. Rajinder S. Sikand. My Nanaji came to Yale in the early 1950s to do pulmonary physiology research. In 1965, he left his work at the Max Planck Institute for Medical Research in Heidelberg, Germany, and came back to the U.S., joining the Yale School of Medicine faculty in 1969. My Nanaji had an overwhelming passion for his medical research and the patients he cared for. Unfortunately, 3 months before his death, he wandered out of the house and was found at the golf course where he and his research colleagues would play. He was ultimately admitted to the Yale-New Haven Psychiatric Hospital. My grandfather died with Alzheimer's disease in July 2008. Accidentally discovering correspondence, journal articles, and the beautiful friendship shared between my grandfather and John Fulton during my thesis research was truly a stroke of luck and a reminder of how close he will always be.

POSITIONALITY STATEMENT

"What are your ideas for radical inclusion for health equity at structural or institutional levels?"
-Jasmine Abrams, Ph.D.

Sitting in *Social Justice and Health Equity*, I encountered this question last September. While writing this thesis, I returned to this question whenever I doubted my analysis of sources or the framing of my argument. History is an art—the art of storytelling—so I felt immense pressure to tell this particular story in an informed and objective manner. While American health care reform aimed to structurally bolster health equity, inclusion was largely overlooked.

While pondering Professor Abrams' question, she shared an additional quote from Audre Lorde: "There is no such thing as a single-issue struggle because we do not live single-issue lives." As I learned, the debate over national health insurance in the U.S. impacted not only the elderly but also older adults with compounding identities, their families, their physicians, and other caretakers—a concern for all Americans. Thus, health equity is not just about individual behaviors or health care, but is a broader social justice issue. Ensuring access to care is necessary, but not always enough. This thesis tells a story of American health care reform, encompassing mental health care, the evolution of geriatrics, psychiatric legitimacy, and political advocacy for the elderly.

This story could have ended with Section III. However, the story of national health care reform was exclusionary. It was one thing to be mentally ill. It was another to be elderly. But it was an even bigger struggle to be a mentally ill elderly individual with an additional marginalized identity—race and gender. In describing the efforts of Winfred Overholser and David Rothschild, I acknowledge their identities as two white men—individuals who have dominated medicine historically. Radical inclusion for health equity may be as simple as telling this story, while simultaneously identifying the structural and individual faults of those involved.

A NOTE ON TERMINOLOGY

Throughout this essay, I describe the diagnoses of *cerebral arteriosclerosis*, *senile dementia*, *senile psychosis/psychoses*, and *Alzheimer's disease*. However, this essay does not seek to quantify the incidence of each disease and thus will use the terms interchangeably, despite the slight biologic differences. The lack of differentiation of these diagnoses in my writing directly reflects the historical discussion of these diseases.[1] Dr. David Rothschild, to whom you will soon be introduced, developed his psychodynamic theory for the diagnosis of senile psychoses based on poor distinctions between the conditions.[2] As such, the terms used to describe a particular diagnosis in this essay do not represent the separation of these diseases. The differences between diagnoses varied from physician to physician and frequently reflected a physician's personal view of the case, not the symptoms presented. For example, gender constructions influenced diagnosis; physicians often diagnosed women with senile dementia, a diagnosis with lesser relevancy and associated with the emotional, hysterical female.[3] Alternatively, physicians fortified their agency and legitimized their practice by diagnosing some cases as Alzheimer's disease or cerebral arteriosclerosis, more "biologically" presenting conditions.[4]

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[1] Israel Spainer Weschler, *A Text-Book of Clinical Neurology* (Philadelphia: W.B. Saunders Company, 1927), 479. Weschler describes the differences between the biological presentation of Alzheimer's disease and cerebral arteriosclerosis as nonexistent—comparing the "silvery wire retinal arteries" associated with both illnesses as "pathognomonic" to one another.

[2] Konstantin Lowenberg and David Rothschild, "Alzheimer's Disease: Its Occurrence on the Basis of a Variety of Etiologic Factors," *American Journal of Psychiatry* 11 (1931): 269, https://doi.org/10.1176/ajp.88.2.269.

[3] Read more on this in section IV; David Rothschild, "The Clinical Differentiation of Senile and Arteriosclerotic Psychoses," *American Journal of Insanity* 99, no. 3 (November 1941): 324–333; David Rothschild, "Clinical Differentiation of Senile and Arteriosclerotic Psychoses," in *The 1947 Year Book of Neurology, Psychiatry, and Neurosurgery,* ed. Hans H. Reese, Mabel G. Masten, Nolan D.C. Lewis, and Percival Bailey (Chicago: Yearbook Publishers, 1947), 335–338.

[4] Nolan D.C. Lewis, *Outlines for Psychiatric Examinations* (New York: New York State Department of Mental Hygiene, 1943), 129. Specifically, Lewis writes, "Differentiation from the senile psychoses is sometimes difficult; the pathological changes lying at the basis of the two psychotic reaction types may be associated. Periodic remissions of the symptoms are more often seen in arteriosclerosis than in senile deterioration. The age, history, and careful survey of symptoms often assist one in determining which is the predominant type of reaction, but where such a determination is not clearly possible, preference should continue to be given, for statistical purposes, to the

INTRODUCTION

Conception, growth, decay, then death.[5]

According to Lawrence Kolb, then-assistant surgeon general of the United States Public Health Service, the human organism went through that exact process. And when that person started to decay, he was especially needy. Such needs were an overwhelming obstacle faced by the U.S. government at the end of the Great Depression through the mid-20th century. Winfred Overholser, Kolb's ally and then-superintendent of the first federally-run psychiatric facility, St. Elizabeths Hospital, illustrated the significance of this encumbrance with a striking statistic: "Within the last decade, the increase in the number of persons over 65 years of age was over 35 percent, as against a general population increase of only 7.2 percent."[6] Even with the passing of the 1935 Social Security Act (SSA), public relief was "insufficient" to address the mental instability and health care inaccessibility faced by the rapidly growing elderly population.[7] As a result, many elderly individuals were thrown into state hospitals and diagnosed with some form of senile dementia. In the latter half of the 1930s, 40% of those admitted to state mental hospitals were over the age of 50.[8]

Senile dementia, however, was not a new diagnosis. Senile psychoses gained significant

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arteriosclerotic classification." Lewis demonstrates how the field's biological basis for diagnosis is favored over the psychopathological given that the classification as "biological" produces better statistics for the field's credibility.

[5] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity* (Washington, D.C.: United States Government Printing Office, 1941), 6.

[6] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 3.

[7] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 58. The Social Security Act (SSA) was signed by President Franklin D. Roosevelt in 1935. At the signing ceremony he bullishly declared that the act was intended to offer "protection to 30 million of our citizens," including the aged, mothers, and children. Nevertheless, he hedged his language in the proceeding statements, noting that: "We can never insure 100% of the population against 100% of the hazards in the pursuit of life, but we have tried to frame a law which would give some measure of protection to the average citizen and to his family against the loss of a job and against poverty-stricken old age." Broadly speaking, the SSA intended to support the aging population who took the greatest hit, financially and emotionally, during and following the Great Depression. Franklin D. Roosevelt, "FDR Social Security Act Speech," SSA video, 1:55, posted by Internet Archive, https://archive.org/details/fdrbig (Accessed September 2022).

[8] David Rothman, *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America* (Boston: Little Brown & Co., 1980), 349.

attention at the start of the twentieth century when German neurologist Alois Alzheimer examined a 51-year-old woman named Auguste Deter.[9] Deter's condition soon became known as "Alzheimer's disease." Following her death in 1906, Alzheimer autopsied her brain and published a paper claiming to have found "tangles and plaques."[10] While documented as a case of "presenile" dementia, Alzheimer's findings sparked psychiatrists' and neurologists' decades-long quest to determine the biological basis for senile psychoses. However, the biological framework researchers banked on did not hold up when employed by Massachusetts psychiatrist David Rothschild. Rothschild, formerly a proponent of anchoring medical theory to biology, abandoned his colleagues when tasked with caring for a patient whose symptoms did not align with the pathological details previously proposed by Alzheimer.[11] This quandary led Rothschild to develop a new theory: there were both pathological *and* sociological factors influencing dementia patients.[12]

While Rothschild received much criticism for this theory, he simultaneously caught the attention of others in the field. Winfred Overholser, who became the president of the American Psychiatric Association (APA) in 1947, picked up on Rothschild's work and used it to better support the aging population. Overholser served as the Massachusetts State Commissioner of Mental Diseases until ousted by Governor James Curley in 1937.[13] Just six months later, Overholser was appointed to the National Committee for Mental Hygiene, serving as research director, and eventually superintendent of St. Elizabeths Hospital, a federal institution for the

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[9] Margaret Lock, *The Alzheimer Conundrum: Entanglements of Dementia and Aging* (Princeton: Princeton University Press, 2013), 31–36.
[10] Alois Alzheimer, "Über eine eigenartige Erkrankung der Hirnrinde," *Allg Z Psychiat* 64 (1907): 146.
[11] David Rothschild and Konstantin Lowenberg, "Alzheimer's Disease: Its Occurrence on the Basis of a Variety of Etiologic Factors," *American Journal of Psychiatry* 11 (1931): 269, https://doi.org/10.1176/ajp.88.2.269.
[12] "New Interests Held Way to Escape from Senility," *The Hartford Courant*, June 12, 1936.
[13] "Report Dr. Thuot to be Appointed: Would Take Commissioner Overholser's Place," *Daily Boston Globe*, July 11, 1936.

mentally ill.[14] In these positions, Overholser took what he believed to be important for the well-being of his patients and employees to the political stage.

What catalyzed such a monumental change in the theory surrounding senile psychoses by Rothschild, and how did his theory go on to serve as a basis for health care reform between 1935 and the latter half of the 1950s? To answer these questions, I lean on medical historian Charles Rosenberg's description of psychiatry's "crisis of legitimacy."[15] Desperate to "legitimize" themselves in order to keep up with other specialties of medicine, Rosenberg postulates that psychiatrists avoided recognition of the social determinants of disease in an effort to gain respectability.[16] Rosenberg also debated the biological and sociological constructions of disease, pointing out that "every aspect of an individual's identity is socially constructed—so also, is disease."[17] Early- and mid-twentieth-century researchers had established that social factors influenced health, but Rosenberg made a crucial distinction: "Disease is at once a biological event, a generation-specific repertoire of verbal constructs reflecting medicine's intellectual and institutional history, an occasion of and potential legitimation for public policy."[18] Overholser

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[14] "Overholser Made Research Director: Mental Hygiene Committee Puts Him On Staff," *Daily Boston Globe*, January 4, 1937; "Dr. Overholser Named to Head St. Elizabeths: Noted New England Psychiatrist Succeeds Late Dr. W.A. White," *The Washington Post*, September 22, 1937; The National Committee for Mental Hygiene, Inc., *Newsletter*, May 1937, Series III, Box 85, Folder 1341, C.E.A. Winslow Papers (MS 749), Manuscripts and Archives, Yale University Library, New Haven, CT [hereinafter referred to as Winslow Papers (MS 749)]. Note that "St Elizabeths" is spelled without an apostrophe throughout this essay, per the institution's official name. However, some newspapers often used "St. Elizabeth's."

[15] Since Rosenberg's piece, many other historians of medicine have provided insight on psychiatry's quest for legitimacy. For more on the history of psychiatry's quest to ground diseases solely in biology, see Anne Harrington, *Mind Fixers: Psychiatry's Troubled Search for the Biology of Mental Illness* (New York: W.W. Norton & Company, 2019).

[16] Charles Rosenberg, *Explaining Epidemics and Other Studies in the History of Medicine* (Cambridge: Cambridge University Press, 1992), 245.

[17] Charles Rosenberg, *Framing Disease: Studies in Cultural History* (New Brunswick: Rutgers University Press, 1992), xiv.

[18] Rosenberg, *Framing Disease*, xii; This is not to say the research of those like Faris and Dunham who identified a correlation between social stressors, namely poverty, and schizophrenia diagnoses in Chicago in the 1930s did not influence the national climate surrounding mental illness, but rather this thesis works to underscore the age group specific study between senile psychoses and social factors that Rothschild and colleagues mapped. Read more on this in R.E.L Faris and H. Warren Dunham, *Mental Disorders in Urban Areas: An Ecological Study of Schizophrenia and Other Psychoses* (Chicago: University of Chicago Press, 1939). For a historical account of this

and Rothschild, in different ways, employed their recognition of the sociological to better define a disease class—senile dementias. Their efforts aided policy growth and change to the medical system.

Using Rosenberg's frameworks on the importance of psychiatry's legitimacy and frameworks for disease, I argue that psychiatrists David Rothschild and Winfred Overholser abandoned their field's signature focus on the biological and highlighted the social factors of aging that influenced senile dementia etiology as a way of fulfilling their medical responsibility. Building on Rothschild's psychosocial theory, Overholser spoke out in the fight for health care reform, which eventually led to Lyndon B. Johnson's signing of Medicare and Medicaid into law on July 30, 1965.[19] The fight for legislation that supported the health and well-being of the elderly was not effortless. Overholser and social welfare activists faced opposition, forcing them to change their tactics and advocate for greater appropriations for state hospitals to increase personnel and space and improve overall care of the elderly.[20] While Overholser and Rothschild persistently acknowledged the social factors that influenced senile psychoses, they nevertheless simultaneously disregarded and inculpated aging women and people of color.

While secondary literature such as historian Jesse Ballenger's book *Self, Senility, and Alzheimer's Disease in Modern America* traces the emergence of senility and Alzheimer's disease and records how policy changes affected the public's view of the disease, my thesis seeks

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research, refer to Matthew Smith, T*he First Resort: The History of Social Psychiatry in the United States* (New York: Columbia University Press, 2023), 16–105.

[19] Typescript of H.R. 6675, "Social Security Amendments of 1965," Series III, Box 26, Folder 108, Herman Miles Somers Papers, Manuscripts and Archives, Yale University Library, New Haven, CT [hereinafter referred to as Somers Papers (MS 1238)].

[20] Overholser specifically advocated for increased funds to support the establishment of more geriatric facilities, as well as medical personnel to staff such facilities. The federal government, however, largely opposed increasing monies to support care for the elderly in their homes and in their communities. If Overholser could not guarantee that patients would be taken care of properly in their communities or homes, he at least wanted to ensure proper supervision and space was available to meet the needs of the growing number of elderly patients in state and federal mental hospitals.

to identify a different relationship.[21] This essay chronicles how Winfred Overholser sought to fulfill his medical responsibility: he adopted Rothschild's widely criticized psychosocial theory behind senile dementia and brought it to the political stage. I trace Overholser's career, focusing on the ways he used his clinical experience and Rothschild's theory to advocate for changes to American Social Security and the federal government's appropriation of funds for elderly health care. Reviewing reports from the United States Public Health Service, Social Security revisions and amendment hearings, and hearings before the appropriations sub-committee for the Department of Health, Education, and Welfare, this essay uncovers the dependence of health care reform on psychiatrists, their colleagues, and their patients. In my review of the secondary literature, no historians have articulated such a relationship between the development of the psychosocial theory and its application to health care policy.

First, I describe the details of psychiatry's initial pathological focus on senile psychoses and the political climate surrounding the aging population, specifically the exclusion of the elderly from the insurance market and society's stigma towards the population. I then recount Rothschild's construction of the psychosocial theory for senile dementia and analyze Overholser's attention to the aged, his use of Rothschild's theory, and various rhetorical strategies to initiate health care policy reform. Finally, I draw attention to the marginalized and forgotten groups within the aging population itself: women and people of color. Such populations, despite policy adjustments and the social model for constructing disease, were perpetually neglected and blamed for their actions and conditions on the basis of their intersecting identities. The story I tell is a political story—one of persistent health and health care disparities resulting from a system in need of reform.

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[21] Jesse F. Ballenger, *Self, Senility, and Alzheimer's Disease in Modern America: A History* (Baltimore: Johns Hopkins University Press, 2010), 3-11.

PART I: HISTORICAL CONTEXTS

Detangling Narratives of the Mind: The Biological Underpinnings in Need of Reassessment

This story begins with a loop. Rather, compounding loops that form a tangled mess. In fact, the real 'mess' that physicians and society faced at the start of the 20th century was an aging population that would soon need more support than ever. The diagnosis of "Alzheimer's disease" emerged from the decade-long study of Auguste Deter.[22] Following her death, Alois Alzheimer autopsied her brain and posited that the protein deposits he observed caused Deter's progressive cognitive impairment, hallucinations, and social incompetence.[23] After a decade of clinical exposure and closely analyzing Alzheimer's publications, David Rothschild and colleagues contested Alzheimer's theory.[24] They argued that the pathological and observed symptoms Alzheimer reported did not align with many of their cases. Rothschild and colleagues concluded that there were no distinct differences between Alzheimer's disease and senile dementia—the symptoms reported as unique to Alzheimer's disease were just as common in other neurological and psychiatric disorders.[25]

Alzheimer's discovery prompted medical awareness of mental disorders affecting the elderly population. In 1909, a Chicago nurse named Jessie Breeze published an informational article that addressed the nursing needs of the elderly. Mental disorders of the aged often took on the definition of "retarded," but Breeze reiterated that "as people grow old they need to be gently guided in ways of living that will prevent too rapid changes."[26] Furthermore, Breeze stressed the importance of suitable living conditions for the aged, requesting that their rooms be "as light and

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[22] Lock, *The Alzheimer Conundrum: Entanglements of Dementia and Aging*, 31.
[23] Peter J. Whitehouse, Konrad Maurer, and Jesse F. Ballenger, *Concepts of Alzheimer's Disease: Biological, Clinical, and Cultural Perspectives* (Baltimore: Johns Hopkins University Press, 2003), 8–23.
[24] Rothschild and Lowenberg, "Alzheimer's Disease," 269.
[25] Rothschild and Lowenberg, "Alzheimer's Disease," 269-271.
[26] Jesse Breeze, "The Care of the Aged," *The American Journal of Nursing* 9, no. 11 (1909): 826–827.

sunny as possible."[27] Unfortunately, such a luxury was not possible for all elderly patients. Between the late 1800s and early 1920s, government welfare officials sequestered most low-income elderly people in "socially undesirable" almshouses.[28] The majority of almshouses, however, shut down during the Great Depression.[29] Consequently, welfare officials and family members transferred the elderly populations inhabiting these almshouses to state mental hospitals.[30] Medical professionals encountered an influx of elderly patients at the start of the 1930s as a direct result of ignorance to the social factors influencing mental disease.

An "Enormous Burden": Attitudes Towards the Aged in the First Half of the 20th Century[31]

What if growing old *was* graceful and not seen as a burden on society? Rebecca B., 39, of Boston, worried about growing old. She worried so much that she brought her worries to Dr. George Crane, psychologist and columnist for *The Boston Globe.*[32] That February 1939, Rebecca signed, sealed, and sent off her question to Dr. Crane, one that many Americans had: "Are there any rules that you can give for safeguarding one's self against a narrow, introvertive old age? If so, please let me have them."[33] Why were so many Americans, like Rebecca, fearful of growing

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[27] Breeze, "The Care for the Aged," 827.
[28] Geri Hall and Kathleen Buckwalter, "From Almshouse to Dedicated Unit: Care for the Institutionalized Elderly with Behavioral Problems," *Archives of Psychiatric Nursing* 4, no. 1 (February 1990): 3–11.
[29] Douglas Milford, "Almshouses," in *The Social History of the American Family: An Encyclopedia*, rev., ed. Marilyn Coleman and Lawrence Ganong (Thousand Oaks: SAGE Publications, 2014), 58; U.S. Department of Labor, *Homes for Aged in the United States*, 1941, 1–2, https://www.google.com/books/edition/Homes_for_Aged_in_the_United_States/tg1XKLvIdpUC?hl=en&gbpv=0&kptab=overview (Accessed November 2022).
[30] Milford, "Almshouses," 58.
[31] U.S. Committee on Economic Security, *Old Age Security in the Economic Security Program* (Washington, D.C.: U.S. Government Printing Office, 1935), 1–5, https://www.google.com/books/edition/Old_Age_Security_in_the_Economic_Securit/beBIAQAAMAAJ?hl=en&gbpv=0 (Accessed October 2022).
[32] George W. Crane, "Case Records of a Psychologist: Growing Old Gracefully," *Daily Boston Globe*, February 22, 1937. Newspaper columns like Crane's were common from the '20s through the '40s—especially for discussions of old age. The public took to newspapers and magazines to ask questions and receive advice on how to "combat" old age. See Mary Jane Burton, "How Far Are You From Insanity?" *Los Angeles Times*, May 21, 1933; Dorothy Dix, "Welcome Old Age As a Friend," *Boston Daily Globe*, May 25, 1925; "Old Folks Adrift: The Aged—Millions of Them—Pose A Grim, Growing Problem," *Kiplinger Magazine; the Changing Times (Pre-1986)* 1, no. 6 (June 1947): 12, https://www.proquest.com/trade-journals/old-folks-adrift/docview/201688514/se-2.
[33] Crane, "Case Records of a Psychologist: Growing Old Gracefully."

old? In a society where the federal government described the elderly as "an enormous burden," Americans had every reason to want to avoid old age and the ostracism that came with it.[34]

Despite the passing of the SSA, which aimed to provide federal benefits to "reduce old-age dependency in the future," the benefits failed to support a modest American life—to cover food, shelter, and basic health care needs.[35] Younger individuals like Rebecca worried about the consequences that came with old age; however, the elderly were already facing them.[36] With no help at the local level, elderly individuals turned their attention to Washington. President

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[34] U.S. Committee on Economic Security, *Old Age Security in the Economic Security Program,* 2; U.S. Congress, Senate, Committee on Labor and Public Welfare, *Studies of the Aged and Aging,* by James E. Murray, and Wilbur J. Cohen (Washington, D.C.: November 1956), 45–100, https://www.google.com/books/edition/Studies_of_the_Aged_and_Aging/82BKvWxyRl0C?hl=en&gbpv=0 (Accessed December 2022). State Hospital admissions data did not help the elderly in how they were viewed by the American public. Of the 109,059 patients admitted to state hospitals for "mental disease" in 1942, 18,558 of them were over the age of 65. Those diagnosed with "senile psychosis" made up over 20% of the 65+ population. With barely enough funds to support their families, the elderly who needed mental health care could not afford private mental health care nor could their children afford to take off work to care for them at home. The elderly, already experiencing significant changes that affected their mental state, now were to be sent to a state mental hospital to receive inadequate care. For some, significant mental health treatment was required, but for others, the state hospital was simply a place for receiving the basic needs that old age insurance and pensions did not cover. Therefore, concerns like the ones Rebecca expressed were not ruled unreasonable. At the same time, the concerns she voiced should have raised more eyebrows than they initially did.

[35] U.S. Social Security Board, *A Brief Explanation of the Social Security Act: Informational Service Circular*, No. 1. by Arthur J. Altmeyer and Vincent M. Miles (Washington, D.C.: U.S. Government Printing Office, 1936), https://www.google.com/books/edition/Informational_Service_Circular/ExpPAQAAMAAJ?hl=en&gbpv=0 (Accessed September 2022). An alternative to federal old age benefits was private insurance. Individuals had to be members of the active workforce to qualify for private health insurance plans—elderly persons were not in this category. The population with the greatest need for health care coverage (the elderly) was thus stranded on a deserted island. With the passing of the 1935 Social Security Act, an American who was gainfully employed prior to retirement and was over the age of 65 could receive anywhere between $10 and $85 per month. Such a monthly payment, however, was intended to cover the individual and his or her family's basic needs such as shelter, food, and clothing—not health services, the priciest expense of them all.

[36] Among the consequences of old age was the inaccessibility to private health insurance plans. In 1933, the Committee on Hospital Service developed a pre-payment framework for medical care in hospitals across the United States, but physicians quickly opposed these plans. Dr. Morris Fishbein, then-editor of the Journal of the American Medical Association, issued a statement in 1932 citing that voluntary (private) insurance systems were "giving rise to all the evils inherent in contract practice" and that they insinuated "solicitation of patients, destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the profession." The medical profession was opposed to the fact that the Blue Cross plans added a third-party contractor to the relationship. Fishbein's statement did not change the fact that hundreds of thousands of Americans relied on private insurance plans to receive medical care, let alone afford it. For more on this, read Robert M. Cunningham, *The Blues: A History of the Blue Cross and Blue Shield System* (United States: Northern Illinois University Press, 1997). Because of the government's oversight of health care reform they became complicit in the exclusionary mechanisms embodied by American health care (or lack thereof) in the 1930s. "Medical Group Urges Federal Help for Sick: Roosevelt Told Third to Half of People Can't Afford Doctors," *The Washington Post,* February 27, 1938.

Roosevelt and his wife, Eleanor Roosevelt, received letters from elderly citizens across the country almost daily.[37] One woman from South Carolina wrote to FDR, "Dear President. I am 72 years old and have no one to take care of me."[38] Another woman expressed similar sentiments: "I am greatly in need of medical aid and food and fuel…sick and too old to work. I am 70 years old; came to South Dakota fifty-five years ago; went through all the hardships of making the country what it is today."[39] Bereft of more comprehensive options to support a modest lifestyle, the SSA seemed like a good deal for Americans. Still, bureaucratic obstacles prevented many elderly persons from receiving assistance. Even then, the funds received depended on the individual's state of residence.[40] Many elderly individuals misunderstood the difference between old age assistance and old age insurance.[41] While old age assistance was a "public" pool of money, old age insurance was a guaranteed "right."[42] Such distinctions limited who qualified for which benefits, further illustrating the U.S. government's reluctance to address the needs of the aged.

PART II: AWAY FROM BIOLOGY, TOWARDS SOCIALIZED MEDICINE

Rothschild Speaks Out: Questioning Prior Findings to Land on a Psychosocial Model

"The mental deterioration of old age is partly due to changes in the brain," psychiatrist David Rothschild shared with *The Hartford Courant* in June 1936. Rothschild framed "senility"

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[37] R.L. Duffus, "Old Age," *The New York Times,* December 17, 1939.
[38] R.L. Duffus, "Old Age."
[39] R.L. Duffus, "Old Age."
[40] To receive old age assistance, individuals needed to prove they were needy enough to receive the money. To receive old age insurance benefits, individuals needed to have worked in some job with a federal insurance plan prior to the age of 65. Given the politics of the first half of the 20th century, many women were not likely to receive their own old age insurance benefits; approximately 30% of the workforce was composed of married and single white women ages 25 to 44 in 1930. As a result, the amount of money elderly individuals received depended on the wealth of their state, marital status, and gender. Married women over the age of 55 would receive half of the amount that their husbands received; extra if they had young children, but the average amount a male would receive hovered between $22 and $24 a month between the years of 1940 and 1943. Read more on this in Claudia Goldin, "The Quiet Revolution That Transformed Women's Employment, Education, and Family," *American Economic Review* 96, no. 2 (2006): 1–21, https://doi.org/10.1257/000282806777212350.
[41] R.L. Duffus, "Old Age."
[42] R.L. Duffus, "Old Age."

as the "difficulty people have in adjusting to the changes in their lives."[43] He further noted that retirement and "loss of friends and relatives and physical infirmities and weakness" exacerbated one's feelings of isolation and uselessness.[44] The "escape" from senility was possible for some, but not for all. Magnified by the Depression, trying times became "too much to cope with," leading elderly persons to "develop the senile mental disease."[45]

Rothschild pioneered the psychodynamic model of senile dementia despite many disagreeing with his theory.[46] Based in Massachusetts, Rothschild served as research director at Foxborough State Hospital from 1927 until 1941 and then as clinical director at Worcester State Hospital from 1946 to 1956.[47] Earlier in his career, Rothschild's research focused on conditions such as encephalitis and broader topics in neuropsychiatry.[48] At the start of the 1930s, Rothschild found a new calling: the elderly. Consciously aware of his unorthodox approach, Rothschild treaded carefully as he presented his psychosocial model for the diagnosis of senile dementia. He was, however, working in a state that had long fought for humane treatment of the "mentally ill."[49] Nevertheless, leaders advocating for the treatment of the mentally ill disregarded the elderly. Rothschild could no longer deny his clinical exposures, so he pushed forward despite criticism—was it his responsibility?

Respected for his training in both clinical care and pathological research, Rothschild applied his clinical experience to his biological research.[50] Rothschild spent most of his career

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[43] "New Interests Held Way To Escape from Senility."
[44] "New Interests Held Way To Escape from Senility."
[45] "New Interests Held Way To Escape from Senility."
[46] Ballenger, *Self, Senility, and Alzheimer's Disease*, 47.
[47] Ballenger, *Self, Senility, and Alzheimer's Disease*, 47.
[48] David Rothschild, "Xanthochromia in Epidemic Encephalitis," *Archives of Neurology & Psychiatry* 15, no. 3 (1926): 365, https://doi.org/10.1001/archneurpsyc.1926.02200210086008.
[49] Richard Hogarty, "Downsizing the Massachusetts Mental Health System: The Politics of Evasion," *New England Journal of Public Policy* 12, no. 1 (1996): 11.
[50] The Commonwealth of Massachusetts, Department of Mental Diseases, *Annual Report of the Trustees of the Foxborough State Hospital*, no. 47 (Massachusetts, Department of Mental Diseases, 1937), 37–38, http://archives.lib.state.ma.us/handle/2452/784468 (Accessed October 2022).

studying lobotomies, schizophrenia, and various senile psychoses. As Rothschild's career progressed, his research and writings on senile psychoses moved further away from the solely biological approach and toward acknowledging how social factors contributed to the biological phenomena seen by contemporaries.

Rothschild published his first article that questioned the biological basis for senile psychosis in 1931. In this piece, Rothschild leaned on a recent case where the patient demonstrated "gradual dementia" throughout childhood, followed by "restlessness and excitement" during his psychoses of later life.[51] Rothschild and his colleague Konstantin Lowenberg contended that such findings highlighted the importance of reconsidering the etiology of senile psychoses. Based on a review of the literature, Rothschild and Lowenberg contended that a "good deal of additional evidence" suggested that senile dementia, Alzheimer's disease, and cerebral arteriosclerosis represented a "heterogeneous group," the "individual members" of which were caused by varying "etiologic agents."[52] The work presented by Lowenberg and Rothschild, however, remained close to the biological precedent in an effort to maintain psychiatric legitimacy. The authors drew on patient cases for their analysis, but largely emphasized histologic images displaying "senile plaques" and solely physical descriptions with no concern for patients' mental states.[53]

With the confirmation of variation in the clinical and pathologic symptoms presented amongst patients with senile psychoses, Rothschild sought to explain what caused the variation. In a later study, Rothschild and co-author James Kasanin considered both the biological and sociological. Emphasizing their clinical experiences with patients, the two pointed out that "approximately 4 percent" of the cases they witnessed at Foxborough State Hospital "proved to

[51] Lowenberg and Rothschild, "Alzheimer's Disease," 269.
[52] Lowenberg and Rothschild, "Alzheimer's Disease," 270.
[53] Lowenberg and Rothschild, "Alzheimer's Disease," 275–279.

be instances of Alzheimer's disease."[54] By contrast, on a national level, "only one case was recorded" between 1916 and 1928.[55] As such, Rothschild and Kasanin identified a clear discrepancy in the rates of Alzheimer's diagnoses nationally versus at the local level. The two went on to note, however, that Alzheimer's disease and senile dementia did not operate independently, and thus, "anything that throws light on the nature and origin of Alzheimer's disease should contribute to the knowledge of senile dementia."[56] While still clearly defining the pathological characteristics, this 1936 paper spent far less time than Rothschild's previous publication debating disease pathology, and instead dove into a case comparison.

In this case comparison, Rothschild and Kasanin provided a psychoanalytic summary of the cases, describing the patient's basic identifying information (gender, age, physical appearance) and general symptoms.[57] However, unlike Rothschild's previous study, the case comparisons included rich histories of each patient, detailing personal information such as marital status, familial relationships, location and length of employment, and time of symptom onset.[58] With greater investigation into patient cases and disease progression, Rothschild's research tackled not only the biological aspects of the disease but, perhaps more importantly, the social factors. Compared to contemporaries—specifically, those who studied senile dementias of varying forms such as Armando Ferraro and Arrigo Frigerio—Rothschild clearly defined the social and cultural mechanisms from which senile psychoses developed.[59] Researchers like

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[54] David Rothschild and James Kasanin, "Clinicopathologic Study of Alzheimer's Disease: Relationship to Senile Conditions," *Archives of Psychiatry and Neurology* 36 (1936): 293, doi:10.1001/archneurpsyc.1936.02260080065004.
[55] Rothschild and Kasanin, "Clinicopathologic Study of Alzheimer's Disease," 293.
[56] Rothschild and Kasanin, "Clinicopathologic Study of Alzheimer's Disease," 293.
[57] Rothschild and Kasanin, "Clinicopathologic Study of Alzheimer's Disease," 295–315.
[58] Rothschild and Kasanin, "Clinicopathologic Study of Alzheimer's Disease," 295–315.
[59] Armando Ferraro, "The Origin and Formation of Senile Plaques," *Archives of Neurology and Psychiatry* 25 (1931): 1042-1062, doi:10.1001/archneurpsyc.1931.02230050118006; Arrigo Frigerio, "Pathologic Anatomy of the Senile Psychoses," *Archives of Neurology and Psychiatry* 13 (1925): 284-285, doi:10.1001/archneurpsyc.1925.02200080131011.

Ferraro and Frigerio published research on the exact same diseases but persistently fell short of acknowledging their psychosomatic manifestations. Rothschild's certainty of how a patient's social history influenced disease etiology only increased in the years to come, despite extensive criticisms from others in the field.[60]

"Practical Values": Social and Economic Conditions of Care[61]

Despite the influence that Freudian psychoanalysis exerted on the field of psychiatry from 1917 until the mid-20th century, most psychiatrists concerned with diseases of the aged turned a blind eye to Freud's system of thought.[62] Up until this point, Rothschild's research cultivated a novel approach to the diagnosis of senile dementia, but his framework remained close to the biological underpinnings of the disease. However, between Rothschild's 1936 publication and 1947, the rise of social psychiatry, developed from tenets of Freudian psychoanalysis, prompted recognition of psychiatry's importance in supporting the American

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[60] Following his 1936 piece, Rothschild received numerous responses from British researchers criticizing his proposal of psychosocial criteria for diagnosing senile psychoses. In 1940, William McMenemey of Oxford presented a similar piece to that of Rothschild and Kasanin's titled "Alzheimer's Disease: A Report of Six Cases." While McMenemey, too, portrayed Alzheimer's disease and senile dementia as parallel diagnoses, he disagreed with Rothschild and Kasanin in claiming that patients must be diagnosed on their own "merits." In this way, he tangentially agreed with the psychosocial model, as defining cases on their own merits would hint at the idea that different cases are caused by different exposures—psychosocial or not. This thought process, however, was inconceivable for British psychiatrists, and thus, McMenemey went on to criticize Kasanin and Rothschild's model, declaring that "until more is known about the disease, the histological picture rather than the symptomatology should be the ultimate proof of diagnosis and should serve in any scheme of arriving at classification." In this way, McMenemey argued that the socially determined expression of the disease (symptoms) must not be acknowledged, only what can be biologically seen through histological samples. This also meant that patients complaining of symptoms of the disease would often be written off until their death. McMenemey was relentless, publishing another piece that contested Rothschild's model, this time titling his piece "A critical review – dementia in middle age." McMenemey was just one of many psychiatrists, primarily from Great Britain, who strongly disagreed with Rothschild. See William H. McMenemey, ''Alzheimer's Disease: A Report of Six Cases,'' *Journal of Neurology and Psychiatry* 3, no. 3 (1940): 236. McMenemey's papers were two of eight papers published between 1936 and 1947 that cited Rothschild in their work that aimed to overshadow his psychosocial model. Citations discovered using the Web of Science tool.

[61] David Rothschild, "The Practical Values of Research in the Psychoses of Later Life," *Diseases of the Nervous System; A Practical Journal on Psychiatry and Neurology* VIII, no. 4 (April 1947): 123.

[62] Nathan G. Hale, *The Rise and Crisis of Psychoanalysis in the United States: Freud and the Americans*, *1917-1985* (New York: Oxford University Press, 1995), 3-7. For more on Freud's influence on the social psychiatry movement, see Elizabeth Ann Danto, *Freud's Free Clinics: Psychoanalysis & Social Justice, 1918-1938* (New York: Columbia University Press, 2005) and Daniel Jose Gaztambide, *A People's History of Psychoanalysis: From Freud to Liberation Psychology* (New York: Lexington Books, 2019).

public. In July 1946, President Harry S. Truman signed the National Mental Health Act that called for the establishment of the National Institute of Mental Health.[63] For the first time in the history of the United States, the psychiatric well-being of American citizens garnered political attention. This political attention to mental health compelled Rothschild to move forward, on his own, and publish one of the most controversial pieces of his career; he titled it "The Practical Value of Research in the Psychoses of Later Life."[64]

What was Rothschild's proposed "practical value"? For Lawrence Kolb, then-assistant surgeon general to the United States Public Health Service, the crux was that the number of elderly admissions to state hospitals would only continue to increase unless changes were made.[65] The practical value that Rothschild saw was similar: assessing patient cases with social factors in mind would inform intervention and policy change benefitting the elderly. Similar to his two previous articles, Rothschild adhered to his traditional scientific approach in presenting three different patient cases. However, in summarizing the cases, Rothschild chose not to present the disease pathology and instead focused solely on the patient's identifying information and social history. Rothschild's call to action was simple:

> Experiences of this type reveal the need for a broad program of mental hygiene for the older population groups, perhaps analogous to the program of prevention and early treatment provided for younger persons, but designed to deal with the special problems of aging. Its establishment would not be a simple task, but in my opinion, such a program would amply repay us by diminishing, and perhaps, ultimately reversing the rising trends for the psychoses of later life.[66]

Rothschild presented the problem, why readers should care, and examined three different cases

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[63] Gerald N. Grob, "Government and Mental Health Policy: A Structural Analysis," *The Milbank Quarterly* 72, no. 3 (1994): 480, https://doi.org/10.2307/3350267.
[64] Rothschild, "The Practical Values of Research in the Psychoses of Later Life," 123–28. Rothschild published this piece in the *Diseases of the Nervous System* journal which was a new journal founded in 1940. This choice was likely a reflection of his fears of public contention. Publishing in a newer journal would lessen the attention that the piece would accumulate. See Titus H. Harris, "Editorial Comment," *Diseases of the Nervous System* 1, no. 1 (1940): 3–4, https://archive.org/details/sim_journal-of-clinical-psychiatry_1940-01_1_1/mode/2up.
[65] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 6–21.
[66] Rothschild, "The Practical Value of Research in the Psychoses of Later Life," 125.

of senile dementia. While Rothschild recognized the pathobiological factors of each case, this piece focused more on the symptoms, thoughts, feelings, and personal histories of the patients.[67]

How did the patient's social and familial relationships inform the development of their symptoms? First, Rothschild delineated one patient's admission to Worcester State Hospital, the length of her symptoms, and suitable treatment mechanisms.[68] After a brief overview, he quickly transitioned the reader's attention; Rothschild declared, "But let us glance for a moment at the patient's history."[69] This statement, perhaps, is the most progressive proposition of the piece. Not only did Rothschild call attention to the patient's history, but he specifically spotlighted the patient's social history. Unlike a typical Freudian case history, Rothschild explored characterizing information that went beyond the individual and dissected their social relations with others. Most importantly, he uncovered that the patient was in good health until the death of her husband. Thus, if a psychiatrist had intervened sooner and provided the patient with treatment at the time of such social changes, they could have mitigated many of the patient's reported symptoms.[70] Furthermore, Rothschild recounted the mental hygiene movement within

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[67] Rothschild's psychosocial model for understanding mental health problems (senile dementia) of the aged urged the consideration of social factors. His model was picked up by sociologists Belknap and Friedsam who confirmed his model. See Ivan Belknap and Hiram J. Friedsam, "Age and Sex Categories as Sociological Variables in the Mental Disorders of Later Maturity," *American Sociological Review* 14, no. 3 (1949): 367–76, https://doi.org/10.2307/2086884. The authors critique psychiatrists and neurologists who came before (and after) Rothschild who rooted senile psychoses solely in biological "damage" to the brain. The two commended Rothschild for his work and went on to explain their own study. In conclusion, which supports my chapter on gender, while Overholser's model was beneficial in many ways, it perpetuated the gender stigma surrounding mental disease. The authors claim that for men, mental health problems can be influenced by a change in their social lives while for women development is influenced by a change in their familial role (i.e. care for the children). However, for upper-class white women, sociologists say the familial role never exists so cases must be considered differently.

[68] Rothschild, "The Practical Value of Research in the Psychoses of Later Life," 125.

[69] Rothschild, "The Practical Value of Research in the Psychoses of Later Life," 125.

[70] The social determinants and stressors that Rothschild uncovered played a critical role in the mental health diagnoses of older patients. In the second half of the 20th century, researchers Holmes and Rahe defined the "social readjustment rating scale," which was influenced by their 1967 study. In the study, Holmes and Rahe looked at the magnitude of typical life events in terms of stress, or "psychological illness," as rated by study participants. What they found was that death of a spouse was unanimously voted as the most stressful social event that man encounters. Also in their list of the top stress-inducing events were retirement and change in financial state—both social determinants of various forms of senile psychosis, as proposed by Rothschild and Overholser. Read more on this study in Thomas H. Holmes and Richard H. Rahe, "The Social Readjustment Rating Scale," *Journal of Psychosomatic Research* 11, no. 2 (1967): 213–218.

the pediatric population, informing readers that a similar model should be employed for the prevention and early treatment of senile dementia(s) among the aged.[71] Here, Rothschild acknowledged that political officials had already recognized the importance of social factors in bettering the mental health of young people, but they were yet to apply it to the elderly—a 'problem' population bound to only get worse.

As Rothschild presented his three sample cases, it became clear that his work as both a researcher and clinical provider had done him a service. Many of the psychiatrists publishing work on senile psychoses occupied one side of the aisle, unable to fully understand the entire picture of the diagnosis because they did not have clinical exposure. Rothschild denounced other researchers who found that older individuals who were "normal mentally" had just as severe cerebral changes as those with senile dementia.[72] These other researchers declared that there was a misalignment in the symptoms reported and the pathological changes of the brain, but they stopped there to avoid the controversial territory of social factors. Rothschild, however, was fearless. He noted that "psychosocial factors might play a role" in the "origin" of "cerebral alterations."[73] With the ability to "do something about such factors" of "worry," "anxiety over failure of health," "financial hardship," and the "loss of relatives," Rothschild proposed reconsidering the approaches to caring for the aging patient, including early intervention and changes to treatment.[74]

For such early interventions and changes to treatment, however, psychiatrists needed support and funding from the government. Rothschild's call to action is where Dr. Winfred Overholser latched on. Consequently, Winfred Overholser, superintendent of St. Elizabeths

[71] Rothschild, "The Practical Value of Research in the Psychoses of Later Life," 125–126.
[72] Rothschild, "The Practical Value of Research in the Psychoses of Later Life," 124.
[73] Rothschild, "The Practical Value of Research in the Psychoses of Later Life," 124.
[74] Rothschild, "The Practical Value of Research in the Psychoses of Later Life," 124.

Hospital in D.C. and chairman of the Committee on Neuropsychiatry for the National Research Council, championed policy changes to old age pensions and health care coverage that supported the development of nursing homes.[75] One of Rothschild's proposed solutions was to create special units for the care of the mentally ill elderly, both in hospitals themselves and directly in communities.[76] This idea further engaged with the frameworks outlined by his psychosocial model—specifically, the processes of historical mapping and personability.

Rothschild, often discredited for his work, pulled away from his field and responsibly stated the facts of patient cases of senile dementia. Surely, Rothschild acknowledged the pathobiological components of the disease. Still, his findings and public criticism of his colleague's research galvanized the national recognition of mental health and the aging population as important political issues. Serving as the foot in the door for national mental health and general health insurance reform in the United States, the elderly also showcased the importance of considering the social factors that influenced health.[77]

PART III: BORDERING THE MEDICAL AND POLITICAL SPHERES

The Right Place at the Right Time: Winfred Overholser Takes Old Age to the Political Stage

When colleagues memorialized Winfred Overholser following his death in 1964, they described him as "one of America's foremost psychiatrists and a tireless champion of the

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[75] "Dr. Overholser Favors Home Care for the Aged," *The Washington Post*, January 16, 1941; U.S. Congress, Senate, Committee on Finance, *Social Security Revision: Hearings Before The Committee on Finance*, 18th Cong., 2nd sess. on H.R. 6000 (Washington, D.C.: U.S. Government Printing Office, 1950), 748–755; Winfred Overholser, "The Problems of Mental Diseases in the Aging Population," Proceedings, *National Conference of Social Work* (New York: Columbia University Press, 1941), 455–463.

[76] Rothschild, "The Practical Value of Research in the Psychoses of Later Life," 126.

[77] Rothschild's theory was anchored to the roots themselves—the social determinants of health. The task of caring for an elderly individual as well as the etiology of the mental disease itself was to be traced back to the environment, as well as the "family relationships" and "social and economic conditions" that the patient was exposed to. The family relationships between family members and mentally ill elderly persons that Rothschild spoke of were influenced by both the social and economic environments. There is no doubt that Overholser and Rothschild were on the same page. See Rothschild, "The Practical Value of Research in the Psychoses of Later Life," 125.

mentally ill."[78] Overholser began his career in Boston, Massachusetts, after completing his undergraduate degree at Harvard in 1912 and his medical studies at Boston University in 1916.[79] He gained experience in the medico-political world at both the state and federal levels. Serving as commissioner of the Massachusetts Department of Mental Disease from 1934 until 1937, Overholser fought for the fair treatment of the mentally ill, demanding that mentally ill individuals should not be held in hospitals "any longer than it is necessary."[80] He advocated for the "best interests of the patient."[81]

Although Overholser had a good reputation among colleagues and patients, James Curley, the governor of Massachusetts from 1935 until 1937, detested him. Beginning in 1935, a growing number of patients entering state hospitals were elderly (Fig. 1).[82] As a result, state hospital psychiatrists like David Rothschild found themselves desperate for more resources. To deliver more resources, however, Overholser needed to provide the state hospitals with more funds. In his previous political role as mayor of Boston, Governor Curley financially backed the state mental health system. At the 89th annual meeting of the APA in 1933, Curley went as far as to say that "whether insanity is curable is a matter of money."[83] As Rothschild's emerging psychosocial model indicated, cases of senile dementia were as much biological as sociological and psychological.[84] Given his thoughts on the relationship between money and mental health, Curley increased the funding available for research and care of the elderly. State mental hospital discharge rates slowly decreased, but admission rates rapidly rose in a fashion that could not be

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[78] Zigmond M. Lebensohn, "In Memoriam: Winfred Overholser (1892-1964)," *The American Journal of Psychiatry* 121, no. 8 (1965): 831-834.
[79] Marjorie Dent Candee, "Overholser, Winfred," in *Current Biography: Who's News and Why, 1953* (New York: H.W. Wilson Company, 1954), 466-467.
[80] "State More Eager To Get Patients Out," *The Boston Globe,* September 17, 1931.
[81] "State More Eager to Get Patients Out."
[82] "State Experts Discuss Old-Age Patient Increase," *The Boston Globe,* December 8, 1939.
[83] "Mayor Curley and Dr. May Among Speakers to American Psychiatric Association at Opening of 89th Annual Meeting Here," *The Boston Globe*, May 31, 1933.
[84] Rothschild and Lowenberg, "Alzheimer's Disease," 284.

offset. Adding insult to injury, Curley did not understand that the high rate of admissions directly reflected the state's inability to properly support the aging population. Therefore, when Overholser requested more funding for the state hospitals, Curley refused the request because he was not seeing an immediate decrease in cases.[85] By his logic, with increased funds, cases should have dropped immediately. Money for therapeutics and research alone, however, was not a silver bullet for decreasing the number of senile cases in state hospitals.

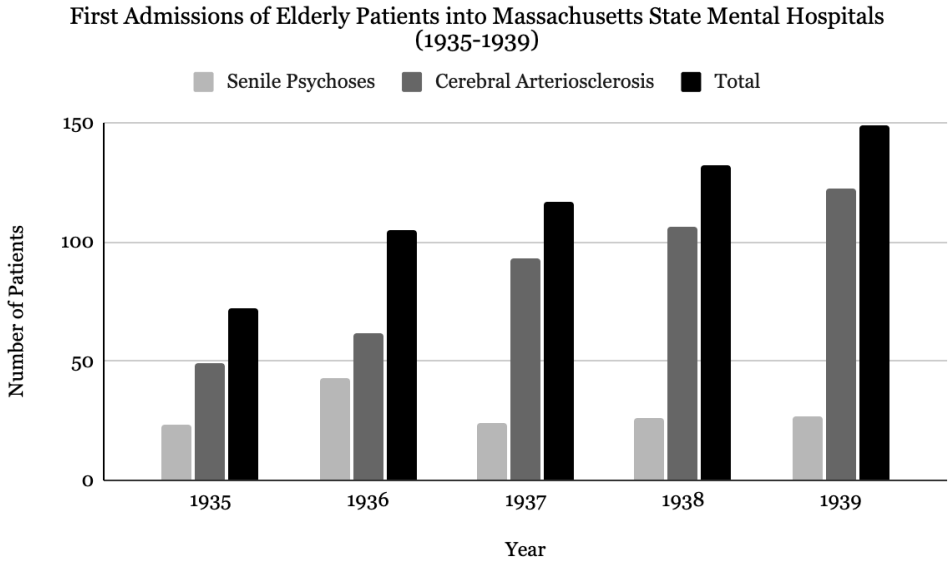

Figure 1. The growing number of elderly patients admitted for the first time to a Massachusetts State Hospital between the years 1935 and 1939. Both diagnoses of 'senile psychosis' and 'cerebral arteriosclerosis' are shown.[86]

Rather than accepting the social factors influencing senile psychoses, and thus acknowledging that money was not a panacea, Curley blamed Overholser for "mismanagement" of the Massachusetts Department of Mental Diseases.[87] Just four months later, in December

[85] "Overholser for Curley Fund Use: Proposes Governor Tap $100,000 for Hospitals," *The Daily Boston Globe*, July 29, 1936.
[86] Commonwealth of Massachusetts, Department of Mental Diseases, *Annual Report of the Commissioner of Mental Diseases*, 1935–1939 (Collection of Reports Courtesy of the University of Michigan). Data was organized, analyzed, and processed into a visual by the student author. Many thanks to Dr. Kylie Smith for her guidance in how to process and showcase psychiatric data of this variety.
[87] "Curley Points to Overholser Speech: State Unable to Care for Mental Cases Properly," *The Boston Globe*, March 10, 1936.

1936, Curley refused to renew Overholser's contract.[88] Strikingly, Curley's dislike of Overholser was unique. The psychiatric community extolled Overholser and his experience in both leadership and clinical roles; the Massachusetts Medical Society did everything in its power to block Curley from ousting him.[89] His commitment to patient needs and health care reform did not go unnoticed. A month after his dismissal, Clarence Hincks, director of the National Committee for Mental Hygiene, appointed Overholser as the committee's research director.[90] Announcing Overholser's appointment, Hincks stated, "We consider Dr. Overholser one of the best-qualified psychiatrists in the United States to undertake this important phase of our work."[91] Hincks proclaimed the committee was "happy to have such a leader participating in our program."[92] Thus, Hincks identified Overholser as capable of advocating for psychiatric patients and engaging with political officials.

Not only did Overholser's leadership receive praise from the National Committee on Mental Hygiene, but he also drew the attention of President Franklin D. Roosevelt and his cabinet. Presumed to be a "rap" at Curley, President Roosevelt suggested that Overholser be appointed superintendent of St. Elizabeths Hospital in Washington, D.C., a position under the Department of Health, Education, and Welfare.[93] On September 21, 1937, Secretary of the Interior Harold Ickes officially appointed Overholser to the position.[94]

Assuming the position of superintendent of St. Elizabeths on Monday, October 4, 1937,

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[88] "Dr. Williams Is Confirmed: Succeeds Overholser," *The Boston Globe,* December 10, 1936; "Council Blocks Curley Ouster of Overholser," *The Christian Science Monitor*, November 13, 1936.
[89] "Asks Retention of Overholser: Massachusetts Medical Society Acts," *The Boston Globe*, November 11, 1936.
[90] "Overholser Made Research Director: Mental Hygiene Committee Puts Him on Staff," *The Daily Boston Globe*, January 4, 1937.
[91] "Overholser Made Research Director."
[92] "Overholser Made Research Director."
[93] "Ex-Bay Stater Was 72: Dr. Winfred Overholser, Mental Health Pioneer," *The Boston Globe*, October 7, 1964.
[94] Harold Ickes to Winfred Overholser, 21 September 1937, MSS35287, Box 1, Folder 19, Winfred Overholser papers, 1911-1965, United States Library of Congress, Washington, D.C.

Overholser got right to work.[95] In his new politically facing role, Overholser drew on state hospital statistics and his own encounters with patients and hospital personnel to advocate for psychiatric provisions that lacked awareness. With growing recognition of the shortcomings of the 1935 SSA, Roosevelt's administration organized a National Health Conference in July 1938. At the conference, the Interdepartmental Committee to Coordinate Health and Welfare Activities debated the need for a national health program.[96] Two of the committee's five recommendations emphasized expanding health services and financial coverage for the mental health of the elderly. In recommendation I-A, the committee suggested expanding public health services under the SSA, specifically "mental hygiene" services aimed at reducing disability and premature mortality.[97] In recommendation III, the committee brought attention to the evidence that one-third of the low-income population received inadequate general medical services. Classifying low-income elderly persons as "doubly handicapped," the committee heightened the need for national health.[98] Following its recommendations, the committee presented the total annual costs for the eight programs they wished to expand. Of the total expenditures, the committee allocated the least funding for the "mental hygiene" program.[99]

Effective Transfers of Information: Denouncing Sources of "Stigma"[100]

An initial spur was needed to trigger the public's awareness of the aging mental health crisis that physicians like Overholser believed would soon grow out of proportion. In his first

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[95] Winfred Overholser to Harold Ickes, 28 September 1937, MSS35287, Box 1, Folder 10, Winfred Overholser papers, 1911-1065, United States Library of Congress, Washington, D.C.
[96] Interdepartmental Committee to Coordinate Health and Welfare Activities, "The Nation's Health," (Pamphlet), July 1938, Series III, Box 85, Folder 1359, Winslow Papers (MS 749)
[97] Typescript of the U.S. Interdepartmental Committee to Coordinate Health and Welfare Activities, *Proceedings of the National Health Conference*, July 18-20, 1938, 30–42, Series III, Box 58, Folder 1355, Winslow Papers (MS 749).
[98] Typescript of the U.S. Interdepartmental Committee to Coordinate Health and Welfare Activities, *Proceedings of the National Health Conference*, 31, Box 58, Folder 1355, Winslow Papers (MS 749).
[99] Typescript of the U.S. Interdepartmental Committee to Coordinate Health and Welfare Activities, *Proceedings of the National Health Conference*, 37, Box 58, Folder 1355, Winslow Papers (MS 749).
[100] Winfred Overholser, "Mental Disease–A Challenge," *The Scientific Monthly* 48, no. 3 (1939): 203–209.

public article as superintendent of St. Elizabeths, Overholser declared "mental disease" a "challenge."[101] Published in the layman's science publication *Scientific Monthly*, Overholser made it apparent to his readers that the national discussion on mental health affected everyone, not just those deemed mentally ill.[102] Overholser wrote that "mental disorder" merited "the attention of every intelligent citizen," given its status as one of the "most pressing social problems."[103] Most crucially, Overholser stressed "the medical, public health, social, and economic points of view."[104] Throughout this call-to-action piece, Overholser ensured that his readers were well-informed. Countering misinformation, he critically explained how discourse on mental disorder by physicians, policymakers, and citizens alike was stigmatizing. The labeling of a mentally disordered person only intensified this stigma and dehumanized the condition.[105] "Mind," he said, "is not a unit, but rather an abstraction which symbolizes the sum total of the reactions of the individual at the social level." Taking a page out of Rothschild's book, Overholser underscored the importance of a comprehensive model for diagnosing psychiatric illness. Capitalizing on Rothschild's initial findings and the profound national statistics, Overholser led the charge in mobilizing the American public in the fight for informed health care reform.

Coincidentally, the same March 1939 *Scientific Monthly* issue included a piece summarizing the recommendations made at the July 1938 National Health Conference and a radio address by Senator Robert F. Wagner following the event.[106] Senator Wagner spent the first two months of 1939 drafting the Wagner Health Bill—Senate Bill 1620—which put all of the

[101] Overholser, "Mental Disease–A Challenge," 203.
[102] Overholser, "Mental Disease–A Challenge," 203–204.
[103] Overholser, "Mental Disease–A Challenge," 203.
[104] Overholser, "Mental Disease," 203.
[105] Overholser, "Mental Disease," 203–204.
[106] "Progress of Science: The Proposed Public Health Program," *Scientific Monthly* 48, no. 3 (1939): 287–288.

conference's recommendations in conversation with one another.[107] The Wagner Health Bill, however, did not specifically address mental health care provisions, let alone the mental health of aging persons. The "mental hygiene" provisions that Wagner included in the bill—tucked under the Maternal and Child Health Program—aimed to address behavioral problems among children.[108] Overholser believed, however, that if the government created a national health program, it ought to include investment in mental hospitals and care for the mentally ill.[109] That said, simply investing in the mentally ill patient was not the secret ingredient to improving American health.

The American public, policymakers, and medical professionals needed to acknowledge the idea first proposed by Rothschild and reaffirmed by Overholser:

> Mental disorder represents a failure of the individual to adjust to his environment, but such adjustment depends on many things: it depends upon his heredity and the constitution with which he was born, on his training, on the functioning of his ductless glands, on the situation with which he is confronted, his education, his native endowment, and many other factors.[110]

Many policymakers and physicians attributed the increased number of elderly patients in mental hospitals to the lengthening of human life and falling birth rates, but Overholser had an additional explanation.[111] Overholser agreed with the population health theory, but also believed that, as with any case of mental illness, social and environmental factors played a large role. The elderly who made it through the Depression endured arduous stressors. The effects of the Depression compounded with the stress the elderly had experienced in the earlier parts of their

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[107] "Progress of Science," 287; Typescript of Wagner Health Bill S.1620 by Robert S. Wagner, 28 February 1939, Box 58, Folder 484, Isidore Sydney Falk Papers (MS 1039), Manuscripts and Archives, Yale University Library, New Haven, CT [hereinafter referred to as Falk Papers (MS 1039)].
[108] U.S. Congress, Senate, Committee on Education and Labor, *Hearings to Establish a National Health Program* (Washington, D.C.: U.S. Government Printing Office, 1939), 776; Typescript of *Congressional Record: Protection and Care of Public Health*, 28 February 1939, Series II, Box 59, Folder 493, Falk Papers (MS 1039).
[109] Overholser, "Mental Disease," 203.
[110] Overholser, "Mental Disease," 206.
[111] Overholser, "Mental Disease," 203.

lives made the population more susceptible to mental illness. Psychiatry attempted to quantify the cause of disease by attributing the increase in elderly patient admissions to the lengthening of human life and falling birth rates.[112] Overholser, however, apprehended that advocating for better mental health provisions did not imply that a strict biological or scientific grounding for diagnosis was necessary for psychiatric legitimacy.

Calling on his colleagues, Overholser clarified his feedback on the proposed national health program:

> Unfortunately, some states have been decidedly backward in their care of the mentally ill, have been niggardly in the appropriations cited, and have allowed partisan spoil politics to interfere with efficiency. It is to be hoped that the new interest in public health now being fostered by the Federal Government will bring about improvement in those states in which it is needed…Even the most vigorous opponents of "state medicine" have always admitted that the care of the mentally ill is a proper function of government.[113]

In educating and communicating directly with the public, Overholser hoped that Americans would become "more acutely aware of the true importance of mental disease in the community and of the needs of the hospitals administering to this group" and thereby bring these considerations to the polls.[114] The public could elect political officials who supported the establishment of a national health program. 1939 opened lengthy discussions on health concerns even after Senator Wagner's proposal failed in committee.

"Social Security Act Only A Start": Demanding Better Provisions for the Elderly

Published at a time of heated political discussion and criticism of the support for the elderly, Overholser's *Scientific Monthly* editorial corroborated his presence at the March 1939

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[112] Psychiatrists viewed quantifying disease as a way to legitimize their practice. For more on this subject, see Allan V. Horowitz, *DSM: A History of Psychiatry's Bible* (Baltimore: Johns Hopkins University Press, 2021); Allan V. Horowitz, *Creating Mental Illness* (Chicago: University of Chicago Press, 2002); Jacqueline Wernimont, *Numbered Lives: Life and Death in Quantum Media* (Cambridge: The MIT Press, 2019).
[113] Overholser, "Mental Disease," 209.
[114] Overholser, "Mental Disease," 210. The timing of Overholser's public statement was important. Franklin D. Roosevelt was up against a Republican challenger, Wendell Willkie, in the 1940 presidential election. Keeping a Democrat in office was crucial for launching the national health proposal further.

annual dinner for the D.C. Chapter of Chartered Life Underwriters, an organization of professionals with extensive knowledge of life insurance programs and support for the aging population.[115] Of the 184 who attended the dinner, only five were doctors, and Overholser was the only psychiatrist.[116] Morris Albert Linton, then-president of Provident Mutual Life Insurance and Senate-appointed member of the Social Security Advisory Council, was the dinner's keynote speaker. Speaking to an audience passionate about social and economic support for the aging population, Linton emphasized that "governmental arrangement of old-age security should be viewed as a program for social welfare rather than a Nationwide savings plan."[117] Although the SSA had been law for four years, members of the American Medical Association (AMA) strongly opposed efforts to establish a national health program, including the ideas debated at the 1938 National Health Conference.[118] Working within such confines, Linton called for a deliberate workaround, pleading, "An immediate necessity is that larger provisions be paid to workers now about to enter retirement."[119] In this statement, Linton asserted that if the federal government would not guarantee adequate financial support for the elderly post-retirement, then providing them with a lump sum of money prior to retirement was the next best alternative.

Six months after Linton backed economic support for the aging population, the United States unofficially entered World War II by supplying allies with military supplies. Witnessing

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[115] Overholser, "Mental Disease," 203-212.
[116] Thomas M. Cahill, "Security Act Only a Start, Linton Says: Larger Pensions Are Needed for Elderly Workers, He Declares," *The Washington Post*, March 10, 1939. Overholser being the only psychiatrist in the room at many "radical" federal welfare events was common. According to records of the Federal Security Agency from 1941, he was also the only physician, let alone psychiatrist serving on the Family Security Committee. In this role he and his colleagues recommended that due to the disparity throughout the country in the "adequacy and quality of general public assistance, including free medical care" federal leadership and assistance needed to be established. See Federal Security Agency, Paul V. McNutt, and Office of the Director of Defense, Health, and Welfare Services, *Brief in Support of Recommendation in Favor of a Category of General Public Assistance to Be Added to the Social Security Act* (Washington D.C.: Government Printing Office, 1941), 11-27.
[117] Cahill, "Security Act Only a Start."
[118] Typescript of National Health Conference Proceedings, Washington. D.C, July 18–20, 1938, "A National Health Program - Report of the Technical Committee on Medical Care," Box 167, Folder 2536, Falk Papers (MS 1039).
[119] Cahill, "Security Act Only a Start."

countries around them engrossed in vicious battle, government officials feared threats to the country's national security. In January 1941, FDR delivered his State of the Union Address, describing the "foundations of a healthy and strong democracy."[120] Avoiding explicit commentary on a national health program, Roosevelt outlined "four essential human freedoms" which he believed would satisfy Americans.[121] Of the four freedoms outlined, freedom three—speaking to economic plans that would "secure to every nation a healthy peacetime life for its inhabitants"—embodied the hopes of Linton, Wagner, and Overholser. To improve the social economy he suggested "bring[ing] more citizens under the coverage of old-age pensions and unemployment insurance" and "widen[ing] the opportunities for adequate medical care."[122]

With no knowledge of what was to come, Roosevelt's State of the Union Address primed the nation with plans necessary for winning the war. Following the attack on Pearl Harbor in December 1941, the number of draftees increased and consequently the number of those unemployed on the homefront decreased.[123] Such changes were important to provide supplies for those at war and maintain a steady workforce, but these changes put mentally ill aging persons in trouble. With more women working and many men conscripted, elderly individuals experienced a lull in familial care. As such, hospitals admitted more senile parents and grandparents, as shown by the steady increase in the percent of first admissions of senile and cerebral arteriosclerosis patients between 1939 and 1944 (Fig. 2).[124] With a ~2% increase in the number

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[120] Annual Message to Congress by President Franklin D. Roosevelt, January 1941, SEN 77A-H1, record group 46, Records of the United States Senate, National Archives, Washington, D.C. [hereinafter cited as Annual Message to Congress, President Franklin D. Roosevelt, January 1941].
[121] Annual Message to Congress, President Franklin D. Roosevelt, January 1941.
[122] Annual Message to Congress, President Franklin D. Roosevelt, January 1941.
[123] U.S. Census Bureau, *Bicentennial Edition: Historical Statistics of the United States, Colonial Times to 1970, Chapter D: Labor* (Washington D.C.: U.S. Government Printing Service, 1975), 101–139, https://www2.census.gov/library/publications/1975/compendia/hist_stats_colonial-1970/hist_stats_colonial-1970p1-chD.pdf (Accessed January 2023).
[124] Halbert L. Dunn and Jesse H. Jones, U.S. Department of Commerce and Bureau of the Census, *Patients in Mental Institutions,* 1939-1945, Records of the Bureau of the Census, National Archives, Washington, D.C. (Accessed December 2023).

of elderly patients admitted to state and federal psychiatric facilities across the country between 1939 and 1941, Overholser ruminated on how to slow the increase and save beds for soldiers returning from the war. Supporting the aged and mentally ill population, he found, required collaboration between physicians, nurses, family members, political officials, activists, and the elderly themselves.[125]

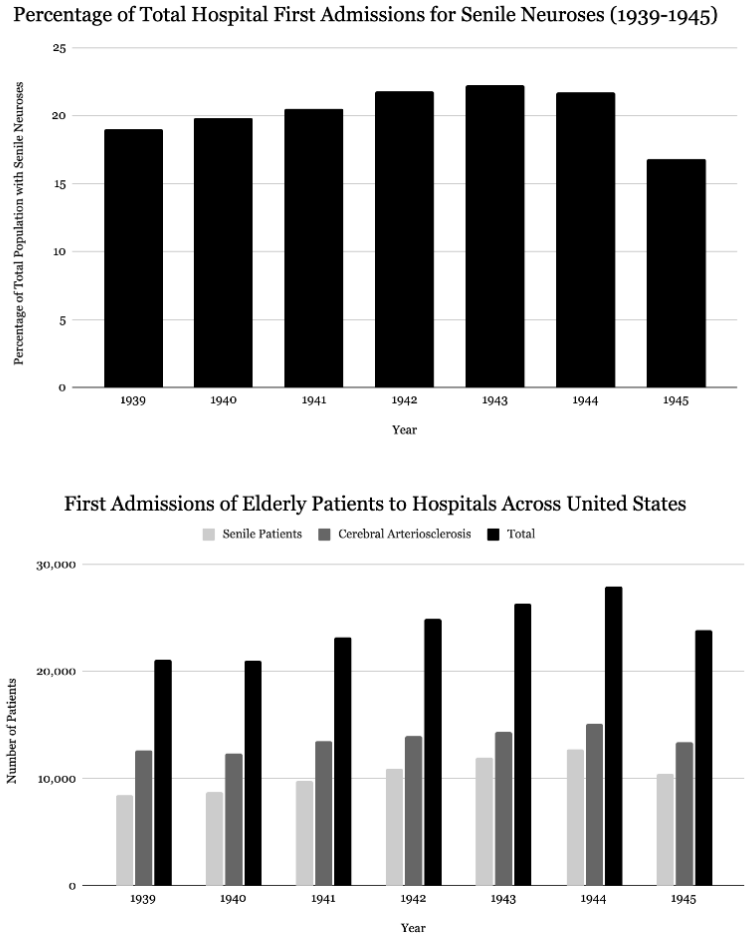

Figure 2. National statistics for first admissions to hospitals focused on caring for psychiatric patients across the country. Both count data and percentages of the overall hospital population per year (1939-1945) are presented.[126] Data compiled and processed by the author.

As an immediate solution, independent of long-term political provisions, Overholser

[125] Winfred Overholser, "The Problems of Mental Disease in the Aging Population," Proceedings, *National Conference of Social Work* (New York: Columbia University Press, 1941), 455–463.
[126] Dunn and Jones, U.S. Department of Commerce and Bureau of the Census, *Patients in Mental Institutions.* Data was organized, analyzed, and processed into a visual by the student author. Many thanks to Dr. Kylie Smith for her guidance in how to process and showcase psychiatric data of this kind.

proposed at-home care serviced by nursing aids or care in nursing homes.[127] Overholser framed mental hospitalization "as a last resort" for use only "after every attempt at home care or nursing in a nursing home has been exhausted."[128] Overholser's suggestion, however, was misleading. In 1939, there were 604,350 nervous and mental hospital beds, but only 22,608 nursing home beds across the country.[129] At this point, supporting the elderly meant not only increasing old age pensions—in benefit amount, eligibility, and accessibility—but also increasing the number of nursing homes and medical personnel in state hospitals.[130]

"A scientific field that has long been neglected": The 1941 Conference on Mental Health in Later Maturity[131]

After the dismissal of the Wagner Health Bill in 1939 and the onset of World War II, the growing number of elderly patients occupying state and federal mental health facilities became increasingly problematic and worrisome. Nevertheless, the issue failed to spark any demands from the people or revisions from the government. Holding the inaugural conference on Mental Health in Later Maturity (MHLM) in D.C. gave the issue a political voice, thus captivating the attention of Americans. Overholser and his close friends and colleagues Thomas Parran, surgeon

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[127] Overholser recognized that "home care" did not entail care for the aging patient by family members such as children or grandchildren given their other responsibilities that contributed to the war effort. Mental hospitals, like St. Elizabeths, however, were not to be viewed as dumping grounds for patients—an easy and convenient option for family members looking to relieve themselves of caring for their aging parents whom they viewed as a financial, physical, and emotional toll. See "Dr. Overholser Favors Home Care for the Aged."

[128] Winfred Overholser, "The Problems of Mental Disease in an Aging Population," *Proceedings of the National Conference on Social Work* (New York: Columbia University Press, 1941): 455-463; Overholser expressed the sentiment that mental hospital admittances should only be seen as a "last resort" for elderly persons many times. For example, he shared the same idea at a presentation he gave to the Medical Society of the District of Columbia, a strictly medical audience, that same year (1941). See Winfred Overholser, "Some Mental Problems of Aging and Their Management," *Medical Annals of the District of Columbia* X, no. 6 (1941): 212–217.

[129] Louis Block and Halbert L. Dunn, *Hospital and Other Institutional Facilities and Services 1939*, U.S. Vital Statistics–Special Reports (Washington, D.C.: U.S. Government Printing Office, 1942), 547, https://www.google.com/books/edition/Vital_Statistics/BxovAAAAMAAJ?hl=en&gbpv=0 (Accessed December 2023).

[130] This trend in advocacy arguments continued through the 1940s. See "Mental Case Jump Laid to Housing," *The Washington Post*, August 1, 1947.

[131] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 147.

general, and Lawrence Kolb, assistant surgeon general, organized the two-day conference in May 1941.[132] They invited experts in psychiatry, geriatrics, sociology, neurology, psychology, and public health, as well as life insurance representatives, to learn from one another and advance an agenda in support of the aged.[133]

On the morning of May 23, 1941, 43 individuals filed into the auditorium of the United States Public Health Service building.[134] Parran provided welcoming remarks, thanking those present for their "time and efforts" and for coming to "postulate and clarify some of the pressing problems concerning mental health maintenance."[135] Counter to sentiments surfacing in the mass media and from other governmental departments, Parran addressed the powerful cultural role that elderly individuals played in society, rather than describing them as an "enormous burden."[136] Such sentiments, however, largely developed out of ignorance. The conference intended to clear up any misconceptions about the meaning of the mental health of aging, its causes, and the needs of the growing population.

The conference agenda also underlined the previously proposed Wagner Health Bill. Parran and Overholser strategically sprinkled in phrases requesting more from policymakers—more provisions that directly supported elderly mental health. Hinting at the Wagner Bill's inclusion of the mental hygiene of children, but exclusion of the elderly, Parran remarked, "In the last 50 years, public health, medicine, sanitation, and vastly improved pediatrics have dramatically raised the average age of our population."[137] He distinguished, however, the diseases of geriatric and pediatric populations: "The diseases of youth are

[132] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 2.
[133] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, III.
[134] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 1. Those present that day included members of the National Advisory Committee on Gerontology, for which Overholser served.
[135] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 1.
[136] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 1. See introductory section on attitudes toward the aged where elderly individuals were labeled as an "enormous burden."
[137] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 1.

characteristically acute, florid, self-limited, brief, and exogenous in etiology, whereas the disorders of later years are chronic, insidious, largely endogenous and progressively disabling before they finally destroy."[138] In making this statement, Parran advanced the viewpoint that if a national health program should extensively cover anyone's mental health, it should prioritize the mental health of the elderly. Later versions of the Wagner Health Bill, which became known as the Wagner-Murray-Dingell Bill, expanded the old age and survivor's insurance plans and raised funding for the construction of additional hospitals and other health care facilities, including nursing homes. The Wagner-Murray-Dingell Bill's response to aging manifested the conference's impact on the political agenda in the mid-twentieth century.

Handing off the audience to Overholser, Parran closed with a line of encouragement: "The United States Public Health Service and the Nation can but profit by your deliberations, for mental health in later maturity concerns us all."[139] Overholser, the resident psychiatrist, avoided medical jargon and spoke to the audience in a similar manner as he did in his pieces for the general public.[140] The conference did not seek to advance Overholser's scientific and medical agenda, but to make the efforts for old age security collective—joining "sociologists, insurance executives, and public welfare officials" with "physicians and psychologists as well, toward a closer and more serious study of the various problems incident to later life."[141] The shared interests of these specialties, however, were not always obvious. Early-twentieth-century physicians viewed senility and mental disease in later life as biological and isolated.[142] Advancing Rothschild's psychosocial model for the purposes of political recognition, Overholser

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[138] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 1–2.
[139] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 2.
[140] Overholser recognized that there were strict distinctions between the audiences he engaged with: medical, public, and political. See Winfred Overholser, "Mental Disease–A Challenge," *The Scientific Monthly* 48, no. 3 (1939).
[141] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 3.
[142] See earlier section (part II) on Rothschild's proposed psychosocial model for understanding mental diseases of old age.

stated that the National Advisory Committee on Gerontology agreed "that a very important aspect of the problem of gerontology was that which has to do with the individual as a unit and in relationship to his environment, that is, to the psychiatric and psychological aspects of the aging being."[143] Overholser admitted the failures of his field historically—neglect of the "impact of social forces" that shaped an elderly person's behavior and instead myopic fixation on the individual. Nevertheless, he informed his medical colleagues that they had the power to change such practices. This unification of specialties, Overholser hoped, would catalyze an effort for change in addressing the problems of aging from all angles. Overholser believed these problems "can to a very appreciable extent be solved by further study"; when the proper resources were available—financial, intellectual, and emotional—the "problem" would cease to exist.[144]

Later in the program, attendees discussed research and practices on the intellectual changes with age, mental disorders of the aged, social maturity, geriatric psychotherapy, and the industrial aspects of aging. In the afternoon session, Dr. William Malamud, a colleague of both Overholser and Rothschild, outlined the specific handling of senile dementia and cerebral arteriosclerosis. Malamud tallied mental hospital admissions across the country, quantifying the "problem of the aged," which aided psychiatry's quest for legitimacy.[145] The conference on MHLM gave someone other than Overholser—Malamud—the opportunity to share these findings and nail down the importance of considering social factors, determined by the U.S. government. Such sociopolitical factors translated directly to the social determinants of mental illness in the aging population. On the basis of multiple investigations conducted by Rothschild, Malamud relayed that collective efforts should not prioritize simply carrying out more medical

[143] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 3.
[144] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 5.
[145] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 113–116. See figures 1 and 2 for the student author's similar collection of data.

research. Rather, "those whose interest lies in the general field of social welfare" should strive for "the planning and execution of changes in social organization, the tempo of living and work, and in the establishment of new values."[146]

"Organic Unity": Harnessing Experts in Social Work[147]

By 1941, there was no denying the biological and social influences on the mental health of the aged. Overholser, like Malamud, knew that the government held the fate of the country's mentally ill aging population in its hands. They were both psychiatrists by training, but their understanding of social determinants helped them uncover that the best efforts for prevention and addressing the mentally ill population depended on government assistance. A month after the MHLM conference, Overholser sought the attention of social welfare activists, knowing that their support would pressure state and federal officials to make changes and increase funding. The National Conference on Social Work sought to demonstrate how political officials could utilize social work and social action as tools for change. The conference included a special afternoon session on "social work in practice."[148] In this portion of the conference, scholars shared information on social work's relationship to children, delinquents, the aged, and the handicapped.[149] Overholser opened his address at the conference with aggravation, "It seems almost superfluous to state that the population in the United States is actually growing older. Nevertheless, recognition of that is not yet general."[150] As in his other public addresses, Overholser raced through the egregious statistics on elderly mental health. Once again, he shared Rothschild's findings and instructed the audience that "we [scholars, government officials, and

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[146] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 111–113.
[147] Joseph Shaplenspecial, "Relief Need Seen Despite Job Rise," *The New York Times*, June 5, 1941.
[148] Overholser, "The Problems of Mental Disease in the Aging Population," 455.
[149] Overholser, "The Problems of Mental Disease in the Aging Population," 459.
[150] Overholser, "The Problems of Mental Disease in the Aging Population, 458. Overholser was categorized as a specialist in the care of the "aged" as geriatrics had yet to be officially defined as a field of medicine. See Mary Anne Forciea, "Geriatric Medicine: History of a Young Specialty," *The American Medical Association, Journal of Ethics* 16 (2014): 385–389, doi:10.1001/virtualmentor.2014.16.5.mhst1-1405.

the public] must, indeed, look considerably farther than the pathology of the central nervous system to discover why patients in the later years of life require hospital care."[151]

The diagnostic social factors that caused psychosis in later maturity varied from case to case. Even so, Overholser recalled that "recent developments in the field of psychosomatic medicine have indicated clearly the close relationship between emotional conflict and various functional and, indeed, structural changes."[152] The 'structural changes' he described represented both structural changes in the aging person's brain and lifestyle. Anxiety amplified the older person's forgetfulness, delusions, and paranoia—symptoms attributed to senility. Overholser proclaimed that a "lack of independence," provoking a feeling of "uselessness" in the individual, was the main contributor to this anxiety.[153] From Overholser's perspective, the lack of independence drove up the number of occupied mental hospital beds.

The dyadic relationship between parent and child illuminated many of the additional social determinants of mental health challenges in old age.[154] Not only did the war effort leave the aging population without familial caretakers, but the "growing urbanization" of society, proposed Overholser, led to cramped housing that resulted in even greater feelings of dependency among the elderly.[155] In response to this housing situation, Overholser demanded the construction of additional geriatric mental health facilities.[156] Moreover, as most aged persons received a meager income, "economic pressure" and the lack of family care likely forced them to

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[151] Overholser, "The Problems of Mental Disease in the Aging Population," 458.
[152] Overholser, "The Problems of Mental Disease in the Aging Population," 458.
[153] Overholser, "The Problems of Mental Disease in the Aging Population," 458.
[154] Dyads are incredibly important sociological interactions explored in geriatric psychiatry. Given the reliance of many elderly individuals on their family members, it is crucial that the individual in addition to their smallest possible social group be considered when analyzing the social factors that influence one's mental health state. For more on this topic, see theoretical discourse on this topic in Joan Monin and Claudia Haase, "Positive Affect in Dementia Care Dyads," *Innovation in Aging* 6, no. 1 (November 2022): 400, https://doi.org/10.1093/geroni/igac059.1573.
[155] See earlier section "Social Security Security Act Only A Start" for reference on familial care patterns during World War II.
[156] "Dr. Overholser Favors Home Care for Aged."

seek "admittance to a mental hospital."[157] In summary, Overholser prescribed, "One of the most important developments in the prophylaxis of mental breakdown in later life will prove to be the establishment of old age pensions."[158] Contextualizing the impact of such social ramifications, he noted, "Although the actual lack of financial security, with its attendant unhygienic living and diet, is a serious matter, it is quite likely that the fear of such insecurity is almost as potent a factor in mental breakdowns in later life."[159] Social welfare leaders would ally with psychiatrists in taking on government officials and the AMA.

Public awareness of the elderly mental health crisis only continued to grow, but policymakers still dragged their feet. Policymakers had not developed additional financial provisions to support the elderly nor had they established a national health program. Overholser refused to fail the growing number of mentally ill old persons. A year prior, in 1941, Overholser advocated to increase accessibility to at-home geriatric care. However, this solution did not suffice.[160] Overholser, therefore, pursued avenues for funding to build separate geriatric facilities—resembling home-like environments—on the grounds of mental hospitals.[161] Overholser disclosed one main problem: many elderly admissions to mental hospitals like St. Elizabeths presented only with minor forms of senile psychoses—reflecting the desire of middle-age Americans to cast off their 'burdensome' parents.[162] On May 26, 1942, Overholser

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[157] Overholser, "The Problems of Mental Disease in the Aging Population," 460.
[158] Overholser, "The Problems of Mental Disease in the Aging Population," 461. This was not the only point at which Overholser directly cited the importance of old age pensions for the mental health of the elderly. In April 1948, Overholser was interviewed for a *Hartford Courant* article explaining that "old age pensions or limited occupations with remuneration must become the general rule because actual financial insecurity or fear of financial insecurity is the chief anxiety producing factor in the older age group." See "Care Of Aged Held Growing More Urgent: Psychiatrist Says Industry Must Revise Policy Toward Elderly," *The Hartford Courant*, April 24, 1948.
[159] Overholser, "The Problems of Mental Disease in the Aging Population," 461.
[160] See earlier section on why home care did not succeed given the effects of the war effort and resulting lack of familial care. See section "Social Security Act Only a Start."
[161] U.S. Congress, Senate, Committee on Appropriations*, Act Making Appropriations for the Government of the District of Columbia and Other Activities: Hearings on H.R. 7041, Before the Committee on Appropriations,* 77th Cong. 320 (Washington, D.C.: U.S. Government Printing Service, 1942), https://www.google.com/books/edition/Hearings/9T1x4xKP8xAC?hl=en&gbpv=0 (Accessed December 2022).
[162] Overholser, "The Problems of Mental Disease in the Aging Population," 459.

and his administrative assistant, Walter Fowler, headed five miles northwest to the Committee Room at the U.S. Capitol to meet with the Appropriations Committee.[163]

Representing Overholser, Fowler found himself in a heated argument with Senators Dennis Chavez of New Mexico and Joseph O'Mahoney of Wyoming. Chavez and O'Mahoney both believed that elderly individuals admitted to mental institutions did not deserve a specialized treatment plan elsewhere—which would relieve the patient of the social stigma associated with mental illness and provide them beneficial care. Citing Overholser's finding that not all those admitted to St. Elizabeths for some form of senile psychosis needed intensive psychiatric care, Fowler presented Overholser's novel idea to care for "the many hundreds of aged individuals suffering technically from mental disorder" in a "suitable institution other than a mental hospital, if such an institution had been made available."[164] Fowler then referred to Overholser's proposal as a "domiciliary nursing home" for the district that would complement the development of geriatrics. In response, the Committee on Appropriations granted Overholser $1,805,000 to plan the development of a geriatric building on the grounds of St. Elizabeths.[165] In securing funding to develop a geriatric facility, Overholser intended not only to increase the number of elderly patients served but also to remove the social stigma surrounding mental illness. Understanding that the aging process already took an immense psychological toll,

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[163] U.S. Congress, Senate, Committee on Appropriations*, Act Making Appropriations for the Government of the District of Columbia and Other Activities,* 320-321.
[164] U.S. Congress, Senate, Committee on Appropriations*, Act Making Appropriations for the Government of the District of Columbia and Other Activities,* 320.
[165] U.S. Congress, Senate, Committee on Appropriations*, Act Making Appropriations for the Government of the District of Columbia,* 323; See also: Office of the U.S. President, *Message of the President of the United States Transmitting the Budget* (Washington, D.C.: U.S. Government Printing Services, 1934), 380–395, https://www.google.com/books/edition/Message_of_the_President_of_the_United_S/LlkoAAAAMAAJ?hl=en&gbpv=0&kptab=overview (Accessed January 2023). This was the largest appropriation made for St. Elizabeths since 1934 when the Men's Receiving Building was established. Appropriations were made possible by the 1941 Lanham Act, which provided funding for the construction of community health facilities, including hospitals. The Lanham Act served as a precursor to the Hill-Burton Act that was passed in 1946. Read more on this in Lewis E. Weeks and Howard J. Berman, *Shapers of American Health Care Policy: An Oral History* (United States: Health Administration Press, 1985), 44–50.

Overholser aimed to minimize further feelings of inferiority among mentally ill aged persons. Residence in a geriatric facility eliminated the social stigma that came with admission to a mental hospital.

Following the death of President Roosevelt in April 1945, Vice President Harry Truman assumed the presidency. Truman's inauguration registered the effort to refocus on domestic issues.[166] Seven months into his term, Truman advocated for a comprehensive health program in a message to Congress.[167] In his message, he recommended four synergistic parts including the construction of hospitals and related facilities; expansion of public health services, medical education, and research; prepayment of medical costs; and protection of wage loss from sickness and disability.[168] In these recommendations, Truman passionately emphasized that "the health of this nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all citizens deserves the help of all the nation."[169] Truman's statement resembled many of the preceding, albeit unsuccessful, statements made by Overholser and his colleagues. President Truman, however, resolved to make such efforts worthwhile. In 1946, Republicans rejected all of Truman's provisions, except the construction of hospitals and related facilities.[170] In a bipartisan effort, Congress compromised and passed the 1946 Hill-Burton Act, which provided federal funding for the construction of hospitals and related facilities.[171] Truman

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[166] Harry S. Truman, "Special Message to the Congress Presenting a 21-Point Program for the Reconversion Period," September 6, 1945, WHCF, Truman Public Papers, Harry S. Truman Library; Hoffman, *Health Care for Some*, 57.
[167] Isidore Sydney Falk, Typescript of summary notes recording evolution of President Truman's response to Congress on a National Program, 1945–1946, Box 62, Folder 562, Falk Papers (MS 1039).
[168] Isidore Sydney Falk, Typescript summary notes of President Truman's message to Congress on National Program, 1945–1946, Box 62, Folder 562, Falk Papers (MS 1039).
[169] Isidore Sydney Falk, Typescript of summary notes recording evolution of President Truman's message to Congress on a National Program, 1945, 1946, Box 62, Folder 562, Falk Papers (MS 1039).
[170] Isidore Sydney Falk, *Memoranda and notes re: Coordination of S. 1606 and S. 1318*, February-March 1946, Box 64, Folder 595, Falk Papers (MS 1039).
[171] U.S. Health Care Facilities Service, *Hill-Burton Is–* [Brochure], June 1971, https://www.google.com/books/edition/Hill_Burton_Is/aISrL0L6C1EC?hl=en&gbpv=0 (Accessed February 2023).

signed the legislation into law on August 13, 1946.[172] The act constituted a tremendous impact on American health care and supported the provision of adequate mental health care for the aged.

Adding to the $1,805,000 allocated for the development of a geriatric facility at St. Elizabeths in 1943, the Hill-Burton Act secured more funding for the development of the facility.[173] Not only did the Hill-Burton Act create opportunities to address the proliferation of geriatric patients in state mental hospitals, but it also helped elderly persons evade the social stigma that Overholser previously condemned.[174] Expressing his satisfaction with the act 8 years after its passing, Overholser encouraged his fellow psychiatrists and medical consultants to take advantage of the Hill-Burton Act's offerings.[175] First citing the amendments to the original act which increased authorized federal spending for hospital needs, Overholser described that many general hospital officials across the nation utilized the available funds, but state mental health facilities had not taken their fair share.[176] With an amendment in 1954 that provided an extra $60,000,000 to specifically fill the "unmet needs of treatment centers, nursing homes, and rehabilitation centers," Overholser urged his colleagues to take what was on the table and develop more geriatric facilities to better serve the mentally ill elderly.[177] Mobilizing his colleagues and Congress, Overholser activated the growth of proper care for the elderly.

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[172] Isidore Sydney Falk, Notes on S. 191, Hill-Burton Bill (Hospital Construction Act) and Related Bills, 1946, Box 62, Folder 574, Falk Papers (MS 1039).
[173] U.S. Senate Committee on Appropriations, *Act Making Appropriations for the Government of the District of Columbia,* 394.
[174] See address given by Overholser at the 1946 Meeting of the American Philosophical Society on Mental Hygiene. Winfred Overholser, "Mental Hygiene," *Symposia on Present Day Social and Economic Aspects of National Health and the United Nations Educational, Scientific and Cultural Organization, and American Participation in Its Activities*, April 18 & 19, 1946, https://www.google.com/books/edition/Proceedings_American_Philosophical_Socie/j-56akwfM_8C?hl=en&gbpv=0 (Accessed December 2022).
[175] Winfred Overholser, "Psychiatry Should Take Opportunity Offered by Hill-Burton to Plan State Hospital Needs," *Mental Hospitals: Architectural Supplement on Psychiatric Services* 5, no. 4 (April 1954): 13.
[176] Overholser, "Psychiatry Should Take Opportunity Offered by Hill-Burton," 13.
[177] Overholser, "Psychiatry Should Take Opportunity Offered by Hill-Burton," 13. Note that while modern day nursing homes are capable of serving many different medical needs of elderly patients, this was not the case in the 1950s and '60s. The mentally ill elderly were drawn up as a whole other monster of their own class.

With Truman in office and his steadfast commitment to a national health program, Overholser took charge in his role as both a practicing psychiatrist and employee under the Federal Security Agency. Embodying Truman's words, Overholser believed that "the health of all citizens deserved the help of all the nation," even if Republicans and the AMA did not. Furthermore, "health" meant not only acute general care but also included mental health care.[178] Prior to establishing the planned geriatric facility, Overholser opened an out-patient psychiatric clinic in the fall of 1947, which he deemed "a most urgent needed facility."[179] According to Overholser, the objectives of the clinic were twofold: it provided free mental health consultations to Americans of any age, race, or gender and also combatted the social stigma and community prejudice of mental hospitals and the mentally ill themselves.[180] The latter benefit specifically assisted in reducing the psychological pressure that the elderly received from society with regard to their mental challenges.

Recognizing his commitment to the health and well-being of American patients, the APA appointed Overholser as its president in 1947.[181] Utilizing his title, Overholser spoke more widely than ever to varying audiences on the mental health of the elderly and their needs.[182] In his 1948 presidential address to the more than five thousand members of the APA, Overholser spoke of the role that the field, and the organization, played in national affairs. Most importantly, Overholser captivated the attention of his audience by deconstructing psychiatry's history. "Psychiatric practice," he explained, "as it then existed [when initially founded] was confined to

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[178] "Psychiatric Clinic," *The Washington Pos*t, September 6, 1947.
[179] "Psychiatric Clinic," *The Washington Pos*t, September 6, 1947.
[180] "Psychiatric Clinic."
[181] Zigmond M. Lebensohn, "In Memoriam: Winfred Overholser (1892-1964)," *The American Journal of Psychiatry* 121, no. 8 (1965): 833.
[182] Genevieve Reynolds, "Mental Breakdowns Increasing Among Older Group, Club Hears," *The Washington Post,* January 9, 1948; "The Fetish of Age," *The Hartford Courant*, May 1, 1948.

the hospitals, with occasional ventures into the courts."[183] Juxtaposing the 1948 climate of psychiatry, Overholser assertively exclaimed, "Psychiatry is now generally recognized as an integral part of medicine…it has come as well to have application to nearly every aspect of social life."[184] The mobilization by the AMA to nix Truman's national health program, unfortunately, targeted many members of the APA. While Overholser disagreed with the AMA's campaign to shut down the plan, he simultaneously recognized the probability that the AMA had influenced many of his audience members.[185] Despite the diversity in opinions, Overholser recognized the elephant in the room. "There are great possibilities for psychiatric advance, but there are likewise resistances, fears, and readiness in some quarters to exploit our differences and disagreements," he admitted.[186] Even so, "there never has been a time when it was more important for us all to stand together, respecting the differences of view among us, and exhibiting among ourselves that tolerance which we advise for our patients."[187] As Overholser came to recognize from Rothschild's research, his position as a psychiatrist morally obligated him to put his self-interest aside and advocate for his patients' best interests. Likewise, in addressing all five thousand-plus members of the APA, he hoped his words would leave many feeling the same way he did.

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[183] Winfred Overholser, "Presidential Address Delivered at the 104th Annual Meeting of the American Psychiatric Association," *The American Journal of Psychiatry* 105, no. 11, (1948): 1.
[184] Winfred Overholser, "Presidential Address," 1.
[185] Overholser, "Presidential Address," 8-9.
[186] Overholser, "Presidential Address," 9.
[187] Overholser, "Presidential Address," 9. Overholser echoed similar sentiments in a piece he wrote for the Journal of Clinical Psychopathology and the Washington Institute of Medicine in 1949. The piece, titled "An Historical Sketch of Psychiatry" chronicled the benefits that American society gained from psychiatry over time. Closing out the piece, Overholser exclaimed that the "crying need" of 1949 was for the "synthesis of all of the schools of thought and methods of approach." He continued, adding that "no one method has a monopoly of the truth…we need urgently a selection and coordination of the best and most helpful in neurophysiology, neurology, psychoanalysis, psychobiology, psychosomatic medicine, neurosurgery, social psychiatry, anthropology, and sociology." At the point by which American society (and medicine, more specifically) bridged all of the specialties listed, psychiatry would be "American" and "psychiatry will truly have come of age." In such a statement like this one, Overholser rooted the 'American dream' and American health in the tenets of social psychiatry—an understanding of the mind and body that recognized the emotional, social, and physical. See Winfred Overholser, "An Historical Sketch of Psychiatry," *Journal of Clinical Psychopathology* 10, no. 2 (April 1949): 1–18 (Viewed 10/2022 at the Medical Historical Library, Call No.: Hist RC438 949o, Yale University, New Haven, CT).

Political Pictures of Pain and Suffering: Social Security Revisions of 1950

With Truman's reelection in 1948, opponents of his national health proposal, the AMA and Republican members of Congress, felt threatened. Ramping up all efforts to keep Truman and his supporters from passing any form of national health care, the AMA's public relations firm, Whitaker and Baxter of Los Angeles, launched its "Keep Politics Out of This Picture" campaign.[188] The campaign deliberately communicated to the public that Truman's plan for "socialized medicine" would damage the medical profession.[189] Inherently speaking, the "picture" *was* political and had been since the Depression, especially when it came to providing health care for the expanding sick and elderly population. For Truman and his constituents, fighting for the right to health care felt like a losing battle—opponents had shut down the proposal numerous times. Nevertheless, social welfare activists, life insurance analysts, and psychiatrists refused to surrender.

At 10 a.m. on Monday, February 6, 1950, Senators George, Byrd, Myers, Williams, and Mrs. Elizabeth B. Springer, acting chief clerk, met in the Senate Office Building, room 312, to preside over revisions to the SSA.[190] The participants discussed improving the old age and survivor's insurance system, changing the public assistance provisions, and expanding the health care benefits that fell under both. Various witnesses attended that day, but Thomas E. Boorde, executive secretary of the General Welfare Federation of America, came to draw specific attention to the health and wellness of the aging population and how revisions should target improving access to health services.

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[188] Hoffman, *Health Care for Some*, 60.
[189] American Medical Association, *Keep politics out of this picture... National Education Campaign - American Medical Association*, The John W. Hartman Center for Sales, Advertising, and Marketing History Collection, Duke University, https://repository.duke.edu/dc/outdooradvertising/XXH2927 (Accessed January 17, 2023); Hoffman, *Health Care for Some*, 60–61. The campaign featured a poster including the famous "The Doctor" painting by Sir Luke Fildes.
[190] U.S. Congress, Senate, Committee on Finance, *Social Security Revision: Hearings Before The Committee on Finance,* 18th Cong., 2nd sess. on H.R. 6000 (Washington, D.C.: U.S. Government Printing Office, 1950), 748–755.

Boorde humbly introduced himself to the committee and shared the founding principle of his organization—promoting the general welfare of the population, as the preamble to the U.S. Constitution stated.[191] "The care of the aged is the obligation of any people or nation, especially of a people with a faith in God," he remarked.[192] Boorde discerned social and economic developments that policymakers failed to acknowledge. With political change, extended lifespans, and inflation, the $10 to $85 a month received by the elderly through the initial SSA no longer met the prices for health services, especially those of the Hill-Burton Act era.[193] Needless to say, these benefits didn't cover the cost of health services in the '40s either, given the role such funds played in basic support for one's family. Drawing on such shortcomings, Boorde emphasized the federal government's inability to provide for the American elderly, stating that "after being in operation for about 14 years, title I of the Social Security Act, making provision for the aged, is found inadequate to the situation."[194] Boorde added that the country's population growth and economic changes left many "not provided for at all" and those who did receive benefits were still unable to get by."[195]

"Inadequate" benefits only perpetuated the positive feedback loop between the elderly and state hospitals. While Overholser and other medical professionals spent the previous decade pushing for fewer state hospital admissions for senility and for the establishment of nursing homes, the lack of significant support for the aged and their families gave them no other choice but to seek admission.[196] Increased admissions to state hospitals did not save state or federal

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[191] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 748.
[192] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 750.
[193] Many health care institutions that were developed in response to funding from the Hill-Burton Act were cleaner and more modern. As a result, health officials believed they had a right to charge more for the care provided in those spaces. While more facilities were needed, increasing the cost of services they provided was not. Read more on this in Beatrix Hoffman, *Health Care for Some: Rights and Rationing in the United States Since 1930* (United States: University of Chicago Press, 2012).
[194] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 750.
[195] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 750.
[196] "Dr. Overholser Favors Home Care for Aged."

governments money—they simply delayed the point at which individuals needed to pay. Given the certainty of receiving two meals a day and minimal supervision, many would spend the rest of their lives in state hospitals.[197] Boorde, representing the American people, had one simple request: "there should be a substantial increase" and extension of coverage for old age pensions.[198] Boorde recommended increasing the monthly old age pension payments to at least $100 and lowering the age eligibility threshold to 60 instead of 65. As Boorde made evident in his Senate testimony, delaying the enactment of a federal old age pension law would only help, rather than hurt, the economic stability of the United States.[199] Without expanding the benefits for the growing aging population, hospital debt that would inevitably never be paid would continue to rack up.

However, Boorde knew that to get policymakers to accept the urgency of elderly health care reform, he needed support from one of their own. Overholser was just that person. In the preceding decade, Overholser saw the same interest in utilizing social workers, sociologists, and American citizens in his demands for better provisions for the aged. Furthermore, Overholser previously lobbied for more funding and increased old age pensions, in addition to establishing a geriatric facility and community mental health clinic at St. Elizabeths.[200] From Boorde's perspective, Overholser checked off all the right boxes for someone that he could call on and cite. Holding a federally funded position, Overholser earned the respect of both politicians and

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[197] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 929.
[198] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 751. Through his testimony, Boorde represented the Social Security Board's own Honorable Arthur Altmeyer. Altmeyer was present in this battle from the start. He made one of his first appearances at the National Health Conference in 1938 where he first advocated for the mental health, and general health care of the elderly. See Typescript of Speech given by Arthur J. Altmeyer at the Sixty-Seventh Annual Meeting Before the American Public Health Association, "The National Health Conference and the Future of Public Health," October 26, 1938, Series III, Box 85, Folder 1357, Winslow Papers (MS 749).
[199] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 751–752.
[200] "Psychiatric Clinic," *The Washington Pos*t, September 6, 1947; U.S. Senate Committee on Appropriations, *Act Making Appropriations for the Government of the District of Columbia*, 323.

physicians to speak on the mental and physical health of the elderly.

Following his requests on behalf of the elderly, Boorde slipped off his professional hat and appealed to emotion. Sharing a quote from Overholser, he explained, "In St. Elizabeths Hospital there are between 200 and 300 sane old folks who do not belong there, who were locked up without any opportunity of defense."[201] Boorde thus argued that inadequate support for the elderly and their health drove more patients into state and federal mental hospitals simply because they were better off there than alone in a community that could not support them. The pension needed to subsidize "a reasonable manner of living."[202] Additionally, if the Social Security Act included health care, older persons in need of medical attention would receive it and therefore not face the added stress of financial instability that further weakened their mental state.[203]

Boorde did not appear that day to deem the elderly a "burden" or to tell stories of 'insane' elderly patients.[204] He attended to provide a voice for the elderly whom "too few people are speaking up for."[205] Beyond gaining credibility by quoting Overholser, Boorde rhetorically strengthened his testimony with pathos. Closing out his statement, Boorde shared a "little story of human interest" from his colleague A.M. Lyon, the director of hospitals and mental hygiene

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[201] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 751.
[202] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 752.
[203] Throughout the 1940s and 1950s, many revisions were made to the SSA. In an interview with John L. Thurston, then-acting Federal Security Agency administrator, the *Los Angeles Times* reported that while the labor statistics were improving, there were a large number of families with no earner or a low-income earner (elderly households) that suffered from the inadequacies of the social insurance program despite public assistance grants provided by the old age insurance system of Social Security. Thurston said that the "Fair Deal" program would provide compulsory national health insurance and broaden Social Security and public health services for the American people. Thurston believed that improving these measures for low-income and elderly individuals would improve the mental health of the people. The reporter then interviewed Overholser, who agreed with Thurston and confirmed that going forward "one in every 19 adults in this country will enter a mental hospital for treatment during his or her lifetime." This source provides greater evidence of Overholser's support for a national health insurance program. See "Needy Getting Public Aid at 5,000,000," *Los Angeles Times*, December 13, 1949.
[204] Earl D. Bond, *Dr. Kirkbride and His Mental Hospital* (Philadelphia: J.P. Lippincott, 1947), 158.
[205] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 752.

for the State of Kentucky.[206] The story, titled "Am I Sick or Just Discarded?" was one of personal experience.[207] Lyon recalled a June afternoon when, sitting in his office, he noticed a car with two men—a father and son—pull up in front of the mental hospital where he worked.[208] The son aggressively emerged from the car and brought a packet of paperwork inside.[209] About two minutes later, he came back out and opened the passenger door, removing a "stooped, wrinkled, and feeble old man" from the vehicle.[210] The old man did not want to enter the building and cried out, "Don't leave me here; don't leave me here; take me home," Lyon recounted.[211] Once in the building, the old man was taken away by a hospital attendant as he continued crying out the same words of fear and neglect. The son exited the building, but quickly turned back, sprinting through the front door only to be left "breathless."[212] The son then asked, "May I take Pap back home?"[213] Lyon, like Overholser, believed that the home environment or something similar, such as a nursing home or geriatric facility, best served elderly individuals struggling with mental changes. He, of course, responded "yes."[214] Falling back on his experience with the care of the elderly, Lyon shared that the "most forceful stabilizing influence is social and economic security."[215] That kind of care, too, required increased overall support for the elderly—primarily economic.

At the conclusion of the hearings, policymakers added no health care provisions to the SSA but increased its monthly benefit payments. For scalable reference, the minimum monthly payment established in 1939 was $10, but the 1950 revisions upped it to $20.[216] The average

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[206] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 753–754.
[207] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 753.
[208] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 751.
[209] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 754.
[210] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 755.
[211] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 755.
[212] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 754.
[213] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 755.
[214] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 755.
[215] U.S. Congress, Senate, Committee on Finance, *Social Security Revision*, 755.
[216] Typescript of H.R. 6000 (Social Security Act Amendments of 1950), Series II, Box 66, Folder 643, Falk Papers (MS 1039).

monthly payment for a single elderly male increased from $26 to $46 following the 1950 revisions.[217] Boorde's testimony, leading only to minimal amendments, encapsulated the aging mentally ill person's experience. After consistent lobbying defeats, the elderly truly did feel the government did not prioritize their welfare. Were they "sick" or just discarded? The events of the preceding 20 years would affirm that they were discarded, not sick. For every success, the mentally ill aging population encountered defeat—signifying the government's neglect of the aged person.

Win Some, Lose Some: The "Psychic and Somatic" Under a Single Roof [218]

Following a partial defeat at the 1950 Social Security revision hearings, Overholser's lobbying efforts in the preceding decade continued to pay off. In 1951, the geriatric building at St. Elizabeths Hospital opened. With the passing of the Hill-Burton Act in 1946, Overholser and his colleagues chased down more funding for the development of a geriatric building—a facility that would move the elderly individuals from the "mentally ill" quarters of St. Elizabeths to a newer environment constructed to resemble the American daily lifestyle.[219] The first floor of the new facility included a "hotel-like lobby," a barber shop, and a beauty shop.[220] The facility also advertised its increased privacy for patients—"more privacy than can usually be found in mental

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[217] Wilbur J. Cohen and Robert J. Myers, "Social Security Act Amendments of 1950: A Summary and Legislative History," *Social Security Bulletin* 13 (October 1950): 3–14; *Typescript of H.R. 6000 (Social Security Act Amendments of 1950)*, Series II, Box 66, Folder 643, Falk Papers (MS 1039); Charles I. Schottland, "The Social Security Act: The First Twenty Years" (Article, Hardcopy), Series III, Box 30, Folder 140, Somers Papers (MS 1238). For further comparison, in 1952 the average daily cost of hospital care was $15.15 per person. See "National Expenditures for Health Care Purposes by Object and Source of Funds," 1951, Series III, Box 26, Folder 106, Somers Papers (MS 1238).

[218] Theodore Fong, "The New Geriatric Unit at Saint Elizabeths Hospital," *Medical Annals of the District of Columbia* XXI, no. 1 (1952): 223–224.

[219] Creating psychiatric settings reminiscent of the quintessential American home was common during this time period. The modeling of "typical" American homes was used for child mental hygiene facilities, as well. See Deborah Doroshow, *Emotionally Disturbed: A History of Caring for America's Troubled Children* (Chicago: University of Chicago Press, 2019), 120–150. The Hill-Burton Act did not officially cover development of "rehabilitation" facilities until 1954. Overholser, however, found a workaround to this by building the geriatric facility on the grounds of St. Elizabeths, which was considered a hospital.

[220] Nate Haseltine, "New St. Elizabeth's Building Ready for Patients," *The Washington Post*, November 18, 1951; "Insane After Sixty," *Newsweek*, November 26, 1951.

institutions."[221] The opening of the facility culminated many years of Overholser's hard work lobbying for better care for the mentally ill aged. While it did not represent his commitment to increasing old age pensions or a national health program, the building did embody his goal of reducing the stigma surrounding the mentally ill aging population. More importantly, the facility provided those without proper familial support with a consistent, calming, and comforting environment to "live out their declining years."[222]

Exterior of New Geriatric Building at St. Elizabeths Hospital

New St. Elizabeths Building Ready for Patients

Figure 4. Photograph of the exterior of the geriatric building at St. Elizabeths opened in 1951. Image courtesy of The Washington Post.[223]

Once the geriatric building was up and running, the number of those admitted soared even higher. As a federally funded program, the geriatric facility at St. Elizabeths relied on support from the federal government. To no surprise, after providing more than $3,000,000 to build the facility, federal officials resisted providing more financial support. Consequently, the

[221] "Insane After Sixty," *Newsweek*, November 26, 1951.
[222] Haseltine, "New St. Elizabeth's Building Ready for Patients."
[223] Haseltine, "New St. Elizabeth's Building Ready for Patients."

facility could not keep up with the demand.[224] The four-story building had 504 beds total, but the lack of funding for personnel prevented the use of an entire floor worth of accommodations through 1953.[225] Given the onsite training of student nurses at St. Elizabeths, it was not difficult to find nurses to work in the facility, but it was a challenge to hire and pay them.[226]

At the 1953 Committee on Appropriations hearings, Overholser presented his case for more personnel to run a fully-functioning geriatric facility at St. Elizabeths.[227] The lack of support for geriatric facilities affected hospitals beyond St. Elizabeths. In fact, Overholser admitted that it "caus[ed] gray hairs for the administration of every state hospital in the whole of the United States."[228] By 1953, Overholser had campaigned on behalf of the mentally ill elderly for just shy of two decades. Unsurprisingly, he was tired and frustrated. For every advance, he encountered a roadblock. His brainchild, the geriatric facility at St. Elizabeths was stuck, and he resolved to find a detour. After a lengthy conversation with Democratic Congressman John Fogarty of Rhode Island, Overholser muttered a statement emblematic of his built-up frustration: "This whole problem of the aged is one that will have to be met sooner or later."[229]

With a waiting list of 7,100 patients by the end of 1953, Overholser recognized the unsustainability of his temporary solution to the problem of caring for the mentally ill elderly.[230] In fact, Overholser found himself pleading with the family members of elderly individuals in a

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[224] U.S. Congress, House, Committee on Appropriations, Department of Labor and the Federal Security Agency, *Appropriation Bill Hearings 1953* (Washington, D.C.: U.S. Government Printing Service, 1952), 206–209, https://www.google.com/books/edition/Hearings/1NiFXk1SciUC?hl=en&gbpv=0 (Accessed January 2023).
[225] U.S. Congress, House, *Appropriation Bill Hearings 1953*, 207.
[226] U.S. Congress, Senate, Committee on Education and Labor, *Hearings on the Servicemen's Education and Training Act of 1944* (Washington, D.C.: U.S. Government Printing Service, 1943), 88–90, https://www.google.com/books/edition/Substandard_Wages/SPBKAQAAIAAJ?hl=en&gbpv=0 (Accessed November 2022).
[227] U.S. Congress, House, *Appropriation Bill Hearings 1953*, 206–209.
[228] U.S. Congress, House, *Appropriation Bill Hearings 1953*, 208.
[229] U.S. Congress, House, *Appropriation Bill Hearings 1953*, 208.
[230] U.S. Congress, House, *Appropriation Bill Hearings 1953*, 206–209.

Minneapolis Tribune headline that read, "Quit Sending Old People to Hospitals."[231] While the Appropriations Committee ultimately gave in and provided the financing to hire 117 additional personnel, the changing political climate made him reflect on his next steps forward.[232] With the end of Truman's term and the inauguration of Republican President Dwight D. Eisenhower, Overholser knew that the liberal agenda and attitudes towards the mentally ill aging population were fleeting. Initially introduced on January 6, 1954, and signed into law that summer, Eisenhower sponsored the Revenue Act which further constricted Americans' access to health insurance based on employment status.[233] Once again, the legislation excluded the elderly, who were unemployed. The next seven years of Eisenhower's presidency continued to hurt and punish this select group. Nevertheless, the guidance Rothschild provided on prevention and early intervention in his 1947 piece was the encouragement that Overholser needed to proceed.

Quinine and the Building of a Canal: Mechanisms of Prevention

In February 1954, the first National Conference on Mental Health took place in Detroit, Michigan. At the conference, various governors of Midwestern states adopted a "ten-point program on mental health."[234] The program emphasized the collaborative effort, prevention methodologies, and importance of adequate personnel to run the state and federal facilities needed to effectively combat the mental health crisis.[235] A week later, Overholser, who served as chairman, spoke with George Cushing and Dr. Jack Ewalt on Michigan's commercial radio station, WJR. In the thirty-minute program, Overholser shared conference takeaways with the

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[231] Geri H. Joseph, "Experts Urge: Quit Sending Old People to the Hospital," *The Minneapolis Tribune*, October 19, 1954.
[232] U.S. Congress, *Appropriation Bill Hearings 1953*, 210.
[233] Hoffman, *Health Care for Some*, 93–94.
[234] U.S. Congress, *Congressional Record: Proceedings and Debates of the 83rd Congress* (Washington, D.C.: U.S. Government Printing Service, 1954), 2929–2942, https://www.google.com/books/edition/Congressional_Record/4H9SOP4SdKcC?hl=en&gbpv=1 (Accessed January 2023).
[235] U.S. Congress, *Congressional Record: Proceedings and Debates of the 83rd Congress*, 2930.

American public in an effort to continue underscoring the collaborative nature of this medico-political problem. The conversation prioritized the immediate attention required for addressing the mentally ill elderly population.

To incorporate aspects of the ten-point program on mental health, clearly defining the term "mental health" for the American public was paramount. The host, George Cushing, asked both Overholser and Ewalt to define mental health at the start of the February 14th programming. Overholser responded timidly, initially comparing the task at hand to "defining consciousness."[236] Prefacing his statement with the idea that the definition vastly changed over the last decade, Overholser continued: "By mental health, we really mean the capacity to get along comfortably with oneself and with other people and to be in good contact with what we choose to call, for lack of a better term, reality."[237] The social and economic "reality" that Overholser referenced made "get[ting] along comfortably with oneself" especially challenging for the elderly and, as a result, caused significant mental decline.[238] Ewalt chimed in with perspective from his work as Commissioner of Mental Health for the State of Massachusetts, citing that the "most important fields of activity" in his day-to-day work were "work[ing] with the people in the community, both to school people taking care of problems in the community" and to "ease tensions, maladjustments and that sort before people even become what you might say 'neurotic.'"[239] This was, simply put, the work of public welfare.

Responding to Ewalt's statement, Cushing brought Overholser back into the conversation to guide the audience towards the focal point: the mental health of the elderly. "Is the greatest

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[236] *In Our Opinion*, "Mental Health: Dr. Winfred Overholser (Superintendent of St. Elizabeth's Hospital), Dr. Jack R. Ewalt (Commissioner of Mental Health for State of Massachusetts)," presented by George William Cushing, aired February 14, 1954, on WJPR, George Cushing Papers and Sound Recordings, Item 240, Archival Collections, Bentley Historical Library, The University of Michigan, Ann Arbor, MI.
[237] *In Our Opinion,* "Mental Health."
[238] *In Our Opinion,* "Mental Health."
[239] *In Our Opinion,* "Mental Health."

problem to take care of those who have mental illness or to seek ways and methods or means to prevent a greater degree of mental illness occurring in this country?" Cushing asked.[240] In response, Overholser established that it was not that simple. The increasing number of state hospital admissions drew concern, but "merely building more and bigger institutions is not going to solve the problem."[241] Certainly, government officials should have prioritized building more geriatric facilities, but preventing future elderly populations from *developing* mental illnesses was a worthwhile investment that would address the problem at its roots. "If we had merely sent quinine down the Panama Canal when they were building it without exterminating the mosquito, the canal would not have been built," Overholser remarked.[242] Overholser's metaphor hinted at the importance of not only treating patients, but also identifying and addressing the upstream social factors such as financial instability, stressful environments, and relationships, all factors of the elderly milieu that Overholser worked to address, in one way or another.

Reflecting on Overholser's Efforts: Political Action Trumps Research

Overholser never simply "quit" in his fight for the mentally ill elderly. A year after his initial call for preventative measures, Congress passed the Mental Health Study Act of 1955 (MHSA).[243] The act, in its most basic form, expanded on the provisions set by the National Mental Health Act signed by Truman in 1946—adding more emphasis on identifying the people's needs, rather than just funding additional research projects with aims determined by researchers or physicians.[244] The 1955 act specifically explored the preventative measures

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[240] *In Our Opinion*, "Mental Health."
[241] *In Our Opinion,* "Mental Health."
[242] *In Our Opinion,* "Mental Health."
[243] *Mental Health Study Act of 1955, Hearings on H.R. 3458 and H.J. Res 230, Before the Subcommittee of the Committee on Interstate and Foreign Commerce,* 84th Cong. (Washington, D.C.: U.S. Government Printing Service, 1955), 1–161, https://www.google.com/books/edition/Mental_Health_Study_Act_of_1955/8l_NAAAAMAAJ?hl=en&gbpv=0 (Accessed January 2023).
[244] *Mental Health Study Act of 1955,* 5–18.

referenced by Rothschild in 1947 and Overholser in 1954. Despite the signing of the MHSA, Eisenhower opposed any and all forms of "socialized medicine." Eisenhower's position on the issue became especially clear when Congress held public hearings in 1958 on the Forand Bill—which provided the elderly access to hospital and nursing home coverage for up to 60 and 120 days, respectively.[245] The Forand Bill, however, failed to benefit the mentally ill elderly as it specifically excluded coverage for facilities that concerned a patient's mental state.[246]

After numerous rejections, the Forand Bill was adopted by Senators Clinton Anderson and John F. Kennedy, restructured, and reintroduced to the Committee on Ways and Means in early 1960.[247] The AMA viewed the restructured bill as a threat.[248] In response, members of the AMA bartered with Democratic Senators Robert Kerr and Wilbur Mills in an effort to gain their sponsorship for an alternative bill, the Kerr-Mills Bill. Both the Forand and Kerr-Mills Bills focused on the elderly, but the Kerr-Mills Bill excluded a large part of the elderly population.[249] For elderly individuals to receive funding from the Kerr-Mills Bill, their economic status had to

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[245] *Social Security Legislation: The Forand Bill, Statement of the Board of Directors of the Physicians Forum*, 24 June 1948, Series III, Box 159, Folder 2294, Falk Papers (MS 1039); While the Forand Bill intended to provide insurance against the cost of hospital, nursing home, and surgical care for persons eligible to receive old age and survivors insurance benefits, nursing home care was not equivalent to psychiatric care. See Letter from Nelson H. Cruikshank (Director, Social Security Department) to Isidore Falk, October 20, 1957, Series III, Box 159, Folder 2292, Falk Papers (MS 1039).

[246] Wilbur J. Cohen, "The Forand Bill: Hospital Insurance for the Aged," *The American Journal of Nursing* 58, no. 5 (May 1958): 698–702, https://doi.org/10.2307/3461578.

[247] Typescript of speech "Medical Care for Our Older Citizens" by John F. Kennedy on the Senate Floor, January 26, 1960, Papers of John F. Kennedy (JFKSEN-0907-030-p0001), Pre-Presidential Papers, Senate Files, Box 905, John F. Kennedy Presidential Library, Boston, MA, https://www.jfklibrary.org/archives/other-resources/john-f-kennedy-speeches/washington-dc-19600126.

[248] While members of the AMA were strongly against the proposed Forand Bill, they did begin to recognize the collaborative effort necessary to properly care for the aging population. In a testimony given by Dr. Leonard Larson of North Dakota, representing the Board of Trustees of the American Medical Association, he exclaimed, "The medical profession has been and is still accurately aware of the existence of medical care problems among the aged. We agree that efforts to solve these problems should be continued and increased." He later added, however, that "the passage of a law will not wipe out these problems, which are of a concern to all of us." Rather than addressing the mentally ill aging population with respect, he referred to the individuals and their illness as "evil." Typescript of testimony from Leonard Larson, M.D. before the Committee on Ways and Means relative to Amendments to the Social Security Act, June 27, 1958, Series III, Box 159, Folder 2297, Falk Papers (MS 1039).

[249] Hoffman, *Health Care for Some*, 118.

fall below an exceedingly low threshold.[250] In spite of Eisenhower's opposition to socialized medicine, Senate leaders voted in favor of the Kerr-Mills Bill 91-2 in August 1960.[251]

Perhaps the passing of the Kerr-Mills Bill signified the beginning of the end. That being said, the bill excluded millions of elderly Americans, and thus, Democratic leadership refused to settle. With Eisenhower's second term coming to an end, John F. Kennedy's presidential campaign became heavily focused on methods to properly support aging Americans. Throughout Eisenhower's second term, the problems facing elderly Americans grew so large that Kennedy excluding support for the elderly in his campaign promises likely would have cost him the election. The AMA would not go down, once and for all, without a dogged fight. In 1961, after Kennedy took office, the AMA launched yet another propaganda parade, known as "Operation Coffee Cup."[252] The campaign specifically targeted Democrats' plans to create a form of national health insurance strictly for the elderly—Medicare. The AMA, without the support of a Republican president like Eisenhower, made little progress in convincing Americans and congresspeople that Medicare should be murdered.[253] Operation Coffee Cup did, however, slow the progress of Kennedy's Medicare Plan. First introducing the Medical Care for the Aged Bill on the Senate floor in 1962, the bill managed to get all but two of the votes it needed to pass.[254] Kennedy framed the two missing votes as a product of the Republican Party's stubborn and

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[250] Hoffman, *Health Care for Some*, 118–119.
[251] Donald A. Barr, *Crossing the American Health Care Chasm: Finding the Path to Bipartisan Collaboration in National Health Care Policy* (Baltimore: Johns Hopkins University Press, 2021), 20.
[252] Christy Ford Chapin, "Ensuring America's Health: Publicly Constructing the Private Health Insurance Industry" (Dissertation, University of Virginia, 2011), ProQuest Dissertations & Theses Global.
[253] Members of the AMA and the Republican party routinely shared similar aggression toward the development of a national health program. In a *Capitol Clinic*, the AMA newsletter, from November 1952, Director Frank Wilson noted that the Republican administration was always in "close agreement with the American Medical Association on several issues reappearing before Congress." See Frank E. Wilson, "How Eisenhower and Republican Party Stand on Major Medical Issues," 11 November 1952, Box 175, Folder 2687, Falk Papers (MS 1039).
[254] Christy Chapin, *Ensuring America's Health America's Health: The Public Creation of the Corporate Health Care System* (New York: Cambridge University Press, 2015), 223.

selfish agenda.[255] "This time," Kennedy sighed, "I believe the Republicans have gone too far."[256]

With little time before his mandated retirement, Overholser, like the AMA, put up one final fight.[257] He made a public plea that mechanisms of patient support be modified. Speaking to a reporter from the *Washington Post*, Overholser described the procedure whereby mentally ill patients were forced to pay at the time of admittance as "all wrong."[258] Overholser opposed the "dumping" of the elderly in state hospitals, but that did not mean he tolerated turning a patient away if they had no other support.[259] He believed the cost of admittance should never be a barrier to care.[260]

Dying in October 1964, Overholser never got to see the day when the U.S. government financially and medically supported the elderly, especially those with some form of mental illness. Fortunately, not long after Overholser's death, President Lyndon B. Johnson signed the

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[255] Typescript of speech, "Statement on Defeat of Medical Care Bill" given by John F. Kennedy on July 17, 1962, Papers of John F. Kennedy, Presidential Papers, President's Office Files, Speech Files, Box 38, John F. Kennedy Library, Boston, MA. Despite the initial defeat of Kennedy's bill, St. Elizabeths benefited directly from Kennedy's initial introduction of the bill. In fact, about a week after its initial defeat, the Bureau of Family Services of the Department of Health, Education, and Welfare publicized on a policy change that would allow for payment made under the old age assistance program to be made to the families of the elderly individual or to nursing homes directly such that the elderly patients could be removed from the mental hospital and receive the financial support to be cared for elsewhere. Up until this point, the meager funding provided could only go towards hospital care. See "New Aid Policy May Help Many Leave St. Elizabeths," *The Washington Post*, *Times Herald*, July 29, 1962. Similarly, Overholser published a piece in October 1961 where he highlighted the successes of the community clinics that had been established. He commented on the introduction of tranquilizers and Metrazol shock treatments, but claims psychiatry of 1961 was faced with "too many tranquilizers." Psychotherapy and understanding the social underpinnings of mental health, however, was crucial for the continued growth of psychiatry, but more importantly the improvement of American mental health. He closed this piece by emphasizing that psychiatric care was no longer just provided by psychiatrists, but by many other medical actors. Given these circumstances, however, Overholser begged that these medical actors did not simply resort to the 'easy way out' (psychotropic drugs), but rather that they engaged with psychotherapy and the social history of each patient they met. See Winfred Overholser, "Some Notes on Mental Disorders," October 1961, Series V, Box 956, Folder 3, Lawrence Z. Freedman Papers (MS 1917), Manuscripts and Archives, Yale University Library, New Haven, CT.

[256] Typescript of speech, "Statement on Defeat of Medical Care Bill" given by John F. Kennedy on July 17, 1962, Papers of John F. Kennedy, Presidential Papers, President's Office Files, Speech Files, Box 38, John F. Kennedy Library, Boston, MA.

[257] Stephen S. Rosenfeld, "Overholser Reaches Retirement Age; Expected to Resign in a Few Months," *The Washington Post*, April 22, 1962.

[258] Dorothy Butler, "St. Elizabeth's Head Asks Change on Patient-Support," *The Washington Post*, April 15, 1962.

[259] Butler, "St. Elizabeth's Head Asks Change on Patient-Support."

[260] Butler, "St. Elizabeth's Head Asks Change on Patient-Support."

Medicare Bill into law on July 30, 1965.[261] Like Kennedy, Overholser's commitment to comprehensive health care for the elderly did not come to fruition, but they both were remembered in such celebratory moments.[262] For Overholser, taking a stand for the comprehensive care of the aging population was finally being recognized.

PART IV: COMPOUNDING EXCLUSIONS

This story of compounding loops is not complete without recognizing those who suffered beyond their aging identity. Despite Rothschild and Overholser's psychosocial model for understanding the mental health of the aging American population, both failed to recognize the depths of what this framework actually entailed. The psychodynamic model, initially proposed by Rothschild, enlisted medical professionals to address their aging patients from all angles—not only their symptoms but also their environment and lived experiences. From this model, one would expect that Overholser and Rothschild would highly regard and respect the gender and racial identities of these patients. Overholser and Rothschild, however, sent varying messages to the public on the importance of truly supporting *every* identity.

Mixed Messages: Hysterical or "Strong"?

Recognizing the influence of gender on the senile population was not a difficult task for Rothschild. Notwithstanding his groundbreaking statements that "personal problems in a broad sense" were the "great importance" of many cases, Rothschild simultaneously used his model to gender the senile brain in the same way that other psychiatrists and neurologists gendered the

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[261] "Dr. Winfred Overholser Dies; Developed Psychiatric Centers," *The New York Times*, October 7, 1964, https://www.nytimes.com/1964/10/07/archives/dr-winfred-overholser-dies-developed-psychiatric-centers-director.html. Even the passing of Medicare in 1965 was not a striking "success." Since its inception, the Medicare bill restricted beneficiaries to a maximum of 190 days of inpatient psychiatric care at public or private hospitals. Arthur E. Hess, "Medicare and Mental Illness," *The American Journal of Psychiatry* 123, no. 2 (1966): 174–176.

[262] Coincidentally, Overholser and Kennedy are buried only two sections away from one another in Arlington National Cemetery in Arlington, Virginia. The locations of their respective tombstones were determined using the "Find a Grave" search engine courtesy of the Arlington National Cemetery Website (see: https://ancexplorer.army.mil/publicwmv/index.html#/arlington-national/search/).

migrainous, anxious, and paranoid brain, among others.[263] Specifically, Rothschild utilized the psychodynamic model for understanding senile psychoses to paint the female brain as intellectually inferior. In fact, the same year that Rothschild published his call-to-action piece on the "Practical Value of Research in the Psychoses of Later Life," he shared strongly gendered statements on the ways that cases of cerebral arteriosclerosis and senile dementia presented themselves in the aging population. The 1947 Yearbook of Neurology, Psychiatry, and Neurosurgery quotes Rothschild as saying, "Senile psychoses are commoner in women than in men…arteriosclerotic psychoses are commoner in men than in women."[264] Not only were senile psychoses more common in women than in men but "intellectual impairment is usually more pronounced in senile than in arteriosclerotic conditions," according to Rothschild. Rather than recognizing gender as a social construct, like the economic and environmental factors he described as essential in determining the mental health of the aged, Rothschild used gender to socially construct his own narrative that elderly women were far less intelligent than their male counterparts. For a scholar who prided himself on resisting the diagnostic tendencies of his field, Rothschild fell short in resisting the gender discrimination with which his field engaged.

Overholser, who agreed with and disseminated Rothschild's psychosocial model widely, took a different stand on the role that gender played in diagnosing the mental health problems of

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[263] Neurology and psychiatry have historically been utilized as vehicles for gendered social control. Specifically, cases of mental illness and neurological conditions have been pathologized by way of the female reproductive system and culturally enforced gender norms. Under these classifications, medicine has painted women as "weak" and hysterical. For more on this, see Elaine Showalter, *The Female Malady: Women, Madness, and English Culture* (New York: Penguin Books, 1987); Elizabeth Lundbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton: Princeton University Press, 1996); Sophie Edelstein, "The Male Treatment of the Female Migraine: Historicizing Migraine Attacks Through a Multifaceted Framework of Sexism," *Sociology Between the Gaps: Forgotten and Neglected Topics* 7 (July 2022): 1–10.

[264] David Rothschild, "The Clinical Differentiation of Senile and Arteriosclerotic Psychoses," *American Journal of Insanity* 99, no. 3 (November 1941): 324–333; David Rothschild, "Clinical Differentiation of Senile and Arteriosclerotic Psychoses," in the *1947 Year Book of Neurology, Psychiatry, and Neurosurgery,* ed. Hans H. Reese, Mabel G. Masten, Nolan D.C. Lewis, and Percival Bailey (Chicago: Yearbook Publishers, 1947), 335–338.

the elderly.[265] Rather than constructing elderly mental health so as to paint one gender identity as less than the other, Overholser saw males and females as equals. Amidst the end of the war and the new studies of "shell shock" (i.e. hysteria) that presented in older soldiers who returned from the battlefield, a 1942 edition of *The Boston Globe* published Overholser's opinions on the psychiatric differences between men and women.[266] Lucrece Hudgins, the AP Feature Service Writer for the *Globe*, asked Overholser, "If a woman is afraid of a mouse, why isn't she afraid of air raids?" Overholser's response was frank, concluding that the woman was never afraid of the mouse and therefore, of course, wasn't afraid of the air raids either.[267] He continued, "Our whole civilization has been built on the thesis that men are the stronger sex, but, I think events in this war prove beyond question that the courage of women is equal to that of men." Bridging the gap between gender and senile old age, Overholser suggested that when somebody, man or woman, responds to danger or struggle, they respond not on the basis of their gender, "but because of being a particular human being."[268] Being "human" was the crux of Overholser's fight for proper care of the elderly—blaming aging individuals for the "burden" they caused was not appropriate when their symptoms were a product of the political environment in which they lived.

Racial Bias: Doctors Who Don't Look Like Their Patients

If only Overholser took the same approach to race that he took to gender. This essay, while celebrating the dedication that medical professionals like Overholser demonstrated to health care reform, specifically for the mental health treatment of the elderly, must also address Overholser's faults. Overholser increased the size and offerings at St. Elizabeths as a way of

[265] Overholser held this opinion for the mentally ill population, more broadly. When he spoke on this issue, he often discretely bolstered a woman's role in society to offset the previous theories disseminated by other members of psychiatry. See Elinor Lee, "Experts Defend the Little Woman: Husbands Can be Naggers, Too, Dr. Overholser Says," *The Washington Post*, February 26, 1960.
[266] Lucrece Hudgins, "Dr. Overholser Says Women Face Danger as Bravely as Men," *The Boston Globe*, January 1, 1942.
[267] Hudgins, "Dr. Overholser Says Women Face Danger as Bravely as Men."
[268] Hudgins, "Dr. Overholser Says Women Face Danger as Bravely as Men."

promoting "better patient care" for the mentally ill. In publications, interviews, and testimonies, Overholser stressed the importance of "comfort" for the mentally ill aging person and how such environmental comfort aided in better mental health.[269] Overholser's argument for "comfort" strengthened his request for federal funds to support a geriatric-specific patient facility at St. Elizabeths. However, if "comfort" truly was the key ingredient to better patient care, why did Overholser shoot down provisions aimed at bettering Black patients' experiences in the facility as soon as they crossed his desk?

When Overholser became superintendent in 1938, he faced an institution experiencing intense cultural shifts. As superintendent, the decisions produced by these structural shifts were now his to make. Despite the ever-increasing influx of elderly patients into mental hospitals across the country and the need for more personnel to meet the needs of the growing population, Overholser refused to hire a Black psychiatry resident when asked by then-Senator Harry Truman. Truman was committed to all aspects of equitable health care for every American. Truman, representing a young Black psychiatrist named Charles Prudhomme from his home state of Missouri, wrote to Overholser requesting that Prudhomme be considered for a clinical position at St. Elizabeths. In his letter, Truman described Prudhomme as "well-qualified" for the position and cited his many accomplishments.[270] More importantly, Truman emphasized the importance of patient comfort created by the care received, which he knew was a publicized interest of Overholser. "I have been informed that there are more than sixteen hundred Negro patients at St. Elizabeths, but that there are no Negro doctors at the institution," Truman wrote.[271] In making this statement, Truman hoped that Overholser's commitment to patient comfort would push

[269] "Interview: What you Should Know About Mental Illness," *U.S. News & World Report*, November 18, 1955, 128.
[270] Letter from Harry S. Truman to Winfred Overholser, 16 March 1938, Part 15, NAACP Discrimination Complaint Files: Hospitals 1940–1955, U.S Library of Congress.
[271] Letter from Harry S. Truman to Winfred Overholser, 16 March 1938, Part 15, NAACP Discrimination Complaint Files: Hospitals 1940–1955, U.S Library of Congress.

through a position offer for Dr. Prudhomme on the basis that patients of color at St. Elizabeths would be more trusting of a physician who looked like them.[272] Alas, Overholser responded to Truman stating that, per the Civil Service Commission, he could only fill positions at St. Elizabeths with individuals whom the Commission had certified—Prudhomme was not one of those individuals.[273]

The three men, Overholser, Prudhomme, and Truman, conversed back and forth for six months, but Overholser continued to refuse to offer Prudhomme a position. However, as Director of Personnel of the Department of the Interior J. Atwood Maulding wrote in a letter to Prudhomme in June of 1938, Dr. Overholser had full discretion over who St. Elizabeths hired—the Civil Service Commission could not stop Overholser from hiring anyone, including Prudhomme.[274] Overholser stopped himself on the basis of his own discriminatory racial beliefs. Nevertheless, Prudhomme, a Black psychiatrist knowledgeable of the racial divisions in psychiatric care, insisted that there be a place for him at St. Elizabeths to provide the patients of color with more comprehensive care and to train physicians, nurses, and social workers of color on how to best care for such patients. Both Truman and Prudhomme acknowledged that Truman's pestering of Overholser was not working and they had to bring the issue to someone at a higher level. Truman thus connected Prudhomme with then-President Roosevelt and First Lady Eleanor Roosevelt. When Prudhomme's letter landed on Roosevelt's desk, his assistant Elizabeth McDuffie decided that the best person to receive Prudhomme's letter was the First Lady.[275]

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[272] For more of an overview on the race relations at St. Elizabeths, see Ben Miller, "Treating Race at St. Elizabeths Hospital," *Rediscovering Black History (blog),* National Archives, 16 December 2020, https://rediscovering-black-history.blogs.archives.gov/2020/09/16/treating-race-at-st-elizabeths-hospital/.
[273] Letter from Winfred Overholser to Harry S. Truman, 17 March 1938, Part 15, NAACP Discrimination Complaint Files: Hospitals 1940–1955, U.S. Library of Congress.
[274] Letter from J. Atwood Maulding to Winfred Overholser, June 4, 1938, NAACP Discrimination Complaint Files: Hospitals 1940–1955, Part 15, Library of Congress.
[275] Letter from Elizabeth M. McDuffie to Charles Prudhomme, 28 November 1938, Part 15, NAACP Discrimination Complaint Files: Hospitals 1940–1955, U.S. Library of Congress.

McDuffie was right. Eleanor Roosevelt sent a personal letter in response to Prudhomme a day after she received his letter from McDuffie.[276] Unfortunately, Eleanor claimed she would give Prudhomme's matter her "personal attention," but she failed to follow through.[277]

In the meantime, Prudhomme took a position at the Veterans Hospital in Tuskegee, Alabama, where he worked with a number of elderly veterans experiencing varying forms of senile psychoses.[278] In his experiences with the elderly patients in Tuskegee, Prudhomme identified the important need for a racially diverse care staff in facilities that provided care for the aged.[279] And so, he wrote to Overholser again. Overholser, for the third time, responded to Prudhomme with a complicated "no." But with the problems of the mentally ill aged being discussed more by the Federal Security Agency, Prudhomme wrote to the secretary of the agency, Paul McNutt.[280] In his letter, he described his qualifications, experiences, but most importantly, the expertise he could bring to St. Elizabeths to address the "place Negro insanity occupies in social welfare." In brief, Overholser wanted to keep his staff white and his patients of color segregated, and he was not going to let Prudhomme change that.

Under Overholser's leadership, patients were separated by gender and race at St. Elizabeths.[281] The separation of patients continued through 1948, as Overholser requested more funding to support new construction that would increase the number of beds available for female

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[276] Letter from Eleanor Roosevelt to Charles Prudhomme, 29 November 1938, Part 15, NAACP Discrimination Complaint Files: Hospitals 1940–1955, U.S. Library of Congress.
[277] Letter from Eleanor Roosevelt to Charles Prudhomme, 29 November 1938, Part 15, NAACP Discrimination Complaint Files: Hospitals 1940–1955, U.S. Library of Congress.
[278] Letter from Charles Prudhomme to Franklin D. Roosevelt, 16 November 1938, Part 15, NAACP Discrimination Complaint Files: Hospitals 1940–1955, U.S. Library of Congress.
[279] Letter from Charles Prudhomme to Franklin D. Roosevelt, 16 November 1938, Part 15, NAACP Discrimination Complaint Files: Hospitals 1940–1955, U.S. Library of Congress.
[280] Letter from Charles Prudhomme to Paul V. McNutt, 23 November 1940, Part 15, NAACP Discrimination Complaint Files: Hospitals 1940–1955, U.S. Library of Congress.
[281] Matthew Gambino, "Mental Health and Ideals of Citizenship: Patient Care at St. Elizabeths Hospital in Washington, D.C., 1903-1962" (PhD diss., University of Illinois at Urbana-Champaign, 2010) 185, ProQuest (3455666).

patients.[282] In part, terminating this segregation in 1948 was emblematic of Truman's desegregation efforts. Although Overholser attempted to increase the number of elderly patients that St. Elizabeths could treat, the populations served were handpicked. In a 1955 piece celebrating a century of St. Elizabeths, Overholser described the assessed property value of the hospital to be $18,000,000, then adding that the new geriatric facility "represents an investment of $3,500,000."[283] Was Overholser's "interest" in patient care rather an interest in the economic profits he secured in welcoming more patients to St. Elizabeths? Such an assumption would align with much of the historical context on national health care reform, but also undermines the positive work that Overholser did contribute to provisions for the elderly.

CONCLUSION

The effort to establish a comprehensive form of national health insurance was multifaceted and influenced by many individuals.[284] For some, the passing of the 1965 Medicare Bill was a long-awaited success. For others, it commemorated thwarted efforts. For all, however, the passing of Medicare demonstrated progress, despite the many exclusions that the bill embodied. For the American elderly, access to a modified form of national health insurance reduced environmental stressors and worries of financial instability—especially given that they no longer had to tap into their Social Security payments to cover the cost of their health care needs.[285] Further, American families had a larger number of supports they could lean on to care

[282] "Four Buildings Top Needs at St. Elizabeth's; Overholser Stresses Requirements for Women Patients," *The Washington Post*, March 24, 1948.
[283] Winfred Overholser, "St. Elizabeth's Centennial," *Public Health Reports* 70, no. 6 (June 1955): 594–596, https://www.jstor.org/stable/pdf/4589137.pdf?refreqid=excelsior%3A444be94936f7254d0bbe070f1a440b35&ab_segments=&origin=&initiator=&acceptTC=1.
[284] Overholser had passed by the time that the Medicare Bill was officially established and thus did not play a role in the lobbying that occurred in the weeks leading up to the passing of the bill. Leading up to its passing, Republicans and AMA members against Medicare tried to eliminate titles under the bill that covered psychiatric care for the elderly. Nevertheless, advocates and allies of Overholser from the APA fought tirelessly to ensure that psychiatric care for the elderly would be covered. See Gerald Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 2014), 266–269.
[285] Medicare did not cover 100% of an older person's medical bills. In 1975, the elderly were responsible for covering approximately 29% of their medical bills while the rest was covered by Medicare. Marian Gornick, "Ten

for their aging parents and grandparents, in addition to the option for nursing home care as opposed to care in a mental institution.[286]

Between 1950 and 1970, the number of elderly individuals in mental institutions decreased while the number of elderly individuals in homes for the aged increased (Fig. 4).[287] With coverage under Medicare, elderly patients could receive care in nursing homes, and the personnel in these homes were capable of providing more all-encompassing care than in mental institutions. Further, care in a home for the aged reduced the stigma that came with mental illness, a long-term effort of Overholser.

The decrease in the number of elderly patients in mental institutions and the subsequent increase in the number in homes for the aged, however, was often racially driven. The systemically racist climate of the U.S. throughout the 20th century led to lower-paying positions for most Black Americans compared to their white counterparts.[288] As such, the amount of coverage Black Americans received from Medicare benefits was often much lower than the amount received by white individuals.[289] Furthermore, the raw number of Black individuals who even benefitted from the Medicare program, compared to whites, was significantly lower,

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Years of Medicare: Impact on the Covered Population," *Social Security Bulletin* (July 1975): 19, https://www.ssa.gov/policy/docs/ssb/v39n7/v39n7p3.pdf.

[286] Grob, *From Asylum to Community,* 268–269.

[287] National Institutes of Mental Health, *Report to the President from The President's Commission on Mental Health* (Washington, D.C.: U.S. Government Printing Service, 1978), https://www.google.com/books/edition/Report_to_the_President_from_the_Preside/H6l_0VN7RNEC?hl=en&gbpv=1 (Accessed February 2023); Similar trends in U.S. mental health admissions can be viewed in U.S. Department of Health, Education, and Welfare and Public Health Service, *Health in the United States: Chartbook* (Washington, D.C.: U.S. Government Printing Service, 1980) https://www.google.com/books/edition/Health_in_the_United_States/wWhrAAAAMAAJ?hl=en&gbpv=0 (Accessed February 2023); Typescript of "Report: The Aged in Mental Hospitals," 1960, Series III, Box 159, Folder 2302, Falk Papers (MS 1039).

[288] Thomas N. Maloney, "Wage Compression and Wage Inequality Between Black and White Males in the United States, 1940-1960," *The Journal of Economic History* 54, no. 2 (1994): 358–81, http://www.jstor.org/stable/2123918.

[289] Karen Davis et al., "Health Care for Black Americans: The Public Sector Role," *The Milbank Quarterly* 65, no. 1 (1987): 226–234, https://doi.org/10.2307/3349956.

according to a 1970 U.S. Bureau of the Census report.[290]

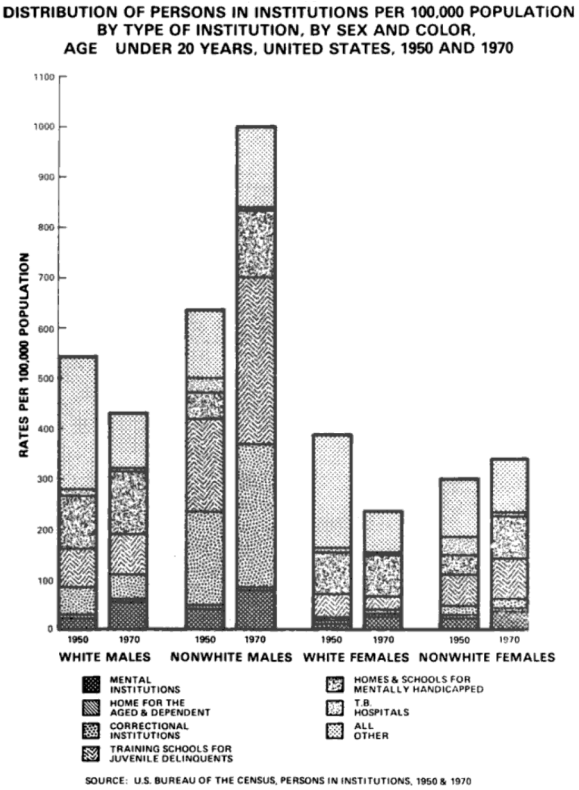

Figure 4. Between 1950 (prior to the passing of Medicare) and 1970, the number of elderly individuals, both white and "nonwhite" admitted to homes for the "aged and dependent" (nursing homes) increased while the number in mental institutions decreased. This was made possible by the financial support provided by Medicare provisions. Figure courtesy of the President's Commission on Mental Health, 1978.[291]

The long-awaited political acknowledgment of the aging population and their health likely would not have occurred without Rothschild's initial skepticism of psychiatric precedent. In line with the birth of social psychiatry, acknowledging the relationship between aging individuals and their social milieus mapped uniquely onto the growing public health crisis of the mentally ill aging population during and after the Depression. Rothschild delivered his findings

[290] See Figure 4. Jacob S. Siegel & the U.S. Bureau of the Census, *Estimates of Coverage of Population by Sex, Race, and Age: Demographic Analysis*, 1974, 17, https://www.google.com/books/edition/Estimates_of_Coverage_of_Population_by_S/OWXfQc0MbWIC?hl=en&gbpv=1&dq=individuals+covered+by+medicare+in+1970+by+race&pg=PA17&printsec=frontcover (Accessed February 2023).

[291] The National Institute of Mental Health, *Report to the President from The President's Commission on Mental Health*, 68.

only to medical audiences—he was not in a position to nationally impact policies that supported the elderly population. Overholser, employing his medical and political positions, could be the voice for Rothschild and many other social psychiatry contemporaries. In turn, Overholser hinged on the theories initially put forth by Rothschild to lobby for various provisions intended to benefit the aging population and make "insufficient" public relief sufficient.[292]

The trend of social psychiatry in the United States, unfortunately, fell as fast as it rose. In fact, the biological focus of psychiatry never truly disappeared. The social psychiatry movement, rather, was a half-doubted blip in the evolution of psychiatry that responded to the biologically unexplainable effects of political strife. As soon as the war ceased and national health insurance partially emerged, psychiatry met its "Wonder Drug" era.[293] The push to acknowledge the impact of social stressors on the mental health of the 'burdensome' elderly population was no longer necessary because psychiatry found an adequate solution. The prescribing of psychotropic drugs granted Medicare its impact through the second half of the 20th century. Reverting back to the biological focus, administering psychotropic drugs to patients was easier than excessive lobbying on Capitol Hill. As historian of medicine Matthew Smith argues, social psychiatry stood as a field of its own, within the larger psychiatric profession.[294] Progressive social policies drove social psychiatry's development until the consumerism of American health care overshadowed the social system.

Refocusing psychiatric and political efforts on social structures, rather than "changes in

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[292] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 58.
[293] For more on the emergence of the "wonder drug" era and psychiatry's journey back to the biological (or rather, further into), see Jonathan Metzl, *Prozac on the Couch: Prescribing Gender in the Era of Wonder Drugs* (Durham: Duke University Press, 2003); Elizabeth Siegel Watkins and Jeremy Green, *Prescribed: Writing, Filling, and Abusing the Prescription in Modern America* (Baltimore: Johns Hopkins University Press, 2012). For more on the way that the psychotropic drug era shaped American Health Care Policy, see Nancy Tomes, "From Outsiders to Insiders: The Consumer-Survivor Movement and Its Impact on U.S. Mental Health Policy," in *Patients as Policy Actors,* ed. Beatrix Hoffman, Nancy Tomes, Rachel Grob and Mark Schlesinger (New Brunswick: Rutgers University Press, 2011), 113–131.
[294] Smith, *The First Resort: The History of Social Psychiatry in the United States*, 58–61.

the individual," helped shed light on mental health and the aged rather than condemning them as the main source of consternation or resource depletion.[295] Furthermore, targeting efforts to address the system rather than a collection of individual, vastly different cases reduced the perceived stigma of mental illness. The narrative herein demonstrates how principles of social psychiatry were moderately effective in addressing age-based health inequities. Overholser and Rothschild's approach negated the broader field's effort to legitimize in the biological and drew attention to modifiable structural determinants. Unsurprisingly, it is possible that psychiatry's shift away from the tenets of social psychiatry triggered a recurrence of the mental health crisis across all ages. More critically, of the approximately 14 million people who reported struggling with a mental illness in 2021, only a third had access to proper care.[296] Attending to the individual and biological etiology of each case is an important and laudable venture. History reveals that absent analysis of social support, race, gender, social histories, governmental public health infrastructure, and subsequent backing from medical professionals, Americans, particularly the elderly, are deprived of their potential to live a healthy and untroubled old age.[297]

"In the discussion of the difficulties which arise in connection with aging, we should never lose sight of the fact that there are compensations, that there are constructive aspects to the problem of getting older," Overholser optimistically reminded us.[298] Therefore, we *can* address the psychiatric needs of the American elderly—it just requires a pinch of reflection, dedication, mobilization, and tracing back to the roots—even today.

Word Count: 14,504

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[295] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 4.
[296] National Institutes of Mental Health, "Mental Health Information: Statistics," *Substance Abuse and Mental Health Services Administration (SAMHSA*), Updated: March 2023, https://www.nimh.nih.gov/health/statistics/mental-illness (Accessed March 2023).
[297] Joan E. Monin, "Social Networks and Social Support," (seminar discussion for SBS 537: Social and Interpersonal Influences on Health, Yale School of Public Health, New Haven, CT, January 20, 2023). Note that this is a specific concern for all Americans because all Americans will at some point reach old age.
[298] U.S. Public Health Service and Federal Security Agency, *Mental Health in Later Maturity*, 4

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BIBLIOGRAPHIC ESSAY

"I can't pay no doctor bills but whitey's on the moon. Ten years from now I'll be payin' still while whitey's on the moon."[299]

I first read Gil Scott-Heron's spoken word poem "Whitey on the Moon" in Professor Lisa Messeri's course, *Anthropology of Outer Space*, in the spring of 2019. I took the course prior to starting my undergraduate education at Yale through the Yale-New Haven Public Schools partnership program. In the course, we listened to, popcorn-style read, and analyzed Scott-Heron's poem line by line. Professor Messeri assigned the poem as a reading for the unit on Afrofuturism. In this context, Scott-Heron's poem embodies the core principles of Afrofuturism and speaks to the racial disparities associated with American scientific discovery. More broadly, however, the poem encapsulates the racial, socioeconomic, and age group disparities in American health care.

Four years later, in the fall of 2022, I sat in the fourteenth row of Harkness Auditorium at the Yale School of Medicine and somehow, some way, Scott-Heron's poem came full circle in my education. Professor Jasmine Abrams, the course instructor for *Social Justice and Health Equity* at the Yale School of Public Health, reflected on how American health care, as an institution, has consistently been exclusionary, both in who health care provisions have covered and how they have covered specific groups of individuals. As I attempted to construct how the social psychiatry movement and its actors impacted health care reform of the post-New Deal era through advocating for the aging population, I consistently reflected on that single line from Scott-Heron's piece. Aging Americans suffered for two whole decades before American

[299] Gil Scott-Heron, "Whitey on the Moon" (audio recording), recorded in February, 1970 on *The Revolution Begins: The Flying Dutchman Masters (Sampler)*, Ace Records, streaming audio. Coincidentally enough, when Matthew Smith's book, *The First Resor*t, came out in January 2023 and I got my hands on a copy, I flipped through and was drawn to Chapter 3, "Swamp Yankees and Proper New Haveners." Certainly, I was partly drawn to this chapter as a New Havener myself, but more importantly because of the chapter's opening quote: "I can't pay no doctor bill (but Whitey's on the Moon)." I was shocked. Smith and I had the same thought.

politicians deemed them a worthy cause for government spending.

The history of psychiatry demonstrates many opportunities to uncover how, specifically, the construction of health care has been exclusionary. I first became interested in the intersectional exclusions exhibited by the fields of psychiatry and neurology when I took Professor O'Donnell's *American Medical Technology* course in the fall of 2021. I shared with her my personal experiences as a young woman with a chronic migraine and seizure disorder. I added how my neurologist explained that many of his treatment approaches were informed by the poor historical practices of neurologists that intended to belittle females experiencing migraine headaches on the basis of sex and gender. Through a research project into the construction of the "female migraine," I became fascinated with how neurologists and psychiatrists defined a patient's illness based on their marginalized identities, often resulting in wrongful diagnoses and inadequate care. As a result, Professor O'Donnell graciously agreed to advise me in an independent study tutorial in the spring of 2022 during which I explored gender and the history of psychiatry. In this tutorial, I read over fifteen secondary source books in addition to a plethora of journal articles on various aspects of the history of psychiatry.[300] I cite this tutorial as the most transformative and academically stimulating experience of my undergraduate History of Science, Medicine, and Public Health studies.

During week five, I read both Deborah Doroshow's article, "Performing a Cure for

[300] Secondary texts read in the tutorial course taken in the spring of 2022 include, but are not limited to Deborah Doroshow, *Emotionally Disturbed: A History of Caring for America's Troubled Children* (Chicago: University of Chicago Press, 2019); Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (New York: Penguin Books, 1987); Jonathan Metzl, *The Protest Psychosis: How Schizophrenia Became a Black Disease* (Boston: Beacon Press, 2009); Jonathan Metzl, *Prozac on the Couch: Prescribing Gender in the Era of Wonder Drugs* (Durham: Duke University Press, 2005); Matthew Smith, *Hyperactive: A Controversial History of ADHD* (London: Reaktion Books, 2012); Elizabeth Lundbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton: Princeton University Press, 1996); Kylie Smith, *Talking Therapy: Knowledge and Power in American Psychiatric Nursing* (United States: Rutgers University Press, 2020); Jack Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge, Cambridge University Press, 2002).

Schizophrenia: Insulin Coma Therapy on the Wards" and Jack Pressman's book, *Last Resort: Psychosurgery and the Limits of Medicine*. On page three, Pressman writes, "A therapeutic fad was driven by a cadre of physicians who overstepped the boundaries of good medicine." In the margins next to this sentence, I left myself a note: "By rooting psychiatry in Meyer's principles of psychobiology, the sociocultural aspects proposed in Freud's psychoanalysis were not fully lost, but there was greater consideration of biology, which made psychiatry just as "scientific" as any other field of medicine." I walked away from these readings frustrated—not frustrated by the authors' interpretations, but frustrated with the historical frameworks for studying the human brain. Was there anyone who believed that the brain wasn't simply a sack of entangled wires with moderately imbalanced neurotransmitters, but rather a living organ shaped by lived experiences and stressors as well?

The social psychiatry movement was led by a group of professionals who wanted to communicate that the human condition was not only biological but also socially and culturally constructed. Nevertheless, social psychiatry was consistently overshadowed by traditional psychiatry and neurology practice in the early and mid-twentieth century. This string of events was especially prominent in the diagnosis of Alzheimer's disease. As I wrestled with these ideas in my tutorial course, I simultaneously began research for a term paper for Professor O'Donnell's spring 2022 seminar, *Marriage and Medicine in Modern America*. While my previous research indicated that the female gender was front and center in defining diagnoses of chronic migraines, the opposite had been argued for Alzheimer's disease—the most common form of pre-senile dementia in modern medicine.

I struggled to conceptualize an analytic framework that did not argue that one gender was inferior to the other, but rather communicated that the medical profession has always gendered

the brain and this "gendering" has consistently depended on the condition at hand. With a women's health-centered approach, I analyzed Alois Alzheimer's notes on his first case of Alzheimer's disease, Auguste Deter. My analysis of the gendered construction of Alzheimer's disease spanned beyond the early twentieth century and sourced material from the Connecticut Society for Mental Hygiene archive held at the Sterling Memorial Library. In the archive, I found pamphlets and physician-authored articles on the employability and hypersexualization of the senile patient, as well as the burden they imposed on American society. To further make sense of these findings, Professor O'Donnell introduced me to Dr. Stephen Casper, a historian of psychiatry and neurology at Clarkson University. Dr. Casper suggested I read Jesse Ballenger's *Self, Senility, and Alzheimer's Disease in Modern America*. Following my first read of Ballenger's book in the spring of 2022, I strongly disagreed with his argument regarding the gendered divide and influences of middle-class masculinity on dementia diagnoses. With a second read over the summer, Ballenger's book provided me with the seed for this thesis—David Rothschild and his 1931 burgeoning psychodynamic theory.

In his book, Ballenger parses through the evolution of Rothschild's psychodynamic model. I, however, wanted to independently explore the shaping of the theory. I defined this stage of my thesis research as the 'Rothschild Rabbit Hole.' Initially, there was little structure to the research I did on Rothschild. I first took to Google Books to see who else had written about Rothschild. There were far more books listed than I had initially anticipated. They all, however, emphasized the same point—Rothschild was the leader in centering psychosocial factors in dementia diagnoses, which brought age-related dementias and care for the aging American population to the forefront of psychiatric practice, especially at the peak of the Great Depression. Despite Ballenger's citing of Rothschild, identifying basic information about him was harder

than expected. For a Massachusetts psychiatrist in the 1930s, Rothschild was not the most distinguishable name out there. Historical newspapers, however, proved incredibly useful as I mapped information. Further, the interlibrary loan service provided through the Yale Library helped me secure copies of Rothschild's most prominent medical articles on the dementias of old age. The newspapers and research articles I discovered prompted me to investigate and statistically analyze the influx of elderly patients into state and federal mental hospitals. Not only did this statistical analysis reinforce my argument for the gendered divide in diagnoses, but it also helped me situate my argument in the demographic effects of World War II. Professor Kylie Smith, a historian of psychiatry and the Director of the Center for Healthcare History and Policy at the Emory School of Nursing, offered additional guidance on the best ways to showcase this sensitive data in a respectful and responsible manner.

As I continued to explore the press-documented actions of Rothschild in the earlier half of the 1930s as well as the increased admissions of the elderly to mental hospitals at the dawn of World War II, I stumbled across Winfred Overholser. Specifically, a 1947 *Washington Post* article featured Overholser explaining that the mental case "jump" seen at state hospitals across the country was a direct reflection of the government's poor support for the elderly.[301] Tracing Overholser's career development throughout the '30s and his eventual landing of the federally appointed position at St. Elizabeths, I suddenly recognized the obvious political theme that loomed over all of the sources I was analyzing. Not only was Overholser a defined political figure, but the historical contexts of the time period perfectly aligned with Rothschild's psychosocial model for understanding dementias of old age. In considering the social stressors caused by the Great Depression, the introduction of Social Security, and the buildup to Medicare, it was almost as if a lightbulb went off in my head.

[301] "Mental Case Jump Laid to Housing," *The Washington Post*, August 1, 1947.

The more I read about and from Overholser, the more I encountered citations of Rothschild's work. With the help of Dr. Melissa Grafe, I located Overholser's archive at the Library of Congress. Unfortunately, the historical specialist for the Overholser collection, Joshua Levy, notified me that over 90% of the archival holdings I was interested in viewing were not accessible to the public as they contained protected patient and government records. I did, however, receive complimentary scans from the Library of Congress that included early correspondence between Overholser and various government officials regarding his appointment at St. Elizabeths. Despite being unable to thoroughly search Overholser's archive, I identified numerous sources through several online databases including Google Books, ProQuest News and Newspapers, the National Library of Medicine, Internet Archive, and HathiTrust. These sources included U.S. government reports and newspaper articles, all of which confirmed my theory that Overholser and Rothschild ran in the same circles—they served on the same medical boards, Overholser routinely cited Rothschild's research, and there is documented evidence of correspondence and professional collaboration between Overholser and Rothschild's close colleague William Malamud. Specifically, Malamud presented on Rothschild's psychodynamic model at the 1941 Conference on Mental Health in Later Maturity, organized by Overholser.

With a bird's eye perspective of the web that connected Overholser, Rothschild, and the American mentally ill aging population, I worked to strengthen my knowledge of the political climate surrounding the Great Depression, the New Deal Era, and the following years that led up to the passing of the Medicare Health Bill in 1965. Both Beatrix Hoffman's *Health Care for Some* and Christy Chapin's *Ensuring America's Health* were incredibly helpful secondary sources in helping me identify the social factors, policy changes, and exclusion of the elderly in initial national health care debates that impacted the mental health of the aged. Scouring the

endnotes of both Chapin and Hoffman's books led me to primary sources that corroborated the immense social pressure put on the elderly and chronologically mapped onto the increased admissions of elderly patients to both federal (St. Elizabeths Hospital) and state (Massachusetts) mental hospitals.

As I found sources, I did my best to preliminarily analyze them. With that being said, I also recognized that my analysis would become stronger when I put the individual sources in concert with one another. This, however, resulted in redundancy amongst many of the sources I had successfully obtained. Nevertheless, this only strengthened my overarching argument as it became more and more clear that the activism and appeal to the public that Overholser routinely utilized was not just a single occurrence but rather a consistent theme in his actions. At the forefront of my argument was American politics and health care reform. With guidance from Hoffman's text, I discovered that many of the key documents tracing the evolution of American health care, specifically for the elderly, were housed right here at Yale in the Isidore Sydney Falk, C.E.A. Winslow, and Herman Miles Somers collections. In Falk's papers, I sifted through folders of speeches, analysis, notes, and pamphlets on the making of the Wagner-Murray-Dingell Bill, the Hill-Burton Act, and the 1950 Social Security Revisions. The Winslow and Somers collections provided me with original pamphlets, speeches, and meeting minutes from the 1938 National Health Conference and Medicare Bill Hearings, respectively.

By the time I hit the depths of the Overholser sections of this thesis, I found myself stuck and in desperate need of inspiration. With a nudge and some re-focusing provided by Professor O'Donnell, she reminded me to zoom out and think about where the story I was telling was eventually going to end. As such, I went back and re-read the later sections of Hoffman's book to re-ground myself. Tracing the process of American health care reform revealed that under

Republican leadership, the health and well-being of the aging American population became so abysmal that presidential candidate John F. Kennedy made supporting the elderly one of his main campaign promises. With such an end-goal in mind, I sat back and reflected on the sources I had left that made up the ’50s.

With documentation of the opening of the geriatrics facility at St. Elizabeths and broader knowledge of the fast-paced innovation and prevention-focused goals of medicine in the 1950s, I recalled a source I discovered earlier in my research process. The source was a radio show audio recording featuring Overholser and former Commissioner of Mental Diseases for the State of Massachusetts Jack Ewalt. I had come across the catalog listing in early October 2022 and with the help of Rachel Woodbrook, the Data Curation Specialist for Humanities, Social Sciences & Medicine at the University of Michigan, I received access to the recording and quickly transcribed it for later use. The radio show, *In Our Opinion*, reported on the National Conference on Mental Health held in Detroit, Michigan, in 1954. Overholser and Ewalt shared the psychiatric profession’s struggle to keep up and serve all of the mentally ill elderly patients who needed care across the nation. However, with a new focus on prevention, Overholser outlined how government involvement, Social Security revisions, and a national health program would aid in solving the large mental health crisis. This source helped me situate the later years of my argument and pushed me straight through to the passing of Medicare in 1965, while also highlighting one of Overholser’s last actionable “fights.”

As referenced in my positionality statement at the beginning of this thesis, in the same way that I describe the moral obligations of Overholser and Rothschild to recognize the social factors influencing mental health and advocate for aged persons, I, too, felt a moral obligation to share just some of the ways by which the individuals I highlight in this thesis fell short of

complete inclusion. My final sections on Overholser and Rothschild's exclusions do not serve as complete summaries, but rather examples of how the various actions and research findings of both individuals were informed by race and gender. In my sleuthing of ProQuest's online periodicals archive, I came across the NAACP Discrimination Complaint Files collection that included hundreds of letters and testimonies documenting racial discrimination by U.S. physicians. In the collection was a well-documented complaint from a Washington, D.C.-based psychiatrist who experienced discrimination on the basis of his race when seeking a position at St. Elizabeths. Overholser was the culprit. When it came to my argument on gender, I leaned on a source I unearthed during my 'Rothschild Rabbit Hole' in early September 2022. I came across the gender-informed diagnosis statement made by Rothschild as I parsed through 50+ yearbooks of psychiatry, neurology, and neurosurgery housed in the lower level of the Medical Historical Library.

In the last leg of my thesis, I was granted the opportunity to refine my understanding of the theoretical frameworks that make up psychology, geriatrics, and public health. This semester, I enrolled in Professor Joan Monin's seminar, *Social and Interpersonal Influences on Health.* An expert in the emotional processes, mental health, and social relationships that impact older adults, Professor Monin introduced me to many fundamental concepts that explain how the social milieu impacts a patient's health, especially for geriatric patients. With this expertise, I revisited parts of my thesis and incorporated more of the social psychology theory that I felt my thesis was initially lacking.

To close, I would like to reminisce on the personal fulfillment and growth that this senior essay has afforded me. When I first started studying the divide between the fields of psychiatry and neurology, early-twentieth-century constructions of Alzheimer's disease, and how social

determinants have shaped psychiatric diagnoses over time, I had a completely different conceptualization of these histories and their themes. To fully understand the human brain, we must acknowledge the experiences that build the brains of those we want to help. A mental health system that doesn't recognize the social conditions and real people needing support, compassion, and understanding is a system that has failed. When I described the advocacy and mobilization of individuals like Overholser, and indirectly Rothschild, I hoped to share the possibility, the steps forward, and backwards, our health care system has made, and the importance of collective effort. The system I described is a system that needed a whole overhaul. The system we are faced with today does, as well—in more ways than one—and the historical record has some advice to offer.