

Books by David J. Rothman

POLITICS AND POWER: THE UNITED STATES SENATE, 1869-1901

THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND
DISORDER IN THE NEW REPUBLIC



The Discovery of the Asylum

Social Order and Disorder

in the New Republic

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would rid itself of corruptions. In a narrow sense this meant getting rid of such blatant centers of vice as taverns, theaters, and houses of prostitution. In a broader sense, it meant reviving a social order in which men knew their place. Here sentimentality took over, and critics in the Jacksonian period often assumed that their forefathers had lived together without social strain, in secure, placid, stable, and cohesive communities. In fact, the designers of the penitentiary set out to re-create these conditions. But the results, it is not surprising to discover, were startlingly different from anything that the colonial period had known. A conscious effort to instill discipline through an institutional routine led to a set work pattern, a rationalization of movement, a precise organization of time, a general uniformity. Hence, for all the reformers' nostalgia, the reality of the penitentiary was much closer to the values of the nineteenth than the eighteenth century.

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*Insanity and the Social Order*

One of the most articulate and elaborate statements of the social origins of deviant behavior appeared in the pre-Civil War analysis of the causes of insanity. Medical superintendents led the investigation and discussion, but the analysis was not an exclusively professional one. It spread from medical journals to popular magazines, from physicians to laymen. The *North American Review*, as well as the *American Journal of Insanity*, took up the issue, and reformers like Samuel Gridley Howe, as well as doctors like Edward Jarvis, pronounced their views. The terminology was to some extent specialized: "mania," "dementia," "melancholia" were technical terms with fairly precise definitions. But the concepts most critical to the interpretation of the origins of insanity were well within the comprehension of the ordinary public. For the analysis depended not on the lessons of anatomy, but on a critique of Jacksonian society.

The question of the etiology of insanity was a comparatively new one for Americans. The colonists had assumed that its cause, like that of other diseases, rested with God's will. The insane received public attention and sympathy as one group among the poor whose incapacitating ailment made them permanently dependent upon relatives or upon the community. But the biological or social agents of mental disease and the precise nature of the affliction prompted little reflection. In the aftermath of the Revolution, however, a spark of interest appeared, lit by Enlightenment ideology and an awareness of very dramatic events in Europe. Just as Beccaria had insisted that humane laws could eradicate crime, so men like Tuke in England and Pinel in

France insisted that kind and gentle treatment would help to cure insanity. The image of Pinel freeing the insane from their chains at Salpêtrière had an immediate and obvious appeal to men in the new republic.¹ They too had just emerged from bondage and intended to bring freedom to others.

The insane were an apt group for this experiment. Raising none of the domestic or international complications that were unavoidable in such issues as the abolition of slavery or the best policy toward the French Revolution, they presented a perfect opportunity to breathe new life into a downtrodden class. But once again, with the insane as with the criminal, the matter was not so simply solved. To provide them with warmth and clothing and remove their chains did not settle the issue, and by the 1830's, Americans calculated that insanity was increasing significantly in their society, not being cured. The problem then became not only to justify republican government in the eyes of the world, but to control what appeared to be an epidemic at home. Prodded by fear as much as by glory, Americans in the Jacksonian period opened an intensive exploration of the origins of the disease.

Every general practitioner in the pre-Civil War era agreed that insanity was a disease of the brain and that the examination of tissues in an autopsy would reveal organic lesions, clear evidence of physical damage, in every insane person. Isaac Ray, one of the leading medical superintendents of the period, when presenting the consensus of his discipline to the legal profession, confidently declared: "No pathological fact is better established . . . than that deviations from the healthy structure are generally present in the brains of insane subjects. . . . The progress of pathological anatomy during the present century has established this fact beyond the reach of a reasonable doubt." Should a particular autopsy reveal no physical changes in the brain, "the only legitimate inference" was that current skills were still too crude to insure accurate results.² Nevertheless, this view did not lead to intensive anatomical or neurological investigations to understand the etiology of the disease. Medical superintendents gave no room in their institutions to this type of research. They had no doubt that organic lesions existed, that insanity was a

bodily ailment. But its first causes they assigned not to body chemistry but to social organization. The solution to the age-old ailment would be found not in the laboratory but in the society, not by looking into the microscope but into the community.

Medical superintendents carefully charted the likely causes of mental illness among their patients. The results seem if not bewildering, then at least woefully naïve and a bit foolish. One physician in New York, for example, listed 43 causes for the disease among 551 patients in 1845. They ranged from ill health (104), religious anxiety (77), and loss of property (28), to excessive study (25), blows on the head (8), political excitement (5), disappointed ambition (41), and going into cold water (1). A colleague in Tennessee attributed the ailment to such phenomena as ill health, disappointed love, pecuniary embarrassment, and "the present condition of the country." Another psychiatrist in Connecticut ranked ill health first, followed by intense mental and bodily exertion, and intemperance; important too were masturbation, Millerism, fear of poverty, and ridicule of shopmates.³ Still, these categories were not absurd or arbitrary. The medical superintendents themselves were a little uneasy with them, always referring to the charts as the "supposed" or "probable" causes of the disease. Nevertheless, they were willing to compile and publish the results, for the particular findings fit well with the general theory by which they explained the origins of insanity.

Medical superintendents linked bodily ailments and injuries to mental illness. Since insanity was a physical disease, sickness or wounds could debilitate the brain. A blow to the head might impair the organ's functioning and bring on insanity. Similarly, disorders in one part of the body might in time adversely affect another; a stomach disorder could damage the nervous system and then attack the brain.

Psychiatrists' tables of causes, therefore, listed somatic problems ranging from burns, concussions, acid inhalation, and heart disease to suppressed menstruation and general poor health.⁴ But a straightforward paradigm of bodily illness leading to mental illness accounted for only a limited number of cases. To understand the others, one had to look beyond such immediate and obvious causes to the workings of American society. Medical

superintendents were convinced that social, economic, and political conditions exerted the crucial influence.

With a regularity that quickly rendered the idea as much a cliché as an insight, professionals and laymen alike attributed insanity to the course of civilization. Mental disorder, announced Edward Jarvis, a leading medical superintendent, was "a part of the price we pay for civilization. The causes of the one increase with the developments and results of the other. . . . In this opinion all agree." Jarvis did not exaggerate the consensus. Isaac Ray reported that "insanity is now increasing in most, if not all, civilized communities." And although some observers thought that "conservative" and "counterbalancing" forces might accompany the march of civilization, he was certain that they have "furnished only an insignificant check to the host of adverse influences" that produce the disease.⁵ Another colleague, Pliny Earle, lectured to medical students on the "constant parallelism between the progress of society and the increase of mental disorders," pondering "whether the condition of highest culture in society is worth the penalties which it costs." And a reformer like Dorothea Dix, confident of the answer, rhetorically asked members of the Pennsylvania legislature: "Is it not to the habits, the customs, the temptations of civilized life and society" that we owe most of these calamities?⁶

A logical deduction from this doctrine was that primitive communities ought to be free of the disease, and so although writers cited only the crude observations of travelers and adventurers for proof, the popular idea went unchallenged. "As a general rule," announced Pliny Earle, "insanity is but little known in those countries . . . which are either in a savage or barbarous state of society." Dorothea Dix blandly asserted that "those tracts of North America inhabited by Indians and the sections chiefly occupied by the negro race, produce comparatively very few examples."⁷ This perspective, of course, offered little comfort to the rest of America which, as a civilized nation — in its own eyes perhaps the most civilized of all nations — seemed especially liable to the disease. One medical superintendent, Samuel Woodward, rated the United States fourth among all countries in the occurrence of insanity. Another, William Rockwell, still more pessimistically contended that

"perhaps there is no country in which it prevails to so great an extent as in these United States," while Isaac Ray agreed that mental illness was "more prevalent here, than it is in other countries." Laymen usually echoed the most dismal estimates. Both Dix and Samuel Gridley Howe put America at the very top of the list.⁸

The link between civilization and insanity was not first forged in the United States. The idea had its origins on the Continent and spread across the ocean. But to a surprising degree, Americans made it their own, grasping it with unrivaled intellectual enthusiasm and employing it in very special ways. The postulate became the base for a detailed critique of Jacksonian society, a specific and original analysis of the dangers of the existing social system.

Before the Civil War, practically no one in the United States protested the simple connection between insanity and civilization. Despite the tenuous quality of the evidence, Americans accepted the conclusion without qualification. The Europeans, however, were far more cautious. Samuel Tuke, one of the leading students of mental illness in England, considered the hypothesis unproven. Noting that some persons believed that British social conditions raised the proportion of the insane, he concluded that the evidence "must be noted as deficient, to an extent which, I believe, does not warrant us to decide." His well-known colleague, Henry Maudsley, was also very skeptical. Travelers' reports, he insisted, were inaccurate guides to the prevalence of the disease among primitive peoples; such informants would be neither competent nor learned enough to reach valid conclusions.⁹ In Germany too, caution was widespread. Wilhelm Griesinger, in a leading textbook on mental pathology, contended that what seemed to be higher rates of insanity in more advanced countries simply reflected improved modes of treatment. Primitive states had probably just as much insanity but it remained hidden there for lack of proper care. Griesinger went on to insist that despite its drawbacks, civilization brought a higher standard of living and innumerable comforts, which "ought to compensate, at least to a certain extent, for any injurious influence of the spread of civilization."¹⁰ Yet, American medical superintendents demonstrated none of the

circumspection of their European counterparts. The connection of civilization to insanity fit well with their preconceptions and perspectives.

The postulate offered no firm guidelines to a social critique. A supposed relationship between insanity and civilization could promote the most conservative or radical conclusions. "Civilization" was a vague, almost meaningless term which did not dictate a well-defined response to particular religious or economic or political practices. A bias in favor of simplicity could inspire a revolutionary program or a reactionary one. In the name of simplicity one could call for aristocratic government — to leave the masses content and untroubled — or the most dramatic form of direct democracy — to eliminate all the superfluities of bureaucratic decisions.¹¹ This criterion in religion could support a John Calvin and Calvinism or a William Ellery Channing and Unitarianism. It could point to the need for the father to exercise unqualified authority or to the propriety of family counsels and democratic participation in the household. In other words, the theory was far too general to account for the explicit interpretations that Americans offered. The appraisal that emerged was ultimately their own and was not heavily indebted to Continental doctrines. The European and scientific literature made convenient and impressive footnotes, but the core of the medical superintendents' and laymen's analysis reflected a native outlook. Their understanding of deviant behavior had far more in common with compatriots' ideas on convicts and delinquents than with those of any Continental thinker or professor.

Medical superintendents' explorations of the origins of insanity took them into practically every aspect of antebellum society, from economic organization to political and religious practices, from family habits to patterns of thought and education. And little of what they saw pleased them. The style of life in the new republic seemed willfully designed to produce mental illness. Everywhere they looked, they found chaos and disorder, a lack of fixity and stability. The community's inherited traditions and procedures were dissolving, leaving incredible stresses and strains. The anatomical implications of this condition were clear: the brain received innumerable abuses, was weakened, and inevitably succumbed to disease. "There is no mystery in this,"

explained Isaac Ray. "As with the stomach, the liver, the lungs, so with the brain — the manner in which its exercise is regulated, determines, to a very great extent, the state of its health." Since American society made unprecedented demands on it, one had to expect that insanity would increase "at a rate unparalleled in any former period."¹² But the biological results were not nearly so critical to explore and clarify as the social origins. And to this consideration psychiatrists devoted the bulk of their attention.

The thrust of the argument was evident in medical superintendents' observations on the ethos and reality of social mobility. They were convinced that the startlingly fluid social order in the new republic encouraged and rewarded unlimited and grandiose ambitions. But rather than point with pride to these attitudes or achievements, they saw only the most pernicious effects. Here was one principal reason why Americans were especially prone to mental illness. "In this country," explained Edward Jarvis to a Massachusetts medical society meeting, "where no son is necessarily confined to the work or employment of his father, but all the fields of labor, of profit, or of honor are open to whomsoever will put on the harness," and where "all are invited to join the strife for that which may be gained in each," it was inevitable that "the ambition of some leads them to aim at that which they cannot reach, to strive for more than they can grasp." As a result, "their mental powers are strained to their utmost tension; they labor in agitation . . . their minds stagger under the disproportionate burden." How different were conditions in a more stable society. "In an uneducated community, or where people are overborne by despotic government or inflexible customs, where men are born in castes and die without overstepping their native condition, where the child is content with the pursuit and the fortune of his father . . . there these undue mental excitements and struggles do not happen." And without such tensions, "these causes of insanity cannot operate." So although Jarvis did not counsel his countrymen to adopt a despotic government or neglect education, he insisted that "a higher civilization than we possess would restrain these [ambitions] within the just limits of prudence and health."¹³

Isaac Ray fully shared Jarvis's outlook. It was "agreeable

enough to people of the old world," he contended, "to follow on in the same path their father trod before them, turning neither to the right hand, nor to the left, and perfectly content with a steady and sure, though it may be slow progress." But in the new world, all citizens struggle "to make, or greatly advance their fortunes, by some happy stroke of skill . . . chance, or some daring speculation." Sleepless nights, fears of failure, and extraordinary stress accompanied these efforts, rapidly consuming mental energies, and thus "strongly predispose the mind to insanity."¹⁴

William Sweetser, a physician of lesser note, popularized this message in a layman's guide to mental hygiene. "Our own peculiar circumstances," he wrote, "are especially favorable to the growth of ambition. . . . Every one sees bright visions in the future . . . our democratical institutions inviting each citizen, however subordinate may be his station, to join in the pursuit of whatever distinctions our forms of society can bestow." Yet, as a result, "the demon of unrest, the luckless offspring of ambition, haunts us all . . . racking us with the constant and wearing anxiety of what we call *bettering* our condition. The servant is dissatisfied as a servant . . . and so it is through all other ranks. . . . All are equally restless, all are straining for elevations beyond what they already enjoy." Relentlessly, "we go on toiling anxiously in the chase . . . until death administers the only sure opiate to our peaceless souls."¹⁵

To aggravate the problem, the achievement of success carried severe penalties. The change from a simple life to "the fashionable or the cultivated style," warned Jarvis, was not easily made. "There must be much thought and toil, much hope and fear and much anxiety and vexation to effect the passage and to sustain one's self in the new position." Since mobility strained every faculty, the price of transit frequently became insanity. Life in the world of commerce and finance took its toll. "Overtrading, debt, bankruptcy, sudden reverses, disappointed hopes," lamented Samuel Woodward in 1842, "all seem to have clustered together in these times, and are generally influential in producing insanity." Medical superintendents had little difficulty in accounting for the increase in the number of insane in 1858: the panic of 1857 had left its mark. Finally, as Jarvis explained,

inflationary cycles, the risks of speculation and innovations in business techniques made fortunes in America especially precarious. Successful men were driven to "more labor, more watchfulness, greater fear and anxiety." Those perched on top of the ladder, as well as those trying to climb it, were liable to fall.¹⁶

A similar dynamic seemed to psychiatrists to operate in other facets of American life. Politics, like business, made citizens so frantic that outbreaks of insanity were common. Americans competed for power as they battled for wealth. Because men on every level of society considered a government office within their reach and appropriate to their talents, many of them paid the price of insanity for excessive ambition. "In this country," declared William Rockwell, "where all the offices of government are open to every man, and where the facilities for accumulating wealth are so numerous, persons even in humble life cherish hopes which can never be realized."¹⁷ A well-ordered society, in which only those fit and able to rule sought position, or even a despotic government, in which the masses had no prospect of exercising power, avoided the pitfalls of so open a system.

American politics endangered the mental health of ordinary voters. Isaac Ray, distressed at the grave implications of "the practical workings of our republican institutions," pointed to the exceptional energy and attention given to political affairs as a case in point. "The public agitation which is never at rest around the citizen of a republic," he complained, "is constantly placing before him great questions of public policy, which may be decided with little knowledge of the subject, but none the less zeal." Every man had a voice in the affairs of the town, the state and the country. "It is not for him to suppose, in any national crisis or emergency, that the government will take care of the country, while he takes care of himself." One day he was in a frenzy over a proposed liquor law, on the next he debated the wisdom of supporting a public highway. And then he turned attention to the qualifications of the various office seekers in never-ending election contests. No sooner was the race for the legislature settled than the contest for Congress began. Ray could not resist a comparison to European conditions. "There, the public attention may be called once a year, to the election of a mayor, but it is an even chance whether the individual has any

part or lot in the issue." Americans, he concluded, judged eternal vigilance to be the price of liberty, but they ought to remember all of its costs.¹⁸

Identical traits characterized the intellectual life of the country. With the same overzealousness with which Americans sought wealth and power, they pursued abstract study. Again, members from every social strata and with varying qualifications participated, not only the well-trained and capable. Part of the problem medical superintendents ascribed to the recent discovery of new areas and methods of study; work in these disciplines, whether phrenology or physiology, easily overtaxed the mind. But these general difficulties were especially acute in the United States. All sorts of people took up the burden of inquiry, and ambition soon outraced proficiency. "The number of those who are, or strive to be, highly educated," remarked Jarvis with obvious regret, "who undertake to be philosophers, chemists, mathematicians, who endeavor to fathom the mysteries of theology . . . who cease the labor of their hands and betake themselves to the labor of their brains . . . have increased in a much greater ratio, than the population of either State or Nation." Americans considered nothing so remote from their everyday concerns that they would resist playing part-time scientist or philosopher. The professional had no exclusive province. A specialist's judgment would not prevent others from conducting their own investigation or reaching their own conclusion.¹⁹

Citizens in the new republic rejected any bounds to their intellectual efforts. They would no more respect their fathers' ideas than they would rest content with his social status. Isaac Ray, with typical nostalgia, remembered that "people once thought they might sometimes abide by the wisdom of their fathers; that some things were considered as settled and others as confessedly beyond the reach of finite intelligence." Previous generations had been quite satisfied in "taking their opinions on trust, in the belief that others might be better qualified by education and experience to form them than they were themselves." In an obvious and deeply felt romance of the past, Ray described how "in the old days," work began at dawn and continued till evening, how people took cheer in modest goods and cultivated domestic affections, how sons and daughters never

puzzled themselves over their mission in life but contentedly performed their duties at day and slept peaceably at night. Today, however, "we question everything; we pry into everything. . . . Subjects which once were supposed to be confined to the province of the learned . . . are now discussed by an order of minds which disdain the trammels of logic." The more complex the subject, the more active the speculation, and the greater the difficulties, the sharper the curiosity. The result, Ray would have it, was that Americans in unprecedented numbers broke their health.²⁰

To these critics, the nation lacked all points of stability. Americans frenetically pursued wealth and power and knowledge without pause or concern for their effects. Imagine a film of a steeplechase race presented at several times its normal speed. Almost simultaneously one rider jumps over a barrier while another skirts a creek, a third topples on a row of hedges and a fourth dashes down the stretch, all moving at breakneck speed. Such was the critics' perspective on Jacksonian society.

Under these conditions, even the institutions which might have slowed the tempo and conceivably offered a sanctuary of security were either without influence or exacerbated the situation. Medical superintendents were hardly cheered by the state of religion. The problem, as they understood it, returned to Americans' unwillingness to accept doctrines on the basis of tradition or the status of their spokesmen. The church could not be an effective sedative in this overwrought society since few were willing to swallow the pill. Psychiatrists distrusted the more successful manifestations of religious enthusiasm in the revival. The subject was not altogether a comfortable one — for belief in God was not supposed to resemble financial or political ambitions, where too much was a dangerous thing. Still, medical superintendents regularly included religious excesses among the causes of insanity. And occasionally, a movement as extreme as the Millerites afforded them the opportunity to denounce "a popular religious error" for having produced "so much excitement in the community and rendered so many insane." The church did little to counterbalance prevailing trends, and at times even stimulated them.²¹

Still more disappointing — indeed, treacherous — was the performance of two critical institutions, the school and the family. It was within their potential to moderate the dangers so prevalent in the social order. But instead, according to medical superintendents, the classroom and the home were two of the chief villains. The frantic quality of American life owed much to the style of training the new generation. The school, for its part, ostensibly disobeyed every sound principle of mental hygiene. It admitted children at too early an age, between three and five, and kept them in the classroom too long, a minimum of six hours per day. It crammed them with information as rapidly as possible, piled lesson upon lesson, lengthened the hours of study, and considered recreation and rest as merely the loss of valuable time. The immediate damage inflicted on young and tender minds was only matched by the predisposition this regimen established for nervous disorders later in life.²²

The classroom unhappily duplicated the pace and principles of the marketplace. Rather than offer an alternative to an overcompetitive and ultimately debilitating system, it reproduced in miniature the conditions of the larger society. "Discipline and development may be theoretically recognized as legitimate objects of education," observed Isaac Ray, "but practically they are regarded as subordinate to that which predominates over all others, viz., the means of distinction which it gives — the medals, prizes and honors." In other words, "we manage the education of our children somewhat as we often manage our capital, going upon the plan of quick returns and small profit." The students' accumulations were like the speculators', large, showy, but not solid. The close fit between the morality of the school and the society also infected children with the spirit of limitless ambition.²³ American education, contended Edward Jarvis, excited "expectations which cannot be realized and led their pupils to form schemes inconsistent with the circumstances that surround them." In the classroom students first learned to "look for success, honor, or advantages, which their talents, or education, or habits of business, or station in the world, will not obtain for them." Therefore, as adults, "they are laying plans which cannot be fulfilled, they are looking for events which will not happen. They are struggling perpetually

and unsuccessfully against the tide of fortune." Without the ability, wisdom or power to satisfy "unfounded hope and ambition," they were "apt to become nervous, querulous, and despondent, and sometimes, insane."²⁴

Medical superintendents ascribed to the family ultimate responsibility for perpetuating this educational system. "The plans of education proposed by many zealous instructors," argued Jarvis, "and adopted by many who are in authority . . . correspond . . . with the willingness of parents and children to carry them out."²⁵ The lessons that children first learned in their nurseries at home were repeated in the school, and parents would allow no other way. A mistaken ambition for the intellectual and social achievement of their children led parents to insist that teachers convey a maximum amount of information in the shortest possible time. And medical superintendents magnified the pervasiveness of this spirit of ambition: No sooner did a young man join the race for success than he not only received the approbation of his own conscience, but immediately became the pride of his parents, the honor of his school, the envy of his friends, and "the hope of the coming age" to commencement speakers.

The family was the one institution that psychiatrists believed might have calmed the frantic spirit at loose in the community. A well-ordered family could protect its charge from the disordered society, inoculating the child against the disease before he suffered exposure. Instead, it brought the germs right into the cradle. Whether indulgent or neglectful or hypersensitive to success, the family failed to discipline its charges. "The asceticism of our ancestors," claimed Ray with another fond look backward, "was infinitely less injurious than the license which characterizes the domestic training of their descendants." Children of this generation scarcely ever felt the authority of any will but their own, and obeyed "no higher law than the caprice of the moment." Family government exercised only "feeble and fitful rule," yielding to the slightest opposition, and encouraged, rather than repressed, children's selfish and indulgent inclinations. Almost from birth, Ray contended, youngsters contemplated life "not as a field of discipline and improvement, but a scene of inexhaustible opportunities for fulfilling hope and grati-

fyng desire." Under this training, patience and perseverance "become distasteful to the mind which can breathe only an atmosphere of excitement. . . . It reels under the first stroke of disappointment, turns upon itself . . . and thus it is that many a man becomes insane." Mental illness, concluded Ray, will continue to increase until the time when the family transmitted "a higher culture" to the nation's children. But he saw little prospect for such a change.²⁶

Medical superintendents broadly defined both the symptoms of the disease and its potential victims. They described in the widest possible terms the kinds of behavior that might constitute evidence of insanity, and repeatedly stressed that the ailment was not the special curse of one group or another, that anyone in American society could succumb to it. The barrier between normality and deviancy was very low. The preconditions for individual pathology so pervaded the society, and the manifestations of the disease were so broad that no one who stood on one side of it today could be sure he would not cross it tomorrow.

Official definitions did not limit insanity to a special style of behavior or restrict the range of possible symptoms. Psychiatrists did not attempt to label one specific mode of conduct deviant and indicative of mental disorder, another normative and therefore healthy. Taken alone, neither anger nor passivity, querulousness nor silence pointed to the disease. Any action could be a manifestation of insanity when placed in the context of the patient's life. At times the extravagance of the behavior made the diagnosis simple. Few skills were necessary for recognizing the insane suffering from delusions, thinking they were Alexander the Great or Christ. Similarly, a total loss of capacity to perform elementary acts without any corresponding physical disability—the unwillingness to eat, inability to talk or control muscles—pointed to the presence of the illness. But not all cases were so straightforward. And medical superintendents, conscious not only of their own needs but of those of lawyers and judges as well, attempted to explicate a more sophisticated guideline.

Isaac Ray's *Medical Jurisprudence of Insanity* was the clearest and most widely read effort. Ray conceded at the outset the difficulty of differentiating abnormal from normal behavior, "of discriminating . . . between mental manifestations modified by

disease, and those that are peculiar, though natural to the individual." He found no fault, therefore, in allowing a jury of laymen, rather than a group of ostensible experts, to settle the question in criminal cases. Nevertheless, there were useful principles to guide verdicts. The Rhode Island medical superintendent cautioned against associating only the most outlandish behavior with the disease, and attempted to extend, rather than narrowly circumscribe, the possible symptoms. "Madness," he insisted, "is not indicated . . . by any particular extravagance of thought or feeling."²⁷ A patient could be quiet and insane, insane on some subjects and not others, able to make rational calculations and yet suffer from irresistible impulses, fit to reach logical conclusions but not moral ones. Insanity might be characterized by violence, as in mania, or by depression, as in melancholia, or by incompetence, as in dementia.

But these categories were abstract. There was, perforce, no master checklist that men could use to reach a decision. "To lay down, therefore, any particular definition of mania, founded on symptoms, and to consider every person mad who may happen to come within the range of its application," argued Ray, would only promote a "ridiculous consequence." Hence, "when the sanity of an individual is in question, instead of comparing him with a fancied standard of mental soundness . . . his natural character should be diligently investigated." Only in this way could an observer know whether his behavior was evidence of madness or merely idiosyncratic. "In a word," declared Ray, "he is to be compared with himself, not with others." When the methodical businessman became confused, when someone economical suddenly turned prodigal, when a jovial and communicative person became morose and withdrawn, when a conservative and religious churchgoer turned radical and freethinking, then there was cause for concern. Insanity was no longer the exclusive province of the raving lunatic or totally incompetent. Medical superintendents opened up the category and alerted the community to a whole new range of possibly deviant behavior.

Nor did the analysis of the origins of mental illness in any way restrict the category of those liable to the disease. Everyone, regardless of social class, might suffer its effects. The rich could not expect a higher standard of living to provide protection and

the poor could not take consolation in believing that their misery offered immunity. Medical superintendents issued identical and unequivocal pronouncements. "Every person," stated one psychiatrist in Connecticut, "is liable to an attack of insanity." His counterpart in Kentucky confirmed: "Insanity is peculiar to no grade in life. There are none so elevated as to be beyond its reach. . . . It has dethroned the monarch, and deepened the gloom of the hovel." In brief, "the disease is as apt to attack the rich as the poor."²⁸

The reasons for the vulnerability of the middle and upper classes were implicit in the postulates on the causes of the disease. By explicitly linking mental illness with keen ambition, hazardous speculations with the vicissitudes of social mobility, medical superintendents left no doubt that men of success might well have to pay the price of insanity for their achievements. They incessantly reproved "unnatural" and "artificial" habits, defining these vague terms as a luxurious, modish or refined style of life. "With the increase of wealth and fashion," admonished Jarvis, "there comes also, more artificial life, more neglect of natural laws of self-government, more unseasonable hours for food and for sleep, more dissipation of the open, allowable and genteel kind." There was no doubt which class he had in mind when warning about the effects of "luxury, self-indulgence, sensuality, and effeminacy . . . late hours, spent in vulgar or graceful dissipation." The combination of these two elements, the "exhausting and perplexing cares and toils of business," together with a "social life and fashion," led inexorably to insanity.²⁹

The poor, not ones to experience these particular penalties of civilization, had their own special problems. As Samuel Woodward explained, the effects of poverty—the struggle for subsistence, the constant threat of ill health, the domestic squabbles and the temptations to vice—all helped to make the lower classes as susceptible to mental illness as the most reckless group of speculators. In fact, contended Woodward, the poor were "more to be pitied," for unlike the upper classes, they did not have the prerogative of reforming their ways. If unable to escape from need, they could not avoid its harsh consequences. Among them, "the causes [of insanity] are generally involuntary," and none the less powerful for being so.³⁰

The medical superintendents' critique of the antebellum social order cannot be dismissed or denigrated as the idiosyncratic view of a group of disaffected Whigs and die-hard Federalists, well out of the mainstream of American life and thought, or as the special perspective of a handful of professional men, faithful to a medical doctrine. Their attack was basic, but they were not responding as bitter outcasts or eccentric scientists. They condemned the very facets of nineteenth-century life which at least in retrospect seem most American: high levels of social mobility and political participation, intellectual and religious freedom and enthusiasm. Invariably, their comparisons between the seeming disorder of their own society and the fixity and stability of more traditional ones, put American innovations in a poor light. Medical superintendents were unable to approve a design that they believed excited each individual, regardless of station, to pursue grandiose goals, that brought every citizen, no matter what his capabilities, into the political arena. Their complaints make them appear almost as reactionary as the most aristocratic French émigré of the old regime. And yet, they were active participants in the new system, eminent and successful men, not bound to one political party or another.³¹ They helped to lead a reform movement that to most contemporaries, as well as historians, epitomized the Jacksonian spirit of humanitarianism. Instead of standing aloof and bemoaning conditions, they plunged in with great energy and commitment to try to set things right. They enjoyed warm personal relations with lay reformers, influencing their thinking in critical ways. Dorothea Dix and Samuel Gridley Howe, for example, accepted and popularized their explanations for the causes of insanity. Psychiatric theories, then, did not reflect the unhappiness of an alienated minority but the widely shared anxiety of antebellum Americans about the social order.

Just as the first penologists located the origins of crime within the community, so psychiatrists linked mental illness to social organization. The epidemic of insanity, like the prevalence of crime, pointed to the most fundamental defects of the system, from mistaken economic, political, and intellectual practices to grave errors in school and family training. The insane were victims of forces beyond their control, not to blame for their

misfortunes. Medical superintendents did not magnify the influence of heredity. Unlike their post-Civil War successors, they believed that it might predispose an individual to insanity, but could not by itself, and without the confluence of other circumstances, bring on the illness. Heredity, declared Samuel Woodward, "never results in alienation of mind without the intervention of exciting causes. If the exciting causes of the disease are avoided, the strongest predisposition need not result in insanity." The "exciting causes" were the key to the problem, and these medical superintendents discovered in abundance in the style of American life.³²

The discussions of insanity, like those of crime, conveyed a heightened, almost hysterical sense of peril, with the very safety of the republic and its citizens at stake. From the inquiry into the causes of crime, it seemed as if Americans faced danger at every turn, and frequently succumbed to it. Officials and reformers pictured streets crowded with taverns, theaters and houses of prostitution, like a western town in a grade-B movie. And the same grim picture emerged from the writings of medical superintendents. The individual was under siege, surrounded by pernicious conditions and practically helpless to defy them. In their estimation, not vice so much as the basic organization of society threatened stability. But the implications of the two critiques were almost identical — wherever the individual turned, some hazard awaited him. Either vice would turn him to crime or stress would bring him to insanity.

Why were medical superintendents so convinced that dangers were omnipresent in the community? Why were their predictions so direful? For one thing, they had been taught, according to the prevailing psychological theory, that the mind operated by association and not through inherited ideas. When the mind became diseased, the fault had to rest with the associations outside it, and psychiatrists, therefore, turned attention to external influences, to the phenomena that the mind was perceiving — in other words, to the society in which the individual lived. For another, medical superintendents were eager to cure mental illness, prodded on by Enlightenment doctrines and a faith in progress, and republic patriotism. Convinced that to identify the source of the problem would be to master it, they

looked avidly for faults in society. Yet, why were they, like the first penologists, so remarkably successful in their search, able to write almost endlessly about the deficiencies in American life? After all, Jacksonian society was not verging on collapse and it is doubtful, for example, whether the rates of insanity were actually increasing. (Evidence is hard to come by, but one recent study, *Psychosis and Civilization*, argues convincingly that the rate of insanity in this country has remained constant from before the Civil War to the present.³³) Rather, psychiatrists' anxieties were ultimately tied to their conception of the proper social order. Against the norms that they held, the American scene appeared chaotic.

Medical superintendents were certain that their society lacked all elements of fixity and cohesion because they judged it by a nostalgic image of the eighteenth century. Frightened by an awareness that the old order was passing and with little notion of what would replace it, they defined the realities about them as corrupting, provoking madness. The root of their difficulty was that they still adhered to the precepts of traditional social theory, to the ideas that they had inherited from the colonial period. By these standards, men were to take their rank in the hierarchy, know their place in society, and not compete to change positions. Children were to be content with their station, taking their father's position for their own. Politics and learning were to be the province of trained men, and ordinary citizens were to leave such matters to them. Family government was to instill order and discipline, and the community to support and reinforce its dictums. This was the prescription for a well-ordered society, one that would not generate epidemics of insanity.

As early as the colonial period, reality did not always fit with such a static theory. But the colonists, lacking intellectual and social incentives, had not been forced to confront the gap. Americans in the Jacksonian period, however, recognized the disparity and were frightened by it. The society was more fluid than before, and greater geographic and social mobility made it more difficult to maintain older theories. Enlightenment ideas and a faith in progress also opened up endless possibilities for achievement, and the prospect of bringing glory to the new republic made these opportunities all the more welcome. As a

result, they looked closely and carefully at their society, and worried about what they saw.

Medical superintendents had little trouble comprehending the influences encouraging individualism in America. But they could not perceive what forces would prevent the separate atoms from breaking off and scattering in wild directions. Was there a nucleus able to hold these disparate elements together? This fundamental and troubling question ultimately revealed the difficulties in conceptualizing the kind of social structure that should accompany republican government. Officials and laymen alike were dubious whether a society so intent on promoting individual effort would be able to achieve cohesion. Could it withstand the strains of widespread physical and social mobility? Could it tolerate unprecedented political participation and a pervasive skepticism toward traditional ideas? Later, in the post-Civil War era, with a confidence born of survival and some measure of success, men would emphatically answer yes. The fear of the father would become the glory of the son. The self-made man would stand as a hero, not a potential madman, a fluid society would be the pride of the country, not the chief cause of crime and insanity. But to Americans in the Jacksonian period the matter was anything but settled. The danger that under continued stress the structure might collapse seemed not at all remote.

And yet, the effect of these conceptions was to promote a vigorous and popular movement for amelioration. Rather than abandon all hope before such a depressing analysis of the nature of American society, medical superintendents and laymen issued a call for action and sparked a revolution in the practices toward the insane. For one corollary of these doctrines held that since mental illness originated in the structure of society, not in God's will or individual failings, the community incurred an inescapable responsibility. Reformers themselves felt the burden that this contention imposed, and educated the public to it. As Edward Jarvis explained, "Society establishes, encourages or permits these customs out of which mental disorder may and frequently does arise." Therefore, it had the clear obligation "to heal the wounds it inflicts." Dorothea Dix, taking her cues from this formulation, demanded of innumerable state legislatures:

"Should not society, then, make the compensation which alone can be made for these disastrous fruits of its social organization?" In similar terms, Samuel Gridley Howe prodded his countrymen to make a broad commitment to the care of the insane. "This duty of society, besides being urged by every consideration of humanity," he declared, "will be seen to be more imperative if we consider that insanity is in many cases the result of imperfect or vicious social institutions and observances."³⁴ Having caused the pain, it was incumbent on the community to help relieve it.

An environmental conception of the causes of deviant behavior encouraged men to believe that such ailments as insanity were curable. The community not only had the moral obligation but the ability to correct the condition. Having located the etiology of the disease in social organization, medical superintendents were confident that a setting which eliminated the irritants could restore the insane to health. The diagnosis of the causes of the disease provided the clues to a cure. To be sure, the very magnitude of the problem ruled out a frontal assault. Where would one begin an effort to limit ambition and intellectual independence, to curb physical and social mobility, to alter the economic, political, religious, and social character of the new republic? Framed in this fashion, the question was unanswerable. But reformers devised a workable solution to this dilemma. Rather than attempt to reorganize American society directly, they would design and oversee a distinctive environment which eliminated the tensions and the chaos. They would try to create — in a way reminiscent of the founders of utopian communities — a model society of their own, not to test a novel method for organizing production or making political decisions, but to exemplify the advantages of an orderly, regular, and disciplined routine. Here was an opportunity to meet the pressing needs of the insane, by isolating them from the dangers at loose in the community, and to further a reform program, by demonstrating to the larger society the benefits of the system. Thus, medical superintendents and laymen supporters moved to create a new world for the insane, one that would not only alleviate their distress but also educate the citizens of the republic. The product of this effort was the insane asylum.



The New World of the Asylum

The sturdy walls of the insane asylum became familiar landmarks in pre-Civil War America. They jutted out from flat rural landscapes or rose above the small houses of new suburbs, visible for some distance and unmistakably different from surrounding structures. Their growth was rapid and sudden. Before 1810, only a few eastern-seaboard states had incorporated private institutions to care for the mentally ill, and Virginia alone had established a public asylum. All together they treated less than five hundred patients, most of whom came from well-to-do families. Few departures from colonial practices occurred in the first forty years after independence; the insane commonly languished in local jails and poorhouses or lived with family and friends. But in the course of the next few decades, in a dramatic transformation, state after state constructed asylums. Budding manufacturing centers like New York and Massachusetts erected institutions in the 1830's, and so did the agricultural states of Vermont and Ohio, Tennessee and Georgia. By 1850, almost every northeastern and midwestern legislature supported an asylum; by 1860, twenty-eight of the thirty-three states had public institutions for the insane. Although not all of the mentally ill found a place within a hospital, and a good number among the aged and chronic poor remained in almshouses and jails, the institutionalization of the insane became the standard procedure of the society during these years. A cult of asylum swept the country.¹

The movement was not born of desperation. Institutionaliza-

tion was not a last resort of a frightened community. Quite the reverse. Psychiatrists and their lay supporters insisted that insanity was curable, more curable than most other ailments. Spokesmen explained that their understanding of the causes of insanity equipped them to combat it, and the asylum was a first resort, the most important and effective weapon in their arsenal.

The program's proponents confidently and aggressively asserted that properly organized institutions could cure almost every incidence of the disease. They spread their claims without restraint, allowing the sole qualification that the cases had to be recent. Practitioners competed openly with one another to formulate the most general and optimistic principle, to announce the most dramatic result. One of the first declarations came from the superintendent of the Massachusetts asylum at Worcester, Samuel Woodward. "In recent cases of insanity," he announced in 1834, "under judicious treatment, as large a proportion of recoveries will take place as from any other acute disease of equal severity." In his own institution, he calculated, 82.25 percent of the patients recovered. Still, Woodward's tone was judicious and moderate in comparison to later assertions. Dr. Luther Bell, from Boston's McLean Hospital, had no doubt that all recent cases could be remedied. "This is the general rule," he insisted in 1840; "the occasional instance to the contrary is the exception." Performance ostensibly kept pace with theoretical statements. John Galt reported from Virginia in 1842 that, excluding patients who died during treatment, he had achieved one hundred percent recoveries. The following year, Dr. William Awl of the Ohio asylum simply announced without qualification one hundred percent cures.²

These statistics were inaccurate and unreliable. Not only was there no attempt to devise criteria for measuring recovery other than release from an institution, but in some instances a single patient, several times admitted, discharged, and readmitted, entered the lists as five times cured. At Pennsylvania's Friends' asylum, for example, 87 persons contributed 274 recoveries. It was not until 1877 that the first major attack on these exaggerated claims appeared, and only at a time when the widespread faith in curability had already begun to evaporate.

Before the Civil War, these extraordinary pronouncements

were widely accepted at face value, and no skeptical voices tried to puncture the balloon of inflated hopes. Psychiatrists, confident of having located the origins of the disease, were fully prepared to believe and to testify that the incredible number of cures was the just fruit of scientific investigation. Personal ambition as well as intellectual perspective made them eager to publicize these findings. The estimates were self-perpetuating; as soon as one colleague announced his grand results, others had little choice but to match or excel him. With supervisory committees of state legislatures and boards of trustees using the number of recoveries as a convenient index for deciding appointments and promotions, medical superintendents were under great competitive pressure to report very high rates. And professionals and laymen alike desperately wanted to credit calculations that would glorify American science and republican humanitarianism. A cure for insanity was the kind of discovery that would honor the new nation.³

The consistency of the claims quickly established their validity. With an almost complete absence of dissenting opinion, the belief in the curative powers of the asylum spread through many layers of American society. Given the hyperbolic declarations of the professionals, laymen had little need to exaggerate their own statements. The most energetic and famous figure in the movement, Dorothea Dix, took the message from Massachusetts to Mississippi. With passion and skill she reported in painful detail on the wretched condition of the insane in poorhouses and jails — “Weigh the iron chains and shackles, breathe the foul atmosphere, examine the furniture, a truss of straw, a rough plank” — and next recited the promise of the asylum. Her formula was simple and she repeated it everywhere: first assert the curability of insanity, link it directly to proper institutional care, and then quote prevailing medical opinion on rates of recoveries. Legislators learned that Dr. Bell believed that cure in an asylum was the general rule, incurability the exception, and that Drs. Ray, Chandler, Brigham, Kirkbride, Aul, Woodward, and Earle held similar views.⁴ Legislative investigatory committees also returned with identical findings. Both Massachusetts and Connecticut representatives heard from colleagues that insanity yielded as readily as ordinary ailments to proper treat-

ment. The most tax-conscious assemblyman found it difficult to stand up against this overwhelming chorus. One after another, the states approved the necessary funds for erecting asylums.⁵

The institution itself held the secret to the cure of insanity. Incarceration in a specially designed setting, not the medicines that might be administered or the surgery that might be performed there, would restore health. This strategy for treatment flowed logically and directly from the diagnosis of the causes of the disease. Medical superintendents located its roots in the exceptionally open and fluid quality of American society. The American environment had become so particularly treacherous that insanity struck its citizens with terrifying regularity.

One had only to take this dismal analysis one step further to find an antidote. Create a different kind of environment, which methodically corrected the deficiencies of the community, and a cure for insanity was at hand. This, in essence, was the foundation of the asylum solution and the program that came to be known as moral treatment. The institution would arrange and administer a disciplined routine that would curb uncontrolled impulses without cruelty or unnecessary punishment. It would re-create fixity and stability to compensate for the irregularities of the society. Thus, it would rehabilitate the casualties of the system.⁶ The hospital walls would enclose a new world for the insane, designed in the reverse image of the one they had left. The asylum would also exemplify for the public the correct principles of organization. The new world of the insane would correct within its restricted domain the faults of the community and through the power of example spark a general reform movement.⁷

The broad program had an obvious similarity to the goals of the penitentiary, and both ventures resembled in spirit and outlook the communitarian movements of the period, such as Brook Farm and New Harmony. There was a utopian flavor to correctional institutions. Medical superintendents and penitentiary designers were almost as eager as Owenites to evolve and validate general principles of social organization from their particular experiments.

The central problem for these first psychiatrists was to trans-

late the concept of a curative environment into reality. Rehabilitation demanded a special milieu, and they devoted almost all of their energy to its creation. The appropriate arrangement of the asylum, its physical dimensions and daily routine, monopolized their thinking. The term for psychiatrist in this period, medical superintendent, was especially apt. Every detail of institutional design was a proper and vital subject for his consideration. His skills were to be those of the architect and the administrator, not the laboratory technician.

The writings of Thomas Kirkbride, head of the prestigious Pennsylvania Hospital for the Insane from 1840 until his death in 1883, testified to the significance of this perspective. He published one of the leading textbooks on insanity, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane, with some Remarks on Insanity and its Treatment*; and the title was ample evidence of the volume's intellectual focus and ordering of priorities.⁸ Kirkbride gave the book over to the location of ducts and pipes in asylums, and to accounts of daily routines. He first discussed the proper size and location for the buildings, the right materials for constructing walls and making plaster, the best width for rooms and height for ceilings, the most suitable placement of water closets and dumb-waiters; then he analyzed how to group patients, to staff the hospital, to occupy the inmates during the day. This type of treatise, it is true, was very useful at a time when building and managing institutions was an infant skill. Still, the objective needs of the situation were only a part of the inspiration for a book like Kirkbride's. Far more important to him was the conviction that in settling these technical matters of construction and maintenance, he was confronting and solving the puzzle of curing insanity.

His attitude was not idiosyncratic. The Association of Medical Superintendents, organized in 1844, had a membership composed exclusively of heads of asylums. Institutional affiliation, not research or private practice, defined the profession; the association's committees were predominantly concerned with administrative and architectural questions. There was a committee on construction, on the proper number of patients for one institution, on the best role of chapels and chaplains in the asylum, on

separate structures for colored persons, on the comparative advantages of hospital and home treatment. The association also published the *American Journal of Insanity*, a periodical devoted to a wide range of issues. But the primary focus of the group was on the structure of institutions. In 1851 it produced its first major policy statement, a definition of the proper asylum architecture. Resolution number eight, for example, declared: "Every ward should have in it a parlor, a corridor . . . an associated dormitory . . . a clothes room, a bath room, a water closet . . . a dumb waiter, and a speaking tube." In 1853 it issued a second declaration on administrative organization. Rule number seven captured its spirit: "The matron, under the direction of the superintendent, should have a general supervision of the domestic arrangements."⁹ In fact, the association was never able to widen its concerns. In the 1870's, when new ideas begin to revolutionize the field, it remained unalterably fixed to its original program, becoming a stumbling block to experimentation and innovation.

There was a functional quality to this narrowness of perspective. Medical superintendents lacked any guidelines with which to design and administer the first mental hospitals. Never before had Americans attempted to confine large numbers of people for long periods of time, and the difficulties were all the greater since their goals extended far beyond simple restraint. Eighteenth-century practices had little relevance to nineteenth-century officials. The almshouse and the jail represented all that medical superintendents wished to avoid in an institution.

Contemporary European practices were not very much more helpful. American superintendents frequently crossed the ocean to examine Continental institutions, but their visits were usually unproductive. Pliny Earle, who first headed the Friends' asylum in Philadelphia and then Bloomingdale in New York, toured the Continent in 1838-39 and then again in 1845, and his reports illuminated the unique problems and special opportunities confronting Americans, who were at once more free to innovate and yet felt more keenly the lack of precedents. European asylums, Earle discovered, were frequently nothing other than a new name carved in an ancient doorway. Each structure had a long history of different uses — a fourteenth-century monastery became later

a sixteenth-century fort, and still later an eighteenth-century almshouse, and finally a nineteenth-century mental hospital. Earle methodically noted how in Prussia the asylums at Siegburg and at Brieg and at Owinsk were all former monasteries; in Halle, the hospital occupied the quarters of the old prison. The Austrian town of Ybbs, he found, turned a building that had served successively as a barracks, a military hospital, and an almshouse into an asylum. So, too, the German town of Sonnestein converted a onetime castle into a place for the insane and the village of Winnental made over to them a nobleman's palace that had once been a monastery.¹⁰ But Americans, in marked contrast, had to start from scratch. "There were no old half-ruined monasteries," observed one Englishman, "to be converted into asylums for their insane poor. . . . Americans had to build their own asylums." They had the opportunity to create something new, and the predicament of precisely how to go about it.¹¹

Medical superintendents received little assistance from their countrymen. No groups of specialists — architects, engineers, bureaucrats — possessed requisite skills for constructing and administering a mental hospital. There were no large-scale organizations in the country whose designs and procedures could be easily emulated. One result of these circumstances was that every new asylum became the immediate focus of attention for other officials. Medical superintendents and legislative investigatory committees from neighboring states seemed to have arrived at the door of a new institution along with its first patients. No sooner did New York State appoint a board of commissioners to construct an insane asylum in 1839 than the committee visited the institutions in Massachusetts, Pennsylvania, and other nearby states; two years later the first trustees of the new Utica asylum made an exhaustive review of procedures in all leading mental hospitals. The tour of inspection was as necessary as it was popular.¹²

But an even more important result of these circumstances was that the concepts shared by medical superintendents exercised an exceptional degree of influence in the actual construction and administration of the first insane asylums. With few precedents to guide them, they experimented with their own ideas; with no

inherited structures to limit them, they built institutions according to their particular designs. Hence, reformatory theory and practical needs fit well together, perhaps too well. It may be that part of the enthusiasm for environmental solutions reflected the lack of experience. Still, this concentrated attention to institutional organization established the guidelines for translating confinement into cure.

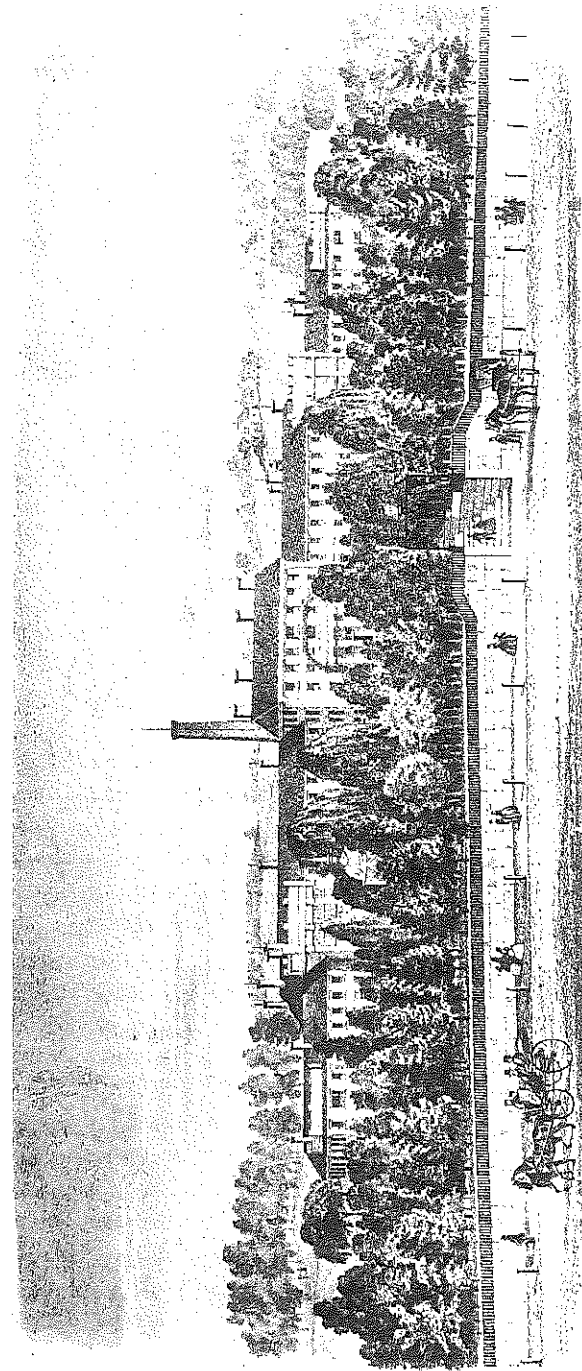
The first postulate of the asylum program was the prompt removal of the insane from the community. As soon as the first symptom of the disease appeared, the patient had to enter a mental hospital. Medical superintendents unanimously and without qualification asserted that treatment within the family was doomed to fail. They recognized the unusual nature of their doctrine and its apparent illogic. Since families had traditionally lodged the insane, it might seem a cruel and wanton abdication of responsibility to send a sick member to a public institution filled with other deranged persons. But they carefully explained this fundamental part of their program. Isaac Ray, chief of Rhode Island's asylum, conceded that "to sever a man's domestic ties, to take him out of the circle of friends and relatives most deeply interested in his welfare . . . and place him . . . in the hands of strangers, and in the company of persons as disordered as himself — at first sight, would seem . . . little likely to exert a restorative effect." Yet he and his colleagues insisted that isolation among strangers was a prerequisite for success. Although the strategy might increase the momentary pain of the disease, it promised an ultimate cure. "While at large," Ray declared, "the patient is every moment exposed to circumstances that maintain the morbid activity of his mind . . . [and] the dearer the friend, the greater the emotion. . . . In the hospital, on the other hand, he is beyond the reach of all these causes of excitement."¹³ How else, asked Edward Jarvis, could the insane escape "the cares and anxieties of business . . . the affairs of the town . . . the movements of religious, political and other associations. . . . Hospitals are the proper places for the insane. . . . The cure and care of the insane belong to proper public institutions."¹⁴

Second, the institution itself, like the patients, was to be

separate from the community. According to medical superintendents' design, it was to be built at a distance from centers of population. Since it was dependent upon the city for personnel and supplies, it could not completely escape contact. But the institution was to have a country location with ample grounds, to sit on a low hillside with an unobstructed view of a surrounding landscape. The scene ought to be tranquil, natural, and rural, not tumultuous and urban. Moreover, the asylum was to enforce isolation by banning casual visitors and the patients' families. If friends and relatives "were allowed the privilege they seek," cautioned Ray, "the patient might as well be at large as in the hospital, for any good the latter may do him by way of seclusion." Correspondence was also to be strictly limited. Even the mails were not to intrude and disrupt the self-contained and insular life.¹⁵

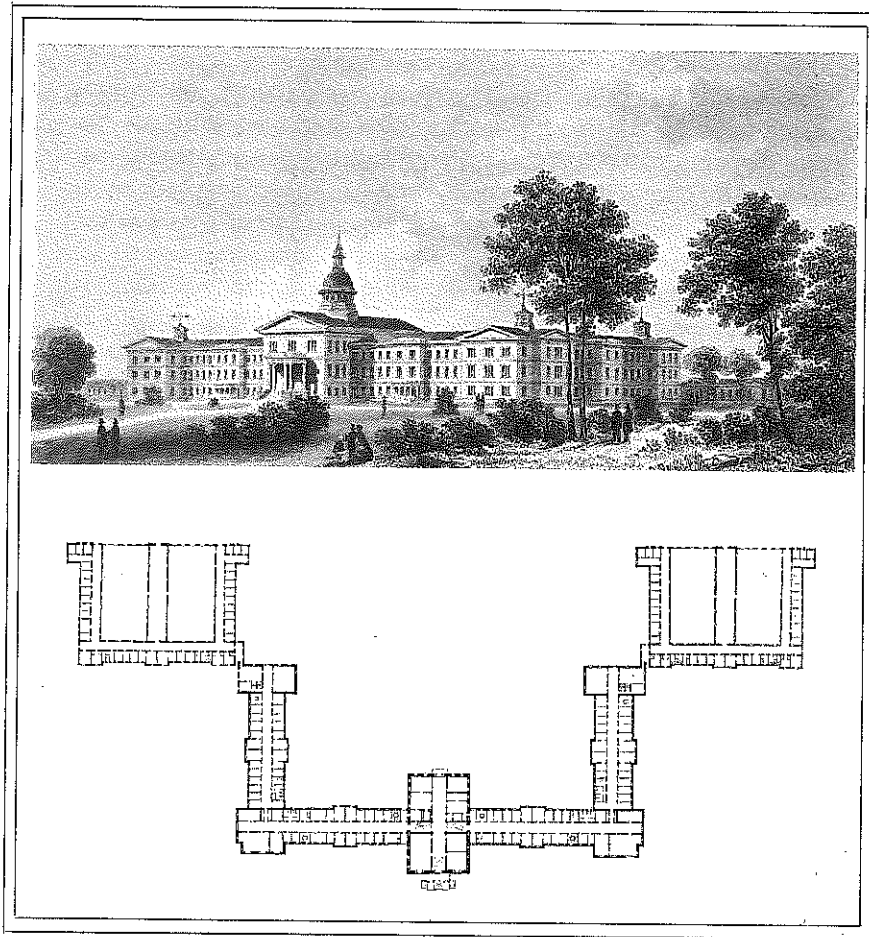
But the most important element in the new program, the core of moral treatment, lay in the daily government of the mentally ill. Here was the institution's most difficult and critical task. It had to control the patient without irritating him, to impose order but in a humane fashion. It had to bring discipline to bear but not harshly, to introduce regularity into chaotic lives without exciting frenetic reactions. "Quiet, silence, regular routine," declared Ray, "would take the place of restlessness, noise and fitful activity." Superintendents had to walk a tightrope, making sure that they did not fall to the one side of brutality or the other of indulgence. "So long as the patient is allowed to follow the bent of his own will," insisted Ray, he exacerbated his illness; outside the asylum, the "only alternative was, either an unlimited indulgence of the patient in his caprices, or a degree of coercion and confinement which irritated his spirit and injured his health." The charge of the asylum was to bring discipline to the victims of a disorganized society. To this end it had to isolate itself and its members from chaotic conditions. Behind the asylum walls medical superintendents would create and administer a calm, steady, and rehabilitative routine. It would be, in a phrase that they and their lay supporters repeated endlessly, "a well-ordered institution."¹⁶

The asylum's designers often labored under severe financial limitations, when legislatures and private philanthropists were



10. *The Worcester State Hospital for the Insane, ca. 1855. Although the structures and the scene seem orderly and placid, the Worcester asylum was beginning to suffer overcrowding and haphazard expansion, the result of the swelling number of chronic and immigrant patients.*

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The Pennsylvania Hospital for the Insane. One of the outstanding private mental hospitals in the pre-Civil War period, the Pennsylvania institution revealed in its design the importance of uniformity and regularity in the treatment of the insane.

not generous with appropriations. Sometimes public officials interfered with their policies, setting down admission requirements that limited administrators' prerogatives. In Massachusetts, for example, the state hospital had to admit the most troublesome and least curable cases first; legislators were more impressed with the convenience than the effectiveness of the institution. And many superintendents were discontented with one facet or another of the asylum's architecture or procedures. Nevertheless, there was usually a close correspondence between founders' ideals and the asylum reality.

No principle was more easily or consistently enacted than the physical separation of the asylum from the community. Almost all the institutions constructed after 1820 were located at a short distance from an urban center. New York erected its state asylum one and one-half miles west of the town of Utica, and Massachusetts built its mental hospital outside Worcester, on a hill overlooking the surrounding farmland. In this same spirit, Connecticut's Hartford asylum went up one mile from the city, with a fine view of the countryside. In Philadelphia, the Pennsylvania Hospital, which had long kept a ward for treating the insane, decided in this period to construct a separate facility for them. The city now surrounded the old institution so that the conditions which made the move seem necessary also simplified the raising of money. The hospital sold off some adjoining lots, at a great profit, and used the proceeds to erect an asylum two miles west of Philadelphia on a one-hundred-and-one-acre farm. Midwestern states followed eastern practices. Ohio's officials, for example, located the mental hospital on the outskirts of Columbus, choosing a site that offered a broad natural panorama.¹⁷

There was, to be sure, a close fit between medical superintendents' desires and the more practical concerns of legislators and trustees. Land outside the city was not only more rural but it was cheaper. So, too, under this arrangement, no established community felt threatened by the intrusion of an asylum, or complained that a lunatic hospital would disturb its peace, safety, and real estate values. To the contrary, budding towns and growing suburbs competed for the right to have the institution in their midst, confident that the resulting income would more than compensate for any nuisance. By common agreement, and to

everyone's satisfaction, the mental hospital secured its quiet and separate location.

The isolation of patients was more difficult to achieve. Medical superintendents had to balance a policy which was to the immediate benefit of the individual inmate with considerations of the long-range interest of mental hospitals in the nation. The asylum was a new institution, and citizens had to be assured that cruel practices would be prohibited. To exclude all of the interested and curious public from its buildings would not only keep distrust alive but even stimulate it. Under these conditions, legislative appropriations and charitable gifts would be curtailed and families would be loath to commit sick members. Some kind of balance had to be struck between isolation and publicity. Superintendents dared not seal off the institution from society.

The most common solution was to allow, and even encourage, tours of the asylum by the ordinary public while making every effort to curtail contact between patient and family. This arrangement would exhibit the institution to the largest number of persons at the least personal cost to the patient. The private Pennsylvania asylum explained to would-be visitors that "the visits of strangers among the patients, are often much less objectionable than those of friends and relatives." Managers would be "glad to show every part of the establishment, and to explain the details of treatment," to anyone genuinely interested in hospitals for the insane. But at the same time they carefully instructed relatives that "the welfare of the patient often demands that they should be completely interdicted." The presence of a family member could provoke an excitement that would take weeks to overcome and delay the recovery.¹⁸

A public institution, like the Utica asylum, opened its doors still more widely to strangers. Aware that many in the state were concerned about the institution's accommodations and management, officials uncomplainingly guided some twenty-seven hundred visitors around the grounds in a typical year, and even took special groups from different sections of the state through the patients' sleeping quarters. Yet they too asked relatives to avoid coming to the institution. The family, they noted, should not "throw any obstacles in the way of recovery, by frequent visits, or requesting friends and relatives to visit."¹⁹ Medical superinten-

dents also discouraged the exchange of letters, fearing that news from home might intrude on the calm and regular routine of the asylum and upset the patients' stability. They did not exclude all reading material, newspapers, and periodicals from the asylum. But they were eager to preserve the insularity of their domain. "Long and tender letters," warned Ohio's superintendent William Awl, "containing some ill-timed news, or the melancholy tidings of sickness and death . . . may destroy weeks and months of favorable progress."²⁰

Superintendents' ability to enforce rigid rules was limited. If regulations were too stringent, the family might vacillate and keep the patient at home too long, or commit and then remove him too soon. The chronic and poverty-stricken insane were captive patients; but psychiatrists, convinced of their ability to cure the disease and eager to make the asylum a first resort, wished to treat the recently sick and those from comfortable households as well. Unwilling to frighten away potential patients, and yet determined to assert control, superintendents adopted two tactics. They discouraged but did not *forbid* relatives to visit and they insisted that a patient be committed for a minimum period — at least three or six months. This strategy was well conceived and in the best institutions, successful. Doctors calmed family fears and gained time to effect a cure, or at least to demonstrate progress. The detailed records of the Pennsylvania Hospital, for example, reveal the loss of only a handful of patients by removal annually.²¹ Thus, once medical superintendents received a patient, they were usually able to separate him fairly systematically from the outside world.

To isolate the insane more rapidly and effectively from the sources of his illness, medical superintendents were also eager to leave commitment laws as simple and as uncomplicated as possible. Most superintendents preferred to allow relatives to bring the patient directly to the institution and arrange for commitment on the spot; only a few believed that prior judicial examination or jury decisions were necessary. The managers of the Utica asylum, for example, objected strenuously to legal formalities in its incorporation act that made the certification of insanity under oath by two "respectable physicians," a prerequisite for admission.²²

Their attitudes were not difficult to understand. Confinement, they believed, was not a punishment but a cure, and hence there was as little cause to begin a legal proceeding before the insane entered an asylum as there was to require it for persons going to any other type of hospital. Furthermore, they found no need to rely upon legal processes when they themselves could easily differentiate between sanity and insanity and every cumbersome requirement might discourage someone from sending a patient to the asylum, a risk which medical superintendents wanted to minimize. Finally, judicial routines too often consumed valuable time, and the longer the delay in admissions, the less the likelihood of a cure. Better for the insane to sit in the asylum than in the courtroom.²³ These objections were generally persuasive. Managers were comparatively free to confine the mentally ill at their own discretion.

The internal organization of the asylum also represented medical superintendents' attempts to realize the idea of moral treatment. They designed and implemented an orderly and disciplined routine, a fixed, almost rigid calendar, and put daily labor at the heart of it. A precise schedule and regular work became the two chief characteristics of the best private and public institutions, and in the view of their managers, the key to curing insanity. The structure of the mental hospital would counteract the debilitating influences of the community. As one New York doctor explained, "the hours for rising, dressing and washing . . . for meals, labor, occupation, amusement, walking, riding, etc., should be regulated by the most *perfect precision*. . . . The utmost *neatness* must be observed in the dormitories; the meals must be *orderly* and comfortably served. . . . The physician and assistants must make their visits at *certain* hours."²⁴ Steady labor would also train inmates to proper habits, bringing regularity to disordered lives. "Useful employment, in the open air," explained the Vermont asylum superintendent, "affords the best moral means for the restoration of many of our patients." Luther Bell, head of the McLean Hospital, fully concurred: "*systematic, regular*, employment in useful body labor . . . is one appliance of moral treatment, which has been proved immeasurably superior to all others."²⁵ Precision, cer-

tainty, regularity, order — these became the bywords of asylum management, the main weapons in the battle against insanity.

From this perspective, the Pennsylvania Hospital arranged the patients' day. They rose at five o'clock, received their medicines at six, and breakfast at 6:30; at eight o'clock they went for a physical examination, and then to work or to some other form of exercise. At 12:30 they ate their main meal and then resumed work or other activities until six, when everyone joined for tea. They passed the evening indoors, and all were in bed by 9:30. This careful division of the day into fixed segments of time to rationalize the inmate's life was the creation of the nineteenth century.²⁶

The procedures adopted at Pennsylvania were followed almost exactly in other hospitals. At the Worcester asylum, patients rose at 5:30 in the summer, 5:45 in the winter; after breakfast, according to the managers, "everything is put in readiness for the visit of the superintendent . . . which commences at precisely *eight* o'clock at all seasons." At Utica, patients awoke to a morning bell at five o'clock, ate at 6:30, and officials strictly instructed the attendants to be punctual. One typical rule: "Breakfast is always to be placed upon the table precisely one hour and a half after the ringing of the bells."²⁷ These regulations had some administrative advantages, enabling superintendents to oversee a more efficient operation. But they reflected even more the strength of a theory that ascribed a therapeutic value to a rigid schedule.

Of all the activities, asylums prized labor the most, going to exceptional lengths to keep patients busy with manual tasks. The Pennsylvania Hospital offered a choice of farming, simple workshop crafts, or household tasks; and superintendent Thomas Kirkbride boasted that many who previously "had unfortunately never been accustomed to labour, nor to habits of industry," were now regularly at work. He encouraged his private patients to do any task; it did not matter whether they planted a garden, husked corn, made baskets or mattresses, cooked, sewed, washed, ironed, attended the furnace or cleaned up the grounds. Outdoor chores were probably most healthy and pleasant, but the critical thing was to keep at the job. This regimen, Kirkbride and his colleagues believed, inculcated regular habits, precisely the trait

necessary for patients' recovery, and thus "rarely failed to contribute to the rapidity and certainty of their cure."

The proof for this was apparent in case histories, and so exemplary tales abounded. One man, in a typical story, had suffered violent fits at least once a month; he took up gardening, applied himself vigorously, and subsequently was free of recurring attacks. Indeed, medical superintendents sounded very much like penitentiary wardens when claiming that their institutions succeeded, where the society had failed, in teaching the virtue of steady labor. Kirkbride was certain that careful administration and a planned "monotony of the parlors and the halls" (wardens talked about the dullness of cells), would lead patients to regard work as a welcome diversion, a privilege and not a punishment. At that moment, every student of deviancy agreed, the inmate was well along the road to rehabilitation.²⁸

Public asylums were even more eager to set patients to work. Administrators' needs seemed to fit neatly with inmates' welfare. Just as it was to the superintendent's personal interest to oversee an economical and efficient operation, so too the patient would benefit from a disciplined and fixed routine. The Worcester asylum had the insane clearing the dining-room tables, washing dishes, cleaning corridors, doing laundry, as well as tilling the adjoining farm; and superintendent Samuel Woodward unhesitatingly defended the hospital's right to utilize and even profit from their efforts. After all, this schedule was the best mode of treatment, and it was striking testimony to the asylum's "system of discipline that the labor of this class of individuals can be made available for any valuable purpose." The institution was entitled to the reward for having brought the insane to this stage of improvement. The managers of the Utica asylum followed an identical course. They reported enthusiastically how patients helped remove the enormous quantities of rubble that had accumulated during the period of construction, how they cleaned and scrubbed the institution daily, and how they raised some of their own food. Their pride in keeping costs down and a belief in the medical value of these tasks gave a self-congratulatory tone to officials' remarks. The well-ordered asylum was a hard-working one.²⁹

The institution achieved its good order and enforced labor

discipline without frequently resorting to the coercion of physical punishment or chains, straitjackets, and other bizarre contrivances. Superintendents everywhere stressed the importance of avoiding harsh penalties and punitive discipline, and their public statements gave first priority to the importance of benign treatment. Of course, declarations of ideals did not always coincide with actual performance, and there were asylums whose professions had little relationship to the hard truth of their practices. Still, many institutions in their first years did live up to these principles. Private asylums in Philadelphia, New York, and Boston were able to avoid in almost all instances artificial restraints and unusual punishment, to maintain well the balance between laxity and cruelty. It demanded great diligence, skillful planning, and painstaking administration, but they achieved the goal.

Pennsylvania's first step was to classify the patient population, dividing the noisy and violent from the quiet and passive, and housing them accordingly. The most dangerous group, those who were most likely to need restraint, entered separate and specially designed buildings. Their rooms were constructed with windows high on the walls, beyond inmates' reach, and could be opened or closed only from an outside hallway. The furiously disordered could not annoy or threaten milder patients, or endanger their own lives. Superintendent Kirkbride chose his attendants well, employed a good number of them—roughly one for every six inmates—and indoctrinated them thoroughly. "We insist," he informed them, "on a mild and conciliatory manner under all circumstances and roughness or violence we never tolerate." A total patient population of about two hundred allowed Kirkbride to reserve for his medical staff the decision to use restraints. Convinced that attendants, no matter how rigorously trained or closely supervised were invariably too eager to apply them—thinking it would save them time and aggravation—Kirkbride gave them no discretion. The physicians, he expected, would first exhaust all other remedies. In fact, the staff usually secluded the violent or suicidal inmate in a guarded room and only if his life seemed in danger did it prescribe some form of restraint. Thus, through wise construction, expenditure of funds, and administrative regulations, Kirkbride minimized physical punishments. In a

typical year, 1842, he happily reported that with the exception of one woman confined to her bed for a few nights, and seven men kept in wristbands or mittens for a few days, "we have found no reason for applying even the milder kinds of apparatus in a single one of the 238 cases under care."³⁰

New York's Bloomingdale Asylum achieved a similar success through identical means. Classification was thorough and intricate for the 150 patients; there were six categories for men, four for women, and two separate buildings to lodge the violent of each sex. The superintendent, Pliny Earle, methodically schooled his attendants, and employed them in adequate numbers, one for approximately every seven inmates. A state legislative committee, after inspecting the institution in 1840, unhesitatingly concluded: "The patients appear to have been remarkably well taken care of. There were none fettered, even with strait-jackets. A pair of stuffed gloves for one patient, and stuffed chairs, with partial restraint for the arms, were the only restraints on any of the whole number in the establishment."³¹

In Boston, the McLean Hospital also managed to enforce discipline without harsh contrivances. Officials gave exceptional attention to classification, convinced that its importance "can not be overrated." They insisted that proper categorization together with "the extensive architectural arrangements . . . has enabled us to dispense almost entirely with restraining measures or even rigid confinement." With a dozen groupings to differentiate among the patients, and with such special facilities as a heated and padded room to calm frenzied inmates, McLean did not have to use mechanical constraints with even one percent of its population. Superintendent Luther Bell screened and selected the attendants very judiciously, considering himself especially fortunate not to "feel the want . . . of a proper kind of assistants." There were in New England, he declared, "a class of young men and women of respectable families, adequate education, and refined moral feelings," who were prepared to devote a few years to asylum employment. Bell hired them in large numbers, on the average of one for every four or five of his 150 patients. He carefully established precise regulations and severely circumscribed their discretionary powers. "No restraint, even of the slightest kind," announced the asylum rules, "should ever be

applied or removed except under the direction of an officer." There is every indication that McLean followed both the letter and the spirit of the law.³²

Public asylums attempted to emulate this performance. Superintendents, regardless of where they served, shared a revulsion against severe discipline, and tried to administer their institutions by the same standards as private asylums. State hospitals were generally less successful in this effort, unable to duplicate the record of Pennsylvania, Bloomingdale, or McLean. Nevertheless, their trustees and managers measured themselves against the criterion of a strict but not cruel discipline, organized a routine, and made necessary revisions to conform better to it. There were lapses and failures, but in the first years of the asylums they were not gross ones. Most mental hospitals in the 1830's and 1840's abolished the whip and the chain and did away with confinement in cold, dank basements and rat-infested cellars — no mean achievement in itself. And often they accomplished more, treating patients with thoughtfulness and humanity.

From its inception, the Utica asylum pledged to avoid corporal punishment, chains, and long periods of solitary confinement to control patients, and during its first years, it kept much of the promise. Managers delighted in describing how quickly they removed the rags and chains that so often bound a new patient, how they bathed and dressed him, and gave him freedom of movement. Almost invariably, they claimed, the patient became quiet, orderly, and responsible. To insure consistent treatment, Utica's regulations also reserved all disciplinary powers to the superintendent, requiring him to keep an official log of every restraint prescribed. Utica's managers instructed attendants precisely and explicitly in their duties: "Under all circumstances," they insisted, "be tender and affectionate; speak in a mild, persuasive tone of voice. . . . A patient is ever to be soothed and calmed when irritated. . . . *Violent hands are never to be laid upon a patient, under any provocation.*"³³

Nevertheless, the organization and structure of the institution prevented full compliance. Attendants were too few — only one for every fifteen patients — to allow close supervision to obviate mechanical restraints. No separate buildings existed for noisy and violent inmates — just makeshift rooms — and patients were

hardly classified. Not surprisingly, superintendents in the 1840's resorted to some odd forms of discipline, such as a warm bath immediately followed by a cold shower; and they themselves complained about overcrowding, tumult, and filth within the institution. These conditions did not go entirely uncorrected. A new manager in the 1850's introduced more intricate classification and abolished the shower-bath treatment. He, too, however, frequently utilized tight muffs and strapped beds to maintain order. If Utica was by no means a model institution, it did demonstrate a real dedication to the idea of mild punishment.³⁴

The Worcester asylum had a similar record. Superintendent Samuel Woodward was intent on demonstrating that the influence of fear and brutal physical force were unnecessary in treating the insane. Despite his good intentions, the asylum did not enjoy consistent success. Performance in its opening years, the mid-1830's, was unsatisfactory. Woodward complained bitterly that the buildings were too few, that classification was impossible, and that attendants were difficult to train. To his extreme displeasure, convalescing patients mingled with violent ones, inmates damaged much of the asylum property, the atmosphere was disorderly, and the patients were clearly not under firm control. Soon, however, the institution entered a second stage, solving within the decade some of these problems. With greater experience and some new facilities, Woodward instilled a steady discipline, so that trustees, including such men as Horace Mann, could boast of "the kindness, the patience, the fidelity, the perseverance and the skill with which the officers and assistants have discharged their duty."³⁵

But conditions again degenerated, and by the end of the 1840's trustees and managers were unhappy with internal procedures. Separation and classification became problems as the number of chronic inmates increased, and violent ones inflicted, in Woodward's opinion, "positive injury" on others, and themselves received inadequate care. But their dissatisfactions notwithstanding, they believed that their asylum represented a fundamental improvement over local poorhouses and jails for the insane. So certain were they of this judgment that they refused to discharge a violent or dangerous patient, even when he was unquestionably incurable, to such places. There he would be chained or handcuffed

or locked in a dungeonlike cell. At Worcester, for all its faults, he would enjoy greater comfort and care.³⁶

The ideals of other public institutions were no different. The directors of the Kentucky asylum insisted that restraints not be utilized, and the managers of the Indiana State Hospital for the Insane diligently instructed attendants to treat patients with "kindness and good will," to "speak to them in a mild, persuasive tone of voice. . . . Violent hands shall never be laid upon patients . . . and a blow shall never be returned." The superintendent at the Eastern Lunatic Asylum at Williamsburg, Virginia, pledged to establish a routine in which "kindness coupled with firmness, are the prominent characteristics." Practice often fell below these standards, but despite the lapses, the world of the antebellum asylum was a universe apart from local jails and almshouses. Medical superintendents' theories and responses brought a new standard of treatment to the insane.³⁷

But the asylum system was highly regimented and repressive. Medical superintendents, carrying out the logic of a theory of deviancy, administered an ordered routine and hoped to eliminate in a tightly organized and rigid environment the instabilities and tensions causing insanity. Their program did resemble that of the penitentiary. Proponents of both institutions insisted on strictly isolating the inmates from society, on removing them as quickly as possible to the asylum, on curtailing relatives' visits and even their correspondence. They both gave maximum attention to matters of design, and both institutions organized their daily routines in exact and punctual fashion, bringing an unprecedented precision and regularity to inmate care.

Superintendents' language, it is true, retained many eighteenth-century usages. Their favorite metaphor was a family one, and they borrowed freely from family vocabulary to describe asylum procedures. The superintendent at the Utica hospital explained his classification system by noting that "our household" was divided into "ten distinct families." When the Worcester asylum was enjoying its most successful years, Samuel Woodward delightedly announced that his 230 patients "form a quiet and happy family, enjoying social intercourse, engaging in interesting and profitable employments, in reading, writing and

amusements." At Bloomingdale, Pliny Earle reported that "the internal arrangements of the Asylum are nearly the same as those of a well-regulated family."³⁸ Patients, unlike convicts, wore ordinary clothing, and medical superintendents even instructed relatives to send along good items to bolster inmates' self-respect. There were no special haircuts, no head-shaving, no identification badges, no number-wearing in the mental hospital; patients walked from place to place, they did not march about or group in formations. By the same token, psychiatrists were very careful not to use penitentiary terminology. Pennsylvania's Thomas Kirkbride, for example, instructed attendants to avoid certain expressions: "No insane hospital should ever be spoken of as having a cell or a keeper within its walls." A household terminology, he assumed, would help to quiet the patients.³⁹

Medical superintendents, however, had very special qualities in mind when they spoke about the family. The routine that they would create in the asylum would bear no resemblance to a casual, indulgent, and negligent household that failed to discipline its members or to inculcate a respect for order and authority. Convinced that the primary fault of the contemporary family lay in its lax discipline and burdensome demands — so that children grew up without limits to their behavior or their ambitions — medical superintendents were determined to strike a new balance between liberty and authority, in a social sense. They did not wish to abandon the benevolent side of family organization, but they hoped to graft onto it a firm and regulatory regimen. They took their inspiration from the colonial period, believing that they were restoring traditional virtues. But to a surprising degree, the result was more in tune with their own era. Regularity, order, and punctuality brought the asylum routine closer to the factory than the village.

If passersby might easily have mistaken an eighteenth-century institution for an ordinary dwelling, there was no confusing a nineteenth-century asylum with a private residence. "The slightest reflection will render it obvious," declared the officials planning the Worcester hospital, "that an edifice designed for the residence of the insane must be materially different, both in form and in interior arrangement, from ordinary habitations."⁴⁰ To protect, confine, separate, and treat the insane demanded

special architectural forms. Managers looked hard for their answers, and since the search was unprecedented, solutions at times differed. But despite some variety, a common pattern emerged. Typically, a central structure of several stories stood in the middle of the asylum grounds, and from it radiated long and straight wings. The main edifice, and usually the most ornate one, was an administration building, fronted with a columned portico and topped with a cupola of height and distinction. Here the superintendent lived, and here the similarity between a fine home and the asylum was most complete. The wings, however, where the inmates resided, had bare and unrelieved façades. Along their length the windows of the patients' rooms divided the space into regular and exact sequences, giving a uniform and repetitious appearance floor after floor. The design of the Hartford Retreat, one of the better institutions of the period, seemed to one later observer exceptionally "plain and factory-like."⁴¹

There were alternative designs available to medical superintendents. They might have constructed a series of small houses or cottages, each sleeping five to ten patients. Classification would have been simplified, construction costs not significantly higher, and married couples could have supervised each lodging, giving a familylike quality to the units. But in fact, they welcomed the regimented quality of the wing design because it fit so neatly with their ideas on order and regularity. Its precise divisions, its uniformity and repetitiousness, symbolized superintendents' determination to bring steady discipline into the lives of the insane and to inspire private families to emulation. Since superintendents did not wish to re-create a prisonlike atmosphere, and wanted no one to confuse an asylum with a place of punishment, they carefully disguised window bars behind sashes and in a few of the more prosperous private institutions, carpeted the long hallways. They retained, however, regularity of appearance. This represented, in visual form, their faith in the ability of a fixed order to cure the insane.

Medical superintendents' confidence in the therapeutic effects of a rigid schedule also introduced a punctuality into the asylum routine. The institution brought a bell-ringing precision into inmates' lives. Officials' careful classification and supervision of inmates also gave the asylum a fixed and orderly quality. There

would be no informal family government or easy mixing of its members here. The mental hospital grouped its patients, assigned them to different buildings, all men to one side of the wings, all women to the other, the noisy and bothersome to the outside, the calm and quiet to the inside. Each class of patients had its own particular obligations and privileges, and a hierarchy of officials watched their behavior, ready to move them from one category to another. Superintendents were determined not to impose a harsh system, but they saw nothing severe or unwarranted in regularity and regimentation. "Nothing is so important," wrote one psychiatrist, "as discipline and subordination, rules and order, in the government of an insane hospital." These virtues would enable patients to escape their disease.⁴²

Thus the insane asylum, like other corrective institutions in the Jacksonian period, represented both an attempt to compensate for public disorder in a particular setting and to demonstrate the correct rules of social organization. Medical superintendents designed their institutions with eighteenth-century virtues in mind. They would teach discipline, a sense of limits, and a satisfaction with one's position, and in this way enable patients to withstand the tension and the fluidity of Jacksonian society. The psychiatrists, like contemporary penologists, conceived of proper individual behavior and social relationships only in terms of a personal respect for authority and tradition and an acceptance of one's station in the ranks of society. In this sense they were trying to re-create in the asylum their own vision of the colonial community. The results, however, were very different. Regimentation, punctuality, and precision became the asylum's basic traits, and these qualities were far more in keeping with an urban, industrial order than a local, agrarian one. The mental hospital was a rebuke to the casual organization of the household and a self-conscious alternative to the informality of earlier structures like the almshouse. It was, in essence, an institution — at its best uniform, rigid, and regular. This was the new world offered the insane. They were among the first of their countrymen to experience it.

7

*The Paradox of Poverty*

Americans in the antebellum era were as concerned and apprehensive about the presence of poverty as they were about the rates of crime and insanity, and gave unprecedented attention to the issue of poor relief. Dependency, like deviancy, became the subject of frequent discussion and detailed research, with legislators and overseers of the poor and philanthropists all attempting to fathom its causes, to estimate its effects, and to frame appropriate responses. Here, too, an acute sense of peril went together with the highest expectations. Observers feared that paupers were draining the nation's resources, demoralizing its labor force, and threatening its stability — and added these worries to a dread of crime and insanity. Yet, reformers also expected to be able to control and even to eliminate poverty in the new republic. The investigation into the nature of dependency, as into deviancy, promised great rewards for success, and awful penalties for failure.

The attempt to ferret out the causes of poverty and formulate a plan to combat it marked a clear departure from earlier practices. Eighteenth-century Americans had not devoted particular energy to these questions or tried to devise new methods of care. They did not interpret the presence of poverty as a social problem, view the dependent as a danger to order, or anticipate that somehow need might be eliminated from the society. Assuming that poverty was providentially caused, they found little to discuss or dispute, and by giving the poor neighbor a fixed rank in the social hierarchy, they forestalled further debate and analysis. In effect, this viewpoint assumed that the poor would

- returns, see Inspectors of the State Prisons of New York, *Sixth Annual Report* (New York, 1853), 25.
49. Despite Lewis's insistence that the prison innovation can be mostly explained in terms of its profitability, the data he gathers shows how much juggling went into the returns. See *The Development of American Prisons*, 201-202, for New Jersey's attempts, and 208-209 for Maryland. A convenient table of the costs of construction in on page 239 — and the sums make eminently clear how much greater the investment was than the returns.
 50. The verdict of an excellent survey of prisons, to be discussed further in ch. 10 below, is that the profit and loss issue cannot be easily resolved. E. C. Wines and Theodore W. Dwight, *Report on the Prisons and Reformatories of the United States and Canada* (Albany, 1867), 266. "The matter," they concluded, "is present in the annual reports, in a manner so complex, confused and obscure, that we find it, in the majority of cases, quite impossible to arrive at clear and satisfactory results." The verdict is even more true for the earlier period. There is a mass of detail, as even a glance at any annual report would reveal, but the general conclusions are hardly persuasive.
 51. W. D. Lewis, *From Newgate to Dannemora*, ch. 8; Orlando Lewis, *The Development of American Prisons*, 133-146. See also, for the New York story, Walter Hugins, *Jacksonian Democracy and the Working Class* (Stanford, 1960), 155-161; "Annual Report of Auburn Prison," *N.Y. Assembly Docs.*, 1842, II, no. 31, p. 14, and "Annual Report of Mt. Pleasant Prison," *N.Y. Senate Docs.*, 1846, I, no. 16, pp. 31-32. A good discussion of the issue is in William Leggett, "The State Prison Monopoly," *Political Writings of William Leggett* (Boston, 1840), 63-64, 83, 263-271. The problems were also found in Tennessee: Jesse C. Crowe, "The Origin and Development of Tennessee's Prison Problem," *Tennessee Historical Quarterly*, 15 (1956), 111-135.
 52. "Government, Discipline of the New-York State Prison," (1834), 18. See too Lieber's translator's preface to *On the Penitentiary*, 14, and *Letter of Gershom Powers*, 16.
 53. Gershom Powers, *A Brief Account of Auburn*, 4. The lockstep was found in practically every penitentiary. For one example, see *Rules and Regulations for the Government of the Maryland Penitentiary* (Baltimore, 1853), 15.
 54. Samuel Gridley Howe, *Prison Discipline*, 55, was a rare exception to the rule. "People generally admire," he unhappily concluded, "the strict discipline, the military precision of the maneuvers, and the instantaneous obedience to every order, which are seen in some congregate prisons." For another description, see B.P.D.S., *First Annual Report* (Boston, 1826), 57-58.
 55. Beaumont and Tocqueville, *On the Penitentiary*, 62, 65; for the Sing-Sing routine, see the 1834 description, "Government, Discipline

- of the New-York State Prison." For a similar pattern in Ohio, see J. H. Matthews, *Historical Reminiscences on the Ohio Penitentiary, from its Erection in 1835 to the Present Time* (Columbus, Ohio, 1884), 16-25, 36, 39.
56. "Government, Discipline of the New-York State Prison" (1834), 16. Beaumont and Tocqueville also noted the military career line, *On the Penitentiary*, 62, citing Lynds in New York, Austin in Massachusetts, and Moses Pilsbury in Connecticut. Many of the careers of the prison leaders are obscure; of the several I examined, no clear pattern emerged. Unlike medical superintendents, there was no prior training or experience. Some came up through the ranks, others entered from the law, on the basis of political influence; still others left a small mercantile business, ostensibly equipped to manage the prison industries.
 57. The design and appearance of the institutions are in the annual reports and the secondary literature cited above. See also George Smith, *A Defense of Solitary Confinement*, 21.

CHAPTER FIVE

1. For European ideas in their American context, see Norman Dain, *Concepts of Insanity in the United States, 1789-1865* (New Brunswick, N.J., 1964). Dain's major interest is with medical thought and development; I have emphasized the social basis of medical superintendents' thinking. This material is also covered, but much less satisfactorily than by Dain, in Ruth B. Caplan, *Psychiatry and the Community in Nineteenth-Century America* (New York, 1969). The title promises more than the book delivers. For the European story, the most stimulating starting point is Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York, 1965); for the English experience, see Kathleen Jones, *Lunacy, Law, and Conscience, 1744-1845* (London, 1955).
2. Isaac Ray, *A Treatise on the Medical Jurisprudence of Insanity* (Boston, 1853, 3rd ed.), 69, 129-130. The volume first appeared in 1838. For similar views see the remarks of Samuel Woodward, superintendent, Worcester State Lunatic Hospital, *Seventh Annual Report* (Boston, 1840), 65-66; see too Connecticut Retreat for the Insane, *Eighteenth Annual Report* (Hartford, 1842), 14.
3. New York State Lunatic Asylum at Utica, "Annual Report," *N.Y. Assembly Docs.*, 1845, I, no. 29, p. 24, table VIII; Tennessee Hospital for the Insane, *Fifth Biennial Report* (Nashville, Tenn., 1861), 22, table VII; Connecticut Retreat, *Thirty-Seventh Annual Report* (Hartford, Conn., 1861), 19, table IX. Almost every institutional report contained a similar chart in these years.

4. Worcester Lunatic Hospital, *Seventh Annual Report*, 76.
5. Edward Jarvis, *Causes of Insanity: An Address delivered before the Norfolk, Massachusetts, District Medical Society* (Boston, 1851), 17; Butler Hospital for the Insane, *Annual Report for 1854* (Providence, R.I., 1855), 13. See too Norman Dain, *Concepts of Insanity*, ch. 4.
6. Pliny Earle, *An Address on Psychologic Medicine* (Utica, N.Y., 1867), 18; Dorothea Dix, *Memorial Soliciting a State Hospital for the Insane, submitted to the Legislature of Pennsylvania* (Harrisburg, Pa., 1845), 5. This theme has been widely discussed in American literature; see, R. W. B. Lewis, *The American Adam* (Chicago, 1955), and Leo Marx, *The Machine in the Garden* (New York, 1964).
7. Pliny Earle, *A Visit to Thirteen Asylums for the Insane in Europe* (Philadelphia, 1841), 124; he cited the travels of Humboldt. Dorothea Dix, "Memorial Praying a Grant of Land for the Relief and Support of the Indigent Curable and Incurable Insane in the United States," 30th Congress, 1st sess., 1848, *Senate Miscellaneous Doc.*, no. 150, p. 2. See, too, Amariah Brigham, *Remarks on the Influence of Mental Cultivation and Mental Excitement upon Health* (Boston, 1833), 91.
8. Worcester Lunatic Hospital, *Sixth Annual Report* (Boston, 1839), 10; B.P.D.S., *Twelfth Annual Report* (Boston, 1837), 95; Butler Hospital, *Annual Report for 1854*, 26. The Dix estimate was in the petition to Congress, "Memorial Praying for a Grant of Land," 1-2; for Howe, see "Insanity in Massachusetts," *North American Review*, 56 (1843), 6.
9. See Samuel Tuke's introduction to Maximilian Jacobi, *On the Construction and Management of Hospitals for the Insane* (London, 1841), lxiii. Henry Maudsley, *The Pathology of the Mind* (New York, 1880; 1st ed., London, 1867), 127-129, 133, 170-171.
10. Wilhelm Griesinger, *Mental Pathology and Therapeutics* (London, 1867; 1st ed., 1845), 138-139, 157. See too James C. Pritchard, *A Treatise on Insanity and Other Disorders Affecting the Mind* (Philadelphia, 1837; 1st ed., London, 1835), 251. This literature is discussed in George Rosen, "Social Stress and Mental Disease from the Eighteenth Century to the Present," *Milbank Memorial Fund Quarterly*, 37 (1959), 5-32; Mark D. Altschule, *Roots of Modern Psychiatry: Essays in the History of Psychiatry* (New York, 1957), ch. 7.
11. W. A. F. Browne, *What Asylums Were, Are, and Ought To Be* (Edinburgh, 1837), 52-53, 62-63; the foreign spokesmen were far more circumspect than their American counterparts.
12. Butler Hospital, *Annual Report for 1853* (Providence, R.I., 1854), 12.
13. Edward Jarvis, *Causes of Insanity*, 14-17, as well as his *Address*

- Delivered at the Laying of the Corner Stone of the Insane Hospital at Northampton* (Northampton, Mass., 1856), 7-8.
14. Butler Hospital, *Annual Report for 1853*, 22-23.
 15. William Sweetser, *Mental Hygiene* (New York, 1850), 358.
 16. Edward Jarvis, *On the Supposed Increase of Insanity* (pamphlet reprinted from the *American Journal of Insanity*, Utica, 1852), 34; see too his *Causes of Insanity*, 16. Woodward's remarks appeared in Worcester Lunatic Hospital, *Tenth Annual Report* (Boston, 1843), 62. The 1857 panic was analyzed in N.Y. Lunatic Asylum, "Annual Report," *N.Y. Senate Docs.*, 1859, I, no. 41, p. 21.
 17. B.P.D.S., *Twelfth Annual Report*, 95.
 18. Butler Hospital, *Annual Report for 1853*, 28-29; Isaac Ray, *Mental Hygiene* (Boston, 1863), 250-256. See too Amariah Brigham, *Mental Cultivation and Mental Excitement*, 78-79.
 19. Edward Jarvis, *Address at Northampton*, 11-12, and *On the Supposed Increase of Insanity*, 31.
 20. Butler Hospital, *Annual Report for 1853*, 23-24; Isaac Ray, *Mental Hygiene*, 257.
 21. Samuel Woodward discussed this issue in his reports; see Worcester Lunatic Hospital, *Sixth Annual Report*, 49; *Tenth Annual Report*, 40-41; *Eleventh Annual Report* (Boston, 1844), 52. See too for a denunciation of the Millerite movement, N.Y. Lunatic Asylum, "Annual Report," 1859, 21-22.
 22. Amariah Brigham, *Mental Cultivation and Mental Excitement*, 50, 82-83; Worcester Lunatic Hospital, *Tenth Annual Report*, 63.
 23. Butler Hospital, *Annual Report for 1859* (Providence, R.I., 1860), 20-21, and *Annual Report for 1853*, 25.
 24. Edward Jarvis, "Tendency of Misdirected Education and the Unbalanced Mind to Produce Insanity," *Barnard's Journal of Education* (1858), 605; *On the Supposed Increase of Insanity*, 32-33. See too his *Address at Northampton*, 9.
 25. Edward Jarvis, "Causes of Mental Disease," *North American Review*, 89 (1859), 325-326. See too William Sweetser, *Mental Hygiene*, 79; Amariah Brigham, *Mental Cultivation and Mental Excitement*, 14-15, 46-47, 50.
 26. Butler Hospital, *Annual Report for 1852* (Providence, R.I., 1853), 18-21; Isaac Ray, *Mental Hygiene*, 259-261. Cf. Norman Dain, *Concepts of Insanity*, 95-96.
 27. The quotations from this volume are found on pp. 134-135. See too, pp. 24-33, 69-71, 138, 250.
 28. Connecticut Retreat, *Thirty-Ninth Annual Report* (Hartford, 1863), 27. Kentucky Asylum, *Annual Report for 1846* (Frankfort, 1847), 20, and its *Report for the Years 1854-1855* (Frankfort, 1856), 35.
 29. Edward Jarvis, *On the Supposed Increase of Insanity*, 34, and his *Increase of Human Life* (n.p., 1872), 228.
 30. Worcester Lunatic Asylum, *Tenth Annual Report*, 61. The presence of many agricultural workers in the asylums was puzzling and

- somewhat disconcerting to the medical superintendents; for their efforts to explain this, see Worcester Lunatic Asylum, *Fifth Annual Report* (Boston, 1838), 45-46, *Sixth Annual Report*, 46, *Eighth Annual Report* (Boston, 1841), 64-65. See too Tennessee Hospital for the Insane, *Third Biennial Report* (Nashville, Tenn., 1857), 41-42.
31. From the careers of fifteen medical superintendents it is clear that most of them attended a medical school, rather than serving some form of apprenticeship; many of them worked their way up the asylum ladder, beginning as a physician, later becoming superintendent. It was not uncommon for chiefs to cross over from one institution to another. A few practiced medicine and took an interest in politics, first serving on an investigatory committee for a state legislature, later getting a legislative appointment to head an asylum. The career lines of this group, as compared with wardens and almshouse heads, was established and certain.
 32. Worcester Lunatic Asylum, *Eighth Annual Report*, 70; see too, *Sixth Annual Report*, 50, and *Seventh Annual Report*, 72-75. For similar discussions, see Edward Jarvis, *On the Comparative Liability of Males and Females to Insanity* (Utica, N.Y., 1850), 20-21; Pliny Earle, *Visit to Thirteen Asylums*, 109; Connecticut Retreat, *Eighth Annual Report*, 16-17; Butler Hospital, *Report for 1854*, 27. See too Norman Dain, *Concepts of Insanity*, 108-113.
 33. Herbert Goldhamer and A. W. Marshall, *Psychosis and Civilization* (New York, 1953).
 34. Edward Jarvis, *Address at Northampton*, 12, and *On the Supposed Increase of Insanity*, 21; Dorothea Dix, *Memorial to the Legislature of Pennsylvania*, 5; Samuel Gridley Howe, "Insanity in Massachusetts," 5.

CHAPTER SIX

1. For asylums' dates of origin, see John M. Grimes, *Institutional Care of Mental Patients in the United States* (Chicago, 1934), 123-125. Brief histories of the nineteenth-century asylums can be found in Henry M. Hurd, *The Institutional Care of the Insane in the United States and Canada* (Baltimore, 1916, 4 vols.). A useful survey also is Albert Deutsch, *The Mentally Ill in America: A History of their Care and Treatment* (New York, 1937).
2. A convenient summary of the optimistic statements is in Pliny Earle, *The Curability of Insanity* (Philadelphia, 1887). The quotations are from pp. 23, 27-29; see too, 38-39, 209, table VI. Earle helped to puncture the myth, but he too had once been guilty of perpetuating it: *Visit to Thirteen Asylums*, 130-131. Almost every memorial of Dorothea Dix repeated these declarations.

3. Pliny Earle, *Curability of Insanity*, was the most important statement; see especially pp. 9, 41-42. Some officials did admit to their techniques: Pennsylvania Hospital, *Fifth Annual Report* (Philadelphia, 1846), 25. For the defensiveness of most superintendents, see Worcester Lunatic Hospital, *First Annual Report* (Boston, 1833), 3, 22-23.
4. Dorothea Dix, *Memorial to the Legislature of Pennsylvania*, 3; quotation is condensed from the original. For other examples of her appeal, see *Memorial Soliciting an Appropriation for the State Hospital for the Insane at Lexington [Kentucky]*, (Frankfort, Ky., 1846), 10-11; *Memorial Praying a Grant of Land*, 25-27; *Memorial Soliciting a State Hospital for the Insane submitted to the Legislature of New Jersey* (Trenton, N.J., 1845), 36-37.
5. *Report of Commissioners to Superintend the Erection of a Lunatic Hospital at Worcester* (Boston, 1832), 19-20; *Report of the Committee on the Insane Poor in Connecticut* (New Haven, Conn., 1838), 3-4. See too Philadelphia Citizens Committee on an Asylum for the Insane Poor, *An Appeal to the People of Pennsylvania* (Philadelphia, 1838), 9; Pliny Earle, *Insanity and Insane Asylums* (Louisville, 1841), 34-39; "Investigation of the Bloomingdale Asylum," *N.Y. Assembly Docs.*, 1831, I, no. 263, pp. 30-31.
6. For an introduction to the literature on moral treatment, see Norman Dain, *Concepts of Insanity*, chs. 1, 5; see, also, J. Sanbourne Bockoven, "Moral Treatment in American Psychiatry," *Journal of Nervous and Mental Disease*, 124 (1956), 183-194, 299-309.
7. *Report of the Insane Poor in Connecticut*, 4-5.
8. (Philadelphia, 1880, 2nd ed.). The volume first appeared in 1847. The entire first part was given over to physical details, the second to administrative details. In this same spirit, see Pennsylvania Hospital, *Second Annual Report* (Philadelphia, 1843), 31-32; Ohio Lunatic Asylum, *Thirteenth Annual Report* (Columbus, Ohio, 1852), 60-61.
9. *History of the Association of Medical Superintendents of American Institutions for the Insane*, John Curwen, compiler (n.p., 1875), 4-7, 24-26, 28-30.
10. Pliny Earle, *Institutions for the Insane in Prussia, Austria, and Germany* (Utica, N.Y., 1853), *passim*, and pp. 107-122, 150-151. Earle traveled in 1849. His trip was not an uncommon one; the regularity with which he and his colleagues went to Europe for investigatory purposes ought to warn intellectual historians about taking the notions of a corrupt old world too literally.
11. Sir James Clark, *A Memoir of John Conolly* (London, 1869), 149. Just as Europeans were more cautious about linking civilization with insanity, so they were wary about a cult of institutionalization; see John Conolly, *An Inquiry Concerning the Indications of Insanity* (London, 1830; reprinted, London, 1964).

12. "Report of the Commissioners to Build a Lunatic Asylum," *N.Y. Senate Docs.*, 1839, I, no. 2, pp. 1-2; N.Y. Lunatic Asylum, "Annual Report," *N.Y. Senate Docs.*, 1842, I, no. 20, pp. 1-2, Appendix A, 47 ff. (Hereafter, "Description of Asylums in the U.S."). This survey of hospital practices is an invaluable compendium of information about the pre-Civil War asylums.
13. Isaac Ray, *Mental Hygiene*, 316; Butler Hospital, *Annual Report for 1856* (Providence, R.I., 1857), 19.
14. Edward Jarvis, *Address at Northampton*, 21-23, 25; Pennsylvania Hospital, *Second Annual Report*, 22-23; Philadelphia Citizens Committee, *An Appeal to the People*, 10-11; Ohio Lunatic Asylum, *Thirteenth Annual Report*, 17, 21; B.P.D.S., *Thirteenth Annual Report* (Boston, 1838), 200; and *Fifteenth Annual Report* (Boston, 1840), 420-421.
15. Thomas Kirkbride, *On the Construction of Hospitals for the Insane*, 36-38; *History of the Association of Medical Superintendents*, 24. Isaac Ray, *Mental Hygiene*, 24; Butler Hospital, *Annual Report for 1856*, 24.
16. Butler Hospital, *Annual Report for 1850* (Providence, R.I., 1851), 23; *Annual Report for 1856*, 19; and *Annual Report for 1855*, 13-14, 18. See also Edward Jarvis, *Visit to Thirteen Asylums*, 136, and his *Address at Northampton*, 26; Philadelphia Citizens Committee, *An Appeal to the People*, 10-11; Connecticut Retreat, *Thirty-Ninth Annual Report*, 27.
17. On location of asylums, see N.Y. Lunatic Asylum, "Description of Asylums in the U.S.," 47-49, 55-56. For the Philadelphia story, Pennsylvania Hospital, *First Annual Report* (Philadelphia, 1842), 17, and *Second Annual Report*, 6; cf. New Hampshire Asylum for the Insane, *Annual Report for 1843* (Concord, N.H., 1843), 20.
18. Pennsylvania Hospital, *Second Annual Report*, 27-28. See also Connecticut Retreat, *Twenty-Eighth Annual Report* (Hartford, 1852), 30, and *Thirty-First Annual Report* (Hartford, 1855), 21.
19. N.Y. Lunatic Asylum, "Annual Report," 1842, 29-30, 32, and "Annual Report," *N.Y. Assembly Docs.*, 1843, III, no. 50, pp. 52-53, 55.
20. Ohio Lunatic Asylum, *Second Annual Report* (Columbus, Ohio, 1840), 40-42.
21. N.Y. Lunatic Asylum, "Description of Asylums in the U.S.," 66, 132; New Hampshire Asylum, *Annual Report for 1843*, 19; N.Y. Lunatic Asylum, "Annual Report," *N.Y. Senate Docs.*, 1847, I, no. 30, pp. 18-19. See also Connecticut Retreat, *Twenty-Eighth Annual Report*, 29. On Pennsylvania Hospital and premature removals, see *Fourth Annual Report* (Philadelphia, 1845), 8-9.
22. Edward Jarvis, *The Law of Insanity and Hospitals for the Insane in Massachusetts* (pamphlet reprinted from the *Law Reporter*, Boston, 1859), 16-17. The best survey of commitment practices is N.Y. Lunatic Asylum, "Description of Asylums in the

- U.S.," 63, 81-82, 93, 123, 149. The New York incident is recounted in the N.Y. Lunatic Asylum, "Annual Report," 1843, 56-59.
23. Francis Bowen, "The Jurisprudence of Insanity," *North American Review*, 60 (1845), 1-37. Most legal discussions of insanity centered on the issue of criminal responsibility, not on procedures for protecting the insane.
24. N.Y. Lunatic Asylum, "Descriptions of Asylums in the U.S.," 185, letter of Dr. James Macdonald, in response to the trustees' request for a plan of organization (italics added).
25. *Ibid.*, 63, 220-221 (italics added).
26. Pennsylvania Hospital, *First Annual Report*, 23-24.
27. Worcester Lunatic Hospital, *Seventh Annual Report*, 86-87; there too, bell-ringing accompanied every shift. N.Y. Lunatic Asylum, "Annual Report," 1842, 30-31. An excellent study of the origins and routine of the Worcester institution is Gerald N. Grob, *The State and the Mentally Ill: A History of the Worcester State Hospital in Massachusetts, 1830-1920* (Chapel Hill, N.C., 1966). See chs. 2-3 for its daily functioning.
28. Pennsylvania Hospital, *First Annual Report*, 27-29. See also its *Seventh Annual Report* (Philadelphia, 1848), 32-33.
29. Worcester Lunatic Hospital, *Seventh Annual Report*, 86-87; quotation is on p. 94; N.Y. Lunatic Asylum, "Annual Report," 1843, 46-49.
30. Pennsylvania Hospital, *First Annual Report*, 13-14, 22, 26; *Second Annual Report*, 41-44; *Fourth Annual Report*, 33-34.
31. "Comptroller's Investigation of Several Institutions of New York State," *N.Y. Assembly Docs.*, 1840, IV, no. 214, p. 90; Governors of the N.Y. Hospital, "Annual Report," *N.Y. Assembly Docs.*, 1842, V, 8-9. See too William L. Russell, *The New York Hospital: A History of the Psychiatric Service, 1771-1936* (New York, 1945), chs. 13-16.
32. N.Y. Lunatic Asylum, "Description of Asylums in the U.S.," 87-90.
33. N.Y. Lunatic Asylum, "Annual Report," 1842, 5-6, 21-23, 27; "Annual Report," 1843, 51-52.
34. *Ibid.*, "Annual Report," 1843, 51-52, 63; "Annual Report," *N.Y. Senate Docs.*, 1851, I, no. 42, pp. 43-45.
35. Worcester Lunatic Hospital, *Third Annual Report* (Boston, 1836), 9, 29-30; *Fourth Annual Report* (Boston, 1837), 21; *Fifth Annual Report*, 10-11; *Sixth Annual Report*, 81. The Horace Mann quotation is from the *Ninth Annual Report* (Boston, 1842), 8.
36. *Ibid.*, *Thirteenth Annual Report* (Boston, 1846), 6-7; *Fourteenth Annual Report* (Boston, 1847), 6-8. For discharge policies, see *Fifth Annual Report*, 6-7. For details, see Gerald N. Grob, *The State and the Mentally Ill*, chs. 3-4.
37. Kentucky Asylum, *Annual Report for 1845* (Frankfort, Ky., 1846), 27 ff.; Indiana State Central Hospital for the Insane, *First Annual*

- Report (Indianapolis, Ind., 1849), 43; N.Y. Lunatic Asylum, "Description of Asylums in the U.S.," 126.
38. N.Y. Lunatic Asylum, "Annual Report," 1851, 44; Worcester Lunatic Hospital, *Ninth Annual Report*, 69; Governors of the New York Hospital, "Annual Report," 1842, 7.
 39. N.Y. Lunatic Asylum, "Annual Report," 1843, 55-56; Indiana State Central Hospital for the Insane, *First Annual Report*, 36-37; Pennsylvania Hospital, *First Annual Report*, 12. For Kirkbride's instructions, see Pennsylvania Hospital, *Fourth Annual Report*, 35.
 40. See the 1832 *Report of Commissioners to Superintend the Erection of a Lunatic Hospital at Worcester*, 1-2.
 41. For designs see N.Y. Lunatic Asylum, "Description of Asylums in the U.S.," 72 (McLean), 122-123, 128-129 (Virginia), 165 (Pennsylvania), 169-170 (Bloomington). For Utica, see N.Y. Lunatic Asylum, "Annual Report," 1843, 39-41; for Connecticut Retreat, *Forty-Fifth and Forty-Sixth Annual Reports* (Hartford, 1869-1870), 21. The first annual reports of an asylum invariably contained a picture or a verbal description of the structure. See too Thomas Kirkbride, *On the Construction of Hospitals for the Insane*, *passim*.
 42. N.Y. Lunatic Asylum, "Description of Asylums in the U.S.," 126. In a letter to the New York trustees, Philip Barbiza, chief of the Virginia institution, displayed all the ambivalence one might expect on this issue. For example: "The law of kindness should be the order of the house; nevertheless, discipline and restraint are absolutely necessary."

CHAPTER SEVEN

1. For citations to the Yates and Quincy reports, see ch. 2, note 1; Board of Guardians of the Poor of the City and Districts of Philadelphia, *Report of the Committee to Visit the Cities of Baltimore, New York, Providence, Boston, and Salem* (Philadelphia, 1827). The New York Society for the Prevention of Pauperism (hereafter, N.Y.S.P.P.), issued annual reports for this period.
2. Yates report, 393. Compare J. R. Poynter, *Society and Pauperism*, xiii, and ch. 4. Americans were closest on outlook, probably without knowing it, to Jeremy Bentham. Also, no economic crises here set off the debate.
3. Yates report, 47; New York Almshouse Commissioner, *Annual Report for 1847* (New York, 1848), 6. See too Anon., *Miscellaneous Remarks on the Poor of Boston* (Boston, 1814), 4.
4. N.Y.S.P.P., *Second Annual Report* (New York, 1819), Appendix, 6.
5. N.Y.S.P.P., *Fourth Annual Report* (New York, 1821), 4-5; and its *Fifth Annual Report* (New York, 1822), 14-15; Theodore Sedgwick, *Public and Private Economy, Part First* (New York, 1836), 95.

6. Yates report, 79-81; the costs were probably even higher, for the returns did not include all towns.
7. Quincy report, 13, and *passim*; Philadelphia Board of Guardians, *Report of the [1827] Committee*, 4-7, 21.
8. Stanley Lebergott, *Manpower in Economic Growth: The American Record Since 1800* (New York, 1964), 188.
9. N.Y.S.P.P., *Second Annual Report*, Appendix, 66.
10. Yates report, 6, 20; Quincy report, 31. The western county was Oneida, Yates report, 47.
11. Philadelphia Board of Guardians, *Report of the [1827] Committee*, 26; N.Y.S.P.P., *Fifth Annual Report*, 33.
12. New York Association for Improving the Condition of the Poor, *Thirteenth Annual Report* (New York, 1856), 36-37. (Hereafter, A.I.C.P.) See also its *Eleventh Annual Report* (New York, 1854), 59. For its early history, see Roy Lubove, "The New York Association for Improving the Condition of the Poor: The Formative Years," *New York Historical Society Quarterly*, 43 (1959), 307-328.
13. Yates report, 37; Quincy report, 9.
14. A.I.C.P., *Twelfth Annual Report* (New York, 1855), 19, and its *Eleventh Annual Report*, 58; New York Almshouse Commissioner, *Annual Report for 1848* (New York, 1849), 86-87. See too Thomas R. Hazard, *Report on the Poor and Insane in Rhode-Island* (Providence, R.I., 1851), 10-11.
15. A.I.C.P., *Fourteenth Annual Report* (New York, 1857), 16.
16. Quincy report, 4; Yates report, 392. A.I.C.P., *Twelfth Annual Report*, 18-19; see too Bernard J. Klebaner, "Poverty and its Relief in American Thought, 1815-1861," *Social Service Review*, 38 (1964), 382-383.
17. New York Select Committee, "Report of Charitable Institutions supported by the State, and all City and County Poor and Work Houses and Jails," *N.Y. Senate Docs.*, I, no. 8, 1857, p. 7.
18. Quincy report, 9; Yates report, 393.
19. N.Y.S.P.P., *Fifth Annual Report*, 15; Philadelphia Board of Guardians, *Report of the [1827] Committee*, 25.
20. Yates report, 3, 392; Philadelphia Board of Guardians, *Report of the [1827] Committee*, 24.
21. Yates report, 392; Quincy report, 6. See also N.Y.S.P.P., *Fifth Annual Report*, 31; John T. Sargent, *An Address on Pauperism* (New York, 1846), 9-13. Cf., Bernard J. Klebaner, "Poverty and its Relief in American Thought," 391-392.
22. Leah H. Feder, *Unemployment Relief in Periods of Depression* (New York, 1936), ch. 2, for the response to the 1857 crisis. A.I.C.P., *Eleventh Annual Report*, 18, *Twelfth Annual Report*, 17.
23. *Ibid.*, *Thirteenth Annual Report*, 13, and *Eleventh Annual Report*, 21, 31.
24. *Ibid.*, *Fourteenth Annual Report*, 16-17; Bernard J. Klebaner, "Poverty and its Relief in American Thought," 384-389.