INSANITY AS A REFLECTION OF MORALITY AND SOCIAL VALUES IN NINETEENTH CENTURY CANADA: THE LONDON, ONTARIO ASYLUM FOR THE INSANE 1870-1902

by

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Submitted in Partial Fulfillment
of the requirements for the degree of
Master of Arts

Faculty of Graduate Studies
The University of Western Ontario
London, Ontario
May, 1981

ABSTRACT

This study of the London, Ontario Asylum for the Insane (London Psychiatric Hospital) from its opening in 1870 until the end of the nineteenth century is one of the first analytical studies of a Canadian mental institution, particularly from the inmates' perspective. The thesis attempts to describe the types of people who were committed to late nineteenth century asylums through analysis of the patients admitted to the London Asylum between 1870-1877.

The administrations of the first two superintendents, Henry Landor and Richard Maurice Bucke are compared. Because their position required an authoritative outlook, they experienced difficulties in dealing with their employer, the provincial government, and with their own subordinates. Discussed are their attempts to apply moral treatment in an institution which, because of serious overcrowding, inevitably became custodial.

Nineteenth century ideas about insanity are examined, and the extent to which definitions of insanity and prescriptions for treatment reflected the moral norms of the time. Particular attention is given to attitudes towards sexuality and family life which became predominant in the late Victorian era.

PREFACE

This study is an examination of the London, Ontario Asylum for the Insane (now the London Psychiatric Hospital) from its opening in 1870 until the end of the nineteenth century. It is one of the first analytical studies of a Canadian mental institution, viewed particularly from the perspective of the inmates.

The treatment of the insane in North America was first discussed by Henry Hurd in The Institutional Care of the Insane in the United States and Canada (1917). In four volumes, Hurd presented an overview of the founding and administration of every North American asylum. Another general account, The Mentally Ill in America,was written by Albert Deutsch and published in 1949.

There has been a great burgeoning of interest in the treatment of the insane on the part of historians in the last fifteen years--beginning with the work of Michel Foucault--who saw the subject as indicative of methods of social control or of prevailing social attitudes. In Madness and Civilization (1965), Foucault related the shift from demonological to medical theories of the origins of insanity and discussed the growth of institutionalization from a philosophical perspective. Norman Dain, in Concepts of Insanity in the United States 1789-1865 (1969), focussed on nineteenth century medical theories concerning the

origins and treatment of insanity and their application in early American mental institutions.

In The Discovery of the Asylum (1971), David Rothman interpreted the rise of prisons, asylums, orphanages and reformatories as governmental moves towards social control through the confinement of deviants and other potentially dangerous members of society. Gerald Grob, in Mental Institutions in America (1973), argued that the establishment of asylums was not part of a deliberate effort to control, but fulfilled a growing social need. Grob also stated that asylums were initially founded to cure patients, but because of rapid overcrowding, they became primarily custodial institutions.

Dain, Rothman and Grob studied mental institutions from the perspective of the administrators and physicians. In So Far Disordered in Mind (1979), a study of the California Asylum for the Insane in the nineteenth century, Richard Fox was the first to examine the mental hospital from the perspective of the patients. By analyzing the backgrounds and characteristics of patients admitted to the Asylum, Fox demonstrated that members of certain ethnic and social groups were more likely to be labelled insane and committed to an institution than were others.

The main primary sources for this study are government documents. Because the Asylum was a charitable institution operated by the provincial government, most of its records are either published in reports or are stored in the Ministry of Health

records in the Archives of Ontario in Toronto.

As a government institution, the London, Ontario Asylum for the Insane was obliged to submit an Annual Report to the Ontario Legislature which was published in the Ontario Sessional Papers. While these Reports are a useful source, invaluable in terms of classifying the patients into categories such as place of birth and residence, age, sex, diagnosis and religion, they must still be approached with caution; the administrators, naturally, would hope to put forward the best face possible of the operation of the Asylum.

Another important source are the Bucke Papers, part of the Regional Collection of the University of Western Ontario. They contain the correspondence, speeches, and works (published and unpublished) of the second asylum superintendent, as well as the Superintendent's Medical Journal and account books, orders and newspaper clippings relating to the London Asylum.

The Middlesex County Court Records provide information on warranted cases, though they can also be sketchy. They provide useful descriptions of the behaviour that led to the arrest of a person as a dangerous lunatic. The Court Records and the interesting papers of Dr. Sippi, Asylum Bursar under Bucke, are located in the Regional Collection of the University of Western Ontario.

In the Archives of Ontario can be found the correspondence and records of the Inspector of Prisons and Asylums, which includes correspondence with the asylum superintendents and occasionally

with families of the patients. This source is particularly valuable in obtaining information about Henry Landor, who did not leave behind any personal papers. Because this study primarily focusses on the patients, extensive use has been made of the patients' Casebooks, also found in the Archives of Ontario. These Casebooks, divided into male and female volumes, devoted a page to each patient with yearly entries following the annual inspection, or on occasions such as incidents of illness, violence, or change of status (through transfer to a new ward or institution, discharge or elopement*). The entries are unfortunately brief, particularly for the Landor administration, but are invaluable in presenting the clearest picture of the kind of person admitted to the London Asylum; the type of behaviour which led to commitment; duration of stay; and experiences in the Asylum. The nature of the Casebooks necessitated the use of a consecutive sample. All those patients admitted between 1870 and 1877 (774) were studied, to reflect the administrations of both Landor and Bucke, and to determine whether the Asylum was operated as a curative or custodial institution.

Finally, the London Psychiatric Hospital, the successor to the London Asylum, has its own museum which includes a replica of the old Medical Superintendent's office, and a collection of papers and photographs which have very recently been catalogued.

* Elopement was the nineteenth century term for escape.

I would like to thank my supervisors, Jean Matthews and Roger Hall of the University of Western Ontario. Dr. Matthews proved an invaluable guide, while Dr. Hall's criticisms forced me to think logically. I would also like to thank George Emery and David Flaherty of Western's Department of History.

Barbara Craig, in charge of health records at the Archives of Ontario, Beth Millar, Special Collections Librarian at the D.B.Weldon Library, University of Western Ontario, and the staff of the Regional Collection, Weldon Library, University of Western Ontario, were also helpful. The aid of Michael Warsh was greatly appreciated. Lastly, I would like to thank my mother and father for their support.

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INTRODUCTION

The construction of the London, Ontario Asylum for the Insane was one of the first acts of the new Ontario government after Confederation. Completed in 1870, it was intended to be one facet of a general scheme to establish a series of asylums to serve the various regions of the province. The construction of the London Asylum was also part of a widespread movement in North America to create specialized institutions for the treatment of the insane. Concurrently, public institutions were built to house other unfortunates such as orphans, the mentally retarded, juvenile delinquents and the destitute.

The Worcester, Massachussetts State Lunatic Hospital (1830) and the Pennsylvania Hospital for the Insane (1840) were landmark institutions in this development. They provided models for the London Asylum and many others in North America, and were based broadly upon the theory that insanity was curable and that the cruelty of the past should be replaced by "moral" treatment.

Moral treatment was first applied by a Quaker philanthropist, William Tuke, at the York Retreat in England, founded in 1792. The success of The Retreat in care without extensive use of restraint revolutionized treatment of the insane in England, and led to the passing of lunacy reform legislation and the establishment of similar institutions by the government.[1]

Tuke's method was based upon the assumption that for most

cases of insanity, only one mental faculty was damaged, thus disrupting the balance of the "emotions". Treatment would involve reasoning with the unimpaired faculties.[2] The power of self-control, a desirable attribute for the general population in the nineteenth century, was important even for the insane. Moral treatment meant that despite the fact that they were considered lunatics, the insane were expected to strive for the same social goals as the general populace.[3]

Moral treatment entailed the use of reward and punishment. If the patient conformed (for example, worked willingly, accepted authority and refrained from alcohol), he was rewarded. If he failed to meet expectations, he was punished, though with a minimum of physical abuse. The medical superintendent was a very powerful, almost "patriarchal" figure in the asylum. His personality and beliefs determined how the asylum would be run and the form treatment or punishment might take.[4]

Patients in all asylums were classified by sex, nature and severity of mental illness, and (primarily in American asylums) socio-economic background. The most violent and acutely insane were to be kept from "contaminating" milder cases. Some patients were constantly occupied in labour or amusements, to direct their energies away from violence, thereby minimizing the need for restraint.

Before patients could be admitted into asylums, insanity itself had to be defined. Because insanity did not appear to have

a physical basis, theories regarding its origin were highly subjective. The definition of insanity, of course, established the parameters of normality in a society. Destructive and violent acts obviously were dysfunctional to society in the nineteenth century (just as they are now) and so were often defined as insane.

Other behaviour, such as refusal to work, intemperance, and sexual deviance were also cited as manifestations of insanity. Physicians and judges, who defined insanity and decided who should be committed to asylums, became arbiters of morality in the nineteenth century.

This thesis is a study of the London, Ontario Asylum for the Insane from its founding in 1870 under the direction of Dr. Henry Landor until the death in 1902 of his successor, Dr. Richard Maurice Bucke. This study will examine the institution from the perspectives of the physicians, employees and patients. As an institutional study, it does not include a detailed discussion of nineteenth century medical philosophy concerning insanity, although theories will be presented as they related to treatment in the Asylum. As a patient history, it does not offer a daily account of activities in the Asylum nor a list of all the physicians and employees in the institution; instead, it attempts to portray experiences encountered by staff members and patients in order to

illustrate and explain the nature of "treatment" offered in the Asylum.

The London Asylum opened with a great deal of optimism for its potential effectiveness. Shortly thereafter, however, it became far too overcrowded to be much more than a custodial institution. In the nineteenth century, the Asylum's function as a curative hospital was largely dependent upon the personalities of its two medical superintendents.

Henry Landor was responsible for the design of the Asylum as well as serving as its first administrator. He followed the model of Thomas Kirkbride, superintendent of the Pennsylvania Hospital for the Insane and an authority on asylum architecture and administration, to create an institution which would cure as well as control. Landor operated the Asylum within the tenets of moral treatment, stressing minimal physical restraint;routine and order;and labour as therapy. Landor appeared to have a very pragmatic attitude towards the treatment of the insane, and ran a fairly successful administration. He introduced the English "cottage system" to North America. Despite the interest in his successor, Landor has never been the subject of historical inquiry. This study will therefore focus on the administration of Henry Landor, and contrast it with the better-known work of R. M. Bucke.

When Bucke replaced Landor as medical superintendent after the latter's death in 1877, he initiated a number of reforms, including the gradual elimination of alcohol as a stimulant, and

a reduction in the use of restraint. He also employed radical surgical techniques to "cure" deviant behaviour such as sexual immorality, an action which clearly demonstrated the propensity of "alienists" (psychiatrists) in the nineteenth century to judge morality as well as treat insanity.

Both Landor and Bucke experienced difficulties in dealing with the provincial government (through the Inspector of Prisons and Asylums) and with their subordinates. This resulted from the fact that the head of a large institution had to develop an authoritative outlook which sometimes conflicted with his role as government employee. At the same time, he had to direct a staff untrained in dealing with the insane, and often inexperienced in living in an institutional setting.

The London Asylum will also be examined from the perspective of the patients. Through analysis of characteristics such as sex, age and ethnicity of patients admitted between 1870 and 1877 (who would experience the administrations of both Landor and Bucke), certain patterns emerged which supported Fox's findings that chances for commital were not randomly spread throughout the population. Current theories regarding the causes of insanity will also be discussed to demonstrate their relationship to moral standards and social attitudes as reflected in the Asylum. The patients' experience in the Asylum is outlined through an examination of the use of alcohol and drugs, diet, patient labour, amusement, restraint, and policy towards

elopement (escape).

Victorian attitudes towards sexuality as seen in the Asylum are discussed through analyses of the treatment of women, and the "disease" of masturbatory insanity. The "wiring" of masturbating patients demonstrated the existence of a strict moral code, as well as the use of surgery to "cure" social problems. Surgical techniques were also employed to treat deviant behavour in women. The relationship between an individual's mental state and his family is also examined to obtain a clearer portrait of the backgrounds of those admitted to a mental institution in the nineteenth century.

What was the real necessity for public institutions for the insane and how valid were the claims of effectiveness of moral treatment? The government opened the London Asylum with great regard for moral treatment, insofar as it entailed little restraint and less cost. Landor had no illusions about curing insanity. "With so many incurables," he wrote, "treatment is confined to taking care of comforts (including) good and nourishing food, clothing [the insane] well, and working those who have the strength to work, exercising out of doors those who can walk." Landor believed in amusement and occupation: "daily dances in the afternoon for an hour or two, music, stereoscopic views, etc. and (the patients) spin, knit, and make all the socks and stockings used. Employment is the rule of treatment..."[5] Even in the first report after the asylum opened, Landor was explaining its

custodial nature and justifying its existence in terms of economy and efficiency.

Neither was the asylum ideal in terms of its custodial capacity. In 1872, Landor wrote, "I regret that two years' occupation compels me now to say that if the presence of the most offensive smells and odours can be taken as an evidence of defective ventilation, then the system adopted in the London Asylum is the worst that could have been devised."[6] It was successful in its custodial role, however, as it kept an average of five hundred patients fed, busy, alive and far from the eyes of the outside world for anywhere up to forty years.

NOTES

1. David J. Rothman, The Discovery of the Asylum: Social Order and Disorder in the New Republic, Boston, 1971, pp. 109-110.
2. Vieda Skultans, English Madness: Ideas on Insanity 1580-1890, London, 1979, p. 58.
3. Andrew T. Scull, "From Madness to Mental Illness: Medical Men as Moral Entrepreneurs," Archives Europeenes de Sociologie 16 (1975): 227.
4. Gerald N. Grob, The Origins of the State Mental Hospital in America, New York, 1973, p. 162.
5. Ontario. Legislative Assembly. Sessional Papers. "Annual Report of the Medical Superintendent, London Lunatic Asylum," no. 4, 1872, p. 155 [hereafter A.R.M.S].
6. Ibid., p. 23.

CHAPTER I

OPENING OF THE ASYLUM

Specific provision for the insane in British North America was first made in New Brunswick in the 1830's, when an asylum was built in Saint John.[1] During the same period in Ontario, the government paid for the maintenance of lunatics in county gaols where they lived in "filth and nakedness".[2] The first real impetus for reform came from Dr. Charles Duncombe, a physician and member of the Ontario Legislative Assembly who in 1836 engineered the appointment of a commission to study the establishment of lunatic asylums in the province.[3] The commission (on which Duncombe served) recommended the building of a large institution in Upper Canada offering moral treatment similar to those established in England and in the United States.

Early action might have been taken on his proposal had not Duncombe joined William Lyon MacKenzie's ill-fated rebellions of 1837-8. Duncombe led "three hundred poorly armed men" against London. When he learned that MacKenzie had been defeated in Toronto and that troops were advancing to London, he ordered his force disbanded. Duncombe fled to the United States where he took up medical practice until he died in 1867.[4]

Because of Duncombe's involvement in the Rebellion, the

reforms associated with him were discredited, and it was not until 1850 that a permanent asylum was built in Ontario. In 1841, a temporary asylum was built in Toronto in an abandoned gaol.[5] It was visited by J. H. Tuke (of the York Retreat in England) who branded it "one of the most distressing places" he had ever seen. "The house," he reported, "has a terribly dark aspect within and without...There were, perhaps, seventy patients, upon whose faces misery, starvation, and suffering were indelibly impressed..."[6]

With the immigration of thousands of indigent Irish Catholics during the potato famines of the late 1840's, the need for all types of large-scale public institutions, such as prisons, hospitals, and asylums, was very great. Private initiative had proven woefully inadequate to the needs of an expanding populace. The establishment of insane asylums in Ontario was implemented through a Board of Inspectors of Prisons and Public Charities.[7]

Founded in 1859 by the government of the United Provinces, the Board divided Canada into five different districts for medical care (Quebec, Montreal, Kingston, Toronto and London).[8] After Confederation, when health care was placed under provincial jurisdiction, the Board was replaced by a single Inspector, and Ontario was divided into the jurisdictional districts of London, Hamilton, Toronto and Kingston. Under normal circumstances, patients were to be sent to the Asylum in their home district, but in an emergency or if there were no vacancy, the patients could be admitted to another institution.[9]

Ontario's first lunatic asylum was opened in Toronto in 1850. By 1854, before completion, it already was seriously overcrowded.[10] In 1856, the Rockwood Asylum was opened in Kingston--in a mansion purchased by the government.[11] In 1861, a branch of the Toronto Asylum was opened in former military barracks at Fort Malden near Amherstburg. Also in 1861, the Orillia Asylum was established in an "unfinished hotel". The Malden and Orillia Asylums were closed and their patients transferred when the London Asylum opened in 1870.[12]

In 1875, an asylum for inebriates was established in Hamilton, but was soon converted to an insane asylum because of the pressing need. A second branch of the Toronto Asylum was built at Mimico in 1894. The Brockville Asylum was opened in 1894, and a home for the female chronically insane was established in Cobourg in 1902. In 1884, the Homewood Retreat, a private asylum, was opened in Guelph.[13]

The Inspector of Asylums and Prisons occupied an extremely important position. Granted the substantial salary of two thousand dollars and travelling expenses, he was responsible for the administration of all public hospitals, asylums, gaols and charitable institutions in the province.[14] John Woodburn Langmuir left "mercantile pursuits" to become the first inspector in 1868, and held the position until 1882. Langmuir was the guiding force behind the rationalisation of health care services in Ontario, and his humour, imagination and sensible attitude was revealed in his

correspondence with the superintendents of the London Asylum. After his resignation, he founded the Homewood Retreat.[15]

Langmuir was succeeded by Charles O'Reilley, who previously had been the Medical Superintendent of the Toronto General Hospital. O'Reilley, in turn, was replaced by Thomas Christie, a Quebec-born physician who had been assistant surgeon at Point St. Charles during the great cholera epidemic of 1847.

* * * * * * * * *

London had been incorporated as a city merely fourteen years when the province decided upon it as the location for a lunatic asylum for southwestern Ontario. The city came to dominate a vast agricultural hinterland in the 1840's and 1850's as a result of the relocation of the local government from Vittoria in 1831--with subsequent construction of the courthouse and administrative offices, the establishment of a strong garrison after the Rebellions of 1837-8, and the key decision to build the Grand Trunk Railway through London in 1851.[16] During the 1850's, London experienced a wild real-estate "boom" which subsequently "busted", leaving the city and many of its citizens virtually bankrupt. In 1860, however, with the discovery of oil in the region, the city appeared once again on a solid financial footing.[17]

In social terms, London was an ethnically and religiously homogeneous city, but its dominant protestantism was dissenting and

non-conformist.[18] Baptist and other evangelical sects had strong followings in the community. Bryan Palmer has argued that the establishment of an asylum in London "emanated directly from the pietism of the community."[19] The Asylum was a boost to London's economy, employing about one hundred people at its 1870 opening, and providing substantial and varied contracts for the city's businesses. It also rapidly became a "must-see" attraction for visitors.

The site chosen for the new asylum was on London's outskirts on the former Hales and Briody farms, where the Governor's Road intersected the Grand Trunk Railway (north of present-day Dundas Street, east of Highbury Avenue). Contemporaries sharply criticized the area as being a swamp. "With the exception of subsidized servitors of the government..." wrote the London Advertiser (9 November 1870), "the selection of this particular location... has been universally condemned." The land was low, flat, muddy, and did not possess a "commanding view", nor a breathtaking landscape to provide the patient with respite from a troubled mind. Sir John Carling, Commissioner of Public Works (London M.P.P. and beer manufacturer) held firm to his decision, however, and the Asylum was built on land purchased from, among others, John and Joseph Hale, Richard Juson, J. Briody, and not surprisingly, Sir John Carling.

A popular view at the time was that the secret for curing

insanity was the physical layout of the asylum itself. One advocate was Dr. Thomas Kirkbride, the Superintendent of the Pennsylvania Asylum, and a noted author on the care of the insane, who believed that the design of the asylum was paramount. The "Kirkbride Plan" called ideally for not more than 250 patients in an asylum 'family' run by a patriarchal medical superintendent. The building was to reflect the superintendent's "undisputed power and authority in the asylum."[20] Kirkbride's model asylum would consist of a central administrative building flanked by male and female wings.[21] Great care would be taken to classify and separate patients according to the nature and extent of their insanity, to avoid, for example, contaminating chronic melancholics with acute cases of dementia.

Dr. Henry Landor was the London Lunatic Asylum's first medical superintendent. A British immigrant, Landor designed the London Asylum (re-named the London, Ontario Asylum for the Insane in 1873), instituting a number of English innovations to the Kirkbride model. In his opening report to the Ontario Legislative Assembly in 1871, Landor compared his new asylum to the Kirkbride model and also to the eighteen recommendations in the 1855 Report of the English Commissioners in Lunacy. Landor affirmed that the construction of the London Asylum followed the Kirkbride resolutions, that is:

> First, that a very large majority of those suffering from mental disease can no where else be... successfully cared for, with equal protection

> to the patients and the community, as in well arranged hospitals specially provided for the treatment of the insane. [emphasis mine]
>
> Second, that neither humanity,economy or expediency can make it desirable that the care of the recent and chronic insane should be in separate institutions.
>
> Third, that those institutions--especially if provided at the public cost--should always be of a plain but substantial character;and while characterized by good taste, and furnished with everything essential to the health, comfort and successful treatment of the patient, should avoid all extravagant embellishment and every unnecessary expenditure.
>
> Fourth, that no expense that is required to provide just as many of these hospitals as may be necessary to give the most enlightened care to all their insane can properly be regarded as unwise, [or] inexpedient.[22]

Kirkbride cogently outlined the necessity of building asylums at a cost acceptable to public administrators and staffed by medical professionals. "while it is extremely desirable for asylums to possess all the comforts of a cheerful, well-appointed home," Landor added, "expensive construction and elaborate ornamentation operates very injuriously against the welfare of the insane." If institutionalisation cost $1,000.00 to $1.500.00 per patient per annum,"a large number of the insane would remain in the hands of friends."[23] At the same time, the English Commissioners had suggested that because the building was intended for the accomodation of pauper patients, "all superfluous external decoration should be avoided."[24] Even in the Asylum, it was considered

essential that a standard of living be maintained appropriate to that of the patient in the outside world.

Construction of the London Asylum began in June, 1869 and the building was ready for occupancy in November, 1870. It had been built at a budgeted cost of $397,000.00.[25] The buildings were located at the centre of the old Hales farm. There was no attempt at "elaborate ornamentation" but, according to the London Advertiser at least (9 November 1870), the entire block when viewed from the road looked "pleasing and inviting."

The dominant section of the Asylum was the centre building, four stories high. The ground floor contained the administrative offices and visitors rooms, the attendants and officers dining-rooms, the food elevators to the general dining-rooms and small store-rooms. The second and third floor contained the patients dining-rooms and the fourth the amusement hall which also was used for church services.[26]

The east and west wings of the central block were three-storied, with floors for the sick, the most feeble, and the "convalescent, quiet and strong."[27] The east and west wings of the flanking blocks were two stories high, with living and sleeping rooms on each floor--under the care of specific attendants. Each wing was traversed by corridors consisting of wards, each of which had

its own doorway leading outside, plus dormitories, sitting room, bathroom, waterclosets, and dust and clothes shafts.[28] The dormitories ranged from single to ten-bed capacity. Each side of the building contained forty-five single rooms, of which twenty were provided with wooden shutters on the windows to contain noisy or violent patients.[29] Windows otherwise had cast-iron sashes and could not be opened more than six inches. The rooms themselves contained birch bedsteads, glued without nails or bolts, which held hair mattresses and pillows.[30]

The capacity of the main building was five hundred patients. Apart from the central structure, Landor introduced a network of small buildings called "cottages". The cottage system had been developed to ease overcrowding in English asylums. By the 1860's, according to Peter McCandless, asylums had become "overwhelmed" by incurable patients, and reformers began to advocate community care for the mentally retarded, epileptics, and the senile--all of whom would likely never be discharged from an institution.[31] 'Alienists', who had argued for years that the home was the root of insanity, said that "farming-out" would result in the physical abuse of the insane.[32] At the same time, a huge extension of the institutional system would be a heavy burden on public finances.

A solution was found in the construction of small "cottage" asylums located near and administered by an established institution, which would house "quiet, chronic cases" and "convalescents". The first such cottage was run by the noted British alienist, J. C.

Bucknill, at his Devon asylum in the 1850's, and it was deemed a success by the government and by the medical community.[33] It is probable that Landor brought the idea of the cottage system with him from England.

At the London Asylum, Landor directed the construction of two out-buildings (later four) each with a capacity for sixty patients to accomodate the chronic insane, leaving the main asylum for the acute insane. The cottages were connected to the central buildings by corridors and were designed to be as homelike as possible.[34] Cottage patients had fewer attendants and were allowed freedom of movement to and from the cottages.

The entire institution was heated by steam, with iron pipes in every room. Numerous cases were later reported of patients suffering burns due to resting against these pipes for long periods of time, so it can be assumed that the heating system was not as efficient as the administration would have liked. The Asylum consumed 25,000 gallons of water daily from three wells, each operated by a large steam pump. Fire plugs (hydrants) were installed at intervals around the buildings, though it was expected that the use of steam would minimize the risk of fire. The Asylum did, however, suffer a typhoid attack its first year due to deficient sanitation.[35]

To the rear of the centre building and connected by a covered passageway was a two-story structure containing the kitchen and laundry. Cooking was done by modern steam ranges. On the east and west end of the main structure were the airing courts--enclosures

surrounded by ten-foot high brick walls. Dr. Landor had designed the walls to slope on the front and sides so that the patients could look over to view the landscape and to reduce the "prison-aspect" of the walls. There was, of course, a fence bordering the entire Asylum property.[36]

The superintendent's residence was a two-story brick building, on the grounds, to the west of the Asylum. There were also two two-story entrance lodges and a number of out-buildings, including two large workshops, a bakery, a storehouse, two barns, a stable and cow house and a mortuary. By 1905, the Asylum ran shops for engineers, carpenters, butchers, painters, plasturers and cobblers.[37]

A chapel was needed owing to the crowded conditions in the amusement hall, and to the unfortunate fact that many patients could not distinguish between the room's function as a church and its function as a dancehall. A chapel with capacity for 450 patients was accordingly built in 1885.[38]

In 1872, an Idiot Asylum for the mentally retarded was built at some distance from the main building, capable of handling 38 inmates. It was the first asylum specifically designed for "idiots" in the province. It had been intended as an all-male refuge, but because there was such an urgent need by females (many of whom were in gaol) eleven were admitted to the Idiot Asylum.[39] After the Orillia Asylum for Idiots was built in 1879, the old Idiot Asylum was enlarged and converted into a "refractory" for violent and

dirty patients with a capacity for two hundred people.[40]

In 1887, the laundry and kitchen were destroyed by fire. The wing was rebuilt with a new amusement hall on the fourth floor, over a new laundry on the third floor and a kitchen on the second. The old amusement hall was converted into an infirmary with forty beds.[41]

The Asylum also ran a large farm, growing oats, rye, potatoes, peas, corn, turnips and other vegetables, fruit and flowers. A professional farmer was hired but the heavy labour was performed by male inmates. Dr. Landor was particularly proud of the Asylum's flowers. Indeed, in 1873, the Asylum won forty-five prizes in every agricultural and horticultural category at London's Western Fair.[42]

The Asylum began to deteriorate shortly after construction. The heating apparatus was faulty--sixty tons of hard coal was necessary to heat the building to fifty degrees in the winter. Smoke escaping from the flues was "at times unbearable."[43] By 1877, the gas supply was insufficient, the roof leaked, the windows (all designed to be raised six inches) were completely stuck, and the chiminies needed to be raised. The Asylum was also bare and bleak. J. W. Langmuir, Inspector of Prisons and Asylums, recommended that appropriations be granted for internal decoration. "Cheerfulness and contentment," he argued, "on the part of the patients cannot be expected in a poorly furnished asylum with bare walls."[44]

Patient labour eliminated part of the foul smells by re-

placing the water-closets with water-tanks, but patient labour was not always welcome.[45] Landor requisitioned an assistant baker or bread-mixer, stating, "I decidedly object to eating or making others eat food prepared by patients."[46]

Given the faulty construction, disagreeable environment, and overcrowding, it was remarkable that the Asylum was even slightly successful as a curative hospital. Within the context of less-than-favourable conditions and a limited budget, the accomplishments of the medical superintendents were indeed impressive.

NOTES

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3. Fred Landon, Western Ontario and the American Frontier, Toronto, 1941, p. 145.

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5. J. S. Heagerty, Four Centuries of Medical History in Canada, Toronto, 1928, p. 274.

6. Ibid., p. 275.

7. Richard B. Splane, Social Welfare in Ontario 1791-1893, Toronto, 1965, p. 31.

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9. Robert W. Powell, The Doctor in Canada, Montreal, 1890, p. 237.

10. Heagerty, p. 276.

11. Margaret Angus, Kingston General Hospital, Montreal, 1973, p. 44.

12. Heagerty, pp. 270-280.

13. Ibid., pp. 281-283.

14. Ontario. Legislative Assembly. Hansard's Debates, 7 February 1868.

15. Splane, p. 12.

16. F. H. Armstrong and Daniel J. Brock,"The Rise of London: A Study of Urban Evolution in Nineteenth Century Southwestern Ontario," in Aspects of Nineteenth Century Ontario: Essays Presented to James J. Talman, edited by F. H. Armstrong, Toronto, 1974, pp. 85-88.

17. Ibid., p. 93.

18. Bryan D. Palmer, "'Give us the Road and We Will Run It':The Social and Cultural Matrix of an Emerging Labour Movement," in Essays in Canadian Working Class History, edited by G. S. Kealey and P. Warrian, Toronto, 1976, p. 108.

19. Palmer, p. 109.

20. Tom Brown, "Architecture as Therapy," Archivaria 10 (Summer 1980): 111.

21. Ibid.

22. Ontario. Legislative Assembly. Sessional Papers. "Annual Report of the Medical Superintendent, Asylum for the Insane, London, Ontario," No. 4, 1872, p. 141 [hereafter A.R.M.S.].

23. 'Friends' included family and guardians of the insane. A.R.M.S., 4, 1869, p. 24.

24. A.R.M.S., 4, 1871, p.143.

25. Henry Hurd, The Institutional Care of the Insane in the United States and Canada, Baltimore, 1917, volume 4, p. 157.

26. The London Advertiser, 9 November 1870.

27. A.R.M.S., 4, 1872, p. 144.

28. The London Advertiser, 9 November 1870.

29. A.R.M.S., 4, 1871, p. 145.

30. The London Advertiser, 9 November 1870.

31. Peter McCandless, "'Build! Build!' The Controversy over the Care of the Chronically Insane in England 1855-1870," Bulletin Of the History of Medicine, 53 (Winter 1979) 4: 556.

32. Ibid., p. 561.

33. Ibid., p. 568.

34. A.R.M.S., 2, 1874, p. 9.

35. Ibid., 6, 1871, p. 65.

36. The London Advertiser, 9 November 1890.

37. Archives of Ontario. Ministry of Health. Record Group 10. Correspondence of the Inspector of Prisons and Asylums, Box 218, File 6448, Stock List, 31 December 1905 [hereafter C.I.P.A.].

38. C.I.P.A., Box 228, File 6571.

39. Hurd, p. 158; A.R.M.S., 4, 1872, p. 15.

40. Hurd, p. 159.

41. Ibid., pp. 159-160.

42. A.R.M.S., 4, 1875, p. 227.

43. Ibid., 2, 1874, p. 17.

44. Ibid., 2, 1877, pp. 29-32.

45. Ibid., p. 231.

46. Ibid., 4, 1875, p. 226.

CHAPTER II

THE PHYSICIANS AT THE LONDON, ONTARIO ASYLUM FOR THE INSANE

The staff of officials in charge of the loons
Sent up here for care and safekeeping
Are qualified men;though some are new brooms
All appear to do very clean sweeping.
Dr. Bucke, Superintendent, is well liked by all
At least in so far as I've heard.
He is always on hand when duty may call
And is always as good as his word.
It is scarcely a year since he came here to stay
And take charge of this lunatic brood.
One thing, I take notice, not least by the way
That the patients get much better food.[1]

In seventeenth and eighteenth century Britain, "mad-doctors" operated asylums solely for profit and often physically abused the lunatics under their care.[2] With the introduction of institutions offering moral treatment, asylum superintendents, medically trained and committed to a minimal use of restraint, endeavoured to remove the "mad-doctor" stigma and become recognised as professionals.

Although North American asylum superintendents were not as closely associated with "mad-doctors" (because the "mad-house" did not have much of an opportunity to proliferate in the colonies prior to the institution of government asylums), they also sought to gain professional status. In 1844, they organised themselves into the Association of Medical Superintendents of American Institutions for

the Insane (AMSAII). Its purpose was to issue guidelines as to "architectural standards, size, mode of governance and personal and professional qualifications" and to promote the belief that to cure insanity, trained personnel were essential.[3]

On a more personal level, the AMSAII provided an opportunity for members of a demanding and socially isolating profession to relate common experiences and share professional knowledge. A sense of affiliation was also aided by the fact that most asylum superintendents were middle class, Anglo-Saxon males.[4] They cultivated similar personalities as well. "The mental therapist," one physician wrote, "was to enter into the patients' tastes, sympathies, foibles and different phases" of their minds, but at the same time develop a self-consciously authoritarian manner. The personal influence and demeanor of the physician, "always so important, is chiefly so in nervous and mental cases. Pure and lofty sentiments are directly conducive to bodily health and vigor."[5]

The history of the AMSAII was not unchequered. In the fight for professional autonomy, the Association had to contend with legislatures and public officials who "defined and administered" public policy, and who felt (quite rightly) that the organisation was a challenge to their authority.[6] The Association was flawed, moreover, by its "administrative outlook" which worked against "experimentation and innovation." This resulted in the AMSAII being a target for criticism by reformers of asylums, following the American Civil War, which dealt a blow to the prestige of the organisation. In its heyday, however, the AMSAII, and its publica-

tion, The American Journal of Insanity, were extremely influential in determining modes of treatment and administration of asylums.[7]

Although its title specified "American" institutions, the AMSAII also included Canadians in its membership. Drs. Landor and Bucke of the London Asylum were both affiliated with the AMSAII; Bucke actually served as its President in 1898.[8] When the Asylum opened in 1870, its Superintendent was immediately part of an established, active and growing professional community.

* * * * * * * * *

The first Medical Superintendent of the London Asylum was Dr. Henry Landor. Born on the Isle of Anglesey (in Wales) in 1815, he graduated from the Aldersgate School of Medicine in 1836. In 1841, he was sent to Australia as a stipendiary magistrate. He returned to England in 1847 and shortly thereafter became a colonial surgeon to the British naval forces on the African Gold Coast. After two years, he contracted "coast fever" and was sent home. While he convalesced, he wrote "The Only Way to Stop the Slave Trade," a pamphlet which won "much praise" for the author. In 1850, he became the resident physician of the Higham Retreat, a private asylum in Norwich. He remained in that position until he emigrated to Canada in 1860, where he was in private practice in London until he was appointed Superintendent of the Asylum at Malden, Essex County, Ontario.[9]

He was transferred to the London Lunatic Asylum in 1869, and administered its affairs "to the entire satisfaction of the Govern-

ment, as also of the public, and with great advantage to the patients coming under his charge."[10] In 1875, he represented the Ontario asylums at the Convention of American Superintendents of Asylums for the Insane held at Auburn, New York, and later submitted a report of the proceedings to the provincial government.[11]

Landor's writings included two pamphlets: Insanity in Relation to the Law (London:1871) and Hysteria in Children as Contrasted with Mania (London:1873). While Superintendent of the Asylum, he wrote a series of articles for the London Free Press on "Social Behaviour," one of which created controversy when readers insisted they could see through the "thin disguise" of the Doctor's "horrible example," and detect the "unregenerate features" of London's ex-mayor, Frank Cornish.[12]

During the winter of 1875-1876, Landor's health deteriorated, and he died the following year,of diabetes mellitus, on 6 January 1877.[13] He was sixty-two years old. The obituary in the London Free Press called him "a gentleman universally respected on account of his attainments, and independence and sincerity of character, and those with whom he was on intimate friendship felt an affection for him which may be said to be rare."[14]

Landor's attainments were not financial; he left his family in almost "absolute poverty". Mary, his widow, was left with three sons and five daughters, four of whom were "helpless" young children. In 1874, Landor had written a letter to Inspector Langmuir, delivered posthumously, asking his superior to provide for his family because of his long service and success at saving the government money.

Langmuir was able to provide Mary Landor with a grant of two thousand dollars (one year's salary) on the grounds that, given Landor's "anxious and nervous" temperament, the pressure of managing an asylum almost certainly shortened his life.[15]

Dr. Landor had been an imaginative and ambitious superintendent. He requisitioned five hundred dollars for the creation of a medical library to train young medical men, as, he asserted, "every first class asylum did."[16] However, by 1876, his last year of superintendency, he was depressed and disillusioned. Had not Landor fallen seriously ill, he might well have resigned his position. He had in fact written a lengthy letter of resignation on 24 July 1876, in which he outlined his dissatisfaction with certain trends in the government's asylum policy.

"More than three-quarters of the administrative work of an asylum" Landor wrote, "consists in...monetary relations...I do not mean merely buying and selling and account keeping, but...[also] quality, quantity and selection of the articles [purchased]." . These activities were now in the hands of the Bursar, who required from the Superintendent nothing more than his signature. Landor declined to give it, saying that "such matters were taken out of [his] hands altogether."[17]

The Superintendent did believe, on Asylum Inspector J. W. Langmuir's "constant assurance," that the remaining one-fourth of his authority [over the patients] would remain with him. He felt threatened by the actions of one Dr. Richard Maurice Bucke, head of the Hamilton Asylum. In July 1876, Bucke had brought Landor a

letter he had received from the Inspector, ordering Landor to release a warranted patient from his custody. Landor himself had received no previous notification, and Bucke had not brought a warrant. According to Stephen Lett, assistant physician at the London Asylum, Bucke had said, "These are your orders" and "threw" them at Lett.[18] Landor wrote, "It is the first time in my life that I have known a Physician of another asylum ordered by an Inspector to enter another asylum and take without notice a patient away. The transaction is as strange in its essential features as it is for its want of common courtesy to me." Landor reached the crux of his discontent" "I feel that by your order, or acquiescence, all authority is slipping or has slipped from me, and the centralisation I have so long prognosticated is accomplished."[19]

Because of his lack of financial security, Landor was unable to follow the example of Joseph Workman, Superintendent of the Toronto Asylum, and "resign at once," but he was seeking employment elsewhere, particularly at the asylum in British Columbia.[20] He told Langmuir:

> Your system has become too unbearably military for endurance by a man who is now in his twentieth year of Asylum Superintendence...I have thought that my long experience and faculty for administration made me more competent to conduct this asylum than any other man in the province. I have lived to find myself mistaken. Any nonentity can register and fulfill orders, I think myself fitted for better things...I regret this termination of my connection both with this asylum and with you, but I cannot live in comfort with a perpetual blister on me arising from the conviction that I am occupying a position without proper authority.[21]

Langmuir urged him to stay on, and Landor, realizing the extent of his illness, finally agreed, saying he would "let it rest until the inevitable comes."[22] Landor had found himself caught between the conflicting values of two eras of asylum administration. When he was trained and first installed as head of an institution in the 1850's, superintendency still involved control of virtually every aspect of asylum management and treatment. By the 1870's, however, government moves to centralize and rationalize public institutions resulted in a substantial loss of that power. For a member of a recently-created but prestigious profession, accustomed to wielding complete authority, the blow was particularly severe.

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The second Medical Superintendent of the London Asylum, and the man whose arrogant behaviour had precipitated Landor's resignation, was Dr. Richard Maurice Bucke.

Bucke was born in Norfolk, England in 1837. One year later his family settled on a "pioneer homestead" in London, Ontario. Bucke experienced a colourful youth; he worked as a labourer in the Mississippi Valley, and as a miner he suffered severe frostbite and had one foot and part of another amputated.[23] He returned to Canada to study medicine at McGill University, where he was a gold-medallist in 1862.

After two years of post-graduate study in England and France, he returned to Canada, married, and set up a private practice as a

general practitioner in Sarnia, Ontario in 1865. He was appointed Medical Superintendent of the Hamilton Asylum in 1876 at the instigation of his close friend, the Provincial Treasurer, T. B. Pardee. Bucke replaced Landor at the London Asylum in 1877 and retained that position until his death (from an accidental fall) in 1902.[24]

R. M. Bucke was an author, literary critic and philosopher as well as an asylum superintendent. In his writings and lectures, he demonstrated the propensity of physicians to judge societal morality. In 1881, he supported the eugenics movement as a means of preventing insanity.[25] He suggested that since the state was "unwilling", clergy, educators and the press should enlighten and "caution" the populace on eugenics.[26] In an interview in The London Advertiser on 8 July 1881, after the death of the American President James A. Garfield, Bucke recommended that the assassin, Charles Guiteau, be hanged; as an evident case of "moral insanity" Guiteau could not be treated, as he had no sense of the wrongness of his actions. "Guiteau should be killed," Bucke stated, "not as punishment for his crime, as he is incapable of understanding that he has committed a crime. But he should be killed as a protection to society, killed as you would kill a wild beast or a rattlesnake."[27]

Bucke, something of a mystic, was also interested in the cosmic nature of insanity.[28] In an article published in 1878, "The Moral Nature and the Great Sympathetic", he described the four basic elements of the brain as faith, love, fear and hate.[29] In Man's Moral Nature (1879), Bucke wrote that longevity was dependent

on the "degree of perfection of the great sympathetic nervous system"; those who had the highest moral nature lived longest.[30] In this same essay, Bucke argued that women possessed a higher moral nature and had a greater capacity for love and faith than men, but because women purportedly had measurably smaller brains, they possessed a "less developed" intellect. Although women "would not be great", they were the "acknowledged civilizers" of the race.[31]

Like other intellectuals and social theorists of the age, Bucke was influenced by the work of Charles Darwin. In an article published in 1892, "The Origin of Insanity", Bucke hypothesized that the race whose evolution was most rapid would experience the most breakdowns in those functions which were recently developed.[32] African, Asian and other 'less-civilized' races which were still in the throes of barbaric instincts and emotions would not be likely to suffer mental breakdowns. Less fortunate were the 'civilized' Northern European races whose recent acquisition of 'genius' made them susceptible to insanity. Bucke neatly rationalized racial supremacy in terms of insanity, and at the same time explained insanity in terms of heredity and physiology without reference to any social or environmental factors.

Like Landor, Bucke was ambitious for the asylum and for himself. He was the first in London to conceive of practical uses for "Professor Bell's instrument", the telephone.[33] It was used, for example, to ring up the police when a patient had "eloped" (escaped). Like Landor in 1876, Bucke in 1879 requested the addition of a pathological research laboratory (he was also refused). Bucke was

a founder of the University of Western Ontario Medical School, which opened in 1881. He served as Professor of Nervous and Mental Diseases, and in 1886, the faculty proposed to elect him Dean. Bucke rather diffidently submitted the offer to the Inspector of Asylums and Prisons, saying that the position would only take one afternoon per week. Inspector O'Reilley refused the request, stating that Bucke had "enough work at the Asylum" and that a medical superintendent was not allowed double duties.[34]

Bucke initiated a number of measures to 'revolutionize' the treatment of the insane. He has been praised in a recent study by Cyril Greenland for furthering the cause of moral treatment, but his reforms often had limited benefits. For example, he abolished the use of alcohol as a sedative, but replaced it with narcotics such as opium derivatives. Bucke did "remove all restraints" as Greenland states, except for leather muffs, leather mitts, the restraint chair, and secluded rooms, all of which appeared in the Asylum casebooks throughout the nineteenth century. It is in fact impossible to conceive that all restraints could be abolished for violent patients in this pre-tranquilizer age.[35]

In the 1890's, Bucke engaged in a series of gynaecological operations to cure insanity in female patients. According to the official history of the Canadian Medical Association published in 1967, "It is hard to realize that (Bucke) aroused such opposition by his reports of (such) surgical treatment."[36] Given the fact that

he was experimenting on a powerless group of women entrusted to his care, often misleading or raising false hopes in the minds of the families of the patients to gain permission to conduct the experiments, it should not be surprising that Bucke was "publicly condemned" by his colleagues for "meddlesome" gynaecology.[37]

Bucke's reign as Medical Superintendent, while successful in many ways, was also marked by problems and internal disputes, probably due to his imperious nature. His first difficulties lay with Stephen Lett, the Assistant Physician and second-in-command, who not only had had the unfortunate encounter with Bucke while Landor was still alive, but himself subsequently had applied for the position of Medical Superintendent of the London Asylum and had lost to Bucke.[38] Inspector Langmuir thought favourably of Lett and recommended him to the Provincial Secretary, but, as he wrote, "the fates seem to have been against you."[39] Certainly the stage was not set for harmony between the new Superintendent and his Assistant Physician.

By 29 March 1877, Bucke was sending complaints about Lett to Langmuir. Bucke wrote that at the officers' dining table, Lett had said, "I wish to have nothing to do with Dr. Bucke's friends." Bucke subsequently had told Lett that "all pretence of friendship must cease between their families." Lett argued that his words had been taken "out of context" and that he meant that he would "devote his time to the amusement of the patients" rather than Bucke's friends. Lett also said (it would appear with some justice) that Bucke "was dragging private and social matters into official reports."[40]

Langmuir replied that he would bring the matter before the Provincial Treasurer, and it was decided that Lett would be switched with Dr. Metcalfe of the Toronto Asylum.[41]

Bucke's feud with Lett did not end there, however. When Lett and his wife allegedly snubbed Bucke during a cricket match between the London and Toronto Asylums, Bucke again felt compelled to write Langmuir, stating that Lett's lack of courtesy was a "mental or moral aberration scarcely short of insanity."[42] While the Asylum Superintendent certainly was over-reacting from a bruised ego, his quarrel with Lett does indicate the importance of social graces in the nineteenth century; it also indicates that the Inspector was not merely a bureaucrat, but an arbiter and a counsellor as well.

Bucke had explosive relations with his staff on other occasions. In 1887, Inspector O'Reilley was brought into a dispute between Bucke and his then First Assistant Physician, Thomas Burgess. Burgess had complained that he had been badly treated by Bucke, and other staff physicians, Drs. Simpson and Robinson, had confirmed that Burgess was the "victim of a conspiracy" between Bucke and Dr. Beemer, Second Assistant Physician. The two "conspirators" wanted to displace Burgess and establish Beemer in his position. Robinson and Simpson said that they would not stay in London because they feared similar treatment from Bucke. As they said, "their throats may be cut at any time." When Inspector O'Reilley made enquiries into the matter, Bucke spoke of a "small rebellion" which had taken place among his medical staff, and that Burgess had mistreated a former attendant, Lizzie McBride. O'Reilley could not find evidence of either charge,

and on questioning Lizzie's sister (another asylum employee), he learned that she "had never heard any complaints (from Lizzie)" and that in fact "she feels she will have lost her best friend when (Burgess) leaves." Burgess wrote that he would be happy to be transferred, but not under "false impressions".[43] The honourable Arthur Sturgis Hardy, Provincial Secretary, advised O'Reilley that "things have gone so far that it won't do to leave Burgess there", and ordered a transfer to the Hamilton Asylum. He also ordered that O'Reilley "had better go no further in getting statements from Miss Pope (the Matron) or others or we will have the whole asylum in such a state of uproar and confusion as to make it impossible to manage it successfully." Besides, O'Reilley had not been authorized "to investigate Bucke and that's what it amounts to." As for Drs. Robinson and Simpson, Hardy said that they "can resign if they want to. They would in his humble view do better to mind their own business."[44]

Bucke found himself embarassed both personally and financially when a legal suit was brought against him in 1891 by a former employee. After a number of petty thefts had been committed in the attendants' rooms, a dining-room girl, Margaret Ross, was called to Bucke's office to explain suspicious behaviour. Bucke ordered her to return nine dollars which had been stolen from another attendant's room. Ross denied all knowledge, but when Bucke threatened to "telephone for a detective and have her arrested", Ross left the office and returned with nine dollars.[45] Ross was discharged and ordered to leave the Asylum. After she had gone, Bucke sent for the Asylum messenger,

S. Thompson, who was engaged to Ross, told him what had happened, and called Ross "a contemptible thief." Thompson then broke his engagement to Ross, and it was on this basis that she sued for slander, and won five hundred dollars damages from Bucke.[46] The Attorney-General advised the Inspector that he could not see how the government could pay the damages, as Bucke had overstepped the bounds of his duties by calling in Thompson. The Inspector thought this governmental decision was "disastrous"; though Bucke had used bad judgment, he was still "acting for the Institution."[47] The Attorney-General finally agreed, but the government took two and a half years to pay the costs. While the Asylum Superintendent was to exercise due authority, he was not to engage in any activities which resulted in financial loss or adverse publicity for the government.

Despite the tribulations Bucke encountered, he was not without humour. He took issue with the Inspector's comments that his assistant physicians were producing "rapidly increasing" families. Comparing the number of children with that of other asylum doctors, he wrote: "if we compare the whole ten men, or the six married men, or the three married men who have had any family since being appointed ...it does not seem to me that we can fairly speak of the rapidly increasing families of the assistant physicians."[48]

Most of the difficulties encountered by Drs. Landor and Bucke in their experiences as asylum superintendents resulted from the fact that they were in a profession that demanded an extremely authoritative outlook. The supervision of what eventually came to eight hundred patients and staff necessitated and strengthened this

authoritative outlook. Yet when Landor found his power being pre-empted, and Bucke his actions being questioned and reprimanded, both men learned that, in the final analysis, they were employees of the government.

NOTES

1. Excerpt from poem written by William E.--admitted to the Asylum three times between 1870-1877. Diagnosed with suicidal melancholia, he admitted himself twice voluntarily [University of Western Ontario, Regional Collection, Bucke Papers, London Asylum Scrapbook, London, 1878].

2. See W. L. Parry-Jones, The Trade in Lunacy, London, 1972.

3. Gerald N. Grob, Mental Institutions in America, New York, 1973, p. 137.

4. Ibid., p. 135.

5. J. Leslie Toley, "Mental Therapeutics," American Journal of Insanity (April 1887) : 347.

6. Grob, p. 141.

7. John Pitts,"The AMSAII 1844-1892",unpublished Ph.D. dissertation abstract, University of Pennsylvania, 1979.

8. J. H. Coyne, Richard Maurice Bucke, Toronto, 1923, p. 41.

9. T. J. W. Burgess, Institutions for the Care of the Insane in Canada, Toronto, 1898, p. 35.

10. London Free Press, "Obituary--Dr. Henry Landor", 8 January 1877.

11. Ontario. Legislative Assembly. Sessional Papers. "Annual Report of the Medical Superintendent, Asylum for the Insane, London, Ontario," No. 4, 1875, p. 26 [hereafter A.R.M.S].

12. Orlo Miller, A Century of Western Ontario: The Story of London, "The Free Press", and Western Ontario, 1849-1949, Westport,Conn., 1949, p. 168.

13. Henry Hurd, The Institutional Care of the Insane in the United States and Canada, Baltimore, 1917, volume 4, p. 572.

14. London Free Press, 8 January 1877.

15. Archives of Ontario. Ministry of Health. Record Group 10. Correspondence of the Inspector of Asylums and Prisons, Box 230, File 6598, 10 January 1877 [hereafter C.I.P.A.].

16. A.R.M.S., 4, 1875, p. 224.

17. C.I.P.A., 230, 6598, Landor to Langmuir, 24 July 1876.

18. C.I.P.A., 230, 6598, Lett to Langmuir, 24 July 1876.

19. Emphasis in original [Ibid., Landor to Langmuir, 24 July 1876].

20. Workman resigned his position in 1876, when, after "twenty-two years of faithful service, he began to chafe in official harness and longed for rest..." Landor cited Workman in his letter of resignation [Hurd, Institutional Care, p. 599].

21. C.I.P.A., 230, 6598, Landor to Langmuir, 24 July 1876.

22. Ibid., 1 August 1876.

23. Cyril Greenland, "Richard Maurice Bucke M.D. 1837-1902," Canadian Medical Association Journal 91 (1964): 385.

24. Ibid., p. 386; George H. Stevenson, "The Life and Work of Richard Maurice Bucke: An Appraisal," American Journal of Psychiatry 93 (1936): 1129.

25. Cyril Greenland, "The Compleat Psychiatrist: Dr. R.M. Bucke's Twenty-five Years as Medical Superintendent, Asylum for the Insane, London, Ontario 1877-1902," Canadian Psychiatric Association Journal 17 (1972): 74.

26. Ibid.

27. The London Advertiser 8 July 1881 as quoted in L.N. Bronson, "Researchers Reflect on Bucke Theories," London Free Press 22 August 1979.

28. In his philosophical work, Cosmic Consciousness, Bucke described a mystical experience he had had in 1871, when he found himself "wrapped by a flame-coloured cloud "[Greenland, Bucke *M.D., p. 389].*

29. This was not very distant from the medieval notion of the body being composed of four humours ["The Moral Nature and the Great Sympathetic," American Journal of Insanity 35 (October 1878) 2: 230].

30. R. M. Bucke, Man's Moral Nature: An Essay, New York, 1879, p. 230.

31. Ibid., pp. 242-251.

32. R. M. Bucke, "The Origin of Insanity," American Journal of Insanity 49 (July 1892) 1: 56.

33. The telephone was installed over the objections of Londoners who marched on City Hall to protest the imposition of wires on their rooftops [Greenland, "Compleat Psychiatrist," p.71].

34. Charles M. Godfrey, Medicine for Ontario, Belleville, 1979, p. 290; C.I.P.A., 231, 6624, Bucke to O'Reilley, 30 August 1886.

35. Greenland, "Bucke M.D.", p. 386.

36. H. E. MacDermot, One Hundred Years of Medicine in Canada, Toronto, 1967, p. 37.

37. Greenland, "Bucke M.D.", p. 386.

38. C.I.P.A., 229, 6589, Lett to Langmuir, 9 January 1877.

39. The fates had been against Lett before when he had applied for the position of Medical Superintendent of the Toronto Asylum in 1875 [C.I.P.A., 229, 6589, March 1875]; Ibid., Langmuir to Lett, 9 January 1877.

40. Ibid., Lett to Langmuir, April 1877.

41. Ibid., Langmuir to Lett, 25 April 1877.

42. While Lett's rudeness may not have been a symptom of insanity, he did eventually spend four years as a patient in an institution. On 20 December 1901, he admitted himself to Kingston Asylum, and was discharged 28 September 1905. He died a fortnight later of general paresis (syphilitic paralysis) [C.I.P.A., 229, 6589, December 1901;Hurd, p. 574]; C.I.P.A., 229, 6589, Bucke to Langmuir, 30 August 1877.

43. C.I.P.A., 231, 6625, Burgess, 25 July 1887.

44. Ibid., 4 August 1887.

45. Ibid., 218, 6450, Ross versus Bucke, 23 August 1890.

46. Ontario. Middlesex County. Court of Queen's Bench. Statement of Claim; Statement of Defence; Notice of Motion and Affidavit in the case of Margaret Alexandria Ross versus Richard Maurice Bucke, 10 November 1890, Bucke Papers, Regional Collection, University of Western Ontario.

47. C.I.P.A., 218, 6450, Ross versus Bucke, 1890.

48. Dr. Burgess,married eleven years, had four children, Dr. Beemer, married eight years, had two children, and Dr. Robinson, married one year, had none [C.I.P.A., 231, 6625, Bucke to Langmuir, ca. 1879].

CHAPTER III

LONDON, ONTARIO ASYLUM FOR THE INSANE

GENERAL STAFF

The physicians at the London Asylum were supported by employees fulfilling a variety of functions. Medical staff controlled and cared for the patients, while support staff maintained the institution. In 1876, the Asylum employed eighty-six staff members, excluding officers (superintendent, physicians, and bursar).

The Matron was responsible for housekeeping and promoting "good feeling and pleasant social life among the officers." She also presided with the Assistant Physician over the officers' meals and saw that everything "was fittingly done." The Steward was in charge of maintaining and issuing supplies.[1]

The medical staff was directed by the chief attendants, who were to be "firm, patient, kind and conciliatory, and an example to those under them." They also compiled a weekly list of how their patients had been "employed, occupied or amused."[2] There were five male and three female chief attendants. That there were fewer female chief attendants may have been to save money on salaries, as well as because fewer chief attendants were required to supervise women [see appendix 1].

There were sixteen male and nineteen female ordinary attendants, who kept their patients clean, fed and busy. They were to encourage

recreation, join "all games and amusements," and read selections from the Bible every day. Attendants were not allowed to use any violence, and would be immediately discharged for striking a patient or for intoxication. The attendants were to perform their duties "quietly, regularly and punctually, without scolding, shouting or loud talking." A patient's misconduct was not to be reported in his or her hearing.[3]

Attendants were allowed to leave the Asylum every other night in summer from 7:00 to 10:00 p.m., and in winter until 9:00 p.m. if unmarried. If married, they could stay out all night. They also were allowed every other Sunday and one day every six weeks.[4]

Other staff included two night watches and two night nurses, four laundresses, a seamstress, a dairy maid, six housemaids and two "general assistants."[5] There were no male domestic servants. Also employed were an engineer and assistant, firemen, carpenters, gardener and assistant, porter, butcher, baker, farmer, tailor, ploughmen and a cowman. An outside night watch was added to protect the orchards and crops from tramps and boys, as well as a "portress" (secretary).[6]

In 1874, the highest paid non-officer in the London Asylum was the Steward, who received an annual salary of six hundred dollars. His female counterpart, the Matron, was paid four hundred dollars (raised to five hundred dollars by 1899). Her wage was identical to that of the farmer, the gardener and the assistant engineer. Ordinary male attendants were paid $213.00 while ordinary female attendants received $90.00. This discrepancy was evident for all employees. It was not however unusual in the nineteenth century

workforce for women to be paid much less than men, as they were expected to marry and withdraw from the paid labour force, or, at least, not to be dependent upon their wages to support a family. The market for young male labour was also more competitive in the London area (as farm labour, in public works, or in construction) than for female labour so that the Asylum administration was forced to adjust male wages upwards to compete.

Though the Asylum was a large employer and the market for labour was competitive, the wages it offered were not particularly high for the London area. In 1874, general labourers in London received $1.37 to $1.50 per day: a high salary "owing to the progress of large works."[7] Skilled labour (machinists, blacksmiths and woodworkers) received from $1.50 to $2.25.[8] In 1887, the average annual wage for farm labour was $159.00 with board and $245.00 without. Female farm help received $6.22 per month with board.

In the late 1880's, there was a serious shortage of female domestic servants on farms because servant girls could not be induced to stay, "owing to the greater attractions in the cities and towns."[9] Working at a large institution like the Asylum may have had benefits unavailable on a farm, such as less isolation and greater freedom of movement. Being part of a large staff also meant sharing in a group identity.

Employees, however, still wanted good wages. In 1881, Bucke was faced with a number of resignations due to a labour shortage in the area. Because he could not raise asylum wages (he operated on a strict budget from the government) and because employees had

specifically cited the bad food as a reason for resigning, he had to improve the board, adding, for example, meat at every breakfast instead of thrice weekly.[10]

The lack of a good wage was also considered a sensitive labour issue. In 1897, a local cigar manufacturer, Hugh McKay, wrote to Thomas Hobbes, M.P.P., with respect to the Asylum shoemaker, Lashbrook, who received $25.00 a month salary plus board (worth ten dollars). Since he was married and lived outside the institution, Lashbrook wanted the $35.00 in cash, as had been granted to others in similar situations. Hobbes forwarded the request to Inspector Christie, and added this addendum:

> Can anything be done in regard to this matter? It is a poor wage for a mechanic and the Trades and Labour Organization could make it hot for us along this line if they get hold of such cases as these.[11]

For this and other reasons, the Inspector had not wanted the acquisition of permanent male attendants. Far from being alarmed at the high turnover rate of employees, Christie was opposed to increasing wages to induce staff to stay. In his opinion, the average male attendant "should be employed young and leave after a few years" having saved up money and being "desirous of getting married." The supervisory staff should be allowed to marry and encouraged to keep their jobs, but the Inspector did not want a staff of "old and middle-aged men."

In 1895, therefore, the salary of supervisory staff was to be raised to $25.00 monthly after eight years service instead of

$220.00 annually. The chief attendant would be paid $30.00 instead of $25.00. Regular male attendants however would have a cut in salary from $20.00 to $18.00 monthly, as there were a "great number of applications" (the labour shortage appearing to be over). Six to eight regular attendants with five to eight years service would be allowed to marry and retain their jobs, but that was to be the limit.[12] This policy was quite understandable. Having a staff composed of old or feeble men in control of violent and physically powerful patients could have tragic results for both attendants and patients.

The duties of certain employees included acting as servants of the medical staff. Occasionally, the two roles conflicted, as in the incident of Dr. Buchan's ladies and the north-building housemaids. As Bucke reported (finding it necessary to burden the Inspector), since Dr. Buchan's arrival at the Asylum, two housemaids had resigned after living in the north building, where he had his quarters. Both servants had said it was impossible to live with the ladies of Dr. Buchan's family who plagued them with "unreasonable and vexatious exactions" as well as "unnecessary ill temper." The Inspector replied that the girls were only required to do up the rooms in the morning, not wait upon them all day. Buchan wrote back protesting that he had been "slandered", but as this was the last correspondence on the subject, it would appear that Buchan's ladies had learnt their lesson.[13] As this anecdote illustrated, Bucke occasionally experienced difficulties in dealing with his

medical staff on an individual basis, so he resorted to the impersonal authority of the Inspector. Also illustrated is the amorphous nature of non-medical staff responsibilities, which were not task-oriented so much as rather like that of domestic servants. Duties were formally outlined, but a clause was always included stating simply that the orders of superiors must be obeyed. Like domestic servants, Asylum staff were expected to conduct themselves morally as well as efficiently.

Government legislators did attempt to issue strict guidelines as to duties and responsibilities, but because the Asylum was an institution, and the job was handling people (and insane ones at that), every eventuality--and relationship--obviously could not be foreseen. Buchan's case also demonstrated priorities. Though physicians were respected and indulged as much as possible, it was not at the expense of good help.

Although there was a high staff turnover, institutional life promoted the development of a close-knit social group, something which the officers encouraged with events like weekly dances, balls, recitals and plays. The employees' "amusement hall" included a billiards table which was a popular recreation.[14] A sense of affinity might also have been heightened by the fact that the attendants wore uniforms: navy blue with white vertical stripes.[15]

The primary agent for solidarity was, of course, the fact that the attendants shared the common experience of dealing with the insane. Training, such as existed, was "on-the-job". For

these primarily young, local men and women, dealing with the insane, or worse, dealing with those who did not appear to be any less sane than their fellow attendants, must have been a trying experience.

As keynote speaker at the Annual Attendants Ball on 19 March 1877, Dr. Bucke in his first speech as Medical Superintendent outlined the special responsibilities of asylum attendants. "Why is it that we require more patience, more intelligence...in dealing with lunatics than in dealing with sane people?" he asked

> It is because insanity is not confined...to a derangement of the intelligence...What we have to contend against...is not so much false ideas and defective reasoning processes, but the far more formidable departures from mental health, of evil desires, vicious habits, malignant passions: it is the manifestations of these which make necessary on the part of the attendants superior qualities of head and heart, which often drive the physicians well nigh to despair.[16]

One year as Superintendent did not increase Bucke's confidence in the "superior qualities of head and heart" of his employees, as was evident by a high staff turnover rate and his speech of 1878: "Since this time last year there have been a good many changes in the staff of the Asylum, and under the same circumstances...there will be a good many changes every year as long as I remain here." There would appear to have been some ill feelings about his strict policy, especially since "under [Landor's] regime," as Bucke wrote, "a great many things about the Asylum seem to have been left very much to chance"and to a 'rule of thumb' management.[17] "Such changes have caused and will cause me more pain than anybody else, though

perhaps you do not believe that," Bucke continued, "You probably think it is a pleasure or a matter of indifference to me to report or discharge any officer or employee...Changes in the Asylum are not made in that way..." The tone of optimism, intimacy and shared purpose displayed in Bucke's first speech was thus replaced by one of isolation, distance, and even some bitterness. Bucke listed the rules whose infringement would be "followed by dismissal". Infringement, however, must have occurred, given the fact that he found it necessary to reiterate them.

> You must keep sober.
> You must not be absent without leave.
> You must not strike or insult a patient.
> You must be honest and tell the truth.
> You must be civil to everyone, and respectful and obedient to those who are in the position of your superiors.
> You must not be guilty of anything approaching immorality.
> You must do the work that you are engaged for the purpose of doing.[18]

Since employees resided in the Asylum and were expected to maintain a moral lifestyle and display exemplary behaviour at all times, it appeared inevitable that the Superintendent would experience difficulties with his staff. Sobriety was one problem. G. "got drunk and quit". Alex A., an attendant "not extra sober" was said to have "ill-used" a patient. The charge was unfounded, but he was reprimanded for having got drunk "for a diarrhoea". Bucke unsuccessfully attempted to prevent the government from awarding a tavern license to the Asylum Hotel, located across the road from

the main gates, fearing it would pose too great a temptation for his staff.[19]

Staff were occasionally guilty of something "approaching immorality." Spring fever was thought to have struck two couples whom Bucke discovered in the "half-dark dining room, more loving than [he] thought decent." One couple was married, and so simply reprimanded; the other was discharged, and Bucke directed that locks be put on the dining-room door. Susan T. and B., both attendants, were discharged for being "very intimate". In another case, attendant A. F. had caused another (unnamed) attendant to become pregnant, and had arranged for her to have an abortion by a physician in Ingersoll. Upon her return, she told Bucke what had transpired, and he had both men (physician and attendant) arrested.[20]

There were various instances of dereliction of duty. This was especially true of the night watches, who were liable to be discovered in their rooms, "snug before the fire", and in secluded corners, fast asleep.[21] There were also the odd cases of theft. In 1878, an attendant, for example, had been appropriating tools from the Asylum, but denied it and continued to deny it even though he was confronted by three witnesses. When a search of his house uncovered a basement full of pieces of Asylum equipment, he too was arrested.[22]

The Inspector and Asylum officials were extremely careful to avoid charges of corruption. When in 1877 Robert Mathison, the Bursar, received an anonymous letter with one hundred dollars enclosed, he suspected one George McD., a local butter contractor of attempted

bribery. McD. had offered Mathison an identical sum the previous Christmas, and the Bursar had told him, "if he ever mentioned money again I would knock his head off."

Mathison confronted McD. with the money in the presence of the Matron, Miss Pope. The contractor denied sending the money, but Mathison "felt assured he was cheating us in butter." The problem of the disposal of the money remained. Inspector Langmuir instructed Mathison to distribute it among four local charities, and publish in the newspaper that such had been done. The charities' acknowledgements of acceptance were also published, and the clippings kept in Langmuir's files. In this way, both the Asylum and the government protected itself from charges of bribery and corruption.[23]

The most serious problem concerned ill-treatment of the patients. Both Landor and Bucke punished this breach of the principal tenet of moral treatment with instant dismissal. In June, 1875, Landor discharged Mrs. L., an attendant in the refractory ward, for repeated violence against patients. Landor had been suspicious of Mrs. L. who had always said that mysterious bruises on her charges had been made by other patients. Mrs. L. apparently would hold a patient and call on another to beat or pull the patient's hair. After Mrs. L. was discharged, she detailed the acts of two other attendants, but Landor decided that she had been the "instigator and ringleader". Besides, even though she would condemn herself most severely at any trial, Landor reasoned that Mrs. L.'s public revelations (in court) would necessitate washing "dirty laundry" in public. But for the two other attendants, young girls, there could be no punishment but the "common gaol where they would

be with thieves and harlots", and Landor doubted if it were justifiable "to destroy all the future of the girls for even this offense." He therefore decided instead to expose them to the whole household and dismiss them "with an expression of disgust."[24]

This charge was a very delicate situation for any asylum superintendent, as reports of maltreatment of patients would seriously damage the credibility of the institution and the reputations of the men running it. It could also cost money, as families of paying patients might be more reluctant to leave their relatives in such an institution. At the same time, Landor recognized the difficulties in preventing such occurrences. "But as you well know," he wrote to Inspector Langmuir, "eyes and ears must be everywhere to prevent one kind of abuse or other among security servants. One is soon cured of too much faith in goodness in an asylum, and the real difficulty is to detect."[25]

This view was supported by the testimony of T. (which was treated with scepticism as he was a patient who was "not sane though... he knows (he) has insane thoughts"). In March 1877, at the end of Bucke's first month as Superintendent, T. told Bucke that he had been "kicked twice in this Asylum, and that he had seen other patients struck several times but not kicked. He says the patients are not as well used by the attendants as they should be."[26] A week before, Bucke had discharged one attendant for beating a patient, and another for "sitting by looking on."[27] In the course of the next year, three attendants were discharged for violence: one for cutting a patient's leg with a pair of scissors, another for striking a

patient, and a third for "throwing down" a patient and tying his feet, with the assistance of four other attendants and a chief attendant. Bucke gave the chief attendant the choice of resigning or having the matter taken to Langmuir, but on the "intercession of friends" (Drs. Metcalfe and Burgess), Bucke withdrew the punishment. Dismissal therefore was not always "instant"--particularly in the case of a competent chief attendant.[28]

A rather ironic fate awaited James S., an attendant who had "struck and kicked" patient John E. in a "passion and not in self-defense". James had "only once" before been reported, for turning a patient out of the dining-room in "rough" fashion. John E., on the occasion in question, had refused to do the work the attendant had ordered him to do. Being "pressed", the patient "raised his hand as if to strike James S. and said, 'Do you want me to kick you?'" James then took hold of him, "threw him down and struck and kicked him several times." Three male attendants nearby might have given James assistance. James was discharged, but at his request, Langmuir entered his name as a prospective guard at the Central Prison in Toronto.[29] It would appear that the attendant possessed qualities not well regarded in an asylum, but useful in a penal institution, which is a good indication of the nature of rehabilitation. The incident also illustrated the fact that patients did not always agree with the physicians' view that employment was good therapy.

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Because the Asylum was a public institution, government policy would also be a consideration in determining Asylum policy. That the Asylum was not immune to the political and social turmoils of the outside world was revealed in correspondence between Inspector O'Reilley and Bucke in 1893. In that year, Oliver Mowat's Liberal government was preparing to fight a provincial election against not only the Conservative opposition, but also the Protestant Protective Association (P.P.A.), a virulently anti-Catholic society which was gaining solid support in southwestern Ontario. The secret society was regarded as more than a fringe group; one of its candidates unexpectedly won a by-election in the riding of East Lambton.

In its campaign sheet, An Eye-Opener for Ontario Electors, the P.P.A. charged the Mowat government with pandering to the "solid Catholic vote" and alleged that Roman Catholic charities and civil servants were favoured by the government.[30] Mowat and his cabinet were "deeply concerned" about the P.P.A. threat, and wanted to counter its charges without renouncing its policy of equal rights for Ontario's French and Catholics. The method used was the distribution of their own campaign document, The Record of the Mowat Government 1872-1894, which stated that although Catholics comprised one-sixth of the population, they held less than one-sixth of government positions.[31] Though Mowat's government was returned with a reduced majority, the P.P.A. did not long outlive the election.

Before the election, however, Mowat's government was thorough in attempting to counter the P.P.A. threat. On 8 November 1893,

Inspector O'Reilley instructed Bucke:

> Please send me a return showing the name, service, amount of salary, religious persuasion, and date of appointment of every official and employee of your institution at present. This return is strictly confidential.

On 10 November, Bucke sent his reply, stating that the return was enclosed "herewith", but that return is absent from the official files.[32] It was apparent that the issue was more than contentious, it was political "dynamite", particularly when it concerned a public institution in southwestern Ontario, a P.P.A. stronghold.

What was notable about the conduct of Asylum employees was not that there were incidents of drunkenness, maltreatment of patients, or "immorality", but that there were so few of them. Given that there was such a large number of young men and women living in an institutional setting for the first time, more incidents might well have been expected. Moreover, for every case of insubordination or abuse, there was one like the "splendid performance" of Mr. England, the launderer, in a Tuesday evening recital, or the Asylum's enthusiastic support of its cricket team. It should not therefore be assumed that because the employees were working in an institution, they were harsh or rigid, or that they were themselves oppressed.

NOTES

1. Ontario. Legislative Assembly. Sessional Papers. "Annual Report of the Medical Superintendent, London, Ontario Asylum for the Insane," No. 2, 1874, p. 21, regulation XXVIII, XXII [hereafter A.R.M.S.].

2. A.R.M.S., 2, 1874, p. 21, XXXIX.

3. Ibid., p. 23, LXVIII, LXXIV;p. 22, LIII.

4. Ibid., p. 22, LI.

5. Archives of Ontario. Ministry of Health. Record Group 10. Correspondence of the Inspector of Asylums and Prisons, box 218, file 6446 [hereafter C.I.P.A].

6. Ibid.

7. A.R.M.S., 2, 1874,

8. University of Western Ontario. Regional Collection.Leonard Family, Scrapbooks, London, ca. 1840-1940.

9. History of the County of Middlesex, Canada, Belleville, 1889, pp. 629-630.

10. C.I.P.A., 228, 6577.

11. Ibid., 218, 6446, 10 February 1897.

12. Ibid., 23 April 1895.

13. Ibid., 29 March 1895.

14. Bucke repeatedly posted notices ordering employees to stop sitting or leaning against the billiards table [University of Western Ontario. Regional Collection. Bucke Papers. Medical Superintendent's Order Book, 18 November 1879 (hereafter Order Book)] .

15. C.I.P.A., 228, 6582, 7 May 1889.

16. University of Western Ontario. Regional Collection. Bucke Papers. London, Ontario Asylum for the Insane, Scrapbook, 19 March 1877.

17. Ibid., Medical Superintendent's Journal, 9 April 1877 [hereafter M.S.J].

18. Scrapbook, "Speech to Employees," 1878.
19. M.S.J., 7 April 1878; 5 December 1878; London Free Press, 17 November 1897; C.I.P.A., 228, 6574, 1881.
20. M.S.J., 7 April 1878; 5 December 1878; London Free Press, 17 November 1897.
21. M.S.J., 10 April 1877; 28 November 1877.
22. M.S.J., 22 October 1878.
23. C.I.P.A., 230, 6606, 19 February 1877.
24. Ibid., 228, 6576, 8 June 1875.
25. Ibid., 11 June 1875.
26. M.S.J., 10 March 1877.
27. Ibid., 8 March 1877.
28. Ibid., 17 September 1877; 9 October 1878; 2 February 1878.
29. C.I.P.A., 229, 6586, 25 November 1881.
30. James T. Watt, "Anti-Catholicism in Ontario Politics: The Role of the Protestant Protective Association in the 1894 Election," Ontario History 59 (June 1967): 57-58.
31. Ibid., p. 59.
32. C.I.P.A., 8 November 1893; 10 November 1893.

CHAPTER IV

CAUSES OF INSANITY AND ADMISSION

Nineteenth century mental care was concerned with the cause as well as the treatment of insanity. With the assembly of the insane in large institutions, physicians were able to study and classify patients on a satisfactory scale to determine causal patterns. From observation of patients, they developed theories which were attempts to explain madness, its origin and its cure.

Alienists recognized that poverty, malnutrition, severe hardships arising from immigration, among other factors, might cause madness or exacerbate existing mental instability. The individual's own excessive behaviour was another important factor. Physicians exhorted the common man to refrain from too much

sex, alcohol or religion. They warned him of the dangers of masturbation or the suppression of natural bodily functions. "Want of an occupation" caused insanity, but so too did overwork. For the alienist of the last century, moderation in all things was not simply the Golden Mean, but was the prerequisite of lasting mental health.

Although an increasingly large assortment of behaviours could be symptoms of mental illness, it was not easy to admit a patient to an Ontario asylum. In Britain, reports of unjust commitments and 'mad-doctors' in league with greedy relations were popularized in sensationalist novels.[1] This resulted in legislation aimed at protecting the interests of the insane which was later adopted by the province of Ontario.[2] Admission was also hindered by the fact that applications far exceeded places. Even with the construction of new asylums and additions to old ones, the supply of unwanted and mad relatives appeared endless.

Admission to the Asylum could be achieved through two avenues. The criminally insane or those who were in county gaols were admitted under warrant of the Lieutenant-Governor. Private admission was obtained through the issuance of a certificate filled out by the family physician and sent directly to the Asylum. An application form was sent from the Asylum, and when a vacancy occurred blank certificate forms were issued.

Each form had to be signed by three physicians; the patient was then admitted. [3]

Despite the fears of many individuals that false imprisonment of sane people was a common occurrence, this view does not appear to be substantiated. Thirty-year-old James S. (#390), for example, was tall, strong, and reportedly "dangerous--violent, suicidal, and everything that is bad." Dr. Landor however could not see "anything wrong with him." By his own account, James had had "bad whisky at Christmas", became drunk and violent, and was sent to gaol as a lunatic. Landor sent him out to work, and in a month, being "well behaved and industrious", James was discharged. James was only institutionalized for four weeks; the Asylum was clearly not the 'hell-pit' of fiction from which no one emerged.

Alcoholism was mistaken for insanity in another case. James B. (#214) was sent to gaol ten times as a dangerous lunatic, on each occasion after a drunken spree. "If he refrains from drink," Landor wrote at the Malden Asylum on 4 November 1869, "he will be well enough." A month later, Landor noted that James was "a little excited occasionally but there is no reason why this man should encumber the wards of an asylum. A home under the control of a father or a refuge would be the proper place for him." Yet Landor had no doubt that "as soon as he had money he would spend it in some tavern and do injury to someone," and he did not order James' release. The patient was transferred to

the London Asylum on 23 November 1870. James left on his own initiative, however, eloping with another patient, William M. Both men were "written off".

Attempts at false or unjust commitment were more likely to come from people outside the Asylum. In his Annual Report of 1873, Landor complained that the forms of admission then in use did not ensure the veracity of statements made. Applicants often made false statements regarding the duration of illness, saying the attack of insanity had been months old when in reality it had been years. Applicants also "suppressed knowledge of former attacks" and represented harmless patients as "suicidal or dangerous" in order to obtain admission. "So long as it was the public's impression that the dangerous and the suicidal were the first chosen," Landor wrote, "all the papers stated that the applicant possessed those qualities." When it became known that admission was awarded to those most likely to be cured, "the period of affliction diminished from years to months." Landor's remedy was to make available sufficient accommodation for all the insane, and, failing that, to impose a fine for misrepresentation. He also suggested that Ontario adopt the English method of requiring separate certificates from physicians who made individual examinations so that collusion (particularly for monetary gain) could be guarded against. [4]

According to Landor, statements made in warranted cases were no better than private cases, since gaol physicians and

wardens sought to rid the gaols of lunatics. They would describe patients as extremely violent to override the warrant procedure and obtain immediate admission to the Asylum. Landor therefore found that the diagnosis with which patients were committed could say more about the unwillingness of others to care for the lunatic than of the unfortunate's actual condition. The 'suicidal' and 'dangerous' may merely have been the unwanted.

The Asylum was not supported by fees of any sort. In 1871, only four percent of the patients were on the paying list. Those who could afford it paid $2.75 weekly, those with less income paid $1.50 or $2.00 weekly, and those with nothing (the majority) paid nothing. Paying and non-paying patients were not treated any differently, and wealthier patients could not pay additional fees to get preferential treatment.[5]

In 1877, Inspector Langmuir wanted to convert one of the cottages into a home for paying patients. Bucke said that this would reduce capacity, because all paying patients would want single rooms. He suggested that these patients be kept in the same building as pauper patients, be housed in a detached building on the grounds, or be put into an entirely separate asylum. Langmuir replied that the Department of Public Works would re-arrange the inside of a building, but was not prepared to build a new one.[6] The Superintendent and the Inspector often engaged in haggling of this sort. The Superintendent would ask for a

library and settle for a billiards table, or design an imposing edifice and settle for a modest church.

An essential aspect of moral treatment was classification. Care was taken to ensure that patients with similar degrees of insanity were grouped together, so that the acutely insane could not corrupt or contaminate the mildly insane. At the London Asylum, the refractory building was reserved for the violent, dirty and noisy patients. Epileptics and chronic maniacs who might be "seized with exacerbations of insanity" were housed in the north building.[7] Quiet chronic patients and those soon to be released were housed in the cottages where "fear of being sent to the main building" had a powerful deterrent effect.[8]

Upon admission, patients were classified as suffering from mania, melancholia or dementia. These categories were extremely broad, and were not disparate diseases but varying degrees of insanity.[9] For example, a patient might be admitted with chronic mania which deteriorated into dementia in the Asylum.

Mania referred to a general state of violent or excited behaviour. Monomania was obsessive behaviour towards one or a few objects. Other forms of mania included religious mania and nymphomania. Dementia, or complete loss of reason, was generally defined as "insensate, utter folly, because the organs of thought have lost their energy and strength requisite for their functions."[10]

Melancholia was the "predominance of a sorrowful and depressing passion."[11] Melancholia tended to be a disease of the middle and upper classes. It implied "suppression of feeling" which was the opposite of "peasant insensibility and peasant noisiness of expression."[12] One early prescribed treatment for melancholia reflected its upper-class nature:

> The cure of melancholy should be attempted in the spring or summer, by travelling far from home, with agreeable company, or if convenient, into foreign countries.[13]

Melancholy in women could best be treated by seeing them well-placed "and married to good husbands in due time".[14]

Epilepsy was also a frequent diagnosis. In the nineteenth century, epilepsy was believed to be caused by "excessive drinking, sudden stoppage of the courses, severe fright, injuries of the head, teething or irritation from worms in the stomach and intestines."[15]

Mania and chronic mania were the most frequent diagnoses at the London Asylum: 28.4 percent of the patients admitted between 1870 and 1877 were labelled as such. Suicidal and dangerous mania accounted for another five percent.

Twenty-two percent suffered from dementia, chronic dementia, approaching dementia, or "complete and chronic dementia subject to paroxysms of excitement." Seven percent of the patients were diag-

nosed as melancholics: chronic, suicidal or dangerous. All suicidal patients were not necessarily melancholics; seventeen inmates with mania and one with dementia were also listed as suicidal.

Twelve patients (1.5 percent) were epileptics, often accompanied by other disorders, but a significantly higher number had fits which resembled epilepsy while in the Asylum.

The causes of insanity were also classified: moral, physical, hereditary or congenital. Moral causes were instances of extreme anxiety or stress and included domestic troubles, death of a close friend or relative, money problems, love affairs, worry and fright. Nine of the ten patients at the Asylum who had become insane through grief were women who had lost a parent or child. Ten patients had domestic troubles, primarily the result of jealousy or ill-treatment.

Adverse circumstances, which included money troubles and business reversals, were usually suffered by men (five men: one woman). Three patients lost their property, while another went insane "brooding over property he though he paid too much for."

Four men and four women worried themselves mad, through "over-mental exertion", "mental prostration and living alone", and even through the "excitement of travelling". Religious excitement was frequently cited as a cause of insanity, although this tended to be discounted by authorities. Isaac Ray,a noted American alienist, attributed "religious monomania" as much to

"neglect of food, sleep, exercise and mental relaxation" as to "passion aroused by religious thought." [16] Joseph Workman, the Superintendent of the Toronto Asylum (1853-1875), believed that a lunatic's nominal religion had "very little to do with the causing of his insanity, though it may have much to do in determining the form of it." [17] Of the patients admitted between 1870 and 1877, seven men and two women at the Asylum had gone insane from religious excitement.

Insane love affected eight women and two men, through "disappointment", "love" or"seduction". One man was frightened by lightning, while a woman went mad through a "want of occupation".

Physical causes of insanity included over-indulgence, uterine disorders, fevers, epilepsy, head injuries, and overwork (though lack of work was a moral cause). Ten men and one woman were listed as mad from drink, which provided justification to proponents of temperance. Fifteen men and one woman were believed to have gone mad through self-abuse; masturbation was the most frequently listed cause for men. Eighteen women suffered from uterine disorders which caused insanity. This designation probably provided the basis for Bucke's later experimentation with gynaecological surgery.

Other patients suffered from sunstroke, inflammation of the eyes, "ill health" or "sickness". One young man had suffered a fever "while in the United States". It was specifically noted where he had been, which could indicate that venturing far from

home unchaperoned was an unusual occurrence, and not an altogether favoured one.

Heredity was the third category of causes designated by Asylum administrators. Heredity as a pre-disposition for insanity was of great concern in the late nineteenth century, as important as excessive behaviour. It was believed that insanity was a manifestation of a general inherited weakness which could take many forms. Dementia in one generation, for example, could result in "feeblemindedness, criminality, alcoholism, tuberculosis, or eccentricity" in succeeding generations.[18] The fact that different members of the same families appeared in asylums and prisons justified this belief. Alcoholism and self-abuse could also taint future generations. In the United States, asylum superintendents, prison wardens, social workers and temperance proponents were among the leaders of the eugenics movement, which was aimed at restricting propagation of 'degenerate' segments of society through planned parenthood.[19]

At the London Asylum, heredity was considered an important causal factor of insanity. Forms of admission inquired whether other members of the patient's family had also suffered from insanity, and patient case histories often listed the designation

'Hereditary' or "Not Hereditary'. Of the cases for which that designation was made, forty-six percent were cited as hereditary, and fifty-four percent as not hereditary, so that no pattern emerged. Eugenicists, however, would have argued that there would have been, at a very minimum, forty-six percent fewer unfortunates in an asylum at the government's expense had eugenics been practised.

Concern for heredity as a causal factor was demonstrated in a number of cases. Alexander G. (#666) was a farmer with suicidal tendencies and melancholia. It was noted on his case file that his parents were cousins, and that his brother was in a Toronto asylum.

Mary Matilda E. (#845) was another patient for whom heredity was seen as a strong causal factor. Her sister Margaret Ann (#982) was also a patient in the Asylum, and another sister had "spiritual views". Mary had been a schoolteacher until she had gone insane from "teaching and excessive study". She fancied she had a "man's brain" and that she was a "Queen Philosopher". She was occasionally violent, throwing dishes and striking others, and sought to save everyone from their sins. She was transferred to the Mimico Asylum in 1890. While Mary's case was seen as strongly hereditary, there also appeared to be strong disapproval for the

'over-educated' woman who did not know the limits of her own intellect.

Elizabeth W.'s case was a fine example of familial degeneracy. Elizabeth (#509), a labourer's wife, was "noisy and troublesome" and made use of "very profane language". In her case file, Landor wrote, "Insane family. Hardly know what relations they are having lived without any of the rules pertaining to morality and in some instances brothers and sisters having carnal intercourse." Four of Elizabeth's relatives were in the Asylum.

Congenital cause for insanity was the fourth category and included birth defects, primarily imbecility (mental retardation). The Asylum established a separate Idiot's Asylum to remove the imbecile, particularly the educable, from the influence of the acutely insane. At the same time, eugenicists advocated homes for imbeciles to prevent them from contaminating society with degenerate offspring.

Certain elements, of course, were much more closely related to insanity than "love" or "fright". Poverty bore the strongest correlation to insanity. If we use occupation as an indicator of class and wealth, we find that the poorest groups composed the largest proportion of inmates. Of those patients whose files listed occupation (54.7 percent did not), farmers made up thirteen percent of male patients, and labourers comprised fourteen percent. Women were primarily domestics (housemaids) or

servants (twenty-two percent and 10.5 percent respectively). The Asylum had been designated primarily for the destitute. Wealthier members of society also were able to look after their own insane or were unwilling to put family members in asylums with the poor.

Certain cases were obviously the result of destitution. Mary M. (#450), an elderly Irish immigrant, became insane from "want and loneliness" and was admitted on 26 June 1871. Although the priest was sent for twice because it was thought she would die, Mary thrived in the Asylum. She talked a "good deal of Irish" and wanted everyone to "partake in any food she had". She was "very occasionally" bad tempered, and died of old age on 20 March 1887.

Mary O. (#882), admitted on 29 October 1874, was "found in the streets, nothing is known of her except what she states herself". She was supposed to have come from Montreal, and "always wanted to go there where she said her little son was." She was an extremely violent patient until she died in 1881.

The case of James A., admitted on 6 June 1874, was indicative both of the effects of poverty and the use of the institution as a home for those with nowhere to go. James (#810) was arrested for vagrancy and for "making use of abusive language" and being "threatening". In gaol, to which he was sent to serve thirty days hard labour, James was "occasionally troublesome" at night. He was committed to the Asylum by Dr. Hobbs, the gaol physician (no known relation to the Asylum gynaecologist). James became a quiet cottager and worked in the garden until he died of marasmus

[see glossary] in 1895. Although the Asylum had not been intended as a home for the destitute, there were few alternatives in late nineteenth century Ontario.[20]

Walter K. (#617) had been a commissioned officer in the British Army and had suffered from "sunstroke" while on service in India. He believed he had to be cured "by the Almighty" for his sins. Walter had been a warranted case from the London gaol where he was committed as a dangerous lunatic. According to the affidavit of William Cartwright, the justice of the peace who was present at his examination, Walter had been found in a swamp by Mr. Hiram Fitfield, a "respectable farmer". It appeared that Walter had been in the swamp four days and nights without food or shelter and was only saved by the "careful nursing" of Mrs. Fitfield. It was decided by "Mr. Niles, J.P., Mr. Dreary, J.P." and Cartwright that Walter was a dangerous lunatic, and he was ordered committed.

Poverty coupled with the hardships of immigration resulted in insanity which led to certain ethnic groups being over-represented in the Asylum. The most statistically significant ethnic group were the Irish: part of the great wave of destitute and sickly Irish peasants who came to North America between 1847-1856 as a result of famine in Ireland.

The arrival of the Catholic Irish aroused xenophobic hostility among white North Americans, particularly Irish Protestants. The Irish spoke strange dialects, followed unusual customs,

and competed fiercely for the lowest jobs. The high rates of crime, alcoholism and insanity among the immigrants seemed to prove claims made by Edward Jarvis, a leading American psychiatrist, and others, that the Irish "could not adapt" to North American life.[21]

Along with anti-Irish sentiment went concern for public health. Each wave of immigrants brought epidemics of cholera, and other diseases. The British government was accused of 'dumping' diseased Irish on Canada.[22] The great numbers of poor Irish overwhelmed existing public charitable institutions and provided the impetus for the construction of hospitals, prisons and asylums in Ontario.[23]

The large proportion of Irish in mental institutions drew medical attention to the case of Irish insanity. Edward Jarvis cited "poverty, lack of education, intemperance, an inability to adapt and consequent discouragements and anxieties" as causes for Irish insanity.[24] The Irish were also alleged to have a low rate of recovery, which could be blamed in part on the difficulties encountered in English-descent, Protestant, middle-class physicians treating Irish Catholic peasants. Moral treatment was based on the personal relationship between physician and patient. Physicians felt less sympathy for patients who were no longer like themselves, while the Irish distrusted these alien figures of authority.[25] At the same time, the influx of insane overcrowded the asylums and made it impossible for physicians to provide adequate treatment for every patient; the result inevitably was custodial institutions.

Of patients admitted to the London Asylum between 1870 and 1877, 147 patients (thirty-six percent of those for whom ethnicity was known) were Irish. Fifty-one percent of the Irish in the Asylum were Catholic, compared with approximately thirty-one percent in the Middlesex County area. Irish Catholics (primarily new immigrants) were therefore over-represented in the Asylum.[27]

The Irish as a whole were the most numerically significant group, followed by 123 'Canadians' (thirty percent). These groups far outdistanced the English and Scottish (ten percent and eleven percent respectively). Patients were also designated as being from Quebec, Ontario, the United States, Nova Scotia and Wales. Germans composed 2.6 percent of the Asylum population, drawn from the predominantly German settlements in the county of Waterloo.

Age was another important factor in admission. Over half of the patients (fifty-three percent) were admitted to the Asylum when they were thirty to fifty years old. Another seventeen percent were in their twenties. Violent individuals would be at the peak of their strength in those years and therefore be most dangerous to society. At the same time, the numbers indicated that the Asylum, while containing a high proportion of chronic patients, was not a refuge for the elderly or the senile. However, it must also be remembered that the elderly insane, particularly the impoverished, could not have had a long life expectancy.

Sex and marital status were other significant factors leading to admission. Of the patients for whom marital status was

SEX/MARITAL STATUS

	Men			Women			
	No.[1]	% Known	% Total	No.	% Known	% Total	Male: Female
Married	55	31	11	125	55	25	2:5
Single[2]	121	69	24	92	40.5	18	4:3
Widowed	2	1	.4	10	4	2	1:5
Total Known	178	101		227	99.5		9:11
Unknown	324		64.5	265		54	4:3
Total	502		99.9	492		99	1:1

1. Patient No. 143 was first to state marital status.

2. 'Single' may include widowed, divorced or separated.

[London Psychiatric Hospital, Casebooks 1870-1880]

known [see table], thirty-one percent of males and fifty-five percent of females were married.

A primary consideration for admittance to the Asylum was place of residence. Patrons would be more likely to place their relatives in institutions closer to home. The government also was consciously striving to establish regional asylums, which served surrounding communities.[27] Nearly half of the Asylum population (48.6 percent) were residents of the neighbouring counties of Essex, Kent, Lambton, Elgin, Middlesex, Oxford and Huron. Middlesex County alone accounted for 18.6 percent of the population. The county of York accounted for 8.4 percent, which was probably the results of efforts to ease the overcrowding at the Toronto Asylum.

Colour was not a statistically significant factor, as there were only four blacks in the Asylum, but their cases presented a vivid portrait of blacks in nineteenth century Ontario. Alfred W. (#25), the "most inveterate tearer of clothing in the house" was a mulatto who was always kept in canvas. Parthina B. (#313) was a "negress called 'Topsy'" who chewed tobacco and asked everyone for a "lilly bit of money" which she stored carefully. Mary Eliz-

abeth S. (#862), admitted on 19 September 1874, appeared to have method to her madness. She was a Baptist Minister's wife, who apparently went insane at the death of her parents. Her madness manifested itself as a desire "to drive her husband out of the house." She attempted acts of violence against him, and fancied that he "and the Freemasons" were against her. With respect to heredity, it was stated that Mary Elizabeth's mother was "slightly insane" and that her father was a "frantic, impulsive" man. These definitions likely came from the Baptist Minister. At the Asylum Mary Elizabeth spent her time making and dressing dolls until she died in 1902.

One of the most unusual cases at the Asylum was that of Isaac J. (#817), admitted 24 July 1874, a black with "no particular delusions," who sat quiet and morose and answered questions "with difficulty". After seven years at the Asylum, Isaac began talking "this morning with attendant Flynn. Says he has not spoken for so long a time as he thought the people with whom he cared to speak felt themselves too good to speak to him on account of his colour, and those around him who were willing to talk with him were crazy." Isaac became excited a week after his transformation, swore constantly and stopped working, but soon calmed down, becoming "quiet and well behaved." He was allowed out on six months probation with his former employer, and was then discharged. Isaac's case demonstrated that any patient who showed signs of recovery and who had recourse to care or employment might be quickly released.

The last classification to be examined is rate of discharge. Fifty-one percent of the patients admitted between 1870 and 1877 died in the Asylum. Half that number (twenty-eight percent) were released, of which 1.5 percent were re-admitted. Eighteen percent were transferred to other institutions, while 1.4 percent eloped. Despite the goals of the institution to cure quickly and release, the Asylum became filled with chronic cases. Yet Landor was not concerned about a low discharge rate. "No reliable conclusion," he wrote, "can ever be drawn, as to the success of asylum treatment in any institution, without a careful and rational valuation of the facts represented by its statistics. A bad workman may spoil good materials, but a good one can hardly make a good article out of bad materials--shoddy will come out but shoddy in spite of the best skill of the weaver...Just so is it with the human mind. We cannot make it over again, and turn it out better than God has made it."[29]

NOTES

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CHAPTER V

TREATMENT OF THE INSANE

The London, Ontario, Asylum for the Insane provided for the control of the lunatic and attempted to effect his re-integration into the larger community. Virtually all aspects of his institutional experience were part of his medical and moral treatment. Medical treatment entailed the use of narcotics and stimulants; most commonly used for somatic (bodily) illnesses, they were also employed in treating various types of insanity. Landor and Bucke had opposing views on the use of drugs and alcohol, but neither man relied solely on chemical treatment. Moral treatment was the regulation of the insane through labour and amusement rather than through restraint. It also entailed concern with a proper diet and a pragmatic attitude towards elopement (escape). Through the methods of moral treatment, the asylum superintendents attempted to make the care of the insane therapeutic and not coercive.

A sedative frequently used by Landor and Bucke at the Asylum was chloral hydrate.[1] A dose of twenty grains on a healthy subject acted "as a mild sedative of the sensory nervous system" and produced after an interval of one-half hour "a light, refreshing, normal sleep". Taken in large quantities, it was a powerful soporific. When it did not induce sleep, chloral hydrate

might occasion "excitement and delirium". It was especially valued as a soporific where opium was "inadmissible" because of its side effects.[2]

Stephen Lett, assistant physician under Landor, was enthusiastic about the value of chloral hydrate. He found the drug useful "in all cases of acute mania where the patient has not so deteriorated as to require free use of stimulants." When a patient suffered from "extreme exhaustion" because of excitement, lack of sleep, or other reasons, chloral "had little or no effect", and wine, whisky, or other alcoholic stimulants had to be given until the patient's condition improved.[3] Where chloral hydrate produced "sleep and quietness", it had none of the "evil effects" of opium; it did not "derange" the digestive organs, check secretions, constipate the bowels nor produce drowsiness.

Landor did not think highly of 'hydrate of chloral', believing that in "long, continued doses" it lowered the "action of the heart and nerves, and if not of the stomach directly, indirectly." Because hydrate of chloral lowered body temperature, Landor considered it "injurious, for if there is one thing more important than another in the treatment of insanity, it is, that it is absolutely essential to maintain and to increase the vital powers of our patients, naturally low."[4]

Landor found that a bottle of "the very best Scotch ale, or the best Dublin stout" was "more pleasant to take" and "not less effective in its operation". Alcoholic beverages were also

advantageous in their tonic effects and "conducive to sound sleep in violent mania"; moreover, they were medicines that would "bear repetition with the best results".[5] Alcohol also was found useful in cases where chloral hydrate was ineffective.

Landor asserted that alcohol tended to "restore the vital powers". By 1872, he was prescribing port wine and whisky along with ale and stout.[6] Lett found that by following Landor's advice and using ale instead of sedatives, he produced results "as satisfactory or more so" than he had with chloral hydrate.[7]

Landor used alcohol as a stimulant most commonly in cases of peurperal mania (relating to childbirth), and on melancholic women who were "delicate", "fretful", "weak", "sleepless", and in poor health. He generally prescribed two glasses of wine daily with beef tea; cod liver oil and wine; or wine daily with "good, nourishing food". A woman with violent mania was prescribed "good food, wine, and exercise". Another with phthisis (tuberculosis) was put on whisky and extra diet. A man who refused to eat anything but "a tin [sic] buttered toast, gin and sugar" was granted his request.[8]

Landor did not give his patients alcoholic stimulants recklessly. He found through experience that alcohol produced fewer side effects than opiates and other drugs. He was not immune to criticism from temperance circles, however. In 1875, given the opinion of "a large class of the people", he made an attempt to diminish stimulants by cutting off all those patients

who were merely feeble and without any particular disease. He issued one-third less whisky, one-half less wine and one-quarter less beer. During the next five months, twenty-four deaths occurred at the Asylum compared to thirteen in the previous period, and eleven cases of scurvy appeared for the first time which "disappeared after increasing the allowance" of alcoholic stimulants. Landor linked the deaths with the decrease in the use of alcohol, and was not overly swayed by prohibitionist sentiment.[9]

Yet he was aware of the negative effects of alcoholism, and argued that a causal link existed between drunkenness and idiocy (mental retardation). In 1872, there were seventeen males and thirteen females in the Idiot Asylum. Two were the offspring of "intemperate drinkers", two of moderate drinkers, "so-called", and the parents' habits of the rest were unknown.[10]

To put Landor's reliance on alcoholic stimulants into perspective, it should be noted that his asylum did not have the highest percentage of alcohol use. When the question of liquor in asylums was brought up in the Ontario legislature, the government pointed out that the London Asylum's expenditures in 1871 included $200.00 for medicine and medical comforts, and $1600.00 for beer, wine and spirits. The Toronto Insane Asylum spent $420.00 and $3,000.00 respectively, which per capita was an increase of fifty-one percent. It was stated that the Toronto Asylum Superintendent, Joseph Workman, approved of stimulants more than Landor did. Workman took his case to the newspapers. In a letter to the editor of

the Toronto Globe in 1876, he disputed the claim of Dr. Dickson (of the Kingston Asylum) that total abstinence in asylums led to a lower death rate. Workman stated bluntly that "total abstainers should leave the domain of medicine".[11]

Like Workman, Landor was a physician trained before the temperance movement became particularly influential, and he was not impressed by the dire warnings of prohibitionists. He had a very pragmatic attitude towards the use of stimulants and sedatives, and regarded alcohol as less of an evil than opium, morphine, and other drugs.

When Bucke succeeded Landor at the London Asylum, he discontinued the use of alcohol. Bucke was much younger than Landor, and was deeply committed to temperance. His first major publication was Alcohol in Health and Disease, published in London in 1880. In the pamphlet he stated that alcohol "no matter how wisely, temperately and carefully used...has not the power commonly ascribed to it of either lessening the pains, ills, or sorrows of life, nor of increasing its joys, comforts or pleasures."[12]

The rare cases for which Bucke prescribed alcohol included a "thin and weak" man who required extra diet and stimulants; a woman with "asthenia" who was given "wine, extra diet", and placed on the "water-bed"; and a man who had problems urinating and was granted one beer daily.[13]

By 1880, Bucke had discontinued the use of alcohol entirely at the London Asylum except in cases of persons "not only feeble,

but actually ill, and even then...very little." When he had assumed charge of the Asylum three years earlier, he had found six hundred patients using $2500.00 worth of beer, wine and whisky, which was a twenty-eight percent increase from the 1871 figure of $1800.00. During the period 1870-1877, there was a thirty percent increase in the number of patients in the Asylum (498 to 712) so that the increase in alcohol use was not great per capita.[14] In 1878, Bucke had initiated his reform with "no evil consequences." In 1879, he had closed the "spirit lists entirely" and reported only one case of withdrawal. He did not believe that alcohol was useful enough to "warrant its retention."[15]

In the place of alcohol, Bucke drastically increased the use of opium, morphine, chloral hydrate and other narcotics. The use of opium became widespread in the late nineteenth century. In the United States, importation of the poppy increased from 24,000 pounds in 1840 to 416,864 pounds in 1872.[16] There were no regulatory agencies controlling the sale of the drug, nor were its effects immediately understood. Inevitably, opium was abused. Many men and women became addicted to the narcotic to which they were first introduced by physicians and chemists. Before food and drug legislation was passed, patent medicines containing opium, chloral, alcohol and other drugs could be purchased at druggists and were advertised as curing everything from "pneumonia to 'nerves'".[17]

Nineteenth century physicians used opium as an anodyne

(painkiller) particularly for the distress of venereal disease.[18] It was also used in diseases of the digestive organs, and as a cure for enteritis, peritonitis, diarrhea and hepatitis. Opium, it was believed, soothed the maladies of the "urino-genital apparatus" and provided "the most relief for diabetes of all found."[19] In cases of insanity, the value of opium or morphia, in the form of acetate of morphia, was "insisted upon"; it manifested good effects in "low, desponding or melancholic" forms of madness.[20] It was also used by drunkards "to relieve intoxication."

Physicians soon recognized that opium had negative side-effects. Opium lessened the appetite, constipated and caused nausea.[21] Most importantly, it was highly addictive and its overdose could cause death.

At the London Asylum, Landor had decided that opium caused more harm than good, and used it primarily in ointments for external application. He had first-hand knowledge of the ill effects of opium abuse. Dr. Joseph M. (#926), admitted in 1875, was a physician who had become manic from morphia abuse and the strain of a "hard country practice". He was "wild and abusive", believing himself to be a god, and that "everything about him is in filth and confusion which he must rectify." Being a paying patient, he was placed in a private bedroom in the Asylum, but was so noisy he had to be moved to the refractory. He wandered "restlessly to and fro muttering to self about inability to do the work he should." He fought with attendants and patients, sustaining a number of black

eyes.

Joseph's abusive behaviour was probably a manifestation of opium withdrawal. Long-term abstinence for an addict will result in an "incapacity to tolerate stress, a poor self-image, and over-concern with discomfort."[22] By 1877, Joseph had quietened down, talking rationally and showing no signs of delusions but merely of "preternatural exciteability". He was discharged, recovered, in 1878. For Landor, no case of opium abuse could have been closer to home.

Bucke's attitude towards opiates was quite different. At the London Asylum, he used substantially more opium especially in the form of liquid morphine and liquid opium sedatives. In 1878, Inspector Langmuir asked Bucke to compile a list of the quantities of opiates and chloral hydrates used in the Asylum between 1875 and 1878, in case the "use of liquors" would again be questioned in the legislature.[23] Bucke sent Langmuir the accompanying table, noting that Tincture of Opium was used "almost entirely in liniments and diarrhoea mixtures, chlorodyne was used in gastrolgia and similar ailments, and the rest of the opiates and chloral hydrate were used as sedatives." Bucke stated that the whole quantity was "small" for so large an institution; the average number of patients taking sedatives was about six; and that at the time (4 October 1878) only one woman, a breast cancer victim, was taking sedatives.[24] Bucke appeared to be slightly disingenuous in preparing the table. Though it outlines the amounts of opiates purchased in each year, it does

AMOUNTS OF OPIUM ETC. PURCHASED

		1875	1876	1877	1878 to Sept 30th	total purchased	total on hand 1878	total consumed
Chloral Hydrate	oz.	30	24	32	--	86	24	62
Liquid Morphine	oz.	--	--	10	10	20	7	13
Morphia	oz.	1/4	1/2	1/2	--	1 1/4	1/4	1
Tc.Opii.Camph.[1]	oz.	176	112	96	16	400	6	394
Tc.Opii.[2]	oz.	88	128	32	--	248	8	240
Ext.Opii.[3]	oz.	2	2	--	--	4	-	4
Pulv.Opii.	oz.	1	4	3	--	8	1	7
Liq.Op.Sedativ[4]	oz.	3	-	2	4	9	4	5
Chlorodyne	oz.	2	-	-	1	3	1	2
Pulv.Ipecac Co.[5]	oz.	2	-	4	-	6	1	5
Pil.Plumbi & Opii.[6]		-	400	600	-	1000	200	800

[C.I.P.A., 234, 6680]

1. TINCTURA OPII CAMPHORATA (compound ticture of camphor)
   40 grains Opium in coarse powder; 30 grains Benzoic Acid; 1/2 fld. drachm camphor; oil of anise; 1 pt.proof spirit.
   Dose: 15 minims.
2. TINCTURA OPII (tincture of opium)
   1 1/2 oz. Opium in coarse powder; 1 pt. proof spirit.
3. EXTRACTUM OPII (extract of opium)
   1 lb. Opium in thin slices; 6 pts. distilled water.
   Dose:1/2-2 grains.
4. EXTRACTUM OPII LIQUIDUM (liquid extract of opium)
   1 oz. extract of Opium; 16 fld. oz. distilled water: 4 fld. oz. rectified spirit. Dose: 10-40 minims.
5. PULVIS IPECACUANHAE COMPOSITUS (compoun powder of ipecacuanhae)
   1/2 oz. ipecacuanhua in powder; 1/2 oz. Opium in powder; 4 oz. sulphate of potash. Dose: 5-15 grains.
6. PILULA PLUMBI CUM OPIO (Pill of lead and opium)
   36 grains Acetate of Lead in fine powder; 6 grains Opium in powder; 6 gr. confection of roses. Dose: 3-5 grains.

[General Council of Medical Education and Registration of the United Kingdom, British Pharmacopeia, London, 1867]

not outline yearly consumption, so that it is impossible to compare consumption during the regimes of the two superintendents. Given Landor's negative attitude towards opium, however, it can be assumed that consumption increased during Bucke's tenure.[25] An examination of the table reveals that all twenty ounces of liquid morphine were purchased after Bucke's establishment as medical superintendent, and thirteen ounces of it had been consumed. Opium and lead pills [see chart] were also becoming an increasingly popular treatment.

Of the cases under examination, eighteen were treated with opiates in the form of laudanum, opium and lead pills, and morphia. Opiates were used primarily for diseases of the stomach. Patients with dysentery and diarrhea were treated with opium alone, or in compounds with ipecac, tannic acid, quinine, lead and alcohol. One patient with colic was given morphine. Another, with 'enteri-peritonitis (a disease of the intestinal system) was given a compound made up of salts, laudanum, one-quarter gram morphia, and three grams calomel. He died. Morphia and sulphate of zinc were also used in an ointment for treating conjunctivitis. In only one case was opium clearly used as an anodyne:a seventy-year-old man who had had 'epithelomia of the lip' turn into cheek cancer. He was given opium for the pain, which became so severe he tried to hang himself. He died of the disease shortly thereafter.

Calomel and quinine were other drugs used by Bucke. Quinine alone or with iron, digitalis and strychnine, and boracic acid were used to treat carbuncles, irregular heartbeat, febrile symptoms,

and ague. The patient with febrile symptoms apparently had become addicted, as she did not want to stop taking her quinine mixture. Calomel, a mercury-based purgative, had been popular at the beginning of the nineteenth century, accompanied by bleeding. Calomel and oil, quinine, iron, chloroform and potassium were used to treat 'mild malarial fever', erysipelas of the face, paralysis (stroke), confined bowels, headache, swollen throat, and bilious attacks.[26]

Cannabis of Indica (compounded with Bromide of Potash) was considered by Landor to be the "least injurious" of sedatives. He was thankful that in those cases where it was essential to produce sleep, he could use a drug "as harmless as this combination."[27] This narcotic was not listed on Bucke's table of drugs. Cannabis Indica, or Indian Hemp, was prescribed by physicians for its "hypnotic, anodyne and anti-spasmodic" properties. It was considered less certain than opium but also had fewer side effects. Cannabis was used to produce sleep in hysterical and chorea cases. As an anodyne, it was not as effective as opium, but did help rheumatism, gout and neuralgia.[28]

Dr. Lett found that Bromide of Potash and Indian Hemp produced good results not only in acute but in periodic cases of mania. One woman's mania which occurred every September was successfully warded off with the drug. Hemp could also be used for lengthy periods of time. Because of the supposed aphrodisiac effects of Indian Hemp, Lett advised that it should not be prescribed for

"masturbators" or patients with "augmented sexual feelings". For these patients, hydrate of chloral was more beneficial.[29]

Phosphorus preparations were "highly valued" as nerve stimulants by Landor and Lett.[30] Phosphorus was used in those cases wanting of "nervous energy" such as dementia and melancholia. As Landor wrote, "If phosphorus acts as a stimulant to the nervous, vascular and secreting organs--if it excites the skin, increases the frequency of the pulse...who can be doubtful that its preparations are valuable in the treatment of the insane, especially in cases of melancholia..."[31]

The phosphorus preparation used as a nerve stimulant at the Asylum was hypophosphite of lime.[32] Michael V. (#393), a dementia case, showed a "marked improvement" from the use of hypophosphite of lime; he worked at odd jobs and could be "trusted anywhere". He was discharged ten months after admission. In the Annual Report of 1872, Lett cited the case of a "sluggish, motionless" man who greatly improved after being on "great doses twice daily" of hypophosphite of lime.[33] The patient was discharged, but was readmitted after a five-year interval, again suffering from melancholia. Hypophosphite of lime was not a curative, but did appear to improve the few cases treated with it. Despite Landor's favourable opinion of phosphorus stimulants, however, he was extremely conservative in their employment.

With respect to the use of artificial stimulants, Landor rather than Bucke appeared to be the true reformer. While Bucke attempted to work within the framework of the temperance movement, Landor was much more pragmatic. Per patient, his use of alcohol was not overly extensive and a regimen which included beef tea, good diet and exercise could hardly have been harmful, and in fact must have been far more beneficial than opium, morphine and calomel. Bucke's abolition of alcohol was therefore not without flaws. Rather, Bucke and Landor had chosen their own poisons.

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Neither Landor nor Bucke relied solely upon drugs to treat the insane. The Asylum was operated according to the tenets of moral treatment, and "regular hours, exercise, good food, kindness and firmness" were the primary elements of care.[34] Moral treatment (now called milieu therapy) required hospitalisation;separation from family and friends; classification by sex; severity of illness and socioeconomic background; and an ordered routine life.[35] Constant distraction by work and amusement were to replace drugs, restraint and physical violence.

An important aspect of moral treatment was "good food". Landor believed that a varied menu was more important than the type of food served, as it alleviated some of the dreary monotony of the institution.

In Landor's Annual Report of 1875, he stated that each patient at the Asylum was fed three-quarter pounds of meat daily and "unlimited" vegetables. The dinners varied, with roast, boiled and stewed meats, curries, fresh fish, corned beef, pork, and pudding thrice weekly. In addition, patients were given stewed apples, prunes, preserves, raisins or cheese and buns once a week. Working men and women were given for breakfast whatever meat had been left uneaten from the day before.[36] "It cannot be said (the patients) are underfed," Landor added in 1877 citing the wide variety of fruits, vegetables and livestock grown on the Asylum farm for domestic consumption.[37]

Inspector Langmuir suggested, however, that breakfasts should be augmented by porridge, potatoes and boiled rice, served alternately. In accordance with his views, the Asylum diet was adjusted as follows:

BREAKFAST

SUNDAY		Bread and Butter, Coffee.
MONDAY	Room 1	Bread and Butter, Fried Potatoes., Coffee.
	Room 2	Bread and Butter, Broiled Bread & Molasses, Coffee.
TUESDAY	Room 1	Bread and Butter, Oatmeal Porridge, Coffee.
	Room 2	Bread and Butter, Fried Potatoes, Coffee.
WEDNESDAY	Room 1	Bread and Butter, Potatoes, Coffee.
	Room 2	Bread and Butter, Oatmeal Porridge, Coffee.
THURSDAY	Room 1	Bread and Butter, Cornmeal Porridge, Coffee.
	Room 2	Bread and Butter, Boiled Rice, Coffee.
FRIDAY	Room 1	Bread and Butter, Boiled Rice, Coffee.
	Room 2	Bread and Butter, Cornmeal Porridge, Coffee.
SATURDAY	Room 1	Bread and Butter, Boiled Bread, Coffee.
	Room 2	Bread and Butter, Fried Potatoes, Coffee.

DINNER

SUNDAY	Stewed Meat, Potatoes, Bread.
MONDAY	Corned Beef, Potatoes, Cabbage, Bread.
TUESDAY	Roast Beef, Potatoes, Bread Pudding, Bread.
WEDNESDAY	Soup, Boiled Beef, Potatoes, Bread.
THURSDAY	Irish Stew, Bread, Baked Bread Pudding.
FRIDAY	Boiled Beef, Potatoes, Pickles, Bread, Bread Pudding.
SATURDAY	Roast Beef, Potatoes, Pickles, Bread, Bread Pudding.

TEA

SUNDAY	Bread, Butter, Tea.
MONDAY	Bread, Butter, Baked Apples, Tea.
TUESDAY	Bread, Butter, Tea.
WEDNESDAY	Bread, Butter, Preserves,Tea.
THURSDAY	Bread, Butter, Buns, Tea.
FRIDAY	Bread, Butter, Apple Pies, Tea.
SATURDAY	Bread, Butter, Stewed Prunes, Tea.

Landor added that this was "probably a better diet than the patients were accustomed to at home on the average, since the great majority were from the labouring classes."[38]

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Both Landor and Bucke recognized the importance of amusements to distract the patients and aid in their recovery. Daily dances were held in the afternoon, while formal balls took place every Tuesday night. Attendants were ordered to dance with patients until at least nine o'clock in the evening. Music was very important therapy; upon application for employment, attendants were asked whether or not they played any musical instruments, and had "no chance" of being hired if they did not.[39] In 1877, the

Asylum purchased instruments to form its own band, and special mention was made in the case histories of patients who played violin or danced a good jig.

Along with the orchestra, the Asylum organized its own Dramatic Club, led by such stellar performers as Dr. Burgess and Mr. England, the launderer. The Asylum also boasted its own Minstrel Troupe.[40] Apart from "Asylum-grown" talent, the patients were treated to performances and concerts by amateur or professional groups from the outside community. Lectures on historical events and slide shows of foreign lands were also offered occasionally.

The Asylum endeavoured to maintain a supply of newspapers and journals for the patients, although as Landor complained, it had received no gifts except "old periodicals" and was forced to purchase its own newspapers and journals.[41] In Asylum regulations, it was stated that attendants be supplied "with books, newspapers, etc., and shall, on suitable occasions, read amusing stories to such patients as will be pleased to hear them."[42]

Patients were also expected to take part in outdoor recreational activities. Attendants were to encourage "and join all games and amusements...The more heartily Attendants enter into amusements and encourage occupation of the patients, the more highly will they be esteemed by the authorities of the Institution."[43] In the summer, patients were able to play cricket and take daily walks through the grounds which were filled with "trees, shrubs, and flowers."[44] They were, however, to be prevented from "plucking or

eating the plants."[45]

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Patient labour was considered an essential facet of moral treatment. For an asylum to refrain from using restraints and still maintain control of the insane, as many of the patients as possible had to engage in activities which would 'divert' them from their insanity. At the same time, patient labour could help offset the costs of running the institution. In a newspaper article in the London Advertiser entitled "Should the Insane Work?" a member of the New York Lunacy Commission was cited as saying that the insane should be compelled to work. The newspaper pointed out that not all lunatics were physically or mentally able to work, but the experience of Ontario's superintendents was that "a very considerable proportion" were not only able, but benefitted from the exertion. "The more the mind can be drawn out and occupied by some productive employment, the more hope (existed) for the insane."[46]

At the London Asylum, only one-half of the patients worked in 1878. The remaining patients spent their winter days in the buildings and their summer days in the airing courts.[47] The working patients were evenly divided between men and women. Patient labour was sex-stereotyped and segregated. Women were employed in the laundry, sewing-room and kitchen, or engaged in general housework, while men worked on the farm and garden, painted, assisted the

the carpenters, and engaged in manual labour. In 1877, Asylum labour had "dug 1870 yards of gas-pipes, made 140 yards of box and other drains...moved 2,000 tons of earth twice, transplanted 560 trees... [and] planted 1477 yards of willow hedges."[48]

Landor did not hide the difficulties inherent in patient labour. "With good attendants,"he wrote,"work can be obtained from patients." He regretted the fact that so few tradesmen became asylum inmates:"We seldom have shoemakers able to follow their trade,even in just repairing shoes and boots," and "tailors are rare inmates, hardly more than two are ever useful in the Asylum." In justifying the large expenditure on shoes and clothing, Landor added that "the trades learnt by the insane [were] not economical,and patients [could better] be employed otherwise."[49]

Patient labour was impractical in other areas.Thomas Scoble, Deputy Inspector of Public Works,had not wanted patient labour to be used in sewer repairs,arguing that "not only would their work be unreliable, but all who are not mentally incapable of labour,are sufficiently sane not to care for working without wages."[50]

There were patients at the Asylum who did not work willingly. The attitude of the administration towards these people is reflected in the fact that the case histories reported such observations as "Won't Work" or "Refuses to work" along with remarks regarding diagnosis, or propensity for violence. Cottagers who did no work were usually sent back to the main building. George H. (#410) went on strike and was sent to the main building. After four months, he promised to work and was returned to the cottage. Daniel S. (#672) declared that he would strike if he did not get "five cents worth of tobacco and a glass of grog

daily, and a pound of soap weekly." His demands were not met, and he attempted unsuccessfully to elope.

Rachael M. (#171), who fancied herself in Scotland, worked in the sewing-room and lived in the cottages. When she stopped working, she was removed to the main building. This was perhaps a trifle unfair, as Rachael was sixty-eight years old. There was also little sympathy for Eliza F. (#135). She was "stupid" and "apt to be cross". According to her clinical report of 1881, she also was "as fat, noisy, and idle as ever"; the physicians often described idle patients in derogatory terms.

On the other hand, praise was heaped upon those who worked well. Before she was admitted, Maria C., or 'Black Maria' (#160) had a propensity "to destroy everything around her." At the Asylum, she was "one of the best patients to work in the laundry" and a "Splendid Ironer". In 1902 she was still "invaluable" in the laundry.

Others were too enthusiastic in their employment. Abigail M. (#131), a case of dementia, sometimes got cross and "swore a little", but was mostly peaceable. Abigail was willing to do scrubbing, but it was very difficult to keep her "from throwing the dirty water out of the window." As Landor noted, patient labour might not always be worth the effort, yet he did believe that in most cases, some form of employment was beneficial. Amelia H. (#161) was a "chronic melancholic" who thought herself "fearfully abused by everyone". She used her tongue "freely" and was apt to get in trouble with other patients. She was always better if she

"could be got to do knitting."

Lack of work, it was thought, could also cause insanity. Susan M. (#734), a single woman, aged "35 or 40", had "quiet and indolent" habits of life. Her mania, manifested by a "variety of delusions", was reported to have been caused by a "want of an occupation." During her first six years of commitment, Susan did "nothing". Once she began working in the kitchen and conversing rationally, she was allowed to go home on a three month probation. She was "noisy and troublesome" at home, however, and had to be returned. She began working steadily in the dining-room and sewing-room but also became engaged in frequent fighting with other patients. She was eventually transferred to the Hamilton Asylum in 1888.

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Moral treatment entailed the minimization of mechanical restraint. At the London Asylum, restraint could not be totally abolished; violent and destructive patients had to be confined at

least for short periods of time if they were not to be heavily sedated with opium. Violent, destructive and dirty patients in the refractory and in the main building were restrained in a number of ways. Those with a propensity to tear their clothes were placed in heavy canvas clothing (strait jackets). Patients liable to strike others, destroy property, or injure themselves had leather mitts, muffs and wristlets locked onto their hands. "The use of the hand-muffs," Landor wrote, "might be resorted to without doing any violence to the feelings of the most advanced advocate of non-restraint, and in my opinion, would be preferable to long confinement in a small badly ventilated room." [51]

However, more severe modes of restraint did exist. Crib-beds (large wooden trunks with slats for breathing) and restraint chairs were occasionally used at the Asylum. Certain single rooms were equipped with shutters which could be drawn along the lengths of the walls so that a patient could be locked in without doing damage to himself or anyone else.

When Bucke took over the administration of the Asylum, he wrote that Landor had used "as much restraint as in any restraint asylum," and might have become "a believer of restraint" in his later years. "For my own part," Bucke wrote, "I am persuaded that the use of mechanical restraint variously applied to meet the requirements of particular cases is the most useful...and least injurious of any form of restraint that can be used." [52] He thereupon purchased six crib-beds and six restraint chairs, looking upon the

beds as "the most absolutely unobjectionable of all forms of restraint," permitting the patient "to be in any position, stretch his legs" and preventing the patient from getting out of bed. Crib-beds confined acute mania patients "who would otherwise have to be chained or stupefied with opium."[53]

Eighty-four of the 774 patients admitted between 1870-1877 were under restraint at some time. Restraint was last used on one of these patients in 1885, although Bucke formally abolished restraint in 1883. Twenty-one patients, twelve women and nine men, were placed in canvas, leather muffs or mitts for clothes tearing. Another twenty-one patients were placed in restraints for fighting or violent behaviour. They were predominantly female (14 women to 7 men) which might be explained by the fact that violently insane men were more likely to commit capital crimes, and the Asylum was intended for the curably, and not for the criminally insane.

Nine of the most violent patients (all women) were placed in secluded (shuttered) rooms for "fighting", "assorted violence", "violence to attendants", actions described as "siezed and choked attendant" (not fatally) and helping "two others pound attendants."[54] Five others, three males and two females, were put in restraint chairs for "beating people up", "hitting attendant and being abusive and violent", being "on a regular spree", "quarrelling", and "kicking at [Dr.] Burgess."[55] Other violent patients, including one woman on a "howling old spree" were kept in canvas, muffs and

mitts.[56]

Fifteen patients were restrained to prevent them from injuring themselves. Two men and two women were put in crib-beds to prevent them from rubbing their knees sore, tearing off dressings, and obstructing an attendant from washing a wounded area.[57] Other patients were placed in canvas, mitts and wristlets to keep them from scratching themselves or smashing their heads into glass.[58]

Nine patients were placed in restraint for refusing to stay dressed. Four patients were put in mitts, muffs and wristlets for destructive behaviour such as smashing windows and breaking furniture.[59] Another destructive patient was placed in the restraint chair every day to prevent her from kicking in window panes.[60] Patients were also put in restraints for "plastering the walls with filth"; "pulling buttons off the patients' clothes";"pulling out sod," "masturbating" and even for "taking restraints off other patients."[61]

Another form of restraint or coercion was the use of the "stomach pump". At least three patients who refused to eat were forcefed.[62] Forcefeeding was more likely to be necessary within the first few weeks of a patient's commital, when the individual had yet to accept his fate. One woman whose sight had rapidly deteriorated during her incarceration refused to eat until her sight was restored. She was fed by stomach pump for nearly two weeks.

Regardless of the extent to which restraints were used at

the Asylum, treatment of the insane in the community outside could be far worse. Owen D. (#205) was brought to the Asylum chained and manacled as a "most dangerous man." When his chains were removed, he was found to be harmless, though he talked incessantly. Charles L. (#988) was brought in ropes and chains but was also not violent in the Asylum. Certainly moral treatment was a far advance compared to such cruelty.

There were occasional instances of violence against patients within the Asylum but they were exceptional. In one extreme example, Mary C. (#287) was found

> tied to a pipe in the watercloset. Had on canvas dress which was covered with blood, hands and face in like condition. She had been confined there by attendant Mary R. as she alleged on account of dirty appearance...Attendant discharged.

Proper asylum procedure was restraint but not violence:"While in the airing court, (Mary) was restrained by a strap around the waist fastening her to a bench to keep her from breaking windows."

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Although the patients were severely restricted in their activities, there were important differences between an asylum and a prison. This was most apparent in the attitude towards elopement. For certain patients, elopement was viewed by Landor and Bucke

as simply the culmination of treatment. Only those soon to be discharged were sent to work in the fields, and Landor relied on their promises that they would not escape. They often eloped, however, "in their haste to get home." The Asylum "did not bother" to recapture them unless they were warranted cases from county gaols in which case they were treated as fugitives.[63]

One patient who had "got away absolutely" paid the Asylum a visit during London's Annual Fair Week:"well dressed and said was in good employment. It was no part of my duty to disturb his freedom, as it was evident he was doing well." If the patients were homicidal, suicidal or dangerous, efforts were made to recapture them, but if they were "harmless wanderers who are always wishing to be on the move without knowing why, I write to their friends, and they are sent back when they reach their homes, which they always do."[64]

Approximately seventy-five patients from the sample eloped at some point, many more than once. Elopers were predominantly male, which was understandable given that outdoor employment was available only to men. Of the patients who eloped more than once, some were wanderers (who might wander as far as Arva, Stratford, and Hamilton) while others were persistently trying to escape, some as many as six times.

James D. (#664) was known as the 'Prophet' because he could "foretell anything". He said all the officers would be "damned" for running church services in the ballroom. He appeared

rational for two months, and was allowed a daily walk, but then became upset again and condemned everyone at the Asylum to hell. During a violent spree he was put in a restraint chair for kicking at Dr. Burgess. Four months later he made a key from a spoon handle and opened the main door, but was caught. He was placed on probation for three months at the request of a friend, but came back himself, saying his "head was not all right" and that he talked at night and "frightened the people." Six months later, "anxious to go away", James eloped and was written off. From the tone of the reports, it was apparent that he was not considered a great risk.

The government's attitude towards elopement was demonstrated in the case of Francis B. (#778). He eloped thirteen months after his commital on 16 February 1874. Two years later, probably to close the file, Bucke asked Langmuir for a discharge, stating that at the time he eloped, Francis' mental condition was "much improved" and it was believed he could take care of himself. The government's position, as written by Langmuir, was that if a patient eloped whose condition admitted his care of himself, a warrant of discharge would be issued after "some little time" was given for his recapture. Francis was accordingly discharged though he turned up at the Milton Gaol in 1879. He was then sent to the Hamilton Asylum. 65

James M. (#997) was more fortunate. He eloped from the chore gang and went home to Lambton. His brother wrote that James was anxious to stay, and he was allowed three months probation. He was discharged, recovered, after he reportedly was doing well at

home. James was a warranted case from Lambton Gaol. Therefore, it is possible to conclude that warranted cases could also be discharged after elopement.

Some patients eloped in a huff. Andrew S. (#69) wandered away because all the workbenches were occupied. He insisted, however, that he "intended coming back for dinner". James C. (#303), a farmer, sawed wood and gardened at the Asylum. He was given a piece of ground to work for himself. Carpenter White, when fixing the fence on 'his' [C's] property, so excited C. that the patient went to town "to get a warrant" for the carpenter's arrest. C. was brought back and sent to his cottage for a time. He "wouldn't stay in" and annoyed everyone so much that he was sent to the main building. A few months later he was back working with the carpenters. By allowing C. his own plot of land, Landor demonstrated imagination and sensitivity.

There were patients no asylum could hold. John C. (#204) "jumped up and ran away" at teatime. He was found at his home in London and was brought back to the Asylum "only after a severe tussel." Six months later, wire which could unlock the ward door was found on him. In succeeding years he was destructive and violent, fighting and breaking glass.

Charles B. (#785) attempted an escape by taking out the window screws in the ward. A year later, he tried to elope, and when "prevented by Mrs. Marks at the gate, drew two putty knives and threatened to butcher her." His temper varied over the next

few years, becoming melancholic, mischievous and violent until he was transferred to the Hamilton Asylum.

James D. B. (#937) engineered a mass escape. On 17 June 1877, using a bent wire key, he eloped, letting three others out with him. All four were found, James and another man concealed under a weigh scale bridge. On 19 June, another wire key was found in the lining of his pants. He was to be searched day and night. On 28 May 1878, another wire was found on him, and on 10 August, he successfully eloped. Mrs. B. telegrammed that James was home, and he was brought back. Three days later, two wire keys were found in his socks. He eloped twice more but finally died in the Asylum in 1890.

Two other notable elopers were circus performers. George P., twenty years old (#897) and probably of gypsy origin, was "supposed to have been with the circus" and was arrested for horse-stealing. He was acquitted by reason of insanity,being purportedly imbecilic, and was sent to the Asylum. George, or 'Soapie' as he was called, was a "very funny boy". He could do "very good tricks", danced well, and fully believed he could accomplish "almost anything under the sun." Between 1877 and 1880 he eloped six times, using bent wires. Bucke allowed him to work with the horses, which showed imagination on his part. As it turned out, it was a mis-calculation. When sent with another patient for the horses in the field one afternoon, George did not return, and had to be written off eloped. He did not appear to be as imbecilic as was first

supposed.

Nicholas L. (#776) was a tightrope walker and a vagabond. He had been a patient at the Malden Asylum in 1865 but had eloped after eighteen months. He turned up in London in 1874, and according to the report of the arresting constable, appeared "entirely out of his mind" and dangerous to be at large. He had given his name and said he had been in the Queen's Service and had escaped from Malden Asylum. He then "threatened to whip half the men" on the street. Landor's deposition stated that "no doubt he had become insane again." Nicholas was sent to the Asylum but was discharged seven months later. [66]

The Asylum's policy on elopement was flexible, moderate and adjusted to each situation. Elopers were not punished; they were returned to the main building where they could be better supervised. Elopement was therefore not regarded as a crime but as a likely and foreseeable consequence of commital.

The attitudes of Landor and Bucke towards moral treatment was illustrated in their concern for an active patient labour force, adequate amusement, minimal restraint or reliance on drugs, proper diet and an enlightened view on elopement. Despite minor shortcomings and operational difficulties, moral treatment was the rule at the Asylum. All aspects of care were directed at the rehabilitation of the patient, and given the over-crowded conditions at the institution, this was no mean effort.

NOTES

1. Chloral hydrate was produced by treating dry chlorine gas with sulphuric acid and a small amount of lime, and converting it into a solid hydrate by adding water [General Council of Medical Education and Registration of the United Kingdom, British Pharmacopeia, London, 1867].
2. Encyclopaedia Britannica, 1890, "Chloral Hydrate", p. 677.
3. Ontario. Legislative Assembly. Sessional Papers. "Annual Report of the Medical Superintendent, London Lunatic Asylum," no. 4, 1872, p. 155 [hereafter A.R.M.S].
4. Ibid.
5. Ibid.
6. Ibid., 2, 1873, p. 155.
7. Ibid., "Appendix-Physician's Report".
8. Archives of Ontario. Ministry of Health. Record Group 10. London Psychiatric Hospital,Patient Casebooks, nos. 525; 546; 553; 364; 367; 373; 698; 472; 986; 240; 729; 765 [hereafter Casebook].
9. The temperance movement was active in London in the 1870's. The London City Directory (London, 1877) listed ten temperance lodges; A.R.M.S., 4, 1875, p. 222.
10. Ibid., 4, 1872, p. 162.
11. University of Western Ontario. Regional Collection. Bucke Papers. London Psychiatric Hospital, Scrapbook, 19 May 1876 [hereafter Scrapbook].
12. Richard Maurice Bucke, Alcohol in Health and Disease, London, 1880, p. 3.
13. The water-bed was a bathtub equipped with a series of harnesses enabling a patient to be suspended in water [Photograph, London Psychiatric Hospital Archives]; Casebook Nos. 24; 987; 399.
14. A.R.M.S., 4, 1878, p. 40.
15. Bucke, pp. 14-20.
16. John S. Haller and Robin M. Haller, The Physician and Sexuality in Victorian America, New York, 1977, p. 275.
17. Barbara Ehrenreich and Dierdre English, For Her Own Good: 150 Years of the Experts Advice to Women, New York, 1979, p. 79.
18. Jonathan Pereira, The Elements of Materia Medica and Therapeutics, Philadelphia, 1854, volume 2, p. 1051.
19. Ibid.
20. Ibid., p. 1049.

21. Ibid., p. 338.
22. Alfred Goodman Gilman et al, Goodman and Gilman's The Pharmacological Basis of Therapeutics, 6th ed., New York, 1980,p.547.
23. Archives of Ontario. Ministry of Health. Record Group 10. Correspondence of the Inspector of Prisons and Asylums, Box 234, File 6680, Langmuir to Bucke, 3 October 1878 [hereafter C.I.P.A].
24. Ibid., 4 October 1878.
25. This appears to be substantiated by the increased mention of drugs in the casebooks after Landor's death.
26. Casebook, Nos. 24; 166; 85; 142; 734.
27. A.R.M.S., 4, 1872, p. 155.
28. Pereira, p. 338.
29. A.R.M.S., 4, 1872, p. 155.
30. Ibid., 2, 1873, p. 155.
31. Ibid.
32. 'Calcis Hypophosphis' was produced by heating phosphorus with hydrate of lime and water and evaporating the solution until it became crystalline [British Pharmacopaeia, p. 415].
33. A.R.M.S., 4, 1872, p. 155.
34. Ibid., 4, 1878, p. 279.
35. Eric T. Carlson and Norman Dain, "The Psychotherapy that was Moral Treatment," American Journal of Psychiatry 117 (December 1960): 519.
36. A.R.M.S., 4, 1875, p. 222.
37. Ibid., 2, 1877, p. 230.
38. Ibid., 4, 1878, p. 275.
39. George Stevenson, "The Life and Work of Richard Maurice Bucke: An Appraisal," American Journal of Psychiatry, 93 (March 1937): 1134.
40. Scrapbook, 1878.
41. A.R.M.S., 2, 1877, p. 229.
42. Ibid., 2, 1874, p. 24, LXXXII.
43. Ibid., p. 23, LXXIV.
44. Scrapbook, 1878.
45. A.R.M.S., 4, 1874, p. 23, LXXV.
46. Scrapbook, 6 December 1898.
47. Ibid., 1878.

48. A.R.M.S., 2, 1877, p. 231.
49. Ibid.
50. Ibid., 2, 1874, p. 25.

51. A.R.M.S., 4, 1872, p. 22.
52. Ibid., 4, 1878, p. 274.
53. Ibid.
54. Casebook, nos. 982; 946; 454; 610; 56; 451; 464; 479; 727.
55. Ibid., nos. 429; 596; 644; 664; 682.
56. Ibid., no. 241.
57. Ibid., nos. 953; 338; 362; 880.
58. Ibid., nos. 415; 104; 570; 166; 146; 234; 606; 502.
59. Ibid., nos. 983; 415; 773; 515.
60. Ibid., no. 122.
61. Ibid., nos. 383; 729; 91; 608; 613; 944; 734.
62. Ibid., nos. 909; 864; 830.
63. A.R.M.S., 4, 1875, p. 221.
64. Ibid.
65. C.I.P.A., 14, 436.
66. University of Western Ontario. Regional Collection. Middlesex County Court Records, 24 January 1874.

CHAPTER VI

MASTURBATORY INSANITY

That mental illness should be viewed within the context of prevailing standards of morality is illustrated in the diagnosis and treatment of "masturbatory insanity". The idea that insanity is caused by masturbation has no physiological basis; for the idea to take hold for over a century was indicative of the fact that it served a social function, at least for the medical profession and its clients. Determining what type of person would be labelled as suffering from the disease, as a result of his demonstrating particular types of behaviour, will illustrate how a society attempted to solve social problems through medical means. By examining the case histories of those patients at the London Asylum who were diagnosed as suffering from "masturbatory insanity", the nature and extent of their deviant behaviour can be evaluated. In this way, we can measure the seriousness of the insanity against the experience of institutionalisation, for it must be remembered that the average patient stayed not months or years, but decades at the London Asylum.

The idea that masturbation was a deviant act was first popularized by "an anonymous [English] clergyman turned quack", who in 1710 published 'Onania, or the Heinous Sin of Self-pollution.'[1] This pamphlet was an advertisement for a patent medicine. The

alacrity with which the cause of masturbatory insanity was taken up by the medical profession revealed growing anxieties about a disorderly, immoral and rapidly changing society, as well as offering a new and exclusive area of expertise for the profession itself.

The new mental disease was given respectability by the French physician and hygienist S. A. Tissot, who advanced the theory that because sexual intercourse increased peripheral circulation, all sexual activity which caused the blood to rush to the head dangerously starved the nerves, and increased the possibility of insanity. Tissot saw masturbation as the worst vice because it could be indulged in easily and at a tender age.[2] With the widespread confinement of the insane in the eighteenth century, physicians observed large numbers of patients masturbating, and made the false connection between masturbation and insanity.[3]

In 1863, a Scottish physician, David Skae, was the first to state that there was a specific type of insanity which was caused by masturbation; symptoms included "a peculiar imbecility and sly habits", "suspicion, fear, suicidal impulses" and a "scared look."[4]

Because of the solitary nature of the vice, the "experts" gave thorough accounts of the symptoms of the disease. An English authority, John Millar, wrote in Hints on Insanity (1861), "if (it) is suspected in men under twenty-five, well brought up and (who) had not mixed freely in the world"; if symptoms were positive, such as secluding themselves from society, avoiding conversation, "if pale and out of health, morose, apathetic, occas-

ionally violent and irritable"; if there were a "peculiar leaden appearance of the cornea, a dull expression and a languid circulation", there was reason to "fear the most".[5] "If his evil habits are persisted in," wrote William Acton, a leading English physician and author, "he may end in becoming a drivelling idiot or a peevish valetudinarian."[6]

It has been argued that the intense anxiety among doctors and parents in the nineteenth century about masturbation was both a "confused response" to the earlier onset of puberty and the acceptance of a respectable middle-class sexual ideology.

Pre-marital and extra-marital intercourse were proscribed as they contravened the increasingly strict bourgeois moral code. This was especially true for women, since the certainty of property and inheritance lines was essential. At the same time, a middle class man was pressured to marry late, after he was well established in business, to ensure that his bride would live in an appropriate style. All of these factors contributed to the anxieties about masturbation.[7]

As the nineteenth century progressed, earlier puberty (which resulted from an improved diet) and a tendency towards later marriage, particularly among the middle class, produced, for the first time, a prolonged adolescence. Parents were dismayed to confront disrespect, disobedience and emotionalism, and they looked for clues in external behaviour to explain this phenomenon. In The Journal of Mental Science (1868), the English alienist Henry Maudesley wrote that the young who indulged in "self-abuse" were

"entirely wanting in reverence for their parents."[8]

Concern about self-abuse was linked to other nineteenth century reform movements in Canada as well as in Europe and the United States. In the 1880's, the Canadian abolitionist and temperance leader, Alexander M. Ross, was one of the first to publicly warn of the "sinful and unphysiological habits secretly practised by Canadian youth". He concluded that one-third of all insanity was caused by masturbation.[9]

In the 1877 Annual Report to the Ontario Legislature by Dr. D. Clark, superintendent of the Toronto Asylum, the "enshrouded moral pestilence" of masturbation was described as being practised "in numberless homes in every part of our land." Not limited to the male sex, it was "the bane of public and private schools among all classes of the community."[10]

The tendency to practise masturbation was not simply a wrong against the person, but like all "such vices", it was "against the State...[producing] the enfeebled body and weak intellect" which fell prey to any "depravity and self-abasement."[11]

Nineteenth century medical experts came up with a variety of solutions for stopping the vice which gave rise to "hysteria, asthma, melancholia, mania, suicide, dementia and general paralysis of the insane."[12]

In Hints on Insanity, John Millar's remedies were rather moderate; the youth, the English authority urged, should be placed "under the constant supervision of an elderly person", given a hard mattress, the private parts must be kept cool and washed frequently, sedatives should be given at bed-time, and astringent

tonics should be applied.[13]

Throughout the latter half of the nineteenth century, however, measures were more drastic. Middle-class men were fearful of the depletion of their semen, "the essential oil of animal liquors, the purest of the body humours."[14] To prevent "softening of the brain," these men would endure plaster casts, cutting of the foreskin with jagged scissors, leeching, acupuncture, electrodes applied to the penis, restraints and surgical intervention.[15]

Others were treated for different reasons:

> By about 1880 the individual who might wish for unconscious reasons to tie, chain or infibulate sexually active children or mental patients--the two most readily available captive audiences--to adorn them with grotesque appliances, encase them in plaster of paris, leather or rubber, to beat, frighten or even castrate them, to cauterize or denervate the genitalia, could find humane and respectable medical authority for doing so in good conscience.[16]

* * * * * * * * *

On 6 March 1877, just three weeks after his arrival as Medical Superintendent of the London Asylum, Dr. Richard Maurice Bucke demonstrated his interest in treating sexual deviancy by "wiring" fifteen male patients in an attempt to stop their habit of masturbation.[17] Wiring was a process of infibulation; a silver wire ring was placed through the foreskin.[18]

Bucke believed that masturbation was directly related to insanity. When the first patients were wired, he wrote: Intend

to make this operation simpler and perhaps modified a good deal in the course of the next six months. There is no doubt that if a plan could be hit upon of stopping this vice M± [sic] a good many cases could be relieved and cured which are now hopeless."[19]

The experiment was not successful. In all cases there was no improvement. The men understandably became "more irritable" and "less talkative than formerly"; one managed to take out the wire and another had to have it removed as "there was a good deal of pain and swelling".

Dr. Bucke was less optimistic in his Annual Report. He doubted that masturbation "is a sole cause of insanity" though he still believed it might help to "bring on an attack" as a result of the patient's "cerebral or ganglionic irritation." Only in a small number of cases "would removal of the habit benefit the patient."[20]

Those who had been wired by Bucke shared certain characteristics. They were described as "dull and stupid", "simple sluggish brained", "sedentary and gluttonous" and "fat, stupid and lazy." One was a Negro, another a "great big roughlooking Irishman." In effect, of those who practised the habit in the Asylum, those wired to prevent masturbation were physically distasteful and also potentially dangerous. They were young (averaging in their late twenties) and strong men, "stupid" but persisting in a habit which displayed both lack of personal control and the limits of institutional control over them. Bucke's experimentation with wiring, while undertaken with the espoused goal of curing hopeless cases,

was carried out on a selected group of undesirables;those least likely to arouse sympathy, and more likely to illustrate the limitations of moral treatment.

In general, characteristics of patients diagnosed with masturbatory insanity fit the description by Maudesley. All of the male patients so labelled were single. Eighty-one percent (9) were temperate and regular in their habits of life. They were not unruly at home. They were fairly evenly divided between dementia and mania, with two cases of melancholia, so that there were no specific symptoms to justify the special label. Seven men of the total diagnosed with masturbatory insanity had been sent to the Asylum because they had committed an act of violence, while three were quiet or suicidal. The patients were young, the average age being twenty-six years. The cases supported the view that masturbatory insanity manifested many of the characteristics associated with adolescence. In a number of cases, the patient was committed for "trying to injure those closest to him", "threatening the life of his father as well as his own", "refusing to work", "will remain in bed if permitted", none of which are uncommon to the turbulence of adolescence.

The case of Hugh M. (#620) was a striking example of the tragic results which could occur from a faulty diagnosis. Hugh, nineteen years old, was a confirmed masturbator who was "continually wearing his strength away and bring himself almost to a state of imbecility." Landor wrote to Hugh's father when Hugh fell mortally ill. His brother wanted to take him home, but Landor

refused, since he did not believe Hugh would survive the trip. Alex M. (Hugh's father) came to the Asylum and Landor again refused to release Hugh, giving him a "letter of protest". Alex stated that Hugh was shivering because his room "was too cold." Stephen Lett, the assistant physician, argued that Hugh's "vital powers" were giving out and his "nervous power" was almost lost, "there being plenty of bed clothes" and the temperature being "a comfortable fifty degrees." Despite the protests of the physicians, Alex decided to take his son home, but the exertion of putting on clothes was too much for Hugh, and he died "then and there." Had Hugh been treated for what appeared to be pneumonia, rather than masturbation, he might have survived.

A striking characteristic in the history of the group of masturbatory insane at the London Asylum was the number of patients who tried to escape from the institution. Thirteen of the patients, eleven male and two female, were diagnosed as having masturbatory insanity or as being insane with the exciting cause as masturbation. Of these thirteen,fifty-four percent (7) attempted at least once to elope from the Asylum. This compares with approximately five percent of the total inmate population.

A possible explanation for the discrepancy is the fact that all thirteen were cottage patients; cottagers generally had a higher elopement rate, understandable given their distance from the main building with the increased security, the greater freedom of movement and activity allowed cottagers as part of their therapy, and the fact that only the most functional, least violent, and most

'sane' patients were allowed to be cottagers. However, this also meant that the "masturbatory insane" patients were the most functional; therefore, these were cases most susceptible to arbitrary, rather than objective and critical labelling.

Some brief case histories will illustrate the nature and extent of the insanity purported to be caused by masturbation.[21] James H., twenty-three years, was a warranted case from Lambton Gaol. He was Roman Catholic, Canadian, a tailor and single, with "not very regular" habits of life. He refused to work, and went about the streets "half-naked". He was diagnosed with mania caused by masturbation. He was first put into the Malden Asylum, and then entered the London Asylum in 1872. In the London Asylum he worked in the tailor shop, and was a "confirmed masturbator". He looked "delicate but never ill."

On 23 December 1878, he eloped and was missed at tea-time. Attendants were sent to his uncle's house in the city but they had had "no tidings" of James H. On 24 December, Bucke reported, "while in the city this evening, I found H. sitting in a room at the Western Hotel, called for a horse to come home. Told patient to get in cutter which willingly did." James H. was treated for frostbite on his toes resulting from his journey. In April 1879, he "disappeared" but was brought back two days later.

James M. was a farmworker, intemperate, and was admitted by warrant from the Middlesex gaol. He was noisy, stripped his clothes off and tore them to pieces, had been insane for two months, and was diagnosed as having mania, caused by masturbation. He was

"strong and healthy" and "apt to be quarrelsome at times." In 1883, after living in the Asylum for eleven years, he "worked steadily until he strayed after dinner" and was picked up in the city. In June 1885, he "strolled away" to the city, and in November, he again eloped. In June 1887, he turned himself in, saying he had gone "to look for work on the railway but couldn't find any."

William P., aged thirty-six, a single, temperate farmer, was committed for melancholia, the cause of which was "supposed masturbation". He was considered "suicidal" and "restless". In June 1880, in his eighth year at the Asylum, he eloped before breakfast and had to be brought back by a neighbour. William did not again elope, but took to "running about the rooms in a wild way" half-clothed.

John K., a warranted case from London, aged thirty-four, was an Irish labourer, whose habits of life were "very bad", and whose particular propensity was that he was "inclined to injure those around him." He was diagnosed with "chronic mania" and appeared to be extremely violent. In 1887, after seventeen years at the Asylum, and after he had become a quiet, well-behaved worker (after a few violent episodes), he "wandered down the railway tracks with John McA...[and was] picked up by the police." He was returned to the main building and eventually to the cottages, where he was again quiet and well-behaved except for an episode where he "choked up sinks with rags and grass."

Elisha B. was a sixteen year old single farmworker when he was committed for trying "to injure his best friends." The exciting

cause was "supposed masturbation". He was "dull and stupid", hardly ever spoke, and had "become a case of dementia and confirmed masturbator." His penis was wired 15 March 1877 (when he was twenty-two years old) with no improvement, and rewired 1 May 1877.

In May 1880, "not being watched carefully", Elisha "walked off". He got halfway to the city and said "he was going home." In August 1880, he was

> found at the end of store by another patient. Was lying on ground with patient Margaret D... Her clothes were not up. B...got up and walked off. A few minutes after M. saw him put her on the ground again and get on top of her. M. interfered. B...taken into wards and not allowed out by self again.

Two of the seven elopers were women. Nancy G., aged thirty-eight, was single, a servant and a "steady" drinker. Her dementia was caused by masturbation, and her hallucination was "the fear of the whole family". By 1880, she had worked in the laundry and the scullery, and "as a rule" was "quiet and well behaved". She could "rarely be got to speak" as she was "too sulky". In February 1893, after twenty-two years of institutionalisation, she was brought back to the Asylum "from the road north of the cottages" where she had been found by a farmer. To prevent further incidents, Nancy was kept at the main building during the night.

The most poignant story was that of Isabella E., a married woman with four children. She was a Baptist who kept regular "habits of life". Her attack lasted six years. Isabella was diagnosed

with dementia, the apparent cause of which was masturbation. She had "delicate" health, being "phthisical" and generally sat in her bedroom and knitted. Given the fact that she was in a bedroom, it can be deduced that her husband was moderately well-off. On 30 October 1896, after being in an asylum for twenty-nine years, she "wandered off and was found on the railway track near City Hospital. A telephone message from the Hospital reported [this]. She was brought back to the Asylum with difficulty, and was sent to the main building for safekeeping." On 4 November, she was returned to the cottages "having quieted down." In 1897, it was reported that she gave "no trouble since she was sent back to the East Cottage" and in fact was a "useful sewer."

At the time, a husband had complete jurisdiction over his wife, and since Isabella was not a warranted case, it may be assumed that she was committed with his consent, if not at his urging. Given the fact that Isabella was a quiet, delicate woman whose "dementia" was caused by masturbation, it could well be that Isabella, for the past six years (the length of her "present attack") had refused to sleep with her husband. This being the case, a charge of masturbation would be the most logical.

Like most of those who found their way outside the Asylum grounds, Isabella followed the railway lines, the quickest and often the sole mode of transportation in the area. That James H. had made it to London and had checked (or stole) into a hotel; that James M. had left for nineteen months and returned voluntarily when he was unable to find work on the railway; that John K. and John McA.

had wandered down the railway tracks; and even that Elisha B. had almost successfully seduced another patient (after two wirings) are all indicative of the fact that, like Isabella, these patients were functional, even imaginative individuals.

Masturbatory insanity does not exist. It was a disease created by quacks and nurtured by eighteenth and nineteenth century medical authorities to explain novel and bizarre behaviour in middle class youth. Parental anxiety about masturbation was anxiety that their sons would fail as models of the bourgeois ideal. They lacked self-control, weakened their "seed", and violated the strict sexual code, thereby hindering their success in the race for property and position.

The consequences of the rise of the idea of masturbatory insanity became tragic when linked to the growth of the asylum. There now was not only a disease, but a treatment: institutionalisation, more often than not for a lifetime. If the disease had not existed, perhaps those labelling the "insanity" would have had to re-evaluate an individual's deviant behaviour, and decide that though problems existed, insanity did not.

If the asylum did not exist, the family would have been more likely to learn to cope with the individual and keep him within the community. The rise of psychiatry and the rise of the asylum also meant the broadening of the borders of what was considered insane behaviour. The nineteenth century "experts" mentioned above made careers and fortunes from naming, classifying and inventing diseases which could become dangerously serious if not

treated in an institution. When the patients are taken into consideration, the consequences of victimisation for spurious causes are indeed tragic.

Certainly some of the patients diagnosed with masturbatory insanity at the London, Ontario, Asylum for the Insane had serious mental problems, and might even have been dangerous to leave in the community. But those who were "steady cottagers" had proven their ability to live semi-autonomously, and often were steady, obedient workers. At the same time, there can be little doubt that James H., Nancy G. and Isabella E. (to name three obvious cases) were not dangerous to society and did not deserve the die in an institution. [22]

For those committed as dangerous lunatics, a solitary act of violence, particularly one which caused no injury, should have resulted in a stay at the county gaol. With the discovery of the asylum, punishment and length of sentence was transferred from the realm of justice to the realm of medicine. In the cases of this sample from the London Asylum, the change in authority worked to their detriment.

NOTES

1. Alex Comfort, The Anxiety Makers, London, 1968, p. 77.
2. Vern Bullough and Bonnie Bullough, Sin, Sickness and Sanity: A History of Sexual Attitudes, New York, 1977, p. 59.
3. R.P. Neuman, "Masturbation, Madness and the Modern Concepts of Childhood and Adolescence," Journal of Social History 8 (Spring 1975): 3.
4. E.H. Hare, "Masturbatory Insanity: The History of an Idea," The Journal of Mental Science 108 (January 1962): 6.
5. quoted in Vieda Skultans, Madness and Morals: Ideas on Insanity in the Nineteenth Century, London, 1975, p. 57.
6. Comfort, p. 53.
7. Vieda Skultans, English Madness: Ideas on Insanity, 1580-1890, London, 1979, p. 75.
8. Neuman, p. 11.
9. Alexander M. Ross, Memoirs of a Reformer 1832-1892, Toronto, 1893, pp. 215-216.
10. University of Western Ontario. Regional Collection. London Psychiatric Hospital, Scrapbook, "Dr. Clark's Remarks on the Enshrouded Moral Pestilence," 1 October 1877.
11. Ibid.
12. Bullough and Bullough, p. 84.
13. Skultans, Madness and Morals, p. 58.
14. John S. Haller and Robin M. Haller, The Physician and Sexuality in Victorian America, Chicago, 1974, p. 196.
15. Gail Pat Parsons, "Equal Treatment for All: American Medical Remedies for Male Sexual Problems, 1850-1900," Journal of the History of Medicine and Allied Sciences 32 (January 1977) 1: 63-65.
16. Bullough and Bullough, p. 103.
17. U.W.O., Reg. Coll., Bucke Papers, Journal of the Medical Superintendent, 6 March 1877 [hereafter J.M.S].
18. Bucke cited Dr. Yellowlees, a contemporary medical authority (Journal of Mental Science, 1876) for the procedure.[Ontario. Legislative Assembly. Sessional Papers. "Annual Report of the Medical Superintendent, Asylum for the Insane, London, Ontario," no. 4, 1878, p. 279 (hereafter A.R.M.S)]; Comfort, p. 103.
19. J.M.S., 6 March 1877.
20. A.R.M.S., 4, 1878, p. 279.

21. Archives of Ontario. Ministry of Health. Record Group 10. London Psychiatric Hospital, Patient Casebooks, 1870-1880, nos. 606; 627; 572; 140; 480; 412; 183.

22. Nancy G. died in the Asylum 17 March 1907. There was no record of release for James H. or Isabella E., which usually implies that the patient died there.

CHAPTER VII

THE TREATMENT OF WOMEN

During the latter half of the nineteenth century, disease in women was an increasingly popular topic of inquiry for medical authorities. The female role, mental state and physical condition were considered equally important elements of "the sex". An aberration of any of these elements could result in insanity. 'Madness' which was the result of a deviation from the appropriate feminine role actually could have been criminal behaviour, immorality, or disrespect of authority. To 'cure' such insanity, physicians institutionalised, drugged or performed surgery on women. What was a social problem (in many cases) was treated through medical means.

A new mental disorder, "moral insanity", was developed by medical 'experts' to describe radical deviation from appropriate social roles. Moral insanity and its counterpart "moral imbecility" were catch-all phrases which referred to the inability of the individual, due to mental disease or defect, to differentiate between moral and immoral conduct. The 'symptoms' of the condition were the actions of the individual, so that outward behaviour was sufficient evidence for the existence of moral insanity. There were no set standards of moral behaviour, so that the decision as to whether an individual was suffering from moral insanity was left to each physician who used his own standards of proper behaviour.

The physician therefore became the arbiter of the moral code for society as a whole. Though that code could vary from physician to physician, each retained the power to commit a patient to an asylum on the basis of personal judgment and prejudice.

Concomitantly, insanity came to be seen no longer as a "gross and unmistakeable inversion of appropriate conduct" but as a collection of "cumulatively disquieting gestures and postures".[1] The boundaries of insanity were widening just as the boundaries of acceptable feminine behaviour were narrowing. Madness had become "domesticated" and the number of higher quality, benevolent public asylums multiplied.

Families were increasingly willing to commit their female relatives to the new public asylums, and in English asylums, where there were no quotas by sex, females soon outnumbered males. Women were liable to be labelled as insane because poverty was very strongly correlated with insanity, and widows, retired governesses, and the aged were the poorest of women.[2]

Institutionalisation was seen not only as a method of curbing deviant behaviour but also as a move towards effective eugenics. It was feared that licentious and mentally deficient females might, if left unchecked, populate the world with degenerate children.

Because sexual activity was narrowly circumscribed for Victorian women, and because women were generally believed by 'experts' to have little if any sexual feelings, deviation from this norm was considered evidence of insanity or mental defect. It was not uncommon for women to be committed to asylums or

institutions for the retarded for masturbation, prostitution, or "overindulgence".[3]

Overt sexuality was no longer merely proscribed, but diagnosed as a symptom of insanity and could lead to commital without the existence of any other symptoms.[4] Puerperal mania, nymphomania and hysteria were labels used to describe anti-social or undesirable behaviour in women.

Though many female asylum patients may indeed have been insane, gender-limited definition of that insanity resulted in stereotyping beyond the institution itself. All women were vulnerable to madness arising from their biological functions; therefore all women should be barred from certain educational, professional and political activities. In this way, medicine was used not simply to treat women, but to subordinate them.

In the London, Ontario, Asylum for the Insane, some women were diagnosed with diseases which had been recently invented, and which were peculiar to their sex. These diseases were often considered to be moral deviations from the strict Victorian code, and had little relevance to actual psychological or emotional breakdown. Yet they reflected prevalent social attitudes towards female sexuality, morality and behaviour.

The history and diagnosis of the "mental disease" of hysteria exemplified the sex stereotyping of insanity. An eighteenth century English physician, John Leake, described hysteria as an "acute pain in the head or temples, as if a nail

was driven into the part", accompanied by "dimness of sight, and involuntary effusion of tears". At other times the patient was "siezed with convulsions, or sudden laughter without apparent cause", and talked "inconsistently, like one delirious." [5]

Hysteria, while not unknown in men, was believed to be most common in women. The eighteenth century neurologist Thomas Willis, and the nineteenth century physician William Dewees, both denied the ancient theory that the uterus was the seat of hysteria.[6] Dewees' description of the causes of hysteria linked them to a life filled with boredom and idleness.

> It seems, that whatever has a tendency to destroy the general tone of the system, especially if this be done gradually, will dispose the body to hysteria; hence the certain influences of too sedentary a life, over-stimulating diet or medicines, if too long continued, long watching, disappointed hope, or abused affection, grief, terror, prolonged anxiety, etc...Hence, hysteria is most frequent in females, and at that period which intervenes between puberty and the final cessation of the menses.[7]

Joel Shew, a nineteenth century English authority on women's diseases, linked hysteria with luxurious, urban living.

> Hysterical females are, for the most part, those who live a life of excitement, attending frequently balls, theatres, and public exhibitions late at night, and especially such as are much addicted to tea and coffee drinking, the use of concentrated and stimulating food, and have little exercise in the open air. [8]

William Harvey, who discovered the circulation of the blood, also theorized about hysteria. He revived the idea of a uterine basis for hysteria, writing that "no one of the least experience can be ignorant what grievous symptoms arise when the uterus either rises up or falls down, or is in any way put out of place..." [9]

Attitudes towards Victorian women were graphically illustrated in the writings of F. Skey, an English physician and lecturer, who described the "typical hysteric" as "a female member of the family exhibiting more than usual force and decision of character, of strong resolution, fearless of danger, bold riders, having plenty of what is termed 'nerve'". [10]

Concern with social control was evident in the Asylum's treatment women. Young women were committed for 'wild' behaviour beyond parental control. Gynaecological operations were used to correct inappropriate actions and ideas. Women were limited to traditionally female occupations at the Asylum, so that re-socialization through employment was along traditional sex-determined lines. However, opportunities for women in the society as a whole were limited; to produce women who were different, would be to produce women who were deviant.

Elaine Showalter has shown that in English asylums, Victorian women were expected to live "according to the narrowest of Victorian sex stereotypes." [11] They were strictly chaperoned and engaged in cleaning, laundry and needlework, so that they had fewer opportunities than men for outdoor activities. [12] This was also the case in the London Asylum; men and women were segregated,

and female patients engaged in traditional female-centred occupations.

Even after commitment, lunatic women were expected to behave like 'ladies'; physicians and male patients alike were shocked by the "rowdiness, obscenity and restlessness" of the more exuberant female insane.[13] At the London Asylum, certain women were committed at least partly because of conduct unbecoming ladies, and their case histories illustrated disapproval by the physicians for maintaining such behaviour in the institution.

Elizabeth Mc., forty-two years of age, was a farmer's wife with eleven children, who worried herself "over a multitude of things" (not surprising considering the size of her family). Admitted 24 September 1873, she imagined people were injuring her, and used "vile, insulting, abusive and abominable language". She was released on a three month probation in October 1879, but was brought back in January because her friends were "unable to get along with her anymore". She was transferred to the Hamilton Asylum in 1888.[14]

Elsie G., aged twenty-six, was committed by her brother, and was a "lively, excited girl, head [set] on a husband and on [Mormon leader] Brigham Young [who, given his polygamy and unusual religious views, must have represented perversion and sexuality to an active imagination]. Noisy, sleepless, restless, laughing." Six months later, Landor wrote, "I am sorry to see no improvement in this young woman. She is wild and violent and disgusting in her talk and manners."

Mary Jane M., aged twenty-two, talked "all the time about young men." She displayed self-restraint in church or at a dance, but if left to herself, "her language is disgusting and her manner coarse." Three years later she had become "very quiet and stupid." This, however, was not seen as deterioration but as improvement, for Landor wrote her uncle to take her home for a visit, and subsequently Mary Jane was released. Very quiet and stupid women may not have been the norm in Victorian society, but they were closer to the ideal held by middle class men such as the Asylum Superintendent. Stupid women were also easier to control than coarse-mannered, lively and excited ones.

Nymphomania was a disease invented in the nineteenth century to explain certain undesirable behaviour in women. Its 'symptoms' included "premarital intercourse, erotic fantasies, seductiveness, obscene language and orgasmic excitement."[15]

Between 1870 and 1877, five women were committed to the London Asylum for immoral sexual behaviour; they were diagnosed with "nymphomania". The women were single and very young (the average age being nineteen years). It therefore would appear that they were incarcerated for the same reasons as are contemporary delinquent girls: sexual promiscuity and lack of parental control. That these women were diagnosed and committed for nymphomania also is indicative of the existence of a strict sexual code which was observed and accepted by the girls' parents, the committing physicians and the Medical Superintendent.

Mary Mc., aged twenty-two, was a servant with "temperate

and industrious habits of life". The 'attack' for which she was admitted on 4 May 1871 was "not her first", and had been of four months duration. She was diagnosed with nymphomania, the exciting cause being "love". She was described as raving mad [with] all the propensities accompanying this form of disorder." Mary was not a "good" patient; she was "very abusive and quarrelsome", and went on sprees of destruction and fighting and was frequently muffed and placed in a restraint chair. In 1880, after nine years of commitment, she quieted down, though she still used "very foul language". She often went to bed "feeling weak", although she would not "let any one examine her." She died of phthisis in the Asylum in 1904.[16] Although Mary became very violent in the Asylum, she was not committed for being dangerous to others. Therefore we should not assume that violent behaviour led to commitment for two-thirds of her life.

Theresa M., aged seventeen, was admitted in 1871 for nymphomania, and released in 1872. She was returned "relapsed" after five days. Theresa was released a second time after 180 days probation, having "recovered sufficiently to be taken care of outside."

Eliza L., no age given and with "sedentary habits", was admitted to an asylum for a second time for nymphomania caused by "uterine irritation and masturbation". She displayed an "inordinate desire for the male sex" and "exposed her person". Eliza was admitted in 1874. Generally quiet for three years, she spent the winter of 1877 in "a state of great excitement. It was next to

impossible to keep attendants on the wards, she used to abuse them so fearfully." By July of that year, however, she had become "quiet and ladylike (for the) past three weeks and (was) on one of the best wards", so that in October, she was "discharged recovered" under the care of her mother. Eliza had either made a full recovery through living on the overcrowded wards, or had learned that to be released from the Asylum, she had to follow certain acceptable patterns of behaviour: in other words, to be quiet and ladylike.

Less fortunate (or less astute) was Lucy D., who entered the Asylum at the age of nineteen on 11 March 1871 and remained there until 1902, when she was transferred to the Cobourg Asylum. Lucy had "regular and active" habits of life, and her nymphomania caused by "suppressed menstruation" had been evident for only two weeks prior to her commital.

In the Asylum, her behaviour reflected boredom and "attention-seeking" rather than madness. A cottager, Lucy was returned to the main building in 1879 (after eight years) after being on a very noisy, "raving" spree lasting several days. In the main building, she would throw herself off the bench she was sitting on amidst a "good deal of moaning". A few months later, "back to her old self", she was returned to the cottages. She was again sent to the main building for "wandering about" and being excited. In the main building, she became "troublesome", breaking glass and fighting, so that she was returned to the cottages. One wonders at the lack of sanity of a woman, now thirty-four years old, who was likely

condemned to spend her life in an institution. Lucy may well have learned that to be treated as less mad (to live in the relative freedom of the cottages) she had to act more mad (breaking glass, fighting and being generally troublesome). Such was the madness of the institution, not of the individual.

As male physicians replaced female midwives and healers in the eighteenth and nineteenth centuries, natural biological functions came to be regarded as morbid states of sickness. Menstruation, menopause and childbirth were female "illnesses", so that womanhood itself became a condition worthy of medical attention. Women were admonished to follow strict instructions during their week of "infirmity". Menarche, for example, was a time when a young girl's activities had to be strictly supervised to avoid 'dangerous influences'.

> Perhaps at no one period of woman's life is attention to the laws of health more requisite than here. A little mismanagement may now lay the foundations for life-long suffering and disease...Cheerfulness, contentment, and a pleasing frame of mind, are very desirable at this time. Severe study and unpleasant discourse, of whatever kind, should not now be undertaken.
>
> Neither should parents be too tender of their daughters at this period. Especially should the reading of novels and books of an exciting nature, the attendance of balls, parties, theatres, etc., be avoided...[17]

Women were subject to other diseases which male physicians could diagnose. Older women suffered from "menopausal mania." Puerperal mania, with which ten percent of female patients in

English asylums suffered, included "mild and short-term symptoms of postpartum depression" as well as "incurable psychosis and suicide." It was also a recognized defence in cases of infanticide.[18] A high instance of infanticide occurred among unmarried (and married) women because of ignorance and inaccessibility of birth control.

Infanticide was not commonly regarded as a very great crime, and throughout the eighteenth century English juries became increasingly reluctant to convict women of what remained a capital offence. The last execution of a mother for infanticide in England took place in 1849. Juries instead accepted the defence of temporary insanity due to some form of "peurperal psychosis". If the crime took place some time after birth, the diagnosis was "lactational" or "exhaustion" psychosis. In this way, the court adapted itself to the phenomenon that a woman was most likely to commit murder in the period directly after birth, and that the most likely victim was the child. The move was popular because of the widespread view that female behaviour was directly linked to biological functions.[19]

At the London Asylum, nine women were committed for peurperal psychosis, which included the effects of childbirth, confinement, peuperal mania, parturition, fall before miscarriage, and uterine irritation after premature labour. The madness they manifested included dementia, mania and melancholia. Each woman had had an average of 5.2 children. Eight of the nine women were discharged, in all likelihood because they had husbands or child-

ren to care for them or who needed their services. Two women were widows, each with a large number of children. One widow had shown signs of lunacy for twenty years; the other was "dangerous to others "and" liked to have her clothes off". [20]

Rachel N., admitted to the Asylum in 1870, had become unhappy and violent after childbirth, and had tried to injure anyone, including her children. She was thirty-one years old and had seven children. She feared the devil and fire, and her insanity had purportedly been caused by a fall before a miscarriage. She was almost blind, and became very violent if irritated. At the Asylum, Rachel was industrious at mending (despite her blindness) though one night in 1880 she frightened all those around her by screaming and saying she was dying. She was diagnosed with hysteria and "the promise of a cold bath effectively silenced her". She was always knitting and "asking to go home", and was finally discharged in 1890.

Elvira E. was admitted three times, in each case immediately after childbirth. She suffered from peuperal mania, becoming "very noisy and obscene" in language. She did not appear to be violent.

Margaret M. and Mary P. believed their "friends" (which included family) were trying to kill them. Margaret continually cried and talked about religion, and Landor prescribed a good diet and wine daily. She slowly improved and was discharged. Mary P. believed her friends were trying to poison her, and would not take any quantity of food. She had had three premature

confinements. She was an inveterate "tearer" (of clothes) at the Asylum and generally had to be kept in canvas.

Rebecca M. and Hannah G., both with peuperal mania, were obviously better treated in the Asylum than at home. Rebecca, a very feeble and exciteable woman, thirty years old, broke glass and destroyed furniture. She was prescribed a glass of wine and ale daily with beef tea. After she had been at the Asylum for six months, an application was made for her discharge (her youngest child being under a year old). However, she became a "little excited" when she was told, and Landor decided it would be better to keep her a little longer.

Hannah G., aged twenty-seven, suffered from an "intense" form of peurperal mania, imagining that people kept under the floor were being killed. She had "filthy habits" and had to be fed with a "stomach pump" her first six weeks at the Asylum. She gradually became quieter and "fat and strong" on a diet of wine, ale, beef tea, and hypophosphate of lime. One year after admission she was allowed to live on probation in a house in the country provided by her husband, who had "stringent instructions" not to "go to visit her until allowed". Mr. G. disobeyed the orders and brought her to his house. Landor subsequently discharged Hannah from Asylum reponsibility. Three weeks later, she was re-admitted under "much the same conditions", since her husband could "do nothing with her at home." One year later she was discharged improved. From the nature of her illness and the terms of her probation, it can be deduced that Hannah's husband was ordered not

to make sexual demands upon his wife. Given the fact that he disregarded the Superintendent's orders regardless of the effect upon his wife, and that she was discharged into the same situation which had caused her breakdown, the prognosis for Hannah's recovery could not have been favourable.

Some women actually thrived in the Asylum environment. Marian S., twenty-six years, was diagnosed with mania caused by parturition. She fancied her friends were "at enmity with her" and used very profane language. She worked in the sewing room, was "fat and hearty" and was fond of dancing. She took"no interest" in her home or friends. In 1883, she was found by Mr. Spicknell in the act of "buttoning her drawers", and patient George H. was suspiciously near her. Marian admitted that George had had "connection" with her in the grove in front of the gardener's house. Three days later, when directed to do some work properly, she "attacked Mrs. Angus and beat her, chasing her to her room and pouring a pitcher of milk over her." She was transferred back to the main building from the cottages. Two days later it was reported that "her menses were on" [this note was probably written with much relief; a scandal of this nature would have been highly undesirable]. Even Marian had had enough of the Asylum by 1885. She ran out of the dining-room but "was found twenty minutes later and brought back". No record was made of subsequent release.

Nineteenth century attitudes regarding the killing of children as a result of "peuperal psychosis" was illustrated in the case of Dorothea R. A farmer's wife, aged forty-two, Dorothea had

always been "industrious" until the beginning of her attack. No cause was given for her "suicidal and homicidal" melancholia. Dorothea had drowned her three children and then tried to drown herself--but had been rescued. She had been committed from Huron Gaol to the Malden Asylum, where a special night watch was placed upon her to prevent any further attempts at suicide.

Dorothea was described as having a "weak, nervous temperament", was sleepless, and afraid of everyone. At Malden, Landor prescribed her a glass of wine every day with "good, nourishing" food. At the London Asylum, to which she was transferred in 1873, she was easily "run down" and her insanity (melancholia) would worsen. She was understandably very sensitive about herself and the circumstances associated with her insanity.

What is surprising to note is that in 1877, the provincial government issued a warrant for her discharge, and she was accordingly released--"quite recovered"--into the custody of her husband. Dorothea's release reflected the leniency of the law towards the murder of young children. Doubtless Dorothea did deserve to be released if she had recovered from her insanity, but so too did other patients at the Asylum who had recovered. What Dorothea had working in her favour, however, was the intervention of her husband.

Four other women were committed for abusing their children or threatening them with violence. Two of the women had three children (not a great number for the period) while the other two had eight and nine children respectively.[21]

Ann A., thirty-nine years, had nine children. She was a domestic servant, "temperate and industrious". She was committed in 1871 for threatening her offspring with violence, and was diagnosed with religious mania and homicidal tendencies. Anne was sent home on probation but was returned after a few weeks' stay. Her husband "could not manage her and the children were not safe." She remained at the Asylum, occasionally fighting and being "noisy and quarrelsome", and if she was reproved, she unleashed a "volley of obscene epithets for the benefit of the attendants". When Ann eventually was released on probation, it was not with the diagnosis improved or recovered. It is likely that her husband needed assistance with the nine children, and since he had committed her and had agreed to care for her, the Medical Superintendent had allowed her release on probation. The case of Ann A. demonstrated the close relationship between a patient's release and the willingness or availability of a family member to attend her.

Caroline H., aged thirty-seven, was a "temperate and industrious" housewife with eight children. She was also one of the most violent patients at the London Asylum. Her father and uncle had been judged insane, and Caroline had displayed "noisy, incoherent conversation and violence, especially towards her children". Her destructive and aggressive behaviour may have been neurologically based, as she often complained of "pain in her head". Caroline was always in canvas (strait-jacket) at the Asylum, and was often placed in mitts, muffs, and secluded in solitary confine-

ment during her violent sprees.

Records on Jane C., aged forty-eight in 1872, are particularly complete, because her husband had had her remanded to the Middlesex County Court on charges of lunacy five times between the years 1872 and 1875. She was admitted to the Asylum at least twice by the courts on the grounds that she was "of unsound mind and not safe to remain with her family". In both cases she was discharged recovered or improved.

According to the court records of 21 August 1873, Jane's lunacy had become apparent to her husband Michael C. two weeks earlier. He noticed that she "could not sleep", "would not remain in the house", and "always wanted to go away". A day earlier she had been standing on the railway tracks. Michael's deposition continued: "I told her she could get killed on the railroad tracks. She said she didn't care. I don't think she's dangerous but I fear she will get away and get killed. She was committed last Christmas for insanity and was in jail seven to eight weeks. I don't think she is safe at large. Sometimes she is sensible, sometimes a fever takes her". Even in this early period, prior commitment to a mental institution was seen as justification for subsequent commitments, and even as sole evidence of madness.[22]

In the same hearing, Jane C.'s neighbour, Rosanna C., stated that Jane had come "over to my house [saying] she was going to Ireland. I took her back home. She was going down the street crying, 'my children, my children'. My husband called her in and gave her tea. She was certainly out of her mind."

Two other women feared that harm was coming to their children. Almira S., who suffered from "peurperal mania", believed her children had been taken from her [as in fact they had been when she was committed]. Margaret T. fancied that her children were being beaten.[23]

The commital of twelve women could be labelled as "husband-related": caused by the husband's death, desertion or abuse;wifely jealousy; or simply access to an avenue for getting rid of unwanted wives. Fidelia C., aged forty-two, and Ellen H., aged thirty-two, were both deserted by their husbands.[24] Fidelia was a schoolteacher with two children whose husband had left her thirteen years previously. She died after nine years in the Asylum. Ellen H., committed for child abuse, had four young children and a husband who insisted he was a bachelor. He was convicted of the misdemeanor of "refusing and neglecting to provide" for his wife and children. His family was forced to live as paupers in the London City Hospital.[25]

Ellen was discharged three months after commitment though her fate and the fate of her children was unclear. She may have simply returned to the pauper hospital.

The insanity of four women seems to have been caused by poor relations with their husbands.[26] Elizabeth M., Eleanore O., and Charlotte C. suffered from melancholia, while Alicia C. was diagnosed with dangerous dementia. Eleanore, fifty years, was a farmer's wife and displayed a propensity for self-destruction and a "desire to strip herself". She clearly improved in the atmosphere of the Asylum. Admitted in 1871, she would sit in the

dining-room the entire day and do no work. By 1881, she was knitting a good deal and was "always good-natured". In 1903, she was released on six months probation and then discharged improved. Eleanore's case was unusual in that patients who remained in the Asylum for over thirty years were rarely discharged. She did not "recover, but "improved"; her family must have been willing and able at that point to care for her. Given Eleanore's advanced age, it could be assumed that her husband was dead. Perhaps only then could she benefit from living at home with her family.

Charlotte G. exhibited religious "exalted" feelings and was hysterical and exciteable. She cried often, sang psalms and prayed "overmuch". Landor prescribed good food, comfort, and ordered that she be led into "more secular feelings". At the Asylum, she began to play at bagatelle and music, and was so far recovered she was ready to go home, and, as Landor wrote, it "would do her good if her husband treated her kindly". Her husband was allowed to take her home for a month in June 1870, where she remained until December 1871. She was then re-admitted with "peurperal mania". She was to be fed well and given a glass of wine daily. In April 1872, she was granted a leave of absence, and was finally discharged in 1873. From the evidence it can be assumed that Charlotte had returned to the Asylum pregnant, and had been granted a leave of absence just prior to giving birth. She was not discharged improved or recovered. Her husband presumably wanted her home to take care of the infant. Landor had little recourse, though he returned Charlotte to an unhappy home life.

An equally tragic case is that of Elizabeth M., a melancholic who often would not eat, and who required constant vigilance since she was "always inclined to injure herself". Landor wrote: "she would do at home with care and kindness, two things hard to be obtained in the country from a rough husband." Four months later he added, "this is a case of difficulty as to her disposal. Would do well in [a] kind home but worse if ill-treated. Nearly blind and cannot work but as all farmers make their wives work and are a rough uncultivated lot of people they cannot suffer an idle woman. They think such idle from inclination...She cannot be happy here and I think she would soon be worse at home". Elizabeth was lonely and isolated at the Asylum. "She would do better if her husband would be more attentive in writing or seeing her. She frets at being here..." The ideal remedy for Elizabeth was to be rid of her husband so that she could leave the Asylum and live peacefully. This was, of course, impossible, as she had no money and no other family, and her husband had jurisdiction over her.

The Asylums could not "cure" insanity, particularly when the insanity was rooted in the family. This dilemma was especially tragic for women who were legally bound and physically weaker than their husbands. Wife-battering and "madness-producing" families are problems which have not yet found solutions. Although Landor acutely diagnosed the situation, he (and Bucke) were ill-equipped to handle it.

On the other hand, there were women who were so impossible

to get along with that their families would have been driven mad had they remained at home.[27] It is questionable whether these women were actually insane; their husbands, however, apparently went to great lengths to be rid of them. Barbara R. believed spirits were haunting her and also "scolded a good deal". Julia Ann N. was jealous of her husband, and prone to scolding and to acts of violence. She was noted as using "foul language". She eloped three times from the institution but was always recaptured. Christina R. was jealous of her husband and believed "certain persons" [other women?] "designed to injure her". In 1877, she was described as a "great nuisance" in the dining-room because of her persistent talking. In 1878, she was well-behaved and good-natured but "fearfully and wonderfully loquacious". Six years later, she was still "talkative and scolding" and would do no work.

The clearest case of an unwanted wife was Elizabeth M. As Landor wrote, she did not appear "to have much the matter with her [except that she was] rather fault finding and exacting--for which reason I fancy her husband wanted to get rid of her."

* * * * * * * * *

In the latter half of the nineteenth century, after Lister's breakthrough in the use of antiseptics made surgery increasingly feasible (c. 1855), physicians in Europe and North America began experimenting with radical surgery on women. The first gynaecolog-

ical operation performed to treat deviant behaviour was the clitoridectomy, developed by an English gynaecologist in 1858 and practised in America in the late 1860's. Ovariotomies and hysterectomies were also introduced, and proved to be more popular operations. The treatment of psychological disorders by surgery "flourished" between 1880 and 1900, with some physicians boasting that they had removed "from 1500 to 2000 ovaries apiece."[28]

The use of gynaecological operations for mental disorders was based upon the premise that if the uterus was the seat of insanity, ovariotomies and hysterectomies would remove the problem. However, "insanity" in women included a wide range of behaviour which could be considered simply "unfeminine". Gynaecological surgery therefore had a social control aspect; the use (or the threat) of it could, in some instances, "tame" recalcitrant or eccentric women.

G. J. Barker-Benfield has termed the castration of women part of the "general anxiety about the racial future of white America." As a eugenics measure, gynaecological operations on the insane ensured that a degenerate line would not be continued.[29]

Yet gynaecological surgery was a very great boon for women debilitated by disorders and infections arising from childbirth, and should not be completely discredited. At the same time, operations such as those performed on the patients at the London Asylum were without the full consent of the women, as the responsibility for their welfare was in the hands of their families and the asylum superintendents.

The uterine basis for female insanity was a theory accepted not only by male physicians. In an address before the 1879 Conference of Charities in Boston, M. Abbie Cleaves quoted Drs. Ray, Bucknill and Blandford (all noted alienists) to support the existence of a "sympathetic connection" between the brain and the uterus, and advocated the addition of a "psychical gynaecologist" to the asylum staff.[30] Cleaves noted the impropriety of male physicians examining female patients:

> The superintendent...cannot make such examination of a female patient, or pursue such methods of treatment as are absolutely required for the relief of many forms of gynaecological disease. [31]

The superintendent was prevented from this by his regard "for the patient's welfare, for his own personal reputation, and for that of his hospital". He recognized the danger "lest an endeavour to arrive at a proper diagnosis of her disease should seem to the disordered mind only an attempt at improper and unpardonable liberties with her person, and, should she ever entirely recover her reason, be so represented to friends and to the community by her perverted and imperfect memory..." [32]

Cleaves' solution to this dilemma was to place insane women under the care of female physicians, since "gynaecological practice [was] legitimately theirs".[33] Her male colleagues did not follow her advice. They were, in fact, greatly opposed to female physicians, realizing the threat they would be to their lucrative business; they feared that women in this sexually separated society

naturally would prefer female gynaecologists.[34] Cleaves' argument was also flawed by the fact that she was advocating female professionalism on the basis of female biological inferiority; her opponents could, as they did, claim that female physicians were themselves prone to uterine diseases, and posed too great a risk to be charged with the care of patients.

At the London Asylum, Landor tended to prescribe beef tea and wine for afflicted female patients. Bucke, in his later years, was much more radical in his approach. Between 1895 and 1900, Bucke directed gynaecological operations on 226 female chronically insane patients. Bucke insisted that the operations had been necessary simply to improve physical health, arguing that "treatment of the mind resolves itself into an endeavour to place the whole physical system on the best possible basis for health and efficiency."[35] However, when asylum statistics displayed a marked increase in the discharge rate of females (from 35% to 51% in 1896, while male rates rose from 34% to 37%) Bucke credited this to the gynaecological operations.

He went further to state his personal views, then common, of the biological basis for insanity in women. "There exists between the female sexual organs and the great nerve centers a closer relation than between these last and any other of the bodily organs."[36] Bucke clearly believed that certain forms of insanity in women resulted from pelvic disorders, and could be treated with surgical intervention. The confusion of science,

morality and sexuality evident in the wiring of the masturbatory insane resurfaced, albeit in a more drastic form.

According to Asylum statistics, 38% of the surgical cases recovered physically and mentally, 26% improved, 32% improved physically but not mentally, and 2.5% died following surgery. That the recoveries which did take place were the result of the operations cannot be assumed. Other factors might have been involved, such as recovery independent of the surgery, shock from the operation, or even the intangible benefits of increased attention and comfort as a result of the operations. Bucke would be particularly anxious for these patients to recover, and the promise of speedy discharge and the support of family members eager to find instant cures could have had a favourable effect upon the patients.

The catalyst for Bucke's experimentation with gynaecological surgery was the presence of Dr. A. T. Hobbs at the London Asylum. Born and educated in London, Ontario, Alfred Thomas Hobbs received his medical degrees from Toronto University and Western University and became a member of the Ontario College of Physicians and Surgeons in 1890. [37] Though it has been written elsewhere that Hobbs was a "visiting gynaecologist", he had in fact become an assistant physician at the Asylum in 1894, and in 1895 had spent seven weeks studying gynaecology in New York at the province's expense.

Hobbs was the impetus behind Bucke's enthusiastic sup-

port of surgical intervention, and the fact that he performed over two hundred operations in the course of five years displayed a strong commitment of his own to the experiment. To publicize their findings, and to counter criticisms, both Hobbs and Bucke published a series of articles defending the surgery.[38] Whether the operations were for good or ill, they established Hobbs' professional reputation. He resigned his position at the Asylum in 1900, citing ill health due to continuous stair climbing to visit his patients in the fourth-floor infirmary, and took up private practice in London.[39] He became a noted expert on the treatment of "mental and nervous diseases" and in 1905 was named Superintendent of the Homewood Retreat in Guelph (a private asylum founded in 1884 by former Inspector J. W. Langmuir).[40]

Though Hobbs had resigned, Bucke was reluctant to give up the gynaecological surgery. As George Stevenson noted in his biography, Bucke's views on certain subjects bordered on the obsessive. [41] In 1901, Bucke wrote Inspector Christie requesting a gratuity for Hobbs, who had been a "most efficient assistant", and said that he would like to see the surgical work carried on. Bucke did not know if Christie felt as he did about the importance of the surgery, "but because of it, fifty women were restored to their families." Bucke also added that the Asylum had a "great mass of instruments and trained nurses, so we'd lose all this as well" if the surgery were discontinued. He concluded that he "deeply felt" for this subject.[42]

The Inspector did not share Bucke's enthusiasm. He replied that he had never approved of Hobbs' trip to New York, so "why give him a gratuity, especially since he was entering private practice?' Bucke answered that Hobbs still visited some of the patients under his care. Christie immediately ordered Hobbs to "stop at once". Bucke procrastinated, saying that he would obey the Inspector as soon as the present surgical cases were completed. Christie wanted to know why operations were still taking place at the Asylum. Bucke replied that there were a few cases which had been slated for surgery some time before, and the "fathers were very anxious" to have the operation done. It was unlikely these "fathers" were pressing merely for surgery to cure physical ailments, but to provide mental cures as had been promised by the Medical Superintendent. The operations ceased shortly thereafter.

Bucke's experiments were also criticized by other members of the medical profession. Superintendent Clark of the Kingston Asylum, for example, charged Bucke and Hobbs with soliciting support from the National Council of Women, thereby using the prestige of the organization to back the operations.[43] Bucke countered by circulating a letter to medical practitioners in southwestern Ontario stating that his work had been attacked as "mutilating helpless lunatics". "Do we have a duty to perform," he asked, "or are we guilty of 'meddlesome gynaecology'?" The letter further stated that he only operated to remove actual

physical disease, he always obtained the consent of friends, and many had been operated on and returned "who had previously been classed as chronic, hopeless cases." [44] The letter did get Bucke support from the profession, but, as stated above, the gynaecological operations did not outlast Hobbs' appointment.

Regardless of Bucke's motives or the outcome of the operations, the morality behind them certainly was questionable. The women patients had few rights and no opportunity for legal redress as long as they were institutionalized. Bucke was anxious to publicize his findings, and used a poor excuse (the Asylum's acquisition of surgical equipment) to justify continuation of the operations. It would appear therefore that more was at stake than the physical well-being of insane women. Surgery may have been able to cure "chronic mania". It may also have cured female aggression, sexuality and independence of mind. As Ehrenreich and English state:

> Late nineteenth century medical treatment of women made very little sense as medicine, but it was undoubtedly effective at keeping certain women...in their place...Surgery was often performed with the explicit goal of 'taming a high strung woman', and whether or not the surgery itself was effective, the very threat of surgery was probably enough to bring many women into line.[45]

Fathers and husbands gave their permission to Bucke to

operate on their daughters and wives in an effort to correct unwanted behaviour. The patient, a powerless lunatic, was not consulted. The lunatic was also likely to be poor, as were most of the Asylum population. As Wendy Mitchinson has noted, in the late Victorian era, the treatment of gynaecological disorders was often "conservative for wealthy women and radical [surgical] for poor women." [46]

The subjects of the surgery were most frequently, therefore, female pauper lunatics, one of society's truly helpless groups. The experiment demonstrated how finely drawn is the line between treatment and victimisation in a total institution.

NOTES

1. Elaine Showalter, "Victorian Women and Insanity," Victorian Studies 23 (Winter 1980) 2: 159.
2. Ibid., pp. 161. 163.
3. Peter Tyor, "Denied the Power to Choose the Good: Sexuality and Mental Defect in American Medical Practice 1850-1920," Journal of Social History 10 (June 1977) 4: 475.
4. Showalter, p. 173.
5. John Leake, Medical Instructions Towards the Prevention and Cure of Chronic Diseases Peculiar to Women, London, 1781, volume 1, p. 255.
6. Vieda Skultans, English Madness: Ideas on Insanity 1580-1890, London, 1979, p. 84; William P. Dewees, A Treatise on the Diseases of Females, 4th ed., Philadelphia, 1833, p. 509.
7. Dewees, p. 515.
8. Joel Shew, Midwifery and the Diseases of Women, New York, 1853, p. 195.
9. William Harvey, An Anatomical Disquisition on the Motion of the Heart and Blood in Animals, London, 1907 as quoted in Skultans, p. 83.
10. F. C. Skey, Hysteria, London, 1867, p. 55 as quoted in Showalter, p. 172.
11. Showalter, p. 167.
12. Ibid., p. 168.
13. Ibid., p. 166.
14. The sample below reflected only those cases with complete records. The files of patients who died or were discharged before 1875 usually stated only name, sex, and dates of admission and discharge or death [Archives of Ontario. Ministry of Health. Record Group 10. London Psychiatric Hospital, Patient Casebooks, 1870-1880, nos. 726; 388; 207; 369; 206 (hereafter Casebook)].
15. Showalter, p. 173.
16. Casebook, nos. 429; 426; 856; 404.
17. Shew, p. 41.
18. Showalter, p. 171.
19. Nigel Walker, Crime and Insanity in England, Edinburgh, 1968, volume 1, pp. 125-128.
20. Casebook, nos. 146; 454; 226; 388; 553; 576; 546; 489; 775.

21. Casebook, nos. 416; 698; 946; 719.
22. University of Western Ontario. Regional Collection. Middlesex County Court Records, 21 August 1873.
23. Casebook, nos. 676; 517.
24. Ibid., nos. 187; 683.
25. Court Records, 19 April 1873.
26. Casebook, nos. 209; 504; 525; 452.
27. Ibid., nos. 194; 378; 397; 407.
28. G. J. Barker-Benfield, The Horrors of the Half-Known Life:Male Attitudes Towards Women and Sexuality in Nineteenth Century America, New York, 1976, pp. 120-121.
29. Ibid., p. 121.
30. M. Abbie Cleaves,"The Medical and Moral Care of Female Patients in Hospitals for the Insane," Proceedings of the Sixth Annual Conference of Charities, edited by F. B. Sandborn, Boston, 1879, pp. 74-76.
31. Ibid., p. 77.
32. Ibid.
33. Ibid., p. 78.
34. Barbara Ehrenreich and Dierdre English, For Her Own Good:150 Years of the Experts Advice to Women, Garden City, N.Y., 1979, pp. 61-63.
35. Cyril Greenland, "Richard Maurice Bucke M.D. 1837-1902," Canadian Medical Association Journal 91 (1964) : 387.
36. "Annual Report of the Medical Superintendent, London, Ontario, Asylum for the Insane, 1896" quoted in Wendy Mitchinson, "Gynaecological Operations on the Insane," Archivaria 10 (Summer 1980): 136.
37. Henry James Morgan, ed. Canadian Men and Women of the Time, Toronto, 1912, p. 537.
38. For example, R. M. Bucke, "Surgery Among the Insane in Canada," Proceedings of the American Medico-Psychological Association 5 (1898): 71-88; A. T. Hobbs, "Gynaecology Among the Insane," The Canadian Practitioner 21 (May 1896): 321-326. See Mitchinson, "Gynaecological Operations", passim.
39. Archives of Ontario. Ministry of Health.Record Group 10. Correspondence of the Inspector of Prisons and Asylums, Box 220, file 6460 [hereafter C.I.P.A].
40. Morgan, p. 537
41. George H. Stevenson, "The Life and Work of Richard Maurice Bucke:An Appraisal," American Journal of Psychiatry 93 (March 1937): 1131.

42. C.I.P.A., 220, 6460.
43. Mitchinson, p. 138.
44. University of Western Ontario. Regional Collection. Bucke Papers. R.M.Bucke, "To Medical Practitioners in Southwestern Ontario," 16 November 1897.
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46. Mitchinson, p. 128.

CHAPTER VIII

MADNESS AND THE FAMILY

The nature and causes of insanity are still largely unknown. Certain mental illnesses have been traced to brain trauma, heredity or chemical imbalance. The origins of other forms of insanity, particularly schizophrenia (a term used to describe a broad spectrum of deviant behaviour),have not been determined. The British psychiatrists R. D. Laing, A. Esterson and David Cooper have argued that schizophrenia does not exist of itself, but results from mentally destructive interpersonal relationships.[1] The most influential and thus potentially most destructive relationship is the family.

Laing et al have stated that schizophrenic behaviour can be, in many cases, the patient's attempt to deal with an intolerable family life. The patient is seen as a victim rather than as a deviant. Treating the patient without treating the family will be largely unsuccessful; the patient will be returned to the same madness-producing environment. At the same time, prolonged institutionalisation is not a satisfactory answer. Cooper writes:

> In the mental hospital (the patient) finds psychiatrists, administrators, nurses, who are his veritable parents, brothers and sisters, who plan an interpersonal game which only too often resembles...the game he failed in at home.

> Once again he is perfectly free to choose. He may decide to oscillate between his family hell and the not dissimilar hell of the conventional psychiatric admission ward.[2]

The conclusions of Laing and his associates resulted from years of personal observation of schizophrenics and their families by trained psychiatrists. For an historian to make similar conclusions from the sketchy evidence of long-dead families requires an enormous leap of faith. However, the patient casefiles of the London Asylum in the late nineteenth century substantiate such conclusions. They portray deeply troubled families whose 'lunatic' members may well have been not aggressors--but victims of both mental and spiritual aggression.

The "insanity" of certain patients definitely manifested itself only or most intensely where family was concerned. Seymour T. (#63) was an "inveterate tearer" and fighter. After being visited by his sister one day, he "took a chair and cut his forehead [by] hitting violently against it." John C. (#204) was "bitterly angry with his wife for no cause." Perhaps the reason was the same as for Jonas E. (#401;917) who displayed "little evidence of insanity" except for "exciteability when speaking of relations" who committed him. Mary G. (#916) also became "noisy and abusive" only when her relatives visited, as did Mary H. (#828) when she saw her husband. Mary S. (#588) would not speak to "or acknowledge her husband."

Augusta K. (#613) went insane through "mental anxiety and family quarrels." Mary C. (#762) had set fire to her husband's

house and threatened to destroy herself. Duncan M. (#808) fancied his mother was "sometimes the Pope of Rome and Queen of England"--both hostile figures of authority to a Scottish Presbyterian. He tried to kill her with an axe.

George L. (#203), "a masturbator for years" had been committed by his father. He was diagnosed as having "dull feelings" and "silent habits" but was "without delusions". He was a "stupid man hardly fit for an asylum", but there was "no other place to receive him" and he could not "get his own living or take care of himself." Eventually, he was discharged.

Martin F. (#787), a printer by trade, was committed for being "dangerous to his mother." At the Asylum,he believed he was hired, and wanted to "rent the super's house to start a printing office for the patients." He worked well in the garden, and played billiards and cricket. At his mother's request, he was allowed out on a six month trial. He was "not sane," Bucke wrote, "but they may be able to manage him at home." He later recovered.

William S. (#213) was a "hopeless" case of melancholia. His mother had died in the Malden Asylum and it was feared that William would elope or commit suicide given the opportunity. According to Landor, there was "no hope for him because the whole family (was) more or less deranged." By 1881, he was "very jolly" and a good worker; he did improve in the Asylum away from his family.

At least two men tried to escape unhappy marriages through apparent insanity. Patrick Mc. (#919), discharged from the British Service as insane, fancied he was not married, and that his wife

"should not marry him." Charles H. (#967) believed himself to be under the influence of witches and that "his wife is dead and his present wife is the spirit of some other person in the same body." His delusions may have been true metaphorically; his wife may not have been the 'same' person he had married.[3]

Other patients were obviously injured psychologically by their families. Daniel S. (#560), a pensioned British soldier with melancholia, would not take food because he felt himself "unworthy" of it. His pension had been sent to his wife for their five children. The Inspector had learned that Daniel's wife had a reputation as a "drunk and a prostitute" and would spend the money for "drunken orgies" as long as it lasted. He ordered that the funds be sent to a "reliable third party."[4]

Maria H. (#842) was admitted for "seeing people around the house whom she tries to drive away." Her son-in-law, William E., was also a frequent resident of the Asylum (#498;643;859). He had first been admitted in 1871 with suicidal melancholia, had recovered, but was re-admitted in 1873 after attempting suicide. His mother too had been judged insane, his sister and mother-in-law were in the Asylum, and his father was "eccentric". William had been a masturbator in his youth and was "probably so up to admission." He told Landor of his habits, and the superintendent "warned him" to give up the practice. He "improved" six months after admission and was sent home on leave with his brother, but returned after three days saying that he had been "very nervous' while he was away and had not slept.

In 1874, he apparently attempted to re-admit himself. Because he had been discharged, and "as he was well enough to earn his own living," Landor could not detain him upon his own request, having no power to do so. He therefore gave William a letter to take to the county court, requesting that he be sent to gaol until he could be admitted to the Asylum by warrant, since "his symptoms were returning." Landor added that if the Sheriff obtained a warrant, William would be immediately admitted.[5]

William's affadavit stated that his wife and two children were with his father-in-law, and that his own father refused to offer any support for his son's upkeep. As Landor wrote, "his relations act more like enemies than friends to him." William was admitted and again released but returned eighteen months later seeking re-admission. Bucke had to obtain permission from the Inspector, who ordered that three physicians--not from the Asylum--examine William. If they declared him insane, he would be allowed to stay.[6] William was subsequently re-admitted.

It was evident that the first priority was to provide refuge for the most needy. An individual could not escape his family problems at the province's expense by admitting himself to an asylum. It first had to be proven that he was dangerous or suicidal, or could not take care of himself outside.

Adelaide B. (#228;684;801;961) also suffered from recurring insanity; she was admitted four times between 1870 and 1877. Adelaide's melancholia was caused by "hysterical malaria." She was first brought to Malden in 1870 "tied hand and foot";she had been

kept at home for some months. She was a Methodist belonging to a "psalm-singing family full of excited nonsensical notions who have filled her mind with the usual amount of trash so that she believes her foolish fancies are spiritual assertions for her guidance." Landor prescribed "plenty of food and wine as soon as she could be persuaded it was righteous to take the latter." This treatment "brought her round" in two months. Landor sent Adelaide home "until the family does it again."

Margaret O. (#298) was victimised by her family even after she was committed. Margaret took "great pride" in keeping herself and her room tidy. In November 1877, she escaped out her window, having been "very cross" for a few days. Two weeks later, an innkeeper notified the Asylum that Margaret was staying at his hotel in Toronto. Two attendants were sent to bring her back, but "on some pretext" she got away from them and went to the house of a relative "who secreted her and would not give her up." The attendants and the police searched the house but could not find her. Bucke then received notification that Margaret had retained a lawyer to keep her out of the Asylum and to put her in possession of property her brother had sold illegally. Margaret had received a medical certificate stating that she was in "moderately good health and of sound mind."

The lawyers were told that the Asylum had no wish to re-admit the patient if her relatives were willing to care for her, and that if she did not return in ten days, she would be discharged. Bucke, however, did not consider her sane. Margaret's nieces were

"anxious to retain her" but Inspector Langmuir suspected that "if she obtains control of the estate, it will find its way to the relatives, and when she is again relegated to an asylum, there will be nothing left." The property was placed under Langmuir's control pending the patient's final disposition (as property of the insane could be siezed to pay for their maintenance).[7]

Langmuir's judgment proved correct. Margaret returned to the Asylum as there were "none to take care of her." She was discharged on probation eleven months later, but experienced a relapse and was found in a House of Providence (for the destitute). Bucke apparently had had enough of Margaret, and requested that she be placed in the Toronto Asylum closer to her "friends".

Other patients had such disagreeable personality traits that their families must have been eager to commit them to the Asylum regardless of their actual mental condition. Rebecca K. (#493) was "always faultfinding and bringing charges against the attendants." Ann F. (#495) with religious monomania, possessed a voice "like a rasp which can be distinguished above most noises including a steam whistle." She did nothing but scold "night and day."

Gilbert T. (#760) who had been sent by his wife, was a "tall, violent" man, very "quarrelsome, talkative, boasting, excited and restless." At the Asylum, he was a bully who was "fond of ruling all about him." Three months after admittance, he was sent home at his wife's request, but was returned as "unmanageable". Landor believed this to be without justification. Gilbert walked

about "like a tamed rabbit", talked rationally, but was "ill-tempered and idle". He would work for short periods of time, then would go fishing. Landor wrote, "I am sure [Gilbert] would do better at home if [his] family would persevere with him and treat him kindly. No doubt his temper makes him unbearable but no more than he has been all his life." Landor finally discharged him--an "idle, good-for-nothing without one insane idea".

Other families had to commit men to protect themselves physically from their actions. John Mc. (#715), always with "celtic Bible in hand," tried to convert his family "with a stick as well as with an argument and reading." Landor diagnosed John as "one of those inebriates, sound when kept from drink but no self-restraint." Because John was not then insane, and as there was "no asylum for inebriates", he was sent home.

George H. (#758) apparently was more violent towards his family. He was a warranted case from Middlesex County Gaol committed for being dangerously insane. Witnesses testified that he was a heavy drinker, and that his fourteen-year-old son had appeared terrified of him. At the Asylum, he was quiet and well-behaved. He was "very anxious to go home." His wife was told she could take him on trial--if she liked. She came to visit him and "played a double game, told him she wanted to take him and us that she didn't. Consequences--he thinks we won't let him go and has struck work." Two years later he was granted permission to go to the city and had to be "written off" when he did not return.

George's case illustrated how deception and "double-binding"

[when words and actions contradict] among family members could exacerbate existing mental problems or create new ones. While Mrs. H. undoubtedly had good reason to wish her husband to remain in the Asylum, the lies she told, probably out of fear, hindered George's recovery. Such deception also obstructed his treatment by making him distrustful of his physicians. Dealing with family members like Mrs. H. must have been extremely trying for asylum physicians; it also must have made them more certain that proper treatment in the home was impossible.

In the cases discussed above, the experiences of the lunatics could not be separated from those of the family. If family relationships had caused madness, then the selection of the patient as 'the' lunatic was more arbitrary than real. This is not to discount the eccentric or violent behaviour in which the patient engaged: merely the diagnosis. The patient, in "going mad" may have been attempting to escape a mad situation.

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Despite the fact that overcrowding and budgetary restraints rendered the Asylum largely custodial, it did have some success as a curative hospital. Henry Landor's approach towards treatment of the insane was pragmatic while Bucke's was experimental. Yet both men achieved the primary goal of moral treatment--control of the insane with the minimal use of physical restraints.

Although he appeared topossess a less arrogant personality than Bucke, Landor proved less able to adjust to the growing bureaucratization of health care in the mid-nineteenth century. His disillusionment must have been reproduced, to some degree, wherever government extended its control. Bucke, by contrast, appeared to suit a bureaucratic rather than an individual regime. While his personality was, to say the least, colourful, he seemed to find it difficult to relate to his colleagues on a personal level.

The Asylum's employees were largely successful in their adjustment to living and working in a mental institution, as demonstrated by the fact that instances of insubordination, intemperance, and maltreatment of patients were rare.

Poverty was the primary factor which led to insanity and commitment. The destitute were becoming an increasingly large proportion of Ontario society during the nineteenth century--straining existing welfare facilities and necessitating a re-structuring and broadening of social services. The problems associated with poverty were exacerbated by massive immigration, which

was reflected in the preponderance of Irish Catholics in the London Asylum.

Treatment at the London Asylum was fairly flexible, and, at times, quite imaginative. While the types of labour performed by patients (particularly women) appeared to benefit the institution more than the patients, they did reduce the necessity for physical restraints. The Asylum also sought new and varied diversions for the patients. Asylum policy appeared most flexible with respect to elopements. In this instance, the non-retributive attitude of the superintendents demonstrated the difference between an asylum and a prison.

Nineteenth century attitudes towards morality and sexuality were most clearly revealed in the treatment of women and masturbatory insanity. The growth of the idea of masturbatory insanity reflected middle-class anxieties more than mental illness, and the type of patient "wired" by Bucke was indicative of social control as well as the existence of a strict moral code.

Nineteenth century stereotypes regarding women were prevalent in the Asylum. Women were to be passive, chaste and uneducated--deviations "resulted" in insanity. Deviations, in fact, could result in commitment. The experiences of women at the London Asylum also demonstrated hardships women encountered in the nineteenth century: successive, often debilitating pregnancies; abuse and desertion; and legal subjugation. Bucke's experimentation with gynaecological surgery may have had physical

benefits for the patients, but it also dramatized the lack of control women had over their own lives.

An individual's insanity was related to his interactions with his family. As illustrated in case histories, the patient was often the victim of an intolerable family life. Nineteenth century attitudes towards insanity, as reflected in the London Asylum, were often bigoted, unfounded and often had negative consequences. Yet the belief in the curability of insanity and in the essential humanity of the insane resulted in treatment which was inevitably benevolent and imaginative.

NOTES

1. R. D. Laing, The Politics of Experience and the Bird of Paradise, Harmondsworth, 1967; R. D. Laing and A. Esterson, Sanity, Madness and the Family, 2nd ed., New York, 1971; David Cooper, Psychiatry and Anti-psychiatry, London, 1970.
2. Cooper, p. 35.
3. Delusion is a "true idea held by the patient which the psychiatrist deludes himself into accepting literally" [Cooper,p.40].
4. Archives of Ontario. Ministry of Health. Record Group 10. Correspondence of the Inspector of Prisons and Asylums, Box 14, File 443 [hereafter C.I.P.A].
5. University of Western Ontario. Regional Collection. Middlesex County Court Records, 24 August 1874.
6. C.I.P.A., 14, 452, 8 March 1879.
7. Ibid., 455.

APPENDIX 1. SALARIES AND WAGE ESTIMATES

Title	1874	1899
Medical Superintendent	$ 2000	2000
Physician (Asst.Super)	(1000)	(1100),900,800
Bursar	1200	1400
Steward (Bursars Clerk)	600	(750)
Storekeeper (inc.rent)	--	1000
Engineer	740	740
Asst. Engineer	400	400
Firemen [stokers]	480 (2)	1776 (7)
Carpenters	1000 (2)	1000 (2)
Bricklayer/Plasterer	--	600
Gardener	400	450
Asst. Gardener	240	300
Butcher	192	360 (w/out board)
Porter & Messenger	192	240
Baker	360	300
Asst. Baker	--	216
Tailor	264	460
Farmer	400	600
Ploughmen	672 (2)	456 (2)
Laundryman & Shoemaker	--	300 ea.
Bandmaster	--	300
Night Watches	480 (2)	--
Chief Male Attendants.	1356 (5)	936 (3)
Ordinary Male Attendants	3408 (16)	7080 (29)
Supervisors	--	2208 (8)
Matron	400	500
Asst. Matron	--	300
Chief Female Attendants	540 (3)	(1) [250]
Ordinary Female Attendants	1740 (19)	(29)
Night Nurses	240 (2)	(4) 6758
Supervisors	--	(7) 1 @ 180 (music) 6 @ 174
Trained Nurse	--	(1)
Cooks and Assistants	420 (3)	852 (6)
Laundresses	432 (4)	564 (4)
Housemaids	504 (6)	720 (6)
Seamstress & Tailoress	120 (1)	312 (2)
Dairymaid	96 (1)	120 (1)
Portress & Typewriter	--	280 (2)
Extra Assistance	100	

[A.R.M.S., 2, 1874; C.I.P.A., 6446,218]

APPENDIX 2. EMPLOYEE SCHEDULE

1. Give your name in full.
2. What was your age last birthday?
3. Are you married, single or widowed?
4. What heretofore has been your occupation?
5. Where were you born?
6. Where do you live now and for how long?
7. What education have you had?
8. Do you play any musical instruments?Do you read music at sight?
9. Is your general health good? Has it always been so?
10. Give your P.O. and telegraph address.
11. What position at the Asylum do you apply for?
12. Give the names and P.O. addresses of at least two persons in your neighbourhood of as good standing and position as possible who can speak as to your character and habits.

I promise, if appointed, to faithfully discharge the duties assigned me, to obey the Rules and Regulations of the Institution; to exercise respect, kindness and forebearance towards patients, and all others with whom I am brought in contact; to abstain from the use of intoxicating liquors, and to lead a strictly moral life, and if appointed I will accept on the express understanding, that my services may be dispensed with at any time without notice, and without reason assigned.

_____

signature

[C.I.P.A., 218, 6446]

MEDICAL GLOSSARY

AGUE	1) a chill 2) malarial fever.
ANODYNE	Medicine that relieves pain. Includes opium, morphine, codeine, aspirin and others.
APOPLEXY	Stroke.
ASTHENIA	Want or Loss of strength.
CALOMEL	Mercury chloride. Heavy white, odorless powder. Cathartic (causing evacuation of bowels).
CEREBRITIS	Disease of the cerebrum.
CHLORAL	Colorless, oily liquid having pungent, irritating odor and prepared by alcohol and chlorine.
CHLORAL HYDRATE	Crystalline substance with aromatic odor & bitter taste, used as hypnotic (also called chloral).
CHOLERA	Acute infectious disease-severe diarrhea & dehydration leading to shock or renal failure.
CHOREA	Ceaseless occurrence of variety of rapid, highly complex jerky movements performed involuntarily.
COLIC	Acute abdominal pain pertaining to colon.
CONJUNCT-IVITIS	Inflammation of eye.
ENTERITIS	Inflammation of intestines.
EPITHELOMIA	Tumor of epithelium (covering of external & internal surfaces of body).
ERYSIPELAS	Contagious disease of skin & subcutaneous tissue due to infection-redness and swelling.
FEBRILE	Pertaining to fever.
GASTRALGIA	Gastric colic.
GENERAL PARESIS	Dementia Paralytica--syphilitic paralysis--degeneration of brain neurons.
GOUT	Hereditary form of arthritis attacking single joint.
HYPNOTIC	Drug inducing sleep.
HYPOPHOSPHITE	Salt of hypophosphorus acid.
IPECAC	From root of ipecacunhuana plant. Emetic (induces vomiting).
MARASMUS	Progressive wasting away of fat and muscle.
NEURALGIA	Nerve pain.

PERITONITIS	Inflammation of abdominal wall lining. Pain, tenderness, vomiting, moderate fever.
PHOSPHORUS	Ordinary white phosphorus-inflammable & poisonous. Used to treat rickets, nervous & cerebral disease, scrofula & tuberculosis, genital stimulant in sexual exhaustion, tonic for exhaustion.
PHTHISIS	Tuberculosis; wasting away of the body [ti-sis]
PUERPERAL	Pertaining to period after labour.
QUININE	Crystalline powder. Treats malaria. Also pain reliever, produces rapid labour, reduces fever.
RECTIFIED SPIRIT	Refined Alcohol.
RHEUMATISM	Inflammation or degeneration of body's connective tissues.
SCROFULA	Tuberculosis of lymph nodes, inflamed structure being subject to a cheesy degeneration.
STRYCHNINE	Extremely poisonous alkaloid used as central nervous system stimulant. Formerly used as bitter tonic, circulating stimulant, and with cathartic drugs.

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