Utopia for the mind: American treatment of insanity in the nineteenth century

Lauren Fleming
James Madison University

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Utopia for the Mind:
American Treatment of Insanity
in the Nineteenth Century
Lauren Fleming

A Thesis submitted to the Graduate Faculty of
JAMES MADISON UNIVERSITY
in
Partial Fulfillment of the Requirements
for the degree of
Master of Arts

Department of History

May 2014
Acknowledgements

This paper and accompanying project have been two years in the making. In that time Dr. Gabrielle Lanier has been the chair of my thesis committee and an invaluable mentor. Thank you for your patience, guidance, and support throughout my graduate school career. Special thanks to Dr. Evan Friss and Dr. Kevin Borg for serving on my thesis committee and giving me constructive feedback on my project.

Thank you to the Colonial Williamsburg Foundation for providing me with images to use in my project and to Western State Hospital in Staunton, Virginia for permission to showcase objects from your collection.

Much gratitude goes to my fellow graduate students who have provided immeasurable moral support and fun times throughout the past two years. Your friendships and encouragement have kept me sane through stressful classes and thesis edits.

Sincere thanks and love to my family for reading and re-reading everything I have ever written. Mom, Dad, and Robin, your love has supported me through so much and I cannot even begin to express how much you mean to me. To Ryan Bachman who has given me encouragement and challenged my ideas for the past two years, thank you. Your love and support mean the world to me and I cannot wait to read your thesis in two years.
Preface

*Utopia for the Mind* was created as an online exhibit with the intent of introducing the topic of nineteenth-century treatment of insanity to a lay audience. The general arrangement of the exhibit follows the progression of this thesis through four primary sections titled: “A New Science,” “Utopian Setting,” “Dystopian Reality,” and “Legacy.”

In the nineteenth century, physicians for the insane sought to create a haven for the mentally ill through the construction of elaborately designed gardens and architectural arrangements. Their attempts to cure insanity were thwarted, however, by the reality of mental illness which necessitated the use of medicine and restraint. Despite the unfulfilled expectations of these physicians, their ideas have lived on and are visible in twenty-first-century psychiatric hospitals and prisons. The following paper mirrors the layout of the online exhibit while presenting a more detailed and academic approach to the topic. *Utopia for the Mind* can be viewed at: laurenfleming26.wix.com/utopia-for-the-mind
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Abstract

In nineteenth-century America a new approach to treating insanity was adopted. This approach was called moral therapy. Physicians who practiced moral therapy tried to create an ideal, curative environment for the disordered mind through landscape and architecture but fell short because reality demanded they use restraints and medicine to limit the behavior of their patients. This paper and accompanying online exhibit explores the conflict between moral therapy's utopian setting and its dystopian reality from the 1830s through the 1870s. By 1880 most American asylums had become centers for custodial rather than curative care but an enduring legacy of moral therapy has continued to the present day.
Introduction

Nathaniel Bishop was a comb-maker from Danbury, Connecticut who served as the leader of a local Christian sect from the 1780s until 1845. This sect, known as the Sandemanians, held a weekly banquet called a Love Feast to symbolize and celebrate Jesus’ Last Supper. One morning Nathaniel’s son, known in the village as Crazy Amos, accidentally burned down the hall where the Love Feasts were held by carelessly firing a rifle outside of the wooden structure. This behavior changed Crazy Amos’ position within the community from a harmless, mentally disordered boy to a dangerous person who potentially threatened the lives of the townspeople. When those townspeople demanded that Amos be dealt with, Nathaniel chained his son to the beams of the local meeting house attic. Crazy Amos remained there until he clawed his way through the second-story wall and escaped into both the forests of southwestern Connecticut and history.¹

The reaction to and treatment of Crazy Amos was typical in America during the eighteenth and early nineteenth century when the family or community was the bedrock of care for the sick and disabled. Once a person was deemed a danger to themselves or others, it was not uncommon to restrain them physically, and sometimes brutally.² Around 1810 a young man known as ‘Si’ Spaulding was chained to the floor of his bedroom due to rambunctious behavior that his father perceived as a loss of reason.³

¹ Sandemanian File, Danbury Museum Archives, Danbury Museum and Historical Society. Danbury, Connecticut. The exact date of this incident is unknown but it fell sometime between 1780 and 1845.

² See Figure 1

³ This behavior included placing tacks beneath his father’s saddle to make the family horse jump, leaving a dead snake in his sister’s bed, and sneaking animals into the kitchen to scare his mother. Si was also reported to be an introvert which, in his case, was interpreted as a sign of depression.
When Si broke away from the chain in his room and tried to run away, he was caught and placed in a specially built wooden cage. Si sat in this cage, naked and covered only by a woolen blanket, until his death 57 years later. During his lifetime this cage was moved periodically as family members passed away, leaving Si in the private care of various relatives. After Si had outlived his entire family the community placed him in the local almshouse, or poorhouse.4

Transferring mentally disturbed individuals from private homes to an almshouse or prison was common after the family or community of an insane person rejected responsibility for them. Many local newspapers in America carried stories similar to that of Crazy Amos and Si, stories in which families would chain up a relative at the behest of the community for alleged crazy behavior. Institutionalized treatment of the mentally ill in asylums, which were most prevalent in Europe until the mid-nineteenth century, was similar. Patients were subject to mockery, abuse, and whipping from their keepers which led many to equate their existence with that of animals. At Bethlem Royal Hospital of London, the community could walk through the asylum to stare at patients who were chained in dank cells amidst puddles of their own filth.5

This practice rested not on intentional brutality, but on misconceptions about the nature of insanity. Until the early nineteenth century, it was commonly believed that mental instability was incurable and that it had irrevocably destroyed the inherent humanity of a person. Terms used in reference to the insane such as demonic, lunacy, and


5 Bethlem was colloquially called “Bedleheem,” “Bedleem,” or “Bedlam.” Treatment of the insane was so notorious at Bethlem Royal Hospital that the term “Bedlam” became associated with scenes of uproar and confusion; a definition that is still used in the twenty-first century. See Figures 2-4.
madness reflected this notion. A demonic person was purported to be possessed by a devil leaving a cure for derangement in the hands of God. Lunacy was a term derived from a belief that intermittent insanity was related to phases of the moon. Madness was a vernacular word suggesting wildness, a lack of restraint by reason, and loss of emotional control. Each of these labels implied an uncontrollable descent into insanity for which there was no cure.

By the beginning of the nineteenth century the scientific community began to reject these terms and the meanings they imbued. This shift was precipitated by the growing professionalization of the medical field and scientific discoveries which invalidated vernacular understandings of mental illness. Physicians chose to use the term insanity to describe their patients because this literally meant ‘not sane.’

These physicians were also called psychiatrists, and superintendents, noting their position in the hierarchy of asylum employment. As madness turned into insanity professional opinion developed the practice of moral therapy, or moral treatment. Moral therapy supported the notion of curability by emphasizing the potential healing power of a structured asylum environment on the diseased mind. By the 1860s this movement was so popular that American asylums replaced private homes and almshouses as the primary care-givers for people like Crazy Amos. This institutionalization utilized the construction of the asylum and the layout of the grounds to limit the use of mechanical restraints and medicine in the treatment of the insane.

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7 It was not until the 1840s in America that asylums began to outnumber almshouses although some form of hospital-like care had been available in a few areas since 1751.
Moral therapists, the physicians who practiced moral treatment, sought to create a utopia where the mind could heal itself without inhumane restrictions. Their writings were often focused on planning heating and ventilation systems, landscaping, and construction methods. When moral therapists broadened these writings to encompass more medicinal themes concerning insanity they emphasized the healing powers of an organized environment and the harmful effects of mechanical restraints. Historical studies on these patterns have tended to evolve around the social implications of nineteenth-century institutionalization rather than deciphering the moral asylum universe as a microcosm of ideological principles paralleling notions of refinement and humanitarianism.\(^8\)

Beginning with Michel Foucault’s *Madness and Civilization* (1961) and the emergence of the social historian in the 1960s, madness studies have focused on power structures.\(^9\) Foucault, for example, argued that lunatics and vagrants were locked up as a means of state control. Every aspect of the treatment of the insane, either in asylums, prisons, almshouses, or the private home, revolved around one set of people exerting control over an abnormal situation. Although many of his historical assertions have subsequently been proven false, Foucault’s notion of power structure and historical

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\(^8\) David Rothman asserts this notion in *The Discovery of the Asylum* but does so to prove that the moral asylum was a means for physicians to control patients. My interpretation follows closely with Rothman but concludes that while control was necessary in asylums physicians were attempting to create the most healing environment they could envision for the benefit of their patients.

relativism has remained a central ideological trend in many studies of nineteenth-century treatment of insanity.\textsuperscript{10}

Social historians were quick to pick up Foucault’s work and explore more nuanced ways that power played out in the asylum world. In broad histories, scholars like Andrew Scull and David Rothman reject the Whiggish view of the nineteenth-century asylum as a creation of noble humanitarians. They argue that mental hospitals were places of control, places where the norm could be reasserted over the insane. In The Discovery of the Asylum (1971), Rothman argues that American asylums emerged as a result of an identity crisis caused by rapid industrialization; the uncertainty created by urban growth in Jacksonian America necessitated the growth of rehabilitative institutions.\textsuperscript{11}

Andrew Scull has come to similar conclusions concerning the rise of English asylums in Museums of Madness (1979).\textsuperscript{12} By employing Émile Durkheim’s theories of deviancy, Scull concludes that nineteenth-century insane asylums were merely dumps for the abnormal; a place where people who did follow social norms, but were not criminals, went to be rehabilitated and often forgotten. Scull further argues that the physicians in

\textsuperscript{10} In his essay “Histoire de la folie: An Unknown Book by Michel Foucault,” Colin Gordon has asserted that many of the qualms about Foucault’s work raised by English speaking historians stem from the readings of imperfect translations of the original text: Histoire de la folie. In English translations there are many omissions, some as large as full chapters, that make it impossible for readers to grasp Foucault’s full argument. For example, in the original French text of Histoire de la folie there is a chapter titled ‘Le monde correctionnaire’ which deals specifically with deviancy theory to argue that the classification of a historical individual as a deviant is historical relativism. Therefore one cannot label a deviant as an insane person based on modern understandings of the definition. Without this missing chapter, readers of the English translation pick up the opposite idea and believe that Foucault argues that deviants and the mentally ill are one in the same. With the inclusion of these omitted sections, the apparent flaws in Madness and Civilization disappear.

\textsuperscript{11} David Rothman, The Discovery of the Asylum: Social Order and Disorder in the New Republic (Boston: Little, Brown, 1971).

these asylums were not concerned as much with curing insanity and caring for patients as they were with furthering their careers and attaining a gentleman status. These assertions are remarkably similar to Rothman’s but dispute the exceptionalistic view of American asylums.

Historian Gerald Grob has criticized both of these scholars for their negative view of nineteenth-century psychiatrists. In Mental Institutions in America (1973) Grob counters Rothman’s negative view of physicians by arguing that they were not merely out for personal gain, but had admirable, multidimensional motives for their work. Scull, in turn, has criticized Grob for his Whiggish interpretation of these early psychiatrists. Despite the disputes between these three scholars, their works are exceptionally similar. All three see the asylum as a way for an industrializing culture to assert control of a deviant class. Likewise, they place the rise of the asylum in the economic context of the early nineteenth century.

The macro-history approach of Scull, Rothman, and Grob reversed itself in the 1980s with the publication of The Anatomy of Madness (1985), a three-volume collection of essays edited by William Bynum, Roy Porter, and Michael Shepherd. Canadian historian Thomas Brown has written that “what united these essays was their deep distrust of the broad overview, the sweeping generalization, their insistence that the nineteenth-century psychiatric experience was so rich in diversity and complexity that it

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could only be understood at the level of the particular, the local, and the individual.”15

Other localized histories written before 1985, such as Nancy Tomes’ *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum Keeping, 1840-1883* (1984), garnered little widespread attention until after the publication of *The Anatomy of Madness*.16

By the 1990s, historians of psychiatry were fully embedded in counter-revisionism and they were increasingly moving away from centralized issues of power. Social interactions, such as those between physicians and patient’s families, began to hold immense value for asylum studies. “*Shattered Nerves*: Doctors, Patients and Depression in Victorian England” (1991) by Janet Oppenheim detailed individual relationships between those involved in asylum culture.17 While power was still essential to such a discussion, it no longer stood front and center. Overall, the impact of the counter-revisionists has been to take the overarching, theoretical findings of Foucault, Rothman, and Scull and apply them to localized cases. This second wave of psychiatric historians provided a more nuanced examination of the field by exploring issues of gender, race, class and society. Micro-history, rather than macro-history became the predominant method of study.

The most recent trend in the study of nineteenth-century madness focuses on the asylum environment. Jeremy Taylor, Christine Stevenson, and Leslie Topp have each

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analyzed the ways in which physical asylums in England were an important aspect of moral treatment; architecture was central to the realization of British moral therapy.\textsuperscript{18} Carla Yanni applies their conclusions to American asylums in \textit{Architecture of Madness} (2007) arguing that American physicians were obsessed with environmental determinism. Architecture and landscape were the best tools physicians had to treat and cure insanity.\textsuperscript{19}

Spatial studies of asylums, like Yanni’s architectural analysis, are much more interdisciplinary than the strict historical monographs of Rothman and Scull. Understandings of material culture are necessary to read the built environment and interpret it as traditional historians would a textually based source. This broadens the field and allows for scholars to look anew at the earliest monographs on madness and either support or refute their conclusions using fresh evidence. Such studies have enlarged the audience influenced by research on madness by appealing to an academic and lay readership.

This public audience has tended to fantasize about asylum life during the past three centuries. In the process myths about patient treatment have been created despite the writings of established historians. In the twenty-first century, movies like \textit{Shutter Island} and television shows like \textit{American Horror Story} have used asylums as the backdrop for horror themed plot-lines. Their popularity incites public responses on blogs


\textsuperscript{19} Carla Yanni, \textit{The Architecture of Madness: Insane Asylums in the United States} (Minneapolis: University of Minneapolis Press, 2007).
and websites that harp on the villainous treatment of mentally ill patients in every past era.

Local news stories about abandoned asylums or new museum exhibits seem to get their facts about the treatment of the insane from popular culture rather than the scholarship of knowledgeable historians. The opening sentence of one news report on the opening of a museum exhibit in Utah states: “The history of the treatment of mental illness paints a barbaric portrait.” In a promotional piece for the Ohio Historical Center, 614 Magazine describes a crib-bedstead on display, a cage-like bed used to contain violent patients, with such colorful language that readers are unable to make their own conclusions about the object. The author of the article writes that “a state mental institution’s crib-bed cage [is] covered in so many bite marks you can almost feel the panic.” Such statements close the mind of the reader and perpetuate the myth that all asylums have been home to brutal treatment and ill intent.

While there were inevitably instances of cruel treatment in asylums, these popular sources fail to look more deeply into the findings of historical scholars to see that nineteenth-century physicians were concerned with helping their patients, not treating them like animals. My exhibit, Utopia for the Mind, seeks to provide a popular medium that blends the public’s morbid fascination with asylums with the informed tradition of madness scholars. By combining the power-centered research of David Rothman with

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20 Ed Yeates, Mental Health Museum Opens in Provo, 16 September 16. http://www.ksl.com/?sid=4280829 (accessed 2 January 2014). This small exhibit opened in an active hospital to explain the general history of health care. See Figure 5.

21 “An Unsettling History: Ohio Historical Center Exhibit Shocks and Sparks,” 614 Magazine, 1 November 2011. http://www.614columbus.com/article/an-unsettling-history-3526 (accessed 2 January 2014). This exhibit was titled “Controversy: Pieces You Don’t Normally See” and included such objects as a Ku Klux Klan robe, an electric chair, and a crib-bedstead. Museum officials said that the exhibit was intended to be neutral and allow visitors to make their own conclusions about the objects on display.
Carla Yanni’s study of space, this online exhibit argues that physicians of moral therapy tried to create an ideal environment for the disordered mind between 1830 and 1870 but fell short because reality demanded they use restraints and medicine to limit the behavior of their patients. Based on the dual nature of this thesis the exhibit has been divided into two primary sections: Utopian Setting, and Dystopian Reality. Two more sections, an introduction and conclusion, are provided to inform the visitor about the historical context for the argument as well as the modern-day legacy of moral therapy.

The introduction begins by detailing the treatment of the insane prior to the moral therapy era of the nineteenth century. It then evolves into the transition phase between 1800 and 1830 when physicians and the public began to accept and practice moral treatment based on scientific advancements and humanitarian aims. Visitors are first introduced to the topic through the story of Crazy Amos and the reality surrounding his confinement in a meeting house attic. They are then taken through the thesis with a series of galleries that use images of art and objects to illuminate the conflicted reality of moral asylums. The following paper presents a detailed analysis of the research and argument presented in *Utopia for the Mind*. 
A New Science

In the late eighteenth century as Crazy Amos was being chained to the meeting house attic in Danbury, Connecticut, several prominent physicians in Europe began challenging the haphazard and often negligent treatment of the insane. They sought to treat mental disabilities actively through moral therapy. The alleged founder of this movement was the French physician Philippe Pinel who famously struck the chains off of his patients at the Asylum de Bicêtre in 1792.22 The widespread popularity of his actions led Pinel to publish *Traité Médico-Philosophique sur l’Aliénation Mentale; ou la manie* in 1801. This publication became the foundational text of the moral therapy movement and led nineteenth-century physicians to declare: “we know not of any work on insanity superior to this…none more worthy of our daily study.”23 What made the work so notable was the radical nature of Pinel’s insistence on treating the insane with respect and dignity and the blueprint he created for managing insanity.

Pinel justified the need for his work by pointing not only to the inhumane treatment of the mentally ill, but also to the misconceptions surrounding insanity itself. In the *Traité* he wrote: “The history of insanity claims alliance with that of all the errors and delusions of ignorant credulity;—with those of witchcraft, demoniacal possession, miracles, oracles and divination.”24 Madness, demonic possession, and lunacy were no longer sufficient scientific terms. Pinel’s statement reflects a rationalized rejection of these superstitious definitions of insanity that had supported a system of custodial care over curative treatment.

22 See Figure 6.
The attacks on prior care did not stop with a denunciation of terms and causes. In the *Traité* Pinel sardonically compared lunatic hospitals, like Bethlem, to despotic governments where loyalty and good behavior could doubtless be maintained by “unlimited confinement and barbarous treatment.” In place of such methods, however, Pinel believed that a degree of liberty should be allowed because the extension of a “few charms” would diminish the unhappy existence of maniacs and perhaps return them to a previous state of sanity. Pinel encouraged the establishment of asylums that recognized the humanity of their patients. In Pinel’s view these asylums would emphasize a mildness of treatment which would prove more beneficial to patients than chaining them to a wall for the rest of their days. Coercion and restraint, by means of aggression, were only necessary when every other avenue of persuasion had proved ineffectual. From this framework Pinel developed *traitement moral*, or moral treatment. Patience and the creation of a kind, healing environment were the cornerstones of this earliest form of moral therapy.

In England, William Tuke established the York Retreat for insane persons belonging to the Quaker Society of Friends. The catalyst for Tuke’s creation of the Retreat was the death of a fellow Quaker, Hannah Mills, in 1790. Mills passed away shortly after her admittance to an asylum, during which time no family or friends had been allowed to visit her. When the Quakers investigated the conditions of the asylum following this incident they were appalled to discover that the patients were treated more

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28 See Figure 7.
like animals than humans. Believing in the inherent humanity of the insane, Tuke established the Retreat in 1793 to separate members of the Quaker Society from the profane and brutal treatment of secular asylums in England. At the Retreat, Tuke instituted a regime of exercise, work, and amusements aimed at treating patients like sane adults.29 His emphasis on the curability of insanity and his acknowledgement of the environment’s role in either helping or impeding a cure for mental illness, mirrored the works of Pinel.

America was not far behind Europe in adopting humane treatment of the insane. Influenced by the work of Pinel and Tuke, Doctor Benjamin Rush wrote the first major American treatise on moral therapy in 1812 titled *Medical Inquiries and Observations upon the Diseases of the Mind.*30 Like his European counterparts, Rush noted that the treatment of America’s insane population in almshouses, prisons, and private family homes was often inadequate and commonly cruel.

Unlike Pinel and Tuke, Rush quickly fell out of favor with mid-nineteenth-century asylum superintendents. By the 1840s the *American Journal of Insanity*, the voice of the Association of Medical Superintendents of American Institutions for the Insane (AMSAII), had begun denouncing Rush’s work. One article claimed that although Rush “inculcates the necessity of mild treatment and kind usage,” his insistence on dominating his patients and disciplining them with the strait waistcoat, the tranquilizing chair, and the administration of cold water up a patient’s sleeves was at odds with moral


30 See Figure 8.
treatment. The AMSAII did not think that Rush went far enough toward kindness in his treatment, although they did recognize him as an important contributor to establishing American asylums.

Moral therapy, as a fiscally expensive and intellectually challenging movement, would not have been possible if these physicians did not have a scientific theory supporting their claim that insanity was curable. Phrenology provided this foundation. Founded in 1796 by the Austrian physician Franz Joseph Gall, phrenology argued that the human brain was divided into two distinct parts: the mind and the intellect. The mind related to the spiritual portion of a person, the soul, while the intellect represented the physical brain. Because the two were separated, the mind, or the humanity of a person, could be retained after the intellect had become diseased.

Phrenology further divided the intellect into faculties, or human characteristics. Prominent faculties, such as anger or excitement, were identifiable by bumps on a person’s head and could be matched to official phrenological charts, busts, or labeled

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31 “The Moral Treatment of Insanity,” 6. The tranquilizing chair was an invention made by Benjamin Rush to regulate blood flow to the brain, lessen muscular action, and ease the general condition of insanity. See Figure 9.

32 Modern science has declared phrenology a pseudo-science which has no basis in actual fact. Eighteenth- and nineteenth-century physicians, however, believed it was legitimate. Therefore, this paper refers to phrenology as a science because its practitioners called it a science.

33 Nahum Capen, Reminiscences of Dr. Spurzheim and George Combe; and a Review of the Science of Phrenology from the Period of its Discovery by Dr. Gall to the Visit of George Combe to the United States, 1838, 1840 (New York: Fowler and Wells, 1881), 86-87.

34 Horace A. Buttolph, “The Relation Between Phrenology and Insanity,” American Journal of Insanity 6, no. 2 (October 1849): 127; Franz Joseph Gall, On the Functions of the Brain and of each of its parts: with observations on the possibility of determining the instincts, propensities, and talents, or the moral and intellectual dispositions of men and animals, by the configuration of the brain and head, trans., Winslow Lewis (Boston: Marsh, Capen & Lyon, 1835).
skulls. This division of the intellect into faculties encouraged the notion of individuality in insanity. One faculty may be diseased in one patient but not in another leading to individualized treatments for patients based on their personal needs. Horace A. Buttolph, Superintendent of the State Lunatic Asylum in Trenton, New Jersey, wrote in 1849 that “phrenology has assisted to elucidate and more fully to establish the correct system of moral treatment of the insane, than any and all former systems of mental science.” Phrenology provided all the scientific justification that superintendents needed to make moral treatment a legitimate method of healing. By declaring that the soul remained intact even after reason had vanished, phrenology defended moral therapy’s concern for healing patients as well as caring for them.

Based on these phrenological principles nineteenth-century moral therapists defined insanity as “a chronic disease of the brain, producing either derangement of the intellectual faculties, or prolonged change of the feelings, affections, and habits of an individual.” Since insanity was a disease of the brain, or intellect, moral treatment could affect the disease in a positive manner. The prolonged change of feelings, affections, and habits of an individual could be restored to their proper existence. More practically, less theoretically, phrenologic principles were woven throughout discussions of the prevention, diagnosis, and treatment of mental illness to bolster superintendents’ insistence on the immersion of patients into a therapeutic environment.

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35 There are unsubstantiated accounts, from blogs and various websites, that physicians for the insane used conformateurs as a way to map the contours of their patient’s skull. See Figures 10-13.


Curing insanity was not the only aim of moral therapists who supported phrenology; they also sought to prevent insanity. Having phrenological analysis done, while a patient was healthy, could provide enough guidance for people to maintain the balance and sanity of their intellect. Buttolph asserted that proper education, good breeding, and good hygiene could intellectually and medically allow for the prevention of insanity.  

Phrenology became so popular among lay people that it became the subject of lectures and skull readings. These readings were much like a palm reading in the sense that a practicing phrenologist would examine his patron’s skull and tell them what characteristics defined their behavior. In 1849 the poet Walt Whitman even had a phrenological analysis done which he then reproduced in the second edition of *Leaves of Grass* (1859). By encouraging public awareness of phrenology, physicians were able to educate the public on the topic of moral therapy and their goal of creating a utopia for the mind; the widespread acceptance of a foundational tenet of moral therapy made the public more receptive to the notion that insanity was curable.

As the belief that insanity was curable became an accepted fact for nineteenth-century Americans, physicians had to define moral treatment. In the words of Doctor Rufus Wyman, Superintendent of the McLean Asylum for the Insane in Massachusetts, moral management should afford agreeable occupation. It should engage the mind, and exercise the body; as in riding, walking, sewing, embroidery, bowling.

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38 Buttolph, “The Relation Between Phrenology and Insanity,” 129.

39 Mechanic’s Hall, Monday Evening, at 7:30, Free. Prof. O. S. Fowler, On Phrenology and Physiology (Worcester, Massachusetts: s.n., 1875?).

40 Gamwell and Tomes, *Madness in America*, 89.
gardening, mechanic arts; to which may be added reading, writing, conversation, &c., the whole to be performed with order and regularity. Even the taking of food, retiring to bed, rising in the morning and at stated times, and conforming to stated rules in almost everything, is a most salutary discipline.  

By removing the chains of the insane and replacing them with a structured asylum, mental amusements such as gardening could induce habits of self-control in patients leading to sanity. In this constructed environment the grounds of the asylum provided a safe, although limited space for patients to move around in and enjoy nature. Meanwhile, the asylum itself allowed for the classification of patients according to their disorder, which in turn allowed for improved individualized care. Medicine and restraint coexisted with environmental determinism in the moral asylum to aid physicians when amusements failed.

Asylums went so far as to include schools and small museums in their plans to further the mental engagement and education of their patients. In diary extracts published in the *American Journal of Insanity* a patient under the care of Amariah Brigham, Superintendent at the New York State Lunatic Asylum, described a cabinet of curiosities kept on the institution’s grounds. This patient relates how one afternoon “Dr. B” took several of the patients to the museum which contained “many good picture, minerals, especially ores of metals and collections in natural history.”  

There were Indian relics, large assortments of ancient and modern coins, and even the head of an Egyptian mummy. Such a description mirrors the contents of many museums and smaller cabinets of curiosities from the mid-nineteenth century which often focused on natural history and

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41 Rufus Wyman, *A Discourse on Mental Philosophy as Connected with Mental Disease, Delivered Before the Massachusetts Medical Society, June 2, 1830* (Boston: The Daily Advertiser, 1830), 24.

the classification of specimens.\textsuperscript{43} The purpose of such displays was to democratize knowledge and ensure that every class of citizen was educated. By adding small museums to asylums, physicians were extending traditional assumptions of the importance of knowledge to peoples previously ignored by intellectual pursuits.

The world written about and developed by physicians for the insane was ideal. In the moral asylum, much like in a museum, everything was in its proper place correctly classified and treated. The abnormal became the normal and the unnatural was so immersed in the established social customs of nineteenth-century society that insanity was no longer something to be feared. What the physicians sought so desperately to create was a utopia for the mind, a place where the most refined, educated aspects of mainstream culture could reside to heal all that did not fit, all that was anomalous. The reality of insanity railed against this utopian vision to create a world where the necessity of restraint and medicine was masked, at least for a short while, by planned gardens and grandiose architecture. No matter how hard moral physicians tried though, they were never able to fully realize their theoretical plans for moral therapy.

\textsuperscript{43} For further information on nineteenth-century museums see Steven Conn, \textit{Museums and American Intellectual Life, 1876-1926} (Chicago: University of Chicago Press, 1998).
Utopian Setting

The moral treatment movement resulted most visibly in the construction of asylums. Initially most American asylums were private institutions supported by funds from wealthy individuals and charity organizations. Their clientele was therefore composed of predominately wealthy patients who could afford to pay fees for their care. The insane poor could be admitted to these private asylums but they were far fewer in number and supported by state subsidies. Beginning in the 1830s state governments began to fund the construction of asylums which allowed for greater numbers of insane poor to receive professional attention. By the end of the nineteenth century, state and federally funded public asylums outnumbered private institutions. Regardless of the source of funding or the clientele for asylums, their superintendents all supported similar interpretations of moral therapy.

Because of superintendents’ enthusiasm for the moral therapy movement monolithic structures of both private and public asylums came to dominate the American landscape and provided a haven for the rich and poor insane. Many of these original asylums have been torn down, altered, or left to ruin making a study of their situation a process of examining textual evidence rather than the completed object. Blueprints and illustrations abound allowing for the words of physicians to be compared to the real life renderings of their thoughts. Through such study it is possible to see that the physical world of the asylum tried, and largely succeeded, in matching the written, theoretical treatises of the physicians. Reality did have constraints though, and physicians did vary their realization of the utopian ideal.
In 1851 the Standing Committee of the Association of Medical Superintendents of American Institutions for the Insane published 26 proposals in the *American Journal of Insanity* that outlined the requirements of moral asylum construction. They detailed everything from the floor plan of the building to the types of material that should be used to construct floors, stair rails, windows, and vents.\(^{44}\)

These instructions indicate that the first rule of asylum architecture was the necessity of situating the building several miles outside of a city or a town on scenic property. According to Thomas Kirkbride, superintendent of the Pennsylvania Hospital for the Insane, one of the greatest errors in the history of the asylum was the location of these institutions within the limits of large cities or in their immediate vicinity.\(^{45}\) In America the rapid industrialization of the nineteenth century and subsequent urbanization led to a pollution, epidemics, and a growing fear of disease caused by city air. This fear represented the popular concept of miasma theory which postulated that the vast amounts of rotting animal and vegetable material in overcrowded cities released harmful poisons into the air which could cause every type of illness including insanity.

The rural situation of asylums was paramount in keeping the diseased mind away from the harmful poisons of city air. Additionally, a rural setting for asylums allowed for the large acreage needed for agricultural laborers, pleasure gardens and scenic views.\(^{46}\) Buttolph agreed with this assessment and further described the ideal setting for an

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\(^{45}\) Thomas S. Kirkbride, “Description of the Pleasure Grounds and Farm of the Pennsylvania Hospital for the Insane, with remarks,” *American Journal of Insanity* 4, no. 4 (April 1848): 350-351. See Figure 14.

\(^{46}\) Kirkbride, “Description of the Pleasure Grounds and Farm of the Pennsylvania Hospital for the Insane, with remarks,” 352.
asylum: “The building itself should be placed on a gentle eminence…and at a convenient
distance from some market town…yet not so near as to subject the patients when abroad
to the annoying gaze of the idle and curious. The surrounding scenery should be
agreeably diversified with hill, valley and lawn.”

Ample land for cultivation and recreation was an indispensable part of the
landscape. Superintendents recognized that a chief source of restlessness and irregularity
of conduct in their patients came from want of mental and bodily occupation. Further,
physical activity and occupation could restore reason in a diseased brain by providing
patients with a distraction from their situation. Gardening, walking, and sports were
logical choices for curative diversions. Once idle minds were put to work, the behavior
that had warranted excessive use of mechanical restraints in old asylums would
disappear; regulated activity in a moral asylum became a restraint.

The pleasure grounds of the asylum were the principal site of these engaging
outdoor activities and they tended to be divided by gender just as women were housed
separately from men within the asylum. Gardens for women were filled with flowers,
while men were provided with plots of land fertile and large enough to grow vegetables.
Each gendered side had private airing courts for patients who required more privacy as
well as larger, more open areas that encouraged socialization. Walkways wound
themselves through the grounds on both the male and female sides often reaching a
distance of at least one mile.


During Kirkbride’s tenure as superintendent, the walkways at the Pennsylvania Hospital for the Insane were arranged with an eye dedicated to detail. Great pains were taken so that patients could have as much extent and variety of views as possible while ambling through the grounds. Engaging scenery was just as important in occupying the mind as physical activity. Another part of the cultivated landscape of moral asylums were farms, greenhouses, and workshops that provided extended space for patients to labor. These sites, like the gardens and walkways, supposedly helped to focus the mind and re-teach patients how to behave in everyday life.

Asylums themselves were the keystone of nineteenth-century moral therapy. Without a properly built institution the care of the insane would be insufficient to actually cure any mental illness. Order, safety, and cleanliness created a comfortable, homelike environment where the mind could be put at ease and focus on regaining its reason. According to the most prominent American superintendents, “[t]he objects to be accomplished by architectural arrangement are, the entire separation of the sexes, their classification, so that persons with one form, and in one state of disease, may not interfere with the comfort or recovery of others; and lastly, the easy and thorough inspection of the whole house by the medical and other officers.” These guidelines referred more to the final goals of the architecture rather than the form of construction which led to a degree of variation in asylum planning during the first half of the nineteenth century.

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49 Kirkbride, “Description of the Pleasure Grounds and Farm of the Pennsylvania Hospital for the Insane, with remarks,” 350.

50 See Figure 15.

Typically, asylums stood at the center of the manicured lawns and active gardens. There was to be a central building which housed the superintendent, his family, employee offices, and often a chapel and school room. From this point, early construction methods varied. The Sheppard Asylum, designed by architect Calvert Vaux in 1861, followed an L-shaped plan with wards extending in two perpendicular wings. The presence of wards, with their own dining rooms, reading rooms, and bathrooms allowed for the classification of patients according to symptoms as well as the removal of the most violent patients to a “noisy ward” located at the end of one wing.

Conversely the State Lunatic Asylum at Utica, New York, built in the 1840s, followed a quadrangle plan which appears like a hollow square when viewed from above. There was one long facade with a central building—housing the superintendent and offices—and two wings. Two more wings extended perpendicularly from the back of this long facade and continued to wrap around an enclosed courtyard. Gardens, courtyards, and clothes yards were located on the outside of this square building allowing for the separation of the sexes and ample space for enjoying nature. The construction of the Utica Asylum took a different shape than the Sheppard Asylum but both structures met the requirements of moral construction by providing practical, classified space.

The individualized nature of asylum construction came to an end in 1854 when Thomas Kirkbride published *On the Construction, Organization and General

52 See Figures 16-17.
54 See Figure 18.
Management of Hospitals for the Insane. This work consolidated decades of information on construction and landscape design for the specific purpose of instructing superintendents on how to build the proper moral asylum. Once Kirkbride compiled this list, the majority of asylums in America were built following what was aptly named the Kirkbride Plan.

Like previous institutions for the insane, Kirkbride asylums were centered on the asylum grounds. The building itself was bilaterally symmetrical with men and women separated by a central building, or pavilion, that housed the superintendent, other physicians, attendants, their families, offices, and reception rooms for patients and their visitors. Patients were housed on wings extending from the sides of this central building that were each set back from the one before it causing the footprint of the building to have a shallow V-shape, almost like a bird in flight.  

This scheme allowed for the categorization and housing of patients according to their specific disease; louder, more violent patients would be in wards further away from the central building and quieter, calmer patients would be in closer wards. Superintendents used the division of wards between different categories of disease to threaten patients with transfers based on their behavior. This act itself prompted some patients to behave well enough that mechanical restraints were unnecessary. Although each ward differed in its human element, the actual construction of each one was identical to the others. The Association of Medical Superintendents of American Institutions for the Insane said that each ward should have a parlor, a corridor, single

See Figure 19.

lodging rooms for patients, an associated dormitory, a chamber for two attendants, a clothes room, a bath room, a water closet, a dining room, a dumb waiter, and a speaking tube leading to the kitchen or central pavilion. Superintendents hoped that providing patients with as many creature comforts as possible would lead to a structured routine that could lessen the occurrence of violent or excited behavior.

Throughout the era of moral treatment, superintendents had a near obsession with the technical aspects of asylum construction. Their treatises on moral therapy included extensive plans for heating and ventilating the building in an attempt to provide comfort for their patients. In an 1845 article for the *American Journal of Insanity* Luther Bell, superintendent of the McLean Asylum detailed the value of having decent heating and ventilation apparatuses. They provided a “pure atmosphere” and enhanced the “cheerful countenances, the vigorous circulation,” and general happiness of patients. Like Bell, Kirkbride saw merit in paying attention to the smallest detail of asylum construction. In *On the Construction* he provided descriptions of materials for the walls, plastering, locks, window screens, water pipes, and plans for dust flues.

This fascination with the mechanical may appear to distract from the actual treatment of the insane, but for moral therapists it was essential. Detailed landscapes and smoothly running facilities meant that better care could be given to specialized needs. Instead of patients being distracted by the pain of their confinement, the moral asylum

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59 See Figure 20.

60 Bell, “Modern Improvements in the Construction, Ventilation and Warming of Buildings for the Insane,” 22-23.
allowed for the refinement and reeducation of their minds in a way only possible in a constructive environment free from abuse and mental repression.
Dystopian Reality

Based on the humanitarian reform of moral therapy and its creation of idyllic institutions, it was easy for moral therapists to believe that they had founded an enlightened system that revolutionized the treatment of the insane; in many ways they had. In describing European asylums prior to moral treatment, British physician Robert Hill declared that the inmates of lunatic asylums had been treated like “the savage and untameable (sic) beast of the forest.” A London physician, John Conolly, wrote that eighteenth-century asylums had been prisons of the worst description in which troublesome beggars, vagabonds, and harmless maniacs were imprisoned in dungeons, whipped out of their madness, “always half famished, often starved to death.”

Physicians in the nineteenth century desperately sought to rectify these tales through the construction of the moral asylum but as late as 1843 they were noting that their institutions for the insane had not entirely replaced the almshouse and the jail as homes for the mentally ill. R.C. Waterston wrote about a “poor Lunatic who has been chained [in an almshouse] for the last twenty years” only a few miles outside of Boston, Massachusetts. This lunatic had an “iron bracelet...screwed about each ancle (sic), while both feet have been so frozen that nothing but stumps remain.” At this same time there were more than twenty mentally ill people held within cells at a Massachusetts jail.

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Delivering the cry of moral therapists, Waterston asked: “What crime have they committed? Why should they be there?...The thief is condemned for a stated time, and with a series of months or years comes his release. But when does the Lunatic gain release? Not until he is cured; and the very manner of his confinement is a guarantee that that can be, never.” Waterston’s statement reflects the underlying assumption of moral therapy: insanity could never be cured in chains, thus the emphasis on a healing environment. Theoretically this meant complete rejection of mechanical restraints and improved use of medicine. Just because superintendents unchained madmen, however, did not mean that these patients stopped behaving irrationally or violently. How, then, could superintendents humanely control aggressive people whom the asylum environment failed to calm? This question incited extensive debate over the use of medicine and mechanical restraints in moral treatment and the realization that the utopian ideal for asylums was unobtainable.

Of the two dystopian qualities practiced in the moral asylum, medicine was the least contentious. The principles of phrenology dictated that insanity was a disease of the mind cured by the structured environment. Physicians, however, recognized that there were often other diseases that accompanied insanity which could only be treated through the application of drugs. This separation of intellectual disorders from diseases of the body meant that moral therapists could justify using medicine by declaring its detachment from moral treatment. In 1847 Buttolph wrote that “[t]he treatment [of insanity] is properly divided into medical and moral; the former, including the use of medicine, baths, regulations of diet, &c., the latter, all those means and influences brought to bear

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upon the person in his new situation.”66 This new situation included all aspects of moral
treatment: association with others, employment, exercise and amusements, rising and
retiring, habits of order and cleanliness, and attendance at religious services.67

Medical treatment, like moral treatment regimens, was tailored to the patients and
their needs. As early as the first publication of the American Journal of Insanity in 1844,
physicians recognized this and began detailing proper use of medicine as a component of
treatment. For each specific subset of insanity, and there were many, different tonics,
medicines, and treatments could be assigned to the patients for their moral benefit that
went beyond those available through architecture and landscape.68

The medical treatment of the insane closely aligned itself with the changes in the
general field of medical practice. From the eighteenth century through about the mid-
nineteenth century physicians of all kinds had practiced what is called heroic medicine.
Heroic medicine entailed copious bleeding, purging, and blistering.69 Traditionally it was
believed that such measures emptied the body of harmful substances and restored a
balance of the humors.

66 Buttolph, “Modern Asylums: and their Adaptation to the Treatment of the Insane,” 375; In 1850 John
Allen repeated this claim when he wrote, “Insanity being a disease involving the organ on which moral and
intellectual manifestations depend, its treatment has very properly been divided into moral and medical.”
See John Allen, “On the Treatment of Insanity,” American Journal of Insanity 6, no. 3 (January 1850): 266.

67 Buttolph, “Modern Asylums,” 375; Thomas S. Kirkbride, “A Sketch of the History, Buildings, and
Organization of the Pennsylvania Hospital for the Insane,” American Journal of Insanity 2, no. 2 (October
1845): 112.

American Journal of Insanity 4, no. 3 (January 1848). Some of the causes of insanity included: Hereditary
predisposition, intemperance, syphilis, use of opium, epilepsy, gun-shot wound, bodily exertion, fever,
dyspepsia, small-pox, pregnancy, lactation, abortion, and hysteria, religious excitement, remorse, home-
sickness, application to study, anxiety, mortified pride, faulty education, seduction, novel reading and
dealing in lottery tickets.

69 Paul Starr, The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the
As the nineteenth century wore on moral therapists began to doubt the effectiveness of heroic measures claiming that they resulted in patient weakness, increased risk of infection, and even death. They lessened their acceptance of bleeding and purging in cases of insanity and relied instead of the growing field of pharmacology and hydrotherapy to produce drugs and restorative measures useful in the treatment of insanity. Medical treatments varied from asylum to asylum based on the beliefs and education of the reigning superintendent. Some physicians, for instance, held on to the practice of bleeding much longer than others. Despite the flexible nature of this practice, physician John Allen provided a clear, general guide for using medicine in 1850 which reveals some of the tensions involved with marrying medical practice to moral therapy. In “On the Treatment of Insanity” Allen divided medicinal treatment not by ailment, but by procedure. The categories he used were purgatives, emetics, narcotics, antiphlogistics, and water. Purgatives, emetics, and narcotics were all drugs that were administered to patients while antiphlogistics and water were therapies, applied to patients that supplemented the therapy available through general asylum construction.

The first drug advocated by Allen was purgatives. Purgatives are laxatives that were used to rid the body of perceived harmful substances. Allen claimed that their use was generally approved by superintendents. Due to their acceptance, Allen went through a listing of the most common purgatives. For early, severe stages of insanity, moderate purgatives were needed such as Calomel and Jalap, Cook’s Pill, and Senna.


72 William Holloway, Calomel, Its History, Properties and Uses, Inaugural Dissertation Presented to the University of Maryland for the Degree of Doctor of Medicine, 1846; “Report Made to the Royal Academy
For mild purgation, in cases of moderate excitement, rhubarb and aloetics acted well.\textsuperscript{73} However, “[d]rastic purgatives are particularly objectionable in lunacy, from the fact that such persons are peculiarly liable to chronic diarrhoea.”\textsuperscript{74} The Journal increasingly objected to the use of heroic medicines although they supported their use in moderation.

Emetics, the second drug, were similarly helpful in treating insanity because, like purgatives, they caused the body to emit harmful substances through vomiting.\textsuperscript{75} Allen opens the section on emetics by making a declaration of usefulness and acceptance similar to the one he adopted for purgatives.\textsuperscript{76} Some physicians objected to their use because of the increased flow of blood to the head during the effort of vomiting which could be particularly harmful where there was “fullness of head or great plethora.”\textsuperscript{77} Allen calms these fears by insisting that he had only ever had success through the use of

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\bibitem{planche} Planche, M., \textit{A History of Medicine}, in the Name of a Committee, Upon a New Jalap Proposed by M. Le Danois as a Substitute for Official Jalap,” \textit{American Journal of Pharmacy} 4, no. 3 (October 1838): 223; Kento Takayama, Hiroyuki Tsutsumi, Takashi Ishizu, and Nobuyuki Okamura, "The influence of rhein 8-O-β-D-glucopyranoside on the purgative action of sennoside A from rhubarb in mice," \textit{Biological & Pharmaceutical Bulletin} 35, no. 12 (2012): 2204-2208. MEDLINE, EBSCOhost (accessed March 11, 2014). Calomel is also known as mercury chloride and no longer used as a medicinal aid. Jalap is a species of flowering plant native to Mexico. When the root of the plant is digested it causes the emptying of the bowels, and a loss of body water. Physicians no longer support the use of Jalap. Senna is another flowering plant which has been used in folk medicine for centuries. Some modern medicines still use the leaves of the Senna plant to induce bowel movements but physicians recommend short-term use because long-term use has been associated with organ failure. No information could be found on Cook’s Pill. See Figure 21.

\bibitem{daniels} Daniels, M., “On the Treatment of Insanity,” 275. Rhubarb has been used all over the world as a mild laxative for centuries. It is still used for this purpose although it is more popularly digested as a food. Aloetics refers to any of the plants in the genus Aloe. The laxative form of aloe is obtained from the processed juice of the aloe plant.

\bibitem{daniels2} Daniels, M., “On the Treatment of Insanity,” 276.

\bibitem{daniels3} See Figure 22.

\bibitem{daniels4} Daniels, M., “On the Treatment of Insanity,” 276.

\bibitem{daniels5} Plethora refers to an excess of blood in the body.

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emetics, particularly “an emetico-cathartic, as an initiatory step in the preparation of cases for a subsequent course of narcotics or tonics.”

Narcotics were the third drug advocated by Allen. He acknowledged that various opinions existed on this particular subject, but his own experience had impressed him favorably as to their use. He does note that Doctor Isaac Ray, the founder of American forensic psychiatry, did not like the use of narcotics due to their addictive properties. In the end, though, Allen concludes that narcotics could be very helpful especially in delivering the effects of “general quietude, indications of drowsiness, nodding and occasional naps.”

The medical treatments, or therapies, supported by Allen proved to be more controversial than the drugs. Antiphlogistic treatments served to reduce fever. The most common method used was localized bleeding. This could be done by cutting open the patient’s skin with a lancet or by cupping. Cupping was more involved, but arguably more humane. It worked by placing a heated cupping glass on the patient’s skin to create a vacuum which brought blood to the surface. The cup was then removed and a scarificator was placed on the area to cut a series of parallel lines in the skin. A second cup was then placed on the same spot to draw and collect the blood.

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81 See Figure 23.

82 See Figures 24-27.
In citing Pinel, Allen makes it clear that excessive bleeding had no positive effect on insanity. 83 Local bleeding, however, was generally accepted because it served to cure other diseases that could coincide with insanity. 84 Not every physician agreed with this assessment leading Pliny Earle, superintendent of the Bloomingdale Asylum, to publish a collection of speeches, quotes, and articles on the subject titled *An Examination of the Practice of Bloodletting in Mental Disorders*. In this collection, Doctor Samuel Woodward, superintendent of the Massachusetts State Lunatic Asylum, is quoted as declaring that moral therapists were generally opposed to general and localized bleeding, a declaration not supported by Allen. Woodward notes that general bleeding in cases of insanity “rarely affords more than temporary relief, and frequently produces injurious effects... But even local bleeding can rarely be relied upon to cure insanity. It is usually prescribed to procure present relief, rather than with the expectation of permanent benefit.” 85 This dispute between Allen and Woodward reveals the contentious nature of heroic treatment within the moral asylum. Bleeding invaded the body and weakened the patient, but in some cases physicians saw positive effects from the practice. Because of the disputed benefits of antiphlogistics many physicians concluded that moderation in medicinal treatments was necessary as a secondary form of therapy.

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Allen next supported the use of bathing, or repeatedly immersing patients in hot or cold water to restore the senses.\textsuperscript{86} The use of water as a method of medical therapy was controversial. Physicians in all fields of medicine recognized the positive effects of cold water on reducing fevers and the effects of hot water to increase circulation and encourage the release of toxins through sweating. Rooms entirely devoted to bathing were a requirement of the moral asylum because of these benefits.\textsuperscript{87} Not only did water prove medically useful for the patients but it was hygienic.

Mild use of water to treat fevers and clean patients was a general, non-contentious part of moral therapy. Issues arouse, however, with the bath of surprise and the cold douche. The cold douche was a form of local bathing in which a stream of cold water fell from a height upon the head of an agitated patient. The bath of surprise was similar to the douche but involved suddenly, and without warning, immersing patients in cold water followed by hot water. Many physicians believed that this would calm down the most excitable and violent patients by shocking them into reason. Patients did not like this practice and viewed the use of extremely hot and cold water as a form of punishment.\textsuperscript{88} Some physicians agreed with this assessment, but saw no harm in using the bath of surprise and cold douche as a punishment rather than a cure.\textsuperscript{89} Rush, for example, was fond of pouring icy cold water down the sleeves of patients as an explicit form of

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\textsuperscript{86} Bathing was referred to as hydrotherapy in the second half of the nineteenth century. Moral physicians writing between 1840 and 1870 did not use the term ‘hydrotherapy’ which is why this paper calls the practice ‘bathing.’
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\textsuperscript{87} J.H. Worthington, “On the Construction of Baths, and the Utility of Warm and Cold Bathing in the Treatment of Insanity,” \textit{American Journal of Insanity} 7, no. 3 (January 1851): 211-212. See Figure 28
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\textsuperscript{88} Ebenezer Haskell, \textit{The Trial of Ebenezer Haskell, in Lunacy, and His Acquittal Before Judge Brewster, in November 1868} (Philadelphia: Ebenezer Haskell, 1869), 43-44. See Figure 29.
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punishment and Allen admitted that “as a means of positive punishment, nothing is equal to the cold bath, as used in the *douche*, bath of surprise, &c.”

A common theme in Allen’s discussion of these various medical practices was an emphasis on use through moderation. He clearly favored and endorsed the methods described above but he was aware of the criticisms against them as well as the pitfalls of using any one method of treatment extensively. The acceptance of heroic medicine was increasingly questioned in the moral asylum. Even Allen, who approved of their careful use, cautioned physicians away from a sole reliance on these practices.

While the improper use of these medical treatments, which included both drugs and therapeutic methods, could do more harm than good, they were still of use in treating insanity. Unfortunately for the utopian ideal of moral therapy, the acceptance of medicine led to a growth in its popularity over that of the healing environment. In 1857 M. H. Ranney read a speech before the Association of Medical Superintends of American Institutions for the Insane which read:

> In thus presenting my views it must not be understood that I advocate entire reliance on medicinal agents in the treatment of insanity. The adoption of proper hygienic rules is essential, as in physical disease generally, Moral treatment, including employment, amusements, the establishment of regular habits, &c., is also a most important auxiliary to recovery. But while admitting the importance of moral treatment, I would avoid an over-estimate of its mechanical part, and carefully investigate not only the laws of physical action, but the influences of medicine on the manifestations of mind, that our noble profession may not become simply an art.”

In this one statement Ranney encompasses several trends in the larger asylum movement.

By the 1860s younger physicians were growing increasingly doubtful of moral therapy’s

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emphasis on environmental determinism. In its place they sought to practice more advanced medicine than the heroic treatments and therapies of their predecessors.

While moral physicians managed to tenuously adapt the use of medicine to fit within their constructed worlds they struggled to do the same with mechanical restraints. Moral therapy had been founded as a reaction against the use of brutality towards the insane leading physicians to theoretically oppose all use of restraints in their institutions. Reality, however, showed many physicians that violent patients could not be controlled simply by their surroundings. This led to the ultimate acceptance of limited restraints in American asylums, but not without heated debate and a reluctant acknowledgement that the world of the moral asylum was imperfect. When even minimal restraints were used in the moral asylum, they illuminated the shortcomings of environmental determinism.

Early in the nineteenth century physicians were quick to realize that restraints needed to be used in asylums and set about determining which ones were the most humane. In 1818 George Parkman, a young man from Boston who had studied under Rush and Pinel, provided a description of the most widely used and accepted forms of mechanical restraints that he observed in moral asylums.92 One of the many devices he discussed was the canvass-strait-jacket, or strait waistcoat. The canvass-strait-jacket was described as having “the lower parts of the arm-pockets sewed very strongly, the back held together by buckles and wide straps, the botom (sic) secured round each thigh by a strap or string.”93 Such a jacket was the best way to confine the upper extremities of a patient.

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92 See Figures 30-31.

93 George Parkman, Remarks on Insanity, (Boston: 1818), 9.
There were, in addition, other devices that Parkman deemed less “heating and irritating” for the patient. Thick leather mittens were used to confine the hands which were secured around the “wrist by a wide and strong strap.” 94 A rope could be attached to a metallic ring on either mitten and then tied to a staple in the floor to further limit the patient’s movement. Ankles and feet could be confined by thick leather straps which, like the mittens, could be tied to the floor near the feet. Parkman noted that if more extensive restraints were needed, patients could be placed in a chair with leather straps wrapping around their chest and thighs. 95

Each of these straps was made of leather or cloth making them less abrasive than metal chains, aiding the perception that they were more humane than manacles used in the old system. Some superintendents completely rejected the practice of fastening the cords of mittens to a staple in the floor, but they still used the mittens when it was necessary to control the movements of patient’s hands. Behavior such as self-injury, violence toward others, masturbation, or feces-smearing warranted the application of such mechanical restraints. 96

Parkman’s straightforward listing of restraints belies the intense debates surrounding these objects. On one end of the spectrum stood superintendents who believed in a system of complete non-restraint. In 1843 the McLean Asylum in Massachusetts claimed that “strait waistcoats, handcuffs, and chains are all laid aside, and it is found that order is most successfully preserved under affectionate treatment.” 97 It

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94 Parkman, Remarks on Insanity, 9.
95 Parkman, Remarks on Insanity, 10.
96 Gamwell and Tomes, Madness in America, 46.
97 Waterston, The Condition of the Insane in Massachusetts, 8.
was important to let the patients know that they would be treated like humans in the asylum, rather than animals. The McLean Asylum sought to show through practice that good behavior was more likely to arise from gentle treatment and a sense of freedom among the patients, than from chains.

Similarly, in an address on insanity before the New York State Medical Society, Samuel White said that no restraint should be used in moral treatment beyond that which was necessary to ensure the safety of the patient and the safety of those around them.\(^{98}\) Although this technically left room for some restraint when safety was concerned, White also said that manacles were ill adapted to facilitate the healing of insanity: “You cannot chain the human mind, nor cure a patient in chains.”\(^{99}\) With this short statement, White, like Pinel, was calling into question the traditional precedent that insanity meant a complete loss of humanity. He was denouncing the customarily indisputable policy of relying on mechanical restraints to deal with the lunatics of his generation.

Many of these ideas came from Europe which, with its longer history of institutionalization, had a head start on scholarship dealing with issues of control in moral asylums. In his address before the New York State Medical Society, White cited several European physicians as inspiration for his work in non-restraint, most notably the English psychiatrist John Conolly. Conolly wrote several important texts on moral treatment including *The Treatment of the Insane without Mechanical Restraints* (1856). This work laid out various steps meant to ensure that an asylum adhered to the strictest notions of non-restraint. Conolly’s first step was to remove any restraints that confined patients

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\(^{98}\) Samuel White, *Address on Insanity Before the New York State Medical Society* (Albany: 1844), 15.

\(^{99}\) White, *Address on Insanity Before the New York State Medical Society*, 15.
when they arrived at an asylum. After this had been done it was important to clean the new patients well, make sure they had good hygiene, and were well nourished. In some instances, these actions alone could be enough to cure insanity.\textsuperscript{100} If patients did become violent, physical interaction with them had to be quick and minimal. Even here, when the attendant was required to control the patient, Conolly prohibited the use of restraints. The best thing for the attendant to do with violent patients was to “[q]quickly drop them on a soft bed or in the padded room until they can calm themselves down.”\textsuperscript{101}

Conolly was a strong advocate of padded rooms. These rooms were entirely covered by wooden frames, padded with fabric stuffed with cocoa-nut fiber, which were affixed to the four walls and floor of the space.\textsuperscript{102} Only patients who were excessively unstable or violent were to be confined to these rooms. If additional restraint was necessary, then a strait jacket was placed on the patient. Once in the room, mastery over reason was up to the patient; such self-discipline was essential to the effectiveness of moral treatment. Instead of the attendant or superintendent controlling and dominating the actions of a mentally unstable person with mechanical restraints, the mind was motivated to learn to control itself.

Conolly’s main argument in favor of padded rooms was that without such spaces it was easier to resort to violence to control an excited patient. He noted one example of a young woman affected with acute mania who was “forcibly undressed, fastened down on loose straw, had strong medicine forced down her throat, and was then left and neglected for many hours...Sickness and purging were produced by the medicine; and she was

\textsuperscript{100} Conolly, \textit{The Treatment of the Insane without Mechanical Restraints}, 38-39.

\textsuperscript{101} Conolly, \textit{The Treatment of the Insane without Mechanical Restraints}, 46.

\textsuperscript{102} Conolly, \textit{The Treatment of the Insane without Mechanical Restraints}, 44.
permitted to lie for twelve hours in a state of indescribable distress.” Conolly maintained that this occurred because there had been no padded room in which she could calm herself down.

Many of Conolly’s notions of non-restraint drew from the earlier practice of fellow British physician Robert Gardiner Hill. Hill was the first and loudest advocate for the exclusion of all restraints from asylums. In a lecture delivered at the Mechanics’ Institution in England, Hill asserted “that in a properly constructed building with a sufficient number of suitable attendants, restraint is never necessary, never justifiable, and always injurious, in all cases of Lunacy whatever.” Moral treatment, with the goal of inducing habits of self-control, was “all and everything.” Properly enacted and followed, moral treatments rendered mechanical restraints obsolete because the regularity and humane discipline of moral asylums taught patients how to revive their own reason. Hill went on to say that the only reason restraints would ever be necessary would be due to imperfections in the asylum construction, or an insufficient number of good attendants.

Hill and Conolly’s notions of non-restraint were never fully accepted in America. Perhaps this was because America did not have a history of brutal treatment in institutions reserved for housing the mentally ill. Whatever the reason, most asylums utilized some form of mechanical restraints, at least in extreme cases of patient violence.

103 Conolly, The Treatment of the Insane without Mechanical Restraints, 48-49.


Even White acknowledged, in the same work in which he claimed a reliance on no restraints, that the use of a belt cast around the waist, wrist bands, and temporary seclusion were required at times as the only preventative measure against patients tearing their clothes and committing other mischievous acts in his institution.\(^{107}\) Thomas Kirkbride wrote that his attendants never employed restraints without his direct order with the caveat that nighttime restraints were invaluable for patients who became excited once the sun went down. Kirkbride even endorsed leather mittens and wristbands as a substitute for more restrictive restraints.\(^{108}\)

Instead of shackling a patient for life in iron, the mittens and strait waistcoat were temporary. Superintendents considered the application of leather restraints completely different from the old system that caged people in an attic. This opinion was held so firmly that Pliny Earle said in 1845 that “It is hardly necessary to remark that all these methods of confinement [manacles, and chains] have been entirely abolished.”\(^{109}\) Earle further noted that even the mittens and muffs were often superseded by the use of the camisole, or strait waistcoat, which was fairly comfortable for the patients to wear.\(^{110}\) The paradox of the moral treatment system was that superintendents regarded their actions as removing the chains from madmen, but they still found it necessary to use some measure of physical control to maintain order within the asylum.

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\(^{107}\) White, *Address on Insanity Before the New York State Medical Society*, 16.


\(^{109}\) Earle, “Historical and Descriptive Account of the Bloomingdale Asylum for the Insane.” 8.

\(^{110}\) Earle, “Historical and Descriptive Account of the Bloomingdale Asylum for the insane,” 8-9.
On the other end of the debate stood superintendents who argued that the emphasis and faith in a patient’s self-control was ill-placed; after all, the patients were insane. George Parkman, who supported the moderate use of restraints such as mittens and the canvas strait waistcoat, sometimes justified enacting harsher methods to control a patient. In a description of the management of lunatics, Parkman wrote that “so much less painful to suffer is judicious restraint than indulgence of extravagance beyond their control, they sometimes beg to be submitted to restraint, to supply want of self-control, and reclaim their freedom, when they feel relieved from the maniacal [or insane] impulse.”\(^\text{111}\) Sometimes, self-control was not within the realm of possibility for a patient, leaving the superintendent with an opening to increase the use of mechanical restraints.

Within the debate one object came to encompass both compassion and cruelty, two conflicting ideals that were woven into the very fabric of moral therapy: the crib-bedstead.\(^\text{112}\) As a physical object, the crib-bedstead has existed in several different forms with several different names. Most modern references refer to the object as the Utica crib after the bed’s American origins at the New York State Lunatic Asylum in Utica. Primary sources from the nineteenth century refer to the object as a restraining bed, enclosed bed, box-bed, locked bed, protection bed, crib, or crib-bed. Regardless of the name, every iteration of the bed followed a basic form: a trunk with semi-open sides.

Amariah Brigham, creator of the Utica crib and superintendent of the New York State Lunatic Asylum, provided a detailed description of the earliest and most


\(^{112}\) See Figure 32.
quintessential crib in an 1846 article for the *American Journal of Insanity.* According to Brigham, the Utica crib was made of pine and measured six and a half feet long, and three feet two inches wide. The interior space between the floor of the bunk and the lid measured fifteen inches. All inner edges were “smoothly rounded off to prevent abrasions by the patient rubbing against them.” The two longest sides of the Utica crib were covered in lattice, or wire mesh. Lattice was the favored material to cover the bed frame because it allowed light and air to enter the enclosed space. Rather than seemingly encaging a patient like an animal, the lattice was viewed as a humane innovation that made the crib seem less like a cage or crate. Brigham later removed the lattice in favor of wooden rungs, similar to stair banisters, because patients would rub against the sides of the crib in an attempt to abrade their skin.

Doctor William Wood, a medical officer of Bethlem Hospital in England, described a similar enclosed bed in the 1852 publication of *Winslow’s Journal of Psychological Medicine.* Like Brigham, Wood noted that the bedstead was essentially a crib with a lid, sometimes fitted with a mattress to cushion the enclosed patient. The lid needed to be “at a sufficient height from the top of the mattress to allow of free movements by turning from side to side, without touching the cross-webbing of the lid.” Although the cribs were in and of themselves a means to confine and constrain movement, their creators were explicit in their consideration of patient comfort. While

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115 See Figure 33.

these cribs prohibited sitting upright, they needed to allow room for the enclosed person to turn over and wiggle around.

Removable mattresses were common accessories to crib bedsteads. They added a touch of the humane to the necessary confinement of patients. Accounts of mattresses are more elusive than general descriptions of the crib frame and are often mentioned only in passing, but they were just as much a part of the crib as the lid.117 When used in crib-bedsteads mattresses could be made of a variety of materials. As Lauder Lindsay, superintendent of the Murray Royal Institute in Perth, briefly mentioned, his bedsteads could have a special or an ordinary mattress.118 There is no way to know for sure what this “special mattress” might have been but based on Lindsay’s fixation with practicality, this mattress could have been washable, easily portable, or perhaps even made in segments so that only the soiled portion of the cushion had to be removed and replaced. Reverend D. S. Welling argued against the use of an ordinary mattress in favor of straw. For Welling, straw was more practical material to use than cloth or any other filling, because it could be removed and thrown away if a patient dirtied it by relieving their bowels.119

Although mattresses added some physical comfort to patients enclosed in the cribs, they could also lessen comfort. Mattresses consumed space in an already limited area thus decreasing the amount of room available for patients to move around within the

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117 This may be attributed to the exotic nature of the crib bedstead. The general population of the nineteenth century knew what a mattress was whereas a crib bedstead was new and challenging.


cribs. This limitation reversed the humane standards of moral therapy that the cribs were intended to embody. Therefore, it was not uncommon for superintendents to vary the measurements of cribs built for their individual institutions in order to meet their particular standards of moral treatment. A crib used at Western State Hospital in Staunton, Virginia and currently on display at Colonial Williamsburg has an interior height of twenty-nine inches, which would provide more room for a mattress and a patient than Brigham’s fifteen-inch-high Utica crib. William Hammond, an American military physician, said that in some cases, the space within the “cage” did not exceed twelve inches, and was probably less. Regardless of these differences, cribs were always used to subdue or restrain patients regardless of comfort or space.

Physicians who perpetuated the spread of the crib argued that the necessity of such a device stemmed from the behavior of the patients. Despite the attempts of moral therapy to treat patients with minimal to no restraint, some individuals were simply too violent or ill-behaved to be treated without the use of some force. Superintendents recorded cases of patients who refused to sleep, walked around at all hours of the day and night, or smeared feces on the walls when unsupervised. Still other patients would squat in the middle of the floor and refuse to move which could cause blood clots or extreme stiffening of the legs. The most violent patients would sometimes throw themselves against the walls of their rooms in an attempt to commit suicide.

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120 Utica Crib, 1870-1910, oak and wire mesh, accession #1985-295, 1 (L), Colonial Williamsburg.


done to restrain such behavior for the benefit of the patient, and superintendents believed that the Utica crib was the perfect solution.

Honoré Aubanel, a French physician who created one of the first prototypes of the crib-bedstead, argued from the beginning that the abuse and restraint prevalent with the use of strait jackets, chains, and mittens, was “remedied, by placing the patient in a covered bedstead, where he can enjoy perfect freedom of motion, and is only prevented from rising.” When Brigham adopted the crib from Aubanel, he noted that the New York State Lunatic Asylum was very “gratified with its operation.” Practice seemed to support these positive claims. The crib managed to control patients in the same way that more overtly abusive tools did while perpetuating an image of humane treatment.

Lindsay provided the most detailed argument in support of the crib’s use in 1878. According to Lindsay, many patients did take issue with the crib, resenting being treated like children literally cribbed, cabined, and confined to a bed with sides and a cover. But these same patients resented “the simple deprivation of their liberty” upon their institutionalization; their qualms applied to every aspect of their situation, not just their placement in a crib. And at the most basic level, Lindsay argued that the insane were similar to children with the added power of greater strength and size. Just as “all parents are agreed as to the inexpediency of indulging children in all their whims,” so too would it be inadvisable to bow to the deluded wishes of the insane. The crib may not have been what the patient wanted, but by Lindsay’s reasoning it was what they needed.

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124 Brigham, “Aubanel’s Restraining Bed,” 188.
Indeed, it could save lives by preventing suicidal patients from throwing themselves against the wall.

Underlying these claims in favor of the crib was the belief that the object was not a mechanical restraint in the sense that it physically bound a person’s limbs to their body, even if it did restrict the movement of patients in such a way that unruly behavior was virtually impossible. In essence, the crib was a smaller, cheaper, more portable version of a padded room. The exact same treatment that was possible within a padded room was possible with the Utica crib. In fact, it was partially due to the absence of a padded room in his asylum that led Aubanel to build his first crib-bedstead. In 1845 Aubanel had “a suicidal patient, who, in his violent attempts at self destruction, several times rushed headlong against the wall.” This was a perfect patient to be placed in a padded room, but Aubanel had none, so he directed his attendants to watch the violent patient by day, and place him in the crib-bedstead at night.127

Self-destruction seems to have been the most common cause of patient placement in a crib-bedstead. This can be seen in the case of Norris Tarbell. On the night of November 25, 1859, Tarbell arrived at the New York State Lunatic Asylum in Utica then under the direction of Brigham. He was in a fit of mania, being restless, incoherent, noisy, and talkative. Attendants at the asylum immediately placed him in a crib-bedstead to try to calm Tarbell’s behavior. They quickly discovered that the crib alone was not sufficient to prevent Tarbell from injuring himself with his hands; he continually tried to mutilate his body. Because of his actions, the attendants took Tarbell out of the crib, placed him in a strait jacket and then put him back in the crib, much as English

physicians would do with patients in a padded room. Unfortunately, for the reputation of the Utica crib, Tarbell was discovered dead in the contraption only sixteen days later on December 11, 1859. An official ruling declared that the cause of death was pneumonia brought on by injuries that Tarbell sustained prior to his arrival at the asylum. Family members disagreed, arguing that it was the inhumane confinement in a crib bedstead that had caused Tarbell’s death.\textsuperscript{128}

The difference in Tarbell’s case from that of someone placed in a padded room is one only of size. In a padded room, even if they were confined in a strait jacket, patients had space to move around. They could roll around the floor, walk around the room, and lay in virtually any position they wanted. Conversely, patients in a strait jacket in a crib could only roll over on their sides. The freedom to sit up and move around was encumbered, if not eliminated by a crib. These issues became exacerbated as the time of confinement increased. Patients could be kept in a crib or a padded room for days at a time, or they could be confined for one night, or a few hours. The length of confinement varied case by case, but many physicians argued that enclosing a patient in a box, even in the form of a room, was more humane the larger the space. Physicians in England who favored padded rooms could therefore denounce the Utica crib without any obvious hypocrisy.

Although the Utica crib had substantial support from qualified American physicians, it still provoked extensive debate and outrage. The most vehement denunciations of the crib came from England where most asylums claimed to follow the

non-restraint system. Conolly declared that the crib was “an apparatus not only inhuman, but one which no person possessing a competent knowledge of the physiology of the brain and the pathology of insanity would venture to introduce into the wards of a lunatic asylum.” The crib was not only abusive in its own form, but Conolly argued that it was a supplement to other forms of subjugation like chains and strait jackets. He was not wrong in the sense that the crib was often used in conjunction with strait jackets or other apparatuses used to confine the hands. The irony is that Conolly was a proponent of the same mechanical restraints used within a padded room.

Many other physicians agreed with Conolly. Daniel Tuke noted that some patients benefited from the crib-bed, but “at the same time… [it] inevitably suggests, when occupied, that you are looking at an animal in a cage.” William Hammond extended this metaphor by directly comparing patients in a crib to wild lions “dashing themselves with violence against the bars.” Once the patients were removed from the crib, much like a lion released back into the wild, they “become entirely quiet and composed.” These physicians saw, personified in the crib, the very method of treatment they were reacting against from the eighteenth century. Physicians of the nineteenth century filled their writings with stories about the inhumanity and barbaric nature of confining people afflicted with insanity to cages, and yet, as Conolly, Hammond, and Tuke argued moral physicians who used the Utica crib were no better than their predecessors.

Patients themselves gave mixed responses to the use of crib-bedsteads. In most cases their voices are shrouded in the inherent biases of the sources that represent them.


130 Tuke, The Insane in the United States and Canada, 55.

Many patients either did not write memoirs or opinions on the subject, or if they had something to say, it was published through the mouth of superintendents. Quoting scripture, one old man from the New York State Lunatic Asylum declared his affection for the “excellent contrivance” which needed to be used “for all crazy fellows as I, whose ‘spirit is willing, but whose flesh is weak.’”\textsuperscript{132} This seems like a ringing endorsement for the crib, but it was included in the 1846 article by Brigham introducing the Utica crib to American physicians. There is no way to know if the patient actually said those words, or if Brigham was simply trying to encourage support for the crib. Similarly, there may have been another patient at the same asylum who insisted that his time in the crib had been horrific, but Brigham chose not to include that testimony for its direct opposition to the article’s purpose. Despite the conflicts that arise from such testimonies, it cannot be denied that they exist, and that some patients did experience the crib in a positive manner.

Other patients had more complex interactions with the Utica crib than the old man in Brigham’s article. For Francis Delilez, the crib represented different things at different times during his stay at the Northern Wisconsin Hospital in Winnebago, Wisconsin. Delilez wrote his memoirs in 1888 with the express intention of proving that to be insane is to be demonic, and to be demonic is to be insane.\textsuperscript{133} Throughout the memoir, Delilez referred to himself as “we” and proved that he continued to believe, at least partially, in the delusions that got him admitted to the asylum in the first place. Most simply, Delilez believed that he was a saintly figure, another patient was a false Christ whom Delilez believed to be the Christ reincarnate, and the attendants of the asylum were demons.

\textsuperscript{132} Brigham, “Aubanel’s Restraining Bed,” 188.

\textsuperscript{133} Francis Delilez, \textit{The True Cause of Insanity Explained or The Terrible Experience of an Insane, Related by Himself: The Life of a Patient in an Insane Asylum by a Patient of the Northern Wisconsin Hospital at Winnebago, Wis.} (Minneapolis: L. Kimball & Co., Printers, 1888), XII.
These three characters acted in concert with one another while in the asylum and laid out the stage for Delilez’s interactions with the Utica crib.

Most nights, the crib in Delilez’s room was simply a place to sleep. At one point he blandly stated that the keeper, or attendant, removed him to his room where he was put in a crib-bedstead to spend the night.\(^\text{134}\) Other times, Delilez showed ownership over this particular bed form by calling it “my crib.” Usually when he referred to it as such, Delilez also viewed the crib as a safe haven. He described one night when he had nightmares that terrified him. In this moment of terror the safest place for him was in the crib: “On entering my bedroom I said to re-assure myself: ‘But after all, they [the attendants] are going to lock thee up in thy crib-bed, and lock thy room door, no one can come and hurt thee herein.’ Then I got in bed. I offered a long prayer: then I slept.”\(^\text{135}\)

In direct contrast to this perceived safety, the crib could represent a form of punishment for Delilez. One evening, Delilez started singing and walking past the false Christ. An attendant told him to be quiet, but Delilez believed that he should “obey God rather than men.” He knew that “to sing aloud while this attendant commanded [him] to keep still was to incur a punishment certain and severe.” But believing that the false Christ encouraged his singing, Delilez continued to raise his voice even louder. The attendant again told him to stop. Delilez continued, so the angry attendant seized and struck him. Delilez still continued to sing. This was too much for the attendant who threw Delilez on the ground and strangled him until he stopped making noise. Once he was

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\(^\text{134}\) Delilez, *The True Cause of Insanity Explained*, 37.

\(^\text{135}\) Delilez, *The True Cause of Insanity Explained*, 63.
finally quiet the attendant locked him in his crib-bed with the express purpose of using it as a punishment.\footnote{Delilez, \textit{The True Cause of Insanity Explained}, 71-72.}

Based on Delilez’s account it is not difficult to view the Utica crib as a complex object. Sometimes the bed had no other purpose or deeper meaning than to act as a place to sleep, and yet at other moments it could be a safe haven or a place of punishment. For superintendents, who made it seem that they were either for or against its use, the crib represented a much deeper debate about the use of restraint in the moral asylum. In one sense, the crib was humane because it allowed the enclosed patient some freedom of movement while restricting violent behavior that could harm the patient or those around him. In another sense, the crib still acted as a cage in which to confine a patient. The reality of treating insanity pushed against the ideological notions of moral therapy to reveal that benevolent treatment was not always easy or possible.

When the moral therapy movement began, physicians were reacting against centuries of abuse and neglect as they applied to the insane. It was therefore essential that their methods of curing insanity not resemble the dark, dirty cells of the eighteenth century in which the insane had been chained and forgotten. Confinement was incongruous with moral treatment. And yet, throughout the nineteenth century, crib-bedsteads were one of the most conspicuous and contentious items in a moral asylum. They represented the ambiguity surrounding the use of mechanical restraints in moral treatment. Both superintendents and their patients had complex relationships with the beds that reveal continuing conflicts surrounding the right, or duty, of sane people to manage the welfare of the insane. The crib-bedstead, while similar to the cages of the
eighteenth century, was also similar to the nineteenth century padded cell. Confinement, whatever adjective you place in front of it, is still confinement, and the crib-bedstead reveals the blurred lines between barbaric and humane control. The reality of treating insanity pushed against the ideological notions of moral therapy to reveal that benevolent treatment was not always easy or possible.
Legacy

The strength of moral treatment as a mechanism for the management and regulation of patient behavior was found in the subtly controlling environment that it created. By limiting the world of the patients to the asylum grounds while seemingly providing them with extensive freedom through the right to walk the grounds and participate in regular daily activities such as meals in a dining room, the moral asylum sought to abandon the brutal methods of management associated with older institutions for the insane. Mental illness, however, is not and was not a simple disease. This made the healing utopia created by nineteenth-century physicians insufficient in managing and curing insanity. There were situations where physically restrictive measures, through medicine and mechanical restraints, were necessary despite the ideological desires of physicians.

Moral therapy did unchain madness from its dark cell, it did create more humane methods of treatment, but it could not negate the necessity of confinement. The reluctant acceptance of this reality by physicians proves that there was and is no universal answer for the question of how to humanely treat the insane. Psychiatrists, and society as a whole, are still struggling with the best ways to manage the mentally ill. In many instances there are no suitable treatment centers for the insane in modern America. An article published by National Public Radio in January 2014 reveals that prisons are currently among the primary holding places for the insane, but they are ill-equipped to handle such inmates. Cook County Jail in Illinois tries to provide therapy and medication for their mentally ill inmates, but they openly acknowledge that their facilities and
resources are inadequate for both custodial and curative care. When insane inmates get violent there is often no recourse for the jail but to use leather restraints on the patient.\textsuperscript{137}

While Cook County Jail mirrors treatment of the mentally ill in the eighteenth century, modern psychiatric hospitals are still relying on the language of moral therapy to describe their practices. In 2013 Western State Hospital in Staunton, Virginia downsized and opened a new campus. The construction and situation of the new psychiatric hospital follows many of the guidelines of asylum construction from the moral treatment era. Mirroring the language of nineteenth-century moral therapists, facility director Doctor Jack Barber stated that the new campus allows for “[n]atural light, views to the outside landscape, different kinds of space, so that you can be more or less stimulated, [and] private room so you have a sanctuary.”\textsuperscript{138} There are even courtyards set up for patient use and classrooms within the facility.

The question of how to manage the insane provokes controversy today just as it did in the nineteenth century. Society tends to cringe at the thought of institutionalization, equating it with twentieth-century lobotomies and uninformed images of brutal conditions involving chains and strait jackets. But rejecting institutionalization in favor of poorly funded community mental health clinics means that most mentally ill people do not have access to the kind of treatment and care that they need. Instead they end up in jail or on the streets, a practice that moral therapists of the nineteenth century sought to end. While America has rejected large, state-run asylums, the legacy of moral therapy


continues to influence psychiatric practice. In Cook County Jail the restraints used on inmates replicate the padded chains and rooms of the moral asylum. At Western State Hospital the idea of a utopia for the mind based on environmental determinism guided the creation of new facilities. Moral therapists may not have been able to negate every inhumane aspect of treatment of the insane with their moral asylums, but they made advances that still have validity.
Figure 1: Charles Bell, "Madness, or a Man Bound with Chains," Essays on the Anatomy of Expression in Painting (1806). Image courtesy of the National Library of Medicine.
Figure 2: T. H. Shepherd, "Bethlem Hospital," 1816. Image courtesy of Wellcome Images.
Figure 3: Richard Newton, "A Visit to Bedlam," 7 August 1794. Image Courtesy of The British Museum.

This image is a satirical representation of people visiting Bethlem. The patients are seen poking their heads through small openings in their cell doors and antagonizing visitors who appear to be angered, scared, and shocked by the behavior of the insane. The patient furthest to the right even has a chamber pot on his head. The drastic appearance of the insane as gaunt, pale, and dirty provides a stark contrast from the visitors who are all dressed in respectable clothing, well-fed, and rosy-cheeked indicating a marked division between the civilized nature of sanity and the uncivilized nature of insanity.
Figure 4: William Hogarth, Plate VIII of *The Rake's Progress*, 1735. Image courtesy of the National Library of Medicine.
Figure 5: This photo accompanies a news article discussing a museum exhibit in Provo, Utah. The author of the article has lain down inside a Utica Crib which he describes as “pretty barbaric,” and “hardly therapy.”

Figure 6: Gravure by Goupil after painting by Roberty-Fleury, "Dr. Pinel in the Courtyard of the Salpêtrière," 1876. Image courtesy of the National Library of Medicine.
Figure 7: W. Archibald, "Perspective View of the North Front of the Retreat, Near York, England," in 1813. Image courtesy of the National Library of Medicine.
Figure 8: Thomas Sully, "Benjamin Rush," c. 1813. Image courtesy of The Trout Gallery.

Figure 9: Benjamin Rush, Tranquilizing Chair, 1811.
Figure 10: Phrenological Skull, European, 19th century. Image courtesy of Wellcome Collection.

Figure 11: Phrenology, "Phrenologis und Medizin," 1851. Image courtesy of the National Library of Medicine.
Figure 12: Depiction of a conformatuer.

Figure 13: David Hess, "Cranoscopische Handgriffe," 1795. Image courtesy of the National Library of Medicine.
Figure 14: H. Billings, Del., from a sketch by Seager, "McLean Asylum for the Insane, Somerville, MA., General View," 182-?. Image courtesy of the National Library of Medicine.

Figure 15: G.A. Tucker, "Illinois Northern Hospital for the Insane," in Lunacy in Many Lands, 1885. Image courtesy of Wellcome Images.
Figure 16: Calvert Vaux, "Sheppard Asylum, front elevation," c. 1860. Image courtesy of the National Library of Medicine.

Figure 17: Calvert Vaux, "Plan of Second Floor," c. 1860. Image courtesy of the National Library of Medicine.
Figure 18: William Clarke, "New York State Lunatic Asylum, Plan," 183?. American Institute of Architects Collection, Athenaeum of Philadelphia.

Figure 20: Calvert Vaux, "Furnace Flues of the Sheppard Asylum, Baltimore, Maryland," c. 1860. Image courtesy of the National Library of Medicine.
Figure 21: Pharmacy Bottle, Jalap, 1800-1899. Photo courtesy of Mental Health Care Museum at Kingston.

Figure 22: J. Gillray, "Gentle Emetic," 1804. Image courtesy of the National Library of Medicine.
Figure 23: J. Gillray, "Breathing a Vein," 1804. Image courtesy of the National Library of Medicine.

Figure 24: Lancet and Case, 19th century. Photo courtesy of Mental Health Care Museum at Kingston.
Figure 25: Cupping Set, c. 1845-1865. Photo courtesy of Mental Health Care Museum at Kingston.

Figures 26 and 27: Scarificator, 1820. Photos courtesy of Mental Health Care Museum at Kingston.

Figure 29: Ebenezer Haskell, *The Trial of Ebenezer Haskell in Lunacy*. Philadelphia: Haskell, 1869.
Figure 30: Replica Iron Wrist Restraint, 1850-1920. Photo courtesy of Science Museum, London.

Figure 31: Replica Restraining Collar, 1850-1920. Photo courtesy of Science Museum, London.
Figure 32: Utica Crib, 1870-1910. Western State Hospital. Photo courtesy of The Colonial Williamsburg Foundation.

Figure 33: Mental Care, Utica Crib, c. 19th century. Photo courtesy of Cleveland State University, Michael Schwartz Library, Special Collections.
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