

Rehabilitation at Rockwood: Women, Mental Illness and Asylums,
Kingston, Ontario 1878-1906

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Introduction

Rockwood, the Asylum for the Insane, was established in 1858 when the crown purchased a forty-acre estate in Portsmouth Village, just west of the city of Kingston, Ontario. Initially, it was built to relieve overcrowding at the Kingston Penitentiary and create a separate asylum for the criminally insane. Though at first only twenty-four female patients were accommodated in the refurbished stables of the estate, in 1859 a new building opened spaces for up to three hundred patients. Despite its original designation as an institution for the criminally insane, the province's need for mental hospitals meant that throughout the 1860s Rockwood increasingly accepted "lunatics" from regional gaols and the overcrowded Toronto asylum, a practice that eventually led to its conversion to a general asylum. In 1877 the Province of Ontario purchased the asylum from the Dominion government; although it was re-named the Asylum for the Insane, Kingston, it continued to be generally referred to as "Rockwood".

The purchase of the institution by the Ontario government marked its entry into the network of asylums that formed part of Ontario's social welfare system during the late nineteenth century. The province's first asylum specifically designed for the care and treatment of the mentally ill had opened in Toronto in 1850. During the late 1850s and early 1860s two smaller branches were added in Amherstberg (in southwestern Ontario) and Orillia to alleviate overcrowding. The demand for treatment facilities for the insane continued to grow during the decade, and the government established a second asylum in London in 1870. By the mid-1870s, however, a critical shortage had again developed, leading Inspector John Woodburn Langmuir to suggest a broad plan for asylum expansion that anticipated future needs through an analysis of

population growth in the province and existing trends in mental illness.¹ The plan sought to provide extensive accommodation for chronic patients with a view to achieving the maximum number of cures through early admission and treatment.² The result of this plan was the establishment of an asylum in Hamilton and the purchase of Rockwood in 1877.

Langmuir's plan was unique, for it was grounded in the realities of public, patient and institutional needs, while also incorporating current theories surrounding the treatment of insanity. To this extent the network of Ontario asylums proved to be typical of nineteenth century institutions in its use of medical theories, but atypical in its implementation of these ideas. For these reasons Ontario's asylums have provided historians with an excellent model for studying the theory and practice of treating the mentally ill in late nineteenth-century Canada. Over the last twenty years historians have developed an increasing interest in the field; a number of studies have emerged that examine a variety of Canadian asylums, particularly those in Ontario. The earliest works focus largely on patient treatment and asylum administration; they include studies of the Toronto and London asylums by Thomas Brown (1980), Cheryl Krasnick Warsh (1982), and S. E. D. Shortt (1986).³ While these authors present full discussions of the implementation of the "moral treatment" therapy that formed the basis of patient care in the late nineteenth century, they place less emphasis on medications and surgeries that continued to be used throughout the period.⁴ Because they focus primarily on asylum administration, and not

¹ Richard Splane, *Social Welfare in Ontario, 1791-1893: A Study of Public Welfare Administration*, (Toronto: University of Toronto Press, 1965), pp. 205-206.

² *Ibid.*, p. 206.

³ Thomas Brown, " 'Living With God's Afflicted': A History of the Provincial Lunatic Asylum at Toronto, 1830-1911," Ph.D. Thesis: Queen's University, 1980; Cheryl Krasnick Warsh, " 'In Charge of the Loons': A Portrait of the London, Ontario Asylum or the Insane in the Nineteenth Century," *Ontario History* vol. 74, no. 3 (September 1982), pp. 138-184; S. E. D. Shortt *Victorian Lunacy: Richard M. Bucke and the Practice of Late Nineteenth-Century Psychiatry*, (Cambridge: Cambridge University Press, 1986).

patient experience, their works in many ways resemble those completed by American scholars in the 1970s and early 1980s.⁵ Only Warsh differs slightly in her approach by including details from the asylum records of a small number of patients. For the most part, however, these early studies pay little attention to the lives of the patients, preventing an understanding of what it meant to be an asylum patient in late-nineteenth-century Ontario.

This inattention to patients began to change in the late 1980s as emerging ideas in the field of social history began to direct historians to investigate the significance of class and gender differences to asylum confinement. In articles written about the Toronto asylum (1987, 1988), Wendy Mitchinson examines gendered patterns in the demographics of asylum populations and the factors that contributed to patient committal, by closely examining the contents of patients' asylum records.⁶ Warsh's 1988 and 1989 studies of the Homewood Retreat in Guelph, Ontario addresses the significance of class differences to committal and the implementation of moral treatment.⁷ Since Homewood was a private asylum, where the state had less influence on the decision to commit an individual, Warsh is able to emphasize the important role of family in this

⁴"Moral treatment" was the accepted therapy for treating the insane among late-nineteenth-century psychiatrists; it is explained in detail in chapter two.

⁵ Richard Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930*, (Berkeley & Los Angeles: University of California Press, 1978); Gerald Grob, *Mental Illness and American Society, 1875-1940*, (Princeton, NJ: Princeton University Press, 1983); Christopher Lasch, "Origins of the Asylum," in *The World of Nations: Reflections on American History, Politics, and Culture*, (New York: Alfred A. Knopf, 1973); David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (1971), 2nd ed., (Boston: Little, Brown and Company, 1990); Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England*, (New York: St. Martin's Press, 1979).

⁶ Wendy Mitchinson, "Gender and Insanity as Characteristics of the Insane: A Nineteenth-Century Case," *Canadian Bulletin of Medical History*, vol. 4 (1987), pp. 99-117, and "Reasons for Committal to a Mid-Nineteenth-Century Ontario Insane Asylum: The Case of Toronto," in *Essays in the History of Canadian Medicine*, eds. Wendy Mitchinson & Janice Dickin McGinnis, (Toronto: McClelland & Stewart, 1988), pp. 88-109.

⁷ Cheryl Krasnick Warsh, "The First Mrs. Rochester: Wrongful Confinement, Social Redundancy, and Commitment to the Private Asylum, 1883-1923," *Historical Papers* (1988), pp. 145-167, and *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923*, (Montreal & Kingston: McGill-Queen's University Press, 1989).

process. Most significant in these works is the extensive use of case studies to underscore their arguments.

A section of Mitchinson's 1991 book, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*, focuses on the interpretation and diagnosis of mental illness in women, based on patients' records.⁸ To a great extent, the two chapters that discuss this topic can be understood as a response to Elaine Showalter's work on women and insanity in England during the late nineteenth and early twentieth centuries.⁹ Though Mitchinson differs from Showalter in that she does not present insanity as a phenomenon to which women were more vulnerable, she does argue that doctors perceived female mental illness to be rooted in their reproductive functions. Mary-Ellen Kelm expanded our understanding of women and mental illness in her articles examining the impact of family relationships in the lives of asylum patients (1992-93, 1994).¹⁰ Using the cases of women committed to the British Columbia Provincial Asylum between 1905 and 1915, Kelm argues that families had a central role in the timing of admission and discharge, and influenced the conditions of their lives while in the institution. To this extent, her work minimizes the importance of physicians in a patient's experience of the asylum.

The common characteristic of the studies written during the late 1980s and early 1990s is the authors' attempts to move away from an exclusively administrative focus to a concentration on patients, their experiences, and the external factors that influenced the terms of their

⁸ Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*, (Toronto: University of Toronto Press, 1991), chapters 10 and 11.

⁹ Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980*, (New York: Pantheon Books, 1985).

¹⁰ Mary-Ellen Kelm, " 'The only place likely to do her any good': The Admission of Women to British Columbia's Provincial Hospital for the Insane," *BC Studies*, vol. 96 (Winter 1992-93), pp. 66-89, and "Women, Families and the Provincial Hospital for the Insane, British Columbia, 1905-1915," *Journal of Family History*, vol. 19, no. 2 (1994), pp. 177-193.

committal. Though Mitchinson, Warsh and Kelm all successfully accomplish this transition in focus, they shift the emphasis from the role of government and asylum staff, and suggest administrative factors were of less significance to a full understanding of nineteenth-century asylums. Thus, by the mid-1990s the literature on Canadian asylums consisted of two polarized groups -- one administratively-focussed, the other patient-focussed -- with little balance between them to suggest mutual relevancy.

Recently, two large studies have been published that use new methods for expanding our knowledge of asylums in Canada. Geoffrey Reaume's *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* (2000), is the first full-length monograph to examine patient experience within the broader framework of patient culture.¹¹ Here patients are treated as a unique social group that developed strategies for coping with confinement and formed particular social relationships while institutionalized. By avoiding a lengthy analysis of treatment and administration, the book grants autonomy to patients by offering a descriptive analysis of the asylum from the perspective of the patients themselves.

Conversely, James Moran's book, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (2000), returns to a more administrative perspective with an emphasis on the role of the state in the development of asylums across Ontario and Quebec.¹² He helps to close the gap between administrative studies and patient-focussed works by acknowledging the significant contributions of communities and local politics to provincial decisions regarding asylum establishment and patient treatment. Contextualizing the asylum

¹¹ Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940*, (Toronto: Oxford University Press, 2000).

¹² James Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario*, (Montreal & Kingston: McGill-Queen's University Press, 2000).

within the arena of state development enables Moran to demonstrate the important relationships that existed between government, asylum, and community.

Despite the ever-increasing body of literature on Canadian asylums, as yet no published works exist that study the asylum's administration with the experience of patients and the various methods of treating the mentally ill. Nor has any study challenged the ideas of Showalter and Mitchinson that place female reproduction at the centre of the diagnosis and treatment of insanity in women. Until recently historians largely ignored the Rockwood Asylum and its place within Ontario's nineteenth-century social welfare system. Though Edgar-André Montigny (1995) and Patrick J. Connor (1996) have written articles that focus on this institution, both authors use it as a case study for examining particular social groups; Montigny focuses on the institutionalized elderly, while Connor looks at the place of asylum attendants.¹³ To date, no study examines the experience of patients at Rockwood and the treatment provided at that institution.

To understand the place of Rockwood in the province's social welfare program, particularly in regard to the treatment of mentally ill women, this memoir follows the experience of 241 female patients¹⁴ committed to the Asylum for the Insane, Kingston between 1878 and 1884. To aid our understanding of this experience it studies the experiences of these women in context with the institution's administration and treatment program through to 1906

¹³ Edgar-André Montigny, " 'Foisted Upon the Government': Institutions and the Impact of Public Policy Upon the Aged. The Elderly Patients of Rockwood Asylum, 1866-1906," *Journal of Social History*, vol.28, no.4 (Summer 1995): 819-836; Patrick J. Connor, " 'Neither Courage Nor Perseverance Enough': Attendants at the Asylum for the Insane, Kingston, 1877-1905," *Ontario History*, vol. 88, no. 4 (December 1996), pp. 251-272.

¹⁴ The use of the cases of 241 women does not indicate a sampling of patients committed during those years, but reflects the absence of 12 women admitted in early 1878. Though these 12 women are listed in the asylum's General Register (AO, RG 10, Series 20-F-3-2), their detailed records are not included in the Female Casebooks (AO, RG 10, Series 20-F-1-1).

when the patients' asylum records are discontinued.¹⁵ This inquiry into the lives of women patients will examine their care based on a variety of influences, both inside and outside the walls of the Kingston Asylum. Rockwood's physical setting, the extensive attention and financial support it received from the Ontario government, and the competency of its medical superintendents and support staff, enabled the asylum to offer its patients a treatment program that was one of the most successful in the province. Yet, as this study will also demonstrate, the benefits of this program could be either enhanced or hindered by external factors such as a patient's social status or the influence of family, friends, and communities. To evaluate the impact of these contributing factors, the memoir is divided into three sections according to processes of committal, treatment and discharge.

Selection of the admission years under study was made by considering both administrative and social factors. From an administrative perspective, 1878 was the first year that Rockwood was operated fully under the Ontario government. Resulting from Langmuir's plan in the mid-1870s, the late 1870s and 1880s saw great efforts put forth by the government and asylum administrators to improve asylum conditions for staff and patients across the province. Patients entering the Kingston Asylum between 1878 and 1884 were also all admitted during the period Dr. William Metcalf was medical superintendent, offering consistency to the circumstances of their committal. Since several women remained in the asylum past 1906 when the patient casebooks were discontinued, the study extends to the early years of the twentieth century to fully appreciate the changes that took place within Rockwood over the last quarter of

¹⁵ In order to preserve anonymity, all the patients included in this study are identified only by their first name and last initial. File numbers are recoded according to the order in which they appear in the records. Patients' asylum records are contained in the female casebooks of the Kingston Psychiatric Hospital Records at the Archives of Ontario (hereafter AO), Toronto, RG 10, Series 20-F-1-1. All references to them throughout the paper can be found within this series. AR with the given year refers to the Annual Reports of the Inspector of Asylums, Prisons and Public Charities contained in the Sessional Papers of the Province of Ontario. This coding system has been adapted from that used by Reaume in *Remembrance of Patients Past....* See p. iii.

the nineteenth century. Socially, the period was chosen in order to respond to the studies of Showalter and Mitchinson, which identify women as specifically vulnerable to diagnoses of insanity during the late nineteenth century. The immense social and economic upheaval that many women experienced may have been a contributing factor in the development of mental and physical illnesses, making the 1870s and 1880s an appropriate period for examining women's admissions to asylums.¹⁶

The extent of Victorian women's susceptibility to mental illness is discussed in the first chapter, which investigates the committal process for women patients admitted to Rockwood between 1878 and 1884. Admission to a nineteenth-century asylum was a complex process that required consideration for not only the patient, but also the needs of their families and communities. To fully consider the circumstances of patients and families when symptoms of mental illness appeared, the chapter provides details of the women's ages, marital status, occupational position, and symptoms to comprehend the social background of these women and the impact of their "troublesome" behaviours. As noted by Kelm and others, asylums were not purely institutions of social control, as suggested by Michel Foucault in his 1965 work *Madness and Civilization*.¹⁷ While these institutions arguably developed from institutionalized power structures that influenced the type of patients admitted, as we shall see, personal circumstances and the nature of the illness had greater significance in determining the reason and timing of committal. As the chapter will demonstrate, patients without sources of family or community support were at the highest risk of committal. Even when these support systems were available, it was generally the severity of a woman's symptoms that led families and friends to commit her

¹⁶ Women's susceptibility to mental illness during the late nineteenth century is discussed in detail in chapter one.

¹⁷ Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (1965), (New York: Vintage Books, 1988).

to an asylum. In most cases Rockwood was used as a last resort when all other options had been exhausted.

Chapter two moves away from the personal circumstances of patients to assess the administration of Kingston's asylum by looking at methods of treatment and patients' daily life. It begins with an introduction to the "moral treatment" program that formed the basis of therapy for the insane across Western Europe and North America during the second half of the nineteenth century. The chapter then examines Rockwood's administration under medical superintendents Dr. William Metcalf and Dr. Charles Clarke, two progressive thinkers who promoted many of the asylum's improvements after its purchase by the province. Following this examination is an evaluation of the more interventionist treatments applied to the women at Rockwood, including medications and operations. It concludes by shifting the focus to look at the women's reactions to treatment, the levels of autonomy patients were able to exercise through various forms of resistance, and the disruptive impact such actions had on the asylum's daily routine.

The final chapter studies the routes by which patients left the asylum, including transfer, death and discharge, in order to evaluate the overall benefit patients received from the asylum's treatment program, and to again demonstrate the influence of families and communities. Because the illness and personal circumstances of each woman were unique, the relative benefit of asylum committal will also vary from patient to patient. "Successful treatment" is not limited to the women who were cured and/or quickly discharged; it also considers the benefit of long-term care for certain patients. Since patients did not all have access to outside support in the form of family or friends, the asylum's role in their lives shall be considered differently from patients who had supportive relatives willing to care for them. In this chapter concepts of family

and community are again addressed to determine the significance of their contribution to patient improvement and discharges at Rockwood. It will be argued that recovery from mental illness was largely determined by a delicate balance of factors that often depended on the involvement of family and community. Together the three chapters will demonstrate what it meant to be a mentally ill woman in Eastern Ontario during the last quarter of the nineteenth century.

1.

**Women and the “Problem” of Mental Illness: Admissions to the
Kingston Asylum, 1878-1884**

Historians studying the process of asylum committal in nineteenth- and early twentieth-century Canada have focussed much of their attention on patients' behaviours and demographic characteristics such as age, marital status, and socio-economic position.¹ The emphasis placed on individual patients and their problems evolved in response to the earlier emphasis on social control theory. The focus on patients rather than institutions allowed researchers to identify asylums as institutions with multiple functions that fulfilled a broader societal need.² As such, an analysis that focuses on the experience of patients forms an important component of asylum admissions. Yet, adopting a perspective that focuses only on patients as isolated entities does not address the important social component of the committal process. Historians of medicine, Mary- Ellen Kelm and Cheryl Krasnick Warsh, have been particularly adept at addressing the significance of social circumstances through their inclusion of the family as the primary location for the committal decision. They argue that because individual families had their own standards of acceptable behaviour, the family unit was the site of the final choice to commit, a decision that was reached independent of professional intervention and whose timing was often contrary to advice given by physicians.³

This important insight of family involvement suggests other possibilities for investigation, such as the role the patients' friends, neighbours or other members of the community. These non-familial relationships are particularly important for studying patients without family or cases where admission was instigated by someone other than a relative. Patient records from the Kingston Asylum suggest that while family was most often the source

¹ See Wendy Mitchinson, "Gender and Insanity as Characteristics of the Insane..." and "Reasons for Committal to a Mid-Nineteenth-Century Ontario Insane Asylum..."; Mary- Ellen Kelm, "The only place likely to do her any good' ..."; Cheryl Krasnick Warsh, "In Charge of the Loons'..." and "The First Mrs. Rochester..."; Geoffrey Reaume, *Remembrance of Patients Past*....

² Mitchinson, "Reasons for Committal...", p. 109.

of a committal request, a number of women patients also entered at the request of friends, neighbours, or authorities. Thus, this memoir advances our understanding of the supportive role of family into a broader concept of community.⁴ In addition, this approach overcomes the disjunction that is created between the family unit and the external community when these relationships are not conceptualized as an integral part of the broader social network.⁵

A thorough examination of asylum admission would consider the role of both family and community relationships to a patient's health and life circumstances in order to demonstrate how perceptions of insanity and changing social circumstances influence committal. Overall, historians have treated committal as a decision that was reached after the family defined one particular behaviour as intolerable, rather than as a process involving a series of events and emotions.⁶ While a specific event often precipitated admission to an asylum, the casebooks reveal that, in most cases, the decision to commit was not reached the moment the troublesome behaviour appeared. Examination of patient records reveals a range of lengths of illness prior to admission; while some patients exhibited erratic behaviour for many years prior to their committal, others were ill for only a few weeks. For example, Lydia J. was listed as being "insane over 20 years" when she was committed to the asylum in March 1878 at age 75.⁷ In contrast, Eliza H. became a patient at Kingston in July of 1884 after experiencing melancholic

³ Kelm, pp. 70-71; Warsh "The First Mrs. Rochester...", pp 150-51.

⁴ Such authority figures might include doctors, police or employers.

⁵ Catharine Anne Wilson, "Reciprocal Work Bees and the Meaning of Neighbourhood," Paper presented to the Canadian Historical Association, (Quebec City, 2001), p. 1. Wilson attempts to correct this problem by looking at the way rural work bees created highly effective social networks, and created a "structural and cognitive order" (p. 2). Examination of this type of social order and its formation is important for a full understanding of community participation in the committal of an individual.

⁶ See examples of patients given in Warsh, particularly Henry P. on page 152. Kelm shows a better awareness of external circumstances, but does not consider committal as a process as such.

⁷ Lydia J., File # 5

behaviour for approximately one month.⁸ The difference between the two women was in relation to the relative danger they posed to others: Eliza had “attempted to commit suicide and to kill her children”, while Lydia’s greatest offence was a “great desire to steal things.”⁹ These cases suggest some variance in the threshold of tolerance for particular behaviours that also may have changed within an individual family or community over time. Eliza’s violent behaviour was undoubtedly more dangerous and less predictable than Lydia’s thievery which could perhaps be controlled by keeping her away from stores and neighbours’ properties.

It is this variance that makes interpretation of levels of tolerance difficult to analyse. Doing so necessitates a careful examination of the unique circumstances of each individual patient, as the following example illustrates: On October 26, 1878 Mary M., a twenty year-old, single domestic, was admitted by warrant to the Kingston Asylum from a goal in the county of Stormont, Dundas and Glengarry, after experiencing recurrent bouts of mania for 3-4 years. Although the admitting physician described her behaviour as “...treacherous, very hard language at times...,” Mary was said not to be dangerous and was identified as temperate and as having “good general health.” Mary’s temperate health might explain why it took 3-4 years for her to be committed; though undoubtedly annoying, her actions were tolerable for they posed no direct threat to anyone. Fourteen months after her admission her file describes her actions as “at times violent and very boisterous... swearing and threatenting...”¹⁰ This notation suggests that the decision to commit Mary may have resulted from her increasingly violent behaviour that posed a threat to others and rendered her unable to work. As a young, unmarried servant perhaps without

⁸ Eliza H., File # 233

⁹ Lydia J., File # 5, Eliza H., File # 233

¹⁰ Mary M., File # 22

a family, she probably lacked sources of social and economic support that could have enabled her to remain outside the asylum.

While Mary's casebook records offer no indication of the precise circumstances of her initial admission to the gaol, the particulars of her social position and behaviours allow for a general profile to be developed, particularly when these factors are considered alongside the cases of other women patients admitted to Kingston between 1878 and 1884. Committal to an asylum depended on the combined interaction of particular behaviours with a unique set of social circumstances. The interplay of these two factors requires that the decision to commit be understood as a process, rather than an immediate reaction to a single event deemed intolerable by a patient's family or community. Patient records do not provide enough detail of the individual's personal circumstances to reach definite conclusions as to why family, friends or neighbours decided to commit; however, they do allow insights into common social problems and behaviours that often led to an asylum admission.

This chapter uses the information in the female casebooks to study the behaviours exhibited by a group of women patients and analyses the significance of their ages, marital status, number of children, and occupations in relation to the reasons for their committal to Rockwood. Careful examination of each factor and the interaction of multiple variables demonstrates why some doctors reported patients as being insane several years before admission while others appeared to be committed immediately. The files also illustrate the way families and communities perceived the asylum as a necessary step at the time of committal. Consideration of the role of various types of institutions within this discussion will help to identify why families and medical authorities viewed an asylum as the most appropriate place to treat these women.

Means of Admission

In nineteenth-century Ontario persons could be admitted to asylums by means of a medical certificate or lieutenant-governor's warrant. Patients admitted by medical certificate were admitted directly from the community at the family's instigation. Certification required the patient to be examined by two or three doctors who signed documents that confirmed a diagnosis of insanity and relating the underlying symptoms of the illness.¹¹ A doctor was also required to complete a "Form of History" for the patient outlining the personal circumstances along with the physical and emotional state of the patient. Medical forms for patients admitted in this manner also provided space for family or neighbours to give background information about the patient.¹²

Warrants issued by the lieutenant-governor were used for patients transferred from prisons to asylums for reasons of insanity. Physicians and/or legal authorities wrote documented certificates verifying the inmate's insanity that could be further supplemented by a supporting statement from family or acquaintances. Regulations also required one of the prison doctors to complete a personal history document known as "Schedule 2". Though less expansive than the Form of History in the medical certificate process, the schedule asked similar questions regarding the patient's background and individual circumstances.¹³

In her study of patients admitted to the Provincial Lunatic Asylum in Toronto, Mitchinson states that women were more likely to be admitted by medical certificate than warrant, due to the less violent nature of their insanity. She argues that women's behaviour, while erratic, did not attract the attention of authorities to the same degree as that of the male

¹¹ Three doctors were required to examine the potential patient until the summer of 1882; from this time forward two doctors were deemed sufficient for this process [Reaume, *Remembrance of Patients Past...*, p. 24].

¹² Ibid., p. 25.

¹³ Ibid.

patients.¹⁴ While this may have been the case in Toronto, it clearly does not explain the admissions at Kingston. Approximately one third (30 percent) of the women included in this study were admitted by medical certificate, while the remaining two thirds (70 percent) came into the asylum by warrant as transfer patients from regional gaols.¹⁵ These results from the Kingston Asylum suggest that the patient's behaviour was only one of many factors determining the mode of admission.

There were several reasons for the high proportion of warrant patients in Kingston than Toronto. One can be identified by looking at the characteristics of the committal process across Ontario. In the late nineteenth century, gaols and asylums were overcrowded. Three times each year the Inspector of Asylums, Prisons and Public Charities made unannounced visits to each of the province's institutions to evaluate conditions, offer recommendations to asylum administrators, and gather information for his annual report to the provincial government.¹⁶ In his 1885 report, Inspector W.T. O'Reilly described the Kingston Asylum as "always having been inadequate as to extent of accommodation for the district assigned to it."¹⁷ Until 1895 Rockwood was the only asylum in the eastern region of the province, requiring it to accommodate the needs of all counties between Toronto and Ottawa. Although measures were taken to ensure the asylum's population never grew beyond its capacity, the growing public

¹⁴ Wendy Mitchinson, *The Nature of Their Bodies...*, p. 303.

¹⁵ AO, RG 10, Series 20-F-3-2, Kingston Psychiatric Hospital Records, General Register, 19 May 1878 – 28 October 1884. From May 1878 the General Registers contained some additional information from that which was presented in the casebooks. Because the first 12 patients in my sample are not included in this group, the ratios given here are approximate.

¹⁶ Three men occupied the Inspector's position over the course of the period studied here. John Woodburn Langmuir held the position from 1868 until 1882 when he returned to private business. In April 1881 Dr. W.T. O'Reilly was hired as an assistant to Langmuir, and after Langmuir's resignation he took over as the Inspector for Ontario's hospitals and mental institutions. O'Reilly died in 1890 and Robert Christie, the former Inspector of the correctional institutions, assumed responsibility for the health facilities.

¹⁷ AR, 1885, *Ontario Sessional Papers* (No. 11), p. 41.

demand for institutional care made over-population a serious concern for administrators throughout the period. Consequently, high demand indicates one reason why only 10 women were admitted to the Kingston Asylum by transfer, arriving in 1884.¹⁸ Patient accommodation at Kingston expanded that year by the addition of a new cottage residence creating additional spaces for patients and permitting administrators to make adjustments between asylums.¹⁹

The concern with overcrowding also meant that priority was usually given to insane prisoners from local gaols classified as “dangerous” to society. Family members and friends of the patient were often forced into placing the problematic relative in a county gaol with the hope that this placement would lead to a more rapid asylum admission. The General Registers at Kingston show that the majority of the women admitted by warrant between 1878 and 1884 had close family or friends listed as primary person(s) of contact, further suggesting the frequent use of this practice.²⁰ While many of the women came from the gaols, the presence of family and relations suggests that they were not dangerous criminals, but troubled individuals whose problems had, over a period of time, become too difficult to manage without some sort of external assistance and intervention.

The means by which a patient entered was also, to a great extent, reflective of class divisions. The province supported patients who were unable to pay for care or who did not have

¹⁸ Additional asylums were later opened at Brockville (1895) and Cobourg (1902).

¹⁹ These 10 admissions are recognized in Dr. Metcalf's 1884 report to Inspector O'Reilly. Metcalf states that admissions for the year included “twenty chronic patients transferred from Toronto to relieve the overcrowded condition of that institution.” It appears that an equal number of men and women were moved to Rockwood. AR, 1885, *Ontario Sessional Papers* (No. 11), p. 118.

²⁰ The General Register of the Kingston Asylum for the Insane includes a column that lists the next of kin or primary person of contact. See AO, RG 10, Series 20-F-3-2, Kingston Psychiatric Hospital Records, General Register, 19 May 1878 – 28 October 1884.

family able to do so; indeed, such cases represent the majority of the women studied here.²¹ This situation meant that the admission of patients depended upon availability of space and the goodwill of provincial administrators. Because overcrowding was such a problem, most individuals requiring the support of the province likely sought admission through the gaol route and, thus, became admitted through the warrant process. Beginning in 1879 the Toronto asylum began to offer improved facilities for those able to pay for their own care, compounding class divisions.²² Moreover, the opening of Guelph's Homewood Retreat in 1883, a private asylum offering treatment in a luxurious environment to individuals able to pay the costs of private care, meant that poorer clients were more likely to occupy the beds at Rockwood and other public institutions.²³

As will be demonstrated in this chapter, class status was only one of several elements influencing patients' admissions and the routes by which they entered the asylum. While the behaviour of patients was decidedly the determining factor in most cases, committal was equally influenced by social factors such as age, marital status and occupation. Though the details of patients' lives prior to committal are not clear, the asylum's casebooks offer insight into the social environment in which they lived. The remainder of this chapter considers the reasons why women were committed to asylums such as Kingston, by considering the role of asylums within Ontario's social welfare system. It explores the illnesses and symptoms of the women who were admitted over a seven-year period and examines the social circumstances of their lives, with a particular emphasis on the role of family and community.

²¹ The General Register also has a column that identifies who was paying for the patient's care (i.e. whether it was the province or family or friends). See *ibid.*

²² Reaume, p. 8.

²³ Because Homewood was a private business, its owners could place limits on the numbers of persons admitted and patients never suffered from the ramifications of overcrowding.

Institutions in Ontario

Before considering the medical and social reasons for a woman's placement in an asylum, it is important to assess the different types of institutions and the problems they were trying to address. One of the major means of determining whether an individual would be placed in an insane asylum rather than some other type of institution is to look at the ages of patients at the time of their committal. Patient ages partially identify the category of persons to whom an asylum offered care, and they provide insight into the types of patients/illnesses faced by asylum doctors. An examination of the women's ages upon entering Rockwood reveals that the asylum indeed housed a relatively young population of women who at time of committal were between ages of childbearing and menopause. Table 1 divides the women into categories according to reproductive life stages:

Table 1: Patient Ages By Life-Stage 1878-1884

Year Age	1878	1879	1880	1881	1882	1883	1884	Total Files	% of Total Files
< 25	1	1	3	1	1	3	2	12	4.3
25-40	12	15	13	18	19	23	22	122	49.2
41-60	11	9	12	14	15	7	23	91	36.7
>60	3	3	1	2	2	2	4	17	6.9
Unknown	0	0	0	2	2	0	2	6	2.4
Total Files	27	28	29	37	39	35	53	248	100.0

Source: AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

The first stage, up to age 24, represents what were the pre-marital and pre-childbearing years for most women; data from the 1881 census suggests women's first marriage typically

occurred between ages 20 and 25.²⁴ The second stage in the table represents the primary childbearing years from ages 25-40, while the third stage focuses on the menopausal stage where childbearing would likely have ceased, but women would still be involved with the rearing of children. Overall, more than 80 percent of the women entered the asylum during these two middle stages, indicating that childbearing and childrearing could influence a women's susceptibility to asylum confinement; this topic will be discussed later in the chapter. The last category, representing only 6.9 percent of the sample, includes women committed during the final stage of their lives when they were past menopause and likely beyond caring for children.

Though the proportion of women in each age category is not significantly different than those found in the general population, the absence of young girls and elderly women demonstrates that the asylum was not intended to be a custodial facility for housing troubled adolescents or women in need of long-term care.²⁵ In total, only 9.8 percent of the women in this sample were committed for wayward behaviour, senile dementia, or the need of palliative care [Table 2].

²⁴ "Table G – Ages of the Married and their Ratios," *General Report of the Census of Canada, 1880-81*, vol IV, (Ottawa: Maclean, Roger & Co., 1885), pp. 60-61. This census report identified 9,188 married females who were ages 16-21. The number of married females ages 21-31 is stated as 91,664. This data shows a near ten-fold increase in the number of married women between these age divisions, suggesting that women most often married during their early 20s. Using this table, Ellen M. Thomas Gee has calculated the 1881 average age at first marriage to be 25.1 for women [Ellen M. Thomas Gee, "Marriage in Nineteenth-century Canada," *Canadian Review of Sociology & Anthropology*, vol. 19, no. 3 (1982), p. 315].

²⁵ Percentages of the various age categories in the general population were calculated from the tables of "Ages of the People" from the 1880-81 census. See "Table F – Ages of the People," *General Report of the Census of Canada, 1880-81*, vol IV, (Ottawa: Maclean, Roger & Co., 1885), pp.22-23.

Table 2: Cases of Wayward Girls, Palliative Care and Senile Dementia

	Number of Cases	% of Total Patients (241)
Wayward Girls*	2	0.8
Palliative Care**	11	4.6
Senile Dementia***	10	4.1
Total (out of 241)	23	9.5

* Includes girls under the age of 20 admitted for “moral” crimes such as excessive drinking, sexual activity, swearing, and boisterous, “unladylike” behaviour. These cases do not include girls whose excitement and swearing began shortly before admission (marking the beginning of the illness) when they were reported as previously having good conduct.

** Includes women who entered the asylum in poor physical health and died within a year of admission.

*** Includes elderly women labelled with “dementia” in their patient file.

Source: AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

The organization of social welfare in Ontario during the late nineteenth century explains why so few of these cases came to be treated in the asylum. Wayward or troubled adolescents were typically placed in orphan homes or reformatories such as the Toronto Magdalen Asylum and the Andrew Mercer Reformatory for Females.²⁶ Such was the experience of patient Louisa A., a palliative case, admitted to Kingston’s asylum in March 1882 at the age of 22. Louisa was blind and had been an inmate of the Brantford Orphan Home and Brantford Blind Asylum since childhood (17 years). Her file suggests that ill health, combined with delusions and violence led to her transfer to Rockwood. Three months after her admission, when a diagnosis of phthisis (tuberculosis) had been confirmed, Louisa was re-admitted to an orphan home to die.²⁷ Her case suggests that doctors, under the authority of the inspector, moved inmates between institutions according to their most severe problem. Thus, Louisa’s final transfer to the orphan home likely arose either from a compassionate desire to let her die in a more familiar environment, or from a

²⁶ Splane, *Social Welfare in Ontario...*, pp. 168-169, 226.

²⁷ Louisa A., # 125

practical decision to create accommodation for a new patient whose condition was best suited to asylum treatment.

As with female adolescents, the asylum was also not the typical location for Ontario's institutionalized elderly. Elderly persons were more often placed in one of the province's Houses of Industry with other "deserving poor of all ages, types and descriptions."²⁸ Because the elderly were generally less able to work, they did not meet with the government's desire to create productive asylums using patient labour.²⁹ Moreover, since many older patients would be unable to benefit from therapeutic work in the asylum their committal was counterproductive to attempts to develop "curative" asylums. These sentiments are reflected in the patient records of Rockwood's elderly women. For example, 65-year-old Sarah S. was identified as "a poor old creature who has lived a lonely & solitary life by the lake shore... a harmless woman who should be in a poor house rather than a lunatic Asylum..."³⁰ Files of several other elderly women contain the common statement that they "might easily be taken care of at home."³¹ These remarks clearly suggest that asylums were not viewed as the proper placements for old people who needed chronic care, rather they were for persons exhibiting symptoms that doctors felt might be cured or alleviated with medical treatment.

²⁸ Montigny, p. 92

²⁹ Splane, p. 96

³⁰ Sarah S., # 199

³¹ For examples see Alice C., # 156 and Ann P., # 240

Interpretations of Insanity in Women

The age of Kingston Asylum patients also reflects the way Victorian doctors interpreted mental illness in women through the connection of female reproductive processes with women's "natural" mental and physical frailty. Nineteenth-century physicians saw women as highly susceptible to insanity because the instability of their reproductive system interfered with their sexual, emotional, and rational control.³² In 1884 Dr. Henry Lyman wrote in his book *The Practical Home Physician*:

Women's entire being, therefore, mental and moral, as well as physical, is fashioned and directed by her reproductive powers. It is easy to understand, therefore, that if these powers be never completely developed, there will and must be an arrest of development of her mental and moral nature.³³

The primary reproductive years were particularly vulnerable ones for women because doctors understood women's health problems as beginning at puberty, and continuing until the completion of menopause.³⁴ Table 1 showed that the Kingston Asylum indeed housed a younger population of women patients who were between 20 and 50 years of age, suggesting that women may have been admitted as a result of prevailing medical perceptions regarding women's health.

The casebooks demonstrate, however, that though doctors believed in a possible relationship between female reproductive processes and women's mental health, the number of patients whose insanity was related to menstrual problems and disorders of the reproductive

³² Elaine Showalter, *The Female Malady...*, p. 55.

³³ Henry M. Lyman, A.M., M.D., et al. "Diseases of Women and Children," in *The Practical Home Physician and Encyclopedia of Medicine: A Guide for the Household Management of Disease...*, (Guelph: The World Publishing Co., 1884[?]), p. 883., CIHM no. 12107.

³⁴ Mitchinson, *The Nature of Their Bodies...*, p. 77.

system was low (approximately 2 percent).³⁵ Such relationships were typically established when physicians had no other explanation for a patient's symptoms. One of these cases was that of 43-year-old Jane D, admitted to Rockwood on November 29, 1882. Jane's records identify her as a dangerous epileptic who had been insane 20 years, though she had worsened in the 6 months prior to admission, suspected to be the result of a fever. Contents of her patient file suggest that seizures occurred quite frequently and, as a result, her mental faculties were "much impaired", leaving her "very stupid." Thus it can be assumed that Jane experienced a gradual deterioration in her physical and mental health over time due to her epilepsy. Yet, a comment written by a gaol doctor verifying Jane's insanity at admission suggests that her reproductive age may also have influenced the interpretation of her illness:

This is a case of insanity, evidently coming on for years, arising from some derangement of the cerebral nervous system as indicated by weakened intellectual powers and increased frequency of epileptic fits, together with loss of restraint over self. The age of patient would suggest that the change in the system occurring at about this age (the menopause) may have increased the duration and severity of this last attack.³⁶

As one of the key stages in a woman's reproductive life, medical experts regarded menopause as a critical phase for women in regard to their mental health. While Jane's epilepsy was understood as the primary cause of her condition, doctors evidently regarded her menopause as a secondary factor, exacerbating the severity of the damage done by the epilepsy.

Cases of childbirth or puerperal mania among asylum patients can also be associated with female sexual health. Mitchinson states that the health problems of many of the women she examined dated back to their marriage and were clearly exacerbated by the birth of children.³⁷ Of the women admitted to Rockwood between 1878 and 1884, puerperal causes were identified

³⁵ Ibid.

³⁶ Jane D., # 157

as responsible for the insanity of 6 percent of patients.³⁸ Reading the records of these patients reveals that most of these women had what would now be regarded as some form of postpartum depression or psychosis; the emotional and physical strain of caring for an infant (often in addition to caring for other children) was perhaps more the exciting cause than the actual physical process of giving birth. This seems to have been the situation of 29 year-old Delmia R., committed to the asylum June 22, 1882. Married with 9 children, Delmia had likely given birth to a child every year since her marriage. Doctors identified her as a case of puerperal mania, with mental affliction caused by “hard work and poor food together with family troubles” after the birth of a child. Her file states that before admission she had been insane 6 years, becoming “better and worse ‘off and on’”. Although Delmia had threatened to take her husband’s life on several occasions, the final decision to commit came after she became “cruel and heartless to her children,” abusing them and making several attempts to “destroy her infant.” Evidently, Delmia’s husband was willing to suffer through his wife’s behaviour so long as she did not pose a threat to their children.³⁹

Like Delmia, patient Melina B. also suffered from the demands of excessive childbearing. Admitted in September 1884, Melina was 47 years old with 10 children. The gaol doctor reported she was anaemic and that her appearance indicated a “profound change in nutrition.” He believed her disorder to be caused by “some mental anxiety of prolonged worry acting upon an insufficiently nourished brain.”⁴⁰ Lack of sufficient food and money forced many

³⁷ Mitchinson, *The Nature of Their Bodies*, p. 61.

³⁸ AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

³⁹ Delmia R., # 139

⁴⁰ Melina B., # 245

mothers to go without in order to adequately feed and clothe their children, making nutritional deficiencies common in many mothers like Delmia and Melina. One nineteenth-century feminist noted that although “marriage *per se* [was] a divinely ordered institution...[a] comparatively small number of women who enter the marriage state booming and vigorous, continue so” due to the strains of childbearing.⁴¹ Even when a woman had a happy relationship with her husband, the daily toil of domestic labour could itself bring about mental breakdown, depending on the amount of work and availability of food, money, and household help.

Interpretations of insanity in women did not focus only on the biological functions of menstruation and childbearing, but were also concerned with female sexuality and sexual behaviour. While the number of women committed to asylums as a result of sexual vice was generally small, Victorian taboos against female sexuality made any engagement in morally questionable behaviour significant to physicians. Kingston, like other asylums, did not have many female patients whose insanity was interpreted as the result of moral vagrancy; of all cases studied here there is only one woman identified as a prostitute.⁴² Mitchinson suggests that the dearth of women diagnosed with moral insanity may reflect the way some women internalized Victorian taboos against female sexuality, causing them to place sexual restrictions upon themselves in an effort to avoid stigmatization.⁴³ Deviant sexual behaviour, when it did appear in patients, tended to be noted by doctors only after the woman had been a patient for some time and was more often described as a symptom of insanity, rather than a cause. Thus one might

⁴¹ Eliza M. Mosher, M.D., “The Health of American Women,” in *Woman: Her Character, Culture and Calling*, ed. Rev. Principal Austin, A.M., B.D., (Brantford: The Book and Bible House, 1890), p. 236, CIHM no. 06583.

⁴² Mary G., # 6

⁴³ Mitchinson, *The Nature of Their Bodies...*, p. 316.

assume that doctors saw these women as only capable of sexually aggressive behaviour when already affected by mental illness.

The sexual behaviours noted in the female casebooks of the Kingston Asylum can be divided into the general categories of vagrancy, eroticism and masturbation. Sexually vagrant behaviours included such acts as prostitution and sexual relations outside marriage. These activities clearly went against the moral standards of middle-class society and were thus believed to be a risk factor for mental deterioration. Erotic behaviours could include stripping, lewd language and sexual advances towards patients or medical staff. They differed from vagrant behaviours in that they were understood as a reflection of insanity, rather than a cause. Asylum staff usually identified women as “erotic” only after they had been patients for some time and sufficient time had passed to properly identify the behaviours as a chronic problem. Like sexual vagrancy, however, erotic behaviour was publically noticeable and likely was a cause of great embarrassment for families and friends of such patients.

Masturbation was the most common sexual vice associated with insanity in the patients’ records, cited as both a cause and symptom. Referring to such patients as “m” cases, Kingston’s doctors clearly saw masturbation as the sexual vice most dangerous to mental health, often overriding other possible causes. In 1884, notes from Elizabeth M.’s admission certificate state that “[t]he cause of insanity is said to be Hysteria, but one of her medical attendants says she is an inveterate ‘M’ case and has been such for years.”⁴⁴ Despite the apparent reluctance of Kingston’s doctors to directly connect sexual functions and behaviours with female insanity, masturbation appears to be the one area that remained problematic for them. Comments from

⁴⁴ Elizabeth M., # 198

Lyman's home medical text suggest that even the most liberal medical practitioners saw the practice as a contributing factor to poor health in women and girls:

The effects, physical and moral, of indulgence in this habit, though greatly exaggerated and distorted in the circulars and books with which the country is flooded by patent medicine venders and other quacks, are nevertheless dire enough. Among them we may enumerate loss of appetite and of flesh, bodily and mental weakness, nervousness, and disorders of the sexual and urinary organs. Yet, perhaps, the most disastrous is the moral effect...⁴⁵

Though masturbation and sexual vice were perceived more often as causes of insanity in men than in women, any transgression of the social code defining feminine modesty could be classified as diseased.⁴⁶

Given the number of women who had sexual behaviours and reproductive functions cited as symptoms or causes of their insanity, it is somewhat surprising that Kingston's physicians did not diagnose any women in this sample with nervous illnesses such as neurasthenia or hysteria, two illnesses commonly associated with disorders of the reproductive system and deviant sexual behaviour. Though Elizabeth M.'s insanity was said to be caused by hysteria, the asylum's doctors clearly regarded her masturbation as the more serious problem.⁴⁷ In the case of Jane D., previously discussed on page 15, reproductive problems were understood to have exacerbated her epilepsy rather than caused it.⁴⁸ Unlike Rockwood, the Homewood Retreat in Guelph had a large majority of its patients diagnosed with neurasthenia. The reasons for this difference seem to be more rooted in the class differences between private and public treatment facilities, than

⁴⁵ Lyman et al., p. 901.

⁴⁶ Carol Groneman, "Nymphomania: The Historical Construction of Female Sexuality," in *Deviant Bodies: Critical Perspectives on Difference in Science and Popular Culture*, eds. Jennifer Terry and Jacqueline Urla, (Bloomington: Indiana University Press, 1995), p. 222.

⁴⁷ Elizabeth M., # 198.

⁴⁸ Jane D., # 157.

actual differences in patient illnesses. "Neurasthenia" was arguably a more socially acceptable label for depression in middle-class society because it was recognized as a definable disease. As such its diagnosis carried implications that patients and families were not responsible for the illness. Kingston's doctors, working in a public asylum, were less concerned with protecting the social status of their patients and therefore were able to more directly diagnose the problem as melancholia. Thus, while female sexuality and reproductive processes influenced doctors' interpretations of insanity in women, they were generally not the primary factors determining a diagnosis.

Illnesses, Symptoms and Behaviours

What behaviours then, were most commonly understood to be symptomatic of insanity? Determining a specific diagnosis of a patient's illness is difficult in most cases, because of the variety of symptoms exhibited. Several women shared similar symptoms, but lack of information in the casebooks makes determination of the origins of the behaviour problematic. It is also difficult to determine whether the behaviours were symptomatic of a mental breakdown or were the result of a psychiatric disorder. While doctors could easily diagnose certain illnesses, the majority of cases could not be specifically classified due to the under-developed state of nineteenth-century psychiatry and the lack of specificity in the records. Furthermore, the state of psychiatric diagnosis explains why the majority of women were classified as suffering from "mania" either of the recurrent, chronic, or acute type. Other "manias" were labelled according to their suspected cause such as epileptic or puerperal.⁴⁹ Thus, a diagnosis of insanity consisted

⁴⁹ Of the 121 records available for 1878-1881, 90 women or 74 percent gave a diagnosis of some type of mania. After 1881, administrators no longer included a labelled diagnosis for most patients. [AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.]

more of reports of symptoms, rather than clear indications of a specific illness. It is for this reason that the contents of patients' records are so vital: Diagnostic labels given to patients in the casebooks and in the General Register are not always consistent and do not necessarily reflect the type of behaviour that was actually taking place. To reach a clear understanding into the illness of a particular patient the details provided in their asylum records must be considered in their entirety.

Often it was a particular combination of symptoms that led a person to be diagnosed as insane. These symptoms reflected behaviours considered abnormal and excessive according to middle-class social norms.⁵⁰ The most obvious example of the presence of a social code of behaviour can be seen through the specific qualities of character addressed in patients' admission notes. The majority of the patients' files state the general quality of their conduct and whether or not they were "industrious", "temperate", and "cleanly in habits". These characteristics clearly reflect the social purity ideals of middle-class philanthropists who saw personal hygiene, a solid work ethic, and a temperate lifestyle as important components of a sound moral existence.⁵¹ Deviating from these ideals was interpreted as a sign of low morality and could be seen as a sign of mental deficiency. Physicians also considered hereditary predisposition to be a dominant factor determining susceptibility to insanity. Nineteenth-century doctors believed that insanity reflected a general inherited weakness that could manifest itself in various ways.⁵² Many of the women studied here had relatives in asylums either before or at the time of their admission and

⁵⁰ Wendy Mitchinson, "Reasons for Committal..." p. 95.

⁵¹ Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925*. (Toronto: McClelland & Stewart Inc., 1991), pp. 18-20.

⁵² Warsh, " 'In Charge of the Loons': A Portrait of the London, Ontario Asylum for the Insane in the Nineteenth Century," *Ontario History* vol. 74, no. 3 (September 1982), pp. 150-151.

were duly noted in their patient file. For most asylum patients, problematic behaviour extended beyond these initial “detectors” of deviance. The majority of the women also experienced varying degrees and combinations of symptoms including violence, delusions, excitement, swearing and refusals to eat, sleep or work. The gendered nature of the social purity movement made swearing and harsh language doubly problematic for women, for it was not only understood as a passive type of violence, but was also seen as an indication of low morality. Doctors’ interpretations of these behaviours thus reflected the “very specific class, gender, and racial/ethnic characteristics, generally supporting the domination of Anglo-Saxon middle-class males over all others.”⁵³

As was the case in many other asylums, violence remained a primary factor motivating families and community members to commit individuals to asylums.⁵⁴ At the Kingston Asylum, the casebooks show 44 percent of the women exhibited violent behaviour prior to their admission, while a further 12 percent are identified as threatening violence before their committal. Using Mitchinson’s three categories of violent behaviour (toward property, others and self), Table 3 shows the prevalence of various types of violence at Kingston⁵⁵:

⁵³ Valverde, p. 33.

⁵⁴ See Kelm “The only place likely...”, p. 74; Mitchinson, “Reasons for Committal...”, p. 96; Warsh “In Charge of the Loons’...”, p. 148 and *Moments of Unreason...*, p. 68.

⁵⁵ Mitchinson, *ibid*, p. 96.

Table 3: Types of Violence Exhibited by Women Admitted to the Kingston Asylum for the Insane, 1878-1884

Type of Violence	Number of Women	Percentage(%) of All Women Admitted (241)
Property	27	11
Others	41	17
Self	36	15
Total Exhibiting Violent Tendencies (including threats)*	134	56

* Several women threatened violence, but did not actually follow through with these threats. This total includes those that actually committed physical violence and those who only threatened to do so.

Source: AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

For persons who behaved violently it was typically the severity and frequency of the outburst that determined how quickly tolerance for the behaviour would cease. A patient's violence could be directed at themselves and others through direct physical assault or attempted suicide, or indirectly by damaging property, throwing objects, or setting fires. Mary Ann M. was committed in 1884 as a pyromaniac with various delusions who "ha[d] been detected several times setting fire to buildings," already having "burned a dwelling house and threaten[ing] to burn more of her neighbours' houses."⁵⁶ Threats of violence or worrisome behaviour could be as much a cause for concern as actual abuse. Such was clearly the case with Elizabeth L., a 29-year-old woman admitted in July 1882. Although Elizabeth was generally melancholy and quiet, a few days before her admission, her sister made the following report:

A few days since a pet kitten was playing in the room when Miss [L.] suddenly jumped up from her seat, caught the kitten and went out to the woodshed where she killed it. When followed by her sister she justified the act by saying the kitten was an imp.⁵⁷

⁵⁶ Mary Ann M., # 243

⁵⁷ Elizabeth L., # 146

Elizabeth was committed a few days later. In this sense asylums served to protect families and the community from behaviour that was dangerous or that was perceived as posing a threat.⁵⁸

As Reaume points out in his discussion of abuse and violence, however, the asylum could also serve as a refuge for victims of family abuse.⁵⁹ Comparing Reaume's study of the Toronto asylum with the asylum at Kingston suggests that this scenario may have been more prevalent at the former institution; however, Rockwood did receive a few patients who clearly needed a place to escape domestic abuse. Lavinia C. arrived in November 1878 with delusions and wandering conversation, the cause of which was said to be a drunken and abusive husband. Later entries in her file remark that after her admission she did not give "the least trouble" and was "perfectly harmless," helping around the ward in any way she could.⁶⁰ The evidence demonstrates that what this patient needed was a means of escaping the abusive home in which she was living.

Lavinia's file also highlights the way excessive drinking could lead to asylum confinement. Alcohol abuse posed a problem whether patients were victims of another person's alcoholism (in Lavinia's case) or suffered from the condition themselves. Consequences were severe for patients whose lives were adversely affected by drink. When Jane C. was confined on June 16, 1884, doctors stated she had threatened to commit suicide and was abusive to her friends and parents. These behaviours were all deemed to be the result of "a too free use of alcohol" and "constant steady drinking".⁶¹ Intemperance became associated with "filth, disease,

⁵⁸ Asylums also protected patients from harming themselves though the primary concern would most likely have been for others living around them. Families would likely have tried to care for the relative at home as long as it was not dangerous for them to do so.

⁵⁹ Reaume, pp. 38-40.

⁶⁰ Lavinia C., # 24

⁶¹ Jane C., # 228

immorality and ignorance,” all of which were incompatible with social purity ideals.⁶² The association of alcohol consumption with men meant that the female drunkard was particularly degraded.⁶³ As well, it meant that in many cases, a woman’s drinking became a suspected cause of insanity even when the extent of its influence was not wholly clear.⁶⁴ Elizabeth R., for example, was admitted in November 1883 with a variety of delusions. On December 8 the physician included a report from the patient’s mother stating that previous to her daughter’s change in behaviour she had been seeing a young man during which time she “used considerable liquor”.⁶⁵ Although Elizabeth’s drinking apparently stopped when she began to behave oddly, the fact that it is inscribed in the casebook suggests the doctors felt it noteworthy as a possible exciting cause. Though a few asylums for inebriates were established during the period, these remained largely an ideal for finding a medical solution to drunkenness.⁶⁶ Where such facilities were unavailable, insane asylums could offer similar care.

Patient violence often resulted from delusions, although delusions could also by themselves be sufficient evidence of insanity, warranting a patient’s committal. Delusions were the most common symptom displayed by women in this sample with 61 percent of them experiencing some sort of imaginary hallucination. This grouping can be organized into 3 general categories, as represented in the following table:

⁶² Warsh, “ ‘Oh, Lord, pour a cordial in her wounded heart’: The Drinking Woman in Victorian and Edwardian Canada,” in *Drink in Canada: Historical Essays*, ed. Cheryl Krasnick Warsh, (Montreal & Kingston: McGill-Queen’s University Press, 1993), p. 81.

⁶³ Ibid.

⁶⁴ Mitchinson, “Reasons for Committal...,” p. 105.

⁶⁵ Elizabeth R., # 193

⁶⁶ Jim Baumohl, “Inebriate Institutions in North America, 1840-1920,” in *Drink in Canada: Historical Essays*, ed. Cheryl Krasnick Warsh, (Montreal & Kingston: McGill-Queen’s University Press, 1993), p. 96.

Table 4: Types of Delusions Experienced by Women Admitted to the Kingston Asylum for the Insane, 1878-1884

Type of Delusions	Number of Women with Behaviour	Percentage (%) of All Women Admitted (241)
Religious*	22	9
Grandeur**	24	10
Paranoia***	71	29
Other delusions	31	13
Total Delusional Patients	148	61

* Includes persons believing they had committed a great sin, had seen angels or the devil, or had connections with God and other religious figures

** Includes persons imagining their social status to be altered via excesses of money or property, association with royalty, marriage to a prominent community member, etc.

*** Includes persons with various sorts of fears and persecution complexes such as general worry, fear of a great calamity, believing neighbours and family were stealing their money and property or poisoning them.

Source: AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

Many patients' records do not offer details of delusions, so they cannot all be clearly classified under these headings. This lack of evidence explains why 13 percent of delusional patients are not accounted for in the table.

The case of patient Jane M. demonstrates why delusions could be so problematic even where violence was not present. Admitted November 1, 1881, Jane had numerous delusions as detailed in the details of her admission report:

This is a case of vagrancy and no history can be obtained in her case. Is incoherent in conversation, believes that she is fed on human flesh, believes that she is made a subject of [illegible]. Believes that she is surrounded by persons determined to murder her. Believes she hears people singing. Believes that she has been compelled to swallow reptiles and worms and that they are now present in her throat. Refuses food – claims her soup is human blood, the meat human flesh, and the bread filled with [illegible] and only weighs 62½ lbs. on the day of admission. A mere skeleton.⁶⁷

Undoubtedly, such behaviour placed relatives in a difficult position when trying to cope with Jane. Not only did Jane's delusions about food and being poisoned lead her to starve herself,

⁶⁷ Jane M., # 116

putting her own life at risk, but her relatives may have harboured a fear that, among neighbours and the local community, the family was mistreating or failing to care for her. The fact that no family history was provided suggests she may not have had family, though it is impossible to determine this either way. Whatever the family circumstances, such a case would clearly require some kind of external assistance and asylum committal offered a ready solution.

The number of women suffering from melancholia (depression) was small compared to those afflicted with mania; only 20 patients (8 percent) are diagnosed as depressed.⁶⁸ The overcrowded condition of asylums over time may have led to fewer admissions of people with depressive illnesses because they were more likely to be harmless than other excited and violent patients.⁶⁹ Nevertheless, the condition was equally problematic because such patients were often suicidal, or at the very least were burdensome due to their erratic behaviour and inability to work. As a case in point, Ella A. was confined in September 1881 suffering from melancholic symptoms that appeared shortly after the death of one of her children. Her file describes:

...great restlessness, sleeplessness, uneasiness, and a continued excitement. Appears to be in a constant grief about something as if some great calamity has befallen her. She appears to be suffering from melancholy and depression of spirits. She imagines she allowed the child referred to - to starve. Habits industrious and conduct good until lately - not inclined to look after household matters. Change was sudden.⁷⁰

Clearly the shock of her child's death led Ella into a temporary state of shock and depression.⁷¹

As with others, a variety of situations led these patients to exhibit symptoms of depression with

⁶⁸ AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks - Female, Jan. 28, 1878-Oct 28, 1884.

⁶⁹ Mitchinson, "Reasons for Committal...", p. 100.

⁷⁰ Ella A., # 108

⁷¹ Ella was released on probation on January 3, 1882 and was discharged on April 13, 1882.

the most common relating to domestic circumstances: grief at the death of family members and exhaustion. As previously stated, puerperal melancholia was also common with many women experiencing depression after the birth of a child.⁷²

The most clearly discernable condition present among asylum patients was epilepsy. Of the 241 patients studied, 16 (6.6 percent) suffered from grand mal seizures on a regular basis. Such seizures involved the patient losing consciousness (the result of which was often a serious fall) and experiencing convulsions most often associated with the disorder. As there were few treatments for epilepsy during this period, and those that did exist were usually unsuccessful, patients suffering with this condition were constantly at high risk of physical injury. Elizabeth L. R. was a 20 year-old woman admitted June 16, 1879 with a diagnosis of "recurrent mania". Examination of her file, however, reveals that the central reason for her admission was related to "frequent recurrences of epileptiform convulsions after which and sometimes before, she becomes very violent, abusive and has crying spells for a longer or short shorter time [sic]." The doctor's notes from July 31, 1888 report that Elizabeth had "several cuts about head, result of falling out of bed during fits." She remained in the asylum until her death in October 1900 when she choked while being fed by a nurse, as a result of a suspected seizure.⁷³

From a medical perspective, epileptic patients were at high risk for admission due to the lack of knowledge about the disorder during the late nineteenth century. By the 1880s, physiological studies had failed to explain the origins of idiopathic epilepsy, though scientists had concluded it was a problem of the brain.⁷⁴ This assumption led many physicians to associate

⁷² The implications of puerperal causes to insanity will be discussed later in this chapter.

⁷³ Elizabeth L. R., # 42

⁷⁴ See the discussion of Hughlings Jackson and W. R. Gowers in Owsei Temkin, *The Falling Sickness: A History of Epilepsy from the Greeks to the Beginnings of Modern Neurology*, 2nd ed., (Baltimore & London: The Johns Hopkins Press, 1971), pp. 348-350.

the disorder with insanity, though it remained unclear to them whether it was a symptom or a cause. Indeed, like Elizabeth L. R., many patients suffering with epilepsy did not have the condition recorded as part of their diagnosis in the General Registers. More often doctors listed some type of general mania, and it is only the detailed descriptions provided in the casebooks that draw attention to cases of epilepsy.

From the familial perspective, however, the example of Elizabeth L. R. illustrates the type of constant danger patients experienced, and the extensive care needed to ensure they did not harm themselves. No doubt it would have been difficult for many caregivers to provide constant watch over relatives suffering with epileptic seizures, particularly given the lack of successful treatments; moreover, lack of resources limited opportunities to alleviate the burden. Families would also have been influenced by medical and social interpretations of the disease. Social reactions to epileptics ranged from viewing them as morally degenerate, intellectually weak and (at the extreme) demonically possessed.⁷⁵ Such inferences could result in the social isolation of individuals and their families. Thus, the extent to which family and friends were able to tolerate the combined pressures of physical care of the epileptic and the social stigma attached to the disorder would largely determine decisions to commit.

Clearly, while symptoms of mental illness were the most visible and direct reason for admission to Kingston, the ability of family and friends to cope with maladies equally significant in determining when and why a patient was committed. For patients who had persons able and willing to care for them, asylum committal often depended on the nature of their relationship to their family and community, as well as the socio-economic circumstances in which the person lived. The final section of this chapter examines the social reasons behind the admission of

⁷⁵ Ibid., pp. 364-66.

women to the Kingston Asylum, looking at the significance of family relationships, marital status, childrearing and socio-economic position.

Social Factors and Relationships

When patients did not have persons willing or able to care for them, their chances of being committed to an asylum increased significantly. Although most women did have someone recorded as next-of-kin, a minority did not. Of the 229 patients listed in the Kingston Asylum's General Register, 28 patients (12 percent) have the "relations" section blank or have "unknown" written. In September 1879 22-year-old Amelia L. entered the asylum as "a stranger" with no relations listed. Her file contains no background information, merely identifying her filthy, emaciated condition upon admission and her general idiocy.⁷⁶ Minnie C. was a "stranger picked up on the streets of Kingston" in 1881, unable to care for herself with "ludicrous" delusions of having 24 children, 3 or 4 per birth.⁷⁷ On February 28, 1883 neighbours of Sarah H. sent her to Rockwood to be cared for after she developed a habit of wandering about the country. Since her husband was already a patient in the male wards, the asylum seemed a likely place for the neighbours to rid themselves of this woman whom they regarded as "a nuisance".⁷⁸ The behaviours of these three clearly women differed; Amelia was in poor physical health, Minnie was violent and delusional, and Sarah was confused and wandering. Yet, the reason for their committal was common to all: a lack of persons able or willing to provide care for them. The

⁷⁶ Amelia L., # 46

⁷⁷ Minnie C., # 99

⁷⁸ Sarah H., # 167

consequence for these women was to have the state assume responsibility for their care by placing them in an institution.

The experiences of Amelia, Minnie and Sarah were not uncommon. Single women were undoubtedly the social group most at risk for asylum confinement both due to the frequent absence of next-of-kin, and their generally lower socio-economic position. As Table 5 demonstrates, more than half of the women admitted to Rockwood in these years were unmarried.

Table 5: Marital Status of Women Patients Admitted to the Kingston Asylum for the Insane, 1878-1884

Marital Status	# of Files	% of Total Files
Married	108	44.8
Single	111	46.1
Widowed	15	6.2
Spinster	1	0.4
Previously married	3	1.2
Total # Women Without Partner*	130	54.0
Not given/unknown	3	1.2
Total # of Files	241	100.0

* Total of single, widowed, spinster, previously married

Source: AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

The large number of single women admitted to the asylum becomes even more profound when placed in context with the social demography of late-nineteenth-century Ontario. Marriage delay did not occur in Ontario to the same extent as it did in other Western countries during the same

period; Ontario women continued to marry in greater numbers than European women.⁷⁹ According to the 1880-81 census only 45 percent of all Ontario women over the age of 16 were unmarried, suggesting an over-representation of single women in the Kingston Asylum of almost 10 percent.⁸⁰ Differences in marital status between asylum women and women in the general population become even more apparent when one looks at figures for women ages 21-61, the age group most likely to be married.⁸¹ While only 32 percent of women in the general population ages 21-61 were unmarried, 53 percent of asylum women in this age group were without a spouse.⁸²

Thus the over-representation of unmarried women in the asylum can be attributed to a combination of social and economic difficulties faced by single women in their everyday lives. Late-nineteenth-century western culture placed limits on the range of acceptable behaviour for women; for the single woman this range was particularly narrow. Since marriage was seen as the fulfillment of a woman's role, Victorian spinsters were socially stigmatized. In examining the situation of women in late-nineteenth-century England, Pat Jalland acknowledges that unmarried women were seen as human failures, despite their high prevalence within society. As well, social theorists reinforced ideas about the "sexual, mental and physiological abnormality of

⁷⁹ R. Marvin McInnis, "Women, Work and Childbearing: Ontario in the Second Half of the Nineteenth Century," *Histoire Sociale – Social History*, vol. 24, no. 48 (November 1991), p. 243.

⁸⁰ These figures were calculated using "Table F – Ages of the People," and "Table G – Ages of the Married," *General Report of the Census of Canada, 1880-81*, vol IV, (Ottawa: Maclean, Roger & Co., 1885) pp. 22-23, 60-61.

⁸¹ This age range was chosen according to the age categories showing the highest numbers of married women. As I already have stated, most women married in their early 20s. Women under 60 would also have been at the least risk of being widowed as a result of the declining physical health of their husbands.

⁸² "Table F – Ages of the People," and "Table G – Ages of the Married," *General Report of the Census of Canada, 1880-81*; AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

spinsters.”⁸³ Deprived of the benefits of marriage, the single woman was susceptible to a variety of nervous disorders and mental defects.⁸⁴ Concerns over the moral well-being of the single woman abounded. The increasing population of single women moving into urban centres at the end of the nineteenth century meant their increased exposure to crime and sexual dangers, making them particularly vulnerable to a moral “fall” into vagrancy.⁸⁵ Given the already limited scope of behaviours considered “normal”, a single woman faced an increased risk of committal if she became erratic, delusional or violent.

While single women were viewed as “abnormal” for remaining unmarried, they also had to contend with the difficulty of living in a society that offered women few alternatives to marriage. Economic survival depended on both the presence of supportive family networks and the availability of work for self-support. The financial situation of widows was made somewhat better by the presence of children who could contribute their labour inside and outside the household.⁸⁶ Some single women were supported financially within their family of origin by parents or a brother, often caring for aging parents, doing domestic work in the home, or working in a family farm or business.⁸⁷ Such an arrangement undoubtedly placed a financial strain on the extended family by stretching already limited resources. The development of delusions, violence or other symptoms of mental illness only compounded the burden the single woman already

⁸³ Pat Jalland, *Women, Marriage and Politics 1860-1914*, (Oxford: Clarendon Press, 1986), p. 255.

⁸⁴ *Ibid.*, p. 256.

⁸⁵ Carolyn Strange, *Toronto's Girl Problem: The Perils and Pleasures of the City, 1880-1930*. (Toronto: University of Toronto Press, 1995), pp. 10, 53-56.

⁸⁶ Lorna R. McLean, “Single Again: Widow’s Work in the Urban Family Economy, Ottawa, 1871,” *Ontario History*, vol. 83, no. 2 (June 1991), p. 134.

⁸⁷ McLean, p. 136; Jalland, p. 261.

placed on family members who were often left with no alternative but to place the unmarried woman in an asylum.

Unmarried women who did not have such a support network faced particularly bleak circumstances due to low wages and diminishing opportunities for paid labour in nineteenth-century Ontario. Since society systematically defined the breadwinner role as male, female labour was regarded as supplementary, with Ontario women earning only 45 percent of the average male wage in the 1880s.⁸⁸ During the nineteenth century industrial capitalism was reshaping the nature of production and work into a largely market-oriented economy whose product orientation created an agriculture that gradually became less dependent on female labour.⁸⁹ Recognizing that at this time the majority of Ontario's population continued to live in rural areas, opportunities for paid work on farms greatly decreased for women leading many to move to urban centres to find waged work in factories. Such a move, however, could also mean the loss of the family and community support network, placing some women at a potentially greater risk of emotional breakdown.

⁸⁸ McLean, p. 131; Marjorie Griffin Cohen, *Women's Work, Markets, and Economic Development in Nineteenth-Century Ontario*, (Toronto: University of Toronto Press, 1988), pp. 129-130.

⁸⁹ For example, during second half of the nineteenth century the main orientation of the market-oriented Ontario farming was to beef, pork and dairy production. After 1860 dairying increasingly turned to cheese for export, an industry that developed on the basis of factory, rather than home production. Though butter continued to be made primarily on farms, its output grew less rapidly than the aforementioned products. The result was that women had increasingly less participation in the growing sectors of the agricultural economy [McInnis, p. 250].

Table 6: Occupations of Single Women Admitted to the Kingston Asylum, 1878-1881

<u>Occupations</u>	<u>Number of Women</u>	<u>Percentage of All Single Women</u>
Women Associated with Husband/Father's Occupation*	8	12.3
Manual Skilled		
Dressmaker	1	1.5
Fancy needleworker	1	1.5
Seamstress	1	1.5
Tailoress	1	1.5
Weaver	1	1.5
Semi- and Unskilled		
Servant*	37	56.9
Other		
Spinster	5	7.7
No Occupation	6	9.2
Unknown	4	6.2
Total	65	100.0

* Includes farmer's daughter, tailor's daughter, farmer's wife, labourer's wife.

** Includes cook, domestic, domestic duties, housekeeper, housemaid, servant.

Source: AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

Though work opportunities for women were limited, the casebooks indicate that 65 percent of the women listed as single, spinsters or widows had definable occupations that were not associated with the occupations of male relatives [Table 6], as compared to 30 percent of married women in the sample [Table 7] whose occupational identity was more often linked to their husbands' work (62.5 percent).⁹⁰ Although married women were much less likely to have

⁹⁰ Eighteen percent of the total women in the sample (married and single) had their occupation defined in terms of their roles as wives or daughters, for example "farmer's wife" or "labourer's daughter". Five women had their occupation listed as "spinster"; since it is unclear what was meant by such a classification, I have not included that occupational listing in the calculation of the number of single women with occupations [AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884]. The classification of occupations in Tables 7 and 8 are adapted from a similar table in McLean's "Single Again..." p. 132 and from Katz's "Status Ranking of Occupations" in his article "Occupational Classification in History," *Journal of Interdisciplinary History*, vol. 3, no. 1, 1972, p. 87.

an individual occupation, the fact that they were associated with their husband's position suggests wives were perceived as making a significant contribution to the household. As Mitchinson has pointed out, this occupational labelling does not support social control theories of the asylum as a place for containing the idle, as a listing of "none" or "no occupation" would suggest; while classifications of female occupations are often vague and inconsistent they nevertheless present women as productive members of society.⁹¹

Table 7: Occupations of Married Women Admitted to the Kingston Asylum, 1878-1881

<u>Occupations</u>	<u>Number of Women</u>	<u>Percentage of All Married Women</u>
Women Associated with Husband's Occupation*	35	62.5
Teacher	2	3.6
Manual Skilled		
Spinner	1	1.8
Seamstress	1	1.8
Semi- and Unskilled		
Servant*	12	21.4
Prostitute	1	1.8
No Occupation	2	3.6
Unknown	2	3.6
Total	56	100.0

* Includes blacksmith's wife, carpenter's wife, doctor's wife, farmer's wife, gardener's wife, labourer's wife, machinist's wife, merchant clerk's wife, miller's wife, school teacher's wife, shoemaker's wife, soldier's wife, tailor's wife.

** Includes domestic, housekeeper, and servant.

Source: AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

⁹¹ Michinson, "Gender and Insanity...", p. 113.

The reasons for keeping records of patients' occupations were likely both economic and social. Patients whose occupations (or that of their husband) suggested a lower economic status would have had fewer financial resources available for the treatment of their illness. Because most men worked away from the home, a husband would have had a difficult time coping should his wife become ill. If he could not afford to hire someone to care for her in the home, an institution became the only alternative.⁹² A patient's occupation also would have given asylum administrators some idea of whether they or their family would be able to make support payments to the asylum during treatment. Since it is unclear from the documentation whether support payments were mandatory or voluntary, it is only possible to speculate about the use of this information.

From a social standpoint, recording occupations provided asylum doctors with insight into the various stresses in patients' lives, which may have contributed to their illnesses. For example, domestic service was the most common independent occupation for women with 57 percent of the single women and 21 percent of the married women working as servants [Tables 6 & 7]. Domestic service offered certain advantages to some women; the constant demand for servants made it easy to find employment, and for single women the position often included food and lodging. Yet the work itself was poorly paid and involved long hours; live-in servants had little privacy and were always at their employer's disposal. Thus overwork, sleep deprivation, poor nutrition, and lack of fresh air were all factors that undoubtedly contributed to the poor mental and physical health of patients working as domestics. Since most employers would have been unwilling to support servants who were unable to work, a domestic's mental illness often

⁹² Mitchinson, "Reasons for Committal..." p. 102.

meant the loss of her job and housing and, consequently, her food and lodging. The need for institutional care therefore became even more pressing.

It may well have been the experience of patient Harriet S. who entered Rockwood in July of 1882, after fits of violence toward her siblings and boisterous behaviour where she would “swear[], laugh[] and imitate[] different things.” Her father’s remarked in his statement to the asylum that Harriet “was always healthy until she went to the States about 4 years ago, her occupation was that of a cook in a private house.” Given that Harriet began to improve by the end of August and was discharged as recovered in October, the file suggests that a mental breakdown caused her insanity.⁹³ Though there is no way to be certain that her work was the cause, it certainly seems to be the most likely source of her troubles given the extent of the information provided in her file.

* * *

Clearly, the development of a patient’s “insanity” depended on the interaction of a variety of symptoms and disturbing behaviours with a particular set of difficult life circumstances for the patient and/or their family. Although the majority of the women studied here exhibited very definite symptoms of some type of mental illness, the actual decision to commit was usually precipitated by accompanying family or social concerns. Thus, in most cases, entrance into Kingston’s asylum occurred due to lack of caregivers; community intolerance for disruptive behaviour, or the family’s gradual inability to cope with the relative’s actions and a need to have the state assume responsibility for the person and their problems.

⁹³ Harriet S., # 144

That many families were willing to suffer through years of turbulent behaviour from the afflicted woman before committing her suggests they felt some uncertainty towards the asylum. As Kelm has pointed out, the development of a public emphasis on asylums as curative facilities did not change their popular reputation as custodial institutions.⁹⁴ Thus, it would also be a mistake to interpret a family's decision to commit as marking the end of their uncertainty regarding asylums or the termination of ambivalent feelings they may have had over committing relatives. This uncertainty sometimes led families to choose to remove relatives from the asylum, despite a lack of improvement in their behaviour. It suggests a concern with the quality of care and treatment that was offered at the Kingston Asylum for the Insane. In an attempt to assess the validity of such concerns the next chapter examines the type of treatment offered to patients at Rockwood during the years these women lived there.

⁹⁴ Kelm, p. 81.

2.

**Refuge or Restraint?: Administration and Patient
Treatment, 1878-1906**

The treatment provided at the Kingston Asylum during the late nineteenth century was, to a large extent, typical of that being implemented in the majority of other institutions for the insane in North America. Psychiatric theory of the period was characterized by holistic approaches to treating mental illness.¹ Moral treatment and other non-interventionist practices formed the basis of patient therapy and were complemented by more invasive therapies such as drugs and surgical operations. These therapeutic methods became widespread beginning in the mid-nineteenth century, marking the first attempt to actively treat mental illness and move away from former asylum practices that offered dismal custodial care. This chapter examines the treatment available to patients at the Kingston Asylum, the steps taken to improve patient therapy during the 1880s and 1890s, the reactions of patients to asylum care, and the influence of family and community during treatment.

Perceptions of insanity began to change in Europe during the late eighteenth century when physicians started to argue for the “curability” of the condition if particular therapeutic measures were taken to procure such a recovery. During the Georgian era some patients showed signs of improvement under a regimen of treatment that aimed to build self-esteem and self-control through a calm, organized atmosphere.² This regimen marked the beginning of what was to become known in the nineteenth-century as “moral treatment”. Philippe Pinel of the Salpêtrière in France and Samuel Tuke of the York Retreat in England spearheaded the movement toward this type of therapy: Theories of moral treatment first appeared in 1801 in Pinel’s *Traité médicophilosophique sur l’aliénation mentale, ou la manie*, where he proposed a

¹ Gerald Grob, *Mental Illness and American Society...*, p. 13.

² Anne Digby, “Moral Treatment at the Retreat, 1796-1846,” in *The Anatomy of Madness: Essays in the History of Psychiatry, vol. II*, eds. W. F. Bynum, Roy Porter and Michael Shepherd, (London & New York: Routledge, 1988), P. 53.

method of therapy which would focus on a patient's intellect and emotions. In 1813 Samuel Tuke incorporated his own Quaker beliefs with Pinel's ideas in his *Description of the Retreat*. This work popularized the term "moral treatment" in English, making it publicly synonymous with the Tuke family's asylum at York.³ Throughout the course of the nineteenth century the principles of this therapy quickly spread across Europe and North America via articles published in medical journals by physicians specializing in the field.

The main purpose of moral treatment was to create a means of transforming asylums from dismal custodial warehouses into hospitals offering a humane atmosphere and the promise of a cure. Though opinions surrounding its implementation varied among medical experts, its central philosophy was to provide a calm and structured environment for patients that would duplicate the ideals of life in a middle-class home; such an atmosphere would allow patients to self-heal without direct interference from medical staff. In 1864 the Scottish Commissioner in Lunacy described the treatment in terms of its difference from previous methods:

Moral treatment may be defined—every mode by which the mind is influenced through the mind itself, in contradistinction to medical treatment, in which the mind is acted upon remotely by material agents, and *through* the body... The application of [the] principles [of moral treatment] might be forcibly brought out by contrasts: where all was darkness, suspicion, vigilance, and locks and bars, there are doors with common handles, plate glass, a park without walls and parole; where you saw fourteen octogenarians in a row, strapped hand and foot, in the American *chaise de force*, who could scarcely articulate their mumbled petition for snuff, there is now no restraint; where no book was allowed to enter, there is now a library of three or four thousand volumes.⁴

Work, exercise, religious instruction and various amusements were seen to enhance patients' self-esteem and peace of mind, while structure, discipline, entertainment and a "gentle system of

³ Digby, pp. 52-53.

⁴ W. A. F. Browne, "The Moral Treatment of the Insane; a Lecture," *The Journal of Mental Science*, vol. 10, no 51 (October 1864), pp. 313, 315.

rewards and punishments” provided them with sound moral values to build and restore their mental health.⁵

The treatment program that was implemented at the Kingston Asylum during the late nineteenth century emerged from these theories, making moral treatment the basis of its rehabilitative therapy. While Rockwood’s doctors continued to use a variety of interventionist operations and medications, they did so only when moral treatment alone proved insufficient to procure improved mental health. As will be seen in this chapter, the success of Kingston’s treatment program lay not so much in its ability to cure patients (though many did recover), but in its ability to provide them with a healthy living environment that offered many of the benefits of life outside the asylum.

The Physical Setting of the Asylum for the Insane, Kingston

The successful implementation of moral treatment depended on the appropriateness of a building’s physical setting, structure, and the quality of its medical staff. Following the example of the York Retreat, medical experts believed the ideal location for an asylum to be in the countryside, close to an urban centre.⁶ Such a setting allowed the institution to receive employees, services and supplies from the city, while avoiding the urban noise and crowding that was counterproductive to the aims of moral treatment. Large properties were preferred so as to later accommodate the building of further facilities on the property, and to provide patients with an adequate space for outdoor work and leisure activities.⁷ The Rockwood estate was purchased specifically to achieve this type of asylum environment. As was previously discussed, it was

⁵ Ibid., p.

⁶ Reaume, p. 6.

⁷ Rothman, p. 138

situated on 35 acres of lakefront property in Portsmouth Village, just west of Kingston. In 1878 and 1880 respectively, the province purchased the neighbouring Jackson estate to the east and Ordnance land to the west, further expanding the property by 170 acres.⁸ The large size of the property would later allow the asylum to avoid the overcrowded conditions that were to become problematic in other institutions. For example, although the Toronto Asylum was originally constructed on over 100 acres, the encroachment of the city upon the property throughout the nineteenth century reduced it to only 26 acres by the 1880s, a situation that made the successful implementation of moral treatment difficult.⁹ Rockwood was fortunate not to face such problems, and its spacious property permitted continual expansion throughout the late nineteenth century.

Recommendations regarding the proper design of the asylum building also abounded. American physician, Thomas Kirkbride, became the leading authority on this aspect of asylum treatment during the second half of the nineteenth century. Head of the Pennsylvania Hospital for the Insane from 1840-1883, Kirkbride's book, *On the Construction, Organization, and General Arrangements of Hospital for the Insane, with some Remarks on Insanity and its Treatment* (1847), provided a extensive analysis of physical and administrative aspects to treating the insane.¹⁰ Most nineteenth-century asylum buildings consisted of a domed central block connected by a series of hallways to two wings, one housing male patients and the other housing female patients. This type of division by sex was common; Kirkbride wrote to Rockwood's superintendent in 1876 that they had only found "advantages in the arrangement,"

⁸ AR, 1880, *Ontario Sessional Papers* (No. 8), p. 38.

⁹ Reaume, p. 6.

¹⁰ Rothman, p. 134 and p. 343, footnote 8.

and that nothing would incite them to “go back to the old plan” of having men and women in the same unit.¹¹ If the size of a property permitted, large cottages were built a short distance from the main asylum building to house non-violent patients who did not require extensive care or supervision. The property might also house exercise yards, a farm, a dairy, vegetable gardens and other facilities used for patient work therapy.

In the case of the Kingston Asylum the central block and the wings were each four stories high with the centre block containing the offices of the medical superintendent and bursar, the reception room, attendants apartments, and patient dining rooms. Many patients had small separate apartments of 1150 cubic feet; the remainder lived in the 6 dormitories of the far wings or in one of the cottages elsewhere on the property.¹² During its first year under provincial jurisdiction the Kingston Asylum had accommodation for 438 patients, housing between 410 and 420 individuals at various times throughout the year.¹³ Over the course of the period under study the asylum population continued to be kept under strict control; although Rockwood’s capacity expanded with the building of additional cottages, the asylum never experienced the overcrowding suffered by institutions elsewhere.¹⁴ Under recommendations made by medical superintendents and the provincial inspector, Rockwood’s other facilities also greatly expanded and improved over the course of the last quarter of the nineteenth-century, increasing farm and recreational facilities, adding décor to the interior of buildings and cribbing to the waterfront.¹⁵

¹¹ AR, 1877, *Ontario Sessional Papers* (No. 2), p. 213.

¹² AR, 1880, *Ontario Sessional Papers* (No. 8), p. 38-40.

¹³ AR, 1879, *Ontario Sessional Papers* (No. 8), pp. 38-39.

¹⁴ Along with the problem of its ever-shrinking property, the Toronto asylum also constantly experienced severe overcrowding. It became particularly problematic in the early twentieth century when administrative offices were converted to dormitories and some patients were forced to sleep on sofas in the corridors. [Reaume, pp. 7-8.]

All of these improvements ensured that the overall physical setting and structure was highly sufficient for the maintenance of moral treatment as a therapeutic treatment.

Asylum Staff

The composition of an asylum's medical staff was the second major factor influencing the quality of patient treatment. At the top of the administrative hierarchy was the medical superintendent and his associate, the assistant superintendent. To a great extent the quality of the institution depended on the competence of the men who held these positions, for it was the superintendent who was responsible for evaluating the condition of the asylum, its requirements and reporting them to the provincial inspector. He was also the institution's head physician and, as such, made crucial decisions regarding patient care and treatment. When the medical superintendent was absent for any reason, these responsibilities were transferred to the assistant superintendent. Because the position combined the chief administrative and medical duties, requiring one person to shoulder the responsibility for all areas of the asylum's operation, it was essential that a medical superintendent be a highly competent individual who was able to cope with the position's many demands.¹⁶

Dr. William Metcalf was arguably well-equipped for overseeing the province's newest asylum acquisition. Educated under Dr. Joseph Workman at the Toronto asylum, Metcalf had worked in asylum administration since 1871, and was Assistant Superintendent of the London

¹⁵ AR, 1879-1896, *Ontario Sessional Papers*. Three times each year the Inspector of Asylums, Prisons and Public Charities made unannounced visits to each of the province's institutions to evaluate their conditions, offer recommendations to asylum administrators, and gather information for his annual report to the provincial government.

¹⁶ All asylums also had a bursar who was in charge of keeping financial records and submitting a separate report to the provincial inspector. Though the bursar's position was also at the top of the asylum hierarchy, it did not involve interacting with patients and thus did not carry the same level of responsibility as the medical superintendent. Unlike the superintendent, the bursar did not face the same degree of public accountability for his actions.

asylum under Dr. Richard Bucke previous to his arrival at Rockwood in 1878. His experience at other Ontario asylums provided him with a sound background in psychiatric theory that he quickly put to use at Kingston. Though Metcalf's position was initially a temporary one (replacing the retired former superintendent), it allowed him the time to fully grasp the needs of the asylum and its patients before the government granted him the job permanently in July 1879.¹⁷ In 1881 Metcalf invited his brother-in-law Dr. Charles K. Clarke to join him at Rockwood as Assistant Superintendent, further strengthening the asylum's administration. Since Clarke had also been educated under Workman, he believed strongly in the benefits of moral treatment and shared many of Metcalf's opinions regarding asylum operation. Their common views allowed them to build a strong foundation for moral treatment and a consistent approach to medicinal and surgical therapies. After Metcalf was murdered by a patient in 1885, Clarke became head medical superintendent and continued developing the reform ideas the two men had initiated during their partnership. Over the next twenty years Rockwood's treatment program expanded greatly under his leadership.¹⁸ The success of the two men as asylum administrators will become clear throughout this chapter as their actions are discussed in relation to the various treatments offered to patients.

One of the most important aspects of administration for the superintendent was the management of the asylum's attendants. Though at the bottom of the employee hierarchy, attendants were responsible for all aspects of patients' day-to-day care including their cleanliness, dress, meals, exercise and activities. This extensive list of responsibilities meant attendants had regular contact with patients and were largely responsible for their welfare. When

¹⁷ AO, RG 63, Subseries A-1, *Correspondence of the Inspector of Asylums, Prisons and Public Charities* [hereafter *Inspector's Correspondence*], vol. 240, file 6783, "Metcalf to Langmuir," 7 July 1879.

¹⁸Greenland, pp. 9-10.

Metcalf became interim superintendent in 1878 he found the condition of the attendant staff deplorable; many were harsh and unsympathetic to the plight of their insane charges, or too old to perform their duties properly.¹⁹ With the permission of Inspector Langmuir he quickly set about replacing many staff with “young active men” who would “best serve the interest of the Asylum.”²⁰ Shortly after, he informed Langmuir that the new men employed were “giving good satisfaction” and to express his happiness regarding the improvements to Rockwood’s staff.²¹ It is somewhat remarkable that Metcalf was able to find such quality workers, for as Connor discusses, attendants were poorly paid, the job was highly stressful and it carried a risk of physical abuse from patients.²² In any case, Metcalf’s actions suggest that he felt that asylum treatment was only as good as its staff, and that moral treatment could only be effective if there were quality physicians and attendants to put the therapy into practice.

Clarke also strongly disapproved of institutions whose staff could not meet the rigorous demands of asylum employment. When he took over as medical superintendent in 1885, he quickly made the decision to create a training program for female attendants. Though nursing schools were developed in Ontario during the 1870s, Rockwood became the first asylum to implement such medical professionalization, and its program marked the earliest attempt in Canada to provide formal training in the care of the mentally ill.²³ Called the Rockwood

¹⁹ Connor, p. 257.

²⁰ AO, *Inspector's Correspondence*, vol. 235, file 6712, “Metcalf to Langmuir,” 1 October, 1878.

²¹ *Ibid.*, 8 October, 1878.

²² Beginning in 1877 attendants at Kingston typically worked a minimum of 70-80 hours per week with weekly wages of \$20 for males and \$10 for females. Though their pay was greater than that earned by domestic servants in the late nineteenth century, asylum attendants had harsher working conditions making service more attractive. See Connor, p. 254 and Shortt, p. 46.

²³ *Ibid.*, pp.10-11.

Training School for Nurses, it also marked a process whereby attendant work was increasingly feminized, marking a gender division in asylum service.²⁴ In order to attract a better social class of women to the occupation, the government provided funding for a 25 percent wage increase for female attendants.²⁵ The first organized lectures began in March 1887, and they included lessons on elementary physiology, anatomy, general nursing of the sick, and nursing of the insane. This two-year program was followed by three months working in the asylum infirmary under a trained nurse. At the end of each year students took oral and practical exams and successful graduates were awarded diplomas and medals. Since all female attendants at Rockwood were required to undergo training and the program increased communication between the various levels of staff, improvements were immediately seen in the administration of patient care.²⁶

Moral Treatment and Patient's Daily Life

Once the initial staffing improvements were made, Metcalf was able to focus his attention on implementing a treatment program at Rockwood that utilized the principles he had learned throughout his experiences in other asylums. With the help of recommendations made by Langmuir and the funding provided by the provincial government, a therapeutic program was developed during the late 1870s and early 1880s that incorporated the basic components of moral treatment. In order to protect patients, one of the first reforms at the asylum was the limitation of public access to the asylum; until 1878 individuals had been allowed to roam freely throughout

²⁴ Connor, p. 264.

²⁵ Ibid.

²⁶ Connor, p. 266.

the wards “without any object in view other than the satisfying of a morbid curiosity.”²⁷ Physical restraints were also largely eliminated, and doctors encouraged patients to channel their energies into asylum work and recreational activities. During Clarke’s years as medical superintendent the Kinston’s facilities and leisure activities greatly expanded, and with the assistance of the more educated nursing staff, the asylum became known for its exemplary implementation of moral treatment.

In order to maintain organization, encourage self-discipline, and promote a healthy lifestyle a schedule of bells or (after 1881) whistles regulated the daily life of the asylum’s patients and staff from early in the morning until bedtime. Mealtimes gave structure to this schedule, and four times a day patients who were well enough assembled in one of Rockwood’s eight dining rooms. The menus at Kingston reflected the tenets of moral therapy that required patient meals to be simple and nutritious. Dinner was the main meal of the day, typically consisting of boiled meat, a vegetable, pudding and bread.²⁸ The Inspector’s Annual Reports suggest that Langmuir and O’Reilly found the quality of meals and dining facilities generally good, though they periodically made suggestions regarding the quantity and variation of food offered. For example, during one of Langmuir’s visits in 1881 he observed that the breakfasts and teas, which consisted only of bread and butter and coffee or tea, were not ample nor varied enough, and recommended that twice a week they be supplemented by porridge and milk at breakfast, and potatoes and rice at tea.²⁹

²⁷ AR, 1879, *Ontario Sessional Papers* (No. 8), p. 42.

²⁸ AR, 1880, *Ontario Sessional Papers* (No. 8), p. 38-40.

²⁹ AR, 1882, *Ontario Sessional Papers* (No. 8), p. 35.

In the morning and afternoon hours between meals, patients who were physically able were encouraged to work within the institution at a variety of different tasks. As the previous chapter indicated, the nineteenth-century social purity movement viewed industriousness as a valuable attribute that indicated a sound moral constitution.³⁰ The desire to instil these mores in asylum patients as a means of restoring their mental health led Victorian psychiatrists to incorporate work therapy into the moral treatment program. By giving an outlet for patients' energy, productive work would promote recovery through the restoration of "the physical health, the sound sleep, the agreeable *sensations*, the mental quiet."³¹ Industry would also help to reduce the need for physical restraint, for, as Metcalf stated in his 1885 report to the inspector: "...it is better for patients to work off superfluous muscular energy by some useful employment than by wrestling with a muff."³² Patient labour also had the added benefit of reducing the number of staff required to operate the institution, giving governments a financial incentive to encourage the implementation of these programs.

Since labour was beneficial to both the patient and the institution, there is little question as to why medical superintendents worked to expand their patient work programs. Rockwood was no different from any other asylum in this respect, and during its early years under provincial administration the demand for tasks in which patients could be gainfully employed grew rapidly. In 1881, 70 women worked at the asylum, representing 33 percent of Rockwood's female population; by 1885 this number had increased to 210 women or approximately 72 percent. Outdoor labour was thought to be most ideal improving for procuring physical and

³⁰ See chapter 1, p. 20, and Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925*. (Toronto: McClelland & Stewart Inc., 1991), pp. 18-20.

³¹ Browne, p. 319.

³² AR, 1885, *Ontario Sessional Papers* (No. 11), p. 122.

mental health, due to its ability to improve a patient's appetite, sleep and physical fitness.³³ Working outdoors, however, remained largely the sphere of men and, due to the sexual division of labour, women rarely benefited in this way. Asylums typically engaged female patient at indoor labour in the laundry, dining rooms, or kitchens. Women who were too frail to perform highly physical tasks worked on the wards sewing or knitting clothing and decorative textiles, a sight which O'Reilly viewed as "particularly pleasing."³⁴ The amount of time spent working varied from patient to patient depending on their physical capabilities. For example, Elizabeth T. entered the asylum in June 1881 suffering from incipient tuberculosis from which she eventually died in 1891. Although her frail health rendered her unable to work for eight of the ten years she spent at Rockwood, from 1886-1888 her health improved for a time and she spent many hours working in the laundry.³⁵ Patient Margaret C. also worked in the laundry from the time of her admission in December 1881 until she injured her hand and wrist in an accident with the clothes mangle.³⁶ Ann M., an elderly patient, was one of the few women to work outdoors at the asylum. Though Ann was 60 years of age at the time of her admission in 1878 and possessed constant delusions, her file identifies her as "the most useful woman in the asylum" for her initiative in taking full charge of the dairy each day from "early till late," a job which she continued at for several years.³⁷ Clearly, work was an important means of keeping patients occupied and maintaining order within the institution. Though Clarke acknowledged the

³³ Lloyd Francis, "Outdoor Work as a Remedial Agent in Insanity," *Journal of Mental Science*, vol. 33, no. 143 (October 1887), p. 366.

³⁴ AR, 1885, *Ontario Sessional Papers* (No. 11), p. 40.

³⁵ Elizabeth T., # 97.

³⁶ Margaret C., # 119.

³⁷ Ann M., # 9.

“tax[ing] ingenuity” that was required to supply useful and profitable work to so many patients, the Kingston Asylum continued to be well-regarded by the inspectors for its sound work program throughout the 1880s.

Doctors believed that in order for patients to benefit fully from a regimen of regular labour, work needed to be complemented by a balance of leisure and recreational activities. By the 1860s, European physicians lauded the benefits of therapeutic “amusements” for their ability to enhance the self-esteem and emotional well-being of the insane.³⁸ These ideas quickly spread to North America and, by the 1870s most Ontario asylums had begun to implement extensive leisure programs for their patients.³⁹ Over the course of the 1880s numerous activities were organized to break the monotony of the daily routine. Since religion played a central role in moral treatment, patients were encouraged to attend any of the Sunday church services offered by clergy from each of the major Protestant denominations in the city. Though Roman Catholic services were not held, priests were frequently brought to the wards of the asylum to offer service to patients of that faith. Staff and patients alike regarded religious services as one of the more uplifting activities, and doctors believed them to be highly beneficial to increasing a patient’s sense of morals and emotional security.⁴⁰

Many leisure activities were also available for patients throughout the week to improve their physical and mental health. For women patients one of the most important was the gradual development of exercise programs at the asylum. Though exercise was valued for all patients, it was given particular attention in regard to Kingston’s female patients as a means of

³⁸ Browne, pp. 330-334.

³⁹ For descriptions of amusements at the London and Toronto asylums see respectively Warsh, “‘In Charge of the Loons’...,” pp. 166 and Reaume, pp. 102-105.

⁴⁰ Reaume, p. 104.

compensating for their inability to participate in outdoor labour. In 1878 Langmuir identified the absence of exercise for women as “[t]he most serious defect apparent in the administration,” and he recommended that a board fence be constructed around the rear yard so that female patients could spend several hours a day walking outside.⁴¹ The following year he further recommended that a similar airing court should be completed for the female patients that were housed in the asylum’s refractory (isolation) wards.⁴² Regarded as “the most natural and common form of exercise” for women, walking was initially viewed as sufficient for preserving their health; for several years it was the only exercise available to women in the asylum.⁴³ Additional programs were not implemented until the 1890s when Clarke introduced formal exercise classes as a means of incorporating physical activity into Rockwood’s various leisure activities. Beginning in 1890 “Physical Culture Classes” were conducted each day in the amusement hall where women could participate in callisthenics put to music performed on the asylum piano.⁴⁴ The patients’ participation in these classes pleased Clarke, who was of the opinion that the classes had value “not only as a curative agent, but also in establishing a healthful discipline in the wards.”⁴⁵

While asylum physicians promoted exercise primarily for its physical benefits, various other activities and materials at the asylum provided the women with more relaxing forms of leisure. Patients had access to a variety of newspapers and other reading materials donated to the

⁴¹ AR, 1879, *Ontario Sessional Papers* (No. 8), p. 40.

⁴² AR, 1880, *Ontario Sessional Papers* (No. 8), p. 42. The refractory wards were the isolation wards where administrators placed violent, troublesome patients until they were once again calm.

⁴³ Edward Playter, “The Physical Culture of Women,” in *Woman; Her Character, Culture and Calling*, ed. Rev. Principal Austin, (Brantford: The Book & Bible House, 1890), p. 224.

⁴⁴ AR, 1892, *Ontario Sessional Papers* (No. 7), p. 76.

⁴⁵ AR, 1891, *Ontario Sessional Papers* (No. 6), p. 98.

asylum, and by the 1890s the asylum produced its own in-house journal. A monthly publication produced by Clarke's daughters, the *Rockwood Review* focussed on "soft", uncontroversial topics of general interest. All members of the asylum population were invited to submit poetry and articles to the paper, helping to create a sense of institutional cohesion among patients and staff.⁴⁶

Social events for patients began to be organized in the early 1880s when weekly dances were held for patients during the winter months from November to April. In 1884 a group of asylum officers and employees organized dramatic and minstrel clubs that performed regularly for patients and periodically, the wider Kingston community. These events proved very popular and became a central component of the entertainment offered at the asylum. The summer was a particularly pleasant season for patients; the good weather allowed for an increase in the variety available activities and increased opportunities to escape the confines of the wards. The government purchased a steamship for the asylum in the summer of 1885, and in the summers that followed, most patients were taken once a week for trips around the lake. Patients who showed themselves to be particularly industrious and well-behaved were rewarded for their labour through participation in annual excursions to the circus and local fairs away from the asylum property. A letter Clarke wrote to Inspector O'Reilly regarding an 1886 circus trip suggests that women may have had less opportunity to participate in these excursions. His request for money for tickets states: "We would like to send male patients working on the farm and a few of the women."⁴⁷ The importance of female reproductive labour to Rockwood's everyday functioning likely made administrators more reluctant to allow large numbers of

⁴⁶ Connor, pp. 264-265.

⁴⁷ AO, *Inspector's Correspondence*, vol. 238, file 6742, "Clarke to O'Reilly," 10 Aug, 1886.

women to go on excursions. Whatever the reason, the letter suggests a gender bias and a second area in which female patients were less able to participate in outdoor activities.

The most significant aspect of entertainment at Kingston, for which the asylum would become renowned, was its music program. Music had long since been an important facet of moral treatment; the Ontario government and asylum administrators strongly favoured staff with musical training and abilities.⁴⁸ Clarke himself had a strong interest in music and held music therapy in high regard. A successful amateur musician himself, he played the cello and violin, and, for a time, attempted to learn the cornet. In later years he would become a non-professional member of the Toronto Symphony Orchestra.⁴⁹ His musical abilities and interests made him particularly attractive as an asylum superintendent; under his leadership music became a central element of patient therapy at the Rockwood. Starting in 1885 patients and staff were encouraged to play the asylum's various pianos and organs, while yearly expenditures for sheet music often reached \$100.⁵⁰ During the week local choirs and other musical groups were invited to perform at the asylum. In 1888 Rockwood hired William Madill, a former army bandsman to conduct the asylum band, making the asylum the first to hire a full-time music instructor. By the late 1880s Kingston had an asylum orchestra and a brass band whose members were a mix of patients and attendants; the groups became well known throughout Kingston and their performances became popular community events.⁵¹

⁴⁸ Warsh states that at the London asylum prospective attendants stood little chance of being hired if they did not have the ability to play an instrument. See "In Charge of the Loons'...", p. 166.

⁴⁹ Greenland, p. 11.

⁵⁰ Connor, p. 262; Greenland, p. 11.

⁵¹ Ibid.

The provincial government provided the Kingston Asylum with a great deal of money to introduce and maintain these leisure activities. Letters from O'Reilly to Clarke during the late 1880s and early 1890s suggest an intention to use Rockwood as a model for other asylum administrators in the province. In January 1888 O'Reilly told Clarke he had invited Dr. Tippi, the bursar from the London asylum, to accompany him to Rockwood's "At Home", noting that Tippi was a "swell" musician and very interested in issues concerning asylum amusements.⁵² In March 1890 he brought Dr. Ross of the Hamilton asylum to Kingston for the "At Home" and a minstrel show, telling Clarke beforehand that he wished "to have the Asylum trotted out a little," allowing Ross to "see all that there is as I think it will open his eyes."⁵³ There can be little question of Inspector O'Reilly's desire to use Kingston as an example, and the asylum's patients clearly benefited from the extensive funding the government provided for this purpose. For many, Rockwood provided entertainment opportunities they did not have in their life outside the asylum where time, money and geographical isolation limited participation in leisure activities.

Interventionist Medical Treatment

Although a regular schedule of work, rest and leisure formed the basic philosophy of therapy at the Kingston Asylum, drugs and surgical procedures were also used as a secondary means of controlling behaviour and treating physical illnesses. Opium derivatives such as morphine and laudanum were used to treat the painful effects of disease. Though dysentery, typhoid fever, phthisis (tuberculosis), and erysipelas (a bacterial infection of the skin) were common diseases at the asylum, there was little doctors could do to treat patients suffering from these illnesses. A very limited number of drugs existed to treat specific behaviours or illnesses

⁵² AO, *Inspector's Correspondence*, vol. 238, file 6742, "O'Reilly to Clarke," January, 1888.

⁵³ AO, *Inspector's Correspondence*, vol. 238, file 6742, "O'Reilly to Clarke," 26 March, 1890.

and most of the time doctors relied on tonics and extensive nursing care to cure patients. One drug that was available and used to treat manic excitement was the alkaloid, hyoscyamine. Throughout the 1880s several of the women in this study were given the drug repeatedly to control their disruptive behaviour and violent outbursts. One such patient was Christy M., committed in March 1883. Two days after her admission Christy was isolated in the asylum's refractory ward to control her troublesome behaviour.⁵⁴ Since the principles of moral treatment did not favour isolation as a method of therapy, doctors administered a hypodermic injection of hyoscyamine in order to calm her and permit her re-admittance to the ward. The drug worked with some success, although doctors noted that Christy was "as noisy as ever" when not under its influence.⁵⁵ While the calming effects of the drug lasted only temporarily and it was not a cure, many nineteenth-century asylum physicians found it to be a useful agent for dealing with patients' violent behaviour.⁵⁶

Metcalf and Clarke regarded surgery as a radical form of treatment that should not be considered until all other avenues were exhausted. The records of the female patients in this study indicate that only three underwent surgical procedures while in the institution, and in each of these cases the procedure was not performed until drug treatments proved unsuccessful. The most serious and radical operations performed at Kingston in the late nineteenth century were performed in 1895 on two epileptic patients in an attempt to decrease the frequency and severity of their seizures. Epilepsy presented a particular difficulty to nineteenth century doctors, for

⁵⁴ Christy M., # 168

⁵⁵ Ibid.

⁵⁶ George H. Savage, "Hyoscyamine, and its Uses," *Journal of Mental Science*, vol. 25, no. 110 (July 1879), pp. 177-184.

although there was a sense that the disorder was caused by a physical problem in the brain, few remedies existed; those that did exist had many side effects and were rarely successful.

The case of Mary Ann W., one of these patients to undergo the experimental brain operation illustrates the tragic circumstances caused by epilepsy. Mary Ann was admitted in January 1883, suffering seizures of varying intensity on and off throughout the year. By December she was experiencing “severe fits very frequently”, but again seemed to improve somewhat.⁵⁷ In November 1885 the severity of her seizures again worsened, inciting doctors to administer bromides, a type of drug that had been used for some years as a treatment for epilepsy. Medication had no effect and was discontinued shortly after. The following July, Mary Ann was placed on amyl nitrite, a vasodilator that was believed to stop seizures during the early aura phase. It also proved unsuccessful and for several years she remained untreated.⁵⁸ In the 1890s the medical staff began recording the frequency of Mary Ann’s seizures and when in 1894 they totalled 253 with an average of 21 per month, it was decided to try the new surgical procedure. “Trephining” as it was known, consisted of removing a portion of the skull with the hope of alleviating cranial pressure on the brain. Unfortunately, the surgery did nothing to improve Mary Ann’s epilepsy, though she demonstrated a marked mental improvement following surgery, sewing, knitting and engaging in conversation.⁵⁹ Nevertheless, Rockwood’s doctors were unconvinced that this result had a direct relationship to the cranial surgery, believing Mary’s mental improvement to be caused by the trauma of surgery itself. For this reason they believed there to be little value in keeping statistical records of the benefits of these

⁵⁷ Mary Ann W., # 181

⁵⁸ For a brief discussion of the use of amyl nitrite in epilepsy see Lyman et al., “Falling Sickness,” in *The Practical Home Physician...*, p. 309.

⁵⁹ Mary Ann W., # 181

operations, and only performed these operations when a patient's epilepsy was very severe and did not respond to available drug treatments.⁶⁰

In earlier years two other patients underwent more minor surgical procedures: An aspiration of the lungs was performed on Sarah G. in December 1883 to remove built-up fluid after a severe attack of pleurisy. The procedure was performed successfully, and Sarah quickly improved with her condition reported as "very hopeful."⁶¹ On April 23, 1888 doctors performed an ovariectomy on patient Bridget T. Six weeks previous to her operation Bridget had begun to lose weight and suffer from bloated legs and a distended abdomen. Although on March 20 doctors tapped a cyst in her abdomen removing over four gallons of fluid, by early April it began to fill again. They later found a solid tumour and decided to operate to remove the ovary. By April 25 she was reported as "doing splendidly", and on May 19 was walking about the ward "gaining flesh all the time."⁶²

The fact that the surgery clearly benefited Bridget's health is highly significant when considered in relation to the many gynaecological procedures performed in the late nineteenth century. The number of asylum women across Europe and North America who underwent ovariectomies and hysterectomies as a treatment for nervous and mental disorders partially validates Elaine Showalter's postulation of the disorder as a "female malady".⁶³ In Ontario, the use of gynaecological surgery for treating mental illness in women was hotly debated among asylum superintendents, particularly during the 1890s when Dr. Richard Bucke of the London

⁶⁰ AR, 1896, *Ontario Sessional Papers* (No. 11), pp. 88, 90.

⁶¹ Sarah G., # 171

⁶² Bridget T., # 36

⁶³ Showalter, *The Female Malady*, p. 5.

asylum began to regularly perform these procedures. Adhering to the nineteenth-century concept of “reflex action” where healthy body parts came to sympathize with diseased organs, Bucke believed the majority of female insanity to be caused by unrecognized and neglected pelvic disease that had spread to the brain.⁶⁴ The majority of Ontario’s other asylum superintendents strongly disagreed with Bucke, arguing that any resulting benefits from the operations were due to the shock induced upon the patient, and could just as easily been reached by any other type of surgical procedure. Clarke was particularly critical of Bucke’s methods, declaring in 1898 that he saw no evidence that uterine disorders were more prominent among insane women.⁶⁵ Though puerperal mania was a common diagnosis at the Kingston Asylum, previous discussion has shown that childbirth had as many social implications as it did physical ones. When Rockwood’s doctors made note of biological disorders they seldom connected it to the patient’s mental state, except where physical discomfort caused emotional stress. This observation explains why surgery became a last resort that was only performed when all other avenues of treatment had been used to no avail.

Disruptive Behaviour and Patient Resistance

Although the therapy provided at Rockwood through moral treatment was designed to create a peaceful atmosphere, order was often disrupted by behavioural problems within the institution. Patients were not always complacent to treatment and exercised autonomy through passive and active forms of resistance. Since most public asylum patients depended on the province for financial support and institutional care they had little recourse to better their

⁶⁴ Richard Maurice Bucke, “Surgery Among the Insane in Canada,” *American Journal of Insanity*, vol. LV, no. 1 (July 1898), p. 4, CIHM no. 01502.; For an explanation of the notion of reflex action and Bucke see Mitchinson, *The Nature of Their Bodies...*, pp. 51, 300.

⁶⁵ Mitchinson, *The Nature of Their Bodies...*, pp. 345-346.

circumstances.⁶⁶ Acts of resistance, whether carried out consciously or unconsciously, became the only mechanisms available to patients to cope with committal and retain a sense of control over their lives.

The patient records of the 241 women included in this study suggest that a majority resisted against their treatment or confinement at some point during their stay at the Kingston Asylum. Though the frequency and variety of rebellious acts committed varied from patient to patient, certain trends can be observed among the women that offer insight into the nature of female resistance. This discussion will demonstrate that while many women patients resisted treatment, they did so through actions generally regarded as passive. In his discussion on forms of resistance, James C. Scott argues that behavioural possibilities are determined by the realities of the material world.⁶⁷ His insights partially explain the behavioural responses of Rockwood's women patients because their ability to (re)act in particular ways was largely determined by the circumstances of their lives in the asylum. As the following cases will demonstrate, the gendered implementation of moral treatment through work and amusements limited the opportunities for the women to resist in a more active manner. It does not, however, explain all passive acts of resistance by women, necessitating a closer examination of the various acts that contributed to these behavioural patterns.

The most active manner of resistance was physical violence toward other humans or property. Because it posed a serious danger to staff and patients and was highly disruptive to daily life, it was one of the most problematic forms of resistance. Calculating a precise determination of the number of physically violent women is difficult; while most long-term

⁶⁶ Warsh, *Moments of Insanity...*, p. 120.

⁶⁷ James C. Scott, *Weapons of the Weak: Everyday Forms of Peasant Resistance*, (New Haven & London: Yale University Press, 1985), p. 38.

patients were involved in such incidences at some point during their committal, the frequency and severity differed with each patient. Nevertheless, certain women became known as frequent instigators of physical fights with fellow patients. In December 1885 doctors identified Martha F. as "one of the most troublesome patients in the institution," for her noisiness and constant habit of striking patients who were too feeble to retaliate. On the few occasions when she chose to confront able-bodied women in the ward, she suffered scratches and black eyes.⁶⁸ Like Martha, it took Harriet R. little time after her July 1884 admission to establish a "'Ward Reputation' as a boxer," becoming very cross with other patients and destroying her clothing.⁶⁹ Most incidences of physical violence were an escalation of less violent verbal arguments. Among Kingston's female patients verbal aggression was the most common form of violence with most physical injuries occurring after a patient had been "quarrelling" with others. Swearing and yelling were also common; as discussed in the first chapter, these behaviours were understood as a passive or lesser form of violence. Kingston's administrators tried to decrease the interference of these patients with others by placing the most violent women in the main asylum building, sometimes in refractory (isolation) wards. Sometimes, however, this approach also proved ineffective and doctors were forced to resort to methods of physical or chemical restraint.

Though more of an escape mechanism than a rebellious act, suicide was another form of resistance that became a constant concern in the asylum. In the sense that it did not pose an immediate physical threat to others, it presented less of a problem than active violence. Yet, a suicide marked the inability of doctors to emotionally reach a patient, and suggested that patients may not have always had adequate supervision. If brought to the attention of the community,

⁶⁸ Martha F., # 200

⁶⁹ Harriet R., # 238

this type of death could damage the institution's already fragile public reputation. Since attendants could be fined for a variety of neglectful offences, a patient's suicide undoubtedly brought a high risk of punishment for staff.⁷⁰ Though several patients made attempts to end their lives, the only successful suicide attempt was that of Mary Ann S., a patient with epilepsy who drowned after jumping into the lake on a cold November day in 1884. Though several persons witnessed the event, none were able to swim, and with the roughness of the lake that day, all attempts to save Mary Ann were in vain; her body was discovered the next day by the wharf.⁷¹ Given the number of women suffering from melancholia who had already threatened or attempted suicide before entering the asylum, it is surprising that more did not die under similar circumstances.

The low number of successful suicide attempts among Rockwood's female patients may be due, in part, to way women killed themselves. Most women attempting suicide either before or after their admission, did so by trying to drown themselves in nearby lakes or rivers; they differed from males who most often hung themselves.⁷² The shores of Lake Ontario, then, became a likely location for women attempting to take their lives. As such, drowning can be read as a more passive means of committing suicide among asylum patients (as compared to hanging) because it was much less likely to be successful. Since many male patients and staff worked outdoors, a woman escaping from a ward to the waterfront was likely to be noticed and intercepted at some point in her journey. Even if she managed to enter the water, drowning did

⁷⁰ Connor, ,p. 260.

⁷¹ Mary Ann S., # 152

⁷² AO, RG 10, Series 20-F-4-1, Kingston Psychiatric Hospital, Superintendent's Journal, 1 January 1880 – 22 October 1889.

not occur immediately, giving others a chance to rescue her. Only in a case like Mary Ann's where extenuating circumstances prevented rescue was a drowning likely to be successful. The second most common suicide method among women was taking a poisonous substance, but, like the case of Eleanor H. who took an ammonia compound in October 1883, the dose taken was usually insufficient to result in death.⁷³ This finding suggests that female suicide attempts may have been a desperate escape or cry for help, rather than an innate desire to die; perhaps several of these women had an unconscious desire to be discovered and saved. It is, however, only possible to speculate about their reasons for attempting suicide since the voices of the patients remain absent from the records.

The difficulty women had escaping from the inside of the asylum building also partly explains why "elopements" (escapes) occurred much less frequently among female patients. Though the superintendent's journal suggests that elopements were common at Rockwood, the vast majority reported involved male patients.⁷⁴ The casebooks show that only 9 of the 241 women admitted between 1878 and 1884 ever attempted to escape. Of these 9, only 6 were successful, and they were gone less than one day before being returned.⁷⁵ Mitchinson suggests that because it was more difficult for women to escape unnoticed, fewer may have attempted to do so.⁷⁶ The fact that the successful few did not travel far before being found may also be due to women's socialization that did not teach them the type of skills needed to avoid capture.⁷⁷ Thus

⁷³ Eleanor H., # 189.

⁷⁴ AO, RG 10, Series 20-F-4-1, Kingston Psychiatric Hospital, Superintendent's Journal, 1 January 1880 – 22 October 1889.

⁷⁵ AO, RG 10, Series 20-F-1-1, Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

⁷⁶ Mitchinson, *The Nature of Their Bodies...*, p. 333.

⁷⁷ Ibid.

while male patients were frequently able to board trains and go extensive distances, women rarely travelled further than central Kingston; instead, they were returned to the asylum within a day of escaping.

Other common forms of resistance among women patients included refusing to work, or taking food and medicines. With fewer options than their male counterparts, women often directed their resistance inwardly upon themselves, particularly when outward rebellion proved to be ineffective.⁷⁸ Such was the case of Mary M. who resigned herself to quietly refusing to “do any kind of work” after two years of acting violent, threatening to kill a nurse, and attempting to elope.⁷⁹ When patients refused to work there was little the asylum staff could do. The feeding tube, however, provided a solution for patients who refused to eat. Although the aggressive force and pain involved in its use did not adhere to the principles of moral treatment, the feeding tube reinforced the authority of asylum staff to administer treatment and usually put an end to such protests.⁸⁰

Acts of patient resistance were significant events in the asylum’s operation. Not only could they be highly disruptive to everyday life, they also represented a point at which moral treatment failed to elicit beneficial results. Patient resistance, however, was not the only factor that became both a general disruption and a problem to treatment. Family influence on patient therapy could also prove to be problematic if relatives were unwilling to co-operate with the regulations of the institution and if they failed to adhere to the advice of the medical superintendent. Though such incidences were rare, patients’ records indicate that interferences

⁷⁸ Warsh, *Moments of Unreason...*, pp. 129-130.

⁷⁹ Mary M., # 232.

⁸⁰ For examples of its effectiveness in getting the patient to eat again see Mary Ann W., #178, Louisa M., # 225, and Ellen W., # 247.

from relatives were sometimes problematic, affecting a patient's course of treatment. The most striking case was that of patient Victoria F., who suspected she was pregnant after admitting to having had sexual intercourse with her husband during his visit to the asylum in October 1883. Dr. Metcalf contacted the husband and requested that he come to Kingston to "give satisfactory explanation his for his wrongdoings". On February 25 Metcalf and Clarke met with him and Victoria's father, Mr. Herron. Victoria's patient file contains the following description of the interview:

...Dr. Metcalf asked Mr. [F.] if the statement made by Mrs. [F.]... was correct. [F.] did not make a positive denial at first but said "I don't think so" and seemed somewhat confused as if not certain whether it would be well to admit or deny the charge. In a few moments he became excited and said that although his wife had sat on his knee for an hour or more, he had no intercourse with her. He became very indignant and made a lot of foolish charges in regard to letter he had received from Dr. Metcalf about his wife, and also accused Dr. Clarke of having treated him rudely upon the occasion of his last visit when he succeeded in forcing his way into No. 1 Ward in spite of the Asylum rules to the contrary...⁸¹

Mr. Herron later described Mr. F. as a " 'regular rake of a man' " who should never be trusted.⁸² Though an examination later revealed that Victoria was not pregnant, this man's disobedience of asylum rules clearly caused a great deal of upset and inconvenience for Metcalf, Clarke and the ward staff who had been on duty at the time of the incident. Mr. F.'s actions both upset his wife and wasted a great deal of administrative time. Clearly, patients were not always the only persons whose negative behaviour caused problems within the institution.

During its first twenty years under provincial jurisdiction, the Kingston Asylum underwent extensive improvements and program enhancements that enabled it to offer patients a modern and humane therapy program. The creativity and insights of Metcalf and Clarke, along

⁸¹ Victoria F., # 183.

⁸² Ibid.

with the financial support provided by the provincial government, allowed for the implementation of an extensive moral treatment program with a wide variety of activities to benefit both patients and staff. The innovative nursing program that Clarke introduced in the late 1880s created a staff of attendants able to provide a quality of medical care to patients that was unavailable at other such institutions at that time. All of these factors demonstrate the asylum's success regarding the fulfillment of government requirements and serving as an administrative model for other asylums. Yet, it is insufficient to only evaluate an asylum in terms of its administrative reform; its overall success needs to be measured through consideration of patients' experiences of treatment. The final chapter will demonstrate that patients' final outcomes were determined by a variety of factors including their treatment in the asylum and the willingness of family members to support them and assist with recovery.

3.

Discharge and Death: The Outcomes of Asylum Treatment

As a means of evaluating the treatment of patients at the Kingston Asylum, this final section examines the routes by which patients left the asylum and the factors that contributed to these outcomes. Within the chapter Rockwood's "success" will be evaluated on the basis of the benefits it offered patients according to their individual circumstances, as well as the overall rates of patients discharged as recovered or improved. In this sense a patient's long-term committal will not necessarily be read in a negative light. Instead, all outcomes will be read in terms of the asylum's ability to offer what appears to be appropriate and beneficial treatment according to the needs of the patients.

The outcome of asylum committal for patients differed greatly, particularly in regard to the length of time spent in the institution. To differentiate between the various outcomes of these women and to assess the effectiveness of treatment for individual patients, this chapter divides the patients into three categories according to length of committal. In making the assumption that patients with minor breakdowns or illnesses should improve within a two-year period, "short-term" will refer to those patients committed under 2 years. Observation of the casebooks suggest that patients confined for 5 years or more were likely to remain there for long periods due to serious mental or physical illness or an absence of persons outside the asylum willing to assume responsibility for their care after discharge; for this reason "long-term" will refer to patients who remained in asylum 5 years after their admission. As a means of differentiating between the previous categories "medium-term" will refer to patients confined in the asylum between 2 and 5 years.

Table 8 presents the routes by which the women patients in this study exited Rockwood. All 248 files in the study have been included in order to achieve full representation of all discharges. It also means that the 7 women who were re-admitted to Rockwood during the

period are represented twice in the table; however, since others in the sample were also in different asylums previous to their admission to Rockwood, or re-entered after 1884 in admissions outside the scope of the sample used here, this variation does not imply any major misrepresentation. In fact, inclusion of these records will help to demonstrate the variety of circumstances that led to discharge and the negative effects that occurred when a patient was released prematurely.

Table 8: Women Patient's Routes of Leaving Asylum 1878-1906

<u>Routes Out of the Asylum</u>	<u>Number of Women</u>	<u>% of Total Sample</u>
Death	82	33.1
Transfer to another asylum	42	16.9
Discharged	103	41.5
- recovered	71	28.6
- improved	24	9.7
- unimproved	6	2.4
- not insane	1	0.4
- unknown	1	0.4
Remaining in 1906	21	8.5
Total Sample	248	100.0

Source: AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks Female, Jan. 28, 1878-Oct 28, 1884.

A small number of women (8.5 percent) in this study still remained at Rockwood in 1906, and they did not leave until sometime outside the scope of this study.¹ As long-term patients these women had spent a significant portion of their lives in the asylum. Though a few remained in the asylum because there was no one willing to assume care for them, the majority

¹ The patient files used in this study only extend as far as 1906 with doctors notes indicating that a new record book began to be used in the fall of that year.

suffered from persistent delusions and violent behaviour which families would have found impossible to cope with at home. Patient Bridget T. was one such case; admitted to Kingston in August 1878, she was delusional and excited, frequently tearing her clothing and "fetching things out [the] window." Since Bridget's health never improved and, previous to her admission, she had continually threatened to kill family and friends, discharging her was almost certainly out of the question. Though twenty-year-old Mary E. was never outwardly violent towards others, she became delusional, incoherent and unable to care for herself following an apparent sexual assault. With both her parents dead and no other relatives to assume care for her, she remained in the institution in the fall of 1906. The stories of Bridget and Mary were typical of the majority long-term patients; while their situations were tragic, the asylum provided the most appropriate environment for the safety of both the patient and her relations.

Transfers

Of the women who did leave Rockwood before 1906, transfers were the least common forms of exit; only 16.9 percent departed in this manner. Little can be said about the final outcome of these women because it is difficult to trace their records after transfer, and such a task goes beyond the scope of the present project. It can be said, however, that the situation of these women was similar to that of other long-term asylum patients, for in the majority of cases a transfer did not occur until a patient had been at Kingston for at least 8 years.² Transfers did not imply leaving the asylum system altogether, but instead suggested a re-adjustment of patient populations between asylums when administrators knew particular patients would predictably require continued, long-term asylum treatment. Such was the case in February 1891 when the

²AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

closing of Rockwood's Regiopolis Branch necessitated the relocation of 14 women to the Toronto asylum. At the time of their transfer these women had been in the Kingston Asylum anywhere from 7-13 years and showed few signs of improving their condition. For example, though Susan L. was generally felt to be a "quiet, harmless old woman" who was no trouble to care for, she experienced "occasional paroxysm[s] of excitement" and continually wandered away if not closely supervised.³ Since, as further discussion in this chapter will show, the longer a patient remained in the asylum system the less likely they were to ever be discharged, transfers became a reality for many patients being treated in public asylums when population adjustments were required.

Death

Deaths represent approximately one third of asylum departures with 82 of the 241 women dying in the institution before recovering. The records of these women indicate specific patterns regarding the length of time spent in the asylum prior to death. Of those who died 83 percent did so after either a short- or long-term stay (with numbers divided approximately evenly between the two), while only 17 percent died after being in the institution for a medium-length stay of 2-5 years.⁴ These figures suggest that deaths either occurred as a result of a specific physical illness the patient acquired before or shortly after entering the asylum, or after a chronic illness that caused a steady decline in their health over an extended period of time. Once a patient reached

³ Susan L., # 150; See files 5, 11, 12, 38, 49, 55, 67, 79, 104, 120, 163, 213, 214 for the other women transferred in February 1891.

⁴ Percentages are calculated from AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

the five-year anniversary of their admission, it seems they could expect to remain in the asylum system until their death.

Table 9: Causes of Death in Kingston Asylum Among Women Patients 1878-1906

<u>Cause of Death</u>	<u>Number of Women</u>
Phthisis (tuberculosis)	20
Senile Decay (old age)	13
Frail/Feeble (includes symptoms such as diarrhea, emaciation, general poor health)	9
Intestinal Disorders*	8
Epilepsy	7
Heart Disease and Stroke	7
Gangrene	2
Erysipelas	2
Exhaustion	2
Anaemia	1
Cancer	1
Choking	1
Cystitis (bladder infection)	1
General Paresis (paralysis)	1
Goitre	1
Marasmus	1
Pneumonia	1
Septicaemia	1
Suicide	1
Unrecognizable Illness	1
Unknown	1
Total of Sample Who Died in the Asylum	82

* Includes those suffering from diarrhea, dysentery, gastroenteritis, colon or bowel problems

Source: AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

Unlike the situation at the Toronto asylum studied by Reaume, where cause of death is unclear in 57 percent of cases, causes of death are available for all but two of the 82 women who died at Kingston.⁵ Post-mortem examinations were routine following the death of a patient with

⁵ Reaume, Table 12, p. 225.

detailed findings recorded in the asylum's post-mortem book and a statement of cause of death included at the end of the patient's casebook file. As Table 9 illustrates, one quarter of deaths among the women occurred as a result of tuberculosis. Tuberculosis, or phthisis as it was called, was one of the most common terminal diseases during the late nineteenth century. The air-borne bacterial infection was particularly prevalent in hospitals and other institutional facilities where high populations combined with poor ventilation facilitated its transmission between patients. Women in asylums had a greater risk of infection than men; Mitchinson relates this finding to the greater amount of time women spent indoors without the benefit of fresh air.⁶ As well, this observation further explains why Inspector Langmuir urged Metcalf to establish better outdoor recreation facilities for women in the late 1870s.

Old age and general frail health were the next most prevalent causes of death, together claiming approximately the same proportion of deaths as tuberculosis. These causes can be closely related, for often the frail and feeble were elderly patients, and the symptoms leading to death in both cases were very similar. Intestinal disorders arose from a variety of causes, including diseases and general feeble health. Heart disease and stroke claimed the lives of 7 patients, all of whom were elderly. Epilepsy could lead to death at any age, though a patient did not usually die of the disorder until they had spent several years suffering from frequent, severe seizures. Evidently, the coroner based his decision determining cause of death upon his most accurate evaluation of the ailment; a patient's age was not generally a factor unless there seemed to be no other clear illness present. Patients who did not die from the most common illnesses died from a variety of causes, including an accidental choking and the suicide of Mary Ann. S.

⁶ Mitchinson, *The Nature of Their Bodies...*, p. 333.

discussed in chapter two.⁷ What is most surprising is that no deaths were attributed to typhoid fever despite the outbreaks of that disease at Rockwood in the 1880s and 1890s; apparently the asylum was able to treat the illness successfully in all of the cases among these women.

Discharge

Not all of the terminally ill women were forced to live out their final days in the asylum. The case of Louisa A., as discussed in chapter one, demonstrated a unique case where a patient was compassionately removed to her former home in the orphan asylum to allow her to die in a familiar setting.⁸ More often, such compassionate discharges occurred at the request of family members, who, upon hearing of their relative's condition, wished to bring them home to die. Sarah L. was admitted to Rockwood in March 1882 at age 58 as a self-supporting patient. Three weeks after her admission, Sarah developed erysipelas of the face that quickly led to other skin infections elsewhere on her body. By May she had several abscesses on her back, legs and hips and her health was quickly failing. When Metcalf informed her family of the situation they decided to remove her to their own home where she died a few days later.⁹ Similarly, in March 1885 doctors diagnosed Martha R. with advanced phthisis (tuberculosis) when her physical health rapidly began to fail. Later in the month her friends came to the asylum and removed her, despite her lack of mental improvement; undoubtedly their objective was to allow Martha to die at home.¹⁰

⁷ See chapter 2, p. 62, and Mary Ann S., file # 152.

⁸ See chapter 1, pp. 11-12, and Louisa A., file # 125.

⁹ Sarah L., # 126.

¹⁰ Martha R., # 235.

Clearly, patients who had supportive family and friends stood a much better chance of spending their final days in the comfort of their own homes surrounded by people who cared for them. This situation was true not only for the terminally ill, but for all the women patients in this study, regardless of the state of their physical or mental health. Although in the majority of cases (over 80 percent) the women returned home with family at the recommendation of the superintendent when they showed signs of recovery or improvement, sometimes relatives chose to take the patient home from the asylum despite a continuation of their illness and lack of improvement. Catherine C.'s daughter requested her mother's discharge after only 6 weeks of committal, though there had been no improvement in her violent tendencies or "unclean" habits.¹¹ Patient Elizabeth W. had a similar experience; admitted at age 76 in 1881 with religious mania, her daughter took her home in April 1882, though there is no suggestion in the file that her mental state had improved. Given Elizabeth's age and symptoms such an improvement seems unlikely; nevertheless, a letter to the asylum from her daughter after she left the asylum states: "[M]other is improving nicely and is quite as well as ever in her mind." Elizabeth's friends also reported that she was "perfectly recovered."¹²

It is difficult to ascertain the precise reasons why these families chose to remove their relative prematurely, although feelings of guilt and ambivalence over the original committal undoubtedly played a significant role in many cases. Improved treatment methods had done little to alter the public image of asylums as custodial institutions. Kelm argues that families may also have been anxious to have inmates resume their roles as wives and mothers. Even short-term confinements could be devastating to family life, and many husbands found it

¹¹ Catherine's file suggests she was incontinent. See Catherine C., # 102.

¹² Elizabeth W., # 109.

impossible to balance childcare with waged labour.¹³ In any case, the previous examples support recent arguments against the image of Victorian asylums as “dumping grounds for social misfits.”¹⁴ The wishes of families were fundamental to deciding on discharge, and in some instances overrode the recommendations of the medical superintendent.¹⁵ Provincial regulations for asylum discharges required an initial period of probational discharge of at least three months, giving families the option of removing their relative from the Kingston Asylum on a trial basis before committing to permanent long-term care at home. Asylum superintendents did not apply for final discharge certificates from the lieutenant-governor until reports from a patient’s family or friends assured the patient’s ability to function outside this institution. These procedures gave family’s greater flexibility and further increased a patient’s chances of being discharged from Rockwood.

Table 10: Length of Committal Before Discharge from the Asylum

<u>Length of Asylum Committal Before Discharge</u>	<u>Number of Women</u>	<u>% of Total Discharged</u>
Short-term (under 2 years)	82	80.0
Medium-term (2-5 years)	13	12.6
Long-term (over 5 years)	8	7.8
<u>Total of Sample Discharged From the Asylum</u>	103	100.0

Source: AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

¹³ Kelm, “Women, Families...,” p. 187.

¹⁴ Charlotte MacKenzie, “Social factors in the admission, discharge, and continuing stay of patients at Ticehurst Asylum, 1845-1917,” in *The Anatomy of Madness: Essays in the History of Psychiatry, vol. II*, eds. W. F. Bynum, Roy Porter and Michael Shepherd, (London & New York: Routledge, 1988), p. 151.

¹⁵ Warsh, *Moments of Unreason...*, p. 95.

The fact that over 40 percent of the women in this study were eventually discharged from Kingston demonstrates the presence of social support for the majority of these female patients. Discharge required the presence of family or friends willing to accept responsibility for the patient's continued care. Although the cases discussed thus far have involved patients who left the asylum with unimproved mental health, this situation only occurred periodically; more typically, families waited until they were informed of improvements before removing relatives. Over 80 percent of the patients who returned home did so after doctors declared them recovered or as showing signs of improvement. These women were typically those whose illnesses were initially of a more minor nature and, for this reason, the majority of them left Rockwood after a committal of less than two years (Table 10). This pattern of short-term committal before discharge suggests not only the presence of familial support, but also that the moral treatment program offered at the Kingston Asylum served its purpose for a large number of women in helping them recover from mental illness. Indeed, of the women admitted in 1880, the number discharged after less than two years confinement had increased by 75 percent from those admitted the preceding year, a rate that continued to rise for each of the years covered in this study (Table 11). This trend suggests that a woman's chances of being discharged were significantly reduced once two years had passed, and after this period she could expect to spend the remainder of her life in the institution.

Table 11: Percentage of Women Discharged After Less Than Two Years Confinement

Admission Year	Percentage of All Eventually Discharged(%)
1878	1.7
1879	4.4
1880	78.6
1881	80.0
1882	94.0
1883	90.0
1884	90.9

Source: AO, RG 10, Series 20-F-1-1. Kingston Psychiatric Hospital, Casebooks – Female, Jan. 28, 1878-Oct 28, 1884.

While the sharp increase in discharges may reflect the administration's need to find a way to increase accommodation as the public demand for asylum care increased, the reports contained in the patients' files suggest that many women did improve significantly under the new conditions provided in the asylum. When Emiline T. arrived at Rockwood in May 1879 she was melancholic and suicidal; however, by November of that year she was "cheerful and trustworthy," having improved to such a degree as to be sent home with her husband on three month's probation. In his letters sent to the superintendent, Emiline's husband reported: "I am happy to inform you that my wife Emiline [T.] is getting along very well. Her mind is alright [sic] and her bodily health improving. She sends her best respects to all." This progress continued and Emiline's final discharge certificate was granted on February 23, 1880.

Like Emiline, patient Catharine M. also benefited significantly from the asylum treatment. Admitted to Rockwood at age 43 in February 1884, she spent only three months in the asylum before being discharged. Married with six children, Catharine had a miscarriage that had sent her into a deep depression where she "labour[ed] under a great trouble." Though she felt that their was "no use in trying to help her," her family quickly had her committed to Kingston where asylum doctors placed her on an iron tonic. Shortly after this treatment doctors

reported her to be sleeping well and “gaining in health and spirit,” though “still inclined to despondency.” Nevertheless, she returned home in early June. The speed of Catharine’s recovery is not unusual given the circumstances under which she entered. Pregnancy at age 43 was difficult under the best of circumstances, particularly when a woman already had a number of children as Catherine did; it is not surprising that the added trauma of a miscarriage sent her into a deep depression. Her file suggests, however, that like many of the other women who suffered from puerperal depression, she had a supportive family who only had her committed as a means of helping her recuperate. By offering proper rest, nutrition, fresh air and exercise, admission to Rockwood gave many women suffering from breakdowns or mild depression the opportunity to recuperate their health in a way that was not possible when they were surrounded with the stresses of everyday life at home.

Examination of the routes by which these women left Rockwood between 1878 and 1906 demonstrates that the final outcome of treatment largely depended on a number of factors including the quality of the asylum’s treatment program, the severity of a patient’s mental condition, susceptibility to physical illness, and the extent of familial and community support outside the institution. Patients with poor mental and physical health stood a much higher chance of remaining in the asylum until death, as did the women who lacked family or friends willing to care for them after discharge. The outlook for those whose depressions and mental breakdowns were milder and occurred after a traumatic event (as in many cases of puerperal mania) was much brighter; provided these women had supportive family or friends, they could normally expect to be discharged within two years of asylum treatment. Although the casebooks show that discharged patients were in the minority at 41.5 percent of admissions (Table 8), it is nevertheless a large minority representing almost half of those entering the institution. These

figures support recent arguments by historians regarding the vital contribution of family and community in determining the final outcome of asylum treatment. Actively involved in all aspects of a relative's committal including discharge, the majority of families did not abandon the afflicted woman, but instead were readily willing to accept her back into the home once doctors confirmed an improved mental condition. The number of women who quickly improved or recovered their mental health after being admitted to Rockwood indicates that the treatment program that was implemented during the late 1870s and 1880s did serve its purpose in successfully treating many patients suffering from mild forms of mental illness. Though nineteenth century psychiatrists did not have the medical knowledge required to successfully treat more severe illnesses, the Rockwood asylum nevertheless provided these patients with a humane and healthy atmosphere in which to live.

Conclusion

Historians studying nineteenth-century asylums have tended to assess the quality of the institution in terms of their ability to provide "curative" treatment to patients. This examination of the Kingston Asylum during the last quarter of the century demonstrates that it is inappropriate to evaluate asylums in the either/or terms of "curative" versus "custodial". Even when an institution offered the most modern facilities and therapy available, its ability to successfully treat patients was limited by the severity of their illnesses and the social circumstances influencing their experience in and outside the asylum.

A conflation of events and influential people placed the Asylum for the Insane, Kingston in an ideal position for implementing all the requirements of a modern program of moral treatment. Contributing to the asylum's success was its physical setting on the shores of Lake Ontario, the strong administration provided by Drs. William Metcalf and Charles Clarke, and the extensive financial support provided by the Ontario government. Although these strengths made Rockwood one of the better-equipped institutions within the province's asylum network, influences from outside the institution largely determined the extent to which the asylum was able to "cure" patients. Though the asylum's superintendents offered recommendations regarding treatment, the final decision to commit or discharge a person lay with a patient's family and friends. Patients who benefited most from their committal to Rockwood were those with minor forms of mental illness who had relatives willing to welcome them back into the family unit at the suggestion of Metcalf or Clarke. Yet, it is also important not to limit the definition of "successful treatment" to patients who were quickly discharged; for patients who suffered from severe forms of mental illness or had no support network outside the asylum, long-term committal was certainly a favourable solution to a difficult problem.

By focussing on the female patients admitted between 1878 and 1884, this study has also demonstrated that Kingston's physicians, like those at other nineteenth-century asylums, frequently related the development of mental illness in women to their biology. Unlike many other institutions, however, reproductive factors primarily influenced the diagnosis of insanity in these women, and not the ongoing perception of their illness. Reproductive concerns are seldom mentioned in the casebooks beyond the initial diagnosis, and gynaecological procedures were only used when specific physical conditions required them. This finding suggests that while the doctors at Rockwood used the language of nineteenth-century medical discourse for their initial interpretation of mental illness, they were more interested in the social implications of reproductive life stages than their physical consequences. For example, in the cases of women suffering from "puerperal" (childbirth) mania there appears to have been an awareness that the illness did not occur from the physical process of giving birth itself, but rather as a result of inadequate sleep, nutrition and emotional support. It can be said then, that while Kingston's women patients may have been admitted to the asylum for reasons associated with their biology, the perception of their illnesses and the treatment they received was less influenced by reproductive processes than previous studies have suggested.

Examining both the lives of patients and the office of the administration permits the evaluation of the treatment program offered at the Asylum for the Insane Kingston, an institution that has until now received little attention from historians. Like any other institution, Rockwood's ability to successfully treat mental illness was largely determined by external factors, the most important of which was the presence and involvement of patients' families and friends. Because the asylum provided its patients with a healthy, stimulating atmosphere that

promoted rehabilitation without invasive surgeries or unnecessary restraint and isolation, overall it can be regarded as one of the more beneficial asylums in late nineteenth-century Canada.

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