Historians of psychiatry and other commentators have long disagreed about the origins of the asylum but not about the custodial nature of that institution in late nineteenth-century America. Whether arguing that economic and population changes forced greater state control or that industrial capitalism dictated some variation of social control, these scholars have enlightened us about the emergence of public policy, the origins of the “institutional state,” and the intricacies of professional development from the vantage point of the policymakers. The clientele of asylums—especially working-class patients and their families—however, remain largely unexamined. As a result, we are left not only with an incomplete picture of the psychiatric hospital in late nineteenth-century America, but also with misconceptions about the resilience of the working class.

There were those among the working class who were buffeted by social and economic change; smaller family living quarters meant less room for various extended kin, periodic unemployment virtually precluded the amassing of savings to survive old age or prolonged illness, and the industrial workday left little time (or energy) for the care of dependent family members. But even these working-class men and women were not necessarily passive victims of social policy, market forces, or changing American values. Irregular work and low wages marked their lives, but most families devised strategies for economic survival, persisted in their traditional values even as the constrictions of urban and industrial life impinged upon their family and community.
relationships, and exhibited amazingly adaptive behavior to the encroachments of the “institutional state.” To observe the asylum from the viewpoint of those working-class patients and their families who constituted the bulk of the asylum’s clientele is to discover that the asylum often functioned quite differently from the way doctors and politicians planned and in a greater variety of ways than we previously have understood.

The experiences of patients and their families at the Pennsylvania State Lunatic Hospital at Harrisburg present an opportunity to examine this congruence of asylum and working-class life. Fifty-five percent of the asylum’s patients were laborers (or the wives or children of laborers), fifteen percent farmers, and another twenty percent held no job; only ten percent had worked in occupations that might have enabled them to put something aside to withstand the financial burden of prolonged illness. The records kept on these working-class patients (individual casebook records, as well as patient registers, prescription books, and numerous state agency records) offer a rare glimpse of life inside those asylum walls and city directories, vital statistics, and censuses allow us to trace the life course of patients and to watch their families’ survival techniques at work as they determined the ways in which the asylum could serve their purposes.

The asylum at Harrisburg opened in 1851 as the first state-supported institution for the insane in Pennsylvania and one which was to accept all the indigent insane, as well as such paying patients as it could additionally accommodate. Like other state asylums, the institution had a dual purpose from the start; primarily it was to provide therapy (and presumably cure) for patients suffering from recent mental illness, but it was also to offer benevolent care for those chronic cases who had suffered years of neglect in almshouses and whom no one really expected to return to the community. During its first two decades, the hospital managed to fulfill its promises. But by the 1870s, the Harrisburg asylum was experiencing all the problems endemic to an industrializing nation in the throes of working out its changing policies of social welfare.

As social welfare institutions multiplied (by 1880, the state supported five insane asylums and counties operated numerous almshouses, jails, and industrial homes for youths), legislators and other social planners became concerned about the most efficient use of public monies. The asylums, with by far the largest budgets, were likely targets and, as their numbers of chronic patients increased and recovery rates decreased, the legislators balked at maintaining the expensive amenities of therapeutic
hospitals. Legislators were suspicious, too, that the managers and superintendents of the hospitals practiced selective admission policies and mishandled budgets. As a result, they moved to exercise greater legislative control; in 1869, they created the State Board of Public Charities (streamlining the administration of all public welfare, but also taking considerable control out of the hands of the asylum officers) and, in 1883, they formed the State Lunacy Commission (essentially setting up the practice of legislative surveillance within the asylum). By the 1880s and 1890s, the publicity about state investigations and watchdog agencies, the decreasing rates of recovery, and the sheer quantity of rhetoric that the asylum superintendents generated in their own self defense reiterated a growing sentiment that the Pennsylvania State Lunatic Hospital and other state asylums had become merely custodial in nature, little more than convenient warehouses for the poor and undesirable.  

The patients at the Pennsylvania State Lunatic Hospital in the last decades of the nineteenth century were largely poor, but the asylum did not function merely as an undifferentiated warehouse for the custodial care of the undesirable insane poor. Frequent attacks in the press or legislature and doctors' warnings to trustees about high mortality rates did leave impressions of mere custodialism and, indeed, even the statistics emerging from the casebook records are bleak on the surface. At least fifteen percent of the patients were hospitalized for more than ten years and close to forty percent died either at the Harrisburg asylum or in some other type of public institution. Yet reconstructing the lives of patients makes it clear that they and their families exercised considerable choice in their use of the asylum and that these working-class people resisted efforts to make them passive victims of state policies or institutional programs. Professionals and politicians already perceived the asylum as a place of last resort, but the families of patients often viewed the asylum as a more benevolent institution.

Even when these people did view the asylum as a place for custodial care, they frequently were far more selective about the use of this function than the public record of the asylum suggests. As the experience of eighty-one patients who had been residents of the city of Harrisburg before they entered the hospital in the 1880s and 1890s suggests, the families of patients did not turn to the hospital simply because it was inconvenient for them to provide care for their disturbed loved ones. Forty-five of those eighty-one patients (55.6%) died either in the asylum or in another institution to which they had been transferred by the hospital. But, of the forty-five, sixteen died within fourteen months of
their admission. Actually, only five lived out those fourteen months; the other eleven died within three months of entering the hospital (two within a week). All sixteen had been bedridden upon admission: two suffered from such maladies as lung infection or heart failure; six others were cases of advanced dementia; and five of the advanced paralysis that accompanies the tertiary stage of syphilis. 7

In the cases of these sixteen bedridden patients whose families undoubtedly knew they were dying, it is clear that their families took advantage of the hospital only after physical care in the home became overwhelming for them or when the disturbed person no longer responded to the family caretaker. One woman, for instance, who had become "confused in mind" after the death of her father and "troublesome," "depressed," and "mischievous," nevertheless, had been cared for in her home for seven months. Only when she "threatened to destroy" herself and expressed a "strong dislike" for her sister who had nursed her did the family bring her to the hospital. A seventy-seven year old widow had been cared for in her home for four and a half years despite her propensity to pound upon walls with any handy object. Finally, she, too, turned upon her nurse and the family resorted to the asylum. And, in another case, one man's family had endured his behavior that included ignoring his business matters and acting "confused" and "irritable," even destroying furniture, for nine months; what became intolerable for them was the task of caring for him when his bowels became impacted and his bladder paralyzed. Possibly out of hope for a last minute reprieve, but more likely because they could no longer manage the necessary care, these (and other) working-class Harrisburg families used the asylum as a refuge for their dying loved ones. 8

Families also used the asylum's promise of custodial care for those they simply could not manage in the home on a long-term basis. The epileptic or feeble-minded person created difficult situations for many families and others suffering from delusions or who threatened (and frequently carried out) violent acts were equally unmanageable. Five of the forty-five Harrisburg patients who died in the hospital (with an average stay of thirty years each) were patients of these types, as were the eight eventually transferred to county almshouses or the State Asylum for the Chronic Insane at Wernersville. Additionally, the circumstances of their families suggest that they were unable to provide care in the home in the way some of those families with dying members had. In one case, the widowed mother of a patient relied upon the wages of her three other children to maintain the household and, in another, a stone mason's wife managed to keep the family together after he was
hospitalized because seven of their eight children worked. And for one patient there simply was no one at home to care for her once her husband died two months after she was hospitalized. Thus for nearly two-thirds of the Harrisburg residents who died in an asylum, their families had made a conscious decision to use the hospital facilities either to eliminate an already real drain on the family resources or to remove the cause of what had become intolerable stress for the family. These families could not spare a wage earner to care for a seriously ill person nor could they afford to hire a special caretaker. They took advantage of the asylum’s assurances about benevolent custodialism for their intractable, much as the others had perceived the short-term nursing benefits the hospital offered for their enfeebled and dying.9

These illustrations of families using the asylum to provide nursing care and long term guardianship simply suggest a variation on the historic characterization of custodialism, of course, but changing social and medical circumstances also altered the tendency toward custodialism and affected the ways in which working-class patients and their families perceived the asylum. For instance, when the trustees reorganized the asylum’s administration in 1880, appointing a male doctor for the men’s wards and, for the first time, a female doctor with equal authority for the women’s wards, they hoped to augment the asylum’s therapeutic role—and they did, but not quite in the way they had planned. Because they assumed an innate connection between women’s nervous systems and generative organs, they thought women doctors could more comfortably minister to the peculiar problems of the female patients and, thus, decrease the incidence of gynecologically-related mental illness. The women doctors who staffed the Harrisburg asylum in the early 1880s, initially agreed with that medical judgment and embarked upon a plan of gynecological exams and treatment for their patients.10

In those they examined, the doctors found pathological conditions ranging from fairly common infections to severely malformed and dysfunctional organs. While they treated infections, prescribed pessaries, and generally did everything they could, their observations quickly convinced them to question the effect their treatments had on the incidence of mental illness among women. They, nevertheless, continued their program of gynecological treatments because they realized that their prescriptions not only made many patients more comfortable physically, but also that their patients derived emotional support from their attentions.11

In one case, for example, a patient’s friends had explained that
“poverty” had triggered her mental illness because she tore her clothes and walked about trying “to sell candy & toys.” Once she was in the hospital, the doctors discovered that, because she had ceased nursing her new born child, her breasts had become engorged and abscessed. Both salves for her breasts and the doctors’ daily attentions helped restore her “industrious” and “good humored” nature. It was only then that the doctors administered a uterine exam and discovered that she also suffered from a serious infection and bilateral lacerations. After five months of daily vaginal douches and, ultimately, surgery, the doctors discharged her as both physically and mentally recovered. In another case, a patient who had borne five children in seven years of marriage had talked “in a foolish manner” and threatened suicide before she was brought to the asylum, yet she submitted to hospitalization quietly. She, too, bore the physical consequences of frequent child-bearing; the doctors treated her for vaginal lacerations, endocervicitis, and cystitis. After nine months of daily medical attention (during which she became progressively calmer) the doctors declared her restored to bodily and mental health. Another woman had been brought to the hospital because her husband thought she was unusually scolding and irritable. The doctors discovered she had developed abscessed breasts while nursing her last child and ordered baths, body rubs, and poultices for her breasts; as the doctors visited her daily, she thanked them for their “attentions” and asked for more baths and bedrest. This woman, like the others, clearly appreciated not only the medical help of the doctors, but also the emotional support and respite the hospital offered.12

A number of ancillary effects of institutionalization for these working-class married women, and hundreds of others like them, are immediately apparent. First, the regular contact these patients had with the doctors undoubtedly played a therapeutic role. While other factors, such as age, the nature of the mental illness, and the recency of it, affect a patient’s chance for recovery, the frequency and quality of contact between doctor and patient influence the outcome of therapy as well. Second, the increased physical comfort these women gained from active medical intervention probably affected the mental state of many of them. That the interaction of “psychological and bodily processes can profoundly affect each other” is a well-established maxim in psychiatric literature as is the tenet that “relief of symptoms by whatever means”—and whatever symptoms—can enable a patient to function more effectively. The records of the two Pennsylvania asylums that offered regular gynecological treatment for women in the 1880s and 1890s verify the
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effectiveness of these therapeutic phenomena; the doctors discharged as
in an improved or restored condition, sixty percent of the patients who
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twenty-five percent of those without the specialized attention. Third,
whatever the reasons for which they were committed, these women
received medical care that otherwise might have been unavailable to
them in their working-class world and this service became one of the
adventitious functions of the asylum.\textsuperscript{13}

The asylum served a number of other secondary medical purposes for
the people who lived closest to it as well, suggesting that the citizens of
Harrisburg perceived the state asylum in their midst as their own
community institution. For example, the city's general hospital—
Harrisburg Hospital and its dispensary on Front Street—served many
of the medical needs of the city's citizens but the managers' policy of
refusing to treat cases of syphilis, "infectious or contagious" disease, and
"incurable" illness (by which they meant tuberculosis) forced families to
seek the asylum's advantages for their family members suffering from
these diseases. Although asylum doctors regularly identified "illness" as
the culprit in many patients' insanity, most suffered from more specific
problems not always captured in the notes taken at the time of their
admission to the asylum. The form of that "illness," however, emerged
when the doctors recorded the cause of death. While the doctors
attributed nearly half of the Harrisburg patients' insanity to illness
(suggesting this cause for only one-quarter of the patients from other
localities), the death records reveal the heavy toll taken by syphilis and
tuberculosis among these asylum patients. We have already seen that
syphilis accounted for a disproportionate number of deaths within a few
months of admission for Harrisburg patients and, with its irreversible
and progressive paralytic effects, syphilis caused about fifteen percent
of the deaths in the asylum each year.\textsuperscript{14}

Another twenty percent, moreover, died from tuberculosis. Neither
the asylum's policy of isolation nor the state's regulations about
inspection of livestock prevented some cases of institutionally-generated
infections, but the asylum doctors were especially frustrated because, as
they said, despite all "hygienic and sanitary precautions," little could be
done about those who had "contracted" the disease "before admission."
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of the asylum; the doctors knew that Harrisburg families were using that institution, not only as a refuge for their insane, but also as a hospital and a sanitarium.\(^1\)

This presence of the institution in Harrisburg spawned an even greater variety of unforeseen and incidental uses of the asylum by working-class families as other comparisons of the general patient population of the asylum and those patients who were residents of the city illustrate. The mortality of the Harrisburg patients, for instance, was higher than that of the patients from other, more distant communities (52.9% compared to 39.4%) and twice as many Harrisburg patients were over the age of sixty-five when they were brought to the asylum. Indeed, the elderly of the city of Harrisburg were disproportionately represented at the asylum. While this age warp accounts for some of the higher death rate, it suggests, nevertheless, that the working people of Harrisburg, to a greater degree than outsiders, viewed the asylum as a place offering both care and guardianship for their needy and elderly ill. Harrisburg patients also differed from the others in that they experienced proportionately more sedation, isolation, and mechanical restraint. But more than one-third of these local residents had physically attacked others, injured themselves, or attempted suicide; only about fifteen percent of the other patients had exhibited similar behavior. In the face of such violence, it was apparently convenient for families in Harrisburg to turn to the asylum in their midst as a place for swift incarceration and control.\(^1\)

Even these families did not merely deposit their sons, wives, or parents at the doors of the asylum and forget them, however. The doctors encouraged spouses, siblings, or parents to visit and wrote to them monthly (sometimes weekly) about the condition of their loved ones. In turn, families freely consulted the doctors about the timing of their visits and letters, asked about the advisability of conveying family news, or requested amenities like daily rations of tobacco for a father or “an egg each morning” for a son. And while the doctors occasionally had to reassure families that no special “permit” was required for visits or warn that a particular visit might be ill-timed, on the whole, families not only moved in and out of the asylum with relative ease, but also retained a measure of control over their family’s destiny; one of the most common complaints of asylum doctors was that of premature removal of a patient by a family member.\(^1\)

The patients themselves often were equally adept at exercising some degree of control over their lives, the asylum, and even their families. Many married women patients, who quite personally had experienced
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the effects of the lack of control over their fertility, high infant mortality rates, and exploitation by their husbands, seldom were articulate about their sufferings, but often quick to realize (and sometimes prolong) the respite the asylum offered. One young Italian woman, for instance, had been married at the age of fourteen and in eight years had given birth to four children, two of whom had died. Her husband accused her of being needlessly jealous of him, but the doctors believed the patient’s account that her husband bought “other women” into their home. Her husband also described her as violent, although the doctors found the patient “gentle and well-behaved” and quite reluctant to leave the asylum even after they declared that she had never been insane. And certainly the woman whose step children verbally abused her and whose only natural child had just died and the women whose husbands beat them welcomed that escape to the asylum.18

For single women facing a life of drudgery as domestic servants, for those without family support systems, or for those exhausted by the caretaking of an elderly parent or relative, the asylum could be benign, protective, and even more tolerant than the outside world and patients often went to great lengths to stay. One woman—and she was not an isolated case—feigned illness and importuned her sister for extravagant “dainties” on visiting days by claiming she would “not live long.” As her doctors concluded, she had decided that “she finds herself well off in the hospital and wishes to remain.” It is clear in many of these cases that working-class patients lacked the vocabulary to express the psychological stresses of their lives, but many of them understood, however unconsciously, that the asylum offered a physical and emotional care that was absent from their home environments.19

Not all patients, of course, so easily traded one kind of passivity for another. Once in the asylum, many patients asserted some measure of control over the doctors and hospital environment through subliminal (and sometimes quite deliberate) expressions of hostility. Anger at hospital policy or staff treatment frequently took the milder forms of complaining and refusal to talk or take medicine or the more drastic action of destruction of hospital property and physical attacks on the doctors, nurses, or other patients. Working-class men, as constrained by gender expectations as women, sometimes escaped the burdens of the role of provider by prolonging their stay in the asylum or, at least, by refusing to work while they were there. One claimed “he will have enough to do after he reached home” and another, the sole support of his mother, decided he did not “like home.” For thirty-eight years he periodically left the asylum on “sprees,” returned voluntarily when he...
could no longer provide for himself, and, while in the asylum, preferred “lounging” to work. Others, especially single indigent men, sometimes dictated which social welfare institution would be their residence. One man so disliked the local almshouse that he broke out, returned to the asylum, and told the doctors “he would not be kept” at the almshouse; he spent the next eight years at the asylum where he “behave[d] well and [was] contented.”

Elopement, however, was the ultimate expression of a patient’s assertiveness; it amounted to the patient’s self-removal from the asylum. One woman’s pattern of escapes is particularly illustrative of this way in which patients sometimes took hold of their own lives. This woman regularly eloped from the hospital, always returning on her own accord within a matter of hours or occasionally after a day or two. Each time she explained to the doctors that she just had a “strong notion to run off.” When she did, she headed toward home but continually frustrated her husband (whom she resented because she thought he had “done her personal violence”) by spending her sojourns at the houses of her neighbors and never entering her own home. After two years of complying with the asylum routine only at the time and in the manner she chose, the doctors finally decided that she was well enough to go home on trial. She behaved in such an “obstreperous” manner, however, that her husband quickly returned her to the asylum (where she spent the rest of her life). Whatever the degree of her mental instability, she obviously had used the asylum staff and her husband to fill some of her own needs.

These uses of the institution by the residents of the city of Harrisburg, by the families of patients at the asylum, and by the patients themselves convey a far less custodial function and more fluid image of the asylum than either nineteenth-century policy-makers or contemporary historians have depicted, yet many nineteenth-century critics of the asylum remained adamant about its brutalizing aspects and its isolation. A member of the Pennsylvania State Board of Charities in the late 1870s had even then described the asylum at Harrisburg as one of those “secret institutions, which to most people represented somewhat strongly the Bastille” and the asylum, on initial impression, did appear isolated and formidable. Its 420-acre farm, massive administration building, six structures housing 900 patients, and separate physical plants for generating electricity, disposing of sewage, processing laundry, and preparing meals were surrounded by more acres of outbuildings and trees—virtually making it a community unto itself. And its location a mile and a half north of the capitol area physically separated it from the neighborhoods of the city.
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Working-class families of Harrisburg, however, proved more astute than that member of the Board of Public Charities. Not only did they discern the many useful purposes of the asylum for their disturbed loved ones, they interacted with it quite comfortably. The asylum, although funded by the state and drawing patients from sixteen surrounding counties, nevertheless, was very much a part of the community of Harrisburg; it hired local men to make repairs, purchased supplies from Harrisburg businessmen, and invited area people to conduct entertainments for the patients. And, in this hard-industry city that offered limited opportunity for working women except domestic service or sewing, the asylum with its staff of over 300 local women and men was a major employer whose workers’ daily contact with the institution removed much of its mystery.

Local residents tolerated the institution’s idiosyncracies and those of its clientele and seldom expressed dismay even when asylum elopers appeared in the streets or on their doorsteps. And while asylum medical officers worried about their responsibilities toward the patients and their families, they, too, often took an attitude of nonchalance toward the more harmless escapees. At the Harrisburg asylum, in 1887 alone there were eleven escapees among the male patients. One man had eloped twice before and, on this occasion, the doctor merely commented that “he will go to his home and probably return again, in a short time, improved by the trip.” The patient did voluntarily return, and three months later he was off, once again, on another “french leave.” Another had been sent to the local dentist unescorted and stayed away for two days. Upon his voluntary return, he reported that he had “had a pleasant time.” Apparently he did; three months later, he was off on a month-long caper. Other patients were home on furloughs, returning to the asylum to complete their convalescence. These were not the majority of patients, of course, but the doctors’ nonchalance about elopers, families’ ease with the doctors, and the community’s daily contacts with the asylum point up the asylum as one of relatively free access.

The fact that patients from Harrisburg families had a higher rate of readmission to the asylum than those from areas outside the city is also testimony to this fluid relationship between the community and the asylum. And while a pattern of repeated recommitments may suggest that doctors prematurely discharged Harrisburg patients out of familiarity with their family situation, in response to families who could easily visit the asylum and exercise personal persuasion, or from the pressures of overcrowding, it is likely that these local families turned to the asylum when a problem arose because it was so handy and familiar to them. Few of these families were either newcomers to the city or
transients. Of the eighty-one Harrisburg patients, fifty-eight had lived in the community for ten years or more and twenty-eight of the thirty-six discharged patients continued to live in the city for at least another decade. Furthermore, few of the repeaters were among those who had been discharged as recovered; one supposedly recovered patient was an opium addict whose cure of the habit did not take, two others returned to the asylum for a few months after a dozen years in the community, another was institutionalized every seven years of her life, and one clearly was sent back to the asylum to die (a use of the asylum already established in the mind of the community). Others’ discharges had been more questionable from the start, nevertheless, their families’ willingness to return them to the asylum suggests that these working-class families did not necessarily view hospitalization as a brutalizing experience nor the asylum as an inaccessible, warehousing institution.

One can, of course, paint a too rosy picture of the asylum. The institution was seriously overcrowded in these last decades of the nineteenth century. In the best of circumstances, intractable patients created disturbances, and, when crowded together, patients were even more at the mercies of each others’ violence. They were subject, too, to harm from their attendants; sometimes the injuries arose from the patient’s own behavior, but all too frequently doctors reported and dismissed attendants who deliberately used excessive force. Furthermore, some patients were at greater risk for institutionalization; the courts were more likely to hospitalize patients without families and some families abrogated any responsibility for their mentally ill. And not all asylum doctors were especially sympathetic to their patients; those who became discouraged about their large numbers of chronic patients, referring to them as a “stagnant mass of humanity,” undoubtedly conveyed that attitude to their charges. Other doctors, influenced by the pessimism engendered by hereditarian theories, sometimes sedated patients merely to keep quiet in the asylum. And the monotony of the asylum routine—and frequently of its inactivity—was endemic to these large institutions, as was the “benevolent neglect” of patients for whom the doctors held out little hope for recovery or for useful activity in the asylum.

Patients did return to the community, however; most who did lived useful lives, others persisted in their recovery for extended periods. And even for those who did not, the asylum provided services for its clientele, and for the community in which it was located, that historians have overlooked and that were unimagined by asylum planners. In a world that did not yet offer such facilities as the nursing home, the sanitarium,
or widely available and affordable medical care for the poor, many working-class families of the Harrisburg area made selective use of the custodial functions of an asylum for the insane and manipulated its therapeutic purposes to fit their needs.

Notes


3. The casebook records yield information about age, marital status, number of children (for some), occupation, place of birth and county of residence, the nature of the admitting agency and source of support, admission and discharge dates, condition at time of discharge, and causes and forms of illness. Most contain accounts of contacts between patient and doctor, as well as remarks about behavior before admission and during commitment, assessments of temperament and hereditary factors, and notes on treatment techniques ranging from drugs and restraint to work and persuasion. The doctors were candid in their notes; some expressed rather negative biases and most freely reported the
use of muffs or cribs to restrain patients and solitary cells to isolate the violent ones. And it is not unusual to find reports of attendants who abused patients or the occasional assistant physician who became addicted to opium.

This breakdown of the asylum population is based on my random sample of 659 patients from the PSLH casebook records of the 1880s and 1890s; it is consistent with the aggregate statistics reported in the asylum's annual reports. The PSLH records are especially useful for determining socio-economic class because the Harrisburg doctors noted the occupations of the husbands or fathers of women who sought no employment outside the home and thus the twenty percent who held no job were truly the unemployed.

4. Both the Pennsylvania State Lunatic Hospital (PSLH) Trustees' Meetings Minutes (now housed at the Pennsylvania State Archives, Harrisburg, with the other PSLH records) and the First Annual Report of the Board of Trustees of the State Lunatic Hospital of the State of Pennsylvania (Harrisburg, 1852) clearly articulate the asylum's purposes; for the history of changing attitudes toward state asylums, see Grob, Mental Institutions.

5. Grob, Mental Illness, ch. 4 and Tomes, A Generous Confidence, ch. 6.

6. Tomes, A Generous Confidence, ch. 6 and PSLH Trustees' Meetings Minutes, 19 April 1883.

7. For superintendents' explanations about mortality rates in antebellum asylums (many of which were used in the late nineteenth century as well), see Barbara G. Rosenkrantz and Maris A. Vinovskis, "Sustaining 'the Flickering Flame of Life': Accountability and Culpability for Death in Antebellum Massachusetts Asylums" in Susan Reverby and David Rosner, eds., Health Care in America: Essays in Social History (Philadelphia, 1979).

8. Each patient was assigned a casebook number, but the asylum changed its systems on at least two occasions and used different numbers for different types of records (and readmitted patients received yet another number), therefore I have adopted the format below which both offers enough information for scholarly research and preserves the confidentiality of the patients. For the illustrative cases, see PSLH Casebook Records: EJ, female, admitted July 1889; ES, female, admitted February 1899; and EL, male, admitted August 1887.

9. PSLH Casebook Records: GK, female, admitted January 1899; IBG, female, admitted February 1894; and PK, male, admitted October 1891. I have reconstructed the family circumstances of these patients based on information found in the County Register of Wills and Deaths, 1893-1905, Historical Society of Dauphin County, Harrisburg; the city directories for Harrisburg (which were published under various titles and with various printers) for 1863, 1867, 1872, 1878, 1882, 1888, 1892, 1895, 1898, and 1901; and the 1860, 1870, 1880, 1900, and 1910 federal manuscript censuses for Harrisburg.


11. For a fuller analysis of the impact of gynecological treatment, and other treatments such as drug therapy, see Constance M. McGovern, "The Myths of Social Control and Custodial Oppression: Patterns of Psychiatric Treatment in Late Nineteenth-Century Institutions," Journal of Social History (forthcoming, September 1986).

12. PSLH Casebook Records: EM, female, admitted July 1881; RS, female, admitted January 1882; and MZ, female, admitted September 1883. Barbara Sicherman, "The Uses of a Diagnosis," in Judith Walzer Leavitt and Ronald L. Numbers, eds., Sickness & Health in America: Readings in the History of Medicine and Public Health (Madison, 1978) has found a similar phenomenon among working class female patients at the Massachusetts General Hospital; she suggests that those patients benefited from (and even
seemed to enjoy) the “psychological as well as physical care they could obtain in no other way.” Wendy Mitchinson, “Gynecological Operations on Insane Women: London, Ontario, 1895–1901,” *Journal of Social History* 15 (Spring 1982): 467–484 also has pointed out the effects of “individualized nursing care” for those Canadian institutionalized women.


14. For the founding of the Harrisburg Hospital, see Robert Grant Crist, *Harrisburg Hospital: The First 100 Years* (Harrisburg, Pa.: 1973), ch. 1. The percentage of deaths in the asylum caused by both syphilis and tuberculosis rose steadily from 1882 through 1910, but the rise in tubercular deaths was more dramatic. About twelve percent died of each disease in 1882; by 1910, seventeen percent of the deaths in the asylum resulted from syphilis and twenty-four percent from tuberculosis. See the Thirty-Second, Forty-Second, Fifty-First, and Sixtieth Annual Report of the State Lunatic Hospital at Harrisburg (Harrisburg, PA., variable publishers, 1882, 1890, 1901, 1911).

15. For the comments of the doctors, which are typical of their perennial complaints about these types of patients, see the Forty-Third and Forty-Fifth Annual Report of the State Lunatic Hospital at Harrisburg (Harrisburg, Pa.: Harrisburg Publishing Company, 1893 and 1895), pp. 17 and 16, respectively, and the quarterly reports the doctors made to the trustees throughout the period, PSLH Trustees’ Meetings Minutes, 1880–1910.

16. Barbara G. Rosenkrantz and Maris A. Vinovskis, “The Invisible Lunatics: Old Age and Insanity in Mid-Nineteenth-Century Massachusetts” in Stuart F. Spicker, Kathleen M. Woodward, and David D. Van Tassel, eds., *Aging and the Elderly: Humanistic Perspectives in Gerontology* (Atlantic Highlands, N.J.: 1978) and “Caring for the Insane in Ante-Bellum Massachusetts: Family, Community, and State Participation” in Litchman and Challinor, eds., *Kin and Communities* argue that the elderly were underrepresented in antebellum asylums. In Harrisburg in the late nineteenth century, that was not the case. An analysis of the aggregate statistics from the Report on Population of the United States at the Eleventh Census: 1890, Part II (Washington, D.C., 1895) reveals that the elderly made up only 4.7% of the adult population of the city; elderly patients from areas outside of Harrisburg represented only 3.2% of the asylum population; 12.7% of the patients in the asylum who were residents of the city, however, were over the age of sixty-five.

17. The frequency of family visits is evident from the PSLH Record of Visitors and Prescription Book, 1881–1882, and the families’ ease with doctors is revealed in the PSLH Letter Press Book of J. Z. Gerhard, 1883 (superintendent, 1881–1891), as well as in the doctors’ remarks in the casebook records.

18. PSLH Casebook Records: LP, female, admitted March 1898; EJW, female, admitted September 1882; and EH, female, admitted August 1883. The casebook records for the female wards of the PSLH are poignant testimony to the experiences of frequent child-bearing and infant deaths of these working-class women. The female patients in the 1880s had averaged a child birth every 2.1 years and, if miscarriages are included, a
pregnancy every 1.9 years. The average number of children was 6.42.

19. For the plights typical of some single women, see PSLH Casebook Records: NK, female, admitted February 1889 and SEH, female, admitted July 1882.


21. PSLH Casebook Records: HD, female, admitted February 1883 and for other patients who were adept at manipulating their families and the doctors, see SMM, female, admitted February 1884; AB, female, admitted February 1899; MAS, female, admitted November 1899; JMW, male, admitted February 1906; WG, male, admitted March 1906; and HB, male, admitted August 1891.


23. Although most attendants spent only a few years working at the asylum, there was a much lower turnover rate among female asylum employees than among males; see PSLH Employment Record Card File, 1892–1908. Especially for the women attendants (60% of whom had been domestic servants and 20% who had not been employed previously), the wages of $11 per month with room and board were comparable to those for unskilled female laborers in the 1890s—and probably a bit better because of the room and board provisions. For wages of working women, see Nancy Cott, ed., Root of Bitterness: Documents of the Social History of American Women (New York, 1972); Alice Kessler-Harris, Out to Work: A History of Wage-Earning Women in the United States (New York, 1982); Mary P. Ryan, Womanhood in America: From Colonial Times to the Present (New York, 1983); and Leslie Woodcock Tentler, Wage-Earning Women: Industrial Work and Family Life in the United States, 1900–1930 (New York, 1979) and for a sense of industrial Harrisburg, see George P. Donehoo, Harrisburg: The City Beautiful, Romantic, and Historic (Harrisburg, Pa., 1927) and Harrisburg and Dauphin County: A Sketch of the History for the Past Twenty-Five Years, 1900–1925 (Dayton, Ohio, 1925); Richard H. Steinmetz, Sr., and Robert D. Hoffsmommer, This Was Harrisburg: A Photographic History (Harrisburg, Pa., 1976); and William Henry Egle, History of the Counties of Dauphin and Lebanon in the Commonwealth of Pennsylvania: Biographical and Genealogical (Philadelphia, 1883).

24. Letters reporting the escapees are in the Board of Public Charities records at the Pennsylvania State Archives, Harrisburg, in the Institutional Population Records, PSLH Discharges, Transfers, Escapes, and Deaths, 1883–1888; the patients cited are PSLH Casebook Records: AW, male, admitted March 1885 and GKT, male, admitted December 1886. A perhaps bizarre example, but one that reiterates the openness of the asylum nevertheless, occurred in the case of one woman patient when her husband came to see her. The doctor's note was terse: "Though sitting in a dining room through which persons passed frequently he behaved with great impropriety. Mrs. _____ now seems to have gonorrhoea." PSLH Casebook Records: AD, female, admitted October 1883. And yet another example of ease with the asylum was the number of relatives of former patients who sought employment there. Among the sample of local Harrisburg patients, five of their siblings became ward attendants after their brother or sister had been discharged.

25. Either the patients or their families appeared in the city directories of Harrisburg between 1863 and 1901 or on the federal manuscript censuses for 1860, 1870, 1880, 1890,
and 1910. The patients who were discharged as recovered and later readmitted are PSLH Casebook Records: JMF, female, admitted December 1892; ABJ, female, admitted September 1886; EKL, female, admitted December 1891; AEP, female, admitted December 1898; and LAC, female, admitted September 1885 (women were far more likely to be repeaters). The other repeaters either had been prematurely removed by relatives, discharged as merely in an improved condition, or sent home on parole. As the asylum became overcrowded, doctors used the parole to make room for new patients; see Grob, Mental Illness, pp. 24-25.

26. The overcrowding at the Harrisburg asylum, especially starting in the 1890s, is evident in the PSLH Annual Reports and the Trustees' Meetings Minutes; injuries of patients (from whatever cause) are reported in the PSLH Casebook Records and the Trustees' Meetings Minutes. Fox, So Far Disordered in Mind, traces the vulnerability of those without families to court-ordered institutionalization and Grob, Mental Illness and “Rediscovering Asylums,” suggests that asylums became convenient places for inconvenient family members. While it was a Harrisburg doctor who made the despairing, and disparaging, remark about her patients, doctors at this asylum drugged relatively few patients simply to keep order in the asylum, at least in the 1880s. And although the doctors' remarks in their annual reports suggest that a small proportion of the patients engaged in useful activity, the Harrisburg doctors never resorted merely to keeping graphs on their patients on which they only used alphabetic designations for the activity and condition of the patient. On the male wards in the 1880s and early 1890s at the state asylum at Norristown, for instance, a patient’s condition and treatment were indicated only by such entries as an “s” if he were sick in bed, a “v” if he had a visitor, an “a” if he worked that day, or an “m” if he had been given medicine; the Harrisburg doctors kept careful, and full, records of their patients.