



The Physician, the Philanthropist, and the Politician

A History of Public Mental
Health Care in Pennsylvania



Ernest Morrison

For Ken Wolensky
With best wishes
Ernest Morrison

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**A History of Public Mental Health Care
in Pennsylvania**

Ernest Morrison

Commonwealth of Pennsylvania
Pennsylvania Historical and Museum Commission
for
The Historical Committee of the Harrisburg State Hospital
2001

Commonwealth of Pennsylvania
Tom Ridge, Governor

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Pennsylvania Historical and Museum Commission
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THE HISTORICAL COMMITTEE OF THE HARRISBURG STATE HOSPITAL WAS ESTABLISHED IN JUNE 1982 TO COLLECT AND PRESERVE THE RECORDS, ARTIFACTS AND STORY OF PENNSYLVANIA'S FIRST STATE HOSPITAL, WHICH FIRST OPENED IN 1851 IN HARRISBURG.

TODAY THE COMMITTEE SEEKS TO PROMOTE A BETTER UNDERSTANDING OF THE STATE HOSPITAL SYSTEM AND ITS ROLE IN PROVIDING FOR THE COMMONWEALTH'S MENTALLY ILL. THIS BOOK HAS BEEN WRITTEN AS PART OF THE COMMITTEE'S EFFORTS TO COMMEMORATE THE ONE HUNDRED FIFTIETH ANNIVERSARY OF THE ESTABLISHMENT OF THE STATE'S FIRST MENTAL HOSPITAL AT HARRISBURG.

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*to lift the curtain of popular misconception
which unfortunately long has existed
with regard to mental institutions.*

Sophia M. R. O'Hara

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Around a chandelier in the main reading room of the Pennsylvania State Library in Harrisburg a motto is inscribed that reads: "Thought never ripens into truth except through action." Although it is Emersonian in character, it is accompanied by no attribution. And search as I may, I have never found it in any dictionary of quotations, although there are dozens of quotations that convey the same basic idea.

Thought and action do go together (despite a widespread belief that individuals are either thinking or acting, but seldom both), and significant actions are invariably preceded by thoughts.

As much as the actions themselves, the *ideas* are what this book is about—*ideas* that led to the acts of the legislature, the erection of buildings, and the evolution in Pennsylvania's treatment of the mentally ill. Its underlying theme, then, traces the shifts in "public policy" in Pennsylvania's treatment of its mentally ill that grew out of this thinking.

Each act of the legislature, the erection of each new hospital building, the implementation of each improvement in medical regimen came about as the result of some new idea, which often emerged from or led to changes in the public's perception—the "public policy" climate—of the manner in which the Commonwealth should provide for its less fortunate citizens, including its mentally ill.

This trend is quite apparent, for example, in the acts of the legislature. Between 1868 and 1873 the acts that established state hospitals at Danville and Warren directed that they be of Kirkbride design. When the legislature committed to building Norristown a few years later, it specified that it be of cottage design; and then in 1901 when Allentown State Hospital was authorized the act directed that it be a "homeopathic" facility.

Moreover, the volume of legislative acts in the 150 years since 1851—which number in the hundreds—is evidence of the concern for and the commitment of the legislature to providing for the mentally ill.

The reader should keep two points in mind throughout. Regardless of the past shifts in public mental-health policy—whether at a given moment a community, county, or state system was preferred—the concern was always for the indigent, not those who could afford to pay. The latter usually went to private hospitals or were cared for at home. This was true even though many of the state facilities admitted some paying patients during much of their history. The policy behind establishing and maintaining both the county and the state schemes was to *provide for the poor*.

Second, the choice of which type of facility—community, county, or state—was in favor at any point was determined not only by the perceived quality of the care the mentally ill might receive in one or the other class of institution, but also by *who should pay* for the indigent's care.

Today, regardless of whether an individual stays in a state or a community mental health center, those who can pay invariably do so with insurance reimbursements, while the indigent are largely provided for with federal funds (Medicare or Medicaid). The state, of course, furnishes facilities, staff, and training at the state hospitals it continues to maintain.

While a people's greatness is usually measured by the wars it wages, the notable cities it erects and the wealth it amasses, the compassion it evidences for its less fortunate citizens—especially those beyond the pale of known treatments or the ability to care for themselves—should also be weighed in making that assessment.

The story of Pennsylvania's role in caring for its less fortunate citizens is an

extensive one stretching from William Penn's time to the present. It touches on areas all across the state, and is as diverse as the many ethnic groups who settled each of the state's regions. While, in some instances, there were similarities, many of the state's mental health ventures followed divergent paths and had unique characteristics. Consequently, rather than try to construct a story along a single, broad continuous plan, I have provided the reader with a cinematographic approach to its manifold events and parts. The individual scenes may be read separately, but together I hope they provide those who examine them with a sense of the rich texture of their diversity.

Two of the chapters included here—"Life Among the Insane" and the "Haviland Survey"—are long. They provide, however, a first-hand, inside look at life in an asylum and county poorhouse, permitting us to see views that are more revealing than those of other reports or narratives.

This is not a happy story; nor is it one with a satisfactory ending. It is a survey of a history marked by struggle, by shifting currents, by charge and counter-charge. In the past 150 years there have been a few individual successes, but no triumphant campaigns, no heroes acclaimed. It was a time in which each new facility, each new treatment methodology, each new agency reorganization, each new appointee, was viewed with hope for future success—a future that only led to yet another facility, treatment regimen, agency reorganization, or new appointee.

Hospitals—especially those for the mentally ill—are seldom thought of as friendly or even "hospitable" places, and history has shown that in some instances "bad" things have happened in them. They are, however, by their very existence evidence of the state's benevolent attitude, its concern for its less fortunate citizens.

Some readers may think this book is not tough enough, others that it is not

compassionate enough. My intent, however, is to tell what I believe is a compelling story, and to leave the judgments on the actions of, or neglect by, those who played a part in it to those readers who wish to make them.

A word, too, on words. I have tended throughout the text to use terms such as asylum, lunatic, insanity, and mental illness in their historical contexts without intending any pejorative connotations.

There is no other area, however, where words have become freighted with so much stigma as in that of mental illness. Historically those so afflicted have been called first lunatics, then insane or crazy, later patients, now mentally ill, and the places they have been kept first asylums, then hospitals, and now mental health centers. As soon as one term became a slur through usage, a new one was devised. Gradually with the use of the word as an adjective—"He is mental."—someday even *mental* may become shunned as *lunatic* now is.

To paraphrase Hamlet, "The stigma lies not in the words, dear reader, but with ourselves." As long as we believe that those who suffer from diseases such as schizophrenia are somehow disgraced (regardless of whether we ascribe the feelings of disgrace to others or to ourselves), whatever term we apply to those who have "lost their reason" will in time become a disgraced term.

Likewise at one time it was the practice when taking photographs of those housed in the state hospitals to block out their faces when printing the pictures. I have always thought that rather than protecting the identity of the patients, we are heaping a final indignity on them. Their minds are impaired so we strip them of their countenance, thus stealing from them the last shred of their humanity.

This, like the avoidance of words, is done more out of fear of offending others than out of benevolence toward patients. Experience has shown that, at a chance

meeting, it is as often we, as they, who avert eyes or turn away faces. With an almost child-like guilelessness, they do not feel the embarrassment or the shame that we do.

I was pleased to discover late in my research that eventually the management of the Philadelphia State Hospital also reversed its position on this practice for the same reason.

Although the title refers mainly to the three individuals who were instrumental in the establishment in 1851 of the first Pennsylvania mental hospital at Harrisburg—the Philadelphia physician Thomas Story Kirkbride, the Boston philanthropist Dorothea L. Dix, and the Ephrata politician Joseph Konigsmacher—the book deals with and is dedicated to a succession of physicians, philanthropists, and politicians and the impact they have had on the Commonwealth's treatment of its mentally ill.

As this book was intended for a general audience, it was decided not to include the usual academic paraphernalia of endnotes. However, a few citations have been inserted in the text. It also seemed appropriate to include some references for further reading on the more important topics covered in this book, so a brief bibliography is included.

There is no other general history of state mental health care in Pennsylvania, although there are countless books covering both the asylum and the community mental-health eras in the United States. There are individual histories, however, of two of Pennsylvania's state hospitals: Fred R. Hartz and Arthur Y. Hoshino's *Warren State Hospital, 1880-1980* and Ernest Morrison's *The City on the Hill* about the Harrisburg State Hospital.

There are several biographies of Dorothea Dix from which the reader may choose ranging from the popular to the scholarly. And there are at least two on Thomas Kirkbride—Nancy Tomes's *A Generous Confidence* and Earl D. Bond's *Dr. Kirkbride and His Mental Hospital*. Copies of Thomas Cope's *Diary* are also available. Full-length biographies of the other principals have yet to be written, although Patricia Davis's *A Family Tapestry, Five Generations of the Curwens of Walnut Hill* includes a substantial amount of material on John Curwen. And, of course, there are numerous books dealing with the various types of mental illness: schizophrenia, depression, epilepsy, autism, senile dementia, etc.

In closing it seems, however, that a note of hope may be in order. Recent developments in drug therapies and in studies of the brain and mind point to, if not identification of the causes of diseases (Manfred Spitzer's *The Mind Within the Net* provides special insights into the mind, its functioning and disorders) such as schizophrenia, or a "cure," or at least a "restoration"—as the early alienists called it—to full productivity and potential for most sufferers.

Finally, just as it was Secretary of Welfare Sophia M. R. O'Hara's expectation for her 1947 report to Governor Edward M. Martin on the state mental health system, it is mine that this book might help

to lift the curtain of popular misconception which . . . long has existed with regard to mental institutions.

Ernest Morrison

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William Penn's Great Law

When he arrived at Philadelphia in October 1682, William Penn, as proprietor, issued a set of laws for his colony that came to be called the Great Law.

The Great Law gave Pennsylvanians the most humane legal code of any American colony. While, for example, the English code listed two hundred capital offenses, Penn's prescribed death only for first-degree murder.

In addition to provisions for a humanitarian prison system, the law specified that if any person or persons fall into decay [author's italics] or poverty, and not able to maintain themselves and their children with their honest endeavors, or shall die and leave poor orphans, that upon complaint made to the next Justices of the Peace of the same County, the said Justices, finding the complaint to be true, shall make provision for them, in such a way as they shall see convenient, till the next County Court, and that then care be taken for their future comfortable subsistence.

Madness in Colonial America

Many of the colonists brought with them all the awe, the fears, and the superstitions about insanity that had prevailed in Europe from the time of the Middle Ages. The common explanation was demonic possession, which from 1487 in the time of Pope Innocent had official, theological justification for various proceedings and methods for purging evil from the body, including the burning of the afflicted at the stake. Much of this abuse was directed at deluded females who it was believed infected men with disease and death through their witchcraft.

The witchcraft trials of colonial New England were based in part on this presumption. And a wide variety of other

methods were in place in New England to handle the mentally ill. The more violent individuals were treated as criminals—the jail, the pillory, the whipping post, or the gallows was their fate. The “harmless” ones were usually housed in kennel-like structures in the town square or “sold off” to the lowest bidder who was to provide for their care and whatever work the buyer could wrest from the individual. The term of servitude was usually one year, when the unfortunates would be resold.

If there were no bidders, the insane were often “dumped” on another town. The individual would be spirited late at night to a distant community, left standing in the town square, confused, unable the next morning to recall where he came from. The point of “selling off” or “dumping” was to relieve the community of the cost of maintaining those who could not do productive work.

Although, following William Penn's lead, Pennsylvania's mentally ill were seldom abused in these manners, even at the Pennsylvania Hospital in Philadelphia, which had an insane department, it was the practice in the late eighteenth and early nineteenth centuries to exhibit the “lunatics” for a fee. Philadelphians commonly used it as a Sunday afternoon pastime for entertaining out-of-town guests. Jeers and taunts would be directed at the patients in the hope that like caged animals they could be goaded into a rage for the amusement of the visitors.

Pennsylvania Hospital

Benjamin Franklin laid the cornerstone for the Pennsylvania Hospital in 1755. The idea for the hospital was not his, however, but that of a young Philadelphia physician, Thomas Bond.

If not substantial, Franklin's role was an important one. In 1751 Bond, who according to Franklin was “zealous and active” in attempting to raise subscriptions for his hospital idea, turned to

Franklin when his efforts met with little success. As Franklin tells the story in his *Autobiography*

he came to me with the compliment that he found there was no such thing as carrying a public-spirited project through without my being concern'd in it. "For," says he, "I am often ask'd by those to whom I propose subscribing, Have you consulted Franklin upon this business? And what does he think of it?"

Franklin first "prepared the minds of the people" by writing articles in the *Gazette*, as was "his usual custom in such cases." The subscriptions picked up, but when after a while they began "to flag," Franklin came up with the scheme of seeking assistance from the Provincial Assembly. When the members from the country objected that the citizens of Philadelphia should provide the expense, he told them that the proposal "met with such approbation as to leave no doubt of our being able to raise two thousand pounds by voluntary donations."

The members of the Assembly were so certain this was "utterly impossible," they agreed to support Franklin's bill for a "capital stock" appropriation if he was able to raise the two thousand pounds. Franklin claimed the members, who had opposed the grant, "now conceiv'd they might have the credit of being charitable without the expence."

When Bond and Franklin told the subscribers the Assembly would match their subscriptions pound for pound, they easily raised the two thousand pounds. Franklin wrote of his involvement "I do not remember any of my political manoeuvres, the success of which gave me at the time more pleasure, or, after thinking of it, I more easily excus'd myself for having made some use of cunning."

Franklin's cunning in securing the support of the Assembly had far-reaching

effects. As the first such effort, it set the precedent for two hundred years of public support of the mentally ill by the Commonwealth. Hundreds of acts by the legislature during the years following that original act appropriated money to build asylums as well as to support private hospitals for their care.

From the beginning, the Pennsylvania Hospital made care of the insane an integral part of its mission. Bond and Franklin's petition to the Assembly specifically mentioned the large number of lunatics in the colony and the problems associated with them as part of the justification for the hospital. "Going at large [they] are a Terror to their Neighbors, who are apprehensive of the Violences they may commit."

According to Thomas Kirkbride biographer Nancy Tomes (*A Generous Confidence*), the hospital took only the more dangerous and disruptive lunatics because of its limited space. The nonviolent cases were usually consigned to the almshouse. In most instances then, the Pennsylvania Hospital's insane patients were in need of restraint with chains, manacles, and straitjackets. They were housed in the basement and only occasionally were permitted out of their cells and into the "crazy yard," a secure area on the hospital grounds where they could get fresh air and some exercise

Such accommodations as barred basement cells and heavy shackles of chains were not considered inhumane in the late eighteenth century. As Tomes writes: "Even the most enlightened of the early [hospital] managers and physicians believed that the insane, by virtue of losing their reason, had reverted to a brutish state." And the Pennsylvania Hospital apparently subscribed to this principle. As one hospital physician wrote in 1794, "madmen, if suffered to have their liberty, resemble beasts rather than men."

Within fifteen years of the hospital's

opening, the insane made up nearly half of its patients. By the 1790s overcrowding had forced the managers to construct for them a separate wing or “department” as it came to be known. Removed from their basement cells into vastly improved new surroundings, their lives took on aspects of normalcy. Although some patients still sat in their rooms, other wrote poems, told their life stories to the matron, worked at various crafts, or learned to play musical instruments.

Finally in 1831, the hospital managers decided to construct a separate building west of the Schuylkill River devoted to the insane. When it opened in 1840, Thomas S. Kirkbride, a young physician who had specialized in their care at the center-city facility, became the manager of the new hospital. It was at the Pennsylvania Hospital for the Insane, that—in spite of his reluctance to accept the position rather than wait for a more desirable one as a surgeon—he developed the ideas on hospital construction and the care of the mentally ill that were to dominate the field for the next half-century.

Benjamin Rush

Benjamin Rush was born in Philadelphia in 1746 of Quaker parentage. Rush was precocious. He graduated from New Jersey College (later Princeton) at age fifteen, did six years of medical apprenticeship, then journeyed to Edinburgh for advanced study. He received a Doctor of Medicine degree there in 1768. Following a year’s further stay in Europe, he returned to Philadelphia, where he set up practice. He soon rose to eminence in the city and eventually became the most celebrated physician in Revolutionary America.

Along with his fellow Philadelphian Benjamin Franklin, Rush was a reformer of prodigious energy. He participated in all manner of causes including prison reform, the abolition of slavery, education for

women, and common schools for children. Rush supported the cause of freedom from England from the outset of the Revolution. He served in the Continental Congress and was a signer of the Declaration of Independence.

Benjamin Rush was the first American physician to attempt an original theoretical systematization of the causes and treatment of mental illness, the first to institute a program of university-level study in mental disease, and the first to write a general treatise, *Medical Inquiries and Observations upon the Diseases of the Mind*, on insanity. Because he paid significant attention to the problems of the insane before any of his fellow physicians, Benjamin Rush is sometimes called “The Father of American Psychiatry.”

In spite, however, of his interest in and sympathy toward the insane, his conclusions concerning the disease and his treatment methodologies were more akin to those of the eighteenth than the nineteenth century. In what is probably a rather charitable description, Albert Deutsch calls his conclusions “unsteady.”

Because of the typical patient’s “excitement,” Rush believed insanity was caused by hypertension in the arteries of the brain. He, therefore, employed purgatives and emetics as well as such practices as blood letting to reduce the blood pressure in the brain. Obviously after enough blood was drawn the agitation of the patient lessened. Deutsch describes Rush’s treatment methodologies as in some respects “more harmful” than “curative,” but credits him with providing more impetus to medical progress than any of his contemporaries.

Rush also invented several devices for treating the insane. One of these was a chair he called the “tranquilizer.” In an effort to reduce a patient’s pulse rate, an agitated man or woman was tightly strapped in this contrivance until all his or her muscular activity had been immobilized. Another of his machines Rush called

the “gyrator.” The intent of this machine was the opposite of the tranquilizer. By rapidly rotating a patient in the gyrator, the blood rushed to the individual’s head, in the hope of rousing a patient out of his “torpid madness.”

Rush was a man of strong opinions

with an equal willingness to publicize them. To him has been credited the idea of the physician as “autocrat” and the patient as completely subservient. It became a fundamental principle of asylum superintendents during the nineteenth century.

The Frankford Asylum and “Moral” Treatment

to fetter strong madness in a silken thread

The Friends Asylum at Frankford, five miles north of Philadelphia, was the first hospital in America designed to care for the mentally ill as a moral treatment facility. It was opened in 1817 on a fifty-acre country site selected for its peaceful nature. The three-story building with two-story wings could accommodate forty patients. At first, only Quakers (members of the Society of Friends) were admitted but in 1834 the hospital was turned into a nonsectarian institution.

“Moral” treatment was first practiced in France and then in England. It consisted of removing patients from their homes to an asylum (preferably a calm retreat in the country) that provided the patient with an intimate family atmosphere. Coercion by blows and the use of bars and chains were replaced with a system of humane vigilance.

Under moral treatment a gentler medical regimen was substituted for the previous practices of bloodletting and purgings. The objective was to “rebuild” the brain into a healthy one using appropriate mental exercises. The attendants were instructed to act as if they were servants. Noisy patients were to be tolerated. The convalescing were allowed access to books, music, and entertainment, and were given at least limited freedom of movement. The primary role of the institution was to help the patient “minister to himself.”

Philippe Pinel, a French village doctor who first began treating the inmates in the asylums of Paris during the French Revolution, devised the term “moral” for this form of treatment. Before Pinel’s arrival the inmates had been kept chained in irons and were treated like desperate, dangerous animals. Pinel removed their

chains and began ministering to them with kindness and sympathy. It was his belief that not enough importance was placed on the emotional causes of mental disease. By use of the word “moral,” he attempted to convey the importance he accorded to the emotions as motivators of human behavior.

Although Pinel’s ideas astounded Robespierre, the latter was too busy at the height of the Revolution to give them much attention and gave responsibility for Paris’s insane over to Pinel. By 1792, Philippe Pinel had formalized the method’s principles, systematized its practices, and dramatized its results.

At the same time that Pinel was working to improve conditions in France, William Tuke was attempting to convince the Yorkshire Quakers in England to build an asylum for members of the Society of Friends. Although there was great opposition to his plans, “The Retreat” was finally erected in 1796. William Tuke’s principal objectives were to provide a family-like environment in noninstitutional-looking buildings and surroundings, to emphasize exercise and employment as conducive to mental health, and to treat the patients as guests rather than inmates. According to Albert Deutsch (*The Mentally Ill in America*), “Kindness and consideration formed the keystone of the whole theoretical structure [of moral treatment]. Chains were absolutely forbidden, along with those resorts to terrorization that were still being advocated in varying degrees by eminent medical men.”

The ideas of Philippe Pinel and William Tuke not only transformed the treatment of Europe’s mentally ill but also swept over the United States. They were the primary impetus behind the design and construction of hospitals such as the Frankford Asylum (which was patterned after Tuke’s “The Retreat”) and those the Commonwealth of Pennsylvania erected between 1850 and 1870. They also provided the principal therapeutic regimen



The new administration building erected at Harrisburg in 1895 (left) with the old Kirkbride Building—the first Pennsylvania State Hospital which opened in 1851—in the background.

employed in asylums until the end of the nineteenth century.

It was at the 1811 Spring Quarterly Meeting of the Philadelphia Society of Friends that the proposal to erect a moral-treatment asylum “for such of our members as may be deprived of their reason” was first presented. A constitution was drawn up and a subscription campaign launched. An important feature of the campaign was the circulation of Samuel Tuke’s *Description of the Retreat near York*.

The ideas of Tuke and Pinel on treatment were closely followed at Frankford. Patients were not considered as subhumans or social pariahs, but as “men and brothers.” The upper stories of the building were reserved for the mild and convalescent cases; the lower for the noisy and incurable. The facility’s constitution stated that the asylum “is intended to furnish, beside the requisite medical aid, such tender sympathetic attention and religious oversight, as may soothe their agitated

minds, and . . . facilitate their restoration.”

The Friends’ ideal was “to fetter strong madness in a silken thread.”

Thomas S. Kirkbride

Among nineteenth century American “alienists—a doctor who treats those whose minds have been “alienated”—none had a wider reputation than Thomas Story Kirkbride. He was born in Bucks County, Pennsylvania, in 1809, a descendant of Quakers who had accompanied William Penn on his initial voyage to Pennsylvania. Kirkbride first studied medicine with a physician who had come from France with Lafayette during the Revolution. Then Thomas attended the University of Pennsylvania from which he received a Doctor of Medicine degree in 1832.

Kirkbride did a year’s apprenticeship at the Friends’ Asylum at Frankfort, and then was named resident physician at the Pennsylvania Hospital. He practiced sur-

gery there for several years until he was appointed physician-in-chief of the new Pennsylvania Hospital for the Insane in 1840. His hospital was a model institution in the treatment of mental illness. Sidney George Fisher, a Philadelphian whose brother-in-law had spent thirty-five years in Kirkbride's hospital, wrote in his diary of an 1862 trip to visit his wife's brother. He described the facility as situated

[in a] beautiful, richly cultivated and wooded country, glowing in autumn colors. We drove first to the house of Dr. Kirkbride. He is highly respectable and has managed this admirable institution for more than 20 years with signal ability and success. . . . The buildings and grounds are extensive and kept in perfect order. He received us very kindly and gave us a note to the superintendent of the enclosure where Alexander lives.

Dr. Kirkbride was an early exponent of "moral treatment." He made a point of visiting his patients each day, of inviting them to his afternoon staff teas, and in making art, music and education readily available. He believed in "free and friendly conversation on any subject in which the patient is interested." His treatment methods stressed "earnest sympathy," "gentle attentions," and "judicious counsel."

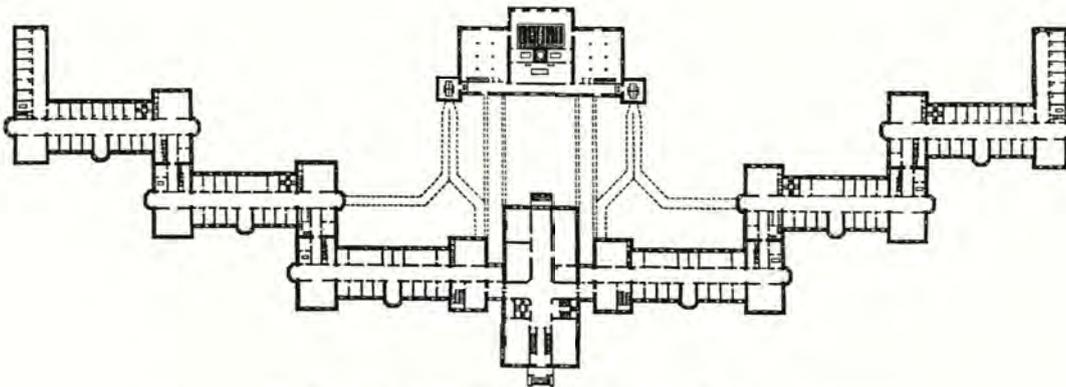
In 1847 Thomas Kirkbride published

a volume titled *On the Construction, Organization, and General Arrangements of Hospitals for the Insane*. It was the standard work in the field for the next forty years. During that period asylums for the insane were erected, internal hospital facilities were organized, and the mentally ill were treated following the ideas, theories and plans that Kirkbride laid down in his book. As Albert Deutsch, wrote in *The Mentally Ill in America*, Kirkbride's "word on hospital construction was accepted as law in America."

Thomas Kirkbride was one of the thirteen founding members of the American Psychiatric Association and served admirably on the boards of other institutions including the first Pennsylvania Lunatic Asylum at Harrisburg. Although his influence on hospital construction began to wane late in the nineteenth century, no one ever personally assailed him or his professional reputation.

Earl D. Bond, in his biography of Kirkbride, describes him as being "gentle as a woman," but "firm as adamant." He was so well known in Philadelphia that a prominent British psychiatrist told the story of a streetcar conductor who could not tell him where the Pennsylvania Hospital for the Insane was, but readily directed him to "Kirkbride's."

PLATE X.



PLAN OF PRINCIPAL STORY OF IMPROVED LINEAR FORM OF HOSPITAL.

A plan from Thomas Kirkbride's classic book on mental hospital construction.

A Kirkbride Asylum

to "first relieve a patient of all his responsibilities and then give them back one by one."

In 1854, Thomas Kirkbride revised and enlarged *On the Construction, Organization, and General Arrangements of Hospitals for the Insane*. This revised work covered much more, however, than simply the design of buildings. Among the subjects Kirkbride discussed were site selection and preparation, drainage and water supply, heating and ventilation, layout of the surrounding "pleasure grounds," the detailed appointments of patients' rooms, the height of the rooms' ceilings, the location of the kitchen, chapel and staff quarters, the daily duties of each employee, even the number of pigs in the piggery. Every subject, every point that Kirkbride covered was dictated from the consideration of its impact on the treatment of his patients, not from any arbitrary architectural or aesthetic point of view.

The following short passage from his long chapter on "Heating and Ventilation" will give some idea of Kirkbride's attention to details:

The steam is to be conveyed from the boilers through an eight-inch iron pipe, till it reaches the air chambers under or near the centre building, and from this point a smaller pipe diverges to each extremity of the hospital. . . . The radiating surfaces may be either made of large cast iron or of small wrought iron pipes. Of the two, the latter are to be preferred on account of the greater facility with which they can be taken down or put up, turned at corners, and repaired in every way, while their cost is no greater.

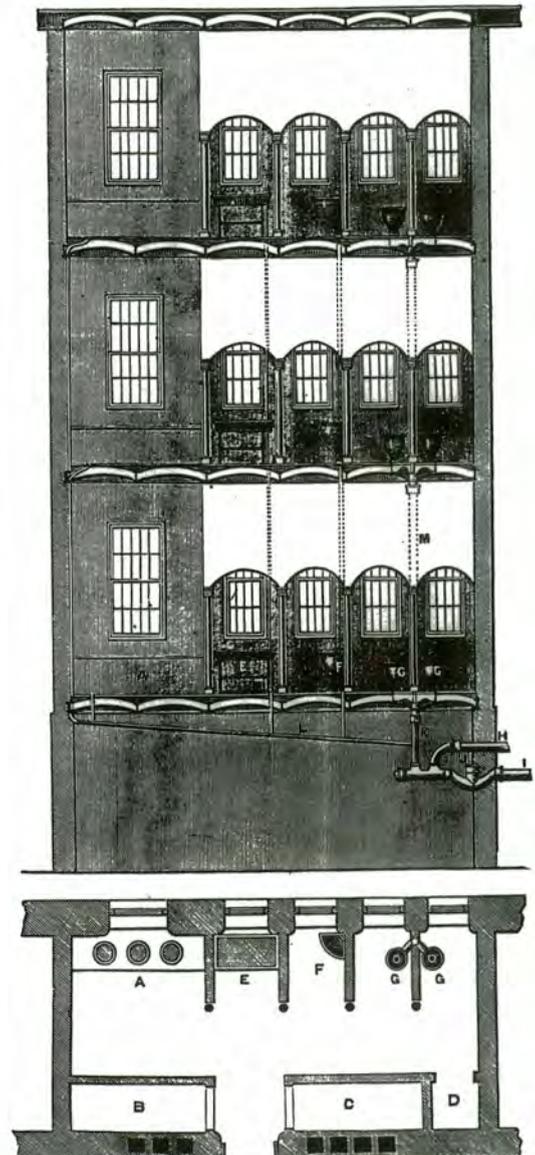
The radiating pipes should be prepared in two or three distinct sets, one or all of which, can be used at pleasure. In the cool mornings and evenings which occasionally occur even in the summer

months, and during the mild weather of spring and autumn, one series of pipes will be sufficient. With the ordinary winter weather, two will be required, and when the temperature is very low, . . . the whole of the three ranges, . . . must be put in operation.

A Kirkbride hospital was to be built linearly, with two eight-ward wings ema

VERTICAL SECTION OF WATER ARRANGEMENTS.

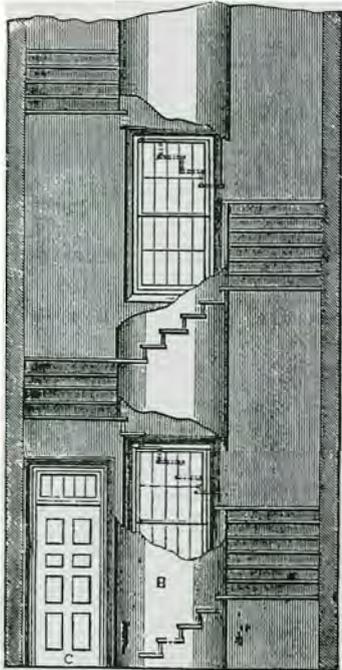
PLATE XXI.



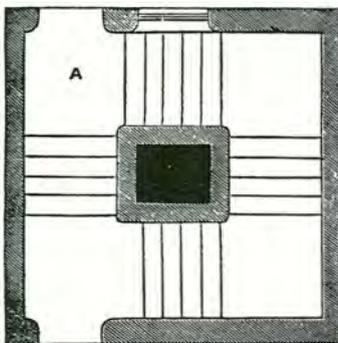
PLAN AND VERTICAL SECTION OF WATER ARRANGEMENTS, AND THEIR VENTILATION.

Vertical Section of Water Arrangements from Thomas Kirkbride's book on the construction of insane asylums.

PLATE XVII.



VERTICAL SECTION OF FIREPROOF STAIRWAY.



PLAN OF FIREPROOF STAIRWAY.

Verticle section and plan for a fireproof stairway of a Kirkbride asylum.

nating from a central building. Each of the wings consisted of four buildings (two wards to each structure). Each of the four was attached but set off from its adjacent members to permit maximum entry of sunlight and fresh air as well as provide separation from the other buildings.

The patients were "classified" (arranged) with the most seriously disturbed at the far end of each wing (in the Eighth Ward), with progressively less disturbed patients housed closer to the central building. The attendants and nurses for each ward lived in the basement of their respective structures, so they were immediately available. Calling tubes were provided from the upper floors to the basement.

As patients got better they were moved or "promoted" from ward to ward closer to the center of the hospital. In the words of Earl Bond a Kirkbride hospital was intended to "first relieve a patient of all his responsibilities and then hopefully give them back one by one."

Patient admission and classification was done in the center or main building. The kitchen and dining facilities (for the staff) were found there, as well as a chapel. The superintendent and his family lived on the upper floors.

It was Thomas Kirkbride's intention that a mental-hospital building should result from a close cooperation between a professional architect and a physician. He visualized it as a collaboration of

distinguished and skillful architects and physicians who have had a large practical experience with mental patients, who are thoroughly familiar with all details of their treatment, and who know the advantages and defects of existing hospitals.

Accordingly, his *On the Construction, Organization, and General Arrangements of Hospitals for the Insane* contained numerous plates illustrating in detail such parts of a Kirkbride structure as a "Longitudinal Section of an Infirmary Ward," the "Plan of a Cellar of a Supplementary Ward," a "Vertical Section of a Fire-Proof Stairway," an "Elevation and Plan of a Kitchen," and a "Vertical Section of Water Arrangements and Their Ventilation" [for bathing and toilets].

Following the tenets of moral treatment, a Kirkbride institution was intended to impress its patients as cheerful and comfortable, and was always to be surrounded by attractive grounds for walking and socializing with other patients. Many of the “pleasure” grounds at the early asylums were covered with an abundant variety of vegetation and stocked with wildlife—turkeys and deer.

According to Kirkbride there must always be “at least one nurse or attendant for every eight patients.” The nurses and attendants were required to possess “tact, pleasantness, patience, a real interest in the work, a sympathy that cannot be questioned, a sound moral character.” And, of course, with a superintendent who had complete and exclusive authority over the facility, any who did not possess these attributes were promptly dismissed.

By the end of the nineteenth century as many as thirty hospitals had been erected around the world following the guidelines that Thomas Kirkbride laid down in his book. A few of them are still standing. At least two of them in

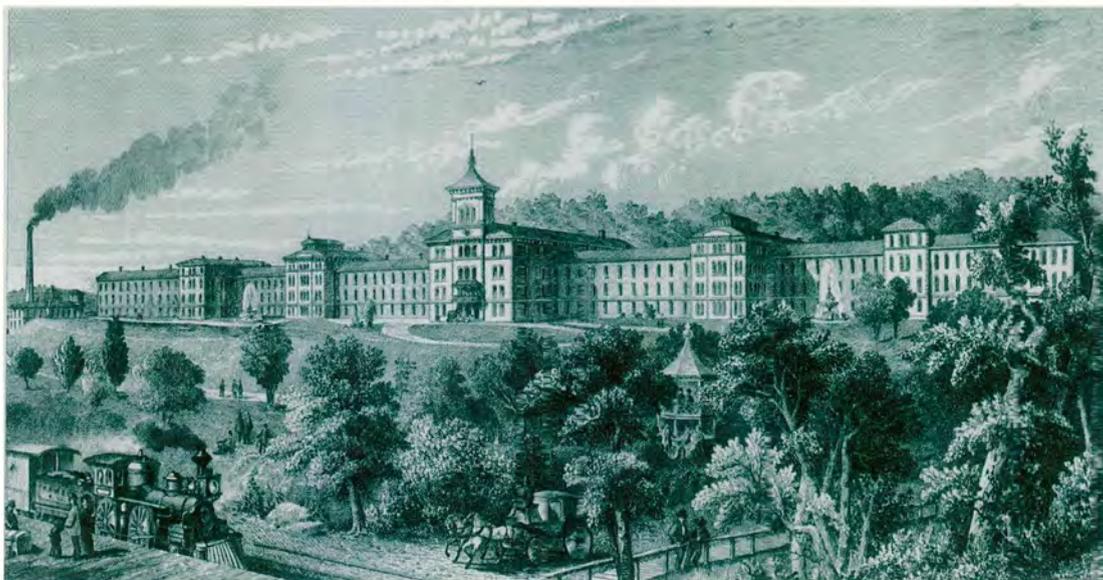
Pennsylvania—at Danville and Warren—are still hospitals for the mentally ill.

The Legislative Sessions of 1838 and 1841

In 1835 Thomas P. Cope, a wealthy Philadelphia merchant and philanthropist, was appointed chairman of an association of Philadelphia residents interested in “procuring for the pauper and indigent insane, the benefits of curative treatment and hospital protection.” The Cope Committee conducted surveys of conditions in the state and prepared a petition to the legislature to establish an institution for the insane.

On January 10, 1838, the Pennsylvania House referred Cope’s petition to a committee headed by Joseph Konigmacher for study and report. Two months later, Konigmacher submitted a lengthy report favoring the establishment of an “asylum for the insane poor of this commonwealth.”

Konigmacher’s committee had gathered data from nearly half the counties in the state and concluded that there were



A print of the architect's sketch for the Western Pennsylvania Hospital for the Insane at Dixmont.

2,300 insane persons out of a population of 800,000. The report opened with a heartrending appeal:

Poverty itself, when abject and hopeless enough to seek relief from public charity, is a bitter portion, . . . to be miserably poor and to be shut out from every pleasant and cheerful prospect, and to be denied the alleviation of sympathy and hope, is an intense aggravation. But to have the mind diseased, distracted and tormented; and to endure, beyond all this neglect, abuse and cruelty, without the power of resistance, . . . presents a picture of human woe, which few can contemplate without a tear of pity.

Governor David R. Porter vetoed the bill, however, which the committee had attached to its report, not because of a lack of sympathy for the cause, but because of the “financial embarrassment” that Porter found the state in when he took office.

Then in the 1841 legislative session, Cope and Konigmacher pushed through another bill for the same purpose. During this session the legislature was especially busy writing philanthropic acts: to establish poorhouses in several counties, to provide pensions to Revolutionary War veterans, and to establish an “Asylum for the Insane of this Commonwealth.” For the several poorhouses, the legislators elected to pass the costs back to the counties. For the asylum, provided for in Act 34—which was signed by Governor Porter on March 31, 1841—they furnished \$50,000 “seed” money to buy land and construct a building, but nothing for its continued maintenance.

The act did not completely overlook the issue—it did specify that the “authorities having care and charge of the poor in the counties, districts and townships of this Commonwealth, shall send to the asylum such insane paupers under their charge . . . and they [the authorities] shall

be severally chargeable with the expenses of the care and maintenance of such paupers.”

The act also directed the hospital trustees to apply “to the maintenance of insane persons in, or to the general use of the asylum any grant of land, any donation or bequest of money or other personal property” that they received. But this money would not have been enough to run a large hospital. In all probability the legislature expected the trustees to be private fundraisers—a practice commonly used in supporting private hospitals and poor houses of the day.

The project’s managers bought land outside of Philadelphia, secured the renowned architect William Strickland to design the structure, and laid the building’s foundation. The group, however, ran into political and financial difficulties.

Cope blamed the failure of the effort on political interference; that the assignment of “the carrying out of it to party men, more intent on making jobs for themselves and their political friends” had killed its chances. Cope wrote in his diary: “[A] lot was contracted for at an extravagant price and another agreement made with an unprincipled demagogue to furnish the materials for the building, who afterwards ran away to escape punishment—and the whole thing was abandoned.”

Thomas Pym Cope

Thomas P. Cope was one of the wealthier nineteenth-century residents of Philadelphia. He was born in Lancaster, Pennsylvania, in 1768 to a plasterer and town burgess. While still a boy, Thomas walked to Philadelphia “without,” as he wrote in his diary, “a dollar either of my own or of any other person.” He first became a lowly merchant’s apprentice, but by the time he was a young man, he had made a fortune sending ships to Europe and the Orient.

By 1838 when he helped Joseph Konigmacher author the first state act for the establishment of a hospital for the mentally ill, Thomas Cope had become one of Philadelphia's leading philanthropic citizens. He was involved in a wide variety of civic and charitable projects, including hospitals, poor houses, the city's first public water supply, and the purchase of land that led to the establishment of Fairmont Park. He shared the concerns of many of his fellow Quakers, devoting time and money to the poor and insane, the abolition of slavery, and Haverford College.

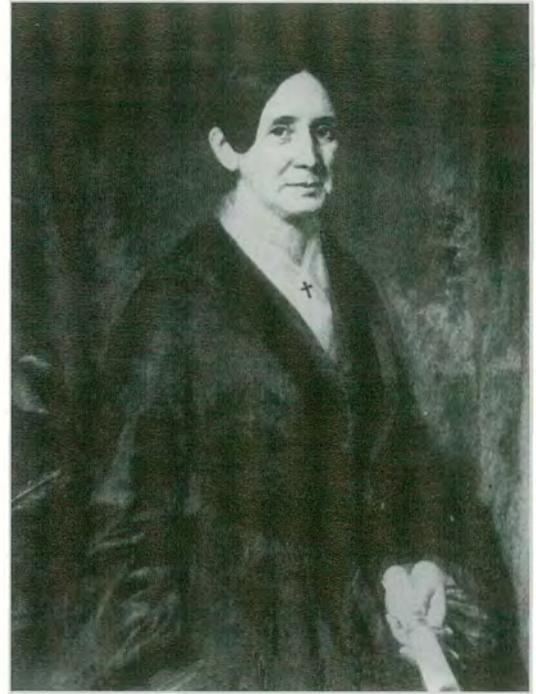
Although Cope was a successful merchant, he seemed to enjoy his political and philanthropic activities even more than making money. He maintained a life-long interest in scientific matters, which resulted in a membership in the American Philosophical Society.

Dorothea Lynde Dix's Memorial

During 1842 and 1843, when travel to parts of Pennsylvania beyond the Appalachian Plateau was primitive, Dorothea Dix, a Boston philanthropist and advocate for the humane treatment of the nation's insane, visited the counties in the state one by one. She systematically sought out and went through each jail and poorhouse in the Commonwealth in search of the "idiotic" and "insane."

No jailer or poorhouse keeper was able to deny her entry. Her bearing, tall and straight with a face of strong but delicate, patrician features; her raven black hair, combed back and then knotted; her determination; her firm and unyielding manner warranted to all her right to be there.

Although her travels in Pennsylvania were not filled with quite the difficulties and dangers that some of her surveys in other states had been—in Massachusetts her claims first were denounced as false, and then in a "dismal-looking" Michigan



Dorothea Lynde Dix, early advocate for the mentally ill.

forest she disarmed a highwayman (with words)—the difficulties she had traveling and the conditions she found in the state's jails and poorhouses were just as shocking.

In the poorhouse at Gettysburg there were eleven patients chained in a damp unventilated basement "crazy room" eight by eight by eight feet high. Several of them had been there for years with nothing to sit or lie on. In the nearby Adams County jail, which she described as in "miserable condition," she found one man whose mental faculties had been defective from birth. He was loaded with chains—a ring about the ankle, connected by a sort of hinge, to a long, stout iron bar, reached above the hips, and to this the iron wristlets were attached.

After traveling from Gettysburg to Chambersburg where she visited the jail, Dix headed west over the Allegheny Mountains. The first leg of the trip by stagecoach left Chambersburg at midnight. It was a nonstop thirteen-and-a-half hour "hard ride" over the mountains to Bedford. (She pitied the poor horse.) The

rest of the trip was by a combination of wagon and stage journeys. At the jail in Allegheny County children and adults, men and women, sane and insane all shared common facilities. Dix wrote:

If it had been the deliberate purpose of the citizens of Allegheny County to establish a school for the inculcation of vice, and obliteration of every virtue, I cannot conceive that any means they could have devised, would more certainly have secured these results, than those I found in full operation last August.

Pittsburgh residents were shocked at her recital of conditions. The Pittsburgh *Daily Gazette and Advertiser* called for an investigation and the mayor scheduled a public meeting and established committees to study the problem.

For Dorothea Dix to get to her next Pennsylvania stop, Warren in the northwest corner of the state, it was necessary for her to go first to Jamestown, New York via Ohio and then turn south back into Pennsylvania. The last leg of her journey down the Allegheny River to Warren was a nineteen-hour ride with an "old waterman astride a drift log half under water."

At Warren as in many counties, including Bradford, Columbia, and Lycoming, Dix found that the paupers, including the insane, were not in the jails but were "set off yearly to those who bid cheapest for their services." In talking to physicians in those counties, she was told, "Some are well dealt by, and others suffer great hardships."

In the Washington County almshouse in the southwestern part of the state, Dorothea Dix found seventy paupers, seven of who were insane. Dix wrote of her visit:

In a large yard, common to all the inmates, was a small building, consisting of a single room, perhaps twelve by fourteen feet. It being a hot day, two windows were opened. I looked in, as requested, and saw first, a young woman

apparently demented, standing upon a sack of straw. At first, I thought there was no other occupant; but a little to the right, . . . I discovered a woman of middle age seated on some straw in a packing box—in a state of entire nudity. On the opposite side of the room, stood a similar box, which at first, I supposed to be empty; but the sound of voices roused a female. She lay coiled up. I cannot imagine how she could have contracted herself into so small a space. Some straw, too, was in this box, and excepting that, she had neither clothing nor covering of any sort. . . . And this is where, in 1839 (following the Konigmacher Committee's survey), it was officially announced, "that the insane of this county are so well provided for, that a state hospital would be useless."

Shortly before Dix's visit to Montgomery County in eastern Pennsylvania, the county had built a new hospital at considerable cost, and although it was "well planned," the insane were placed in the basement. Dix condemned both the construction and the wretched condition to which the inmates were abandoned. Moreover, she found that "these miseries are augmented by the entire incapacity of those who have the immediate care of this department."

The result of Dorothea Dix's travels across Pennsylvania by buggy, canal boat, and wagon was a fifty-five-page *Memorial* to the state legislature. Her detailed, county-by-county study opened:

I come to represent to you the condition of a numerous and unhappy class of sufferers, who fill the cells and dungeons of the poor-houses, and the prisons of your state. I refer to the pauper and indigent insane, epileptics and idiots of Pennsylvania. I come to urge their claims upon the commonwealth for protection and support, such protection and support as is only to be found in a well conducted Lunatic Asylum.

I must ask you, . . . to examine with patient care the condition of this suffering, dependent multitude which are gathered to your alms-houses and your prisons, and scattered under adverse circumstances in indigent families; weigh the iron chains, and shackles, and balls, and ring-bolts, and bars, and manacles, breathe the foul atmosphere of those cells and dens . . . examine the furniture of these dreary abodes, some for a bed have the luxury of a truss of straw . . . Examine their apparel. The air of heaven is their only vesture.

Do your startled perceptions refuse to admit these truths? They exist still; the proof and the condition alike; neither have passed away . . . Gentlemen, it is just, not generous action, I ask at your hands.

Dorothea Dix's *Memorial* was read in the Pennsylvania House of Representatives on February 3, 1845. James Burnside, a representative from Centre and Clearfield Counties, moved that two thousand copies of it be printed in English and five hundred in German for distribution "so that it could be better and more widely studied." (Until 1846 all Legislative Journals, executive documents, and laws in Pennsylvania were printed in both English and German.)

On March 8, 1845, the "select committee" to which the *Memorial* had been referred reported out a bill, No. 493, entitled "An Act to establish an asylum for the insane poor of the Commonwealth [to be] called the Pennsylvania State Lunatic Hospital and Union Asylum for the Insane." The House passed the bill on March 29, the Senate on April 11, and three days later Governor Francis Rawn Shunk signed it into law.

Dorothea L. Dix

Little is known of Dorothea Dix's childhood other than that she was born on April 4, 1802 in Maine, when it was still

part of the Massachusetts frontier. Although her father was there managing her grandfather's land holdings, he apparently spent much of his time as an itinerant Methodist lay minister. For some reason—perhaps because of her father's inability to provide adequately for his family—the first written record finds Dorothea at age fourteen living in Boston with her seventy-year-old grandmother.

Dorothea grew up with an elderly woman who "was a typical example of the New England Puritan gentlewoman of the period—dignified, precise, inflexibly conscientious, . . . and with little trace of emotional glow or charm." It was an age, too, of training the young "to habits of rigid industry, of exacting iron diligence over school lessons, and of inculcating the dogmas of the catechism."

From the very beginning Dorothea Dix was drawn to the disadvantaged. After tutoring the children of William Ellery Channing, the Unitarian minister, she opened a school for young women since the only Boston schools were for boys. One of her students wrote to a friend that Dix was "tall and dignified . . . and very shy in her manners. . . . She was strict and inflexible in her discipline. . . . Fixed as fate we considered her."

For several years Dix taught, traveled, and wrote books for children. Then in 1841 she was approached to teach Sunday school to the women in the Cambridge jail. When she discovered several insane women among the drunkards, thieves, prostitutes, and vagrants, she was launched on her lifetime work.

She traveled over Massachusetts visiting jails and prepared a memorial to the state legislature. After describing all the horrible details she told them: "You would not treat your lowest dumb animals with such disregard to decency." She closed her memorial with an impassioned plea:

Men of Massachusetts, I beg, I implore, I demand, pity and protection for these of my suffering,

outraged sex. Fathers, husbands, brothers, I would supplicate you for this boon. . . . put away the cold, calculating spirit of selfishness and self-seeking, lay off the armor of local strife and political opposition; . . . consecrate [these halls] with one heart and one mind to the works of righteousness and just judgment. . . . Gentlemen, I commit you to this sacred cause.

Although there were outraged cries of disbelief, eventually with the help of William Channing, Horace Mann, and others she was able to persuade the Massachusetts legislators that her catalog of horror was true. Rhode Island was her next state, followed by Pennsylvania and New Jersey. The hospitals at Trenton and the one at Harrisburg were the first ones, however, actually to be built in response to her memorials. Both were completed at about the same time.

Dorothea Dix called them her "first born." As a result of her efforts, by the time of her death in 1887, more than thirty such institutions had been built throughout the world. Although she was not a philanthropist in the sense of having endowed institutions with large sums of money, she had sufficient income that freed her to devote all her time and energies to the disadvantaged, especially the mentally ill.

Founding of the American Psychiatric Association

In October 1844 the Superintendents of American Institutions for the Insane, as they called their organization, gathered at the Jones Hotel on Philadelphia's Chestnut Street. The thirteen men in attendance selected Samuel Woodward of the Worcester, Massachusetts, Asylum as president, Samuel White of the Hudson, New York, Asylum as vice president, and Thomas Kirkbride of Philadelphia as secretary and treasurer of the organization that later became the American Psychiatric Association.

Among the other distinguished members of the original thirteen were Isaac Ray of Augusta, Maine, Luther V. Bell, of the McLean Asylum at Somerville, Massachusetts, Pliny Earle of Bloomingdale Asylum, New York, and William M. Awl, of the Ohio Lunatic Asylum, Columbus.

William Maclay Awl, a native of Harrisburg, Pennsylvania, was a product of the apprentice system, although he attended one course of lectures at the University of Pennsylvania. He, however, along with Thomas Kirkbride and Samuel Woodward, were considered to be eminent in the field. As early as 1827, Awl reported completing a difficult surgical operation—the removal of a tumor, with ligation of the left carotid artery.

At that first meeting the group of superintendents appointed committees to prepare reports on sixteen subjects, including Restraint and Restraining Apparatus, the Construction of Hospitals, the Jurisprudence of Insanity, the Prevention of Suicide, Provisions for Insane Prisoners, and the Causes and Prevention of Insanity.

The superintendents adopted a resolution that the abandonment of "personal restraint is not sanctioned by the true interests of the insane" and also agreed that "mental occupation" of patients was to be recommended.

Thomas Kirkbride served as president of the association from 1862 to 1870. He attributed "the real progress that was made in the provision for the treatment of insanity" in the second half of the nineteenth century to the organization.

Among the tenets the group developed during this period were the following:

That insanity is a disorder of the brain, to which everyone is liable.

That properly and promptly treated, it is as curable as most other serious diseases.

That in most cases, it is better

and more successfully treated in a well-organized institution, than at home.

The insane should never be kept in almshouses nor in penal institutions.

That the superintendent, a medical officer, should have complete charge of medical, moral and dietetic treatment of the patients, and the unrestricted power of appointment and discharge of all persons employed in their care.

Construction of the First Pennsylvania Asylum

According to Thomas Cope, the major defect in the bill of 1841 to establish a state asylum had been the "political interference" that surrounded the construction of the hospital. The House managers in the 1845 effort were able to beat down, however, any efforts to politicize the bill. The most serious of these was an attempt by Jeremiah M. Burrell to have the bill amended to include a provision that the state purchase one hundred acres of land within five miles of Greensburg in Westmoreland County and that five men from Westmoreland be appointed commissioners. The motion was defeated fifty-two to twenty-seven.

The final version of the bill named six highly respected, responsible advocates for the mentally ill as "building commissioners": two physicians, Luther Reiley and Hugh Campbell; two lawmakers, Joseph Konigmacher and Charles B. Trego; and two businessmen, Jacob Haldeman and James Lesley. Later three additional men were added: a lawyer and two bankers, apparently to provide expertise that the original group of men lacked. Dorothea Dix was in Harrisburg to assist the commissioners in their early deliberations.

Reiley, who was born in Lebanon County, was elected president of the group. He, like most country doctors, had studied with a practicing physician and then, after a term as a soldier in the War

of 1812, set up practice in Harrisburg. He soon became the most popular doctor in town. Although he was more interested in the professional life, he did agree to stand for election and served one term in the Twenty-fifth Congress.

It was not until July of 1848, however, that the building commissioners chose the land, hired a contractor, and began excavation. John Haviland of Philadelphia, who had a considerable reputation, was selected as architect. Haviland's designs included the Walnut Street Theater and the Franklin Institute, as well as a number of city churches. He was best known, however, for his innovative design for the penitentiary at Pittsburgh and the Eastern State Penitentiary at Philadelphia. The Eastern State Penitentiary, which incorporated the results of a generation of experiments in penal reform, was one of the most famous American structures of the day.

The Pennsylvania State Lunatic Hospital finally opened in October 1851 with John Curwen, a former medical student of Dr. Kirkbride, as superintendent. And it was probably at Dix's suggestion that, as the building was nearing completion and the trustees to run the new hospital were designated, Dr. Kirkbride was added to the names of the building commissioners as a trustee.

Joseph Konigmacher

Joseph Konigmacher of Ephrata was an influential state figure between the years of 1837 and 1855. He first came to prominence as a member of the Reform Convention, which was responsible for revising the Pennsylvania Constitution in 1837-1838. He was elected a state representative in 1838 and a senator ten years later. It was Konigmacher who authored the three acts to establish a state mental hospital in Pennsylvania. Later as a member of the Senate Appropriations Committee for a number of years, he

helped to push through John Curwen's annual appropriation requests for the hospital at Harrisburg.

Konigmacher was, in spite of his personal wealth, always strongly identified and popular with the working class. Even his name, which meant awning maker, helped to endear him with the Pennsylvania Germans he represented. A short heavyset man, he was of a kind, amiable disposition. At one time he owned great amounts of property in Ephrata, including a farm, a hotel, and a tannery and was president of the Reading and Columbia Railroad.

Joseph Konigmacher died broke, however, in 1861. He made out his will the day before his death in a rundown Lancaster hotel, but when his estate was settled his liabilities exceeded his assets and his heirs were left with nothing. It was a "bitter portion" for the man who had championed the poor and the weak. His wife had died the year before; their son became a ward of her brother.

Asylum Life

One visitor to an early nineteenth-century asylum described the sound coming from the building as he approached it as that of "a hive of buzzing bees." This never-ending din, of course, was what led to Kirkbride's linear design with the more disturbed patients housed at the extreme ends of the building's wings; it also meant that quieting the patients at night so that those who were able to sleep could was a crucial part of the duties of the nurses and attendants, who were on call day and night.

The day in a state asylum followed an unvarying pattern. The hospital steward rang the morning wake-up bell at 5 AM. The attendants and assistants were expected to rise immediately and start work within the half hour.

The attendants would wake the patients and see that they were washed, their hair combed, and that they were properly dressed for the day. The bedding had to be aired each morning—replaced if soiled—and the floors carefully swept. Whenever required (when a patient made messes on them) the walls and windows also were washed. The beds were to be ready for inspection by 10 AM. The rule was "nothing can be considered clean that can be made any cleaner." [Hartz and Hoshino, *Warren State Hospital*, 82]

The assistants helped with these chores as well as setting the tables in the two dining rooms (the men and women ate in separate rooms in the center building). Meanwhile, the matron was busy in the kitchen and the dining rooms overseeing the preparations for breakfast.

Two attendants were always on duty in each dining room. Their responsibilities included carving the meat, seeing that each patient received an appropriate portion, and then cleaning the room after the patients left. They also had to ensure that



Patients working under the supervision of two attendants in the fields at Wernersville State Hospital.

no patient removed a knife or fork from the room—the utensils were counted following each meal.

In walking those patients who had permission to be on the grounds, the attendants were directed to keep together those they took out and to prevent any straggling. Twice weekly, on Wednesdays and Saturdays, the attendants shaved the male patients.

The hospital was “closed at half-past nine” each night. Before shutting the door to a patient’s room the attendant had to be certain the patient was in the room, wish him or her a “good night,” and then close and bolt the door. All the lights in the wards were then extinguished and the attendants and other employees of the hospital went to their rooms. By ten o’clock all lights in their rooms were also to be out.

The steward, who had the most responsible nonmedical position in the hospital, took care of all the buying (including furniture, implements, and even farm stock) and the accounts (including patient charges) and also saw to the opening and closing of the house each day, its security, as well as its cleanliness, warmth, and ventilation. It was he, moreover, who was “to receive visitors, give them suitable information and accompany them to such parts of the building and grounds as are open for examination.”

While the patients spent much of their waking hours simply sitting in the hallways or in the day areas when such were available, there were respites from this sedentary life. The idea of work as therapy was an essential part of the Kirkbride plan for patient “restoration.” He wrote in *On Construction*:

Labor, judiciously used, is one of our best remedies; it is as useful in improving the health of the insane, as in maintaining that of the sane. It is one of the best anodynes for the nervous; it often—but not always—composes the

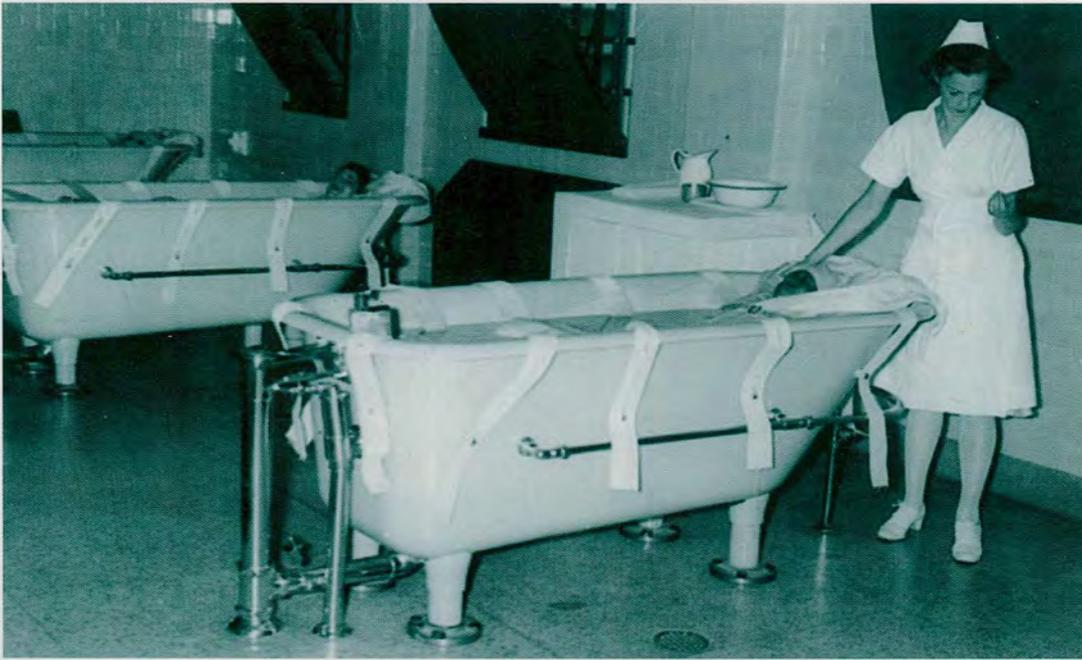
restless and excited, promotes a good appetite and a comfortable digestion, and gives sound and refreshing sleep to many who would, without it, pass wakeful nights.

Kirkbride then described the types of work he believed were appropriate. These consisted mainly of the farm or the garden for the men and laundry and sewing for the women. He proposed, too, “systematic courses of instruction in well furnished schoolrooms,” the availability of “well selected libraries” and of lectures, the playing of various games including ten-pins, the inspection of pictures and of “collections of curiosities,” the playing of musical instruments, and, of course, liberal amounts of exercise—either in walks around the “pleasure grounds” or in use of a gymnasium where available.

These ideas on work, education, recreation, and exercise were embraced by all of the early hospital superintendents. For example, in the 1880s at Danville picnics were a frequent part of patient life. Large groups of patients—numbering anywhere from fifty to eighty would spend an entire afternoon in the woods.

They would play games, listen to talks, or look at unusual objects or wildlife in the woods. Refreshments were liberally supplied. A typical spread might consist of beef and ham sandwiches, rolls, butter, fruit spreads, pickles, peanuts, coffee, ice cream, and cake. According to one of the superintendent’s reports, after everyone had finished eating, the attendants would pass out “cigars for the men and a pinch of snuff for the old ladies.”

The use of patient labor was also highly acceptable to the state legislature. Many of the state hospitals became largely self-sufficient by producing most of their produce and meat and making or repairing materials such as bedding and clothing. The male patients also shoveled snow and mowed lawns. In some instances they were even used to construct outbuildings



Hydrotherapy treatment at Mayview State Hospital during the mid-1940s. Straps were used to prevent the patient from slipping down into the water to commit suicide.

and dig sewer lines, although Kirkbride would probably have objected that such heavy labor was of questionable value as therapy.

All this work, of course, meant that the state's appropriations for "running" the hospitals could be kept to a fraction of the total cost of their operation. This also meant that the superintendent was as much a "manager" of a large-scale business as a physician.

From the beginning, chapels and church services were invariably a part of asylum life. In the first several hospitals, the chapels were set aside in the main building, usually on the top floor. More than simply a room, they often had a stage at one end and doubled as a place for patient gatherings, dances, and parties.

At Christmas the chapels would be decorated and a typical celebration and church service held. During the early years at Harrisburg, the governor usually came to greet the patients and help pass out oranges to them.

Although these early chapels were bare by modern standards, they did have some appointments. John Curwen's wife

Martha Elmer, for example, donated a stained glass window and Dorothea Dix induced the Society of Friends to donate a large, handsome Bible for the chapel at Harrisburg.

In later years, especially under the influence of the cottage plan, the trustees and superintendents began to erect separate buildings as chapels. Several of these were substantial, if not lavish. Among them, the building architect John Dempwolf erected at Harrisburg is most impressive.

Restraints and Therapies

Reading the narratives in the early asylum superintendent's annual reports—which were designed for review by the governor and the legislature—often conveys a scene of pastoral even idyllic patient life. Picnics, access to books and pictures, walks and carriage rides around the "pleasure grounds," along with the opportunity to view magic lantern slide shows, to attend readings or dramatic entertainments, or to participate in teas with the superintendent were all reserved

most likely for those patients who lived in the first or second wards of the hospitals.

Those who were housed in the outer wards—especially the “dreaded” seventh or eight wards, as one of Thomas Kirkbride’s patients described them—led a quite different existence. With little in the way of genuine therapeutic techniques available for their physician to use in soothing their troubled minds, they passed their days mainly in seclusion and in restraint, their nights locked in their cells along with the howling and wailing of their neighbors.

We have to read between the lines on the pages of the annual reports, to review the attached statistical charts, and to scan the steward’s procurement ledgers in order to catch a glimpse of this other side of asylum life. The careful reader will look for the statistics about those who died; pause at how the estimates of those who were considered incurable overwhelm the count of those the superintendents believed were curable; seek out the hidden pur-

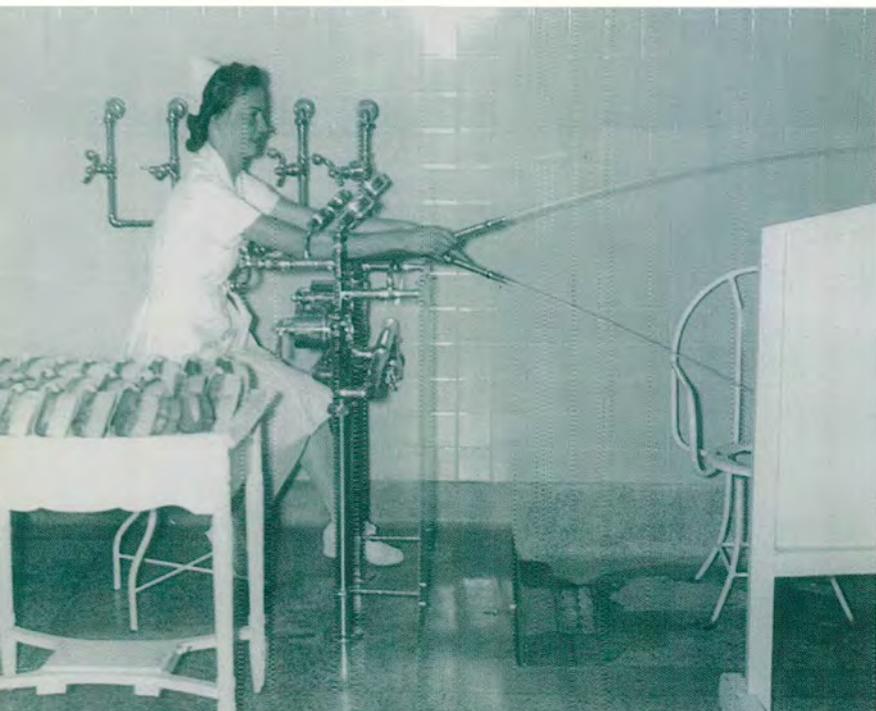
chases of restraining devices (cuffs, jackets, bed straps, wet packs, cribs); and check for the dismissal of attendants for abuse of patients as well as for incompetence.

Only then do we begin to comprehend the nature of this other life, to realize that hospital chairs were made of the heaviest materials (to prevent patients from throwing them at each other or attendants); that patients were locked in their rooms at night (to prevent them from harming others); that the walls of their rooms were scrutinized each morning (because patients often smeared feces on them); that the silverware had to be accounted for after each meal because a knife or fork might be used as a weapon; and that patients’ clothing was sometimes taken from them to prevent them from ripping it apart. With these insights we finally realize that asylum life was at times violent, patient behavior frequently revolting, and a nurse or attendant’s life difficult.

Therapies, too, were rudimentary by today’s standards. The drug arsenal of asylum physicians consisted mainly of alcohol, opium (along with its many derivatives, especially morphine, which was a favorite of Kirkbride’s), and bromide of sodium, then later in the nineteenth century, of “sedative cocktails” such as scopolamine. Other than drugs, the most common therapeutic techniques relied on hydrotherapy, consisting of various types of baths and showers, wraps and packs—hot (to stimulate) and cold (to quiet).

John Curwen

John Curwen was born at Walnut Hill outside of Philadelphia in 1812. Following a secondary education at the Newburgh Academy at Newburgh, New Jersey he entered Yale University. At Yale he studied Latin, Greek, philosophy, and mathematics. This was supplemented by occasional lessons in chemistry, pharmacy, mineralogy, geology, rhetoric, and astronomy. After



Betty Williams of St. Francis Hospital administering a spray water treatment at Mayview State Hospital in 1946. Note the intravenous packs on the table.

he graduated from Yale in 1841, Curwen went to the University of Pennsylvania where he got a medical degree in 1844. From then on he was known as "Dr. John" to his family and close friends.

He practiced for a time with a cousin and then won an appointment as the assistant physician at the Wills Eye Hospital in Philadelphia. In 1846 he joined Thomas Kirkbride in the Mental and Nervous Department of the Pennsylvania Hospital. He remained there five years, eventually becoming Kirkbride's assistant.

In this capacity, Curwen made the rounds each morning with Kirkbride, assisting the senior physician in administering the patient's medical and moral treatment. Although he was seldom permitted to make treatment decisions on his own, John was expected to know each patient's condition intimately and to observe Kirkbride's manner with the patients—those he disciplined by removing from a more to a less favored ward; and those he encouraged by invitations to the afternoon teas.

John Curwen had been seeking a superintendent's position unsuccessfully for some time and was about to go into private practice when the offer at Harrisburg was made. He accepted the appointment, as he told Dorothea Dix, so that he would be able to marry, not because he particularly wanted the position. Its rural location struck him as being far removed from the amenities to which he was accustomed.

Curwen was crisp and businesslike, although in later years he sported large mutton-chop sideburns that hung beneath his lower jaw. Even when he visited the governor's mansion Curwen was anxious to conduct his business and leave. After one visit to Governor William F. Johnston, he wrote that the governor wasted "some useless breath" in discussing a recent storm. As a hospital superintendent, John Curwen also apparently had little appreci-

ation or interest in even the simplest of social or political maneuvering. At one point he wrote Kirkbride:

I learned this afternoon one cause of the feelings on the part of certain members of the Board toward me; that I have not made it a point to call on them at their houses, . . . which I think is a rather lame reason but as their vanity has been touched, I will endeavor hereafter to apply to the wound the application needed.

John Curwen also seems to have been a very cautious, careful physician. Although the law required that two persons certify to a patient's condition before admission, Curwen insisted on three before he would admit them to the Pennsylvania Lunatic Hospital. His favorite, often-stated expression was: "I cannot afford to take chances."

He was a man of conviction as well as resolve. When his first steward, Will Slaymaker, did not work out, he fired him without hesitation. And when, as a newly appointed commissioner for the construction of a new state hospital at Wernersville, he first saw the site, he exclaimed, "You are not thinking of putting a hospital here in this hole?" When it turned out they were, and for what he believed were political reasons, he resigned immediately.

At Harrisburg, John Curwen continued many of the practices he had learned at the Pennsylvania Hospital. He regularly advised each patient's family how its relative was doing. And he seems to have had the welfare of his patients uppermost in his mind. Even when years later he came under fire for administrative problems at the hospital, there were never any claims against his reputation as a doctor.

Curwen was the only protégé of Kirkbride's to manage a large public mental hospital. He wrote numerous papers and books on insanity and served for many years as the secretary and eventually as the president of the American

Medico-Psychological Association (formerly the Association of Medical Superintendents of American Institutions for the Insane and now the American Psychiatric Association). In 1881 he became the superintendent at Warren State Hospital.

John Curwen's departure from Harrisburg was abrupt. Speculation has attributed this to several possible factors: his reluctance to appoint a female physician; his numerous, long absences from the hospital (he helped select other hospital sites, was frequently called on to examine criminals around the state who were believed insane, and was sent by the governor on various fact-finding trips); and discrepancies in accounting for funds that had been appropriated by the legislature. He was never formally charged; the board of trustees simply refused to renew his appointment in 1880, and placed Jerome Gerhard, his first assistant, in charge.

Dixmont

The Pennsylvania legislature not only expected the trustees of its asylums for the insane to raise funds to supplement those it appropriated to erect and maintain the hospitals, it also encouraged local groups to build private facilities by agreeing to "charter" them. With the authority of the Commonwealth behind them, this turned them into quasi-state retreats; enjoying a reputation and preferred status not enjoyed by county institutions. The earliest of these charters was for Dixmont in Western Pennsylvania.

In March 1848 the legislature granted articles of incorporation to the Western Pennsylvania Hospital at Pittsburgh, in which one ward was to be designated for the care of insane patients. According to the act, a number of the citizens of the area "actuated by a sense of religious duty, and the benevolent disposition to extend aid, comfort and relief to indigent and afflicted humanity, have made large voluntary contributions in money and real

estate, with the view to the foundation and endowment of a public hospital for the reception and care of the insane and afflicted, as well as the sick, helpless and infirm."

By the end of 1853, the first year the hospital was in operation, it was clear that there were a great many more patients in the almshouses and jails than the twenty-six beds that had been provided for the area's insane.

Two years later, with the help of a \$10,000 appropriation from the state legislature, the local managers of the Western Pennsylvania Hospital bought a 177-acre farm overlooking the Ohio River south of Pittsburgh. Although the board of managers had first proposed building in Pittsburgh, Dorothea Dix rejected the idea and picked a site eight miles down the Ohio River from the city. The Board of Managers proposed calling the new facility Dixmont, but according to Dix biographer, Dorothy Clarke Wilson, the philanthropist permitted it to carry the family name, not in her honor, but in memory of her grandfather.

The cornerstone laying ceremonies on July 19, 1859 was turned into an elaborate affair. A special train made up of "elegant cars" was run to the site from Pittsburgh's Liberty Street Station. According to the *Pittsburgh Gazette*, the two hundred ladies and gentlemen who set out from Pittsburgh on the train at 10 AM were joined by others along the line until the excursion arrived an hour later at Kilback Station. The crowd then assembled in a "delightful grove" protected by the trees from the glare of the noonday sun.

After the placing of numerous objects in a jar, including a letter from Dorothea Dix (who was unable to attend) along with a copy of her 1845 *Memorial* to the legislature, the jar was sealed and set in an aperture in the stone. Then the speech-making began. Finally following a number of short speeches and several lengthy "ora-



Superintendent Henry A. Hutchinson, M.D. standing in front of a three-story wing of Dixmont. Hutchinson, the second hospital head, served in that position from 1884 until 1945.

tions”—the *Gazette* called them the “intellectual feast for the day”—everyone “took to the baskets.” When the crowd finished eating the food that the hospital’s board of managers had provided, they went to look over the site of the future hospital.

Although the river was narrow at that spot, the site Dorothea Dix had selected was described as a “garden, smiling with whatever is beautiful.” The surrounding hillsides were covered with tall elms, the broad fields “waved” their “burdens of corn and grain” in the breeze, and trim hedgerows divided the meadows into neat squares. In the distance the smoke rising over the river and the “scream” of steamboat whistles reminded the gathering of “commerce and its dependencies in the far off world.” With the fleecy clouds in the sky it was a picture, according to the *Gazette*, to which the painter “Turner alone could do justice.”

Dixmont opened on November 11, 1862, with another special train from Pittsburgh. On that occasion the Pittsburgh, Fort Wayne and Chicago Railroad provided enough cars to transport the entire household of 111 patients along with all their attendants and other members of the staff from the Western Pennsylvania Hospital.

The building at Dixmont was a typical Kirkbride structure with accommodations for seventy beds in each wing. It was lighted with gaslights and heated with a central hot air system. According to Dorothea Dix, the ventilation in the building was “excellent” and there was an “abundance” of fresh water from the Ohio. The west wing of the building was not completed and occupied until 1868, at which time construction on the east wing began.

As was typical of nineteenth-century asylums, most of the food was produced on the hospital grounds. The farm not only provided vegetables but also extensive dairy and poultry products. There was a



Formal gardens on the south lawn, Dixmont.

large orchard that contained apple, sweet and sour cherry, pear, quince, peach, and plum trees from which the patients picked and canned the fruit. There was also a bakery that supplied much of the bread, rolls, cakes, doughnuts, and pies consumed by the patients and staff. A greenhouse provided flowers for the wards, dining room, and grounds.

Dixmont continued to be associated with the Western Pennsylvania Hospital as a "department" for the mentally ill until 1907, when it became a separate entity known as the Dixmont Hospital for the Insane. In 1945, it was taken over by the Commonwealth and the name changed to Dixmont State Hospital.



Portrait of despair—patient at Philadelphia State Hospital, probably taken in early 1960s.

Origins of Insanity

Since the time of the ancient Greeks, physicians have debated the origins of insanity—whether the condition was somatic, the body was diseased and affected the mind causing the symptoms (the excitement, delusions, or fits); or was psychic, "outside of the body," with the mind causing the bodily symptoms. Belief in the later, of course, led to the reasoning that the mentally ill are possessed of evil spirits.

Hippocrates was perhaps the first doctor to reject the supernatural trappings that most early physicians accorded mental illness. In writing of epilepsy, known by the Greeks as the "sacred disease," he declared, "The Sacred disease seems to me to be no more divine and no more sacred than other diseases; but springs from natural causes like other diseases." At the same time Hippocrates claimed "Men ought to know that from the brain, and from the brain only, arise our pleasures, as well as our sorrows, pain and grief . . . and by the brain, too, we become mad or delirious, and filled with fears and terrors . . ."

But Hippocrates was the exception. Many Greek physicians and those who followed them over the next two thousand years shifted back and forth between belief in psychic and somatic origins for mental illness. Prior to the nineteenth century, however, which of the origins a physician believed in made little difference in the treatment accorded to his patients; it was seldom humane. Those who ascribed somatic sources resorted to blood-letting and purging as means of therapy; those who believed in psychic origins resorted to chains, flogging, and the application of terror and torture to dispel the spirits inhabiting the individual. The objective of any of these treatments was to quiet the disturbed, their forced silence being about the only measure of a treatment's "success."

By the end of the eighteenth century which of the two views—the somatic or the psychic—was current at a given time depended largely on the understanding of the mind-body relationship prevalent at the time. Frequently physicians ascribed a mix of the two causes (the somatic and the psychic) in their treatment of patients. Benjamin Rush, for example, believed that the origins of insanity were somatic, the result of an excitement of the blood vessels in the brain, and often resorted to blood letting to relieve the "pressure" on the

brain, but in general treated his patients along moral or psychic grounds.

Fifty years later when John Curwen addressed the crowd assembled in 1859 for the cornerstone laying at Dixmont, he summed up the thinking at mid-century concerning insanity and the hospitals that the state had begun erecting for those who suffered from it:

There are even yet many prejudices to be overcome in the public mind in respect to the insane. May these friends here not be turned aside from their course by any senseless clamor. We can trace the spirit of opposition to these noble institutions back to the time when the insane were treated like brutes, chained, whipped, and caged. Things are now different. We of the medical profession know how the impression goes abroad . . . an impression that an asylum of this kind is a terrible place, a place of punishment and almost of disgrace. We wish, however, that it could be seen by all as we see it, how necessary it is that as soon as possible those showing symptoms of insanity should be sent to the asylum. Insanity is a disease of the body affecting the mind, and we treat it as a disease, and we need the patient under our care in the early stages of his sickness.

Although insanity had been common to the Western experience since the Middle Ages and there was a growing conviction among the physicians during the asylum era that it was of bodily origin, the belief was still widespread among the public and some professionals that anxiety brought on by personal mishaps or by such general causes as industrialization accounted for many of those who were afflicted. The reasons given in the early Pennsylvania asylum records (as diagnosed at the time of admission) included: overexertion, grief, failure in business, domestic trouble, financial difficulty, intemperance, excessive study, disordered menstruation, loss of job, use of drugs,

heat stroke, and religious excitement. Although the catalog of activities ascribed as causes was lengthy and filled with unusual, sometimes exotic-sounding reasons, "unknown" or "not assigned" were cited for about half of the admissions to the state's hospitals well into the twentieth century.

The idea that the complexity of life in an increasingly urbanized and industrialized society leads to mental illness has never been confirmed. Moreover, as early as 1848, Thomas Cope questioned this widely-held assumption about the cause of insanity. In March of that year he wrote in his diary:

We are apt to think the cultivator of the soil is more exempt from mental anxieties than the Citizen. The annual Report of the Pennsylvania Hospital, makes the following exhibit: Of 633 male patients, 95 are farmers, 49 labourers, 19 physicians, 40 clerks, 28 carpenters, 21 shoemakers, 18 seamen, 15 teachers. . . . Not one merchant is named in this list of the insane and yet the life of a merchant is a life of constant care and anxiety. Can it be that imaginary evils are more injurious to the mind than actual misfortunes?

Although there have been many studies claiming to show a relationship between such events, for example, as economic hard times and an increase in the incidence of mental illness, these are seldom convincingly linked as true causes and effects. Newspapers in Philadelphia (*The Evening Star* and the *Press*) questioned, for instance, whether or not the surge of new admissions following the Panic of 1873 to the city's almshouse and Blockley (its insane ward) was legitimate, stating their concern that the public was being swindled by those who wanted room and board.

The Civil War

The Pennsylvania State Lunatic Hospital at Harrisburg had been open



Bands were popular items at many of the state hospitals. They were often made up of both patients and attendants. Pictured here is the group at Harrisburg State Hospital in 1885.

slightly less than a decade when the nation exploded in civil war. The ground immediately across the Pennsylvania Canal in front of the hospital became the most important staging ground and training camp in Pennsylvania for the Union Army. Life in the camp was primitive. Laundry and bathing facilities were almost nonexistent.

The hospital soon became an extension of the camp. Officers marched large groups of men up to the hospital to take baths. And, according to Superintendent John Curwen, the kitchens at the facility “cooked hundreds of pounds of beef and pork” as well as prepared “thousands of gallons of coffee” for the men. The soldiers reciprocated. Several regimental bands played for the asylum residents.

Of much greater importance, however, the Civil War was to have a profound impact on the country’s youthful medical profession. The demand for physicians to

treat battle casualties was enormous. The North alone sustained 275,000 wounded men during the four-year conflict and the soldiers who suffered from diseases such as dysentery and diarrhea (which killed more than 57,000) numbered in the hundred thousands. Antisepsis was unknown, and anesthetics often unavailable. Hospitals were makeshift and equipment primitive. (See Morrison, p. 624.)

Many of the nation’s doctors had had little more than a few years of apprentice duty with a more “experienced” physician before they were thrown into field hospitals. Those who had graduated from medical colleges often had taken no more than a year or two of courses in medical subjects and then, with little practical experience, had begun treating patients.

Whenever there were major battles, hospitals were called upon to send doctors to the scene of the conflict. Physicians with surgical experience were particularly

in demand. As John Curwen wrote in a letter to Dr. Kirkbride, "under the urgent call of the Governor [Curtin] for medical men to go to Gainesville [probably Gaines Mills] to attend to the wounded, I have allowed Dr. Schultz to go with the party which will leave here at 1 AM tonight."

Solomon S. Shultz (later the superintendent at Danville State Hospital, 1868-1891) and J. A. Miller, two of Curwen's assistant physicians, were also undoubtedly among the local doctors who from time to time were called on to examine incoming recruits at nearby Camp Curtin.

In addition to producing an abundance of trained surgeons as well as refinements in surgical practices and equipment, the Civil War led the medical profession to develop a new discipline, neurology. The large number of soldiers with damage to their nervous systems caused by gunshot wounds led to this new medical field. As the writer Albert Deutsch put it, "Neurology as a profession was practically created by the Civil War." (Deutsch, pp. 246, 276.)

There was almost no demand during the war, however, for psychiatrists to treat mentally ill soldiers. Several members of the Association of Superintendents of Hospitals for the Insane, including Thomas Kirkbride, did bring the problem of insane soldiers being discharged without any provisions for their safe return home to Surgeon General Joseph Barnes's attention.

Many of these men wandered about the country confused, destitute, and half naked until someone took them to a nearby asylum. In his reply to the superintendents, the surgeon general pointed out that all insane soldiers were to be sent to the Government Hospital for the Insane at Washington (later St. Elizabeths), and directed the superintendents to transfer any such patients from their facilities there. The army's practice, however, of discharging them; untended continued. In the decades that following the Civil War the

neurologists, who treated nervous diseases and the psychiatrists who treated patients with personality disorders, developed mutual feelings of suspicion and distrust. Eventually the disagreements turned into open hostility. The neurologists berated the psychiatrists as being "hospital administrators" rather than physicians, while the psychiatrists claimed the neurologists were interfering in areas that were historically the responsibility of psychiatrists.

Danville

Seventeen years after the opening of the Pennsylvania State Lunatic Hospital at Harrisburg, the General Assembly passed legislation "to establish an additional State hospital for the insane." It was to relieve pressure on the Harrisburg facility by covering the "northern district of the state" which included Monroe, Carbon, Pike, Wayne, Susquehanna, Wyoming, Luzerne, Columbia, Montour, Sullivan, Bradford, Lycoming, Tioga, Clinton, Centre, Clearfield, Elk, Cameron, McKean, and Potter Counties.

Act 49 of April 13, 1868, provided for what was to become the Danville State Hospital. The legislature directed the building commissioners to erect a Kirkbride building, by expressly stating in the act that it "shall be in strict accordance with the propositions on construction of hospitals for the insane adopted by the Association of Medical Superintendents of American Institutions for the Insane."

John Curwen, one of the commissioners charged with erecting the hospital, made a preliminary survey of the district and recommended locations from which a site selection commission made the final choice. He gave them a long list from which to choose.

The commissioners—probably the most distinguished group of site selection individuals in the history of the Commonwealth—included Governor John W. Geary, the Speaker of the House



Recent photograph of the "Isaac Ray" building, the last ward on the male side of the Danville State Hospital. Note in the exposed section the original under-structure stone that was quarried on the grounds.

Wilmer Worthington of Chester County, the senator from Allegheny County, Russell Errett (both legislators being members of the Committee on Charitable Institutions), along with Thomas Kirkbride, Dorothea Dix, Isaac Ray (a prolific writer on medical issues, especially insanity, and possibly the most brilliant of the founding members of the Association of Medical Superintendents of American Institutions for the Insane), John McArthur Jr. of Philadelphia, the architect for the hospital, and Solomon S. Shultz, who had been appointed superintendent of the new facility.

The commissioners visited farms in the neighborhoods of Williamsport, Bloomsburg, Wilkes Barre, Towanda, Lock Haven, Tunkhannock, Athens, Bellefonte, and Danville. When they met in Harrisburg on July 2, 1868, the commis-

sioners unanimously concluded that a 250-acre farm lying on an extensive plateau 101 feet above the river at Danville was ideal. The farm was originally owned by Daniel Montgomery (founder of "Danville"), whose son left it to his daughter, Margaret. Margaret married W. W. Pinneo, who as executor of her estate conveyed it to the commissioners for the state hospital.

The Pinneo farm included a fine orchard, and adequate spring water for cooking and drinking. It lay on a branch of the canal and railroad in the center of the hospital's district, and had extensive stone, brick-clay, and sand on the premises with sufficient lime for making cement located nearby. Moreover, it was situated in a rich agricultural district so that flour, grain, and articles of produce were "conveniently available" at the "lowest price." The commissioners also judged that Danville could provide "such a population" from which "may be draw[n] the majority of those who may be engaged for the various positions in the Institution."

Although in 1868 the population of Danville was only 3,600 and the area was rural, there were iron mills, blast furnaces, and rolling mills in full operation in the community. Iron ore was mined in the hills west of town and brought on a narrow gauge railroad down to the mills.

Danville was also proud of its fourteen hundred-seat opera house, said to be surpassed in elegance and comfort in Pennsylvania only by Philadelphia's Academy of Music. The wealth and philanthropic spirit of the town can be noted by the citizen's backing of the project with a contribution of \$16,123.12 toward the \$26,600 price the state paid for the land.

Governor Geary came back to Danville on August 26, 1869, for the cornerstone laying. The town was decorated that day as a "vast concourse" for the parade to the hospital site. Isaac Ray delivered the address. He told the gathering:

We come together to lay the foundation of an institution unlike most of those that give rise to occasions like this. The structure whose massive walls are to rest on this spot is to commemorate no victory of war, no triumph of a cause achieved by sacrifices of life and property. It is designed to minister to the advancement and glory of no sect or party. It is designed not even as a storehouse of the treasures of science and art. . . . No, my friends, it is nothing of the kind.

The institution we now inaugurate with solemn ceremonies . . . springs from those common instincts and virtues of our nature which have received from the civilizing influences of our time a scope and direction unknown to the polished nations of antiquity. To relieve suffering both of body and mind; to rescue helpless men and women; to lead back the wandering mind out of the darkness and mazes of disease into the unclouded light of reason; . . . to improve this ministry to the disordered mind by the intelligent application of medical science—such are the ends which it belongs to enterprises like this to fulfill.

Solomon S. Schultz, the first superintendent at Danville, had served at Harrisburg as a first assistant to John Curwen and as a surgeon at several Civil War hospitals. His initial task at the new hospital was “to lay out, grade, and Macadamize” the roads of approach and to the rear of the building, so that “all the materials could be drawn to the ground in the easiest manner.”

The completed structure was 1,143 feet long. The center building contained seventy rooms for offices and apartments for the superintendent, assistant medical officers, steward, and matron; a dispensary, library, sewing room, kitchens, and dining rooms; as well as storerooms for groceries, meat, medicines, and “tin and stone ware.”

A chapel was located on the top floor of the center building. It doubled as a lecture and concert hall. At one end of the hall, a small gallery accommodated “the dissolving apparatus to which the gases required for illumination are brought by iron pipe from a place convenient for their manufacture in the cellar.”

The hospital opened on October 18, 1872. The first patient arrived three weeks later. During the next year 210 patients were admitted. Of these, forty-four men and twenty women, who were from the district Danville served, were transferred from Harrisburg.

Although Schultz provided the usual statistical tables in his first annual report, he explained that the “square cut figures of tables . . . fail to teach,” that the causes of insanity are seldom straightforward, and that even the professional has difficulty eliciting them from the family or the patient.

As the superintendent wrote, “Among the sources of fallacy under this head, is also the giving of only one cause, when it would be difficult, if not impossible to describe correctly which one out of half a dozen was most potential. The last one of a series gets the credit of mischief which belongs equally to a number, any one of which would have been lifted into prominence had it been the last to come into play.”

As a further illustration of statistical error, he cited the confusion over the relationship between alcohol and insanity. “In other words whether a particular person shall be insane, or a drunkard may depend upon the merest accidental trifle, and drunkenness may be as much an evidence or symptom of a disordered nervous system as insanity, so that statistics are at fault if they always ascribe the insanity of a drinking man to his intemperance.”

Schultz also claimed that such information as “duration of the disease before admission” is frequently wrong as it is usually “dated only from the first uncon-

trolled outburst of excitement," while it was "generally recognized that well marked and decided insanity may exist when the person still knows everybody and remembers everything."

Solomon S. Schultz served as superintendent at Danville for twenty-three years and built an institution that Thomas Kirkbride would have been proud of. Not only was the structure itself of Kirkbride design, but Schultz's "cheerful cordiality, sympathy and a rare degree of tact, which, combined with a sense of humor, was effective . . . to a notable degree . . . in his treatment of his patients," reflected Kirkbride's therapeutic methods.

Through Schultz, Danville became the "type and example of what such institutions should be." According to a biographic sketch in the Board of Public Charities 1891 *Annual Report*, Dr. Shultz was not only "zealous and judicious in the treatment of the insane," he also "properly and wisely applied . . . the vast sums of public money with which he was entrusted."

Habeas Corpus

Patients' rights did not first become an issue in the 1960s. The right of a patient to communicate with an attorney and to have a judge issue a writ of *habeas corpus*, "commanding that the alleged lunatic be brought before him for a public hearing," was affirmed by an act of the General Assembly in 1869. Act 54 of April 20 that year made it unlawful "for any superintendent, officer, physician or other employee of an asylum to intercept, delay or interfere with, in any manner whatsoever" such contact between a patient and his or her attorney. The act also guaranteed patients the right to a trial by jury.

At any hearing of *habeas corpus*, the law specified, "the onus of proving the alleged lunatic to be insane shall rest upon such persons as are restraining him or her of his or her liberty." The number of hearings under the act was not large, but

it apparently had a restraining effect.

John Curwen, for example, proudly told a newspaper reporter (*Harrisburg Telegraph* October 10, 1902) that he had been subjected to only one *habeas corpus* request during his career.

While an individual could be placed in an asylum by relatives or friends or legal guardians, as a safeguard from capricious commitments, this could only be done on the receipt of a sworn certificate by two or more "reputable physicians" following their "personal examination" of the man or woman.

This safeguard was not, of course, failsafe as in a few pages Adriana Brinckle's tale, "Life Among the Insane" will show.

Asylum Architects

John Haviland

In the early decades of the state's asylum-building years, the architects were chosen from among those who had a solid reputation, especially for designing public buildings. The trend started with the selection of John Haviland, of Philadelphia, to construct the first state hospital at Harrisburg. Haviland, who was an English-trained architect, had opened his practice in 1816. Among the major structures he had been credited with by 1848 were Philadelphia's Walnut Street Theater, the Franklin Institute, and several city churches.

Haviland was best known, however, for his design of the Eastern State Penitentiary. This facility, which was renowned worldwide as a model penitentiary, "gave every prisoner a separate cell (with its own exercise yard) arranged along corridors radiating from a central core—a scheme that offered maximum surveillance with a minimum of supervisory personnel." (George B. Tatum, article "John Haviland," Macmillan *Encyclopedia of Architects*.) Rather than an extrava-

gance, the separation of prisoners was intended to “avoid contamination” from other prisoners as well as to isolate them so they could reflect on their sins.

In spite of Haviland’s reputation, John Curwen began to complain about the building—both in his annual reports and correspondence—soon after he arrived in Harrisburg. His complaints, however, of doors not closing properly and of windows leaking air appear to have been the result of faulty construction rather than design.

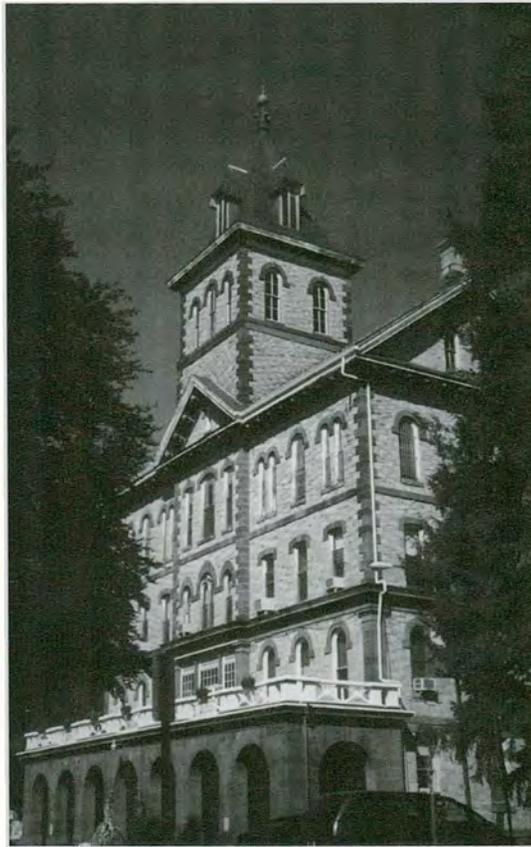
Then in 1881, when Jerome Gerhard replaced John Curwen at Harrisburg, and began calling for replacement of the hospital building, he placed the blame for the building’s problems squarely on its construction.

The time has come, I most firmly believe, when it is our duty to press upon those in authority the necessity of reconstructing the entire institution. This hospital has served a good purpose for one generation, but the buildings have always been unsatisfactory. They were badly constructed in the beginning, have been a constant expense to keep in repair and can never be made secure against fire.

And ten years later, in Gerhard’s final year as superintendent, when the legislature was still ignoring his pleas for a new building, he made one last appeal by invoking the memory of Dorothea Dix. He quoted her as having told him that she could not help but feel that “it would be a good thing if it would burn to the ground, providing the patients and everybody were safely out of the building.”

John McArthur Jr.

In 1869, the same year that John McArthur Jr. had been chosen to design the Commonwealth’s second state hospital, which was to be located at Danville, the Philadelphia-based architect also was appointed the chief architect for Philadelphia’s City Hall.



Contemporary photograph of the center building at Danville State Hospital. Erected in 1869 from a design by John McArthur Jr.

Although City Hall has never been considered architecturally distinctive—one writer calls it an “insult to taste” and another proclaims that “its only claim to distinction should be the marvelous manner in which it combines bulk with sterling insignificance”—today it immediately signifies “Philadelphia” as does no other building.

McArthur (May 2, 1823–January 18, 1890) first came to prominence at age twenty-five when his design of a new House of Refuge Building for Philadelphia received first prize. He went on in the 1850s and 60s to design a number of major hotels for Philadelphia, including the La-Pierre, the Continental, and the Girard House. The Girard House, on Chestnut at Ninth, had accommodations for a thousand guests and boasted a magnificent ironwork balcony. The Continental Hotel, which stood across Chestnut from



Kitchen in the old Kirkbride Building at Harrisburg, with cart being readied to transport food to one of the patient wing buildings, 1890s.

the Girard, included an elevator among its attractions and was considered the town's outstanding lodging place.

During the Civil War McArthur was put in charge of building U.S. hospitals at Annapolis, Philadelphia, and San Francisco. He was also responsible for the design of Philadelphia's Public Ledger Building and several private residences, most notably that of the journalist George W. Childs.

Although the cornerstone to Philadelphia's City Hall was laid on July 4, 1874, the structure was not completed until 1900. The building, which contains more than six hundred rooms, cost \$23 million. According to Fodor's tour guide of the city it is the "largest city hall in the country and [without supporting steel] the tallest masonry-bearing building in the world."

At the end of the nineteenth century, as the nation moved from the Victorian Age into the modern period, the monumental and extravagant designs of the earlier period gave way to more modest and functional approaches. Not only did

the cost of putting up large buildings legislate against them, public sentiment demanded a more restrained approach. The erection of hospital buildings such as those at Danville and Warren, which took years to complete, gave way to those that were more economical and more quickly erected.

Coupled with this turn in public and political sentiment, the medical profession, too, began a spirited debate over the nature of appropriate hospital design. The population of most mental hospitals had grown well beyond the expectations of those who built them. This overcrowding led to cries of patient "warehousing" rather than treatment, and to suggestions that a "cottage" approach to hospital construction was better suited than the old Kirkbride monolithic, linear design.

Joseph Wilson, Addison Hutton, and John Dempwolf

Well into the twentieth century—even with a change in design criteria—Pennsylvania continued to employ archi-

pects who were known for their municipal buildings to design its mental hospitals. Among them were Joseph Wilson and Addison Hutton of Philadelphia, and John Dempwolf of York (See “The Cottage Plan”). Today, a century and a half after they were erected, the only remaining representatives of the early asylum-building years in the state are the two that John McArthur Jr. built at Danville and Warren.

The Board of Public Charities

On April 24, 1869, Governor John W. Geary signed a bill establishing a Board of Public Charities. The resultant board, which consisted of five commissioners, was to have “full powers, . . . at all times to look into and examine the condition of all charitable, reformatory or correctional institutions within the state.”

The board’s responsibilities not only included all financial matters—which, at least, for the first few years predominated in their activities—but also the “government and management” of hospital “inmates”; the “official conduct” of trustees, directors, and other officers and employees, the “condition of the buildings, grounds and other property”; and “all other matters” of their “usefulness and good management.” The commissioners were to have free access to the grounds, buildings, and all books and papers relating to the institution.

Moreover, they were “authorized and required” to visit all of the state’s charitable institutions at least once a year, the county and city jails or prisons and alms or poor houses at least once every two years.

The General Assembly established the Board of Public Charities for a number of reasons. *Habeas corpus* suits by complaining inmates and newspaper articles that painted sensational pictures of asylum life—of attendants who choked patients, or used “douches” (a bucket of cold water



Wernersville State Hospital, 1895. Located on the second floor of Building 12 over the dining hall, this seven-hundred-chair hall was used for assemblies and religious services.

thrown in the face) to quiet them, or who used the “stomach pump,” a rubber tube used to force-feed patients who were trying to starve themselves to death—had fueled public and press criticism of asylums and led to requests for legislative action.

Responsible newspapers such as the *Philadelphia Evening Bulletin* and *Public Ledger* and the *Lancaster Express* came to the defense of the hospital superintendents and their facilities. “Yellow” journalists, however, played up *habeas corpus* cases (almost all of which were overturned by the courts) and wrote lurid, sensational articles including ones that fed the popular fear that sane people were being held in the asylums against their will.

A few judges even began to believe that lay people were as capable as doctors in determining who was sane and who was not. John Curwen wrote to Thomas Kirkbride about a case he had had at Harrisburg in 1870 in which a man who was violent when drunk was released by a judge after witnesses testified they never had seen him under the influence of liquor. The night after the judge released him, the man got drunk and forcibly tried to enter the judge’s house. “Ever since,” Curwen wrote, “the patient has been kept safe in the hospital by order of that judge.”

Even more important to the legislature, however, the creation of the Board of Public Charities eliminated the burden of reviewing the large number of reports

being sent to the governor and the legislature and then of separately determining each facility's appropriation.

Before the creation of the board, the trustees and superintendents of each hospital (along with all other state charitable facilities) had prepared lengthy annual reports addressed to the governor and the legislature. These were designed, at least in part, to support their statements of need for additional staff, money for new buildings, repairs to existing facilities, or new equipment. Asylum statistical data such as that showing "cure rates," percent of "restorations" of the "number treated" or of the "number admitted," even the occupation and place of nativity of those being treated, were aimed indirectly at justifying a hospital's claim not only of treatment "successes," but also of the great need remaining.

Now the superintendent's reports went to the Board of Public Charities. It was the report the board compiled from those it received from around the state that was sent to the governor and legislature. Moreover, the board now decided how much to ask for each institution (asylum, prison, orphanage, almshouse). This meant that the state's asylums had to compete, not only with each other, but also with all the other charitable groups for an appropriation line in the board's budget request.

Many of the older superintendents such as John Curwen at Harrisburg saw the board's establishment as an attack on their authority within their institutions. (After several meetings with the board, Curwen wrote to Thomas Kirkbride: "I found their charity towards me was limited. I think the word charity will not convey the true intentions of the actions of that board.")

The Board of Public Charities had been established, however, more because of the "bad conditions of the county poor houses and jails, and the abuses of the inmates of these and other public and pri-

vate institutions"—the "keeping of the insane poor in jails and filthy apartment in county alms-houses, without proper care or medical attendance"—than because of conditions in state facilities. Although things changed in later years, the board's first report in 1871 actually lauded Curwen's facility:

The Board have made several visits to this institution, and have been highly gratified with the earnest and intelligent administration of its interest, under the wise superintendence of the physician-in-chief, Dr. John Curwen, who has occupied this position since February 13, 1851.

Eventually however, the board developed an agenda of changes that ran counter to the asylum practices the hospital superintendents—following Kirkbride's lead—had developed from early in the nineteenth century. The main thrust of the board's initial recommendations, more correctly demands, pertained to the admittance of paying patients at state run facilities, the removal of the chronic insane to separate buildings, and the nature of the "authority" (and ability) of the superintendents.

The board wanted state institutions to stop taking paying patients. They believed that by following the superintendent's vision of the asylum as a "multi-class institution," the "State had been drawn away from her clear duty [to the poor], to enlist in a scheme of charity [for those who could pay] which is never recognized as the proper function or duty of the state." It was the board's position that this was a form of personal patronage being dispensed by the superintendents to their friends. The superintendents held that their admittance policy let them select paying patients to give a needed democratic balance to their institutions by including those who were educated, genteel, and curable and those who were not.

The board also recommended that the

state use the hospitals it had built for treating those that were curable, and remove the chronic to separate, less expensive structures. This, they believed, would reduce the demand for building new hospitals in the style of those already erected. Such a two-tiered systems (with patients housed in inferior facilities) was exactly what Dorothea Dix and Thomas Kirkbride had fought against earlier.

The board began to criticize Curwen and his concept of an asylum, rather than Thomas Kirkbride, according to Nancy Tomes, because of the latter's eminence in the profession.

Initially it was Curwen's practice of accepting paying patients rather than only the indigent insane that was challenged, but later the board began attacking his "authority" within the hospital. The Board believed that asylums "should be subject to the supervision of some party not connected with their immediate management," then later went so far as to claim that the "Authority of experts is limited."

Ultimately, the Board of Charities began asserting its own authority by proposing several changes in asylum practice. The board first recommended moving the criminally insane from the penitentiaries to state hospitals. The superintendents, believing that a secure hospital wing for convicts would further increase the "moral odium" attached to insanity and to their institutions by blurring the "distinction between virtue and vice," prepared a "memorial" in February 1874 to the legislature requesting that the board's proposal be rejected. Kirkbride, Curwen, Isaac Ray, S. S. Shultz of Danville, and J. A. Reed of Dixmont signed the memorial.

Although the memorial was successful, the legislature eventually backed the board it had established. Nine years later the legislature increased the powers of the Board of Charities as well as its size. The 1883 act directed that the "board shall appoint a committee of five to act as the committee on lunacy." One of the members

had to be a member of the bar and another a practicing physician, each of at least ten years' standing.

Among the new powers the act gave the board and its new Committee on Lunacy were the right to license all "places in which any person can be detained as a lunatic, or of unsound mind," and, with the consent of the chief justice of the Supreme Court and of the attorney general, to establish rules and regulations governing such places.

Moreover, the Act of May 8, 1883, named a large number of specific areas for which the committee was to prescribe regulations. The regulations were to "insure the proper treatment of persons detained"; to "guard against improper or unnecessary detention of such persons," to "establish the forms to be observed warranting the commitment, transfer of custody" of patients; to "specify the reports and information" to be furnished by the superintendents; to appoint inspection boards in every county; to "insure" that all "proper visitors, members of the family, personal friends, or attorneys" were given admission to patients; and to withdraw the license of any house or place for violations of the act or the rules that the committee established.

It further specified that each establishment which was subject to the act had to keep the following "books": An admission book, a discharge book, a case book in which the hospital regularly entered all the facts bearing on each patient and his or her case, and a medical journal in which, at least once a week, a statement was "written of all matters which are of special importance bearing on the treatment and condition of the patient." The act also mandated that a person had to be examined and the "results of the examination reduced to writing" within twenty-four hours after an individual was admitted.

By the end of the nineteenth century, the Kirkbride model of an asylum had fall-

en from its pedestal—both his arrangements for a hospital building and his method of ministering to the mentally ill. Attacks by the Board of Public Charities on the authority of the superintendents, and by younger physicians anxious to establish their own credibility in the treatment of the insane ultimately led to its downfall.

“Insane Asylum Warfare”

The success of the asylum superintendents in thwarting the Board of Public Charities' efforts to establish a department for the criminally insane at Danville made the board and its president, George Harrison, even more determined to assert their authority over the management of the state hospitals.

The struggle between the two groups as well as within the medical profession unleashed what one superintendent called “insane asylum warfare.”

For some reason, in spite of its benign country-doctor image, medicine historically has been blistered by discord. In the mid-twentieth century it was the struggle over the advent of health insurance and fear of a “socialization” of medicine. In the late nineteenth century it was over the nature of providing for the indigent insane.

The nineteenth-century debate of lay versus professional control over the decision-making process in ministering to the insane was aggravated by several additional factors: the elitism among the various professional disciplines, (e.g., the neurologists versus the psychiatrists); the historic argument over treatment methodologies (whether it was the body or the mind that needed curing); and whether the proper treatment should be aggressive or less assertive. With the insane, of course, such side issues as whether and when to use restraints added yet another layer to the controversy.

Having been blocked in their efforts

to get legislation providing for housing the criminally insane at Danville, the board did win a partial victory in its campaign to have separate facilities constructed for the chronic ill.

The superintendents, especially Curwen and Kirkbride, also vigorously contested that plan. In the superintendent's memorial to the legislature, Curwen wrote that separate asylums for the chronic ill meant that they would degenerate into “receptacles for the safe-keeping of an afflicted class . . . rather than [serve as] a curative institution.” According to Curwen, to make real progress the state must build enough asylums for all the indigent insane.

While separate chronic buildings were not erected until several decades later, the board was successful, in getting Curwen's subsequent appropriation bills amended to prevent him from taking any paying patients as long as there were indigents seeking care. Then later (in 1893), rather than separate buildings for the chronic ill on existing hospital grounds, the board was able to get the legislature to erect an entire hospital, Wernersville, for them.

Controlling his admittance policy, of course, weakened Curwen's ability to mold the character of his institution. Moreover, in having demonstrated its power with the legislature, the board gained significant ground in the struggle to establish its authority over the superintendents.

By the 1880s, the clash between the superintendents and the neurologists not only had come into the open, it had become rancorous. The neurologists averred that although the superintendents might have started as physicians they had become largely administrators.

Medicine had changed greatly since the first decades of the nineteenth century, when doctors, including most of the asylum superintendents, had taken a few courses in medicine as part of a two-year program and then gone into practice.

The new generation of physicians—the neurologists and the younger psychia-

trists (the “young Turks” as they came to be known)—were anxious to assert themselves and their ideas on treating the insane. Paramount among their propositions was the rejection of Kirkbride’s linear building and his ideas of moral treatment. The new generation of doctors was interested in employing a dispersed “cottage plan” rather than a single monolithic hospital structure for ministering to the insane, and in treating their patients’ somatic symptoms rather than their psychic condition.

Along with the Board of Public Charities, the young Turks believed that the chronically ill should be isolated to permit the professionals to concentrate on those who were deemed curable. They also condemned the current asylum arrangement on the ground that it failed to produce substantial research capability and certainly no results.

In an 1894 talk to the American Medico-Psychiatric Association (the name the Association of Medical Superintendents of American Institutions for the Insane had given itself the year before), S. Weir Mitchell, the eminent neurologist of his day, leveled these charges against the asylum superintendents directly. He was sharp in his criticism, especially of their isolation from general medical practice:

You were the first of the specialists and you have never come back into line. . . . You . . . live apart. . . . Your hospitals are not our hospitals; your ways are not our ways You live out of range of critical shot; you are not preceded or followed in your ward work by clever rivals, or watched by able residents fresh with the learning of the school. [Your annual reports are filled with] too comfortable assurance of satisfaction. [Your practices show] too many signs of contented calm born of isolation from the active living struggle for intellectual light and air in which the best of us live.

Although his report was scathing, Mitchell made several recommendations that in time began to bear fruit. He suggested revision in patient employment, which he claimed was poorly planned; he recommended increasing recreational and exercise facilities, more variety in diet, and a lessened use of mechanical restraints. All these he asserted would reduce the appearance of the asylum as a prison. He also suggested educating the public in newspapers and lay journals to change the public’s impression of insanity as always dangerous. And he recommended placing greater emphasis on treating patients outside of the confines of the asylum.

In time, many of Mitchell’s recommendations came to pass, some not until well into the twentieth century. Others, however, were implemented soon after he made them. Training schools for asylum nurses and attendants began to appear at hospitals around the country, women physicians began to treat female patients, and medical schools, which previously were indifferent to courses on mental disease, began added such material to their curriculum.

Benjamin Rush’s *Medical Inquiries and Observations upon the Diseases of the Mind*, the only text on mental illness for seventy years, was soon replaced by newer works; the first two, as Deutsch (*The Mentally Ill in America*) pointedly observes, being written by neurologists.

In the ensuing decades the power of the Pennsylvania Board of Public Charities continued to grow, that of the superintendents of the asylums declined. In 1923 the Commonwealth adopted its first Administrative Code, which reorganized the structure of state government and specified the basic powers and duties of the executive departments, boards, and commissions.

Previously, in each statute authorizing an institution, the legislature had

declared the board the governor was to appoint to be a “body politic and corporate.” The new code made these boards administrative bodies in the Board of Public Charities, which two years earlier had become the Department of Welfare. In 1955, a further change was made making the role of the boards of mental health institutions “advisory” in place of “administrative.”

The debate over lay versus professional control continued—if not to rage—to simmer for more than a century. Symptomatic of its perseverance is the

story Howard K. Petry’s son Robert tells about his father, who was the superintendent at Harrisburg State Hospital from 1934 to 1954. Whenever the father, a physician, drove his son through the hospital gates after a trip “downtown” to visit an administrator at the Department of Public Welfare, Robert remembers him saying, “It sure is good to get back home, where we know who the crazy ones are.”

Today the state hospital superintendents are not required to be physicians, but are often managers appointed to their positions by the Department of Public Welfare.

“Life Among the Insane”

The Story of Adriana Brinckle

In 1885 the Lunacy Committee of the Board of Public Charities ordered—in a unanimous opinion—the release of Adriana P. Brinckle from the Asylum for the Insane at Harrisburg. She had been there for twenty-seven years. Two years later her story appeared in the *North American Review*.

Adriana’s story—with its Ibsenian overtones of a strong-willed young woman, determined to make her own way, and a weak man fearful of a loss of family “honor”—unfolded twenty years before Ibsen’s *A Doll’s House* appeared.

As tragic as her story may appear we should remember that the middle of the nineteenth century was an age of rigid ideals, a time when prison was a frequent outcome for indebtedness or theft (conversion) of someone else’s property. Moreover, honor—one’s name, even one’s signature—was given much greater currency than today.

Still, knowing this, it is hard to believe that a Judge of the Pennsylvania Supreme Court would have participated in such a shameful affair, and

it is also nearly impossible to believe that John Curwen did not know of her situation, and still acquiesced in keeping her.

In his admittance book he left the columns under her name for “Apparent Cause of Insanity” and “Occupation” blank, and wrote “friends” in the one for “Committed By.” Rarely did he miss entering some diagnosis for cause of insanity and wrote under occupation for other female patients “daughter of farmer, physician, etc.”

He certainly released other patients—even when first admitted—that he declared were not insane. But men (and women) in powerful positions are sometimes guilty of irresolute actions.

Adriana’s story is included here, however, more for the picture it paints of life in a nineteenth-century Pennsylvania asylum. And, of course, the actions of the Board of Public Charities and its Lunacy Committee do deserve to be characterized as commendable. As small an act as it was, the posting, that Adriana mentions, of a notice that grievances could be freely sent to the committee indicates that the men of the committee were sincere

in their efforts to reach out to and help those who were incarcerated in asylums. The men of the committee must have suffered through countless frivolous letters to find the few that deserved their attention.

Regardless of which of the three insane-asylum-warfare principals' positions we may feel was the more just, each of the warring factions—the superintendents, the lay Board of Public Charities, and the “young Turk” neurologists—did have the best interests of the indigent mentally ill at heart.

Adriana's story, condensed, but in her own words

I do not think any woman in America is better qualified than I to supply the material for a good sermon on insane asylums—for I was locked up in one for twenty-eight years. During those years I never lost my reason—it is a wonder I did not—and so what I say may be relied upon as being truthful.

My story is simple. I was put in the asylum for two reasons: the first was that I was extravagant and too fond of dress. The other that my family wanted me relieved of the disgrace of being publicly accused of obtaining goods under false representations, by resorting to the insanity defense.

My father was William Draper Brinckle, a physician, who lived in Girard Row, Philadelphia. My mother died while I was young.

I was placed in the State Hospital for the Insane at Harrisburg, Penn., on July 14, 1857 (hospital records show her admittance date as July 13, 1858), on the commitment of two physicians, one my father, the other a stranger to me. My father, occupied with his professional duties, was of course, much away from home, so that I grew up, wandering at my own pleasure. Yet my educa-

tion was by no means neglected; for I received a thorough training in the ordinary English branches, became quite familiar with the French language, and acquired a thorough knowledge of music.

I was naturally of a gay temperament and inclined to extravagance, and I knew that I had my father to help me out of possible financial straits. In the year in which I was placed in the asylum there was a general panic and my father was unable to pay my debts.

The particular difficulty in which I became involved was that of buying furniture on part credit, for a parlor which I had rented in the home of two old ladies. Their house was small and I had no room for a piano. I therefore moved to a large house securing furnished parlors. Having no use for the furniture which I had purchased, I sold it. This proceeding came to the knowledge of the dealer from whom it had been purchased, and he prosecuted me. Before the time came for my appearance in court I was placed in the asylum.

My father was advised to take this course by the late Judge George W. Woodward, then of the Supreme Court of Pennsylvania.

Judge Woodward, who accompanied me [to Harrisburg], represented that it was better than being imprisoned in a jail, and that insanity was after all the bluntest horn of the dilemma, because it preserved family honor. I was led into the presence of Dr. John Curwen and Mrs. Cole, the matron. To these people Judge Woodward, in my presence, spoke of my extravagant tendencies; what he said when my back was turned I do not know. He wished me good-bye rather sorrowfully, and I think when he left it was with a little remorse at what he had done.

Everything in the institution was strange to me. They put me in the best

ward at first. I found life insupportably dull. The only things that made existence tolerable were music, which I loved passionately, and fancy work, which I liked less because of its monotony. It was change, however, from the sameness of idling.

My nurses were Susan Spiegelmyer and Ruth Noble. At the end of a year in the asylum, under the kindly care of these nurses, an attack of dyspepsia, from which I suffered prior to my incarceration, disappeared. I think the regular way of living and the plain food effected that cure.

In my observation [however] the nurses at the Harrisburg Hospital, for some reason or other, were not all rational beings. Perhaps it was the contact with mad women. Perhaps the fact that some were promoted to be nurses, first having been patients, made this seem to me true.

In June 1858, my father came to see me for the first time, and complimented me on my rosy cheeks and generally healthy look. That was all very well, but I wanted to get out, and I told him so. He promised me that if I would wait until the troubles caused by my debts had blown over he would have me released. Then he went away. I never saw him again, and he died four years later. He wrote to me, however, and gave me the impression that my release would be a more difficult matter than anticipated. The man who can be said to have managed my detention was Judge Woodward, whose visits to me were frequent.

Soon after my arrival at the asylum, I met at a picnic given to all the patients a young inmate of good family. He was a son of a judge of one of the upper counties of Pennsylvania, well bred and entertaining. After meeting several times we became engaged to be married. He was not considered insane,

but it seems his family thought the hospital would be a good prescription to cure a certain intemperate disposition with which he was afflicted. He was addicted to the use of wine. My father and Judge Woodward wrote to Dr. Curwen, asking him to put a stop to our meeting.

For seven years, however, we wrote letters to each other, and we were all along determined that I should become his wife. It was the knowledge of his being near me that made me less active in my efforts to escape. At the end of the seven years of which I have spoken, my friend was removed from the asylum, I think to the Pennsylvania Hospital for the Insane in Philadelphia. I have completely lost trace of him.

Untrained nurses in a hospital for the insane know no more about treating insane people than I know about prescribing for a case of fever. The secret of proper conduct toward the insane is management. It requires tact. The ex-laundry-woman or factory girl who becomes a nurse cannot understand such a problem as the mind, and when the patient is refractory [stubborn] she can only meet it with brutality. Those who are deprived of reason cannot understand violence, nor has it any good effect on them. I have seen a patient who had been struck look in surprise at the nurse who struck her, and ask, "Why do you do that? What have I done?" We may just as well thrash a cripple for limping, or vent our malice upon a blind man because he cannot see.

The only way in which patients can get on the right side of sane nurses is by doing their work for them. They are often expected to help to sweep and clean up. I saw a harmless patient who was sitting listlessly on a heating register attacked and beaten because she would not work. One nurse knocked her



Interior of the old laundry at Harrisburg State Hospital, 1910.

down and then called another nurse to her assistance. Together they got a patient afflicted with homicidal mania to join them and the three pounded the unfortunate creature until she was black and blue.

One of the patients in a ward adjoining mine was found one morning hanging with her head wedged between the transom and the doorframe. She was quite dead. How she had even got in that position was a mystery. Probably one of her associates helped her up with a chair and then removed it.

Altercations with patients are, of course, frequent from the very nature of their maladies, and the position of a nurse or attendant in an insane asylum is a very trying one. It requires great patience and force of character, accompanied by a high order of intelligence. No two cases are alike.

I am happy to certify that during the entire period of my incarceration I personally received mild and courteous treatment from the superior officers of the institution, as well as from the attendants. [The circumstances of Adriana's confinement probably were well known throughout the hospital.]

When I was playing a melodeon or doing embroidery, I watched the peculiarities of those around me. Mary, a patient from Carlisle, who was admired for her self-possession, smiling face, and quiet demeanor, took up a chair, one morning, and attacked an attendant with it. The latter eluded her, and the chair went against the wall with so much force as to break the plaster.

Some lunatics seem to live in a world of their own. An old lady once astonished and amused us by exclaiming, without any warning or provocation, "Two cats and the bird of paradise

are waiting to convey you to your heavenly home, and you are to sit for nine days between the cats and the bird of paradise." Then she stopped, and forgot that she had said anything. Another patient lived in the bathroom, and made friends with the rats (they were numerous). Some one else thought she was the wife of President Buchanan, and had the hallucination that her husband frequently ran a locomotive through Washington Avenue, Philadelphia, with a big bonnet in front of it, to remind her of the annoying fact that in her young days she had been a milliner. And another woman [with delusions] frequently mentioned that she had enjoyed herself in previous years riding on the back of a dolphin at Cape May

My observing powers were concentrated during my stay on such persons as these: One man who had cut his throat; a murderess of her own child; a woman who had been a nurse and who killed an infant, under her care; a woman who had severed her child's jugular vein; another who had killed her husband; one who became insane through accidentally killing her child, and any number of patients with suicidal mania.

Others who apparently were not insane

A victim like myself was a Mrs. Z —, who with her baby, was in the hospital. I knew her well and was certain that she was not insane. Her husband was thriftless, she sued him for support, and he, out of revenge, put her in the asylum. Her friends soon applied to the court and she was liberated.

One man who was wrongfully placed in the asylum got out. He crossed the Susquehanna River far ahead of his pursuers, who left the hos-

pital in full chase after him. He eluded them, pawned his watch to raise money, rallied his friends around him, and shortly afterward returned to the institution for his clothes—a free man. He had never been insane but was committed to the hospital, through some conspiracy, on the certificate of irresponsible physicians.

The story of Adriana's release

In the fall of 1884 a notice, which the new law required, was posted in our ward, telling us that if we had any grievances, we could write freely about them to the Committee of Lunacy of the Board of Public Charities. Before I had time to avail myself of the opportunity of getting a hearing, I was taken very ill and was too weak to do anything. When I recovered I found that the patients had torn down and destroyed the print law the committee had posted, and I did not remember the name of any gentleman upon it.

Fortunately, Miss Annie Drinker, a convalescent, recalled the name of the medical member of the committee and wrote to him. Dr. A. J. Ourt, secretary of the committee, Dr. Morton and Mr. Philip C. Garrett, chairman of the committee visited me shortly afterwards. Soon after this the committee fully investigated my case and ordered my immediate release.

I do not think my story can create in the mind of the reader any but the one impression—that I am a wronged woman. No one, it appears, is now responsible for my incarceration. My counsel informs me that an action will not lie against the State or the hospital authorities, as my commitment was made in due form of law. [Adriana's father and another physician had certified to her insanity.] Apart from this, all those who procured my incarceration

tion have since died. My release came about solely under the operation of the new lunacy law of Pennsylvania, and the zealous efforts of the gentlemen whose duty it is to carry the law into effect.

Adriana had been one of John Curwen's "paying" patients. Since her father's death, twenty-four years before her release, his estate had maintained her in the hospital. As she only had limited funds left and "didn't know what to do," Adriana spent the

last years of her life in the Convalescent's Retreat at Glen Mills.

Unlike Ibsen's Nora, when Adriana left the Pennsylvania State Lunatic Asylum, there was no one on which to slam the door. Her father and Judge Woodward were dead, and John Curwen had moved from Harrisburg to the superintendency at Warren. Nine years later Curwen was elected president of the American Medico-Psychiatric Association.

Civil War General John Frederick Hartranft served two terms as governor of Pennsylvania starting in 1873. After leaving office, Hartranft became the president of the board of trustees of the Norristown State Hospital. He served in this position from 1880-1889.



The Cottage Plan

Norristown State Hospital

By the beginning of the last quarter of the nineteenth century, Kirkbride's ideas on hospital construction were beginning to be questioned. Experiments in Gheel, Belgium with a "cottage" arrangement in place of the individual "wing" buildings of a monolithic Kirkbride structure provided greater separation of the various "classes" of patients so that the more agitated could be widely dispersed from those who were recovering or less disturbed. The new structural arrangement (sometimes called a segregate or detached system) also significantly reduced the likelihood that a fire could destroy an entire hospital.

There were problems of perception, too, with a Kirkbride hospital. Because of their size, critics—both within the political arena and the medical profession—eventually began describing such buildings as philanthropic and bureaucratic white elephants. Although those who lived packed in them would hardly have

thought of them that way, opponents started to call them "palaces." As one nineteenth-century history described it, the cottage plan corrected "the lamentable inconsistency of caring for a portion of the indigent insane in palaces, while an equally deserving number of them are lying in squalor in the almshouses."

Act 89 of May 5, 1876, to establish a state hospital for the insane for the city and county of Philadelphia and the counties of Bucks, Montgomery, Delaware,

Chester, Northampton and Lehigh contained no language—as had previous acts—directing that the building commissioners follow the plans "adopted by the Association of Medical Superintendents of American Institutions for the Insane." It said that the plan for the new hospital "shall be in accordance with the best design for the construction of such institutions; shall be well and securely built without expensive architectural adornments or unduly large or costly administrative accommodations." The act went on to direct that "its general character" was to be subject to the approval of the governor and the Board of Public Charities.

After reducing the field to five architects, who were invited to make detailed presentations before them, the Norristown building commissioners selected the Philadelphia firm of Wilson Brothers & Company to design the hospital. Joseph M. Wilson, as did his brothers John Allston and Frederick Thorn, had a considerable reputation as both a building and bridge designer. Although Joseph began work after graduation from Rensselaer Polytechnic Institute as an architect and engineer for the Pennsylvania Railroad in charge of bridges and buildings along Philadelphia's Main Line, he first came to prominence when he was selected to oversee the

design and construction of the main exhibition building and Memorial Hall for the Centennial Exhibition in Philadelphia in 1876.

Although the firm of Wilson Brothers continued the railroad design and engineering work with which all three brothers got their start (they were responsible for the Reading Terminal in Philadelphia, the Chesapeake & Ohio Railroad's Union Station in Richmond, Virginia, and the Broad Street Station in Baltimore), the firm erected many residences, churches, factories, and other commercial structures, as well as medical facilities.

Through the patronage of the Drexel family in Philadelphia, the brothers designed office buildings, including the Drexel Office Building (Philadelphia's first skyscraper) and the Drexel Institute at 32nd and Market Streets.

The State Insane Asylum at Norristown was the first hospital to follow the "cottage" plan that the Commonwealth erected for its mentally ill. Rather than a true cottage plan with separate buildings,

however, Norristown can best be described as consisting of a U-shaped arrangement of a series of dispersed mini-Kirkbride structures—each with a small center building and short wings of "cottages" on each side—all fronted by an administration building. Construction of the hospital began in March 1878 and was completed in February two years later.

A far more representative copy of the Gheel cottage plan, however, was that undertaken in the rebuilding of the first state asylum at Harrisburg by the superintendent Henry Orth. Commencing in 1891 Orth, who that year had followed Jerome Gerhard at Harrisburg, began a campaign to do a complete overhaul of the facilities at the site. Orth's first annual report was short—only five pages—but 80 percent of his annual reports were devoted to the "deplorable and almost uninhabitable conditions of the building" he had inherited. He claimed, "the sure but gradual deterioration of the inferior materials in the house has been going on for years, and cannot be retarded."

In 1893 Orth convinced the legislature to appropriate \$100,000 to rebuild the administration portion of the old Kirkbride Building. He hired Addison Hutton of Philadelphia to design the new structure. Orth's long-range plans—which were carried out over the next twenty years, included a central building and four cottages on each side, all connected with underground corridors. His scheme also included separate buildings for a bakery, congregate dining room, chapel, amusement hall, and a dormitory for nurses. Hutton designed the Administration Building and one for the chronic ill along with the overall plans for the site, the remaining cottages by John A. Dempwolf of York.

Addison Hutton was born near Pittsburgh in 1834. In 1857 he became an apprentice to Samuel Sloan, the well-known Philadelphia architect. Within two years, Sloan was sending Hutton south to



Hiram Corson: early advocate of female doctors to treat women patients in state hospitals.

North Carolina and Mississippi to oversee the building of Sloan designs for private homes. By 1862 Hutton was receiving independent architectural commissions such as the one for Henry Morris's "cottage" at Newport, Rhode Island. That same year he opened his own office in Philadelphia.

Among the many commissions he completed—some in partnership with Sloan—were ones for the State Hospital at Middletown, Connecticut; the Third Presbyterian Church in Pittsburgh; the Ridgway Library, the Philadelphia Saving Fund Society and the Women's Medical College in Philadelphia; and Parrish Hall, the first building of Swarthmore College. Hutton also designed a number of important private residences in the Philadelphia area, especially many of the fine Main Line homes. He served as the architect for Haverford and Bryn Mawr Colleges. Many of the dormitories and lecture halls on both campuses were designed and constructed by him. Packer Hall at Lehigh University was another of his college buildings.

According to his granddaughter and biographer, Elizabeth Biddle Yarnall, Hutton had "little tolerance for the overly ornate," although he was "fond of finely executed work." The Philadelphia architect had a special affection for designing hospitals. "I plead," he wrote, "that the skill of an architect can modify the appearance of almost any thing . . . so as to render it a thing inoffensive and, with perhaps a slight addition to the expense, a thing of beauty."

At a lecture Hutton gave to the architectural students at the University of Pennsylvania in 1894 titled, "The Planning of Hospitals," he summarized his views on the connection between architecture and responsibility for the less fortunate:

The Middle Ages were the cathedral building centuries. The nineteenth century is the era of

railroads and high buildings. The twentieth century, with the growing tendency of the strong to help the weak and the unfortunate . . . may prove to be an age of scientific healing and more universal, enlightened, and charitable work than has ever before been seen in the world.

Hutton abandoned the more severe classical design of a Kirkbride Building and adopted what he called the "Colonial" style. In this he followed the same thinking that was exhibited in some of the old mansions he built in and around Philadelphia. Hutton designed the new Administration Building at Harrisburg and one for the Chronic Ill. (The remaining "cottages" that completed Orth's plan for the site were the work of John A. Dempwolf.)

The most original building design that Hutton produced for Orth was done in 1900. The Chronic Ill Building, which stands at the opposite end of the site from the Administration Building, is really two buildings in one. Each structure, one for the men and the other for the women, was rotated 45 degrees so that the corners were to the front, back, and sides. Hutton joined the two together with a large rectangular dining room to be used by the occupants of both buildings.

Each of the structure's two dormitory buildings opened in the center to a large "airing court." The whole structure thus provided maximum ventilation and sunlight for the patients but afforded adequate separation of the men and women as well as privacy. It admirably fulfilled Hutton's hope that "on every day of the year in which the sun shines, at least three walls will be bathed in sunshine."

Hiram Corson

Norristown and Montgomery County were the focal points for numerous protest movements and activities during the last half of the nineteenth century.

A country physician, Hiram Corson, was at the center of many of these. In the late 1850s and early 1860s, Hiram and his brother William were staunch abolitionists. They were responsible for helping to engineer many escapes along the Montgomery County Underground Railway. And as soon as Hiram had graduated from the two-year medical program at the University of Pennsylvania and entered practice as a country doctor, he began to take up numerous "radical" causes associated with the profession.

The first of these had to do with the common practice among physicians of the day of prescribing alcohol for medicinal purposes. One biographic sketch (Theodore Bean, *History of Montgomery County*, Vol. 1) describes how Corson approached the issue. "No sooner had he begun his professional routine, than he threw himself against the whole system with the decision of a quick mind and the cool intrepidity of a hero." Hiram Corson began lecturing and writing papers condemning the practice and regularly presented resolutions at state and national medical society meetings attempting to get them to do the same. This later technique of introducing resolutions year after year to medical societies of which he was a member became one of his standard "activist" approaches for the causes he undertook.

Hiram Corson's next mission became a lifelong one—to improve the treatment of the Commonwealth's mentally ill. In 1877 he wrote a series of newspaper articles about the "bad management of the insane in the Montgomery County Almshouse." The articles came to the attention of Governor John F. Hartranft, who as a result appointed Corson a trustee of the State Hospital at Harrisburg. When Corson made his first inspection as a new trustee, he immediately charged, "beside the torturing appliances, pleasantly called 'restraining measures,' there are cells in which they [the patients] could be shut up for slight breaches of rules."

John Curwen (the superintendent at Harrisburg) must have considered Corson a troublesome agitator, as did many other physicians, rather than a constructive co-professional. It was Corson's opinion, for example, that the superintendents of public and private mental hospitals were "tyrants" over their patients as well as "bad managers of their facilities," and although Curwen was never accused of being despotic, he certainly believed in Thomas Kirkbride's idea of the superintendent as an autocrat.

Of all the practices in the management of the insane, however, Hiram Corson "deplored" none more than the practice of male physicians treating female patients. It was his belief that women were as capable physicians as men, moreover, that they alone should be treating females.

Largely as a result of Corson's efforts the first two female physicians were hired at state hospitals—Margaret A. Cleaves at Harrisburg (after Curwen departed) and Alice Bennett at Norristown. This was the culmination of a nineteen-year-long fight by Corson (from 1860 to 1879) both publicly and within the Pennsylvania Medical Society that initially rebuffed his efforts. Only after Corson gained the support of the Montgomery and Lancaster County Medical Societies was he able to overcome the domination by physicians from Philadelphia and get the state society's position changed. Finally in 1879, largely through his efforts, the General Assembly passed an "Act for the Better Regulation of the Female Insane." The act unfortunately made the appointment of female physicians optional rather than mandatory, as Corson had originally written it.

We should not consider Hiram Corson, however, as simply a medical activist. He was the author of numerous papers, most notably several on scarlet fever and diphtheria, and was reported as the originator of the ice-treatment for those diseases. Some of his other articles

included ones on "Pneumonia," "Diseases of Children," "The Use of Opium in Obstetrics," and "Meddlesome Midwifery," which from the title we can assume he did not favor. His ice-treatment in treating scarlet fever and diphtheria proved effective and eventually came into general use throughout the United States. In spite of his radical views on various reform subjects, he was honored by medical societies and the profession at large.

Search for New Measures

The decades between the Civil War and the turn-of-the-century were marked by significant changes in the nation's business, political, and social makeup. The failure of the North to impose its political and business system on the South through Reconstruction, as well as the Panic of 1873, which was brought on by excessive railroad construction, and which led to six lean years for the nation's economy, especially that of its growing industrial might, created feelings of dissatisfaction with the economic and political, and to a lesser degree, the social systems of the country.

At the same time, the period leading to the twentieth century saw a shift from a nation of "island communities" with their "personal, informal ways," as the writer Robert H. Wiebe describes it, to one of an "urban-industrial life" with its "regulative, hierarchical needs."

It is difficult, of course, to trace any direct connection between these changes and the increased number of those being treated for mental illnesses. The growing number of patients in the state hospitals might be attributed to an expanded population (Pennsylvania's nearly tripled in the fifty years after the opening of the state hospital at Harrisburg), or to a greater receptivity to placing family members in such facilities, or to other causes, rather than to industrialization or urbanization.

Edward Shorter, for example, believes that neurosyphilis was the major cause for

the increase (see "Wernersville and Act 272"). Nonetheless, the sense of a need for wider individual control over the nation's political and business environment that grew out of the changing economic, political, and economic conditions certainly contributed to the conviction that the state bore greater responsibility for the care of its less fortunate citizens. And this in turn led to a willingness on the part of policy makers, especially those in state legislatures, to provide for the nation's indigent insane.

During the last half of the nineteenth century most physicians, philanthropists, and politicians believed that, at least in part, the growing number of patients was a reflection of the nation's industrialization and urbanization. Legislatures, including Pennsylvania's General Assembly accepted the proposition that it was the price that society paid for change and thus the state should assume the burden in providing facilities and care for those who unfortunately bore the direct consequence of the nation's growth.

The final decades of the nineteenth century marked, therefore, not only the coming to maturity of the medical profession, including psychiatry, but also a search by the legislature for the means to control as well as to provide for the growing numbers of the state's poor mentally ill.

Warren State Hospital

By the Act of August 14, 1873, Governor John F. Hartranft was authorized to appoint three commissioners to select a site and build a hospital for the insane of the northwestern district of the state: the counties of Erie, Crawford, Mercer, Venango, Warren, McKean, Elk, Forest, Cameron, and Clarion. Governor Hartranft appointed Dr. William Corson, Dr. John Curwen, and General James A. Beaver (Pennsylvania governor, 1887-1891). The commissioners were instructed



Construction of the hospital, designed by Philadelphia architect John McArthur Jr., began in 1874. It was not finished until 1882.

to select "good arable land, with an adequate supply of pure water, and large facilities of drainage from the buildings," which lay "within convenient distance from some town, and easy access by railroad."

After surveying more than seventy farms in the several counties of the district, the commissioners purchased three contiguous farms totaling 330 acres for \$33,000 in the heart of rich farmland in Warren County near the mouth of the Conewango River, on lands that David Rittenhouse of Philadelphia had originally surveyed. The commissioners reported that the high ground in the rear of the main property was "covered with wood," and contained "sufficient stone for the erection of the hospital building, of a good quality, easily worked, and of a light cheerful color." And they observed that at the "base of this elevation" were "ample supplies of brick clay from which the brick can be made for the construction of the interior walls."

The commissioners hired John McArthur Jr. as architect based on his previous experience at Danville. The building was planned as a Kirkbride structure; it would be one of the last ones built

in accordance with the propositions of the Association of Medical Superintendents of American Institutions for the Insane. It consisted of a main four-story center building with three horizontal sections on either side at right angles to the center building. Each of the three wing structures was connected by transverse wings parallel with the center. Although the structure was considered to be "fire-proof," the floors were Georgian pine and the rest of the woodwork, walnut, ash, and oak.

The cornerstone laying ceremonies took place on September 10, 1874 before an estimated crowd of five thousand people. After describing it as the "fourth edifice of the kind within the Commonwealth" (the second, in Philadelphia, was not strictly speaking an asylum for the insane but a Training School for Idiotic and Feeble-Minded Children), the "fourth great monument of her beneficence and charity," Governor Hartranft told them:

Is there a more fitting channel through which the current of her bounty and benevolence could flow? No scientific or social problem has been more perplexing than the treatment and care of the insane and modern civilization has

given no more striking and noble manifestation than the earnestness with which the world addresses itself to the solution of this problem.

No part of the policy of the State has reflected more honor upon her citizens than the omniscient provisions she has made for her insane, and it is a satisfaction to know that the beneficence so creditable to her mind and heart, has not been misapplied, and that much and permanent good has been accomplished by this charitable work.

In addition to copies of Governor Hartranft's address and the Memorial of the Medical Society of Pennsylvania recommending building the hospital, the commissioners placed a copy of the plans and specifications for the hospital along with a set of the paper currency and silver coinage of the United States for 1874 in the cornerstone.

Construction of the hospital that began in 1874 was not completed, however, until 1882, partly because of the size of the task, but also because the legislature's

appropriations were often made piecemeal from year to year as intermediate work was completed. In the fifth year of work on the building, the superintendent for construction, John Sunderland, reported the carpenter shop, which had been set up on the grounds to make the finished woodwork and furniture for the hospital, had produced 1,971 window frames and 1250 doorframes. Moreover, according to Sunderland, the finished building contained 1,465,643 pounds of iron beams and 31,500 perches of stone.

The construction plan was unique. The wings were put up first in reverse order, from the extremities to the center building, which was erected last. In this way the commissioners hoped to provide first for "the excited class of each sex, which are always the first admitted" and then "By the plan adopted, . . . [provide for] nearly two thirds of the whole number for which the hospital is designed."

There was some grumbling by the staff over this inverse construction plan; the building commissioners dismissed this by stating, "no one is properly calculated to be an officer of a hospital for the insane, who is not willing for a time to suffer some personal inconvenience for the benefit of those entrusted to his charge."

A year after the Warren State Hospital opened, John Curwen, who had spent thirty years at Harrisburg as superintendent, became the hospital's head. He filled his new position for nineteen years.

Asylum Afflictions: Fire and Disease

It seems inappropriate to speak of psychiatrists as having *fears*, but the two most dreaded events in nineteenth- and early twentieth century asylums were fire and contagious disease. Asylum superintendents looked upon the prospect of either with apprehension.

In the crowded conditions of a hospital ward an infectious disease could quickly become an epidemic, and a fire at night



"Bird's-eye" view of Warren State Hospital. Probably taken in the 1970s after farming was discontinued.

in a building with patients locked in their rooms could have devastating results.

Thomas Kirkbride had devoted considerable thought to the issue of fire. Chapter XXXI of his *On the Construction, Organization, and General Arrangements of Hospitals for the Insane* was devoted to ways to construct buildings so that fires would be minimized and if started could be contained at the point of origin. Roofs were to be of tin or slate; side walls were to be “arched” and “run up from the cellar to the roof”; the buildings were to have “stone floors, and iron doors on one side” of each ward to prevent a fire commencing in one section from spreading to any other. A Kirkbride hospital was to be heated by steam and the fires for generating the steam were to be in a detached, fireproof structure. In a subsequent chapter Kirkbride covered the “Means of Extinguishing Fire,” which recommended the availability of iron tanks of water in the attic and the maintenance of an effective “night-watch.”

Notwithstanding the concerns and attention given to preventing them, most of the state hospitals suffered from fires, some quite heavily. While these were usually in the outbuildings—the barns, laundries, kitchens, and icehouses—at least one fire virtually destroyed a main building. On Saturday evening, March 5, 1881, a fire ravaged the center administration building, all the female wards and a quarter of the male wards at Danville State Hospital. The fire began in a closet on the female side of the house.

Fortunately most of the patients were gathered for a program in the auditorium at the time the fire was discovered, so their removal to the outbuildings was carried out in an orderly fashion in spite of the snow and slush on the ground. Several of the 220 male patients escaped, however, in the confusion but were returned within a few days. The 172 female patients were cared for in the outbuildings until they could be transferred to Warren and

Harrisburg. While the outer portions of stone were substantially undamaged, the restoration of the structure’s interior was not completed for three years, at which time the women returned.

From that time on Danville State Hospital maintained a ready, well-equipped fire department of staff members who trained regularly. Periodic fire drills were also held for the patients and staff. In 1896 the hospital acquired “motorized equipment” and, according to the *Danville Intelligencer*, by 1934 had a modern chemical truck, hook and ladder truck, thousands of feet of hose, and a full-time paid foreman—thirty members from the various departments of the hospitals served as firemen.

Other Kirkbride buildings suffered from fires, but apparently not significant enough to cause a loss of life. In such cases, the superintendents apparently chose not to mention them in their annual reports. Adriana Brinckle states (see “Life Among the Insane”), that during her twenty-eight years at Harrisburg there were five fires in the house, one of which was severe enough that it required the hurried evacuation of the building at night.

Perhaps the most tragic Pennsylvania asylum fire occurred not at a state institution but at Philadelphia’s Blockley Almshouse—a forerunner of Philadelphia State Hospital. Ten male inmates, who were locked in their rooms and secured to their beds, died in the February 12, 1885, conflagration that, according to the *Philadelphia Inquirer*, left “only the walls of the insane wards standing.”

Just weeks before the disaster, a group of consulting physicians, including the distinguished S. Weir Mitchell, had inspected the facility and cited it for numerous fire hazards. Although they faulted the building as “highly combustible,” it was the manner in which the patients were handled that received the greatest condemnation. The hospital’s paralytics—who would need individual assis-

tance to exit the building, were housed on the fourth floor. Inmates who were considered dangerous were cuffed to their beds and then locked in individual cells on the third floor, the locks requiring considerable effort to open due to their age. To get to the fire escape once released, such patients had to walk through three wards, each of which was secured from the next by a lock that required a unique key. Moreover once unlocked, the doors swung inward rather than out.

Less dramatic than fires but much more frequent and the cause of greater losses of life was the occurrence of infections that quickly turned into epidemics. One of the observations each hospital superintendent liked to make at the beginning of his annual report to the governor and the legislature was that the hospital had been "free of infectious disease."

There were years, however, in which this could not be done. In 1890, for example, Solomon S. Shultz of Danville had to state, "we were visited with an outbreak of dysentery which continued nearly three months, affected 12 per cent of the patients, and caused 12 deaths. Additional patients were affected with diarrhoeal troubles; of these two died."

Schultz went on to make the point that "mortality would have been less had not insane delusions in a considerable number interfered with and frustrated all efforts at treatment." He also attributed some of the deaths to "feeble and old persons, who succumb at the first onset of every trifling affection."

Periodically, each of the hospitals reported outbreaks of other diseases such as diphtheria or typhoid fever, usually with less impact than the 1890 dysentery episode at Danville, but with deaths still frequently resulting. Then later during World War I, influenza struck most of the state hospitals, in some cases with heavy losses. At Wernersville, for example, fifty-three male patients and four employees died during the epidemic.

Fire and disease then were the two most feared pestilences that beset asylums; asylums crowded with patients, many of whom were unable or unwilling to escape their arrival.

Wernersville State Hospital

With the Act of June 22, 1891, the Pennsylvania legislature provided for the construction of yet another hospital for the insane. By 1890 the population of patients in the five state hospitals had increased to 5,200. The condition of many of these, perhaps 85 percent, was considered to be chronic. Lacking any medical prognosis of recovery, state officials foresaw little chance, other than death, of the eventual release of these patients who were beginning to fill up their institutions. At the same time, these chronic insane required minimal medical treatment or even attention. Considered as beyond cure, their only need was for custodial care.

The General Assembly presented Governor Robert E. Pattison with two alternatives for the care of these chronic insane. One would return them to the city and county almshouses, the other would authorize the construction of a new hospital. The governor vetoed the first bill and approved the second.

The hospital at Wernersville—the result of the 1891 Act—was designated to relieve the pressure that housing these chronic ill placed on the existing facilities. It was fully the legislature's intent, however, that the new hospital be self-sustaining. The act specified that as soon as the commissioners had acquired the land for the facility along with temporary quarters, they transfer twenty able-bodied harmless chronic insane from each of the hospitals for the insane, to the premises and farm provided, for said asylum to engage in farm work, grading, macadamizing, excavating for buildings and such other employment as may be required.

Accordingly in early July 1893, after

having selected property near Reading—known for its pure water and fresh air spas—three of the five commissioners Governor Pattison had appointed to oversee site selection and construction personally visited Danville, Norristown, and Harrisburg and selected one hundred male and thirty female patients to work at the site. During the hospital construction, the men were housed in an old mill and a barn and the women in a cottage that came with the property.

While the women prepared meals in the kitchen of the cottage, the men began converting the pigpen adjacent to the mill into a bathroom. Pipes were connected to the boiler in the mill. Women bathed on Thursdays and the men on Saturdays. One of the patients, a carpenter, added a room on the west of the washhouse for use as a laundry drying room. He also made tables, benches, and other furnishings required for use in the dayrooms. While most of the male patients were busy fitting out the barn as a dormitory, another, a stonemason, began building a stone wall at the pond inlet.

At the cornerstone laying on November 29, 1892, Governor Pattison told the assembled crowd that “The nineteenth century marks the dawn of the treatment of the insane. . . . The erection of insane hospitals has resulted in the greatest good to the entire people, for many lives had been rescued from dungeons. Through their efforts and treatment, there has been a decrease instead of increase in insanity among the people.” The governor then elaborated on his ideas of caring for the insane:

In some of the institutions I have visited the very cheapest labor is used in the corridors at night. This is wrong. I would like to see even a more minute classification of the insane, with a view of effecting a cure, if possible,

and to do this the very best talent must be used in the attendance on the patients.

The Wernersville building commissioners selected the architectural firm of Rankin and Kellogg of Philadelphia to design the hospital. John H. Rankin, the senior partner of one of the most successful Beaux-Arts firms in Philadelphia, had been born in Lock Haven. He and Thomas Kellogg were both graduates of the two-year architectural course at Massachusetts Institute of Technology (M.I.T.) Rankin worked with Wilson Brothers and Company following his graduation in 1889 and Kellogg held a position with the leading architectural firm in New York, McKim, Mead, and White, at the start of his career.

Although Rankin and Kellogg had founded their own firm not too long before their selection as the architects for the Wernersville State Asylum for the Chronically Insane, the firm soon became very successful at winning contracts to design government buildings. (It is possi-



Wernersville Administration Building, about 1912. The bell in the Independence Hall look-alike tower was rung each evening as a signal for patients, field workers, and their attendants to return to the hospital. The tower was removed in 1961.

ble, of course, the men were recommended by Wilson Brothers and Company, Rankin's former employer, who had built the state hospital at Norristown in 1876.)

Among Rankin and Kellogg's commissions in the ensuing years were the U.S. Post Office and Federal Building in Indianapolis, Indiana, the U.S. Department of Agriculture Building in Washington, D.C., and the U.S. Army Supply Depot in San Francisco. In the Philadelphia area, the firm was responsible for the Chestnut Hill Academy, the Provident Trust Company bank, the Elverson Office Building, the Camden (New Jersey) County Court House, and the Philadelphia Post Office, among others. They also erected numerous private residences, hotels, schools, libraries, and churches throughout Pennsylvania as well as the Homeopathic Hospital in Buffalo, New York.



Print shop at Wernersville State Hospital in 1920. This fully-equipped letterpress-offset facility regularly printed nearly two hundred different administrative and medical forms.

The hospital at Wernersville was similar in design to the one at Norristown, adding weight to the possibility of, if not the direct involvement of Wilson Brothers and Company in securing the contract for Rankin, the firm's influence through him on the hospital's design. The Rankin-Kellogg structure consisted of a rectangu-



Wernersville Administration Building foyer in 1896.

lar arrangement of a series of dispersed mini-Kirkbride-like structures each fronted by an administration building.

The patient-occupied buildings were constructed of steel and concrete with and roofed with slate. The Administration Building was constructed of brick and wood. The dormitories are separated by open spaces from each other and the Administration Building, but are all interconnected with enclosed corridors. One unique design feature, however, of the Administration Building was its close similarity in appearance to Independence Hall

The patients at Wernersville had to be "able-bodied, harmless, chronic insane." They could only be admitted on transfer from other state hospitals or county almshouses, and they had to have been insane for more than a year. They were employed in farm work, or in the orchards, gardens, kitchen, bakery, laundry, or sewing rooms. In the first years there were seven mechanics, three tailors, five cobblers, four painters, eight carpenters, nine mule-team drivers, a blacksmith, a mason, and a printer. The remaining male



Taking in the hay at Byberry, 1932.

patients were laborers. The work of the patients was “voluntary,” although the initial act specified that: “Patients shall be assigned for labor by the superintendent . . . in farm or ward work of other useful labor, for the purpose of enabling said inmates to contribute . . . to the cost of their maintenance.”

It was the attendant’s duty to “direct” and “encourage” patients in their assignments. Each attendant leaving the ward with patients became their foreman in the field. In September 1894, a “company” system was organized along military lines. Each foreman had between fifteen and twenty patients. Each of the twenty-five companies at Wernersville was identified army-style as Company A, B, C, etc.

Over the years the hospital was self-supporting, manufacturing and planting everything needed for daily living. In general patients built all grounds improvements—roads, bridges, stone curbing and walks.

Blacks and the Asylum

The information available on African Americans in the Pennsylvania state hospital system is sketchy. We know that there were such patients in the state hos-

pitals almost from the beginning—but we do not know this from the voluminous statistics about their patients that hospital superintendents began collecting in the middle of the nineteenth century. Until late in the century, no statistical record of their presence was kept. On occasion we find a passing mention of a black patient in the text of a hospital annual report or a newspaper article, but nothing more.

Blacks probably were more likely than whites to be assigned to county almshouses rather than the state hospital. County officials probably objected to paying the state to take a black; moreover, they also may have seen the labor they performed on the local poor farm as a necessary exchange for the cost of keeping them. Transporting them, too, from the urban areas to the first state facilities, which had been erected in the middle of the Commonwealth, would have been considered prohibitive.

One of the ten inmates who died in the 1885 fire at Philadelphia’s Blockley Almshouse, for example, was identified as an African American by the *Philadelphia Inquirer*. And Jerome Gerhard, who followed John Curwen as the superintendent at Harrisburg, noted in his 1887 annual

report that he helped a black gain his freedom through a *habeas corpus* proceeding. The man, who had been sent to the hospital from the Eastern Penitentiary, "did not show any symptoms of insanity." Gerhard wrote:

He was industrious and anxious to make money. I allowed him to work on the new building, and to keep all he could earn. After he had saved thirty dollars, I applied to court for an order to discharge him, which was granted and he left the Hospital a happy man.

Much of the lack of information can be attributed at mid-nineteenth century to the small number of blacks (less than 2 percent of the total population) in the Commonwealth. The superintendents probably saw little need to collect data on such a small sample of individuals. The number of blacks in rural areas—where the first state hospitals were erected—was probably even smaller.

The superintendents were, of course, susceptible to the same biases as were present in the general population. At an early meeting of the Association of Medical Superintendents of American Institutions for the Insane (AMSAAI), for example, it was agreed that—although separate buildings need not be constructed—it was desirable to keep blacks separated from the white population. Generally the doctors had no problem with mixing them, but they believed that it would cause anxiety among their white patients.

In northern states other than Pennsylvania, separate facilities were usually provided. This seldom meant separate buildings, but rather segregated wards. According to Gerald Grob (*Mental Institutions in America*), several states, including Indiana and Ohio, simply refused to admit African Americans. At the Massachusetts General Hospital, Grob quotes the trustees as being "confronted with the 'painful necessity' of rejecting black applicants because of the 'unwilling-

ness of the ward patients to admit them.'"

While it is doubtful that the provisions of the AMSAAI's policy would have had any influence at rural hospitals such as Danville, Warren, or Harrisburg, where the number of blacks was likely insignificant, it is possible that at facilities such as Norristown, Wernersville, and later Philadelphia separate wards were maintained for them.

A review of the annual reports at Norristown shows that the first year that African Americans were reported in the statistical charts for the hospital was 1886 when there were 17 out of a total population of 708 patients. This number rose to 29 in 1887, and 32 in 1888 and 1889; the population of whites showed a corresponding increase in those same years.

Blacks were not reported as patients at Wernersville until 1901, but the size of the population that year—thirty-six out of a total of eight hundred patients—would indicate that they probably had been in the hospital much earlier. That year, too, Wernersville's superintendent Samuel S. Hill specified that of the blacks, twenty-four were men and twelve were women. By 1914 the population had risen to fifty-one blacks, of who thirty-nine were men and twelve were women. None was identified as a child, and no further breakdown by type or cause of illness, county of origin, employment status at time of hospital entry, or length of stay was supplied. One might assume that the twelve women were chronic cases, but this is simply speculation.

Grob summarizes the situation regarding African Americans in mental hospitals up through the mid-twentieth century:

Like the overwhelming majority of most white Americans, virtually no member of the psychiatric profession was willing to challenge the dominate separate but equal doctrine that was the basis of public policy. . . . A few who might

have been opposed took the position that their function was to provide care and treatment and not to educate the public on racial issues. . . . Concerned also that integrated hospital wards might undermine public and legislative support for their institutions, they followed what appeared to be a reasonable and logical policy.

When the Department of Welfare took over the responsibility of data reporting from the individual hospitals in the 1920s, blacks were still less than 5 percent of the state's population; however, beginning in the 1940s their number began to grow at a pace faster than that of the general population. By 1960 they numbered 852,750 statewide, which represented slightly more than 7.5 percent.

In one of the few demographic studies specifically targeting blacks and mental health in Pennsylvania, Robert J. Kleiner of the Philadelphia Region Commonwealth Mental Health Center reviewed data (from an unidentified source) for the five-year period 1951 through 1955. He reported that there were 2,013 new admissions of blacks to all Pennsylvania mental hospitals during those years.

Kleiner's study—which was designed to review the impact of migration on mental health—disclosed that African Americans who had moved from the South to the North “clearly” were “under-represented” when compared to blacks already living in the North. However, black “Southern females [who had moved to the North] showed more mental illness than [black] males [who had come north],” while among Northern migrants [those who moved between northern states], it was the male that was “over-represented in the patient population.”

Kleiner's tentative conclusion concerning females was that Southern migrant families being “matri-centered” placed a considerable burden of responsibility and stress on married females in

[their new] urban situations”

When John Logan arrived at Harrisburg State Hospital as a new physician following World War II, he encountered no black patients at the facility. There were also few blacks working there. Today they are there in significant numbers as both employees and patients.

Poor Farms

Most of Pennsylvania's counties and large cities ran poor farms or poor houses—some like Blockley were called almshouses. Along with the state's jails, the poor farms were the primary source of material for Dorothea Dix's 1848 memorial to the legislature. These facilities were used to house the aged poor, those the courts had found guilty of nonviolent crimes such as vagrancy or had been judged incapable of paying their debts, along with the community's indigent insane. The county poor farms were more jail than refuge. A man and woman usually were paid to run them with the hope that some work could be gotten from those housed there in return for the county's cost of maintaining the farms. The purpose of many of these Dickensian facilities was more to get the individuals away from the general population than true humanitarian concern for the state's less fortunate.

One of the objectives of the 1848 act providing for the Commonwealth's indigent insane had been to remove them from the county's care to the state hospital, which was anticipated to have not only a “curative” function, but also a uniformity in treatment which was lacking across the various counties.

Since the establishment in 1848 of the first state asylum, the policy pendulum of state vs. county care has swung back and forth, the legislature insisting at one point that the mentally ill should be treated in state hospitals, and then (when the state facilities became too crowded) that the



Patient snow removal crew at Byberry, 1935.

excess patients could be transferred back to the counties.

Since the counties had to “pay” for each of their residents housed at a state facility, they usually objected to the legislation mandating state care, and then stalled or even refused to transfer patients to the state hospitals because the cost of keeping them on the poor farms was considered less than the state charged for them. And, although some state hospital superintendents objected when the counties did not send them all their patients, when overcrowding became serious enough at the superintendent’s facility, he conveniently overlooked the laws directing the counties to send them to the state hospital.

Eventually many of the poor farms were closed by the counties, but in 1897, when the General Assembly—in yet another policy reversal—authorized payment by the state for the care of mental patients in facilities built by poor districts, provided these hospitals had experienced physi-

cians as medical superintendents, were staffed by trained nurses, and gave care equal to that of the state hospitals, several counties openly converted their poor farms into county mental hospitals. The state Board of Public Charities considered the standards beyond the reach of most poor districts, so two years later the legislature amended the law to require only that the board be satisfied with the equipment and care provided.

Soon after the Department of Welfare was created in 1921, it closed seven licensed and one unlicensed county “asylum.” In 1934, however, there were still thirteen county “mental hospitals” caring for 14,361 patients

Finally, by the act of September 29, 1938, the legislature assumed direct control of eight of the county public mental hospitals as state hospitals and closed the remainder. This 1938 “State Care Act” prohibited any county, city, or district from operating an institution for the care of mental patients.

The Twentieth Century

Allentown and Farview State Hospitals

In 1901 the General Assembly passed acts that provided for two state hospitals for the insane, both to be erected in the northeast corner of the Commonwealth. The two, however, were to be of quite different character.

The legislation (there was an act in each of the years 1901, 1903, and 1905) that led to a new hospital at Allentown specifically directed that the facility be a "homeopathic" hospital. The act of July 18, 1901—the most comprehensive of the three—stated, for example, that the commissioners were "to select a site and build a hospital, to be conducted under homeopathic management, for the care and treatment of the insane."

It was a further stipulation of the 1901 act that the board of trustees "shall appoint a competent and skillful physician, of the homeopathic medical school and practice" as superintendent. The purpose in specifying the hospital as homeo-

pathic was to permit the Board of Public Charities to transfer patients from any other state hospital for the insane, or to authorize the commitment of new patients from any part of the state "giving preference to those whose family or friends desire them to receive homeopathic treatment."

Interest in homeopathic medicine (the brainchild of a German physician, Samuel Hahnemann), swept the United States in the late nineteenth century. Its main tenets were two: that of administering microdoses of medication in successively larger amounts until it was determined what quantity cured the patient; and that "like cures like," an idea closely related to the principle of immunization. The physician, Emil von Behring, for example, who first demonstrated that immunization was a practical therapeutic procedure, believed that Hahnemann should be credited as the discoverer of this idea.

In contrast, the May 11, 1901, act that authorized erecting a hospital at Farview in Wayne County specified a function for that facility different from the one



An August 1935 view of the Pittsburgh City Home and Hospital Administration Building at Meyview

to be erected at Allentown. It was unique among all the state asylums the legislature would build.

Farview was established expressly to furnish both medical and custodial treatment to the criminally insane from across the state. The building commissioners selected a site in Wayne County located on the eastern plateau of the Moosic Mountains that included more than 1,500 acres, of which the state purchased 669 and the Delaware and Hudson Company



Dixmont post office with horse and buggy standing in front, about 1900. The postmaster and his family lived in an apartment on the second floor.

and the Hudson Coal Company donated 799.

By arranging its massive brick, Jacobean Revival style building to form restrictive inner courtyards, the structure was designed to be a “prison without fences.”

The hospital—which was built to accept only males—admitted its first patient in December 1912. In ten years, the population rose to nearly six hundred inmates. The attendants at Farview hold job titles different from those at other state hospitals, where they were known as guards.

The Mental Hygiene Movement

“There is a hygiene of the personality as well as of the body and its principles are those that promote an adjustment of human beings to themselves and the world at large.” Thus Norristown State Hospital Superintendent Arthur Noyes opened the “Mental Hygiene” chapter of the 1940 edition of *A Textbook of Psychiatry*. Noyes went on to explain that

Mental health implies much more than an absence of delusions, hallucinations, intellectual deterioration, or other symptoms that we associate with mental disease. Rather it is the nearest approach to a state of mind through which we may achieve maximum efficiency and greatest happiness, unhampered by habits and attitudes towards life that lead to varying degrees of failure.

The Mental Hygiene Movement swept the United States following the publication in 1909 of the book *A Mind That Found Itself* by Clifford Beers, a former mental hospital patient.

Beer’s book attracted widespread attention, including that of such notables in the fields of psychiatry and psychology as Adolph Meyer and William James.

With the support of such professionals plus a large segment of the public who had read *A Mind That Found Itself*, a National Committee for Mental Hygiene was formed. The movement for mental hygiene was hardly unique. The early decades of the twentieth century were, as Albert Deutsch wrote, “rich in the rise of reform movements—political, economic and social.”

The chief objectives of the National Committee for Mental Hygiene were to work for the protection of the mental health

of the public; to help raise the standard of care for those in danger of developing mental disorders; to promote the study of mental diseases and disseminate knowledge concerning their causes, treatment and prevention; and to combat the belief that mental disease carried, as an "incurable disease," the stigma of disgrace.

It took a number of years for the movement to gain strength. The entrance of the United States into the First World War gave impetus, however, to both psychiatry and hygiene in many fields. The problems of the health of its citizens, while previously ignored, became urgent matters of national public policy.

A great interest in mental hygiene and social work was manifest following the war. In working with the problems of mentally disabled soldiers ("shell shocked"), the National Committee for Mental Hygiene proposed establishing a training school for psychiatric social work. As a result, a number of schools began to offer courses in mental hygiene, and in the summer of 1918 a school for psychiatric social work was opened at Smith College.

Although the bond between mental hygiene and social case work grew stronger over the next few years, the depression beginning in 1929 led to the belief that mental hygiene had been over emphasized, that other factors such as an individual's physical and socio-economic condition needed to be considered along with the hygienic.

While it is difficult to make a direct connection between the mental health movement and the Pennsylvania State Hospital system, the effect of what became a worldwide movement on behalf of the mentally ill profoundly influenced psychiatrists and social workers everywhere. Arthur Noyes, for example, closed his chapter on "Mental Hygiene" in the 1940 edition of his *A Textbook of Psychiatry* by writing:

The message of mental hygiene is for all who have difficulties to

face, for him who works for social betterment, for the sane and for the psychotic. It seeks to strengthen the personality equipment of the individual and to promote the health and happiness of the race. An understanding of the forces underlying human behavior should teach us how and why people fail in the process of adaptation, as well as why it behooves us not to be too captious of those who have not succeeded when called upon to face problems beyond their ability.

The Haviland Survey

From June 1 to December 1, 1914, Clarence Floyd Haviland, the first assistant physician at Kings Park State Hospital, Long Island, traveled throughout Pennsylvania examining all the institutions caring for the insane. His survey was made for the Public Charities Association of Pennsylvania. The study was paid for by Charles C. Harrison, the son of George L. Harrison, first president of the Board of Public Charities.

Haviland visited eight state hospitals for comparison purposes, but his survey



Dr. Samuel S. Hill, second Wernersville State Hospital superintendent (1897-1927), stands behind a seated Mrs. Hill, as a chauffeur and Mrs. Hill's sister pose in a Stanley Steamer in this early twentieth-century photo.

and report, which was published in April 1915, was directed at three types of institutions: those maintained by municipalities, those by maintained counties, and those that were unlicensed.

Reviewing the report in its entirety leaves the reader with the impression that the situation had improved only slightly from when Joseph Konigmacher and Dorothea Dix made their statewide surveys seventy years earlier. Haviland's report makes it clear, however, that the improvement was superficial in most cases and that abysmal conditions still existed all across the state. Virtually all the facilities Haviland visited were overcrowded, few provided any medical treatment for the insane, and the physical plants were often "impossible."

Of the institutions maintained by municipalities, his general conclusion was that "none have been properly performing their function as institutions for the treatment and possible cure of insanity." He found it particularly regrettable that

Political and secular interests have apparently submerged the medical spirit, and as a result it is certain that many unfortunate insane persons have failed of recovery through lack of proper medical facilities and treatment. The conviction appears irresistible that whatever may have been past policies the welfare of the community would be best served by removing these hospitals from municipal control.

He described Philadelphia's Blockley as an "ancient, monasterial structure." The building for the insane formed part of general plant housing an almshouse and a general hospital. Light and air were "deficient." Overcrowding was of a "serious degree." In some places beds actually touched each other. "Day space was so limited," he wrote, "that benches were placed in rows across the room to provide seating accommodations." And basement bathrooms were "poorly lighted and ventilated."

Most incredible, however, were Haviland's remarks on Blockley's fire protection. Ten years after the disastrous 1893 fire, he still found much to improve. Some of the stone stairways were enclosed in wooden towers and others led only to the cellar. A number of iron fire escapes even had wooden platforms.

Although the medical work at Blockley appeared "fairly efficient"—which was unusual for most of the city institutions he visited—there were seventy-seven patients either in restraints or seclusion when he visited due to a lack of adequate attendants.

At Philadelphia's Byberry (the city's poor farm), Haviland found the patients living in old farmhouses that were "rather crude accommodations." Although Byberry was better than Blockley, its "parent" institution, the chief defects he found were an insufficient water supply, great fire risk, and unsanitary sewage disposal. Cesspools were used which were too close to the buildings including one adjacent to the barn. Byberry was run by a "head farmer" who reported to the superintendent at Blockley.

At another urban facility, Pittsburgh's Marshalsea, Haviland found even worse conditions. The plant consisted of a general hospital, almshouse, and tubercular colony. Tubercular patients mingled with the others. The plant itself was "archaic." For the most part the wards were bare, lacked furniture, and were "desolate in appearance." Haviland described some of the wards as "equipped with concrete floors, with center drains, similar to a stable." The exercise yard was especially "objectionable." The grass was worn off, and during the absence of the women from the yard, he counted eighteen large rats running about it in.

The situation of the care and medical work at Marshalsea was distressing. There were two physicians to care for 324 insane patients and another 291 inmates in the almshouse, with but one attendant to

twenty-three patients for day duty and one to ninety for night duty. According to Haviland, the most deplorable feature of the institution, however, was the political influences that operated in the selection of employees, many of whom were incompetent.

One woman at the facility accidentally scalded herself to death. In spite of an order the year before by the Committee on Lunacy that a safety device be installed on the hot water line, no action had been taken. And while Haviland was visiting, an attendant laid a sick patient on the cold concrete floor to clean the man's bed, whereupon the shock of such treatment caused him to collapse and die later the same afternoon.

Haviland described Marshalsea as providing "only the most crude custodial care." He condemned it by declaring: "The fact that no patients have been discharged as recovered for seven years tells the whole tale."

Haviland found the conditions slightly better—but far from ideal—at the nineteen licensed county institutions he visited. The most striking feature he found was the "close association between the institutions for the insane and almshouses," in some instances both the insane and paupers being cared for in the same building, and in a few cases in the same ward. The inevitable result of this arrangement was that the "care of the insane tends to the almshouse standard."

He discovered that mechanical means of restraint and confinement were frequently substituted for proper personal treatment and attention. It was agreeable he noted that there was "little evidence of actual physical abuse," but he stated that it was "indisputable" that "gross neglect exists." Haviland summarized the county situation as follows:

Dreary, desolate wards, lack of recreation, or other means of exciting or maintaining active interest are alone sufficient not only to hin-

der improvement or recovery, but must necessarily result in actually hastening the terminal process of deterioration.

Amazingly, just as Dorothea Dix had singled out Adams County as grossly deficient, so did Haviland. In Gettysburg the



First library at Philadelphia's Blockley Hospital, 1923. The worker near the window was a patient, Mary Fawlor.

building for the insane was at the rear of the almshouse. The building was in good repair, but the halls were too narrow and there was no regular dining room, a short hall serving in its place. The food was brought in buckets from the almshouse. The "cells" for seclusion had concrete floors. They did have electric lights, but the wiring was attached to the surface of the walls making it accessible to the patients. Because of the lack of attendants, seclusion was sometimes used for from six to eight weeks.

There were only two wards for each sex—bare and without sufficient seating facilities—so that little classification of patients was possible. The visiting physician came once a week. He refused to pull teeth. After listening to the all-night wailing of one woman in pain, the farmer in charge pulled it for her. Fire protection

was insufficient. Sewage flowed untreated into an open ditch about 150 yards from the main building. Haviland observed that the ditch “was absolutely stagnant.” Women lived on the second floor, but there were no locks on the stair doors. Haviland found women patients doing housework in the male wards, without any attendant present.

Patients were left alone much of the time. Once locked in the exercise yard, for example, they were left unattended. In one of the yards, Haviland saw “five concentric rings beaten in the earth about a tree by the ceaseless pacing of patients. He found one woman with an open, undressed cancer, and another with “ulcerations of the nose, apparently of luetic



Occupational therapy at Byberry in the 1930s.

[syphilis] origin.” Neither of these patients nor a tubercular patient were isolated, but mingled freely with the others. Haviland wrote that

A particularly reprehensible practice in this community is the custom of committing insane patients to the State Hospital only if they belong to one of the “better families” or if they are particularly disturbed or troublesome.

At Woodville in Allegheny County he found some things to commend, such as the buildings and the availability of drinking fountains. But sewage flowed untreated into a neighboring creek, tubercular patients were mixed with the insane, and fire protection needed improvement. He found one third-floor dormitory with a hundred patients that had but a single exit to a stairway, although an outside iron fire escape had been installed. It was inaccessible, however, as iron bars covered the oval window that led to it.

The building at Hollidaysburg in Blair County was satisfactorily fire-proofed, although at times the pressure was insufficient to take water to the second floor. Whenever this occurred, it was



Male patients standing and lying idle in the yard at Philadelphia, 1947.

carried up in pails. The hospital, however, was overcrowded with the result there was little day space. The men's wards, moreover, were bare, with only a few chairs. He claimed that the "custodial care at the facility was below even the usual standard of county institutions," and recommended "as a matter of humanity" that the patients should be removed at the "earliest possible moment."

The third class of facilities surveyed was the unlicensed almshouses. Haviland's summary of this group was that, while the majority provided fair material conditions for paupers, none had any proper means of caring for the insane. None of the local authorities, moreover, had "any idea as to what constitutes proper treatment for the insane." Haviland claimed, "there can be no doubt that many insane patients have failed of recovery . . . by the barbarous treatment to which they have been subjected."

In one of these institutions, he found that five of the "defective women" inmates had borne children; one even had her child in the house with her. In another, he found two "standing cells" used to quiet agitated patients. They were "merely two small closets, just large enough for an adult to stand erect in with the door closed. If a person once sank down," he wrote, "it would thus be impossible to again assume an erect posture."

Haviland's report was a major indictment. Little had changed in the thirty years since the Pennsylvania Board of Public Charities had been given the responsibility for "all institutions" in which insane patients were housed. It would seem particularly alarming that he was able to uncover nineteen unlicensed institutions.

Haviland's general summary of the state was that although there was "little evidence of actual physical abuse, what may be even worse, there is the most utter neglect." He called "un-American" the practice of sending patients "belonging to

the better families" to state hospital and others to the "county custodial institution," and declared it "should no longer be tolerated." Then in a backhanded compliment he wrote: "The only results obtained in the State of Pennsylvania, which have been even approximately satisfactory, have been in the state hospitals."

Haviland closed his report by discussing the "relative merits of state and county care." He cited six arguments in favor of local facilities—ideas he apparently had heard from county officials during his tour: the possibility of patients who remained near home receiving more frequent visitors, greater opportunity for occupation, the avoidance of "massing together" in large institutions, availability of more homelike surroundings, greater number of recoveries, and lower maintenance cost, especially for the chronic insane. Haviland debunked all six. He found that the "unvisited" rate for the state hospitals was 40.4 percent, while that for the twenty-one city and county institutions was 39.9 percent. He admitted that maintenance cost less in a county hospital, because "proper facilities cost more than does their lack," then curtly dismissed this point by saying: "It is cheaper to die without medical attendance than with it."

In addition to proposing a "state care system" for Pennsylvania that removed the insane from the counties and municipalities, Haviland also made several other recommendations, among them the development of a state civil service and a uniform method of commitment.

The year following the survey, C. Floyd Haviland took charge of the Connecticut State Hospital. While there he served as chairman of the executive committee of the Connecticut Society for Mental Hygiene. Then in 1926 he became superintendent of the Manhattan State Hospital in New York as well as president of the American Psychiatric Association.

It was not until twenty-four years

after Haviland made his report, however, that the Pennsylvania legislature finally passed a "State Care" act which took control of all county and municipal hospitals for the mentally ill.

Torrance

In 1915 the Pennsylvania Legislature passed the next to last of its many acts to build a "State Hospital for the Insane." The June 13, 1915, act directed Governor Martin G. Brumbaugh to appoint five citizens as a Building Commission to erect buildings to be known as the Western State Hospital for the Insane.

The act specified that the land should be on a site west of the Allegheny Mountains, reasonably near a railroad, and containing not more than five hundred acres.

After indicating the necessity for a nearby source of potable water, the legislature directed that the property shall consist of "arable land or land capable of being made arable, so that, as far as practicable, the food for the inmates of said

hospital may be produced on said land."

The act stated that the plans and specifications for the building must accommodate at least one thousand patients. Furthermore, they must permit provisions for additional accommodations "without undue cost, from time to time."

Although Torrance was intended to serve as a relief valve for the system's overcrowding, it soon reached and exceeded its capacity. By the early 1940s it had a population of 2,551 patients against a rated capacity of 1,670. Moreover, it was estimated that to properly accommodate the mentally ill out of the million and a half citizens of the eleven counties the hospital served, it would be necessary to construct additional facilities to handle another 800 patients. This would entail capital expenditures of \$7.6 million.

And like most of the state hospitals, Torrance struggled with severe employee shortages as well as more patients than it was designed to house. At the low point, in December 1943 (with no more than 40 percent of the staff meeting the minimum standards for the hospital), the Depart-



Mayview State Hospital patients playing softball ca. 1940 as part of their physical therapy program, with the hospital building in the background. Note that the Kirkbridge idea of adjoining, but offset, ward buildings is still visible in this 1940s view of the hospital.

ment of Welfare ordered the hospital to cease admissions. The needs of the service area were so urgent, however, that it was impossible to comply with the order.

The Department of Welfare

The Department of Welfare was born in the most raucous legislative session ever held in the Pennsylvania House of Representatives. For six months, commencing in late 1920, administration supporters and an anti-Sproul faction within Governor William C. Sproul's own party had wrangled over legislative initiatives.

Once again on the night of April 25, 1921, the pro-Sproul forces found themselves blocked by an all-night filibuster. Thoroughly frustrated, they waited until House Speaker Robert S. Spangler adjourned the session at 12:10. At that point, in the words of one reporter, they "kidnapped the organization of the House of Representatives and rescued the Governor's legislative program."

Following the departure of Spangler and many members of the anti-Sproul faction, the governor's friends locked the doors to the chamber, elected a speaker pro tem and began passing Sproul's program. According to the Harrisburg *Patriot*, "One by one, the welfare department bill, the second class city, a non-partisan ballot repealer, and other measures were brought out of committee, where the opposition thought they were buried, and [were] passed. Any member who objected to the proceedings was 'howled down.'"

As bills had to be "read" in two separate sessions before being voted on, the speaker pro tem adjourned for one minute at 12:54, then called the members into session again, appointed a chaplain pro-tem to offer a short prayer, and presented each of the bills for a second consideration. By the time several senators—attempting to find out what had happened during the earlier House session—had broken the locks and stormed into the chamber, the

governor's legislative program had been passed.

Although the newspapers around the state reported the activities on page one, they did not seem too concerned over the mischief—the "rump" session, as the *Philadelphia Inquirer* called it—in Harrisburg. Either they supported the governor's program, or else saw the situation in the legislature as business as usual.

The fight over the creation of the Department of Welfare was brought on, in part, out of concern over the "power" it would invest in the department's secretary. One member of the House charged that "The Czar of Russia and the Emperor of Germany never had greater power" than the bill would confer on the head of the proposed department.

The fear, of course, was for the patronage—not legislative or administrative—power that would come with the new department. In the days before civil service, Pennsylvania's executive departments were filled with the faithful of the party of the governor in office. The governor dispensed department head positions to important party supporters who had helped get him elected, and then the department heads dispensed hundreds of lower-level jobs to party friends around the state.

Every time the governor's mansion changed party hands, virtually all of the bureaucrats in the executive branch were replaced. The proposed Department of Public Welfare was seen as the biggest patronage plum the legislature had ever created.

The act itself—which Governor Sproul signed on May 25, 1921—made few changes in the administration of the state hospitals or the management of the state's mentally ill. It abolished the Board of Public Charities, the Lunacy Committee, and the state Prison Labor Commission and combined their powers and responsibilities in the new department.

All issues including the rules for commitment, transfer, or release of patients remained as before. Moreover, the licensing of facilities, the preparation of standard forms to be used, and the need for inspections of all houses holding the mentally ill stayed in force and were vested in the Department of Welfare.

The new agency had gargantuan responsibilities. They included, in addition to mental hospitals, all "county, city, borough, township, or poor district" prisons, hospitals and "houses which conducted the business of receiving, boarding, or keeping infant children."

Over the years the issue of the department's size disappeared. In 1957 the General Assembly combined the departments of Welfare and Public Assistance in an even larger unit, the Department of Public Welfare.

Wernersville and Act 272

In his *A History of Psychiatry*, Edward Shorter states that a "major component in the press of bodies" into the nineteenth-century asylum was a "genuine increase in the rate of mental illness." And he goes on to assert that the psychiatric illness that "most demonstrably increased" was neurosyphilis. Shorter contends that the "syphilitic infiltration of the central nervous system is of capital importance in the history of psychiatry"—far more than all the "social constructions" that have been claimed for the rise in mental illness during the asylum period.

Syphilis—sometimes called in the 1900s the "disease of the century"—was first detected in Europe in the late eighteenth century, but soon grew to epidemic proportions that swept first Europe and then America.

"Of all the infections which attack man," wrote Arthur P. Noyes of Norristown State Hospital in his *Textbook of Psychiatry*, "syphilis produces the most devastating effect upon his mental life

when the microorganism which causes this disease invades the brain." Somewhere between ten and fifteen years following infection, a chronic inflammation of the lining of the brain, the meninges, begins. The nearly inevitable terminal stage, especially in males, is paresis or paralysis. Among the early symptoms are jumbled speech, an irregular gait, delusions of grandeur, and loss of rational behavior—borrowing and spending, for example, large sums of money. During the final stage, "progressive paralysis" as it is sometimes called; the patient dwindles into complete mental and physical decay. The limbs, especially the lower ones, often become paralyzed, the patient is unable to raise their eyelids, and the mind borders on idiocy.

From the very earliest, the annual reports at Pennsylvania asylums included "syphilis" as a cause of admittance for a few patients. But others who in much greater numbers were recorded as having died of paresis after spending time in the hospitals undoubtedly were also victims of the disease. By the end of the nineteenth century it had become one of the major problems at state asylums, although the disease was almost never mentioned in the texts of the reports.

In 1898, for example, the statistics in Harrisburg Superintendent Henry Orth's annual report show that eleven of his twenty-eight decedents (39.3 percent) died of paresis that year. And that twenty-two (4.7 percent) of the male patients remaining in the hospital were suffering from the disease. A decade later the deaths from paresis at Harrisburg had risen to 48 percent, and of the males remaining, paresis was recorded as the form of insanity for 15.8 percent.

The epidemic in Pennsylvania became serious enough that in 1921 the legislature decided it was a major public health issue. On May 16 that year—over the strenuous objections of the Wernersville superintendent and the hospital board—

the legislature passed Act 272. This amendment to the original one establishing the hospital for the “chronic insane,” provided for the reception, detention, care and treatment at Wernersville, of persons suffering with syphilis.

The act directed that “Any person afflicted with syphilis who is an inmate of any State Hospital for the Insane or any almshouse or poorhouse,” was, at the direction of the Board of Public Charities, to be committed to Wernersville. Moreover, the commissioner of Health or any health officer in any community was also authorized to send any person who was suffering with syphilis to Wernersville.

The treatment of all individuals committed to Wernersville under the act was under the “control and supervision” of the Commissioner of Health. At the same time the act specified that the hospital superintendent had responsibility for the supervision and the care of these individuals “except with regard to the supervision over their medical treatment and discharge.” The Commissioner of Health was the only one who could discharge one of these quarantined patients. His certificate, moreover, had to specify that the person was either “cured” or is “no longer a menace to the health of the community.”

By October 1922, 150 patients, all women, had been transferred to Wernersville from other institutions. Eventually the number being treated for syphilis rose to 1,129, of which 375 were females—most probably prostitutes swept off the streets and out of the jails of eastern Pennsylvania communities.

Although other such programs would follow, this was probably the first instance of the Commonwealth using its state hospitals in an attempt to solve a major health problem, rather than merely treating those with some form of mental illness.

The First Pennsylvania Mental Health Act

In 1923 the General Assembly placed two laws affecting mental health on the books. The first of these, in June, adopted the state’s first Administrative Code. It reorganized the structure of state government and specified the basic powers and duties of the executive departments, boards, and commissions.

The code modified the character of institutional boards of trustees including those at state hospitals, changing them from independent public corporations responsible for making decisions concerning the management of the hospitals, including hiring and firing, to administrative bodies within the Department of Welfare. Although their powers were somewhat curtailed by the 1923 act, it was not until 1955 that they were stripped of all authority by a change of their responsibilities to strictly “advisory.”

Then in July 1923 the General Assembly passed the state’s first Mental Health Act. It consisted of a codification and update of all mental health statutes enacted since the 1845 act establishing the first state hospital at Harrisburg. This effort had been accomplished by a commission appointed in 1919. The new law applied to all mental health facilities, public and voluntary.

The act established uniform hospital admission, commitment, transfer, and discharge procedures. It also made provisions for handling of those convicted of crimes, spelled out the rights of patients, and assigned responsibilities for the cost of caring for the mentally ill. The act also changed Wernersville State Hospital’s role from its original one of handling only the chronic ill to that of the other state hospitals.

Perhaps the most striking aspect of the new law, however, was its establishment of standard terminology and defini-

tions. Words like *asylum*, *insane*, and *lunatic* were eliminated in its language. Mental illness, mental disease, mental disorder, mental patient, and mental hospital took their place. By this time, too, the names of each of the asylums had been changed officially to that of "state hospital."

Western State Psychiatric Hospital

On June 23, 1931, Governor Gifford Pinchot signed the General Assembly's bill to accept a gift from the University of Pittsburgh of a "suitable site for a Western State Psychiatric Hospital on the campus of or in the neighborhood of the University of Pittsburgh."

Act 324 directed the Department of Property and Supplies to conduct preliminary surveys, develop plans and provide estimates for the construction of the hospital, which when completed would be turned over to the Department of Welfare.

The hospital was unique. It would not only provide treatment for psychiatric patients, but also would conduct research into mental health issues and provide training of medical and other personnel in "mental diseases, mental defects and their complications."

The Western State Psychiatric Hospital (now known as the Western Psychiatric Institute and Clinic) opened in 1942. With the University of Pittsburgh Medical School, the institute provides clinical instruction in psychiatry and graduate work in psychiatric nursing and administration.

Among the objectives of the institute was the development of a strong program of psychiatric education in all its phases, as well as an aggressive program of psychiatric research. To meet these objectives, the clinical director initially selected patients individually from other hospitals around the state. In this way it was possible to ensure that a representative mix of the desired types of mental illness was achieved.

By 1955 undergraduate teaching to medical students was taking part of the time of all twenty-one full-time staff members. Clinical facilities for teaching the students consisted of 150 beds. Integration between the psychiatric and the other departments in the medical school was achieved by rotation of residents, a sharing program, mutual research, and consultation.

In 1979 the legislature directed that the institute be leased back to the university under an arrangement whereby the state would continue to make regular appropriations for its operation.

At the start of the twenty-first century the University of Pittsburgh's health operations comprise an internationally renowned academic medical center providing full care services; a network of teaching hospitals offering the latest tools for diagnosing and treating a wide variety of illnesses; and a research center involved in extensive studies of both the mind and the body. The activities conducted in the research center include trials in gene therapy; the development of revolutionary new artificial hearts, lungs and kidneys; and the use of new brain-imaging methods to watch the mind in action, providing a window into how healthy brains work and leading, it is hoped, to the discovery of new clues as to how behavioral afflictions can be treated.

Shock Therapy

From the time of Benjamin Rush until the twentieth century, therapy for the mentally ill consisted almost exclusively in efforts to calm the excited and stimulate the depressed. Hydrotherapy was among the earliest therapeutic techniques applied to mental patients in American asylums. It has a history, however, dating back to the Greeks.

Many of the early techniques were crude. The *douche*—a bucket of cold water



Mental patients at the Pittsburgh City Home and Hospital—later Mayview State Hospital—undergoing a water pack treatment ca.1927. Nurses had to wrap the patient carefully in layers of ice-cold wet sheets and blankets, mummy fashion.

in the face—or the “bath of surprise”—dropping a patient through a trap door into an icy bath—was designed to shock the poor unfortunate into his senses.

By the early twentieth century, however, physicians had developed more subtle applications of the various hydrotherapies. A variety of baths, douches, sprays, and wet packs had come into vogue as means of ministering to the mentally ill. These seldom had real curative value, but did provide some efficacy as a sedative or stimulating agent with temporary benefits.

There were “rain” and fully submerged baths, and fan, vapor, and Scotch douches, as well as jet sprays. These were primarily used to calm the agitated, but also to “massage” those who were in need of stimulation. The wrapping of patients in wet packs or wet sheets was principally used, however, to restrain the excited. Wrapped securely around the patient, the wet sheet or pack would shrink as it dried and further restrict the patient. Abuses of this technique were reported at times in some Pennsylvania state hospitals.

Then in the early decades of the twentieth century the first therapies that

changed a patient’s physiological state began to appear. The three most prominently used in Pennsylvania state hospitals were insulin-coma, metrazol-convulsion, and then later electroshock. All three procedures were developed in Europe but were quickly adopted by American hospitals.

In 1933 a Viennese physician, Manfred Sakel, accidentally induced a deep coma in a patient by injecting a high dose of insulin. After he recovered from the coma, the patient, who was psychotic as well as a drug addict, appeared to improve. Sakel began experimenting on animals with insulin. Soon favorable results from this insulin-coma procedure began to be reported. By 1936 it was being widely used throughout the United States.

The procedure is a complicated and lengthy one. The coma is induced by giving increasingly larger doses of insulin on successive days until the desired depth of unconsciousness is achieved. The depth and duration of the coma is varied based on the experience and practice of the individual therapist, although the textbook average was given at about fifty hours. The patient does require close nursing

supervision for an extended period during treatment.

About the same time, a young Hungarian, Ladislav von Meduna, had begun examining the brains of former epileptic and schizophrenic patients and concluded that there was a mutual antagonism between epilepsy and schizophrenia. This led him to the idea that if he induced convulsions in schizophrenics similar to those in epileptics, it might lead to a cure. To achieve the desired convulsion, he began injecting first camphor and then metrazol into his patients. Meduna claimed recovery in ten of his patients, good results in three and no change in thirteen. Interest in the method spread quickly.

Meduna's method of inducing convulsions was soon overtaken, however, by the invention of electroconvulsive therapy, or ECT, by two Italian doctors, Lucio Bini and Ugo Cerletti. Their work, which was first reported in 1938, was introduced in the United States two years later. Its use spread rapidly as it was much more convenient to administer than either insulin or metrazol.

An electroconvulsive treatment could be administered in a matter of minutes. The patient was simply stretched out on a table, his or her arms and legs held to prevent injury when the convulsion occurred, and the two electrodes applied to each temple. After approximately five minutes of unconsciousness, the patient rouses gradually over the next ten minutes.

ECT was introduced at Pennsylvania state hospitals in 1941. At Harrisburg State Hospital this was done first in a research mode. Five hundred sixty-six patients were selected for treatment without regard to their disorder. Of that number, Superintendent Howard Petry, reported that about half showed enough improvement that they could be returned to their homes. By the end of the decade about six hundred of Petry's patients were receiving an average of seventeen electroconvulsive treatments each year.

It soon became the treatment of choice everywhere. At Philadelphia, for example, nine thousand electroconvulsive treatments were logged in a two-year period in a single ward building.

In the 1958 edition of his *Modern Clinical Psychiatry*, Arthur Noyes wrote: "In the depressions of involuntional melancholia and of manic-depressive psychosis the improvement following electroconvulsive shock therapy is striking. In 80 percent or more of these disorders five to ten treatments are followed by full or social recovery. Prior to the treatment . . . protracted depression, sometimes lasting for years, was the rule."

There is—especially over time—an apparent eroding of brain capability. With each electroshock treatment a patient loses some memory. While this is seldom permanent or significant following a single series, a patient who must return for several treatments because of relapses, can appear eventually to lose a noticeable amount of memory. (Latest studies, however, fail to show any permanent cellular impairment.) Still this seems to be preferable to having a schizophrenic fall into a permanent delusional state.

Although it found favor in some schools of psychiatric thought, lobotomies—the severing of selected nerves in the brain—were only performed occasionally in Pennsylvania hospitals. Most facilities either found the procedure objectionable or too risky to perform without experienced surgeons interested in doing such operations. Lobotomies were performed, however, at Philadelphia with some frequency. In the two-year period between 1950 and 1952, twenty-five patients were lobotomized in one building alone. Of these five patients were reported as "much improved," ten "slightly improved," and ten as "unchanged."

Wilbur M. Lutz, the clinical director at Wernersville also performed large numbers of a modified version of the lobotomy—the transorbital leucotomy—during

the late 1940s. In a transorbital leucotomy only a few of the frontal nerves were severed. Lutz claimed that his patients were ambulatory within a matter of hours, required little or no nursing care, and that “the operation produced none of the undesirable personality traits or intellectual deficits” of a traditional lobotomy.

With the advent of the psychotropic drugs, use of ECT and the other shock treatments declined. Electroconvulsive treatments are still employed, however, for those patients who do not show improvement from any of the available drug therapies.

“Full State Care”

Byberry and the “Full State Care” Act of 1938

Byberry, named for the Philadelphia neighborhood in which it resided, stood on a 1,100-acre site near the northeastern boundary of the city. The facility began as the city’s poor farm in the mid-nineteenth century, and became a mental hospital in 1906. Its location was chosen as the remotest possible spot from center city. Byberry became perhaps the most notorious of the poor farms in Pennsylvania and certainly the most infamous of the state’s mental hospitals.

The state took control of Byberry in 1938, when—as part of its “Full State Care Act” of September 29—the legislature assumed responsibility for eight of the thirteen existing county public mental hospitals and closed the rest. The state took over all properties, equipment, and patients for which the counties and cities had been responsible. By this act counties, cities, or institution districts were prohibited from operating a facility for the care of mental patients, although general hospitals were authorized to provide temporary inpatient psychiatric services.

In what was yet another swing in the pendulum of state versus local mental health care, Act 21 opened by declaring, “Experience has proven that the care and maintenance of indigent mentally ill persons, mental defectives and epileptics should be centralized in the State Government in order to insure their proper and uniform care, maintenance, custody, safety and welfare.” Moreover the act asserted, “Complete care for such persons in institutions operated exclusively by the State Government will effect great economies for municipal subdivisions.”

The “Full State Care” Act of 1938 was the result of an extraordinary session of the General Assembly that Governor

George H. Earle convened in July of that year. “Care for the mentally ill and feeble-minded” was one of the subjects of this special session. As a result of the legislation, Blakely, Lancaster, Mercer, Ransom, and Schuylkill County mental hospitals were closed. Clarks Summit, Embreeville, Hollidaysburg, Mayview, Retreat, Somerset, Woodville, and Philadelphia’s Byberry became state hospitals.

The township of Byberry dated to the time of William Penn. The original settlers in 1675 were Quakers. They would have been distressed greatly to know that the beautiful, level lands that so pleased them in 1675, with their abundance of good water, would become known as the site of such notoriety two hundred and fifty years later. And in an even greater irony Byberry was the site of Benjamin Rush’s birth in 1746.

The place was named Byberry in honor of the settler’s native town, near Bristol, England. In Old English *By* meant to build up. *Berry* meant town. As a compound it signifies a habitation or castle on a hill. At the Byberry in England, Henry VIII erected a royal palace and lived there during a portion of his time, giving rise to the belief that that was the source of the name, one that is unique in England.

The state spent \$8 million in the first few years after the takeover at Philadelphia on construction and renovation, in addition to the facility’s annual operating cost of more than \$2 million. As a 1947 report to Governor Edward M. Martin stated, “this, however, has accomplished nothing but the most acutely necessary repair, replacement, and expansion.” The institution reported it was short of its personnel quota by 14 physicians, 47 nurses, and 299 attendants. Without adequate staff, restraint became a “necessary safeguard.” In the month of May 1946 alone 49,609 hours of “restraint” were logged in the male division.

Mayview and Retreat

The state had little alternative following the enactment of the Full State Care Act in 1938 other than to take over Philadelphia because of its sheer size. Among the remaining institutions the Department of Welfare considered for incorporation into the system, Mayview and Retreat were representative of the two classes of facilities (other than the state hospitals) in existence at that time for treating the mentally ill. Mayview, near Pittsburgh, was a community-based almshouse and mental hospital of long standing; Retreat, along the Susquehanna River in the north central part of the state, which was dedicated exclusively to serving the mentally ill of Luzerne County, was of much more recent origin.

By 1938, the Department of Welfare apparently had come to believe that enough of the problems had been corrected that C. Floyd Haviland had uncovered in 1914 at Mayview—then known as Marshalsea—making the facility an appropriate takeover candidate.

Mayview's long history began in 1804. The Overseers of the Poor in Pittsburgh had maintained an almshouse in the city commencing in that year. In 1852 the Overseers relocated it out of the city to a new site at Homestead along a picturesque bend in the Monongahela River. The overseers built a large brick home on elevated ground with an immense front lawn—embellished with trees, shrubbery and walks—that sloped down to the river. By 1870 the records of the facility, which could accommodate three hundred individuals, showed there were sixty mental inmates. They were all the mild-mannered or chronic insane, the more excited or difficult cases being sent to Dixmont. By 1888 the census of insane at Homestead

was 164, while an additional 96 patients were maintained at Dixmont.

By 1890, however, the Carnegie Steel Company's plant facilities were beginning to encroach on the property, so the city once again moved its poorhouse to a tract in Upper St. Clair Township in Allegheny County. The railroad station erected to



Patient picnic at Retreat State Hospital, July 28, 1964.

serve the almshouse was named Marshalsea after the debtors' prison where Dorritt of Charles Dickens's novel *Little Dorritt* lived with her pauper father. The name, which carried connotations of derision and disgrace, was finally changed in 1916 to Mayview.

As C. Floyd Haviland discovered during his 1914 survey, the city made no effort to provide other than custodial service for its mentally ill at Marshalsea. Finally in 1923—with the appointment the previous year of Mrs. Enoch Rauh as head of Pittsburgh's Department of Charities—Mayview began to treat its mentally ill for other than their physical illnesses.

Under Rauh's guidance occupational therapy, social service, and physical thera-



1930s Mayview physical therapy program, cleaning vegetables from the garden.

py units were established within the Mental Department of the hospital. By 1930, Mayview was employing various hydrotherapy techniques; in 1933 insulin shock therapy was introduced; and early in the 1940s hospital physicians began administering electroshock and metrazol convulsive treatments.

In contrast to Mayview, Retreat was established in 1898 as an outgrowth of the problems of overcrowding in the state hospitals that had led to the "Dual Care Act" of May 1897. Previously, mental patients from Luzerne County had been committed to Danville State Hospital, which by 1893 was so crowded that the trustees of the institution passed a resolution to stop taking patients.

Following passage of the Dual Care Act, the Luzerne County Poor District began to build its own hospital on a 146-acre site along the Susquehanna River. Provision was made for four hundred acute mentally ill patients, the first of which arrived in June

1900 from Danville. By the following year, three hundred patients were being cared for. In addition to the patient building, which like a Kirkbride asylum contained separate wings for men and women, the site also housed a kitchen, bakery, laundry, and boiler building. By 1906 additional structures had been erected including an infirmary building—all connected by covered corridors—thereby

adding two hundred beds to the facility's capacity.

Both Mayview and Retreat had, however, unique features of note. Standing apart from the other buildings at Mayview was the nursery. There were about ten births a year at the hospital. Until 1940, unwed mothers were brought from Pittsburgh to Mayview. In the baptismal registry at St. Agatha's in nearby Bridgeville the mothers of the hospital's newborns were listed as *Mater Amentes* (mentally ill) or *Illegitimus*. Other children in the nursery were there as the result of having been deserted or abused. The children were cared for by a live-in attendant and an assistant. According to an unpublished history of Mayview by Father George T. De Ville, the children all romped in one central playroom during the day.

Retreat State Hospital, on the other hand, was noted for its inaccessibility. The hospital property is located on the east bank of the Susquehanna south of Wilkes-Barre in the shadow of a steep mountain. U.S. Route 11 lies across the river on the west bank. From the time of its opening until 1951—when the state finally built a



1930s Mayview physical therapy program, broom making.

bridge across the Susquehanna—Retreat could only be reached by a flat-bottomed ferry. The ferry was often inoperative due to river conditions, sometimes for periods as long as three or four weeks. Floods, low water, or winter ice isolated the institution.

If Retreat was separated on occasion from the outside, Mayview had no similar concerns. It not only had the usual farm, garden, greenhouse, and electric power plant, it also had its own mine from which the coal to run the plant was taken.

The State Hospital System at its Peak

By 1947, when Secretary of Welfare Sophia M. R. O'Hara, made a report to Governor Martin, the system of state hospitals had reached maturity. As O'Hara reported, however, many of the twenty-one facilities were aging and most had problems of low budgets, overcrowding, lack of staff, poor care, and sometimes ineffective management.

According to O'Hara, she had prepared the report "to lift the curtain of popular misconception which unfortunately long has existed with regard to mental institutions." In what was probably directed more at the legislature than the governor, the secretary outlined a "ten-year program of education, training, research and construction" she hoped to embark on what would provide "new and expanded institutions of modern hospital design," all to be "supported by your informed and intelligent aid."

The report included pictures of dilapidated showers at Dixmont, "cuffs" on the beds in lieu of nurses at Philadelphia, modernized but crowded conditions at Harrisburg, patients in seclusion or seated side-by-side on rows of benches (waiting Godot-like) in a day room at Retreat, peeling paint and cracked plaster in the patient sleeping quarters at Somerset, a woman wearing the "camisole" and long



1930s Mayview Physical Therapy Program.
Chair caning and matmaking.

lines of patients queued up for dinner or naked to take a shower at Wernersville, outmoded plumbing and run-down cells for seclusion at Norristown, and congested dining, jammed shop, and crowded sleeping areas at Hollidaysburg.

Although O'Hara's report included pictures of modern facilities and patients engaged in meaningful activities, it also depicted ones showing extreme overcrowding, large groups of listless patients, lack of professional attention, and ones of outmoded, deteriorating, unhealthy, understaffed facilities. As the caption for a photograph of men lying on the floor and leaning against the wall of a hallway at Norristown stated, it also often portrayed "studies in futility."

In 1947 the annual operating cost for the state hospital system was \$18.4 million. This represented a Spartan per capita cost of \$424 a year for the state to house, feed and clothe each of its patients. (See Appendix B for details)

The Philadelphia Mental Health Survey Report

In June 1952 the committee that Governor Fine had appointed to "make a complete study of the mental health needs of the Philadelphia area" made its report. Leonard T. Beale, chairman of the committee, opened the report by telling the governor: "Your Committee finds that the situation in the Philadelphia area is one of the most serious and potentially explosive public health emergencies in its modern history."

The report stated that Philadelphia State Hospital with a bed capacity of 4,709 had a resident population of 6,300, and was "restricting admissions to five male and five female cases per week." The committee reported that the situation at Philadelphia State Hospital is "in no way unique." It asserted: "All the state hospital facilities in the Philadelphia area are tragically overcrowded and in some wards to a degree which is little short of revolting."

After claiming that the deficiency in both the quantity and quality of personnel was due to "inadequate wages and housing facilities, the report maintained that this "tended to limit facilities for treatment with consequent longer residence of the patients, a lowered percentage of cure and further refusal of admission to other ill patients." Moreover, it asserted the "conditions described have handicapped research which is the principal means by which the growing magnitude of the problem of mental illness can be checked and the increasing expense of institutional care ultimately lessened."

The committee made recommendations for both the short term and the future. Among those for immediate implementation, it suggested that patients be moved from Philadelphia to Embreeville State Hospital, which apparently had some excess capacity. It also suggested giving urgency to the already planned building construction at both facilities—a

two-thousand-bed hospital at Embreeville and two three-hundred-bed buildings at Philadelphia, one for medical and surgical patients and the other to be used for the reception of new patients.

For the long term, the report recommended the augmentation of staff "at all levels" as well as increases in pay for "qualified physicians, psychologists, social workers and attendants," and the construction of geriatric units at both Philadelphia and Embreeville. Most striking of the future recommendations, however, was one to build a new hospital in Delaware County with an initial capacity of two thousand beds.

"Crazy" Harry

One of the more effective, and certainly the most flamboyant, of the secretaries of welfare was Harry Shapiro, a Philadelphia lawyer and former member of the Pennsylvania Senate. In recognition of his exploits, the members of the Capitol Press Corps called the wildest poker game they played "Crazy Harry." Shapiro, along with Governor George M. Leader who had appointed him secretary in January 1955, were appalled at the conditions in many of the state hospitals and were determined to take action to correct them.

Shapiro was especially knowledgeable. He was credited with having authored much of the state's mental health care legislation in the 1930s and 1940s while he was in the Senate, including having spearheaded the fight for centralized control in 1938. Shapiro also had served as chairman of the Senate committee that looked into the problems at Philadelphia State Hospital (Byberry). Once in this position—on being refused entry to inspect the facility—he climbed over the fence at night to see the situation firsthand.

Although Shapiro had initially been a Republican, he had some basic disagreements with his party, and so one day he

simply stood up in the Senate chamber and moved over to the Democratic side. He then was elected for two more terms as a Democrat.

At first the new secretary of welfare attempted to clean up things by sending inspection teams to the worst of the hospitals to make recommendations for improving their management. Shapiro started with hospitals known to have some of the more intractable problems, those at Allentown and Philadelphia. By December 1955, when progress by this method had proved to be too slow, he and Governor Leader pushed through the House a bill that not only placed mental health personnel under the merit system but also transferred the administrative powers of the individual state hospital boards of trustees to the Department of Welfare. They were divested of most of their responsibilities and became largely advisory bodies for the superintendents.

The changes that Harry Shapiro implemented as secretary of welfare were administrative rather than medical; however, any intrusion into the running of the hospitals tended to be seen by the superintendents and the trustees as interference in decisions over the care of the mentally ill by a nonmedical individual. Shapiro's "political" behavior especially annoyed them. Each time he arrived at a facility it was with a large retinue of department employees as well as with a personal photographer. Picture taking always seemed to be a significant part of his travels. Although he was attempting to force change by raising the public's awareness of problems through publicity, within the hospitals he was seen as using the visits as an opportunity for personal news making.

In May 1958, Shapiro ordered that all nonessential hospital employees living on hospital property in state-owned buildings be moved out into the community. The secretary claimed it was inappropriate for

them to be living in state quarters while there was a shortage of space for patients. Although some superintendents interpreted the order as giving them the discretion to retain their medical staff on the hospital grounds in a permanent "on call" status, the secretary made it clear he wanted them out too. When some superintendents balked, Shapiro simply held up the paychecks of all those who had not left. They soon departed.

The Department of Welfare was now fully "in charge." The state hospital superintendents had become employees of the department, and the trustees, whose jobs were no longer political plums, were reduced to an advisory role.

American Psychiatric Association Study of 1955

No sooner had Governor George M. Leader appointed Harry Shapiro secretary of the Department of Welfare in 1955 than Shapiro hired the American Psychiatric Association (APA) to study the state's mental health program.

The focus of the APA investigation, which was completed in 1956, was more on the side of the professional than the human dimension. Unlike the surveys of Dorothea Dix in 1845 and Arthur Haviland in 1914, it was not an exposé of neglect and abuse. There was no mention, for example, of the severe problems that Albert Deutsch found at Philadelphia in 1948 (see the "Closing of Byberry"), although they most certainly still existed at the time the survey team visited.

Instead the 1956 APA report portrayed problems in terms of needed or improved facilities, staff, and programs—all of the discussions of which were directed toward an "ideal program" for Pennsylvania. One of its important sections, for example, was devoted to "New Ideas." Among those the study concluded would be helpful were branch hospitals, half-way houses, sheltered workshops,

therapeutic farms, community mental health centers, and the establishment of psychiatric units in general hospitals. These suggestions were directed, of course, toward reducing the overcrowding in state hospitals as well as improving patient care.

In some respects, the study was even laudatory in tone. It recounted the "unprecedented interest" in mental health that the survey team found throughout the state, especially in citizens groups. It described the General Assembly's legislation and appropriations as "forward-looking" and of "record proportions." And it called Harry Shapiro an "extraordinarily dynamic" secretary who has "exhibited a determination to fight without let up."

It acknowledged, however—after describing biennium appropriations for operating expenses as having risen from \$30 million in 1943 to \$110 million in 1953 and then to \$193 million in 1955 (of which \$140 million was earmarked for mental health), and of \$42 million allocated in 1955 for new construction at mental hospitals and schools—that "except for scattered improvements in service, the same amount of overcrowding and shortages still occur."

Much of the lack of improvements in service was attributed to the low per capita expenditures in Pennsylvania in comparison to other states. While Michigan was spending \$4.08 per patient and New York \$3.38, the Commonwealth was spending \$3.02. There was also considerable variation between the state's hospitals. The per capita at Hollidaysburg was \$4.15, while that at Philadelphia was \$2.73, the lowest in the state.

At the same time the demands on the state's mental hospital infrastructure was "running far ahead of the facilities provided." Virtually all of Pennsylvania's hospitals were cited as being "especially short of day space for activity therapies." Frequently occupational therapy shops had been set up in basement areas con-

verted from storage rooms, or in other available space. These makeshift arrangements were too small to serve more than a handful of patients at a time.

In its building section, the report recommended the construction of new admissions buildings, geriatric units, and recreational centers at all hospitals and stated that the building situation was especially bad at Allentown, Farview, Harrisburg and Philadelphia.

At Harrisburg beds were needed for 930 patients; at Embreeville there were leaking roofs as well as one building that was a fire hazard and needed to be razed, and although Philadelphia had the greatest shortage in number of beds, Farview came in for even greater condemnation because of its "severe overcrowding."

Of the fourteen hospitals rated as overcrowded, Farview was calculated as 62.5 percent, while Danville—with the lowest rating—stood at 11.5 percent. Percentages, of course, are somewhat deceptive. Philadelphia was appraised at 57.1 percent, not too far behind Farview's rating, but in terms of real numbers this represented a shortage of nearly 2,400 beds for its total population of 6,567 patients.

There were also major shortages of staff. Among psychiatrists, only five of the seventeen state hospitals had half of their quota, while twelve hospitals had a deficit of over 60 percent, and five were "so inadequately staffed that little more than custodial care can be expected." The thirty-eight psychologists in the state system also represented a deficit of 62 percent of those the APA recommended as required for an adequate program.

According to the report, the reasons for the shortages lay in the "isolation of several of the institutions," the "connection between the care of mental patients and the indigent," "inadequate financing," and the "operation of the spoils [patronage] system." From an historical perspective, however, the study attributed the

long-term cause to the “lack of scientific treatment techniques” having “placed the whole program in a condition of essential hopelessness, which attracted few people.”

Although the several hundred pages of the report had a positive ring throughout, those four words—condition of essential hopelessness—seemed to carry a weight out of all proportion to their number and position in the middle of the analysis, to expose a system with serious difficulties, one that, for all the report’s hopeful stance, appeared to offer little real hope.

Citizens Mental Health Groups

A significant element in the press to conduct the 1955 American Psychiatric Association study came from citizen groups around the state, especially from Harry Shapiro’s fellow Philadelphians.

Prominent among these organizations was the Pennsylvania Citizens Association (PCA), a 1950 outgrowth of the Pennsylvania Charities Association, which had been organized at Wilkes Barre in 1912. According to Max Silverstein (*Vital Connections: Integrated Care for the Seriously Mentally Ill*), the Pennsylvania Citizens Association’s mental health committee took on a corporate identity in 1952 as Pennsylvania Mental Health, Inc. (PMH), and then associated itself with the National Association for Mental Health. Financial support for the fledgling organization continued to come from PCA as well as the Philadelphia United Fund, the Pittsburgh United Fund, and other community groups around the state.

Just as earlier the Pennsylvania Charities Association had played a major role in the legislative campaigns that led in 1921 to creation of the Department of Welfare and in 1949 of the General State Authority (which initiated a \$65 million building program for the “treatment and safe keeping of the wards of the state”), so, too, Pennsylvania Mental Health, Inc. pro-

vided strong, capable support for the American Psychiatric Association’s 1955 study.

The organization’s members designed and then conducted a statewide inventory of Pennsylvania mental hospital services, both their strengths and weaknesses. Members across the state visited their local state hospital and, using a standard questionnaire, gathered the information needed to shape the APA survey. In summarizing their findings they reported on buildings as firetraps, patients sleeping on the floor for lack of beds, and personnel ratios at less than half the minimum standards prescribed by the APA.

With the initiatives of the APA study and presentations by the various citizens organizations before the legislature, the General Assembly increased funding for mental health, approved a new state hospital building in Delaware County to relieve overcrowding, and—although not the separate cabinet-level position desired—did approve establishment of a mental health chief as a deputy secretary within the Department of Welfare.

The promising start in 1956 following the release of the APA study was soon succeeded in the 1957 legislative session, however, with deep cuts in funds for mental health. As Silverstein puts it, from then on “a constant battle took place between Pennsylvania Mental Health and the political leadership of the Commonwealth” until 1963 when, under the impetus of President Kennedy, the U.S. Congress stepped into the mental health picture. During that period, however, the PMH was successful in getting the General Assembly to increase the per-patient expenditure level from \$2.60 in 1952 to \$12 in 1962.

When federal funds for a planning study became available in 1962, PMH, the Pennsylvania Association for Retarded Children, the Pennsylvania Medical Society, the Pennsylvania Psychiatric Society, and members of the health and

welfare councils in the state developed a draft plan for the Office of Mental Health.

The final draft that the Office of Mental Health submitted to the National Institute of Mental Health was accepted immediately and a grant of \$398,600 was provided to the state for development of a comprehensive mental health planning study.

It was this plan, which was completed in December 1965 that led to the 1966 Pennsylvania Mental Health and Mental Retardation Act. At a ceremonial signing of the bill in the "old section" of the Pennsylvania Hospital in Philadelphia, Governor William W. Scranton called the bill, "a triumph for the citizen's mental health movement."

Return to the Community

In the late 1840s and early 1850s Dorothea Dix waged the foremost struggle of her career on behalf of the nation's indigent insane. It was a fight that one biographer calls the "most dramatic battle of her life." Believing that greater strides could be made at the federal level than by pressing the individual states to action, Dix began a years-long campaign to have Congress approve a "land bill."

The federal government was being besieged during that period by speculators, the railroads, development companies, and private adventurers, each hoping to secure free public lands for their individual enterprises, all promising some public good in exchange for the receipt of a "juicy plum" of public land.

Unlike the other claimants, Dorothea Dix had no votes or bribes with which to enlist congressmen to her cause. She persevered, however, until she had persuaded enough senators and representatives to pass a bill that distributed 12.23 million acres of land to the states for the construction of asylums—the cost of the buildings to be financed by the states through the resale of the excess land. In spite of a per-

sonal and generally sympathetic meeting between Dorothea Dix and President Franklin Pierce, he vetoed the bill because he believed it was constitutionally unsound.

It would be another hundred years until the federal government finally entered the mental health field—with the passage of the National Mental Health Act in 1946, and the establishment of the National Institute of Mental Health. The Second World War had created a "success" environment in the nation. If science could split the atom and develop a vaccine for polio, it seemed plausible that other areas such as mental health would benefit from federal involvement and money.

Prior to that time "the framework of mental health policy . . . with an extensive system of public mental hospitals whose foundations had been laid in the early nineteenth century . . . appeared stable," as Gerald Grob writes in *From Asylum to Community*. Although there were disagreements over the details," according to Grob, "there was little disposition to question the concept that the mental hospital was the appropriate location for the care and treatment of the mentally ill."

The time was ripe following the war, however, for a wave of public beneficence in regard to mental health. Advocacy groups in support of a greater governmental role—both within the profession and among the general public—sprang up and began lobbying for greater federal involvement. While before no more than occasional voices were raised questioning the nation's state asylum scheme, following the war the floodgates of criticism, questions, and suggestions, and the condemnation of the one hundred-year-old system were opened wide. President Pierce's doubt over the constitutionality of the U.S. government entering an area traditionally reserved for the states was ignored in the calls for action.

In 1955, at the suggestion of the American Psychiatric Association and the mental health council of the American Medical Association, Congress passed and President Eisenhower signed a Mental Health Study Act. Five years later the study group's report included a proposal to provide a mental health clinic in every community with more than 50,000 individuals. In 1963 President Kennedy took up this idea when he presented a plan for a national program of mental health centers. The president stated: "I believe that the abandonment of the mentally ill . . . to the grim mercy of custodial institutions too often inflicts on them a needless cruelty which this Nation should not endure."

President Kennedy signed the resulting legislation in October 1963. The act provided for community centers that would provide services (i.e., emergency and outpatient care) designed to reduce the number of patients who would otherwise have been admitted to state hospitals.

The act was reauthorized in 1970 and in 1975 the original list of "services" the centers could offer was expanded. No more, however, than a third of the planned centers were actually built.

About the same time that the community mental health center idea was born, the discovery of the effects of tranquilizers on mental patients became known. While previous therapies (metrazol convulsive, electroshock, hypnosis, and insulin shock) had provided only occasional and frequently no more than temporary relief, the new psychotropic drugs seemed to offer dramatic and possibly permanent change. Also, patients who had not previously responded to any of the available treatments now seemed to exhibit remarkable improvement. The drugs, moreover, appeared to benefit large numbers of patients.

With the use of drugs such as thiorazine, and the availability of community centers where patients with relapses could go for short-term stays, state hospital psy-

chiatrists began to empty the "back wards" housing the nation's and the state's chronic mentally ill.

Between 1965 and 1980, the number of patients in Pennsylvania's state hospital dropped from 53,917 to 10,796, an 80 percent reduction. Still the new drugs did not reach everyone. While one third of the remaining patients had been hospitalized under four years, 28 percent had been patients between three and twenty years, and 40 percent had been living in the state system for more than twenty years. Schizophrenia was still the predominant disorder among both chronic patients and new admissions.

While few voices have been raised to suggest a return to the asylum-era system, those in opposition to "deinstitutionalization," as it has come to be called, are many. Arguments abound asserting that the community centers are used primarily by the middle-class, that the indigent who have been returned to the community have ended up on the streets rather than in the care of a center, that without the daily oversight of a hospital staff member, medication is often forgotten, that city jails have once again become defacto mental institutions.

After thirty years, however, the community mental health center idea is still dominating the mental health picture and appears destined to continue doing so for the foreseeable future.

Staff Needs

In October 1962, the Office of Mental Health's Program Research and Statistics group under Robert P. Wray prepared yet another in the long succession of studies and reports dating back to the nineteenth century. This report again cited the lack of adequate staff for Pennsylvania's state hospitals. Using quotas established by the American Psychiatric Association, Wray's staff found that the state system was deficient in every category of employee from

physician and social worker to therapist and laboratory assistant.

There had been an increase of 466 full-time employees in the seventeen hospitals from 1961 to 1962, including an additional twenty-three psychologists and seventeen social workers. However, in no job category had the growth kept pace with the increase in number of patients. Moreover, they had fallen far short of the American Psychiatric Association's standards. Between 1956 and 1962, for example, the number of physicians had increased from 220 to 272, but this was still 121 short of the standard, while during the same period the figure for attendants had increased from 5,584 to 6,352 that was 1,241 short. Wray's report listed a far more striking statistic, however, among registered nurses. Their numbers actually had fallen between 1956 and 1962 from 971 to 885. Moreover, nurses represented the most striking deviation from

the standard. The American Psychiatric Association estimated a total of 2,191 nurses were required to handle Pennsylvania's patient population. This left a whopping shortfall of more than 1,300. (These numbers were still better, however, than Thomas Kirkbride's one attendant or nurse for each eight patients of a hundred years earlier.)

Although by 1962 the number of full-time employees stood at 12,174 for the seventeen hospitals, there was little hope of making up any of the gap between that level and the

American Psychiatric Association's standard. There were only 172 vacant positions across the whole system, and any requests for funds for additional personnel would probably go unfilled.

While the APA continued to set standards, its president, Harry Solomon told the group:

The large mental hospital is antiquated, outmoded, and rapidly becoming obsolete. We can still build them, but we cannot staff them; and, therefore, we cannot make true hospitals of them. After 114 years of effort, . . . rarely has a state hospital an adequate staff, . . . and our standards represent a compromise between what was thought to be adequate and what it was thought had some possibility of being realized.

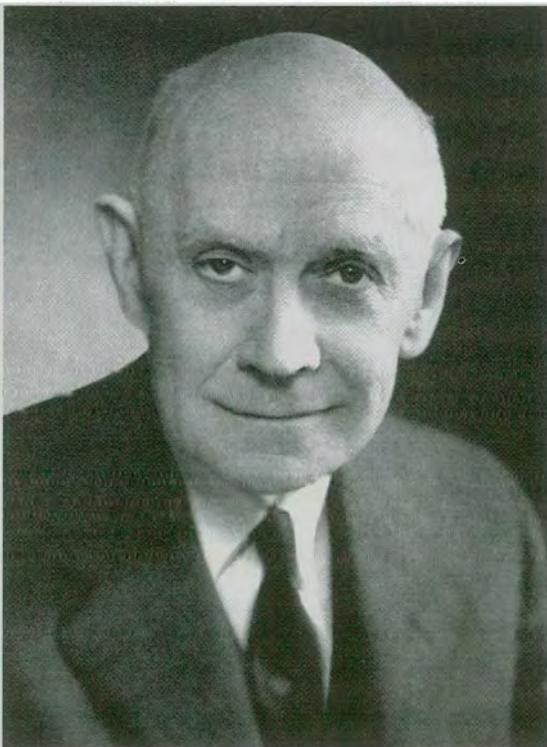
Arthur P. Noyes, "Mr. Psychiatry"

John Curwen was probably the best known of the Pennsylvania state asylum superintendents of the nineteenth century. Like Curwen, the two most prominent twentieth-century psychiatrist-superintendents in the Commonwealth also served as presidents of the American Psychiatric Association.

While Daniel Blain was hired at Philadelphia State Hospital (in the hope he could turn the trouble-ridden facility around), both late in his career and following his presidency of the A.P.A., Arthur P. Noyes had a long as well as distinguished career at Norristown State Hospital before he headed the association.

Following Noyes' death in 1963, Secretary of Welfare Arlin M. Adams called him the "dean of state mental hospital psychiatrists," and described him as a "true champion of clinical research and study in the field of mental health."

Noyes was not only a physician but also a respected author and teacher. During his twenty-seven-year service in Pennsylvania, Noyes contributed generously to medical and scientific publications



Arthur P. Noyes, superintendent of Norristown State Hospital from 1936-1959. Noyes, who served as the fourteenth president of the American Psychiatric Association, was a distinguished writer on mental illness and organized an annual national research conference focusing on the treatment of mental illness.

and was the author of several books, among them a *Textbook of Psychiatry*, a *Textbook of Psychiatric Nursing*, and *Modern Clinical Psychiatry*. The latter book went through at least six printings. It was widely used in the United States and was translated into several foreign languages.

Arthur Noyes was a native of Enfield, New Hampshire. In 1899 he graduated at the head of his class at Kimball Union Academy and entered Dartmouth College on a scholarship. He graduated Phi Beta Kappa three years later. Following medical studies at the University of Pennsylvania, he accepted an internship in City Hospital, Blackwell's Island, New York. After teaching at the University of Chattanooga Medical School, he returned to the University of Pennsylvania for graduate study in psychiatry. Following a stay on the staff at the Boston Psychopathic

Hospital, Noyes accepted appointment as an instructor at the Harvard Medical School, where he became the chief executive officer of the hospital.

In 1936 Noyes became superintendent at Norristown State Hospital following a similar appointment at the Rhode Island State Hospital. He had the honor of having two institutions named for him—the Arthur P. Noyes Neuropsychiatric Institute at New Hampshire State Hospital and the Arthur P. Noyes Research Foundation at Norristown State Hospital.

Although he made substantial contributions in the field of mental health, according to Secretary of Welfare Adams, Noyes's "astute wisdom was tempered by the serenity of his gentle nature." Adams continued, "Beloved by thousands throughout the nation, he will always be 'Mr. Psychiatry' to those in the state system."

Community Mental Health

The Scranton Administration and Mental Health

The 1960s were a time of great civic unrest across the nation. Unleashed in part by protests over the war in Vietnam, the civil rights movement was perhaps the most conspicuous of the public demonstrations of the decade. Although the civil rights movement is primarily associated with the emancipation of the nation's blacks, especially those in the South, it also included numerous initiatives, principally court actions, on behalf of the mentally ill.

Court suit after court suit was undertaken across the state and the nation: for "unconstitutionally confining an appellant after termination of sentence for original conviction"; for transferring a patient from Philadelphia State Hospital to Farview (a maximum security facility) "without notice and a hearing"; for the right to treatment in the "least restrictive alternative setting, including in facilities outside the institution"; for failure "to give proper warnings before an exam;" for failure of a staff psychiatrist at Philadelphia "to inform a patient of Thorazine's possible side effects"; for the "use of electro-convulsive therapy over a patient's objections"; for "summary revocation" of a patients' leave of absence "without notice or right of appeal"; and many other cases all leading to the 1972 Alabama decision in *Wyatt v. Stickney* for the "right to treatment."

The courts were not alone, however, in their activities in support of mental patients. Between 1963 and 1966 the Scranton Administration took several major steps that changed the mental health picture in Pennsylvania.

William W. Scranton was a Republican, but a moderate. According to a biographer, George D. Wolf, Governor Scranton was an ardent advocate of civil rights legislation as well as other liberal

causes. During his administration, Scranton put through the state's first college loan program, several major conservation programs, a 50 percent increase in public school financial support, and established geriatric centers, as well as a system of community colleges.

On a number of occasions, proposals had been made for establishing and then for extending civil service in the state. For example, the need for civil service status for hospital employees had been the first of several recommendations C. Floyd Haviland made in his 1914 report. Although some progress had been made in the intervening years, state government was still largely run by political appointees when George Leader became governor in 1955.

Governor Leader's efforts at expanding the limited civil service coverage then in existence failed in the legislature, as had earlier such efforts. Leader was so determined, however, to "professionalize" his administration that he issued an executive order requiring the heads of all agencies not serviced by the Civil Service Commission to "administer, under the present Commission contract arrangements" the forty-one technical and professional positions in the executive branch his order cited.

Among those jobs named in the Leader executive order were a number of state hospital positions, including mental hospital medical directors, nurses, occupational therapists, pathologists, physical therapists, psychiatric physicians, and psychologists.

Finally eight years later on August 27, 1963, Governor Scranton approved amendments to the Civil Service Act that extended coverage in a single, uniform, modern legislative civil service system to a large portion of the state's workforce, including those previously covered in Governor Leader's executive order.

In addition to such provisions as standardized recruitment and selection meth-

ods, the act prohibited discrimination against any person because of political, religious, or fraternal affiliations, race, national origin, or other non-merit factors. In addition to those in a dozen other agencies the act covered all positions now existing or hereafter created in the Office of Mental Health.

Then following a third "special session" of the legislature that Governor Scranton called in April 1966 to consider establishing in law the recommendations from a planning initiative begun in 1963, Pennsylvania's mental health program was revised in a direct, more visible way. (Special Sessions were required because the Pennsylvania Constitution placed limits on the regular session.) While professionalizing the workforce would, over time, improve the level of care patients received, the enactment by the legislature of a bill authorizing a return to a tiered system of county, city, and state responsibility for mental health care dramatically changed its basic character. Following the lead of the federal government, the legislature established a comprehensive system by which counties or groups of counties could provide or purchase preventive, diagnostic, therapeutic, or rehabilitative services for the mentally ill.

The act provided for the administration of community services according to annual plans as approved by the Department of Public Welfare. The county systems were to be run by county mental health and mental retardation boards. The intent, of course, was to make available



Governor Raymond Shafer at Byberry, October 1967. After assuming control at Philadelphia, Dr. Daniel Blain embarked on a program of inviting legislators and finally the governor to see firsthand the conditions at the hospital. Shafer is being greeted by Dr. Blain and members of the hospital staff on the governor's arrival from Harrisburg.

appropriate services as close to a patient's home as possible.

Act 6 of the 1966 Special Session provided comprehensive coverage of all aspects of mental health care: voluntary and involuntary commitments, the rights of those committed, the control of their funds, habeas corpus proceedings, transfer of patients between facilities, even the use of mechanical restraints.

These, of course, were largely a codification of existing laws or practice. It was the establishment of county mental health and mental retardation programs that was new.

Under Act 6, those counties that wanted to develop—singly or jointly



Inspecting a ward with Dr. Blain and Charlotte S. Kelly, president of the hospital board of trustees. L to R: Dr. Joseph Adlestein, deputy secretary, Office of Mental Health, unidentified, Dr. Thomas George, Secretary of Public Welfare, Governor Shafer, Dr. Blain and Mrs. Kelly.



Governor Shafer talking to a worker in the hospital cafeteria.

with a neighbor—mental health plans taking advantage of grants available from the federal government, could now begin to construct mental health clinics or hospitals.

Following the signing of Act 6, the counties adopting such plans began to provide both outpatient and in-hospital services. They became the first agency of recourse for the mentally ill, with the state mental hospitals handling referrals of the more severely disturbed and long-term cases.

The Unit System

In line with similar developments across the nation, Pennsylvania's state hospitals began conversion to a "Unit System" in the mid-1960s. At Philadelphia State Hospital this new approach divided the facility into six smaller hospitals, each designed to be more manageable, easier to administer, and more responsive to patient needs. Where patients previously had been segregated by "sex, symptoms, and problems," the new units were organized around "catchment" areas (the community or county from which a patient had come). At Harrisburg State Hospital, for example,

there were four areas: Dauphin, Cumberland/Perry, York/Adams, and Lancaster.)

In many cases these units were designed to coincide with newly established or planned Community Mental Health centers. The breakup into units was intended to be a "therapeutic tool," however, not simply an administrative arrangement. Unitization was founded on the concept of decentralization in which authority and responsibility for patient care was placed in the hands of the clinical director of each unit.

At Philadelphia, the reorganization into units came to be known at the "Great Migration." In less than a month during October 1967, 4,500 patients were transferred (and sometimes retransferred) to their new locations. More important, virtually all the hospital staff was affected by the moves. (*Organizational Obstacles to Change in a Large Mental Hospital*, Howard M. Kaplan and Daniel Blain, talk presented at the 125th Annual Meeting of the American Psychiatric Association, Miami Beach, Florida, May 5-9, 1969)

While there were difficulties in making the mass patient moves, even greater problems arose in staff acceptance and adjustment to the change. Departments and even units within departments began to battle over changing responsibilities, lines of accountability, and especially over patients. A typical attitude of the nurses and attendants, even in some cases of the psychiatrists was: "I'm not sending my 'good' patients to other units. If I do, I'm going to get stuck with all the problem patients from the other units, as well as the ones who already are here." In some of the larger hospitals, it took nearly a year for the disputes and especially personal attitudes to resolve themselves.

The unit system was also designed to break up the staff "caste" system that existed at most state hospitals. Multidisciplinary teams, consisting of a psychiatrist, a psychologist, rehabilitation



Group therapy session at Philadelphia State Hospital, ca. 1970s.

counselors, nurses, social workers, and aides were organized for each catchment area. And the medical teams became more closely allied with the community mental health unit in the county which they served, than with their fellow professionals in the other “units” in the hospital. Patients and community volunteers, moreover, participated in treatment decisions. The objective as expressed in one report was that mental hospitals should be “schools for living,” not “dormitories for dying.”

By most accounts the conversion was considered a success, the turmoil associated with making the change worth the strife. According to Franklyn R. Clarke, superintendent of the Philadelphia State Hospital, for example, the transformation to a unit system at that facility was the “most successful” therapeutic tool available to the hospital since the advent of tranquilizers in the previous decade. Throughout many of the other state hospitals, however, the unit system was viewed

more as a management measure than a therapeutic device.

Psychiatric Nursing

While the duties of an attendant changed little over the years—remaining largely tasks in maintaining order—those of a nurse evolved by the middle of the twentieth century into duties that required a skilled professional.

The requirements of helping the individual reestablish mental health are quite different from those employed with a patient suffering from a physical disease. Arthur Noyes summarized this difference well when he wrote in his *A Textbook of Psychiatry*:

For the most part the agencies employed by the psychiatric nurse in an effort to cure her patient are not drugs or surgical techniques but measures which as far as possible reestablish interests, activities and contacts of normal life and promote a happy, effective and social functioning of the personali-

ty. These agencies should be regarded as medical measures and received the same zealous and thoughtful application, as do the measures of physical treatment.

In the case of physical disease the treatment of the patient's symptoms may often be quite impersonal, but in mental disorder we must remember that it is the patient and not his hallucinations, delusions or tics that we wish to treat.

One of a nurse's first tasks with a new patient was gaining his or her confidence. The nurse's bedside manner, the atmosphere she created, acted as subtle therapeutic measures, exerting a real influence on the patient. As Noyes noted, "the patient attaches little value to mere verbal professions of benevolence. He is quick to note the intonations of the voice, the aspects of the face and all those expressive movements of the body which speak more truthfully than do words."

Moreover, as the physician was usually able to see each patient no more than a few times a week, the nurse became his or her main contact. It was necessary, therefore, for a psychiatric nurse to develop and maintain accurate and complete records covering the patient. The record to be maintained included a description of the patient and his or her behavior, what kind of an individual the patient was at the onset of illness as well as how his maladjustments had developed.

Among the many unique techniques that the mid-twentieth-century psychiatric nurse had to master were those of administering the various hydrotherapies: wet pack and continuous-flow bath. Patients undergoing either treatment required almost constant monitoring. Any patient in a bath had to be watched to prevent an attempt to drown him or herself. And when employing the wet pack, which required a careful wrapping of the patient in layers of wet sheets and blankets mummy fashion—but snugly and smooth-

ly without wrinkles—patients had to be checked regularly for any difficulties in breathing or weakening of the pulse.

Feeding of mental patients was another important nursing responsibility. Large numbers of patients required special attention. Many arrived at the hospital undernourished, others would not take sufficient food, and some would refuse to eat at all. Persuasion or spoon-feeding worked for some of these; for others tube feeding was necessary.

The real test of a nurse's suitability for handling psychiatric patients was her methods of caring for disturbed and excited ones. The behavior of the restive, destructive and ill-tempered patient could be exasperating, but the nurse, in the words of famed psychiatrist, Adolph Meyer, "must be capable of rising with impartiality and benign serenity above the distortions and aggravations of a fighting patient."

Suicide watch of any patient suspected of such inclinations was an important part of the nurse's duties. Patients would employ what one would imagine to be the least likely methods in successful attempts; one thrust a needle into her heart.

In closing his thoughts on psychiatric nursing, Noyes wrote, "The nurse should remember that the chief end of treatment . . . is to make the patient again a socialized member of his community, . . . by reestablishing emotional bonds, the severance of which has isolated him from his fellows."

Perhaps the most difficult obstacle the nurse had to overcome in achieving this was to allay the psychological traumas sustained by enforced hospitalization. The dignity, pride, and self-respect of a patient who had been removed from his home, often unceremoniously and against his wishes, thrust behind locked doors and barred windows, deprived not only of his freedom but his clothing and personal effects, and forced to live with strangers in

what was perceived as a hostile environment would certainly suffer extreme blows.

At mid-century there were twelve hundred nurses in the state's mental hospitals. This was about one nurse for each fifteen patients. Although the ratio in Pennsylvania was slightly better than the national average, the number of nurses was only 46 percent of the quota established by the American Psychiatric Association. There were wide variations, moreover, across the system. At Danville the number of nurses was 85 percent of the APA quota while at Farview it was a meager 13.6 percent.

All student nurses in Pennsylvania were required at that point to take three months' work in psychiatry at an accredited affiliate institution. Nearly all of the state hospitals offered in-patient training programs for graduate nurses, while the University of Pittsburgh and the University of Pennsylvania offered both advanced courses and a masters degree with a major in psychiatric nursing.

Wyatt v. Stickney

On April 13, 1972, the U.S. Middle Court in Alabama issued its final decree in the case of *Wyatt v. Stickney*. The case began when Ricky Wyatt, through his aunt, sued the state of Alabama—Dr. Stonewall B. Stickney, as Commissioner of Mental Health and the State Mental Health Officer—over the quality of care he was receiving at Bryce Hospital, Tuscaloosa. His case, however, soon became a class action suit on behalf of all “patients involuntarily confined for mental treatment purposes in Alabama mental institutions.”

In an earlier decision the court withheld its final disposition of the case for appointment of a master and professional advisory committee to “oversee the minimum constitutional standards” that a federal court, might reasonably assume over a state-operated organization.

In its April decree, the court agreed with the plaintiffs that the hospital's treatment program was “deficient in that it failed to provide a humane psychological and physical environment,” that there were insufficient doctors to “administer adequate treatment,” and that “non-therapeutic, uncompensated work assignments and the absence of any semblance of privacy, constituted dehumanizing factors.”

The court's decision was no less than a patient's “bill of rights.” It provided among other things that

- Patients have a right to privacy and dignity.
- Patients have a right to the least restrictive conditions necessary.
- Patients have an unrestricted right to send sealed mail.
- Patients have a right to be free from unnecessary or excessive medication.
- Patients have a right to be free from physical restraint and isolation.
- Patients have a right not to be subjected to treatment procedures such as lobotomy, electro-convulsive treatments or other unusual or hazardous treatment procedures without their consent.
- Patients are not deemed incompetent to manage their affairs, to contract, to marry, to register and vote, or to hold professional or occupational or vehicle operators' licenses by reason of their commitment to a mental hospital.

The District Court further stipulated that its order would be implemented “forthwith and in good faith,” and that “unavailability of funds, staff or facilities would not justify a default by the defendants.”

Following the court's decision in *Wyatt v. Stickney*—which was applicable nation-

wide—almost all aspects of daily existence at Pennsylvania State Hospitals were completely reordered. The thrust of the court's decision was that each patient's treatment (including all therapeutic tasks and any labor) must be tailored to his or her individual condition and needs.

After *Wyatt* a separate "treatment plan" was required for each patient. The U.S. District Court, moreover, established precise staffing ratios, the minimum acceptable number for each position in a state hospital. It specified, for example, that two psychiatrists, four physicians, three psychologists, twelve nurses and seventy aides were required for each 250 patients. It even set standards for the number of toilets and showers, the frequency of linen service, the size of the physical plant, and the patient's nutritional requirements.

The case was a major blow to the idea of the hospital as self-sufficient. The provision of the decree that stated, "no patient shall be required to perform labor which involves the operation and maintenance of the hospital," spelled the end of farm, orchard, dairy, and garden operations using patient labor.



Special Philadelphia State Hospital work detail, 1946.

Patients were permitted to work on a voluntary basis after *Wyatt*, but all such labor had to be compensated in accordance with the prevailing minimum wage. Since these operations could only be run efficiently by the state using uncompensated patient labor, and contracting out the farm and dairy herds made them too expensive for the return in meat and produce, farming stopped at all state hospitals.

The State Hospital as "City"

In spite of *Wyatt v. Stickney*, peonage—as it came to be called—died a hard death at Pennsylvania State Hospitals. In her budget presentations to the Pennsylvania General Assembly two years after the Alabama District Court's decision in the *Wyatt* case, Secretary of Welfare Helene Wohlgenuth, informed the members of the House that many of the state hospitals were still keeping patients with special skills or even those who were "needed" as laborers long after they had qualified for release.

While this was reported by Wohlgenuth—and picked up by the press—as if it were an egregious evil, the whole fabric of asylum life was built around peonage, and the adjustment to fully state-supported institutions would be a dramatic "change-of-life" as well as an expensive transformation.

By the beginning of the twentieth century, the state's lunatic asylums were largely self-sufficient communities. Like medieval principalities—with the superintendent as prince and the patients and staff as serfs—they functioned as separate, self-contained cooperatives.

The system had been established during the previous three-quarters of a century, not just to satisfy the medical profession's theory of labor as therapeutic for the mentally ill, but also to fulfill the legislature's desire to keep the cost of running the asylums as low as possible.

As late as 1915, for example, in the act to establish Torrance State Hospital, the legislature had specified that the property be of arable land so that "as far as practicable, the food for the inmates of said hospital may be produced on said land."

The two needs—the physician's and the legislature's—had blended into a harmonious whole, a mutually satisfying arrangement for economically fulfilling the state's sense of obligation to its mentally disturbed.

The legislature did continue to supply funds for new buildings as well as major renovations to old ones, and a modest three dollars (at the turn of the century) per patient for subsistence, but the remainder of the hospital's needs came from the farm, garden, orchards, piggery, and the wide variety of manufacturing operations carried on at each institution. Except for staples such as coffee, sugar and coal, virtually all of the products that were consumed were produced on the hospital grounds with patient labor.

Wernersville took special pride in its dairy herd of Ayrshire and Holstein cows. For many years this herd ranked third in Berks County for the production of milk poundage and butter fat. The hospital also maintained several greenhouses. Thousands of two- to six-inch flowerpots were used each year during the cold-weather months to start plants for the garden and farm.

And in 1903, the legislature appropriated \$10,000 for the state hospital at Harrisburg to purchase yet another adjacent farm bringing the hospital's acreage up to 412. By that year the farm at Harrisburg was producing more than a hundred tons of hay each season—enough to supply all of the facilities' needs. And we learn from hospital steward J. B. Livingston's meticulously kept records that the kitchen used prodigious amounts of food. In 1904 the patients and staff consumed 173,793 pounds of beef, 29,109

pounds of butter, 12,162 dozen eggs, 17,159 pounds of ham, 51 barrels of salt fish, 9,025 pounds of coffee, 1,699 barrels of flour, and 205 gallons of oysters along with smaller amounts of clams, crabs and lobster. The latter items probably ended up, however, in the staff rather than the



Completed in 1900 the "Farm Colony" building at Warren was removed from the hospital proper. It was intended not only as a temporary structure for the patients and attendants who worked on the farm, but also to relieve the crowding in the main building.

patient dining rooms.

Even Farview, which was built as a prison-hospital for the criminally insane, maintained extensive farm property. It was hewn out of one hundred acres of what was described by a 1926 Wayne County local history as "wild land."

In 1896 an Industrial Building was erected at Wernersville. The structure was used to manufacture brushes, brooms, rugs, and baskets, as well as provide facilities for shoe repair and weaving. A print shop was established in the east end of the building in 1917. It was in almost continuous operation during the next sixty years. According to a 1976 history of the institution by George H. Merkel two hundred different administrative and medical forms were printed there in large quantities. A photographic darkroom was installed in 1958 and the shop became a combination letterpress-offset printing facility, complete with a process camera and platemaker.

Although Thomas Kirkbride had cautioned against the therapeutic value of hard labor, all of the facilities took advantage of their available free work forces. At Harrisburg they dug sewer and water lines as well as building foundations. At Danville they graded roads. At Wernersville they were used to renovate old and erect new buildings. At Warren they constructed bridges to the islands in the river on which the patients then fabricated picnic facilities that were widely used by the patients and staff.

At all of the hospitals the men were employed shoveling snow in the winter and cutting grass in the summer. The latter they did with hand mowers but in teams of a dozen or more men. And each spring they were busy plowing, planting, trimming fruit trees, fertilizing the fields, and tending stock. The women were also actively employed year round. They sewed and repaired clothing and items such as pillowcases, worked in the laundry and the ironing room, served in the kitchen, and manufactured or repaired many of the small objects used throughout the hospital.



Patients at Harrisburg shoveling snow off the hospital's walkways in the 1950s.

While potatoes, wheat, and corn were the main crops, they were only the big money items. In addition to vegetables such as beans, cabbage, carrots, cucumbers, lettuce, onions, squashes, and tomatoes, the gardens at Harrisburg, for example, also produced asparagus, eggplant, kale, parsnips, parsley, rhubarb, rutabaga, radishes, spinach, salsify, turnips, and mushrooms. And each hospital maintained an herb garden in which most of the spices used in the kitchens were grown.

The "piggery" was an integral part of nineteenth-century asylum life as well as at the county almshouses. Kirkbride had specifically included provisions for them in his original plans for a hospital, and in conducting his survey in 1914, C. Floyd Haviland had mentioned piggeries—questioning their proximity to the water supply—at a number of the facilities he visited.

Gradually as the 1970s progressed, each of the state hospitals wound down their farm, garden, and manufacturing operations. At first, some of them made attempts to use patients on a voluntary basis—as part of their written therapy plan—but the justifications for such use were hardly worth the result. In some instances contract labor was used. Eventually, all of the hospitals accepted the Wyatt decision and eliminated patient labor from their programs.

Much of the farmland at those state hospitals still in existence has been sold off for commercial development or is used by the state for other functions. At Harrisburg, for example, the State Police, the Pennsylvania Game Commission, and the Department of Environmental Protection are now occupants of some of the former State Hospital's farm property.

Vecchione v. Wohlgemuth

Two years after *Wyatt v. Stickney*, the Pennsylvania Secretary of Welfare Helene Wohlgemuth was sued by a seventy-year-old widow who had been held in Byberry as "a person in need of observation, care, and treatment for a mental disability."

Elvira Vecchione, who was entirely without means of support other than her Social Security benefits, had been confined at Byberry for a year and a half commencing in October 1971. Her sole assets beyond her monthly Social Security check were \$500 she received during her stay at the hospital as her share of an estate.

Under Commonwealth law Elwood N. Shoemaker, the revenue agent at Byberry, had assessed Vecchione for the costs of care and maintenance and appropriated \$2,610.48 of her Social Security benefits, and also took custody of her personal belongings and bank account. A portion of this amount was returned at the time of her discharge pursuant to the Pennsylvania statute, but at no point was she given an opportunity to challenge the action or the amount of the charges the state had assessed her.

Under the law, the defendants were not required to grant her a hearing, make a final determination of liability, or even as the U.S. District Court found, initiate a court proceeding or make any kind of accounting of its action.

The case was processed as a civil rights matter that dealt with the right of patients confined in state mental hospitals who were not incompetent and had less than \$2,500 in assets to control and manage their own property as opposed to the right of the Commonwealth to summarily seize—without prior notice or hearing—and make disposition of the funds during the patient's hospitalization. (The state law did require the hospital to initiate court action for those patients who were incompetent or had more than \$2,500.)

Not only did Elvira's attorneys argue

that she had been denied due process, but that her Social Security benefits were shielded from the claims of creditors including the state, and that throughout her hospitalization at Byberry she had been "afforded less than the constitutionally required treatment under *Wyatt v. Stickney*." This latter, according to them, thereby prolonged her stay and the costs she had been assessed, or possibly even warranted that she should not have been committed at all.

On July 11, 1974, the U.S. District Court found for Vecchione. Having established without sufficient justification two classes of individuals—those who were competent and those who were not—the state law did not grant her (the state's attorneys had agreed that she was competent) any procedure to seek restoration of her property. The court found, however, an even "more fundamental problem" with the state's attempt to justify its statute in its statements concerning the law's "factual underpinning."

The District Court's decision rejected the hypothesis "that mental patients may be presumed less competent to handle their own assets than the public at large." Moreover, it cited Elvira's situation as similar to that of an accident victim who was temporarily unable to leave a hospital to "manage" his or her funds. The state had no authority to seize the property or assets of an individual in such circumstances.

Following *Vecchione v. Wohlgemuth*, Pennsylvania State Hospitals returned all funds they had taken from patients including petty cash sums for them to use in the cafeterias and canteens. The case was of minor impact on the state's funding of patient care, but it was a significant blow to their "authority" over other patient actions.

Patient Abuse

From the first, the annual reports of nineteenth-century Pennsylvania asylum

superintendents included occasional comments about the firing of attendants not just for incompetence but also for the abuse of patients. Much of the abuse, of course, never was reported. Moreover, as the patient population rose in late nineteenth-century asylums, the ratio of nurses and attendants to patients dropped at many institutions leading to greater inducements for mistreatment of patients.

The result: overworked attendants who in confronting situations of destructive or unruly conduct frequently attempted to secure acceptable behavior through coercion or the increased use of restraints. And the excessive, especially long-term use of restraints often became a barely disguised form of abuse. Locked up or straightjacketed patients easily could be ignored or forgotten—for days, sometimes even for weeks.

Although the problem of patient abuse was far more prevalent in county and city institutions than in state hospitals, it also existed there; it also continued well into the twentieth century. As late as the 1970s Secretary Helene Wohlgemuth had to fire one of her state hospital superintendents who refused to stop incarcerating disruptive patients in animal-like cages. His defense at the hearing at which his dismissal was upheld was that use of the cages was “therapeutic” rather than punitive.

Perhaps the most pervasive instances of abuse that surfaced at the state hospitals in the late twentieth century—other than at Philadelphia State Hospital—occurred at Farview in 1975.

Following a series of articles in the *Philadelphia Inquirer* during 1976, Governor Milton Shapp appointed a task force that, at the conclusion of an eight-month study, reported that a “pattern of brutality, corruption and crime was rampant” within Farview and had been going on for years. The study noted that the abuse of patients was systematic; it included instances not only of gross neglect but also of frequent beatings. At least

six patients had died following mistreatment. It was the conclusion of the Shapp Task Force on Maximum Security Psychiatric Care that Farview be closed and three regional facilities near the state’s major population centers be built. It was hoped that—among other enhancements—this would permit the hiring of a more competent, professional staff.

When Governor Dick Thornburgh followed Milton Shapp into office in 1979, he appointed a second task force to review the situation. The new group advocated keeping Farview open as the state’s maximum-security facility for the criminally insane. They recommended a \$4.25 million plant renovation, the hiring of additional medical personnel, and the implementation of a series of management reforms. The *Inquirer* called it a “capitulation to politics.”

While the instances of abuse apparently declined, the problems at Farview continued. In December 1980, the superintendent resigned following several armed escapes with guns that a visitor had smuggled into the facility.

Mental Health Plans

In the years following the passage of the Mental Health Act of 1966, the Commonwealth began emphasizing the preparation of planning reports, first periodically, and then by the 1980s on a three-year cycle with annual updates. The Office of Mental Health considered these reports to be the most “effective mechanism for establishing program direction” as well as the “basis for rational decision making.” The reports were lengthy documents covering both the state hospitals and the community mental health system. Much of the “planning” was directed at, or driven by budgetary considerations.

According to the 1986 plan, the state hospital population was continuing to decline while that of the community mental health system continued to grow, although fifteen state hospitals with a census of

7,869 patients were still in operation. The Joint Commission on Accreditation of Hospitals accredited eleven of these fifteen hospitals and fourteen were certified to receive Medicare patients.

Many, however, of the Commonwealth's counties—primarily those in rural areas—did not have a community mental health system in 1986. Only eighteen of the state's counties had active programs, although twelve more were developing plans or discussing the possibility of instituting a community mental health system.

The 1986 report estimated the future rate of decline in the number of state hospital patients to be around 3 percent a year, although at that point the office had no plans to close additional state facilities. A reduction in staff, however, of 583 (from 12,255 to 11,672) was planned during the next three-year cycle. It was aimed at covering the drop in number of patients, but was scheduled to be accomplished "through carefully managed attrition" rather than dismissals.

At the same time, it was anticipated that the state hospital patient population would "increasingly consist of the seriously ill psychiatric patients," including the "chronically ill" young adults who "cannot be treated in community settings." According to the report, the patient population was "younger and more seriously ill and difficult to treat than at any time in the past."

During the 1980s, patients with "schizophrenic reactions" were still the predominant group among the state hospital population—around 60 percent of the total. Schizophrenics also accounted for much of the movement into and out of the state hospitals during this period. They comprised 57 percent of the admissions and 66 percent of the transfers in (from community mental health facilities). Schizophrenia was also the predominant mental disorder of those who died in the hospitals.

A comparison of the budget requirements between the state and the communi-

ty system presents some interesting contrasts. The community mental health system was being estimated to cost \$148.7 million a year while the state system ran at \$439.8 million—85 percent of which was for staff salaries. Slightly over 25 percent of the state hospital budget was covered by the federal government and an additional 11 percent (\$46.48 million) was still being received in collections from patients.

The 1986 Office of Mental Health report summarized the role of the state mental hospitals as that of providing "active inpatient psychiatric treatment to individuals whose mental illness requires more extended treatment than acute inpatient care provided in the local community," or treatment which consisted of "specialized services which cannot be provided economically by most local communities." The System Organization and Management section of the plan closed optimistically by stating:

Recognizing that there will probably be no significant budget growth in the near future, the hospital system will be managed with a strong emphasis on cost containment and cost efficiency while maintaining and improving patient care.

Farview was the only state hospital to be singled out in the report for a detailed critique. Although Farview was the designated "maximum security" facility for the state, there were "forensic units" at other state hospitals, especially those like Philadelphia that were in metropolitan areas.

In the years between the 1980 investigation at Farview and the 1986 Office of Mental Health report, various plant renovations had been completed to upgrade security and to bring the hospital in compliance with the provisions of the 1974 Rehabilitation Act.

Moreover, during that period, Farview had implemented revised policies and procedures to provide for improved patient

admission, discharge, and continuity of care; the making of reports to the court; the use of seclusion and restraints; in developing an Affirmative Action Plan and increasing the number of minority employees; and in training the clinical staff in the management of “assaultive behavior.”

Closing of Byberry in Philadelphia

A lake where all the world's tears have flowed

In 1988, the Department of Public Welfare announced the closing of the Philadelphia State Hospital at Byberry. During the previous half century the very word, Byberry had become infamous, one that signified the neglect of Pennsylvania’s mentally ill—just as the name of the London hospital, Beth-lem, had entered the language two hundred years earlier as Bedlam, portraying a place of noise and confusion.

Byberry was among the hospitals that Albert Deutsch had visited in preparation for his 1948 book *The Shame of the States*.

In the book, he reflected on what he had seen there:

Hundreds of patients sleeping in damp, bug-ridden basements. Noisy and violent patients made life intolerable in barn-like day-rooms because there weren’t seclusion rooms where they might be isolated until calmed down. . . .”

As I passed through some of Byberry’s wards, I was reminded of the pictures of Nazi concentration camps at Belsen and Buchenwald. I entered buildings swarming with naked humans herded like cattle and treated with less concern, pervaded by a fetid odor so heavy, so nauseating, that the stench seemed almost to have a physical existence of its own.

The Shame of the States included photos of the male “incontinent ward,” which Deutsch described as “a scene out of Dante’s Inferno, [where] three hundred nude men stood, squatted and sprawled in this bare room, amid shrieks, groans, and unearthly laughter.”

As part of its “State Care” act eliminating local and county mental hospitals, the state had taken over Byberry in 1938 and renamed it Philadelphia State Hospital. When he signed the legislation in September 1938, Governor George Earle proclaimed: “Today Byberry and all its horrors end—tomorrow brings a new institution, a new hope for those unfortunate patients.”

The new year, however, saw a new Governor, Arthur James. According to the *Philadelphia Inquirer* (July 10, 1938), James met, within weeks of being elected, with Philadelphia Republican party leaders to decide how to fill the hospital’s eight hundred patronage positions.

As a city facility, Byberry had a long history of patronage problems. When earlier superintendents had fired attendants for incompetence as well as for neglect or abuse of patients, the dismissed individual would frequently go to City Hall and get the director of Public Health and Charities



In an effort to improve patient quality of care, Governor George M. Leader conducted on-site inspections of numerous state hospitals. Here Governor Leader points to inadequate sanitation facilities at Byberry in Philadelphia in 1956.

to order the attendant rehired, often with a raise.

In December 1938, the newly appointed state board of trustees met at Byberry for its first meeting. One of the members became so sickened by the stench, however, that the meeting was moved back to center city. During the meeting several of the trustees told D. H. Woolley, the new superintendent that Governor Earle had appointed, that they would handle all hiring and firing so he “wouldn’t be burdened with the responsibility.”

Woolley reportedly told them, “If you think you’re going to turn Byberry back into a political roost while I’m superintendent, you’re crazy. You can get in your cars and start out for Byberry right now, because you’re the new superintendents.”

The trustees did not hold another meeting for two years. Woolley, however, remained for twenty-seven months. During that period he fired more than two hundred attendants for abusing patients. When he resigned in January 1941 he told reporters gathered at the hospital:

I wake up at night in horror over this place. I can see myself and members of my staff before a coroner’s jury and a grand jury charged with the responsibility for roasting to death aged and blind people. Yet in every report I ever made to the state, I outlined this condition very thoroughly because it is so horrible. And it still exists.

Byberry finally burst onto the public’s awareness as a *snake pit* following World War II. Not only did Deutsch’s book—with its chapter on Byberry—appear, but several national magazines, including *Life* and *PM* published lengthy exposés, and a number of conscientious objectors, who had served at Byberry during the war went public with their stories of patient neglect, abuse, and in one case even murder. Then in 1946 the Veterans Administration abruptly terminated an agreement it had made with the hospital just months earlier

because of the “abominable conditions” its inspectors found there.

By the early 1960s, Byberry had a rated capacity of 4,200 patients but the numbers housed there ran to more than 6,800. Two thousand of these simply roamed the hospital property that straddled Roosevelt Boulevard in northeast Philadelphia. Some of them actually lived on the grounds, a few even died there unmissed until their rotting bodies were accidentally discovered.

In 1966 the National Institute of Mental Health conducted an in-depth study of Byberry at the request of the Scranton Administration. The institute’s report included a recommendation to appoint a first-rate psychiatrist as superintendent. Governor Scranton selected Daniel Blain, who was serving as the medical director for the American Psychiatric Association, but had previously served as president of the organization and at one time had been the commissioner of mental health for California.

The seventy-year-old Blain arrived in October 1966 and started the practice of taking state legislators on tours of the facility. When they were appalled at what they saw, he told them, “You get what you pay for!” And continued to push the legislature for more money.

Blain told a reporter that when he arrived there, Byberry received \$5.15 per patient for daily maintenance, as compared to the \$32 Haverford State Hospital received for each patient. Philadelphia not only received the lowest level of support of all of Pennsylvania’s mental hospitals, it ranked near the bottom nationally.

During his tenure as superintendent, Dr. Blain worked to increase funding and to reduce the patient population and change the hospital from a custodial to a treatment facility. In three years the number of patients was down to 3,600. And with continued reductions in the number

of patients, Dr. Blain expressed the hope to turn Byberry into a “treatment” rather than a “custodial” facility.

But the days of the large state mental hospital handling thousands of patients in one facility were over. The advent of psychotropic drugs and the return to a community mental health system saw the start of a dramatic reduction in the number of patients being hospitalized in state facilities. By the time Byberry finally closed in 1990 the number had dropped below five hundred.

Fifty years of state management had little more than marginal impact on Byberry. Over the years, innumerable grand juries and “blue ribbon” committees from the legislature had investigated the hospital. But in 1987 a state report still called for “immediate and drastic action . . . to reverse Byberry’s history of neglect, poor management, absence of treatment and rampant abuse.”

Thousands of people knew about the conditions; no one seemed able to do anything about them. Writing for the *Philadelphia Inquirer* in 1988, William Ecenbarger called Byberry “a lake where all the world’s tears have flowed.”

The Schizophrenic Mind

About 1 percent of the population develops schizophrenia during its lifetime. (In the nineteenth century those who exhibited the symptoms were classified as suffering from dementia praecox.) Although the cause of schizophrenia is still unknown, the disorder was named by Eugen Bleuler following his observations in the early 1900s, of his patients at a Swiss hospital whose word associations had lost their continuity—he referred as schizophrenic.

When people think or talk of “madness,” they are usually referring to the symptoms of schizophrenia—delusions, disordered thoughts, and confused speech. The disease strikes men and women with

about the same degree of frequency, although men usually first become ill in their early twenties, while the onset in women is usually five years later.

Typically those who become ill with the disorder have several episodes during their lifetime.

Recent research confirms Bleuler’s belief that schizophrenic patients are not missing a normal store of words, but that they are missing a “goal-directed access” to them. Their disordered thinking processes have difficulty producing normal word associations. One of Bleuler examples was “wood-dead cousin,” a meaningless jumble spoken by one of his patients. When he learned, however, that the patient’s cousin had died recently and had been buried in a wooden coffin, it became obvious the expression had been constructed out of an indirect association.

Another frequent symptom of schizophrenia is delusions. Although delusions by definition are ideas with an unlikely, impossible, or false content, to the individual experiencing a delusion, its reality is beyond question, or refutation.

Acute delusions are frequently accompanied by strong emotions and increased anxiety. In her semi-autobiographical novel *I Never Promised You a Rose Garden*, Joanne Greenberg writes of the “darkmindedness” of schizophrenia, of seeing and hearing the external world as if “through a key hole,” and of her manic episodes as an “erupting volcano,” a volcano so fierce it “would not let her rest” but “kept hurling her from one side of the room to the other.”

Individuals in an acute delusional state are often suspicious and apprehensive. When acute delusions become part of a person’s basic values and attitudes, they are considered to have become chronic. Acute delusions can be effectively treated with drugs, while chronic delusions seldom respond to them.

The use of drugs in treating the mentally ill dates back to the Middle Ages

when it was believed laxatives would eliminate toxins bottled up in the colon. For several centuries opium, and by the beginning of the nineteenth century morphine were employed to sedate agitated patients. (Kirkbride prescribed morphine in water for his patients.) By mid-century sedatives such as potassium bromide became popular in asylums.

During the early asylum years those who did not respond to the available “treatments” that were intended to keep them quiet, especially at night, were isolated in wards away from the less manic patients—the depressed, the epileptic, the senile—to avoid disturbing them. For this reason the most agitated residents were typically housed in the “dreaded” seventh and eighth wards which, as one of Thomas Kirkbride’s patients wrote, were filled with “yelling and howling.”

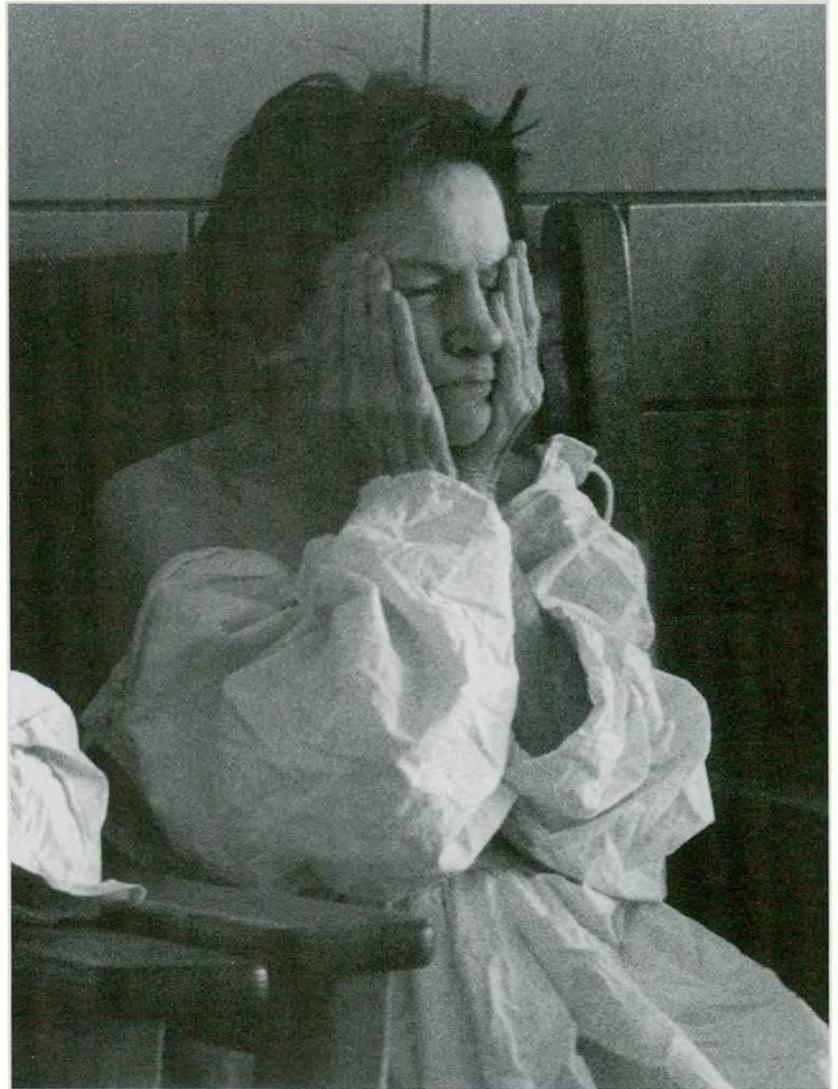
In the early decades of the twentieth century physicians began experimenting with various convulsive-shock treatments (insulin and Metrazol) after they discovered that inducing convulsions in patients reduced their excitement level. Later, when it was found that the shock (leading to a convulsion) could be administered more effectively by electro-convulsive devices, these machines quickly replaced the earlier treatment methods.

Then in 1951 a Paris physician, Henri Laborit, who was interested in improving anesthetics used in surgery, began administering antihistamines to a large number of mental patients as a test group and observed that the patients became sleepy and less apprehensive. He got the drug into the hands of several Paris psychiatrists who confirmed his observations. Although the results of their tests were not equally impressive in all patients, those who responded dramatically had one thing in common—they were schizophrenics. By the 1960s the “psychotropic” drugs were in wide use throughout the United States.

When the drugs were first used at the

Harrisburg State Hospital in 1958, the results showed that they “produced some degree of change in our total hospitalized population, and in some produced changes to a marked degree, assisting in reclaiming heretofore inaccessible ‘back hall’ patients, at least to a working status.”

As much as the 1960s public policy change that led to the community mental



Female patient at Philadelphia State Hospital ca. 1960.

health system, the new drugs were also responsible for helping to empty the state hospital system and “return” large numbers of the mentally ill to society. The difficulty in a progressive release policy lies, of course, in making certain that patients continue to take their medication after being

discharged. Unless they are in the care of someone responsible to see that they do, they often stop. Thus, like roving bands of Medieval madmen, large numbers of these patients have been expelled to wander unattended the city streets—to sleep in doorways, on grates, and under bridges.

Now, however, with our greater understanding of the mind and mental illness, we seem to be on the verge, at the start of a new century, of developing even better therapeutic strategies for schizophrenics.

Not Guilty by Reason of Insanity

Today the words *insane* and *insanity* are only used in legal parlance. In the eyes of the law individuals can be judged to be “Not Guilty by Reason of Insanity.” In this sense insanity is not a specific disease but a question of whether the individual knew right from wrong at the moment of committing a crime.

The concept of an insanity defense in a criminal case has a long history in English common law dating to early in the fourteenth century. Although the insane were not acquitted they were usually spared by a royal pardon, but forfeited all their property to the King. By the seventeenth century jurists began devising “tests” for determining the degree of insanity that rendered a person not guilty by reason of insanity. This culminated in the eighteenth century when an English judge laid down his “wild beast” test. According to Judge Tracy, “a man must [have been] totally deprived of his understanding and memory, and not know what he did, no more than an infant, than a brute, or a wild beast; such a one is never the object of punishment.” The notion of not guilty by reason of insanity was finally codified in English law in 1843 and was first cited in a U.S. case the following year.

Although such a plea was entered in individual cases over the next several

decades, few states, including Pennsylvania, had any law providing for an insanity defense during the period. In his final message to the Commonwealth in January 1845, Governor Porter highlighted the problem facing mid-nineteenth-century Pennsylvania courts:

Although the system of imprisonment adopted by Pennsylvania some years ago . . . has been justly regarded as the most admirable . . . yet there is one department which remains to be provided for, that of establishing, . . . a department for the charge of the insane inmates. There have been, almost every year, since I have been governor . . . some unfortunate persons confined in the penitentiary . . . who either were partially insane when committed, or became so afterwards. As the law now stands, there is no remedy for these cases, but to pardon them, or confine them in the same manner as other criminals are confined. Both these modes are oftentimes wrong, and I respectfully urge it upon your consideration to make some provision for redressing the evil in the future.

Almost as soon as the asylum at Harrisburg opened in 1851, John Curwen was called on by the courts to examine criminals judges suspected might be insane and to provide them with “expert” opinions concerning the man or woman. It was not until April 20, 1869, however, that the General Assembly codified any rules governing an insanity defense. Act 54 of that year stated: “Whenever any person is acquitted in a criminal suit, on the ground of insanity, the jury shall declare this fact in their verdict, and the court shall order the prisoner to be committed . . . for safe keeping or treatment.” Thus the Pennsylvania state hospitals themselves became the location at which the criminally insane were incarcerated.

When the jury gave a not-guilty-by-reason-of-insanity verdict in a homicide

case the prisoner had to undergo three years of treatment and could only be discharged from the asylum following the “unanimous opinion of the superintendent, the managers of the hospital, and of the court before which he or she had been tried that the man or woman “has recovered and is safe to be at large.”

By the end of the century state hospital superintendents were called on more and more to testify in such cases. (For example, at the trial of Charles Guiteau, who shot President James Garfield in 1881, no less than eight medical witness testified in favor of Guiteau’s insanity while fifteen asserted that he was sane and responsible under the law.)

Early in the twentieth century the psychiatric profession began entering the discussion more actively than previously, when it mainly had been involved in giving testimony concerning the sanity of individuals. Following celebrated cases—the assassination of President Garfield, the attempt on Theodore Roosevelt’s life, and the murder of the architect Stanford White by the wealthy Harry Thaw—members of the American Psychiatric Association began efforts to frame the issue around psychiatric concerns rather than legal ones.

One writer, Gregory Zilboorg (*One Hundred Years of American Psychiatry*) calls the 1920s the “golden years of awakening in the field of psychiatric criminal jurisprudence.” In 1923, for example, William White, superintendent at St. Elizabeths in Washington, D.C. pleaded for less aggressive and revengeful motives in criminal law and for the individualization of each case. White argued to overturn the legal system’s “separation of the act from the actor.” According to White, “The remedies upon which the law seems to repose are hangovers of a theological age.” He also suggested that to gain a more balanced perspective criminal lawyers serve an internship in a prison just as doctors serve one in a hospital.

With the help of the medical profession and the increasingly liberal inclination of the public toward the mentally ill during the middle years of the twentieth century, the interpretation of what constituted criminal insanity was redefined and expanded by many state legislatures and courts.

During the last several decades of the twentieth century, however, public outcries over a few prominent cases, such as that of John Hinckley, who shot President Reagan, led to a definite shift in public policy, to a more restrained approach in determining the criteria for such a defense. The records show, however, that the defense of criminal insanity or “diminished capacity” (which was one of the mid-twentieth century refinements of the law) is seldom used and moreover is often unsuccessful.

A far greater change in policy has occurred in recent decades, however, in the area of involuntary commitment to state facilities. Whereas in the 1960s, public policy turned away from forced commitment and to moving patients out into the community, by century’s end, the number of involuntary placements in state facilities began to grow once again—by 1995 it was estimated nationwide at 1.2 million a year. Family members initiate most of these commitments, however, not the legal system, and most of them come from lower socio-economic levels.

A New Century

As the Commonwealth enters the third century of ministering to its mentally ill poor, we might well ask, “What have we accomplished?” “How far have we come?” “What remains to be done?”

These are not easy questions to answer. Each question is burdened with complications, each answer subject to dispute.

Although the greatest number of mentally ill patients is now being treated in community mental health centers around

the Commonwealth, the state hospital system is still intact—but with a greatly reduced number of facilities and a much smaller patient load.

Allentown, Clarks Summit, Danville, Harrisburg, Mayview, Norristown, Torrance, Warren, and Wernersville are still accepting patients—mainly on referral from a community center. Hollidaysburg was closed in 1977, Eastern Pennsylvania Psychiatric Institute in 1981, Dixmont in 1984, Philadelphia in 1990, Woodville in 1991, Embreeville in 1997, and Haverford in 1998. Retreat, Somerset, and Farview State Hospitals were transferred to the Department of Corrections in 1980.

The goal at the state hospitals is to move residents into appropriate community programs whenever possible and provide long-term care for the others. The typical caseload at each of the nine open state hospitals is now between three hundred and four hundred. A few of these patients are considered to be chronic, and in one or two instances the individual has been hospitalized for as long as twenty years.

In retrospect, the state's effort between 1851 and 1951 at handling the flood of new mentally ill patients appears to have been largely ineffectual. It was for the General Assembly as much as for the patients a "subway with no stops!" as the Philadelphia *Inquirer* once called Byberry. It must be acknowledged, however, that the venture was a valiant, if not a heroic one. The construction of hospital after hospital; the search for new means with which to handle the enormous influx; the continuing debate over whether local or state control was preferable (although the various shifts never seemed to change the lot of the patients, many of whom lived in cruel circumstances), all give evidence of the concern that was felt by a broad constituency in the General Assembly, the executive departments, and among the general public. While not many would

express pride in the results, the effort was commendable.

Perhaps the most serious mistake of the policymakers was to assume that the mere placing of county facilities, such as Philadelphia's Byberry, under state management—because experience had shown that service by the counties and cities was so much poorer—would change the lot of those who were hospitalized in them. It did not. Without the means and will to manage huge numbers of patients in any meaningful way, the source of control made little difference. Placing them into a series of smaller facilities might have provided some relief, but the cost to build and staff them in the numbers required was probably beyond anything the legislature would have been willing to suffer.

While it may seem, moreover, that little if any progress was made in the treatment of mental illness until the middle of the twentieth century and the advent of psychotropic drugs, like an aspirin to a headache, they only treat the symptoms of diseases such as schizophrenia, not the cause.

Even the newer drugs being developed today—for want of a better term they are being called "atypical"—still treat the symptoms. They do show promise, however, of helping greater numbers of schizophrenics with fewer of the side effects of the psychotropic drugs developed in the 1950s.

Research, of course, seems to show the way to the future. According to Michael A. Swartz [*New Insights into Understanding and Treating Schizophrenia*] the results of recent research into the brain and how it functions are helping us to develop an understanding of the various etiologies of schizophrenia—what needs to be done (the changes that have to occur in the brain of a schizophrenic), but not, at this point, how to do it. Swartz concludes, "Perhaps in another decade."

When drug therapy is successful in relieving a patient's psychotic event, mov-

ing him or her back into the community often destroys necessary support mechanisms. Although a patient's failure to take his or her medication is often cited as the most pressing problem, that is only a symptom of a larger problem. Recent studies into psychosocial treatment issues have made it abundantly clear that adequate support is essential to prevent relapses for those released to the community.

There is strong evidence that given the right circumstances the mind can heal itself, at least, partially. Just as the body has restorative powers, so too the mind has shown that it is not only capable of restoring (replacing) damaged cells but also of infinitely extending itself—far beyond what was believed only a few years ago. But it requires a substantial support system for the individual for this to occur.

Understanding families (or their surrogates) are needed—as much as to insure that a patient “takes his or her medication”—to provide constant, understanding support to help the individual rebuild basic coping mechanisms in order to learn how to handle a wide variety of even the most simple life situations, especially ones that produce stress.

Curiously the one constant throughout one-and-a-half centuries of concern over mental illness has been that of the importance of “early treatment.” From the first, the superintendent-alienists regularly sounded the note and modern psychiatrists still consider it an important element in treatment. Determining the difference, however, between a first psychotic episode and an idiosyncrasy or eccentricity

is not easy to do. To expect family members to be able to do so is unrealistic, especially since neither science nor government has a good answer.

Along with “promoting and improving” the quality of family life, the key component of the Department of Public Welfare's mission is still “to protect and serve Pennsylvania's most vulnerable citizens.” Among the department's deputy secretaries is one for “Mental Health and Substance Abuse.” The services provided include inpatient treatment and rehabilitation, outpatient, partial hospital care, emergency and crisis intervention, psychosocial rehabilitation, family support services, specialized behavioral health rehabilitation for children and adolescents, and community residential and treatment services.

There is a role in the current scheme of things for a state hospital system. Those who are chronic or acutely ill need more than a few days or even weeks in a community mental health center. And continued research into mental illness is mandatory. It is not clear, however, whether the requirement for a state hospital role is continuing to shrink, has leveled off, or can be replaced eventually by some other form of support.

Although state and federal concern has expanded well beyond that of caring for the indigent—into providing facilities and support for those who have the means as well as into basic research—it is the poor who still bear the brunt of inadequate service

MENTAL HEALTH CARE ACTS ¹
of the
PENNSYLVANIA GENERAL ASSEMBLY

<u>Date of Act</u> ²	<u>Act Number</u>	<u>Hospital Establishment</u>	<u>PURPOSE</u>
May 11, 1751 ³	—	Pennsylvania Hospital	to contribute two thousand pounds and provide for the incorporation of an asylum to be built for the relief of the sick poor and for the reception and care of lunatics.
April 29, 1835	152		to exempt from taxation privately owned real estate in Philadelphia County held to construct an asylum for persons deprived of their reason.
March 4, 1841	34		to construct an asylum for treatment of the insane. ⁴
April 14, 1845	440	Harrisburg	to establish the first State Hospital
March 18, 1848	218	Dixmont	to incorporate private hospital as a voluntary organization with state funding making it a quasi-state facility.
April 8, 1861	supplement ⁵		to return chronic insane criminals to the penitentiary or county prison from which they had come.
April 13, 1868	49	Danville	appointed site-selection commissioners.
April 20, 1869	54		to establish and insanity defense law.
April 24, 1869	66		to establish a Board of Public Charities.
March 27, 1873	54	Danville	approved appointment of hospital board by governor.
August 14, 1873 (1874)	223	Warren	appointed site-selection commissioners.

¹ Excludes minor acts, especially those appropriating bi-annual operating funds or for building maintenance or new construction.

² Date of the governor's signature approving the act.

³ Act of the Provincial Assembly; confirmed by the King in Council, May 10, 1753.

⁴ Land was purchased across the Schuylkill River from Philadelphia but the building was never erected.

⁵ Supplement to Act 440 of April 14, 1845. A second supplement the same date added trustees to the hospital board.

<u>Date of Act</u>	<u>Act Number</u>	<u>Hospital Establishment</u>	<u>PURPOSE</u>
May 5, 1876	89	Norristown	
June 4, 1879	83		to encourage/authorize the appointment of female physicians to treat female patients.
June 8, 1881	83	Warren	approved appointment of hospital board by governor.
May 8, 1883	21		gave the Board of Public Charities authority over all places housing insane persons. Also established a Lunacy Committee within the Board.
June 22, 1891	379	Wernersville	to serve only the chronic ill from other state hospitals.
May 25, 1897	64		"Dual Care Act" permitting the treatment and care of insane patients in county and local institutions.
July 18, 1901	737	Allentown	to serve those desiring homeopathic care
May 11, 1905	400	Farview	to provide a separate facility for the criminally insane.
April 16, 1903			
			to provide for the commitment of individuals who are habitually "addicted to alcoholic drink or intoxicating drugs" to a state hospital.
May 28, 1907	221		to provide for employment of patients and for the distribution and sale of such manufactured goods to other state institutions.
May 28, 1907	290 & 292		established the Joint Legislative Commission to Investigate Various Charitable Institutions.
May 1, 1913	101		to authorize the Board of Public Charities to obtain indictments against officers of institutions for failure to provide proper care or maintenance of patients.
June 18, 1915	1055	Torrance	

APPENDIX A

<u>Date of Act</u>	<u>Act Number</u>	<u>Hospital Establishment</u>	<u>PURPOSE</u>
May 6, 1921	272		to commit all persons afflicted with syphilis to Wernersville.
July 11, 1923	414		first Mental Health Act. Established uniform admission, commitment and discharge procedures; and codified all acts since 1845. Also revised mental health terminology to be used.
April 11, 1929	487		authorized Department of Public Welfare to determine legal residence of patients and require proper district to pay costs.
June 23, 1931	324	Western State Psychiatric	Designated to specialize in diagnosis and research.
May 28, 1937	267		to imposed liability on individuals, counties, and poor districts for care of mental patients.
September 29, 1938	53	Clarks Summit, Embreeville Hollidaysburg, Mayview, Philadelphia, Retreat, Somerset, and Woodville	"Full State Care" act that abolished all county and community mental health facilities. Eight hospitals named were taken over as state hospitals
April 18, 1949	599	Eastern Pennsylvania Psychiatric	
December 14, 1955	853		to change the duties of hospital boards from management of their facilities to a strictly advisory role. Also established the position of Commissioner of Mental Health as a deputy secretary.
July 13, 1957	582		to consolidate the Departments of Welfare and Public Assistance into one.

<u>Date of Act</u>	<u>Act Number</u>	<u>Hospital Establishment</u>	<u>PURPOSE</u>
June 13, 1961	319	Haverford and Eastern State School and Hospital	
August 26, 1965	381		to authorize state participation in the new federal Medicaid program.
October 20, 1966	96		to establish in law major recommendations from the planning initiatives begun in 1963 providing for a community services system taking advantage of federal grant funds.
July 31, 1968	unassigned		to set forth the details of the state's Medicaid program.
April 14, 1972 and December 6, 1972	221		to remove responsibility for treatment of persons with problems of alcohol or drug abuse from Department of Public Welfare and the Office of Mental Health. Split mental health and mental retardation programs into two separate offices.
July 25, 1975	93		removed the stipulation that the superintendent must be a physician.
July 9, 1987	207		removed the requirement that the Commissioner of Mental Health have credentials as a psychiatrist.

STATE HOSPITAL SYSTEM
at the peak of its maturity-1947

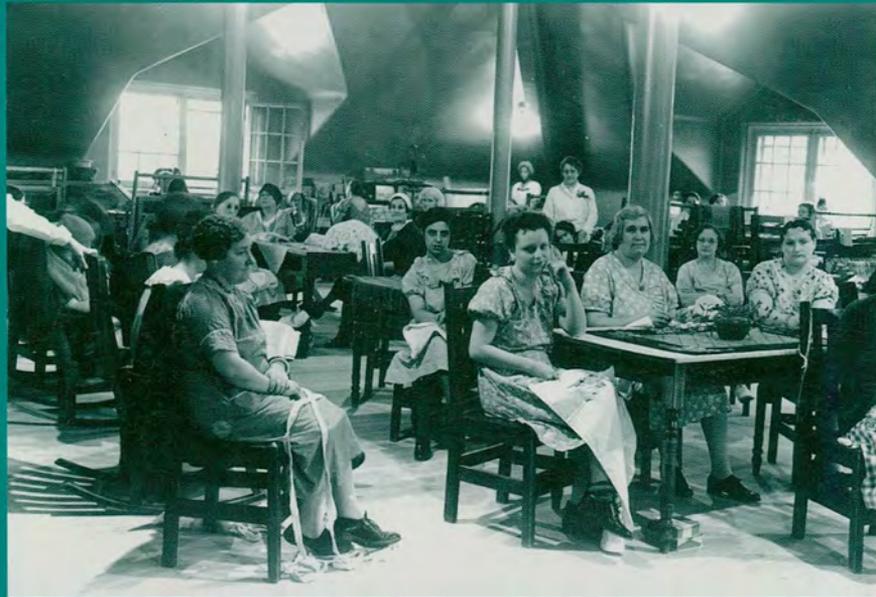
<u>STATE HOSPITAL</u>	<u>PLANT INVESTMENT</u>	<u>ANNUAL OPERATING COST</u>	<u>NUMBER OF PATIENTS</u>	<u>AVERAGE COST PER PATIENT</u>
Allentown	\$6,728,943	\$744,438	1,966	\$379
Philadelphia	\$13,453,357	\$2,111,014	6,100	\$346
Clark's Summit	\$1,440,000	\$574,396	1,046	\$533
Danville	\$5,168,714	\$903,586	2,918	\$642
Dixmont	\$1,776,307	\$332,358	973	\$596
Embreeville	\$500,000	\$135,700	300	\$832
¹ Farview	\$3,826,025	\$585,103	1,098	\$281
Harrisburg	\$5,958,888	\$1,568,173	2,441	\$368
Holidaysburg	\$529,957	\$219,957	369	\$314
Laurelton	\$3,408,320	\$750,883	903	\$421
Norristown	\$9,355,200	\$1,390,333	4,954	\$504
² Pennhurst	\$6,464,431	\$837,736	2,279	\$420
³ Polk	\$5,192,162	\$998,091	3,176	\$329
Mayview	\$8,500,000	\$1,265,489	3,005	\$370
Retreat	\$2,699,012	\$556,430	1,103	\$803
⁴ Selinsgrove	\$3,603,797	\$376,401	897	\$369
Somerset	\$891,169	\$152,212	463	\$491
Torrance	\$5,038,907	\$944,263	2,551	\$549
Warren	\$6,868,324	\$2,057,047	2,562	\$310
Wernersville	\$4,176,072	\$682,366	1,851	\$342
Woodville	\$6,516,765	\$1,193,215	2,428	\$452
	\$102,096,350	\$18,379,191	43,383	\$424

- NOTES:
1. Farview was the hospital for the criminally insane. It is now run by the Department of Corrections.
 2. Pennhurst served mentally defective children from the eastern half of the state.
 3. Polk was the equivalent of Pennhurst for the western half of Pennsylvania.
 4. Selinsgrove was a "colony" for epileptics
 5. Figures are taken from the 1947 *Pictorial Report on Mental Institutions in Pennsylvania*. Hospitals that are still open are shown in bold print.

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*Front Cover (clockwise): Dorothea Lynne Dix, early advocate for the mentally ill.
Roosevelt Avenue entrance to Philadelphia State Hospital in the 1950s.
Interior of Female One at Harrisburg showing one of the day sitting areas, about 1910.
Superintendent Henry A. Hutchinson, M.D. standing in front of a three-story wing of Dixmont.*

*Back Cover: Top: Occupational therapy at Byberry in the 1930s.
Bottom: Betty Williams of St. Francis Hospital administering a spray water treatment at
Mayview State Hospital in 1946.*