"Taken to Vt. State Hospital": Localizing the History of Mental Health Institutions, A Study of the Vermont State Asylum for the Insane, 1891-1912

Alecia Bassett
University of New Hampshire, Durham

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“TAKEN TO VT. STATE HOSPITAL”:
LOCALIZING THE HISTORY OF MENTAL HEALTH INSTITUTIONS,
A STUDY OF THE VERMONT STATE ASYLUM FOR THE INSANE, 1891-1912

BY

ALECIA BASSETT

BA History & Anthropology, University of New Hampshire, 2014

THESIS

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This thesis was examined and approved in partial fulfillment of the requirements for the degree of Master of Arts in History by:

Thesis Director, Elizabeth Mellyn, Associate Professor of History
Marion Girard Dorsey, Associate Professor of History
Nikhil Tomar, Assistant Professor of Occupational Therapy

Approval signatures are on file with the University of New Hampshire Graduate School.
ABSTRACT

“TAKEN TO VT. STATE HOSPITAL”:
LOCALIZING THE HISTORY OF MENTAL HEALTH INSTITUTIONS,
A STUDY OF THE VERMONT STATE ASYLUM FOR THE INSANE, 1891-1912

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Often, the term “insane asylum,” invokes a macabre image of a crowded, outdated institution that does not so much care for its patients as secludes them from society. This popularized notion about care for the mentally ill in the many decades before contemporary medicine, is, as often times is the case, based in both fact and fiction. Institutional demands, such as overcrowding, forced many asylum administrators to organize and restructure various aspects of asylum life to meet this need. This study utilizes officer’s reports, institution accounts, and patient records to create a local history of the Vermont State Asylum for the Insane that builds an understanding of how architectural planning, patient categorization, and day-to-day operations all influenced the institution within its first twenty years. By doing so, two major conclusions can be drawn: 1) that generalized histories of asylum building in the late-nineteenth and early-twentieth centuries are often reductive in nature. For example, in the later years of the nineteenth century, mental health movements such as moral management had increasingly come under scrutiny, and many states turned to other methods to address inherent institutional problems. 2) Despite this trend, Vermont continued to utilize moral management in new ways to address the same issues. To understand the institution’s approach, and avoid leaving them underrepresented in broader historical accounts, it is necessary to examine the Vermont State Asylum in the context of its own history.
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Introduction

On December 9, 1905, the *Vermont Journal* reported that “Willard Allard, a farmer, aged 72,” was placed under arrest for the murder of “Thomas McCormick, a wood chopper, aged about 50.” It seems that both men had been drinking when they got into a quarrel that ended with Allard striking “McCormick with a club, knocking him down and dragging him out of doors,” where Allard then “smashed his skull with an axe.” At first glance, it might seem as though this was a drunken altercation that had drastically taken a turn for the worst, but what stands out is that towards the end of the article, it is briefly noted that Allard had been “sent to Waterbury for observation” nearly eight years prior.\(^1\) Another newspaper elaborates on Allard’s previous time at the asylum, reporting that in December, 1897, he was committed to the Waterbury asylum after being charged with poisoning horses, but “was released 10 months later as sane.”\(^2\) Because of this, the defense argued against a charge of first-degree murder, instead introducing witnesses to “show Allard’s insanity.”\(^3\)

Allard himself argued that he acted in self-defense, stating that he “didn’t mean to let him [McCormick] get up and hurt me.” Others took the defense stand, stating that Allard, a “short, grey-bearded man,” who was “almost dwarfish,” as well as a Civil War veteran, had been “somewhat excited and talking incoherently” that day; his wife also testified that Allard “had acted strangely all day” and done things “he had never done

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\(^1\) “A Brutal Murder,” *Vermont Journal* (Windsor, Vermont), December 09, 1905.

\(^2\) “Slain with an Axe,” *Spirit of the Age* (Woodstock, Vermont), December 09, 1905.

\(^3\) “Insanity is Claimed,” *The Barre Daily Times* (Barre, Vermont), December 21, 1905.
before,” including striking her. Others stated that “following a sickness,” Allard had begun “to make threats against the neighbors,” while a neighbor noted that Allard would get “generally silly when in liquor unless he was crossed, when he would rouse up, rave and threaten to kill someone.” While the reiteration of these incidences seemed to have been meant to show Allard’s instability, and possible insanity, it appears that, at least to one reporter, Allard was not convincing in his defense, since he told his story with “great unconcern – much as he would describe the killing of an animal.” The same article also noted that Allard “sat through the proceedings with utter indifference, apparently paying no attention to the testimony.”

Of course, Allard’s defense used this as a show of his mental state, and a Dr. W.L. Wasson, who worked for the state hospital, testified to the fact that “he examined Allard last Wednesday and found his physical condition good.” Furthermore, while Wasson found that Allard’s “mentality was of a low order and his reasoning limited, he also believed that Allard “knew right from wrong and might be feigning insanity.” Having previously been a patient at the asylum, Allard would have certainly been in a position to mimic insane behavior. The prosecution argued that Allard’s behavior was not reflective of an insane person, but instead of an alcoholic, closing with the argument that Allard “could not be an imbecile, as he would never have been discharged from the state

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4 “Slain with an Axe,” Spirit of the Age (Woodstock, Vermont), December 09, 1905.
5 “Arguments Begun,” St. Albans Weekly Messenger (Saint Albans, Vermont), December 28, 1905.
6 “Slain with an Axe,” Spirit of the Age (Woodstock, Vermont), December 09, 1905.
hospital for the insane had such been his condition, and that confinement where he could not get liquor resulted in his [previous] cure at Waterbury.”⁷

Ultimately, Allard found himself back in Waterbury, found guilty of the second-degree murder of Thomas McCormick. After his conviction, he had been sent to the state prison in Windsor, where the next documentation of him is as prisoner “#3679, William Allard, murder 2nd degree, Age: 72, Height: 5’1/4”, Eyes: lgt. Brn., Hair: gray… Term of Confinement: natural life, When Discharged: taken to Vt. State Hospital Waterbury, Mar. 21 1906.”⁸

On June 28, 1889, nearly twenty years before Allard found himself in Waterbury for the second time, Charles C. Warren had signed a deed for the sale of three pieces of land over to the State of Vermont in the amount of fifteen thousand dollars. This land represented Warren’s farm, 500 acres of meadow and pasture. All of this land was to be “for the purpose of beginning the construction of the buildings contemplated to be erected upon thereon, for the purposes of an Asylum for the Insane.”⁹ This sale signaled the official birth of the Vermont State Asylum, complete with five hundred acres and one hundred and fifty dairy cows.

The purchase of the Warren Farm by the State of Vermont had been prompted by the unwillingness of the trustees of the Brattleboro Retreat to continue caring for state-funded patients. The Retreat had been founded in 1834 as part of a private bequest, and by the 1880s, there had developed a consistent dialogue of criticism between the

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⁹ Vermont State Hospital Real Estate Records, 28 June 1889, VSH-005, Container VSH-00136, Vermont State Archives and Records, Middlesex, Vermont.
institution and the state, which had also appropriated funds for its use.\textsuperscript{10} Namely, while the Retreat protested that having to accept the indignant insane led to overcrowding, state commissioners criticized the provided facilities. In turn the Retreat trustees complained about the lack of financial support from the state. As early as 1867, both Retreat trustees and the State Commissioner of the Insane advocated for a new solution to care for the state’s insane.\textsuperscript{11}

This form of dialogue was not unfamiliar to the time, as the mid-nineteenth century had seen a flurry of social reform aimed at building hospitals for the insane.\textsuperscript{12}

This reform movement was, most notably, led by Dorothea Dix who famously declared before the Massachusetts legislature in 1843: “I proceed, gentlemen, briefly to call your attention to the present state of insane persons confined within this Commonwealth, in cages, cellars, stalls, pens! Chained, naked, beaten with rods, and lashed into obedience!

\textsuperscript{10} Esther Monroe Swift & Mona Beach, \textit{Brattleboro Retreat: 150 Years of Caring, 1834-1984} (Brattleboro: The Book Press, 1984), 57.

\textsuperscript{11} “Commissioner’s Report” in \textit{Vermont Legislative Documents and Official Reports, Annual Session of the General Assembly, 1867} (Montpelier: The Secretary of State, 1867), 59-61.

\textsuperscript{12} The word insane is derived from the Latin \textit{insānus}, which means \textit{in-} (not), \textit{sānus-} (healthy, sound in body or mind). The Oxford English Dictionary traces its use back to the late sixteenth-century to describe persons “not of sound mind, mad, mentally deranged.” It was not until the late eighteenth/early nineteenth centuries that insane began to be used as an absolute, meaning instead of referring to someone as having insanity or being an insane person, they were merely insane. This attributes to the word’s use to describe institutions for the mentally ill as insane asylums. In this study, the word insane and mentally ill will be used interchangeably, although insane was the contemporary terminology for the time period researched, mentally ill is contemporary to the reader. For further insight into the etymology of the word insane, please see: https://www-oed-com.unh.idm.oclc.org/view/Entry/96605?redirectedFrom=insane#eid.
In the years leading up to this speech, Dix had extensively toured facilities for the insane, both in the United States and abroad.

These facilities included hospitals, prisons, and poorhouses across states such as Massachusetts, New Jersey, Pennsylvania, and Illinois. Often, cities constructed mental institutions alongside, if not completely incorporating them with, welfare and penal institutions in order to meet budgetary restrictions. While patients with sufficient means would have had the ability to pay for better accommodations in superior institutions, those from a lower socio-economic background were often dependent on community funded institutions such as poorhouses. When certain patients, such as the chronically ill, were unable to be gainfully employed in poorhouses, they were often sent to prisons and other facilities that could hold them for extended periods.

Many of the horrid conditions that Dix so vividly described were the result of the insane being held in such institutions, which did not treat them or provide them with dedicated care but simply warehoused them. Yet, a little over forty years later, five hundred acres of land was being purchased for the express purpose of a dedicated institution for the insane. This begs the question of how institutions for the insane transformed from being “cages, cellars, stalls, pens” to being an institution situated on a

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13 Dorothea Dix, “Memorial to the Legislature of Massachusetts” (1843), https://archive.org/stream/memorialtolegisl00dixd/memorialtolegisl00dixd_djvu.txt.
16 Ibid., 78.
17 Swift & Beach, 58.
vast estate, where patients had relative open access to outbuildings and the farm, and why
the Vermont State Asylum for the Insane was built.

Historian Gerald N. Grob attributes the conditions that Dix found to the fact that
during the early to mid-nineteenth century, many urban centers had begun to establish
their own municipal mental programs. This was a direct result of state institutions often
being located in a location central to the whole state instead of in high population cities.
These urban facilities were often burdened by a lack of an effective administrative
structure and sufficient budgets, which necessitated their incorporation into other urban
institutes, like prisons.\footnote{Grob, \textit{Mental Illness and American Society}, 27.}
The construction of the Vermont Asylum for the Insane in Waterbury shows a divergence from such municipal trends, instead resituating the asylum
back to the center of the state, and away from higher population cities such as Burlington
and Brattleboro.

A closer study of the Vermont State Asylum reveals that its location is not the
only trend from which it deviates. By reviving a local history of the asylum, it becomes
possible to demonstrate that histories of mental health institutions are, at times, reductive
in nature and can be misleading to our contemporary understanding of the subject. By
focusing on more generalized, broader trends in the history of institutions for the
mentally ill, sweeping histories have lacked nuances and left places such as the Vermont
State Asylum, which does not neatly conform to these generalized trends, unrepresented.
For that reason, this study will emphasize the importance of examining institutions in the
context of their own local histories.
As David J. Rothman argues, “the discovery of the asylum takes us directly into
the community. Institutions…cannot be understood apart from the society in which they
flourished.”¹⁹ This includes, for example, the introduction of the Vermont Poland Pauper
Law of 1886 that stipulated towns in Vermont would no longer bear the burden of caring
for their paupers, but instead could transfer their care to the responsibility of the state. As
explained before the state congress, “under this law it is only necessary for Overseers of
the Poor to prove that their idiotic, non-compos, and demented paupers are dangerous, to
enable their towns to relieve themselves of the burden of support, by sending them to the
State Insane Asylum.”²⁰ Grob, on the other hand, argues that the development of mental
institutions was “shaped not only by psychiatrists and other external professional and
social groups, but also by the nature and behavior of their patients.”²¹ As the core of the
institution’s population, it was these persons and their experiences that were shaped by
the asylum, and in turn, their lives as patients molded the asylum itself.

In order to best grasp how the Vermont State Asylum developed, this work will
be divided into four main chapters. Chapter I: “On the Construction,” addresses the
history of asylum building in the United States, putting particular emphasis on the
influence of psychiatric movements that originally evolved abroad, while Chapter II: “An
Act Providing for the Care, Custody, and Treatment of the Insane,” highlights how these
architectural details were applied to the Vermont State Asylum, and what factors
influenced its construction. Together, Chapter III: “Diverting the mind” and Chapter IV:

¹⁹ David J. Rothman, The Discovery of the Asylum: Social Order and Disorder in the
²⁰ Message of Carroll S. Page, Governor of the State of Vermont, to the General
Assembly, October Session, 1890 (Montpelier: The Watchman Publishing Co., 1890).
²¹ Grob, Mental Illness and American Society, xi.
“A Brutal Murder,” give insight into who would have been a patient at the asylum, and what their experiences would have been like as such. By analyzing each of these elements, it is possible to create a history of the Vermont State Asylum that utilizes general narrations of the development of mental health institutions in the United States, while also emphasizing the local history and characteristics that make Vermont State Asylum distinctive.
Chapter I: “On the Construction”: A History of Asylum Building

Dorothea Dix and England’s Asylums

In order to best understand mental health reform in the United States during the nineteenth century, it is necessary to first trace its origins back to similar movements that were occurring in England, especially those that would later influence American activists such as Dorothea Dix. According to historian Leonard Smith, legislation that addressed the need for public responsibility of the mentally ill emerged much earlier than in the United States with “specific provisions relating to the care and control of lunatics in the Vagrancy Acts of 1714 and 1744.” These provisions were similar to the Vermont Poland Pauper Act as they provided the ability for communities to establish institutions committed to caring for the indigent insane. Smith contends that despite these developments, it was still not until the latter part of the eighteenth century that committal to an institution was favored above caring for the insane at home.

He attributes this change to the growing understanding that curing insanity required “removal of the sick individual from the ‘morbid associations’ that had contributed to his disorder. The patient had to be separated from family and friends…where unwelcome influences could be kept away.”

Combined with the phenomenon of an “urban renaissance,” which saw the “creation of a range of new civic and philanthropic institutions” built on charitable donations, the building of lunatic hospitals exploded in England, popping up in almost every community. This movement was only furthered by the action of social reformers who felt it was their moral duty to

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23 Smith, 4.
expose the mistreatment of those confined in institutions that did not live up to their charitable originations.

In particular, Akihito Suzuki attributes institutional reform in this time period to a set formula that most social reformers followed. Namely, they would “find a glaring abuse in an asylum, publicize the result of an investigation, shock the public, humiliate those who were involved in managing the institution, and win reform.”

Evidence of such methods is demonstrated in several printed exposés of lunatic asylums, such as the one written by Edward Wakefield after his tour of Bethlehem Hospital in London in 1814. Wakefield wrote: “One of the side rooms contained about ten [female] patients, each chained by one arm to the wall; the chain allowing them merely to stand up by the bench or form fixed to the wall, or sit down on it… Their nakedness and their mode of confinement gave this room the complete appearance of a dog kennel.”

As the tale goes, after coming across a similar scene, Godfrey Higgins, a local magistrate, had to step outside of the cell to vomit, unable to stand the stench of confinement.

Furthermore, when Wakefield mentions that one room contained about ten female patients, it is without the context that most rooms within Bethlehem were designed to house only two or three patients. In 1815, the year after Wakefield’s tour, Bethlehem Hospital was renovated to hold 346 patients. However, this still did not account for the severe overcrowding for which Bethlehem continued to be known. It was because of this environment that Bethlehem Hospital gained its infamous nickname – Bedlam. Nor was

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26 Suzuki, 15.
Bedlam the only hospital to face condemnation for the condition of its patients. Many others faced the scrutiny of social reformers, including that of the York Lunatic Asylum.

Awareness of less than desirable conditions in England’s asylums had been emergent since before the nineteenth century, and stories of patient mistreatment motivated reformers as early as the eighteenth century. In 1791, Hannah Mills, a member of York, England’s Quaker community, died during a six-week stay at the York Lunatic Asylum. William Tuke, a fellow Quaker, was deeply disturbed by her death, and filled with concern over the questionable treatment that arguably led to her demise. This event led him to propose that a retreat for other mentally ill Quakers be built that would be run by the Society of Friends, and offer proper treatment and confinement for those that needed it.²⁷ When William Tuke first imagined the York Retreat, he envisioned an institution that would feel more like a family home.

Tuke’s vision of creating an asylum that simulated a domestic setting was influenced by the contemporary medical belief that held, under the right conditions, insanity could be domesticated – literally. The evidence of this influence on Tuke is highlighted by the fact the York Retreat was designed and constructed with the idea that the patients would have (reasonable) unrestricted access of the institution and participate in a domestic setting in order to restore them to sanity.²⁸ Patients were meant to feel as though they were part of an extended family where the doctors and caretakers were the head of the household, and the patients, wayward children.

²⁸ For more information regarding the ideals the York Retreat was founded upon, from a nineteenth-century point of view, see: John Batty Tuke, *Lunatics as Patients, not Prisoners* (London: S.N., 1889).
The wish to maintain as calming and domesticated environment as possible meant that the York Retreat was essentially a manor house situated on an eleven-acre farm, complete with gardens in which certain patients found employment. The house was composed of a male and female ward, with a billiard and games room for the men, and a parlor for the women, as well as separate courtyards for each gender, so that they could exercise outside. Furthermore, there were separate rooms for the violently insane, so that they would not disturb the recovery of the other patients. The use of restraints was also forbidden within the Retreat, and Tuke’s grandson, Samuel, who was manager of the Retreat from 1813 to 1847, credited the use of non-restraint as a result of a deep dedication to the “moral treatment, or management” of insanity.

Moral treatment, or moral therapy, refers to a school of psychological thought that advanced the idea that to treat the mentally insane effectively, they needed to be provided with accommodations that fostered a humane environment. Such an environment would allow the patients the ability to cultivate rationality and moral strength, thus achieving liberation from, and control over, their illness. This movement emerged as early as the mid-1770s, with Philippe Pinel, a French medical superintendent, claiming to be the first to remove his patients from chains, and lasted until the early twentieth century. As Samuel Tuke wrote, “It was believed, that the general treatment of insane persons was, too frequently, calculated to depress and degrade, rather than to awaken the slumbering

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30 Tuke, 39, 59.
31 Digby, 32.
32 Philippe Pinel, *A Treatise on Insanity: In which are Contained the Principles of a New and More Practical Nosology of Maniacal Disorders Than Has Yet Been Offered to the Public...* (Sheffield: W. Todd, 1806).
reason, or correct its wild hallucinations.”

Ostensibly, the York Retreat was designed to provide its patients with a domestic setting because family homes were where the insane were most humanely treated.

Suzuki argues that historians “have not so much verified as assumed the diminishing role of the family vis-à-vis that of the asylum and the psychiatric profession” during the nineteenth century. She proposes instead that institutional psychiatry and domestic psychiatry reinforced each other; that how families dealt with and understood insanity was an important piece of the cultural framework of institutionalization. The early nineteenth century saw family “idolized as the essential basis of private affection and public virtue,” and as such, “patterns of behavior of many men and women…were actually conditioned by the cultural emphasis laid on family.”

This emphasis explains the Tuke’s entrenched belief in moral therapy because, more often than not, families were less concerned with confinement than with seeking out care for family members they could no longer take care of themselves. Suzuki compares the practice of moral therapy at the York Retreat to the types of psychological healing that would have been practiced in a domestic setting, where “patients were persuaded to behave themselves without recourse to physical coercion or the threat of violence,” namely through the “strong emphasis on the power of personal influence on the patient.” Arguably, the practices of the York Retreat were the efforts of a “first

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33 Tuke, 26.
34 Suzuki, 2.
35 Ibid., 3.
36 Ibid., 116.
generation of practitioners of institutional moral treatment” to “create a sense of family within institutional walls.”

Part of creating a sense of family was providing a physical environment that also mimicked a domestic setting. While the York Retreat’s idyllic landscape and organization seems comparable to the farmland described in the Vermont State Asylum deed, it was actually unique for its time, particularly concerning its local. As noted, the York Retreat stood in direct contrast to other contemporaneous institutions in England, which often faced censure for the treatment of its patients, evidenced by Wakefield’s review of Bethlehem Hospital noted above.

Built in response to such publicized scandals, the administrators of the York Retreat tried to address similar issues in a variety of ways. Notably, admission to the York Retreat was, ideally, to be kept at 300 patients or less at any given time. By limiting the overall number of patients, the York Retreat attempted to restrict the number of patients any caretaker or doctor had to interact with, allowing for more sincere and

37 Ibid., 117-118.
38 Borthwick Institute for Archives, University of York, York, UK, https://www.york.ac.uk/borthwick/resources/retreat/.
meaningful interactions and individualized treatment. While the Retreat publicized itself as unique in its commitment to designing an asylum based on moral therapy, Smith contends that a commitment to moral management was a common trait amongst many English institutions by this time, and not just explicit to the York Retreat. In particular, he notes the similarities between the work that the Tukes were doing at the York Retreat, and the therapeutic ideals that Thomas Arnold was espousing at Leicester Lunatic Asylum. Much as the Tukes believed in building a familial relationship between the physician and his patients, Arnold also “advocated relationship-building and the development of ‘esteem and confidence’ to achieve these ends.”39

While the Tukes and Arnold understood moral management as a more passive therapeutic tool, encouraging positive relationships between themselves and their patients, other physicians understood it inversely. Thomas Dunston of St. Luke’s, for example, understood fear to be the best tool by which to encourage amenability from his patients. Clearly, there was a mix of opinions concerning how to best achieve a relationship between physician and patient. Smith attributes such discrepancies in treatment between institutions to the fact that physicians believed “if a technique was shown to work, it was legitimate,” no matter the inconsistency.40

Yet, there was one aspect of moral therapy that the York Retreat excelled at, which other institutions did not: the ability to provide diversionary activities. While Arnold wrote extensively about the importance of exercise and labor in the rehabilitation of the insane, he was unable to provide such pastimes in the restricted, urban confines of Leicester. The country setting of the York Retreat, on the other hand, allowed the Tukes

39 Smith, 153.
40 Ibid., 154.
to “proceed considerably further” in this facet, and, as Smith argues, combined with “Samuel Tuke’s skills as a publicist,” cemented the York Retreat as the epitome of a successful asylum.\textsuperscript{41}

The urban locality of many English asylums, such as Leicester Lunatic Asylum or the Manchester Lunatic Hospital, did not only prohibit the attainment of providing outdoors activities, but also resulted in many incidences of overcrowding, as higher urban populations held a proportionally greater number of insane compared to their suburban counterparts.\textsuperscript{42} When it became necessary to turn away patients due to already overcrowded facilities, many of the insane were instead “likely to be incarcerated in poorhouses or penal institutions.”\textsuperscript{43} This is not dissimilar to what Grob argues was happening in the United States. In fact, when Dix left England and began to tour the United States’ poor houses and prisons it is possible that she saw many more characteristics of Bedlam than of the York Retreat in her home country.

Due to ill health, Dorothea Dix had begun a tour of Europe in the 1830s, where she became familiar with multiple charitable institutions dedicated to the care of the insane through acquaintances with the institutions’ benefactors. Most notably, this included Samuel Tuke of the York Retreat. Arguably, it was because of these influences that when Dix returned to the United States in 1837, she began to donate her own time to charitable work. This included teaching Sunday school classes to female convicts in East Cambridge Jail, and it was there that Dix was first confronted with the treatment of the

\textsuperscript{41} Ibid., 155.
\textsuperscript{42} Ibid., 106-108.
\textsuperscript{43} Ibid., 3.
mentally ill in the States.\textsuperscript{44} The condition of the insane at East Cambridge Jail spurred her to further investigation, and in doing so, Dix consistently found American institutions, namely poorhouses and other municipal facilities, to be lacking, or even nonexistent, with the mentally ill often chained, unwashed, and subject to physical abuse.\textsuperscript{45} Nor was Dix the only American reformer noticing the condition of the insane at this time.

In 1841, Edward Jarvis, a Harvard educated physician and social reformer himself, noted that systems in the United States were characterized as follows:

The whole arrangement and apparatus of these establishments were for security; to save the public from harm; to defend the keepers and to make them as little trouble as possible; often the manacles were used as the cheapest way of governing them, and thus the expense of attendants was reduced.\textsuperscript{46}

Jarvis understood the lack of access to institutions dedicated to the insane not only as an absence of the proper facilities, but also as a cost-cutting measure. By chaining up the mentally ill in institutions that were not designed for their care, the mentally ill were bound to suffer. In Jarvis’ words: “Galled by the needless restraints of confinement and manacles, goaded by the harshness of tyrannical treatment, it is not surprising that the spirit raved in maddened fury, until exhausted, it sunk into hopeless imbecility.”\textsuperscript{47}

The “hopeless imbecility” of the insane concerned not only social reformers, but also society as a whole, as communities became increasingly aware that insanity affected all social classes. In fact, the year before Jarvis published his work, a journal in Exeter,

\textsuperscript{44} Manon S. Parry, “Dorothea Dix (1802-1887),” in \textit{American Journal of Public Health} Vol. 96, No. 4 (April 2006), 624-625.
\textsuperscript{45} Dorothea Dix, “Memorial to the Legislature of Massachusetts” (1843), https://archive.org/stream/memorialtolegisl00dixd/memorialtolegisl00dixd_djvu.txt, 5-6.
\textsuperscript{46} Edward Jarvis, \textit{Insanity and Insane Asylums} (Louisville: Prentice and Weissinger, 1841), 4.
\textsuperscript{47} \textit{Ibid.}, 5.
New Hampshire reported that: “The number of insane persons and idiots in the United States in 1840 was, 14,500, which is very near one in every thousand of the white population.”

As Smith notes, concern with the insane population grew because anxieties “associated with the disorderly poor” were only exaggerated when “unpredictability and chaotic behavior” was “added to their defects.” Yet, it was also apparent that insanity was not limited to the lower classes, as its presence was felt in the middle and upper classes as well. The combination of these factors produced a charitable response from the upper classes, for “in a self-consciously enlightened and prosperous age, there was a perceived responsibility on leading members of the community to ensure disinterested provision for victims of disadvantage.”

This same “perceived responsibility” was what Dix drew on in her speeches to various state and government officials in her quest to gather funds for the construction, and/or rehabilitation, of hospitals for the mentally ill that could provide the same sort of specialized care that the York Retreat did. This trend also resonated with the contemporaneous multidenominational religious movement that was occurring in the United States. Spanning from the 1790s to the 1850s, the Second Great Awakening was defined by the belief that morality was linked to self-liberation and self-control, and that all members of a society had to express such constraints in order to find moral perfection.

48 “General Intelligence,” *Christian Journal* (Exeter, New Hampshire), October 5, 1843. Note: this statistic aligns closely with the numbers reported in the 1840 census transcribed in *The American Journal of Insanity*.

49 Smith, 3-4.
and usher in the next coming of God.\textsuperscript{50} They believed that since the mentally ill did not have the same ability to express such control (as per their condition), that it was left to other members of society to help them achieve it, in order to maintain the salvation of society as a whole. As they had in England, the “self-consciously enlightened” members of society felt responsible “to ensure disinterested provision for victims of disadvantage.”

Several historians have also argued that Dix’s reform efforts were influenced by her own mental illness, as it is possible that throughout her life she suffered from depression.\textsuperscript{51} Others, such as Sonya Michel, have further argued that Dix capitalized on contemporary gender roles by juxtaposing her moral responsibility to a vulnerable class with the disturbing conditions she was bringing to light. Dix used her femininity to both highlight her “‘convictions of duty’ and her sense of ‘what is womanly and becoming,’”\textsuperscript{52} Notably, Dix exploited the same brand of shocking discourse Suzuki argues characterized English reform in her own crusade for change. Whether it was one, or a combination, of these factors, Dix led people to believe it was the responsibility of a moral government to take care of those in need, and that the right asylum would allow for the insane to continue their spiritual development and correct their irrational tendencies.

However, it must be noted that the 1840 census that drew such alarmed responses from some members of society was highly contested by others. The 1830s had seen an attempt to gather statistics concerning persons with physical disabilities, deafness, and blindness in the United States, but the 1840 census added the categories “insane and

\textsuperscript{51} For example discussion, see: David L. Gollaher, \textit{Voice for the Mad: The Life of Dorothea Dix} (New York: Free Press, 2000).
\textsuperscript{52} Sonya Michel, “Dorothea Dix; or, the Voice of the Maniac,” \textit{Discourse} Vol. 17, No. 2 (Winter 1994-1995), 49.
idiotic” in “the first attempt to measure the extent of mental illness and mental retardation in the United States.” 53 Often, persons who were counted as insane and idiotic were not defined by medical or scientific definitions. Instead, census takers relied on the “community and familial definitions of insanity…as the basis of classifications.” 54 This lack of formal classification resulted in an “indiscriminate grouping of the mentally ill and the mentally defective.”

Furthermore, “the term idiot…was then used in a generic sense, to cover all the mentally defective.” 55 This led to an exaggerated number of people counted as idiotic, because the mere lack of the ability to read or write could have a person marked down as such, with no regards to actual mental efficacy. This led to a disproportionate rate of insanity along racial lines, with “one out of 995 white persons…recorded as insane or idiotic,” as opposed to “one in every 144.5” African-Americans found insane or idiotic in the northern states alone. 56

The generalization of these conditions in such a way led to a tremendous amount of backlash from the medical community, especially from superintendents of mental institutions. In particular, Dr. John M. Galt II, superintendent of the Eastern State Hospital in Williamsburg, Virginia, held issue with the statistics concerning enslaved and

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55 Albert Deutsch, “The First U.S. Census of the Insane (1840) and Its Use as Pro-Slavery Propaganda,” in Bulletin of the History of Medicine Vol. 15, No. 5 (May 1944), 471.
56 Ibid., 472. For original, see: U.S. State Department, Compilation of the Enumeration of the Inhabitants and Statistics of the United States, as Obtained at the Department of State, from the Returns of the Sixth Census (Washington, 1841).
freed African-American peoples. He was one of the few superintendents who accepted African-Americans into his institution, and as such, had a patient base composed of both white and colored persons. Galt felt that the numbers of African-American insane “‘differed too widely’ to be trusted,” and “even asserted that an accurate ratio between the sane and insane of any population was virtually impossible to certain.” He argued that “the line between the two was ‘exceedingly indefinite, and whether certain persons shall be classed as sane or insane depends pretty much upon the general tenor of mind of the individual who makes any calculation.’”  

While it has been argued that Galt’s racially integrated asylum, and his use of slave labor there, made his peers consider him “a backwards provincial who subscribed to ‘antiqued notions,’” there is no doubt that most agreed with him that the 1840 census was not an accurate accounting of the state of insanity in the United States.  

In 1844, Galt became one of thirteen medical superintendents who came together “to communicate their experiences to each other, cooperate in collecting statistical information relating to insanity, and assist each other in improving the treatment of the insane.” Labeling themselves the Association of Medical Superintendents of American Institutions for the Insane (AMSAII), these thirteen men formed what is now known as the American Psychiatric Association. The aggrandized statistical data of the 1840 census had convinced this group of men that there needed to be a cohesive, institutional approach to the study of insanity. Not only did they believe that better statistical data needed to be

collected, but also that they could standardize asylum practices. One of these thirteen men was Dr. Thomas Story Kirkbride, who set out to revolutionize asylum architecture.

*The Kirkbride Plan*

Much like Dix, Dr. Thomas Story Kirkbride, the medical superintendent of the Pennsylvania Hospital for the Insane from 1840 to 1883, had believed that care of the insane should fall on the states. He felt that those most likely to make use of the asylum came from the largest class of tax paying citizens and therefore deserved access to institutions that those taxes would ultimately support. The large number of insane found in institutions dedicated to their care was a phenomena new to the nineteenth-century, with more than ninety percent of committed patients in public institutions.

Grob argues that this phenomenon coincided with a “widening role of the state” as older systems of poor relief began to decline. Previous to the nineteenth century, the United States had utilized poor relief structures similar to those in England that were based on the “belief that public order required appropriate mechanisms for the relief of poverty and dependency.” This meant that “fiscal and supervisory responsibility” was given to local communities. Nineteenth century economic and industrial changes that encouraged mobility, fostered larger populations, and saw the appearance of new family structures, meant that these relief systems came under enormous amounts of pressure. Increasingly, state governments took on welfare functions, often in the form of boards of

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public charity. These boards frequently reacted to immediate circumstances, and did not establish any particular policy making. The passing of the Poland Pauper Law in Vermont is a direct reflection of this trend, with the state taking on responsibility for the indigent and insane poor.

Even as providing for the disadvantaged became largely under the purview of state governments, Dix’s push for reform continued to be based on a belief in individual social responsibility to provide for those persons. Her criticisms of the treatment of insane persons were communicated in the theatrical ability to shock her audience enough to promote boards of charity and other government structures to provide new, innovative asylums. Kirkbride, on the other hand, was less concerned with who funded the institutions, and more with how to design asylums that facilitated the ability to be able to provide moral therapy. He, much like the Tukes in England, was a proponent of moral management techniques, and believed institutions built along the guidelines propagated by moral treatment were essential to cure the insane.

How heavily English psychiatric movements influenced American practitioners is a topic of debate among contemporary historians. Rothman, for example, argues that there was little English sway on the development of asylums in the U.S., and that the “American asylum was essentially homegrown, whatever the resemblance to European counterparts,” having developed in reaction to “peculiar American conditions and needs.” This directly contrasts Grob, who contends that “British tradition…seems to

98 Grob, Mental Illness and American Society, 72-73.
99 For a further discussion of Kirkbride’s professional background that led him to embrace moral treatment, see Tomes, 63-67.
100 Rothman, xlv.
have provided much of the impulse for asylum building.\textsuperscript{101} When looking at Kirkbride’s push for institutional reform, it seems that, at least he, was a product of both English influence and American circumstance. Chiefly, Kirkbride had his own connections to the York Retreat. Not only was he born to a Quaker family, but after completing medical school, Kirkbride also held a residency at the Friends Asylum for the Insane, which was a privately run Quaker institution, much like its English counterpart.\textsuperscript{102}

Arguably, this is where Kirkbride was first introduced to an asylum run on the basis of moral therapy. The use of moral therapy was a direct contrast to other institutions that Kirkbride would have been familiar with, especially in an urban area such as Philadelphia, where “most urban welfare institutions,” including asylums and almshouses, “remained undifferentiated in both structure and function.”\textsuperscript{103} To that end, Kirkbride also embraced the idea of replicating, as much as possible, a domestic setting. His goal was to create “an intimate family atmosphere in which the patient’s natural emotions…could be manipulated to induce sane behavior. The patients’ minds were to be constantly stimulated and diverted by amusements… regular physical exercise would tone their bodies and calm their minds.”\textsuperscript{104}

Kirkbride’s manuscript, \textit{On the Construction, Organization, and General Arrangements of Hospitals for the Insane} (2\textsuperscript{nd} edition, 1880) demonstrates his commitment to moral therapy and attention to detail. This manual was the basis for the architectural plans of the many hospitals built in collaboration with Dix, and is also the

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\textsuperscript{103} Grob, \textit{Mental Institutions in America}, 14.
\textsuperscript{104} \textit{Ibid.}, 62.
\end{flushleft}
basis for what would become known as the Kirkbride Plan. Each building was centered on a main administrative building, with four wings on each side arranged en echelon, or staggered. The overall effect was a building that when viewed from above looked rather like a bat.\textsuperscript{105}

![Blueprint of the Kirkbride Plan](image)

**Figure 2: Blueprint of the Kirkbride Plan.**

The purpose of this arrangement was to provide adequate air, light, and ventilation into each of the wards. Furthermore, the separation of each ward allowed for the categorization of patients, first by gender, and then by diagnosis. For example, violent patients were kept in the outermost wards in order to keep them from disturbing the other patients.\textsuperscript{106} Kirkbride also dedicated a large portion of his manuscript to describing details of indoor plumbing, the designation of windows, activity rooms, selection of construction site and so on. Carla Yanni, an architectural historian, argues that attention to all of these aspects of the asylum came from an awareness of state of the art nineteenth-century architecture.\textsuperscript{107} Kirkbride utilized advanced contemporary

\textsuperscript{105} Kirkbride, 163.
\textsuperscript{106} Ibid., 112.
\textsuperscript{107} Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis: University of Minnesota Press, 2007), 51-78. For a further discussion
architectural details in order to distinguish his asylum from prisons and poorhouses, which were likely to fall victim to fires, spread of disease, and other situations caused by crowded conditions, cramped layouts, and outdated building materials (such as wooden structures instead of stone buildings).108

Another aspect of the Kirkbride Plan was Kirkbride’s attention to an idyllic, country landscape with plenty of room for patients to enjoy outdoor activities, and calming views from their rooms. In 1842, towards the beginning of his tenure at Philadelphia Hospital, Kirkbride had already drawn attention to the efficacy of his techniques by providing tours of the institution. It seems that Kirkbride certainly delivered on what he had promised. One such account noted: “We turned away to the front window, and the midday sunlight lay upon the landscape around, and the green fields, dotted here and there by flocks of sheep stretched out at ease, wore an appearance of tranquilising [sic] repose.”109 The tranquil feeling that embraced the news reporter was exactly the same feeling that was meant to help calm, and hopefully, cure the insane. Together, these details represented the first codified asylum architecture in the United States.110

Nor was Kirkbride the only medical superintendent using moral treatment to guide the transformation of the physical attributes of the asylum. In a report concerning

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108 Ibid., 52.
109 “Visit to the Insane,” The Dolly Madisonian (Washington, DC), January 05, 1842.
110 Yanni, 51.
the New Hampshire Asylum for the Insane in 1842, the superintendent reports patient access to gardens and other outdoor spaces, explaining that: “Those who labor are the healthiest and happiest…Manual labor assists the restorative means used, and in many cases it materially promotes recovery, by giving health to the system, arresting the attention and inducing former habits of thought and action.”

Of course, it is not surprising that other medical superintendents were engaging with the same landscape and architectural details that Kirkbride was espousing. As mentioned above, in 1844 (the same year the New Hampshire Asylum superintendent reported on the success of access to manual labor) Kirkbride, along with thirteen other medical superintendents, had founded the AMSAII, the precursor to the American Psychiatric Association. The AMSAII, as outlined by The New York Herald, was:

Composed of medical gentlemen having charge of institutions for the insane. Every such establishment on the continent of America is entitled to a representative in the body. It is quietly, voluntarily and hopefully endeavoring to work out the problem of the causes, treatment and prevention of insanity. Their annual meetings are held for this purpose, and to diffuse among the whole member any discovery or information that any one member may have obtained during the preceding year; also to exchange ideas and consult upon the best general means of treating the insane.

This collaboration was the beginning of the professionalization of the treatment of the insane as its own medical field.

Psychiatry, as it is understood today, was not practiced in the nineteenth-century. Instead, many of the medical superintendents came from different medical backgrounds.

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112 Tomes, 6.
Kirkbride, for example, was originally trained as a surgeon, whereas Dr. Horace A. Buttolph, medical superintendent of New Jersey State Hospital at Trenton (the first asylum to be built along the Kirkbride Plan), was a family practitioner.\textsuperscript{114} Often, the first time most physicians were exposed to mental illness was when they took up residencies in asylums after medical school. This meant, “explanations of the etiology, symptoms, and prognosis of mental disease reflected not only the social background and medical training of physicians, but their experiences within mental hospitals.”\textsuperscript{115} Wards frequently separated patients based on their behaviors rather than any specific diseases, and asylum superintendents found themselves mostly administering to managerial chores as opposed to medical duties.

This created a widening gap in practice between physicians who worked in hospitals and those that worked in asylums, as the former became increasingly reliant on “biologically oriented science.”\textsuperscript{116} Even as the AMASAI\textsuperscript{II} espoused avid collection of statistical data concerning the mentally ill, asylum superintendents continued to hold on to a somatic understanding of mental illness, where environment affected the body, which in turn affected the mind. This encouraged the belief that “institutionalization was required for the treatment of the insane,” care becoming synonymous with treatment. If anything, this “reinforced the managerial character of the specialty.”\textsuperscript{117} However, beginning in the mid-nineteenth century, asylum superintendents started to become aware of the gap that was widening between their practice and that of other medical

\textsuperscript{114} Tomes, 59.
\textsuperscript{115} Grob, \textit{Mental Illness and American Society}, 30.
\textsuperscript{116} Ibid., 31.
professionals. They were also aware that their current classification of patients based on symptoms was not as precise as one based on etiology, the cause of disease, would be. However, to do that, it would be necessary to gather conclusive empirical data concerning mental illness.

Given this context, the popularity of the Kirkbride Plan amongst asylum superintendents is not surprising. The construction of these new asylums would allow medical professionals to both create an institutional environment that provided treatment for the insane, while also allowing for architectural details that would make collecting empirical data an easier process. The fact that such practices continued to revolve around a physical institution has much to do with the then pervasive belief that the environment caused sickness. In particular, many superintendents believed that “high levels of social mobility and political participation, coupled with freedom of religion and speech, made Americans particularly vulnerable to unhealthful enthusiasm.” The institution became vital to the treatment of the insane because it not only “forced the patient to break with the obviously improper environment in which he lived, but it also provided the physician with the opportunity to establish and to manipulate the environment and therefore change behavior.”

In other words, it was believed that “only the hospital could recreate an atmosphere free from the evils and temptations characteristic of society.” In fact, the AMSAII recommended that asylums should not be located less than two miles outside of any large town, in order to avoid any community influence. Furthermore, an asylum offered a concrete space in which “proper attention” could be paid to “rational routines”

118 Gonaver, 9.
119 Grob, Mental Institutions in America, 166.
so that “a person whose habits and sense of reason had either broken down or been
deformed…might be restored to sanity.”\textsuperscript{120} By controlling the environment, one could
control the outcome of the disease.\textsuperscript{121} Yet, part of controlling insanity also required
having a better empirical understanding of its progression.

In his architectural plans, Kirkbride came up with a solution to allow for the
continual task of better classifying patients: the staggered wings not only allowed for
more windows and airflow, but also allowed patients to be separated into different wards
based on their symptoms. Segregating patients by symptoms permitted superintendents to
make more pronounced efforts to adopt a common nosology. As Grob argues, “most
psychiatrists recognized that a precise classification system would not only illuminate the
course and development of a specific illness, but might also make possible the
identification of those conditions that determined health and disease.”\textsuperscript{122} Even though
“behavioral symptoms were amorphous and far more difficult to categorize,” the physical
institution continued to serve as the best setting through which to galvanize the study of
insanity.

This interest in better understanding and classifying patients’ symptoms also
explains the fact that the Kirkbride Plan did not account for any hospital to hold more
than 250 patients. A limited purview within any given institution meant that
superintendents could become more intimately familiar with each of his patients
symptoms. If medical supervisors better understood their patients based on their variety
of symptoms, then it would be easier to classify, treat, and cure them. Furthermore, if all

\textsuperscript{120} Gonaver, 9.
\textsuperscript{121} Gerald N. Grob, \textit{The Mad Among US: A History of America’s Mentally Ill} (New York:
The Free Press, 1994), 64.
\textsuperscript{122} Grob, \textit{Mental Illness and American Society}, 35.
asylums were designed along this construction, supervisors could also rely on each other to work in unison to better recognize and classify their patients. To that end, institutional reform focused on the physical construction of the asylum because architecture was a way to manifest, and further, scientific knowledge.

Social Order and Revisionist History

As is inherent to most processes of change, institutional reform movements that focused on the construction of asylums faced criticism, both by contemporaries and modern historians. While the Kirkbride Plan had provided a new institutional push for the standardized architecture of asylums in the United States, there had been other previous attempts to systematize institutions abroad. These institutions embraced the challenges of design, categorization, and patient liberty in a variety of ways. For example, the York Retreat had focused on the gender division of wards and access to the outdoors, and therefore had been mostly built along the plan on an ordinary English manor house. Other hospitals in England, however, had instead embraced pavilion style architecture. Jeremy Taylor, an architectural historian, argues that in the nineteenth century hospital administrators had become particularly concerned with portraying hospitals as “healthy,” with particular focus on ventilation, cleanliness, and open space; all details thought to attract donations and patrons.123

These were much the same qualities that Kirkbride had espoused, though while the Kirkbride Plan favored a series of interconnected wards, pavilion style hospitals usually favored detached or semi-detached wards in an attempt to provide complete

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separation between patients based on their diagnosis. Developed before a widespread belief in germ theory, this model nonetheless fulfilled a similar “fundamental need” by preventing “air acting as a notional carrier of infection.” Much like the Kirkbride Plan fulfilled Dorothea Dix’s desire for reform, the pavilion style hospital had been the product of reform efforts driven by another female activist, Florence Nightingale.124

Figure 3: Royal Herbert Hospital, an example of pavilion architecture.

There had also been attempts to standardize public institutions more generally. In the late eighteenth century, Jeremy Bentham had introduced what he named a Panopticon. Having been inspired by the idea that those under constant surveillance would always regulate their behavior by a set standard of rules, Bentham designed a building in which wards, cells, or chambers surrounded a single watchtower. That watchtower was to be built so that the inmates of the Panopticon would not know

124 Taylor, ix.
whether or not they were being watched, leading them to observe acceptable behaviors constantly.125

![Figure 4: Jeremy Bentham's Panopticon.](image)

While the Panopticon ended up being primarily used in the construction of prisons, Bentham had also intended its use in the building of hospitals, schools, and asylums; or rather, any institution in which surveillance, or the perceived notion of it, was valuable. However, the Panopticon was not integrated into asylum designs because the open concept was subversive to the soothing environment that superintendents thought essential to treatment. In contrast, the staggered wings of the Kirkbride Plan provided for the segregation of patients prone to outbursts from the others, allowing for the regulation of a controlled environment, as well as the ability to categorize patients by their symptoms.

Yet, when dealing with the idea of a controlled environment, questions arise about whether the said environment is actually curative to the patient, or, if patients are merely acting out social norms as imposed on them by the heads of such institutions.126 For that reason, social control has also been a heated topic when discussing the built environment

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of mental asylums. Social control can be understood in one of two ways: as an informal means of control to develop behaviors that are acceptable within any given society, or as a formal means, which is usually government sanctioned, in order to maintain control within a society.\textsuperscript{127} Therefore, social control can be understood in terms of pressures to act within societal norms, or as the government’s ability to imprison those breaking societal rules. \textit{Émile Durkheim} even goes so far as to argue that morality itself is a form of social control, defining morality as “a system of rules for conduct,”\textsuperscript{128} where a higher authority, whether government or religion, impresses an “obligatory character”\textsuperscript{129} upon those it governs. From this point of view, social reform movements of the nineteenth-century aimed at institutionalizing the mentally ill were not focused on curative treatments, but instead segregating patients from society and obliging them to act by societal norms in order to deem them “cured.”

Grob argues that such criticisms are the direct result of work done by revisionist scholars in 1960s, which interpreted mental hospitals as part of an “inherently repressive” system. He contends these academics came to regard mental illness not as a disease “within the conventional meaning of the term,” but rather as “an abstraction designed to rationalize the confinement of individuals who manifested disruptive and aberrant behavior.” Revisionist historians therefore concluded that trends in asylum building occurred for “one of two reasons: either the generalized fear of social disorder, or because of the rise of market capitalism and its concomitant demand for greater

\textsuperscript{128} \textit{Émile Durkheim}, \textit{Sociology and Philosophy} (New York: Routledge, 2010), 35.
\textsuperscript{129} \textit{Ibid.}, 38.
productivity.” Either way, according to this approach, “the primary function of mental hospitals…was to confine social deviants and/or unproductive person.”

The argument then becomes that the construction of insane asylums, along with poor houses and prisons, were broad attempts to mask society’s ills under a façade of traditional norms. In particular, Michel Foucault argues in his *Madness and Civilization* that the interest in the insane asylum was linked to Enlightenment archetypes concerning the control of reason. Moral treatment merely replaced physical chains and imprisonment with the mental restraints of social expectations and bourgeois ideals. Therefore, when historians such as Rothman and Grob discuss the idea of “social deviants” (alcoholics, the poor, mentally ill, etc.), they are discussing those people that did not act within standard social expectations, creating their characterization as a group outside of normal society.

Indeed, there is some evidence that the revisionist history outlined above is accurate to an extent. As will be discussed more in depth in the next chapter, the Vermont State Asylum for the Insane was involved in a discourse concerning the function of the institution as a place of confinement versus treatment, as debated by its board of trustees and medical supervisors. However, there is more evidence that asylum building, unlike previous methods for dealing with the insane, was not focused on merely warehousing patients, or pressuring them into acceptable behavioral norms. This is demonstrated by an institutional trend that offered the illusion of freedom, even more so than the York Retreat or the Kirkbride Plan. Leslie Topp explores this development in her monograph, *Freedom and the Cage*.

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130 Grob, *Mental Illness and American Society*, ix-x.
While Topp’s particular research focuses on Central European institutions, her review of the concept of the villa system is quite applicable to the institutional management of the Vermont State Asylum, where patients were employed throughout the hospital grounds with tasks that maintained the grounds, and inspired self-sufficiency, such as working with the dairy cows, planting crops, or working in the sewing room. Topp notes that the Kirkbride Plan can be classified as “corridor style” architecture, with the sprawling structures merely a variety of wards expanding from the same path.\footnote{132} She contends that his model failed to express any sort of freedom on behalf of the patient, whatever its original intent, because it represents an “excessively restrictive system” despite its superficial openness.\footnote{133} For this reason, asylum architects who embraced the morality school began to move away from such designs. Instead, they started to become interested in allowing the patients more freedom, while giving the appearance of security, and vice-versa.

Topp refers to this paradox as “caged freedom,” where the purpose of the asylum was to promote freedom to the patients, while still exerting social and spatial control over them.\footnote{134} The villa system was the result of that paradox. By building asylums that were composed of multiple buildings, on spacious grounds, yet still employing use of walls and window bars, Topp argues that asylum architects found a way to give the appearance of separation from the rest of a community, while “measuring out freedom” to those within its grounds. Patients had the ability to feel as though they had unrestricted access

\footnote{133} Ibid., 157.
\footnote{134} Ibid., 11.
to an institution’s grounds, while it was still possible to monitor their movements.\textsuperscript{135} In the United States, despite their commitments to non-restraint, many nineteenth century medical supervisors had been unwilling to expand the design of their asylums beyond that of the Kirkbride Plan. One exception was John Galt II, superintendent of Eastern Lunatic Hospital in Virginia.

Historian Wendy Gonaver argues that Galt was influenced to embrace the villa system, which she interchangeably refers to as the cottage system, after his own European travels.\textsuperscript{136} She notes that Galt was especially influenced by the Southern tradition of hiring out slaves. He saw that the while such slaves remained in bondage, they were able to function in larger society as well. As such, Galt believed that “family living and the cottage system of care were a logical extension of moral therapy; patients who internalized the discipline of the institution could be entrusted to interact peacefully with members of the broader community.”\textsuperscript{137} Furthermore, for chronic patients who were destined to be institutionalized for the long term, “cottage care offered the chance to experience conditions that simulated freedom.”\textsuperscript{138}

Interestingly, Galt’s incorporation of the cottage system into the Eastern Lunatic Hospital seems to have lost him the esteem of his peers, particularly that of Kirkbride. Kirkbride was of the belief that “alternative modes of care…would weaken the ability to provide moral therapy.” The AMASAI\textsuperscript{II} seems to have sided with Kirkbride on this account, as it continued to publish about the efficacy of the Kirkbride Plan.\textsuperscript{139} As an

\begin{footnotesize}
\begin{itemize}
  \item \textsuperscript{135} Topp, 115.
  \item \textsuperscript{136} Gonaver, 50.
  \item \textsuperscript{137} Ibid., 196.
  \item \textsuperscript{138} Ibid., 10.
  \item \textsuperscript{139} Ibid., 10.
\end{itemize}
\end{footnotesize}
alternative to the cottage system, asylum superintendents in northern states appeared to have embraced a system of parole where patients deemed recovered, incurable, or harmless would be released back into the care of their families or communities. Grob argues that this system demonstrated to patients that “‘self-control’ would be rewarded and that sequestration ‘is but a means to an end, and that end, restoration to their homes,’” thus further accentuating concepts of moral therapy.\textsuperscript{140}

Thus, as a northern institution, it is not surprising that upon its construction in 1891, the Vermont State Hospital was built primarily along a corridor style, with the architectural emphasis on the main winged building. However, by 1895, funds were already being appropriated to purchase land that would allow for the building of the “Annex,” which was a separate house to home twenty-five to thirty quieter patients that worked on the farm.\textsuperscript{141} The construction of the Annex, along with other similar outbuildings, highlights the fact that, early into its history, the superintendents of the State Hospital seemed eager to embrace an institutional style that incorporated many different concepts, even as other institutions drew a hard line between which were advantageous to the management and treatment of its patients and which were not. The incorporation of cottage style management was especially interesting considering the absence of institutions such as slavery, which persuaded Galt of its efficacy. Instead, the varied approaches seemed to have stemmed from the influence of both the medical superintendents of the asylum, as well as its Board of Trustees, which will be touched on in more depth in Chapter II.

\textsuperscript{140} Grob, \textit{Mental Illness and American Society}, 25.
\textsuperscript{141} Marsha R. Kincheloe & Herbert G. Hunt, Jr., \textit{Empty Beds: A History of Vermont State Hospital} (Barre: Kincheloe, 1988), 4.
The End of an Era?

Intriguingly, as the Vermont State Asylum was beginning construction, historians such as Stephen Verderber have argued that the influence of the Kirkbride Plan had already died off in the United States. Verderber pinpoints the end of the Kirkbride Era to the late 1850s, noting that this was when Kirkbride and his plan had begun to face criticism for the high costs of running his institutions and the impracticalities of limiting admission of patients to fewer than 250 persons. Furthermore, wealthier families had begun to fund private asylums, believing that this would afford higher quality of care and accommodation for their family members.142 Nancy Tomes, on the other hand, argues that the Kirkbride Plan did not begin to go out of vogue until the 1880s. She asserts that because Kirkbride had so staunchly set himself in opposition to alternative institutional methods, he had inhibited his own influence in the long run. Namely, he had failed to see the possibilities that outpatient care provided for cash-strapped institutions.143 Furthermore, the very association that Kirkbride had founded, the ASMAII, had already come to consider moral therapy outmoded, and had again begun to doubt the curability of the insane.

The ideal environment, and eventually Kirkbride’s theory, did not afford much attention if it was no longer linked to curability. The later decades of the nineteenth century saw a reversal of trends in the care of the mentally ill that had made Kirkbride’s approach prevalent. The physical structure of the asylum had been deemed essential to the practice of moral management, as it provided a space free of outside influences,

143 Tomes, 283-94.
where a physician could more readily assert his impetus for self-control over that of a patient’s. Yet, the basis for this practice rested on the understanding that moral therapy was a restorative therapy. By the end of the nineteenth century, asylum superintendents had become increasingly aware that the number of chronic cases in their purview had swelled, and patients were not being cured at the rates previously thought possible.

The AMASII acknowledged this issue as early as 1866, when they raised recommended patient admittance from 250 patients to 600. Yet, despite this response, entrance to many asylums continued to grow, either by states placing even higher ceilings on patient admission, or from a refusal to build new facilities. Grob argues that because of the stagnation in patient populations caused by chronic cases, by the end of the nineteenth overcrowding “had reduced mental hospitals to the status of inadequate poorhouses.”

Despite the acknowledgement of this issue, states did not seem inclined to solve the issue by further budgeting for new asylums or expansions to existing ones. In fact, some states went so far as shutting down all smaller asylums in favor of integrating insane populations into larger, central general hospitals. This is what occurred in New York with the passing of the State Care Act of 1890, which reverted all “county asylums to the status of poorhouse” under the premise that “large hospitals were more economical and promoted better individual care.”

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144 Smith, 3; Gonaver, 9.
145 Grob, Mental Illness in America, 4.
146 Ibid., 100.
147 Ibid., 5.
148 Ibid., 199.
149 Ibid., 89.
trends that inspired such enthusiasm for the Kirkbride Plan only a couple of decades earlier.

Other states, such as Wisconsin, attempted to limit patient populations by shifting financial accountability away from the state. In 1871, the Wisconsin Hospital for the Insane discontinued being state funded, and instead “required that families with sufficient means assume financial responsibility for patients,” as well as transferred “fiscal burden back to the counties.” This resulted in many patients who could not afford care at the public hospital to be once again be confined in jails and poorhouses, where officials, as before, found it difficult to “maintain order and create a more humane environment.”

While the Kirkbride Plan had seemed to standardize asylum practice for a brief period, it began to be called into question when moral therapy did not present high rates of curability, and states had to begin making new policies due to high chronic patient populations.

Perhaps in foresight of these difficulties, Dorothea Dix had attempted to secure federal funding for care of the insane in perpetuity. In 1850, Dix had helped draft the Bill for the Benefit of the Indigent Insane, which, if it had passed, would have allotted twelve million acres of federal land to be used for estates to establish asylums. She considered this the ultimate goal of social reform concerning the mentally ill. The twelve million acres would ensure that not only would the federal government provide care for the insane, but also that they would never again need to be regulated to jails or

\[150\] Ibid., 93.

almshouses because their care would fall to the federal government. However, President Franklin Pierce ultimately vetoed the bill.

In his veto message, Pierce begins by acknowledging that he was “compelled to resist the deep sympathies of my own heart in favor of the humane purpose sought to be accomplished.” Further into his speech, the President explains why he felt bound to ignore his moral obligations, stating:

I readily and, I trust, feelingly acknowledge the duty incumbent on us all as men and citizens, and as among the highest and holiest of our duties, to provide for those who, in the mysterious order of Providence, are subject to want and to disease of body or mind; but I can not find any authority in the Constitution for making the Federal Government the great almoner of public charity throughout the United States… I can not avoid the belief that it would in the end be prejudicial rather than beneficial in the noble offices of charity to have the charge of them transferred from the States to the Federal Government.\(^{152}\)

In the end, Pierce barred the bill, and essentially ended Dix’s campaign, by arguing it was unconstitutional for the care of the insane to fall on the federal government, and not the state.

Despite the evidence that there seems to have been both a professional and political trend moving away from the endorsement of mental health institutions during the mid-nineteenth century, the Vermont State Hospital, founded towards the end of the century, seems to contradict this evidence. Even as public distrust was on the rise, as institutional practices appeared to fail and revert back to methods of warehousing, the Vermont State Hospital seemed not to embrace these same trepidations. In fact, as late as 1896, Vermont journalists were still using much of the same language that Dix was to espouse the mission of the State Hospital. The Stowe Journal reported: “the measure of

civilization… is said to be the care which makes of its unfortunate… It is a measure of
the depth of its humanity, its religious and its social character… in the care of her insane
and feeble minded… Vermont is in the front rank.\textsuperscript{153}

One can certainly hear echoes of Dix, urging the politicians before her to “feel
more deeply the imperative obligation which lies upon [them].”\textsuperscript{154} Yet, these echoes are
coming nearly four decades after Verderber, and other historians, have argued they
stopped being influential. While in states such as New York and Wisconsin, state
governments and medical supervisors were moving away from mid-nineteenth century
trends due to doubts in their efficacy; Vermont State Asylum seemed to instead embrace
the challenge. Its medical supervisors continued to regard moral management as a way to
deal with institutional problems that had yet to be solved.

\textsuperscript{154} Dorothea Dix, “Memorial to the Legislature of Massachusetts” (1843),
https://archive.org/stream/memorialtolegisl00dixd/memorialtolegisl00dixd_djvu.txt.
Chapter II: “An Act Providing for the Care, Custody and Treatment of the Insane”

The Poland Pauper Law, a Vermont state law passed in 1886, was a revision of an earlier law addressing town versus state responsibility regarding Vermont’s poor and insane as outlined in Acts and Resolves, No. 42. It set the stage for placing the insane solely under state responsibility, declaring: “Insane persons in any town destitute of the means to support themselves, and having no relatives in the State bound by law to support them, shall be supported by the state.”\(^{155}\) Prior to its ratification, care of the insane was the responsibility either of family members, or lacking that, the community in which they lived. Grob notes that the appearance of new poor laws was not unusual for the time, as the United States was undergoing social and economic changes that were putting stress on traditional forms of welfare. He also notes “state involvement in welfare…was not based initially on a systematic and comprehensive analysis of existing problems,” but instead were “ad hoc responses to immediate circumstances.”\(^{156}\) This is true of the Poland Pauper Law, which was not passed in concert with other social welfare laws, but instead in the wake of several years of dispute concerning the admission of state patients to Vermont’s only other asylum, the private Brattleboro Retreat.\(^{157}\)

Furthermore, the act provided stipulations for how much the State Asylum could charge per patient. At the time of the act’s passing, the Brattleboro Retreat was receiving “one dollar and twenty-five cents” per patient from towns from which the patient had been committed. With the Poland Pauper Act, it was determined that the State Asylum

\(^{155}\) Acts and Resolves passed by the General Assembly of the State of Vermont at the Ninth Biennial Session, 1886 (Springfield: Press of Springfield Printing Company, 1887), 35.

\(^{156}\) Grob, Mental Illness and American Society, 72-73.

\(^{157}\) Swift & Beach, 57-58.
would instead charge the state “three dollars and seventy-five cents” per week for each
insane poor institutionalized there, which was parallel to the Brattleboro Retreat’s actual
cost of care per patient. The Retreat’s Board of Trustees, who wished to address the
deficit between costs of care and paid admissions, advocated for this budget. That
means the State Asylum was potentially collecting only $195.00 dollars a year to care for
the state insane, which would be equivalent to approximately $5300.00 by modern
standards. This was a higher budget per patient than other comparable New England
institutions; the Massachusetts Board of State Charities spent $3000.00 per patient at the
Danvers Lunatic Asylum.

As well as determining cost, the Poland Pauper Law provided a stipulation
concerning admittance to the State Hospital: a probate court had to find any patients
admitted found insane based upon the written testimony of “two physicians legally
qualified and residents of [Vermont].” Grob notes that in most cases, individuals were
committed to institutions in a “loose and informal manner,” and not all states required a
medical certificate to determine the sanity of a patient. Rather, in at least 25 other states,
a person’s sanity and subsequent commitment, was determined by a court, whether a
judge or lay jury. Vermont was therefore unusual in the fact that insanity was
determined by physicians, placing the power to define insanity in the hands of medical
experts, as opposed to family members or court members. These seemingly stricter

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158 Ibid., 58.
159 Acts and Resolves, 36.
160 Grob, Mental Illness and American Society, 82.
161 Acts and Resolves passed by the General Assembly of the State of Vermont at the
Eighth Biennial Session, 1884 (Rutland: The Tuttle Co., 1885), 54.
162 Grob, Mental Illness and Society in America, 10.
standards were most likely due to the issue that had lent a hand in the revision of their poor laws to begin with, namely overcrowding at the Brattleboro Retreat.

Since having opened in 1834, the Brattleboro Retreat had struggled with an overflow of patients. In the institute’s biennial report, it was determined that the Brattleboro Retreat was capable of caring for a maximum of 400 patients, but that “the average number of patients for the ten preceding years has been 445, and for the last two preceding year 461.” The majority of these patients were classified as “insane poor of towns,” accounting for 255 of 485 patients in 1890.163 To address these overcrowding issues, the Retreat had begun to release the chronic, but “harmless and incurable,” ill back into the care of the towns from whence they came, similar to the system of parole that Grob describes, where patients would not technically be discharged from the institution, but instead allowed home under the pretext of good behavior; this resulted into the release of 109 patients in 1889.164 However, this often resulted in an illusory balance between admissions and discharges, as most patients were chronic cases and destined to be readmitted.165

The issue lay in the fact that most towns were also unable to cope with the burden of caring for the mentally ill long term – both logistically and financially. The chronically mentally ill needed long-term support, and were often unable to work, which meant family members were often incapable, or unwilling to continue caring for them.

165 Grob, Mental Illness and Society in America, 24.
Therefore, upon their discharge from the State Hospital, they chronically ill would fall back into the care of the town, often being discharged back to local poorhouses, becoming a drain on town and poorhouse funds. The passing of the Poland Pauper Law meant that the state now had a responsibility to care for the insane when towns did not have the means to, so chronic patients were often sent back to the asylum when a new group of patients was discharged, seeming to create space. This created a cycle in which the “harmless and incurable” were ultimately continually readmitted to the Brattleboro Retreat.

In light of this issue, the Vermont legislature passed “No. 94 – An Act Providing for the Care, Custody and Treatment of the Insane Poor and Insane Criminals of the State,” in 1888, a mere two years after the endorsement of the Poland Pauper Law. Act 94 provided for a committee of three trustees, whose position required them to “judge the proper care, custody and treatment of such insane poor require, either by providing for their care… in the insane asylum at Brattleboro… or by providing a new asylum.” While the law does not address who was qualified to be one of the three trustees, it did specify that they were to be granted a “sum of one hundred thousand dollars” in order to carry out the provisions of their task.  

It does seem that consideration was taken to afford these funds to the expansion of the Brattleboro Retreat; however, the supervisors of the Retreat made it clear they were not interested in continuing to admit both the insane poor and the criminally insane, as expected of a state institution. In fact, the supervisors reported in their 1890 state report

166 Acts and Resolves passed by the General Assembly of the State of Vermont at the Tenth Biennial Session, 1888 (Burlington: The Free Press Association), 105.
that they “did not consider [themselves] legally holden to care for the transient class, nor under obligation to receive the convict and criminal insane.”  

The reluctance of the Brattleboro Retreat to accept the criminally insane was a common hesitancy amongst medical superintendents who subscribed to moral management. Jails were exactly the type of institutions that they were trying to detach asylum practices from, and when advocating non-restraint practices, it did not bode well to have to incorporate the “prisonlike features” of a convicts’ wing. Furthermore, there were often misgivings about having the vice of convicted criminals in an environment that was meant to be restoring morality to its patients. However, these concerns were often overridden by state boards, which, concerned more with financial parsimony, saw an advantage to caring for the criminally insane in a state hospital as opposed to a penitentiary.

In wake of this reluctance, the committee of trustees in charge of deciding how to best use the sanctioned $100,000, reported that: “the management of the institution absolutely declined to enlarge its capacity by the erection of new buildings or the enlargement of those now in use.” While it may seem odd that the supervisors of the Retreat had no interest in continued admission of state patients, each of whom brought with them state-sourced funding, it does begin to make sense when looking at their financials of that same year. It was reported that the Brattleboro Retreat received $49,968.44 for the care of the insane and criminally poor from 1889-90, while they

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168 Tomes, 302.
169 Ibid., 301.
received $58,415.91 for the care of private patients that same year. At this time, the Retreat had only 105 privately paying patients, meaning they were making $10,000 more in a year for treating only a quarter of their patient base.\textsuperscript{171} Clearly, it made much more fiscal sense for the institution to cater to privately paying patients than it did state funded ones, assuming their were more private patients available. Nor was this an unusual practice for institutions at the time.

Often, price per patient was “arbitrarily fixed by the legislature,” leading to many finding themselves “lacking sufficient operating funds.” To make up for this deficient, institutions would charge private patients “sums higher than those paid by local communities,” making private care a more profitable expenditure. To avoid this issue, some states, such as New York, passed legislature that provided “an annual appropriation based upon careful cost estimates,” as opposed to paying per patient, eliminating public versus private discrepancy. Vermont, however, chose to continue paying out per patient, and used the provided funds to purchase Charles C. Warren’s dairy farm in Waterbury, with the expectation that the new state hospital would relieve the Brattleboro Retreat “of the class having no legal claim upon” the institution.\textsuperscript{172} As states continued to take more responsibility for their indignant poor and insane, private institutions increasingly closed their doors to those they thought belonged in state funded institutions.

When choosing the site, the trustees noted that the Warren farm was “an exceptionally fine [site], being centrally located with reference to the principal sources of its population, in a healthful, pleasant and fertile district, surrounded by grand and

\textsuperscript{171}“Biennial Report of the Officers of the Vermont Asylum for the Insane for the period ending July 31\textsuperscript{st}, 1890,” 18.
\textsuperscript{172}Ibid., 4.
picturesque scenery….”\textsuperscript{173} Furthermore, the asylum building was intentionally designed so that “the rooms are so arranged that there is scarcely a patient’s room… which does not have either the morning or afternoon sun.”\textsuperscript{174} Even the building itself was designed to enhance the asylum’s scenic setting, with “the long lines of the building, its broken plan, varying heights, and rounded forms” meant to “produce a picturesque yet harmonious effect, quite in keeping with the pleasant valley and the encircling hills.”\textsuperscript{175} This interest in the scenery when selecting the site is, of course, reminiscent of Kirkbride’s own insistence on an idyllic landscape.

In fact, although it was constructed nearly forty years after the first Kirkbride building, the Vermont State Asylum for the Insane embodied many of the same physical qualities thus far described, and represents the institutional push that Kirkbride symbolized. The building itself, while not an exact replica of the Kirkbride Plan, maintains most of its basic concepts. The original plan included a main administrative building, with five wards of each side connected by a series of corridors, which would allow for categorization of patients by gender and diagnosis. These corridors were enclosed between wards, more similar to Kirkbride’s blueprints than the comparable pavilion model, which often had open corridors connecting individual ward-buildings.\textsuperscript{176}

In 1891, the beginning of construction, it was determined that only four of the five wards were to be built due to lack of funding. These monetary limitations forced the kitchen, laundry, and employee quarters to all be built in the basements under those wards. It was not until 1894 that the hospital had enough funding (after being

\textsuperscript{174} \textit{Ibid.}, 7.
\textsuperscript{175} \textit{Ibid.}, 8.
\textsuperscript{176} Taylor, 100.
appropriated $150,000.00) to complete the building as originally imagined. For comparison, almost twenty years earlier, the Worcester State Lunatic Hospital in Massachusetts had been granted $110,000.00 for the construction of their own Kirkbride building.177 This meant, when completed, the hospital was “twelve halls with five wards on each side of the center building,” not to mention various outbuildings, including a new kitchen, laundry room, boiler building, and farm buildings.178

Figure 5: Architectural Sketch of Vermont State Asylum for the Insane at the Warren Farm.

As described in *The American Architect and Building News*, the goal was:

To provide accommodations for the various classes of insane in a series of wards, having so far as possible, all the light and air advantages of entirely isolated buildings, yet adapted by the connecting corridors… [with] two circular wards, one general ward, [and] one criminal ward…

The same article also reported “the cost of the institution completed will approximate to the lowest cost of such structures yet reached in this country, viz, $600 per patient…”

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178 Kincheloe & Hunt, 2-3.
accommodate 400 patients and will cost about $250,000.”179 This was a higher number of patients than Kirkbride had originally advised, but it is likely the architects were accounting for both a larger building site than found in a city and the number of patients that would have to be transferred from the Brattleboro Retreat. By maintaining the lowest building cost per patient, the asylum seems to have been able to undermine the argument that the Kirkbride Plan was too expensive to remain popular. With this in mind, it may not then be surprising that two months after opening, the hospital recorded in its supply accounts book a year subscription for the AMSAI publication, *The American Journal of Insanity*; it cost five dollars.180

However, when describing the planned architecture for the site, the language used also shows an awareness of the caged freedom concept that Topp addresses in her architectural history. Describing the building as “somewhat unique in asylum architecture,” the trustees note the building will be comprised of “a central administration building and two wings, each composed of a group of wards connected by corridors in such manner as to give them nearly, if not all, the advantages of the so-called detached or cottage system, and at the same time secure economy in management.”181 This “secure economy in management” is further addressed when describing the outline of the wards, which were meant to separate patients by gender and condition, while also ensuring quick access to all wings and wards for means of administration.182

182 Ibid., 7.
As for the wards themselves, they are described as being complete with “day rooms, two small, associated dormitories, bed rooms, dining room, bath and toilet rooms.” In particular, “three circular buildings” were utilized as wards for the chronic patients, where each was “two stories high and arranged for 25 patients, the first floor being used for a day room, and the second floor for an associated dormitory,” and included two enclosed sun rooms, as well as a dining room “large enough for the whole 75 patients.” Furthermore, each wing included a “building for the criminal insane… two stories high, complete ward arranged for twelve patients on each floor,” as the new state legislation required the new hospital to accept criminally insane patients. 183 The buildings for the criminally insane included separate entrances to enhance their segregation from the other patients. This was another stipulation that was included in the 1888 law that had allowed for the construction of the State Asylum.184

In comparison to other contemporary Kirkbride buildings, this was a very similar design. For example, the Kankakee Hospital in Illinois, built in 1880, was smaller, but also was designed with six wards meant for twenty-five patients on either side of a main administrative building. It was also differentiated by the fact that acute and violent patients were kept in the central part of the building as opposed to the ends of the building.185

Even though the main asylum building had been described as having all of the advantages of a cottage system, it was not until the second year of its operation that patients began to be housed in buildings situated outside of the main building. One such

183 Ibid., 7.
184 Acts and Resolves passed by the General Assembly of the State of Vermont at the Tenth Biennial Session, 1888 (Burlington: The Free Press Association), Sec. 17, 107.
185 Grob, Mental Illness and American Society, 101.
building was a “retreat” for “twenty quiet female patients.” The supervisors describe this “retreat” as giving the patients “out-door occupation, diversion and amusement” where “all restraint is thrown off” and “the patients here have all the comforts and conveniences of a retired, well-kept, first-class summer boarding house.” Another was a cottage for male patients, located almost a mile away from the main building, where patients with adequate “self control” and the ability to “make themselves agreeable to their companions” lived.\textsuperscript{186} The building of such outbuildings continued throughout the asylum’s accessible history. In 1895, a brick house, referred to as the “Annex,” was built on the further reaches of the asylum’s land to create a farm colony where twenty-five to thirty convalescent male patients lived and had the freedom to work on the asylum’s farm.\textsuperscript{187}

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{image6.jpg}
\caption{"Home for Convalescent Patients," 1898.}
\end{figure}

\textsuperscript{187} Kincheloe & Hunt, 4.
Ten years later, asylum superintendents continued to allow patients access to areas outside of the main building, and in 1905 “fifteen acres of meadow in the rear of the hospital was fenced off… and three large sun shelters built to accommodate one hundred patients each.” This construction allowed for about “ninety-five percent of the patients… to avail themselves of recreation, amusement, and rest out of doors.” As provided in the asylum’s 2016 National Register of Historic Places Registration Form, the map in Figure 7 gives an overview of the asylum’s grounds. While not to scale, the map does reveal the multiple outbuildings still in existence today; for example, the Annex still stands, which has been outlined below.

Figure 7: Map of Asylum Grounds.

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188 Kincheloe & Hunt, 8.
189 For the complete registration form, see: https://www.nps.gov.nr/feature/places/pdfs/16000765.pdf
While other superintendents had long since espoused the virtues of outdoor activity and exercise on the health of the mind, many did not have the luxury of constructing an asylum that allowed it to the extent that the Vermont State Asylum did.\textsuperscript{190} Furthermore, guided by the authority of Kirkbride, many superintendents had dismissed the notion of caring for patients outside of the main asylum, as it was believed to disruptive of moral environment that superintendents were supposed to be creating.\textsuperscript{191} This did not mean, however, that all asylum superintendents rejected the idea of care outside of the asylum. Often, practicality outweighed theoretical practice. Thus, in many cases, overcrowding caused by small patient population limitations forced them to look elsewhere.

During the 1880s, in Massachusetts, for example, there was a program for home care put into place. It was an attempt to board the passive, chronically insane with families in private homes, who were given a stipend by the state. This cleared up patient populations in overcrowded institutions, while saving the state expenditures associated with asylum care.\textsuperscript{192} Home care was a practice that lasted through 1914, despite the construction of large state asylums, such as the rebuilding of Worcester State Hospital on a 275-acre farm in 1877.\textsuperscript{193} Yet even other institutions relied on a system of parole, where the chronically insane would be released on good behavior back to their families and/or communities.\textsuperscript{194} Grob notes that home care never reached its full potential in Massachusetts because many asylums were located in urban centers, and the families that

\textsuperscript{190} Smith, 106-108.  
\textsuperscript{191} Gonaver, 50.  
\textsuperscript{192} Grob, \textit{Mental Illness and American Society}, 84-86.  
\textsuperscript{193} “Trustees’ Report,” 8.  
\textsuperscript{194} Grob, \textit{Mental Illness and American Society}, 25.
were willing to accept in-home patients tended to live in lower income, rural and farming areas.\textsuperscript{195}

Despite being located in a more rural part of Vermont, the administrators of Vermont State Asylum seemed to have never considered home care or parole as an alternative to institutional care. In fact, it seems that because of these architectural details and commitment to outdoor employment, that the hospital’s trustees and superintendents believed that they were on the cutting edge of asylum design. In its opening year, the trustees reported that their “management of the insane” was “superior to those of any institution in the country.” Not to mention that they believed their use of alternative housing to be a “new feature in the treatment of this unfortunate class of people,” which was in fact “first introduced… into our asylum.”\textsuperscript{196}

This strain of language continues throughout the hospital’s biennial reports - in 1894, the superintendent notes how outdoor access to the farm and other areas of the institute, allowed for “excellent results” from both an “economic point of view, as well as of moral treatment.”\textsuperscript{197} Even as late as 1912, the superintendent espouses the idea that whereas in times past a “‘Lunatic Asylum’ was considered a place of last resort… and the feeling was almost universal that his [the patient’s] doom was sealed,” patients were now taking “more comfort” and were “reluctant to return to their homes.”\textsuperscript{198} While similarities

\begin{itemize}
\item \textsuperscript{195} Grob, \textit{Mental Illness and American Society}, 85.
\item \textsuperscript{196} “Biennial Report of the Trustees of the Vt. State Asylum for the Insane for the years 1891-92,” 4.
\item \textsuperscript{197} “Third Biennial Report of the Trustees of the Vermont State Asylum for the Insane for the term ending June 30, 1894,” in \textit{Vermont State Officers’ Reports for 1893-94} (Rutland: The Tuttle Company, 1894), 8.
\item \textsuperscript{198} “Twelfth Biennial Report of the Trustees of the Vermont State Hospital for the Insane at Waterbury for the term ending June 30, 1912,” in \textit{Vermont State Officers’ Reports of 1911-1912} (Rutland: The Tuttle Company, 1912), 8.
\end{itemize}
can be drawn between the architectural details of the Vermont State Asylum, Kirkbride’s *On the Construction*, and contemporary European villa asylums, it is arguable that the trustees and superintendents were correct in considering their institution to be unique, to an extent.

Other asylums in the United States, such as Kankakee Hospital in Illinois, and Eastern State Hospital in Virginia, had also incorporated the cottage system into asylum administration, following European models even more closely, by creating an artificial village. Yet, as was the case with John Galt II, these institutions were influenced to embrace such systems by other documented impetuses, like slavery. As a non-slave holding state, administrators in Vermont would not have had the opportunity to draw parallels between outpatient care and outsourced slave labor. Nor did they adopt the same alternative forms of outpatient care that other institutions in New England seemed to have been turning to. Instead, the Vermont State Asylum was providing such care on its own asylum grounds. The asylum administrators were utilizing architectural elements that allowed them to give the impression of patient freedom within a predominant institutional system.

Of course, these men would not be the first to consider their institutional planning to be inimitable (Tuke and Kirkbride almost certainly would have said the same), but what truly made the Vermont State Hospital distinctive was its comprehensive mixture of asylum designs. Arguably, the trustees and superintendents incorporated all of the various elements as outlined above because of the environment in which they were building and running the asylum. For example, while Kirkbride was able to provide tranquil scenery

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200 Gonaver, 14.
for his patients in Philadelphia, it was only provided through the patients’ windows. With five hundred acres of farmland at their disposal, the asylum in Waterbury could more readily bring their patients outside. Likewise, with a country setting came the capability to provide components of design just not feasible for asylums located in cities.

Furthermore, it is likely that those running the asylum embraced such a varied combination of asylum designs because of challenges that they faced in daily and yearly operations. As previously discussed, the asylum was originally devised to hold approximately four hundred patients in a single, albeit winged, building. When the hospital officially opened in August 1891, they accepted a total of twenty-nine patients that month, only one of who was female. These numbers continued to steadily increase throughout the hospital’s first year of operation, but remaining well under total capacity, having only reached a high of 215 patients by December.

This remained true for the next five years, with the hospital seeing 190 patients in July 1892, 195 patients in January 1893, 209 in August 1894, and 242 in April 1896. However, in the spring of 1896, with the completion of the rest of the main building, more patients began to be transferred from the Brattleboro Retreat, as originally intended. This resulted in a population spike with 242 patients in April increasing to 392 within the month. In the month after that, the asylum was caring for 498 patients.201 With more patients in admission than the hospital was originally designed to hold, it is not unsurprising that the superintendent and trustees turned to alternative housing.

201 Vermont State Asylum Admissions and Discharge Volume 1, August 1891- October 1899, VSH-002, VSH-00105, Vermont State Archives and Records, Middlesex, Vermont.
Buildings such as the Annex and the women’s retreat served a dual purpose, not only to provide means of outdoor employment for the patients, but also to relieve the pressures of overcrowding. With the hospital catering to more patients than it was built to handle, Dr. William H. Giddings, a born and raised Vermonter who graduated from the University of Vermont Medical School in 1866, and who was the asylum’s superintendent from 1892 to 1897, urged for expansion in order to better care for his patients.202

As early as 1894, Giddings states that in full wards, it was “impossible to separate those suffering from different forms of disease as to extend proper treatment.” This impediment meant that attendants were often required to “resort to mechanical restraint… to prevent their disturbing those who would otherwise remain quiet, and thus the very object sought to be obtained is in a great measure thwarted.”203 Consequently, the incorporation of the cottage system into the running of the state asylum was most likely not just the result of forethought concerning theoretical concepts such as moral therapy, but also a reaction to the real life demands of effectively running an institution for the mentally ill.

While transfers from the Brattleboro Retreat were one factor for the overcrowding that the asylum was facing, in their 1898 Biennial Report, Trustees George W. Wing, William N. Platt, and E.P. Gilson, seemed to have placed the blame on the Poland Pauper Law. According to their account, “the towns and cities have found how easy it is under the statute to have their defective wards committed to State care.” They also foresaw that

this problem would only continue to get worse, arguing, “the decrease of infantile mortality… tends to the survival of the unfit” and that, “the strain and stress of modern civilization undoubtedly does and will continue to contribute to our hospitals.” The belief that modernity was pathogenic was not uncommon during this time period. Many medical superintendents believed that the “increasing demands of modern civilizations,” including social and geographic mobility and new social structures, led to excesses, such as “addiction to alcohol…sexual excesses…improper nutrition…and domestic difficulties,” which were all possible of inducing insanity. 204

The trustees’ solution was to continue to expand the hospital in order to allow for supervision of the “insane, paupers, and criminals,” who were thought to be especially vulnerable to these immoderations. It was their belief that without “special guidance” these classes of people would “drift into immorality and crime,” and it was through supervision that the growth of the class would diminish. 205 This approach seems to suggest that the trustees did indeed view the use of the asylum as a means of social control. However, even if the trustees’ true intention was to institutionalize patients as a means of supervising and controlling them, it is likely that it might not have worked.

Grob has argued that contrary to popular belief, asylums were in fact subversive to social control. Instead, he maintains that patients of insane asylums were, by the nature of their condition, “no means quiescent or accommodating; their behavior sometimes revealed an inability or refusal to conform.” Often, this meant that despite whichever intended purpose prompted institutionalization, patient behavior often dictated its

204 Grob, Mental Illness and American Society, 38.
outcome. It then fell on medical superintendents to organize their therapeutic aims accordingly. Thus, by confining the “insane, paupers, and criminals” to the asylum, the trustees understood they were serving the dual purpose of removing this population from the strain of civilization, while also protecting the public from any misdeeds they may commit. Yet, it was how the medical superintendents then dealt with these patients, within the limitations of the resources they had that reveal the asylum’s genuine motivations.

It is important to note, then, that while institutionalization was the end all objective of the Board of Trustees, the medical superintendent at the time, Dr. Frank W. Page, did not take the same point of view. While the trustees seemed to offer no hope regarding the recuperation of the asylum’s patients beyond limiting them to the asylum, Page contended that despite a “general belief in the incurability of insanity, facts incontestably prove that the majority of insane do recover if proper treatment is early instituted.” This aligns closely with Rothman’s argument that the rise of the institution was the result of a changing societal belief that the causes of insanity, poverty and crime were no longer part of the natural order of things. Instead of being considered part of God’s plan, insanity, poverty, and crime were social deviances whose outcome could be manipulated by man. If that were the case, the asylum then offered the chance to create an environment where patients were free from such stresses, allowing them to be cured.

The discrepancy between the views of the Board of Trustees and Page was not unusual in itself. Grob characterizes the end of the nineteenth century as being a period of

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208 Rothman, 112.
increasing pessimism. He argues that previously both medical superintendents and social activists “believed that the overwhelming majority of acute cases of insanity could be cured.” However, as religious authority declined, economic depressions hit, and there was an apparent increase in crime and degeneracy, all while populations of chronic patients continued to grow, outlooks on curability began to shift, with many coming to believe that “the claims by the older generation of cure were untrue.” In fact, many of the statistics concerning recovery rates found to be “grossly exaggerated,” with individuals “recovering” on multiple occasions, and readmissions disregarded. This led to a new interest in the heredity as the “decisive element in determining…disease,” as opposed to a patient’s environment.\footnote{Grob, Mental Illness and American Society, 39.} Therefore, it can be argued the Board of Trustees highlight the new trend that Grob identifies at this time, while Page continued to believe in the merits of moral management.

Page wished to aid this treatment by making sure “the admission of the non-insane to an Asylum [was] absolutely impossible.”\footnote{“Biennial Report of the Vermont State Asylum for the Insane for the term ending June 30, 1898,” 17.} This suggests that part of the overcrowding issues the asylum was facing was due to admission of patients who could not be medically classified as insane.\footnote{Grob notes that this was especially true of elderly patients, most of whom suffered from dementia and other age related illnesses. See: Grob, Mental Institutions in America, 188.} There is corroborating evidence that patients were periodically discharged for that reason, Henry G. Anthony, for example, was discharged with the notation “not insane” on December 20, 1891.\footnote{Vermont State Asylum Admissions and Discharge Volume 1, August 1891- October 1899, VSH-002, VSH-00105, Vermont State Archives and Records, Middlesex, Vermont.} Page argued that
because the Board of Trustees granted discharges, but the medical superintendent, such as himself, did not, many of those who had been cured had not been released, as was just. He called for a revision of such procedure, arguing “the insane, in spite of their misfortunes and infirmities have certain rights equal to the best of us, which should be carefully preserved.” While the Board of Trustees seems to have focused on public concerns, Page remained much more patient-oriented in his outlook.

Besides wishing to revise how patients were discharged, Page continued to remain committed to the ideal of non-restraint treatment. He testified that in the sixteen months prior to the report, mechanical restraint “had ceased to exist as a means for the care and control of the insane in the Asylum. The use of drugs, sometimes called chemical restraint, is strictly forbidden.” Additionally, Page had begun to abolish the use of seclusion, noting that of 504 patients, “but three or four are secluded in their rooms… and then only occasionally, in order to avoid collision and trouble with other patients.” Along with these measures, Page was the first superintendent to suggest that the asylum name be changed to the Vermont State Hospital for the Insane from the Vermont State Asylum for the Insane, as he believed that one of the institute’s goals should be eliminating “the alms house characteristic” and elevating the asylum “to the plane of a hospital for the proper care and treatment of insane individuals.” Page’s successor, Dr. Marcello Hutchinson, continued these efforts, and happily reported that in the first year of his

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214 Ibid., 16, 17, 18.
administration (1900), the daily average number of patients in restraint and/or seclusion was 1.56 patients.215

The contrast between the proposed approaches of the asylum’s trustees and its superintendents show the beginning of the influence of new medical movements, as suggested by Verderber. However, the Vermont State Hospital continued to remain unique in that it was not the medical administration that was pulling away from concepts of moral therapy, but the government structure. While Kirkbride had tried to provide for issues of overcrowding through aesthetic details, Vermont trustees and superintendents had to deal with, and react to it, with feasible, on-the-ground provisions. For the trustees, that meant expanding and continuing to contain the insane and poor population, while the medical professionals chose to focus on treatments that would allow for the cure and discharge of patients. Thus, the mixture of Kirkbride architecture and cottage system building highlights the contrasting goals of its administration that had begun to come to a head within its first decade. For the superintendents, secondary buildings allowed for both dealing with overcrowding and offering patients work-based treatment free of restraint, while for the trustees it was a way to allow more patients to remain committed.

Chapter III: “Diverting the mind”: A Patient’s Life

While thus far, attention has mostly been paid to how patients were housed, it is also important to explore what life would have actually been like for a patient admitted to the asylum. As mentioned above, the asylum was well under its total capacity for patients for a couple years after opening. However, once the asylum reached more than 400 patients, it is very likely that the wards became much less comfortable. The architects originally intended each of the wards to hold around twenty-five patients, for a total of approximately 200 patients in each wing, separated by gender. This in itself suggests that those designing the asylum expected equal numbers of male and female patients to be admitted, which seems to have held true.

By June 1896, when the asylum reached a total of 498 patients, 239 of who were female and 259 male, the asylum was housing an excess of thirty-nine female patients and fifty-nine male patients. That meant that the asylum had enough people to fill three additional wards, but had to fit them in the existing wards. Furthermore, these numbers do not account for the attendants that also lived within the asylum. In 1894, it was reported that there were as many as one attendant per five patients, which would account for nearly another 100 bodies within the asylum. These attendants often slept in the ward with the patients, a practice reported as late as 1904. It then stands to reason that the wards would be very crowded, which can be evidenced in the following photograph; one can only imagine how cramped the space would feel once it was full of bodies.

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217 Kincheloe & Hunt, 8.
Of course, mobile patients would not have been limited to their wards, but would have also had access to day rooms and outdoor spaces. In fact, patients that were able-bodied would not have only had access to such rooms, but also would have been expected to participate in some tasks related to the pieces of day-to-day running of the asylum. Physical labor was considered part of their treatment, “by diverting the mind to give mental and physical health.” Thus, male patients found themselves “employed in the garden, on the farm, in the dairy, and in grading, as well as in kitchen and laundry work” while female patients were “employed in kitchen, laundry and domestic work.” The backgrounds of asylum employees show expertise in these areas as well. For example, R.H. Boisselle listed his occupation as “farming” on his employment card, while at the asylum he functioned as nurse; it would not be a stretch to conclude that he oversaw patients working in the fields.

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218 This, and the following photos, were courtesy of: Vermont State Asylum Photographs and Photographic Albums 1893-2001, VSH-001, VSH-00089, Vermont State Archives and Records, Middlesex, Vermont.
Existing accounts payable records confirm that patients were actually employed in various occupations around the asylum. As early as 1891, the asylum placed an order with the company Wyman & Wallace for cotton, spools, half-inch thimbles and needles. In 1904, well over 3,000 articles were produced in the sewing room, including items such as aprons, coats, mittens, and sheets. This number does not even include the much longer list of articles that were repaired as well. It is conceivable that occupation was not only beneficial for the wellbeing of the patients, but also for the financial state of the institution. In the 1904 Biennial Report, Dr. Hutchinson highlighted the success of the asylum farm, reporting a $10,591.88 profit beyond what goods were reinvested into the asylum. These included a “variety and quantities of vegetables… to enrich and vary the diet” as well as milk, which was considered “necessary and advantageous for the feeble and physically sick and a good food for all.” This was a substantial amount of money when yearly operations cost the asylum an average of $200,000.00.

This income is likely also what helped to keep down the average cost of keeping patients, which in 1904 was $3.95 per patient/week, reflecting only a two-dollar increase in the past ten years. While this sort of financial gain was a desirable by-product of patient employment, it was not the primary goal. To begin, it would have been

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223 Ibid., 8, 22.
224 Ibid., 12. In 1894, the biennial report accessed an average weekly expense of $2.88 per patient; see “Third Biennial Report of the Trustees of the Vermont State Asylum for the Insane for the term ending June 30, 1894,” 10.
225 This was not particularly true of asylums that functioned within slave holding states, such as the Eastern State Hospital in Virginia. Galt, the superintendent there, routinely employed his patients on the asylum grounds. However, some of his patients were slaves,
somewhat unreasonable to rely completely on patient labor as a source of income, when, often times, many patients were not capable of physical labor. However, “inaction was considered harmful even to the normal mind,” and so, patient employment was considered a critical therapeutic tool to those that could participate.\textsuperscript{226}

Another benefit of patient employment seems to be that the farm provided the asylum with some of the foodstuffs required to feed both the patients and the staff, including 649, 895 pounds of milk, 322 bushels of onions, and 596 pounds of maple syrup, looking back at expenditure reports reveals that a majority of the money spent by the asylum was spent on purchasing food. Moreover, it reveals that Dr. Hutchinson was not exaggerating his commitment to providing his patients an enriched, varied diet. It seems that patients had access to a range of fruits, such as apples, cranberries, and raspberries, not to mention cheese, coffee, fresh fish, and “26,204... eggs, dozen.”

Other purchases, such as clams, marmalade, and almonds, were acquired in much smaller amounts, and most likely made their way to the superintendent and officers’ tables.\textsuperscript{227} By looking through the receipts and disbursements of the asylum at any given time, it is possible to get a glimpse into the day-to-day lives of its patients. With so many eggs purchased, it is easy to imagine patients sitting down in their dining rooms for breakfast, enjoying those eggs with a side of fruit and a cup of coffee, before their days began in the field or the sewing room.

\textsuperscript{226} Grob, Mental Illness and American Society, 23.
When they were not asleep in their wards, or working at the asylum, the patients were allowed to pursue other mentally stimulating activities. In many of the biennial reports, there are notations for expenditures for goods such as books and tobacco. In 1894, there was even $260.00 set aside to purchase a new piano. Furthermore, there seems to have been extensive donations of newspapers and magazines, and books, including novels, picture books, and congressionalist works, as well as articles like playing cards, painting materials, flowers, and candy, both from private donors and
businesses such as the Burlington Free Press. The presence of these materials give context for not only how patients would have occupied their free time, but also how they would have utilized spaces such as the sitting room and reading rooms pictured below.

There is also a specific reference to an assortment of events that patients were allowed to attend, with one superintendent noting that “dancing parties have been held each week during the winter months and there has been an evening with the graphophone, beside several with impersonators and readers.” Patients were also provided with access to weekly religious services, whether they were Roman Catholic or Protestant. Access to such amusements was a typical trait of asylums that ascribed to moral management, as they were thought to “shift the patient’s trains of thoughts away from distressing or delusional preoccupations.” It is unclear whether these activities were available to all patients, or if they were limited to just those considered docile and agreeable, similar to those granted cottage living. It is also possible that privately paying patients (those not paid for by the state), were given access to even more materials, as a notation in an accounts payable makes note of $42.50 allotted for “private patients books.”

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230 Smith, 155. See also: Grob, Mental Institutions in America, 66.
Whether or not all patients enjoyed these pursuits, the presence of such spaces as reading rooms, chapels, and day rooms, as well as their depictions served an ulterior motive for the asylum – a form of advertising. While to the modern person, the idea of advertising an insane asylum may not seem a standard device, in reality, at its core, an asylum was subjected to the same business principals as any other financial or public institution. Namely, it was a business that functioned via the the willingness of people to
send their loved ones there. Nancy Tomes, a public health historian, argues that the rise of institutionalization for the mentally ill in America corresponded with families’ unwillingness to care for family members. She contends that beginning in the mid-nineteenth century, families no longer wished to care for ill family members themselves, but desired to see them treated as though they were still part of a family.

Grob attributes this change to “traditional ways of caring for poor and dependent persons” being undermined by factors such as “rapid population growth, urbanization, immigration, and high rates of geographical mobility.” As such, families increasingly turned to institutions as a way to fulfill their obligations “toward dependent persons incapable of surviving by themselves.” Mental hospitals, in turn, promoted themselves as places that could offer treatment and custody of dependent family members, fulfilling their ethical and moral responsibilities for them. Arguably, this trend expressed itself much earlier in England, as evidenced by the York Retreat. This created a paradox in which there was a need to “promote the asylum in the public eye as a serious and stable institution, and at the same time calm the family’s fears with domestic allusions and spaces.” The language found in the State Asylum’s biennial reports, as well as their use of imagery in everyday use, such as postcards, shows at least partial awareness of the need to address this issue.

Postcards, such as the one seen in Figure 11, would have been available for purchase outside of the asylum, meaning that visitors and other people besides patients would have had access to them. Much as a person would purchase a postcard with the

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232 Tomes, xix.
234 Yanni, 55.
local mountain or historical monument while traveling to send back home, those people visiting Waterbury, Vermont would have the option to choose a postcard showcasing the asylum as a local landmark. The particular postcard shown here was available for purchase at the Record Book and Stationery Store right in town.\(^{235}\) The State Asylum was certainly not the only institution aware of how vital advertising was to their bottom line. In their edited volume, \textit{Nineteenth Century American Asylums: A History in Postcards}, Alma Wynelle Deese and Cathy Faye, showcase over 300 hundred images utilized by asylums across the United States advertising their institutions.\(^{236}\) While the State Asylum may not have been unique in this venture, the images it chose do correspond with the aims they had when building the hospital.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{postcard}
\caption{Postcard, 1910.}
\end{figure}


The postcard above is inscribed on the back with the simple message, “Arrived O.K. in Troy. Stanley met me and Al says Mack saw me but I did not. Will write tomorrow, Janet.” It showcases four places, starting at the top left, and going clockwise: the Second Hall, Officers’ Quarters, Patients’ Dining Room, and Day Hall – Second Ward. When looking at this postcard, the viewer is rewarded with many appealing features. The Second Hall offers an outside perspective of the hospital’s brick architecture with open porches, while the Officers’ Quarters reveal a cozily decorated living space. Both the Patients’ Dining Room and the Day Hall show tranquil, well-lit rooms, complete with fireplaces, and even relaxing patients. Such imagery would surely attract anyone looking to admit a family member, as it seems they would have all the same, if not more, comforts of home life. It might perhaps also attract someone looking for employment, as the presence of the Officers’ Quarters certainly suggests a comfortable place of service. Yet, it is unlikely that such advertisements were aimed at those patients who were placed there as wards of the state. Instead, they were most likely a means to attract private patients.

While the asylum was originally built to take in both Vermont’s insane poor and criminally insane persons, they were accepting private patients from the very beginning. In August 1891, of the first twenty-nine admitted patients, two were privately paying, twelve were criminally insane, and fifteen were state patients. By July 1894, 12 of 209 patients were noted as “private,” and in September 1895, that number had risen to fifteen. As the notations in the admissions ledger became more specific, it is possible to discern that some patients stays were supported both by private funds and state funds, as was the

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case with “John Pratt 3/5 private, 2/5 state.” Other notations reveal how much private patients were paying per week of their stay. In March 1898, Clara M. Holmes was being charged $4.00/week, a dollar more than the proffered $3.00/week the asylum received from state patients. By 1904, the asylum had an average of twenty-eight private patients, from which they were collecting $15,008.28 in a biennial period, which would mean an average of $5.00 per patient/week. Compared to the $236,060.04 received from the state, it seems like a paltry sum. However, it is still more profit than the asylum farm garnered, and it is fathomable that the asylum would want to attract as many private patients as possible to continue to rise that profit margin. Due to patient confidentiality constraints, archival access to who these private patients would have been, beyond their names and dates of admission and/or possible discharge, was severely limited. However, the institutional records of the criminally insane are not subject to the same restrictions, which allows for a deeper insight into who would have been a patient in the separate convict wards of the asylum.

238 Vermont State Asylum Admissions and Discharge Volume 1, August 1891- October 1899, VSH-002, VSH-00105, Vermont State Archives and Records, Middlesex, Vermont.
Chapter IV: “A Brutal Murder”: Diagnosis and Classification

As briefly touched upon in Chapter II, many medical superintendents were unwilling to accept the criminally insane in the same institutions that accepted other, more innocuous patients, believing that criminal behavior would be subversive to the healing environment they were attempting to create.\(^\text{240}\) Often, they instead advocated for the construction of separate wards in already existing penal institutions, arguing that they were better suited to “provide separate maximum security quarters.”\(^\text{241}\) In fact, in 1874, the asylum superintendents at the Pennsylvania State Hospital for the Insane at Danville managed to block legislation attempting to provide a new wing for insane criminals. Often, when such incidences occurred, state boards found the means to secure separate institutions that would allow them to “remake the state hospital according to their own specifications.”\(^\text{242}\)

This certainly seems to have been what occurred in Vermont, as when the superintendents of the Brattleboro Retreat refused to continue admitting state patients, the state chose to build a new asylum in Waterbury. However, it should be noted that there was yet another subset of superintendents who believed that integrating asylums into prisons only reinforced the fear of sending family members to mental institutions by drawing similarities between hospital commitment and penal incarceration.\(^\text{243}\) While the available documentation assumes the former as the rational behind allocating space for the criminally insane at the Vermont State Asylum, it seems that concerns about the disruptive behavior of the criminal insane was still taken into consideration. When it was

\(^{240}\) Tomes, 301-02.
\(^{242}\) Tomes, 303.
\(^{243}\) Grob, *Mental Institutions in America*, 140.
constructed, the asylum provided separate, secured wards at the end of either wing of the main building. These circular wards, which can be evidenced in Figure 5, included separate entrances from the rest of the asylum, only solidifying the criminally insane as a distinct class of patient. It was in these circular wards that William Allard, convicted of second-degree murder, would have served out his life sentence.

While William Allard’s story ends when he is taken to the Vermont State Hospital, as his medical records were not accessible in the archive, the details of his court case serve to highlight what types of factors played into a patient’s admittance to the asylum, and what characteristics led both doctors and the general public to deem someone insane. Allard, for example, already had a history of instability and violent outbursts before being (re)-admitted to the asylum in 1906. While this certainly played into the ruling on his case, it is interesting to note what other characteristics and personality traits were considered important. Dr. Wasson, for instance, did not find Allard’s intellectual bearing as important as his ability to tell right from wrong. The reporter, on the other hand, was put off by Allard’s seeming lack of response to the court proceedings and his own actions; two separate responses that suggest the ability to express oneself by normative behavior plays into perceptions of one’s mental health. Based on the story his court case tells, Allard consistently acted outside of these norms, murder being his most obvious transgression, and thus spent the rest of his life at the state asylum.

Behaviors such as the ones that Allard displayed were essential to medical superintendents’ understandings of insanity. Grob argues, “given their inability to demonstrate a relationship between anatomical changes and behavior, psychiatrists tried
to identify the presence of mental disease by observing external symptoms.” Often, good health was defined by the brain’s involuntary functions performing normally and “under the control of the will.” Therefore, it was often abnormal behavioral symptoms such as Allard displayed that convinced medical superintendents of the presence of disease. Of course, Allard’s medical record would have reflected a more concrete diagnosis upon his admittance. Even without access to his personal record, it is possible to conceive how he might have been diagnosed and categorized based on the medical record of another patient considered criminally insane. In fact, it is quite likely that Allard would have known James Peter Allen, an arsonist that was serving his own sentence at the asylum during both of Allard’s incarcerations.

On June 19, 1875, James Peter Allen had pleaded guilty to arson, having “set fire to and burned the barns and dwelling house and 14 head of cattle belonging to John Hanks of Randolph.” He was sentenced to eighteen years, and on March 19, 1891, was transferred to the “Insane Asylum at Brattleboro.” From there, Allen was one of the first patients transferred to the new asylum at Waterbury, admitted on August 8, 1891, at the age of 39. Partial pieces of Allen’s medical records were obtainable from the archive, and in Figure 12, one can see an example of the medical form that was filled out by the medical superintendent for each patient admitted to the asylum. Allen’s entry (see Figure 13 for a facsimile) gives insight on what characteristics and physical conditions were used to diagnose insanity. For example, family history seemed to be an important

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244 Grob, Mental Illness and American Society, 37.
245 Ibid., 34.
246 “Orange County Court,” The United Opinion (Bradford, Vermont), June 19, 1875.
consideration, as the form asks about both the patient’s parents’ habits and their own mental state. It also considers the patient’s hygiene, asking about their habits, and whether they are dirty or destructive. Furthermore, it questions suicidal and homicidal tendencies, physical condition, and educational level, while offering a space to note any diagnosis.

One can mentally fill in the blanks for Allard’s file, noting both homicidal tendencies and “low order” mentality and “limited” reasoning, but when reading Allen’s file, it appears that not much is known about his past history, and that his insanity seems to have been first documented around the same time as his act of arson.248 The doctor noted that Allen’s physical condition was “fair” and his disease was “stationary,” while his insanity stemmed from a history of self-abuse.249 This is confirmed by a newspaper report that during his initial incarceration Allen “made some threats of self destruction and wanted a razor, but he was closly [sic] watched and no harm was done.”250

Ultimately, Allen was diagnosed as having “chronic mania.” While such a diagnosis would not be found in the *Diagnostic and Statistical Manual of Mental Disorders* today, it is possible to draw potential conclusions about what Allen was suffering from. In the nineteenth century, mania would have been used to describe patients’ suffering from

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249 Vermont State Hospital Patient Ledgers, 1891-1898, VSH-002, F-42020, Vermont State Archives and Records, Middlesex, Vermont.
250 “Orange County Court,” *The United Opinion* (Bradford, Vermont), June 19, 1875.
episodes of over activity, similar to today’s understanding of people who suffer from manic episodes.\textsuperscript{251}

As such, Allen would have most likely suffered from chronic periods of an “abnormally and persistently elevated, expansive, or irritable mood,” as well as “abnormally and persistently increased goal-directed activity or energy,” similar to symptoms that people with bipolar disorders would exhibit.\textsuperscript{252} Whereas modern forethought, and access to a comprehensive diagnostic manual, make guessing what Allen suffered from relatively easy, it would not have been the same for asylum doctors who were attempting to understand, categorize, and process hundreds of patients with illnesses not standardized as they are today. Their attempts to do so are reflected in the number of categories that were used to sort and label patients.

Each of the biennial reports given by the superintendent included charts that tracked the diagnoses of the patient population, such as the ones featured in Figures 15-17. Some of the conditions are comparable to those used today, such as dementia, while others, like “alcoholic insanity” is now understood in the context of addiction.\textsuperscript{253} During his stay, and considering his trial, it is possible to imagine that William Allard would have been diagnosed as such. Allen, on the other hand, with his diagnosis of chronic mania, seems to have been part of a large subset of patients, both male and female, at the asylum with that diagnosis; it was second only to the number of patients identified with paranoia.

\textsuperscript{253} “Biennial Report of the Vermont State Asylum for the Insane for the term ending June 30, 1898,” 34.
**Figure 14: Patient History Ledger – Example**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Town:</th>
<th>County:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted:</td>
<td>Age:</td>
<td>Civil Condition:</td>
</tr>
<tr>
<td>Occupation:</td>
<td>Religion:</td>
<td>Education:</td>
</tr>
<tr>
<td>Insane relations:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habits:</td>
<td>Insanity commenced:</td>
<td></td>
</tr>
<tr>
<td>No. Of previous attacks:</td>
<td>No. Of previous admissions:</td>
<td></td>
</tr>
<tr>
<td>Date and duration of previous attacks:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal:</td>
<td>Homicidal:</td>
<td>Criminal tendencies:</td>
</tr>
<tr>
<td>Patient is: dirty, excitable, destructive</td>
<td>Disease is: increasing, decreasing, stationary</td>
<td></td>
</tr>
<tr>
<td>Has patient ever been restrained, or secluded: if so, in what manner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habits of parents:</td>
<td>Consanguinity of parents:</td>
<td></td>
</tr>
<tr>
<td>Alleged causes of insanity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis:</td>
<td>Ward:</td>
<td></td>
</tr>
<tr>
<td>Present physical condition:</td>
<td>strong pulse pupils heart</td>
<td></td>
</tr>
<tr>
<td></td>
<td>fair tongue speech lungs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[illegible] temperature skin</td>
<td></td>
</tr>
<tr>
<td>Condition of bowels and digestive functions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accompanying bodily disorders:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brought by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>From:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted on the order of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical certificates signed by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correspond with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telegraph to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directions in event of death:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MEDICAL HISTORY
**Figure 15: Patient History Ledger - Peter James Allen**

<table>
<thead>
<tr>
<th>Name: Peter J. Allen</th>
<th>Town: State Prison</th>
<th>County: Windsor/Orange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted: Aug. 8. 1892</td>
<td>Age: 39</td>
<td>Civil Condition: Single</td>
</tr>
<tr>
<td>Occupation: Laborer</td>
<td>Religion: -------</td>
<td>Nativity: England</td>
</tr>
<tr>
<td>Insane relations: Unknown</td>
<td>Education: Read &amp; Write</td>
<td></td>
</tr>
<tr>
<td>Habits: Good</td>
<td>Insanity commenced: 1874</td>
<td></td>
</tr>
<tr>
<td>No. Of previous attacks: unknown</td>
<td>No. Of previous admissions: unknown aside from Vt.</td>
<td></td>
</tr>
<tr>
<td>Date and duration of previous attacks: Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal: No</td>
<td>Homicidal: Yes</td>
<td></td>
</tr>
<tr>
<td>Criminal tendencies: Homicidal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient is: dirty, excitable, destructive</td>
<td>Disease is: increasing, decreasing, stationary</td>
<td></td>
</tr>
<tr>
<td>Has patient ever been restrained, or secluded: if so, in what manner? No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habits of parents: Unknown</td>
<td>Consanguinity of parents: Unknown</td>
<td></td>
</tr>
<tr>
<td>Alleged causes of insanity: Self-abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis: Chronic Mania</td>
<td>Ward: [illegible]</td>
<td></td>
</tr>
<tr>
<td>Present physical condition: strong pulse pupils heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>fair tongue speech lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[Illegible] temperature skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition of bowels and digestive functions: Healthy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accompanying bodily disorders: None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brought by: Trustees … [rest is illegible]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>From: Vt. Asylum for the Insane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted on the order of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical certificates signed by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correspond with: Supt. of Prison</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telegraph to: “ “ “</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directions in event of death:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEDICAL HISTORY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
While Allen’s diagnosis of chronic mania was adroitly recorded, as little as twenty years earlier, his diagnosis potentially would not have been as clear-cut. Medical professional and anthropologist, Arthur Kleinman, reasons, “diagnosis is a semiotic act in which the patient’s experienced symptoms are reinterpreted as signs of particular disease states.” This means that such reinterpretations “only make sense with respect to specific psychiatric categories and the criteria those categories establish.” In the case of mental illness, most times this requires understanding both the biological abnormality and/or the “complaints of other ordinary kinds of human misery, e.g. injustice, bereavement, failure, unhappiness.”

As mentioned previously, medical superintendents often failed to find significant correlation between physical ailments, such as brain lesions, and behavioral traits, which often required them to classify their patients based on external symptoms.

While medical superintendents were often confronted by the fact that a nosology based on external symptoms was more or less inadequate because they were fluid between behavioral states, a new set of statistics provided by the 1870 census provided an impetus for more distinct categorization. In 1888, Frederick H. Wines of the Illinois Board of State Commissioners of Public Charities used the census to define seven categories: “mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy.” These categories, and their subgroups, provided descriptive enough classifications that it allowed for superintendents to “organize material and communicate with each other.” As such, asylum physicians, including those at Vermont State Asylum, as evidenced in Figure 16, quickly embraced these categories.

\[255\] Grob, *Mental Illness and American Society*, 34.
### TABLE XIX.

*Form of Mental Disease in Cases Admitted.*

<table>
<thead>
<tr>
<th>Form of Disease</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic insanity</td>
<td>9</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Mania</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; Acute</td>
<td>15</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>&quot; Chronic</td>
<td>16</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>&quot; Recurrent</td>
<td>5</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>&quot; Typho</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>&quot; Delirious</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Melancholia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; Acute</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>&quot; Sub-acute</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>&quot; Chronic</td>
<td>5</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>&quot; Agitated</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>&quot; Specific</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>&quot; Recurrent</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; Primary</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot; Secondary</td>
<td>11</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>General paralysis</td>
<td>7</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Paranoia</td>
<td>14</td>
<td>8</td>
<td>22</td>
</tr>
<tr>
<td>Climacteria</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Circumoral</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Puerperal</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Confusional</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Senile insanity</td>
<td>10</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Epileptic</td>
<td>10</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Choreic</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Adolescent insanity</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Post febrile</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Post operative</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Constitutional inferiority</td>
<td>3</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Not insane</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>126</td>
<td>91</td>
<td>217</td>
</tr>
<tr>
<td><strong>Total number of persons</strong></td>
<td>164</td>
<td></td>
<td>204</td>
</tr>
</tbody>
</table>

Figure 16: "Form of Mental Disease in Cases Admitted," 1898.
TABLE IX.

*Occupation of Persons Admitted.*

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>No occupation</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Railroad hand</td>
<td>2</td>
<td>.....</td>
</tr>
<tr>
<td>Housewife</td>
<td>.....</td>
<td>49</td>
</tr>
<tr>
<td>Laborer</td>
<td>32</td>
<td>.....</td>
</tr>
<tr>
<td>Painter</td>
<td>4</td>
<td>.....</td>
</tr>
<tr>
<td>Servant</td>
<td>.....</td>
<td>10</td>
</tr>
<tr>
<td>Salesman</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Housemaid</td>
<td>.....</td>
<td>2</td>
</tr>
<tr>
<td>Druggist</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Dressmaker</td>
<td>.....</td>
<td>2</td>
</tr>
<tr>
<td>Gardener</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Mill operator</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Farmer</td>
<td>31</td>
<td>.....</td>
</tr>
<tr>
<td>Carpenter</td>
<td>6</td>
<td>.....</td>
</tr>
<tr>
<td>Canvasser</td>
<td>2</td>
<td>.....</td>
</tr>
<tr>
<td>Civil engineer</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Professor</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Contractor</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Attorney</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Tailor</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Stone cutter</td>
<td>4</td>
<td>.....</td>
</tr>
<tr>
<td>Teamster</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Housekeeper</td>
<td>.....</td>
<td>5</td>
</tr>
<tr>
<td>Plumber</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>School teacher</td>
<td>.....</td>
<td>3</td>
</tr>
<tr>
<td>Musician</td>
<td>2</td>
<td>.....</td>
</tr>
<tr>
<td>Clerk</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Blacksmith</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Ship builder</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Hotel keeper</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Quarry men</td>
<td>2</td>
<td>.....</td>
</tr>
<tr>
<td>Circus employer</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Stenographer</td>
<td>.....</td>
<td>1</td>
</tr>
<tr>
<td>Traveling man</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Pedlar</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Court clerk</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Shoemaker</td>
<td>2</td>
<td>.....</td>
</tr>
<tr>
<td>Photographer</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Butcher</td>
<td>1</td>
<td>.....</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>119</td>
<td>85</td>
</tr>
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</table>

Figure 17: “Occupation of Persons Admitted,” 1898.
TABLE X.
Probable Causes of Disease in Persons Admitted.

<table>
<thead>
<tr>
<th>CAUSES</th>
<th>PHYSICAL</th>
<th></th>
<th></th>
<th>MENTAL</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Wom'n</td>
<td>Total</td>
<td>Men</td>
<td>Wom'n</td>
<td>Total</td>
</tr>
<tr>
<td>Traumatism</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overwork</td>
<td>6</td>
<td>4</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overstudy</td>
<td>4</td>
<td></td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scarlet fever</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masturbation</td>
<td>7</td>
<td>2</td>
<td>9</td>
<td></td>
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<tr>
<td>Illness</td>
<td>1</td>
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<td>4</td>
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<td></td>
</tr>
<tr>
<td>Congenital defect</td>
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<td></td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Heredity</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td>11</td>
<td>26</td>
</tr>
<tr>
<td>Insolation</td>
<td>4</td>
<td></td>
<td>4</td>
<td></td>
<td></td>
<td></td>
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<td>La Grippe</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Intemperance</td>
<td></td>
<td></td>
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<td></td>
<td>10</td>
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</tr>
<tr>
<td>Domestic infelicity</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Fright</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Confinement</td>
<td></td>
<td></td>
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<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Grief</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typhoid fever</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Specific</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
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</tr>
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<td>Fever</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td></td>
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<tr>
<td>Disappointment</td>
<td></td>
<td></td>
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<td>2</td>
<td>4</td>
</tr>
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<td>Misfortune</td>
<td></td>
<td></td>
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<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Puerperal</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Adversity</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Apoplexy</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Climacteric</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typho pneumonia</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Chorea</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Meningitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overwork and illness</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Disappointment in love</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

| Physical causes             |          |          |        |        |          |        |
| Mental causes               |          |          |        |        |          |        |
| Not stated                  | 3        | 3        | 6      |        |          |        |
| Unknown                     | 44       | 44       | 88     |        |          |        |
| Totals                      | 69       | 26       | 95     | 50     | 40       | 90     |

Figure 18: “Probable Causes of Disease in Persons Admitted,” 1898.
However, despite the introduction of the aforementioned categories, classification of mental diseases continued to be difficult, as it was nearly “impossible to correlate physiological changes with specific behavioral patterns.” Still relying on symptomology as opposed to etiology meant that medical superintendents were continually in the process of classifying and categorizing patients in order to better understand the causes of their illness. Indeed, “Form of Disease” was not the only grouping used to classify patients – the statistical charts contained in the appendix of each biennial report provide insight into the myriad of ways that classification occurred. Several of these correspond with information found on the medical form that was filled out for each patient, such as occupation and probable cause of insanity.

Other considerations that played a role in classification were based on race, ethnicity, and gender as it was “assumed that the behavior of patients was not totally unrelated to their backgrounds.” For example, Southern physicians often insisted that emancipation had resulted in increased rates of insanity amongst African-Americans because “the abolition of slave discipline simply permitted them to indulge their passions and appetites unrestrained by the reason that was characteristic of whites.” Furthermore, diseases could differ between genders. In particular, hysteria was often thought to be a disease specific to female patients because of its correlation to abnormalities of female sex organs.

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Based on the variety of ways in which patients were continually categorized during this era, it is likely that efforts to do so influenced the decisions the administrators of the asylum made when attempting to organize both the patients and the buildings in which they were housed. When dealing with patients that ranged from the criminally insane to the more innocuous patients who were allowed to live outside of the main building, it can be seen that decisions had to be made on the ground in regards to running the asylum. Namely, with such a diverse population, it would not have been possible for one administrative plan to fit all scenarios. Thus, an effort to classify patients effectively and study their disorders highlights the importance of examining asylums based on local circumstances. The types of patients that the asylum accepted would have influenced how patients needed to be separated, and accordingly, would have also influenced how the trustees and superintendents chose to design it past its original conception.

For example, as a northern, non-slave holding state, the Vermont State Asylum chose to incorporate the cottage system into their otherwise decidedly Kirkbride styled institution. While Galt had done the same in Virginia, Vermont’s superintendents saw its potential for chronic patients, rather than a system of parole or home care. Furthermore, they chose to build the institution on a 500-hundred acre farm that would allow patient employment, something that was often not practical at contemporary urban institutions. Finally, it was made a condition of the original law that proposed the construction of the asylum, that in its construction, there would be provision for a “ward or building for the insane criminals which shall be separate and apart from the buildings occupied by the
other patients in said asylum.” This was occurring even as other medical superintendents doubted the benefits of caring for the criminally insane alongside other patients. Ostensibly, private asylums that did not accept criminally insane patients, or those without five hundred acres to build on, would not have had the same desire or option to create such a ward. Asylum design was very much manipulated by environmental factors such as patient population and condition, which makes local history all that more important in the study of mental asylums.

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262 Acts and Resolves passed by the General Assembly of the State of Vermont at the Tenth Biennial Session, 1888 (Burlington: The Free Press Association), 107.
Conclusion

While in its early years, the Vermont State Asylum was considered the height of contemporary medical practice, and a place where the state’s insane could be both secure and cured, the role that asylums played in American society has always been heavily debated. There are historians who considered asylums of the nineteenth century “proof of human progress, humanitarianism, and progressive sentiment,” while others have “insisted that mental hospitals were inherently repressive.” These opposing views of institutionalization have often aligned with the social currents of era in which the historian is writing. Those writing about mental health in the decades during, and after, the 1960s, were writing in a time where society was dealing with the aftermath of the Community Health Act of 1963.

This act was based on the rising promotion of deinstitutionalization in public health. In the decades after 1940s, institutions for the mentally ill came under fire for a series of reasons. It was believed that mental illness was the result of unresolved social tensions, and if caught early enough, mental illness could be prevented altogether. This spurred further belief that public health was the best way to revolutionize mental health treatment, namely through local community centers, and shutting down all mental health institutions. Part of the agenda of such public health reformers was aimed at dismantling the importance of state hospitals on the basis of conditions that included “overcrowding, staff shortages, and inadequate facilities.” Smaller community health

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263 Grob, Mental Illness and American Society, ix.
264 Steven M. Gillon, That’s Not What We Meant to Do: Reform and Its Unintended Consequences in Twentieth-Century America (New York: W.W. Norton & Company, 2000), 89.
265 Ibid., 90.
centers were argued to combat these conditions while also saving individual states the millions of dollars it took to run larger state institutions.

In these debates, there are echoes of the same arguments that Dix, Kirkbride, and Jarvis had used nearly 100 years earlier to promote institutionalization, rather than oppose it. The need to resolve social tensions and provide adequate facilities seems to be a mainstay of mental health reform, then and now. These were the arguments that eventually won public health reformers the vote in Congress, and the Community Health Act of 1963 promised $150 million dollars over three years to construct new centers with the goal of diminishing hospital population rates by fifty percent across the country. By 1980, Vermont had reduced patient numbers by ninety-five percent.266 It is not surprising that Vermont passed the objective by nearly another fifty percent; after all, from the beginning, the asylum expressed an interest in maintaining patients’ liberties.

However, the Community Health Act had its own broader, unintended consequences. Community health centers had failed to be built at the promised rate, leaving one center for every 100,000 thousand people, while seventy-five percent of patients released had conditions that required constant supervision.267 As more communities had to deal with mentally ill that did not have proper treatment, and the federal government shifted to more conservative powers, many of the premises that had originally encouraged the passing of the bill, fell apart. Numerous patients who had been released from downsizing hospitals did not end up at community health centers, but instead at nursing homes, and “psychiatric ghettos,” private homes and motels that converted into boarding rooms for the mentally ill. Just as in the nineteenth century,

266 Ibid., 97.
267 Ibid., 98.
institutional strategies had failed to provide for a chronic patient population. Once again, the mentally ill had been released on the complaint of squalid, overcrowded conditions, just to end up in much the same, or worse, homeless.  

While the Community Health Act failed to deliver on its promises, it nonetheless left a mark on American society, and especially on social historians. Thus, when referencing historical interpretations of the importance of mental institutions and their consequences, it is important to remember the context in which such historians are writing. When Rothman argues that the rise of the institution was based on the belief environment was essential to the cure of mental illness, there are echoes of the arguments made by public health reformers from the decade in which he was writing. Though Rothman seems to remain detached from influences of his time, it remains that the study of mental health is based heavily in cultural influences. Stigma across time has helped rationalize and justify different institutional approaches to the care of the mentally ill, which is evident in the mental healthcare practices of the nineteenth century, the 1960s, and most currently its entanglement with the criminal justice system.

This is no different for the many biennial reports and records that have been used here. Trustees and superintendents of the asylum, who were biased in their own ways, wrote many of the administrative records. They did not only function as head of the asylum, but were often deeply involved in social policy. Thus, the asylum records reflected both the societal context, as well as, the professional context of the asylum administrators. It was medical understandings of mental illness that often influenced what stance state governments took on institutionalization. The belief in the ability to cure

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268 Ibid., 104.
269 Grob, Mental Illness and American Society, 91.
mental illness spurred the movement for institutionalization, but when those views began to change, some states withdrew funding. Indeed, state reports were often used as a forum in which to ask for more funding, and as a result, often times depended heavily on data and accounts that would gain them this funding. They also served as a form of advertisement, much as the postcards did, in order to attract patients. Of course, that is not to say that the superintendents were not dedicated to their patients, or that the asylum was not as it seemed, but it is important to keep in mind how written records can reflect the goals of their authors, and to create an institutional history around those aims.

Here, that institutional history reveals an asylum that seems to have defied traditional narratives, maintaining a commitment to non-restraint and patient autonomy for several decades after most historians argue they went out of vogue. While other institutions, such as the Wisconsin Hospital for the Insane, became discouraged by increasing chronic patient populations, and withdrew funding for state care of the insane, Vermont continued to find new solutions for issues such as overcrowding, while remaining committed to the tenants of moral management. This resulted in the incorporation of the cottage system, despite other medical professionals qualms about the effect of outpatient care on the asylum environment.

Even by the 1920s, when evidence of the influence of biomedical movements, such as eugenics, begins to appear in the state reports, there is still commitment to such ideals. Dr. D. Grout, the first medical superintendent to suggest sterilization of female patients, still boasted of limiting mechanical restraint to only those “who are subject to violent impulses to suicide or self-mutilation,” while also taking note of patient access to “moving-picture shows,” among other amusements, and the continued success of therapy
through employment.²⁷⁰ Despite these characteristics, there is also language that suggests the asylum had become a place to once again warehouse the mentally ill, with Grout even implying that it is in the best interest of the “morals of the community…to corral and incarcerate.”²⁷¹ Such contradiction hints at the inherent paradox of asylum life, where the goal was to create an environment where the “institutional aspects of the institution” were not explicitly exercised.²⁷² Often, practical needs would overcome therapeutic goals.

Despite the limitations in this history due to patient confidentiality laws and other archive restrictions, the early history of the Vermont State Asylum also alludes to the possible cyclical nature of mental health reform. The same arguments concerning overcrowding, adequate facilities, and patient liberties have continued to define mental health reform. In just the first twenty years of the asylum, there were goals to both give the patients more freedom and to segregate them from their communities. That these are the two opposing poles of reform is only emphasized by the measures taken in the Community Health Act. While the asylum believed in freedom on its grounds, it was still part of reform movement that was based in institutionalization; on the other hand, the efforts in the 1960s attempted to do away with the institution altogether.

In his account of the unintended consequences of deinstitutionalization, Steven M. Gillon argues that they were the result of “a culture that combined liberal efforts to expand personal liberty and a conservative crusade to limit government spending and power.”²⁷³ The 120-year history of the Vermont State Asylum for the Insane ended much the same way, with heavy downsizing occurring in the 1960s, followed by severe flooding in 2011 due to Storm Irene, and permanent closure as a hospital that same year.

²⁷¹ Ibid., 8.
²⁷³ Gillon, 118.
A much smaller, modern psychiatric hospital was opened in Berlin, Vermont, while the Waterbury campus reopened for the use of state offices in 2015. The asylum fields once farmed by its patients are now part of a town park system, with trails that allow visitors to wander the old asylum grounds. The building’s listing on the National Register of Historic Places stands testimony to its lengthy history of caring for Vermont’s mentally ill, while its architectural form continues to produce a harmonious effect against its rural, idyllic backdrop.²⁷⁴


Figure 19: Vermont State Hospital Campus, 2017.
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