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"In Charge of the Loons":* A Portrait of the London, Ontario Asylum for the Insane in the Nineteenth Century

By Cheryl L. Krasnick

In recent years the historical study of insanity roughly has followed two approaches: the structuralist model which places the rise of the asylum within the framework of industrial capitalism with attendant movement towards social control; and the institutional model which examines individual asylums, the goals on which they were founded, and the inevitable result of overcrowding — the custodial asylum. An example of the former is Michel Foucault’s seminal work, *Madness and Civilization* (1965) in which the French philosopher relates the shift from demonological to medical theories of the origins of insanity to the rise of the capitalist state. David Rothman’s *The Discovery of the Asylum* (1971) describes the early nineteenth century asylum movement in the United States as social control through the confinement of deviants.

Norman Dain’s *The Concept of Insanity in the United States 1789-1865* (1969), which discussed medical theories and their application in early American mental institutions, is an example of the institutional approach. In *Mental Institutions in America* (1973) Gerald Grob argues that the establishment of asylums was not part of a deliberate effort to control, but fulfilled a growing social need. The first major Canadian study of the lunatic asylum, also dealing with the institutional imperatives of the treatment of insanity, is Tom Brown’s dissertation, “Living with God’s Afflicted”: A History of the Provincial Lunatic Asylum at Toronto, 1830-1911” (Queens, 1980).¹

All the above works have examined the mental institution from "above", that is, from the perspective of the administrators and physicians. In *So Far Disordered In Mind* (1979), a study of the California Asylum for the Insane, Richard Fox has been the first historian to examine the mental hospital from the perspective of the patients. By analyzing the backgrounds and characteristics of patients admitted to the Asylum, Fox demonstrates, for example, that members of certain ethnic and social groups were more likely to be diagnosed insane and committed to an institution than were others.
What follows here is a similar examination of a Canadian institution. The London, Ontario, Asylum for the Insane will be discussed for the years 1870 to 1902 (from its opening under the guidance of Henry Landor to the death of its second medical superintendent, Richard Maurice Bucke) from the perspective of the patients. This approach is possible through extensive use of available patients' casebooks. Divided into male and female volumes, the books devote a page to each patient with yearly entries following an annual inspection, or on occasions such as incidents of illness, violence, or change of status (through transfer to a new ward or institution, discharge or "elopement" [escape]). The entries are unfortunately brief, but are invaluable in presenting a clear portrait of the kind of person admitted to the London Asylum; the type of behaviour which led to commitment; duration of stay; and experiences in the Asylum.

The nature of the Casebooks necessitated the use of a consecutive sample. All those patients admitted during Landor's tenure, 1870 to 1877 (774), have been statistically analyzed to determine the composition of the inmate population, differentiations in treatment during the administrations of Landor and Bucke, and the success of the London Asylum as a curative institution. This article is divided into two parts, the first dealing with the asylum's administration and admission procedures, the second focussing on the actual treatment prescribed and practised.

Part I: "Superior Qualities ... Malignant Passions": Administrative and Admission Procedures

The construction of the London Asylum was part of a widespread movement in North America to create specialized institutions for the insane, based upon the principle of "moral treatment." Moral treatment was first applied by a Quaker philanthropist, William Tuke, at the York Retreat in England, founded in 1792. The success of The Retreat in advocating care without extensive use of restraint revolutionized treatment of the insane in England and led to the passing of lunacy reform legislation and the establishment of similar institutions by the government.2

Tuke's method was based upon the assumption that for most cases of insanity, only one mental faculty was damaged, thus disrupting the balance of the "emotions". Treatment would involve reasoning with the unimpaired faculties.3 Moral treatment entailed the use of reward and punishment. If the patient conformed (for example, worked willingly, accepted authority and refrained from alcohol), he was rewarded. If he failed to meet expectations, he was punished, though with a minimum of physical abuse.

Specific provision for the insane in British North America was first made in New Brunswick in the 1830s, when an asylum was built at Saint John.4 During the same period in Ontario, the government paid for the
maintenance of lunatics in county gaols where they lived in “filth and nakedness”.

The first real impetus for reform came from Dr. Charles Duncombe, a physician and member of the Upper Canadian Legislative Assembly, who in 1836 engineered the appointment of a commission to study the establishment of lunatic asylums in the province. The commission (on which Duncombe served) recommended the building of a large institution in Upper Canada offering moral treatment similar to those established in England and in the United States.

Early action might have been taken on his proposal had not Duncombe joined William Lyon MacKenzie's ill-fated rebellions of 1837-8. After his attempt to capture London failed, Duncombe fled to the United States where he took up medical practice until he died in 1867.

Because of Duncombe’s involvement in the Rebellion, the reforms associated with him were discredited and it was not until 1850 that a permanent asylum was built in Ontario. In 1841 a temporary asylum had been built in Toronto in an abandoned gaol. Interestingly enough, it was visited by J.H. Tuke (grandson of William Tuke) who branded it “one of the most distressing places” he had ever seen. “The house,” he reported, “has a terribly dark aspect within and without.... There were, perhaps, seventy patients, upon whose faces misery, starvation, and suffering were indelibly impressed....”

With the immigration of thousands of indigent Irish Catholics during the potato famines of the late 1840s, the need for all types of large-scale public institutions, such as prisons, hospitals, and asylums, was very great. Private initiative had proven woefully inadequate to the needs of an expanding populace. The establishment of insane asylums in Ontario was finally implemented through a Board of Inspectors of Prisons and Public Charities.

Founded in 1859 by the government of the United Provinces, the Board divided Canada into five different districts for medical care (Quebec, Montreal, Kingston, Toronto and London). After Confederation, when health care was placed under provincial jurisdiction, the Board was replaced by a single Inspector, and Ontario was divided into the jurisdictional districts of London, Hamilton, Toronto and Kingston. Under normal circumstances, patients were to be sent to the Asylum in their home district, but in an emergency, or if there were no vacancy, the patients could be admitted to another institution.

Ontario's first lunatic asylum was opened in Toronto in 1850. By 1854, before completion, it was already seriously overcrowded. In 1856, the Rockwood Asylum was opened in Kingston — in a mansion purchased by the government. Five years later, a branch of the Toronto Asylum was opened in former military barracks at Fort Malden near Amherstburg. Also in 1861,
the Orillia Asylum was established in an "unfinished hotel". The Malden and Orillia Asylums were closed and their patients transferred when the London Asylum opened in 1870.15

In 1875, an asylum for inebriates was established in Hamilton, but was soon converted to an insane asylum because of the pressing need. A second branch of the Toronto Asylum was built at Mimico in 1894. The Brockville Asylum was opened in 1894 and a home for the female chronically insane was established in Cobourg in 1902. In 1884, the Homewood Retreat, a private asylum, was opened in Guelph.16

London had been incorporated as a city for merely fourteen years when the province decided upon it as the location for a lunatic asylum for southwestern Ontario. The city had come to dominate a vast agricultural hinterland in the 1840s and 1850s as a result of the relocation of the local government from Vittoria in 1831 — with subsequent construction of the courthouse and administrative offices, the establishment of a strong garrison after the Rebellions of 1837-8, and the key decision to build the Grand Trunk Railway through London in 1851.17 During the 1850s, London experienced a wild real-estate "boom" which subsequently "busted" leaving the city and many of its citizens virtually bankrupt. In 1860, however, with the discovery of oil nearby, the city appeared once again on a solid financial footing.18

The construction of the London, Ontario Asylum for the Insane, one of the first acts of the new Ontario government after Confederation, was an enormous boost to London's economy. The Asylum employed about one hundred people at its 1870 opening and provided substantial and varied contracts for the city's businesses. It also rapidly became a "must-see" attraction for visitors.

In the nineteenth century, the Asylum's function as a curative hospital largely reflected the personalities of its two medical superintendents. Henry Landor was responsible for the design of the Asylum as well as serving as its first administrator. He attempted to create an institution which would cure as well as control, but had few illusions about finally curing insanity. "With so many incurables," he wrote, "treatment is confined to taking care of comforts (including) good and nourishing food, clothing [the insane] well, and working those who have the strength to work, exercising out of doors those who can walk." Landor believed in amusement and occupation: "daily dances in the afternoon for an hour or two, music, stereoscopic views, etc. and (the patients) spin, knit, and make all the socks and stockings used. Employment is the rule of treatment...."19 In short Landor appeared to have a very pragmatic attitude towards the treatment of the insane, and ran a fairly successful administration.
When Bucke replaced Landor as medical superintendent after the latter's death, he initiated a number of reforms, including the gradual elimination of alcohol as a stimulant and a reduction in the use of restraint. He also employed surgical techniques to "cure" insanity in women and such deviant behaviour as masturbation. Such actions demonstrated a propensity on the part of "alienists" (psychiatrists) in the nineteenth century to judge morality as well as treat insanity.

*Dr. Henry Landor, first superintendent, London Asylum, circa early 1870s (Photo: Archival Teaching and Research Museum, London Psychiatric Hospital)*
Henry Landor, born in Wales in 1815, had been the resident physician in a private asylum in Norwich before he came to Canada West. He gained some notice in England for his pamphlet *The Only Way To Stop The Slave Trade* (1849) which he wrote after a stint as colonial surgeon to the British naval forces on the African Gold Coast. He immigrated to Canada in 1860 and was in private practice in London until appointed Superintendent of the small Malden Asylum at Amherstburg. He subsequently was transferred to the London Asylum in 1869. In fact, the London Asylum was built to Landor’s specifications and was modelled on Thomas Kirkbride’s landmark Pennsylvania Asylum. Landor as well introduced the “cottage system” to North America. A British innovation, the cottages were small satellite buildings on asylum grounds which eased overcrowding and afforded greater freedom of activity to chronic, quiet patients. Landor’s writings included two pamphlets: *Insanity in Relation to the Law* (London, 1871) and *Hysteria in Children as Contrasted with Mania* (London, 1873). While Superintendent of the Asylum, he wrote a series of articles for the *London Free Press* on “Social Behaviour”, one of which gained notoriety when readers insisted they could see through the “thin disguise” of the Doctor’s “horrible example” and detect the “unregenerate features” of London’s ex-mayor, Frank Cornish.

Despite a successful career, Landor, burdened by diabetes, died depressed and disillusioned in 1877. During his last year of superintendentcy, in 1876, he submitted a lengthy letter of resignation to the Inspector of Prisons and Asylums, J.W. Langmuir. Asylum administration, he suggested, was changing in Ontario:

> Your system has become too unbearably military for endurance.... I have though my long experience and faculty for administration made me more competent to conduct this asylum than any other man in the province. I have lived to find myself mistaken. Any nonentity can register and fulfill orders. I think myself fitted for better things.... I regret this termination of my connection both with this asylum and with you, but I cannot live in comfort with a perpetual blister on me arising from the conviction that I am occupying a position without proper authority.

Langmuir urged him to stay on and Landor finally agreed, saying he would “let it rest until the inevitable comes.” Landor had found himself caught between the conflicting values of two eras of asylum administration. When he was trained and first installed as head of an institution in the 1850s, superintendency still involved control of virtually every aspect of asylum management and treatment. By the 1870s, however, government moves to centralize and rationalize public institutions had resulted in a substantial loss of that power. For a member of a new but prestigious profession, accustomed to wielding complete authority, the blow was particularly severe.

Landor’s replacement was Richard Maurice Bucke. Born in 1832 and raised on a “pioneer homestead” near London, Ontario, he studied medicine at McGill University. After post-graduate work in Europe, he set up private practice in Sarnia until he was appointed Medical Superintendent of the
Hamilton Asylum in 1876. Succeeding Landor in 1877, he remained at the London Asylum until his death in 1902.24

R.M. Bucke was an author, literary critic and philosopher as well as an asylum superintendent. In his writings and lectures, he demonstrated the propensity of nineteenth century physicians to judge societal morality. In 1881, for example, he supported the eugenics movement as a means of preventing insanity.25 He suggested that since the state was “unwilling”, clergy, educators and the press should enlighten and “caution” the populace on eugenics.26 In an interview in *The London Advertiser* on 8 July 1881, after the death of the American President James A. Garfield, Bucke recommended that the assassin, Charles Guiteau, be hanged; as an evident case of “moral insanity”, Guiteau could not be treated, he argued, as he had no sense of the wrongness of his actions. “Guiteau should be killed,” Bucke stated, “not as punishment for his crime, as he is incapable of understanding that he has committed a crime. But he should be killed as a protection to society, killed as you would kill a wild beast or a rattlesnake.”27

Bucke was also interested in the cosmic nature of insanity.28 In an article published in 1878, “The Moral Nature and the Great Sympathetic”, he described the four basic elements of the brain as faith, love, fear and hate.29 In *Man’s Moral Nature* (1879), Bucke wrote that longevity was dependent on the “degree of perfection of the great sympathetic nervous system”; those who had the highest moral nature, he concluded, lived longest.30 In the same essay, Bucke argued that women possessed a higher moral nature and had a greater capacity for love and faith than men, but because women purportedly had measurably smaller brains, they possessed a “less developed” intellect. Although women “would not be great”, they were the “acknowledged civilizers” of the race.31

Because Bucke apparently had had a mystical experience, after reading Walt Whitman’s *Leaves of Grass* in 1871 — he found himself “wrapped in a flame-coloured cloud” — he became an ardent Whitman devotee. In 1883, Bucke published a biography of Whitman, subsequently was occasional physician to the poet and eventually his literary executor. He gradually came as well to resemble Whitman, adopting the full beard, baggy clothing and wide-brimmed hat of the poet.32 In Bucke’s philosophical *Cosmic Consciousness* (1901), he described the mystical experiences as evidence of a higher level of consciousness. Only a handful of men, such as Christ and Walt Whitman, he argued, had reached the highest level of consciousness.33

Despite an imperious personality, Bucke was better suited than Landor for modern asylum superintendence. A younger man than Landor, and one who numbered government bureaucrats among his friends, Bucke
did not “chafe” under government control. Yet his theories and treatment of insanity proved much more radical and controversial than those of Landor.

Nineteenth century mental care was concerned with the cause as well as the treatment of insanity. With the assembly of the insane in large institutions, physicians were able to study and classify patients on a satisfactory scale to determine casual patterns. From observation of patients, they developed theories which were attempts to explain madness, its origin and its cure. Alienists recognized that poverty, malnutrition and severe hardships arising from migration, among other factors, might cause madness or exacerbate existing mental instability. An individual’s own excessive behaviour was another important factor. Physicians exhorted the common man to refrain from too much sex, alcohol or religion. They warned him of the dangers of masturbation or the suppression of natural bodily functions. “Want of an occupation” caused insanity, but so too did overwork. For the alienist of the last century, moderation in all things was not simply “the Golden Mean”, but the prerequisite of lasting mental health.

Although an increasingly large assortment of behaviours could be classified as symptoms of mental illness, it was not easy to admit a patient to an Ontario asylum. In Britain, reports of unjust commitments and “mad-doctors” in league with greedy relations were popularized in sensationalist novels. This exposure resulted in legislation aimed at protecting the interests of the insane which was later adopted in the province of Ontario. Admission was also hindered by the fact that applications far exceeded places. Even with the construction of new asylums and additions to old ones, the supply of unwanted and mad relatives appeared endless.

Admission to the Asylum could be achieved through two avenues. The criminally insane or those who were in county gaols were admitted under warrant of the Lieutenant-Governor. Private admission was obtained through the issuance of a certificate filled out by the family physician and sent directly to the Asylum. An application form was then sent from the Asylum, and when a vacancy occurred blank certificate forms were issued. Each form had to be signed by three physicians; the patient was then admitted.

There are few sources extant, such as admission forms with medical testimonies, which describe the behaviour which led to commitment. Records on Jane C., aged forty-eight in 1872, are particularly complete, because her husband had had her remanded to the Middlesex County Court on charges of lunacy five times between the years 1872 and 1875. She was admitted to the London Asylum at least twice by the courts on the grounds that she was “of unsound mind and not safe to remain with her family”. In both cases she was discharged recovered or improved.
According to the court records of 21 August, 1873, Jane's lunacy had become apparent to her husband Michael C. two weeks earlier. He noticed that she "could not sleep", "would not remain in the house", and "always wanted to go away". A day earlier she had been standing on the railway tracks. Michael's deposition continued: "I told her she could get killed on the railroad tracks. She said she didn't care. I don't think she's dangerous but I fear she will get away and get killed. She was committed last Christmas for insanity and was in jail seven to eight weeks. I don't think she is safe at large. Sometimes she is sensible, sometimes a fever takes her". Even in this early period, prior commitment to a mental institution was seen as justification for subsequent committals.37

In the same hearing, Jane C.'s neighbour, Rosanna C., stated that Jane had come "over to my house [saying] she was going to Ireland. I took her back home. She was going down the street crying, 'my children, my children'. My husband called her in and gave her tea. She was certainly out of her mind."

Despite the fears of many individuals that conspiracies to imprison sane people were common occurrences, this view does not appear to have been substantiated in the Ontario records. Thirty-year-old James S. (#390), for example, was tall, strong and reportedly "dangerous — violent, suicidal and everything that is bad." Dr. Landor however could not see "anything wrong with him." By his own account, James had had "bad whisky at Christmas", became drunk and violent, and was sent to gaol as a lunatic. Landor sent him out to work and in a month, being "well behaved and industrious", James was discharged. James was only institutionalized for four weeks; the Asylum was clearly not the "hell-pit" of fiction from which no one emerged.

Alcoholism was mistaken for insanity in another case. James B. (#214) was sent to gaol ten times as a dangerous lunatic, on each occasion after a drunken spree. "If he refrains from drink," Landor wrote at the Malden Asylum in November 1869, "he will be well enough." A month later Landor noted that James was "a little excited occasionally but there is no reason why this man should encumber the wards of an asylum. A home under the control of a father or a refuge would be the proper place for him." Yet Landor had no doubt that "as soon as he had money he would spend it in some tavern and do injury to someone," and he did not order James' release. The patient was transferred to the London Asylum on 23 November, 1870. James left on his own initiative, however, eloping (escaping) with another patient, William M. Both men were "written off".

Attempts as false or unjust committal were more likely to come from people outside the Asylum. In his Annual Report of 1873, Landor complained that the forms of admission then in use did not ensure the veracity of
statements made. Applicants often made false statements regarding the duration of illness, saying the attack of insanity had been months old when in reality it had been years. Applicants also "suppressed knowledge of former attacks" and represented harmless patients as "suicidal or dangerous" in order to obtain admission. "So long as it was the public's impression that the dangerous and the suicidal were the first chosen", Landor wrote, "all the papers stated that the applicant possessed those qualities." When it became known that admission was awarded to those most likely to be cured, "the period of affliction diminished from years to months". Landor's remedy was to make available sufficient accommodation for all the insane, and failing that, to impose a fine for misrepresentation. He also suggested that Ontario adopt the English method of requiring separate certificates from physicians who made individual examinations so that possible collusion (particularly for monetary gain) could be minimized.38

According to Landor, statements made in warranted cases were no better than private cases, since gaol physicians and wardens sought to rid the gaols of lunatics. They would describe patients as extremely violent to over-ride the warrant procedure and obtain immediate admission to the Asylum. Landor therefore found that the diagnosis with which patients were committed could say more about the unwillingness of others to care for the lunatic than of the unfortunate's actual condition. The "suicidal" and "dangerous" may merely have been the unwanted.

As a public institution, the Asylum did not maintain itself solely through fees. In 1871, only four percent of the patients were on the paying list. Those who could afford it paid $2.75 weekly, those with less income paid $1.50 or $2.00 weekly, and those with nothing (the majority) paid nothing. Paying and non-paying patients were not treated any differently, and wealthier patients could not pay additional fees to get preferential treatment.39 In 1877, Inspector John Woodburn Langmuir wanted to convert one of the cottages into a home for paying patients. Bucke said that this would reduce capacity because all paying patients would want single rooms. He suggested that these patients be kept in the same building as pauper patients, be housed in a detached building on the grounds, or be put into an entirely separate asylum. Langmuir replied that the Department of Public Works would rearrange the inside of a building, but was not prepared to build a new one.40 The Superintendent and the Inspector often engaged in haggling of this sort. The Superintendent would ask for a library and settle for a billiards table, or design an imposing edifice and settle for a modest church.41

An essential aspect of moral treatment was classification. Care was taken to ensure that patients with similar degrees of insanity were grouped together so that the acutely insane would not corrupt or contaminate the mildly insane. At the London Asylum, the refractory building was reserved for the violent, dirty and noisy patients. Epileptics and chronic maniacs who
might be "seized with exacerbations of insanity" were housed in the north building.42 Quiet chronic patients and those soon to be released were housed in the cottages where "fear of being sent to the main building" had a powerful deterrent effect.43

Upon admission, patients were classified as suffering from mania, melancholia or dementia. These categories were extremely broad, and were not viewed as disparate diseases but varying degrees of insanity.44 A patient, for example, might be admitted with chronic mania which deteriorated into dementia in the Asylum. Mania referred to a general state of violent or excited behaviour. Monomania was obsessive behaviour towards one or a few objects. Other forms included religious mania and nymphomania. Dementia, or complete loss of reason, was generally defined as "insensate, utter folly, because the organs of thought have lost their energy and strength requisite for their functions."45

Melancholia was the "predominance of a sorrowful and depressing passion."46 It tended to be a disease of the middle and upper classes and implied "suppression of feeling" which was the opposite of "peasant insensibility and peasant noisiness of expression."47 One early prescribed treatment for melancholia reflected its upper-class nature:

The cure of melancholy should be attempted in the spring or summer, by travelling far from home, with agreeable company, or if convenient, into foreign countries.48 Melancholy in women could best be treated, it was thought, by seeing them "well-placed and married to good husbands in due time."49

Epilepsy was also a frequent diagnosis. In the nineteenth century, epilepsy was believed to be caused by "excessive drinking, sudden stoppage of the courses, severe fright, injuries to the head, teething or irritation from worms in the stomach and intestines."50

Mania and chronic mania were the most frequent diagnoses at the London Asylum: 28.4 percent of the patients admitted between 1870 and 1877 were labelled as such. Suicidal and dangerous mania accounted for another five percent. Twenty-two percent suffered from dementia, chronic dementia, approaching dementia, or "complete and chronic dementia subject to paroxysms of excitement". Seven percent of the patients were diagnosed as melancholics: chronic, suicidal or dangerous. All suicidal patients were not necessarily melancholics; seventeen inmates with mania and one with demen-
tica were also listed as suicidal. Twelve patients (1.5 percent) were epileptics, often accompanied by other disorders, while others had fits which resembled epilepsy while in the Asylum. 

The causes of insanity were also classified as moral, physical, hereditary or congenital. Moral causes were instances of extreme anxiety or stress and included domestic troubles, death of a close friend or relative, money problems, love affairs, worry and fright. Nine of the ten patients at the Asylum who had become insane through grief were women who had lost a parent or child. Ten patients had domestic troubles, primarily the result of jealousy or ill-treatment.

Adverse circumstances, which included money troubles and business reversals, were usually suffered by men (five men: one woman). Three patients lost their property, while another went insane “brooding over property he thought he paid too much for.” Four men and four women worried themselves mad through “over-mental exertion”, “mental prostration and living alone”, and even through the “excitement of travelling”. Religious excitement was frequently cited as a cause of insanity although this tended to be discounted by authorities. Isaac Ray, a noted American alienist, attributed “religious monomania” as much to “neglect of food, sleep, exercise and mental relaxation” as to “passion aroused by religious thought.” Joseph Workman, the Superintendent of the Toronto Asylum (1853-1875) believed that a lunatic’s nominal religion had “very little to do with the causing of his insanity, though it may have much to do in determining the form of it.” Of the patients admitted between 1870 and 1877, seven men and two women at the Asylum had gone insane from religious excitement.

Insane love affected eight women and two men through “disappointment”, “love” or “seduction”. One man was frightened by lightning while a woman went mad through a “want of an occupation”. Physical causes of insanity included over-indulgence, uterine disorders, fevers, epilepsy, head injuries, and overwork (though lack of work was a moral cause). Ten men and one woman were listed as mad from drink which provided justification to proponents of temperance. Fifteen men and one woman were believed to have gone mad through self-abuse; masturbation was the most frequently listed cause for men. Eighteen women suffered from uterine disorders which were considered to have caused insanity. This designation probably provided the basis for Bucke’s later celebrated experiments with gynaecological surgery. Other patients suffered from sunstroke, inflammation of the eyes, “ill-health” or “sickness”. One young man had suffered a fever “while in the United States”.

Heredity was the third category of causes designated by Asylum administrators. Heredity as a pre-disposition for insanity was of great concern in the late nineteenth century, as important as excessive behaviour. It was
believed that insanity was a manifestation of a general inherited weakness which could take many forms. Dementia in one generation, for example, could result in "feeblemindedness, criminality, alcoholism, tuberculosis, or eccentricity" in succeeding generations. The fact that different members of the same families appeared in asylums and prisons justified this belief. Alcoholism and self-abuse might also taint future generations.

At the London Asylum, heredity was considered a most important causal factor in insanity. Forms of admission inquired whether other members of the patient's family had also suffered from insanity and patient case histories often listed the designation "Heredity" or "Not Hereditary". Of the cases for which that designation was made, forty-six percent were cited as hereditary, and fifty-four percent as not hereditary, so that no pattern emerged, but forty-six percent would still have been regarded as an excessive number.

Concern for heredity as a causal factor was demonstrated in a number of documented cases. Alexander G. (#666) was a farmer with suicidal tendencies and melancholia. It was noted in his case file that his parents were cousins and that his brother was in a Toronto Asylum. Mary Matilda E. (#845) was another patient for whom heredity was seen as a strong causal factor. Her sister Margaret Ann (#982) was also a patient in the Asylum, and another sister had "spiritual views". Mary had been a schoolteacher until she had gone insane from "teaching and excessive study". She fancied she had a "man's brain" and that she was a "Queen Philosopher". She was occasionally violent, throwing dishes and striking others, and sought to save everyone from his or her sins. She was transferred to the Mimico Asylum in 1890. While Mary's case was seen as strongly hereditary, there also appeared to be disapproval for the "over-educated" woman who did not know the limits of her own intellect.

Elizabeth W.'s case was a fine example of familial degeneracy. Elizabeth (#509), a labourer's wife, was "noisy and troublesome" and made use of "very profane language". In her case file, Landor wrote, "Insane family. Hardly know what relations they are having lived without any of the rules pertaining to morality and in some instances brothers and sisters having carnal intercourse." Four of Elizabeth's relatives were in the Asylum.

There were cases in which "heredity" may have meant destructive interpersonal relationships, particularly with respect to the families of the insane. The patient casebooks portray deeply troubled families whose "lunatic" members may well have been victims of mental and spiritual aggression. William E., poet and patient, was a frequent resident of the Asylum (#498;643;859). He had first been admitted in 1871 with suicidal melancholia, had recovered, but was re-admitted in 1873 after attempting suicide. His mother too had been judged insane, his sister and mother-in-law were in the
Asylum, and his father was "eccentric". William had been a masturbator in his youth and was "probably so up to admission." He told Landor of his habits and the superintendent "warned him" to give up the practice. He "improved six months after admission and was sent home on leave with his brother, but returned after three days saying that he had been "very nervous" while he was away and had not slept.

In 1874, he apparently attempted to re-admit himself. Because he had been discharged, and "as he was well enough to earn his own living," Landor could not detain him upon his own request, having no power to do so. He therefore gave William a letter to take to the county court requesting that he be sent to gaol until he could be admitted to the Asylum by warrant since "his symptoms were returning." Landor added that if the Sheriff obtained a warrant, William would be immediately admitted.56

William's affadavit stated that his wife and two children were with his father-in-law and that his own father refused to offer any support for his son's upkeep. As Landor wrote, "his relations act more like enemies than friends to him." William was admitted and again released but returned eighteen months later seeking re-admission. Bucke eventually had to obtain permission from the Inspector, who ordered that three physicians — not from the Asylum — examine William. If they declared him insane, he would be allowed to stay.57 William was subsequently re-admitted. It was evident that the first priority was to provide refuge for the most needy. An individual could not escape his family problems at the province's expense by admitting himself to an asylum. It first had to be proven that he was dangerous or suicidal, or could not take care of himself outside.

Adelaide B. (#228;684;801;961) also suffered from recurring insanity; she was admitted four times between 1870 and 1877. Adelaide's melancholia was caused by "hysterical malaria." She was first brought to Malden in 1870 "tied hand and foot"; she had been kept at home for some months. She was a Methodist belonging to a "psalm-singing family full of excited nonsensical notions who have filled her mind with the usual amount of trash so that she believes her foolish fancies are spiritual assertions for her guidance." Landor prescribed "plenty of food and wine as soon as she could be persuaded it was righteous to take the latter." This treatment "brought her round" in two months. Landor sent Adelaide home "until the family does it again."

Congenital cause for insanity was the fourth category and included birth defects, primarily imbecility (mental retardation). The Asylum established a separate Idiot's Asylum in 1872 to remove the imbecile, particularly the trainable one, from the influence of the acutely insane. At the same time, reformers concerned with the "hereditary taint" advocated homes for imbeciles to prevent them from contaminating society with degenerate offspring.
The statistics bore out the assumption that the London Asylum had been built primarily for the destitute and labouring poor. Of those patients whose files listed occupation (54.7 percent did not), farmers made up thirteen percent of male patients and labourers comprised fourteen percent. Women were primarily servants (32.5 percent). Wealthy members of society, it seems, were able to look after their own insane or were unwilling to put family members in asylums with the poor.

Certain cases were obviously the result of destitution. Mary M. (#450), an elderly Irish immigrant, became insane from "want and loneliness" and was admitted on 26 June, 1871. Although the priest was sent for twice because it was thought she would die, Mary thrived in the Asylum. She talked a "good deal of Irish" and wanted everyone to "partake in any food she had". She was "very occasionally" bad tempered and died of old age on 20 March, 1887.

Mary O. (#882), admitted on 29 October, 1874, was "found in the streets, nothing is known of her except what she states herself". She was supposed to have come from Montreal and "always wanted to go there where she said her little son was". She was an extremely violent patient until she died in 1881. The case of James A., admitted on 6 June, 1874, was indicative both of the effects of poverty and the use of the institution as a home for those with nowhere to go. James (#810) was arrested for vagrancy and for "making use of abusive language" and being "threatening". In gaol, to which he was sent to serve thirty days hard labour, James was "occasionally troublesome" at night. He was committed to the Asylum by Dr. Thomas Hobbs, the gaol physician. James became a quiet cottager and worked in the garden until his death in 1895. Although the Asylum had not been intended as a home for the destitute, there were few alternatives in late nineteenth century Ontario.

Walter K. (#617) had been a commissioned officer in the British Army and had suffered from "sunstroke" while on service in India. He believed he had to be cured "by the Almighty" for his sins. Walter had been a warranted case from the London gaol where he was committed as a dangerous lunatic. According to the affidavit of William Cartwright, the justice of the peace who was present at his examination, Walter had been found in a swamp by Mr. Hiram Fitfield, a "respectable farmer". It appeared that Walter had been in the swamp four days and nights without food or shelter and was only saved by the "careful nursing" of Mrs. Fitfield. It was decided by "Mr. Niles, J.P., Mr. Dreary, J.P." and Cartwright that Walter was a dangerous lunatic and he was ordered committed.

Poverty coupled with the hardships of immigration resulted in insanity which led to certain ethnic groups being over-represented in the Asylum. The most statistically significant ethnic group were the Irish. Of patients admit-
ted to the London Asylum between 1870 and 1877, 147 (thirty-six percent of those for whom ethnicity was known) were Irish-born. Fifty-one percent of this group were Catholic. The arrival of the Irish Catholic peasants between 1847-1856 aroused xenophobic hostility and concern for public health among white North Americans. Each wave of immigrants brought epidemics of cholera, typhus, and other diseases. The British government was accused of "dumping" diseased Irish on Canada. The great numbers of poor Irish overwhelmed existing public charitable institutions and indeed provided much of the impetus for the construction of hospitals, prisons and asylums in Ontario.

The large proportion of Irish in mental institutions soon drew considerable medical attention to the case of Irish insanity. The Irish were alleged to have a low rate of recovery which could be blamed in part on the difficulties encountered in terms of English-descended, Protestant, middle-class physicians treating Irish Catholic peasants. Moral treatment, after all, was based on the personal relationship between physician and patient. Physicians felt less sympathy for patients who were no longer of their class who spoke strange languages and possessed different and often distasteful habits. The Irish, for their part, distrusted these alien figures of authority. At the same time, the influx of insane overcrowded the asylums and made it impossible for physicians to provide adequate treatment for every patient; the result inevitably was custodial rather than curative institutions.

Following the Irish in terms of numerical strength at the London Asylum were 123 "Canadians" (thirty percent of the total). These two groups far outdistanced the English and Scottish (ten percent and eleven percent respectively). Patients were also designated as being from Quebec, Ontario, the United States, Nova Scotia and Wales. Germans composed 2.6 percent of the Asylum population, drawn from the predominantly German settlements in the county of Waterloo.

Age was another important factor in admission. More than half of the patients (fifty-three percent) were admitted to the Asylum when they were thirty to fifty years old. Another seventeen percent were in their twenties. Violent individuals would be at the peak of their strength in those years and therefore more dangerous to society. At the same time, the numbers indicated that the Asylum, while containing a high proportion of chronic patients, was not a refuge for the elderly or the senile. However, it must also be remembered that the elderly insane, particularly the impoverished, could not have had a long life expectancy.

Sex and marital status were other significant factors leading to admission. Of the patients for whom marital status was known (see Table, below), thirty-one percent of males and fifty-five percent of females were married.
SEX/MARITAL STATUS

<table>
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<tr>
<th></th>
<th>Men</th>
<th>%</th>
<th></th>
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<td>11</td>
<td>11</td>
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<td>125</td>
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<td>25</td>
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<tr>
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<td>1</td>
<td>.4</td>
<td>.4</td>
<td></td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>1:2</td>
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</tr>
<tr>
<td>Total</td>
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<td>101</td>
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<td>99.5</td>
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</tbody>
</table>

1. Patient No. 143 was first to state marital status.
2. “Single” may include widowed, divorced or separated.

[Source: Archives of Ontario, London Psychiatric Hospital, Casebooks 1870-1880]

A primary consideration for admission to the Asylum was place of residence. Patrons would be more likely to place their relatives in institutions closer to home. The government also was consciously striving to establish regional asylums, which served surrounding communities. Nearly half of the Asylum population (48.6 percent) were residents of the neighbouring counties of Essex, Kent, Lambton, Elgin, Middlesex, Oxford and Huron. Middlesex county alone accounted for 18.6 percent of the population. The county of York contributed 8.4 percent which was probably the result of efforts to ease the overcrowding at the Toronto Asylum.

Colour was not a statistically significant factor as there were only four blacks in the Asylum. Alfred W. (#25), the “most inveterate tearer of clothing in the house” was a mulatto who was always kept in canvas. Parthina B. (#313) was a “negress called ‘Topsy’” who chewed tobacco and asked everyone for a “lilly bit of money” which she stored carefully. Mary Elizabeth S. (#862), admitted on 19 September, 1874, appeared to have method to her madness. She was a Baptist Minister’s wife, who apparently went insane at the death of her parents. Her madness manifested itself as a desire “to drive her husband out of the house”. She attempted acts of violence against him and fancied that he “and the Freemasons” were against her. With respect to heredity, it was stated that Mary Elizabeth’s mother was “slightly insane” and that her father was a “frantic, impulsive” man. These definitions likely came from the Baptist minister. At the Asylum, Mary Elizabeth spent her time making and dressing dolls until her death in 1902.
One of the most unusual cases at the Asylum was that of Isaac J. (#817), admitted 24 July, 1874, a black with “no particular delusions”, who sat quiet and morose and answered questions “with difficulty”. After seven years at the Asylum, Isaac suddenly began talking “this morning with attendant Flynn. Says he has not spoken for so long a time as he thought the people with whom he cared to speak felt themselves too good to speak to him on account of his colour, and those around him who were willing to talk with him were crazy.” Isaac became excited a week after his transformation, swore constantly and stopped working, but soon calmed down, becoming “quiet and well behaved”. He was allowed out on six months probation with his former employer and was then discharged. Isaac’s case demonstrated that any patient who showed signs of recovery and who had recourse to care or employment might be quickly released.

Fifty-one percent of the patients admitted between 1870 and 1877 died in the Asylum. Half that number (twenty-eight percent) were released, of whom 1.5 percent were re-admitted. Eighteen percent were transferred to other institutions while 1.4 percent “eloped”. Despite the goals of the institution to cure quickly and release, the Asylum became filled with chronic cases. Yet Landor was not concerned about a low discharge rate. “No reliable conclusion,” he wrote, “can ever be drawn, as to the success of asylum treatment in any institution, without a careful and rational valuation of the facts represented by its statistics. A bad workman may spoil good materials, but a good one can hardly make a good article out of bad material — shoddy will come out but shoddy in spite of the best skill of the weaver ... Just so it is with the human mind. We cannot make it over again, and turn it out better than God has made it.”

Notes to Part I

*The title is an excerpt from a poem written by William E. — admitted to the London Asylum three times between 1870-1877. Diagnosed with suicidal melancholia, he admitted himself twice voluntarily. The staff began: The staff of officials in charge of the loons/sent up here for care and safekeeping/are qualified men, though some are new brooms/all appear to do very clean sweeping. University of Western Ontario, Regional Collection, Bucke Papers, London Asylum Scrapbook, London, 1878 (hereafter Scrapbook). I would like to thank Professors Jean Matthews and Roger Hall, advisors for the Masters thesis from which this article was derived, and Professor George Emery for aid in statistical analysis. All are members of the University of Western Ontario history department.


21. To label Cornish “colourful” would certainly be an understatement. First elected Mayor of London in 1861, Cornish was constantly embroiled in personal and political escapades. In one notable drunken spree he drove his horse and carriage through a crowded City Hall arcade scattering pedestrians in his wake. He was arrested and, in his capacity as city magistrate, called his own name in police court, gave himself a lecture on the evils of drink, and fined himself four dollars. He built up an “unbeatable” political machine in London and eventually became the first Mayor of Winnipeg (1874). Orlo Miller, *A Century of Western Ontario: the Story of London, “The Free Press”, and Western Ontario, 1849-1949*, Toronto, 1949, pp. 168, 124-5.


29. This was not very distant from the medieval notion of the body being composed four humours [“The Moral Nature and the Great Sympathetic,” *American Journal of Insanity* 35 (October, 1878) 2: 230].


33. Ibid., p. 39.


38. In 1878 three physicians were to examine a prospective patient separately. The number was reduced to two by 1887. *Revised Statutes of Ontario*, 1877, Volume II, Chapter 220, sections 8-9; 1887 Volume II, Chapter 245, sections 7-8; *A.R.M.S.*, 2, 1873, p. 156.


41. *Sessional Papers* No. 4 (1875) p. 224; Bucke repeatedly posted notices ordering employees to stop sitting or leaning against the billiards table. University of Western Ontario Regional Collection. Bucke Papers. *Medical Superintendent’s Order Book*, 18 November 1879. The amusement hall was first used for church services but a separate chapel with capacity for 450 patients was built in 1885. The new facility was required partly to ease overcrowding and partly because many patients could not distinguish between the previous chapel’s function as a church and its function as a dancehall. *The London Advertiser*, 19 November, 1870; C.I.P.A., Box 228, File 6571.


46. Ibid.


49. Skultans, p. 80.


51. A.O., L.P.H., Casebooks, volumes 1-2, patient nos. 142; 407; 421; 555; 663: 729; 734; 806.

52. Dain, p. 94.
Part II: “For Care and Safekeeping”: Treatment of the Insane

Treatment at the London, Ontario Asylum for the Insane provided for the control of the lunatic and attempted to effect his re-integration into the larger community. Virtually all aspects of his institutional experience were considered part of his medical and moral treatment. Medical treatment entailed the use of both narcotics and stimulants; most commonly used for somatic (bodily) illnesses, they were also employed in treating various types of insanity. Medical superintendents Landor and Bucke had opposing views on the use of drugs and alcohol, but neither man relied solely on chemical treatment. Moral treatment (now called milieu therapy) was conceived as the regulation of the insane through labour and amusement rather than through restraint. It also entailed concern with a proper diet and a pragmatic attitude towards elopement (escape). Through employing the methods of moral treatment, the asylum superintendents attempted to make the care of the insane therapeutic and not coercive.

A sedative frequently used by both Landor and Bucke at the Asylum was chloral hydrate. A dose of twenty grains on a healthy subject acted “as a mild sedative of the sensory nervous system” and produced, after an interval of one-half hour, “a light, refreshing normal sleep.” Taken in large quan-
tities, it was a powerful soporific. When it did not induce sleep, chloral hydrate might occasion “excitement and delirium”. It was especially valued as a soporific where opium was “inadmissible” because of its side effects.2

Stephen Lett, assistant physician under Landor, was particularly enthusiastic about the value of chloral hydrate. He found the drug useful “in all cases of acute mania where the patient has not so deteriorated as to require free use of stimulants”. When a patient suffered from “extreme exhaustion” because of excitement, lack of sleep or other reasons, chloral “had little or no effect” and wine, whisky or other alcoholic stimulants had to be given until the patient’s condition improved.3 Where chloral hydrate produced “sleep and quietness”, it had none of the “evil effects” of opium; it did not “derange” the digestive organs, check secretions, constipate the bowels or produce drowsiness.

Landor did not think so highly of “hydrate of chloral”, believing that in “long, continued doses” it lowered the “action of the heart and nerves, and if not of the stomach directly, indirectly.” Because chloral hydrate lowered body temperature, Landor argued it “injurious, for if there is one thing more important than another in the treatment of insanity, it is, that it is absolutely essential to maintain and to increase the vital powers of our patients, naturally low.”4

Landor found that a bottle of “the very best Scotch ale, or the best Dublin stout” was “more pleasant to take” and “not less effective in its operation”. Alcoholic beverages were also advantageous in their tonic effects and “conducive to sound sleep in violent mania”; moreover, they were medicines that would “bear repetition with the best results”.5 Alcohol also was found useful in cases where chloral hydrate was ineffective. Landor asserted that alcohol tended to “restore the vital powers”. By 1872, he was prescribing port wine and whisky along with ale and stout.6 Lett eventually found that by following Landor’s advice and using ale instead of sedatives, he produced results “as satisfactory or more so” than he had with chloral hydrate.7

Landor used alcohol as a stimulant most commonly in cases of puerperal mania (relating to childbirth), and on melancholic women who were “delicate”, “fretful”, “weak”, sleepless” and in poor health. He generally prescribed two glasses of wine daily with beef tea; cod liver oil and wine; or wine daily with “good nourishing food”. A woman with violent mania was prescribed “good food, wine, and exercise”. Another with phthisis (tuberculosis) was put on whisky and extra diet. A man who refused to eat anything but a “thin buttered toast, gin and sugar” was granted his request.8

Landor did not give his patients alcoholic stimulants recklessly. He found through experience that alcohol produced fewer side effects than
opiates and other drugs. He was not, however, immune to criticism from temperance circles. In 1875, given the opinion of "a large class of the people", he made an attempt to diminish stimulants by cutting off all those patients who were considered merely feeble or without any particular disease. He issued one-third less whisky than previously, one-half the amount of wine and one-quarter the beer. During the next five months, twenty-four deaths occurred at the Asylum compared to thirteen in the previous five month period and eleven cases of scurvy appeared (for the first time) which "disappeared after increasing the allowance" of alcoholic stimulants. Landor linked the deaths with the decrease in the use of alcohol and so was not overly swayed by prohibitionist sentiment. Yet he was aware of the negative effects of alcoholism and argued that a causal link existed between drunkenness and idiocy (mental retardation). In 1872 there were seventeen males and thirteen females in the Idiot Asylum. Two were the offspring of "intemperate drinkers", two of moderate drinkers "so-called", but the parents' habits of the rest were unknown.

To put Landor's reliance on alcoholic stimulants into perspective, it should be noted that his asylum did not have the highest percentage of alcohol use in the province. When the question of liquor in asylums was brought up in the Ontario legislature, the government pointed out that the London Asylum's expenditures in 1871 included $200.00 for medicine and medical comforts, and $1600.00 for beer, wine and spirits. The Toronto Insane Asylum spent $420.00 and $3,000.00 respectively which, per capita, was an increase of fifty-one percent. It was stated that the Toronto Asylum superintendent, Joseph Workman, approved of stimulants more than Landor did. Workman in fact took his case to the newspapers. In a letter to the editor of the Toronto Globe in 1876, he disputed the claim of Dr. Dickson (of the Kingston Asylum) that total abstinence in asylums led to a lower death rate. Workman stated bluntly that "total abstainers should leave the domain of medicine".

Like Workman, Landor was a physician trained before the temperance movement became particularly influential and he was not impressed by the dire warnings of prohibitionists. He had a very pragmatic attitude towards the use of stimulants and sedatives and regarded alcohol as less of an evil than opium, morphine or other drugs. When Bucke succeeded Landor at the London Asylum, he discontinued the use of alcohol. Bucke was much younger than Landor and deeply committed to temperance. Indeed, his first major publication was Alcohol in Health and Disease (London, 1880), in which he stressed that alcohol "no matter how wisely, temperately and carefully used ... has not the power commonly ascribed to it of either lessening the pains, ills, or sorrows of life, nor of increasing its joys, comforts or pleasures."

The rare cases for which Bucke prescribed alcohol included a "thin and
weak” man who required extra diet and stimulants; a woman with “asthenia” who was given “wine, extra diet” and placed on the “water-bed”; and a man who had problems urinating and so was granted one beer daily. By 1880 Bucke had discontinued the use of alcohol entirely except in cases of persons “not only feeble, but actually ill, and even then ... very little.” When he had assumed charge of the Asylum three years earlier, he had found six hundred patients using $2500.00 worth of beer, wine and whisky, which was a twenty-eight percent increase from the 1871 figure of $1600.00. During the period 1870-1877, there was a thirty percent increase in the number of patients in the Asylum (498 to 712), however, so that the increase in alcohol use was not on a great per capita basis. By 1878 Bucke reported that he had initiated his reform with “no evil consequences”, and a year later when he had closed the “spirit lists entirely”, noted only one case of withdrawal. Alcohol, he had concluded, was simply not useful enough to “warrant its retention”.

In the place of alcohol, Bucke drastically increased the use of opium, morphine, chloral hydrate and narcotics. The use of opium was widespread in the late nineteenth century. In the United States alone, importation of the poppy increased from 24,000 pounds in 1840 to 416,864 pounds in 1872. There were no regulatory agencies controlling the sale of the drug, nor were its effects immediately understood. Inevitably, opium was abused and many men and women became addicted to the narcotic to which they were first introduced by physicians and chemists. Before food and drug legislation was passed, patent medicines containing opium, chloral, alcohol and other drugs could be purchased at druggists and were advertised as curing everything from “pneumonia to ‘nerves’”.

Nineteenth century physicians used opium as an anodyne (painkiller) particularly for the distress of venereal disease. It was also used in diseases of the digestive organs and as a cure for enteritis, peritonitis, diarrhea and hepatitis. Opium, it was believed, soothed the maladies of the “urino-genital apparatus” and provided “the most relief for diabetes of all found.” In cases of insanity, the value of opium or morphia in the form of acetate of morphia was “insisted upon”; it manifested good effects in “low, desponding or melancholic” forms of madness. It was also used by drunkards “to relieve intoxication”. Physicians soon recognized that opium had negative side-effects, however. It lessened the appetite, constipated and caused nausea. Most importantly, it was highly addictive and its overdose could cause death.

At the London Asylum, Landor had decided opium did more harm than good and he used it primarily in ointments for external application. He had first-hand knowledge of the ill effects of opium abuse. Dr. Joseph M. (#926), admitted in 1875, was a physician who had become manic from morphia abuse and the strain of a “hard country practice”. He was “wild and abusive”, believing himself to be a god and that “everything about him.”
was “in filth and confusion which he must rectify”. Being a paying patient, he was placed in a private bedroom in the Asylum, but was so noisy that he had to be moved to the refectory. He wandered “restlessly to and fro muttering to [him] self about inability to do the work he should”. He fought with attendants and patients, experiencing a number of black eyes. In retrospect, Joseph’s abusive behaviour was probably a manifestation of opium withdrawal. By 1877, Joseph had quieted down, talkingrationally and showing no signs of delusions but merely of “preternatural exciteability”. He was discharged, recovered, in 1878. For Landor, no case of opium abuse could have come closer to home.

Bucke’s attitude towards opiates was startlingly different. At the London Asylum, he used substantially more opium especially in the form of liquid morphine and liquid opium sedatives. In 1878 Inspector John W. Langmuir asked Bucke to compile a list of the quantities of opiates and chloral hydrates used in the Asylum between 1875 and 1878, in case the “use of liquors” would again be questioned in the legislature. Bucke sent Langmuir the accompanying table (see below), noting that Tincture of Opium was used “almost entirely in liniments and diarrhoea mixtures, chlorodyne was used in gastralgia and similar ailments and the rest of the opiates and chloral hydrate were used as sedatives.” Bucke stated that the whole quantity was “small” for so large an institution; the average number of patients taking sedatives was about six; and that at the time (4 October 1878) only one woman, a breast cancer victim, was taking sedatives. Bucke appeared to be slightly disingenuous in preparing the table. Though it outlines the amount of opiates purchased in each year, it does not outline yearly consump-

<table>
<thead>
<tr>
<th>AMOUNTS OF OPIUM AND OTHER DRUGS PURCHASED AT THE LONDON ASYLUM</th>
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<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Chloral Hydrate</td>
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<tr>
<td>Liquid Morphine</td>
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<tr>
<td>Opium &amp; Ipecac</td>
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<tr>
<td>Lead &amp; Opium Pills</td>
</tr>
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</table>

[Source: Archives of Ontario, Correspondence of the Inspector of Prisons and Asylums, Box 234, File 6680]
tion so that it is impossible to compare consumption during the regimes of the two superintendents. Given Landor’s negative attitude towards opium, however, it can be assumed that consumption dramatically increased during Bucke’s tenure. An examination of the table reveals that all twenty ounces of liquid morphine were purchased after Bucke’s establishment as medical superintendent and that thirteen ounces of it had been consumed. Opium and lead pills were also becoming an increasingly popular treatment.

In the casefiles under examination, eighteen patients were treated with opiates in the form of laudanum, opium and lead pills, and morphia. Opiates were used primarily for diseases of the stomach. Patients with dysentery and diarrhea were treated with opium alone or in compounds with ipecac, tannic acid, quinine, lead and alcohol. One patient with colic was given morphine. Another, with enteriperitonitis (a disease of the intestinal system) was given a compound made up of salts, laudanum, one-quarter grain morphia and three grains calomel. He died. Morphia and sulphate of zinc were also used in an ointment for treating conjunctivitis. In only one case was opium clearly used as an anodyne: a seventy-year-old man who had “epithelomia of the lip” turn into cheek cancer. He was given opium for the pain which became so severe he tried to hang himself. He died of the disease shortly thereafter.

Calomel and quinine were other drugs used by Bucke. Quinine alone or with iron, digitalis and strychnine, and boracic acid used to treat carbuncles, irregular heartbeat, febrile symptoms and ague (acute fever). The patient with febrile symptoms apparently had become addicted as she did not want to stop taking her quinine mixture. Calomel, a mercury-based purgative, had been popular at the beginning of the nineteenth century, often accompanied by bleeding of the patient. Calomel and oil, quinine, iron, chloroform and potassium were used to treat “mild malarial fever”, erysipelas of the face, paralysis (stroke), confined bowels, headache, swollen throat and bilious attacks.

Cannabis Indica (compounded with Bromide of Potash) was considered by Landor to be the “least injurious” of sedatives. He was thankful that in those cases where it was essential to produce sleep, he could use a drug “as harmless as this combination”. This narcotic was not listed on Bucke’s table of drugs. Cannabis Indica, or Indian Hemp, was prescribed by physicians for its “hypnotic anodyne and anti-spasmodic” properties. It was considered less certain than opium but also had fewer side-effects. Cannabis was used to produce sleep in hysterical and chorea (a nervous disorder characterized by spasmodic twitching) cases. As an anodyne, it was not as effective as opium, but did help rheumatism, gout and neuralgia.

Dr. Lett found that Bromide of Potash and Indian Hemp produced good results not only in acute but in periodic cases of mania. One woman’s mania which occurred every September was successfully warded off with the
drug. Hemp could also be used for lengthy periods of time. Because of the supposed aphrodisiac effects of Indian Hemp, however, Dr. Lett advised that it should not be prescribed for "masturbators" or patients with "augmented sexual feelings". For these patients, hydrate of chloral was more beneficial.29

Phosphorus preparations were "highly valued" as nerve stimulants by Landor and Lett.30 Phosphorus was used in those cases wanting of "nervous energy" such as dementia and melancholia. As Landor wrote, "If phosphorus acts as a stimulant to the nervous, vascular and secreting organs — if it excites the skin, increases the frequency of the pulse ... who can be doubtful that its preparations are valuable in the treatment of the insane, especially in cases of melancholia..."31

The phosphorus preparation used as a nerve stimulant at the Asylum was hypophosphite of lime.32 Michael V. (#393), a dementia case, showed a "marked improvement" from its use; he worked at odd jobs and could be "trusted anywhere". He was discharged ten months after admission. In the Annual Report of 1872, Lett cited the case of a "sluggish, motionless" man who greatly improved after being on "great doses twice daily" of hypophosphite of lime.33 The patient was discharged, but was readmitted after a five-year interval, again suffering from melancholia. Hypophosphite of lime was not a curative, but did appear to improve the few cases treated with it. Despite Landor's favourable opinion of phosphorus stimulants, however, he was extremely conservative in their employment.

With respect to the use of artificial stimulants, Landor rather than Bucke appeared to be the true reformer. While Bucke attempted to work within the framework of the temperance movement, Landor was much more pragmatic. Per patient, his use of alcohol was not overly extensive and a regimen which included beef tea, good diet and exercise could hardly have been harmful and in fact must have been far more beneficial than opium, morphine and calomel. Bucke’s abolition of alcohol was therefore not without flaws. Put simply, Bucke and Landor had chosen their own poisons.

Neither Landor nor Bucke relied solely upon drugs to treat the insane. The tenets of moral treatment suggested that "regular hours, exercise, good food, kindness and firmness" were primary elements of care.34 Moral treatment required hospitalisation; separation from family and friends; and classification by sex, severity of illness and socioeconomic background (if space permitted) plus an ordered routine life.35 Constant distraction by work and amusement were to replace drugs, restraint and physical violence.
A central element of moral treatment was “good food”. Landor believed that a varied menu was more important than the type of food served, as it alleviated some of the dreary monotony of institution life. In his Annual Report of 1875, he stated that each patient at the Asylum was fed three-quarter pounds of meat daily and “unlimited” vegetables. The dinners varied, with roast, boiled and stewed meats, curries, fresh fish, corned beef, pork, and pudding thrice weekly. In addition, patients were given stewed apples, prunes, preserves, raisins or cheese and buns once a week. Working men and women were given for breakfast whatever meat had been left uneaten from the day before.36 “It cannot be said [the patients] are underfed,” Landor added in 1877, citing the wide variety of fruits, vegetables, and livestock grown on the Asylum farm for domestic consumption.37

Inspector J.W. Langmuir suggested, however, that breakfasts be augmented by porridge, potatoes and boiled rice, served alternately. When this was carried out, Landor attested that the Asylum offered “probably a better diet than the patients were accustomed to at home on the average, since the great majority were from the labouring classes.”38

Both Landor and Bucke recognized the importance of amusements to distract the patients and aid in their recovery. Daily dances were held in the afternoon while formal balls took place every Tuesday night. Attendants were ordered to dance with patients until at least nine o’clock in the evening. Music was considered very important therapy. Upon application for employment, prospective attendants were asked whether they played any musical instruments and had “no chance” of being hired if they did not.39 In 1877 the Asylum purchased instruments to form its own band and special mention was made in the case histories of patients who played the violin or danced a good jig.

Along with the orchestra, the Asylum organized its own dramatic club led by such stellar performers as Dr. Burgess and Mr. England, the launderer. The Asylum also boasted its own Minstrel Troupe.40 Apart from “Asylum-grown” talent, the patients were treated to performances and concerts by amateur or professional groups from the outside community. Lectures on historical events and slide shows of foreign lands were also offered occasionally.

The Asylum endeavoured to maintain a supply of newspapers and journals for patients although, as Landor complained, it had received no gifts except “old periodicals” and was forced to purchase its own materials.41 In Asylum regulations, it was stated that attendants be supplied “with books, newspapers, etc., and shall, on suitable occasions, read amusing stories to such patients as will be pleased to hear them.”42

Patients were also expected to take part in outdoor recreational ac-
tivities. Attendants were to encourage "and join all games and amusements .... The more heartily Attendants enter into amusements and encourage occupation of the patients, the more highly will they be esteemed by the authorities of the Institution." \cite{43} In the summer patients were able to play cricket and take daily walks through the grounds which were filled with "trees, shrubs, and flowers." \cite{44} They were, however, to be prevented from "plucking or eating the plants." \cite{45}

Patient labour was considered an essential facet of moral treatment. For an asylum to refrain from using restraints and still to maintain control of the insane, it was thought that as many of the patients as possible had to engage in activities which would "divert" them from their insanity. At the same time patient labour could help offset the costs of running the institution. In a newspaper article in the *London Advertiser* entitled "Should the Insane Work?", a member of the New York Lunacy Commission was cited as saying that the insane should be compelled to work. The journal pointed out that not all lunatics were physically or mentally able to work, but the experience of Ontario's superintendents was that "a very considerable proportion" were not only able, but benefitted from the exertion. "The more the mind can be drawn out and occupied by some productive employment, the more hope [existed] for the insane." \cite{46}

At the London Asylum, only one-half of the patients worked in 1878. The remaining number spent their winter days in the buildings and their summers in the airing courts.\cite{47} The working patients were evenly divided between men and women. Patient labour was sex-stereotyped and segregated. Women were employed in the laundry, sewing-room and kitchen or engaged in general housework, while men worked on the farm and garden, painted, assisted the carpenters and engaged in other manual labour. In 1877 Asylum labour had "dug 1870 yards of gas-pipes, made 140 yards of box and other drains ... moved 2,000 tons of earth twice, transplanted 560 trees ... [and] planted 1477 yards of willow hedges." \cite{48}

Landor did not hide the difficulties inherent in patient labour. "With good attendants", he wrote, "work can be obtained from patients." He regretted the fact that so few tradesmen became asylum inmates: "We seldom have shoemakers able to follow their trade, even in just repairing shoes and boots," and "tailors are rare inmates, hardly more than two are ever useful in the Asylum." In justifying the large expenditure on shoes and clothing, Landor added that "the trades learnt by the insane [were] not economical and patients [could better] be employed otherwise." \cite{49} Patient labour was impractical in other areas. In 1873 Thomas Scoble, Ontario's Deputy Inspector of Public Works, had not wanted patient labour to be used in sewer repairs, arguing that "not only would their work be unreliable, but all who are not mentally incapable of labour, are sufficiently sane not to care for working without wages." \cite{50}
There were patients at the Asylum who did not work willingly. The attitude of the administration towards them is reflected in the fact that the case histories reported such observations as “Won’t Work” or “Refuses to Work” along with remarks regarding diagnosis or propensity for violence. Cottagers, living in the outbuildings, who did no work usually were sent back to the main building. George H. (#410), for example, went on strike and was sent to the main building. After four months he promised to work and was returned to his cottage. Daniel S. (#672) declared that he would strike if he did not get “five cents worth of tobacco and a glass of grog daily, and a pound of soap weekly.” His demands were not met so he attempted unsuccessfully to elope.

The London Asylum, circa 1895 (Photo: The Regional Collection)
Rachael M. (#171), who fancied herself in Scotland, worked in the sewing-room and lived in the cottages. When she stopped working, she was removed to the main building. This was perhaps a trifle unfair as Rachael was sixty-eight years old. There was also little sympathy for Eliza F. (#135). She was "stupid" and "apt to be cross". According to her clinical report of 1881, she was also "as fat, noisy, and idle as ever"; the physicians frequently described idle patients in derogatory terms.

On the other hand, praise was heaped upon those who worked well. Before she was admitted, Maria C., or "Black Maria" (#160), had a propensity "to destroy everything around her". At the Asylum, she was "one of the best
patients to work in the laundry” and a “Splendid Ironer”. In 1902 she was still “invaluable” in the laundry. Others were thought too enthusiastic in their employment. Abigail M. (#131), a case of dementia, sometimes got cross and “swore a little” but was mostly peaceable. Abigail was willing to do scrubbing, but it was very difficult to keep her “from throwing the dirty water out of the window.” As Landor noted, patient labour might not always be worth the effort, yet he did believe that in most cases some form of employment was beneficial. Amelia H. (#161) was a “chronic melancholic” who thought herself “fearfully abused by everyone”. She used her tongue “freely” and was apt to get in trouble with other patients. She was always better if she “could be got to do knitting.”

Lack of work, it was thought, could also cause insanity. Susan M. (#734), a single woman aged “35 or 40”, had “quiet and indolent” habits of life. Her mania, manifested by a “variety of delusions”, was reported to have been caused by a “want of an occupation”. During her first six years of commitment, Susan did “nothing”. Once she began working in the kitchen and conversing rationally, she was allowed to go home on a three month probation. She was “noisy and troublesome” at home, however, and had to be returned. She began working steadily in the dining-room and sewing-room but also became engaged in frequent fighting with other patients. She was eventually transferred to the Hamilton Asylum in 1888.

Moral treatment entailed the minimization of mechanical restraint. At the London Asylum, restraint could not be totally abolished; violent and destructive patients had to be confined at least for short periods of time if they were not to be heavily sedated with opium. Violent, destructive and dirty patients in the refectory and in the main building were restrained in a number of ways. Those with a propensity to tear their clothes were placed in heavy canvas clothing (strait jackets). Patients liable to strike others, destroy property, or injure themselves had leather mitts, muffs and wristlets locked onto their hands. “The use of the hand-muffs”, Landor wrote, “might be resorted to without doing any violence to the feelings of the most advanced advocate of non-restraint, and in my opinion, would be preferable to long confinement in a small badly ventilated room.”

More severe modes of restraint did exist. Crib-beds (large wooden trunks with slats for breathing) and restraint chairs were occasionally used at the Asylum. Certain single rooms were equipped with shutters which could be drawn along the lengths of the walls so that a patient could be locked in without doing damage to himself or anyone else. When Bucke took over the administration of the Asylum, he wrote that Landor had used “as much restraint as in any restraint asylum”, and might even have become a “believer of restraint” in his later years. “For my own part”, Bucke wrote, “I am persuaded that the use of mechanical restraint variously applied to meet the requirements of particular cases is the most useful ... and least injurious
of any form of restraint that can be used." He thereupon purchased six crib-beds and six restraint chairs, looking upon the beds as "the most absolutely unobjectionable of all forms of restraint," permitting the patient "to be in any position, stretch his legs" while still preventing him or her from getting out of bed. Crib-beds confined acute mania patients "who would otherwise have to be chained or stupified with opium."  

Eighty-four of the patients admitted between 1870-1877 were under restraint at some time. Restraint was last used on one of these patients in 1885 although Bucke formally abolished the practice in 1883. Twenty-one patients, twelve women and nine men, were placed in canvas, leather muffs or mitts for clothes tearing. Another twenty-one patients were placed in restraints for fighting or violent behaviour. They were predominantly female (14 women: 7 men) which might be explained by the fact that violently insane men were more likely to commit capital crimes and the Asylum was intended for the curable, and not for the criminally insane.

Nine of the most violent patients (all women) were placed in secluded (shuttered) rooms for "fighting", "assorted violence", "violence to attendants", actions described as "Seized and choked attendant" (not fatally) or helping "two others pound attendants". Five others, three males and two females, were put in restraint chairs for "beating people up", "hitting attendant and being abusive and violent", or being "on a regular spree", "quarrelling", and "kicking at [Dr.]Burgess". Other violent patients, including one woman on a "howling old spree", were kept in canvas, muffs and mitts.

Fifteen patients were restrained to prevent them from injuring themselves. Two men and two women put in crib-beds to prevent them rubbing their knees sore, tearing off dressings, and stopping an attendant from washing a wounded area. Other patients were placed in canvas, mitts and wrislets to keep them from scratching themselves or smashing their heads into glass. Nine patients were placed in restraint for refusing to stay dressed. Four patients were put in mitts, muffs and wrislets for destructive behaviour such as smashing windows and breaking furniture. Another destructive patient was placed in the restraint chair every day to prevent her from kicking in window panes. Patients were also put in restraints for "plastering the walls with filth", "pulling buttons off the patients' clothes", "pulling out sod", "masturbating" and even for "taking restraints off other patients".

Another form of restraint or coercion was the use of the "stomach pump". At least three patients who refused to eat were force-fed. Force-feeding was more likely to be necessary within the first few weeks of a patient's committal, when the individual had yet to accept his fate. One woman whose sight had rapidly deteriorated during her incarceration refused to eat
until her sight was restored. She was fed by stomach pump for nearly two weeks.

Regardless of the extent to which restraints were used at the Asylum, treatment of the insane in the community outside could be far worse. Owen D. (205) was brought to the Asylum chained and manacled as a “most dangerous man”. When his chains were removed, he was found to be harmless, though he talked incessantly. Charles L. (988) was brought in ropes and chains but was also not violent in the Asylum. Certainly moral treatment was a great advance compared to such cruelty.

There were instances, as well, of violence against patients within the Asylum but they were exceptional. In one extreme example, Mary C. (287) was found tied to a pipe in the watercloset. Had on canvas dress which was covered with blood, hands and face in like condition. She had been confined there by attendant Mary R. as she alleged on account of dirty appearance ... Attendant discharged

Proper asylum procedure was restraint but not violence: “While in the airing court, [Mary] was restrained by a strap around the waist fastening her to a bench to keep her from breaking windows.”

Although the patients were severely restricted in their activities, there were important differences between an asylum and a prison. This was most apparent in the attitude towards “elopement”. For certain patients, elopement was viewed by Landor and Bucke as simply the culmination of treatment. Only those soon to be discharged were sent to work in the fields and Landor relied on their promises that they would not escape. They often eloped, however, “in their haste to get home”. The Asylum “did not bother” to recapture them unless they were warranted cases from county gaols in which case they were treated as fugitives.

One patient who had “got away absolutely” later paid the Asylum a visit during London’s Annual Fair Week: “well dressed and said was in good employment. It was not part of my duty to disturb his freedom, as it was evident he was doing well.” If the patients were homicidal, suicidal or dangerous, efforts were made to recapture them, but if they were “harmless wanderers who are always wishing to be on the move without knowing why, I write to their friends (which included family) and they are sent back when they reach their homes, which they always so.”

Approximately seventy-five patients from the sample eloped at some

Staff members playing croquet on grounds, London Asylum, circa 1890s (Photo: The Regional Collection, D.B. Weldon Library, The University of Western Ontario, London)
point, many more than once. Elopers were predominantly male, which was understandable given that outdoor employment was generally available only to men. Of the patients who eloped more than once, some were wanderers who might wander as far as Arva, just north of London, Stratford and Hamilton while others persistently tried to escape, some as many as six times.

James D. (#664) was known as the "Prophet" because he could "fortell anything". He said all the Asylum's officers would be "damned" for running church services in the ballroom. He appeared rational for two months and was allowed a daily walk, but then became upset again and condemned everyone at the Asylum to hell. During a violent spree he was put in a restraint chair for kicking at Dr. Burgess. Four months later he made a key from a spoon handle and opened the main door, but was caught. He was placed on probation for three months at the request of a friend, but came back himself, saying his "head was not all right" and that he talked at night "and frightened the people". Six months later, "anxious to go away", James eloped and was "written off". From the tone of the reports it was apparent that he was not considered a great risk.

The government's attitude towards elopement was demonstrated in the case of Francis B. (#778). He eloped thirteen months after his committal on 16 February, 1874. Two years later, probably to close the file, Bucke asked Langmuir for a discharge, stating that at the time he eloped, Francis's mental condition was "much improved" and it was believed he could take care of himself. The official position, as recorded by Langmuir, was that if a patient eloped whose condition admitted his care of himself, a warrant of discharge would be issued after "some little time" was given for his recapture. Francis was accordingly discharged though he turned up at the Milton Gaol in 1879. He was then sent to the Hamilton Asylum.

James M. (#997) was more fortunate. He eloped from the chore gang and went home to Lambton. His brother wrote that James was anxious to stay and he was allowed three months probation. He was discharged, recovered, after he reportedly was doing well at home. James was a warranted case from Lambton Gaol. It is possible, therefore, to conclude that warranted cases could also be discharged after elopement.

Some patients eloped in a huff. Andrew S. (#69) wandered away because all the workbenches were occupied. He insisted, however, that he "intended coming back for dinner". James C. (#303), a farmer, sawed wood and gardened at the Asylum. He was given a piece of ground to work for himself. Carpenter White, when fixing the fence on "his (C's) property, so excited C. that the patient went to town "to get a warrant" for the carpenter's arrest. C. was brought back and sent to his cottage for a time. he "wouldn't stay in" and annoyed everyone so much that he was sent to the main
building. A few months later he was back working with the carpenters. By allowing C. to retain his own plot of land, Landor demonstrated imagination and sensitivity.

There were patients no asylum could hold. John C. (#204) “jumped up and ran away” at teatime. He was found at his home in London and was brought back to the Asylum “only after a severe tussle”. Six months later, a wire which could unlock the ward door was found on him. In succeeding years, he was destructive and violent, fighting and breaking glass. Charles B. (#785) attempted an escape by taking out the window screws in the ward. A year later he tried to elope and when “prevented by Mrs. Marks at the gate, drew two putty knives and threatened to butcher her.” His temper varied over the next few years, becoming melancholic, mischievous and violent until he was transferred to the Hamilton Asylum.

James D.B. (#937) engineered a mass escape. On 17 June, 1877, using a bent wire key, he eloped, letting three others out with him. All four were found — James and another man had concealed themselves under a weigh scale bridge. On 19 June another wire key was found in the lining of his pants. He was ordered to be searched day and night. On 28 May, 1878, yet another wire was found on him and on 10 August, he successfully eloped. Mrs. B. telegraphed that James was home and he was brought back. Three days later two wire keys were found in his socks. He eloped twice more, but finally died in the Asylum in 1890.

Two other notable elopers were circus performers. George P. (#897), twenty years old (and probably of gypsy origin) was “supposed to have been with the circus” and was arrested for horse-stealing. He was acquitted by reason of insanity, being purportedly imbecilic and was sent to the Asylum. George, or “Soapie” as he was called, was a “very funny boy”. He could do “very good tricks”, danced well, and fully believed he could accomplish “almost anything under the sun”. Between 1877 and 1880 he eloped six times using bent wires. Bucke allowed him to work with the horses, which showed imagination on his part. As it turned out, it was a miscalculation. When sent with another patient for the horses in the field one afternoon, George did not return and had to be written off. He did not appear to be as imbecilic as was first supposed.

Nicholas L. (#776) was a tightrope walker and a vagabond. He had been a patient at the Malden Asylum in 1865, but had eloped after eighteen months. He turned up in London in 1874 and, according to the report of the arresting constable, appeared “entirely out of his mind” and dangerous to be at large. He had freely given his name and said he had been in the Queen’s Service and had escaped from Malden Asylum. He then “threatened to whip half the men” on the street. Landor’s deposition stated that “no doubt he had become insane again”. Nicholas was sent to the Asylum but was discharged seven months later.66
The Asylum's policy on elopement was flexible, moderate and adjusted to each situation. Elopers were not punished; they were returned to the main building where they could be better supervised. Elopement was therefore not regarded as a crime but as a likely and foreseeable consequence of commital.

That mental illness should be viewed within the context of prevailing standards of morality is illustrated in the diagnosis and treatment of "masurbatory insanity". The idea that masturbation was a deviant act was first popularized by "an anonymous [English] clergyman turned quack", who in 1710 published "Onania, or the Heinous Sin of Self-pollution," as an advertisement for a patent medicine. The alacrity with which the cause of masturbatory insanity was taken up by the medical profession revealed growing anxieties about a disorderly, immoral and rapidly changing society, as well as offering a new and exclusive area of expertise for the profession itself.

This new mental "disease" was given respectability by the Swiss physician and hygienist Simon-Andre Tissot, who advanced the theory that because sexual intercourse increased peripheral circulation, all sexual activity which caused the blood to rush to the head dangerously starved the nerves and increased the possibility of insanity. Tissot saw masturbation as the worst vice because it could be indulged in easily and at a tender age. With the widespread movement for confinement of the insane in the eighteenth century, physicians observed large numbers of patients masturbating and made the false connection between masturbation and insanity.

Because of the solitary nature of the vice, the "experts" gave thorough accounts of the symptoms of the disease. An English authority, John Millar, wrote in Hints on Insanity (1861), "if [it] is suspected in men under twenty-five, well brought up and [who] had not mixed freely in the world"; and if the man was "pale and out of health, morose, apathetic, occasionally violent and irritable", then there was reason to "fear the most". "If his evil habits are persisted in," wrote William Acton, a leading English physician and author, "he may end in becoming a drivelling idiot or a peevish valetudinarian." One noted nineteenth century alienist considered disrespect in youth to be a symptom of masturbation. In The Journal of Mental Science (1868), Henry Maudesley wrote that the young who indulged in "self-abuse" (masturbation) were "entirely wanting in reverence for their parents."

Concern about self-abuse was linked to other nineteenth century reform movements in Canada as well as in Europe and the United States. In the 1880s the Canadian abolitionist and temperance leader, Alexander M. Ross, was one of the first publicly to warn of the "sinful and unphysiological habits secretly practised by Canadian youth". He concluded that one-third of all insanity was caused by masturbation.
In the 1877 Annual Report to the Ontario Legislature by Dr. D. Clark, Superintendent of the Toronto Asylum, the "enshrouded moral pestilence" of masturbation was described as being practised "in numberless homes in every part of our land." Not limited to the male sex, it was "the bane of public and private schools among all classes of the community." The tendency to practise masturbation was not simply a wrong against the person, but like all "such vices", it was "against the State ... [producing] the enfeebled body and weak intellect" which fell prey to any "depravity and self-abasement."

On 6 March, 1877, just three weeks after his arrival as Medical Superintendent of the London Asylum, Dr. R.M. Bucke demonstrated his interest in treating sexual deviancy by "wiring" fifteen male patients in an attempt to stop their habit of masturbation. Wiring was a process of infibulation; a silver wire ring was placed through the foreskin.

Bucke believed that masturbation was directly related to insanity. When the first patients were wired, he wrote: "I intend to make this operation simpler and perhaps modified a good deal in the course of the next six months. There is no doubt that if a plan could be hit upon of stopping this vice many cases could be relieved and cured which are now hopeless."

This experiment was not successful. In all cases there was no improvement. The men understandably became "more irritable" and "less talkative than formerly"; one managed to take out the wire and another had to have it removed as "there was a good deal of pain and swelling". Those who had been wired by Bucke shared certain characteristics. They were described as "dull and stupid", "simple sluggish brained", "sedentary and gluttonous" and "fat, stupid and lazy." One was a black, another a "great big roughlooking Irishman." In effect, of those who practised the habit in the Asylum, those wired to prevent masturbation were physically distasteful and also potentially dangerous. They were young (averaging in their late twenties) and strong men, "stupid" but persisting in a habit which displayed both lack of personal control and the limits of institutional control over them. Bucke's experimentation with wiring, while undertaken with the espoused goal of curing hopeless cases, was carried out on a selected group of undesirables; those least likely to arouse sympathy, and more likely to illustrate the limitations of moral treatment.

In general, characteristics of patients diagnosed with masturbatory insanity fit the description by Henry Maudesley. All of the male patients so labelled were single. Eighty-one percent (9) were temperate and regular in their habits of life. They were fairly evenly divided between dementia and mania, with two cases of melancholia, so that there were no specific symptoms to justify the special label. The patients were young, the average age be-
ing twenty-six years. The circumstances supported the view that masturbatory insanity manifested many of the characteristics associated with adolescence. In a number of cases, the patient was committed for “trying to injure those closest to him”, “threatening the life of his father as well as his own”, “refusing to work”, “will remain in bed if permitted”, none of which are uncommon to a turbulent adolescence.

At the London Asylum, Landor tended to prescribe beef tea and wine for afflicted female patients. Bucke, in his later years, was much more radical in his approach. Between 1895 and 1900 Bucke directed major gynaecological operations on 226 female chronically insane patients. Bucke insisted that the operations had been necessary simply to improve physical health, arguing that “treatment of the mind resolves itself into an endeavour to place the whole physical system on the best possible basis for health and efficiency.” However, when asylum statistics displayed a marked increase in the discharge rate of females (from 35% to 51% in 1896, while male rates rose from 34% to 37%) Bucke credited this to the gynaecological operations.

He went further to state his personal views, then common, of the biological basis for insanity in women. “There exists between the female sexual organs and the great nerve centers a closer relation than between these last and any other of the bodily organs.” Bucke clearly believed that certain forms of insanity in women resulted from pelvic disorders and could be treated with surgical intervention. The confusion of science, morality and sexuality evident in the wiring of the masturbatory insane resurfaced, albeit in a more drastic form.

According to Asylum statistics, 38% of the surgical cases recovered physically and mentally, 26% improved, 32% improved physically but not mentally, and 2.5% died following surgery. That the recoveries which did take place were the result of the operations cannot be assumed. Other factors might have been involved such as recovery independent of the surgery, shock from the operation, or even the intangible benefits of increased attention and comfort as a result of the operations. Bucke would be particularly anxious for these patients to recover, and the promise of speedy discharge and the support of family members eager to support these “instant” cures could have had a favourable effect upon the patients.

The female patient was a special case at the London Asylum not merely because her sexual organs purportedly made her more susceptible to insanity, but because the female lunatic was so helpless in the nineteenth century. Legally bound to and physically weaker than their husbands, with few economic opportunities, many women ended up in the London Asylum as the result of marital victimisation. Landor acutely diagnosed the situation, but both he and Bucke were ill-equipped to handle it.
The committal of twelve women in the test sample could be labelled as "husband-related": the result of a man's death, desertion, physical abuse, or his wish to be rid of an unwanted wife. Fidelia C., aged forty-two, and Ellen H., aged thirty-two, were both deserted by their husbands. Fidelia was a schoolteacher with two children whose husband had left her thirteen years previously. She died after nine years in the Asylum. Ellen H., committed for child abuse, had four young children and a husband who insisted he was a bachelor. He was convicted of the misdemeanor of "refusing and neglecting to provide" for his wife and children and his family was forced to live as paupers in the London City Hospital. Ellen was discharged three months after commitment though her fate and the fate of her children was unclear. She may have simply returned to the pauper hospital.

Eleanore O. (#504) was a fifty-year-old farmer's wife and melancholic, who displayed a propensity for self-destruction and "a desire to strip herself." She clearly improved in the atmosphere of the Asylum. Admitted in 1871, she would sit in the dining-room the entire day and do no work. By 1881, she was knitting a good deal and was "always good-natured". In 1903 she was released on six months probation and then discharged improved. Eleanore's case was unusual in that patients who remained in the Asylum for more than thirty years were rarely discharged. She did not "recover", but "improved"; therefore her family must have been willing and able at that point to care for her. Given Eleanore's advanced age, it could be assumed that her husband was dead. Perhaps only then could she benefit from living at home with her family.

Charlotte G. exhibited religious "exalted" feelings and was hysterical and excitable. She cried often, sang psalms and prayed "overmuch". Landor prescribed good food, comfort, and ordered that she be led into "more secular feelings". At the Asylum she began to play at bagatelle and music and was so far recovered she was ready to go home and, as Landor wrote, it "would do her good if her husband treated her kindly". Her husband was allowed to take her home for a month in June, 1870, where she remained until December, 1871. She was then re-admitted with "puerperal mania". She was to be fed well and given a glass of wine daily. In April, 1872, she was granted a leave of absence and was finally discharged in 1873. From the evidence it can be assumed that Charlotte had returned to the Asylum pregnant and had been granted a leave of absence prior to giving birth. She was not discharged improved or recovered. Her husband presumably wanted her home to take care of the infant. Landor had little recourse though he returned Charlotte to an unhappy home life.

An equally tragic case is that of Elizabeth M., a melancholic who often would not eat and who required constant vigilance since she was "always inclined to injure herself". Landor wrote: "she would do at home with care and kindness, two things hard to be obtained in the country from a rough hus-
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band." Four months later he added, "this is a case of difficulty as to her disposal. Would do well in [a] kind home but worse ill-treated. Nearly blind and cannot work but as all farmers make their wives work and are a rough uncultivated lot of people they cannot suffer an idle woman. They think such idle from inclination .... She cannot be happy and I think she would soon be worse at home". Elizabeth was lonely and isolated at the Asylum. "She would do better if her husband would be more attentive in writing or seeing her. She frets at being here..." The ideal remedy for Elizabeth doubtless was to be rid of her husband so that she could leave the Asylum and live peacefully. This was, of course, impossible, as she had no money and no other family and her husband had jurisdiction over her.

In conclusion, despite the fact that overcrowding and budgetary restraints eventually rendered the Asylum largely custodial, it did have some success as a curative hospital. Henry Landor's approach towards treatment of the insane was pragmatic while Bucke's was experimental. Yet both men achieved the primary goal of moral treatment — control of the insane with the minimal use of physical restraints.

Although he appeared to possess a less arrogant personality than Bucke, Landor proved less able to adjust to the growing bureaucratization of health care in the mid-nineteenth century. His disillusionment must have been reproduced, to some degree, wherever government extended its control. Bucke, by contrast, appeared to suit a bureaucratic rather than an individual regime. While his personality was, to say the least, colourful, he seemed to find it difficult to relate to his colleagues on a personal level.

Poverty was probably the primary factor which led to insanity and commitment. The destitute were becoming an increasingly large proportion of Ontario society during the nineteenth century — straining existing welfare facilities and necessitating a restructuring and broadening of social services. As the century wore on, the problems associated with poverty were exacerbated by massive immigration, which was clearly reflected for example, in the preponderance of Irish Catholics at the London Asylum.

In retrospect, treatment at the London Asylum was fairly flexible and at times quite imaginative. While the types of labour performed by patients (particularly women) appeared to benefit the institution more than the patients, they did reduce the necessity for physical restraints. The Asylum also sought new and varied diversions for the patients. Asylum policy appeared most flexible with respect to elopements. In this instance, the non-retributive attitude of the superintendents demonstrated the difference between an asylum and a prison.
Nineteenth century attitudes towards morality and sexuality were most clearly revealed in the treatment of women and masturbatory insanity. The type of patient "wired" by Bucke was indicative of concern for control as well as the existence of a strict moral code. The experiences of women at the London Asylum reflected moreover the general hardships women encountered in the nineteenth century: successive, often debilitating pregnancies; abuse and desertion; and legal subjugation. Bucke’s experimentation with gynaecological surgery may have had some physical benefits for the patients, but it also dramatized the lack of control women had over their own lives.

Finally, an individual’s insanity was most closely related to his interactions with his family. As illustrated in these case histories, the patient was often displayed misunderstanding of mental illness and more than occasionally had negative consequences. But the belief in the curability of insanity and in the essential humanity resulted in treatment which was also benevolent and imaginative.

Notes
to Part II

1. Chlormal hydrate was produced by treating dry chlorine gas with sulphuric acid and a small amount of lime and converting it into a solid hydrate by adding water (General Council of Medical Education and Registration of the United Kingdom, British Pharmacopeia, London, 1867).


4. Ibid.

5. Ibid.

6. Ibid., 2, 1873, p. 155.

7. Ibid., "Appendix-Physician’s Report".

8. Archives of Ontario. Ministry of Health. Record Group 10. London Psychiatric Hospital, Casebooks, nos. 525; 546; 553; 364; 367; 373; 698; 472; 986; 240; 729; 765 (hereafter Casebook).


10. Ibid., 4, 1872, p. 162.


13. The water-bed was a bathtub equipped with a series of harnesses enabling a patient to be suspended in water. Casebook nos. 24; 987; 399.


17. Boker’s Stomach Bitters, for example, was 42.6 percent alcohol by volume while Wyeth’s New Enteritis pills for diarrhea contained arsenite of copper, bichloride of mercury and morphine. *Ibid.*, pp. 288, 284; Barbara Ehrenreich and Dierdre English, *For Her Own Good: 150 Years of the Experts Advice to Women*, New York, 1979, p. 79.


25. This appearance to be substantiated by the increased mention of drugs in the casebooks after Landor’s death.

26. *Casebook*, nos. 24; 166; 85; 142; 734.


32. “Calcis Hypophosphis” was produced by heating phosphorus with hydrate of lime and water and evaporating the solution until it became crystallized (*British Pharmacopoeia*, p. 415).


42. *Ibid.*, 2, 1874, p. 24, LXXXII.


44. *Scrapbook*, 1878.

45. *A.R.M.S.*, 4, 1874, p. 23, LXXV.

46. *Scrapbook*, 6 December, 1898.


52. Ibid., 4, 1878, p. 274.

53. Ibid.

54. Casebook, nos. 982; 946; 454; 610; 56; 451; 464; 479; 727.

55. Ibid. nos. 429; 596; 644; 682.

56. Ibid., no. 241.

57. Ibid., nos. 953; 338; 362; 880.

58. Ibid., nos. 415; 104; 570; 166; 146; 234; 606; 502.

59. Ibid., nos. 983; 415; 773; 515.

60. Ibid., no. 122.

61. Ibid., nos. 383; 729; 91; 608; 613; 944; 734.

62. Ibid., nos. 909; 864; 830.

63. A.R.M.S., 4, 1875, p. 221.

64. Ibid.


71. Comfort, p. 53.

72. Neuman, p. 11.


75. Ibid.

76. University of Western Ontario, Regional Collection, Bucke Papers, Journal of the Medical Superintendent, 6 March, 1877 [hereafter J.M.S.]


78. J.M.S., 6 March, 1877.


81. Casebook, nos. 187; 683.

82. Court Records, 19 April, 1873.