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PSYCHIATRIC CARE IN ONTARIO'S ASYLUMS IN A COMPARATIVE CONTEXT, 1890-1910

by

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Abstract

The late nineteenth and early twentieth centuries marked a number of significant changes in psychiatric care worldwide. A few critics have argued that care was segmental, inefficient and detrimental to those it intended to serve. The field was quickly "losing professional credibility" (J. Duffin, *History of Medicine,* 285) as poorly trained clinicians could not find answers to the "maladies that are the triumph of the quack, religious or otherwise" (*The Bulletin of Ontario Hospital for Insane*). It can be argued that the infantilized mode of care administered by those within and outside asylum walls hindered any efforts for recovery as it created a cloud of dependency and anxiety.

The interplay between various social, political and cultural factors and their relative impact on treatment make it all the more interesting as a period of research and study. This paper will explore the contemporary nature of the asylum as it relates to the travels of two physicians utilizing *The Bulletin of the Ontario Hospital for the Insane* for the period between 1894 and 1911.

The development of the asylum from ignorance and superstition to knowledge and hope has been brief. An act passed in 1835 granted magistrates the right to confine the mad in secure places – old horse stables or unoccupied buildings – or if necessary chained. Those dangerous to people or property were locked up, but the act expanded to include those who might do injury to themselves and peculiarities considered a nuisance in public.

The late nineteenth and early twentieth centuries marked a number of significant changes in psychiatric care. The interconnectedness of social, political and cultural factors of the time make it an interesting period of research and study. The field lost professional credibility as poorly trained clinicians could not find answers to "maladies that are the

triumph of the quack, religious or otherwise." (Bulletin of Ontario Hospital for Insane) The concluding remarks of one physician at a symposium on psychoanalysis illustrate the dire need for proper education. "The sooner we face the shameful but undeniable fact that unqualified empirics can relieve distressing affections in cases that have defied medical skill … the sooner this flagrant lack in our system of education be remedied and the better will it be for the dignity and honour of the medical profession." (Bulletin of Ontario Hospitals for Insane, 1910) The state of education with respect to psychiatry in Ontario was so poor that two psychiatrists by the names Dr. Daniel Clark and Dr. Harvey Clare travelled to Munich, Germany, on a fact finding mission. This paper will explore the contemporary nature of the asylum as it relates to their writings utilizing the *Bulletin of the Ontario Hospital for the Insane* for the period 1894 to 1911.

Admissions

Medical care in Germany was considered the best in the world. The clinic was bright and spacious for incoming patients. A great deal of attention was paid to this point. The subtle differences between "asylum" and "hospital" were apparent in Germany. Admission forms allowed early cases of mental trouble access without the label of insanity. In urgent situations, patients were promptly admitted into the hospital and transferred to the appropriate ward. Those "hopelessly insane" were darted off to asylums. "If certificates are necessary and the patient is poor, only one certificate is made by an outside practitioner, the other being furnished, without cost by a member of the staff." A man who commits a crime as a result of disease was sent to the clinic for observation for six weeks. The examination methods were so thorough that there was "no possibility of a malingerer making good his deception." They lived in isolation but were "thoughtfully cared for and treated" and given suitable employment rather than fretting out their souls in idleness.

Admission was free from circumlocution and red tape. The steep cost (75 cents to $1 a day) was offset by a universal health insurance system for the poor. They were allowed to stay as long as there was hope of an early cure or if they were of scientific interest. Those infected with tuberculosis were not isolated from non-tuberculosis patients. It is sad to note that more than half of patients admitted were alcoholics but timely treatment restored them to a life of usefulness. Alcoholics, epileptics and those on the verge of insanity were admitted without certificates. "There is no complaint about illegal detention; in fact persons confined in the clinics are simply regarded in the same light as patients in other hospitals." (Bulletin of Ontario Hospitals for Insane, 1908) The fact that more than twenty five hundred patients were treated every year proves how the clinic reached incipient cases in a way impossible by the asylum system.

A patient's material comforts were not carefully considered as "what are regarded as the essentials by us are considered luxuries by the Germans." (Bulletin of Ontario Hospitals for Insane, 1908) A soft bed fashioned out of wooden boxes with sides three feet high and filled with wood wool was preferred over an iron bedstead. All necessities were supplied and "we heard no complaints from patients" (Bulletin of Ontario Hospitals for Insane, 1908). The German people had just as much faith in the clinic as in their general hospitals.

It was estimated that one in three hundred people living in Toronto during this period of time were insane. (Bulletin of Ontario Hospitals for Insane, 1908) A formal institution was desperately needed since public buildings for care consisted of two or three homes scattered throughout the city. The Toronto asylum was built in 1850, far from the bustling downtown core, so patients could recuperate in the peace and quiet of the countryside. Its dome tower was visible for miles as it stood at over 120 feet tall. The architecture was specifically designed to intimidate patients and so it "usually is not resorted to until the day of treatment is past." (Bulletin of Ontario Hospitals for Insane, 1894) It was a symbol of hope for many who wished to escape the destitute lives they were living. It offered food, clothing and shelter to those in need. The grounds were beautifully landscaped with gardens, trees and fountains and a number of large three story cottages that housed non-resistant patients.

The personal biases of Ontario physicians determined whether or not a patient was admitted to the asylum. An explanatory note from two physicians and a detailed form accompanied every new patient. The form was an initiative of the provincial government in order to determine the importance of heredity and consanguinity on the course of mental disease. Most doctors within and around the city were not aware of these new procedures and so many patients were sent to the asylum with incomplete papers and a poor explanation of their condition. They were often turned away due to lack of space.

The people living inside the asylum were quite colourful. Women made up approximately one-half of the population. Society viewed promiscuous behaviour as a form of mental deficiency thus resulting in their institutionalization. The fear of living with an abusive partner culminated in sickness and breakdown for many women. Their reasons for collapse were not recognized by the medical community since it was easier to assign responsibility to the traumatized patient than address systemic problems in the community. However, doctors were more likely to advocate for incarceration of perpetrators if the family and larger community complained about a male's violent or indecent behaviour. A male's sexual urges were not immune from confinement. The 'self-centred' act of masturbation was looked down upon as it was seen to sap the vitality out of someone rendering them 'idiotic.' This practice was linked to nearly fivefold more males than females at one asylum. (Reaume, 2000) The middle class attempted to cleanse society of feeblemindedness at the turn of the nineteenth century. All the idiots,

half-wits, epileptics and 'wandering women' were involuntarily imprisoned so they could not contaminate the healthy gene pool.

A mere six dollars a week would buy the cleanliest, warmest and best furnished room in the Toronto asylum. There were six wards devoted exclusively to paying customers who received not only the most private space but special privileges such as painting supplies, sewing materials and catered food. The poor were accepted but forced to live in cold, overcrowded and rat infested quarters.

All patients were greeted with a warm bath and plenty of rest on their first night. A complete physical exam was performed head to toe for any physical abnormalities. Hot water baths were prescribed for those suffering from toxic origins, hot wet packs for the excited, saline baths for the exhausted and hammock therapy for patients in need of fresh air. Treatment for acute insanity, a result of alcohol or drug inebriety, was quite successful and so "we had many applications for the admission for treatment of acute cases without the accompanying certificates of insanity." (Bulletin of Ontario Hospitals for Insane, 1907) These requests were denied. They were considered outcasts by hospital and so refused shelter, food and medical help. They were instead confined in common gaols for thirty days to atone for their sins. It was not uncommon to see men of poor status in gaols for years waiting for their chance to enter the asylum. "If it were not for the open door of the common gaol he must die in the streets." (Bulletin of Ontario Hospitals for Insane, 1910) An alcoholic voluntarily wishing to "cast out the devil" was permitted to receive treatment but in a private asylum. Those unable to manage their affairs or "who place their families in danger or distress" were barred from public hospitals but committed in private institution for one year. It was only after their "usefulness in the community is practically ended" that the poor could secure admission to public hospitals.

Education

A psychiatric clinic was attached to every German medical school. The large lecture rooms entertained both medical and law students who were required to understand real knowledge of insanity rather than arguing the right and wrong theory. Portraits of past scholars adorned hallways. Their "fine facilities for teaching and research" were envied by the visiting doctors who wrote about laboratories fitted with ingenious appliances and multiple rooms devoted for psychological study.

The German students received knowledge from some of the greatest minds in psychiatric history. The works of Dr. Sigmund Freud – namely psychoanalysis and free association – were taught to encourage students to discover and appreciate the significance of the processes that manifests itself as a symptom. His research was met with such brilliant

success as to "greatly encourage workers in this and allied spheres of investigation." (Bulletin of Ontario Hospitals for Insane, 1908) The intense training made it very difficult to implement into practice as the root of troubles are found in childhood. "It is admitted that this demands three year's incessant practice [with] a good previous knowledge of neurology being assumed." (Bulletin of Ontario Hospitals for Insane, 1908) The difficult conversion of an 'intolerable existence' into a happy life required years of patience and servitude. The process of free association focuses on a given symptom and the thoughts that come to mind. The patient was urged to suspend judgement in order to free the personality from constraint and gain self-control over aberrant thoughts. The goal was to take away ideas and not add them to the mind.

The works of Dr. Carl Jung were taught and are currently taught to students around the globe. A word is called out and the patient must respond with the first word that comes to mind. The focus was not on the answer but the emotional response attached with certain thoughts. It was meant to provide insight into the mentality and type of psychosis present. Hypnosis was rarely used to search for forgotten memories due to its grave disadvantages. The methodologies taught to German students had a profound influence in redirecting the world's attention on new and practical problems but were unfortunately neglected by clinicians outside German-speaking countries. (Bulletin of Ontario Hospitals for Insane, 1908)

"The physician must guide his patients in the hour of danger, and to observe the first signal of mental distress." (Bulletin of Ontario Hospitals for the Insane, 1908) This unfortunately was not the case as medical graduates left school without having seen a single case of insanity or without having heard of the subject. (Bulletin of the Ontario Hospitals for the Insane, 1908) They were left to acquire knowledge through sufficient experiences in the community. A number of physicians practiced suggestion therapy with disastrous consequences. Their noble intentions were overshadowed by lack of consensus among clinicians as to presenting symptoms of certain diseases or classification of disease. The apparent simplicity of most psychiatric cases was due to the fact "we do not try to find out what is wrong with each individual but are content to make a diagnosis, pigeonhole the case and pass on to the next." The "bugaboo of classification" created an environment of endless confusion and so the general practitioner lost faith in the psychiatrist and the psychiatrist pointed the finger of scorn at the neurologist. Their suspicions resulted in stagnant progress of the profession.

The nursing profession slowly replaced old-time guards in the asylums. Primarily youthful girls were taught the essential principles of nursing, record keeping and application of different baths & massages. Their training took place inside the asylum with lectures provided by hospital staff and physicians. The school was a source of "continuous mental inspiration" to the entire staff as their cheerful personalities command the best effort. Their kindness made home treatments much less difficult for

physicians. The "onward march of progress would be retarded and the skill of the physician and surgeon would be robbed of their most brilliant triumphs" if not for the lady of the lamp.

Treatment

The end of the nineteenth century saw an official end to the use of physical coercion – no more were patients confined to beds, coats or chairs but free to participate in work and entertainment as part of their therapy. The introduction of hydrotherapy in 1906 offered an alternative method of treatment for the ill. It was in large rooms that excited or depressed patients would sit in large tubs with oversized brims for six to eight hours every day for days on end. The temperature of the bath was kept constant between 96 to 100 degrees Fahrenheit to calm nerves. It was believed that dilation and contraction of blood vessels altered physiological processes like heart contractions and the secretion and elimination of toxins from body. The sedative effects resulted in the use of fewer hypnotics.

One in four women admitted had an illness due to a female related cause. It was standard teaching of the time to relate problems in the area of a female's pelvis to her brain. The uterus was believed to be the source of instability in women and so its removal would result in alleviation of symptoms. The superintendent, Dr. Clark, saw surgery as an attack on a woman's "innate sense of modesty" and so banned the practice from the Toronto asylum during this period of history. (Reaume, 2000)

The middle-to-late nineteenth century saw many changes as moral therapy coursed it way into mainstream practice. It taught that kindness and productive labour would bring about a stable mind. The gender divisions were apparent in the asylum. Only two of thirty two jobs were exclusively for women unlike the nineteen solely for men. Women were not permitted to work outdoors but assigned domestic chores like sewing, scrubbing floors and dusting. They did not work in the bakery, on the farm or in the garden – areas of female work in traditional households of the time. The kitchen was an almost exclusively male domain. They were responsible for the general maintenance and upkeep of asylum. Those allowed to work outside were the most privileged for they had fresh air on a regular basis, an extra egg for breakfast and beer with supper.

A patient's class status prior to confinement was reflected in the type of job they preformed in the institution. The majority worked very long hours – from morning till night – possibly because asylum life would be very lonely without a meaningful way to spend time. (Reaume, 2000) Janet, a faithful worker in the dining room, worked until she died of heart problems. Work provided an emotional attachment for many as it was linked to experiences outside the hospital. One patient, Sandra, confined for the last 30

years of her life, was suspicious of others, especially whites, to whom she referred as her enemy. She was happier in the laundry room rather than on the ward. A working population was essential to an asylum's internal economy. Their hard work meant less was spent to pay staff for maintenance or care of patients. It may be argued that moral therapy was an indirect form of exploitation. There are accounts of dissent among patients as evidenced by letters addressed to the superintendent of the asylum (Reaume, 2000). Their demands for wages or early dismissal were dismissed as payment for services would create jealousy and dissatisfaction among patients. This was not conducive to the physical or mental improvement of the patient. The criticisms of finance that employment "materially lessens the cost of their maintenance" were addressed but downplayed as they argued the goal of therapy was to improve the mental condition of patients so they may return home. (Bulletin of Ontario Hospitals for Insane, 1907)

All patients were considered fit to work. It was argued that work was the universal process of grinding down the class status of everyone in the workforce. Indolent patients learn to "fall in line and perform such duties as may be assigned to them." (Reaume, 2000) They were not asked or permitted to overwork themselves, however, those that refused to work had comments like "lazy" and "useless" written in their files. (Reaume, 2000) The cheap labour force reduced maintenance costs thus increasing the state of asylums.

It was argued outdoor employment delayed the progression of disease in patients. They are better behaved – less noisy, quarrelsome and destructive – during the day and more restful at night. A few general symptoms – coated tongue, constipation, diminished secretions and sallow complexion – resistant to other treatments, disappeared once patients engaged in meaningful work. (Bulletin of Ontario Hospitals for Insane, 1894) The buzz of activity inside the asylum illustrated to the public that its citizens were contributing in some form to society. A working asylum in many respects became a public relations operation to prove its legitimacy in society. Moral therapy eventually lost ground by the early twentieth century as more physicians placed a greater emphasis on the physical basis of insanity.

The officials in Toronto urged staff to use tact when dealing with excited patients. They cautioned the use of restraints as it would increase a patient's excitement and solidify prejudices against others. Hot wet packs would have a calming effect without resorting to drugs. Hyoscine more than 1/100 of a grain and Sulphonal of no less than 30 grains in a glass of hot milk were seldom used for therapeutic effect. Intervals between feedings were no more than 3 hours. The use of sedatives and hypnotics was a last resort.

The erosion of stigma attached to confinement was "crucial to encouraging a more positive reputation for the profession" but society unfortunately did not see it that way.

In 1910, Dr. Clark wrote "the public was not only indifferent but terror stricken and very often heartless." (Bulletin of Ontario Hospitals for Insane, 1910) These unfortunate hostilities resulted in the emotional collapse of many patients. In 1890, Irene was released from the asylum only to return six years later for severe depression as a result of people "taunting her with having been there [asylum]". The support she received from her sister was not enough to overcome the harassment and prejudices she encountered in the community. (Reaume, 2000)

The resources in German hospitals were far below those of British-style asylums. The use of continuous baths to settle nerves of excited patients were not routinely used as they were of "crude pattern, without hammock of any kind, and without any means of continuous hot water supply". (Bulletin of Ontario Hospitals for Insane, 1908) The cure instead was bed rest and so the "insane asylum lost most of its terror" (Bulletin of Ontario Hospitals for Insane, 1908). The wards were clean and bright but cheerless and patients were merely for show as "pathological rarities, psychological curiosities and anatomical freaks" were more important than care. Attention was paid to each individual without neglecting welfare of patient. The seclusion room was furnished with dark heavy shutters, but well lit with a window glazed with very thick plate glass to make it impossible to break. The rooms were rarely used since "we no longer know what his condition is although we listen to screams or peer at him through a peep-hole." (Bulletin of Ontario Hospitals for Insane, 1908) Another difference of note was follow-up of case studies. Interesting patients were not lost sight of after discharge since staff kept in touch with these patients.

Conclusion

The travels of two psychiatrists, Drs. Clark and Clare, conclude with some reassuring words. "No where did we see so good a system of clinical records as in Ontario nor do the medical staff place themselves so constantly and intimately into relationship with their patients." The problem unfortunately did not lie with practicing physicians but the traditional medical curriculum. The outcome of the visit was profound. In 1905, Kraeplin's diagnostic methods were adopted to bring some order into their chaotic asylum. In 1907, Dr. Clark implemented grand rounds three times a week to discuss diagnoses and develop standards among psychiatrists. The psychiatrists were well on their way to transforming psychiatric care not only in Toronto but the rest of the province.

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