

The Indiana Hospital for the Insane:

Varying Perspectives of Moral Treatment Landscape

by

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Seclusion, then,—but plenteous streams of light,  
    Pouring with radiant beam the window through,  
Must mark thy castle fair; with groves bedight  
    And meads of softest green, and sprightly view  
Of distant scenes;—a village spire or two,  
    And aught that can with sanity unite  
A healthier look at life. Thus wisely do,  
    And well thy labors fortune shall requite  
With well-earned gold; and time, the lost one's mental sight.<sup>1</sup>

Written in 1841, the poem “Madness; or the Maniac’s Hall” reflects the ideology of the “moral treatment” era of the 1830s–1870s in which landscape and environment dominated the treatment of the mentally ill. Changing social and medical perceptions of the insane resulted in a dramatic increase in the construction of mental institutions, including the Indiana Hospital for the Insane established near the city of Indianapolis in 1848. The administrators of the Indiana Hospital for the Insane subscribed to the moral treatment philosophy, emphasizing the components of work, amusement, fresh air, and a domestic atmosphere accompanied by strict rules and regulations. With “plenteous streams of light,” and “meads of softest green,” the Indiana Hospital for the Insane’s administrators attempted to cure the insane within an “ideal” environment.<sup>2</sup> Investigating the implementation of their philosophy uncovers the tensions and conflicts within this ideal environment and differing perspectives on the landscape’s use.

An emphasis on “history from the bottom up” prevails today as historians concern themselves with uncovering formerly “silent” voices. Rather than interpreting past events through the eyes of the empowered, history from the bottom up incorporates the common person’s viewpoint. This approach allows for a richer and more diverse perspective on the past. Voices of the mentally ill are particularly difficult to hear since many patients kept no record of their experiences while in institutions, although a few published post-treatment accounts. Some recent secondary sources work through these difficulties

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<sup>1</sup> *The American Journal of Insanity*, vol. III, “Madness; or the Maniac's Hall; a Poem in seven Cantos by the author of 'the Diary of a Solitaire' London 1841” (Utica, NY: D. Bennett, 1846-7), 101.

<sup>2</sup> *Ibid.*

and focus on patients, but few examine the differences between the idealized and restrictive moral treatment atmosphere, and patients' diverse reactions to this environment.<sup>3</sup> Thus, important questions remain unanswered. In regard to the Indiana Hospital for the Insane, how did patients there make sense of their environment? Historians theorize about notions of "space" versus "place," alleging space becomes place when an individual attaches meaning to their environment.<sup>4</sup> Did the patients at the Indiana Hospital for the Insane view the hospital as space or place? Due to their physical restrictions, how did patients move through the landscape in ways that differed from the administrators? How did the making of meaning and interpretation of the landscape vary based upon each group's viewpoint? The importance of history from the bottom up lies in acknowledging these different perspectives and competing interpretations of place.

Rather than studying patients' relationships to the hospital environment, most of the extant literature describes the evolution of moral treatment and the reasons for the construction of mental institutions. Most authors view these changes as responses to humanitarian reform or the need for social control. In his 1949 work *The Mentally Ill in America*, Albert Deutsch asserts a significant portion of the mentally ill in colonial America experienced horrible conditions, neglect, and ill-treatment.<sup>5</sup> Deutsch moves from this bleak period through the moral treatment era and into post-World War II, visualizing the reforms in each era as "a progression from a dark past to a somewhat more knowledgeable and enlightened present."<sup>6</sup> Later histories, beginning with Michael Foucault's 1965 work, *Madness and Civilization: A History of Insanity in the Age of Reason*, dispute Deutsch's theory of enlightened

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<sup>3</sup> A good example of a source that does this well: Anne Digby's *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985).

<sup>4</sup> For notions of space and place, see Tim Cresswell's "Defining Place," in *Place: A Short Introduction* (Malden, MA: Blackwell Pub, 2004). On divergent views of moving through landscapes, see Dell Upton's "White and Black Landscapes in Eighteenth-Century Virginia" in *Material Life in America, 1600-1860*, ed. St. George, Robert Blair (Boston: Northeastern University Press, 1988). Also see Elizabeth Kryder Reid's "Sites of Power and the Power of Sight: Vision in the California Mission Landscapes" (Based on a paper presented at *Vision and Landscape*, a symposium at the Department of Landscape Architecture, University of Illinois, Champaign-Urbana, October 5, 2002).

<sup>5</sup> Albert Deutsch, *The Mentally Ill in America: A History of Their Care and Treatment from Colonial Times*, 2nd, revised and enlarged ed. (New York: Columbia University Press, 1949).

<sup>6</sup> Gerald N. Grob, *Mental Institutions in America: Social Policy to 1875* (New York: The Free Press, 1973), 12n.

treatment emphasizing that reforms reflected society's desire for social control rather than humanitarian concerns.<sup>7</sup> Building on Foucault, in his 1971 *Discovery of the Asylum: Social Order and Disorder in the New Republic*, David Rothman argues asylums afforded stability because "the felt need for order and discipline that affected psychiatrists, wardens, and superintendents had a common root outside the asylum, that is, in a society deeply apprehensive about the prospect of disorder."<sup>8</sup> However, Gerald Grob challenged these social control theorists in his 1973 book *Mental Institutions in America*, stating mental institutions evolved as "humanitarian efforts designed to cope with the needs of individuals and families created by urbanization, industrialization, and immigration."<sup>9</sup> Many historians conclude today that the creation of mental institutions resulted from an amalgamation of concerns such as better treatment for the insane, fears about the disruption of social order, and the belief in the curability of insanity within an institutional environment.

In addition to arguing for or against social control and humanitarian theories, many secondary sources contend medical professionals believed proper architecture facilitated moral treatment. Nancy Tomes focuses on this particular aspect in *The Art of Asylum-Keeping: Thomas Story Kirkbride and the Origins of American Psychiatry*.<sup>10</sup> A significant figure in the treatment of the mentally ill in the nineteenth century, Kirkbride headed the Pennsylvania Hospital for the Insane, assisted in the establishment of the Association of Medical Superintendents of American Institutions for the Insane (later known as the American Psychiatric Association), and wrote a treatise on the architectural elements necessary to facilitate moral treatment. His 1854 book, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane with Some Remarks on Insanity and Its Treatment*, influenced the construction

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<sup>7</sup> Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Pantheon Books, 1965).

<sup>8</sup> David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, Rev. ed. (Boston: Little, Brown, 1990), xxxiv.

<sup>9</sup> Katherine K. Ziff, "Asylum and Community: Connections between the Athens Lunatic Asylum and the Village of Athens, 1867-1893" (PhD diss., Ohio University, Athens, OH, 2004), 23.

<sup>10</sup> Nancy Tomes, *The Art of Asylum-Keeping: Thomas Story Kirkbride and the Origins of American Psychiatry* (Philadelphia: University of Pennsylvania Press, 1994).

of many mental institutions across the United States.<sup>11</sup> Administrators such as Kirkbride believed the success of moral treatment hinged upon the relationship between patients and their environment. Physicians viewed moral treatment as the “humane and scientifically correct mode of treating insanity.”<sup>12</sup> Tomes argues the hospital’s “ward arrangements and governance . . . re-created the social environment patients came from, yet recast its features in therapeutic terms.”<sup>13</sup> The “science” of moral treatment incorporated both the hospital regimen and the physical surroundings within which treatment occurred, and the structures at the Indiana Hospital for the Insane attempted to adhere to these ideals. Constructed in 1848, the first building housing patients at the Indiana Hospital for the Insane incorporated some architectural features similar to Kirkbride’s recommendations. The second hospital building for patients, opened in 1879, conformed closely to the ideal architecture he espoused.

A complex environment existed at the Indiana Hospital for the Insane during the moral treatment era. Administrators attempted to enforce an institutional power structure and particular social, racial, sexual, and behavioral boundaries. Contrasting the ideals of the administration and their physical representation with the ways in which patients utilized the environment reveals that patients’ perspectives did not always agree with the administration’s. Affective bonds, unity, and respect for the institution did occur among some patients, but others found distinct ways of expressing their dissatisfaction with the moral treatment ideology. The therapeutic landscape often became a battleground due to patients and administrators vying for environmental control.

### **Notions of Insanity**

During the nineteenth century, understanding of the nature of disease moved from the eighteenth century focus on bodily humors and heroic treatment toward Enlightenment ideals of “faith in reason,

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<sup>11</sup> Thomas Story Kirkbride, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane* (Philadelphia: Lindsay & Blakiston, 1854). Also reprinted and revised 1880.

<sup>12</sup> Tomes, 22.

<sup>13</sup> *Ibid.*, 131.

humanism, democracy, [and] liberal institutions to cure society's ills."<sup>14</sup> In keeping with these ideals, views of mental illness also changed. In addition to the belief that brain disease caused insanity, prior concepts of insanity incorporated supernatural elements such as demonic possession, mysticism, and punishment for sin. By the nineteenth century, the focus on the supernatural diminished, replaced by a belief that "the cause of mental illness could usually be found in the patient's immediate past, in a physical illness, period of prolonged stress, emotional trauma, or overindulgence in debilitating vices."<sup>15</sup> Some of these traumas and overindulgences included hard study, masturbation, domestic disagreements, childbirth, alcoholism, and religion.

Along with different conceptions of mental illness, a reform movement for the humane treatment of the insane began during this time; its most well-known advocate was Philippe Pinel of France. Pinel "emphasized the importance of the emotional causes of mental disease and called for more careful diagnosis and observation."<sup>16</sup> In America, reformer Dorothea Dix championed the mentally ill during the mid-nineteenth century, insisting upon government involvement in erecting institutions for the insane. Dix visited Indiana in 1846–7. Although her direct impact on the formation of the Indiana Hospital for the Insane is unknown, she certainly called attention to the inadequate care of the insane in the state's poorhouses and jails.

New perspectives on the physical and emotional causes of mental illness, the promotion of humanitarian reforms, and rational Enlightenment beliefs resulted in the formation of new treatment ideologies. These treatments were based on the idea that "long-standing problems could be solved by conscious and purposeful human intervention."<sup>17</sup> Medical professionals viewed prior methods of informal, community-based care of the insane as unsuccessful, believing the mentally ill needed isolation from the dangerous and corrupting influences of society that contributed to their derangement. Without

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<sup>14</sup> Lynn Gamwell and Nancy Tomes, *Madness in America: Cultural and Medical Perceptions of Mental Illness Before 1914* (New York: Cornell University Press, 1995), 11.

<sup>15</sup> Tomes, xiii.

<sup>16</sup> Gamwell, 37.

<sup>17</sup> Gerald N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: The Free Press, 1994), 25.

access to today's psychotropic drug therapies, medical treatment for insanity consisted of the occasional administration of purgatives, emetics, stimulants, and tonics. Within an institutional setting, medical treatments and moral therapy "could be employed in ways that would persuade patients to internalize the behavior and values of normal society and thus promote recovery."<sup>18</sup> In its simplest form, moral treatment meant "psychological methods . . . employed to help in what was seen as a mental disorder."<sup>19</sup> This did not necessarily mean wholly humane treatment; rather, physicians focused on effective methods of restoring reason. These methods stressed proper and productive behavior through the strict regulation of work, amusement, and exercise emphasizing the "human, rather than beastlike, nature of the insane."<sup>20</sup> By removing the patient from "normal" society and establishing a restrictive, self-contained environment, mental health professionals believed they could cure mental illness.

Mental health professionals convinced residents of Indiana to commit their friends and family to the Indiana Hospital for the Insane by using positive and negative imagery, promoting civic pride, and offering hope. In illustrations, the hospital resembled a country estate, its well-manicured grounds enjoyed by strolling couples and horse-drawn carriages. The commissioners' and superintendents' annual reports refer to the institution as "*a home* for the wretched and homeless maniac," and the patients of each ward constituted a "family."<sup>21</sup> Emphasizing the dangerous nature of insanity, the reports avow the insane were "liable from insane impulses to commit the most serious depredations upon the persons and property of others."<sup>22</sup> Administrators appealed to civic pride, stating residents should be pleased with "this great enterprise founded in the goodness and benevolence of the hearts of a great people and executed by their

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<sup>18</sup> Ibid., 27.

<sup>19</sup> Digby, 33.

<sup>20</sup> Tomes, 5.

<sup>21</sup> *Annual Reports of the Commissioner and Superintendent of the Indiana Hospital for Insane to the General Assembly, November 1852* (Indianapolis: J. P. Chapman, 1852), 18.

<sup>22</sup> *Third Annual Report of the Commissioners and Superintendent of the Hospital for the Insane to the General Assembly of the State of Indiana* (Indianapolis: John D. Defrees, 1847), 20.

liberality.”<sup>23</sup> Residents of the state were compelled to support the building of the hospital through taxation, and statements such as this may have been attempts to smooth opposition.

Perhaps most importantly, the hospital administrators provided hope to the community as families struggled to care for the insane at home. An 1862 letter from Hellen and Franklin Alford states, “Aunt Kellams is gon crazy again and father brought her here and we just put her up stairs and make her stay there father is a going to send her off tomorrow to Indianapolis.” Later the Alfords write, “we have been confined to the house for the last three Days and Knights with the care of your Aunt Kellams. I want to take her to Washington ToDay and make the necessary arrangements to have her taken to the Lunatic Assylum to be cared for for we can do nothing for her.”<sup>24</sup> Most families could not afford to stay home to take care of their mentally ill relatives and the institution offered an alternative. Mental health professionals asserted that if treated promptly, the mentally ill would recover. Doctors postulated that “under skillful treatment, at least eighty in every hundred will recover the right use of their reason.”<sup>25</sup> Hope of a cure likely influenced a family’s decision to commit their insane relatives. Anna Agnew, a patient at the institution from 1878–1885, wished she had been admitted earlier, stating “unfortunately, for all concerned, I was not taken to the asylum for a period of several years after the time when common sense, if not common humanity, should have decided that such was the only proper place for me.”<sup>26</sup> Sending friends and relatives away must have been difficult, but families assuaged guilt through belief in the healing properties of a self-contained treatment facility. Within this specially constructed environment, medical practitioners employed their moral treatment ideology on those committed to their care.

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<sup>23</sup> Ibid., 17.

<sup>24</sup> Franklin Alford, Unpublished Letter to J. Warren Alford dated 9 March 1862, Folder 11, Alford Family Papers, 1856-1889 (bulk 1861-1862), Collection M 0229, William Henry Smith Memorial Library, Indiana State Historical Society, Indianapolis, IN.

<sup>25</sup> *Fourth Annual Report of the Commissioners and Superintendent of the Hospital for the Insane to the General Assembly of the State of Indiana* (Indianapolis: John D. Defrees, 1848), 21.

<sup>26</sup> Anna Agnew, *From Under the Cloud, or, Personal Reminiscences of Insanity*, 3rd ed. (Cincinnati: Robert Clarke & Co, 1887), 20. For a detailed description of Anna Agnew’s life, see Lucy Jane King, *From Under the Cloud at Seven Steeples, 1878-1885* (Zionsville, IN: Guild Press, 2002).

### Architecture, Ideology, and Administration Perspectives

Before the construction of state hospitals, poorhouses and jails held the insane poor. The wealthier classes sent their relatives to private asylums, but the costs of these asylums precluded the poor from utilizing them. The insane poor had no institutional alternative to poorhouses and jails if their families could not or would not care for them. Medical professionals regularly railed against the conditions suffered by the insane in poorhouses and jails. Typically, these facilities were the antithesis of the medical community's idea of proper treatment. The moral treatment emphasis on work, amusement, and exercise necessitated the construction of an environment where "the building was as important as any drugs or other remedies."<sup>27</sup> Structures needed proper ventilation to remove impurities from the air, pleasing exteriors and interiors, and numerous windows offering patients light and scenic views. Administrators stressed the necessity for acres of farm land amenable to cultivation, beautiful gardens, and lush lawns. All of these elements contributed toward diverting a patient's mind away from their illness. Administrators believed the neglected insane housed in overcrowded poorhouse and jail facilities would benefit from these bucolic landscapes.

Historians often credit Kirkbride with influencing the design of many of these therapeutic mental institutions. However, many medical professionals agreed on most of the ideal aspects of construction before the publication of Kirkbride's book. The value of his book lies in its floor plans and extremely detailed descriptions of proper room size, heating and ventilation systems, bathroom facilities, and the layout of the grounds. Kirkbride stressed the importance of a proper location away from disturbing influences, requiring at least one hundred acres to "secure adequate and appropriate means of exercise, labor, and occupation for the patients."<sup>28</sup> Although emphasizing the positive benefits of work, Kirkbride cautioned "great care is always to be observed, that no one is urged to do more work than is really safe

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<sup>27</sup> Andrew Scull, "The Social History of Psychiatry in the Victorian Era," in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Scull, Andrew (Philadelphia: University of Pennsylvania Press, 1981), 10.

<sup>28</sup> Thomas S. Kirkbride, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane* (Philadelphia: Lindsay & Blakiston, 1854; repr. 2<sup>nd</sup> ed, Philadelphia: J. B. Lippincott & Co, 1880), 38.

and advantageous for him.”<sup>29</sup> Most institutions used patient labor to defray some of the costs of running the facility, but this labor never fully supported the institution. The extensive grounds also served as the means by which patients could exercise in the open air, mainly via long walks supervised by their attendants. Patients could also sit and admire the ornamental gardens. Medical professionals believed in the healing properties of landscape and its effectiveness in helping to restore reason. Considered “valuable agents for preserving as well as restoring health,” an emphasis on sunshine, exercise, and nature prevailed.<sup>30</sup>

As for the structure itself, Kirkbride recommended “a centre building with wings on each side.”<sup>31</sup> Known as the linear design, each wing extension was set back from the preceding wing allowing for the best possible ventilation and admission of light. Utilized for the administration’s purposes, the center building held the superintendent’s office, reception rooms, and sleeping accommodations. Kirkbride and other medical professionals also emphasized the importance of first impressions. The architecture of the building should not be overly ornamental and “every thing repulsive and prison-like should be carefully avoided.”<sup>32</sup> Patients and families needed to view the institution as a place of refuge, rather than one of incarceration.

Each ward within the structure should include a parlor, a dining room, single rooms and dormitories, and water closets. Rooms faced opposite each other down long, twelve-foot wide corridors. Ideally, bay windows were situated at the ends of each corridor. Kirkbride devoted a section of his book to the proper construction of windows in patients’ rooms, advising they “should be placed low enough to make it pleasant to a person sitting in the room.”<sup>33</sup> Realizing the need for security, Kirkbride described the construction of functional, yet ornamental window guards. In addition, he asserted “great care should be taken in locating the building, that every possible advantage may be derived from the views and scenery

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<sup>29</sup> Ibid., 220.

<sup>30</sup> Ibid., 279.

<sup>31</sup> Ibid., 54.

<sup>32</sup> Ibid., 52.

<sup>33</sup> Ibid., 69.

adjacent, and especially as seen from the parlors and other rooms occupied during the day.”<sup>34</sup> If unable to walk on the grounds due to inclement weather or illness, the patients could at least view the grounds from their windows.

Having decided on Indianapolis as the setting for the new Indiana hospital, in 1845 the commissioners of the hospital purchased 160 acres of “the farm of N. Bolton, lying two miles wes[t] of Indianapolis, on the McAdamized national road.”<sup>35</sup> Described as partly cultivated and partly forested, the commissioners’ report declared the site “is the most elevated spot in the neighborhood, and will command an extensive view of the surrounding country when cleared of the forest trees.”<sup>36</sup> Although floor plans and blueprints of the Indiana Hospital for the Insane’s main structures remain unlocated, Sanborn maps and descriptions in the commissioners’ and annual reports afford clues to the buildings’ conformity to moral treatment architecture. In 1845, Dr. John Evans, the first superintendent of the hospital, visited mental institutions in Ohio, Pennsylvania, Massachusetts, and New York to familiarize himself with the advantages and disadvantages of each architectural style. The hospitals Evans encountered were “generally constructed with a main building and wings, the former for the accommodation of those who take care of the institution—the wings for patients.”<sup>37</sup> Opinions differed as to the amount of patients an institution could effectively service, with Evans recommending a medium-size building holding 135 to 150 patients. Upon the opening of the Indiana Hospital for the Insane, the demand for admission quickly strained the limits of the building’s ideal occupancy.

The construction of the Indiana Hospital for the Insane’s first building commenced in 1846 and conformed to the linear plan of a center building with two wings. Composed of brick, the building consisted of three full stories supplemented by basement and attic stories. Each story was eleven feet high, with an eight foot high basement. The building opened for the admission of patients in 1848, but

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<sup>34</sup> *Ibid.*, 53.

<sup>35</sup> *Report of the Commissioners of the Lunatic Asylum or Indiana Hospital for the Insane to the General Assembly December, 1845* (Indianapolis: J. P. Chapman, 1845), 1-2.

<sup>36</sup> *Ibid.*, 2.

<sup>37</sup> *Report on the Subject of Hospitals for the Insane by John Evans, M.D. Made to the Commissioner of the Lunatic Asylum of Indiana June 22, 1845* (Indianapolis: J. P. Chapman, 1845), 4.

completion of the center building and the first two wings did not occur until 1851. The addition of more wings continued until approximately 1874. Evans stressed “building in a right line, except to allow the wings to fall back of each other, as they are added to the main building allows the best possible ventilation from the external air.”<sup>38</sup> The first hospital faced east in accordance with Evans’s recommendation that “the rooms be so situated that each patient can enjoy the cheering influence of the direct rays of the sun in his apartment.”<sup>39</sup> Albert Thayer, a former patient, described the interior of the wards as hallways “over a hundred feet long . . . flanked on either side by a row of bed-rooms as well as a dining-room, bath-room, clothes-room, etc. The bed-rooms vary in size, containing from one to twelve beds. Each ward accommodates from twenty to twenty-five patients, over whom are placed two attendants.”<sup>40</sup>

Upon completion of all wings in the late nineteenth-century, the first building consisted of over 600 rooms totaling 206,341 square feet. By the turn of the century, the Indiana Hospital for the Insane complex included another Kirkbride style building called “Seven Steeples.” This four-story brick building encompassed 337,274 square feet or 7.7 acres. Seven Steeples was 1,046 feet long, containing 1,142 rooms and 1,970 windows. The first building became known as the Department for Men and the new Kirkbride as the Department for Women. The grounds also included a pathological department, general store, bakery, power house, carpenter shop, laundry, fire department, upholstery department, machine shop, boiler house, repair shop, tin shop, paint shop, oil house, junk shop, morgue, officers’ barn, farm barn, ice house, patient pavilions, gate lodge, pump house, and gas house, totaling 614,696 square feet of floor space. From its inception, the Indiana Hospital for the Insane functioned as a distinct society, largely because its architecture conformed to moral treatment’s policy of segregation from the outside world.

In separating patients from normal society, moral treatment practitioners could focus on inculcating proper social conduct away from harmful influences. Administrators constructed a mentally

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<sup>38</sup> Ibid., 6.

<sup>39</sup> Ibid., 3.

<sup>40</sup> Albert Thayer, “The Indiana Hospital for the Insane. Inhuman Treatment of the Inmates,” *The Rough Diamond*, 1886, p. 11.

and physically restrictive atmosphere via a classification system and numerous rules and regulations. One of the most important aspects of moral treatment architecture included the classification of patients based on their behavior. The construction of a center building flanked by wings allowed “adequate separation and classification of the inmates . . . and the treatment of the various classes could be precisely calibrated to match their behavior.”<sup>41</sup> Classifications ranged from quiet, convalescent, and infirm, to violent, troublesome, filthy, and epileptic. Well-behaved patients lived closest to the center building, with the most violent and noisy patients at the ends of the wings to prevent them from disturbing others.

Before the completion of the first Indiana Hospital for the Insane building, its administrators called for the erection of a “separate building, constructed with special reference to the care of the noisy and furiously insane.”<sup>42</sup> Constructed in 1850 and not destroyed until 1874, these lodges or “strong rooms” consisted of sixteen rooms in a building “eighty feet long, thirty feet wide, [and] two stories high.”<sup>43</sup> Upon the completion of the north and south main hospital wings, the basements of these buildings also housed violent patients. Oftentimes, epileptic patients and chronic patients lived in these accommodations. Administrators believed an epileptic patient “will do more harm to his ward companions during one of his paroxysms, than can be counteracted by the physician in many months.”<sup>44</sup> Also, administrators viewed patients who masturbated as “the most dangerous, troublesome and disgusting” class who “openly and shamelessly obey their brutal propensities.”<sup>45</sup> With the importance of separating patients from society’s improper influences well-established, hospital administrators would not risk patients’ exposure to this behavior within their own institution.

Additional classifications based on gender and race existed as well. Ideally, male and female patients were housed in completely separate buildings. If this proved impossible, they lived on opposite

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<sup>41</sup> Scull, 10.

<sup>42</sup> *First Annual Report of the Commissioners and Medical Superintendent of the Hospital for the Insane to the General Assembly of the State of Indiana* (Indianapolis: John D. Defrees, 1849), 21.

<sup>43</sup> *Ibid.*

<sup>44</sup> *Annual Reports of the Commissioner and Superintendent of the Indiana Hospital for Insane to the Governor, November 1853* (Indianapolis: Austin H. Brown, 1853), 21.

<sup>45</sup> *Annual Report of the Commissioners, Treasurer, and Medical Superintendent of the Indiana Hospital for the Insane to the General Assembly of the State of Indiana* (Indianapolis: J. P. Chapman, 1851), 30.

sides of the center structure. Administrators exercised caution when male and female patients gathered together, so as not to feed their “morbid appetites and vicious propensities.”<sup>46</sup> Many of the early state institutions did not accept African American patients. The 1854 annual report of superintendent James S. Athon addressed this inequality, claiming “it is not merciful, it is not philanthropic.” At the same time, Athon remarked in Indiana “where the prejudice of color is more distinct, it would be worse than useless to attempt an association.”<sup>47</sup> He recommended the construction of separate buildings if the state wanted to admit African American patients. Athon raised the issue again in 1856 asserting the hospital should allow the admission of African American patients in spite of their lack of citizenship because, “notwithstanding this prohibition, [the African American] is a human being, and suffers alike in mind and body with his white neighbor.”<sup>48</sup> Although the hospital admitted some African American patients during the nineteenth-century, the tensions between these patients and white patients persisted. According to superintendent William Fletcher in 1887, although African American patients and white patients lived on the same wards, they could not dine together. Fletcher indicated the presence of African Americans “caused a great deal of trouble” with a white patient who said “she would not sit down with any ‘damn nigger’.”<sup>49</sup> Apparently, the administration considered the protest of one woman more compelling than the appropriate and equal treatment of patients of both races. Racial boundaries within the institution mimicked those of larger society during this time. Far fewer African American patients than white patients appear on the Indiana Hospital for the Insane’s admission records in the nineteenth century.

Considered less important than behavioral segregation, classification according to social status rarely happened. The only specific reference to upper class patients at the hospital occurs in the 1849 annual report advising “extra and better apparel than merely that required by law, should be sent with

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<sup>46</sup> *Twenty-fourth Annual Report of the Indiana Hospital for the Insane for the year ending Oct. 31, 1872 to the Governor* (Indianapolis: R. J. Bright, 1872), 21.

<sup>47</sup> *Annual Report of the Indiana Hospital for Insane to the General Assembly, November 1854* (Indianapolis: Austin H. Brown, 1854), 36-7.

<sup>48</sup> *Annual Report of the Indiana Hospital for Insane for the year ending Oct. 31, 1856 to the General Assembly* (Indianapolis: Joseph J. Bingham, 1856), 25.

<sup>49</sup> *Report of Committee of the House of Representatives on the Management and Affairs of the Indiana Hospital for the Insane, Session of 1887* (Indianapolis: Wm. Burford, 1887), 15.

those accustomed to it, that when they become better, so as to attend church, ride or walk out, their self-respect may be preserved.”<sup>50</sup> During Anna Agnew’s stay, she remarked “‘servants’ and ‘mistresses’ are on a complete level here.”<sup>51</sup> An article in the *American Journal of Insanity* states “in the best conducted establishments, the violent of both classes are mingled together.”<sup>52</sup> Because state institutions admitted more working class patients than upper class patients, financial feasibility prevented the provision of separate wards for each social class.

In addition to classification, administrators imposed strict behavioral rules and regulations as part of moral treatment. Not only had patients who “lost their reason also forfeited their right to independent action,” moral theorists believed that routine “would curb uncontrollable impulses . . . re-creat[ing] fixity and stability to compensate for the irregularities of the society.”<sup>53</sup> For the most part, the superintendent had unlimited authority in the day-to-day operation of the institution. Kirkbride maintained the superintendent “should have entire control of the medical, moral, and dietetic treatment of the patients . . . and should exercise a general supervision and direction of every department of the institution.”<sup>54</sup> Administrators instituted a regimen of proper diet, exercise, sleep, mental diversion, and moral and religious discipline. As witnessed in their classification schemes, administrators emphasized bodily cleanliness, believing that “without cleanliness . . . it is worse than useless to attempt the restoration of a wandering mind.”<sup>55</sup>

Although hours differed depending on the season, administrators established a routine where patients typically rose around 5:00 a.m., washed up, took their medicine half an hour later, and ate breakfast. After breakfast, those patients permitted off their wards would take a morning walk and then participate in some type of employment activity. Women often sewed dresses, vests, sheets, quilts, and

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<sup>50</sup> *Annual Report 1849*, 36.

<sup>51</sup> Agnew, 123.

<sup>52</sup> Henri Falret, "On the Construction and Organization of Establishments for the Insane," *The American Journal of Insanity* X (1853-4): 235.

<sup>53</sup> Tomes, xx; Rothman, 133.

<sup>54</sup> Kirkbride, 193-4.

<sup>55</sup> *Annual Report 1854*, 21.

curtains; canned fruits and vegetables; ironed; helped in the ward; and worked in the kitchen or laundry. Men performed manual labor on the farm or assisted in various shops such as the carpenter shop, upholstery shop, and mattress shop. Those unwilling to labor could “delight in carriage riding, and in the invigorating exercise of walking over the fields, and through the extensive woodlands adjoining the hospital.”<sup>56</sup> Agnew said “going to the sewing-room to assist is not obligatory upon any patient,” but many patients did engage in these activities.<sup>57</sup> It appears that administrators did not force patients to work against their will, but they likely frowned upon those who did not wish to work. They certainly considered this behavior significant enough to remark upon it in the ward reports.

After their morning employment, patients received medicine at 11:45 a.m. and ate dinner around 12:15 p.m. Patients performed more exercise and labor after dinner, received medicine at 5:30 p.m., had tea at 6:00 p.m., and participated in evening amusements. During the hospital’s earlier years, most amusements consisted of reading, letter-writing, or playing games, but activities soon expanded to include music, dancing, gymnastics, billiards, and bowling. At 8:00 p.m., patients retired for the night, locked in their rooms.

Although the patients’ routine may sound lenient, attendants closely scrutinized patient conduct. From the administration’s perspective, successful treatment depended upon the conformity of patients to expected behaviors, and the established rules purposefully restricted patients’ freedom of choice and physical movement. Administrators charged attendants with “prevent[ing] improper conduct or bad postures” and “inculcat[ing] respect for the officers and confidence in their management.”<sup>58</sup> Bells regulated the daily schedule and patients marched to their meals single file. According to Thayer, “under Dr. Rogers’ rule the patients were not permitted, not even in the convalescent ward, to talk with one another during meal time,” although Dr. Fletcher later eased this restriction.<sup>59</sup> Upon leaving their rooms in the morning, patients usually could not return to them until bedtime. If they stayed inside the ward, they

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<sup>56</sup> *Annual Report 1851*, 22.

<sup>57</sup> Agnew, 170.

<sup>58</sup> *Annual Report 1849*, 43-4.

<sup>59</sup> Thayer, 15.

sat in chairs in the corridors or in the day rooms. Administrators often violated patients' privacy by reading patients' correspondence to their friends and family before mailing the letters. Although undoubtedly a comfort to some patients, the administration intended religious services to "inculcate regularity and subordination in the household" and serve as "a means of keeping up the police of the house as well as for its moral influence."<sup>60</sup>

Administrators also attempted to control all negative outside interference. In his 1854 annual report, Athon mentions that the south wing's proximity to the public road "is going to become a source of great annoyance to the patients and should by all means be abated. Seventy-five or eighty patients will be exposed to the daily scenes of a thoroughfare, the injuries of which are hardly calculable."<sup>61</sup> Clearly, this situation did not conform to the "sprightly view of distant scenes" espoused in the opening poem.<sup>62</sup> In 1884, William Fletcher urged "the closing up of the street upon the north side of the Hospital" because "the passing of persons so near those back wards is very injurious to the patients."<sup>63</sup> Administrators did not welcome any intrusions of normal society unless expressly permitted.

At the same time as they restricted certain intrusions, administrators allowed visitors to tour the hospital's interior and exterior. Superintendent R. J. Patterson's 1849 annual report affirms "within the last eleven months, more than five thousand visitors have been permitted to visit the wards of this institution."<sup>64</sup> Some administrators expressed qualms about this practice, acknowledging that many visitors wanted to see the patients only to satisfy a morbid curiosity. Patterson claimed "it has ever been revolting to our feelings, and contrary to our sense of duty and propriety, to make an *exhibition* of our patients," yet he admits that "there will always be a certain number of patients in each hall who feel

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<sup>60</sup> *Annual Report 1854*, 33; *Annual Report of the Commissioners, Superintendent, and Treasurer of the Indiana Hospital for the Insane for the year ending Oct. 31, 1858 to the Legislature* (Indianapolis: John C. Walker, 1859), 29.

<sup>61</sup> *Annual Report 1854*, 36.

<sup>62</sup> *The American Journal of Insanity*, vol. III, "Madness; or the Maniac's Hall," 101.

<sup>63</sup> *Thirty-sixth Annual Report of the Trustees and Superintendent of the Indiana Hospital for the Insane for the fiscal year ending October 31, 1884 to the Governor* (Indianapolis: Unknown, ca.1884), 9.

<sup>64</sup> *Annual Report 1849*, 27.

degraded by exposure to the stare of strangers.”<sup>65</sup> According to Kirkbride, “the exhibition of the insane to large or small bodies of unprofessional persons, as is sometimes done, is an outrage on humanity.”<sup>66</sup> Yet rather than refusing to admit visitors in the patients’ best interests, superintendents provided public access, and not only to the well-behaved patients. Referring to the “back ward” housing of violent patients, Bryce Martin, a porter and assistant usher at the hospital, claimed “E ward is a back ward, and the door is generally thrown open, and the visitors can look in if they wish.” Martin also testified that if visitors “want to see more we generally show them.”<sup>67</sup> The practice of allowing visitors to tour the hospital likely served to convince visitors of the institution’s successful treatment philosophy. In addition, as a state-sponsored institution, administrators probably felt the public had some rights in this regard. The administrators appeared willing to sacrifice some patient dignity to satisfy public curiosity and further faith in the goals of the institution. Yet, in exposing patients to the stares of strangers, administrators again reinforced the limitations upon patients’ physical and mental movement through the landscape.

Analyzing the moral treatment philosophy and the hospital’s specially constructed environment reveals the beliefs of the administration in its healing properties. Within this environment, administrators separated patients according to their conformity to ideal behaviors and instituted a strict treatment regimen. In the early years of the hospital’s operation, medical professionals believed they could cure mental illness. They saw the hospital as both a refuge from the appalling conditions of the poorhouses and jails, and as an ideal setting for a superintendent to wield his medical expertise and power in controlling deviant behavior and restoring reason. The goals of the administrators are fairly well articulated, but how did patients at the Indiana Hospital for the Insane interpret their environment? In what ways did they conform to the goals of the administration and how did they subvert them? How did administrators attempt to reign in these unacceptable behaviors through increasingly tighter environmental control?

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<sup>65</sup> Ibid.; *Annual Report 1851*, 35.

<sup>66</sup> Kirkbride, 297.

<sup>67</sup> *Report of Committee of the House of Representatives*, 639; Ibid., 645.

## The Patients' Perspective

Patient-focused narratives are becoming increasingly popular, but few narratives concentrate on the meaning patients attached to the hospital environment. Dating from 1858–1863, the patient prescription books from the Indiana Hospital for the Insane are helpful supplements in uncovering patient voices. Although written by superintendents and physicians, the information contained within these books serves to reconstruct patient experience. This primary source information illuminates the positive and negative relationships patients had to the hospital environment.

The patient population at the Indiana Hospital for the Insane during the nineteenth-century consisted primarily of white, working class people. Most originated from the United States; however, patients also came from Ireland, Germany, England and other countries. The male patient population included farmers, laborers, teachers, clerks, carpenters, and merchants. The female patient population consisted mainly of housewives, school girls, seamstresses, and teachers. As the hospital grew, so did the patient population. In 1848, there were 40 patients in the hospital; in 1858, 277 patients; in 1871, 477 patients; in 1880, after the construction of Seven Steeples, the hospital had 1,010 patients; by 1887 there were 1,588.

The diversity of patients' impressions of the hospital presents an interpretative challenge. Some patients had positive experiences through participating in recreational and work-related activities, establishing friendships, and developing an appreciation of the institution's "familial" structure. During the "free" time allotted to them in the mornings and afternoons, many patients walked the grounds and enjoyed the scenery. Donations enabled the administrators to "transplant about three thousand shrubbery, forest, and fruit scions" and the grove included "seats and other facilities for exercise and enjoyment."<sup>68</sup> Recreational activities included Fourth of July and May Day celebrations where patients listened to orations and enjoyed picnics. Patient pavilions provided a place for dancing. Free time also afforded an

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<sup>68</sup> *Annual Report of the Indiana Hospital for Insane to the Governor, November 1855* (Indianapolis: William J. Brown, 1855), 18; *Annual Report of the Commissioners, Superintendent, and Treasurer of the Indiana Hospital for the Insane for the year ending Oct. 31, 1863 to the Governor* (Indianapolis: Joseph J. Bingham, 1864), 11.

opportunity for patients to bond through playing games with one another, such as checkers and chess. Many patients utilized the library and superintendents consistently appealed to donors for more books and magazines to stock the library. According to prevailing theory, amusements “awaken in the bosom of the insane an interest in surrounding things, which may be adroitly used by the Physician for the restoration of the patient.”<sup>69</sup> Evaluating the effectiveness of amusements proves impossible, but they certainly helped break the monotony of the hospital routine and afforded some features of normal society.

For most of the morning and afternoon, patients participated in work-related activities. Many patients appreciated these activities as a means of passing the time and alleviating boredom. The case notes reveal the choice to work or not likely belonged to the patient, but attendants and physicians always urged patients to participate for the health benefits and the regulation of behavior. Work and exercise appear to have benefited some patients. For one man, exercising outdoors resulted in his becoming “very obedient and manageable by his attendants.”<sup>70</sup> Another patient “was persuaded to go out with the gardener and work and a marked change for the better was at once perceptible, he became more cheerful and talkative.”<sup>71</sup> A female patient occupied herself “in the kitchens and dining rooms where she works and sings all the while.”<sup>72</sup> Anna Agnew spoke highly of the institution’s sewing room, describing it as a cheerful oasis for patients to gossip, sing, and otherwise relieve monotony.<sup>73</sup> Although attendants closely monitored work and exercise, some patients surely benefited from a change of scenery and exposure to tasks that afforded distraction, albeit temporary.

Patients established affective bonds, made acquaintances, cultivated friendships, and helped each other. The prescription books describe connections between patients, noting one gentleman who “takes especial care of one of the patients in his ward – stays by his side constantly and assists in walking him

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<sup>69</sup> *Annual Report 1854*, 33.

<sup>70</sup> “Prescription Book for Male Patients, 1858-1863,” Patient #1319, 9, Central State Hospital Collection, Indiana State Archives, Indianapolis, IN.

<sup>71</sup> *Ibid.*, Patient #2219, 459.

<sup>72</sup> “Prescription Book for Female Patients, 1858-1863,” Patient #1309, 2, Central State Hospital Collection, Indiana State Archives, Indianapolis, IN.

<sup>73</sup> Agnew, 169-171.

back and forth through the hall.” Another patient “seems to regard it as his duty to create fun for his associates.” The intervention of one patient during another patient’s attempted suicide by “rush[ing] to the window, and seiz[ing] him by the heel of the right foot just as he was falling” provides an extreme example of the bonds between patients.<sup>74</sup> At times, this attachment existed between patients and attendants as well. Anna Agnew stated she and the night watch attendant remained friends after Anna’s recovery.<sup>75</sup> She also spoke highly of some of the other attendants and superintendents.

Perhaps most importantly, many patients developed some kind of attachment to the institution. Even Albert Thayer, who published a pamphlet outlining abuses at the hospital, described the grounds as beautiful and the claimed “grand beauty and loveliness tends to make the place a delightful and cheerful retreat for them that are afflicted with disordered minds.”<sup>76</sup> Another patient stated “she had been fortunate in meeting better friends here than ever she had met elsewhere. She said she had been much better treated here than ever she had been treated by her own family.” One patient informed the doctors that “in case she died at Hosp’l (which she said she wished to, as the folks here had been her best friends), she requested to be buried in Hosp’l Grave Yard.”<sup>77</sup> One could argue the doctors writing the case notes invented patient attachments to make the institution appear benevolent, but the even-handedness of the case notes in detailing positive and negative reactions dispels this notion. The testimonies of former patients coincide with this assertion. Some patients remained at the institution for years and developed a sense of the institution as a place, rather than merely a space. Patients likely became attached via peaceful walks through the cultivated grounds, by making friends and sharing stories with other patients, and by playing games, dancing, and sitting amongst the groves of trees.

Although some patients may not have seen the institution as a home, some did welcome it as a sanctuary. Afraid of discharge, a female patient pled “to be permitted to remain in Hospital, as she feared

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<sup>74</sup> "Prescription Book for Male Patients," Patient #1360, 33; Ibid., Patient #2171, 435; Ibid., Patient #2002, 356.

<sup>75</sup> Agnew, 34.

<sup>76</sup> Thayer, 15.

<sup>77</sup> "Prescription Book for Female Patients," Patient #1647, 162; Ibid., Patient #1992, 337.

she would have to go to Poor House and be an object of charity.” Another patient upon discharge “manifested much gratitude for the treatment she received while here.”<sup>78</sup> Patients who escaped often reappeared within a few days. One patient reached Indianapolis, but “badly frightened, he returned to the Hosp’l.”<sup>79</sup> In 1873, a former patient wrote to Superintendent Everts informing him “for a while I got a long very [well] at home, but of late I have been suffering mentally and phsically. Indeed I feel my mental trouble to such an extent that I am afraid that it will produce worse results. My object in writing is to find out if I can get back into the Hospital as a patient.”<sup>80</sup> This patient clearly identified with the hospital, believing it might alleviate his illness.

Still, patients did not always react favorably to life within the institution. Oftentimes patients suffered involuntarily commitment and had difficulty adjusting to the hospital’s routine. Patients experienced fear and homesickness. One patient “seems to be in great fear at times that he will not get well” and another “frequently cryes when speaking of his family.” A female patient greeted her husband “crying aloud Sam! Sam! Why did you leave me here.”<sup>81</sup> These emotions placed more stress on patients’ already fragile psyches. Many patients likely feared they had been abandoned by their families. Mentally ill persons commonly experience hopelessness and commitment to an institution full of strangers probably intensified this feeling.

Whether influenced by their illnesses or not, unhappy patients deliberately or unintentionally rejected hospital rules with small gestures. Documented in the case notes, examples of these behaviors include a female patient who “refuses to eat and when the Bell rings for dinner and other meals she cries piteously.”<sup>82</sup> Oftentimes patients desired to remain inactive, including a man who “begs very hard to be allowed to laz in bed on every fridaz” and the patient who “when not urged by his attendant to sit up or

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<sup>78</sup> Ibid., Patient #1604, 144; Ibid., Patient #1391, 32.

<sup>79</sup> "Prescription Book for Male Patients," Patient #2250, 474.

<sup>80</sup> "Inmate Disposition Records," Letter dated 31 October 1873 from Joseph M. Bare to Superintendent Everts, Central State Hospital Collection, Indiana State Archives, Indianapolis, IN.

<sup>81</sup> "Prescription Book for Male Patients," Patient #1586, 142; Ibid., Patient #1801, 252; "Prescription Book for Female Patients," Patient #1899, 291.

<sup>82</sup> "Prescription Book for Female Patients," Patient #1591, 139.

walk the hall will lay down upon the seats or floor until again forced up.” Other patients disassociated themselves from others. One would “not shake hands with any one but remains obstinately quiet” and another would “never associate with the other patients and declare[d] that they are possessed of the Devil.”<sup>83</sup> Due to their illnesses, depressed patients may have wanted nothing more than to give in to lethargy, and delusional patients may have feared associating themselves with other patients or the administrators. In rejecting therapeutic methods of nourishment, purposeful activity, and appropriate social interaction, patients opposed administrators’ goals.

More overt rejections of rules and regulations included fighting and escape attempts. Patients fought with each other, with one male patient throwing “a spittoon at one of his associates striking him upon the head.” They also fought with their attendants, even ganging up on them with one patient “seiz[ing] a chair, the other patient a bucket, and knock[ing] down both attendants by striking them upon the head.”<sup>84</sup> Rather than displaying ideal social behaviors, these patients rebelled. Meant to induce self-control, patients utilized exercise and employment to express personal dissatisfaction. During daily exercise, one patient “concocted a plan with another patient to make their escape which they succeeded in doing.” Other patients exploited employment in ingenious ways like the patient who “eloped from the farm while out at work, avoiding the vigilance of the attendant by making the excuse to go to well after a drink of water.”<sup>85</sup> Another patient “desired to go out to work with the carpenter this privilege was granted him, it was accidentally discovered by his attendant that he had made a false key evidently for the purpose of releasing himself from the bonds of the institution.”<sup>86</sup> Another patient from the carpenter shop stole a rasp, used it to remove the window sash, and made his escape by climbing down his bed sheets. A female patient unsuccessfully tried to escape from the sewing room hiding “in the wash house where she was

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<sup>83</sup> "Prescription Book for Male Patients," Patient #1552, 128; Ibid., Patient #432, 73; Ibid., Patient #1823, 268; "Prescription Book for Female Patients," Patient #1358, 19.

<sup>84</sup> "Prescription Book for Male Patients," Patient #1867, 287; Ibid., Patient #1653, 179.

<sup>85</sup> "Prescription Book for Male Patients," Patient #1431, 72; Ibid., Patient #1310, 2.

<sup>86</sup> Ibid., Patient #1663, 184.

found several hours afterward.”<sup>87</sup> Originally intended to promote health and healing, at times patients used work and landscape to suit their own purposes. Their rejection of these treatments afforded some individual identity and control over their surroundings.

The most blatant rejection of the “healing” hospital environment came via suicide attempts. A male patient “notwithstanding the vigilance of the attendants . . . was found suspended in the dormitory by means of a rope attached to the casement of the window.” Another patient “attempted to hang herself with sheet to transom night before last.” In addition to using the window, a female patient used the camisole, a protective restraint device, in committing suicide. She was discovered “in a recess of the Lodge in a sitting posture with the sleeve of a camisole around her neck; the body of camisole being attached to the iron window sash. The attendant saw that she was dead.”<sup>88</sup> Although originally designed to permit light and therapeutic views, apparently some patients viewed the hospital’s windows as a means to a final end.

Whether symptomatic of their illnesses or expressions of autonomy, administrators and attendants interpreted these patient behaviors as contrary to the goals of the institution. Thus, administrators attempted to correct them by suspending privileges such as walking and working. Superintendents moved patients from the “better” wards to the back wards as punishment for their behavior. Given the choice of working or not working, patients did not have the same option when it came to eating as therapy consisted of both external and internal nourishment. Patients refusing to eat had to endure the stomach pump, an extremely unpleasant experience where the doctor or attendant forced a tube into the patient’s throat. At times the very threat of the stomach pump changed the patient’s mind, one doctor claiming “the sight of the stomach pump, however, was generally sufficient – never had to use it.”<sup>89</sup> Nutrition played an important role in treatment and administrators usually successfully ensured patients’ adherence to the diet.

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<sup>87</sup> Ibid., Patient #1735, 215; “Prescription Book for Female Patients,” Patient #1499, 86.

<sup>88</sup> “Prescription Book for Male Patients,” Patient #1400, 51; “Prescription Book for Female Patients,” Patient #1678, 179; Ibid., Patient #1879, 279.

<sup>89</sup> Ibid., Patient #2546, 611.

Utilizing these various forms of punishment, administrators repressed patients' attempts to freely negotiate their environment and their own bodies.

Administrators also reached for physical restraint to quell patients' subversion of the rules. Upon assuming the superintendent position, Fletcher discovered "there were two hundred and fifty persons under some form of restraint."<sup>90</sup> Forms of restraint included the shower-bath and "cribs, straps, anklets, hand-cuffs, collars restraint, chairs, camisoles, [and] leather mittens."<sup>91</sup> Although William Fletcher abolished most forms of restraint during the beginning of his administration in 1883, other administrators continued using restraints after Fletcher left. Ostensibly used to protect patients from self-destructive behaviors, administrators also utilized restraints as punishment. Fletcher described the crib-bed as "a bed with slats up the sides and a door locked down as a piano box," stating "in the days when cribs were used you could not walk at night from this house to the other without being distressed by the cries of persons. In the effort to get out, the locks being worn, there was a constant clashing."<sup>92</sup> Violent patients or patients who would not stay in their beds were placed into these punitive cages like wild animals. In addition to crib-beds, administrators often used the shower-bath in reprisal for unwelcome behaviors. Deluged with ice water until they calmed down, patients feared this treatment. Administrators played upon this fear, as witnessed in the case of one patient who "refused to answer questions unless threatened with the shower bath." After being struck by a patient "1/5 African," one physician exclaimed "a nigger is a nigger the world over. They are treacherous and mean 9 cases out of ten. I corrected her slightly for her manners etc. by resort to shower bath etc."<sup>93</sup> Notes similar to these reveal that many patients suffered these non-humanitarian means of restraint. Physically controlling a patient's body limited the ways patients moved through their environment, tipping the balance of power towards the administration.

Attendants punished patients for their behavior through physical abuse, a clear violation of attendant rules ordering that "*violent hands shall never be laid upon patients under any provocation, and*

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<sup>90</sup> *Report of Committee of the House of Representatives*, 13.

<sup>91</sup> *Annual Report 1884*, 19.

<sup>92</sup> *Report of Committee of the House of Representatives*, 14.

<sup>93</sup> "Prescription Book for Female Patients," Patient #2350, 517; *Ibid.*, Patient #1372, 22.

*a blow shall never be returned.*”<sup>94</sup> In an 1887 investigation into allegations of patient abuse at the hospital, the Committee of the House of Representatives concluded “there are many cases of brutal and inhuman treatment which have never been brought to light.” Statements by former patients, relatives of patients, attendants, and physicians reveal that abuse occurred fairly frequently. The father of a patient, R. A. Merithew said “he never saw an attendant interfere to prevent patients abusing each other.” One of the attendants also told Merithew that forcibly preventing patients from getting up from their seats on the ward served as a means of “breaking them in.” Teasing, striking, and kicking of patients occurred frequently. According to former patient George Marstell, “when [patients] do not do just what is wanted of them they were forced to do so.” A former attendant testified that attendants “took the precaution not to bruise a patient so as to show marks” and that other attendants would guard the doors while abuse occurred.<sup>95</sup> Although administrators typically fired attendants who committed these abuses, the stresses of the job, employee turnover, the unkind nature of some attendants, and the high ratio of patients to attendants resulted in continuing abuse. Fears of abuse likely limited a patient’s desire to express autonomy. Physical restrictions and punishment worked to prevent free expression and ensured most patients followed the rules of the institution.

### **Success and Failure of Architecture and Ideals**

Administrators and moral treatment architecture attempted to regulate the behaviors of the patients confined to the hospital. Yet by the late nineteenth-century, the moral treatment ideology fell out of favor. Many factors contributed to its decline including custodial care, limitations of the facilities, and financial concerns. By the latter part of the century, physicians realized that their estimates of “curability” were unrealistic. Rather than witnessing an 80 percent cure rate, physicians saw discharged patients returning to the hospital time and again. Originally giving preference to recent cases, the hospital continued to be overwhelmed by chronic and long-term cases. The hospital facility attempted to keep

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<sup>94</sup> *Annual Report 1849*, 43.

<sup>95</sup> *Report of Committee of the House of Representatives*, 13; *Ibid.*, 12; *Ibid.*, 299; *Ibid.*, 692; *Ibid.*, 416.

pace with the number of new cases, but overcrowding became a significant issue and hallways and day rooms filled up with beds. Kirkbride believed that “a crowded institution cannot fail to exercise an unfavorable influence on the welfare of its patients.”<sup>96</sup> Overcrowding impeded a therapeutic ideology based on a soothing and calming atmosphere. Lining the hallways with beds prevented patient access to windows and the healing properties of landscape and sunlight. Overcrowding likely affected the system of classification by behavior, as administrators didn’t have enough room to ensure the ideal separation of patients. Surely such close proximity among patients resulted in greater tensions as they attempted to carve out individual spaces. An increasing patient population ensured that patients received little individual attention, and care eventually became custodial rather than curative.

In addition to space constraints, the limitations of architecture arose in other ways. Mentioned numerous times in the annual reports, poor ventilation meant that “the stench within the wards from the water-closets [was] almost intolerable.”<sup>97</sup> The buildings frequently needed repairs including the installation of a heating system, interior and exterior paint, remodeling of bathrooms and water closets, new floors and ceilings, and destruction of unsteady structures. The 1860 annual report indicates that “the slate roofing in parts is displaced so much as to permit the rain to come through and thus destroy the ceiling, and soil and dampen the walls, and occasionally the bedding.” Superintendents constantly appealed to the legislature for additional funding to make these repairs to the buildings. This money was not always forthcoming as seen in 1857 when the legislature “failed to make any provision whatever for the support of the Hospital.”<sup>98</sup> The hospital closed temporarily and discharged 303 patients. Due to regulations classifying patients by behavior, violent patients condemned to basement wards because of lack of space never realized the benefits of moral treatment. Their lives consisted of a “dark, damp,

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<sup>96</sup> Kirkbride, 49.

<sup>97</sup> *Annual Report of the Commissioners, Superintendent and Treasurer of the Indiana Hospital for the Insane for the year ending October 31, 1861 to the Governor* (Indianapolis: Berry R. Sulgrove, 1861), 6.

<sup>98</sup> *Annual Report of the Commissioners, Superintendent and Treasurer of the Indiana Hospital for the Insane for the year ending October 31, 1860 to the Legislature*, by (Indianapolis: John C. Walker, 1860), 15; *Annual Report of the Commissioner and Superintendent of the Indiana Hospital for the Insane for the year ending Oct. 31, 1857 to the Governor* (Indianapolis: Joseph J. Bingham, 1857), 6.

cheerless, barred and stifling dungeon.”<sup>99</sup> Although admittedly “high risk,” some of these patients were not allowed outside for years—hardly ideal, humane, or “moral” treatment.

Current psychological studies reveal that aspects of moral treatment architecture may have been detrimental to the recovery of patients at the Indiana Hospital for the Insane. Mayer Spivack theorizes that the indestructible nature of furnishings and materials in old hospitals negatively affects patient behavior as “patients are often led to behave as they are expected, or in this case, ‘told’ by their environment to behave.”<sup>100</sup> If furnishings are of an indestructible nature, administrators clearly expect patients to abuse them. This demonstrates the administrators’ lack of confidence in patients’ ability to conform to accepted behavior. Spivack also discusses the effects of tunnels and corridors. The hospital’s long corridors likely resulted in the amplification of noises and the creation of echoes which although distracting to some, may have been interpreted as “threatening mysteries” to the mentally ill patients.<sup>101</sup> The hospital lacked room for patients’ personal space and identity. Large day rooms and chair-lined corridors impeded conversation and privacy. Studies show that rearranging the furniture into informal groupings and putting up privacy partitions in day rooms positively affects patient interaction and sense of self.<sup>102</sup> The arrangement of rooms at the Indiana Hospital for the Insane inhibited these outcomes.

Administrators’ misguided ideals supplemented architectural limitations. The inflexible nature of the moral treatment policy at times resulted in inhumane treatment of patients. Strict control over patient behaviors left little room for compassionate individual treatment, or a desire to understand why patients expressed certain behaviors. The system of reward and punishment intended to ensure cooperation resulted in abuses.

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<sup>99</sup> *Annual Report 1872*, 12.

<sup>100</sup> Mayer Spivack, *Institutional Settings: An Environmental Design Approach* (New York: Human Sciences Press, Inc, 1984), 89.

<sup>101</sup> *Ibid.*, 111.

<sup>102</sup> *Ibid.*, 125; Also see Charles J. Holahan, "Environmental Change in a Psychiatric Setting: A Social Systems Analysis," *Human Relations* 29, no. 2 (1976) and Lawrence R. Good, Saul M. Siegel and Alfred Paul Bay, *Therapy By Design: Implications of Architecture for Human Behavior* (Springfield, IL: Charles C. Thomas, 1965).

Prior to the building of Seven Steeples, Governor Hendricks advocated for the expansion of the Indiana Hospital for the Insane. The limitations of the facility at that time prevented the state from caring for many insane persons. In an 1875 speech, the governor proclaimed, "Everybody else has a home. These poor . . . hopeless wrecks of humanity must also have a home."<sup>103</sup> What type of "home" did the Indiana Hospital for the Insane ultimately provide? Tomes judges correctly that it is dangerous "to generalize about 'the' patient experience of the asylum."<sup>104</sup> One can say that the early years of moral treatment emphasized *treatment* over past methods which utilized chains and isolation. This, perhaps, exemplifies moral treatment's greatest achievement. Optimism over the ability to cure the insane may have led in some way to the development of treatment methods today. Some superintendents surely must have wanted to help patients rather than stigmatize and shun them. Undoubtedly some patients benefited from moral treatment, at the very least because the architecture of the hospital was superior to that of poorhouses and jails. The hospital's cultivated landscape may have positively impacted some patients as "nature views appear to reduce psychological arousal more effectively than urban scenes."<sup>105</sup> The recent studies mentioned indicate Kirkbride and other proponents of moral treatment correctly emphasized the healing properties of landscape and scenic views.

Yet, as much as administrators espoused ideals of home, the bars covering patients' windows implied incarceration rather than domesticity. Some superintendents and physicians undoubtedly saw patients as "cases," rather than as individuals. The language in the prescription books indicates that physicians judged patients by their actions, even though illness instigated many of these actions. Physicians described quiet patients as good, friendly, agreeable, and, most importantly, manageable. Physicians referred to patients displaying unacceptable behavior as stupid, filthy, idiotic, and troublesome. They viewed women especially as wanton, lecherous, slanderous, and indolent. In keeping with Enlightenment ideology, "Americans who lost their reason also forfeited their right to independent

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<sup>103</sup> "The New Hospital," *The Indianapolis Journal*, 16 October 1879, 5.

<sup>104</sup> Tomes, xxi.

<sup>105</sup> Steven K. Barnhart, Nathan H. Perkins and John Fitzsimonds, "Behaviour and Outdoor Setting Preferences at a Psychiatric Hospital," *Landscape and Urban Planning* 42 (1998): 148.

action.”<sup>106</sup> Physicians believed in the redirection of patients’ independent actions which did not conform to therapeutic standards. Their judgmental views likely facilitated the use of harsh treatments such as the shower bath and restraints.

Physicians and superintendents saw patients mainly on rounds, perhaps once or twice daily. In comparison, attendants spent most of their time among the patients, attempting to exercise firm control over patient behavior. Former patient Mrs. E. A. Squier claimed the attendant “ruled us with a rod of iron. No one could move or speak without her consent, and no one dared ask for that.”<sup>107</sup> Squier professed life on one ward consisted of rows of women lining the hallway, prevented from speaking or standing. She declared the “motionless and silence were awful to bear” and there was “no respite but our daily walks and going to our meals. Even then conversation was forbidden.”<sup>108</sup> As long as the patients maintained the appearance of proper behavior, some administrators remained unconcerned with the ways in which attendants ensured cooperation. Administrators certainly knew abuses existed and even prescribed certain punishments themselves. The language used to describe patients, combined with the strict regulations, monitoring of behavior, and punishments used to coerce behavior, makes it difficult to argue the hospital possessed a wholly humanitarian or even mostly pleasant environment. Although many patients likely needed twenty-four hour care and surveillance, the lack of understanding of mental illness hampered a truly healing hospital atmosphere.

Ultimately, patient and administration perspectives resulted in a negotiation of power as ideas about the proper usage of the hospital landscape differed. Patient and administration perspectives reveal tensions between the ideal and the real usage of the Indiana Hospital for the Insane’s landscape. In their efforts to understand the hospital as place, rather than merely space, patients interpreted treatment and utilized architecture in ways that did not always conform to administrators’ expectations. Although

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<sup>106</sup> Tomes, xx.

<sup>107</sup> Albert Thayer, *Indiana Crazy House* (Indianapolis, IN: by the author, 1886), 2.

<sup>108</sup> *Ibid.*, 4.

inhibited by physical restraint and architectural design, patients negotiated the environment in search of personal expression. Many times autonomous behaviors took the form of resistance.

While administrators viewed the hospital environment as curative, healing, and ultimately necessary to society, patients interpreted the environment as restrictive, punitive, sanctuary, home, or a combination of all or any of these. Try as they might, hospital administrators never achieved the total hegemony they desired. Patient voices still come through even in the midst of a strictly controlled environment, and the incorporation of their voices results in a truer picture of the complexity of life within these institutions.

Financial concerns, overcrowding, and the introduction of new drug therapies eventually led to mass deinstitutionalization and a return to community-based care. Most of the structures belonging to the Indiana Hospital for the Insane—later known as Central State Hospital—were torn down by 1995. The earlier years of the institution may have witnessed better patient care, but the treatment never achieved the results hoped for by administrators, families, or patients.

Mental illness remains a complex issue that affects millions of people worldwide. Even with advances in treatment and psychotherapy, patients do not experience a 100 percent cure rate. One can hope that more patients benefited from moral treatment than suffered abuse, yet an examination of primary sources elicits doubt, especially when patient behavior did not conform to the dominant ideology. Those afflicted with mental illness today can certainly identify with the anguish, confusion, and fears of those afflicted in the past. Within an institution or outside of one, mental illness is painful. Although the reliance on “seclusion” and “plenteous streams of light” mentioned in the “Maniac’s Hall” eventually diminished, perhaps moral treatment succeeded in restoring some “lost one’s mental sight.”<sup>109</sup>

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<sup>109</sup> *The American Journal of Insanity*, vol. III, 101.

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