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The First Mrs. Rochester: Wrongful Confinement, Social Redundancy, and Commitment to the Private Asylum, 1883-1923

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The First Mrs. Rochester: Wrongful Confinement, Social Redundancy, and Commitment to the Private Asylum, 1883-1923

CHERYL KRASNICK WARSH

Résumé

Historians have debated the growth of asylums as either a movement towards social control or as a benevolent reform; yet commitment was primarily initiated by kin. The rapid overcrowding of asylums reflected the success of institutions in responding to family crises. Through analysis of 1,134 case histories of a private asylum, the Homewood Retreat of Guelph, Ontario, the dynamics of the late Victorian and Edwardian middle-class household are evident in the circumstances which culminated in the decision to commit. Urban industrialization and the declining birth rate rendered households less able to care for the insane, while the permeation of capitalist relations into family life rendered the heads of households less willing to care for nonproductive adult members, particularly socially redundant women. The diagnosis of neurasthenia enabled members of the middle class to institutionalize kin for behaviour which, although not violent or destructive, was irritating and antagonistic, thereby reflecting the high standard of middle-class proprieties.

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In the popular mind in the Victorian and Edwardian periods, the asylum was synonymous with abuse and the unlawful seizure of liberty. A wary British and North American public viewed the rapid expansion of the asylum network and, armed with the images created by sensationalist novels, was receptive to the charge that many inhabitants of lunatic asylums were victims of wrongful confinement instigated by greedy or autocratic relatives. Particularly suspect were the private institutions where keepers sought to profit from the lengthy confinement of the mad. Was this in fact the case? How much did the perception of unholy conspiracy between "mad-doctor" and relations coincide with the realities of an ever-increasing patient pool? The kin of asylum patients were, in fact, the major impetus behind commitment, but their motivations were based not so much upon greed as upon the internal dynamics of the family, and upon the economic structure of western society in the nineteenth and early twentieth centuries.

The historiography of asylums has explored the impact of the capitalist economy upon the growth of such institutions since the publication in 1965 of Michel Foucault's *Madness and Civilization.* Andrew Scull, David Rothman, and Michael Katz, for example, have noted that the incarceration of nonproductive elements of society into asylums, workhouses, reformatories, and schools had coincided with the expansion of a mobile, landless, indigent population both required for industry and feared by industrialists.[1] Norman Dain and Gerald Grob, on the other hand, have argued that the concept of a socially controlling elite fails to explain the benevolent motivations of community reformers faced with a growing, homeless mentally ill element, which could no longer be justifiably housed in the horrendous living conditions of the preindustrial past. Grob has further argued that the growth of asylums was accompanied by the optimistic theories of a new group of alienists who believed that insanity was a curable disease.[2] The subsequent accumulation of large numbers of incurables, and the construction of more asylums to meet further demands, were neither anticipated nor desired by the founders and the physicians.

Both these perspectives have relied upon medical publications, annual reports, and boards of directors minutes which have outlined the considerations of the asylum administrators, but not the concerns of the patients themselves. Recent institutional studies by Nancy Tomes, Anne Digby, Ellen Dwyer, and Elizabeth Lunbeck have focussed upon patient records and correspondence to evoke the voices of

1. Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason,* trans. Richard Howard (New York, 1965); Andrew T. Scull, *Museums of Madness: The Social Organization of Madness in Nineteenth Century England* (New York, 1979); David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston, 1971); Michael B. Katz, Michael J. Doucet, and Mark J. Stern, *The Social Organization of Early Industrial Capitalism* (Cambridge, 1982).
2. Norman Dain, *Concepts of Insanity in the United States 1789-1865* (New Brunswick, N.J., 1964); Gerald N. Grob, *Mental Institutions in America: Social Policy to 1875* (New York, 1973) and his *Mental Illness and American Society 1875-1940* (Princeton, N.J., 1983).

of the hitherto mute patient population.[3] These authors have concluded that it was neither a dominating elite nor a state reformer, but the families of the patients themselves who provided the impetus for the rapid growth of the original asylums, the impetus being a "search for order" within the household. From this viewpoint, an increase in the custodial population may be seen, not as the failure of the institution, but as its functional success in meeting the needs of families, if not the visions of its founders.

This study will further develop this perspective by integrating asylum historiography with the research tools of family history and the application of contemporary family psychiatry theory. Since the publication in 1965 of Peter Laslett's *The World We Have Lost*, social historians have fruitfully collected quantitative data (such as vital statistics and taxation records) to explore the inner dynamics of the family and the structure of communities.[4] Through the use of statistics, historians such as Michael Anderson, Tamara Hareven, Gordon Darroch, and Chad Gaffield have developed a life-course perspective of the family which investigates "the *meanings* of ages" and the synchronization of needs, resources, and expectations.[5] At different stages of the life cycle, families employed various strategies to cope with personal crises and socio-economic change. Institutional records have uncovered many of these strategies. Marta Danylewycz and Bettina Bradbury, for instance, have investigated convent and orphanage records in Quebec to determine strategies employed by the permanently unmarried and the poverty-stricken.[6]

The patient records of the Homewood Retreat of Guelph, Ontario have been investigated for this study. Opened in 1883, Homewood was (and is) a private asylum catering to a middle-class clientele, primarily from southern Ontario, Quebec, and the northeastern United States. Using a random start, every fifth male and every third

3. Nancy J. Tomes, *A Generous Confidence: Thomas Storey Kirkbride and the Art of Asylum-Keeping 1840-1883* (Cambridge, 1984); Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat 1796-1914* (Cambridge, 1985); Ellen Dwyer, *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums* (New Brunswick, N.J., 1987); Elizabeth Lunbeck, "Psychiatry in the Age of Reform: Doctors, Social Workers and Patients at the Boston Psychopathic Hospital 1900-1925," PhD diss., Harvard University, 1984.
4. Peter Laslett, *The World We Have Lost*, 2nd ed. (New York, 1973).
5. Michael Anderson, *Family Structure in Nineteenth-Century Lancashire* (Cambridge, 1971); Tamara K. Hareven, ed. *Transitions: The Family and the Life Course in Historical Perspective* (New York, 1978); A. Gordon Darroch and Michael Ornstein, "Ethnicity and Class: Transitions over a Decade, Ontario 1861-1871," *Historical Papers* (1984): 111-37; Chad Gaffield, *Language, Schooling and Cultural Conflict: The Origins of the French Language Controversy in Ontario* (Kingston, 1987); Glen H. Elder, Jr., "The Life Course Perspective," in *The American Family in Social-Historical Perspective*, ed. Michael Gordon, 3rd ed. (New York, 1983), 54.
6. Marta Danylewycz, *Taking the Veil: An Alternative to Marriage, Motherhood and Spinsterhood in Quebec, 1840-1920* (Toronto, 1987); Bettina Bradbury, "The Fragmented Family: Family Strategies in the Face of Death, Illness and Poverty, Montreal, 1860-1885," in *Childhood and Family in Canadian History*, ed. Joy Parr (Toronto, 1982).

female admission between 1883 and 1923 was selected, a bias which reflected the predominance of female admissions after 1900. Cases with extremely sparse data, such as no date of discharge or personal information, were replaced by more complete matching cases (that is, same sex, diagnosis, and year of admission). The sample thus comprised 567 male and 567 female admissions and spanned the administrations of Stephen Lett (1883-1901) and Alfred Hobbs (1901-23). The literary richness of the patient histories has opened a window not only to the lives of those admitted to Homewood, but to the lives of their families as well.

The objection might be raised that families of the mentally ill were unusual, and that their experiences shared little in common with those of the general population. This would be a valid objection if there had been a universally accepted definition of insanity, but there was not, particularly in the nascent field of the neuroses, or neurasthenia. Furthermore, once a family recognized and accepted a member as mentally ill, the decision to commit was not inevitable, even in more severe or destructive cases. As Henry Harbin has noted in his study of contemporary family psychiatry, "the basic assumption underlying the hospital treatment approach . . . has been an individually oriented (either biological or psychological) model of madness. Yet most people are placed in the hospital because their family or the community is unable to tolerate their disturbing behaviour, no matter what the etiology of the illness happens to be."[7]

The family, in fact, had a number of options to exhaust: to ignore the behaviour, to care for the individual at home, or to admit him to a rest home, hospital, or asylum. The decision to commit, therefore, may be seen as a family strategy in a time of crisis (see Table I). How families arrived at the decision to send members to Homewood will thus shed light upon the inner dynamics of the late Victorian middle-class household.

Table I
Admitting Party

	Female (n=567)	Male (n=567)
Family	453	327
Physician	74	145
Friend	3	22
Outside Authority	4	7
Patient (Self-Admitted)	7	34
Army	1	1
Nurse/Attendant	1	1
Employer	0	3
Unknown	24	27

Source: Homewood Sanitarium Collection, Guelph, Ontario, Patient Registers, 1883-1923.

7. Henry T. Harbin, "Family Treatment of the Psychiatric Inpatient," in *The Psychiatric Hospital and the Family* (Jamaica, N.Y., 1982), 4.

The fear of wrongful confinement was a generalized one in nineteenth-century Britain and North America. When Charles Reade published *Hard Cash* in 1863, a "melodramatic novel depicting the ease with which sane persons could be committed to English asylums," the book's audience must have "shared the hero's terror" when he found himself locked up; "at the fatal word 'asylum', Alfred uttered a cry of horror and despair, and his eyes roved round the room in search of escape."[8] The mysteries of the mind and the machinations of the mad-doctors rendered plausible the notion that anyone, if sufficiently upset, could be incarcerated as a lunatic. Asylum hysteria or "lunacy panics" resulted in the appointment in 1858-59 and 1876-77 of two major committees of the British House of Commons, and in the patients' rights crusade organized by Elizabeth Packard of the United States in the 1860s and 1870s.[9] Predictably, these activities were met by the strenuous objections of asylum superintendents. "Some minds positively revel in conjuring gruesome pictures that have for their background the harrowing experiences related in Reade's *Hard Cash*," complained Edward Runge, superintendent of the St. Louis (Missouri) Insane Asylum. "Collusion between the victim's kindred and the authorities is either charged openly or more often mysteriously whispered about."[10]

As a private asylum, the Homewood Retreat was particularly vulnerable to public distrust. As M.C. (#632, 1905),[11] a disgruntled expatient wrote, "Your place is run largely upon a financial basis — to create large dividends and to make the stocks valuable is not blameworthy and you are, I believe, adept at the business but the law as it stands makes you too much of a boss and autocrat." This patient had accepted the stereotype of the private asylum, although Homewood was far from being a profitable venture until well after 1900. Its shaky financial footing, however, did render it more dependent upon satisfying its clientele which, as Tables II and III illustrate, were solidly middle class.[12] Did Homewood's managers then wrongfully confine individuals in collusion with their families? If "wrongful" connotes sinister motivations, then the answer would certainly be negative. If, however, it was meant to exclude any motivations or circumstances other than the actual state of mental health, then "wrongful confinement" did indeed occur.

Every family had its own standards of tolerable behavior. As the primary unit for social control, the family's dominant members evaluated the behaviour of each

8. Charles Reade, *Hard Cash*, 2nd ed. (New York, 1889), 230 as quoted in Peter McCandless, "Liberty and Lunacy: The Victorians and Wrongful Confinement," *Journal of Social History* 11 (1977-78): 366.
9. McCandless, "Liberty and Lunacy," 366.
10. Edward Runge, "How to Deal with the Insane," *American Journal of Insanity* 55 (April 1900): 636.
11. Patients in this sample were alphabetized and assigned numbers which do not correspond with the patient registers. The revised lists are held at the Archives of Ontario, the Homewood Sanitarium, and by the author. Where confidentiality could be compromised, the generic X replaces surname initial. Dates are years of first admission.
12. Compare occupation tables with the London, Ontario Asylum for the Insane, a public institution where, in 1900, 62 per cent of patients were farmers or labourers. S.E.D. Shortt, *Victorian Lunacy: Richard M. Bucke and the Practice of Late Nineteenth-Century Psychiatry* (New York, 1986), 32.

individual member, and decided when that behaviour became unacceptably disruptive. Louise C. (#86, 1902), an alcoholic, clearly had overtaxed the tolerance of her husband. In a lengthy, impassioned letter to Dr. Hobbs, he wrote, "she is the most selfish woman you ever met; everything is judged by how it affects herself — her children or family are nothing to her if they don't agree with her wishes; she is the biggest hypocrite you ever saw." He instructed that "the sooner she is made to realize that she is in your Sanitarium for treatment and not there on any pleasure trip the better for herself."

Table II
Occupations

Occupations*	Female	%	Male	%
Merchant/Manufacturer	4	1	88	16
Professional	70	12	92	16
Other While Collar	35	6	75	13
Artisan/Skilled Labour	12	2	26	5
Farming	4	1	76	13.5
Semi-/Unskilled Labour	0	0	13	2
Other (Including Domestic)	330	58	14	2.5
Not Given/None	112	20	183	32
Total	567	100	567	100

*Occupational structure devised by Gordon Darroch, "Occupational Structure, Assessed Wealth, and Homeowning during Toronto's Early Industrialization, 1861-1899," *Histoire sociale/Social History* 16/32 (November 1983): 381-410.

Table III
Parental/Spousal Occupations

Occupations	Female	%	Male	%
Merchant/Manufacturer	77	13.5	57	10
Professional	76	13.5	49	9
Other White Collar	29	5	13	2
Artisan/Skilled Labour	11	2	9	1.5
Farming	61	11	69	12
Semi-/Unskilled Labour	8	1.5	2	.5
Other	4	.5	75	13
Not Given/None	301	53	293	52
Total	567	100	567	100

Familial reactions to patient behaviour and motivations for commitment reflected perceived breaches in standards of tolerable behavior within the family. These breaches included behaviour inappropriate to middle-class proprieties, such as refusal to work, public display, and sexual promiscuity; and behaviour disruptive to family harmony, which ranged from violence to irritability (see Table IV). The refusal to work was the antithesis of the basic principle of middle-class ideology. Depending upon his or her

labouring role in the household, in the workplace, or on the farm, the nonproducer could be an inconvenience or a major crippler of the family economy. Among the Victorian middle-class, the refusal to work was particularly dreaded by parents of young men as the temporal gap between adolescence and self-support steadily increased. According to Carroll Smith-Rosenberg, this transformation had commenced with the decline of rural crafts and with the rise of urbanization and geographical mobility. The middle-class family was robbed of its "instrumental centrality" and "generational relations — principally between fathers and sons — altered dramatically. No longer was the father's power to determine the economic choices, and thus control the future of his maturing sons, unquestioned...."[13]

Table IV
Family-Related Reasons for Commitment

Behaviour Intolerable to Middle-Class Standards	**No.**
Public Display	11
Refusal to Work	20
Financial Irresponsibility	3
Sexual Excesses	8
Masturbation	17
Behaviour Disruptive to Family Harmony	
Jealousy and Suspicion	23
Insubordination Towards Parents	12
Refusal to Have Sexual Relations with Spouse	2
Violence Towards the Family	31
Irritability Towards the Family	70
Socially Redundant Individuals	
Male Social Isolation	15
Female Spinsterhood	10
Female Widowhood or Desertion	18
Female Loss of Role in Family or Loss of Caregiver	41

Fatherless boys were even more difficult to control. Arthur D. (#693, 1913), diagnosed with neurasthenia and "mental excitement," appeared to be an incorrigible rather than mentally ill seventeen year old. His mother, a "very highly strung, nervous" widow, was unable to control him. Arthur smoked pipes and cigarettes, and "runs away frequently from his mother . . . spending money wildly, buying motorcycles, and hiring carriages. Running away frequently to neighboring Cities, and last week ran away to Toronto, spending all his money, and then forging cheques on his Mother." When Arthur entered the asylum, the symptoms he manifested included attempting to run away, inquiring "if there were any girls to play with around here," and asking "if he would be allowed to smoke, and to have his revolver, and knives with him . . . . He walked about the corridor with his hat on, with an air of considerable importance." Arthur was visited often by his mother until he escaped nine months after admission.

13. Carroll Smith-Rosenberg, "Sex as Symbol in Victorian Purity: An Ethnohistorical Analysis of Jacksonian America," in *Turning Points: Historical and Sociological Essays on the Family*, eds. John Demos and Sarane Spence Boocock (Chicago, 1978), 218-19.

Susie K. (#266, 1905) was a twenty-two-year-old single woman who "helped at housework" at home. The referring physicians described her as "quiet, passive," and "moody." Her mother stated that she "does nothing unless forced [and] becomes somewhat cross when compelled to do anything. . . ." She showed "no interest in general work or welfare of the place." After two years of her listlessness and inactivity, her mother could no longer cope and committed her as insane, although she was discharged two months later. John B. (#612, 1910), thirty-three years old and living on his parents' farm, had changed from being a "quiet industrious citizen to a lazy boisterous person." He "lies in bed a good part of the day and wanders round at night," and "indulges in all kinds of silly talk."

Henry P. (#978, 1914) displayed more distinctive symptoms of mental illness; yet it would be external factors which led to his commitment. Aged thirty, Henry had been a clerk for the CPR in his northern Ontario town, had graduated from McGill Medical School, and had worked for a year in a hospital. Described as "a good mixer, fond of company," and "never extravagant," Henry was noticed to be acting "peculiar" — nothing more — until he threw a glass of ginger ale on the floor and cried that there was acid in it. In a few days, he was sent to the first of a series of asylums far from home. The decisiveness of the family's response was due to the fact that he had caused a public scene at the victory party for his father's election as mayor. Although, in hindsight, his family noted his "odd" behaviour, it had been tolerated until he had broken another tenet of Victorian society: respectability.

Other public officials found it too socially costly to keep mentally unsound family members at home. Hugh S. (#1050, 1885), the alcoholic son of a senator, was admitted when his father became "disgusted to think that one belonging to me will go round the streets of Toronto and through the slums spending the money that he never earned." Harriet X. (#528, 1913), a resident of western Canada, was a forty-three-year-old mother of six children ranging in age from five to nineteen. She had been a "strong, wiry girl" of an "athletic turn," and had had a good public-school and college education. Married at twenty-one, Harriet's confinements were "all more or less difficult." At the last birth, she had suffered "considerable tearing and laceration" and required surgery. Although her husband stated that she was of a "cheerful disposition," she had lately been exhibiting "a great deal of anxiety regarding the welfare of the children." At the same time, her husband was elected mayor of their large city and Harriet's duties grew "considerably." Along with the social functions and committees attendant upon the office, a visit from the governor general provided additional public duties for which she "faithfully gave her time and energy." Given the daunting prospect of a mother of six performing these duties along with her domestic chores within the context of 1912 technology, it is not surprising that Harriet suffered a physical breakdown, succeeded by mental symptoms. She was nursed at home until she demanded to be allowed to attend her social functions, at which point she was sent to Homewood, many hundreds of miles away from the eyes of the local citizens.

Physicians who referred such individuals to asylums were sympathetic to the middle-class drive for respectability. In fact, by "ascribing unconventional ideas and actions to insanity, [alienists] set themselves up as the guardians of the respectable code,

and of the social system it buttressed." When charges of wrongful confinement were raised in the British press in the 1840s, one anonymous physician admitted that "thinking of two evils, it is better to risk the confinement of an eccentric person improperly, than to leave him at liberty to become a disgrace to himself and his family."[14]

By the second half of the last century, the admission of household members exhibiting behaviour intolerable to the standards of the middle-class family was facilitated by the widespread medical acceptance of the diagnosis of neurasthenia. Neurasthenia, or nervous exhaustion, was coined by the American neurologist George Miller Beard in 1869 to describe a malaise considered to be affecting a growing segment of the Victorian middle class. Late nineteenth-century neurologists likened the human body to an electrically powered machine, possessed of a "limited amount of nervous energy." When the machine became overstimulated, by the modern urban stresses of "the railroad, the steam engine, the telegraph, and the increased mental activity of women," the body would break down and require an extended period of rest in a secluded environment, preferably a sanitarium.[15]

The diagnosis of neurasthenia was a badge of success akin to the executive ulcer. In his address to the Ontario Medical Association in 1905, New York physician William B. Pritchard termed it "a disease of bright intellects; its victims are leaders and masters of men, each one a captain of industry. . . . The neurasthenic is the archetype of the poohbah."[16] Beard listed over seventy symptoms of neurasthenia, including "insomnia, flushing, drowsiness, bad dreams, cerebral irritation, dilated pupils, pain, pressure and heaviness in the head. . . ."[17] So popular was the diagnosis that by 1901, Alphonse D. Rockwell was calling it "the newest garbage can of medicine."[18] Neurasthenia was a relatively innocuous diagnosis and facilitated the movement of middle-class patients into asylums. Since few individuals would never exhibit at least some neurasthenic symptoms, it was not difficult for a physician, faced with behaviour which families could no longer tolerate, to arrive at a diagnosis satisfactory to himself, family members, and, frequently, the patients themselves. As Table V indicates, neurasthenia was the primary diagnosis among patients admitted to the Homewood Retreat between 1883 and 1923. Among male patients, only alcoholics were admitted in greater numbers. Table VI illustrates the range and frequency of symptoms cited in neurasthenic cases.

Alcoholism and neurasthenia were not the only symptoms commonly cited as grounds for commitment. Perhaps nowhere was there more universal agreement,

14. McCandless, "Liberty and Lunacy," 377; *Times* (London), letter to editor from "Vigil," 5 October 1844, as quoted ibid., 373.
15. Barbara Sicherman, "The Paradox of Prudence: Mental Health in the Gilded Age," in *Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew T. Scull (Philadelphia, 1981), 220.
16. William B. Pritchard, "The American Disease: An Interpretation," *Canada Lancet* 37 (July 1905): 11, 985 and 987.
17. George M. Beard, *American Nervousness: Its Causes and Consequences* (New York, 1881), 7.
18. As quoted in Sicherman, "Paradox of Prudence," 35.

among physicians and laymen, with respect to the need for controls on behaviour, than on sexual promiscuity in women. Physicians frequently "confused insanity with immorality, especially sexual, and with other forms of nonconformist behaviour."[19] Alice H. (#218, 1910) led a life considered immoral by her family and aggravated the situation by her profanity and open promiscuity. She, on the other hand, perceived her trouble as "one of constant and unwarranted persecution by the members of her family." In letters to her at the institution, male family members clearly detailed the motivations behind her commitment. Her brother-in-law wrote, "the existing method of 'living,' if you can call an endless sarcasm of argument and wrangling, living at all, simply can't go on any longer...." Her brother added,

> People who are laws onto [sic] themselves end up in lunatic asylums and that's what a lunatic is, a person who is a law onto herself. . . . Unless you can become an entirely changed woman, you will have to stay in an asylum somewhere all your life. . . . If you acted sanely, people would in time forget that you were once in an asylum. Your social life is spoiled here for several years and you would have to live very quietly. *It's better that people should think you insane than that they should think you a bad immoral woman, and that's what many people thought till they heard you were in an asylum, which of course explained things* (italics added).

Table V
Diagnosis

Diagnosis	Female	Male	Total
Depression	85	45	130
Agitation	49	21	70
Delusion	31	12	43
Alcoholism	23	168	191
Addiction	51	51	102
Multiple Addictions	12	19	31
Neurasthenia	192	144	336
Dementia Praecox	55	27	82
Senility	16	13	29
Syphilis	0	33	33
Epilepsy	7	8	15
Manic-Depression	13	8	21
Peurperal Psychosis	12	n/a	12
Imbecility/Defective Neurosis	3	0	3
Involutional Melancholia	4	1	5
Other Causes	13	14	27
Not Given	1	3	4
Total	567	567	1134

Table VI
Neurasthenic Symptoms

Symptoms	Frequency Cited* Female	Male	Total
Melancholia	52	35	87
Insomnia	35	22	57
Restlessness, Mania	23	26	49
Delusions, Obsessions	26	21	47
Nerves, Anxiety	26	20	46
Neuralgia, Dizziness	22	15	37
Feelings of Persecution	19	14	33
Lack of Concentration	12	21	33
Suicidal	14	15	29
Hysteria, Emotionalism	22	6	28
Choking, Tremors, Back/Heart Pain	15	13	28
Antagonistic Attitude	12	15	27
Hypochondria	16	5	21
Depreciation	11	10	21
Fatigue, Weakness	8	12	20
Lack of Ambition	8	12	20
Reclusive	13	6	19
Gastro-Intestinal Disorders	15	3	18
Violence	9	6	15
Eating Disorders	9	5	14
Wanders	6	7	13
Sexual	9	3	12
Financial Irresponsibility	2	4	6
Filthy Habits	1	4	5
Malingering	1	1	2

* In the majority of neurasthenic cases, more than one symptom was cited, and each has been tabulated separately.

More common than such instances of female sexual promiscuity, yet equally destructive to family harmony, was sexual abuse of women within marriage. English feminist Henrietta Muller has observed that "to many women, sexual intercourse is an unpleasant and fatiguing obligation."[20] The fear of excessive childbearing was the target for many feminists and birth-control advocates who sought to improve the quality of life for women like Elizabeth M. (#320, 1913), a sixty-two-year-old farmer's wife. Elizabeth had undergone thirteen pregnancies and raised eleven children to adulthood with great affection, despite the fact that her husband was a "niggardly" man and "hard" on the family. This was a "cause of discouragement" to the patient. Though "fond of company," Elizabeth never travelled or visited much and, after forty years of this life, she became

20. Lucy Bland, "Marriage Laid Bare: Middle-class Women and Marital Sex c. 1880-1914," in *Labour and Love: Women's Experience of Home and Family*, ed. Jane Lewis (Oxford, 1986), 128.

"weak," "pale," "run down," and severely depressed. At thirty-one years of age, Nellie B. (#44, 1920) had four living children under nine years and had lost a three-year-old child. While her domestic relations were described as "fairly happy," she had been "under considerable stress in the raising of a large family, the husband's sexual demands being considered as extreme. . . . She has been gradually depreciating for some little time, keeping very late hours working for the children, and their care in the day time has lately made her irritable. This has made the children fretful and a vicious circle has been established." Her physician added, "In my opinion her family life has been the main cause of her breakdown. Her husband thinks he is kind to her, but his kindness is the wrong type." When her husband came for her after five months of treatment, she "absolutely refused" to board the train with him, and subsequently was transferred to a public asylum.

Spousal abuse could also take the form of brutal physical violence. Arthur R. (#1016, 1892), a fifty-year-old "gentleman," had attempted suicide and exhibited delusions of grandeur. The immediate cause of his commitment was his "uncontrollable" sexual propensity. "Of late [he] attacked [his] wife who is ill in bed after confinement with ruptured organs and attempted to have connection, doing her serious injury." Arthur was uncontrollable despite the fact that he had become totally blind and suffered from multiple sclerosis. His symptoms were strongly indicative, however, of general paresis of the insane, the tertiary stage of syphilis. As might be expected, Arthur was never visited in the two years he spent at Homewood prior to his death.

Arthur had exhibited another symptom which was disruptive to family harmony: unwarranted jealousy towards his wife. Pathological jealousy was one of the most dangerous of all mental symptoms, since there was a likelihood that it could lead to the murder of a spouse or another "as retribution for an often imaginary infidelity."[21] Thomas B. (#591, 1884) was committed after he became suspicious of his wife, and she believed he would harm her. Thomas H. (#815, 1919) also had become "restless, suspicious and made [unjustified] charges of infidelity against his wife."

Violence towards the family, as would be expected, also often produced an institutional response. Violent family members were less likely to be taken home by kin if the violence were directed towards the family rather than towards strangers. Family members sometimes asked outright that the offender be committed for an indefinite period — in fact be incarcerated in the asylum without parole. Thomas M. (admitted 28 August 1888), an alcoholic, possessed a temper so violent that his wife was "broken down in health and cannot live with him." His son "wanted to know how long [Dr. Lett] could detain him and if we could make this a permanent home for him. I replied [that] as long as he remained insane I could help him." Charles S. (#1070, 1910) was feared by his "nearest," especially "his wife being with him alone most of the time. While he has never threatened either his own life or the life of others," his physician believed there was "always a danger." While Charles apparently made a fair mental recovery from a diagnosed involutional melancholia, he was never visited while in the asylum.

21. Sydney Brandon, "Physical Violence in the Family: An Overview," in *Violence in the Family*, ed. Marie Borland (Atlantic Highlands, N.J., 1976), 1.

Yet even instances of overt violence against family members did not necessarily lead to permanent confinement. Joanna R. (#445, 1887) was described as mentally unsound for eleven years and "sometimes very violent." Paranoid, manic, and delusional, Joanna beat her children "severely," forcing her daughter to "leave home at night to avoid maltreatment." After six years of confinement, she was discharged at her family's request on condition that a nurse be provided, and that she "sleep with wire screens." Della B. (#36, 1888), a twenty-one-year-old single girl from Mobile, Alabama, was another intractable case. A victim of mania supposedly caused by a "love affair," Della had been force-fed for "several months," was "filthy" in habits, and went through the "full line of medication including hypnotics, opiates, sedatives, massage, emenagogues, swedish movement and electricity." She gained weight at Homewood and showed some improvement; she baked a "delicious cake" and played piano, although she also attacked her nurse "savagely." Despite these incidents, and Lett's confidence to her brother that she habitually masturbated, her mother visited her frequently, brought her jewellery and, after nine months of treatment, took her home accompanied by a private nurse hired from the Homewood staff.[22] In this case, strong and persistent representations by physicians, family, and friends could not persuade Mrs. B. to accept her daughter's apparently hopeless condition or the need for institutionalization, despite Della's patent unsuitability for home care. As Table VII demonstrates, discharge, like commitment, was commonly at a kin's initiative.

If decisions to commit and discharge from the asylum were familial choices, social forces beyond the control of individual households also influenced and limited the choices available, particularly for behaviour less dramatic than that exhibited by Della and Joanna. The commitment process was greatly influenced by the presence or absence of another individual, usually a family member, who took responsibility for home care. The demographics of the nineteenth century did not, however, auger well for the process. As Katz, Doucet, and Stern have demonstrated, Canadians were on the move.[23]

Table VII
Discharge

	Female	Male
Recovered	99	109
Improved	104	130
Unimproved/At Kin's Initiative	147	91
Transferred	63	38
Died	35	38
Escaped	3	28
Discharged (reason not given)	116	133
Total	567	567

22. Homewood Sanitarium Collection, Guelph, Ontario, Dr. Stephen Lett, superintendent's journal, 19 August 1888.
23. Katz, Doucet, and Stern, *Social Organization*, ch. 3.

Constantly searching for cheap land and economic advancement, this mobile population was tardy in establishing the roots necessary for the proper care of the old or the sick.

The nature of the family was also changing. At the turn of the century, a high adult-mortality rate persisted as the fertility rate continued to fall. In 1900, one-quarter of all American children under fifteen years would lose one parent while one in sixty-two would lose both. In their adult years, these orphans were consequently less likely to have kin to care for them should they experience a period of mental illness.[24] In addition, the extended family was also shrinking, as a decline in fertility resulted in the halving of the average size of completed families. In 1851, a Canadian woman would have borne an average of 7.02 children, while by 1921, the average had dropped to 3.54 children.[25] This demographic shift had "potentially important implications for old people and for society. Those who did not marry and those who had no or few living children might need public welfare. . . . Some 56 percent of [American] women over 44 who were living in or admitted to almshouses in 1910 had borne no children."[26]

Along with the diminution of the pool of potential caregivers came the lessening of the sense of moral responsibility for kin members, a phenomenon which was an integral part of the effect of a capitalist economy upon human relations. In an industrial society, people compare each other's material possessions and, indirectly, their own market and social value. This process involves raising the significance of material objects from "simply representing a use-value to also representing a social value. It is in this context that social relations develop between things. The material objects almost take on a life-like quality of their own. This process, whereby material relations develop between people, and social relations develop between things, is referred to as reification."[27]

The process of reification permeated family life, producing, as Shorter has termed it, "economic egoism."[28] Unlike its preindustrial antecedents, the family under industrialism no longer was a multifaceted corporate entity, responsible not only for food, shelter, and clothing, but also for education, medicine, and care for the aged and infirm. As Eli Zaretsky has stated, "so long as the family was a productive unit based upon private property, its members understood their domestic life and 'personal' relations to be rooted in their mutual labour."[29] The result of the removal of labour from the home (apart from domestic maintenance and childcare) and the decline of real

24. Peter Uhlenberg, "Death and the Family," in *American Family*, 172.
25. Roderic P. Beaujot and Kevin McQuillan, "The Social Effects of Demographic Change: Canada 1851-1981," *Journal of Canadian Studies* 21:1 (Spring 1986): 59.
26. Daniel Scott Smith, "Life Course, Norms and the Family System of Older Americans in 1900," *Journal of Family History* 4:3 (Fall 1979): 292.
27. Michael L. Warsh, "Domestic Concatenations: The Reification of Social Relations in Family Law," unpub. paper, Faculty of Law, University of New Brunswick, Fredericton, 1988, 4.
28. Edward Shorter, *The Making of the Modern Family*, 2nd ed. (New York, 1977), 259.
29. Eli Zaretsky, *Capitalism, The Family and Personal Life* (New York, 1976), 29-30.

property ownership was the separation of personal life and labour — a bifurcation which held ramifications for the traditional social-welfare functions of the family. As Harry Braverman has concluded,

> The ebbing of family facilities, and of neighbourly feelings upon which the performance of many social functions formerly depended, leaves a void. As the family members, [working] away from home, become less able to care for each other in time of need, and as the ties of neighbourhood, community and friendship are reinterpreted on a narrower scale to exclude onerous responsibilities, the care of humans for each other becomes increasingly institutionalized. . . . In addition, the pressures of urban life grow more intense and it becomes harder to care for any who need care in the conditions of the jungle of the cities. Thus understood, the massive growth of institutions . . . [represents] the clearing of the market place of all but the "economically active" and "functioning" members of society.[30]

The individualization of household members was accompanied by the privatization of the nuclear family and its glorification as the centre of personal fulfillment. The closed windows draped with heavy brocades which characterized the middle-class home represented families turning inward from a society perceived as something "alien, impersonal, remote and abstract — a world from which pity and tenderness had fled in horror. . . . Yet the very conditions that gave rise to the need to view privacy and the family as a refuge from the larger world made it more and more difficult for the family to serve in that capacity."[31] Kin members, as well as employees, were increasingly measured by economic worth in the capitalist psyche. In his study of English immigrants, Ross McCormack has noted that "family relationships could be ruthlessly instrumental. In 1905 a Portsmouth woman living with her son and daughter-in-law in Winnipeg lost her sight and thus her ability to contribute to the family economy; she was turned out of the house and deported."[32] In her discussion of life-history interviews conducted with individuals born before 1908 and living in Hamilton, Ontario, Jane Synge contrasted the experiences of farm families, where "unneighbourliness" or neglect of elderly parents would be subject to severe social censure, with the recollections of urban dwellers, whose parents feared "being deserted in old age."[33]

The separation of productive (that is, wage-earning) and nonproductive elements of society had particularly detrimental effects for women. The economic dependency of wives and daughters was "the hallmark of middle-class respectability."[34] Yet, as Peter

30. Harry Braverman, *Labor and Monopoly Capital: The Degradation of Work in the Twentieth Century* (New York, 1974), 279-80.
31. Christopher Lasch, "Social Pathologists and the Socialization of Reproduction," in *American Family*, 183.
32. Ross McCormack, "Networks among British Immigrants and Accommodation to Canadian Society," *Histoire sociale/Social History* 17/34 (November 1984): 365.
33. Jane Synge, "Work and Family Support Patterns of the Aged in the Early Twentieth Century," in *Aging in Canada: Social Perspectives*, ed. Victor W. Marshall (Toronto, 1980), 139-40 and 144.
34. Deborah Gorham, *The Victorian Girl and the Feminine Ideal* (London, 1982), 11-12.

Stearns has observed, "Is it too fanciful to suggest that the dependence preached on women generally, of every age, served as a logical preparation for the special dependence of old age? Dependence of course is a nasty word, and heightened institutionalization reflects its harshness when there was no alternative."[35] The dependency which accompanied old age was a socio-economic consequence of a natural life-course event. Other life-course events affected women's independence, including spinsterhood (a word which took on its present perjorative meaning only in the 1750s), widowhood, and the empty-nest stage. The common thread of these life stages is that such women were not perceived as housewives, the only respectable state for the Victorian and Edwardian lady. Instead, these dependent women had become redundant women. When these disreputable, although natural, life stages were coupled with mental illness, the double burden of dependency/redundancy left women especially vulnerable to institutionalization.

With this in mind, Homewood's case histories were examined for patients who were committed, not on the basis of extreme changes in behaviour or worsening of mental symptoms, but due to factors external to their mental state: the death of an important family member, for example, or the marriage of another. These factors resulted in the patients' loss of familial role or of a caregiver. Given the lack of economic opportunity and deficiency in education for women and the persistence of patriarchal family relations at the turn of the century, it should not be surprising that among Homewood's patients, socially redundant females outnumbered males by a ratio of five to one (see Table IV).

The permanently unmarried middle-class woman was the focus of much discussion and concern throughout the nineteenth century. In England, it was estimated that 15 per cent of women would reach their fifties without being married. Contemporary observers blamed the surplus of women upon war casualties, male emigration, and the tendency for Victorian middle-class men to postpone marriage until it was economically feasible. Modern demographers, however, have noted that the increase in female spinsterhood had actually been a product of the eighteenth century, and that the rate had remained fairly constant throughout the nineteenth. Increased urbanization, however, rendered the spinster population more visible.[36]

Nor did English Canada possess other institutional means of masking the existence of this group. In Catholic countries, taking the veil was an option pursued by many middle-class women until alternatives in employment existed. British writers like Mary Astell and Lady Mary Wortley Montagu "lamented the lack of the kind of association and professional outlet for the middle-class women in Protestant England that the convent bestowed on the continent."[37] In Canada, a similar schism between French and English cultures existed. In Quebec, Marta Danylewicz has noted that land scarcity,

35. Peter N. Stearns, "Old Women: Some Historical Observations," *Journal of Family History* 5:1 (Spring 1980): 53.
36. Mary S. Hartman, *Victorian Murderesses* (New York, 1977), 112.
37. Olwen Hufton, "Women Without Men: Widows and Spinsters in Britain and France in the Eighteenth Century," *Journal of Family History* 9:4 (Winter 1984): 371.

migration, and constricted economic opportunities had lowered the provincial marriage rate from nine per thousand in 1830 to 6.6 per thousand in 1880. Fully 33 per cent of women in Montreal were single at the age of forty in 1881. The convent absorbed many of these women. In 1881, 4.4 per cent of single females over twenty were nuns, while by 1921, 9.1 per cent had entered convents.[38] In the nation at large, the percentage of women who were single between the ages of forty-five and forty-nine rose from 8.2 in 1851 to 11.1 by 1921.[39] These figures envelop a great deal of personal suffering.

The plight of the spinster was seen by many observers, particularly female, as the glaring failure of respectable society to provide for members who had been bred to uphold middle-class culture. No gentle-born woman, it was understood, was ever completely safe from the possibility of economic hardship. Mary Agnes FitzGibbon, for example, was the niece of John A. Macdonald and the wife of a gentleman of titled family. When her husband was committed to an insane asylum, she became the sole support for herself and her daughter and took up journalism. In 1896, FitzGibbon described the redundant female as "the non-professional woman, usually the daughter of a professional man, and she is generally in every sense a 'gentlewoman'. . . . She has been brought up by her parents in a sort of haphazard way. The possibility of matrimony is a sort of mirage on the horizon. She is really fitted only to fill a niche in some household. . . ."[40] A "niche" does not evoke a position of power or permanency, but its lack could evoke contempt. London's *Saturday Review* graphically illustrated reified relations in its commentary: "Married life is a woman's profession, and to this life her training — that of dependence — is modelled. Of course, by not getting a husband, or losing him, she may find she is without resources. All that can be said of her is, she has failed in business and no social reform can prevent such failures."[41]

This narrowly conceived indictment failed to account for the patriarchal inequities, both societal and familial, that exacerbated the plight of the spinster and of all women alone. Limited job opportunities and gender-based wage differentials meant that single women faced many more economic hardships, and were less likely to be able to protect themselves financially in periods of unemployment or sickness, or in old age.[42] The only respectable employment open for middle-class women was that of governess or companion. To be in service in another middle-class home was often degrading as well as difficult and lonely work. Nor was it clear that the role of governess confirmed one's middle-class standing. Jeanne Peterson, for example, has concluded that the ambiguity of the governess's social status caused inconsistency and confusion in her relations with her employers and other servants, and this led to the high proportion of governesses in

38. Danylewicz, *Taking the Veil*, 52 and 17.
39. Ellen M. Gee, "Marriage in Nineteenth-Century Canada," *Canadian Review of Sociology and Anthropology* 19:3 (1982): 315.
40. Marilyn Barber, "The Gentlewomen of Queen Mary's Coronation Hostel," in *Not Just Pin Money*, eds. Barbara K. Latham and Roberta J. Pazdro (Victoria, B.C., 1984), 147.
41. R. Strachey, *The Cause: A Short History of the Women's Movement in Great Britain* (London, 1928, 1978), 92 as quoted in Margaret Stacey and Marion Price, *Women, Power and Politics* (London, 1981), 66.
42. Hufton, "Women Without Men," 358.

insane asylums.[43] Furthermore, what other options were there for these socially isolated women in middle-class society? The aristocratic practice of continued financial support for retired servants, to take another option, was a casualty of capitalism. Lengthy service "was much less the rule" in middle-class society "and paternalism was expensive."[44]

The exploitation of the governess was not limited to Britain, as illustrated by the case of Ella A. (#16, 1917), a twenty-seven-year-old single companion. Ella had experienced a "healthy infancy and childhood," was very fond of school, and attended a private academy until she was eighteen, studying painting, drawing, and music — all designed, that is, so that she could fill a specific social niche. Possessed of a "bright, cheerful temperament," Ella performed her household duties properly and "if anything was overconscientious." Seventeen months prior to commitment, she was employed as a companion to a rich lady whose husband was serving overseas and whose life was "social affairs." Ella was nominally the governess of a twelve-year-old, but her duties grew considerably; she "would rise at seven, get child ready for breakfast and breakfast at eight, devoted whole time to child or mother as she could manage servants, household, pack and unpack" for her mistress's many trips. Ella would be left in charge of the household for weeks at a time, and there were "employed servants of whom she was in fear. They indulged in booze. When the child was sick she was practically a professional nurse." Learning from an outsider that her health had exceedingly deteriorated, Ella's parents wrote her mistress asking that she be released. Her employer minimized the reports, and it was with "great difficulty" that consent was finally granted. Her parents were "greatly shocked at her appearance" and placed Ella in a general hospital. She weighed sixty-nine pounds and suffered "the greatest possible degree of emaciation."

Among Homewood's patients, social isolation frequently resulted from family strategies. Maintenance of a respectable lifestyle in Victorian middle-class society was often a difficult endeavour. Patricia Branca has estimated that model budgets allowed only 12 per cent of annual income for education costs, servant's wages, charities, and incidental expenses.[45] The placement of sons in businesses and professions was expensive and was likely to displace the daughter's rights for a proper education or a dowry. Even gainfully employed daughters who lived at home "committed a high proportion of their income to the family economy, underwriting not only their share of the family budget but also the education costs of their brothers."[46] It was also a common practice for families to keep one daughter home to care for a surviving parent in old age. This was accomplished by actively discouraging daughters from marriage and paid employment by convincing the youngest daughters from an early age that they were "too weak and/or infirm to consider marriage." In some cases, necessity ruled; only one child

43. M. Jeanne Peterson, "The Victorian Governess: Status Incongruence in Family and Society," in *Suffer and Be Still: Women in the Victorian Age*, ed. Martha Vicinus (Bloomington, 1972), 13.

44. Elaine Showalter, "Victorian Women and Insanity," in *Madhouses*, 317; Peterson, "Victorian Governess," 9.

45. Patricia Branca, *Silent Sisterhood: Middle Class Women in the Victorian Home* (London, 1975), 58, f. 22.

46. Danylewicz, *Taking the Veil*, 67.

survived to care for a widowed parent. In Daniel Scott Smith's study of older Americans, he found that in 1900 80 per cent of such children lived with their mothers.[47]

The girl at home began life "as the primary object of affection to many," and then "came by degrees to be first to none," as the ranks of significant others were depleted with the natural passage of time.[48] Many of these women found their way to Homewood. Mary A. (#3, 1916) was a thirty-seven-year-old whose mother had been an invalid most of her life. As "the oldest girl [Mary] has been the head of the house, directing all the domestic details, and at the same time devoting herself most assiduously and self-sacrificiously to her mother's care. Her early assumption of domestic responsibilities rendered her a very serious minded and careful girl." Mary had "no close associations at all among men" except her mother's doctors, and later her own. She complained of being "very nervous, very much run down [and] feeling weak." She was sent to hospital to have a "slight nasal operation," but her physician felt that there was "very little the matter with her and so told her. This upset her considerably and she began to lose confidence in him." Her subsequent "persecutory delusions" were in relation to her doctor. Mary was, however, "amenable" and "anxious to recover her health." When she was institutionalized, she deteriorated rapidly. She had to be force-fed and, between periods of improvement, became "restless, emotional and depressed." She was visited by her family twice in three years and was subsequently transferred to the public asylum in Verdun, Quebec.

Mary W. (#525, 1916), aged forty-nine, had acted as housekeeper for her mother in Dartmouth, N.S. Upon her mother's death, she had lived with her brother and his wife. She admitted "for sometime past her relationships in her brother's home have not been very cordial. She has been easily irritated, without cause, and that this has given rise to much unpleasantness in the home. Her brother eventually found out that the relationships between his wife and the patient were not good and he insisted upon her leaving the home and taking rooms." Mary decided to take up voluntary war work in England and her brother arranged the passage, but at the last moment she refused to go, and since that time became increasingly seclusive, depressed, and unable to sleep. She came to Homewood reluctantly, but signed a voluntary application "as she knows that it is her brother's desire that she place herself under sanitarium care." Mary showed improvement at Homewood, but her depression and homesickness worsened with the "inability to get her brother to set any definite date for his coming to take her home." She remained three years, until her brother transferred her to the public asylum in Montreal.

Social isolation and economic dependency due to life-course transitions were the experiences of many widows as well. In 1911, 3.4 per cent of male and 8.2 per cent of

47. Howard P. Chudacoff and Tamara K. Hareven, "From the Empty Nest to Family Dissolution: Life Course Transitions into Old Age," *Journal of Family History* 4:1 (Spring 1979): 82 and 73; Diana Gittins, "Marital Status, Work and Kinship, 1850-1930," in *Labour and Love*, 262; Smith, "Older Americans," 294.

48. Steven Mintz, *A Prison of Expectations: The Family in Victorian Culture* (New York, 1983), 165.

female Canadians over fifteen years were widowed.[49] With a declining birth rate, the likelihood of widows being childless rose, and this may have worsened their situation. As Smith has concluded, "a simplistic view of the conjugal family system might lead one to think that not marrying was the most obvious decision leading to an isolated old age. A conjugal family system is, after all, based on relationships established by marriage. Marriage did erode ties to kin of orientation, but in 1900 those who did not marry had not erased that linkage . . . . Childless widows, not spinsters, were the losers in the great gamble, marriage, of a conjugal family system."[50]

One big loser of this gamble was Margaret F. (#163, 1919), a seventy-seven-year-old childless widow. At the time of her husband's death, "considerable money was left to her and she and the stepson have looked after this jointly." Her stepson, who obviously believed the money should have been left to him, described Margaret as having "practically no education" and "no idea of the value of money." The two had a functional relationship, however, until a third party entered: Margaret's nephew. According to the nurse accompanying Margaret, the nephew had been trying to "confiscate" some of her funds, and it was ordered that he not be allowed to visit the patient. Margaret exhibited only very mild symptoms of senility and, given her financial resources, she could easily have been provided with home care. Her peremptory commitment to Homewood was probably related to the struggle for money in which she was caught. With Margaret safely ensconced in the institution, her stepson could have her declared insane by the court, and the family fortune would be protected. With no children or allies to look after her interests, Margaret was institutionalized, was never visited, and died six months after commitment.

Social redundancy and the increase in female commitment to asylums were a pattern apparent throughout North America and Great Britain. In Victorian England and Wales, applications to admit women to institutions had consistently outnumbered those for males. In 1871, the census revealed that, for every one thousand male lunatics, there were 1,182 females. By 1872, out of a total of 58,640 certified lunatics in England and Wales, 31,822 were women.[51] In her study of first admissions to the English York Retreat, the first private asylum, Anne Digby has determined that between 1796 and 1910, "women usually outnumbered men although the difference . . . showed a widening, if fluctuating, disparity." By 1910, 61.3 per cent of first admissions were female. Digby has concluded that "this trend reflected that in other mental institutions during our period. . . . The growing preponderance of female over male patients [after 1850] may well have been a response to contemporary psychiatry's stress on women's peculiar vulnerability to mental shipwreck." Another revealing York statistic was the marital status of first admissions; overall, single and widowed patients comprised 67.3 per cent and, of these, "women consistently outnumbered men among the single and the widowed."[52]

49. Alison Prentice et al, *Canadian Women: A History* (Toronto, 1988), 412.
50. Smith, "Older Americans," 292.
51. Showalter, "Victorian Women and Insanity," 315-16.
52. Digby, *Madness, Morality and Medicine*, 174-76.

Similar findings were uncovered in Nancy Tomes's study of the Pennsylvania Hospital for the Insane. "Whereas at the old eighteenth century hospital (c.1780-1830) men had outnumbered women by 70 to 30 per cent, at the new asylum (1841-1883), the sexes were divided more evenly, 55 to 45 per cent." The greatest shift was among single female patients who rose in numbers from 31 per cent prior to 1830 to between 40 and 43 per cent after 1840.[53] In Canada, the public system was based upon equal distribution of male and female beds so that sex differentials cannot be accurately determined. At Homewood, however, after an initial period of stagnation prior to 1900, the percentage of female admissions consistently grew and, in fact, was ultimately responsible for the retreat's success (see Table VIII).

If we dismiss the presumption, popularly believed by centuries of physicians, that women were more "prone" to insanity, we are left to conclude that they were in fact less powerful and more dispensable to the family economy. Young and Willmott have pinpointed this phenomenon to the nineteenth century: the growth of industrial society removed economic functions from the home without altering the authority of the head of the household. The economic contributions of women no longer matched their dependent status. Consequently the family became asymmetrical, with the power, authority, and economic resources concentrated in the hands of the master of the house.[54] The exercise of power within the family should be understood "not only as the circumstances in which the will of one person triumphs over that of another, but the circumstances in which the views, interests or wishes of one category or group [men] are normally given precedence, in which case there is no struggle or conflict, but rather superiority is taken for granted."[55] Such superiority would manifest itself in decisions crucial to the household, including the decision to commit.

The future of redundant women in the household, therefore, was dependent upon the good nature of the male head or upon his sense of moral obligation. That moral obligation may have been easily exhausted in the private, individualistic haven of the Victorian and Edwardian home, in which case the standards for tolerated behaviour correspondingly increased. As the diagnosis of neurasthenia demonstrated, mental symptoms requiring commitment were not only mania, suicidal depression, or violence. Consider the case of Fanny E. (#156, 1919) who lived with her sister's family for only ten days following surgery, and was committed for being "hysterical, irritable, ugly" and lacking in "affection" for her relatives, or Mary H. (#230, 1909), a widow who showed no appreciation for the "lovely home" her "kind and considerate" relatives had provided her. "On the contrary, she is always fretting and complaining and worrying about one thing or another, and making herself a constant source of annoyance and uneasiness on the part of her relatives."

53. Tomes, *A Generous Confidence*, 322.
54. Michael Young and Peter Willmott, *The Symmetrical Family* (New York, 1973), 31; see also Stephen Edgell, *Middle Class Couples: A Study of Segregation, Domination and Inequality in Marriage* (London, 1980), 69.
55. Jane Lewis, "Restructuring Women's Experience of Home and Family," in *Labour and Love*, 16.

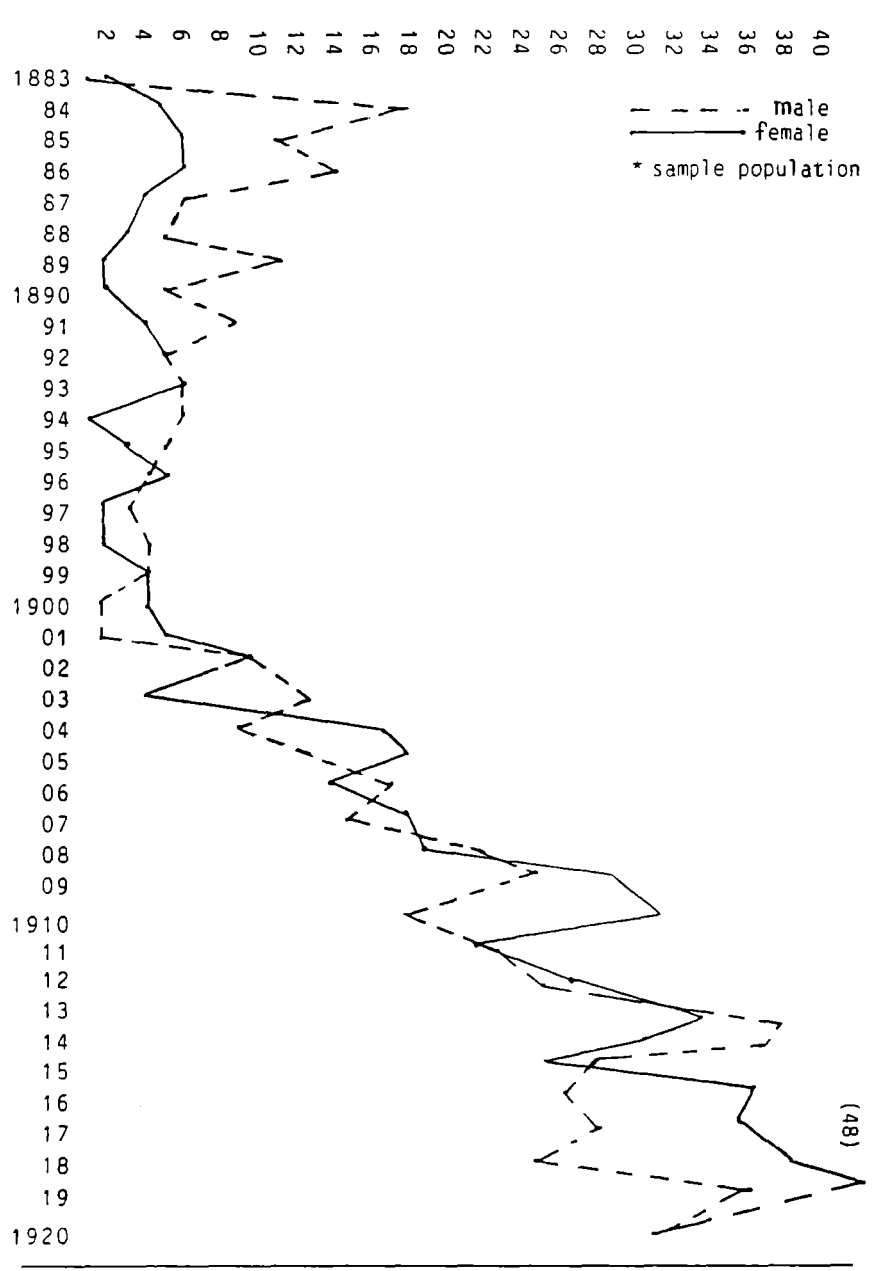

Table VIII
Annual Admissions, 1883-1920*

In none of these cases is the behaviour of the family portrayed in anything but the best possible light. In the case of Charles and Ida P. (#406, 1890), both parties displayed neurotic symptoms, but only one partner, Ida, was hospitalized, a demonstration of the family's power structure. Upon marriage, Charles uprooted Ida from her kin and settled her in a small Nebraska town, but their first year of marriage, Charles insisted, had been "perfectly happy." One month after their anniversary, Ida gave birth to twins, a daunting prospect in a pioneer setting. Charles recognized that "the work and care . . . of nursing and tending two delicate babes seemed to wear my dear, young wife down much" but he "looked to the future and hoped the little ones would more than repay us." Twenty-two months later, Ida gave birth to another child, and was therefore caring for three babies under two years of age. During this pregnancy, Ida was "irritable and nervous and worried much over the coming child and the addition to her already numerous and heavy cares." While her husband "was very sorry for her," she "would not believe that and at times talked very spitefully and unjustly to me about the matter." For his part, Charles admitted that he was "of a hasty temper" and "often lost patience with her." Her major, lasting delusion was the fear that she was pregnant for a third time. During this period, Charles threatened suicide several times, but was not committed. Ida's final breakdown occurred following an attack of influenza, an extremely debilitating illness at the turn of the century. In the midst of a bitter quarrel, Charles put his revolver to his head and threatened "to put myself beyond the reach of her accusations." Later that day, Ida became hysterical and did not eat or sleep for two days until she was sent back to her family. She was committed to Homewood when her sisters could no longer take the strain of caring for her. The dynamics of this tragic family have fascinating implications. Had the roles been reversed — had Charles, overburdened with work and physically debilitated, come home to a bad-tempered wife who repeatedly threatened suicide — Ida would still have been more likely to be committed.

It would appear, then, that the fear of wrongful confinement, like most generalized fears, had some kernel of truth behind it. While the cases of malevolent seizures of liberty were rare, the realities of the household in late Victorian and Edwardian middle-class society rendered certain elements — socially redundant women in particular — more susceptible to institutionalization than others. The reification of family relations increased the material and emotional costs of maintaining nonproductive members who were disruptive to family harmony. Few of these patients were prone to violence or destructive behaviour; rather, they were irritating, obnoxious, and aggravating, and the explosion of medical interest in the neuroses, or neurasthenia, facilitated popular acceptance of institutional care for these patients. The evidence would suggest that irritability was the luxury of the powerful in an individualistic age.